Arizona Department of Juvenile Corrections
Use of Temporary Stabilization Units

Department has not always followed its policy and procedures for referring youth to temporary stabilization units (TSUs), and youth isolation can potentially have negative consequences and undermine the Department's mission to rehabilitate youth

Performance Audit

June 2021
Report 21-104

A Report to the Arizona Legislature

Lindsey A. Perry
Auditor General

ARIZONA Auditor General
Making a Positive Difference

ARIZONA Auditor General

Making a Positive Difference

The Arizona Auditor General's mission is to provide independent and impartial information and specific recommendations to improve the operations of State and local government entities. To this end, the Office provides financial audits and accounting services to the State and political subdivisions, investigates possible misuse of public monies, and conducts performance audits and special reviews of school districts, State agencies, and the programs they administer.

The Joint Legislative Audit Committee

Senator **Nancy Barto**, Chair
Senator **Rosanna Gabaldon**
Senator **David Livingston**
Senator **Juan Mendez**
Senator **Kelly Townsend**
Senator **Karen Fann** (ex officio)

Representative **Joanne Osborne**, Vice Chair
Representative **Tim Dunn**
Representative **Steve Kaiser**
Representative **Jennifer L. Longdon**
Representative **Pamela Powers Hannley**
Representative **Rusty Bowers** (ex officio)

Audit Staff

Dale Chapman, Director
Jeff Gove, Manager
Kaylee Arteaga, Visual Communications Specialist

Cassandra DeCocq, Team Leader
Ashley Bjurstrom

Contact Information

Arizona Auditor General
2910 N. 44th St., Ste. 410
Phoenix, AZ 85018-7271

(602) 553-0333

contact@azauditor.gov

www.azauditor.gov

LINDSEY A. PERRY
AUDITOR GENERAL

ARIZONA
AUDITOR GENERAL

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

June 21, 2021

Members of the Arizona Legislature

The Honorable Doug Ducey, Governor

Mr. Jeff Hood, Director
Arizona Department of Juvenile Corrections

Transmitted herewith is the Auditor General's report, *A Performance Audit of the Arizona Department of Juvenile Corrections—Use of Temporary Stabilization Units*. This report is in response to a September 14, 2016, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights to provide a quick summary for your convenience.

As outlined in its response, the Arizona Department of Juvenile Corrections agrees with all the findings and plans to implement all the recommendations.

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

Sincerely,

Lindsey A. Perry

Lindsey A. Perry, CPA, CFE
Auditor General

Report Highlights

Arizona Department of Juvenile Corrections (Department)
Use of Temporary Stabilization Units

Department has not always followed its policy and procedures for referring youth to temporary stabilization units (TSUs), and youth isolation can potentially have negative consequences and undermine the Department's mission to rehabilitate youth

Audit purpose

To determine whether the Department's use of TSUs for delinquent youth committed to its care is consistent with Department policy and best practices for rehabilitating delinquent youth.

Key findings

- Department has established 2 TSUs (1 for males and 1 for females) to isolate and stabilize youth who are an imminent danger of inflicting substantial injury to themselves or others, and 84 percent of youth in its care between January 2019 and February 2020 spent time in TSUs.
- Department policy and procedures outline youth de-escalation, TSU referral, check-in, and admission procedures and time frames, and it regularly reviews for compliance with several of these procedures. Department policy and procedures also indicate that TSU should only be used as a last resort when a youth is an imminent danger of inflicting serious physical harm to themselves or others and after all appropriate and practical interventions have been taken to safely stabilize and de-escalate the youth's behavior.
- Although the Department's TSU policy is consistent with best practices, it did not follow its TSU referral policy and procedures for 12 of 30 referrals we reviewed. Specifically, Department staff either did not follow the policy and procedures or document the required TSU referral details in incident reports.
- Department's noncompliance with TSU referral policy and procedures may increase youth exposure to isolation, which can potentially have a range of negative consequences, including psychological, physical, and developmental harm for youth, and undermine its mission to rehabilitate youth.
- When youth are referred to TSU, they are also subject to strip searches and, in many cases, mechanical restraints, both of which can cause trauma and have other negative impacts.
- Department does not review TSU referrals to help ensure compliance with TSU policy and procedures but identified and implemented revised documentation requirements and supervisory approval procedures for some TSU referrals during our audit. The Department reported that these changes have resulted in a decrease in TSU referrals.

Key recommendations

The Department should:

- Follow its policy and procedure requirements for referring youth to TSU and ensure that TSU referrals comply with policy and procedure by:
    - Developing and implementing policies and procedures for reviewing compliance with the Department's de-escalation and TSU referral procedures to identify, track, and reduce noncompliant TSU referrals.
    - Revising and implementing its TSU policy and procedures to address any differences between policy and standard practice as needed.
    - Ensuring its staff are trained on any TSU policy and procedure revisions.

TABLE OF CONTENTS

Figures

TABLE OF CONTENTS

Tables

INTRODUCTION

The Office of the Auditor General has issued the first in a series of 3 audit reports of the Arizona Department of Juvenile Corrections (Department) as part of the Department's sunset review. This performance audit determined whether the Department's use of youth isolation (temporary stabilization unit or TSU) for delinquent youth committed to its care is consistent with Department policy and best practices for rehabilitating delinquent youth. The second performance audit will determine whether the Department's processes for evaluating its evidence-based treatment programs provided to youth committed to its care are consistent with best practices and the final audit report will provide responses to the statutory sunset factors.

Department operates secure care correctional facility for supervising, rehabilitating, and educating delinquent youth who pose a threat to public safety

Arizona Revised Statutes (A.R.S.) §41-2816(A) requires the Department to operate and maintain or contract for secure care facilities for the custody, treatment, rehabilitation, and education of youth who pose a threat to public safety and have engaged in a pattern of conduct characterized by persistent and delinquent offenses that, as demonstrated through the use of other alternatives, cannot be controlled in a less secure setting.[1] As of January 2021, the Department operated and maintained 1 secure care correctional facility in the City of Phoenix, the Adobe Mountain School (Facility), where youth committed to its care by the Superior Court of Arizona reside until released.[2] According to statute, youth who are at least 14 years old and under the age of 18 years old, or under the age of 19 years old if subject to retained jurisdiction, and who have been adjudicated or previously adjudicated delinquent for a felony offense or are seriously mentally ill and have been adjudicated delinquent for any offense, may be committed to the Department's care.[3] As of November 2020, 186 youth resided in the Facility (see Figure 1, page 2, for information on the offenses that led to these 186 youths' commitment to the Facility).

Department mission statement

To rehabilitate the youth in our care by providing evidence-based treatment, pro-social, and educational and career training programs which will lead them to become productive, law abiding members of society.

Source: Auditor General staff review of the Department's fiscal year 2021 Strategic Plan.

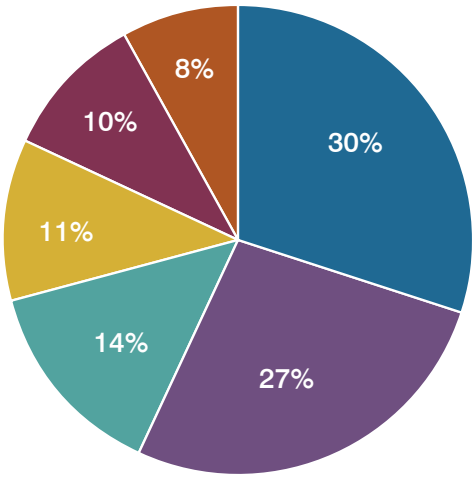
---

1 A.R.S. §41-2801 defines secure care as confinement in a facility that is completely surrounded by a locked and physically secure barrier with entrance and exit restrictions.

2 A.R.S. §41-2818 authorizes the Department to release a youth from the Facility on parole and to establish release conditions with which the youth must comply if it determines the youth is not likely to be a threat to public safety if released and the youth's continued treatment, rehabilitation, and education in a less restrictive setting are consistent with protecting the public's safety and interest. A.R.S. §41-2820 also requires the Department to discharge youth from its jurisdiction regardless of rehabilitative progress when they reach 18 years old, or 19 years old if the courts retained extended jurisdiction over the youth. A.R.S. §8-202(H) requires the court to retain extended jurisdiction over a youth who is at least 17 years old and who has been adjudicated delinquent until the youth reaches 19 years old if the State filed a notice of intent to retain jurisdiction at the time it charged the youth with an offense.

3 A.R.S. §§41-2801, 8-202, and 8-342. Additionally, according to A.R.S. §13-501(A), youth between the ages of 15 to 17 years old who are charged with certain violent felony offenses, such as first- or second-degree murder or armed robbery, are prosecuted as adults. Similarly, A.R.S. §13-501(B) allows county prosecutors the authority to prosecute youth who are at least 14 years old and who commit various felony offenses as adults. According to A.R.S. §41-2820(C), the Department must discharge committed youth who are convicted as an adult for an offense that did not occur at the Facility.

Figure 1
Category of most serious offense committed by the 186 youth residing in the Facility and examples of offenses in these categories[1]
As of November 2020



Offense category	Examples of offenses
Crimes against persons	Aggravated assault, aggravated robbery, sexual conduct with a minor
Property offenses	Burglary or theft
Drug offenses	Drug paraphernalia, sale or possession of narcotic drugs
Weapon offenses	Minor in possession of a firearm or misconduct with a weapon
Public order offenses	Escape, unlawful flight from law enforcement, or disorderly conduct
Other offenses	Probation violation or interfering with a monitoring device

[1] The youth committed to the Department's care may have committed more than 1 offense that led to their commitment to the Department. According to the Department, it determines a youth's most serious offense that led to the youth's commitment to the Department based on offense class, type, and severity.

Source: Auditor General staff analysis of the Department's November 2020 "Just the Facts" document and interviews with Department staff.

The Facility is a secure care correctional facility and as such, it has measures that are designed to help provide for the safety and security of the public, youth who reside at the Facility, Department staff, and Facility visitors. These security measures include locked buildings, a barbed wire fence around the perimeter of the property, 1 entrance and exit point where Department staff conduct security screenings of incoming persons and their belongings, and cameras for monitoring the Facility grounds and building interiors (see Figure 2, page 3, for photographs of some of the Facility's security features).

The Facility consists of various buildings, including housing unit buildings where youth reside, education buildings, medical buildings, a cafeteria, and an administration building, as well as outdoor recreation areas such as basketball courts and a swimming pool (see Appendix A, pages a-1 through a-3, for a map and additional photographs of Facility buildings and grounds). As of June 2020, the Facility had 12 housing units for youth including general population housing units, specific housing units for youth with histories of substance abuse, mental health issues, and sexual offenses, and 1 housing unit where all female youth reside.[4] The Department assesses each youth to determine a youth's risk to recidivate and associated treatment needs and for male youth uses this information to determine a youth's housing unit placement. Each housing unit contains locked, single- or double-occupancy cells with built-in beds and a toilet and sink, common areas such as a day room, a laundry room, and hallways, and a control room where supervisors can monitor the housing unit common areas via cameras.[5] Additionally, the Facility includes 2 Temporary Stabilization Units (TSUs) for isolating youth to stabilize and de-escalate youth behavior that represents a danger to themselves or others (see page 6 through 10 for more information).

[4] One of the general population housing units also contains a section for youth with a history of aggression and violence. Additionally, the Facility includes an intake housing unit where youth reside when they first arrive at the Facility, a housing unit for youth who violated parole, and a quarantine housing unit that was established in March 2020 in response to the COVID-19 pandemic.

[5] According to the Department, single-occupancy rooms could be used to house youth who have been adjudicated for sexual offenses, are a risk of being a danger to others, or for youth with mental health issues.

Figure 2
Photographs of Facility security features

Perimeter fence

Single entrance and exit point

Source: Department-provided photographs.

Department provides treatment programs and other services for youth rehabilitation

Consistent with statute, the Department provides an array of services at the Facility to help support youth rehabilitation, including:

- **Treatment programs—**Consistent with its statutory responsibility to provide treatment to youth, the Department provides various group and individual treatment programs under the supervision of licensed clinical staff to youth depending on youths' assessed risk to recidivate and treatment needs.[6] For example, the Department has a treatment program for youth with aggressive and violent behavior and another treatment program for youth with moderate to severe substance use issues.[7]

- **Education and vocational training—**The Department operates a school at the Facility where youth participate in educational classes and vocational and career education programs, such as cosmetology and automotive technology (see textbox for the Department's statutory requirements related to youth education). Youth can also earn school credit by participating in a work crew to learn vocational skills, including landscape maintenance and kitchen operations.[8]

- **Extracurricular and religious activities—**The Department also offers opportunities for youth to participate in pro-social activities, such as interscholastic sports and a Boy Scouts of

Statutory requirements for youth education

A.R.S. §41-2831(E) requires the Department to provide an appropriate education to all youth committed to the Facility who have not received a high school diploma or a high school certificate of equivalency. According to A.R.S. §41-2822.01(A), youth who are confined in the Facility and have not received a high school diploma, a high school certificate of equivalency, or an exception from the Department director must attend school full time. Youth who have a high school diploma or high school certificate of equivalency may still attend school or vocational training but are not required to do so.

