A REPORT
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Performance Audit Division

Performance Audit

Arizona Department of Juvenile Corrections—

Suicide Prevention and Violence and Abuse Reduction Efforts

September • 2009
REPORT NO. 09-09

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
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September 22, 2009

Members of the Arizona Legislature

The Honorable Janice K. Brewer, Governor

Michael Branham, Director
Arizona Department of Juvenile Corrections

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Arizona Department of Juvenile Corrections—Suicide Prevention and Violence and Abuse Reduction Efforts. This report is in response to an October 5, 2006, 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 with this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

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

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

This report will be released to the public on September 23, 2009.

Sincerely,

Debbie Davenport
Auditor General

Attachment

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SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Juvenile Corrections (Department), focusing on the Department's efforts to prevent suicide and reduce violence and abuse among incarcerated juveniles. This audit, conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq., and pursuant to an October 5, 2006, resolution of the Joint Legislative Audit Committee, is the second in a series of three reports. The first report focused on the treatment services provided to juveniles in secure care and transitioning juveniles into the community, while the third report will focus on the 12 statutory sunset factors.

This audit follows up on steps the Department took to improve suicide prevention and reduce violence and abuse following a U.S. Department of Justice review. During 2002 and 2003, three suicides occurred at one of the Department's facilities. In June 2002, after the first suicide, the U.S. Department of Justice began an investigation under the Federal Civil Rights of Institutionalized Persons Act (CRIPA) into whether the constitutional and federal statutory rights of juveniles in the Department's custody were being violated. In January 2004, the U.S. Department of Justice issued a report finding serious deficiencies with the Department's suicide prevention policies and practices, and a failure to protect juveniles from physical and sexual abuse. In September 2004, the U.S. Department of Justice filed a lawsuit in federal court, which resulted in a memorandum of agreement between the State and the U.S. Department of Justice to address the deficiencies. In September 2007, the Department had substantially complied with all of the more than 120 mandatory provisions in the memorandum of agreement and was released from federal monitoring. Additionally, the lawsuit was dismissed.

Department has improved suicide prevention practices, which promote safety, but minor improvements are possible (see pages 9 through 18)

The Department has significantly improved its suicide prevention practices, but some minor changes could further ensure the appropriate treatment of juveniles who are

at-risk for suicide. In the 2004 CRIPA investigation, the U.S. Department of Justice identified several deficiencies in the Department's suicide prevention practices that contributed to three suicides within 12 months at one of the Department's secure care facilities in 2002 and 2003. In response to these findings, the Department significantly revised its suicide prevention practices to conform to national standards and identified best practices. The Department made improvements in areas such as training staff to identify and respond to suicidal behavior, appropriately monitoring juveniles with suicidal behaviors, improving communication among staff regarding juveniles with suicidal behaviors, and modifying its physical facilities to be suicide resistant. These revised policies and practices better safeguard the health and well-being of juveniles who are at-risk for suicide and/or self-injurious behavior. Since 2003, no suicide attempt has resulted in death, and since January 2007, the number of serious suicide attempts has averaged less than one per month.

Even though the Department has instituted suicide prevention policies and procedures that are consistent with best practices, it should make some minor improvements. Specifically:

- The Department should continue to monitor juveniles' treatment plans to ensure that they address juveniles' suicidal or self-injurious behavior and that its modified procedures have been implemented by all staff.

- The Department should expand its regular assessments of its separation practices to include the review of unnecessary and/or inappropriate referrals for juveniles exhibiting suicidal and/or self-injurious behavior and take appropriate action based on what it finds.

- Juveniles should not be placed into suicide-proof smocks without a mental health assessment.

- Finally, the Department should ensure staff prepare incident reports for all juveniles placed on its daily suicide prevention status list.

Department data shows decreased juvenile violence at its facilities; Department should continue its efforts to reduce violence (see pages 19 through 29)

The Department should continue its efforts to reduce juvenile violence at its secure care facilities. In response to the 2004 CRIPA investigation, the Department has taken several steps to improve the safety of juveniles entrusted to its care, and beginning in 2008, the Department reported a decrease in violence at these facilities. In particular, the number of juvenile-on-juvenile assaults decreased from 152 to 71

(approximately 53 percent) between the second and fourth quarters of 2008, and the number of juvenile-on-juvenile fights decreased from 339 to 116 (approximately 66 percent) during 2008.[1]

Steps the Department took include the use of a community policing model to help it better identify and address violent activity at its secure care facilities, increased staffing, gang intelligence efforts, and implementation of treatment programming designed to help juveniles address anger and violence issues. Although the Department has improved its staff-to-juvenile ratios, it should review whether it has sufficient staff to maintain ratios it agreed to during CRIPA monitoring. If additional staff resources are needed, the Department should review and consider various options for obtaining these resources, including shifting internal staff resources or working with the Legislature to obtain additional staff resources. The Department should also continue to monitor the level of violence within its secure care facilities and adjust its practices when necessary if the reduced levels of violence do not continue.

To help guide staff actions when assaults and fights do occur, the Department has developed policies and procedures informed by national standards issued by the American Correctional Association and the National Commission on Correctional Health Care. The Department also provides training on crisis intervention, behavior management, and restraint techniques to provide staff with appropriate response techniques. Auditors' analysis of seven incidents involving juvenile assaults and fights at the four facilities between February and April 2009 found that staff and supervisors responded properly.

Department has taken some successful steps to address abuse, but can further strengthen staff awareness of appropriate staff-juvenile boundaries (see pages 31 through 39)

Although the Department has taken action to address the abuses of staff-juvenile boundaries identified in the 2004 CRIPA investigation, opportunities exist to further strengthen staff awareness of appropriate boundaries. In response to abuses identified during the CRIPA investigation, the Department has revised its juvenile grievance process, enhanced its investigation of these types of abuses, and initiated a change in its organizational culture that includes zero tolerance for abuse of any kind. In addition, through its policies, procedures, and training, the Department identifies appropriate staff-juvenile boundaries to promote safety and rehabilitation. The Department has held staff accountable by disciplining or terminating staff when

1 For department data cited in this report, auditors reviewed the Department's internal controls over the collection and management review of data and concluded that the Department has sufficient controls to ensure the reliability of the data. Auditors did not assess the Department's data processing and reporting internal controls (See Appendix A, pages a-i through a-ii, for more information about the methods auditors used).

they violate staff-juvenile boundaries. The Department also provided numerous incident reports where staff documented their efforts to redirect juvenile misbehavior in accordance with department policies, procedures, and trainings on boundaries.

Despite these actions, staff-juvenile boundary issues continue to pose challenges. More subtle, inappropriate staff-juvenile interactions, such as the use of pet names, verbal sparring and joking, and undue familiarity, still take place, creating the potential for more serious abuses. Specifically:

- During visits to the Department's secure care facilities in March 2008, June through August 2008, and May 2009, auditors observed several instances of staff-juvenile boundary violations. These violations included lack of staff redirection of juvenile misbehavior, inappropriate language, and generally inappropriate interaction with juveniles. As prescribed by department policies and trainings, these observed behaviors and interactions are considered inappropriate and unprofessional. Although these boundary violations can occur, they may not always be addressed by supervisors or management because either they do not know about them or do not recognize them as violations. In fact, some of the interactions observed by auditors involved experienced staff. However, as previously mentioned, the Department has taken action to address boundary violations when it is aware of these violations.

- New staff also reported seeing evidence of boundary issues. As part of the Department's training academy, new staff receive on-the-job training (OJT) in housing units at the Department's secure care facilities. At the end of their OJT, new staff complete a written debriefing of their experience, noting any discrepancies between observed staff behaviors or practices at the secure care facilities and academy training. This debriefing is then submitted to academy staff. For the fiscal year 2009 academy classes, auditors reviewed 331 OJT written debriefings and found that 85 of the new staff (approximately 26 percent) reported observing a staff-juvenile boundary issue. The most common staff-juvenile boundary violations noted included inappropriate handshakes; language; touching, such as hugs and pushing; and using nicknames.

To address inappropriate staff-juvenile interactions, the Department should take several steps. First, it should launch an awareness campaign that continually reinforces appropriate staff-juvenile boundaries and the range of behaviors that may violate these boundaries. Second, the Department should improve its process of providing its facility superintendents with the written debriefing information provided by new staff. Finally, the Department should analyze and use this information to identify potential staff-juvenile boundary issues at secure care facilities and develop and implement corrective action plans to respond to these issues.

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INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Juvenile Corrections (Department) focusing on the Department's efforts to prevent suicide and reduce violence and abuse among incarcerated juveniles. This audit, conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq and pursuant to an October 5, 2006, resolution of the Joint Legislative Audit Committee, is the second in a series of three reports. The first report focused on the treatment services provided to juveniles in secure care and transitioning juveniles into the community, while the third report will focus on the 12 statutory sunset factors.

The Federal Civil Rights of Institutionalized Persons Act (CRIPA) authorizes the U.S. Attorney General to investigate potential violations of institutionalized individuals' constitutional or legal rights. During 2002 and 2003, three suicides occurred at one of the Department's facilities. After the first suicide in 2002, the U.S. Department of Justice began an investigation of the Department under CRIPA into whether the constitutional and federal statutory rights of juveniles in the Department's custody were being violated. In January 2004, the U.S. Department of Justice issued a report finding serious deficiencies at the Department. In September 2004, the U.S. Department of Justice filed a lawsuit in federal court, which resulted in a memorandum of agreement between the State and the U.S. Department of Justice to address the deficiencies. In September 2007, the Department had substantially complied with all of the more than 120 mandatory provisions in the memorandum of agreement and was released from federal monitoring. Additionally, the lawsuit was dismissed. This audit reports on the Department's continuing efforts to address some of those findings (See pages 4 through 5 for more information on this investigation and the report findings).

Department's correctional facilities

The Department's mission is to enhance public protection by changing the delinquent thinking and behaviors of juvenile offenders under its jurisdiction. To help accomplish this mission, the Department operates four correctional facilities (also called secure care facilities). As illustrated in Table 1 (see page 2), these facilities are located in Phoenix, Tucson, and Buckeye, and as of July 30, 2009, the Department reported housing 506 juveniles.

Table 1: Secure Care Facility Populations, Funded Beds, Staff, and Operating Costs (Unaudited)

Secure Care Facility	Location	Number of Juveniles (As of July 30, 2009)	Funded Beds (Fiscal Year 2010)[1]	Number of Staff (As of July 30, 2009)	Operating Costs Millions (Fiscal Year 2009)[2]	Year Opened
Adobe Mountain	Phoenix	207	200	262	$23.3	1971
Black Canyon	Phoenix	85	80	131	8.8	1987
Catalina Mountain	Tucson	89	88	141	11.6	1967
Eagle Point	Buckeye	125	112	158	12.9	1999

1 According to department officials, when the number of juveniles in secure care exceeds the number of budgeted beds, the Department reassigns available staff, caseworkers, or pays overtime, although the funding for overtime is limited.

2 Facility operating costs only include those directly charged to the facilities and not shared costs such as transportation, quality assurance, and health costs such as physician and pharmacy costs.

Source: Auditor General staff summary and analysis of juvenile population, funded beds, and staffing data provided by department staff and of the Arizona Financial Information System *Accounting Event Transaction File* for fiscal year 2009.

The Department's secure care facilities include individual housing units with the smallest facility having three housing units and the largest facility having eight units. The housing units are arranged in a campus-like manner with each unit being separate from any other building. Each facility is surrounded by a perimeter fence topped with razor wire and is equipped with multiple security cameras that monitor the housing units, other buildings, and outdoor locations at each facility. The units contain either single- or double-occupancy rooms that house between 16 and 32 juveniles. According to the Department, single-occupancy rooms are ordinarily used only for sex offenders or for juveniles who exhibit sexually inappropriate behavior. Each housing unit also has a common area where juveniles participate in treatment groups and other free-time activities.

In addition, each facility has a separation program that is designed to maintain a safe environment that provides for the de-escalation and stabilization of juveniles who department staff determine pose a threat to themselves or to others, are a serious and continuing escape risk, may damage property, or if the juvenile requests a self-referral. A juvenile's stay in these programs is intended to be temporary, ranging from a few minutes to several hours, until the juvenile can be re-integrated into his/her normal housing unit. The separation program at each facility is required by department policy to maintain comprehensive program activities substantially equivalent to those offered during regular programming and maintain daily activities and program schedules. The Department also provides medical services at each secure care facility 24 hours a day, 7 days a week.

Juvenile activities and supervision while in secure care

While in secure care, a juvenile's day is fully scheduled. Juveniles begin their days with basic hygiene and breakfast. Monday through Friday, juveniles attend school and receive treatment rehabilitation. Specifically, the Department provides:

- Education and vocational rehabilitation—The Department operates accredited schools at all four secure care facilities. Juveniles can earn their eighth-grade certificate and high school diploma from the Department's schools or a General Equivalency Diploma (GED). Juveniles can also enroll in community college and earn college credit on-line. The Department also offers vocational services to juveniles to teach them practical job skills such as building trades, automotive, cosmetology, medical transcription, computer-aided drafting, fire science, and culinary arts.

