

Conditions of Confinement at the Arkansas Juvenile Assessment and Treatment Center

*Submitted to the
National Center for Youth Law and the Disability Rights Center
August 13, 2007*

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Executive Summary

The following report was prepared in the wake of considerable turbulence at the Arkansas Juvenile Assessment and Treatment Center (Alexander). A long and troubling history of poor practice and mistreating youth in custody resulted in terminating the contract with the previous private provider that operated Alexander. In January 2007, G4S Youth Services, LLC (G4S) assumed operational control of Alexander. Since that time, a number of substantiated incidents of mistreating youth in custody at Alexander have surfaced, prompting the National Center for Youth Law and the Disability Rights Center to request the assistance of experts to evaluate the adequacy of measures taken at Alexander to protect youth from harm.

It was also against this backdrop, in March 2007, that the Arkansas State Legislature took action, in the form of Senate Resolution 31, “to evaluate needed reforms to the state’s juvenile justice system to more effectively and efficiently serve youth committed to the Division of Youth Services of the Department of Health and Human Services and to identify best practices that will reduce unnecessary reliance on large juvenile correctional facilities and promote the development of an appropriate continuum of community based treatment alternatives in the least restrictive setting possible consistent with public safety.” (emphasis added). The authors of this report hope that its contents, observations and recommendations can form a useful foundation from which to pursue the work contemplated by SR 31.

This report details a series of issues that compromise the safety of youth at Alexander. Based upon numerous interviews with facility administrators, line staff and more than two dozen youth, as well as a review of individual case files, operational policies and procedures, and other documentary evidence, we offer a comprehensive series of observations and recommendations intended to directly address the most common sources of harm to youth in secure correctional confinement: the risk of harm from themselves, from other youth, and from staff.

In the authors’ view, however, the over-reliance on secure correctional confinement of young people who do not require this most expensive and restrictive level of custody to protect public safety and promote law-abiding behavior is the most pressing and pervasive issue compromising the safety of youth at Alexander. A growing body of evidence indicates that exposing youth to secure correctional confinement is detrimental and *increases* rather than decreases their likelihood of further penetrating the justice system. Of the 647 youth committed to secure Division of Youth Services facilities during FY 2006, only 212 (33%) were committed for “person” offenses. Only 29 of the 647 youth (4%) were committed for the most serious “Y” felonies, while more than twice that number, 72 youth (11%), were committed for “public order” misdemeanors such as Disorderly Conduct. In FY 2006, a full 45% (293 of 647) of all DYS

commitments to Youth Service Centers were for misdemeanor offenses. In the first quarter of 2007, only 16% of DYS commitments were for felony offenses against persons.

These and other similar data contained in the body of this report confirm that a large percentage of the Alexander population are confined as a result of Violations of Probation (typically technical violations involving no new criminal charges), Misdemeanor law violations, disruptive behavior at school including fights, treatment program violations, as well as for offenses involving public order, property and or drug use, rather than for any “violent” behavior. Such youth are misplaced in a high-security facility such as Alexander and would benefit from thoughtful, individualized programming and supervision in their home communities.

In addition, many of the youth incarcerated at Alexander experience serious mental illnesses, emotional disturbances and/or developmental disabilities and struggle to comply with facility regulations while suffering near-constant torment by other youth, as well as by some staff. According to G4S administrators, approximately 30 percent of the Alexander population is inappropriate for placement at the facility and for their program by virtue of the youths’ intellectual, emotional, and/or developmental disabilities. These youth fill beds at Alexander in part because no other more appropriate alternative exists.

While there is no doubt that a segment of the Alexander population poses an unacceptable risk to public safety and requires safe and therapeutic forms of secure care, these youth are in a distinct minority. It is the consensus of those DYS officials, G4S staff and administrators, and others with whom we spoke that many, if not most, of the youth confined at Alexander could be safely managed and well monitored using various community-based programming techniques. By drawing upon well-established community-based supervision and support models to build a full continuum of care, Arkansas officials could redirect scarce funding from maintaining expensive institutions to building local programming in the home communities of Arkansas’ most needy youth and families. Such an approach would not only prove far more beneficial to the youth currently confined at Alexander, but could also help drive an economic development engine targeting the most impoverished communities in the state.