Source: Auditor General staff review of A.R.S. §§41-2831 and 41-2822.01.

6 A.R.S. §§41-2802, 41-2815, and 41-2816.

7 As discussed on page 1, our second audit will determine whether the Department's processes for evaluating its evidence-based treatment programs is consistent with best practices. This second audit will provide additional information on how the Department assesses each youth's risk to recidivate and associated treatment needs.

8 To participate in a work crew, youth must complete an application and the Department reported they will complete an interview with Department staff from the designated area. Youth receive school credit for participating in a work crew during their scheduled school hours.

America program, as well as recreation, including swimming and basketball. Additionally, consistent with statute, youth are also able to voluntarily participate in religious services offered at the Facility.[9]

See Figure 3 for an overview of a Facility housing unit's daily schedule for youth activities.

Figure 3
Housing unit daily schedule at the Facility[1]

[1] Housing units follow a general, standard schedule for the specific activities that occur throughout the day. However, an individual youth's schedule may vary within the standard schedule.

[2] According to Department staff, expectation and closure groups are opportunities for staff to meet with youth to discuss expectations for the day, any updates related to the Facility, check-in with the youth, or address youth behavior.

[3] All housing units are assigned an hour of visitation on either Saturday or Sunday. Visitation is held in-person and limited to 2 immediate family members only, such as the youth's parent or legal guardian and siblings. The Department reported that it offers video visitation for families unable to visit the Facility due to distance or economic reasons. Due to the COVID-19 pandemic, the Department expanded its video visitation for youth and families and as of August 2020, provided limited in-person visitation.

[4] According to Department staff, responsibility time is free time for the youth and can include a variety of activities, including watching television, playing card games, or reading.

[5] As discussed above religious services are voluntary.

Source: Auditor General staff review of a weekly housing unit schedule and interviews with Department staff.

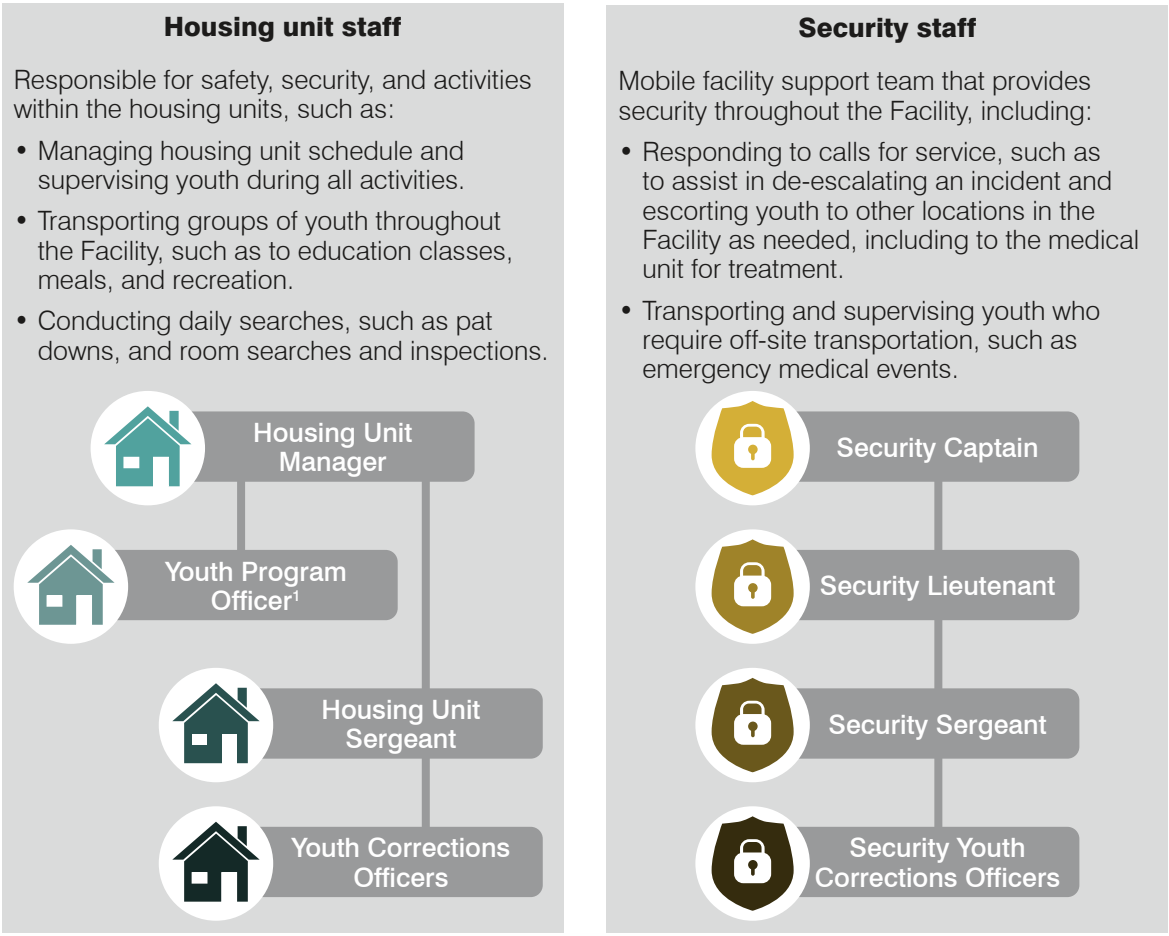
Various Department staff provide youth supervision and security at the Facility

Department housing unit and security staff are charged with the day-to-day supervision and security of youth at the Facility and have different responsibilities related to these purposes (see Figure 4, page 5). For example, housing unit staff are responsible for managing youths' schedules and supervising youth during the various activities in which they participate throughout the day, such as during treatment programs, meals, and recreation. Meanwhile, security staff are a mobile support team that respond to any security calls for assistance, including incidents such as a youth refusing to follow a staff directive or multiple youth involved in a fight. According to the Department, Facility staff most commonly make 2 types of security calls requesting security staff assistance with youth behavior—nonemergency security calls for assistance with youth behavior that does not yet represent a danger to the youth or others and emergency security calls for assistance with youth behavior that represents a danger to the youth or others (see page 7 for more information about emergency and nonemergency security calls). According to the Department's Security Captain who oversees all security staff, security calls are typically

[9] A.R.S. §41-2804.01(E) and (F) require the Department to make available religious programs that accommodate the religious faiths held by all youth in secure care facilities as long as a religious program would not interfere with the safety or security of the Facility, staff, or youth, and requires that participation in religious programs be strictly voluntary.

made by housing unit staff, but can be made by any Department staff member at the Facility who needs additional assistance from security staff.

Figure 4
Youth supervision and security responsibilities and organization chart for housing unit and security staff



[1] Youth program officers are case managers assigned to youth in each housing unit.

Source: Auditor General staff review of Department policy, training documents, organization charts, and interviews with staff.

In addition, the Department has 2 TSUs for isolating youth to stabilize and de-escalate dangerous behavior, and other Department staff are responsible for supervising youth while they are in the TSUs (see pages 6 through 10 for more information). Specifically, the Department's Clinical Director, who is a licensed psychologist, oversees both TSUs. Additionally, each TSU is staffed by a TSU Supervisor who is a licensed, qualified mental health professional responsible for supervising TSU youth corrections officers who are specifically assigned to TSU (TSU staff). TSU staff provide day-to-day supervision and oversight of youth in TSU and receive specific training related to their TSU responsibilities.[10]

As of October 1, 2020, the Clinical Director and both TSU Supervisor positions were filled and the Department reported it had 162 housing unit and 48 security positions filled, with 10 vacancies in each area, and 12 filled TSU

[10] TSU staff are not qualified mental health professionals but they receive 16 hours of training specific to TSU operations in addition to the standard training program all Facility youth corrections officers receive.

staff youth corrections officer positions with 3 vacancies. See Table 1 for more specific details regarding positions and vacancies for housing unit, security, and TSU staff.

Table 1
Staffing levels for housing unit, security, and TSU positions
As of October 1, 2020
(Unaudited)

	Positions filled	Vacancies
Housing unit		
Housing Unit Manager	7	0
Youth Program Officer	18	4
Housing Unit Sergeant	11	0
Housing Unit Youth Corrections Officer	126	6
Security		
Security Captain	1	0
Security Lieutenant	5	0
Security Sergeant	7	0
Security Youth Corrections Officer	35	10
TSU		
Clinical Director	1	0
TSU Supervisor	2	0
TSU Youth Corrections Officer	12	3

Source: Department-provided information.

Facility's TSUs are intended to isolate youth to stabilize and de-escalate dangerous behavior

Department has established 2 TSUs to isolate and stabilize youth who are an imminent danger of inflicting serious physical harm to themselves or others, and 84 percent of youth in Facility have spent time in TSUs—The Department has established 2 TSUs—1 for male youth and 1 for female youth—at the Facility for the purpose of isolating youth and stabilizing and de-escalating their behavior.[11] According to Department policy and procedures, TSUs are intended to only be used as a last resort when youth are an imminent danger of inflicting serious physical harm to themselves or others. Youth can also request a self-referral to TSU for personal reasons, such as wanting time away from peers because they are frustrated.[12] TSUs have single occupancy cells that contain a built-in bed, a toilet, and sink, and TSU staff can monitor each cell via video camera from a central control room located in each TSU. See Figure 5, page 7, for photographs of the boys' TSU and Appendix A, page a-3, for additional photographs of the boys' TSU.

While in TSU, youth are required to complete worksheets as part of a reintegration plan that is intended to help the youth address the behavior that led to the TSU admission and are also required to meet with a Department

[11] The boys' TSU is a separate, standalone unit that serves all male youth in the Facility, whereas the girls' TSU is located within the female housing unit. According to the Department, the boys' TSU has 10 cells and the girls' TSU has 6 cells.

[12] According to Department policy, prior to sending a youth to TSU for a self-referral, Department staff should discuss the underlying issues and attempt to problem solve with the youth. Department policy also requires that youth in TSU for a self-referral meet with various staff, such as their housing unit manager or case manager, who should make all reasonable efforts to encourage the youth to return to regular programming as soon as possible.

qualified mental health professional in TSU as soon as they are stable, cooperative, and able to process the incident that led to their admission. While in TSU, youth receive the same meals, and visitation and telephone privileges, as youth in the housing units.[13]

Figure 5
Boys' TSU photographs

TSU lobby

TSU cell

Source: Department-provided photographs.

From January 2019 through February 2020, the Facility had 3,287 referrals to TSU—2,922 referrals for danger to self or others and 365 self-referrals (see Figure 6, page 8, for more information related to these referrals). These referrals involved 365 of the total 433 youth (84 percent) who were in the Facility at some point during that time frame. Of the 2,922 TSU referrals for danger to self or others, 76 percent of these referrals resulted in the youth being admitted to TSU, and 24 percent of the referrals did not result in admission.

Additionally, according to the Department, from June 2019 through February 2020, security staff responded to 1,382 nonemergency security calls, of which 150 calls, or approximately 11 percent, resulted in a youth being referred to TSU.[14] Additionally, the Department reported that during this same time period, security staff responded to 1,248 emergency security calls, of which 937 calls, or approximately 75 percent, resulted in a youth being referred to TSU.[15]

Department policy and procedures outline TSU process and time frames—The Department's TSU policy and procedures outline the following process and required time frames for de-escalating youth behavior and TSU referral, check-in, and admission (see Figure 7, page 10, for an overview of the Department's de-escalation and TSU referral, check-in, and admission procedures):

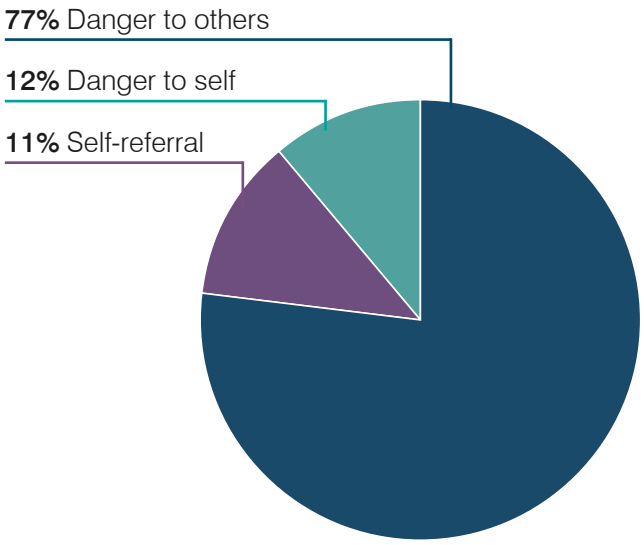
- **Department staff attempt to de-escalate youth behavior and if needed, refer youth to TSU for being a danger to themselves or others—**When youth engage in behavior that leads staff to believe they are an imminent danger to themselves or others, Department staff are required to perform the following TSU referral process:

[13] If a youth remains in TSU for more than 24 hours, Department policy requires it to provide youth with educational services, 1 hour of large muscle group exercise, and counseling from the chaplain if requested.

[14] The Department reported it began tracking security calls that resulted in TSU referrals in June 2019.

