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Performance Audit Division

Performance Audit

Arizona Supreme Court

Administrative Office of the Courts—
Juvenile Detention Centers

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Debra K. Davenport
Auditor General

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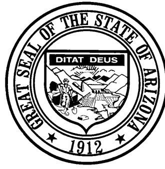

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November 29, 2007

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Transmitted herewith is a report of the Auditor General, a Performance Audit of the Arizona Supreme Court, Administrative Office of the Courts (AOC)—Juvenile Detention Centers. This report is in response to Arizona Revised Statutes (A.R.S.) §41-2958 and was conducted under the authority vested in the Auditor General by A.R.S. §41-1279.03. I am also transmitting with this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in their responses, the AOC, the Santa Cruz County Probation Department, the Mohave County Probation Department, the Maricopa County Juvenile Probation Department, and the Pima County Juvenile Court agree with the findings and plan to implement the recommendations specific to them. In addition, a response from the Coconino County Juvenile Court is included.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on November 30, 2007.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

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cc: The Honorable Ruth V. McGregor
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The Honorable Margaret McCullough
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The Honorable Eileen Willett
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Maricopa County Juvenile Court

The Honorable Richard Weiss
Presiding Juvenile Court Judge
Mohave County Juvenile Court

The Honorable Patricia Escher
Presiding Juvenile Court Judge
Pima County Juvenile Court

The Honorable Kimberly A. Corsaro
Presiding Juvenile Court Judge
Santa Cruz County Juvenile Court

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Supreme Court, Administrative Office of the Courts (AOC)—Juvenile Detention Centers pursuant to Arizona Revised Statutes (A.R.S.) §41-2958, which requires a review of the programs and commissions established by the Legislature within the judiciary. This audit was conducted under the authority vested in the Auditor General by A.R.S. §41-1279.03.

Juvenile detention centers provide temporary and safe custody of juveniles pending court disposition. Arizona has 14 such juvenile detention centers—two in Maricopa County and one each in 12 other counties. Greenlee and La Paz Counties have agreements to use juvenile detention centers in adjacent counties. More than 12,000 juveniles were detained in these juvenile detention centers at some point during fiscal year 2006. The presiding judge of the juvenile court is statutorily responsible for the supervision of the detention center. However, the centers are primarily funded and operated by their respective counties. The Supreme Court has administrative authority over all courts and court programs, including juvenile detention centers. The AOC assists the Supreme Court with its administrative responsibilities. Since 1998, the State has contributed more than $20 million in juvenile detention center construction or renovation funding. Juvenile detention centers offer various services to detained juveniles, including education, healthcare services, nutrition, recreation, and visits from family.

Review of operations shows opportunities for improvement (see pages 11 through 30)

Auditors' review of operations at five juvenile detention centers disclosed wide variation in the degree to which adequate safety, security, and other practices were in place as compared to state operational guidelines, national standards, best practices, and the juvenile detention centers themselves. Auditors selected five juvenile detention centers to represent centers of different population sizes, location, age, and population composition. Auditors then reviewed these five juvenile detention centers across selected operations in the areas of safety and security, healthcare, behavior management, and staffing and training. Three of the juvenile

detention centers—Coconino County, Pima County, and Maricopa County's Durango center (Maricopa-Durango)—operated adequately in virtually all aspects of operations reviewed. The two other juvenile detention centers—Mohave County and Santa Cruz County—need to improve in many areas. In all, auditors have identified more than 20 recommendations in this report for improvements at these two juvenile detention centers. Examples of problems identified at one or both of these juvenile detention centers included the following:

- **Safety and security:** Control rooms were not fully secure, procedures for careful control of keys were inadequate, and perimeter areas that could not be monitored by cameras were not periodically inspected.

- **Healthcare:** Staff not trained by healthcare providers conducted health screenings and administered medications, access to prescription medications was not sufficiently limited, and suicide screening and monitoring needed improvement.

- **Behavior management:** Better procedures are needed for evaluating juvenile behavior, limiting the use of isolation, and restricting the use of mechanical restraints.

- **Staffing:** Both juvenile detention centers struggled to maintain adequate staffing because of staffing shortages. As a result, both juvenile detention centers have resorted to locking some juveniles in their rooms because of staffing shortages. For example, the Santa Cruz County center sometimes conducts school in shifts with half the juveniles in school and the other half locked in their rooms. A recent report from the AOC cited a shortage of staff as a contributing factor to escapes from the Mohave County juvenile detention center in October 2006.

Although the areas for improvement centered on these two juvenile detention centers, auditors also identified some problems at the Maricopa-Durango and Pima County centers. Most notably, the Maricopa-Durango center was concerned about its ability to comply with federal and state laws that call for keeping juveniles separated, by sight and sound, from adult inmates. In addition, the Pima County center should determine if external blind spots at the center pose a security risk and, if so, take steps to routinely monitor them.

State-wide effort needed to improve operating standards (see pages 31 through 40)

The Supreme Court and the AOC have an opportunity to make practices such as those discussed in Finding 1 more uniform across centers by strengthening

operational guidelines. Arizona's *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona* (Guidelines), developed by an advisory committee in 1998, contain minimum guidelines for juvenile detention center operations. These minimum guidelines are detailed in some areas, but vague in others. As a result, a juvenile detention center can technically comply with the Guidelines, but not necessarily guarantee a safe environment for juveniles and staff. For example, one guideline recommends that juvenile detention centers establish policies and procedures regarding control of keys. However, this guideline provides no further direction, and as a result, a facility can comply with the guideline simply by having a policy and/or procedure that may or may not provide adequate detail about appropriate practices. The Supreme Court does not mandate that the juvenile detention centers comply with the Guidelines, but instead encourages them to voluntarily comply.

Standards that are more rigorous and that carry a compliance requirement can help eliminate the types of disparities that auditors identified, and also are in keeping with practices used in other states.[1] Auditors obtained information from nine other states in which the judicial branch operates or oversees juvenile detention centers and found that eight had mandatory standards. In March 2007, the AOC began an effort to review the Guidelines to determine which ones addressed constitutional or statutory requirements. This review could serve as a springboard for the Arizona Judicial Council to direct the AOC to work with the county juvenile courts to identify and/or develop and implement mandatory operational standards. Doing so should involve reviewing and improving current guidelines to ensure they provide adequate direction and detail to juvenile detention centers, and adopting new standards where appropriate. The standards should include sufficient detail and information to provide juvenile detention centers with the guidance they will need to establish conforming policies, procedures, and practices.

The Arizona Judicial Council assists the Supreme Court and the chief justice in the development and implementation of policies and procedures for the administration of all courts. For example, it studies the internal operation of the courts and plans for future developments. It also promotes improvements and responds to issues concerning judicial administration by reviewing and recommending for adoption by the chief justice proposed administrative orders, code sections, rules, and policies.

Once such standards are developed, the AOC would need to take several steps to help juvenile detention centers implement them. These include providing training and technical assistance to appropriate county juvenile court and juvenile detention center staff on the mandatory standards, assisting county juvenile court staff in obtaining additional resources from their respective boards of supervisors if needed, and identifying additional resources, such as best practices and tools used by some juvenile detention centers, to share with other juvenile detention centers to help comply with the operational standards.

Revised standards should also be used to increase accountability and provide critical information to improve juvenile detention center operations. Standards that help to provide accountability and data for decision making are sometimes referred to as performance-based standards. These types of standards can be linked to

1 California, Connecticut, Illinois, Indiana, MIssouri, North Dakota, Texas, and Virginia have operational standards that their juvenile detention centers are required to meet. Utah enforces compliance with juvenile detention center policy and procedures.

goals, have objective measurements of performance, communicate expected or best practices, and require the implementation of processes to document operations. Coconino, Graham, and Pima Counties' juvenile detention centers have used some form of performance-based standards already within their juvenile detention centers. Further, implementing state-wide, performance-based standards for juvenile detention centers would be consistent with the Supreme Court's goal to ensure accountability in the courts.

Supreme Court should improve juvenile detention center screening (see pages 41 through 45)

The Supreme Court should help ensure that only appropriate juveniles are detained by developing and implementing policies and/or standards to assist county juvenile courts in making this determination. Juvenile detention centers use various tools to make this determination, possibly resulting in inconsistent decisions from county to county. Auditors' review of studies on juvenile detention centers identified some potential risks of detaining juveniles. Reports indicated, for example, that juveniles may be at a higher risk of death by suicide or illness when in the custody population and that detaining juveniles may widen the gulf between juveniles and the potential positive influences of the community. Additionally, according to Supreme Court data, Hispanic and African-American youth are disproportionately detained in relation to their population proportion. Detention may also be used inappropriately to house juveniles who are mentally ill.

Under the direction of the Arizona Judicial Council, the AOC should work with the county juvenile courts to develop and implement policies, procedures, and/or standards to assist in appropriately and consistently screening juveniles for detention. These policies and/or standards should also recognize legitimate county-level concerns regarding the safety of the juveniles and the community within their jurisdiction. To help ensure that there are viable alternatives to detention, the AOC and counties should continue with their efforts to identify and use detention alternatives. According to a U.S. Office of Juvenile Justice and Delinquency Prevention report, alternatives to detention are typically more cost-effective and can be less harmful than detaining a juvenile in detention.[1] According to the Pima County juvenile court director, redirecting juveniles from detention into alternative programs has proven cost-effective for Pima County. Specifically, Pima County reported that it has reduced its average daily juvenile population in detention by 49 juveniles, dropping from an average daily population of 176 juveniles in 2003 to 127 in 2006, which has resulted in cost savings. The Supreme Court and the AOC, through their management of federal funding and their own Juvenile Probation Services Fund, have been able to redirect monies to counties to fund alternatives to detention and should continue to do so by continuing to request funding for the use of effective alternatives to detention.

[1] Austin, James, Kelly Dedel Johnson, and Ronald Weitzer. *Alternatives to the Secure Detention and Confinement of Juvenile Offenders*. Juvenile Justice Bulletin. Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Sept. 2005.

Supreme Court should improve juvenile detention center inspection program (see pages 47 through 56)

To help ensure that juvenile detention centers provide a safe and secure environment for detained juveniles, the Supreme Court, through the AOC, should take the lead in developing a more comprehensive juvenile detention center inspection program. Traditionally, state inspections of these juvenile detention centers have been done primarily by the Arizona Department of Juvenile Corrections (Juvenile Corrections), with the AOC also conducting its own inspections in recent years. Inspections done by the AOC and Juvenile Corrections are somewhat limited, as each inspection reviews for compliance with an average of only 3 of the 74 existing guidelines, and there is no enforcement of resulting recommendations. Auditors' review of inspection reports found that in some cases, findings and corresponding recommendations are noted in reports for 4 consecutive years with no indication of compliance by the juvenile detention center.

For several reasons, the Supreme Court, through the AOC, would be better suited than Juvenile Corrections to develop and implement a comprehensive juvenile detention center inspection program. First, although Juvenile Corrections has the statutory responsibility to inspect juvenile detention centers, it does not have statutory authority to enforce its recommendations. The Supreme Court and the AOC are in a better position to work with the juvenile court's presiding judges and juvenile court directors to achieve compliance. Second, when inspections were originally established, the Supreme Court lacked the capability and clear authority to conduct them. According to the AOC's Director, at that time, superior courts were considered county courts and the AOC was not involved with the county courts until subsequent lawsuits determined that court employees are state employees. However, the AOC has increased its level of involvement with juvenile detention centers from a state-wide perspective, such as facilitating the effort to establish operational guidelines. Inspecting juvenile detention centers would be consistent with these types of efforts. Finally, the Director of Juvenile Corrections has indicated that Juvenile Corrections has focused on its own facilities because of federal monitoring that resulted from serious safety and security issues. Although this federal monitoring was completed in September 2007, Juvenile Corrections now must establish internal processes to prevent these issues from reoccurring in its facilities in the future.

Therefore, the Legislature should consider revising statute to replace Juvenile Corrections with the AOC as the entity responsible for inspecting juvenile detention centers. If it is given this responsibility, the AOC should develop and implement a comprehensive juvenile detention center inspection program. Finally, the AOC should review its staff resources and assess whether it has sufficient staff to properly implement and maintain an improved inspection program. If additional staff resources are needed, the AOC should review several options, including shifting internal staff resources or working with the county juvenile courts and/or the Legislature to obtain needed staff resources.

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INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Supreme Court, Administrative Office of the Courts (AOC)—Juvenile Detention Centers pursuant to Arizona Revised Statutes (A.R.S.) §41-2958, which requires a review of the programs and commissions established by the Legislature within the judiciary. This audit was conducted under the authority vested in the Auditor General by A.R.S. §41-1279.03.

Delinquent act—An act that, when committed by an adult, is illegal.

Incorrigible behavior—Also called status offenses, these are offenses, such as truancy from school or violating curfew, that are not crimes if committed by adults. According to the federal Juvenile Justice and Delinquency Prevention Act, status offenders should not be held in detention.

Source: Auditor General staff summary of information in the AOC's *Juveniles Processed in the Arizona Court System: FY2006* report and the Arizona Juvenile Justice Commission *2006 Annual Report.*

Juvenile justice and detention in Arizona

When juveniles commit delinquent acts or demonstrate incorrigible behavior, police, parents, school officials, or probation officers may refer them to juvenile court. Upon referral, a probation or detention officer will initially determine whether to detain a juvenile in a juvenile detention center based on various factors, including the seriousness of the act, the existence of a warrant, and/or whether the juvenile violated probation. According to the AOC, in fiscal year 2006, 48,395 juveniles were referred to juvenile court in Arizona. Although 12,068 of these juveniles were detained in juvenile detention centers, only 7,774 were detained as the result of a referral. The rest were detained as the result of court holds, warrants, as consequences of probation, or for another jurisdiction. Table 1 (see page 2) shows demographic information about juveniles in detention centers during fiscal year 2006.

Arizona Juvenile Court Rule 23

A juvenile should be detained in a juvenile detention center only if there is probable cause to believe:

- The juvenile would not be present for any hearing;
- The juvenile is likely to commit an offense that injures himself or herself or others;
- The juvenile must be held for another jurisdiction;
- The interests of the juvenile or public require custodial protection; or
- The juvenile is charged with an offense that may be prosecuted in adult criminal court.

Source: Auditor General staff summary of Arizona Juvenile Court Rule of Procedures 23(D).

Once referred, the county attorney must decide whether to file a petition in juvenile court alleging that the referred juvenile is a delinquent and requesting the court to assume jurisdiction over the juvenile. If the juvenile has been detained in a juvenile detention center, the county attorney must file this petition within 24 hours of the juvenile's admission to detention. Arizona Juvenile Court Rules of Procedure 23 provides guidance on when to hold a juvenile in detention (see textbox above for specific guidelines).[1] Once the county attorney files a petition, hearings are held to determine whether to keep the

[1] The Supreme Court adopts rules to direct procedural matters for all courts in the State.

Table 1: Demographics of Juveniles In Arizona Juvenile Detention Centers Fiscal Year 2006

	Number of Juveniles Detained
Gender	
Male	9,068
Female	3,000
Total	12,068
Age	
8-13	1,144
14-15	3,832
16-17	7,041
Unknown	51
Total	12,068
Ethnicity	
Hispanic	5,293
Anglo	4,554
African-American	1,201
Native American	860
Asian or Pacific Islander	44
Other	87
Unknown	29
Total	12,068

Source: Auditor General staff summary of data obtained from the AOC's *Juveniles Processed in the Arizona Court System: FY2006.*

juvenile in detention (or place the juvenile in detention if not there already), dismiss the petition, or transfer the juvenile to adult court. Juveniles cannot be held in detention more than 24 hours after a petition is filed without a hearing. If the case is kept in juvenile court and not dismissed, it proceeds to adjudication, which is similar to a trial in adult court, but without a jury.

Juvenile detention provides for the temporary and safe custody of juveniles pending court disposition. The federal Juvenile Justice and Delinquency Prevention Act and A.R.S. §8-305(C)(1) require that juveniles be kept separated from adult inmates. Juvenile detention centers also provide a wide range of services that support the juvenile's physical, emotional, and social development, including education, visitation, communication, counseling, continuous supervision, medical and healthcare services, nutrition, recreation, and reading.

As shown in Table 2 (see page 3), Arizona has 14 juvenile detention centers located in 13 different Arizona counties. A.R.S. §8-305 requires counties to maintain a juvenile detention center that is separate from adult jail or to enter into an agreement with other public or private entities to provide a juvenile detention center. Maricopa County has two juvenile detention centers, 12 counties have one center, and two counties—Greenlee and La Paz—have none. Greenlee County has an agreement with Graham County to house its detained juveniles for a lump sum of $175,000 per year, amounting to $146 per day per juvenile in fiscal year 2007. La Paz County pays Yuma County $80 per day for each day that a juvenile is detained in its facility. In addition, Graham County has an agreement with the Federal Bureau of Prisons to hold federal juvenile offenders from around the country. Some juvenile detention centers set aside beds to use as part of court-ordered treatment programs. Both Mohave and Yavapai Counties have such programs in their facilities.

The juvenile detention centers are part of the superior court in each county, and the presiding juvenile court judge in the county supervises the juvenile detention center and appoints people to administer its operations. Although the Supreme Court has administrative authority over all superior courts, detention oversight has traditionally rested with the presiding juvenile court judge. This is consistent with statute that specifies that the presiding juvenile court judge shall supervise the juvenile detention center and appoint staff to administer its operations. The county board of supervisors authorizes and funds detention centers and staff. The AOC assists by providing training and technical assistance.

Table 2 lists the 14 juvenile detention centers in the State, the year constructed or last renovated, the total number of beds, and the average daily population for fiscal year 2007. The functional capacity of a juvenile detention center might be lower than the total number of beds in the center for several reasons. For example, some facilities do not have enough staff to supervise all the juveniles that a juvenile detention center could house, or some of their beds may be set aside because of special programs or agreements with other entities.

Table 2: Arizona Juvenile Detention Centers' Construction Dates, Total Beds, and Average Daily Populations

County	Year Built or Last Renovated	Total Beds	Average Daily Population (FY 2007)
Pima	2000	265	123.6
Maricopa (Durango)	2005	222	398.2[1]
Maricopa (Southeast)	2004	184	
Pinal	2007	96	38.3
Yuma	2002	80	51.6[2]
Yavapai	1997	57	33.2
Graham	2000	48	15.0[3]
Mohave	1999	45	27.3
Navajo	2005	42	12.9
Coconino	2001	40	20.6
Cochise	2001	40	20.4
Gila	2000	26	20.1
Santa Cruz	2000	19	14.9
Apache	2002	13	5.3

1 Combined average for both Maricopa County detention centers.
2 Combined average for both Yuma and La Paz Counties.
3 Combined average for both Graham and Greenlee Counties.

Source: Auditor General staff summary of information supplied by county detention and court administrators and the AOC.

Detention center services

Arizona's juvenile detention centers provide the following services to juveniles:

- **Education**—A.R.S. §15-913 requires each juvenile detention center to offer an education program to serve all school-age juveniles in the center. Typically, the county school superintendents are responsible for implementing education programs within their counties' juvenile detention centers. The North Central Association Commission on Accreditation and School Improvement and the Commission on International and Trans-Regional Accreditation, an alliance of American educational accrediting agencies, accredited all of the juvenile detention center schools, except those in Maricopa County, in December 2006. The Maricopa County Regional School District, which operates the two juvenile detention schools in Maricopa County, did not participate in the accreditation process with the other detention schools. However, they are working with the AOC to complete the accreditation process. This accreditation allows juveniles to transfer credits earned while in detention to similarly accredited schools when released.

- **Health services**—Most of the State's juvenile detention centers offer on-site medical care to juveniles. This can vary from a nurse available for a few hours a day to a registered nurse who is available 24 hours a day. Those juvenile detention centers that do not provide on-site medical care transport juveniles off-site to a clinic or hospital to receive care.

- **Food services**—Juvenile detention centers provide meals to detained juveniles, either by having their own staff prepare meals, through a private contractor, or through agreements with the county sheriff. According to detention administrators, 10 of the 14 juvenile detention centers in the State participate in the United States Department of Agriculture's School Lunch Program and, therefore, must meet prescribed nutritional standards. The juvenile detention centers in Apache, Gila, Navajo, and Santa Cruz Counties do not participate in the national school lunch program. According to the Navajo and Apache detention administrators, they do not participate in the program because of extensive oversight requirements for participation. According to the Gila County detention administrator, the Gila County juvenile detention center usually participates, but it is temporarily not enrolled because of problems getting the required contract from the food service provider. The Santa Cruz County detention administrator said that the juvenile detention center has filed paperwork with the county board of supervisors and is awaiting its response.

- **Recreation**—According to the *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona* (Guidelines), juveniles should receive at least 1 hour of exercise and 1 hour of leisure time each day. The exercise time is supposed to be outside unless the detention administrator approves holding the exercise elsewhere. According to AOC staff, all 14 juvenile detention centers have an outdoor recreation yard.

- **Visitation**—Juvenile Court Rule 23 requires juvenile detention centers to allow parents, guardians, custodians, or legal counsel to visit a juvenile upon admission to a juvenile detention center. Further, juvenile detention centers must make provisions for regular visits. Juvenile detention centers vary in how often and when they allow juveniles to have visitors, ranging from twice a week to daily. Additionally, some juvenile detention centers use the potential for extra visits as an incentive for well-behaved juveniles.

State assistance

The AOC, on behalf of the Supreme Court, provides the following forms of assistance to juvenile detention centers:

- **Coordination of education funding**—According to AOC staff, the AOC performs several activities to coordinate education funding for juvenile detention centers. Specifically, the AOC applies to the Arizona Department of Education (Department) for federal and state education grant funds used to supplement detention education services in each juvenile detention center. The AOC then enters into intergovernmental agreements with the county school superintendent and the presiding juvenile court judge to define each party's responsibility in developing detention education programs and using funds appropriately. In addition, the AOC provides data on the number of detained

students to the Department to determine the amount of education funds that are allocated according to state statutes. The Department then uses this student population data to obtain federal funds to provide support in educating juveniles in detention who are at risk for educational failure and for special education funds.