It is our opinion and our primary recommendation that the most effective way to ensure the safety of the greatest number of youth is for the Arkansas Division of Youth Services to undertake an aggressive, transformative initiative to reduce the population at Alexander by approximately two-thirds through the design of safe and effective, individualized supervision plans that emphasize home and other community placements, and by reconfiguring secure care in Arkansas to reflect current best practices in the field by permanently closing Alexander and replacing it with one or possibly two secure, therapeutic facilities each with no more than 40 beds.

Included among our other recommendations for immediately improving the safety of youth at Alexander while broader systemic reforms occur are the following:

- Reduce the exposure of low-risk youth to confinement at Alexander by applying a validated external risk assessment instrument to help identify youth who can be safely managed in their home communities.
- Accelerate the thoughtful and well-planned discharge and subsequent supervision of youth currently in secure confinement by systematically targeting misdemeanants, probation violators and other non-violent offenders for the development of individualized, community-based plans into which youth can be discharged with an assurance that supervision and support will be available to guide their success.
- Develop a willing cadre of non-residential, neighborhood-based service providers who operate diverse and culturally competent programming in or near the home communities of DYS youth, and who are committed to working with challenging youth and willing to enter into “no eject – no reject” policies as part of their service contracts.
- Examine models of “fiscal realignment” developed in several other states that encourage local jurisdictions to treat low-risk youth locally rather than committing them to DYS for assignment to Alexander.
- Ensure that staff ratios at Alexander are met consistently and that they represent the number of staff actually deployed to supervise youth at any given time. Ensure that all staff provide vigilant, pro-active supervision designed around positive interaction with youth and efforts to identify and de-escalate tensions before they develop into violent confrontations.

Introduction

A series of recent events involving the safety of youth confined at the Arkansas Juvenile Assessment and Treatment Center (Alexander) prompted a request from the National Center for Youth Law (NCYL) and the Disability Rights Center (DRC) for an assessment of the conditions of confinement and the adequacy of measures to protect youth from harm. Alexander became the focus of much unwanted attention and concern by media, youth advocates and state officials in late 2006 with the revelation that the contracted operator of the facility at that time had forcibly medicated youth in its care. The subsequent termination of that contract and the transfer of operational control of the facility to G4S Youth Services, LLC (G4S) in January 2007 appeared to address the immediate concern caused by the previous contractor, but several more recent substantiated incidents of violence against youth by members of the G4S/Alexander staff fostered lingering worries for the safety of youth confined in that facility.

We toured the Alexander, from June 5 through 8, 2007, during which time we saw all housing units, dining areas, the gym, medical unit, most school areas and recreation yards as well as administrative areas. We also interviewed 30 youth in secure confinement at Alexander, as well as the newly appointed Directors of the Department of Human Resources (DHS) and the Division of Youth Services (DYS), and large numbers of DHS and G4S staff. We also reviewed a range of documents relating to facility operations. (See appendix A for a complete listing of staff interviewed and documents reviewed.) Despite limited access to some key documents¹, we have assembled in this report several observations and recommendations that we hope will prove helpful to G4S, DHS and youth advocates around the state as together they struggle to ensure the safety of those Arkansas youth confined in secure correctional facilities. While the majority of our commentary focuses on the operational practices of G4S, to be clear, DHS is ultimately accountable for the performance of its private contractors and thus is responsible for enacting the various remedies required to protect youth from harm. In addition to implementing required reforms, DHS must also ensure that information is freely exchanged between the various agencies involved (e.g., DHS, G4S, State Police, etc.) so that reforms may be implemented without unnecessary duplicity.

¹ Once on site, we were informed that we could not access many key documents based on confidentiality concerns. In some cases, DHS agreed to provide access to certain documents pertaining only to DRC clients (institutional/medical/mental health/education files; documents pertaining to suicide precautions) and in other cases, G4S staff examined the relevant document and reported the findings to us (e.g., log book with information pertaining to a single instance of room confinement). In still other cases, we received copies of documents with the names of youth redacted. In most cases, however, we were denied access to many critical documents. As a result, some of our observations are based on information gleaned from youth and staff interviews and observations of facility operations.