[15] According to the Department, security staff were able to help de-escalate youth behavior for the security calls that did not result in a youth being referred to TSU.

Figure 6
Referral type for the 3,287 TSU referrals made from January 2019 through February 2020



Source: Auditor General staff analysis of Department TSU referral data.

- **Attempt to stabilize and de-escalate a youth's behavior—**Department staff should use all appropriate and practical interventions to stabilize and de-escalate a youth's behavior prior to referring a youth to TSU, such as relocating the youth to a quiet and private area to help the youth address the behavior with coping skills or handing off the situation to a supervisor or qualified mental health professional to help the youth address the behavior. If the staff member(s) have used all appropriate and practical interventions and still believe the youth is a danger to themselves or others, then they may initiate a TSU referral.

- **Call security staff for further assistance—**Security staff must be called for assistance with the referral and are required to attempt further interventions to stabilize and de-escalate the youth's behavior, such as relocating the youth to a quiet or private area to hear the youth's concerns or to mediate any disagreements between youth.

- **Security staff transport youth to TSU if youth behavior does not stabilize—**If the further interventions do not stabilize and de-escalate the youth's behavior, security staff are then authorized to transport the youth to TSU.[16] Security staff are also authorized to transport youth to TSU using mechanical restraints, such as handcuffs, under certain circumstances.[17]

- **Submit incident report describing the need for TSU referral—**After security staff take custody of the youth to transport them to TSU, the referring staff member has 90 minutes to complete and submit an incident report for TSU staff's review. The incident report should indicate whether the youth was referred for being a danger to themselves or a danger to others and describe details about the behavior and events that necessitated the referral, including interventions the referring staff member and security staff attempted prior to referral and transport to TSU.

[16] Effective January 2021, the Department revised its TSU policy and procedures to require security staff to determine whether a youth's behavior would likely meet TSU admission criteria prior to transporting a youth to TSU and if unable to make this determination, to refer the incident to the shift commander to make the determination (see page 18 for more information). According to the Department, a shift commander is the designated employee in charge of all Facility operations during a specific shift.

[17] Department policy allows its staff to use mechanical restraints as necessary to transport youth inside the Facility when a youth's behavior leads staff to reasonably believe the youth will attempt to or will substantially disrupt the Facility, will attempt to escape and/or engage in violent behavior, or when doing so is immediately necessary to prevent injury, property damage, or escape. Department policy states that staff should only use the amount of force or control reasonably necessary and the Department reported that its staff most commonly use handcuffs when restraints are necessary for transporting youth.

- **Department staff conduct TSU check-in procedures—**Once a youth is transported to TSU, Department staff are required to perform the following TSU check-in process:

    - **Youth is isolated in TSU cell and strip searched—**Upon arrival to TSU, youth are isolated in a TSU cell and receive a mandatory strip search intended to discover and remove contraband in the youth's possession, such as weapons, to help maintain the youth's and staffs' safety and security. Strip searches are required to be conducted by 2 staff members who are the same gender as the youth and are typically conducted by security staff.

    - **Health unit staff conduct health check as applicable—**If a youth was transported to TSU in restraints, has injuries, or was referred to TSU for being a danger to themselves, TSU staff should request and health unit staff should perform a health unit check to identify and treat any youth injuries.

- **TSU Supervisor or TSU staff make admission decision—**Once the referring staff member submits an incident report, the TSU Supervisor or TSU staff have 30 minutes to review the incident report, conduct an interview with the youth if his/her behavior permits, and assess any additional information from witnesses to the incident and/or a security camera review to determine if the youth should be admitted to TSU or released.[18] According to the TSU policy, TSU admissions decisions are based on the following criteria:

    - If the youth is determined to be a danger to themselves or others, the youth should be admitted to TSU and may remain confined there for up to 24 hours until the TSU Supervisor or another qualified mental health professional determines the youth is stable and cooperative to be released. For a youth to remain confined in TSU longer than 24 hours, the youth must receive a due process hearing conducted by a TSU hearing officer to determine whether the youth's TSU admission was appropriate and if the youth continues to engage in behavior that warrants further confinement.[19]

    - If the youth is determined to not be a danger to themselves or others and is stable and cooperative, the youth should not be admitted to TSU and must be released and returned to their regularly scheduled activity as soon as possible.

    - If an incident report is not received within the 90-minute time frame, the youth should not be admitted to TSU and must be released and returned to their regularly scheduled activity as soon as possible unless a shift commander grants an extension to submit the incident report.[20] Additionally, if the TSU Supervisor or another qualified mental health professional determines the youth is not stable to be released, the youth can be admitted to TSU even if an incident report is not received within the 90-minute time frame. A decision to admit a youth to TSU when an incident report was not received within the 90-minute time frame must be documented in an incident report describing the behavior that led to the admission decision.

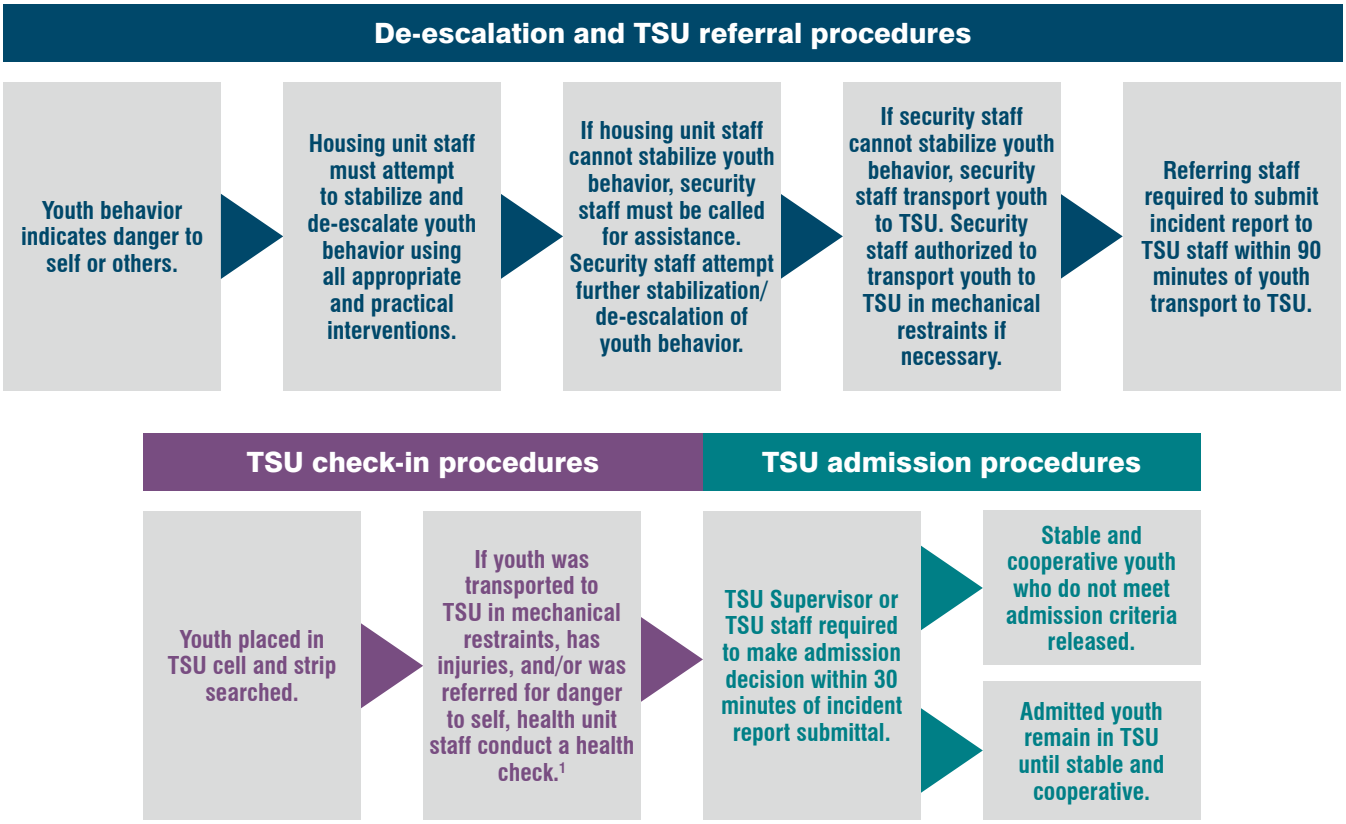
---

[18] As of August 2020, the Department reported that only qualified mental health professionals, including TSU Supervisors, the Clinical Director, and Department psychologists, are authorized to make TSU admission decisions.

[19] A TSU hearing officer can authorize the youth to remain in TSU for an additional 24 hours based on this determination. Facility administration are authorized to approve extended confinement in additional 24-hour increments up to 120 hours and the Department Director is authorized to approve extended confinement indefinitely until the TSU Supervisor or another qualified mental health professional determines the youth is stable and cooperative to be released.

[20] According to the TSU policy and procedures, a shift commander can grant an extension up to 60 minutes for the incident report submittal to TSU if the incident report is likely to be received outside of the 90-minute time frame for good cause and extraordinary circumstances. The shift commander must notify TSU staff when granting an extension and explain the reason(s) for doing so. TSU staff are required to document the approved extensions and extraordinary circumstances justifying them in a TSU tracking log.

Figure 7
Department de-escalation and TSU referral, check-in, and admission procedures



[1] A health check is intended to identify and treat any injuries the youth may have.

Source: Auditor General staff review of TSU policy and procedures.

Department regularly reviews compliance with several TSU procedures—The Department's quality assurance (QA) staff complete a monthly review of records for youth referred to TSU to assess whether Department staff complied with several TSU procedures (see Finding 1, pages 17 through 19, for information and recommendations related to some TSU policy and procedure requirements that are not included in these QA compliance reviews). This review includes assessing compliance with the following referral, check-in, and admissions procedure requirements:

- Incident report was submitted by referring staff within 90 minutes.
- Health check was conducted during the check-in process, if applicable.
- Admission decision was made by TSU Supervisor or TSU staff within 30 minutes of incident report receipt.
- Admission decision for admitted youth was consistent with admission criteria (see page 9 for admission criteria).[21,22]

QA staff review records for all youth referred to TSU on specific days and review up to 20 days of referrals each month.

[21] QA staff do not review admissions decisions for youth who are not admitted to TSU.

[22] QA staff also review staff compliance with other TSU procedures that occur after a youth is admitted to TSU, such as whether a reintegration plan was completed or the youth's parent was notified of the TSU admission, as required by the TSU policy.

Department's TSU policy and procedures were developed in response to federal lawsuits and investigations alleging civil rights violations

According to the Department, its TSU policy and procedures were largely developed in response to previous federal lawsuits and investigations that alleged civil rights violations, as follows:

- **1986 federal lawsuit alleged punitive use of isolation—**The Department was established in 1990 when it separated from the Arizona Department of Corrections (now known as the Arizona Department of Corrections, Rehabilitation and Reentry [ADCRR]) as a result of a 1986 federal lawsuit alleging ADCRR violated youths' civil rights by using punitive isolation as well as failing to rehabilitate them, denying them a free and appropriate public education, and failing to provide due process for parole revocation.[23,24] For example, the lawsuit alleged ADCRR confined youth in solitary confinement cells for time frames ranging from several hours to several months, and failed to provide these youth with appropriate counseling, recreation, education, and other rehabilitative treatment. In 1993, the Department entered into a court-approved consent decree to address the plaintiff's claims, including specific claims related to TSU, formerly known as Separation. In the consent decree, the Department agreed to the following:

    - Separation should only be used to protect youth or others from imminent risk of injury, destruction of property, disruption of the Facility, or for youth who were an escape risk.
    - Staff should attempt to avoid the use of Separation and only escort youth to Separation if less restrictive efforts were unsuccessful.
    - When youth are admitted to Separation, staff should develop an action plan to return the youth to programming and release the youth from Separation when they meet criteria outlined in the action plan.
    - Youth should receive a hearing to determine if confinement in Separation for longer than 24 hours is necessary.

    Based on the Department's compliance with the 1993 consent decree, the lawsuit was closed in 1998.

- **2002 federal investigation found lack of due process and excessive use of Separation—**In 2002, the U.S. Department of Justice began an investigation under the Civil Rights of Institutionalized Persons Act (CRIPA) to determine whether the civil rights of youth in the Department's custody were being violated.[25] The findings from the investigation included that the Department failed to provide adequate due process procedures before isolating youth in Separation and that youth were kept in Separation for extended and inappropriate periods of time. As a result of this investigation, the U.S. Department of Justice filed a lawsuit against the State in 2004.[26] The State entered into a Memorandum of Agreement (Agreement) with the U.S. Department of Justice to address the deficiencies the investigation identified, including ensuring that youth confined in Separation for more than 24 hours received a due process hearing and that a quality assurance team would review all uses of Separation over 24 hours. Court-appointed consultants monitored the Department's implementation of the Agreement and the Department was relieved of this monitoring in 2007 as a result of changes to its operations.

---

[23] Johnson v. Upchurch, CIV-86-195, U.S. Dist. Ct. for Dist. of AZ.