- Treatment programming—After school, juveniles participate in treatment groups. The Department provides treatment programming to all juveniles at its correctional facilities. This programming consists of core treatment that is provided to all juveniles and, depending on the juvenile's needs, can also include specialty treatment programming, such as sex offender, mental health, and chemical dependency treatment (See the Office of the Auditor General's performance audit of the Department's treatment programs, Report No. 09-02, for more information).

- Behavior management—The Department uses a variety of behavior management interventions to provide structure and prevent or minimize negative juvenile behaviors while building on strengths, beliefs, and behaviors. The Department's main behavior management program, System for Change, is designed to provide behavior management tools, treatment approaches, and educational expectations for all juveniles. Additionally, the clear establishment of rules and consequences provides structure for staff to maintain an appropriate therapeutic environment.

Treatment groups are held in the housing units, while each facility has buildings with dedicated space for school that are also used for treatment groups. Juveniles' schedules include time for treatment groups, behavior management groups, and recreation. During the evenings, juveniles have dinner and then generally have some personal time for phone calls, mail, and showers. On weekends, juveniles' schedules include time to clean their housing units, participate in recreation and work crews, and have the opportunity to see visitors.

Over the course of a day, juveniles are supervised by a variety of staff (see textbox, page 4). For example, according to department procedure, a housing unit with 24 juveniles should maintain a ratio of at least one staff to 12 juveniles during the first

Facility staff who regularly interact with juveniles

Youth Corrections Officer—Provides direct supervision of juveniles, acts as primary staff for a small number of juveniles, and facilitates behavior management.

Youth Corrections Officer III—Provides direct supervision of juveniles while also supervising other Youth Corrections Officers on a housing unit.

Youth Program Officer III—Case manager who works with the psychology associate to develop a juvenile's treatment plan and assists other staff with treatment and behavior management groups.

Psychology Associate—Licensed masters-level mental health professional who serves as the clinical lead for a juvenile's treatment plan, which includes running treatment groups and ensuring behavioral health services are provided.

Youth Program Supervisor—The residential manager who oversees daily operations of housing units and assists facility administration by providing leadership in the facility.

Security—Youth Corrections Officer who provides assistance to housing unit staff by responding to calls for assistance, providing video surveillance, and supervising the entry and exit of staff and visitors.

Source: Auditor General staff summary of housing unit staff descriptions found in the Department's treatment program manuals, formal job descriptions, and employee handbook, and information provided by department officials.

shift (See Finding 2, pages 22 through 23, for a discussion of department staffing). Most housing units have two to three Youth Program Officers, a Youth Corrections Officer III, a Youth Program Supervisor, and a Psychology Associate, who is responsible for treatment, counseling, and assessments.

2004 federal investigation identified unsafe conditions

Between April 2002 and March 2003, three juveniles committed suicide at the Adobe Mountain facility. In June 2002, the U.S. Department of Justice notified the State of its intent to begin an investigation under the Civil Rights of Institutionalized Persons Act (CRIPA) into whether the constitutional and federal statutory rights of juveniles in the Department's custody were being violated. In January 2004, the Department of Justice issued a report finding serious deficiencies at three of the Department of Juvenile Corrections' secure care facilities and in September 2004, filed a lawsuit against the State in the U.S. District Court for the District of Arizona.[1] The identified deficiencies, which the report noted harmed or put juveniles at-risk for harm, included:

- **Inadequate suicide prevention measures**—Although the investigation found that the Department adequately screened youth to identify those at risk for suicide, the youth who were identified as at-risk for suicide were inadequately monitored by the Department's mental health staff, which included psychiatrists, psychologists, and psychology associates. Specifically, these juveniles were not placed on suicide precautions or seen in a timely manner by mental health staff. In many cases where juveniles were seen by mental health staff, the staff failed to document their clinical assessments. Staff also failed to effectively communicate among themselves about which juveniles needed close observation. Additionally, juveniles at-risk for suicide were inadequately supervised by staff, who lacked the training and tools necessary to intervene in the event of an attempted suicide. Finally, the investigation noted that the housing units contained objects that could be used as anchor points in a suicide attempt.

1 *U.S. v. the State of Arizona, et al.*, CV-04-01926, U.S. Dist. Ct. of Ariz.

- **Deficient correctional practices for preventing abuse and violence**—The investigation found that the Department failed to protect youth from sexual abuse, including inappropriate and illegal sexual relationships between juveniles and staff, as well as juvenile-on-juvenile sexual violence. In addition, staff physically abused juveniles by hitting them or slamming them to the ground. Staff were also complicit in fights between juveniles, either by encouraging fights or by not intervening. The report also noted that the Department inadequately investigated allegations of sexual or physical violence and that the Department's process for determining whether its Internal Affairs Unit should investigate allegations of abuse was subjective, time consuming, and cumbersome. Finally, some incidents that should have been referred to the Internal Affairs Unit for investigation were not, while those investigations that were done were generally very untimely.

The State subsequently entered into a memorandum of agreement with the U.S. Department of Justice in September 2004 and agreed to implement more than 120 mandatory provisions. A committee of consultants jointly agreed to by the U.S. Department of Justice and the Department of Juvenile Corrections monitored the implementation of the provisions. The consultants issued six semi-annual reports reflecting the Department's progress in meeting the mandatory provisions. In September 2007, a federal judge dismissed the lawsuit against the Department when it showed substantial compliance with all of the provisions.

Department created new units to monitor practices

To help comply with the mandatory provisions resulting from the CRIPA investigation and improve monitoring and the implementation of proper practices, the Department created two new units. The Inspections and Investigations Division replaced the Department's Internal Affairs Unit in 2004, and according to a department official, a new Quality Assurance Unit was created in 2006 to ensure staff follow policies and procedures. As of August 21, 2009, the Department reported these two units had 29 authorized full-time equivalent (FTE) positions. These units have several responsibilities, including:

- **Inspections and Investigations Division (19 FTE, 0 vacancies)**—This division contains both a professional standards unit and a criminal investigations unit. Each investigates noncompliance with department policy and criminal allegations, including allegations of child abuse. The professional standards unit investigates allegations of staff misconduct that may or may not result in criminal charges and is led by a commander and has 3 investigators plus an equal employment opportunity coordinator. According to department data, in 2008, this unit initiated 329 administrative investigations. Sixty-nine cases were sustained; 179 were not sustained, were unfounded, or were exonerated; 17

were closed inactive (which refers to cases where staff resigned prior to the completion of an investigation); and 64 were informational only. Informational only means that the Department discovered offenses outside of its jurisdiction and then shared that information with the appropriate agency.

The criminal investigations unit, which is staffed by certified peace officers, investigates criminal offenses by juveniles and staff. Department procedure requires a criminal investigation in response to allegations of criminal misconduct. This unit is led by a commander and includes four investigators. According to department data, in 2008, 1,450 criminal investigations were completed. Of these investigations, 260 were submitted to the County Attorney; 104 were cleared by arrest; 543 were cleared without the suspect's being charged (which may happen when a victim does not desire prosecution, when the case does not meet the filing criteria for the county attorney, or when the case involves a misdemeanor offense); and another 543 were cleared as informational only. Other staff in the unit includes two K-9 officers who conduct searches of the facilities, juveniles, staff, and visitors; a therapy dog handler; a criminal background investigator who conducts background checks on prospective employees; and one staff who serves as an evidence technician and conducts accident-related investigations.

- Quality Assurance Unit (10 FTE, 0 vacancies)—This unit was established pursuant to the memorandum of agreement with the U.S. Department of Justice and is responsible for ensuring that department staff adhere to department policies and procedures and coordinating the implementation of the Department's quality assurance programs. This unit has a team of four inspectors and four institutional coordinators. The inspectors conduct formal audits of each facility twice a year. During these audits, inspectors review compliance with a variety of operational, educational, and treatment policies and procedures. Individual facilities must develop a corrective action plan to address any deficiencies identified by the audits. The unit conducts follow-up audits to determine whether the deficiencies were fully addressed. Institutional coordinators at each of the four facilities monitor facility compliance with department policies and procedures, conduct weekly and monthly inspections, and coordinate all quality assurance activities in the facilities, including followups and corrective action plans.

Budget

The Department received specific funding from the Legislature in fiscal years 2005 and 2006 to address problems identified during the CRIPA investigation. According to the Joint Legislative Budget Committee's (JLBC) fiscal year 2005 and 2006 appropriations reports, the Department received a combined total General Fund

appropriation increase of $11,790,600 for fiscal years 2005 and 2006 to address CRIPA-related issues. Of this amount, $1,669,800 represented one-time monies for equipment and the completion of suicide prevention renovations. This appropriation also increased department staffing by 208 FTE positions.

However, at the same time, the Legislature reduced the Department's General Fund appropriation by a combined total of $5,085,900 for fiscal years 2005 and 2006 to reflect a reduction in the juvenile population served by the Department. Specifically, the Legislature reduced the number of funded beds from 818 to 623, a reduction of about 25 percent.[1] The resulting General Fund reduction resulted in the elimination of 117 FTE positions. In addition, the Department's budget was further reduced in fiscal year 2006 by $637,300 to eliminate 132.7 vacant FTE positions.

The Department's fiscal year 2009 total authorized FTE positions of 1,163.7 was similar to the Department's authorized FTE positions for fiscal year 2006. However, the Department's fiscal year 2010 authorized positions were reduced by 113 FTE to a total of 1,050.7 FTEs.

Scope and objectives

This performance audit sought to determine the extent to which changes made by the Department in response to the 2004 CRIPA investigation are still in place, specifically focusing on preventing suicide and reducing violence and abuse among incarcerated juveniles.

This audit was conducted 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.

The Auditor General and staff express appreciation to the Department's Director and staff for their cooperation and assistance throughout the audit.

1 The JLBC no longer reports funded beds in its appropriations reports.

FINDING 1

Department has improved suicide prevention practices, which promote safety, but minor improvements are possible

The Arizona Department of Juvenile Corrections (Department) has significantly improved its suicide prevention practices, but some minor changes could further ensure the appropriate treatment of juveniles who are at-risk for suicide. In its 2004 report, the U.S. Department of Justice identified several deficiencies in the Department's suicide prevention practices that contributed to three suicides within 12 months at one of the Department's secure care facilities in 2002 and 2003. In response to these findings, the Department significantly revised its suicide prevention policies and practices and achieved substantial compliance with U.S. Department of Justice provisions in September 2007. As a result, the Department has not had any additional suicides, has sustained a low number of serious attempts, and has better safeguarded the health and well-being of juveniles who are at-risk for suicide. However, the Department should make some additional, minor improvements to its suicide prevention and treatment practices to further ensure the appropriate treatment of juveniles who are at-risk for suicidal behaviors.

Federal investigation identified weaknesses in Department's suicide prevention practices in 2002 and 2003

During 2002 and 2003, the Department experienced three suicides at its Adobe Mountain facility. After the first suicide, in 2002, the U.S. Department of Justice began a Civil Rights of Institutionalized Persons Act (CRIPA) investigation of the Department's correctional practices. The U.S. Department of Justice retained the services of an independent investigator, who conducted a review of the Department's

Three juveniles committeed suicide at the Adobe Mountain facility between 2002 and 2003.

suicide prevention practices in three of its facilities.[1] The investigator's report identified several deficient suicide prevention practices, including poor training, inconsistent staff communication, and unsafe facilities.[2] Specifically the report found:

- **Inadequate training**—The Department did not provide comprehensive suicide prevention training and did not ensure that all facility staff received initial and annual training on suicide prevention practices. According to the report, "staff cannot detect, make an assessment, nor prevent a suicide for which they have no training."[3]

- **Need for improved assessments, monitoring, and treatment**—Although the Department had adequate procedures for identifying potentially suicidal behavior (see textbox), because court and county records were not always available, past suicidal and/or self-injurious behavior was not always included in the intake assessment.

  Additionally, the Department did not have a formal process to monitor ongoing suicide risk. The report identified "several incidents" where juveniles identified as at-risk for suicide and/or self-injurious behavior were not placed on close observation or seen by mental health staff in a timely manner.[4] Further, for those juveniles placed on suicide precautionary status, supervision was not always performed consistently and documentation of the supervision intervals was often inaccurate or not completed.[5] Also, not all staff were aware that they should place a juvenile on suicide precautionary status when a suicidal and/or self-injurious behavior was initially observed.

Reception, Assessment and Classification (RAC)—Department procedures require department staff to screen juveniles for suicidal behavior within 1 hour of the juvenile's arrival at a department secure care facility. Juveniles are monitored by RAC staff until they are assessed for suicidal ideation.

Source: Auditor General staff summary of the Department's suicide prevention procedure.

Finally, the report stated that all juveniles discharged from suicide precautionary status should receive treatment and regularly scheduled follow-up assessments by mental health staff.