- Training—The AOC provides various trainings to juvenile detention center personnel. The AOC holds two multi-day detention officer training academies each year that cover such topics as mental health issues and direct supervision of juveniles. In addition, the AOC produced several 1- to 2-hour, computer-based training programs that discuss issues of liability, ethics, and juveniles with special needs that it provides to juvenile detention centers to assist in training. The AOC also reports providing a trainer certification program and other trainings during topic-specific training sessions and conferences.

- Monitoring—As discussed in Finding 4 (see pages 47 through 56), both the AOC and the Arizona Department of Juvenile Corrections (Juvenile Corrections) inspect juvenile detention centers.

- Technical assistance—The AOC reviews juvenile detention center policies, procedures, programs, and services and conducts manpower surveys. The AOC reports that this assistance was often provided at the county's request to help the centers make budget or funding requests to their county boards of supervisors.

Staffing and budget

The county boards of supervisors provide funding, including funding for staff, for their own juvenile detention centers. The funding appropriated to operate these facilities varies widely, depending on the juvenile detention center's size and population. For example, in fiscal year 2007, Maricopa County spent more than $33 million to operate two juvenile detention centers with 406 total beds, whereas Santa Cruz County spent just over $900,000 to operate a facility with 19 total beds. Staffing at these facilities also varies widely. For example, the Maricopa-Durango center had 200 FTE positions for detention officers, and 192 of these positions were filled as of July 20, 2007. This does not include juvenile probation officers, support and administrative staff, and medical and psychological staff. In comparison, the Santa Cruz County center had 13 FTE detention officer positions, of which 12.5 were filled as of July 20, 2007.

As shown in Table 3 (see page 6), for fiscal years 1998 through 2001, the Legislature appropriated a total of over $20 million to the State Aid to Detention Fund (Fund) to help fund the construction of new juvenile detention centers and to expand or renovate existing juvenile detention centers. This appropriation was supplemented with interest accrued to the Fund, resulting in a total of more than $22 million that was available to the counties to either construct or renovate juvenile detention centers. The Fund was designed to supplement monies from the counties, and in order to

Table 3: State Aid to Detention Fund Revenues, Expenditures, and Changes in Fund Balances
Fiscal Years 1998 through 2007
(Unaudited)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Revenues										
State appropriations	$5,451,300	$6,600,000	$ 5,600,000	$2,500,000						
Interest	140,403	568,622	517,173	542,176	$ 191,957	$ 21,901	$ 9,320	$ 8,343	$ 7,935	$ 6,660
Total revenue	5,591,703	7,168,622	6,117,173	3,042,176	191,957	21,901	9,320	8,343	7,935	6,660
Expenditures										
Aid to counties	112,500	2,676,498	5,071,410	7,017,081	5,832,575	508,404		84,944		6,500
Personal services and employee-related							35,873	37,587	39,470	
Professional services							34,252	62,550	20,570	38,236
Travel						2,475	584	1,794	2,424	143
Other operating							384	3,124	47,697	9,491
Total expenditures	112,500	2,676,498	5,071,410	7,017,081	5,832,575	510,879	71,093	189,999	110,161	54,370
Operating transfers out						400,000				
Total expenditures and operating transfers out	112,500	2,676,498	5,071,410	7,017,081	5,832,575	910,879	71,093	189,999	110,161	54,370
Net change in fund balances	5,479,203	4,492,124	1,045,763	(3,974,905)	(5,640,618)	(888,978)	(61,773)	(181,656)	(102,226)	(47,710)
Fund balance, beginning of year	0	5,479,203	9,971,327	11,017,090	7,042,185	1,401,567	512,589	450,816	269,160	166,934
Fund balance, end of year	$5,479,203	$9,971,327	$11,017,090	$ 7,042,185	$1,401,567	$ 512,589	$450,816	$269,160	$166,934	$119,224

Source: Auditor General staff analysis of Arizona Financial Information System (AFIS) Revenues and Expenditures by Fund, Program, Organization, and Object and Trial Balance by Fund for fiscal years 1998 through 2006, and AFIS Management Information System reports for fiscal year 2007.

qualify for funding, counties had to contribute a substantial amount in the form of cash or in-kind contributions. In all, $21.3 million was given out as aid to counties. All of the counties that received state monies used them either to build new juvenile detention centers or to expand or renovate existing ones. Some recent projects have been planned or built without any of these monies. For example, Pinal County constructed a new juvenile detention center in 2007, and Santa Cruz County is planning the construction of a new juvenile detention center that is scheduled for completion in 2010, both using county monies. Santa Cruz County's new juvenile detention center will house 32 juveniles with an estimated $7.9 million construction budget. With the construction of the Santa Cruz County juvenile detention center, Yavapai County will be the only county in the State that has not built a new center since 1999.

The AOC has used the remaining monies to help counties purchase some additional equipment or supplies for the juvenile detention centers and to help fund the training and technical assistance it provides to the counties.

Scope and methodology

This performance audit focused on the operations of five juvenile detention centers in Arizona, the guidelines for detention center operations, processes for screening juveniles for detention, and the AOC's and Juvenile Corrections' processes for inspecting juvenile detention centers. This report presents the following findings and recommendations:

- Although three of the five reviewed juvenile detention centers generally maintain adequate operations in the areas reviewed by auditors, two juvenile detention centers should improve various operational areas, including security, behavior management, healthcare, and staffing.
- Under the direction of the Arizona Judicial Council, the AOC should work with the county juvenile courts to develop, implement, and mandate compliance with operational standards for juvenile detention centers, including some standards that are linked to goals and outcome measures where appropriate.
- Under the direction of the Arizona Judicial Council, the AOC should work with the county juvenile courts to develop and implement policies, procedures and/or standards for appropriately and consistently screening juveniles for detention, while also recognizing legitimate county-level concerns regarding the safety of the juveniles and the community.
- The Legislature should consider revising statute to replace Juvenile Corrections with the AOC as the entity responsible for inspecting juvenile detention centers. If it receives this statutory responsibility, the AOC should develop and implement a comprehensive juvenile detention center inspection program.

Auditors used various methods to study the issues addressed in this report. These methods included interviewing AOC, juvenile court, and county juvenile detention center administrators and staff; and reviewing statutes, court rules and administrative orders, the *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona,* all AOC inspection reports for 2005 and 2006, all Juvenile Corrections inspection reports from 2006, and selected other AOC and Juvenile Corrections inspection reports from 2002 through 2004 and 2007. Auditors also used the following specific methods:

- To assess the State's juvenile detention center operations, auditors selected a sample of 5 of the 14 juvenile detention centers for in-depth review. These centers included the Coconino County, Maricopa-Durango, Mohave County, Pima County, and Santa Cruz County juvenile detention centers. See Appendix A, pages a-i through a-iv, for a detailed discussion of the method that auditors used to select the 5 juvenile detention centers for review, the specific operations reviewed at these juvenile detention centers, and the activities auditors performed to assess the juvenile detention centers.

- To assess the use and application of the juvenile detention center operational guidelines, auditors interviewed representatives of and/or national experts from the National Center for Juvenile Justice, National Council of Juvenile and Family Court Judges, National Partnership for Juvenile Services, Council of Juvenile Correctional Administrators (CJCA), and the American Correctional Association (ACA). Auditors also reviewed literature to identify best practices for detention, including appropriate operational standards for detention centers, such as standards advocated by the National Commission on Correctional Health Care and ACA. (See Appendix B, pages a-v through a-x, for more information on the various national experts interviewed and literature reviewed.) Additionally, auditors reviewed the Coconino County juvenile detention center's performance-based standards, and based on these standards, created a model of a performance-based standard overlaid on the CJCA's performance-based standards structure. Lastly, auditors interviewed juvenile detention center officials and reviewed juvenile detention center guidelines or standards from the following nine states: California, Connecticut, Illinois, Indiana, Missouri, North Dakota, Texas, Utah, and Virginia.[1]

- To assess the processes that counties use to determine whether juveniles should be detained, auditors interviewed representatives and/or national experts from the National Center for Juvenile Justice, National Council of Juvenile and Family Court Judges, and the CJCA. Auditors also reviewed literature to identify best practices for detention, including literature on uses of detention, screening juveniles for detention, and using alternatives to detention (See Appendix B,

[1] Auditors obtained information from nine states: California, Connecticut, Illinois, Indiana, Missouri, North Dakota, Texas, Utah, and Virginia. With the exception of Utah, these states were selected because their respective judiciaries operate or monitor juvenile detention centers. Auditors contacted Utah to obtain information regarding the use of juvenile detention center operational standards where the juvenile detention center is operated by a single state executive agency.

pages a-v through a-x, for more information on the various national experts interviewed and literature reviewed.) Additionally, auditors reviewed Pima County juvenile detention center's validated screening instrument, the Supreme Court's funding of alternatives to detention, and information from Pima County regarding detention expenses versus the costs for alternatives to detention.

- To evaluate the AOC's and Juvenile Corrections' processes for inspecting juvenile detention centers, auditors observed two AOC and two Juvenile Corrections inspections of two juvenile detention centers in May 2007, reviewed the resulting inspection reports in addition to reviewing other reports as previously listed, and interviewed AOC and Juvenile Corrections directors, program administrators, inspectors, and county detention administrators. In addition, auditors interviewed administrators of juvenile detention center monitoring agencies in seven states for an overview of their juvenile detention inspection process.[1]

- To develop information for the Introduction and Background, auditors reviewed information contained in the AOC's *Juveniles Processed in the Arizona Court System: FY2006* report, summarized information from the Arizona Financial Information System for fiscal years 1998 through 2007, and compiled unaudited information from each county juvenile detention center on the age and size of their juvenile detention center and who provides educational and food services.

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Chief Justice of the Arizona Supreme Court; the AOC director and staff; the presiding juvenile court judges, juvenile court directors, detention center administrators, and juvenile detention center staff at all of the juvenile detention centers visited by auditors; and the Juvenile Corrections director and staff for their cooperation and assistance throughout the audit.

1 The seven states contacted regarding juvenile detention center monitoring were Connecticut, Illinois, Indiana, Illinois, Missouri, Utah, and Virginia.

FINDING 1

Review of operations shows opportunities for improvement

Auditors' review of operations at five juvenile detention centers disclosed wide variation in the degree to which adequate safety, security, and other practices were in place relative to state operational guidelines, national standards, best practices, and the juvenile detention centers themselves. Auditors selected 5 of the 14 juvenile detention centers in the State for a review of selected operational areas. This review found that the Coconino County, Maricopa-Durango, and Pima County centers generally employ adequate safety and security measures, provide sufficient healthcare services, implement incentive-based behavior management systems, maintain adequate staffing levels, and provide staff training that helps ensure the welfare of juveniles under their care. In contrast, the juvenile detention centers in Santa Cruz and Mohave Counties face challenges in several of these areas that, if left unaddressed, place these juvenile detention centers, their personnel, and juveniles entrusted to their care at increased risk for potential harm.

Review focused on a cross-section of juvenile detention centers and guidelines

To review juvenile detention center operations, auditors selected the following five centers: Coconino County, Maricopa-Durango, Mohave County, Pima County, and Santa Cruz County. These juvenile detention centers represent a mix of urban and rural centers that serve different-sized juvenile populations and have varying levels of access to resources. Auditors then used a combination of national standards, best practices, the state operational guidelines, and practices in place at the juvenile detention centers as a basis to review selected operations at these five juvenile detention centers. In particular, the state operational guidelines establish minimum guidance and serve as the philosophical foundation for delivering quality, secure care services, and were developed by various state, county, and community stakeholders in 1998. These 74 guidelines draw heavily from the American Correctional

The state operational guidelines establish minimum guidance and serve as the philosophical foundation for delivering quality, secure care services.

Association's *Standards for Small Juvenile Detention Facilities*, as well as several other national organizations that provided support and documentation for the development of the guidelines.[1] Auditors reviewed 18 of these guidelines in the general categories of safety and security, healthcare services, behavior management, and staffing and training, and reported on 13 of them deemed most representative of these general categories.[2]

Some safety and security practices need improvement

As illustrated in Table 4, although the Coconino County, Maricopa-Durango, and Pima County juvenile detention centers had effective safety and security practices in most or all respects, the Mohave County and Santa Cruz County juvenile detention centers did not fare as well. Additionally, Maricopa County should continue with its efforts to address a situation at its Durango center where, contrary to federal and state laws, juvenile detainees are at times exposed to adult inmates being brought to the juvenile court building to attend dependency hearings.

Table 4: Analysis of Safety and Security Measures at Juvenile Detention Centers
As of August 2007

Safety and Security Measures	Juvenile Detention Center				
	Coconino	Maricopa	Mohave	Pima	Santa Cruz
Control Room: Ensures safe movement of juveniles and staff and monitors daily activities					
• Fully enclosed to protect detention personnel and ensure security	✓	✓		✓	✓
• Locked to protect detention personnel and safeguard security	✓	✓	✓	✓	✓
• Entry restricted to authorized personnel only	✓	✓		✓	
Key Control: How keys are issued, tracked, and stored					
• Control room and exterior keys <u>not</u> given to detention personnel who work directly with juveniles	✓	✓		✓	
• All keys are inventoried at the end of every shift	✓	✓	✓	✓	
Perimeter Security: Steps taken to ensure security and integrity of center					
• Detention personnel visually inspect center perimeter daily	✓		✓		
• Camera surveillance allows detention personnel a broad range of facility views	✓	✓	✓	✓	✓
• Direct periodic visual inspection of blind spots by staff to ensure area security	✓		✓		

Source: Auditor General staff summary of *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona (1998)*, observations, interviews with juvenile detention center management and staff, and reviews of juvenile detention center policy and procedure manuals and documentation.

1 American Correctional Association. *Standards for Small Juvenile Detention Facilities*. Springfield, VA: Goodway Graphics, 1991.

2 The 18 guidelines selected are shown in Appendix A.

Control room important for secure operations—The control room functions as the eyes and ears of a juvenile detention center and helps to ensure the safe and secure movement of juveniles and staff, as well as monitoring daily activities. The control rooms at the Coconino County, Maricopa-Durango, and Pima County centers are fully enclosed and use procedures and practices to help ensure they remain secure. For example, only one or two control officers staff these control rooms, and they exercise primary control over the door to this room. As one detention administrator observed, too many people in the control room can distract a busy control room officer from focusing on center security. Photo 1 shows the Pima County center control room.

Too many people in the control room can disrupt control room operations.

Photo 1: Pima County Juvenile Detention Center Control Room West

Source: Auditor General staff.

However, the Santa Cruz and Mohave County centers face some challenges in control room operations, including physical design limitations. Although the Santa Cruz County center has an enclosed and locked control room, access to this room is not restricted. All detention staff at the juvenile detention center, including those who work directly with juveniles, have access to the control room. Based on auditors' observations, these staff routinely enter and exit the control room to retrieve medications, report forms, and other items.

Although the Mohave County center has a locked control room, this room is not fully enclosed, and as such, not fully secured. As illustrated in Photo 2 (see page 14), the control room has an open design, and juveniles routinely pass by it during daily activities. All detention personnel at this center also have keys to the control room and enter and exit this room several times a day to perform various job duties. Additionally, the control panel used to open and close the center's doors sometimes fails to operate correctly. The problems with the center’s control panel led to detention officer inaction, which may have been a contributing factor in three escapes in October 2006. Although the Mohave County Board of Supervisors

authorized funding for a new control panel in August 2007, the Mohave County center should continue to work with its Board of Supervisors to obtain the needed funding to enclose its control room. The Mohave County center should also continue with its reported practice implemented in August 2007 of restricting access to its control room to only the control officer and supervisors, and revise its policies and procedures to reflect this change.

Photo 2: Mohave County Juvenile Detention Center Control Room

Source: Auditor General staff.

Key control contributes to center security—Key control helps to ensure that juveniles and juvenile detention center staff only have access to necessary areas within the juvenile detention center. Essential elements of key control include processes for assigning juvenile detention center keys to staff, issuing and tracking keys, and storing keys. Although the Maricopa-Durango, Coconino, and Pima County centers all have different procedures to control access to and the use of center keys, all of their procedures help ensure that juvenile detention center keys are appropriately controlled. Specifically, the Maricopa-Durango center has a fully automated password-protected key control system that automatically tracks and inventories keys. According to detention officials at the Pima County center, keys remain in the residential units and are routinely accounted for by a residential unit control officer at the end of each shift. The Coconino County center uses a system where detention personnel exchange some form of identification or personal keys for juvenile detention center keys and then return the center's keys at shift's end. Further, according to detention officials, detention officers who work directly with juveniles at these juvenile detention centers do not have keys to the control room or exterior doors.

However, both the Mohave and Santa Cruz County centers should take steps to improve their key control procedures. Specifically, the Santa Cruz County center issues control room and exterior door keys to all staff. Providing these keys to staff who work directly with juveniles exposes the center to potential security breaches if the keys are obtained by nonauthorized personnel. A July 2007 AOC report noted this practice and recommended that the Santa Cruz County center revise its key

control practices. Consistent with the AOC's recommendation, the Santa Cruz County center should develop and implement a key control system. In particular, this system should ensure that keys to exterior doors and the control room are not issued to staff who work directly with juveniles. Additionally, this system should include policies and procedures that specify which staff should have access to keys, and require that keys be properly issued, tracked, and stored.

Although Mohave County center officials reported restricting access to its control room in August 2007, detention staff still have keys to the control room and exterior doors. Additionally, procedures do not prescribe how keys should be assigned to specific personnel even though procedures require that the control officer counts all keys at shift's end. Similar to the Santa Cruz County center, the Mohave County center should revise its policies and procedures to ensure that keys are properly issued, tracked, and stored. These policies and procedures should also specify which staff should have access to keys, and indicate that staff who work directly with juveniles do not have control room and exterior door keys.

Both the Mohave and Santa Cruz County juvenile detention centers should improve their key control policies and procedures.

Perimeter security helps safeguard all center exits and entrances—

A safe and secure juvenile detention center relies on its staff to control all center entrances and exits. All five juvenile detention centers have procedures that allow only detention staff to open and close exterior doors and gates. Proper exterior perimeter security also includes using a combination of juvenile detention center perimeter walks and camera surveillance to ensure perimeter integrity, elements found in the policy at the ACA-accredited Eastern Arizona Regional Juvenile Detention Facility located in Graham County. Although camera surveillance offers a broad range of juvenile detention center views, perimeter walks allow detention personnel to more closely examine those areas that may be beyond a camera's view. For example, a perimeter walk may reveal contraband thrown into an exterior recreation or courtyard area or juvenile detention center weaknesses that might facilitate escape attempts.

The Coconino and Mohave County centers use cameras and daily perimeter walks to secure their perimeters. In addition, the Mohave County center received funding in August 2007 to install razor wire around the perimeter of juvenile detention center courtyards. However, the Pima County and Maricopa-Durango centers primarily use cameras and periodic perimeter walks (the Maricopa-Durango center twice a month and the Pima County center once every 5 days), whereas the Santa Cruz County center relies solely on camera surveillance. Based on auditors' observations, which center management confirmed, exterior blind spots exist at the Maricopa-Durango, Pima County, and Santa Cruz County centers that cameras cannot monitor. As a result, the Maricopa-Durango center plans to implement revised policies in early 2008 that will require two perimeter walks per day. The Pima County and Santa Cruz County centers should determine if exterior blind spots at their juvenile detention centers pose a potential threat to juvenile detention center security, and if so, take steps to ensure that these blind spots are routinely monitored by either adding or adjusting a camera or conducting daily perimeter walks.

A.R.S. §8-305(C)(1) requires that juveniles be kept sight- and sound-separated from adult inmates.

Maricopa-Durango detention center juveniles not always kept separated from adult inmates—The Federal Juvenile Justice and Delinquency Prevention Act of 1974 and A.R.S. §8-305(C)(1) require that juveniles be kept separated from adult inmates. This involves both sight and sound separation. According to Maricopa County juvenile court and detention officials, armed Maricopa County Sheriff's Office deputies escort adult inmates through a small area of the juvenile detention center and into holding areas prior to escorting these adults up an elevator to juvenile court. Adult inmates are typically brought to juvenile court to attend dependency hearings. Escorting these adult inmates through this one small area of the juvenile detention center and into the holding areas sometimes exposes juveniles to these inmates in both areas. This practice appears to violate federal and state provisions regarding the separation of juveniles from adults. It may also have the potential to compromise center security and places juveniles and court personnel at risk for potential harm because weapons enter the center, a practice prohibited by center policy, and juveniles may fall victim to verbal abuse by adult inmates.

According to a Maricopa County juvenile court official, the presiding judges of both the superior and juvenile courts have been made aware of this issue and the juvenile court is exploring options for addressing this situation. Based on auditors' observations and review of the issue, some of these options might include identifying alternative entry points to the juvenile court building for adult inmates, installing a camera in the elevator area to better monitor when adult inmates are being escorted into the center, placing juveniles in holding cells on one floor of the juvenile court building and adult inmates on another floor of the building, and/or having the control room exercise control over the door to the elevator area.

Adequate healthcare services help ensure juveniles' well-being

Although three of the five juvenile detention centers reviewed generally provide adequate healthcare services to juveniles, some juvenile detention centers need to obtain a health services authority and improve services such as health screening, tuberculosis (TB) testing, pharmaceutical administration, and suicide prevention and intervention. As illustrated in Table 5 (see page 18), the Coconino and Pima County and Maricopa-Durango centers provide sufficient healthcare services in all of these areas. In fact, the Pima County center is the only juvenile detention center in the State accredited by the National Commission on Correctional Health Care. However, both the Mohave and Santa Cruz County centers need to improve in some of these areas.