[24] In January 2020, the Arizona Department of Corrections' name was changed to ADCRR.

[25] CRIPA authorizes the U.S. Department of Justice to protect the rights of individuals in the care of state institutions, such as state and locally operated correctional facilities and mental health facilities. See 42 U.S.C. §1997.

[26] United States of America v. The State of Arizona, et. al., CV-04-01926, U.S. Dist. Ct. for Dist. of AZ.

Department has referred some youth to TSU contrary to its TSU policy and procedures, and youth isolation can potentially have negative consequences

Although Department's TSU policy is consistent with best practices, it did not follow its TSU referral policy and procedures for 12 of 30 referrals we reviewed

Department's policy and procedures governing TSU use are consistent with best practices for correctional use of youth isolation—Best practices and other standards for juvenile justice indicate youth isolation in correctional facilities should be minimized because it can potentially have a range of negative consequences for youth and juvenile justice agencies (see page 15 for more information on these negative consequences).[27] For example, the Council of Juvenile Justice Administrators (CJJA), the National Institute of Corrections' *Desktop guide to quality practice for working with youth in confinement* (Desktop Guide), and the American Academy of Child and Adolescent Psychiatry all indicate that youth isolation should be used only when youth are a danger to themselves or others and after less restrictive interventions, such as verbal de-escalation techniques, have proven ineffective.[28,29] In addition, federal law prohibits federal facilities from placing youth alone in a cell, room, or other area for discipline, punishment, retaliation, or any other reason other than that the youth's behavior poses a risk of immediate physical harm that cannot otherwise be de-escalated.[30]

Consistent with these best practices and standards, the Department's policy and procedures for TSU, which is a form of isolation, indicate that it should only be used as a last resort when a youth is an imminent danger of inflicting serious physical harm to themselves or others and after all appropriate and practical interventions have been taken to safely stabilize and de-escalate the youth's behavior (see Introduction, pages 6 through 10, for more

---

[27] Boesky, L. (2014). "Mental health," in *Desktop guide to quality practice for working with youth in confinement*. National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Retrieved 1/22/2020 from https://info.nicic.gov/dtg/sites/info.nicic.gov.dtg/files/DesktopGuide.pdf; Umpierre, M. (2014). "Rights and responsibilities of youth, families, and staff," in *Desktop guide to quality practice for working with youth in confinement*. National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Retrieved 1/22/2020 from https://info.nicic.gov/dtg/sites/info.nicic.gov.dtg/files/DesktopGuide.pdf; Deitch, M. (2014). "Behavior management," in *Desktop guide to quality practice for working with youth in confinement*. National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Retrieved 1/22/2020 from https://info.nicic.gov/dtg/sites/info.nicic.gov.dtg/files/DesktopGuide.pdf; Council of Juvenile Correctional Administrators. (2015). *Council of Juvenile Correctional Administrators toolkit: Reducing the use of isolation*. Braintree, MA. Retrieved 10/10/2019 from http://cjca.net/wp-content/uploads/2018/02/CJCA-Toolkit-Reducing-the-Use-of-Isolation-1.pdf; Godfrey, K. (2019). *Reducing isolation. A report on the key findings in the effects of isolation and room confinement*. Braintree, MA: The PbS Learning Institute Inc. Retrieved 10/10/2019 from https://pbstandards.org/media/1159/pbsreducingisolationjune2019.pdf.

[28] American Academy of Child and Adolescent Psychiatry. (2012). *Policy Statement: Solitary confinement of juvenile offenders*. Washington, DC. Retrieved 3/19/2021 from https://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx; Umpierre, 2014; Boesky, 2014; Council of Juvenile Correctional Administrators, 2015. As of February 2020, the Council of Juvenile Correctional Administrators changed its name to CJJA.

[29] The Desktop Guide contains multiple chapters written by researchers/experts in a variety of different correctional related areas to provide resources and information to juvenile justice staff, supervisors, and administrators.

[30] 18 U.S.C. §5043.

information about the Department's TSUs for isolating youth to stabilize and de-escalate dangerous behavior, and see Appendix A, page a-3, for photographs of the Department's boys' TSU). These interventions include relocating the youth to a quiet or private area to hear the youth's concerns, mediating disagreements between youth, and handing off the situation to a supervisor or qualified mental health professional to help de-escalate the situation. Department policy requires the referring staff member to attempt to stabilize and de-escalate youth behavior using all appropriate and practical interventions prior to a TSU referral and for security staff who respond to calls for assistance with youth behavior to attempt further interventions prior to transporting the youth to TSU. Department staff are required to document in an incident report whether the youth was referred to TSU for being a danger to themselves or a danger to others and describe details about the youth's behavior and events that necessitated the referral, including describing interventions the referring staff member and security staff attempted prior to referral. The Department also reported that its staff should explain in the incident report any reasons why interventions were not practical or appropriate. Finally, Department policy does not list specific behaviors that should result in an automatic TSU referral. Instead, according to the Department, Department staff are required to assess each youth's dangerousness and the imminence of danger individually, based on the youth's prior history and tendencies. See Introduction, pages 7 through 10, for more information on the Department's TSU referral process and textbox below for Department's definition of danger to self and danger to others.

Danger to self—A danger of inflicting serious physical harm on oneself, including attempted suicide or the serious threat thereof. Without intervention, danger to self will result in serious physical harm or serious illness to the youth. For example, a youth may threaten to harm themselves or repeatedly hit their head against a wall or door.

Danger to others—A danger of inflicting serious physical harm on others, including attempted assault or the serious threat thereof. Without intervention, danger to others will result in serious physical harm or serious illness to another individual. For example, a youth may assault or threaten to assault another youth or staff.

Source: Auditor General staff review of the Department's TSU policy and procedures and TSU referral incident reports.

Department did not follow its TSU referral policy and procedures for 12 of 30 referrals we reviewed—Our review of a stratified random sample of 30 TSU referrals Department staff made for youth over a 14-month period found that Department staff did not adhere to TSU policy and procedures for 12 of these referrals.[31] Whether because of staff failure to follow the policy and procedures or to document the referral details in the incident reports, these incident reports did not describe the youth's behavior and events that necessitated the referral for an imminent danger of inflicting serious physical harm to themselves or others, the interventions the referring staff member and security staff attempted to stabilize and de-escalate the youth's behavior prior to referring and transporting the youth to TSU, and/or why further interventions were not practical or appropriate.[32] Examples from these 12 TSU referrals included the following:

- In 1 incident, a youth was described as obnoxious, not following staff directives or instructions, and laughing and encouraging the behavior of another youth who was using profanity toward staff in a tone that was described as aggressive. The youth was referred to TSU for being a danger to others. Although a check box was marked on the incident report indicating the youth was counseled and then referred to TSU, contrary to Department policy, the incident report narrative did not describe the actions staff took to counsel the youth. Additionally, the incident report indicated that the youth would not care about 1 type of intervention, but did not describe details about any other interventions housing unit or security staff took to stabilize

[31] We randomly sampled 30 of the 2,922 TSU referrals Department staff made for youth being a danger to self or others from January 2019 through February 2020. Our sample was stratified as follows: 20 referrals for being a danger to others—10 in which youth were admitted to TSU and 10 in which they were not admitted; and 10 referrals for being a danger to self—5 in which youth were admitted to TSU and 5 in which they were not admitted. We did not review any of the 365 TSU referrals from this time period in which youth requested a self-referral because our review was intended to assess Department staffs' referrals of youth to TSU for being a danger to themselves or others. The sample for this testwork was not designed to be representative of the population and the results should not be projected to the entire population. See Appendix C, page c-1, for more information about the sample design.

[32] For 1 of the 12 referrals, Department records did not contain an incident report documenting the youth's referral to TSU, which the Department's TSU policy requires staff to complete.

and de-escalate the youth's behavior or explain why further interventions were not practical or appropriate prior to referring and transporting the youth to TSU. The incident report also did not describe details about the youth's behavior and events that necessitated the referral for an imminent danger of inflicting serious physical harm to others, contrary to Department policy. For example, although the incident report indicated the youth was encouraging another youth who was exhibiting threatening behavior, it did not explain how the youth represented a threat of physical harm after security staff arrived and removed the other youth who was exhibiting threatening behavior. The youth was transported to TSU in handcuffs, received a strip search upon arrival, and was later released from TSU after nearly 2 hours for not meeting admission criteria.

- In another incident, a youth ran out of area and climbed onto the roof of a housing unit, climbed down and started to run toward another housing unit, but stopped and ran toward staff once security staff arrived. The youth was then physically restrained, placed in handcuffs, and referred to TSU for being a danger to others. The incident report indicated that prior to the youth running, Department staff took several actions to try and prevent the youth from running out of area, including explaining how staff counseled the youth and having a staff member more closely monitor the youth as they were walking outside. However, contrary to Department policy, the incident report did not describe details about the youth's behavior after being restrained that necessitated the referral for an imminent danger of inflicting serious physical harm to others. The youth received a strip search upon arrival at TSU and was later released from TSU after more than 2 hours for not meeting admission criteria.

- In another incident, a youth made an inappropriate sexual comment to a teacher during an education class and was removed from the classroom and referred to TSU for being a danger to others. Although the incident report described the youth's inappropriate comment as threatening, it did not further describe details about the youth's behavior and events that necessitated the referral for an imminent danger of inflicting serious physical harm to others, contrary to Department policy. Instead, the incident report stated that the youth attempted to "explain [his/her] way out of consequences" by saying that he/she was only talking about a planet during a science class about planets. Additionally, the incident report did not describe any interventions housing unit or security staff took to stabilize and de-escalate the youth's behavior prior to referring and transporting the youth to TSU, contrary to Department policy, or explain why further interventions were not practical or appropriate. The youth was transported to TSU in handcuffs, received a strip search upon arrival, and was later released from TSU after 1 hour and 30 minutes for not meeting admission criteria.

Additionally, we reviewed these 12 referrals with Department managers and found:

- For 5 of the 12 referrals, Department managers agreed that Department staff's actions documented in the incident reports related to the referrals were inconsistent with TSU policy and procedures. For example, in the incident involving a youth described as being obnoxious and not following staff directives, a Department manager indicated staff could have taken additional interventions prior to making the referral, such as placing the youth in his/her room for up to 1 hour as allowed by Department policy.

- For 7 of the 12 referrals, Department managers explained why they believed that Department staff's actions were appropriate, but their explanations were inconsistent with the Department's TSU policy and procedures. For example, in the incident involving a youth running out of area, a Department manager stated the Department's protocol for handling youth who run out of area requires youth to be automatically taken to TSU. However, the Department's TSU policy and procedures indicate that running out of area or climbing on buildings or fences may be classified as a danger to self or others under certain circumstances but that this determination should be considered on a case-by-case basis. Additionally, in another incident involving a youth living in a high-risk housing unit for youth with a history of aggression and violence, Department staff referred the youth to TSU for making gang signs but the incident report did not describe details about the youth's behavior and events that necessitated the referral for an imminent danger of inflicting serious physical harm to others. A Department manager explained that it is easier to remove youth in this high-risk housing unit from others when their behavior is escalating so they do not escalate other youth; however, this reason is not consistent with the Department's stated requirement that staff should assess each youth's dangerousness and the imminence of danger individually.

See Appendix B, pages b-1 through b-6, for descriptions of all 12 TSU referrals for which staff did not adhere to TSU policy and procedures.

Department's noncompliance with its TSU referral policy and procedures may increase youth exposure to isolation, which can potentially have negative consequences

As previously discussed (see page 12), best practices and other standards for juvenile justice indicate youth isolation in correctional facilities, such as TSU, should be minimized because it can potentially have a range of negative consequences for youth and juvenile justice agencies. The Department's TSU referral policy and procedures are intended to help ensure TSU is used as a last resort, which can help minimize its use. Additionally, if a youth is referred to TSU, the Department's TSU procedures specify required time frames for TSU admissions decisions, require youth to be released as soon as they are stable and cooperative, and require a due process hearing for youth to remain confined in TSU longer than 24 hours, which can help minimize the amount of time youth spend in TSU (see Introduction, page 9, for more information about these processes). However, Department noncompliance with its TSU referral policy and procedures may increase youth exposure to isolation, which literature has shown can potentially have the following negative consequences:

- **Isolation has a range of potential negative consequences for youth—**According to juvenile justice literature, isolation should only be used as a last resort for youth in correctional facilities because it can lead to a range of potentially negative consequences. Specifically, according to CJJA, academic research has shown that isolation can cause psychological, physical, and developmental harm that can result in persistent mental health problems or suicide.[33] CJJA indicates that experts believe adolescents are particularly vulnerable to the psychological harm that can be caused by isolation because their brains are still developing. For example, CJJA reports that subjecting developing adolescents to isolation can cause permanent psychological damage and multiple studies suggest it is highly correlated with suicide. As a result, CJJA states that isolating or confining a youth in his/her room should be used only to protect the youth from harming him/herself or others and if used, should be for a short period and supervised.