- **Inconsistent communication**—Staff communication regarding juveniles who were on suicide precautionary status was inconsistent, which limited the number of staff who were aware of the management needs of juveniles at-risk for suicidal and/or self-injurious behavior. Additionally, the Department did not have integrated medical and mental health files, and therefore, information on suicidal and/or self-injurious behavior was not readily available in one location to all staff

1 Lindsay M. Hayes, Project Director with the National Center for Institutions and Alternatives and a nationally recognized expert on juvenile suicide.

2 Hayes, L. M. (2003). *Report on suicide prevention practices within the Arizona Department of Juvenile Corrections* [Internal document]. Washington, D.C.: U.S. Department of Justice, Special Litigation Section, Civil Rights Division.

3 Hayes, 2003

4 Close observation is a level of supervision used when juveniles present with suicidal and/or self-injurious behavior.

5 Suicide precautionary status is the status assigned to juveniles assessed to need a higher level of supervision because of suicidal and/or self-injurious behavior.

who might need it. Also, a daily suicide prevention status list was not maintained at all facilities, and an incident report was not always completed for suicidal and/or self-injurious behavior.[1]

- **Unsafe facilities and placements**—Juveniles were placed in housing units and rooms that contained features or furniture that could be used for self-harm, such as bars on the window and large openings in the vents. Also, juveniles appeared to spend a lot of time confined to their rooms during the day, including the three juveniles who had committed suicide, all of whom had been confined to their rooms at the time of their deaths. The report stated that "isolation should be avoided" and, whenever possible, suicidal juveniles should be housed in the general population.[2]

  In 2002 through 2003, the CRIPA investigation found that housing units contained features or furniture that juveniles could use for self-harm.

  The report also stated that removal of a juvenile's clothing "should be avoided whenever possible, and only utilized as a last resort for periods in which the youngster is physically engaging in self-destructive behavior."[3]

- **Lack of intervention procedures**—Department procedures did not address the prompt response by staff to suicidal and/or self-injurious behavior. Specifically, the report stated that there was a lack of first aid kits at one facility, that some staff did not know how to use emergency response equipment, and that not all staff were trained in CPR.

- **Nonexistent follow-up review process**—The Department did not have procedures for a follow-up review after a completed suicide. The report stated that "many juvenile correctional systems have reduced the likelihood of future suicides by critically reviewing the circumstances surrounding instances as they occur."[4]

Department significantly improved suicide prevention practices from 2003 through 2007

In response to these findings, the Department significantly improved its suicide prevention practices to conform to national standards and identified best practices. These improved practices better safeguard the health and well-being of juveniles who are at-risk for suicide and/or self-injurious behavior. Specifically, since 2003, no suicide attempt has resulted in death, and since January 2007, the number of serious suicide attempts has averaged less than one per month.[5]

Since 2003, no suicide attempt has resulted in death.

1 Juveniles on suicide precautionary status should be placed on a daily suicide prevention status list.

2 Hayes, 2003

3 Hayes, 2003

4 Hayes, 2003

5 Department policy defines a serious suicide attempt as a suicide attempt that requires medical treatment and/or hospitalization.

Prior to the CRIPA report's release in January 2004, the Department began improving its suicide prevention practices in 2003. Revisions continued throughout the monitoring period, which ended in 2007, with input from the U.S. Department of Justice and the independent investigator who worked with the Department. The Department's revised suicide prevention policies and procedures, and most practices conform to national standards or best practices.[1] Specifically:

- Enhanced suicide prevention training—The Department provides 8 hours of initial suicide prevention training for new staff and 2 hours of annual "refresher" training for all staff. The 2 hours of annual training meets the agreed-upon requirement with the U.S. Department of Justice, but between 2005 and 2007, the Department actually offered more hours of annual training than required and reported that it will provide more hours of refresher training when necessary. This enhanced suicide prevention training covers such areas as the Department's suicide prevention policy, predisposing factors to suicide, warning signs and symptoms of suicidal behavior, and instruction in how to use emergency response equipment, including the use of a suicide rescue knife. The initial and annual training also include mock drills simulating an emergency response to a suicide attempt. The Department consistently ensures close to 100 percent compliance with staff attendance at these trainings. Auditors' review of nine 2008 and 2009 internal Quality Assurance (QA) reports, representing each of the four facilities, found that attendance for the new staff training is consistently at or close to 100 percent, and since May 2008, the Department has improved annual training attendance to more than 90 percent at each facility.[2]

- Improved monitoring and assessments—Consistent with department policies, when a juvenile expresses or engages in suicidal and/or self-injurious behavior, staff supervision is increased until he/she is seen by mental health staff. Auditor interviews with a total of 16 direct care staff and mental health staff at the four facilities determined that all staff were aware of the current supervision procedures even though these procedures were not always followed. The Department also uses three different supervision levels for all juveniles identified as suicidal and/or self-injurious—constant, 10-minute intervals, and 15-minute intervals. Mental health staff determine and assign these levels when they conduct a mental health assessment. Auditor review of nine 2008 and 2009 internal QA reports indicated that department staff documented the correct supervision level for juveniles on the suicide prevention status list during every review except one in January 2008. Additionally, department policies require mental health staff to conduct an Initial Precautionary Risk Assessment to assess juveniles' suicide risk level and a daily Crisis Intervention Assessment to monitor juveniles while they are on suicide precautionary status. Auditors' review of a sample of 30 juvenile placements on the daily suicide prevention status list,

1 Hayes, L.M. (2004). *Juvenile suicide in confinement: A national survey.* Retrieved March 25, 2009, from http://www.ncjrs.gov/pdffiles1/ojjdp/214434.pdf; Council of Juvenile Correctional Administrators. (2009). *PbS goals, standards, outcome measures, expected practices and processes.* Retrieved April 14, 2009, from performancebasedstandards.org/DocLib/PbS_Standards_April_2009.pdf

2 All internal QA reports were prepared by the Arizona Department of Juvenile Corrections Quality Assurance Unit.

from March 23, 2009 through May 15, 2009, found that 100 percent of the placements had an associated initial assessment and 97 percent of the placements received daily assessments while on the list to monitor behavior.

- **Better communication**—Review of nine 2008 and 2009 internal QA reports showed that housing units at all four facilities consistently posted the daily suicide prevention status list and made it available to all housing unit staff as required. This list informs staff about which juveniles are on an increased level of supervision for suicidal and/or self-injurious behavior. The Department has also automated this list so that it is immediately available to all staff who have access. Maintaining this suicide prevention status list is consistent with the independent investigator's recommendations, which stressed the importance of a uniform method to "communicate the management needs" of suicidal juveniles to all facility staff.[1] Additionally, medical and mental health files are integrated so that mental health information is maintained in one location and available to all authorized staff. The Department also has an agreement with the Administrative Office of the Courts to obtain the juveniles' medical records from the juvenile courts within a specific time frame after commitment to the Department.

The Department has modified all housing units so they are "suicide resistant."

- **Safe facilities**—The Department has modified all housing units and separation units to be "suicide resistant" with no protrusions in the living environment that could be used for self-harm. According to the Department, these modifications were extensive, and many were completed prior to receiving monies the Legislature appropriated in fiscal years 2005 and 2006 to address the CRIPA investigation findings.

- **Improved intervention procedures**—Suicide prevention training includes mock drills, and staff are taught how to use emergency response equipment. Also, according to a department official, departmental training records show that 94 percent or more of the facility staff, including education staff, have been trained in CPR and first aid. Additionally, auditor review of twelve 2008 and 2009 internal QA reports showed that almost 100 percent of facility staff were wearing rescue packs (which also contain a suicide rescue knife) as required.

- **Comprehensive follow-up review process**—The Department follows a comprehensive review process to review incidents of serious and completed suicide attempts. For example, this process includes a review of department procedures and circumstances surrounding the incident. Other steps in the follow-up process include assessing whether staff need additional training and whether program services are adequate. In April 2009, auditors observed the Department's reviews for two juveniles who had recent, serious suicide attempts. For both reviews, the Department followed all steps of the review process.

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1 Hayes, 2003

Department should continue progress by making some minor improvements to align all practices with policies and procedures

The Department has instituted suicide prevention policies and procedures that are consistent with best practices, and for the most part follows these policies and procedures, but it should make some minor improvements. Specifically, six department internal QA audits from April 2008 through March 2009 found that some treatment plans or progress notes for suicidal and self-injurious juveniles did not always specify the treatment that will be provided to address the suicidal behavior. Additionally, for the incidents reviewed, staff referred the majority of juveniles who exhibit suicidal and/or self-injurious behavior to separation—a practice not in line with department procedure, which calls for doing so only when directed by mental health staff. Staff at the Catalina Mountain facility also put suicidal and self-injurious juveniles into suicide-proof smocks prior to an assessment from a mental health professional, contrary to department procedure. Finally, department staff prepared incident reports for only about half of the juveniles on the daily suicide prevention status list from March 23, 2009 through May 15, 2009, which department officials attributed to mental health staff who completed other documentation noting the suicidal/self-injurious behavior, but not an incident report. Department procedure calls for completing incident reports for all juveniles on the list.

Some treatment plans did not always address suicidal and/or self-injurious behavior.

Suicidal or self-injurious behavior not always addressed in some treatment plans—Some treatment plans and progress notes did not always address suicidal and/or self-injurious behavior. The Department's suicide prevention procedure states that juveniles who make suicidal threats or engage in self-injurious behavior should have treatment plans that address these behaviors. Additionally, according to department officials, when a juvenile is on the suicide prevention status list, staff should revise the treatment plan to address the suicidal and/or self-injurious behavior and treatment should be initiated. The Department developed these procedures in response to the CRIPA investigation.

The inconsistency in incorporating suicidal or self-injurious behavior into treatment plans has been noted repeatedly. The final CRIPA monitoring report, which was issued in September 2007, noted, "…the consistency of quality treatment planning for youth discharged from suicide precautions remains uneven. [As] such, there is spotty documentation to demonstrate the specific strategies utilized by mental health staff to decrease self-injurious behavior of youth on their caseload."[1] Additionally, auditors reviewed the six department internal QA reports issued between April 2008 through March 2009 that included a review of juvenile treatment plans for suicidal/self-injurious juveniles. All six internal QA reports found that documentation continued to be a concern because some of the treatment plans and progress notes reviewed did not address the juvenile's suicidal/self-

[1] Hayes, L., Kraus, L., Leone, P., & Van Vleet, R.K. (2007). *Sixth semi-annual report.* [Internal document]. Washington, D.C.: U.S. Department of Justice, & Phoenix AZ: Arizona Department of Juvenile Corrections.

injurious behavior. For example, a January 2009 internal QA audit of the Department's Black Canyon School found that only four of eight case files reviewed had a treatment plan to address the suicidal behavior and only five of eight case files reviewed had progress notes that addressed treatment for suicidal/self-injurious behavior.

The Department reported that it has addressed the situation. Auditors' review of a May 2009 internal QA audit of the Department's Catalina Mountain School found that all juvenile case files reviewed had treatment plans that appropriately addressed suicidal and self-injurious behaviors. According to department officials, they are taking additional steps to ensure the development of appropriate treatment plans for suicidal juveniles. Specifically, the Department has modified its suicide prevention procedures to state that when a juvenile is removed from the suicide precautionary status, the treatment plan should reflect the new treatment problem. Also, department officials are developing more specific procedures related to the treatment expectations for juveniles who have been identified as having suicidal or self-injurious behaviors.

Given the Department's inconsistency in this area, it should continue to monitor juveniles' treatment plans to ensure that they address the suicidal or self-injurious behavior and that its modified procedures have been implemented by all staff.

Use of separation program—Department practices help to ensure the safety of juveniles under its care, but auditors found that the Department's use of separation for juveniles exhibiting suicidal and/or self-injurious behavior was not fully in line with department procedure or best practices. Specifically, the Department's suicide prevention procedure states that juveniles should be sent to separation if housing unit staff have determined that the juvenile is "a serious and immediate danger to him/herself" and the "living unit is an inappropriate and/or unsafe environment" for the juvenile (see textbox for description of the separation program). According to the independent investigator hired by the U.S. Department of Justice, "use of isolation or room confinement (which occurs in over 50 percent of all juvenile suicides) not only escalates the youth's sense of alienation while [feeling] despair, but further removes the individual from proper staff observation."[1] According to the independent investigator, the original conceptualization for the Department's suicide prevention practices was that only juveniles exhibiting the most serious self-injurious behaviors would be transferred to

The Department's use of separation was not fully in line with department procedure or best practices.

Separation program—Located in a free-standing building or a limited access unit, this program is used for de-escalation and stabilization of juveniles' exhibiting behaviors that pose a substantial risk of injury to self or others. Behaviors warranting separation also include destruction of property and a serious continued risk of escape. Juveniles may also request a self-referral. According to department officials, the program attempts to expeditiously address the issues that resulted in the juvenile's referral to separation.

Juveniles placed in separation are continuously monitored by staff and cameras that are in each room. Although confined to a room, if a juvenile is placed in separation for a full day, he/she will receive 1 hour of education and time for large muscle recreation.

Source: Auditor General staff summary of the Department's separation policy, auditor observations, and information from department officials.