What emerged during the course of our review was an image of a facility, indeed an entire juvenile justice system, struggling to keep pace with the relentless influx of predominantly non-violent youth committed to DYS custody. On June 7, 2007 there were 70 youth (28 of whom were Misdemeanants) committed to DYS custody who were waiting, sometimes for months, in local detention centers until space was created for their absorption into DYS facilities. Alexander's intake staff, case managers, trackers and youth care workers struggle to stay ahead of the constant stream of relatively low-risk youth being added to the system weekly. We witnessed the well-intended but somewhat ad hoc efforts of DYS clinical staff at Alexander to manage the flow by attempting to target misdemeanants for swift release. We heard frustrated theories and countless anecdotes that "the judges send too many misdemeanants", "private providers won't take difficult kids or kick kids out of their programs too quickly" or "technical probation violations and aftercare failures are the biggest problem" to explain the rate at which low-risk youth are committed to costly secure correctional confinement.

Perhaps most striking was the consensus among virtually everyone with whom we spoke that large numbers of youth at Alexander are inappropriately placed in that high-security correctional setting. High-security correctional environments are appropriate only for that small segment of youth that is particularly violent or that presents an appreciable escape risk. In contrast, many of the youth at Alexander are seriously mentally ill, emotionally disturbed and/or developmentally disabled youth who struggle to comply with facility regulations while suffering near-constant torment by other youth, as well as by some staff. (One boy who had been at Alexander for nearly a year has a full-scale IQ of 47.) According to G4S administrators, approximately 30 percent of the Alexander population is inappropriate for placement at the facility and for their program by virtue of the youths' intellectual, emotional, and/or developmental disabilities. These youth, say G4S administrators, are unable to benefit from their confinement at Alexander. They are commonly the most difficult to protect from other youth and they stretch the patience of staff to dangerous breaking points.

Of equal concern is the large number of youth whose crimes and history suggest that they pose little or no physical threat to public safety. These youth, identified during our interviews with both staff and youth, confirmed that a large percentage of the Alexander population is confined as a result of Violations of Probation (typically technical violations involving no new charges), Misdemeanor law violations, disruptive behavior at school including fights, treatment program violations, as well as for offenses involving public order, property and or drug use, rather than for any "violent" behavior. Although these behaviors by adolescents are difficult, challenging, even maddening to deal with, they are seldom truly dangerous and should not be managed by reliance on our most expensive and extreme correctional option.

While there is no doubt that a segment of the Alexander population poses an unacceptable risk to public safety and requires safe and therapeutic forms of secure

care, these youth are in a distinct minority. It was the consensus among those DYS officials, G4S staff and administrators, and others with whom we spoke that many, if not most, of the youth housed at Alexander could be safely managed and well monitored using various community-based programming techniques. In fact, it is our estimate, based on interviews and available data regarding committing offenses and histories of youth at Alexander, that approximately 100 of the facility's 140 youth should be transitioned home or into other community-based settings with the support of a range of local services designed to ensure public safety and guide the youth on a constructive path to adulthood.

This over-reliance on secure correctional custody for youth who could be safely managed in less restrictive settings is not only wasteful from a fiscal standpoint, it is also inconsistent with the stated goals and mission of DYS to, *"Provide safe, secure, effective individualized treatment for juveniles to enhance integration back to society with the life-skills that promote a crime-free life style."* Treatment that is characterized largely by placement in a setting that was not designed to and is not capable of meeting the youth's specific needs can hardly be called effective or individualized. Relying on secure custody for the many low-risk youth at Alexander is also at odds with the role of Alexander as defined in the DHHS/DYS 2007-2009 Budget Request: *"Alexander Juvenile Correctional Facility provides centralized intake for juveniles committed to [the] Division. The target population of juveniles assigned to Alexander is the most serious violent offenders, difficult to place sexual offenders, and juveniles who disrupted a placement due to behavior management issues."*

DYS possesses the statutory authority to manage most committed youth in the setting it believes is best suited to protect public safety and to rehabilitate the youth. Alexander, therefore, does not have to be the default placement for so many non-dangerous youth, and every effort should be made to alter this long-standing practice of relying on Alexander and other forms of secure correctional confinement to manage challenging youth. To be clear, DYS has the statutory authority to manage these youth in other settings that are better suited to safely address their many needs than is possible at Alexander.