Health services authority should oversee healthcare services—Based on auditors' review and observations, the Coconino, Mohave, and Pima County and Maricopa-Durango centers each have a medical professional who serves as the health services authority for the juvenile detention center. The health services

authority is responsible for the design and provision of health services within juvenile detention centers and final medical decisions for juvenile care. At the Coconino, Maricopa-Durango, and Mohave County centers, a medical doctor serves as this authority and governs the provision and delivery of health services, such as health screenings, TB testing, pharmaceutical administration, and suicide prevention and intervention programs. A registered nurse serves in this role at the Pima County center.

The Santa Cruz County center lacks such an authority, and this may affect the type and quality of health services delivered to juveniles. According to detention officials, detention staff transport juveniles to a local health clinic for medical treatment on an as-needed basis. According to these same officials, the County Board of Supervisors has authorized funding for one healthcare position, a registered nurse, which detention officials intend to also designate as their health services authority. The Santa Cruz County center should continue its efforts to hire a registered nurse and designate this position as the health services authority.

Health screening provides valuable baseline information—The Coconino County center uses detention staff trained by a qualified healthcare provider to administer a health screening to all juveniles upon admission. The Pima County center uses only qualified healthcare providers to perform such screenings. This information provides detention and medical personnel with general healthcare information that they use to identify juveniles' special needs. In contrast, detention personnel who are not trained or who have received limited training from a qualified medical provider do all initial health screens at Maricopa-Durango and Mohave and Santa Cruz County centers, although healthcare professionals at the Maricopa-Durango and Mohave County centers later conduct a health screening. The National Commission on Correctional Health Care, an organization supported by representatives from the fields of medicine, law, and corrections, and dedicated to improving healthcare in correctional facilities, recommends that childcare workers, such as juvenile detention officers, receive health screening training.[1] This recommendation serves as the basis for the operational guideline in this area, which further states that this training be done by a qualified healthcare provider. The absence of such training may place these juvenile detention centers at risk for compromising the health and well-being of juveniles under their care.

TB testing protects staff, juveniles, and communities—Juvenile detention centers represent high-risk environments for tuberculosis (TB). All five juvenile detention centers screen detention staff as a condition of employment, although the Mohave County center only started to test detention staff during the audit and the Maricopa-Durango center lacks a formal policy regarding TB testing for staff. In accordance with a recommendation from the federal Centers for Disease Control and Prevention for the prevention and control of TB in correctional and detention facilities, the Coconino County, Maricopa-Durango, and Pima County centers also screen juveniles within 7 days of admission to their centers.

Juvenile detention centers are high-risk environments for tuberculosis.

1 National Commission on Correctional Health Care. *Standards for Health Services in Juvenile Detention and Confinement Facilities*. Chicago: National Commission on Correctional Health Care, 2004.

For example, the Maricopa-Durango center TB-tests all juveniles at the 72-hour mark of their detainment and receives the test results within 48 hours. According to juvenile court officials, the Mohave County center tests only those juveniles committed to Juvenile Corrections; the Santa Cruz County center tests these juveniles as well as those who are Mexican nationals. Therefore, the Mohave and Santa Cruz County centers should develop and implement policies to test all juveniles for tuberculosis within 7 days of admission.

Table 5: Analysis of Healthcare Services at Juvenile Detention Centers As of August 2007

Healthcare Service	Juvenile Detention Center				
	Coconino	Maricopa	Mohave	Pima	Santa Cruz
Health Services Authority—Oversees the provision and delivery of all health services	✓	✓	✓	✓	
Health Screening—Done by a healthcare provider or detention personnel trained by a qualified healthcare provider	✓			✓	
Tuberculosis (TB) Testing—Juvenile detention centers represent high-risk environments for TB					
• Test all detention personnel	✓	✓	✓	✓	✓
• Test all juveniles within 7 days of admission	✓	✓		✓	
Pharmaceuticals—How medications for juveniles are stored and administered					
• All medications are securely stored	✓	✓		✓	
• Access restricted to supervisory detention or medical personnel	✓	✓		✓	
• Medications administered by healthcare personnel or detention personnel trained by a qualified healthcare provider	✓	✓	✓	✓	
Suicide Prevention and Intervention—Identifies potential suicide risk and guides mental health and detention actions					
• Objective screening instrument used to assess potential suicide risk	✓	✓	✓	✓	
• Suicide risk levels reflect a juvenile's needs and guide detention operations	✓	✓		✓	
• Direct supervision of juveniles on suicide watch	✓	✓	✓	✓	

Source: Auditor General staff summary of *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona (1998)*, National Commission on Correctional Health Care *Standards for Health Services in Juvenile Detention and Confinement Facilities (2004)*, Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, AOC inspections reports, observations, interviews with juvenile detention center management and staff, and reviews of juvenile detention center policy and procedure manuals and other documentation.

Pharmaceuticals require proper administration and storage—Pharmaceutical practices and procedures should ensure the secure storage, restricted access, and proper administration of medications to juveniles. Based on auditor interviews with detention officials and medical personnel, observations and review of policies, procedures, and other documentation, the Coconino and Pima County and Maricopa-Durango centers require medications to be securely stored. Additionally, the Pima County and Maricopa-Durango centers restrict access to medications to only medical personnel and require medications to be administered only by healthcare staff. The Coconino County center restricts access to medications to supervisory detention and medical personnel and requires medications to be administered using a combination of healthcare staff and detention staff trained by a qualified healthcare provider. According to healthcare staff and juvenile court officials at the Mohave County center, healthcare staff administer weekday morning medications, and trained detention staff administer medications at all other times. Detention officials at the Santa Cruz County center stated that the Santa Cruz County center uses untrained detention staff to administer medications. Both the Mohave and Santa Cruz County juvenile detention centers have stored medications in an unsecured cabinet in the control room, which all detention personnel can access, when medical staff are not present. According to a Mohave County juvenile court official, in August 2007, the Mohave County center began storing prescription medications in a locked medical box in the control room and all other medications and first aid supplies in a locked cabinet. The Mohave County center should continue with this practice and revise its policies and procedures to reflect this change.

Suicide prevention and intervention safeguards juveniles—An effective suicide prevention and intervention system includes staff training, a screening mechanism to assess potential suicide risk, and the determination of suicide risk and supervision levels that guide mental health and juvenile detention center actions. According to mental healthcare staff and detention officials, at the Maricopa-Durango and Pima County centers, mental health clinicians train detention personnel on appropriate suicide prevention and intervention procedures, whereas supervisory detention staff certified as trainers in suicide prevention and intervention deliver this training at the Coconino, Mohave, and Santa Cruz County centers.

Additionally, with the exception of the Santa Cruz County center, these centers use a combination of health screening questions and objective suicide risk screening instruments to assess potential suicide risk. In particular, the Maricopa-Durango and Pima County centers use the Massachusetts Youth Screening Instrument, Second Version (MAYSI-II), a standardized mental health screening instrument specifically designed to screen juveniles for suicide risk and general mental health issues. Most notably, the Pima County center was one of several sites nation-wide

to pilot the MAYSI-II (English and Spanish versions) between July 2003 and June 2004. The Coconino and Mohave County centers use an objective suicide screening questionnaire that directs detention staff to notify a supervisor when a juvenile answers "Yes" to questions about suicide. According to the AOC and Santa Cruz county juvenile court officials, the Santa Cruz County center uses a suicide screening questionnaire reviewed and approved by a mental health professional. However, this questionnaire requires detention staff to interpret a juvenile's responses rather than rely on objective scoring criteria to assess risk. The Santa Cruz County center should adopt a more objective suicide screening questionnaire, such as the MAYSI-II or questionnaires similar to those in use at the Coconino and Mohave County centers.

Mental health staff at the Coconino County, Pima County, and Maricopa-Durango centers place juveniles on different levels of suicide risk that determine how detention staff should monitor, house, and clothe a juvenile, as well as determine a juvenile's activity level. For example, the Pima County center uses four risk and observation/supervision levels that incorporate the range of suicidal behaviors a juvenile may display and the level of observation/supervision detention staff need to follow. The Coconino County center uses a similar four-level approach, and the Maricopa-Durango center uses two levels. At these three centers, observation/supervision level increases as a juvenile's risk for suicide increases. As such, observation/supervision can range from detention staff doing wellness checks every 15 minutes to direct constant visual observation/supervision. Only mental health staff can remove a juvenile from suicide watch or downgrade his/her prior risk level at these centers.

Although only mental health staff at the Mohave and Santa Cruz County centers can remove a juvenile from suicide watch, these centers use a single level approach to suicide risk and observation/supervision. This approach may not be the most effective way to address the range of suicidal behaviors a juvenile may display or to direct detention actions. Moreover, this single-level approach does not reflect the current multiple-level approach to suicide risk and supervision recommended by the National Commission on Correctional Healthcare and a nationally recognized suicide research expert.[1] This multiple-level approach to suicide risk and supervision calls for supervision levels to adjust according to a juvenile's risk for suicide. Therefore, the Mohave and Santa Cruz County centers should implement a multiple-level approach to suicide risk and observation such as the approaches in place at the Coconino County, Maricopa-Durango, and Pima County centers.

Lastly, the Santa Cruz County center houses a juvenile at risk for suicide alone in a cell without a camera. In addition, this cell has a door with a small, partially painted window that offers a limited view of the cell and, therefore, a limited view of the juvenile. The Santa Cruz County center should either place a camera in the cell designated for suicide watch or replace the door with a full-view, shatter-proof glass door. This would allow a detention officer walking by the cell or in the control room to more directly monitor the juvenile.

1 Hayes, Lindsay M. "Juvenile Suicide in Confinement: A National Survey." Baltimore: National Center on Institutions and Alternatives, Feb. 2004.

Many of the recommendations made to improve healthcare services at the juvenile detention centers will require changes to policies, procedures, and forms. Therefore, the juvenile detention centers should ensure that a qualified medical and/or mental health professional reviews and approves any revisions to medical and/or mental health policies, procedures, and forms.

Behavior management practices can be improved

Although three juvenile detention centers implement generally sound behavior management programs, as shown in Table 6, two juvenile detention centers should improve their behavior management practices. In particular, the Mohave and Santa Cruz County centers should modify their use of isolation, and the Mohave County center should modify its mechanical restraint practices.

Table 6: Analysis of Behavior Management Practices at Juvenile Detention Centers As of August 2007

Behavior Management Practice	Juvenile Detention Center				
	Coconino	**Maricopa**	**Mohave**	**Pima**	**Santa Cruz**
Behavior Management System—Serves to reinforce, reward, and redirect juvenile behavior					
• Objective measures, such as grades or points, used to assess a juvenile's behavior	✓	✓	✓	✓	
• Meaningful rewards and privileges used to encourage and reinforce positive behavior	✓	✓	✓	✓	
Isolation—The placement of a juvenile in a locked room to control harmful and/or threatening behavior to self or others					
• Locked in a room only when a juvenile displays harmful and/or threatening behavior to self or others	✓	✓		✓	
• Not locked in a room in lieu of supervision	✓	✓		✓	
Mechanical Restraints—Allow for a brief way to safely secure a juvenile at risk of harm					
• Notify medical personnel when juvenile placed in restraints		✓	✓	✓	
• Not used to attach juveniles to stationary objects in lieu of supervision	✓	✓		✓	✓
• Use verbal de-escalation techniques as part of a crisis intervention program	✓	✓	✓	✓	✓

Source: Auditor General staff summary of *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona (1998)*, observations, interviews with juvenile detention center management and staff, and reviews of juvenile detention center policy and procedure manuals and other documentation.

Behavior management serves to reinforce, reward, and redirect juvenile behavior—Behavior management involves the use of various methods to manage the behavior of juveniles. Based on interviews with detention officials, four of the five juvenile detention centers that auditors visited use an incentive-based system designed to reinforce positive behavior with meaningful rewards and privileges. Two different incentive-based systems are in place. Detention officials at the Mohave County and Maricopa-Durango centers indicated that these centers use a traditional level system in which juveniles earn points by displaying positive and compliant behavior. As juveniles earn more points, they are promoted to higher levels that allow more privileges. According to detention officials, juveniles at the Pima County center earn grades, and juveniles at the Coconino County center earn points as part of the Step-Up Program. In this program, detention officers mentor and work with juveniles on a series of exercises designed to improve the juvenile's decision-making ability and create a relapse prevention and community re-entry plan. In both systems, juveniles can then use these points or grades to earn rewards and privileges, such as extra recreation time, additional phone calls, or longer visits with family members. Detention personnel at these four juvenile detention centers use observations and behavior checklists or logs to objectively and consistently determine if a juvenile has earned points and grades or can keep points.

The Santa Cruz County center should take steps to improve its behavior management system. The Santa Cruz County center does not use a system that assigns points or grades based on an objective measure of a juvenile's behavior; rather, progress within the Santa Cruz County center's system depends primarily on length of stay. For example, male juveniles do not earn the "privilege" of wearing socks and underwear until they have spent almost 2 weeks in detention. A July 2007 AOC report noted the use of underwear as a privilege and suggested that the Santa Cruz County center reevaluate its reward and privilege structure to be more meaningful and valuable to juveniles. A juvenile's progress also depends on the subjective judgment of detention personnel as the policy on this behavior management system offers little guidance. Detention officials explained that although Santa Cruz County detention personnel discuss a juvenile's behavior, they do not use any objective measures, such as points or grades, to determine if rewards or privileges have been earned. Therefore, the Santa Cruz County center should use objective measures, such as points or grades, which can serve as goals for juveniles, and decision-making tools for detention personnel, and not rely on length of stay.

According to a detention official, in September 2007, the Santa Cruz County center eliminated the practice of using underwear and socks as a reward or privilege and now issues these items upon admission. Detention officials also indicated that based on input from the juveniles, the juvenile detention center plans to explore using other, more meaningful rewards or privileges, such as longer showers and more phone time. The Santa Cruz County center should continue its efforts to explore the use of more meaningful rewards and privileges, and revise its policies and procedures to reflect this change.

Isolation and mechanical restraints should be used as temporary tools to redirect juvenile behavior—Detention staff use isolation and mechanical restraints to safely, securely, and temporarily control a juvenile whose behavior poses a threat to self or others. According to the state operational guidelines, these tools should be used sparingly and only after all other efforts to calm a juvenile have failed. According to detention officials, all five juvenile detention centers that auditors visited use either the Handle with Care or Nonviolent Crisis Intervention programs to teach detention staff verbal de-escalation techniques, safe physical holds, and mechanical restraint use. The Mohave County center uses both programs.

Detention staff use isolation and mechanical restraints to temporarily redirect inappropriate juvenile behavior.

According to detention administrators, the Coconino County center uses isolation less than once a month, and the Maricopa-Durango and Pima County Centers use isolation only for those instances when a juvenile is displaying particularly harmful and/or threatening behavior to self or others.

Handle with Care and Nonviolent Crisis Intervention (NCI)—Programs that teach detention staff verbal de-escalation techniques, safe physical holds, and mechanical restraint use. The Coconino, Pima, and Santa Cruz County centers use Handle with Care, the Maricopa-Durango center uses NCI, and the Mohave County center uses both programs.

Isolation—A form of special management that involves the placement of a juvenile in a locked room to control aggressive, disruptive, or threatening behavior to self or others.

Mechanical Restraints—Instruments of physical restraint used to prevent juvenile self-injury, injury to others, or property damage.

Source: Auditor General staff summary of interviews with juvenile detention center staff, information obtained from the Handle with Care and Crisis Prevention Institute Web sites, and the Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona.

The Santa Cruz County center confines juveniles to their rooms at times because of staffing shortages. For example, the Santa Cruz County center sometimes conducts school in shifts to ensure adequate supervision. In these instances, half the juveniles attend class, while the other half is locked in their rooms. Additionally, the Santa Cruz County center sometimes locks juveniles in their rooms when a detention officer must transport a juvenile to court. A July 2007 AOC report recommended that the Santa Cruz County center increase its current staff from 12 to 20 to ensure adequate shift coverage and juvenile supervision. According to Santa Cruz County juvenile court officials, one way the juvenile detention center is trying to deal with this problem is by sometimes using probation personnel with detention experience to provide coverage when they have insufficient staff. Given the need to eliminate unnecessary and potentially harmful periods of isolation, the Santa Cruz County center should work with the Probation Department of Santa Cruz County to formally designate specific probation personnel as backup coverage when the juvenile detention center experiences staffing shortages.

Similar to the Santa Cruz County center, the Mohave County center also confines juveniles to their rooms at times because of staffing shortages. For example, staffing shortages resulted in one residential wing of juveniles being locked in their rooms for at least 2 hours during an auditors' May 2007 site visit. According to juvenile court officials, the Mohave County center has taken steps to reduce its detention population by finding alternatives to detention for juveniles, such as home placement, regional youth shelters, or electronic monitoring. However, a June 2007 auditor site visit revealed that 4 of the 13 juveniles in the center were in

various stages of lockdown (isolation). One of these juveniles, a 10-year-old with diagnosed behavioral and mental health issues, remained housed by himself in an isolation cell for most of his 6-week stay. This juvenile consistently disrupted programming activities and displayed combative and argumentative behavior toward staff and other juveniles. Staff deemed isolation the most effective way to protect this juvenile from harm and allow other juveniles and staff to do daily activities with minimal disruption. The County Board of Supervisors authorized funding for six new detention staff positions in August 2007. Once these positions are filled, the Mohave County center should be able to reduce its use of isolation.

All five juvenile detention centers have handcuffs and leg irons (shackles), and four of the five have a restraint bed. According to juvenile court officials and detention administrators, with the exception of the Mohave County center, none of the juvenile detention centers auditors visited use mechanical restraints to attach juveniles to stationary objects within the juvenile detention center in lieu of supervision. In particular, a juvenile court official stated that such use violates safety and security policies, such as those for fire and evacuation, and also goes against best practices. However, based on auditors' review of 253 incident reports from the Mohave County center for July 2006 through April 2007, 14 of these reports described some juveniles as being cuffed or shackled within the facility and sometimes to stationary objects as a result of escape concerns and behavioral issues. For example, during one site visit, auditors observed the same 10-year-old juvenile mentioned previously shackled to a wall in the juvenile detention center's intake area. The Mohave County center should cease the practice of mechanically restraining juveniles to stationary objects within the juvenile detention center as such practice may compromise the safety and well-being of juveniles.

Additionally, according to a Mohave County juvenile court official, the Mohave County center has a policy that allows for the use of mechanical restraints on juveniles who pose an escape risk. However, auditors' review of the policy on escape risk did not find language that supported such use. Further, the Mohave County center's policy on use of force and restraints indicates that mechanical restraints should be used as a precaution against escape only during a juvenile's transfer out of the juvenile detention center. Yet, some of the incident reports reviewed by auditors described juveniles being cuffed or shackled due to escape concerns, but these juveniles were not being transferred out of the juvenile detention center. According to Coconino, Maricopa, and Santa Cruz county juvenile court officials, these centers do not use mechanical restraints on juveniles who pose an escape risk. Both Coconino and Pima report that they may increase the supervision of a juvenile who poses an escape risk. In addition, a Pima County juvenile court official stated that they might use restraints on a juvenile who has a history of trying to run from or evade staff within the facility. Therefore, the Mohave County center should revise its escape risk policies and procedures to enhance supervision of juveniles who pose an escape risk and only use mechanical restraints in instances where juveniles have a history of trying to evade staff.

Adequate staffing and training important for juvenile welfare

Adequate staffing and staff training are important to ensure the safety, security, and proper care of detained juveniles. As shown in Table 7, three of the five juvenile detention centers have staffing ratios that already meet or exceed state and/or national standards, and provide staff training without compromising juveniles' participation in programming. However, the Santa Cruz and Mohave County centers struggle with staffing limitations that affect staff training and interrupt juveniles' participation in various juvenile detention center programs.

Inadequate staffing can compromise center security and juvenile welfare

—Juvenile detention centers need to have an adequate number of detention staff to directly monitor and manage juveniles' behavior. An adequate staff-to-juvenile ratio allows detention staff to act more proactively and derail potential problem situations that could compromise the staff's and juveniles' well-being. The Coconino and Pima County and Maricopa-Durango centers all maintain staff-to-juvenile ratios that meet or exceed the State's recommended minimum daytime level of 1 detention staff to 10 juveniles (1:10). In some instances, these juvenile detention centers also have ratios that meet or exceed the staff-to-juvenile ratio of 1:8 endorsed by the National Juvenile Detention Association.[1]

An adequate staff-to-juvenile ratio allows detention staff to act more proactively and derail potential problem situations.

Table 7: Analysis of Staffing Ratios and Staff Training at Juvenile Detention Centers As of August 2007

Staffing Ratios and Staff Training	Juvenile Detention Center				
	Coconino	Maricopa	Mohave	Pima	Santa Cruz
Staffing Ratios—Adequate ratios allow detention personnel to directly monitor and manage juveniles					
• Staff-to-juvenile ratios meet or exceed state guidelines or national standards	✓	✓		✓	
• Staffing levels do <u>not</u> disrupt programming activities of juveniles	✓	✓		✓	
Staff Training—Adequate staff training can help to ensure the safe and secure operation of juvenile detention centers					
• Training hours for new detention personnel meet or exceed state guidelines or national standards	✓	✓	✓	✓	✓
• Annual training requirements for continuing detention personnel	✓	✓	✓	✓	✓
• Staffing levels do <u>not</u> affect when training can occur	✓	✓		✓	

Source: Auditor General staff summary of *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona (1998)*, observations, interviews with juvenile detention center management and staff, and reviews of juvenile detention center policy and procedure manuals and other documentation.

[1] National Juvenile Detention Association. *Minimum Direct Care Staff Ratio in Juvenile Detention Centers*. June 8, 1999.