1 Hayes, 2003

separation because these were highly disruptive behaviors in a housing unit and required more serious attention. The investigator further stated that at the time of the final CRIPA monitoring report in September 2007, the Department's procedures and practices were consistent with this approach. Specifically, juveniles were taken to separation only after a mental health staff member had seen them and determined separation was necessary based on a suicide risk assessment.

Since the final monitoring report was issued, however, department staff have inconsistently followed these procedures. Specifically, auditors' review of 137 incidents of suicidal and/or self-injurious behavior where the juvenile was sent to separation, from March 23, 2009 through May 15, 2009, found that for 87 of the 137 incidents, or 64 percent, juveniles were immediately sent to separation after exhibiting the suicide threat and/or self-injurious behavior.[1] These immediate referrals to separation were made prior to an assessment by a mental health staff member. Additionally, for some of these incidents, department documentation did not indicate whether the juvenile was an immediate danger to him or herself. According to a department official, the reason for the increased use of separation is the result of staff shortages and mental health staff not always being readily available to meet with juveniles. Although department procedure requires 24-hour mental health coverage, these staff are not always physically available at a facility to address suicidal and/or self-injurious behavior but may be on-call. For example, in some cases, these incidents occurred during shifts or hours when mental health staff were not scheduled to work or when they were with other juveniles. As a result, department officials reported training staff to err on the side of caution when preventing suicide. Due to these considerations and the use of cameras for additional monitoring in the separation program, department practices ensure the safety of these juveniles because they can be more closely monitored until a mental health professional can conduct an assessment.

However, auditors' interviews with 17 housing unit staff and mental health staff from the four facilities found that 10 of these staff believed that sending a juvenile to separation after any type of suicidal or self-injurious behavior was standard practice. Although there will be instances where staff may need to immediately refer a juvenile who exhibits suicidal or self-injurious behavior to separation, to ensure that the use of separation for suicidal or self-injurious juveniles follows department procedures and expectations, the Department should expand its regular assessment of its separation practices to include the review of unnecessary and/or inappropriate referrals for juveniles exhibiting suicidal and/or self-injurious behavior and take appropriate action based on what it finds.

1 Auditors reviewed 158 incident reports from March 23, 2009 through May 15, 2009, for suicidal threat and/or self-injurious behavior. However, 21 of these incidents occurred while the juvenile was already in separation and therefore were excluded from this analysis.

Use of suicide-proof smocks—Clothing practices for suicidal juveniles at one of the Department's secure care facilities are not in line with department procedures. The Department's suicide prevention procedures state that juveniles should wear "regular secure facility clothing unless the [mental health staff] requires the juvenile to wear suicide resistant clothing (i.e., jumpsuit with Velcro closures, smock, pajamas, etc.)."

However, juveniles at one facility were placed in suicide-proof smocks as a general practice and prior to a mental health assessment or orders from mental health staff. Auditors' review of incident reports, separation logs, and mental health assessments from March 23, 2009 through May 15, 2009, showed that in 14 out of 28 incidents, juveniles sent to separation at the Department's Catalina Mountain School for suicidal and/or self-injurious behavior were immediately placed in suicide-proof smocks. According to staff interviewed at this facility, this practice was instituted for all juveniles who were sent to separation for suicidal or self-injurious behavior, and juveniles were removed from this precaution only if directed by mental health staff when they conducted the mental health assessment. Staff stated that they were not sure why this practice was instituted, except as an added security measure as directed by mental health staff.

Juveniles at the Catalina Mountain School were placed in suicide-proof smocks prior to an assessment or orders from mental health staff.

This practice may further safeguard juveniles who exhibit suicidal behavior, but it is inconsistent with department policies and best practices. According to the independent investigator hired by the U.S. Department of Justice, the removal of a juvenile's clothes (excluding belts and shoelaces) should be avoided as much as possible and used only as a last resort when juveniles are engaging in self-injurious behavior.[1] According to a department official, the use of suicide-proof smocks should not be a standard practice, and as of May 2009, the Department has addressed this concern through a meeting with its facility mental health staff, including its clinical director.

Incident reports not always completed—Although department procedures require the preparation of an incident report for all suicidal and/or self-injurious behavior, staff have not consistently prepared these reports. The Department's procedure for incident reporting lists self-harm, including self-injurious behavior and suicide threat, as reportable incidents.

However, not all juveniles on the suicide prevention status list had an associated incident report. Auditors' review of the daily suicide prevention status list and incident reports for suicide threat and/or self-injurious behavior from March 23, 2009 through May 15, 2009, determined that 44 out of 86, or 51 percent, of the juveniles on the list did not have an associated incident report. Department officials attributed this to mental health staff who completed other documentation noting the suicidal/self-injurious behavior concern, but not an incident report. However, not preparing an incident report is inconsistent with department policy and best

1 Hayes, 2003

practices. Best practices state that "all staff who came in contact with the [juvenile] before the incident (or while responding to the incident) should submit a statement as to their full knowledge of the youth and the incident."[1] According to department officials, all juveniles placed on the suicide prevention status list should have a corresponding incident report, and as of May 2009, the Department has addressed this concern through a meeting with its facility mental health staff, including its clinical director.

Recommendations:

1.1. The Department should continue its plan to modify current procedures to develop and implement more specific guidelines for mental health staff related to the treatment expectations for juveniles who have been identified as having suicidal or self-injurious behaviors.

1.2. The Department should continue to monitor juveniles' treatment plans to ensure that they address the suicidal or self-injurious behavior and that its modified procedures have been implemented by all staff.

1.3. The Department should expand its regular assessments of its separation practices to include the review of unnecessary and/or inappropriate referrals for juveniles exhibiting suicidal and/or self-injurious behavior and take appropriate actions based on what it finds.

1.4. The Department should ensure that juveniles are not placed in suicide-proof smocks unless a qualified mental health professional deems it necessary as stated in policy. If suicide-proof smocks are not used appropriately, the Department should take steps to re-align facility practices with its procedures and best practices.

1.5. The Department should ensure that its staff prepare an incident report for all juveniles placed on its daily suicide prevention status list.

[1] Hayes, 2004

FINDING 2

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

The Arizona Department of Juvenile Corrections (Department) should continue its efforts to further reduce juvenile violence at its secure care facilities. In response to the 2004 Civil Rights of Institutionalized Persons Act (CRIPA) investigation, the Department has taken several steps to improve the safety of juveniles entrusted to its care. Beginning in 2008, the Department has reported a decline in violence at its secure care facilities. Steps the Department took to promote juvenile safety include the use of management practices, such as a community policing model, as well as treatment programs and a behavior management system designed to help juveniles address anger and violence issues. Further, when assaults or fights between juveniles occur, department staff reported that they respond according to department procedures and use their training to keep juveniles safe.

Department data shows juvenile violence at lower level

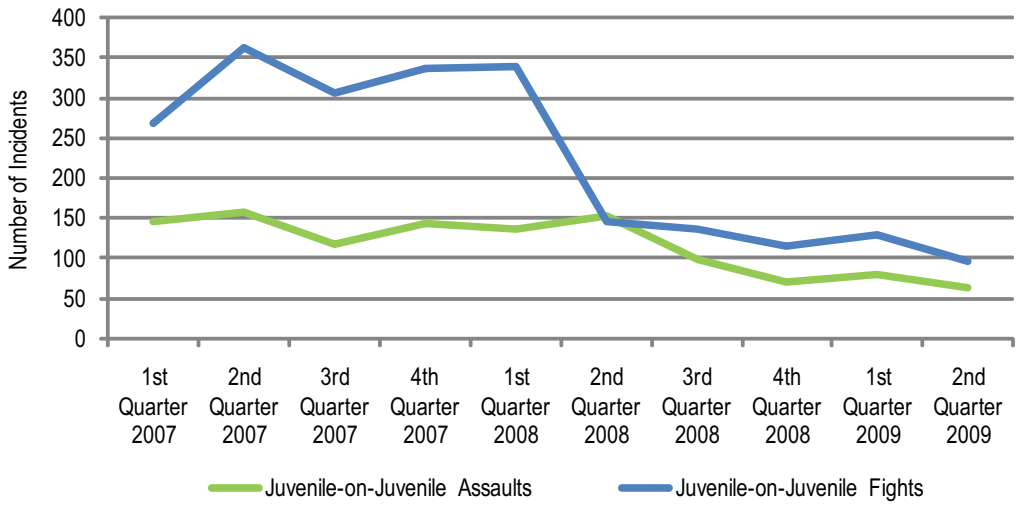
The Department's data shows a lower level of juvenile-on-juvenile violence at its secure care facilities since the 2004 CRIPA investigation found significant violence at two of its secure care facilities. Specifically, in the 2004 CRIPA investigative report, federal officials found that sexual and physical abuse of juveniles by other juveniles and staff occurred at "incredibly disturbing frequency" at one of the Department's secure care facilities for males, Adobe Mountain School (see Finding 3, pages 31 through 39, for discussion on staff abuse of juveniles).[1] In addition, federal officials reported a prevalence of inappropriate sexual activity among juveniles at the Department's secure care facility for females, Black Canyon School.

1 Acosta, R.A. (2004, January 23). *Letter to Janet Napolitano, Governor of Arizona RE CRIPA investigation of Adobe Mountain School and Black Canyon School in Phoenix, Arizona; and Catalina Mountain School in Tucson, Arizona*. Washington, D.C.: U.S. Department of Justice.

The reported decreases in juvenile-on-juvenile violence at the Department's secure facilities became especially pronounced beginning in the second quarter of 2008.[1] This reported decrease occurred both for assaults and fights. For assaults, the Department draws from policy and Arizona Revised Statutes (A.R.S.) §§13-1203 and 13-1212 to define an assault as intentionally, knowingly, or recklessly causing or attempting to cause any physical injury to another person, including the use of bodily fluids to injure or infect another person. In contrast, the Department defines a fight as any physical altercation between two or more juveniles with the intent to harm or intimidate. Typically, an assault involves one juvenile attacking and victimizing an unwilling or unsuspecting juvenile, whereas a fight involves two willing participants. Figure 1 illustrates the number of juvenile-on-juvenile assaults and fights between the first quarter of 2007 through the second quarter of 2009. Specifically, according to department data, the number of juvenile-on-juvenile assaults decreased from 152 to 71, or approximately 53 percent, between the second and fourth quarters of 2008, and the number of juvenile-on-juvenile fights decreased from 339 to 116, or approximately 66 percent, during 2008.[2] These reductions are not the result of housing fewer juveniles, because the average daily population remained relatively stable from the first quarter of 2007 through the second quarter of 2009.

Department data showed the number of juvenile-on-juvenile assaults decreased approximately 53 percent between the second and fourth quarters of 2008.

Figure 1: Juvenile-on-Juvenile Violence by Quarter
First Quarter 2007 through Second Quarter 2009



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

1 According to department officials, the Department lacked valid and reliable data prior to 2007.

2 For department data cited in this report, auditors reviewed the Department's internal controls over the collection and management review of data and concluded that the Department has sufficient controls to ensure the reliability of the data. Auditors did not assess the Department's data processing and reporting internal controls (See Appendix A, pages a-i through a-ii, for more information about the methods auditors used).

Department officials attributed the reported decline in juvenile violence to several factors, including a change in organizational culture, treatment programming improvements, daily violence reduction meetings, more modern security measures, staff training, and the Department's behavior management program called System for Change. In addition, department officials stated that the Department's educational, sports, and recreational programs provide juveniles with opportunities to engage in pro-social activities that can help them transition back to their home communities.

Department taking violence prevention and suppression steps

The Department has taken several steps to help improve the safety of juveniles entrusted to its care.[1] Some of the steps to help promote juvenile safety include the use of various management practices, such as a community policing model, as well as implementation of treatment programming designed to help juveniles address anger and violence issues. However, various threats, such as changes in funding, department management, staffing levels, and the size of the juvenile population, could undermine these efforts. Therefore, the Department should continue to monitor the level of violence at its facilities and assess the effectiveness of efforts aimed at trying to sustain a reduced level of violence.

Management practices designed to promote juvenile safety—The Department uses various management practices to help it identify and address sources of violence. In particular, the Department has adapted some community policing approaches shown to be effective at preventing and reducing crime in the community and applied them to help manage its secure care facilities.[2] These include the following:

- COMPSTAT—In November 2007, the Department adapted a management approach from community policing known as Computer Aided Statistics (COMPSTAT) to help it better identify and address violent activity at its secure care facilities. According to department officials, although COMPSTAT has long been used in law enforcement, its use in juvenile corrections is both innovative and uncommon. Using incident report information that is entered into the Department's database (Youthbase), COMPSTAT uses crime-mapping technology to identify both the "hot spots" of violent activity and the juveniles responsible. COMPSTAT provides real-time data that allows the Department to target efforts at reducing violent activities.

In November 2007, the Department adapted a community policing approach to help it better identify and address violent activity.

1 A lack of complete and accurate violence data prior to 2007 and the recent implementation of some of the Department's management practices limited auditors' ability to draw conclusions about the direct effect of these management practices on the level of violence.