In spite of all this, and perhaps because if it, DYS is presented with a clear choice – either continue to pour money into the sprawling Alexander, or transform itself into a system worthy of the children and families of Arkansas. New executive leadership, unencumbered by decades of practice within failed juvenile correctional models, brings with it new hope that secure correctional confinement will be reserved only for those Arkansas youth who pose a legitimate threat to public safety, and the rest can be managed with the aid of willing local service providers committed to ensuring public safety and the safety of youth through the thoughtful and creative use of community-based services in the home communities of DYS youth.

It is our opinion, an opinion shared by many individuals with whom we spoke that the most effective way to ensure the safety of the greatest number of youth is to undertake an aggressive, transformative initiative to reduce the population at Alexander by approximately two-thirds through the design of safe and effective, individualized supervision plans that emphasize home and other community placements, and by reconfiguring secure care in Arkansas to reflect current best practices in the field by permanently closing the Alexander and replacing it with one or possibly two secure, therapeutic facilities each with no more than 40 beds.

It is our opinion that the conditions of confinement described below are in part a product of the muddled role Alexander is forced to fill. As home to all of the state's confined juvenile sex offenders, most of the state's violent offenders, girls committed for a wide variety of offenses, and a vast assortment of other far less serious but nonetheless *needy* youth, Alexander is a patchwork of correctional fabric that has evolved based on the needs of the system, rather than on the needs of youth. Unfortunately, it has not met the needs of either with any great success. By stepping back and refocusing its mission more squarely on public safety and meeting the needs of Arkansas' most challenging youth and families, DYS can safely reduce its reliance on secure custody and redirect savings to fund meaningful services in the home communities of DYS youth and their families.

Arkansas Senate Resolution 31 could supply the vehicle for a thoughtful, in-depth examination of Alexander's role within DYS, and for a detailed analysis as to the risks and needs presented by youth currently confined in DYS secure facilities. By harnessing the potential within SR31 to align the needs of youth (and their families) with a rich and fully funded continuum of services in the neighborhoods where DYS youth live, and restricting its use of secure correctional confinement to those youth who pose a legitimate threat to public safety, Arkansas' DYS could emerge from its current state of turmoil to assume the stature of a model state juvenile justice system.

Measures to Protect Youth from Harm Due to Unnecessary Exposure to Secure Correctional Confinement

Youth in correctional facilities are at risk of harm from several sources. The three most commonly recognized sources of harm include: 1) other youth; 2) themselves; and 3) staff. A fourth and more expansive source of harm, however, stems from reliance on secure correctional confinement for youth who do not require this level of custody to protect public safety and promote law-abiding behavior. There is in fact a growing body of evidence that exposure of youth to secure correctional confinement is detrimental and increases rather than decreases their likelihood of further penetrating the justice system.

Secure correctional confinement of youth is not only the most expensive dispositional option available in most jurisdictions, it is also widely recognized as possessing the greatest number of potentially damaging consequences for young people. It is for these reasons that national standards for compulsory placement of youth in out-of-home settings call for reliance on the least restrictive option consistent with public safety. Secure correctional confinement of youth is increasingly viewed as a disposition of last resort, for use only when all other less secure options have been exhausted. Research conducted over the past 20 years has established that youth exposed to secure custody exhibit higher rates of recidivism than those in less restrictive settings; they are more likely to experience deterioration in their mental health and an increased propensity toward suicidal behavior; they are less likely to further or complete their education, and their prospects for gainful employment are significantly reduced.

Observations: Despite evidence that secure custody is a strong predictor for recidivism, Arkansas continues to incarcerate a highly disproportionate number of first-time commitments and non-violent offenders to DYS secure facilities. According to the DYS Statistical Report for SFY 2006, a total of 647 youth were committed to DYS youth service centers in 2006. Of those youth, 517 (80%) were first time commitments. An additional 87 had only one prior DYS commitment to a youth service center.