However, because of the small size of the Santa Cruz County center (19 beds), the staff-to-juvenile ratio tends to be more sensitive to population shifts. Although a February 2007 Juvenile Corrections inspection report noted that the Santa Cruz County center had a staff-to-juvenile ratio of 1:6, auditors observed this ratio at 1:10 and 1:11 during site visits on separate days in June 2007. The Santa Cruz County center struggles at times to maintain adequate staffing because of ongoing staffing shortages and fluctuating detention populations. As previously mentioned, the Santa Cruz County center sometimes has to lock juveniles in their rooms to ensure the safe operation of school activities and the secure transport of juveniles to court. The Santa Cruz County center also has only a limited number (three) of female detention officers. A July 2007 AOC report noted that this type of limited staffing places the County at risk for potential liability concerns because the juvenile detention center sometimes lacks female juvenile detention officers when female juveniles are present. This same AOC report included a staffing analysis using the National Institute of Corrections Ten-Step Staffing Analysis model that showed the Santa Cruz County center as understaffed. Based on this analysis, the AOC report recommended that the Santa Cruz County center increase its current staffing level from 12 to 20 full-time officers to ensure desired staffing levels on all shifts.

According to Santa Cruz County juvenile court officials, although the Santa Cruz County center filled one of two vacant on-call positions in July 2007, the Santa Cruz County center struggles to recruit qualified candidates because of its stringent screening process and competition from area law enforcement agencies. These same juvenile court officials indicated that a new 32-bed juvenile detention center for Santa Cruz County is scheduled for groundbreaking in late 2007 or early 2008, with a target completion date in 2010. Current staffing challenges are likely to increase given the staffing needs a juvenile detention center of this size requires. According to one juvenile court official, the Administrative Services Director for Santa Cruz County has agreed to try to obtain funding for two new full-time juvenile detention officer positions beginning in fiscal year 2009. In the interim, this same official stated that probation fees will be used to temporarily fund these positions, with one position starting in January 2008 and the other in April 2008. Although these efforts can improve the immediate staffing challenges at the Santa Cruz County center, the Santa Cruz County Detention Administrator should work with the Chief Probation Officer to formally designate probation personnel as backup coverage when the juvenile detention center experiences staffing shortages. To address ongoing staffing challenges, the Santa Cruz County center should work with the Presiding Judge of the Juvenile Court and the County Board of Supervisors to ensure adequate staffing at its juvenile detention center.

The Mohave County center has faced similar staffing shortages. Specifically, September 2006 and February 2007 Juvenile Corrections inspection reports noted that the Mohave County center had daytime staff-to-juvenile ratios of 1:19 and

1:15, respectively. A January 2007 AOC report cited a shortage of staff as a contributing factor to three juveniles escaping from the Mohave County center in October 2006. The Mohave County center has taken some steps to address inadequate staffing and juvenile supervision. According to a juvenile court official, the Mohave County center placed a cap on its detention population in May 2007, and the County Board of Supervisors authorized six new positions in August 2007. These steps should help the Mohave County center maintain sufficient staff coverage to adequately supervise juveniles without having to compromise programming activities.

Staff training helps to ensure center security and juvenile welfare—Providing adequate staff training can help ensure the safe and secure operation of juvenile detention centers. According to detention administrators, all five juvenile detention centers provide new detention staff with 80 to 130 hours of training during their initial year of employment, and continuing detention staff with 25 to 50 hours of annual training. The initial number of training hours provided to staff at all five juvenile detention centers meets, and in some cases exceeds, both the state guideline of 80 hours and national standards of 120 hours.[1] All five juvenile detention centers use a combination of professional trainers or detention personnel certified as trainers to deliver training in areas such as suicide prevention and intervention, safety and security procedures, and crisis intervention.

Detention staff training can help ensure safe operations.

The delivery of training varies among the five juvenile detention centers. The Mohave and Pima County centers each conduct a 2-week academy, and the Maricopa-Durango center conducts a 3-week academy. According to juvenile detention officials, the Coconino County center relies on the shadowing of more experienced detention personnel for a given period and staff attendance at the biannual juvenile detention academies that the AOC conducts. Additionally, detention officials at the Santa Cruz center indicated that they also rely on the shadowing of more experienced detention personnel, attending the AOC biannual juvenile detention academies, and using computer-based training modules.

However, staffing constraints at the Santa Cruz County center can affect the conditions under which training can occur at this juvenile detention center. Detention officials indicated that because of staffing shortages, the Santa Cruz County center may lock juveniles in their rooms while detention staff receive training. This situation places staffing and training needs in competition with one another, and potentially compromises the juvenile detention center's security and the juveniles' welfare. The Santa Cruz County center should continue the aforementioned partnership with the Probation Department of Santa Cruz County to ensure that training needs are met and juveniles remain engaged in programming activities.

1 American Correctional Association. *Standards for Small Juvenile Detention Facilities*. Springfield, VA: Goodway Graphics, 1991.

Recommendations:

1. The Santa Cruz County center should:

    a. Restrict access to its control room to only necessary control room and supervisory personnel;

    b. Develop and implement a key control system. In particular, this system should ensure that keys to exterior doors and the control room are not issued to staff who work directly with juveniles. Additionally, this system should include policies and procedures that specify which staff should have access to keys and require keys to be properly issued, tracked, and stored;

    c. Determine if exterior blind spots at the juvenile detention center pose a potential threat to juvenile detention center security, and if so, take steps to ensure that these blind spots are routinely monitored by either adding or adjusting a camera or doing a daily perimeter walk;

    d. Continue its efforts to hire a registered nurse and designate this position as the health services authority;

    e. Ensure that only a qualified healthcare provider trains detention personnel how to perform health screenings;

    f. Develop and implement policies to test all juveniles for tuberculosis within 7 days of admission to lessen the potential health risks for both the juvenile detention center and its community;

    g. Ensure that detention personnel receive training from a qualified healthcare provider in medication administration;

    h. Fully secure all medications and limit control room keys to necessary staff;

    i. Adopt a more objective suicide screening questionnaire such as the MAYSI-II, or a questionnaire similar to the one that the Coconino or Mohave County centers use;

    j. Implement a multiple-level approach to suicide risk and observation/supervision similar to the approaches in use at the Coconino and Pima County and Maricopa-Durango centers to more effectively address a juvenile's needs and direct detention actions;

    k. Either place a camera in the cell designated for suicide watch or replace the door with a full-view, shatter-proof glass door;

l. Ensure that a qualified medical and/or mental health professional reviews and approves any revisions to the medical and/or mental health policies, procedures, and forms at the Santa Cruz County center;

m. Use objective measures, such as points or grades in its behavior management system, which can serve as goals for juveniles to strive toward and decision-making tools for detention personnel, instead of length of stay. The Santa Cruz County center should also continue its efforts begun in September 2007 to explore the use of more meaningful rewards and privileges, and revise its policies and procedures to reflect these changes;

n. Work with the Chief Probation Officer to formally designate specific probation personnel as backup coverage when the juvenile detention center experiences staffing shortages to ensure that juveniles are not subjected to unnecessary and potentially harmful periods of lockdown, juveniles are adequately supervised, and staff training needs get met. Also, work with the Probation Department of Santa Cruz County to develop and implement policies and procedures to reflect this partnership; and

o. Work with the juvenile court's Presiding Judge and the County Board of Supervisors to ensure adequate staffing at its juvenile detention center.

2. The Mohave County center should:

   a. Enclose its control room to protect detention personnel and juvenile detention center security activities. The Mohave County center should also continue its reported practice implemented in August 2007 of restricting access to its control room and to one or two detention officers assigned to work the control room, and revise its policies and procedures to reflect this change;

   b. Revise its policies and procedures to ensure that keys are properly issued, tracked, and stored. These policies and procedures should also specify which staff should have access to keys and indicate that staff who work directly with juveniles do not have control room and exterior door keys;

   c. Ensure that only a qualified healthcare provider trains detention personnel how to perform the initial intake health screening;

   d. Develop and implement policies to test all juveniles for tuberculosis within 7 days of admission to lessen the potential health risks for both the juvenile detention center and its community;

   e. Continue the reported practice implemented in August 2007 of storing prescription medications in a locked medical box in the control room and

all other medications and first aid supplies in a locked cabinet. The Mohave County center should revise its policies and procedures to reflect this change;

f. Implement a multiple-level approach to suicide risk and observation/supervision similar to the approaches in use at the Coconino and Pima County and Maricopa-Durango centers to more effectively address a juvenile's needs and direct detention actions;

g. Ensure that a qualified medical and/or mental health professional reviews and approves any revisions to the medical and/or mental health policies, procedures, and forms at the Mohave County center;

h. Examine its use of isolation and consider what role the six new positions authorized by the County Board of Supervisors in August 2007 can play in addressing this issue;

i. Immediately stop the practice of mechanically restraining juveniles to stationary objects within the juvenile detention center, as such practice may compromise the safety and well-being of juveniles; and

j. Revise its escape risk policies and procedures to enhance supervision of juveniles who pose an escape risk and only use mechanical restraints in instances where juveniles have a history of trying to evade staff.

3. The Maricopa-Durango center should:

   a. Continue with plans to implement revised policies in early 2008 that will require two perimeter walks per day;

   b. Explore options designed to eliminate or minimize juvenile exposure to adult inmates, as required by federal and state sight and sound laws. These options may include identifying alternative entry points to the juvenile court building for adult inmates, installing a camera in the elevator area to better monitor when adult inmates are being escorted into the center, placing juveniles in holding cells on one floor of the juvenile court building and adult inmates on another, and/or having the control room exercise primary control over the door to the elevator area; and

   c. Ensure that only a qualified healthcare provider trains detention personnel how to perform health screenings.

4. The Pima County center should determine if exterior blind spots at the juvenile detention center pose a potential threat to juvenile detention center security, and if so, take steps to ensure that these blind spots are routinely monitored by either adding or adjusting a camera or doing a daily perimeter walk.

FINDING 2

State-wide effort needed to improve operating standards

The Supreme Court and the Administrative Office of the Courts (AOC) have an opportunity to make the operations at juvenile detention centers, such as those discussed in Finding 1, more uniform by strengthening operational standards. State-wide guidance for juvenile detention centers is contained in the *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona* (Guidelines). However, many of these guidelines do not provide detailed guidance for center operations, and even when they do, compliance is voluntary. Therefore, under the direction of the Arizona Judicial Council, the AOC should work with the county juvenile courts to identify and/or develop and adopt mandatory standards for juvenile detention center operations, including some standards that are linked to goals and outcome measures.

State guidelines for detention center operations

The Arizona Supreme Court's Guidelines for juvenile detention centers represent minimum guidance for juvenile detention center operations, and juvenile detention center compliance with these guidelines is voluntary. A 23-member Detention Standards Advisory Committee (Committee), which had representatives from various county juvenile courts, as well as the Arizona Departments of Administration, Education, Economic Security, Juvenile Corrections, Health Services, and the Governor’s Division for

Guidelines consist of two sections:

Operational guidelines—Provide guidance regarding the minimum level of care expected by the Directors of Juvenile Court Services. For example, the day-room operational guideline states that day rooms with sufficient space shall be provided for the use of multipurpose programming activities. The AOC and the Arizona Department of Juvenile Corrections (Juvenile Corrections) inspect the juvenile detention centers against these guidelines. Detention centers voluntarily follow the operational guidelines.

Best practices—Rigorous guidance that juvenile detention centers can voluntarily try to achieve. Some best practices stand alone, whereas others expand on the existing operational guidelines. For example, the day-room best practice states that a day room should provide 35 square feet of unencumbered floor space per juvenile for the maximum number of juveniles expected to use the day room at one time, and sufficient seating and writing furnishings for each juvenile using the day room.

Source: Auditor General staff summary of *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona (1998).*

Children, drafted the Guidelines in 1998. With further input from the County Directors of Juvenile Court Services, the draft was approved. According to an AOC official and a juvenile detention administrator, who was the original Committee's co-chair, one of the Committee's and Juvenile Court Directors' main focuses was to develop and adopt guidelines that all juvenile detention facilities in the State could meet.

The Guidelines are structured into two parts: (1) operational guidelines and (2) best practices. The operational guidelines provide guidance regarding the minimum level of care expected by the Directors of Juvenile Court Services. The best practices advocate a more rigorous standard of care. Detention centers are encouraged to voluntarily comply with both sections.

Juvenile detention center compliance with operational guidelines is voluntary.

Many guidelines too general to provide meaningful guidance for juvenile detention center operations

Although the Guidelines provide detailed guidance in some areas of detention center operations, the guidance provided in other key areas of operations is vague or absent and left to the discretion of the juvenile detention centers. As a result, a juvenile detention center can technically comply with the Guidelines, but not necessarily guarantee a safe environment for juveniles and staff.

Guidelines provide varying levels of guidance to juvenile detention centers—Despite providing detailed and specific direction in some operational areas, the Guidelines provide inadequate direction for detention operations in other areas. For example, some guidelines provide significant detail and direction, whereas others provide detail when the operational guidelines and best practices are combined, and still others lack sufficient detail to guide juvenile detention center operations. However, even the most detailed guidelines have some potential gaps. Together, this varied guidance creates opportunities for the types of problems that auditors identified and reported in Finding 1. Specifically:

- **Directive guidelines**—These operational guidelines provide at least minimum guidance on what should be done; when it should be done; by whom; and what documentation may be necessary; and reference relevant local, state, and federal codes and laws. Based on auditors' review of the Guidelines, an estimated 49 of the 74 operational guidelines provide directive or more detailed guidance. Records and documentation provides an example of a more detailed guideline. This guideline directs juvenile detention centers to maintain a written or electronic daily activity log, an individual record or file for each juvenile held in the detention center containing information on daily behavior observation and demographic statistics, and an individual medical record for each juvenile that contains the medical consent of parents or legal guardians and other medical information. This guideline also states that any

An estimated 49 of 74 operational guidelines provide more detailed guidance for operations.

unusual incidents involving a juvenile should be written in an incident report and retained in the juvenile's case file, and indicated that unusual incidents requiring a report would include fights, assaults, attempted and completed escapes, and suicidal threats and attempts. Finally, the guideline specifies certain time frames for actions, names specific positions who are responsible for given records or documentation actions, gives examples of information contained or expected within specific types of records, and specifies that records should be retained as required by juvenile detention center policies and procedures, statute, and/or administrative rules and regulations.

- Supplemented guidelines—Supplemented guidelines are nondirective within the operational guidelines, but have associated information in the best practice section that can provide further direction for juvenile detention operations. Based on auditors' review, 7 of the 74 operational guidelines are supplemented by best practice information, which would then make the guideline more directive or detailed. Population management is an example of a supplemented guideline. Within the operational guidelines, population management addresses the broad concepts of monitoring juveniles' movement to and from areas within detention and in and out of the facility. For example, this guideline prescribes that juvenile detention centers monitor if a juvenile has moved from his or her living unit to the gymnasium or to a court appearance. However, population management is further addressed within the best practices section. According to best practice, detention staff should develop both formal and informal processes to account for their population. For example, it recommends that detention staff account for all juveniles every 15 minutes, or more if needs dictate. The best practice also recommends that juvenile detention centers conduct a physical population count at least once per shift or, at a minimum, three counts in a 24-hour period. Finally, the best practice states that population counts should reflect youth at high risk of suicide, recovering from intoxicants, considered a security risk, or who are ill.

- Nondirective guidelines—Based on auditors' review, an estimated 18 of the 74 operational guidelines provide no guidance for juvenile detention operations beyond instructions to set a plan, policy, or procedure in place. They provide no additional information regarding what the plan, policy, or procedure should include. These nondirective guidelines include guidelines for key control, behavior management, use of physical force, and disciplinary reports and hearings. For example, the key control guideline states that the director of the juvenile court should develop policies and procedures relative to the control and security of all keys and electronic entry devices for the juvenile detention center in his or her care. However, the guideline does not provide any guidance to juvenile detention centers as to what good key control policies and procedures should entail, such as policies and procedures for assigning juvenile detention center keys to staff, issuing and tracking keys, and storing keys.

An estimated 18 of 74 operational guidelines provide insufficient guidance.

In addition to the 74 guidelines, there is additional guidance that is only contained in the best practices section. Specifically, there are 13 best practices that do not have a corresponding operational guideline. For example, one of the best practices, orientation and training of volunteers, states that volunteers shall receive documented orientation and/or training prior to being assigned duties and that all volunteers shall agree in writing to abide by facility policies and procedures.

Compliance with guidelines does not necessarily guarantee safe juvenile detention centers—Since some of the guidelines are not sufficiently detailed or are nondirective and even some of the more detailed guidelines still have gaps, juvenile detention centers can comply with the guidelines, but still exhibit issues within their facilities that may compromise the safety and security of the staff and juveniles. For example:

The key control guideline only recommends establishment of policies and procedures.

- **Key control**—The key control guideline recommends that juvenile detention centers establish policies and procedures regarding key control. This guideline provides no further direction, and as a result, a facility can comply with the guideline simply by having a policy and/or procedure. For example, a 2007 Juvenile Corrections inspection report of the Mohave County center stated it was in compliance with the guideline for key control because it was found to have written policies on key control. However, the Juvenile Corrections report indicated that although the center did adhere to the spirit of the key control guideline, their policy was inadequate and should be redrafted. Additionally, as noted in Finding 1 (see pages 11 through 30), auditors found a number of weaknesses with the key control system at the Mohave County center.

- **Suicide prevention and intervention**—This guideline provides more directive or detailed guidance regarding how juvenile detention center administrators, medical personnel, and staff should prevent and intervene with a juvenile's attempt to take his or her own life. However, even if a juvenile detention center is in compliance with this guideline, the center may still have operational issues that could potentially compromise juveniles' safety. For example, a 2004 AOC inspection report of the Santa Cruz County center recommended that this juvenile detention center improve its suicide screening instrument by providing more detail, possibly revising its instrument to adopt a screening tool that is within the National Commission on Correctional Health Care (NCCHC) guidelines, and have a medical professional review and approve the instrument because there is not a medical professional at the juvenile detention center. Additionally, as noted in Finding 1 (see pages 11 through 30), auditors found some weaknesses with the suicide prevention and intervention system at the Santa Cruz County center as compared to the practices at the other juvenile detention centers auditors reviewed.

AOC should work with the county juvenile courts to develop operational standards

The Arizona Judicial Council assists the Supreme Court and the chief justice in the development and implementation of policies and procedures for the administration of all courts. For example, it studies the internal operation of the courts and plans for future developments. It also promotes improvements and responds to issues concerning judicial administration by reviewing and recommending for adoption by the chief justice proposed administrative orders, code sections, rules, and policies.

Under the direction of the Arizona Judicial Council, the AOC should work with the county juvenile courts to develop, implement, and require compliance with comprehensive detention center operational standards. Such an effort would be consistent with how other states direct juvenile detention operations and could build on efforts that the Supreme Court is already undertaking to determine what guidelines may already be constitutional or statutory requirements. As a part of that process, and also under the direction of the Arizona Judicial Council, the AOC should work with the county juvenile courts to begin implementing performance-based standards that include goals and outcome measures to help increase accountability and improve juvenile detention operations. Adopting performance-based standards would be consistent with national efforts to strengthen the juvenile justice system.

Fully developed, mandatory operational standards would improve direction for detention center operations—Under the direction of the Arizona Judicial Council, the AOC should work with the county juvenile courts to develop and implement mandatory juvenile detention center operational standards. This should involve reviewing and improving current guidelines to ensure that they provide adequate direction and detail to juvenile detention centers and adopting new standards where appropriate. The standards should include sufficient detail and information to provide juvenile detention centers with the guidance they will need to establish conforming policies, procedures, and practices. To assist in developing appropriate operational standards, the AOC and the county juvenile courts should consult the American Correctional Association (ACA), the NCCHC, the National Partnership for Juvenile Services (NJPS), the Council of Juvenile Corrections Administrators (CJCA), and the Annie E. Casey Foundation. According to AOC staff, the AOC initiated an effort in March 2007 to review the Guidelines to determine which specific guidelines address constitutional or statutory requirements. According to this staff, the AOC implemented the review of the Guidelines to recommend that guidelines containing constitutional or statutory requirements were made mandatory and were no longer considered part of the voluntary Guidelines.

Under the direction of the Arizona Judicial Council, the AOC should work with the county juvenile courts to identify and/or develop and implement mandatory standards.

Making such standards mandatory rather than voluntary offers an additional way to help ensure consistency. The standards should be made mandatory by either placing them in their entirety into the Arizona Code of Judicial Administration (Code) or by placing a statement in the Code to the effect that county juvenile detention centers must adopt and comply with the standards. The Code is a compilation of all the policies and procedures for the administration of Arizona's courts.

The AOC should help juvenile detention centers transition to operational standards.

Once the Arizona Judicial Council approves these standards, the AOC would need to take several steps to help juvenile detention centers transition as they implement the operational standards. These include providing training and technical assistance to appropriate county juvenile court and detention center staff regarding the mandatory standards, assisting county juvenile court staff in obtaining additional resources from their respective county boards of supervisors if needed, and identifying additional resources, such as best practices and tools used by some juvenile detention centers, to share with other juvenile detention centers to help comply with adopted standards.

Adopting mandatory standards would be consistent with practices used in other states that place oversight for the juvenile detention system with the state courts. Auditors obtained information from nine such states regarding the use of voluntary guidelines or mandated standards and found that eight of these states use mandated standards.[1] For example, Virginia's Department of Juvenile Justice places its standards for juvenile residential facilities, which includes secure detention facilities like Arizona's detention centers, in its Administrative Code, thus requiring and enforcing compliance with the standards.

Performance-based standards offer further improvement over traditional standards—Once it has instituted mandatory standards and under the direction of the Arizona Judicial Council, the AOC should work with the county juvenile courts to further develop these standards to increase accountability and provide critical information to improve juvenile detention center operations. Standards that help to ensure accountability and provide data for decision making are sometimes referred to as performance-based standards. These types of standards can be linked to goals and typically have objective measurements of performance, communicate expected or best practices, and require the implementation of processes to document operations. According to national experts in juvenile justice, these types of standards are strong tools to assess conditions within juvenile detention centers and provide accountability for operations.