2 Willis, J., Mastrofski, S., & Weisburd, D. (2003). *COMPSTAT in practice: An in-depth analysis of three cities*. Washington, D.C.: Police Foundation; Fleissner, D., & Heinzelmann, F. (1996, August). Crime prevention through environmental design and community policing. *National Institute of Justice Research in Action,* 1-4.

The Department conducts bi-weekly COMPSTAT meetings wherein all levels of department and secure care facility management use COMPSTAT data to discuss violent incidents, such as assaults and fights, and the juveniles responsible for them. Meeting participants discuss and provide input on the action plans developed by secure care facility-level stakeholders to address these incidents and the involved juveniles. For example, in April 2009, Adobe Mountain School management presented an action plan on a juvenile responsible for several violent and/or disruptive incidents during a 4-week period. The plan included one-on-one counseling with mental health staff, efforts to schedule family counseling, and loss of privileges because of negative behaviors. Two weeks after implementing this action plan, the juvenile had a reduced number of violent or disruptive behavior incidents.

Department personnel who attend bi-weekly COMPSTAT meetings

- Director
- Deputy Director
- Superintendent of Education
- Clinical Director
- Assistant Director, Support Services
- Division Director, Legal Systems
- Chief Administrator, Investigations and Inspections or representative
- Chief Administrator, Safe Schools
- Quality Assurance Administrator
- Gang Intelligence Officer
- Research and Development Administrator
- Secure Facility Leadership (superintendents and assistant superintendents)
- Division Director, Community Corrections
- Other personnel as deemed necessary

Source: Auditor General staff observations of meeting participants who regularly attend bi-weekly COMPSTAT meetings and summary of attendance requirements for these meetings per department procedure.

- **Crime Prevention Through Environmental Design**—According to a department official, in April 2004, the Department implemented a community policing approach known as Crime Prevention Through Environmental Design (CPTED). This approach attempts to adapt a physical environment, such as a juvenile's housing unit, to reduce or remove opportunities for illegal activity or misbehavior.[1] Additionally, department training on CPTED states that most people do not want to be observed committing criminal acts. As such, the Department has installed cameras throughout the housing units of its secure care facilities to not only help monitor juveniles, but also to discourage them from misbehaving. In addition, department trainings on CPTED teach staff how to physically position themselves to ensure maximum visibility of juveniles on a housing unit while also being mindful of blind spots that they and the cameras cannot view.

- **Increased staffing levels**—During the CRIPA investigation, federal officials found that inadequate staff supervision of juveniles "clearly resulted in harm to the youth."[2] In response, the Department received funding from the Legislature in fiscal years 2005 and 2006 for additional staff (See Introduction and Background, pages 6 through 7, for more information).

Additionally, as part of the CRIPA monitoring process, the Department agreed with the U.S. Department of Justice to meet various staff-to-juvenile ratios during its first, second, and third staffing shifts. For example, for a housing unit with 24 juveniles, the agreed to staff-to-juvenile ratio is 1:12 during first shift, 1:8 during second shift, and 1:12 during third shift. Auditors' review of reported staffing ratios at each of the Department's secure care facilities over a 2-week period in April 2009 revealed that the Department meets its reported daytime ratios nearly all of the time. This represents an improvement from the CRIPA finding that none of the three secure care facilities reviewed in 2004 met the Department's own staffing ratios.

During a 2-week period in April 2009, the Department met its daytime staff-to-juvenile ratios nearly all of the time.

1 Fleissner & Heinzelmann, 1996

2 Acosta, 2004

The Department struggles at times with third-shift coverage. Auditors' review of reported staffing ratios at each of the Department's secure care facilities over a 2-week period in April 2009 showed that third-shift staffing ratios ranged from 1:7 to 1:33. This review also showed that 158 of 350 (45 percent) third shifts had staffing ratios that did not meet the staff-to-juvenile ratio agreed to during CRIPA monitoring. However, according to department officials, during third shifts, the Department uses security staff as "rovers" to conduct security checks on the housing units, ensure juveniles have access to restrooms in those housing units where juveniles' room lack such facilities, and perform various administrative tasks for housing unit staff.

Given its current staffing challenges and fiscal constraints, the Department should review its staff resources and assess whether it has sufficient staff to properly maintain the staff-to-juvenile ratios agreed to with the U.S. Department of Justice or needs additional staff to do so. If additional staff resources are needed, the Department should review and consider various options for obtaining these resources, including shifting internal staff resources or working with the Legislature to obtain additional staff resources.

- Other intelligence-gathering and sharing efforts—According to a department official, since July 2008, in addition to bi-weekly COMPSTAT meetings, the Department conducts daily violence reduction meetings on the previous day's serious incidents, such as incidents of violence, threatening/intimidating by juveniles, and suicidal/self-injurious behavior. During these video conference meetings, many of the same representatives from COMPSTAT meetings review these incidents, though without using COMPSTAT data, and devise more immediate strategies to address them. Meeting participants also discuss treatment issues, transition planning, and other more general topics related to facility operations, such as staffing or training.

  In addition to the daily violence reduction meetings, department officials reported that each secure care facility conducts a daily facility management meeting. According to department officials, these meetings provide staff an opportunity to review any violent incidents or issues concerning facility operations.

  Finally, according to a department official, since March 2005, the Department has conducted gang intelligence efforts to identify, document, and monitor gang members and gang-related activities at its secure care facilities. Although the Department reported that it had a gang

Department personnel who attend daily violence reduction meetings

- Deputy Director
- Superintendent of Education
- Clinical Director
- Division Director, Legal Systems
- Chief Administrator, Investigations and Inspections or representative
- Chief Administrator, Safe Schools
- Deputy Administrator, Safe Schools
- Classification and Case Management Administrator
- Quality Assurance Administrator
- Secure Facility Representatives (superintendents, assistant superintendents, psychologists, and school principals)
- Division Director, Community Corrections
- Parole Supervisors

Source: Auditor General staff observations information provided by the Department.

intelligence component prior to 2005, it did not have dedicated staff to perform this function. The Department follows criteria specified in Arizona Revised Statutes (A.R.S.) §13-105.09 to document gang membership and enters this information into a state-wide gang member database housed within the Department of Public Safety. One function of the Department's Gang Intelligence Coordinator is to use this database to check gang member status for juveniles newly admitted to the Department. In April 2008, the Department added a category to its incident reporting system to help identify and monitor potential gang members and gang-related activity among its juvenile population. All department staff can review gang information using COMPSTAT or Youthbase and, according to department officials, use this information to help develop treatment plans and make housing assignments for juveniles. According to department data, as of June 23, 2009, the Department had documented 146 juveniles as gang members, or approximately 27 percent of the 549 juveniles committed to secure care.

Treatment programs designed to address anger and violence issues—The Department has modeled its treatment programs after the current thinking in the field of juvenile treatment. These programs are designed to help juveniles address a range of emotional and behavioral problems, including anger and violence. The Office of the Auditor General's performance audit of the Department's rehabilitation and community re-entry programs (see Report No. 09-02) provides additional information on the first two programs as follows:

- New Freedom—New Freedom serves as the Department's core treatment program for all juveniles and, according to a department official, has been in place since February 2006. New Freedom includes substance abuse, behavioral health and educational programming elements. For example, New Freedom includes program materials designed to help juveniles address aggression and violence. In addition, New Freedom incorporates approaches, such as cognitive behavioral therapy, shown to have greater success in reducing recidivism.[1] However, the Auditor General's performance audit of the Department's rehabilitation and community re-entry programs (see Report No. 09-02) found that the Department should take several steps to better implement this program.

- System for Change—Based on cognitive behavioral approaches, System for Change is the Department's core behavior management program for its male secure care facilities and has been in place since February 2008. According to the System for Change program manual, the goal of this program is to create a "safe environment that allows juvenile offenders the opportunity to

Cognitive behavioral therapy—"Our thoughts cause our feelings and behaviors, not external things, like people, situations, and events," and "the benefit of this fact is that we can change the way we think to feel/act better even if the situation does not change."

Source: National Association of Cognitive Behavioral Therapists. (n.d.) *Cognitive-behavior therapy*. Retrieved September 24, 2008, from http://nacbt.org/whatiscbt.htm

1 Landenberger, N.A., & Lipsey, M.W. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology*, 1, 451-476; Latessa, E.J., Cullen, F.T., & Gendreau, P. (2002). Beyond correctional quackery—Professionalism and the possibility of effective treatment. *Federal Probation*, 66(2), 43-49; Lipsey, M.W. (1992). Juvenile delinquency treatment: A meta-analytic inquiry into the variability effects. In T.D. Cook et al. (Eds.), *Meta-analysis for explanation: A casebook* (pp. 83-127). New York: Russell Sage Foundation Publications; Lipsey, M.W., Chapman, G.L., & Landenberger, N.A. (2001). Cognitive-behavioral programs for offenders. *The Annals of the American Academy of Political and Social Science*, 578, 144-157; US Department of Justice, Bureau of Prisons, National Institute of Corrections (2001). *Moving from correctional program to correctional strategy: Using proven practices to change criminal behavior*. Washington, D.C.: DOJ.

change their thinking and behavior from delinquent to pro-social." As part of this program, juveniles set written behavioral objectives each morning and share their progress or struggle in meeting these objectives with other juveniles and staff during sessions held throughout the day. These sessions allow juveniles to receive feedback from peers and staff on how their thought processes may hinder achievement of behavioral objectives and ways to better deal with problems.

In addition, department officials reported that the Department has processes available, such as its Intensive Restorative Community Culture Group, Campus-Wide Extra Help Group, and Individual Behavior Plans, to help staff manage persistent, disruptive, and at times aggressive juvenile behavior. These processes also help juveniles address these behaviors.

- Social Responsibility Group—According to a department official, as part of the New Freedom curriculum, the Social Responsibility Group (Group) targets juveniles identified as gang-affiliated with programming designed to help them address their gang activity, violence, and other criminal behavior. For the Department, gang affiliation or membership places juveniles at risk for continued anti-social behavior. As such, department officials reported that the Department uses the previously discussed gang intelligence efforts to identify potential and/or gang-involved/affiliated juveniles as possible candidates for this Group. Additionally, the Department hired a consultant who provided gang intervention training to staff in 2008 and 2009. The Department implemented this Group in July 2009.

Ongoing monitoring will help ensure actions and practices sustain a reduced level of violence—The Department has undertaken several actions intended to reduce the level of violence in its secure care facilities, but various threats could undermine these efforts. These threats include changes in funding, department management, staffing levels, and the size of the juvenile population. Therefore, the Department should continue to monitor the level of violence within its secure care facilities, assess whether its actions and practices are having a positive impact on reducing violence, and adjust when necessary if it finds that these actions and practices no longer help to sustain reduced levels of violence.

Staff responses to juvenile violence were appropriate for incidents reviewed

Although the Department has reported a decline in violence at its secure care facilities, juvenile violence continues to occur at department facilities. The Department has developed and implemented a comprehensive set of policies and procedures that guide staff actions when assaults and fights do occur. The Department also provides training on crisis intervention, behavior management, and

restraint techniques that provide staff with the skills necessary to successfully restore order and keep juveniles safe. Auditors' review of incident reports involving juvenile assaults and fights, and interviews with staff involved in those incidents, showed staff actions aligned with procedure and training.

According to a department official, the Department's policies for responding to juvenile violence are based on national standards.

Department policies and procedures designed to keep juveniles and staff safe when violence occurs—The Department's policies for responding to juvenile violence, which according to a department official are modeled after American Correctional Association and the National Commission on Correctional Health Care national standards, and associated procedures provide guidance to and establish requirements for staff responses to assaults and fights between juveniles. These procedures include:

- Use of force—When violence occurs, department procedure requires staff to first attempt, if possible, nonphysical interventions, such as relocating the juvenile or handing the situation off to another staff, prior to initiating any use of force (See page 27 for discussion on Therapeutic Crisis Intervention). Department procedure also requires staff to exercise patience and good judgment, and always consider all the factors affecting a juvenile before using or escalating the use of force. However, when nonphysical interventions are not possible or practical, department procedure requires staff to use only the amount of force necessary to restore order and keep juveniles safe.

  When staff determine that physical force may be needed, department procedure requires them to call security for assistance, safeguard any juveniles not involved in the fight or assault by securing them in their rooms if the incident occurs in the housing unit or having them sit or take a knee and remain quiet if an incident occurs elsewhere, and isolate the juvenile identified as the suspect. Staff response to two juveniles fighting may sometimes include a physical restraint hold followed by the use of mechanical restraints, such as handcuffs.

- Incident reports and debriefings—Department procedure requires staff to document any events that may compromise the safety and security of employees and juveniles in an incident report, which must be completed by the end of their shift. However, if a juvenile is referred to separation, procedure requires staff to complete an incident report within 90 minutes or request a time extension if necessary. For incidents involving any use of force or juvenile assaults, department procedure requires involved staff, and housing unit and security management, to hold a debriefing within 5 working days of the incident.

Training provides staff with needed skills to respond to incidents—In addition to procedures that outline appropriate staff responses to juvenile assaults and fights, the Department provides several trainings to its staff on appropriate response techniques. These include:

The Department provides staff with training in crisis intervention, behavior management, and restraint techniques.