Compounding the human and fiscal costs of relying too heavily on secure correctional custody for youth in Arkansas is the fact that a great many of these youth have been committed to secure facilities as a result of non-violent behavior that poses only a very limited risk to public safety, a risk that in most instances could be safely managed through the use of high-quality, non-residential, community-based programs. Of the 647 youth committed to secure DYS facilities during SFY 2006, only 212 (33%) were committed for “person” offenses. Only 29 of the 647 youth (4%) were committed for the most serious “Y” felonies, while more than twice that number, 72 youth (11%), were committed for “public order” misdemeanors such as Disorderly Conduct. In FY 2006, a full 45% (293 of 647) of all DYS commitments to Youth Service Centers were for misdemeanor offenses. In the first quarter of 2007, only 16% of DYS commitments were for felony offenses against persons.

During the course of our review, we encountered many youth committed to secure DYS institutions for the first time as a result of non-violent and/or relatively non-serious behavior. Below are brief descriptions of some of these youth:

- A 17 year old female diagnosed with bi-polar disorder who spent the previous five years in foster care after being raped by a neighbor at age 12. After multiple foster home placements the girl was moved to a residential facility at age 16 after hitting a foster parent. She was successfully discharged from the residential program but was placed in an emergency shelter while a more suitable placement was sought. Although emergency shelters are intended for brief stays of approximately 72 hours, this girl remained in the shelter for 10 weeks until

she finally left and resumed an earlier pattern of serious drug use. She was eventually arrested and sent to Alexander on Violation of Probation and Domestic Battery charges stemming from the incident with the foster parent.

- A 16 year old boy reported having been at Alexander for five months on his first DYS commitment stemming from a school fight. He was arrested by school police and because he was on probation for driving without a license, his probation was revoked and he was placed in secure correctional confinement at Alexander. This boy reported being in 10th grade and living with his mother and two siblings. He was scheduled to be released a few weeks after our interview. He reported to know little about the specifics of his aftercare plan but would be returning to live at home and attend school.
- Another youth interviewed was a 15 year old boy on his first commitment to DYS. He had been in secure confinement for two months. He reported originally being placed on probation almost two years before for a curfew violation. Most recently, he reported being kicked out of school due to disruptive behavior and was placed on electronic monitoring (EM) for 30 days. While on EM he reported receiving a call informing him that his brother was in trouble a few blocks away. He left his house to aid his brother and was subsequently charged with violating the terms of his probation.
- One 17 year old youth who was soon to be released had been at Alexander for six months after running away from a treatment program. The youth was originally arrested for stealing three car stereos and a golf cart from a local garage. He reported having no violent offense history. Although all the stolen items were returned, he did not appear for his dispositional hearing because he feared the outcome. He was subsequently taken into custody and sent to a treatment program that he believed required him to obtain his GED prior to being released. Having failed his GED test on more than one occasion in the past, he was convinced he could not earn his release before turning 18. Consequently he ran away from the program and was later taken into custody and sent to Alexander.
- Another 17 year old we interviewed reported being charged with two counts of Theft of Property after breaking into a local motorcycle shop. He was immediately caught and all the merchandise was returned. Due to an underlying substance abuse problem, he was sent to a drug program where he received his GED and successfully completed the program. Upon his return to court, however, he learned that the family who held legal custody had relinquished custody. Absent another placement, the youth was sent to Alexander.

The youth described above are only a small fraction of the many youth currently incarcerated at Alexander whose risk to public safety appears sufficiently low to make

them excellent candidates for individualized community-based supervision and monitoring. Given the cost of secure confinement and evidence that exposure to secure correctional environments will contribute to their likelihood of recidivism, these youth and others like them should be spared this experience in favor of safe and effective community-based programming.