Performance-based standard elements:

1. **Goal**—What the standard is meant to achieve
2. **Standard**—Rigorous expectation, not minimum standards
3. **Outcome or Performance Measure**—Rate of occurrence, number of instances, percentage of respondents, etc.
4. **Expected Practices**—Illustration of the standard done well; what the standard should look like when achieved
5. **Processes**—Verified policies, processes, use of a test or form

Source: Auditor General staff summary of *PbS Goals, Standards, Outcome Measures, Expected Practices and Processes*. PbS Learning Institute. Braintree, MA. Council of Juvenile Correctional Administrators, 2007.

The Coconino, Graham, and Pima County centers use performance-based standards.

Coconino, Graham, and Pima County centers use some form of performance-based standards—According to juvenile detention and court officials from Coconino, Graham, and Pima Counties, these juvenile detention centers use some form of performance-based standards. For example, the Coconino County juvenile detention administrator indicated that his juvenile detention center has used performance-based standards to evaluate a number of

[1] California, Connecticut, Illinois, Indiana, Missouri, North Dakota, Texas, and Virginia have operational standards that their juvenile detention centers are required to meet. Utah enforces compliance with juvenile detention center policy and procedures.

its own operations. Although the Coconino County juvenile detention administrator indicated that he used the Guidelines as the basis for his detention operations, he has gone beyond the Guidelines to also develop goals, outcome measures, expected practices, and processes to collect and analyze data related to some operations. As illustrated in Figure 1, one such performance-based standard that the Coconino County center has developed and tracked is related to the percentage of parents visiting detained juveniles. For this standard, the juvenile detention administrator established a standard that at least 70 percent of detained youth will have an in-person contact with a parent or guardian. The juvenile detention administrator also established expected practices and processes to help measure progress toward achieving this standard.

Implementing state-wide, performance-based standards for juvenile detention centers would be consistent with the Arizona Supreme Court's goal to increase accountability in the courts. One goal of the Supreme Court's Strategic Agenda for Arizona's Courts 2005-2010 is to ensure accountability. One way the Supreme

Figure 1: Model of a performance-based standard for visits with juveniles in detention

- **Goal**—Maintain and encourage juvenile-and-parent relationship. Parents should be involved with a juvenile's progression through detention. The juvenile's family and significant others should be encouraged to maintain regular contact with the juvenile. Alternative times should be individually arranged for visitors who are legitimately unable to visit a juvenile during the regularly scheduled visitation periods.
- **Standard**—At least 70 percent of youth will have in-person contact with their parent or guardian while in detention.
- **Performance Measures**—Percentage of juveniles who receive a visit from their parent or guardian, the timeliness of the visits in relationship to the juvenile's behavior management plan, and the long-term successful reintegration of the juvenile into his or her community.
- **Expected Practice**—Detention personnel should encourage and accommodate parents' and guardians' visits with their children in detention.
- **Processes**—Disseminating information and skills through staff training and the use of the facility's database to document visits received by juveniles and develop reports to track progress toward the standard.

Coconino County’s use of a target standard and performance measurement for parents’ visits with juveniles in detention

	November 2006
Percentage of youth who have had in-person contact with parents or guardians while in Coconino County Juvenile Detention	62.9
Target minimum percentage	70.0
Variance from target percentage	(7.1)

Source: Auditor General staff summary of interviews and data provided by the Coconino County juvenile court director and juvenile detention administrator, summary of *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona* (1998), and auditors' analysis of the PbS standards structure (2007).

Court envisions this occurring is by having courts adopt standards to measure operations and performance. In response to this goal, the juvenile courts' Juvenile Performance Measures Workgroup (Workgroup) has already drafted performance standards for the Arizona juvenile justice system. For example, the Workgroup proposes measuring the number of hours of community restitution juveniles worked in a year and the total dollar amount of money collected for victims through court-ordered victim restitution.

Developing and implementing performance-based standards would also bring Arizona current with national efforts in juvenile justice. Auditors identified the following efforts regarding performance-based standards at the national level:

- **Federal juvenile justice agency funds a performance based-system**—The U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP), an office within the U.S. Department of Justice that works to prevent delinquency and strengthen the juvenile justice system while protecting children and enhancing public safety, funded the creation of an award-winning program called Performance-based Standards (PbS) to improve the conditions within juvenile confinement settings. The Council of Juvenile Correctional Administrators (CJCA) runs this program, which created standards for juvenile confinement linked to goals and supported by outcome measures, expected practices, and processes. This program is now in its 12th year and has participants in 184 facilities in 28 states. The program resulted directly from a 1994 congressionally mandated study that found fault with existing procedure-based standards that were not linked to outcomes. The study found that compliance with procedure-based standards did not ensure regularity in operations among facilities. The report recommended performance-based standards that offered information on how to improve operations as they are outcome-based and measure goal attainment.[1]

- **National experts advocate performance-based standards**—The Director of the NJPS, Center for Research and Professional Development, Executive Director of the CJCA, and Director of the National Center for Juvenile Justice (NCJJ) advocate performance-based standards as a way of understanding existing operational practices and identifying ways to improve and be accountable for operations.

Two accrediting organizations, which supported creating the Guidelines, have moved to performance-based standards.

- **Accrediting organizations now require or suggest performance-based standards**—Two accrediting organizations, which were recognized for supporting the creation of the Guidelines, the ACA and the NCCHC, have implemented performance-based standards. The NCCHC suggests the use of performance-based standards, but does not require compliance with them for accreditation. However, the ACA, under the 4th edition standards, now requires its accredited agencies to implement performance-based standards.

1 Parent, Dale G., Valerie Lieter, Stephen Kennedy, Lisa Livens, Daniel Wentworth, and Sarah Wilcox. *Conditions of Confinement: Juvenile Detention and Corrections Facilities*. Cambridge, MA: Abt Associates Inc., Aug. 1994.

As the Director of the ACA Standards and Accreditation Department stated, the ACA members, consisting of over 19,000 individuals representing detention, correction, attorneys, architects, prison advocacy groups, and more, proposed standards that would accurately demonstrate the effect of operations.

Since it will take additional time and resources to develop and implement these types of standards, as well as the processes needed to measure progress toward meeting the standards, the AOC should work with the Arizona Judicial Council to establish a time frame or schedule for fully developing and implementing these standards.

Recommendations:

1. The AOC should seek the Arizona Judicial Council's direction regarding the need to identify and/or develop mandatory juvenile detention center operational standards.

2. If the Arizona Judicial Council approves the need to identify and/or develop mandatory juvenile detention center operational standards, the AOC should work with the county juvenile courts to review and improve the operational guidelines to ensure that they provide adequate direction and detail to juvenile detention centers and identify new standards where appropriate. The standards should include sufficient detail and information to provide juvenile detention centers with the guidance they will need to establish conforming policies, procedures, and practices.

    a. To assist in developing appropriate operational standards, the AOC and county juvenile courts should consult the American Correctional Association, the National Commission on Correctional Health Care, the National Partnership for Juvenile Services, the Council of Juvenile Correctional Administrators, and the Annie E. Casey Foundation.

3. Upon completing the guideline review and standards development, the AOC and county juvenile courts should submit the recommendations to the Arizona Judicial Council for its consideration and approval. The AOC and the county juvenile courts should also seek the Arizona Judicial Council's guidance regarding the most appropriate method for mandating compliance, such as recommending placing the standards in the Code or recommending that the Code indicate that county juvenile detention centers must comply with the standards.

4. Upon the Arizona Judicial Council's final approval of the standards, the AOC should take several steps to help juvenile detention centers transition as they implement operational standards, including:

    a. Providing training and technical assistance to appropriate county juvenile court and juvenile detention center staff on the mandatory standards;

b. Assisting county juvenile court staff in obtaining additional resources from their respective boards of supervisors if needed; and

c. Identifying additional resources, such as best practices and tools used by some juvenile detention centers, to share with other juvenile detention centers to help comply with the adopted standards.

5. Once it has instituted mandatory standards, the AOC should seek the Arizona Judicial Council's approval and then work with county juvenile courts to develop and implement performance-based standards and the processes needed to measure progress toward meeting the standards, as appropriate.

6. If the Arizona Judicial Council authorizes performance-based standards, as well as the processes needed to measure progress toward meeting the standards, the AOC should establish a time frame or schedule for fully developing and implementing these standards.

FINDING 3

Supreme Court should improve juvenile detention center screening

The Supreme Court should help ensure that only appropriate juveniles are detained by developing and implementing policies, procedures, and/or standards to assist county juvenile courts in making this determination. Arizona's juvenile detention centers use various tools and/or processes to assess whether juveniles should be detained. Although detention centers are needed to house juveniles who are at risk to harm others or fail to appear for court, studies indicate that these determinations need to be made carefully because juveniles in confinement can experience negative outcomes. As a result, the AOC should seek direction from the Arizona Judicial Council regarding the need to develop and implement policies, procedures, and/or standards for appropriately and consistently screening juveniles for detention, and if approved, work with county juvenile courts to develop and implement these policies, procedures, and/or standards.

Juvenile detention centers use various screening tools

The Supreme Court has not developed policies, procedures, or standards to help in assessing whether juveniles should be detained, which may result in inconsistent decisions from county to county. Arizona Juvenile Court Rule 23(D) provides five criteria to guide decisions for detaining juveniles. However, absent statewide guidance on the appropriate application of Rule 23(D), three county juvenile court directors indicate that their counties have implemented different approaches to determine if a juvenile should be detained or released while awaiting his or her court appearance. One difference is illustrated by the use of validated screening instruments in some counties, while other counties rely on the judgment of probation officers to determine if a juvenile should be

Arizona Juvenile Court Rule 23(D)

Five criteria to detain a juvenile:

- The juvenile would not be present for any hearing;
- The juvenile is likely to commit an offense that injures him- or herself or others;
- The juvenile must be held for another jurisdiction;
- The interests of the juvenile or public require custodial protection; or
- The juvenile is charged with an offense that may be prosecuted in adult criminal court.

Source: Auditor General staff summary of Arizona Juvenile Court Rule of Procedure 23(D).

The methods used to determine if a juvenile should be detained vary from county to county.

detained. For example, Maricopa and Pima Counties have a specific group of juvenile probation officers who use validated screening tools to evaluate juveniles for detention. According to these court directors, these officers are posted at the detention centers 24 hours a day. The Santa Cruz County Chief Probation Officer stated that Santa Cruz County has a probation officer on call, and this officer does not use a screening tool, but relies on his understanding of Rule 23(D) and the input from detention personnel to determine if a juvenile should be detained. Although auditors did not identify any instances where a juvenile was inappropriately detained, without policies or standards to help guide these determinations, juvenile detention centers may detain juveniles inconsistently from county to county. For example, a juvenile may be detained for breaking curfew or shoplifting in one county, but would not be detained for those offenses in another county.

The AOC's Director and some county juvenile court officials recognize that each county may detain juveniles for varying reasons. Two county court officials indicated to auditors that their manner for screening juveniles for detention is effective, whereas one county court official recognized faults within their individual system and is working to improve it.

Detention can have harmful effects on juveniles

Although detention might be needed to house juveniles who are at risk to harm others or fail to appear for court, studies indicate that decisions to place juveniles in detention need to be made carefully because detention may pose serious risk to detained youth. A U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP) report states that detention widens the gulf between juveniles and the potential positive influences within the community, such as the juvenile's family, school, and employment.[1] Additionally, according to one study examining deaths nation-wide of young people in juvenile justice facilities, juveniles in the custody population are at an approximately 8 percent higher risk of death than juveniles in the general population.[2] The authors were unable to determine the precise cause for this difference since detention centers tend to house higher rates of “at risk” youth than the general population and, because of privacy laws, individual data on juvenile deaths is unavailable. Nevertheless, the authors found that both suicide and illness occur at higher rates in juvenile detention facilities than the general population and that some characteristics of the detention center, such as its size and locked sleeping quarters, are correlated with the increased rates.

Detention may also not be appropriate for juveniles with mental illnesses. According to a 2003 federal Government Accountability Office report, a growing number of youth are being referred to the juvenile justice system solely to obtain mental health

1 Austin, James, Kelly Dedel Johnson, and Ronald Weitzer. *Alternatives to the Secure Detention and Confinement of Juvenile Offenders*. Juvenile Justice Bulletin Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Sept. 2005.

2 Gallagher, Catherine A., and Adam Dobrin. Deaths in Juvenile Justice Residential Facilities. *Journal of Adolescent Health*, 2006. 38 (2006): 662-668.

services.[1] Additionally, some Arizona juvenile detention administrators stated that mental health is a consideration for how they serve juveniles in detention and that a high portion of their detained juveniles have mental health issues. For example, as of July 27, 2007, one detention administrator stated that upwards of 60 percent of their detained juveniles have mental health issues. An OJJDP publication supports these numbers, reporting that 60 percent of male and 70 percent of female juvenile detainees met diagnostic criteria for one or more psychiatric disorders.[2] Some juvenile detention officials in Arizona say juveniles with mental health issues demand more intensive supervision and different skills from detention officers. The Pima County detention administrator stated that they are taking steps to address this issue by creating special housing units for juveniles with special behavioral needs. These units, one for each gender, provide specially trained staff and increased supervision for juveniles with behavioral problems. The detention administrator also stated that approximately 90 percent of youth housed in their special housing units have a mental health diagnosis.

Finally, the Supreme Court is reviewing the representation of minorities in juvenile detention centers. Specifically, the Supreme Court's Commission on Minorities in the Judiciary (Commission) issued its calendar year 2004 Equitable Treatment of Minority Youth Second Arizona Statewide Report Card to be used with the intent to reduce over-representation of minority youth in the justice system, as well as to provide a baseline to evaluate progress toward that goal; to identify potential problems at decision points in the juvenile justice system; and to provide a tool for administrators and policy-makers to prioritize and focus limited resources to improve the system.[3] According to data in the Commission's 2004 report and the AOC's Juveniles Processed in the Arizona Court System: Fiscal Year 2006, Arizona detained a larger proportion of the Hispanic and African-American juveniles in Arizona than their proportion in the population. For example, African-American juveniles represent 4.37 percent of the general population in Arizona, but 9.95 percent of the juveniles detained in Arizona. Hispanic juveniles represent 37.49 percent of the general population in Arizona but 43.86 percent of the juveniles detained in Arizona.

The Supreme Court is reviewing the representation of minorities in juvenile detention centers.

The Pima County Juvenile Court has taken some steps to reduce the number of minority youth in detention. The Juvenile Court Director for Pima County stated that they have worked with the W. Haywood Burns Institute to reduce the number of minority youth in detention and the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative to develop and use a validated tool to screen appropriate youth

1 U.S. Government Accountability Office. *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services*. Washington D.C.: U.S. Government Accountability Office, April 2003.

2 Linda A. Teplin, Abram, Karen M., Gary M. McClelland, Amy A. Mericle, Mina K. Dulcan, and Jason J. Washburn. Psychiatric Disorders of Youth in Detention. *Juvenile Justice Bulletin*. Washington D.C. Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice, April 2006.

3 Arizona Supreme Court. Commission on Minorities in the Judiciary, Juvenile Justice Services Division. Arizona Supreme Court. Administrative Office of the Court. *Equitable Treatment of Minority Youth: Second Arizona Statewide Report Card: Calendar Year 2004*.Phoenix: Supreme Court, State of Arizona, n.d.

into detention. The Director of Juvenile Court Services for Maricopa County recognizes the strength of Pima County Juvenile Detention's validated screening tool and is working to integrate some of the strengths of Pima's screening tool into its own validated screening instrument.

Screening standards needed

The AOC should seek direction from the Arizona Judicial Council regarding the need to develop and implement policies, procedures, and/or standards for the application of Arizona Juvenile Court Rule 23(D) to appropriately and consistently screen juveniles for detention. If the Arizona Judicial Council approves, the AOC should then work with the county juvenile courts to develop and implement these policies, procedures, and/or standards, including a potential requirement that counties use a validated screening instrument. Counties are already attempting to detain only appropriate juveniles, and the total number of juveniles detained state-wide has dropped from 13,660 in 2002 to 12,068 in 2006. However, because counties may detain juveniles for different reasons and have different options for alternatives to detention, the potential exists that a juvenile in one county would be detained for a reason that would not justify detention in another county. Thus, policies and/or standards should provide for greater consistency among detention centers throughout Arizona. However, these policies and/or standards should also recognize legitimate county-level concerns regarding the safety of the juveniles and the community within their jurisdiction.

To help ensure that there are viable alternatives to detention, the AOC should work with the counties to continue their efforts to identify and use detention alternatives. A report by the OJJDP states that alternatives to detention are typically more cost-effective and can be less harmful than detaining a juvenile in detention.[1] According to this same report, positive alternative options to detention may include outright release, home detention, electronic monitoring, intensive supervision, day and evening reporting centers, skills training, and services to help juveniles and their families.

Redirecting juveniles from detention to other programs has been cost-effective for Pima County.

According to the Pima County Juvenile Court Director, redirecting juveniles from detention into alternative programs has proven cost-effective for Pima County. Specifically, the Pima County juvenile detention administrator indicates they have reduced their average daily juvenile population in detention by 49 juveniles, dropping from an average daily population of 176 juveniles in 2003 to 127 in 2006. This has resulted in cost savings. Specifically, according to the Pima County Juvenile Court Director, it costs $154 a day to detain a juvenile versus $6.46 a day for electronic monitoring, $47.10 for a day at their Domestic Violence Alternative Center, or $65 a day to provide services for juveniles at an evening reporting center. According to this

[1] Austin, James, Kelly Dedel Johnson, and Ronald Weitzer. *Alternatives to the Secure Detention and Confinement of Juvenile Offenders*. Juvenile Justice Bulletin Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Sept. 2005.

same official, Pima County has redirected cost savings to two new staff positions: Clinical Director and a Senior Research Director for their Juvenile Court. Additional community benefits may also be occurring. The Pima Juvenile Court studied 3,299 juveniles screened at its juvenile detention center from October 7, 2005 through December 31, 2006. More than 2,070 of these juveniles were released at intake, with nearly 94 percent of those released identified as low risk to re-offend. Less than 6 percent of these juveniles re-offended within 4 weeks of release, and just over 10 percent re-offended between 5 to 8 weeks. According to the Annie E. Casey Foundation, a re-offense rate that is less than 10 percent of the release cohort is acceptable. Rates under 5 percent are generally considered good, whereas very low re-offense rates may indicate that the screening instrument is too restrictive.[1]

The Supreme Court and the AOC, through their management of federal funding and their own Juvenile Probation Services Fund, have been able to redirect monies to counties to fund alternatives to detention. For example, in fiscal year 2008, the AOC granted nearly $900,000 to counties for various detention alternatives. This money is going to five different counties and includes money for a day reporting center in Yavapai County, foster care and shelter beds in Pinal County, support staffing at a proposed evening reporting center in Pima County, and money to a community-based vendor helping juveniles re-enter the community after a stay in detention in Mohave County. Although these monies will expire in fiscal year 2008, the Supreme Court is requesting funds in its fiscal year 2009 budget request to continue its support for these types of alternative programs. The AOC should continue to encourage the use of alternatives to detention by continuing to request funding for the use of effective alternatives to detention and funding projects that help juveniles reintegrate into their communities after a stay in detention.

In fiscal year 2008, the Court directed almost $900,000 to alternative detention projects at the county level.

Recommendations:

1. The AOC should seek the Arizona Judicial Council's direction regarding the need to develop state-wide policies, procedures, and/or standards for the application of Arizona Juvenile Court Rule 23(D) to appropriately and consistently screen juveniles for detention, while also recognizing legitimate county-level concerns regarding the safety of the juveniles and the community within their jurisdiction.

2. If the Arizona Judicial Council approves the need to develop juvenile detention screening policies, procedures, and/or standards, the AOC should work with the county juvenile courts to develop such policies, procedures, and/or standards, including a potential requirement that counties use a validated screening instrument, and then submit its recommendations to the Arizona Judicial Council for its consideration and approval.

[1] Steinhart, David. *Juvenile Detention Risk Assessment: A Practice Guide to Juvenile Detention Reform*. Baltimore, MD: Annie E. Casey Foundation, Juvenile Detention Alternatives Initiative, 2006

3. The AOC should work with the counties to continue their efforts to identify and use detention alternatives.

4. The AOC should continue to encourage the use of alternatives to detention by continuing to request funding for the use of effective alternatives to detention and funding projects that help juveniles reintegrate into their communities after a stay in detention.

FINDING 4

Supreme Court should improve juvenile detention center inspection program

To help ensure that juvenile detention centers provide a safe and secure environment for detained juveniles, the Supreme Court, through the Administrative Office of the Courts (AOC), should develop and implement a more comprehensive juvenile detention center inspection program. Although both the AOC and the Arizona Department of Juvenile Corrections (Juvenile Corrections) conduct inspections of juvenile detention centers, these inspections are limited, and there is no enforcement of the recommendations that result. Since the Supreme Court is better positioned to conduct inspections of these facilities and has administrative authority over these facilities, the Legislature should consider amending statute to replace Juvenile Corrections with the AOC as the entity responsible for inspecting detention centers. Additionally, the AOC should develop and implement a more comprehensive inspection program.

Inspections of juvenile detention centers limited

Although both Juvenile Corrections and the AOC conduct inspections of juvenile detention centers, these inspections are limited in scope and impact. Statute requires Juvenile Corrections to conduct inspections of juvenile detention center operations, and the AOC conducts similar inspections of these facilities. However, each Juvenile Corrections and AOC inspection reviews compliance with only a minimal number of operational guidelines. Additionally, because recommendations from Juvenile Corrections and the AOC are not enforced, some identified issues continue for years at some juvenile detention centers.

