STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Arizona Department of Juvenile Corrections—
Suicide Prevention and Violence and Abuse Reduction Efforts

REPORT HIGHLIGHTS
PERFORMANCE AUDIT

Our Conclusion

A 2004 federal investigative report under the Civil Rights of Incarcerated Persons Act (CRIPA) found serious deficiencies at the Arizona Department of Juvenile Corrections (Department) involving suicide prevention, violence, and sexual abuse. Following the CRIPA investigation, the State entered into a memorandum of agreement to address more than 120 mandatory provisions. Starting in 2003, the Department made significant improvements, and in 2007 was found to be in substantial compliance with all of the mandatory provisions and was released from federal monitoring. However, the Department can make minor improvements to its suicide prevention practices, continue to reduce juvenile violence, and strengthen staff awareness of the appropriate boundaries for staff-juvenile conduct.

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Suicide prevention practices promote safety, but minor improvements possible

Between April 2002 and March 2003, three juveniles committed suicide at the Department's Adobe Mountain secure care facility. After the first suicide, the federal government initiated its CRIPA investigation. The Department subsequently made significant improvements in its suicide prevention practices. As a result of these improvements, serious suicide attempts are down to less than one per month since January 2007, and no suicide attempt has resulted in death since 2003. These improvements include:

- **Improved staff training**—The CRIPA report found that the Department provided inadequate suicide prevention training to its staff. The Department now provides 8 hours of suicide prevention training for new staff and 2 hours of annual refresher training. Training involves mock drills that simulate responding to suicide attempts.
- **Improved monitoring of suicidal youth**—Previously, the Department did not have a formal process for monitoring suicidal youth. It now has three monitoring levels—constant, 10-minute intervals, and 15-minute intervals. The level of supervision is assigned by mental health staff who conduct an initial risk assessment and then a daily intervention assessment for each juvenile on the suicide prevention status list.
- **Better communication**—Prior to the CRIPA report, some staff were unaware which juveniles were at-risk for suicidal behavior. The Department now has a suicide prevention status list, which is automated and made available to all staff, and it is posted daily in housing units.
- **Safer facilities**—The Department has also made housing units and separation units suicide resistant. The Department modified its housing units, in part, using special funding provided by the Legislature.

Minor improvements needed to align practices with policies and procedures—Department procedures require that juveniles making suicidal threats should always have treatment plans that address the behavior. Although the Department has inconsistently revised treatment plans to address the suicidal or self-injurious behavior, it has taken steps to address this area.

Department procedure also states that juveniles should only be placed in separation if they are "a serious and immediate danger" to themselves. However, department staff inconsistently followed these procedures. A majority (64 percent) of the 137 juveniles reviewed who made suicidal threats and were taken to separation from March 23, 2009 through May 15, 2009, were immediately separated before an assessment by mental health staff, even though department documentation was not clear that they were an immediate risk for self-harm. This keeps the juveniles safe, but it is not fully in line with department procedure or best practice.

According to a department official, staff shortages and the unavailability of mental health staff result in staff erring on the side of caution and taking those juveniles to separation until they can be seen by mental health staff.

Similarly, routinely putting such juveniles in suicide-proof clothing is against department policy. At one facility, according to a review of incidents from March 23, 2009 through May 15, 2009, some juveniles placed in separation were also immediately placed in suicide-proof smocks. The Department has corrected this situation.

Department data shows decreased juvenile violence; Department should continue efforts to reduce violence

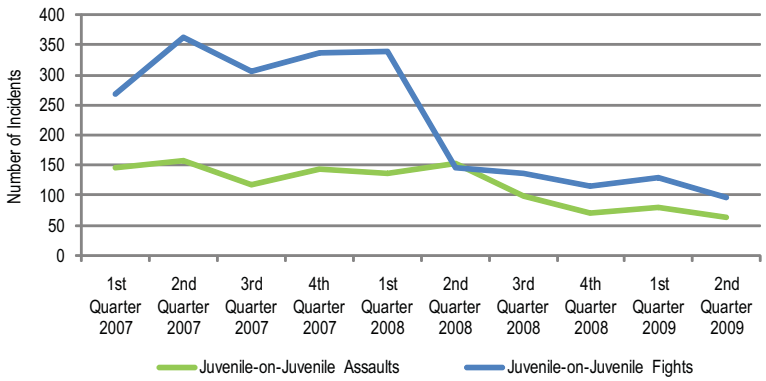
Department data shows a dramatic decrease in juvenile-on-juvenile assaults and fights since 2008. An assault is an intentional or reckless act or attempt to cause physical injury to another, including using bodily fluids. A fight is a physical altercation between two willing participants.

The Department has implemented several practices and programs to help address violence in its secure care facilities:

- Using crime mapping technology to identify "hot spots" and the juveniles responsible.
- Making living unit changes, such as installing cameras.
- Increasing the minimum staff-to-juvenile ratio.
- Identifying gang members and gang activity. As of June 2009, about 27 percent (146) of the 549 juveniles in secure care were gang members.
- Implementing treatment programs designed to help address anger and violence, and gang activity.

Further, the Department has adopted nationally recognized standards to address violence in its facilities. The Department trains staff on how to respond in crisis situations to reduce potential injury to juveniles and staff, including how to perform safe physical holds. Auditors reviewed seven incidents involving juvenile assaults and fights, and found that staff followed department procedures in responding and used their training to keep juveniles safe.

Juvenile-on-Juvenile Violence by Quarter
First Quarter 2007 through Second Quarter 2009



Source: Auditor General staff summary of violence data provided by the Department.

Department addressing abuse, but can strengthen staff awareness of appropriate staff-juvenile boundaries

In an effort to change the culture at its secure care facilities, the Department publicly declared that sexual, physical, and verbal abuses are inappropriate and unacceptable. Further, to protect staff and juveniles, the Department has established clear guidelines on appropriate boundaries for staff-juvenile conduct. Such limits begin breaking down when staff use pet names, participate in verbal sparring and joking, fail to redirect misbehavior, or are too lenient or too strict.

Despite training, disciplining or terminating staff, and redirecting juveniles, more subtle staff-juvenile boundary issues present challenges to the Department. Auditors observed some minor staff-juvenile boundary violations at all facilities, including violations by experienced employees. For example, auditors observed a unit manager call a juvenile "sweetheart." In another instance, rather than redirect the juvenile's behavior, a superintendent bantered back and forth with a juvenile who was hanging out the door where his treatment programming was occurring. Such boundary breaches indicate that the Department needs to continue to emphasize and reinforce appropriate staff-juvenile boundaries and their importance.

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A copy of the full report is available at:
www.azauditor.gov
Contact person:
Dale Chapman (602) 553-0333

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