As noted, there are also a significant number of youth who experience seriously disabling conditions that, when combined with their offense history, present a risk to public safety sufficient to warrant their placement in a safe, secure and therapeutic environment. While it is true that these youth may need a secure environment, their placement at Alexander is neither appropriate nor therapeutic and serves to exacerbate their problem behaviors. Below are brief descriptions of some of these youth:

- PT is a very slight, 16 year old boy with a full scale IQ of 47. He was committed to DYS after engaging in inappropriate sexual activity with his disabled 7 year old brother. PT's ability to focus and follow simple directions is limited, creating unique supervision and management needs for staff. He has a poor sense of social boundaries and frequently invades the personal space of others, provoking the ire of some youth. He is also a frequent bed-wetter. He was expelled from a previous placement for inappropriate sexual acting out behavior, which given his history and limitations, should have been expected. His management needs far exceed the ability of Alexander staff to meet.
- DA is a 16 year old boy with a history of Schizophrenia, Bipolar Disorder, PTSD and who is prescribed several psychotropic medications. He has a history of serious suicide attempts and experiences visual and auditory command hallucinations. He has engaged in head banging that has resulted in a loss of consciousness and self-biting that has drawn blood. He has trouble controlling his bowels and is tormented and ridiculed by other youth and staff after soiling himself. He was moved to Alexander from a hospital setting where he assaulted a staff member who physically abused him. He is frequently the target of abuse by other youth and staff, which presents serious safety/management problems at Alexander and requires that he be assigned a one-on-one staff person for much of the week.
- HC is 15 years old and experiences auditory hallucinations, depression with multiple suicide attempts, and has a full scale IQ of 75. HC also has a history of a congenital gastro-intestinal abnormality resulting in an inability to control his bowel and occasional soiling. He was committed to DYS on a sexual assault charge in which the victim was another child. He is a common target of torment by other youth and is deeply fearful for his safety.

These and many other youth like them fill beds at Alexander in part because no other more appropriate alternative exists. For these youth, exposure to the Alexander

correctional environment is a hostile experience that heightens their fears and anxieties, often provoking negative behavior from them, other youth and from staff. These are youth who carry the deep scars of physical and emotional abuse inflicted long before their commitment to DYS, and whose developmental disabilities cry out for a small, safe and therapeutic setting rather than 140-bed secure correctional environment that is Alexander.

Recommendations for Reducing Unnecessary Exposure to Secure Correctional Confinement

DYS officials need not wait for the results contemplated by SR31, but can begin immediately to take steps that will safely reduce the costly burden of low-risk/high-needs youth in secure correctional confinement. Below are a series of steps that could be formalized to begin the process of realigning DYS resources with the actual public safety needs of the community and the rehabilitative needs of those youth committed to its care.

1. **Limit Admissions and Reduce Length of Stay.** The primary means by which unnecessary exposure to secure correctional settings can be prevented is by limiting the number of youth who enter such facilities and reducing the length of stay for those who do enter. This can be accomplished through a series of administrative and programmatic policies designed to reserve secure correctional confinement exclusively for those youth who pose a legitimate threat to public safety that cannot be satisfactorily mitigated through less restrictive options. For the many other youth committed to DYS who can be safely and successfully managed in a non-residential, community-based setting, a rich continuum of programs and services drawing upon proven models of care must be developed in communities and neighborhoods across the state. By establishing fiscal incentives for jurisdictions to supervise and treat youth locally, and disincentives to the commitment of low-risk youth to DYS, the foundation can be laid for transforming juvenile justice in Arkansas into a coherent system that builds and relies more upon the strengths of communities to care for their youth, and less upon expensive and ineffective correctional confinement for youth who do not require that level of custody.

The three general target populations at Alexander ripe for community-based programming are Probation Violators (including those youth who have been discharged from alternative programs due to rule violations), Misdemeanants, and all variety of Non-violent Offenders. By aggressively and systematically targeting these categories for youth to fill non-custodial programming, the population at Alexander could be reduced as a first step toward closing and replacing this youth prison with small, therapeutically-oriented secure facilities.

- **Probation Violators** – Although we were unable to obtain an accurate count of youth committed to Alexander for violating the terms of their probation or aftercare plan, many officials with whom we spoke believed that such violations constituted a relatively large percentage of Alexander youth. We were also told by supervisors within the intake and clinical teams that probation violations were typically unaccompanied by a new charge but rather constituted “technical” or rule violations. Given that these youth were viewed as presenting a sufficiently limited risk to public safety that they were initially placed on probation, every effort should be made to impose sanctions for misbehavior

short of incarceration. Many jurisdictions are turning to the use of a structured “sanctions grids” to ratchet-up sanctions on youth for technical violations of probation as an alternative to secure correctional confinement. Other jurisdictions limit the amount of time for which a youth can be returned to custody for a technical violation. Many probation violations stem from failures by youth to comply with all the rules of a community-based program. It is certainly true that some service providers are quicker than others to eject a youth who presents challenges for program staff. Challenging youth, however, are the nature of the beast in juvenile justice. Truly committed service providers understand this and are commonly willing to abide by contractual agreements not to “eject or reject” youth who are in or referred to their programs.