Two agencies perform detention center inspections—Juvenile Corrections has the statutory responsibility to conduct inspections of juvenile detention centers, but the AOC also performs inspections. Specifically, A.R.S. §8-306(B) requires Juvenile Corrections to inspect each county juvenile detention

center semiannually and to make a written report on the condition and operation of each juvenile detention center, along with recommendations, to the presiding judge of the respective county's juvenile court and board of supervisors. However, statute does not provide Juvenile Corrections with the authority to enforce compliance with inspection findings and recommendations. Juvenile Corrections performs one inspection of each juvenile detention center during the first 6 months of the year and a second inspection during the last 6 months of the operational year. Although not appropriated staff to perform these inspections, Juvenile Corrections reports that these activities could be performed by the equivalent of one full-time staff person. Juvenile Corrections inspectors conduct inspections using the *Operational Guidelines and Best Practices for Juvenile Detention Care in Arizona* (Guidelines). For Juvenile Corrections inspections, inspectors select and examine an average of 3 to 4 of the 74 guidelines at each juvenile detention center during one 6-month period, and then select and review a different set of about 3 of the Guidelines at each juvenile detention center during the next inspection (See Finding 2, pages 31 through 40, for more information on the Guidelines).

In 2002, the AOC began to conduct inspections of juvenile detention centers with Juvenile Corrections. Although it does not have a statutory responsibility to conduct inspections, according to the AOC's Director, the AOC started inspecting the conditions of the juvenile detention centers with Juvenile Corrections to monitor facility construction and provide technical assistance because state monies were being used to construct new or rehabilitate existing juvenile detention centers. These inspections are performed by one AOC staff person. In 2004, the AOC started conducting its own annual inspections of each juvenile detention center, and stopped conducting inspections with Juvenile Corrections. They started conducting separate inspections because according to AOC staff, some juvenile detention centers preferred to not have both agencies inspecting at the same time. Even though separate inspections are conducted, according to the Juvenile Corrections Director, the AOC and Juvenile Corrections have an informal agreement to make both programs compatible. The AOC and Juvenile Corrections both inspect using the Guidelines; however, each focuses on different areas of the Guidelines. AOC inspectors have examined an average of 2 of the 74 guidelines in their inspections. In addition, the AOC inspects each juvenile detention center once every 3 years as part of an operational review of each county's juvenile court system. These reviews examine juvenile detention center compliance with statutes and rules that require the filing of a petition alleging incorrigible or delinquent conduct or a criminal complaint within 24 hours of detaining a juvenile, a juvenile's right to make a phone call upon detainment and to have visitors, that juveniles be detained separate and apart from confined adults, and that the juvenile detention center offers an education program.

Inspection Components

AOC and Juvenile Corrections inspections consist of the following:

- An interview between the juvenile detention center administrator and inspector to discuss and review juvenile detention center policies and procedures related to the particular guidelines under review.
- Review of recent Fire Marshal and Health Department reports.
- A followup on issues from the previous inspection.
- A facility walk-through in which the facility is inspected for cleanliness, safety, and security issues.

Source: Auditor General staff analysis of inspection reports and observations of Juvenile Corrections and AOC inspections.

Inspections are limited and lack enforcement—Even though the two agencies between them conduct a total of three inspections annually at juvenile detention centers, these inspections are limited. Inspections have not covered all the Guidelines, the scope of Juvenile Corrections inspections is limited, and issues of noncompliance have not been addressed. Specifically:

- **Inspections do not cover all the Guidelines**—According to inspectors, the AOC and Juvenile Corrections coordinate which areas of the Guidelines they will inspect during the course of the year based on issues that have occurred at one juvenile detention center, which may be a concern for the other juvenile detention centers, new and revised guidelines, and guidelines not recently reviewed. However, since each inspection only reviews juvenile detention center compliance with an average of three of the Guidelines, Juvenile Corrections and the AOC have yet to inspect for juvenile detention center compliance with many of the Guidelines. Auditors' review of the Juvenile Corrections biannual and AOC annual inspection reports from 2003 to 2007 found that while inspections covered most of the 36 operational guidelines pertaining specifically to health services, recreation, juvenile rights, and safety and security, ten important guidelines related to health and safety and security have not been reviewed by either Juvenile Corrections or the AOC (see textbox for specific guidelines not inspected).

Health, Safety, and Security Guidelines that Juvenile Corrections and the AOC have not reviewed between 2003 and 2007 include:

- Medical care and treatment
- Medical information and records transfer
- Internal review process for health services
- Fire safety procedures
- Classification for special needs
- Behavior management system
- Disciplinary reports and hearings
- Control of entry and exit to detention facilities
- Firearms and offensive weapons
- Personal and valuable property

Source: Auditor General staff review of Juvenile Corrections and AOC inspection reports for 2003 to 2007.

- **Juvenile Corrections inspections limited**—Juvenile Corrections inspections focus on whether the juvenile detention centers have policies and procedures that address the Guidelines, but generally do not determine whether the juvenile detention centers follow their policies and procedures. Auditors' observation of inspections and auditor review of Juvenile Corrections inspection reports found that they seldom reviewed logs and records or noted observations as evidence that the juvenile detention center was following their policies and procedures. In a few instances, auditors observed Juvenile Corrections inspectors asking staff if they followed a particular procedure, but the inspectors did not verify this information. According to a Juvenile Corrections inspector, since the juvenile detention center administrator is responsible for following policies and procedures, Juvenile Corrections relies on administrator assurances that policies and procedures are followed. In contrast, auditor observation and report review found that AOC inspections included more observations and reviews of various logs and records to determine whether the juvenile detention centers followed their policies and procedures.

AOC inspections have resulted in more findings and recommendations.

Further, auditors found that AOC inspections resulted in more findings and recommendations than Juvenile Corrections reports. For example, in the 2005 AOC inspection reports for the 14 detention centers, there were a total of 76 issues and corresponding recommendations discussed, including followup on issues from the previous year's inspections. For Juvenile Corrections' 14 inspection reports from the first 6 months of 2006, only 6 issues were noted among 5 detention centers. For Juvenile Corrections' 14 inspection reports from the second 6 months of 2006, only 4 issues were noted among two centers. This disparity in findings and recommendations may result from the more limited scope of Juvenile Corrections inspections, which largely focus on a review of policies and procedures, instead of determining whether detention centers follow their policies and procedures.

- **Compliance with recommendations not enforced**—When Juvenile Corrections and AOC inspections include findings and recommendations, juvenile detention center compliance with the recommendations has largely depended on the juvenile detention centers' willingness to take action. Although the AOC has authority to enforce compliance with inspection recommendations through the Supreme Court's authority over the presiding judges of the juvenile court in each county, it has not exercised this authority to ensure that the juvenile detention centers address recommendations.

Limited inspections weaken oversight and lessen juvenile and public protection—The limited inspections and lack of enforcement have resulted in inspection findings that have continued for several years without correction. Auditors' review of inspection reports found that, in some cases, findings and corresponding recommendations were noted in reports for 4 consecutive years with no indication of compliance by the juvenile detention center. For example:

- **Juvenile detention center staff not tested for tuberculosis**—Separate inspections conducted by Juvenile Corrections and the AOC found that a juvenile detention center had not tested its staff for tuberculosis. The Guidelines prescribe testing staff for tuberculosis within 6 months of hiring and annually thereafter to reduce the risk of juveniles' and staff's contracting the disease. However, a 2004 Juvenile Corrections inspection report found that a juvenile detention center was not testing its staff for this disease. Additionally, according to this same report, the juvenile detention center did not comply with this guideline for at least a year prior to the 2004 inspection. Subsequent inspections conducted by Juvenile Corrections and the AOC in 2005 and 2006 noted continued noncompliance with this guideline. During the audit, auditors brought this issue to the attention of AOC officials. As indicated in Finding 1, according to this juvenile detention center's administrator, as of April 2007, all staff had been tested for tuberculosis (see Finding 1, pages 11 through 30, for additional information).

- **Health Services Guideline not followed**—For four consecutive inspections conducted in 2004 through 2007, the AOC found that one juvenile detention center did not have on-site access to a licensed medical professional to oversee medical care. The Guideline prescribes that a licensed medical professional be designated as the facility's health services authority, responsible for the design and provision of health services, including final medical judgments. Although the juvenile detention center had access to a county health nurse, according to a 2002 AOC inspection report, the nurse was rarely available to the facility. The AOC's 2004 inspection report again noted that the nurse did not routinely visit the juvenile detention center and that detention officers were dispensing prescription medication to the juveniles without supervision by a licensed medical professional. The AOC's 2005 through 2007 inspection reports reiterated that no licensed medical professional routinely conducts site visits at that juvenile detention center. These inspection reports recommended that the county contract with a medical service provider or create a position within the county health department to properly monitor juvenile medical care. In September 2007, the deputy county manager reported that the county was interviewing nurses, but the position had yet to be filled.

Detention officers dispensed prescription medication without supervision by a medical professional.

- **Juveniles confined to rooms upon admission**—A 2004 AOC inspection found that a juvenile detention center had a policy of confining juveniles to their rooms for 24 to 48 hours after admission while awaiting school placement. The inspector noted that this practice could contribute to the risk of juveniles' becoming suicidal because of isolation and reduced contact with detention personnel, and recommended involving newly admitted juveniles in program activities. The AOC's 2005 inspection noted that the juvenile court director decided to retain this policy. As a result, the inspector restated the original recommendation and added that if detention personnel continue the policy, they should adopt another policy to maintain a visual watch log on the juveniles along with documented hourly verbal contact. The AOC then discontinued pursuing this issue. According to AOC staff, it sometimes stops pursuing issues if the juvenile court director decides not to follow the recommendation, or if funding from the county board of supervisors is necessary to comply with the recommendation. In September 2007, this juvenile detention center's administrator indicated that they were revising their policy and will begin allowing juveniles to participate in detention programs upon admission, unless they need close supervision because of the influence of alcohol or drugs, or are a threat to themselves or staff.

Supreme Court should improve the juvenile detention center inspection program

To ensure that juvenile detention centers properly safeguard and care for detained juveniles and ensure public protection, the Supreme Court should develop and implement a comprehensive juvenile detention center inspection program. Specifically, the Legislature should consider replacing Juvenile Corrections with the AOC as the entity responsible for conducting inspections since the Supreme Court, through the AOC, may be better positioned to develop and conduct a comprehensive inspection program. If given this responsibility, the AOC should then develop and implement a comprehensive inspection program to include a review of juvenile detention centers' compliance with the Guidelines.

Supreme Court may be better suited to conduct all juvenile detention center inspections—Several factors indicate that the Supreme Court, through the AOC, may be better suited to develop and implement a comprehensive juvenile detention center inspection program. Specifically:

The Supreme Court has the authority to enforce inspection recommendations.

- **Supreme Court authorized to enforce findings**—As previously mentioned, the Supreme Court has the authority to enforce compliance with its inspection findings and recommendations. The Supreme Court has authority over the presiding judge of the county juvenile court, which in turn oversees juvenile detention center operations, and thus has the ability to enforce compliance with its findings and recommendations. In contrast, absent specific statutory authority, Juvenile Corrections lacks authority to enforce compliance with its inspection findings and recommendations. Although both the AOC and Juvenile Corrections work with juvenile detention centers to achieve compliance, in the event that a juvenile detention center chooses not to comply, the Supreme Court has the authority to mandate compliance.

- **Supreme Court now very active in oversight**—When inspections were originally established, the Supreme Court, through the AOC, did not have the capability or the clear authority to conduct inspections of juvenile detention centers. According to the AOC's Director, the AOC had minimal staff that supported only the Supreme Court and its functions. Further, at that time, superior courts were considered county courts, and the AOC was not involved with the county courts until subsequent lawsuits determined that court employees are state employees. Therefore, the Department of Corrections was first given the responsibility to conduct juvenile detention center inspections in 1970, and this responsibility was transferred to Juvenile Corrections when it was created in 1991.

However, circumstances have changed, and the AOC now has significant involvement in assisting the juvenile detention centers. First, as previously noted, the AOC now conducts annual inspections of each juvenile detention center. Additionally, the AOC reviews juvenile detention center operations during operational reviews of county juvenile court systems every 3 years. The AOC also provides technical support to the juvenile detention centers, including training academies, assistance in obtaining federal grants for education, and additional inspections at the request of juvenile detention centers.

Finally, in cases where funding is needed to achieve compliance with inspection findings and recommendations, the AOC advocates for juvenile detention centers to obtain necessary funding in its inspection reports. For example, in 2006, one juvenile detention center had an escape occur that resulted in the AOC's conducting a special review of the juvenile detention center and its operations. This special inspection involved a more comprehensive review of the juvenile detention center's operations than an annual inspection would typically involve. According to a county juvenile court official, the inspection report, which indicated a need for additional staff, along with other analysis performed by county personnel, provided important information for the county board of supervisors' consideration in deciding to appropriate six additional staff to the juvenile detention center.

- **Juvenile Corrections focused on correctional issues**—Inspecting juvenile detention centers is a lesser priority for Juvenile Corrections. According to the Juvenile Corrections' Director, although Juvenile Corrections has a responsibility to inspect juvenile detention centers and could also provide technical support to the juvenile detention centers, their time is taken up by federal monitoring as a result of serious safety and security issues within its own juvenile corrections facilities, which is a top priority for the agency. Although the Director reported that federal monitoring was completed as of September 2007, Juvenile Corrections still needs to establish internal processes to prevent these issues from reoccurring at its facilities in the future.

Therefore, the Legislature should consider revising statute to replace Juvenile Corrections with the AOC as the entity responsible for inspecting juvenile detention centers.

The Legislature should consider giving the AOC responsibility for inspections.

AOC should develop a more comprehensive inspection program—

If given the statutory responsibility for inspecting juvenile detention centers, the AOC should increase the scope and impact of its inspections to bring Arizona's inspection program more in-line with those in other states that auditors reviewed. Auditors' interviews with juvenile detention inspection administrators in six states, five in which the local or state judiciary administer the juvenile detention centers

The AOC should conduct a thorough inspection of each juvenile detention center at least once every 3 years.

and one where a state executive agency administers detention centers, found that five of these states conduct more extensive inspections than those performed by the AOC or Juvenile Corrections.[1] These five states review juvenile detention center compliance with all applicable standards or guidelines during an inspection, as opposed to the review of a limited number of guidelines, as is the practice in Arizona. Inspection teams in Indiana and Illinois conduct these extensive inspections annually, while inspections in Connecticut and Virginia are conducted every 3 years. In Utah, privately operated centers are inspected for all guidelines annually, whereas state-run centers are inspected every 2 years. In all five states, inspectors visit the facilities in between inspections for various purposes, such as to conduct less-extensive inspections, including unannounced spot checks for compliance, to follow up on past issues, and to provide technical assistance.

Similarly, if given the responsibility for inspecting juvenile detention centers, the AOC should develop and implement policies and procedures establishing a comprehensive juvenile detention center inspection program. This program should consist of a thorough inspection of each juvenile detention center at least once every 3 years where compliance with all the Guidelines is assessed. This inspection should include a review of policies and procedures for adherence to each guideline, a review of supporting evidence to determine if the juvenile detention center's policies and procedures are followed; a review of fire and health inspection reports; a facility walk-through for cleanliness, safety, and security issues; and satisfaction interviews with staff and juveniles. The inspection report should comprehensively detail all aspects of the inspection, including which documents were reviewed and/or observations were made to determine compliance, and details of all discussions regarding issues and recommendations. The AOC should conduct additional annual inspections of juvenile detention centers to spot-check against a few selected guidelines, follow up on issues found during past inspections, inspect for issues that have surfaced among the juvenile detention centers, check for compliance with newly created guidelines, conduct a facility walk-through for safety and security issues, and provide technical assistance.

In addition to conducting more comprehensive inspections, the AOC should enforce compliance with its recommendations by requiring and approving corrective action plans, and continuing to follow up with juvenile detention centers on their efforts to implement corrective actions. Depending on the seriousness and the nature of the deficiency, followup may consist of additional site visits and/or a review of documentation submitted by the juvenile detention center. The AOC should perform followups and enforcement of juvenile detention center inspection findings and recommendations, regardless of whether or not it receives sole responsibility to conduct inspections. If a juvenile detention center has difficulty complying with a finding or recommendation because it lacks resources and/or funding, the AOC should establish and implement procedures for working with the

1 Auditors interviewed state inspection officials in Connecticut, Illinois, Indiana, Missouri, Utah, and Virginia. Only Missouri does not conduct inspections of its juvenile detention centers. Auditors contacted Utah to obtain information where the detention center is operated by a single state executive agency.

juvenile detention center and enlisting the assistance of the presiding judge to help secure compliance. Finally, the AOC should review its staff resources and assess whether it has sufficient staff to properly implement and maintain the improved inspection program or needs additional staff to do so. If additional staff resources are needed, the AOC should review and consider various options for obtaining these resources, including shifting internal staff resources or working with the county juvenile courts and/or the Legislature to obtain additional staff resources.

Recommendations:

1. The Legislature should consider revising statute to replace Juvenile Corrections with the AOC as the entity responsible for inspecting juvenile detention centers.

2. If given responsibility for inspections, the AOC should develop and implement a comprehensive juvenile detention center inspection program by developing and implementing policies and procedures that require the following:

    a. Conducting a thorough inspection of each juvenile detention center every 3 years where compliance with all guidelines is assessed, including reviewing juvenile detention center policies and procedures for adherence to each guideline; seeking supporting evidence to determine if the juvenile detention center's policies and procedures are followed; reviewing fire and health inspection reports; conducting facility walk-throughs to inspect for cleanliness, safety, and security issues; and conducting satisfaction interviews with staff and juveniles;

    b. Preparing comprehensive inspection reports that include which documents were reviewed and/or observations were made to determine compliance, and details of all discussions regarding issues and recommendations;

    c. Conducting additional annual inspections of juvenile detention centers to spot-check against a few selected guidelines, follow up on issues found during past inspections, inspect for issues that have surfaced among the juvenile detention centers and for compliance with newly created guidelines, to conduct a facility walk-through to look for safety and security issues, and to provide technical assistance;

    d. Enforcing compliance with inspection recommendations by requiring and approving corrective action plans;

    e. Following up with juvenile detention centers on their efforts to implement corrective actions through site visits and/or documentation reviews; and

f. Working with detention centers and enlisting the assistance of the presiding judge in cases where the juvenile detention center has difficulty complying with a finding or recommendation because of a lack of resources and/or funding.

3. The AOC should review its staff resources and assess whether it has sufficient staff to properly implement and maintain the improved inspection program or if it needs additional staff to do so. If the AOC determines that it needs additional staff resources, it should review and consider various options for obtaining these resources, including shifting internal staff resources or working with the county juvenile courts and/or the Legislature to obtain additional staff resources.

4. If the AOC does not receive sole responsibility to conduct inspections and both the AOC and Juvenile Corrections continue to inspect juvenile detention centers, the AOC should ensure that recommendations resulting from these inspections are implemented.

APPENDIX A

Selection process for juvenile detention centers

The State has 14 juvenile detention centers (centers) located in 13 counties. To select juvenile detention centers to audit, auditors reviewed both the AOC and Juvenile Corrections inspection reports for all 14 juvenile detention centers. Auditors initially conducted a preliminary on-site review for 7 juvenile detention centers. These 7 juvenile detention centers represented key characteristics deemed representative of the State's juvenile detention centers, including:

- Size of average daily population (number of juveniles served)
- Center location (rural, urban, and/or border county)
- Center age (old, new)
- Population composition

Auditors, working in collaboration with the Office of the Auditor General's senior methodologist, used the preliminary audit work on the 7 juvenile detention centers to make a final selection for audit fieldwork. Because of other auditing commitments and limited resources, a full review of all 14 juvenile detention centers was not feasible. Therefore, auditors selected juvenile detention centers that would both represent most of the juveniles housed in state juvenile detention centers and best reflect significant variations in center size, urbanization, age, and proximity to the Mexican border. Based on these characteristics, the following county juvenile detention centers were selected for review during fieldwork:

- **Maricopa County-Durango—**Largest average daily population in the State with an estimated 237.6 juveniles per day in fiscal year 2007; urban; new juvenile detention center opened April 2005; and serves the most detained juveniles.[1]

- **Pima County—**Third-largest center in the State with a fiscal year 2007 average daily population of 123.6; urban, yet encounters border-related issues; new juvenile detention center opened February 2000; together with Maricopa County, accounts for the majority of detained juveniles in the State.

1 Fiscal year 2007 average daily population for Maricopa-Durango represents an estimate based on an auditor analysis of monthly data provided by Maricopa County juvenile court officials. Based on average daily population, Maricopa County has the two largest juvenile detention centers in the State—Durango and its Southeast center.

- **Coconino County**—Average daily population of 20.6 in fiscal year 2007; serves a large rural area; new juvenile detention center opened July 2001; serves a large Native American juvenile population.

- **Mohave County**—Average daily population of 27.3 in fiscal year 2007; rural, yet rapidly growing area; new juvenile detention center opened 1999.

- **Santa Cruz County**—Average daily population of 14.9 in fiscal year 2007; rural and encounters border-related issues; original juvenile detention center opened in 1990; serves a large Hispanic juvenile population.

Auditors used most of the same characteristics to exclude the remaining juvenile detention centers. For example, the age of a juvenile detention center served to exclude Pinal County (too new) and Yavapai County (too old) in that juvenile detention center "newness" or "oldness" may account for some operational deficiencies. Similarly, small average daily population and/or unique population served to exclude Apache, Graham, and Navajo County juvenile detention centers. Graham County juvenile detention center also houses federal juvenile detainees and represents the only juvenile detention center in the State accredited by the American Correctional Association. Therefore, auditors did not select this juvenile detention center. Auditors excluded Cochise, Gila, and Maricopa County Southeast juvenile detention centers because these juvenile detention centers possess characteristics (i.e., average daily population, location/urbanization) similar to those of the five juvenile detention centers selected. Lastly, the Yuma County center was not selected because it was felt that any operational issues that may arise in a juvenile detention center of this size with a fiscal year 2007 average daily population of 51.6 would also be present in the larger juvenile detention centers of Maricopa-Durango and Pima Counties. Similarly, any border-related issues that the Yuma County center may have would likely also occur at the Pima and Santa Cruz County centers.