  Similarly, the Desktop Guide states that a great deal of research has found that placing incarcerated youth in isolation settings can traumatize these youth and lead to mental health problems and suicidal behavior.[34] Additionally, the Desktop Guide cites research indicating that isolation can produce or exacerbate feelings of hopelessness or agitation; that youth with mental health and trauma-related disorders are inherently more vulnerable to the potentially negative effects of isolation; and that isolation can produce mental health symptoms in nonmentally ill youth.[35] Although the Desktop Guide notes that the degree of psychological deterioration will vary depending on several factors, such as the duration and intensity of isolation and whether the youth perceives the isolation as threatening or unjust, it also notes that youth are inherently more vulnerable to the damaging effects of isolation because they are still developing cognitively, emotionally, physically, and psychologically.[36] As a result, the Desktop Guide states that if isolation must be used, it should only be done as a response of last resort, used for the briefest amount of time possible, and only in extreme circumstances when it is absolutely necessary for safety.[37,38]

---

[33] Council of Juvenile Correctional Administrators, 2015.

[34] Deitch, 2014.

[35] Boesky, 2014.

[36] Boesky, 2014.

[37] Boesky, 2014.

[38] CJJA and the Desktop Guide identify additional potential negative impacts associated with prolonged or lengthy exposure to isolation. However, our review focused on the potential negative impacts associated with the general use of isolation because all but 3 of the 12 noncompliant referrals we reviewed resulted in youth being confined in TSU for less than 2.5 hours. The 3 additional noncompliant referrals resulted in each of the youth being confined in TSU for more than 5, 17, and 18 hours, respectively.

- **Isolation used for reasons other than to prevent imminent harm can undermine youth rehabilitation and is ineffective in managing youth behavior—**The Desktop Guide indicates that the use of isolation and other control measures, such as force and mechanical restraints, as a response to misbehavior can contribute to a culture of fear and mistrust.[39] According to research cited in the Desktop Guide, youth must feel safe in order to work successfully on their therapeutic needs and any sense that they are at risk of harm can undermine their rehabilitative progress. Additionally, using isolation in response to youth's behavior, rather than other de-escalation techniques, could deprive youth of opportunities to learn coping skills and apply practices learned in therapeutic programs. For example, the Desktop Guide reports that research has repeatedly found that using isolation can be counterproductive in addressing youth misconduct, stating that it is ineffective in identifying the underlying causes of youth misconduct and may deprive youth of opportunities to learn to improve their behavior or to practice new problem-solving skills.[40] Further, according to CJJA, there is no research showing the benefits of using isolation to manage youth behavior. Instead, CJJA indicates research has shown that the facilities that minimally use isolation have fewer injuries to youth and staff, less suicidal behavior and overall violence, and healthier staff-youth relationships that lead to less recidivism.[41]

Additionally, when youth are referred to TSU, they are also subjected to strip searches and in many cases, mechanical restraints, which have been shown to have a range of potential negative consequences that are not mitigated by minimizing the amount of time spent in TSU. Although juvenile justice literature indicates that restraints and strip searches may be necessary for safety and security in some cases, they also have the following potential negative consequences for youth and juvenile justice agencies:[42]

- **Mechanical restraints, including handcuffs, can be traumatic and have other negative impacts—**The Desktop Guide indicates that the use of mechanical restraints, including handcuffs, can traumatize youth, especially those with histories of abuse and trauma.[43] When mechanical restraints are improperly used for punitive purposes, such as using them in response to disruptive behavior or rule breaking, the Desktop Guide reports that it can promote a culture of fear and violence, be detrimental to the quality of positive staff-youth relationships, and can cause injuries to both youth and staff.[44]

- **Strip searches are more invasive than other search methods and thus can also be traumatic—**According to the Desktop Guide and the Juvenile Law Center, strip searches are more invasive than other search methods, such as pat downs, and thus can be traumatic.[45] The Juvenile Law Center reported that strip searches can cause youth to experience anxiety, depression, shame, and guilt and can retraumatize youth who are survivors of sexual abuse.[46] The Desktop Guide also reports that being subjected to a strip search can intensify a youth's fears, sense of hopelessness, and potential for self-harm.[47]

Ensuring compliance with the TSU de-escalation and referral procedures is important to help mitigate and minimize the risks of the negative consequences linked to the use of isolation, mechanical restraints, and strip searches. Specifically, the relationship between these practices and the associated potential negative consequences was established by a body of research that assessed the impacts on various youth populations over a long period of time. Additionally, because these impacts may manifest themselves differently in youth, and may not

---

[39] Deitch, 2014.

[40] Deitch, 2014.

[41] Council of Juvenile Correctional Administrators, 2015.

[42] Umpierre, 2014.

[43] Boesky, 2014; Deitch, 2014.

[44] Deitch, 2014.

[45] Nelsen, A. (2014). "Admission and intake," in *Desktop guide to quality practice for working with youth in confinement*. National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Retrieved 01/22/2020 from https://info.nicic.gov/dtg/sites/info.nicic.gov.dtg/files/DesktopGuide.pdf; Juvenile Law Center. (2017). *Addressing trauma: Eliminating strip searches*. Philadelphia, PA. Retrieved 03/05/2020 from https://jlc.org/sites/default/files/publication_pdfs/AddressingTrauma-EliminatingStripSearch.pdf.

[46] Juvenile Law Center, 2017.

[47] Nelsen, 2014.

manifest immediately after experiencing these practices, establishing a causal link between the practices and the negative consequences can be difficult. The Department would likely need to conduct extensive, costly, and time-intensive research to observe and measure these negative consequences on a systematic basis. Therefore, ensuring compliance with its existing TSU policy and procedures, which are designed to minimize use of TSU, can minimize youth exposure to isolation and its negative consequences.

Finally, as discussed in the Introduction, the Department's TSU policy and procedures were largely developed in response to previous federal lawsuits and investigations that alleged civil rights violations (see page 11). For example, as a result of an investigation related to CRIPA, the State entered into an Agreement related to use of Separation, now known as TSU.[48] Ensuring compliance with the Department's TSU policy and procedures, including ensuring that staff comply with documentation requirements, is important to help demonstrate continued compliance with this Agreement and other agreements that resulted from previous lawsuits and investigations.

Department does not review TSU referrals to ensure compliance with policy and procedures but implemented supervisory approval procedures for some TSU referrals during audit

Department lacks process to review staff compliance with TSU imminent danger referral requirement and interventions taken to stabilize and de-escalate youth behavior—Although CJJA indicates juvenile justice facility directors should monitor and enforce compliance with isolation policies and procedures to ensure staff are held accountable for consistently implementing these policies and procedures, the Department does not have a process to review its staffs' TSU referrals.[49] Specifically, as discussed in the Introduction (see page 10), the Department has a process to review its staffs' compliance with several TSU procedures, including compliance with required time frames for incident report submittal and reviewing if admissions decisions were consistent with the Department's TSU admission criteria. However, this process does not include a review and determination of whether housing unit and security staff adhered to TSU policy and procedures by referring youth to TSU only if they are an imminent danger of inflicting serious physical harm to themselves or others and after taking all appropriate and practical interventions to safely stabilize and de-escalate the youth's behavior, including documenting the youth's behavior that necessitated the referral and the interventions taken.

Reviewing Department's staffs' compliance with the Department's de-escalation and TSU referral procedures would enable the Department to identify, track, and reduce referrals that do not comply with its policy that youth be referred to TSU only when they are an imminent danger of inflicting serious physical harm to themselves or others and after taking all appropriate and practical interventions to safely stabilize and de-escalate the youth's behavior. Specifically, the Department could identify if and how often its staff do not comply with TSU referral policy and procedures and potential causes for this noncompliance, such as lack of documentation and inconsistent interpretation or implementation of de-escalation and TSU referral procedures. The Department would then have information for identifying and making improvements to reduce noncompliant TSU referrals, such as providing additional staff training on the appropriate use of TSU and/or additional de-escalation techniques, imposing requirements to consult with or obtain assistance from clinical staff or supervisors before referring a youth to TSU, and addressing differences between policy and practice. For example, although Department staff reported to us that all youth involved in fights should be transported to TSU until camera review can determine whether any of the youth were victims, rather than aggressors, Department policy does not list specific behaviors that should result in an automatic TSU referral. Additionally, as previously discussed (see page 14), Department staff reported that in some cases it is easier to remove high-risk youth from others when their behavior is escalating so they do not escalate other youth, but this reason is not consistent with the Department's stated requirement that staff should assess each youth's dangerousness and the imminence of danger individually.

---

[48] CRIPA authorizes the U.S. Department of Justice to protect the rights of individuals in the care of state institutions, such as state and locally operated correctional facilities and mental health facilities. See 42 U.S.C. §1997.

[49] Council of Juvenile Correctional Administrators, 2015.

Department reported that improvements to TSU documentation requirements and referral procedures during the audit decreased youth referrals to TSU—During the audit, the Department identified and implemented revisions to its TSU procedures that it reported resulted in a reduction in TSU referrals. Specifically, the Department reported that, beginning in September 2020, it required security staff to document in the TSU referral incident report any de-escalation interventions they used prior to transporting a youth to TSU. The Department also reported it required security staff to determine if a youth's behavior would likely meet TSU admission criteria prior to transporting the youth to TSU and if they are unable to make this determination, to refer the incident to a supervisor to make the determination. The Department revised its TSU policy and procedures to include these requirements, effective January 2021. According to the Department, after making these changes, the incidence of youth being referred to TSU decreased and the number of emergency security calls that resulted in a TSU referral also decreased. Specifically, according to the Department:

- From September 2020 to January 2021, the average number of monthly TSU referrals for danger to self and danger to others decreased by 39 percent when compared to the average number of monthly TSU referrals for danger to self and danger to others during the 14-month period we reviewed.
- From September 2020 to January 2021, approximately 36 percent of emergency security calls resulted in a TSU referral, which represented a decrease from the approximately 75 percent of emergency security calls that resulted in a TSU referral from June 2019 through February 2020.

In addition to the revisions described above, effective January 2021, the Department incorporated the following revisions in its TSU policy and procedures:

- Stating that TSU should not be used as a punishment or consequence for youth misbehavior.
- Clarifying the criteria for classifying running out of area or climbing on buildings or fences as a danger to self or others by adding that a youth exhibiting this behavior may be a danger to self or others if they do not become stable and cooperative without direct, physical intervention by Department staff.
- Adding a continuum of 21 interventions that Department staff can use to stabilize and de-escalate youth behavior prior to referral to TSU.
- Requiring security staff to document in the TSU referral incident report the specific behaviors displayed by a youth that made an incident/area unsafe if security staff did not attempt further interventions to stabilize and de-escalate youth behavior.

Recommendations

The Department should:

1. Follow its policy and procedure requirements for referring youth to TSU.
2. Ensure that TSU referrals comply with its policy and procedure requirements by:
    a. Developing and implementing policies and procedures for reviewing housing unit and security staffs' compliance with the Department's de-escalation and TSU referral procedures to identify, track, and reduce noncompliant TSU referrals. These policies and procedures should include procedures for:
        - Reviewing incident reports and other documentation associated with TSU referrals, including specifying the staff responsible and time frames for conducting these reviews. These procedures could include a risk-based approach and sampling methods for reviewing TSU referrals, as appropriate.
        - Addressing individual staff members' noncompliance with the de-escalation and TSU referral procedures, including outlining potential remedies and consequences for noncompliance, such as additional training, more frequent supervision and coaching, and disciplinary actions.

- Identifying and addressing systemic causes of noncompliance, such as the need for additional staff training, additional methods and/or tools for de-escalating and managing youth behavior, consultations and assistance from clinical staff and/or supervisors, and policy and procedure changes.

b. Revising and implementing its TSU policy and procedures to address any differences between policy and standard practice as needed, including clarifying procedures for handling TSU referrals for fighting and high-risk youth.

c. Ensuring any TSU policy and procedure revisions are included in staff training materials and provide staff with training on any changes.

Department response: As outlined in its **response**, the Department agrees with the finding and will implement the recommendations.

Auditor General makes 2 recommendations to the Department

The Department should:

1. Follow its policy and procedure requirements for referring youth to TSU.

2. Ensure that TSU referrals comply with its policy and procedure requirements by:

   a. Developing and implementing policies and procedures for reviewing housing unit and security staffs' compliance with the Department's de-escalation and TSU referral procedures to identify, track, and reduce noncompliant TSU referrals. These policies and procedures should include procedures for:

      - Reviewing incident reports and other documentation associated with TSU referrals, including specifying the staff responsible and time frames for conducting these reviews. These procedures could include a risk-based approach and sampling methods for reviewing TSU referrals, as appropriate.

      - Addressing individual staff members' noncompliance with the de-escalation and TSU referral procedures, including outlining potential remedies and consequences for noncompliance, such as additional training, more frequent supervision and coaching, and disciplinary actions.

      - Identifying and addressing systemic causes of noncompliance, such as the need for additional staff training, additional methods and/or tools for de-escalating and managing youth behavior, consultations and assistance from clinical staff and/or supervisors, and policy and procedure changes.