- **Misdemeanants** – On June 7, 2007 a total of 70 youth committed to DYS were backed up in local detention facilities, often for months, awaiting space in a secure DYS facility, typically Alexander. Of these 70 youth, 28 were misdemeanants. As noted earlier, the proportion of misdemeanants already in DYS secure facilities is already considerable. According to the Arkansas DHHS statistical report for SFY 2006, 293 of the 647 (45%) youth committed to DYS secure facilities were misdemeanants. By definition a misdemeanor is a low-level offense that rarely involves any serious violence. These are offenses that often fall within the range of behaviors in which youth commonly engage. While the behavior is clearly illegal and not to be excused, the response by authorities to such behavior should be proportional and measured to equal the severity of the act. Again, youth who engage in the wide range of misdemeanor offense behaviors are typically neither violent nor predatory offenders, but rather youth whose behavior can and should be addressed through an array of community-based sanctions instead of secure correctional confinement.
- **Non-Violent Offenders** – In FY 2006, only 128 of 647 youth (20%) committed to secure DYS Youth Service Centers were committed as a result of felony offenses against a person. The remaining 519 were committed as a result of misdemeanor, property, public order, drug and “other” offenses. These are the very types of offenses for which community-based sanctions and programming is best suited. Halting the flow of these offenders into the DYS custodial system by creating alternative plans prior to absorption into the system and further reducing their numbers by expediting discharge plan development for those already in confinement, would form another step toward safely reducing the population at Alexander in preparation for its closure.

2. **Develop an External Classification System.** Along with the concerted effort to reduce secure correctional confinement of low-risk/high-needs youth, a structured external classification instrument should also be developed, empirically validated, and used to guide placement decisions for youth committed to DYS. Given the preponderance of evidence that higher rates of recidivism, substance abuse,

delinquency, violence and poorer school performance are found among youth who experience confinement in congregate facilities -- a phenomenon that researchers term, "peer deviancy training" – efforts must be made to identify those many youth who do not require, and will not benefit from secure confinement. Developing and relying upon a sound and empirically validated classification system that is capable of identifying those youth who should be managed in the community should be a priority of DYS.

Although DYS uses an external "risk assessment guideline form", this instrument is seldom used to inform decision making. The form does not appear to be consistently completed nor does it have any bearing on placement decisions for youth. Several G4S administrators and members of the DYS intake team noted that many of the youth in custody at Alexander score very low on the risk assessment guideline form – well below the threshold for secure correctional confinement. The risk assessment form identifies those with scores of six or below as being low risk and not eligible for secure placement. Nonetheless, according to those Alexander officials familiar with the instrument and its use, youth are regularly placed at Alexander who score in the lowest risk range. We were not able to obtain a census of youth at Alexander arranged by risk scores. Such a census, however, could be a useful tool for identifying segments of the population at Alexander who should be immediately considered for less secure placement.

3. Replace Alexander with Small, Secure and Therapeutic Environments.

Simultaneously, while safely reducing Alexander's population through individualized community-based service planning, one or possibly two small, secure and therapeutically-oriented facilities could be established to house those youth for whom there is a legitimate public safety risk. The State of Missouri has successfully pioneered this small, therapeutic approach to safely manage high-risk youthful offenders, becoming what many juvenile justice professionals regard as the best juvenile rehabilitation system in the country. By relying on an expansive array of community-based alternatives, Missouri juvenile justice officials are able to devote expensive secure bed-space exclusively to those youth who pose a public safety risk. Missouri's model of secure care is unique in that it relies on a number of small (fewer than 40 beds) secure but home-like settings typically located within 50 miles of the home communities of each youth. These secure facilities place an emphasis on rehabilitative programming and have become a national model for secure care of youth, boasting a recidivism rate of just 8%. Arkansas could benefit enormously from this approach to safely manage its most high-risk youth.