Selection process for state operational guidelines

In order to review operations at the five centers selected, auditors had to decide what operational areas to examine. Auditors first examined the state operational guidelines in an effort to identify general operational areas of interest. The state operational guidelines establish minimum guidance for the safe and effective operation of juvenile detention centers in the State and were developed by various state, county, and community stakeholders in 1998. Auditors reviewed all 74 state operational guidelines with an eye toward identifying those guidelines that most directly address and/or affect safety and security issues. These issues possess the potential, individually and collectively, to increase or decrease the risk of operational failure, as well as enhance or compromise juvenile care.

Of the 74 possible guidelines, auditors selected 18 guidelines from all four operational areas in the operational guidelines. Based on auditors' review, these selected guidelines focus on safety, security, and juvenile welfare. These operational areas are:

- Administrative/Management—Detention officer training, policy and procedure manual.

- Juvenile Services—Health services authority, health screening (includes tuberculosis testing), pharmaceuticals, suicide prevention and intervention.

- Detention Operations—Staffing ratios, classification, records and documentation, behavior management, population management, isolation, mechanical restraints, transporting juveniles, searches of persons and facility, key control.

- Physical Plant—Control room and perimeter security (part of larger guideline on security and hazardous materials).

Auditors then used these 18 guidelines as a basis to conduct on-site observations and interviews aimed at assessing selected operations at the five juvenile detention centers. Auditors also considered national standards, best practices, and practices already in place at the juvenile detention centers as part of the review process. Auditors made between two and four site visits to each of the five juvenile detention centers selected for review and spent close to 100 total hours (between 15 and 20 hours per juvenile detention center), interviewing detention personnel and observing juvenile detention center practices and procedures. Auditors collected policy and procedure documents and reviewed various juvenile detention center policies and procedures, reports, and logs. Auditors also implemented structured interviews with juvenile court personnel, such as chief probation officers, detention administrators, detention supervisors, and detention officers, as well as conducted extensive interviews with other court personnel, including court directors and AOC administration.

Auditors reported on 13 of the 18 operational guidelines deemed most representative of the general categories of safety and security, healthcare services, behavior management, and staffing and training as presented in Finding 1 (see pages 11 through 30).

APPENDIX B

This appendix provides more information about the people interviewed and resources used while conducting this audit. It includes biographies of some of the people interviewed and a bibliography of sources used in the audit.

Biographies

Included below are the biographies of six individuals representing national-level organizations in the area of juvenile justice who were consulted for Findings 2 and 3 of the Juvenile Detention Audit. These individuals generously shared their years of professional experience and expertise in the field of juvenile justice with the auditors. They were referred to auditors by their agencies, or auditors contacted them based on their research. Their help was critical to the development of the direction and scope of Finding 2's discussion on standards and performance-based standards, and to a lesser extent, Finding 3's discussion on screening the appropriate juveniles into detention.

- Barbara Dooley, Ph.D., is the Associate Director for Training for the National Partnership for Juvenile Services (NPJS), Center for Research and Professional Development, and is the Standards Committee Chair for the National Juvenile Detention Association (NJDA), which was enfolded into the NPJS in 2004. Dr. Dooley has worked with the Arizona Administrative Office of the Courts to share her knowledge with Arizona's detention personnel on suicide prevention training. Dr. Dooley worked for many years as the Director of Madison County Juvenile Court Services in Jackson, Tennessee. As director of the Madison County Juvenile Court Services, she served as a practitioner resource for the creation of the *Desktop Guide to Good Juvenile Detention Practices* (1996).

- Earl Dunlap is the Chief Executive Officer of the NPJS and, prior to its merge with the NPJS, was the Executive Director of the NJDA since 1985. Mr. Dunlap works on a series of state and federal grants targeting the improvement of training and professional development for detention caregivers, the reduction of facility-crowding issues, and the overall improvement of quality of life in juvenile detention. Mr. Dunlap has been the Director of Juvenile Justice and Detention

Services/Training Resource Center for Eastern Kentucky University since 1991 and has been the Chief Executive Officer of his own consulting service, Earl L. Dunlap Inc., where he has provided consulting, training, and technical assistance in all facets of juvenile justice since 1985. Mr. Dunlap develops alternatives-to-detention and diversion programs with state and local officials nation-wide. Mr. Dunlap served as a consultant to the Justice Policy Institute's *The Dangers of Detention: the Impact of Incarcerating Youth in Detention and Other Secure Facilities* (Nov. 2006) and served on the advisory board for the Abt Associates Inc. study, written by Dale Parent, *Conditions of Confinement: Juvenile Detention and Corrections Facilities* (1994). Mr. Dunlap served on the American Correctional Association's Board of Governors from 1986 to 1988.

- Hunter Hurst has been the Director of the National Center for Juvenile Justice (NCJJ) since its founding in 1973. The NCJJ is a non-profit research organization concentrating solely on the juvenile justice system and the prevention of juvenile delinquency and child abuse and neglect. The NCJJ is the research division of the National Council of Juvenile and Family Court Judges. Mr. Hurst has conducted 26 juvenile detention assessment and planning studies, including three state-wide studies and a national post-occupancy survey of administrator satisfaction with newly built facilities. Before joining the NCJJ, Mr. Hurst served as Director of Intake, East Baton Rouge Parish, Louisiana Family Court, and Director of Survey and Planning Services for the National Council on Crime and Delinquency in Austin, Texas. Mr. Hurst served on the advisory board for the Abt Associates' study, *Conditions of Confinement: Juvenile Detention and Corrections Facilities* (1994), written by Dale Parent.

- Edward J. Loughran is Executive Director of the Council of Juvenile Correctional Administrators (CJCA) and is the director of the CJCA Performance-based Standards project. Mr. Loughran authored Performance-based Standards (PbS) for Youth Correction and Detention Facilities: A System for Continuous Improvement, a presentation for the *Measuring Success: Examples of State and District Data Collection Systems* Web seminar. Mr. Loughran is also involved with a Models for Change project, sponsored by the John D. and Catherine T. MacArthur Foundation, in which he examines mental health issues in the juvenile confinement system. Previously, Mr. Loughran was a Program Director for juvenile offenders and Administrator with the New York State Division for Youth. He has served as Director of Juvenile Justice Programs for the Robert F. Kennedy Memorial, where he administered a grant to provide technical assistance to several juvenile correctional agencies across the country. Mr. Loughran was a consultant on the *Desktop Guide to Good Juvenile Detention Practices* (1996) and served as Commissioner of the Massachusetts Department of Youth Services (DYS) from 1985 to 1993. Prior to that, he served for more than 5 years as Deputy Commissioner. During his tenure, the National Council on Crime and Delinquency declared the DYS the most cost-effective juvenile justice agency in the country, with the lowest recidivism rate.

- **Mary V. Mentaberry** has served as Executive Director of the National Council of Juvenile and Family Court Judges (NCJFCJ) since October 2004. In that role, Ms. Mentaberry oversees all areas related to the administration of the organization and works with the United States Senate and House of Representatives to ensure continued funding for NCJFCJ. She has worked with the NCJFCJ in numerous capacities since 1969, including serving as the Director of the organization's Permanency Planning for Children Department from 1996 to 2004. As Director of the Permanency Planning for Children Department, she had oversight for all the work underway within the department, including the Model Court Projects, various state court improvement and research projects, and the Juvenile Delinquency Guidelines Project. Ms. Mentaberry has also authored or co-authored numerous publications, including the 2004 report *Building a Better Court: Measuring and Improving Court Performance and Judicial Workload in Child Abuse and Neglect Cases*.

- **David Roush, Ph.D.,** serves as the Director of the NPJS Center for Research and Professional Development. Dr. Roush is also a faculty member in the School of Criminal Justice at Michigan State University. Dr. Roush served as the Task Force Vice-Chair for the 2004 National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities. Dr. Roush authored the *Desktop Guide to Good Juvenile Detention Practices* (1996), as well as the article "The Performance-Based Standard: Implications for Juvenile Health Care," published in the *Journal of Correctional Health Care* (2004). When he was the Director of the Calhoun County Juvenile Home in Michigan, Dr. Roush served as a consultant to the Abt Associates' study written by Dale Parent, *Conditions of Confinement: Juvenile detention and corrections facilities* (1994). Dr. Roush served on the American Correctional Association's Board of Governors from 1988 through 1990 and has been on the standards development committees for both the National Juvenile Detention Administration (NJDA) and American Correctional Association. Dr. Roush also served as the Lead Consultant to the NJDA/Office of Juvenile Justice and Delinquency Prevention (OJJDP) Juvenile Justice Personnel Improvement Project and as the Director of the Calhoun County Juvenile Home, where he developed the Intensive Learning Program and the W.K. Kellogg Foundation-sponsored Holistic Environmental Life-skills Project. These programs received the Certificate of Merit and the Gould/Wysinger Award from OJJDP.

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AGENCY RESPONSE

Supreme Court

STATE OF ARIZONA
ADMINISTRATIVE OFFICE OF THE COURTS

Ruth V. McGregor
Chief Justice

David K. Byers
Administrative Director
of the Courts

November 26, 2007

Ms. Debra K. Davenport, Auditor General
Office of the Auditor General
2910 N. 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Davenport,

Enclosed you will find our response to the recommendations found in your juvenile detention performance audit report.

However, before providing our response to the specific recommendations, we believe it is important for the readers of this report to understand the evolution of the conditions and operations of the juvenile detention centers in the last decade. Up until 1997, many of the juvenile detention centers across the state were in deplorable condition. Under the leadership of former Chief Justice Thomas Zlaket, the AOC embarked on a facilities major plan to replace these facilities with newly constructed or renovated centers. The Legislature provided approximately $20 million to fund this effort over a three year period. The counties matched this funding with over $150 million in local funding. The AOC oversaw the construction efforts. The end result has been a substantial upgrade to the condition of all juvenile detention centers across the state.

In addition to securing funding for new facilities, AOC worked with the local juvenile courts to implement several other important initiatives, all of which are in place today. These efforts included developing and implementing operational guidelines, establishing training academies, and implementing schools in each detention center.

While the Supreme Court and the AOC helped orchestrate the master plan to upgrade juvenile detention facility conditions as well as implement general guidelines and practices, the detention center governance structure has been and continues to be highly decentralized; funded by local county boards of supervisors and overseen by the presiding juvenile court judge in each county. Aside from the one-time detention construction funding, the Legislature does not provide any ongoing operational funding for the centers. The only state-level statutory mandate related to juvenile detention

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centers rests with the Arizona Department of Juvenile Corrections; to conduct inspections.

Although there is always room for improvement, it should be noted the juvenile detention centers are well-run and are not beset with problems. In fact, while over 100,000 juveniles have passed through the detention centers in the past 10 years, there have been no suicides and escapes or other significant health, welfare or security risks are a rare occurrence. This type of track record is one the Arizona Judicial Branch is proud of.

The audit report and recommendations provide an opportunity for the AOC and juvenile courts, subject to the Arizona Judicial Council's direction and approval, to identify those standards and best practices which are appropriate to mandate at a statewide level and which practices are appropriate to leave to local control.

We appreciate the audit work and cooperation of your staff throughout the audit.

David K. Byers, Administrative Director
Administrative Office of the Courts

Enclosure

Administrative Office of the Courts
Juvenile Detention Audit
Response to Auditor General Recommendations

Finding 1

As the recommendations are directed to the juvenile detention administrators in the counties selected for review, we will not respond directly to the recommendations included in Finding I.

Finding 2

1. The AOC should seek the Arizona Judicial Council's direction regarding the need to identify and/or develop mandatory juvenile detention center operational standards.

   The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2. If the Arizona Judicial Council approves the need to identify and or develop mandatory juvenile detention center operational standards, the AOC should work with the county juvenile courts to review and improve the current operational guidelines to ensure that they provide adequate direction and detail to juvenile detention centers and identify new standards where appropriate. The standards should include sufficient detail and information to provide juvenile detention centers with the guidance they will need to establish conforming policies, procedures, and practices.

   a. To assist in developing appropriate operational standards, the AOC and county juvenile courts should consult the American Correctional Association, the National Commission on Correctional Health Care, the National Partnership for Juvenile Services, the Council of Juvenile Correctional Administrators, and the Annie E. Casey Foundation.

   The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

3. Upon completing the guideline review and standards development, the AOC and county juvenile courts should submit the recommendations to the Arizona Judicial Council for its consideration and approval. The AOC and the county juvenile courts should also seek the Arizona Judicial Council's guidance for the most appropriate method for mandating compliance, such as recommending placing the standards in the Code or recommending that the Code indicate that county juvenile detention centers must comply with the standards.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

4. Upon the Arizona Judicial council's final approval of the standards, the AOC should take several steps to help juvenile detention centers transition as they implement operational standards, including:
   a. Providing training and technical assistance to appropriate county juvenile court and juvenile detention center staff on the mandatory standards;
   b. Assisting county juvenile court staff in obtaining additional resources from their respective boards of supervisors if needed; and
   c. Identifying additional resources, such as best practices and tools used by some juvenile detention centers, to share with other juvenile detention centers to help comply with the adopted standards.

   The finding of the Auditor General is agreed to and the audit recommendation will be implemented, to the extent that resources allow. As previously noted, the primary responsibility for funding juvenile detention centers rests with the local boards of supervisors and local juvenile courts. The AOC, when requested, will provide whatever assistance we can.

5. Once it has instituted mandatory standards, the AOC should seek the Arizona Judicial Council's approval and then work with county juvenile courts to develop and implement performance-based standards and the processes needed to measure progress toward meeting the standards, as appropriate.

   The finding of the Auditor General is agreed to and the audit recommendation will be implemented. As the juvenile court committees work to develop the appropriate standards, consideration will be given to which standards would be best suited to include performance-based standards. Again, we will implement whichever standards the Arizona Judicial Council chooses to adopt.

6. If the Arizona Judicial Council authorizes performance-based types of standards as well as the processes needed to measure progress toward meeting the standards, the AOC should establish a time frame or schedule for fully developing and implementing these standards.

   The finding of the Auditor General is agreed to and the audit recommendation will be implemented. However, given the pending budget cuts, any time table we develop will be dependent upon available staff time and resources.

Finding 3

1. The AOC should seek the Arizona Judicial Council's direction regarding the need to develop statewide policies, procedures and/or standards for the application of Arizona Juvenile Court Rule 23(D) to appropriately and consistently screen juveniles for

detention, while also recognizing legitimate county-level concerns regarding the safety of the juveniles and the community within their jurisdiction.

The finding of the Auditor General is agreed to, and the audit recommendation will be implemented. Appropriate and consistent screening of juveniles for detention is consistent with best practice and we agree this is an area we should review. As the audit report suggests, any such policies, procedures, or standards will need to have the capability of incorporating local considerations.

2. If the Arizona Judicial Council approves the need to develop juvenile detention screening policies, procedures and/or standards, the AOC should work with the county juvenile courts to develop such policies, procedures and/or standards, including a potential requirement that counties use a validated screening instrument, and then submit its recommendations to the Arizona Judicial Council for its consideration and approval.

   The finding of the Auditor General is agreed to, and the audit recommendation will be implemented.

3. The AOC and counties should continue with their efforts to identify and use detention alternatives.

   The finding of the Auditor General is agreed to and the audit recommendations will be implemented.

4. The AOC should encourage the use of alternatives to detention by continuing to request funding for the use of effective alternatives to detention and funding projects that help juveniles reintegrate into their communities after a stay in detention.

   The finding of the Auditor General is agreed to and the audit recommendations will be implemented.

Finding 4

1. The Legislature should consider revising statute to replace Juvenile Corrections with the AOC as the entity responsible for inspecting juvenile detention centers.

   As this recommendation is directed toward the Legislature, our response is not necessary.

2. If given responsibility for inspections, the AOC should develop and implement a comprehensive juvenile detention center inspection program by developing and implementing policies and procedures that require the following:

a. Conducting a thorough inspection of each juvenile detention center every three years where compliance with all guidelines is assessed, including reviewing juvenile detention center policies and procedure for adherence to each guideline; seeking supporting evidence to determine if the juvenile detention center's policies and procedures are followed; reviewing fire and health inspection reports; conducting facility walk-throughs to inspect for cleanliness, safety, and security issues; and conducting satisfaction interviews with staff and juveniles;
b. Preparing comprehensive inspection reports that include which documents were reviewed and/or observations were made to determine compliance, and details of all discussions regarding issues and recommendations;
c. Conducting additional annual inspections of juvenile detention centers to spot-check against a few selected guidelines, follow up on issues found during past inspections, inspect for issues that have surfaced among the juvenile detention centers and for compliance with newly created guidelines, to conduct a facility walk-through to look for safety and security issues, and to provide technical assistance;
d. Enforcing compliance with inspection recommendations by requiring and approving corrective action plans;
e. Following up with juvenile detention centers on their efforts to implement corrective action plans through site visits and/or documentation reviews; and
f. Working with detention centers and enlisting the assistance of the presiding judge in cases where the juvenile detention center has difficulty complying with a finding or recommendation because of a lack of resources and/or funding.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented, provided we are given the responsibility and necessary resources to implement the recommendation. It is our understanding, based on conversations with the Auditor General's Office, the intent of this recommendation is to establish a process to perform comprehensive detention center inspections. While the voluntary guidelines are currently the only benchmark from which we conduct our inspections, the auditors' intent is that we use whatever guidelines are in place at the time we assume responsibility for conducting inspections, if the Legislature so chooses to revise the statute. If the Arizona Judicial Council directs the AOC and the county juvenile courts to develop and implement operational standards, we would then use those standards as the benchmark for conducting our inspections.

3. The AOC should review its staff resources and assess whether it has sufficient staff to properly implement and maintain the improved inspection program or if it needs additional staff to do so. If the AOC determines that it needs additional staff resources, it should review and consider various options for obtaining these resources, including shifting internal staff resources or working with the county juvenile courts and/or the Legislature to obtain additional staff resources.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We have no doubt that additional resources will be

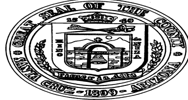
needed to fully implement the audit recommendations, as we currently have less than one FTE available to perform the inspection function.

4. If the AOC does not receive sole responsibility to conduct inspections and both the AOC and Juvenile Corrections continue to inspect juvenile detention centers, the AOC should ensure that recommendations resulting from these inspections are implemented.

   The finding of the Auditor General is agreed to and the audit recommendation will be implemented. Whatever standards the Arizona Judicial Council adopts or are otherwise in existence in state law, such as fire codes, will be implemented. However, we cannot be responsible for implementing recommendations made by an outside agency, such as Juvenile Corrections.

PROBATION DEPARTMENT
SANTA CRUZ COUNTY

James A. Soto
Presiding Superior Court Judge



Primitivo Romero III
Chief Probation Officer

November 26, 2007

Ms. Debra K. Davenport, Auditor General
State of Arizona Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Davenport:

I am in receipt of the revised preliminary draft report that was prepared by your office concerning Arizona's juvenile detention centers. The revised report, which contains various recommendations relating to how we should operate our juvenile detention center in Santa Cruz County, was received on November 19, 2007. As requested in your letter dated November 16, 2007, the purpose of this letter is to respond to the various recommendations that were included in said report. I will include the recommendation that was made and respond accordingly based on the instructions provided in your letter.

a. Restrict access to its control room to only necessary control room and supervisory personnel.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We are committed to making some significant adjustments in terms of who has access to the control room. A decision has been made to designate a control room officer for each shift, where said officer will be solely responsible for opening exterior doors and observing the monitors that capture activity on the inside and outside the detention center. The control room officer will also be responsible for handling telephones and the radio communications system for the Probation Department. In preparation for this change, we immediately began working on adding a work station in the day room that non-control room officers will use when working with the juveniles under our care. Officers will have access to a telephone and a computer from this work station. It is important to note that several work requests have been submitted to the appropriate county office to ensure that the infrastructure is in place to support the work station. For example, the necessary data ports are being added, we have ordered the computer and the printer, work requests have been submitted to have the appropriate department mark the "officer only" area around the work station, etc. As we indicated in our letter dated October 30, 2007, we will keep whatever logs we need in this work area within the day room. Furthermore, meetings between non-control room officers to share information during shift changes will take place in the intake area. The preceding will eliminate the need for non-control room officers to go into the control room. We commit to making the aforementioned changes involving who can access the control room (to include the necessary changes to our policies and procedures) no later than February 26, 2008.

b. Develop and implement a key control system. In particular, this system should ensure that keys to exterior doors and the control room are not issued to staff who work directly with juveniles. Additionally, this system should include policies and procedures that specify which staff should have access to keys and require keys to be properly issued, tracked, and stored.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. As of November 16, 2007, detention officers are no longer allowed to take keys to the detention center home with them. In fact, officers are now required to turn in their personal keys upon reporting for work in exchange for the keys that they need while on duty. Furthermore, we are in the process of finalizing a policy that will ensure that keys to exterior doors and the control room are not issued to officers that work directly with juveniles. We anticipate implementing the policy no later than December 26, 2007. It is worth noting that a log will be used and/or maintained by the control room officer on a daily basis to track who is in possession of a set of keys. We cannot emphasize enough that the set of keys that officers will be able to check out will not include a key to exterior doors or the control room.

c. Determine if exterior blind spots at the juvenile detention center pose a potential threat to juvenile detention center security and, if so, take steps to ensure that these blind spots are routinely monitored by either adding or adjusting a camera or doing a daily perimeter walk.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. As a matter of fact, we are currently doing perimeter walks three times a day and have been doing them since early October 2007. Each shift is responsible for engaging in a perimeter walk to ensure that things on the exterior of the building are safe and secure. In addition, on October 22, 2007, we approved the purchase of four additional cameras that will be placed on the exterior of the facility. A monitor will be added to the control room so that the control room officer will be able to observe what is being captured by these cameras. We are confident that the aforementioned cameras, which we are told will be installed very soon (the wiring is already in place), will eliminate the blind spots that currently exist.