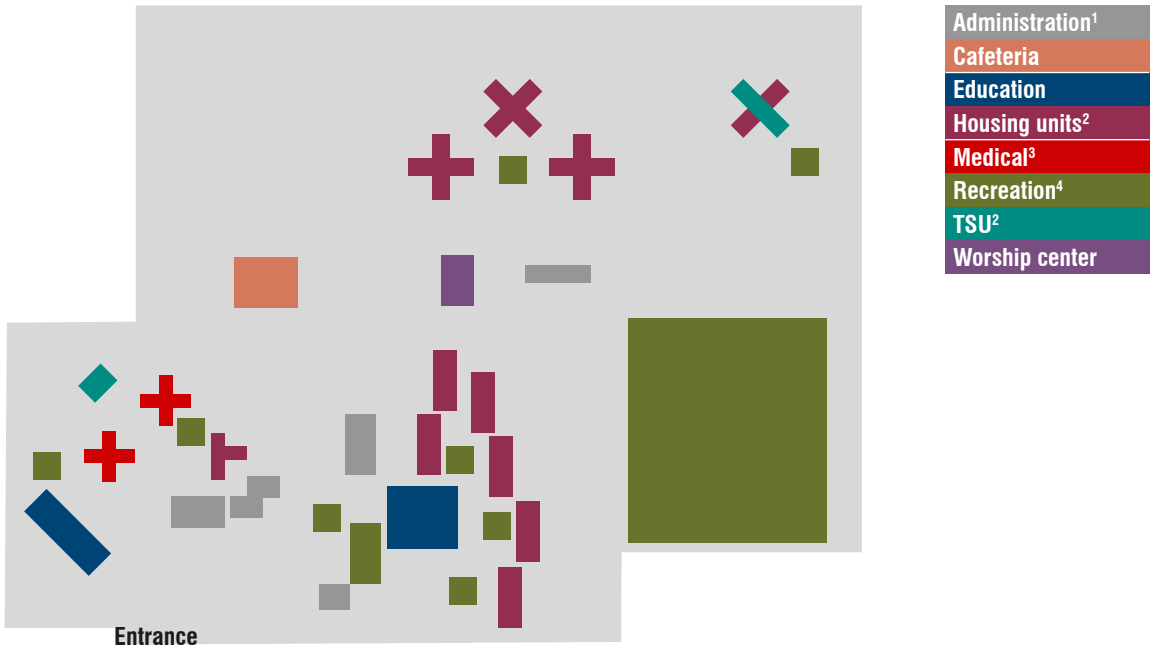
   b. Revising and implementing its TSU policy and procedures to address any differences between policy and standard practice as needed, including clarifying procedures for handling TSU referrals for fighting and high-risk youth.

   c. Ensuring any TSU policy and procedure revisions are included in staff training materials and provide staff with training on any changes.

Map and photographs of Facility and TSU

As discussed in the Introduction (see page 2), the Facility consists of various buildings, including housing units where youth reside and education buildings, as well as outdoor recreation areas such as basketball courts and a swimming pool. The Facility also includes 2 TSUs—1 for boys and 1 for girls—for the purpose of isolating youth and stabilizing and de-escalating their behavior. Figure 8 shows a map of the Facility; Figure 9, page a-2, includes photographs of the Facility; and Figure 10, page a-3, includes additional photographs of the boys' TSU.

Figure 8
Facility map



[1] Administration includes the main administration building at the Facility, as well as staff office space and a warehouse for equipment and supplies.

[2] As discussed in footnote 11 (see page 6), the boys' TSU is a separate standalone unit that serves all male youth in the Facility, while the girls' TSU is located within the female housing unit.

[3] Medical includes the Facility's health unit, as well as a medical isolation unit that was established in response to the COVID-19 pandemic.

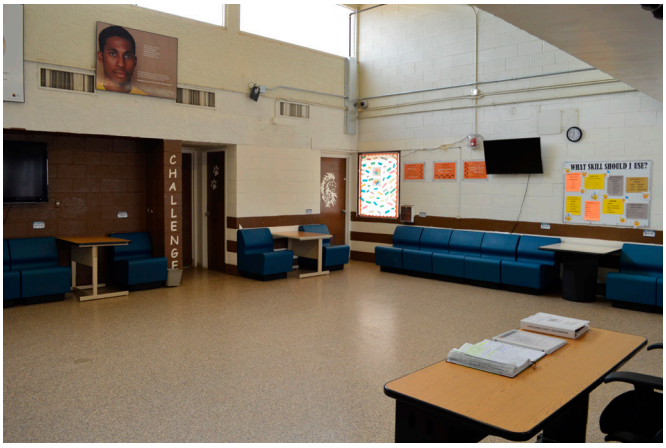
[4] Recreation areas at the Facility include a recreational field, a gymnasium, basketball courts, and a swimming pool.

Source: Auditor General staff review of Facility map and interviews with Department staff.

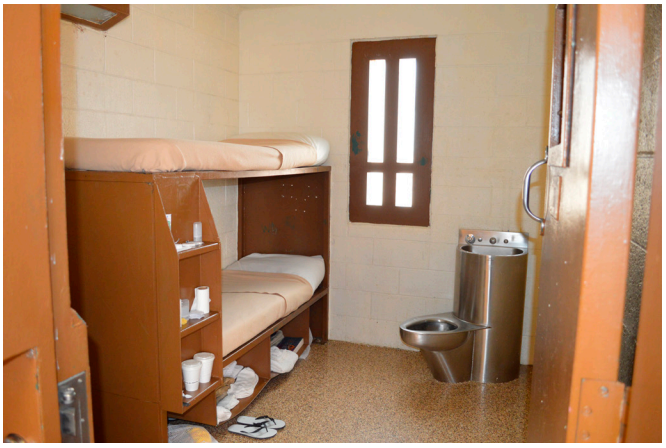
Figure 9
Facility photographs


Administration building

Housing unit



Housing unit day room


Youth cell


Basketball court

Vocational education classroom

Source: Department-provided photographs.

Figure 10
Boys' TSU photographs

Boys' TSU building


TSU lobby


TSU hallway


TSU cell

Source: Department-provided photographs.

TSU referrals that did not adhere to TSU policy and procedures

As discussed in Finding 1 (see page 13), our review of a stratified random sample of 30 TSU referrals Department staff made for youth over a 14-month period found that Department staff did not adhere to TSU policy and procedures for 12 of these referrals. Table 2 includes information from the incident report we reviewed for each of these 12 referrals. It summarizes the information included in the incident reports about the youth's behavior and events that resulted in the referral to TSU, the interventions the referring staff member and security staff took prior to referring and transporting the youth to TSU, and information that was not documented in the incident report but should have been.[50] Finally, it provides our assessment of Department staff's compliance with TSU policy and procedures related to documenting their adherence to imminent danger referral requirements and use of de-escalation and stabilization interventions for dangerous/threatening youth behavior.

Table 2
Incident descriptions and documentation compliance for 12 TSU referrals for which Department staff did not adhere to TSU policy and procedures

Incident description	As required by TSU policy and procedures: Documented details about behavior and events that necessitated referral for danger to themselves or others?	As required by TSU policy and procedures: Documented that staff took all practical and appropriate interventions to stabilize and de-escalate dangerous/threatening youth behavior?
During medication distribution, housing unit staff discovered that a youth had surreptitiously not taken his/her medication. The incident report indicated that housing unit staff questioned the youth, then obtained the medication and referred the youth to TSU for being a danger to themselves. The incident report did not describe details about how or why the youth's failure to take medication necessitated the TSU referral for an imminent danger of inflicting serious physical harm to themselves or describe any interventions Department staff took to stabilize and de-escalate the youth's behavior prior to referring and transporting the youth to TSU, contrary to Department policy, or explain why further interventions were not practical or appropriate. A Department manager indicated that this incident could have been handled without referring the youth to TSU.	✗	✗

[50] Potential interventions include relocating the youth to a quiet or private area to hear the youth's concerns, mediating disagreements between youth, and handing off the situation to a supervisor or qualified mental health professional to help de-escalate the situation.

Table 2 continued

Incident description	As required by TSU policy and procedures: Documented details about behavior and events that necessitated referral for danger to themselves or others?	As required by TSU policy and procedures: Documented that staff took all practical and appropriate interventions to stabilize and de-escalate dangerous/ threatening youth behavior?
A youth was described as obnoxious, not following staff directives or instructions, and laughing and encouraging the behavior of another youth who was using profanity toward staff in a tone that was described as aggressive. The youth was referred to TSU for being a danger to others. Although a check box was marked on the incident report indicating the youth was counseled and then referred to TSU, contrary to Department policy, the incident report did not include details about the actions Department staff took to counsel the youth. Additionally, the incident report indicated that the youth would not care about 1 type of intervention, but did not describe details about any other interventions Department staff took to stabilize and de-escalate the youth's behavior or explain why further interventions were not practical or appropriate prior to referring and transporting the youth to TSU. The incident report also did not describe details about the youth's behavior and events that necessitated the referral for an imminent danger of inflicting serious physical harm to others, contrary to Department policy. For example, although the incident report indicated the youth was encouraging another youth who was exhibiting threatening behavior, it did not explain how the youth represented a threat of physical harm after security staff arrived and removed the other youth who was exhibiting threatening behavior. A Department manager indicated that the staff involved in the incident did not normally work in the housing unit and may not have been as familiar with the youth, which could have led to the decision to refer the youth to TSU. However, using TSU for this reason is not authorized by TSU policy and procedures.	✗	✗
A youth ran out of area and climbed onto the roof of a housing unit, climbed down and started to run toward another housing unit, but stopped and ran toward staff once security staff arrived. The youth was then physically restrained, placed in handcuffs, and referred to TSU for being a danger to others. The incident report indicated that prior to the youth running, Department staff took several actions to try and prevent the youth from running out of area, including explaining how staff counseled the youth and having a staff member more closely monitor the youth as they were walking outside. However, contrary to Department policy, the incident report did not describe details about the youth's behavior after being restrained that necessitated the referral for an imminent danger of inflicting serious physical harm to others. When asked how this and another similar referral (see next case) complied with policy, security and housing unit managers reported that running out of area should result in an automatic TSU referral, but Facility management and clinical staff reported that TSU referrals for running out of area should be determined on a case-by-case basis as specified in Department policy.[1]	✗	✓
A youth, along with 2 others, ran out of area and climbed on top of a housing unit. According to the incident report, after being counseled by staff, this youth was the first to come down off the roof by a ladder, was restrained, and transported to TSU for being a danger to others. Similar to the prior example, the incident report did not describe details about the youth's behavior after being restrained that necessitated the referral for imminent danger of inflicting serious physical harm to others, contrary to Department policy.	✗	✓

Table 2 continued

Incident description	As required by TSU policy and procedures: Documented details about behavior and events that necessitated referral for danger to themselves or others?	As required by TSU policy and procedures: Documented that staff took all practical and appropriate interventions to stabilize and de-escalate dangerous/ threatening youth behavior?
A youth made an inappropriate sexual comment to a teacher during an education class and was removed from the classroom and referred to TSU for being a danger to others. Although the incident report described the youth's inappropriate comment as threatening, it did not further describe details about the youth's behavior and events that necessitated the referral for an imminent danger of inflicting serious physical harm to others, contrary to Department policy. Instead, the incident report stated that the youth attempted to "explain [his/her] way out of consequences" by saying that he/she was only talking about a planet during a science class about planets. Additionally, the incident report did not describe any interventions Department staff took to stabilize and de-escalate the youth's behavior prior to referring and transporting the youth to TSU, contrary to Department policy, or explain why further interventions were not practical or appropriate. A Department manager explained that the youth involved in this incident has a history of escalating very quickly and is given very strict boundaries with immediate consequences when acting out. The manager further explained that in this specific situation, TSU works as a timeout or reset so the youth can regain his/her composure. However, using TSU for this reason is not authorized by TSU policy and procedures.	✗	✗
A youth was referred to TSU for being a danger to others, but a Department staff member never completed or submitted an incident report related to the referral. As a result, Department records do not contain any details or information about the incident. The Department's TSU policy requires staff to complete an incident report for all TSU referrals and does not allow for any exceptions to this requirement.	✗	✗
A youth refused to come out of his/her cell and stand by his/her housing unit door when asked to do so by Department staff and was referred to TSU for being a danger to others. However, the incident report did not describe details about the youth's behavior and events that necessitated the referral for an imminent danger of inflicting serious physical harm to others or describe interventions Department staff took to stabilize and de-escalate the youth's behavior prior to referring and transporting the youth to TSU, contrary to Department policy, or explain why further interventions were not practical or appropriate. A Department manager explained that the youth was on a behavior management plan because of a history of refusing to follow staff directives and being disruptive. The manager further explained that housing unit staff had been instructed to call security to transport the youth to TSU if he/she failed to follow staff directives. However, using TSU for this reason is not authorized by TSU policy and procedures.	✗	✗