- System for Change—This course teaches staff about behavior management tools, strengths of adolescents and characteristics of juvenile delinquents, and supervision strategies in managing and relating to juveniles with specific high-risk behaviors. As part of the Department's 8-week training academy that staff attend prior to working with juveniles, staff receive 24 hours of training in this course. In 2009, the Department provided a 2-hour refresher to continuing staff as part of their annual training requirements.

- Therapeutic Crisis Intervention (TCI)—As a crisis prevention and intervention program, TCI teaches staff how to prevent crises from occurring, de-escalate potential crises, and reduce potential and actual injury to juveniles and staff. New staff receive 24 hours of training in this course and must pass a skills test as part of the training. Additionally, the Department provides a 2-hour annual refresher training on TCI.

- Handle with Care—This training also teaches staff de-escalation techniques, but focuses more on how to perform safe physical holds, such as the primary restraint technique. Staff must also perform these holds as part of the training. New staff receive 16 hours of training in this course and continuing staff receive an annual refresher training that also requires demonstration of the holds as part of the training.

In addition to these trainings, in 2009, the Department will provide staff with 8 hours of annual training on the Department's treatment programs and 2 hours of training on its organizational philosophy.

For incidents reviewed, reported staff actions aligned with procedure and training when violence occurred—For the incidents auditors reviewed, direct care staff and supervisors reported that they followed procedure and used their training to respond to juvenile violence. Auditors reviewed documentation for a total of seven incidents drawn from all four secure care facilities involving assaults and fights between juveniles during February through April 2009 and interviewed 14 of the direct care staff and supervisors involved in those incidents. This review found that direct care staff responded in accordance with procedure and used their training to keep juveniles safe. In addition, supervisors of the direct care staff involved in these incidents reviewed the actions taken by their staff for procedural compliance and to identify and discuss any opportunities for improvement, such as staff positioning before or during an incident. Based on this review, auditors noted the following characteristics of direct care staff and management responses:

- **Direct care staff reported following procedures to keep juveniles safe**—For the incidents reviewed, seven of seven direct care staff reported that the main procedures they followed were:

  1. Calling security for assistance;

  2. Trying to break up, separate, and/or restrain the juveniles involved in the assault or fight; and

  3. Securing the juveniles not involved in the incident in their rooms if the incident occurs in the housing unit or directing them to get down on one knee if the incident occurred elsewhere.

  In addition, direct care staff had to physically restrain juveniles in all seven incidents reviewed. For six of the seven incidents, direct care staff reported using the restraint technique they learned in the Handle with Care training. However, for one incident reviewed, a direct care staff reported that he used an unapproved restraint because the juvenile's size and body position did not allow him to apply the proper restraint. The Department terminated this staff person in July 2009 for other incidents where he physically or verbally abused juveniles and engaged in other staff misconduct, such as neglect of duty, insubordination, and dishonesty. Additionally, the Department reported using these types of incidents for training. Finally, all incidents reviewed resulted in juveniles being referred to separation and all direct care staff documented the details of the assaults or fights in incident reports within the 90 minutes allotted by department procedure.

Six of seven direct care staff reported that they used the restraint technique learned in training.

- **Supervisory review of violent incidents focused on juvenile and staff safety**—Six of the seven supervisors reported that they reviewed the incident reports detailing the assaults or fights, and three reviewed the camera footage of the incidents when available. For all incidents reviewed, all seven supervisors reported that they held debriefings with involved staff to ensure juvenile and staff safety, procedural compliance, and to identify and discuss any circumstances that may have contributed to the incident or any areas where staff could have responded differently. However, auditors' review of documentation for these seven incidents revealed that only two of the seven supervisors submitted documentation showing that debriefings were held with the involved direct care staff and within the time frame allotted by procedure. Documenting incident debriefings in accordance with procedure helps to assure facility management that supervisors and direct care staff have critically reviewed incidents in a timely manner and, when needed, developed approaches to reduce the risk of future incidents. Therefore, the Department should review documentation for incident debriefings to ensure that supervisors conduct debriefings within the time frame allotted and include direct care staff involved in the incident, as required by procedure.

Recommendations:

2.1. The Department should review its staff resources and assess whether it has sufficient staff to maintain staff-to-juvenile ratios agreed to with the U.S. Department of Justice or needs additional staff to do so. If additional staff resources are needed, the Department should review and consider various options for obtaining these resources, including shifting internal staff resources or working with the Legislature to obtain additional staff resources.

2.2. The Department should continue to monitor the level of violence within its secure care facilities, assess whether its actions and practices are having a positive impact on reducing violence, and adjust when necessary if it finds that these actions and practices no longer help to sustain reduced levels of violence.

2.3. The Department should review documentation for incident debriefings to ensure that supervisors conduct debriefings within the time frame allotted and include direct care staff involved in the incident, as required by procedure.

FINDING 3

Department has taken some successful steps to address abuse, but can further strengthen staff awareness of appropriate staff-juvenile boundaries

The Arizona Department of Juvenile Corrections (Department) has taken action to address the abuses identified in the 2004 Civil Rights of Institutionalized Persons Act (CRIPA) investigation, but opportunities exist to further strengthen staff awareness of appropriate staff-juvenile boundaries. As a result of the CRIPA investigation's findings of physical and sexual abuse of juveniles, the Department took several steps to prevent and identify these types of abuses, including revising its juvenile grievance system, creating an investigations and inspections unit, and changing its organizational culture. It also revised policies and procedures and developed additional training to further delineate appropriate interactions between staff and juveniles. However, inappropriate staff-juvenile interactions, such as the use of pet names, verbal sparring and joking, and undue familiarity, still take place, creating the potential for more serious abuses. Therefore, the Department should enhance staff awareness of these issues through increased communication and monitoring.

Department response to abuses identified during CRIPA investigation

The Department has taken steps to respond to the juvenile physical and sexual abuse findings identified by the CRIPA investigation. Specifically, the CRIPA investigation reported that the Department failed to protect juveniles from physical and sexual abuse and that the Department's juvenile grievance and abuse investigation processes did not adequately address such abuse. In response, the Department revised its juvenile grievance process, enhanced its investigation of these types of abuses, and initiated a change in its organizational culture that includes zero tolerance for abuse of any kind.

The Department has taken steps to respond to the juvenile physical and sexual abuse findings the CRIPA investigation identified.

CRIPA investigators found frequent abuse—In its January 2004 CRIPA investigation report, U.S. Department of Justice officials reported that physical or sexual abuse of juveniles by department staff occurred frequently at two of the three secure care facilities reviewed. Federal officials cited several examples where department staff either sexually or physically abused juveniles, or failed to protect juveniles when other juveniles attacked them.

In addition, federal officials reported that the Department had a dysfunctional grievance system and ineffective abuse investigation process. Specifically, CRIPA investigators found the Department's juvenile grievance process to be inadequate because staff at times denied juveniles access to this process. Investigators also reported that juveniles throughout the Department's secure care facilities characterized the grievance process as a "joke" and lacked faith in the process, and therefore did not use it to report alleged abuse. Finally, when juveniles did file grievances, CRIPA investigators found that the Department often did not resolve these grievances in a timely or fair manner, or in some instances, did not investigate them. In particular, CRIPA investigators reported that grievances involving abuse allegations were not automatically investigated by the Department's Internal Affairs Unit, but rather fell subject to two administrative screening processes, both of which were "wholly subjective, time-consuming, and cumbersome."[1]

Department has taken action to prevent, identify, and respond to abuse—In response to the CRIPA findings, the Department took the following steps:

- Improved juvenile grievance process—The Department changed its juvenile grievance policies and procedures to help ensure juveniles have access to a system that identifies and promptly resolves their grievances. For example, department policy requires any grievance that may involve abuse to be immediately forwarded to the Department's Inspections and Investigations Division for investigation. In addition, department procedure requires department staff to inform juveniles of their right to grieve any condition, circumstance, or action they deem unjust. Further, Juvenile Ombudsmen at the Department's secure care facilities help ensure juvenile grievances get resolved in a timely and just manner. In calendar year 2008, the Department reported that it received 798 juvenile grievances and, according to a department official, 98 percent of juveniles felt satisfied with the outcome.

In 2008, according to a department official, 98 percent of juveniles filing grievances reported satisfaction with the outcome.

- Improved investigations of employee misconduct—In April 2004, the Department created an Inspections and Investigations Division to help ensure the timely investigation of all allegations of abuse and employee misconduct. Department procedure requires that any grievances involving suspected neglect, abuse, or employee misconduct are automatically forwarded to this division for investigation. In addition, procedure requires an Inspections and

1 Acosta, 2004

Investigations investigator to review these grievances within one business day of receipt and determine whether to investigate or refer them back to the appropriate facility superintendent. Employee misconduct can range from alleged policy and procedure violations to criminal acts. In calendar year 2008, the Department's Inspections and Investigations Division reported that it conducted 329 investigations of alleged employee misconduct and found sufficient evidence to support the allegation in 69 investigations.

If the Department determines through its investigations that staff have violated department policies, engaged in misconduct, and/or potentially committed a criminal act, it may discipline or terminate the staff person and potentially pursue criminal prosecution. For example, between December 2008 and July 2009, the Department issued letters of reprimand, suspension, and dismissal to 21 employees for staff misconduct. This misconduct included actions such as giving juveniles food, poor supervision of juveniles, horseplay, inappropriate and racist language, and sexual contact with a juvenile. In addition, of the 78 employees the Department terminated in calendar year 2008, 10, or approximately 13 percent, were terminated because of sexual and physical abuse of juveniles, and other staff-juvenile boundary violations.[1] The Department has also pursued criminal prosecution for 2 of these former staff. In addition, a department official reported that a third former staff member faces possible prosecution pending the county attorney's review of charges.

- A change in organizational culture—In May 2006, the Department launched an initiative known as "ADJC Changing Attitudes and Behaviors" (ACAB) to change its organizational culture. ACAB incorporates the Department's expectations of safe environment, respect, responsibility, and positive communications that help the Department align its efforts with its own vision of safer communities through successful youth. New department staff receive ACAB training as part of the Department's 8-week pre-service training academy. In addition, the Department periodically provides ACAB refresher training as part of staff's annual training requirements. Staff will receive this training in 2009. The Department has also placed ACAB posters throughout its secure care facilities and created a special award, known as a CABBY, to recognize those staff and juveniles who practice ACAB principles.

  In addition, the Department implemented Project Zero Tolerance as part of its cultural change initiative. Through Project Zero Tolerance, the Department publically declared that sexual, physical, and verbal abuse was inappropriate and unacceptable. Further, the Department provided the Director's cell phone number and established an e-mail address where reports of suspected abuse submitted by department staff, families and guardians of committed juveniles, and members of the public go directly to the Department's Director. In accordance with procedure, the Inspections and Investigations Division then investigates all cases of suspected abuse. And, as previously discussed, juveniles can report their concerns through the juvenile grievance process.

Through Project Zero Tolerance, the Department declared that sexual, physical, and verbal abuse was inappropriate and unacceptable.

[1] Other reasons for staff terminations included neglect of duty, insubordination, dishonesty, and absence without approved leave.

- **Assessments for potential victimization**—Department procedure requires mental health staff to assess juveniles for assaultive and sexually aggressive behavior and for risk of sexual victimization upon their admission to the Department's secure care facilities. If the assessment indicates that the juvenile is a potential victim, then mental health staff are required to make a recommendation for any supervision, treatment, or management needs and include a course of action to address the juvenile's potential for victimization in the juvenile's case plan.

- **Vulnerability assessments**—In January 2008, the Department conducted assessments of its secure facilities to identify and address environmental factors, such as blind spots or poor lighting, where juveniles or staff could be vulnerable to sexual victimization. Department officials stated that the issue is particularly problematic for the Department because of the age of its secure facilities, which were designed long before the issue of sexual assault was considered.

Department sets clear staff-juvenile boundaries

The Department has established clearly defined staff-juvenile boundaries to help keep both juveniles and staff safe. Specifically, department policies and procedures and staff training identify appropriate and inappropriate staff-juvenile interactions and behaviors to promote safety and rehabilitation.

Policies and procedures specify appropriate boundaries—Department policies and procedures provide staff with clear guidance on establishing appropriate staff-juvenile boundaries. These policies and procedures require staff to conduct themselves in a professional and courteous manner when dealing with juveniles and limit their relationships with juveniles to professional and job-related activities only. For example, procedures require staff to maintain self-control regardless of provocation; provide consistent guidance and structure to all juveniles; and maintain fair, firm, consistent, and courteous professional behavior with juveniles and their families. In addition, department procedures specifically prohibit staff from accepting any gift from a juvenile, exchanging anything of monetary value with a juvenile, and becoming involved in an intimate relationship with a juvenile.

Department procedures prohibit staff from accepting any gift from a juvenile and becoming involved in an intimate relationship with a juvenile.