d. Continue its efforts to hire a registered nurse and designate this position as the health services authority.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We continue to work with the deputy county manager and the county health services director on obtaining the services of a registered nurse. The preceding is something that we have been requesting for many years now (as has been documented in inspection reports that have been prepared by the Administrative Office of the Courts [AOC] and the Arizona Department of Juvenile Corrections [ADJC]). We are pleased to report that our detention administrator participated in an interview of the sole applicant for the correctional health nurse position on October 25, 2007. The person has quite a bit of experience and appears to be a good candidate. We are waiting for word on whether or not the person will be offered the position. One possible obstacle may be the salary range that is in place, but we will wait to see what happens. If salary becomes an issue, we have communicated to the county health services director that we are willing to join him in approaching the deputy county manager to see if the salary range can be increased to ensure that we are able to hire and retain the services of an experienced and well qualified nurse. It is important to note that we have been requesting status updates on a regular basis from the county health services director on the correctional health nurse position. As a matter of fact, we met with him on November 19, 2007, and he related that the sole applicant is in the process of undergoing a background check. He expressed that if everything goes well with the background check, the person will be offered the position in the very near future.

e. Ensure that only a qualified healthcare provider trains detention personnel on performing health screenings.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We expect that once the correctional health nurse is hired, he or she will be solely responsible for doing all health screenings. However, since we do not know when the correctional health nurse will be hired (or how often she will be available if she is hired), we have solicited the assistance of the county health services director in identifying a qualified healthcare provider who could train detention staff on how to perform a health screening. The preceding was first requested on October 26, 2007. I spoke with the

county health services director on November 19, 2007, and inquired on the status of our request. He stated that he had been considering various options but that he would be contacting the Arizona Counties Insurance Pool to see if they can assist us. It is important to note that we have and will continue to be very persistent in arranging for this training to be provided to staff as soon as possible.

f. Develop and implement policies to test all juveniles for tuberculosis within 7 days of admission to lessen the potential health risks for both the juvenile detention center and its community.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We have begun working on a policy that will ensure that every juvenile who is ordered detained beyond the detention/advisory hearing (which would take place within forty-eight hours from the time a child is detained) will be tested for tuberculosis. A log will be created to ensure that the preceding is done consistently and without exception. We envision having a day, Wednesday for example, where we take juveniles who need to be tested to the clinic. We would take the juveniles back on Friday to have qualified medical staff determine if they are positive or not. Of course, once the correctional health nurse is hired, our hope is that he or she will conduct these tests without us having to transport juveniles to the clinic. It should be noted that because some juveniles are released from custody within forty-eight hours from the time they are detained (e.g., if the State chooses not to file a petition or a judicial officer decides to release a juvenile after the detention/advisory hearing), these juveniles will not be tested for tuberculosis. Regardless, we plan to finalize and have the new policy in place by December 26, 2007.

g. Ensure that detention personnel receive training from a qualified healthcare provider in medication administration.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We expect that once the correctional health nurse is hired, he or she will be solely responsible for medication administration. However, since we do not know when the correctional health nurse will be hired, we have solicited the assistance of the county health services director in identifying a qualified healthcare provider who could train detention staff on how to properly administer medication. The preceding was first requested on October 26, 2007. I spoke with the county health services director on November 19, 2007, and inquired on the status of our request. He stated that he had been considering various options but that he would be contacting the Arizona Counties Insurance Pool to see if they can assist us. It is important to note that we have and will continue to be very persistent in arranging for this training to be provided to staff as soon as possible.

h. Fully secure all medications and limit control room keys to necessary staff.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We have ordered two medicine cabinets that can be locked and will be placing them in the office that is adjacent to the control room (where officers have their lockers). One cabinet will be for prescription medication, while the other cabinet will be used to store non-prescription medication, first aid supplies, etc. As for limiting control room keys, the preceding will be done as was stated previously. In fact, no one aside from management staff will have access to a key that opens the control room.

i. Adopt a more objective suicide screening questionnaire such as the MAYSI-II, or a questionnaire similar to the one that the Coconino or Mohave County centers use.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We have obtained a copy of the suicide screening questionnaire that is in use in Coconino County as well as its policies and procedures as it relates to the use of said questionnaire. We plan to start making use of the aforementioned questionnaire after we provide detention staff the necessary training and instruction on completing the questionnaire. Our commitment is to do the latter no later than February 26, 2008.

j. Implement a multiple level approach to suicide risk and observation/supervision similar to the approaches in use at the Coconino County, Pima County, and Maricopa County centers to more effectively address a juvenile's needs and direct detention officer actions.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We have obtained a copy of the suicide risk and observation/supervision policies that are in place in Coconino County. We plan to start making use of its multiple level approach to suicide risk and observation/supervision after we provide detention staff the necessary training and instruction. Our commitment is to do the latter no later than February 26, 2008.

k. Either place a camera in the cell designated for suicide watch or replace the door with a full-view, shatter proof glass door.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. Within days after this recommendation was made by the individuals who conducted the on-site portion of this audit, we asked the county to add a camera to the room/cell that is used for suicide watch. The preceding has not been done yet, but we have been assured that the camera will be in place in the next few weeks. We met with the individual who will be responsible for installing the camera on October 22, 2007, and we explained to him exactly what we need. We also emphasized that we need to have the camera in place as soon as possible.

l. Ensure that a qualified medical and/or mental health professional reviews and approves any revisions to the medical and/or mental health policies, procedures, and forms at the Santa Cruz County center.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We will make absolutely certain that a qualified medical and/or mental health professional reviews and approves any revisions to any of our medical and/or mental health policies. We will maintain documentation with regard to who, why, and when someone reviews and/or approves changes.

m. Use objective measures, such as points or grades in its behavior management system, which can serve as goals for juveniles to strive toward and decision-making tools for detention personnel, instead of length of stay. The Santa Cruz County center should also continue its efforts begun in September 2007 to explore the use of more meaningful rewards and privileges, and revise its policies and procedures to reflect this change.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We requested and received a copy of the policies involving the behavior management system being used in Coconino County and will consider what other counties are using. The important thing is that we have decided to do away with the system that provides rewards or privileges based on length of stay. We continue to have internal discussions with regard to the various changes that we could make to our behavior management system. It is worth noting that said changes will reflect the input that we have received from juveniles in terms of those things that they value the most while in detention (e.g., the ability to take more time when they shower, additional recreational opportunities, longer periods of visitation, more telephone privileges, etc.). Of course, detention staff will receive training and instruction on how to appropriately use whatever behavior management system we decide to adopt. We anticipate having a new behavior management system in place by February 26, 2007.

n. Work with the Chief Probation Officer to formally designate specific probation personnel as backup coverage when the juvenile detention center experiences staffing shortages to ensure that juveniles are not subjected to unnecessary and potentially harmful periods of lockdown, juveniles are adequately supervised, and staff training needs get met. Also, work with the Probation Department of Santa Cruz County to develop and implement policies and procedures to reflect this partnership.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The juvenile detention center, which is a part of the Probation Department, will continue to be supported, to the extent possible, by juvenile probation staff whenever there are staff shortages at the detention center. We plan to make use, whenever possible, of those individuals assigned to juvenile probation who used to be assigned to juvenile detention. The preceding will ensure that officers with experience in a detention setting can be made available to assist. However, since these former juvenile detention officers are quite busy, too, our focus will be on making every effort to have the county increase the number of positions that it currently funds so that it will not be necessary for us to rely on probation officers or surveillance officers to provide backup coverage. Nevertheless, we will be creating a policy to have probation personnel provide backup coverage and anticipate having said policy in place by February 26, 2008.

o. Work with the juvenile court's Presiding Judge and the County Board of Supervisors to ensure adequate staffing at its juvenile detention center.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We will work closely with our Presiding Juvenile Court Judge, the county Board of Supervisors and county administration to make every effort to have adequate staffing at our juvenile detention center. Our position will be that in order for us to be able to safely and effectively carry out our duties while following detention operational guidelines and best practices, we need to be staffed at a level that follows the National Institute of Corrections Ten-Step Staffing Analysis system (as the AOC has recommended). For a facility of the size we operate, we should have twenty full time detention officer positions based on the aforementioned system, and we currently only have twelve. Fortunately, county administration has made a verbal commitment to fund two additional full time detention officers commencing July 1, 2008. Based on the fact that we do not want to wait until July 1, 2008, to have additional staff in place, we will be using probation fees to fund the two positions earlier in the year. As a matter of fact, we will be funding one position commencing January 1, 2008, and the other one April 1, 2008. The preceding should help at least to some extent.

I would like to take this opportunity to address a few more things involving the revised draft report.

First, thank you for making the change to reflect that the report (and recommendations) that we received from the AOC concerning our detention operations was provided to us in July 2007 as opposed to April 2007 (as was indicated in the preliminary draft report). The preceding was important to us, because when we met with your staff for the on-site portion of this audit, we had not had much time to make certain changes to our programming and/or policies. Incidentally, I also believe it is important to point out that the assessment of our detention operations was completed by the AOC at our request. The preceding is a testament that we are always open to and/or actively seek recommendations that may be made by the AOC, the ADJC or any other agency or entity that has the expertise to assist us improve our existing practices as it pertains to our detention operations.

Second, I would also like to share my concerns involving the inspections that ADJC staff conducts pursuant to Arizona Revised Statutes §8-306.B. As I stated earlier, we value their opinions and recommendations and look forward to the two inspections they conduct every year of our facility. We see the inspections and their recommendations as an opportunity for us to improve our detention operations. However, I find it interesting that they conducted an inspection of our facility on February 1, 2007, where, among other things, they looked at our suicide prevention and intervention policies and our key control policies. Yet, despite the latter, and considering that the aforementioned statute requires them to make "such recommendations at it deems advisable," they voiced no concerns over either, nor did they make any recommendations. In essence, we received their report and figured that what we were doing was acceptable and/or appropriate. Frankly, I find it perplexing that the direction that we received from two State agencies within a span of eight months concerning two important aspects of our detention operations (i.e., suicide prevention and intervention and key control) can be so incredibly different.

Third, I also believe it is important to note that, with regard to staffing issues, I am disappointed that your office did not make the time to conduct an analysis concerning how many detention officers we should have to safely operate our facility. The preceding would have been helpful as we continue to work with county administration on the latter. In other words, it is something we could have used to further support our argument that we are significantly understaffed and that some of our existing practices, which your office does not approve (e.g., dividing the detention population into two groups where the groups take turns participating in our programming activities), are directly related to the reality that we are understaffed. The fact is, we do not like to make the adjustments that we are forced to make, but we do it out of necessity in order to protect both juveniles and staff. Incidentally, with regard to staffing issues, I would like to point out that we forwarded the AOC report to our deputy county manager one week from the day that we received it (on July 17, 2007, to be exact). We pointed out that the AOC was recommending that we have twenty full time detention officers to operate our facility, and we requested the county's assistance to address the latter issue in order to minimize the liability we currently face as a result of being understaffed.

Fourth, I want to point that it is unfortunate that the report focused exclusively on the negative and/or our perceived shortcomings. Although it can be argued that we have just been extremely fortunate, the fact remains that the only escape that has taken place in our seventeen year old facility occurred in 1991. In addition, assaults on officers are non-existent, juveniles rarely file grievances against staff members, the use of mechanical restraints is extremely uncommon and juveniles have never seriously hurt themselves while in our care. To be clear, the preceding is not to say that we are going to reluctantly make various changes since everything has been functioning reasonably well. On the contrary, we have chosen to embrace the recommendations and will make a concerted effort to implement all of them (particularly those that we have direct control over), but it would have been appropriate, I believe, to acknowledge that we are also doing various things right as is evidenced by the things I mentioned earlier.

In closing, I want to take this opportunity to thank and acknowledge Mr. Michael Nickelsburg and Ms. Kathleen Abbott for their assistance and professionalism throughout the audit process. We have learned a great deal from this process and look forward to improving our detention operations as a result of implementing the various recommendations that they have made. If you have any questions or need to speak with me for whatever reason, I can be reached at (520) 375-7640. I can also be reached by way of electronic mail at promero@courts.az.gov. Thank you for your time and attention in this matter.

Sincerely,

Primitivo Romero III
Chief Probation Officer
Santa Cruz County

c: Hon. James A. Soto, Presiding Superior Court Judge
Hon. Kimberly A. Corsaro, Presiding Juvenile Court Judge
Mr. Rob Lubitz, Director of the AOC Juvenile Justice Services Division
Mr. Fernando A. Matiella, Chief Deputy Probation Officer
Mr. Omar A. Villa, Juvenile Detention Administrator
Mr. Dale C. Chapman, Performance Audit Manager
Mr. Michael Nickelsburg, Senior Performance Auditor
Ms. Kathleen Abbott, Performance Auditor

MOHAVE COUNTY PROBATION DEPARTMENT

[ ] Mailing Address: P.O. BOX 7000, KINGMAN, AZ 86402-7000
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November 20, 2007

Ms. Debra K. Davenport, Auditor General
State of Arizona
2910 North 44th Street
Suite 410
Phoenix, AZ 85018

Dear Ms. Davenport:

1. I was pleased to have our Detention Center chosen for an in-depth performance audit by your agency. I was very impressed with the professionalism, objectivity and genuine concern demonstrated by your auditors Michael Nickelsburg, Kathleen Abbott and Heather Weech. You can be proud to have such dedicated individuals on your team.

2. Here are my written comments on their recommendations:

a. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. Our control room needs to be enclosed and we will work with the County and other sources to obtain the necessary funding to make the renovations. The control room will be enclosed once funding is secured. We will continue to restrict access to our control room and revise our written policies to reflect this change.

b. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. On November 13th, 2007 we instituted stricter key control procedures. We will update our written policies to specify which staff will have access to keys and further ensure staff who work directly with juveniles do not have control room and exterior door keys.

c. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We will ensure only a qualified healthcare provider trains detention personnel on performing the initial intake health screening and we will update our written policies to reflect this change.

d. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We will direct all juveniles admitted to our Detention Center be tested for TB within 7 days and inform parents, guardians, and courts that the TB testing will be performed. However, our healthcare provider will not force test any juvenile who refuses testing. We may, under certain circumstances, medically isolate those who refuse testing. Our written policies will be updated to reflect this change.

e. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We will continue to store prescription medication in a locked medical box in the control room and store other medications and first aid supplies in a locked cabinet. Our written policies will be updated to reflect this change.

f. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. In order to more effectively address a juvenile's needs and direct detention actions, we will implement a multiple-level approach to suicide risk and observation/supervision similar to the approaches used at Coconino, Pima County and Maricopa-Durango centers. Our written policies will be updated to reflect this change.

g. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We will ensure qualified medical and/or mental health professionals review and approve any revisions to our medical and/or mental health policies, procedures and forms at our Detention Center.

h. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. We're grateful the Mohave County Board of Supervisors recognized the need and approved funding for six new positions at our Detention Center. The additional staff will now allow us the opportunity to limit isolation and to have juveniles out of their cells more frequently during the day.

i. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. Even while any juvenile restrained to a stationary object within our Detention Center was under constant supervision, on October 26, 2007 we directed this practice be stopped immediately. We've removed restraining devices from stationary objects and have asked building maintenance to remove the anchor points for the restraining devices as well.

j. The finding of the Auditor General is agreed to and the audit recommendation will be implemented. Again, thanks to the Mohave County Board of Supervisors and their approval of additional staff, we have revised our procedures and will update our written policies to enhance supervision of juveniles who pose an escape risk and only use mechanical restraints in instances where juveniles have a history of trying to evade staff.

3. Thank you for sending your auditors. I'm confident their recommendations as implemented will help make our Detention Center a safer place for the juveniles in our custody and our staff.

Sincerely;

Friend L. Walker, Chief
Mohave County Probation Department

SUPERIOR COURT • JUVENILE PROBATION DEPARTMENT
Maricopa County

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CAROL L. BOONE – Chief Juvenile Probation Officer

November 26, 2007

Ms. Debra K. Davenport, CPA
Auditor General
2910 North 44th Street, Suite 410
Phoenix, AZ 85018

Dear Ms. Davenport:

We are responding to the revised preliminary report draft from your office, dated November 16, 2007, reference the detention centers.

RECOMMENDATIONS:

The Maricopa-Durango center should:

a. **Continue with plans to implement revised policies in early 2008 that will require two perimeter walks per day.**

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

We have established policy that states: "Staff will walk through the exterior grounds for visual monitoring twice daily". Further, there is a facilities coordinator who does an early morning facilities perimeter check. The facilities coordinator will use the check list established for Detention staff.

b. **Explore options designed to eliminate or minimize juvenile exposure to adult inmates, as required by federal and state sight and sound laws.**

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The MCJPD Durango Detention Center has referred this matter to the Deputy Court Administrator Facilities Coordinator. He is working with the Office of Management and Budget (OMB) and Facilities Management (FMD) to look at solutions/options designed to minimize juvenile exposure to adult inmates. The option being explored at this time is identifying an alternative entry point to the juvenile court building for adult inmates.

c. Ensure that only a qualified healthcare provider trains detention personnel on performing health screenings.

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Upon admission, juveniles receive a self-report medical profile by detention personnel. This information is reviewed by a registered nurse from the clinic within 8 hours of detainment. In addition to the medical profile, the juveniles receive a face to face medical screening by a registered nurse within 8 hours of admission. Medical concerns are referred to the medical director or nurse practitioner.

An official medical training session on the medical profile has been developed and added to the education curriculum. This will be given by the clinic staff to all new employees who will be administering the medical profile and ongoing training will also be provided as the medical profile is revised.

Sincerely,

Carol Boone
Chief Juvenile Probation Officer

cc: The Honorable Eileen Willett

SUPERIOR COURT OF THE STATE OF ARIZONA

Pima County Juvenile Court
2225 EAST AJO WAY
TUCSON, ARIZONA 85713-6295
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Rik Schmidt
Director of Juvenile Court Services
Jesus Diaz
Deputy Director of Juvenile Court Services

An Organization committed to:
*Community Protection
*Restoring Victims
* Successful Youth and Families

November 26, 2007

Debbie Davenport
Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Davenport:

Pima County Juvenile Court Center is committed to providing quality services to the youth and families we serve. Consequently, the performance audit that was conducted has been informative and helpful in meeting this goal. We are particularly pleased with the emphasis placed in the report on our efforts to address Disproportionate Minority Contact (DMC) and our engagement in the Juvenile Detention Alternative Initiative (JDAI). As reflected in the data provided during this audit, we have been able to reduce our detention population from an average daily population (ADP) of 173 in 2004 to 127 in 2006. This reduction has occurred while maintaining public safety as a cornerstone to our activities.

We agree with the one finding and recommendation that was offered to Pima County in the audit report. Specifically, we have implemented a policy, effective November 1, 2007, that will require conducting and logging perimeter checks of our detention facility on a daily basis to ensure that any potential safety or security threats are eliminated. While perimeter checks were already being periodically completed, the issuance of our policy will formalize the daily requirement. We appreciate the efforts of the audit team in identifying this issue.

Pima County is experiencing substantial growth (ten percent over five years) in our population of youth between ages eight through seventeen. However, despite this growth we have been able to substantially reduce our detention ADP, while delinquency activity has dropped in nearly all categories, with an overall decrease of 7.6 % in total felonies/misdemeanors from 2002 to 2006. We remain committed to the principle of equal justice for all youth entering our Juvenile Justice system and would like to acknowledge the strong collaborative partnership that is in place in Pima County, particularly in relation to the appropriate and effective use of detention.

Sincerely,

Rik Schmidt
Director of Juvenile Court Services

RS/bcs
Cc: Patricia Escher, Presiding Judge

SUPERIOR COURT OF ARIZONA

COCONINO COUNTY JUVENILE COURT CENTER

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Margaret McCullough, Presiding Juvenile Court Judge | Bryon Matsuda, Director | Charles D. Adams, Superior Court Judge

November 21, 2007

Ms. Debbie Davenport
Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Re: Revised Preliminary Report – Juvenile Detention Centers

Dear Auditor General Davenport

We have received your Revised Preliminary Report. The Audit Information regarding Coconino County Detention's operations is accurate as reported. We have appreciate your staffs' excellent efforts to work with our Detention Administration in order to obtain a more comprehensive understanding of our facility. We also enjoyed your staffs' high levels of professionalism and positive engagement.

As you have learned from your auditing process, implementing quality juvenile detention services is a complicated and a challenging work. Because of many of the aspects you have reported and more, no two detention centers can operate exactly the same. A general standardization or "cookie cutter" approach to operations for all detention centers would not be possible or be correct, but the implementation of correct principles could be possible if sufficient resources permitted. If the Audit has recommendations for the development and implementation of statewide "standards", County Juvenile Detention Administrators and staff should be utilized in the identification and development process. They are clearly some of the business experts. A timeline for completion would be needed, but a sufficient amount of time is also necessary to do a thorough work.

I look forward to our continued effort to improve the services we provide for our most troubled youth.

Sincerely

Bryon Matsuda
Coconino Juvenile Court Services Director

Cc: Judge Margaret McCullough, Presiding Judge
Mr. Rob Lubitz, Juvenile Justice Services Director

Performance Audit Division reports issued within the last 24 months

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06-05 Arizona Department of Transportation—Aspects of Construction Management
06-06 Arizona Department of Education—Administration and Allocation of Funds
06-07 Arizona Department of Education—Information Management
06-08 Arizona Supreme Court, Administrative Office of the Courts—Information Technology and FARE Program
06-09 Department of Health Services—Behavioral Health Services for Adults with Serious Mental Illness in Maricopa County

07-01 Arizona Board of Fingerprinting
07-02 Arizona Department of Racing and Arizona Racing Commission
07-03 Arizona Department of Transportation—Highway Maintenance
07-04 Arizona Department of Transportation—Sunset Factors
07-05 Arizona Structural Pest Control Commission
07-06 Arizona School Facilities Board
07-07 Board of Homeopathic Medical Examiners
07-08 Arizona State Land Department
07-09 Commission for Postsecondary Education
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Future Performance Audit Division reports

Department of Environmental Quality—Vehicle Emissions Inspection Program

Arizona Supreme Court, Administrative Office of the Courts—Juvenile Treatment Programs