Table 2 continued

Incident description	As required by TSU policy and procedures: Documented details about behavior and events that necessitated referral for danger to themselves or others?	As required by TSU policy and procedures: Documented that staff took all practical and appropriate interventions to stabilize and de-escalate dangerous/ threatening youth behavior?
A youth was being disruptive and then began making hand gestures out of a housing unit window to other youth and was referred to TSU for being a danger to others. The incident report indicated housing unit staff took several actions to stabilize and de-escalate the youth's behavior, including directing the youth to stop and sit down several times, but the youth did not comply. The Department reported that the youth was making gang signs, which can be considered threatening because it often leads to violence. However, the incident report did not document and describe details about how the youth's use of hand gestures necessitated the referral for an imminent threat of inflicting serious physical harm to others, contrary to Department policy. Instead, the incident report indicated that housing unit staff were informed by a Department manager to refer the youth in this housing unit, which, according to the Department, primarily houses youth with a history of aggression and violence, to TSU when they do not follow several directives.[2] A Department manager indicated that the youth had been given multiple opportunities to follow directions and still would not listen and needed to go to TSU. The Department manager further explained that because of the type of youth in this housing unit, it is easier to remove these youth from others when their behavior is escalating so they do not escalate other youth in the housing unit. However, this explanation is not consistent with the Department's stated requirement that staff should assess each youth's dangerousness and the imminence of danger individually (see Finding 1, page 13).	✗	✓
A youth was overheard threatening to assault another youth when all the youth in a housing unit were locked in their rooms at night. While the youth were still locked in their rooms for the night, staff transported the youth who made the threatening remarks to TSU for being a danger to others. However, the incident report did not describe details about the youth's behavior and events that necessitated the referral for an imminent danger of inflicting serious physical harm to others while the youth was locked in his/her room. It also did not describe interventions Department staff took to stabilize and de-escalate the youth's behavior prior to transporting the youth to TSU, contrary to Department policy, or explain why further interventions were not practical or appropriate. A Department manager indicated that the youth could have been left in his/her room and staff could have waited until the morning to address the situation by attempting to resolve the conflict between these youth.	✗	✗

Table 2 continued

Incident description	As required by TSU policy and procedures: Documented details about behavior and events that necessitated referral for danger to themselves or others?	As required by TSU policy and procedures: Documented that staff took all practical and appropriate interventions to stabilize and de-escalate dangerous/ threatening youth behavior?
A youth was doing flips across housing unit furniture and was directed several times by staff to stop and stand by his/her door but initially refused to do so. The incident report indicated the youth eventually went to his/her room in irritation, but then punched and kicked the door and the youth was transported to TSU for being a danger to themselves. However, the incident report did not describe what interventions Department staff took to stabilize and de-escalate the youth's behavior after the youth punched and kicked the door and prior to referring and transporting the youth to TSU, contrary to Department policy, or explain why further interventions were not practical or appropriate. A Department manager indicated he/she recalled this incident and felt the officer potentially referred the youth to TSU too quickly and could have taken other actions to de-escalate the youth's behavior, such as having the youth meet with clinical staff.	✔	✘
A youth was asked to go to his/her room for behavior management purposes, after admitting to stealing from another youth, but refused and instead asked to speak with another staff member. Rather than attempting further interventions, housing unit staff then attempted to restrain the youth and the youth began to resist, which is considered potentially violent behavior. The housing unit staff member indicated he/she was able to eventually apply handcuffs without further incident and the youth was transported to TSU for being a danger to others. However, the incident report did not describe details about the youth's behavior after being restrained that necessitated the referral for an imminent danger of inflicting serious physical harm to others, contrary to Department policy. The incident report described an intervention staff took for behavior management purposes and explained that the staff member moved the other youth in the housing unit into their rooms to deal with this youth. However, it did not describe any other interventions Department staff took to stabilize and de-escalate the youth's behavior after the youth was restrained and prior to referring and transporting the youth to TSU, contrary to Department policy, or explain why further interventions were not practical or appropriate. A Department manager indicated that the housing unit staff member could have taken other interventions prior to referring the youth to TSU, such as handing the youth off to another staff member.	✘	✘

Table 2 continued

Incident description	As required by TSU policy and procedures: Documented details about behavior and events that necessitated referral for danger to themselves or others?	As required by TSU policy and procedures: Documented that staff took all practical and appropriate interventions to stabilize and de-escalate dangerous/ threatening youth behavior?
According to the referring officer's incident report narrative, a youth was doing work in the housing unit when the officer witnessed 2 other youths running toward him/her and then throwing closed fist punches at the first youth. A supplemental narrative from a second officer indicated that all 3 youths were throwing closed hand fists at each other, but it appeared the first youth was being jumped by the other 2 youths. All 3 youths were restrained, and security staff transported all 3 youths to TSU for being a danger to others. Although the incident report indicated the first youth had been attacked by the other 2 youths, it did not describe details about the first youth's behavior that necessitated the referral for an imminent danger of inflicting serious physical harm to others once all 3 youths were restrained, contrary to Department policy. Additionally, it did not describe any interventions Department staff took to stabilize and de-escalate the youth's behavior prior to referring and transporting the youth to TSU, contrary to Department policy, or explain why further interventions were not practical or appropriate. Multiple Department managers indicated that all youth involved in fights should be transported to TSU until camera review can determine whether any of the youth were victims, rather than aggressors, and can be released. However, Department policy does not list specific behaviors that should result in an automatic TSU referral.	✗	✗

[1] As mentioned on page 14, the Department's TSU policy and procedures indicate that running out of area or climbing on buildings or fences may be classified as a danger to self or others under certain circumstances but that this determination should be considered on a case-by-case basis. According to clinical staff, running out of area and climbing on buildings or fences can be considered danger to self or others because youth and staff could get hurt in the attempt to restrain youth or youth may run out of area with the intent of hurting themselves.

[2] As discussed in footnote 4 (see page 2), 1 of the Facility's general population housing units contains a section for youth with a history of aggression and violence.

Source: Auditor General staff review of the Department's TSU policy and procedures and Department incident reports for 12 TSU referrals for which Department staff did not adhere to TSU policy and procedures. We identified these 12 TSU referrals from our review of a random sample of 30 of the 2,922 TSU referrals Department staff made for youth being a danger to self or others from January 2019 through February 2020, and interviews with Department staff.

APPENDIX C

Scope and methodology

The Arizona Auditor General has conducted this performance audit of the Department's use of youth isolation (TSU) pursuant to a September 14, 2016, resolution of the Joint Legislative Audit Committee. The audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq.

We used various methods to study the objectives and issues addressed in this performance audit. These methods included reviewing the Department's statutes, website, and policies and procedures; reviewing federal law related to youth isolation; interviewing Department staff; and reviewing best practices for rehabilitating delinquent youth and use of youth isolation.[51] In addition, we used the following specific methods to meet the audit objectives:

- To obtain information on the Department's use of TSU, we analyzed Department data for all 3,287 TSU referrals from January 2019 through February 2020, including self-referrals, and data for all youth who were in the Facility on January 1, 2019 and March 1, 2020, and all youth who arrived at the Facility from January 2019 through February 2020. We determined that this data was sufficiently reliable for audit purposes.

- To determine whether the Department's use of TSU is consistent with its policy and best practices, we reviewed a stratified random sample of 30 of the 2,922 TSU referrals Department staff made for youth being a danger to themselves or others from January 2019 through February 2020.[52] This sample was stratified as follows: 20 referrals for being a danger to others—10 of the 1,900 referrals in which youth were admitted to TSU and 10 of the 624 referrals in which they were not admitted; and 10 referrals for being a danger to self—5 of the 314 referrals in which youth were admitted to TSU and 5 of the 84 referrals in which they were not admitted.[53]

- To obtain information for the Introduction, we reviewed relevant State statutes, Department documents and reports, and documentation from the Department's 1986 and 2002 federal lawsuits and investigations.[54]

---

[51] Boesky, L. (2014). "Mental health," in *Desktop guide to quality practice for working with youth in confinement*. National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Retrieved 1/22/2020 from https://info.nicic.gov/dtg/sites/info.nicic.gov.dtg/files/DesktopGuide.pdf; Council of Juvenile Correctional Administrators. (2015). *Council of Juvenile Correctional Administrators toolkit: Reducing the use of isolation*. Braintree, MA. Retrieved 10/10/2019 from https://nicic.gov/council-juvenile-correctional-administrators-toolkit-reducing-use-isolation; Godfrey, K. (2019). *Reducing isolation. A report on the key findings in the effects of isolation and room confinement*. Braintree, MA: The PbS Learning Institute. Retrieved 10/10/2019 from https://pbstandards.org/media/1159/pbsreducingisolationjune2019.pdf; Umpierre, M. (2014). "Rights and responsibilities of youth, families, and staff," in *Desktop guide to quality practice for working with youth in confinement*. National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Retrieved 1/22/2020 from https://info.nicic.gov/dtg/sites/info.nicic.gov.dtg/files/DesktopGuide.pdf; Nelsen, A. (2014). "Admission and intake," in *Desktop guide to quality practice for working with youth in confinement*. National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Retrieved 01/22/2020 from https://info.nicic.gov/dtg/sites/info.nicic.gov.dtg/files/DesktopGuide.pdf; Juvenile Law Center. (2017). *Addressing trauma: Eliminating strip searches*. Philadelphia, PA. Retrieved 03/05/2020 from https://jlc.org/sites/default/files/publication_pdfs/AddressingTrauma-EliminatingStripSearch.pdf; Deitch, M. (2014). "Behavior management," in *Desktop guide to quality practice for working with youth in confinement*. National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Retrieved 1/22/2020 from https://info.nicic.gov/dtg/sites/info.nicic.gov.dtg/files/DesktopGuide.pdf; American Academy of Child and Adolescent Psychiatry. (2012). *Solitary confinement of juvenile offenders*. Washington, DC. Retrieved 3/19/2021 from https://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx.

[52] We did not review any of the 365 TSU referrals from this time period in which youth requested a self-referral because our review was intended to assess Department staffs' referrals of youth to TSU for being a danger to themselves or others.

[53] We sampled equally between admissions and nonadmissions based on the potential increased risk of noncompliance for referrals resulting in nonadmissions. Additionally, because 86 percent of the 2,922 TSU referrals were for danger to others, we reviewed more of these referrals.

[54] Johnson v. Upchurch, CIV-86-195, U.S. Dist. Ct. for Dist. of AZ; United States of America v. The State of Arizona, et. al., CV-04-01926, U.S. Dist. Ct. for Dist. of AZ.

- Our work on internal controls, including information system controls, involved reviewing the Department's policies and procedures related to the use of TSU, interviewing Department staff, and conducting limited test work of the Department's TSU data. Our work included reviewing the following components and associated principles of internal control:
    - Control activities including the design of control activities, such as policies and procedures.
    - Information and communication related to the use of quality information that is complete and accurate.
    - Internal control system monitoring.

    We reported our conclusions on applicable internal controls in Finding 1.

We selected our audit samples to provide sufficient evidence to support our findings, conclusions, and recommendations. Unless otherwise noted, the results of our testing using these samples were not intended to be projected to the entire population.

We conducted this performance audit of the Department in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We express our appreciation to the Department Director and his staff for their cooperation and assistance throughout the audit.

Auditor General's comments on Department response

We appreciate the Department's response including its agreement with the audit finding and its plan to implement our recommendations to improve its use of TSU. However, the Department's response states that "elements of the report have the potential to mislead readers" and includes several paragraphs related to this statement that necessitate the following comments and clarifications.

1. The Department makes the following statement related to potential negative consequences of youth isolation discussed in the report (see Department's response, page 2):

   "[A]lthough the TSU program is thoroughly explained in the Introduction, the report identifies TSU as a 'form of isolation' without fully distinguishing TSU from the other various types of isolation. As described by the research cited in the report, the term 'isolation' encompasses a broad spectrum of interventions which differ in terms of purpose, location, and duration, ranging from the use of lengthy solitary confinement, during which youth do not have access to programming opportunities, to short-term therapeutic de-escalation strategies like TSU. Including the term 'isolation' in the finding and throughout the report without providing that context may lead readers to believe that TSU is comparable to solitary confinement, which it is not. It is also important to note that the cited research regarding the potential negative consequences of isolation is not specific to the use of TSU. The report identifies the potential negative consequences of improper use of isolation but fails to distinguish between the best practices exemplified by TSU and the other types of isolation, which differ greatly from the therapeutic model used by ADJC."

   Both CJJA and the Desktop Guide acknowledge that isolation encompasses a range of interventions that differ in terms of purpose, location, and duration. Additionally, as discussed in Finding 1 (see pages 12 through 13), the Department's use of TSU as outlined in its TSU policy and procedures is consistent with practices recommended by CJJA and the Desktop Guide for minimizing the use of youth isolation in correctional facilities. Further, while in TSU, youth receive programming and services, such as meeting with a Department qualified mental health professional, and they receive the same meals, and visitation and telephone privileges, as youth in the housing units (see Introduction, pages 6 through 7).

   However, the negative consequences described in our report can still potentially manifest themselves through the Department's use of TSU. Specifically, both CJJA and the Desktop Guide describe a range of potential negative consequences associated with isolation that can lead to mental health problems for youth. Although the Desktop Guide indicates that the degree of psychological deterioration will vary depending on several factors, such as the duration and intensity of isolation and whether the youth perceives the isolation as threatening or unjust, neither CJJA nor the Desktop Guide indicate that these problems are associated only with certain types of isolation and not with other types. Finally, best practices and other standards for juvenile justice indicate youth isolation should be used only when youth are a danger to themselves or others and that isolation used for these purposes should be minimized.