Training teaches staff how to maintain professional boundaries—During the Department's 8-week pre-service training academy, new department staff attend several training courses that address staff-juvenile boundaries. For example, the Department's training on professional boundaries provides guidance and skills to new staff on appropriate boundaries and explains that boundaries offer protection by setting limits on behavior between staff and juveniles. Through

role playing and using real-life scenarios in this training and other department trainings, new staff are able to learn and demonstrate the appropriate response to juvenile-initiated boundary breaches, such as a juvenile who asks for favors or compliments a staff member. In addition, new staff learn that juveniles sometimes challenge boundaries to not only test limits with and manipulate staff, but also to determine if their environment is safe. These skills and knowledge are reinforced by other department training courses as well.

In addition, department trainings on boundaries emphasize that by setting clear boundaries, staff teach delinquent juveniles pro-social behaviors and appropriate social interaction. Given that part of the Department's stated mission is to change the delinquent thinking and behavior of juveniles, appropriate staff-juvenile boundaries play an essential role in helping the Department realize its mission.

Department trainings on boundaries alert staff to the evolution of boundary breaches.

Department trainings on boundaries also alert staff to the evolution of boundary breaches. Boundary breakdowns can begin with inappropriate but less serious breaches, such as using pet names, verbal sparring and joking, failure to re-direct juvenile misbehavior, or coming down too hard or easy on a juvenile. Although these types of boundary violations may initially seem inconsequential, they may progress to more serious violations that can potentially compromise safety and undermine department efforts to correct anti-social behavior. To demonstrate this evolution, the Department's training on professional boundaries uses an actual case wherein a department staff member initially brought in deodorant and toothpaste for a juvenile, then allowed this juvenile to bully him, and finally brought pornography in for the juvenile.

Finally, new department staff and juveniles receive training on the Prison Rape Elimination Act, a federal law aimed at addressing the problem of sexual abuse of incarcerated persons through prevention and detection. In particular, this training teaches juveniles how to recognize sexual abuse and their rights not to be victims of it. The Department also hangs posters throughout its facilities to reinforce this message. A department official reported that continuing department staff received this training in 2008. In addition, the Department included the Correctional Professional, a training on boundaries, as part of its 2008 annual training requirements for department staff. According to a department official, the Department will also provide this training on an as-needed basis. Further, as part of its 2009 annual training requirements for department staff, the Department has included ACAB training on its organizational expectations of safe environment, respect, responsibility, and positive communications; and cultural competency training.

Some minor yet inappropriate staff-juvenile interactions observed at all facilities

Despite these policies and training and reported staff efforts to maintain appropriate boundaries with juveniles, there are instances where staff-juvenile boundary issues continue to present challenges for the Department. Specifically, auditors observed instances where more subtle boundary violations occurred. Further, new department staff, who spend time at secure care facilities as part of the pre-service training academy, have also noted instances of staff-juvenile boundary violations at these facilities. However, the Department has taken action to address some staff-juvenile boundary violations by redirecting juveniles or disciplining staff.

Staff-juvenile boundaries an issue for experienced and new staff—

Auditors observed several instances of staff-juvenile boundary violations.

During visits to the Department's secure care facilities in March 2008, June through August 2008, and May 2009, auditors observed several instances of staff-juvenile boundary violations. These violations included lack of staff redirection of juvenile misbehavior, inappropriate language, and generally inappropriate interaction with juveniles. As prescribed by department policies and trainings, these observed behaviors and interactions are considered inappropriate and unprofessional. In addition, auditors observed two interactions of secure care management staff with juveniles that showed that even veteran staff experience challenges with staff-juvenile boundaries. For example:

1. **Unit manager uses nickname with juvenile**—During an interview with a unit manager at one of the Department's secure care facilities, this manager explained that she and her staff exercise good boundaries with the juveniles because they talk about boundaries at debriefings and receive training on them. About 20 minutes after this interview, auditors observed this same unit manager asking a juvenile to leave her office because she needed to unlock the unit door to let someone leave. This unit manager said to the juvenile, "…Oh sweetheart, you need to leave now…"

   This unit manager displayed no recognition that using the term "sweetheart" was a pet name and a staff-juvenile boundary violation according to department training.

2. **Facility superintendent banters with and fails to redirect juvenile**—Auditors observed a juvenile hanging out of the door of a trailer where treatment programming was occurring. The juvenile yelled to a passing facility superintendent. The two then began to banter back and forth with the facility superintendent noting that he has known the juvenile so long that "…hey, I used to change your diaper…" The juvenile remained hanging out of the trailer throughout this 20-30-second interaction until staff in the trailer finally redirected the juvenile to return to programming.

Superintendent—Has responsibility for daily operations at a juvenile correctional facility, similar to a warden of an adult prison.

Both the failure to immediately redirect the juvenile, and the bantering and joking between the facility superintendent and the juvenile represented staff-juvenile boundary violations, according to department training.

Based on auditors' observations of several boundary violations during their visits to secure care facilities in March 2008, June through August 2008, and May 2009, it appears that these violations can occur, but may not be addressed by supervisors or management because either they do not know about them or they do not recognize them as violations.

New staff in training have observed numerous boundary issues—As part of the Department's pre-service training academy, new staff receive on-the-job training (OJT) in actual housing units at the Department's secure care facilities. At the end of their OJT, these new staff complete a written debriefing of their experience, noting any discrepancies between observed staff behaviors or practices at the secure care facilities and academy training. This debriefing is then submitted to academy staff. For the fiscal year 2009 academy classes, auditors reviewed 331 OJT written debriefings and found that 85 of the new staff, or approximately 26 percent, reported observing a staff-juvenile boundary issue. The most common staff-juvenile boundary violations noted included inappropriate handshakes; language; touching, such as hugging and pushing; and using nicknames.

Department actions can help to maintain appropriate staff-juvenile boundaries—The Department has taken action to address some staff-juvenile boundary violations committed by both staff and juveniles. As previously discussed, between December 2008 and July 2009, the Department issued letters of reprimand, suspension, and dismissal to 21 employees for staff misconduct. In addition, between April and July 2009, the Department provided numerous incident reports where staff documented their efforts to redirect juvenile misbehavior in accordance with department policies, procedures, and trainings on boundaries. These reported efforts frequently included counseling juveniles about their misbehavior and, when necessary, restraining them and placing them in separation when their behavior posed a danger to themselves or other juveniles. Finally, a department official explained that a juvenile's treatment team also holds him or her accountable for misbehavior and addresses this behavior accordingly. However, auditor observations and OJT debriefings suggest that more subtle staff-juvenile boundary issues continue to be a challenge for the Department.

Increased communication and awareness needed to reinforce appropriate staff-juvenile boundaries

The Department should take some additional steps to reinforce appropriate staff-juvenile boundaries. These steps include heightening staff awareness of staff-juvenile boundary issues, further prioritizing these issues as essential to promoting safety, and using OJT written debriefing information to identify and address "hot spots" for boundary issues.

Heighten awareness of and prioritize staff-juvenile boundary issues—Although the Department's training emphasizes the need for and creates an awareness of appropriate staff-juvenile boundaries for new staff, this emphasis and awareness should continue for staff as they remain on the job. Auditors conducted 12 interviews with secure care staff and supervisors across several housing units at Adobe Mountain School and found that discussion of staff-juvenile boundaries generally occurred only after a boundary breach had happened rather than as a daily communication reinforcing the safety and security benefits of boundaries. In particular, although six of six secure care-line staff reported that their supervisors regularly discussed general housing unit and safety and security issues with them, these same staff also said that their supervisors either did not include or seldom included discussion of staff-juvenile boundaries as regular feedback on their job performance. Similarly, six of six housing unit supervisors reported that facility management infrequently addressed staff-juvenile boundaries as regular feedback on their job performance. However, three of these supervisors reported that they discuss staff-juvenile boundaries with their housing unit staff. Additionally, as previously discussed, auditors' observations of several boundary violations during their visits to secure care facilities suggest that these violations can occur, but may not be addressed by supervisors or management because either they do not know about them or they do not recognize them as violations.

Therefore, the Department should expand its efforts to increase staff awareness of boundary issues by launching an awareness campaign that continually reinforces appropriate staff-juvenile boundaries and the range of behaviors that may violate these boundaries. In particular, the Department should adapt its current trainings on boundaries to an annual refresher required of all staff. In addition, the Department should provide staff with a daily visual reminder, similar to the ACAB posters, that reinforces the need for staff-juvenile boundaries and further prioritizes staff-juvenile boundaries as a safety issue.

Make better use of OJT written debriefing information to identify "hot spots" for staff-juvenile boundary issues—OJT written debriefings provide useful information that can help department management determine where boundary issues occur. According to a department official, although the Department provides these training evaluations to secure care facility

superintendents upon request, the Department does not consistently provide them with all of the evaluations. One superintendent indicated that it would be helpful if he received all written debriefings related to his facility. The Department should consistently provide all OJT written debriefings to secure care facility superintendents.

In addition, according to a department official, the Department does not track or report on OJT debriefing information. However, analysis of this information would help the Department determine the extent of problems identified by the debriefings. Given the potential usefulness of debriefing information, the Department should improve its process for systematically analyzing OJT written debriefing information to help identify staff-juvenile boundary issues at secure care facilities, determine the prevalence of such issues at these facilities, and develop and implement action plans to address any problems. Additionally, the Department should follow up on the implementation of the action plans to ensure that the actions have addressed the problems.

Recommendations:

3.1. The Department should launch an awareness campaign that continually reinforces appropriate staff-juvenile boundaries and the range of behaviors that may violate these boundaries by doing the following:

a. Adapt its current trainings on boundaries to an annual refresher required of all staff, and

b. Provide staff with a daily visual reminder, similar to the ACAB posters, that reinforces the need for staff-juvenile boundaries and further prioritizes staff-juvenile boundaries as a safety issue.

3.2. The Department should consistently provide all OJT written debriefings to secure care facility superintendents.

3.3. The Department should improve its process for systematically analyzing OJT written debriefing information to help:

a. Identify staff-juvenile boundary issues at secure care facilities;

b. Determine the prevalence of such issues at secure care facilities;

c. Develop and implement action plans to address any problems; and

d. Follow up on the implementation of action plans to ensure that the actions addressed the problems.

APPENDIX A

Methodology

Auditors used various methods to study the issues addressed in this report. These methods included interviewing Arizona Department of Juvenile Corrections (Department) management and staff; observing operations at each of the Department's four secure care facilities between March and August 2008, and April and May 2009; and reviewing statutes, policies and procedures, and various reports and documents related to the U.S. Department of Justice Civil Rights of Institutionalized Persons Act investigation that began in 2002.

Additionally, auditors assessed the Department's internal control structure that supports the collection and management review of data from incident reports such as fights, assaults, and suicidal behavior to determine the completeness and reliability of the database where this information is maintained. Auditors' work on the controls over the Department's data included assessing the completeness and accuracy of applicable policies and procedures; interviewing various staff and management responsible for data input accuracy to assess supervisory controls over data input and various data checking mechanisms in place at the Department; observing critical controls over the data, including but not limited to meetings where incidents are reviewed by staff and confirmed as accurately reported; and reviewing department quality assurance audits, which include reviews of incident report data accuracy. Auditors did not assess the Department's data processing and reporting internal controls because this work was not within the scope of the audit objectives.

Based on auditors' review and understanding of the Department's overall internal control structure over incident report data collection and management review, auditors determined that the internal controls are adequate to offer assurance that the risk of error is acceptable for auditors to rely on these data for conclusions in audit findings in the report.

Auditors also used the following specific methods:

- To determine whether the Department has sufficient and appropriate policies and procedures and follows these policies and procedures to keep potentially suicidal juveniles safe from harm, auditors reviewed best practice information from *PbS Goals, Standards, Outcome Measures, Expected Practices and Processes April 2009* published by the PbS Learning Institute and Juvenile Suicide in Confinement: A National Survey by Lindsay M. Hayes.[1,2] Auditors also reviewed the 158 incident reports involving suicide threats made by juveniles or juveniles who engaged in self-harming behavior listed on the Department's incident report tracking logs between March 23, 2009 and May 15, 2009, and compared juveniles listed on the Department's suicide prevention status list to the Department's incident-report-tracking logs for every day during the same time period. Additionally, auditors interviewed facility housing unit staff at the four facilities to determine whether staff understood and were following the Department's suicide prevention policy and procedures. Finally, auditors reviewed twelve 2008 and 2009 internal quality assurance audits of the Department's four facilities.

- To evaluate the Department's efforts to reduce violence at its secure care facilities and the internal controls the Department has established to prevent and respond to violent incidents, auditors reviewed and analyzed department juvenile-on-juvenile assault and fight data from January 1, 2007 through March 31, 2009, observed various department management meetings, and reviewed department treatment and programming manuals. Auditors also selected seven total incidents of juvenile violence (at least one from each of the Department's four secure care facilities) that occurred between February and April 2009 for review. Auditors then reviewed documentation related to the incidents and interviewed staff and supervisors at each of the Department's four facilities that were involved in these incidents.

- To determine whether appropriate boundaries exist between staff and juveniles and the internal controls the Department has to ensure appropriate interactions between staff and juveniles, auditors reviewed 331 debriefing forms completed by new staff after their on-the-job training between August 2008 and March 2009. Auditors also reviewed the Department's professional boundaries training curriculum and information related to the Department's culture change initiative. Finally, auditors observed staff-juvenile interactions in March 2008, June through August 2008, and May 2009.

- To provide information for the report's Introduction and Background, auditors summarized information from the Joint Legislative Budget Committee's appropriations reports for fiscal years 2005 and 2006, the Department's 2004 through 2007 annual reports, the Department's Web site, and other agency-provided documents.

1 *Council of Juvenile Correctional Administrators.,* 2009

2 Hayes, 2004

AGENCY RESPONSE

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Dear Ms. Davenport:

This is the Arizona Department of Juvenile Corrections' (ADJC or "the Department") response to your preliminary draft performance audit of the Arizona Department of Juvenile Corrections – Suicide Prevention and Violence and Abuse Reduction Efforts ("the Report"). The Department is gratified by your team's conclusion that ADJC's secure facilities have become far safer places for the juveniles committed to ADJC. We believe that the achievements you noted also result in increased safety for our staff. Just as importantly, the Department knows that only by providing a safe environment can it successfully accomplish its mission of enhancing public safety by changing the delinquent thinking and behaviors of the youth committed to it. Your findings reflect the hard work and determination of well over 1000 Department employees for the past five years. As the audit report also recognizes, this agency's commitment to further improvement is ongoing. In fact, it is as strong as ever.

Although the Report briefly and fairly discusses the Department's history, the auditors naturally focused on the period during which they conducted their review. The Department believes that placing their findings in historical context will provide the reader further appreciation of their significance, particularly as ADJC prepares for its statutorily mandated sunset review.

ADJC was created in 1989 when the State Legislature separated it from the Arizona Department of Corrections. Establishing a stand-alone juvenile corrections agency demonstrated this State's recognition that the needs of juveniles in the corrections system are substantially different from those of adult inmates both because of the developmental differences between the two populations and as a matter of constitutional law. The juvenile justice system rests upon the foundational notion that juveniles who commit crimes are capable of change. The Legislature codified that principle at ARS §§ 41-2801, *et. seq*, the Departments enabling statutes, when it created the Department.

ADJC's establishment was in large part a response to *Johnson, et. al. v. Upchurch, et. al.* (D. Ariz, No. CIV-86-195-TUC-RMB), a class action conditions of confinement lawsuit filed

against the Department of Corrections in 1986. The juvenile plaintiffs in that case, who were incarcerated in Catalina Mountain School (then called Catalina Mountain Juvenile Institution) in Tucson, contended that Arizona was violating their constitutional rights by failing to provide adequate treatment, rehabilitation, and education, by isolating them without due process of law, and by subjecting them to physical and emotional mistreatment. The case was resolved by a consent decree signed by the parties in 1993, which provided for federal court monitoring to ensure the implementation of the agreement by the newly created Department. When the case ended in 1998, ADJC was found to have successfully addressed its legal deficiencies.

Unfortunately, despite millions of dollars spent and more than five years of work during *Johnson v. Upchurch*, sustaining change proved more difficult than creating it. As the auditors' Report discusses, just five years after *Johnson v. Upchurch* was dismissed, ADJC was once again subject to federal monitoring. The gains made over the course of a decade unraveled to the point where three juveniles housed at Adobe Mountain School in Phoenix committed suicide within one year (2002-2003), prompting investigation by the United States Department of Justice (USDOJ) pursuant to the federal Civil Rights of Institutionalized Persons Act (CRIPA). The USDOJ conducted an inspection and review of ADJC facilities in 2002-2003, resulting in the filing of *United States v. The State of Arizona, et. al.* (D. Ariz., No. CV-04-01926-PHX-EHC) in federal district court on September 15, 2004.

As your Report notes, the USDOJ's January 2004 investigative report detailed numerous serious deficiencies at ADJC. The wide range of issues included the physical conditions of the Department's secure care facilities, suicide prevention, and protection of juveniles from harm, as well as treatment issues including special education programming, treatment programming and medical and mental health services.

On September 15, 2004, the State and the USDOJ entered into a Memorandum of Agreement that required ADJC to correct its deficiencies by enacting over 120 specific provisions. The deadline for compliance was September 15, 2007. The USDOJ appointed a four member "Committee of Consultants," all nationally recognized experts on juvenile corrections practices, to monitor the Department's progress. On September 15, 2007, the USDOJ dismissed its lawsuit against the Department as scheduled. In the Committee of Consultants' final monitoring report, they found ADJC to have achieved substantial compliance with every provision of the CRIPA agreement in just three years. Department staff and administrators are rightfully proud of that accomplishment.

In its approach to implementing the CRIPA agreement, the administration of this Department sought from the outset to design and carry out a plan of action *not* focused on complying with the CRIPA agreement; the necessity of compliance was a given. Instead, ADJC conceived a strategy for transforming the agency in a manner that would sustain the gains made in order to achieve compliance *after* the Department of Justice and their concluded their work in Arizona.

From the perspective of ADJC's administration, every Department action between 2003 and 2007 was formulated and taken in order to avoid a repeat of the Department's post-*Johnson v. Upchurch* regression. Thus the Department welcomed this audit of CRIPA issues related to the safety of juveniles in ADJC facilities. We believed that ADJC had not only avoided backsliding, but had continued to improve conditions for juveniles since the CRIPA lawsuit's dismissal. The Department is pleased that the audit team examined ADJC using the standards of the federal monitors in CRIPA and confirmed that those standards are still being followed, and ADJC facilities are safer for juveniles today than they were even at the conclusion of the CRIPA case in 2007.

To be sure, ADJC remains a work in progress. With the aftermath of *Johnson v. Upchuch* always in mind, we are not satisfied with the improvements we have made. Nor is ADJC complacent regarding the continuous planning and effort necessary to avoid reverting to unsafe conditions. Our challenge is only heightened by the State's unprecedented economic challenges – the substantial budget reduction the Department has already borne and the likely prospect of further cuts. That said, I would be remiss if I did not express my pride in ADJC staff and all we have accomplished together.

Just five years ago, ADJC garnered notoriety in Arizona and in the national juvenile corrections community. Some juvenile court judges publicly expressed reluctance to commit offenders to the Department, fearing for their safety. Today, this Department has regained the trust of the judiciary, and it serves as a resource, fielding inquiries from sister agencies around the country, often at the suggestion of DOJ attorneys or the nationally recognized experts who monitored us.

The Department responds to the Report's specific findings and recommendations as follows:

Findings and Recommendations

The Department's concurrence in the audit team's three findings does not constitute agreement with all of the specifics in the report. However, rather than addressing specific areas of disagreement with the audit report narrative, the Department believes it is more productive to look forward by responding to the audit team's findings and recommendations.

Finding 1: The Department has improved suicide prevention practices, which promote safety, but minor improvements are possible.

The Department agrees with the finding.

Recommendations:

1.1 The Department should continue its plan to monitor current procedures to develop and implement more specific guidelines for mental health staff related to the treatment expectations for juveniles who have been identified as having suicidal or self-injurious behaviors.

The Department will implement the recommendation. The recommendation itself reflects that the Department is already in the process of complying. Doing so is part of ADJC's ongoing strategy for institutionalizing and building upon the gains made during CRIPA.

1.2 The Department should continue to monitor juveniles' treatment plans to ensure that they address the suicidal or self-injurious behavior and that its modified procedures have been implemented by all staff.

The Department will implement the recommendation. The recommendation itself reflects that the Department is already in the process of complying. Doing so is part of ADJC's ongoing strategy for institutionalizing and building upon the gains made during CRIPA.

1.3 The Department should expand its regular assessments of its separation practices to include the review of unnecessary and/or inappropriate referrals for juveniles exhibiting suicidal and/or self-injurious behavior and take appropriate actions based on what it finds.

The Department will implement the recommendation. The recommendation itself reflects that the assessments to which it refers are in progress. ADJC has begun to assess practices in this area as part of its regular Quality Assurance process. ADJC notes, however, that it will always train staff to err on the side of safety where there is concern that a juvenile is contemplating self-harm. This is especially so when a corrections officer must make a decision as an incident unfolds and before a qualified mental health professional is available. In the best of circumstances, it is sometimes difficult for staff to spend the one-on-one time necessary to determine the seriousness of any threat to self. Doing so may prove increasingly difficult as ADJC absorbs further budget reductions.

1.4 The Department should ensure that juveniles are not placed in suicide-proof smocks unless a qualified mental health professional deems it necessary as stated in policy. If suicide-proof smocks are not used appropriately, the Department should take steps to re-align facility practices with its procedures and best practices.

The Department will implement the recommendation. As the Report states, the Department believes it has already corrected this issue.

1.5 Department should ensure that its staff prepare an incident report for all juveniles placed on its daily suicide prevention status list.

The Department will implement the recommendation. As the Report states, the Department believes it has already corrected this issue.

Finding 2: Department data shows decreased juvenile violence at its facilities; Department should continue its efforts to reduce violence.

The Department agrees with the finding.

Recommendations:

2.1 The Department should review its staff resources and assess whether it has sufficient staff to maintain staff-to-juvenile ratios agreed to with the U.S. Department of Justice or needs additional staff to do so. If additional staff resources are needed, the Department should review and consider various options for obtaining these resources, including shifting internal staff resources or working with the Legislature to obtain additional staff resources.

The Department will implement the recommendation.

2.2 The Department should continue to monitor the level of violence within its secure care facilities, assess whether its actions and practices are having a positive impact on reducing violence, and adjust when necessary if it finds that these actions and practices no longer help to sustain reduced levels of violence.

The Department will implement the recommendation. The recommendation itself reflects that the practice to which it refers is in progress and has been successful.

2.3 The Department should review documentation for incident debriefings to ensure that supervisors conduct debriefings within the time frame allotted and include direct care staff involved in the incident, as required by procedure.

The Department will implement the recommendation.

Finding 3: Department has taken some successful steps to address abuse, but can further strengthen staff awareness of appropriate staff-juvenile boundaries.

The Department agrees with the finding.

Recommendations:

3.1 The Department should launch an awareness campaign that continually reinforces appropriate staff-juveniles boundaries and the range of behaviors that may violate these boundaries by doing the following:

a. Adapt its current trainings on boundaries to an annual refresher required of all staff.

b. Provide staff with a daily visual reminder, similar to the ACAB posters, that reinforces the need for staff-juvenile boundaries and further prioritizes staff-juvenile boundaries as a safety issue.

The Department will implement the recommendation. As the auditors found, the Department has invested a great deal of effort in establishing and reinforcing appropriate professional boundaries between staff and youth. While not required by the CRIPA agreement or the federal monitors, this initiative was and remains part of ADJC's strategy for sustaining and improving upon CRIPA gains.

3.2 The Department should consistently provide all OJT written debriefing information to secure care facility superintendents:

The Department will implement the recommendation.

3.3 The Department should improve its process for systematically analyzing OJT written debriefing information to help:

a. Identify staff-juvenile boundary issues at secure care facilities;

b. Determine the prevalence of such issues at secure care facilities;

c. Develop and implement action plans to address any problems; and

d. Follow up on the implementation of action plans to ensure that the actions addressed the problems.

The Department will implement the recommendation.

Conclusion

Despite unprecedented fiscal challenges, ADJC is committed to fulfilling its statutory and constitutional responsibilities to the citizens of Arizona and the juveniles and families we serve. We remain dedicated to consolidating the gains made under the CRIPA agreement and building on them.

ADJC appreciates the contributions to that effort made by the audit team as well as their professionalism and cooperation throughout the audit process.

Sincerely,

Michael Branham
Director

Performance Audit Division reports issued within the last 24 months

07-10 Department of Economic Security—Division of Child Support Enforcement
07-11 Arizona Supreme Court, Administrative Office of the Courts—Juvenile Detention Centers
07-12 Department of Environmental Quality—Vehicle Emissions Inspection Programs
07-13 Arizona Supreme Court, Administrative Office of the Courts—Juvenile Treatment Programs

08-01 Electric Competition
08-02 Arizona's Universities—Technology Transfer Programs
08-03 Arizona's Universities—Capital Project Financing
08-04 Arizona's Universities—Information Technology Security
08-05 Arizona Biomedical Research Commission
08-06 Board of Podiatry Examiners

09-01 Department of Health Services, Division of Licensing Services—Healthcare and Child Care Facility Licensing Fees
09-02 Arizona Department of Juvenile Corrections—Rehabilitation and Community Re-entry Programs
09-03 Maricopa County Special Health Care District
09-04 Arizona Sports and Tourism Authority
09-05 State Compensation Fund
09-06 Gila County Transportation Excise Tax
09-07 Department of Health Services, Division of Behavioral Health Services—Substance Abuse Treatment Programs
09-08 Arizona Department of Liquor Licenses and Control

Future Performance Audit Division reports

Arizona Department of Juvenile Corrections—Sunset Factors

Department of Health Services—Sunset Factors