2. The Department makes the following statement related to the sample of TSU referrals we reviewed (see Department's response, pages 2 through 3):

   "The OAG expressed concern that referrals resulting in non-admission reflected an 'increased risk of noncompliance,' and oversampled non-admissions by more than double their actual occurrence, as explained in footnotes 31 and 53 and Appendix C of the report. The audit finding focuses on this very narrow, non-representative sample of TSU referrals, and the OAG categorized 12 of the 30 referrals they reviewed

as being inconsistent with policy. This may inadvertently lead readers to an incorrect assumption about the overall frequency of noncompliant referrals."

As stated in Finding 1(see page 13) and Appendix C (see pages c-1 through c-2), our sample was not designed to be representative of the population of all referrals nor to determine the estimated incidence of noncompliant referrals in the overall population. Therefore, our report does not include an estimate of or otherwise discuss the amount of noncompliance in the overall population of TSU referrals from which we sampled. As stated in Appendix C, our decision to sample equally between referrals resulting in admission and nonadmission was based on our assessment that referrals resulting in nonadmission may be more likely to be noncompliant. This sample design is consistent with government auditing standards that indicate when a representative sample is not needed, a targeted selection may be effective when the auditors have isolated risk factors to target the selection. Government auditing standards for reporting audit findings also state that auditors should give readers a basis for judging the prevalence and consequences of their findings by relating the instances identified to the population or the number of cases examined and quantifying the results, and if the results cannot be projected, limit their conclusions appropriately. Therefore, in Finding 1 we present the number of noncompliant referrals in relation to the total number of referrals we reviewed but limit this conclusion by stating that that it should not be projected to the entire population.

3. The Department makes the following statement related to the 12 TSU referrals we concluded were noncompliant with Department policy (see Department's response, page 3):

"ADJC had the opportunity to review the 12 referrals to TSU that the report categorized as non-compliant with policy and procedures. For some of the referrals, ADJC agrees that the incident reports lack some of the necessary documentation. However, for several of the incident reports, ADJC believes that the referrals were actually made consistent with policy and procedure and include all of the necessary documentation. Our differing conclusions do not detract from the importance of ensuring consistent compliance with policies and procedures but reflect our concern that the report overstates the actual incidence of noncompliance."

Although the Department believes that the incident reports for some of the noncompliant referrals we identified included all necessary documentation, Appendix B (see pages b-1 through b-6) provides specific details about the documentation included in the incident reports we reviewed and the specific reasons that we concluded it was insufficient according to the Department's TSU policy and procedures for each of the 12 noncompliant referrals. Additionally, as previously discussed, our report does not include an estimate of or otherwise discuss the amount of noncompliance in the overall population of TSU referrals from which we sampled.

DEPARTMENT RESPONSE

ARIZONA DEPARTMENT OF JUVENILE CORRECTIONS

DOUGLAS A. DUCEY
Governor

JEFF HOOD
Director

June 15, 2021

Ms. Lindsey Perry, Auditor General
Arizona Office of the Auditor General
2910 N. 44th Street
Suite 410
Phoenix, AZ 85018

Re: Temporary Stabilization Unit Performance Audit

Dear Ms. Perry:

Attached please find our response to the audit report regarding the Arizona Department of Juvenile Corrections' (ADJC) use of its Temporary Stabilization Unit (TSU) to de-escalate and stabilize youth who pose an imminent danger to themselves or to other youth and staff. We appreciate the critical role that the Office of the Auditor General (OAG) plays in ensuring state agencies are performing at the highest level and in accordance with statutory requirements and national standards. ADJC especially appreciates the OAG's emphasis on ongoing communication throughout the course of the audit and the auditors' openness to learning about the challenges of operating a juvenile correctional facility to provide care and treatment to youth with serious behavioral and emotional needs who require access to the rehabilitative programming ADJC provides.

ADJC is committed to promoting public safety and rehabilitating Arizona's most seriously delinquent youth by prioritizing the use of evidence-based practices and ongoing quality assurance monitoring to ensure our efforts are aligned with nationally recognized best practices. ADJC strives to optimize the safety of youth and staff while ensuring that programming opportunities promote youth rehabilitation consistent with each youth's individual developmental and criminogenic needs. Consistent with the objectives of the Arizona Management System, ADJC is continuously engaged in efforts to improve the administration of the TSU program. ADJC appreciates the work the OAG has done and has already proactively implemented many of the recommendations in the report in addition to other initiatives beyond those recommended by the Auditor General.

As the report makes clear, ADJC's TSU program and the policies and procedures associated with it are consistent with nationally-recognized best practices. Research indicates that youth who are in crisis and creating a danger to themselves or others may need to be separated from other youth for a short time until they become calm. Many procedural safeguards are in place to ensure that any potential negative consequences are minimized to the greatest extent possible, including limiting the amount of time youth spend in TSU after they are referred. In fact, the

comprehensive TSU admission process exists specifically to ensure that only youth who pose an imminent danger to themselves or others are admitted to TSU. Once admitted, youth are provided with therapeutic interventions delivered by qualified mental health professionals and overseen by a psychologist. ADJC closely monitors admissions to TSU to ensure they comply with policy and provides robust protections and due process safeguards that enable youth to challenge their admission.

Throughout the audit process, the OAG made note of opportunities for ADJC to improve its processes to ensure compliance with policy, and ADJC has already undertaken many of the suggested changes, as noted in the report. The report correctly points out that, while ADJC has a process to review admissions, a similar review process did not exist to review referrals. ADJC recognizes the importance of reviewing whether referrals to TSU are consistent with policy and procedure and properly documented in order to ensure that the agency continues to operate TSU in accordance with national best practices. In January 2021, the Department began piloting a monthly review of all non-admitted referrals to TSU to determine whether the referring incident report contains documentation of behavior that meets referral criteria and documentation of interventions attempted to prevent the referral or an explanation why interventions were not possible. The team reviewing these incident reports assigns and tracks follow-up actions to correct staff non-compliance with policy and also recommends any policy changes necessary to facilitate prompt, accurate, well-documented referrals to a separate TSU Policy and Data Review Team.

While ADJC agrees with the audit finding and will implement all of the OAG's recommendations, we remain concerned that the finding and other elements of the report have the potential to mislead readers who may not have extensive knowledge of juvenile corrections or a thorough understanding of the sampling methods used by the OAG. As a result, the report may leave readers with an inaccurate impression of ADJC's use of TSU.

Specifically, although the TSU program is thoroughly explained in the Introduction, the report identifies TSU as a "form of isolation" without fully distinguishing TSU from the other various types of isolation. As described by the research cited in the report, the term "isolation" encompasses a broad spectrum of interventions which differ in terms of purpose, location, and duration, ranging from the use of lengthy solitary confinement, during which youth do not have access to programming opportunities, to short-term therapeutic de-escalation strategies like TSU. Including the term "isolation" in the finding and throughout the report without providing that context may lead readers to believe that TSU is comparable to solitary confinement, which it is not. It is also important to note that the cited research regarding the potential negative consequences of isolation is not specific to the use of TSU. The report identifies the potential negative consequences of improper use of isolation but fails to distinguish between the best practices exemplified by TSU and the other types of isolation, which differ greatly from the therapeutic model used by ADJC.

Additionally, as previously discussed, the Department has a robust process for reviewing admissions to TSU to ensure compliance with ADJC's court-approved, evidence-based processes and policies. The OAG, therefore, focused their attention on ADJC's compliance with policy during the referral process, which was not subject to the same robust review process as admissions until recently. The OAG expressed concern that referrals resulting in non-admission

reflected an “increased risk of noncompliance,” and oversampled non-admissions by more than double their actual occurrence, as explained in footnotes 31 and 53 and Appendix C of the report. The audit finding focuses on this very narrow, non-representative sample of TSU referrals, and the OAG categorized 12 of the 30 referrals they reviewed as being inconsistent with policy. This may inadvertently lead readers to an incorrect assumption about the overall frequency of noncompliant referrals. As the footnotes acknowledge, non-admissions do not, in fact, represent 50% of all referrals, and the sample was not designed to be representative of all referrals to TSU or projected to the entire population. Referrals resulting in non-admission comprise only 24% of the referrals. However, ADJC agrees that referrals should be regularly reviewed, and ADJC has already instituted a process for doing so.

Finally, ADJC had the opportunity to review the 12 referrals to TSU that the report categorized as non-compliant with policy and procedures. For some of the referrals, ADJC agrees that the incident reports lack some of the necessary documentation. However, for several of the incident reports, ADJC believes that the referrals were actually made consistent with policy and procedure and include all of the necessary documentation. Our differing conclusions do not detract from the importance of ensuring consistent compliance with policies and procedures but reflect our concern that the report overstates the actual incidence of noncompliance.

We would like to once again thank you for conducting this performance audit. ADJC remains committed to continuous improvement. We appreciate your partnership as we work to rehabilitate the youth in our care by providing evidence-based treatment, prosocial activities, education, and career training that will lead them to become productive, healthy, law-abiding members of society.

Sincerely,

Jeff Hood
Director

Finding 1: Department has referred some youth to TSU contrary to its TSU policy and procedures, and youth isolation can potentially have negative consequences

Recommendation 1: The Department should follow its policy and procedure requirements for referring youth to TSU.

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

Response explanation: As outlined in our cover letter, ADJC is concerned that the use of the word "isolation," without further explanation, may lead readers to incorrectly believe that TSU is comparable to other types of isolation, like solitary confinement. Additionally, the report's sampling methodology was not designed to be representative of all TSU referrals and therefore overstates the frequency of non-compliance with policy and procedure. ADJC also believes that some of the referrals the OAG categorized as non-compliant were actually compliant with policy and procedure. Nevertheless, ADJC has implemented improvements, which include policy changes reinforced with updated training and piloting a process to review TSU referrals and take corrective action, to ensure all TSU referrals are made in compliance with policy and procedure.

Recommendation 2: The Department should ensure that TSU referrals comply with its policy and procedure requirements by:

Recommendation 2a: Developing and implementing policies and procedures for reviewing housing unit and security staffs' compliance with the Department's de-escalation and TSU referral procedures to identify, track, and reduce noncompliant TSU referrals. These policies and procedures should include procedures for:

- Reviewing incident reports and other documentation associated with TSU referrals, including specifying the staff responsible and time frames for conducting these reviews. These procedures could include a risk-based approach and sampling methods for reviewing TSU referrals, as appropriate.
- Addressing individual staff members' noncompliance with the de-escalation and TSU referral procedures, including outlining potential remedies and consequences for noncompliance, such as additional training, more frequent supervision and coaching, and disciplinary actions.
- Identifying and addressing systemic causes of noncompliance, such as the need for additional staff training, additional methods and/or tools for de-escalating and managing youth behavior, consultations and assistance from clinical staff and/or supervisors, and policy and procedure changes.

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

Response explanation: As previously stated, ADJC believes that some of the referrals that the OAG categorized as non-compliant actually did comply with policy and procedure. However, ADJC recognizes the importance of reviewing referrals to TSU and is currently piloting a process to examine TSU referrals for compliance with policy and procedures. The review team analyzes TSU referrals that did not result in TSU admission to determine whether each referring incident report contains documentation of

behavior meeting TSU admission criteria and interventions taken to prevent referral or the reasons why such interventions were not possible. If it is determined that an incident report does not comply with policy, the individual or systemic causes for noncompliance are examined and necessary follow-up actions are identified accordingly. As a result, staff have received individualized coaching, training needs have been identified, and additional policy changes have been implemented. The review team has conducted 5 monthly reviews and plans to formalize this process in policy.

Recommendation 2b: Revising and implementing its TSU policy and procedures to address any differences between policy and standard practice as needed, including clarifying procedures for handling TSU referrals for fighting and high-risk youth.

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

Response explanation: ADJC has made several changes to the policy to address differences between the policy and standard practice. For example, the TSU policy has been updated to further clarify the purpose of TSU. The definitions of "danger to self" and "danger to others," and examples of behaviors that may meet these criteria have been further clarified. The policy has been updated to include a continuum of possible interventions staff can utilize to de-escalate youth behavior prior to referring the youth to TSU. Updates were also made to policy to emphasize the requirement that staff include specific details describing the youth's behavior, how the behavior poses an imminent threat, what interventions were attempted prior to referring a youth to TSU, and why other interventions were not appropriate or practical in all referrals to TSU, including referrals for fighting and high-risk youth.

Recommendation 2c: Ensuring any TSU policy and procedure revisions are included in staff training materials and provide staff with training on any changes.

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

Response explanation: ADJC agrees that revisions to policy and procedure should be included in future and recurrent training materials and has already incorporated recent policy changes into training materials. ADJC uses a multi-front training strategy, using both formalized training for new recruits and current staff, written communication through traditional channels such as email and flyers, and individualized training provided by supervisors and during regular huddle board meetings. In addition to incorporating policy changes into training materials, ADJC has provided staff with written correspondence explaining the policy changes that have already been implemented and will continue doing so as additional policy changes are adopted.


ARIZONA
Auditor General
Making a Positive Difference