Measures to Protect Youth from Harm While in Secure Custody

The next section of this report is organized according to the risk of harm presented to youth by other youth, by themselves and by staff. Under each major section, various issues pertaining to the facility's ability to protect youth from these forms of harm are discussed, along with observations regarding the adequacy of the measures currently in place. Each section also includes recommendations for improving the quality of protection from harm in each area.

While many of the ways in which youth are harmed in the correctional setting can be mitigated by improving facility operations, clearly the best way to protect youth from these harms is to limit their exposure to the correctional setting in the first place. Although this report provides a comprehensive review of the various risks of harm faced by youth at Alexander, we want to be clear that our professional opinion is that for many youth, their unnecessary placement at Alexander in the first place is a threshold matter that must be addressed for DYS to overcome the challenges that have plagued its operations for many years.

Measures Designed to Protect Youth From Harm By Other Youth

Staffing and Supervision.

Adequate numbers of staff must be deployed to supervise youth during waking and sleeping hours in order to protect youth from harm. The number of staff available to supervise youth is directly relevant to nearly all of the measures designed to protect youth from harm. Without adequate numbers of staff, it is difficult to engage youth in structured programming or to closely supervise and monitor tensions brewing among youth. Staff are also unable to de-escalate these tensions effectively because they must attend to the needs of so many other youth. Some staff may not intervene in fights immediately, choosing instead to await the arrival of backup staff, which creates the potential for youth to inflict more serious injuries during physical altercations. These ratios are not meant to be calculated based on the number of staff in the building, but rather those who are *directly supervising* youth at any given time. Generally, supervisors, floaters/relief staff, and those assigned to control rooms and intake areas are not counted toward these ratios.

- **Observations.** Facility administrators reported that the G4S contract provides for a continuous staff-youth ratio of 1 staff for every 8 youth (1:8). In contrast to the previous provider, Cornell Companies, Inc., G4S includes only Youth Care Workers (YCW) and Assistant Unit Managers in the ratio, and specifically excludes case managers and Unit Managers from these calculations. This reportedly provides

richer staff coverage than had been provided previously at Alexander. Interviews with G4S staff, facility administrators, and line staff and a review of a single day's staffing roster (June 8, 2007) suggested that, on paper, the housing units were staffed according to the targeted 1:8 ratio most of the time. Staff reported that, at times, the staffing level may fall out of ratio for short periods when a staff person was required to transport youth to another part of the campus but that Unit Managers and roving Security staff would provide additional coverage as needed.

However, there were numerous times throughout our visit when the 1:8 ratio was not maintained for longer periods of time. At approximately 1:30pm on a weekday, we toured the New Dorm and made several counts of youth and staff in order to pinpoint the ratio. Among the four pods, the following ratios were observed: 1:12, 1:10, and two pods with 1:9. A YCW was posted in each pod, and an additional YCW was reportedly taking a break, although relief coverage had not been provided. The Unit Manager was on the unit, but is not counted in the staff-youth ratio, per facility administrators.

At other times, the number of staff was sufficient to meet the 1:8 ratio, but staff did not appear to be properly deployed to maximize their ability to supervise the youth and to intervene at the first sign of tension. During outdoor recreation one afternoon, approximately 35 youth were observed playing basketball, loading into a van, or sitting in groups in the same general area. Although there were sufficient numbers of staff in the area, they were not well deployed. Several staff members were huddled together in a group leaving large numbers of youth relatively unsupervised. During this recreation period a fight between two youth erupted in the van parked near the basketball court. Staff responded to intervene but better deployment of staff in the first place could have prevented the fight from occurring.

Similarly, while the 1:8 ratio may be achieved much of the time, a lack of quality or proactive supervision by assigned staff provides opportunities for youth to harm each other. For example, nighttime staffing in the Girls' Dorm frequently consists of three staff and 19 girls. Although this would fall within the 1:8 ratio, the quality of supervision by staff was questionable. Several girls reported that numerous incidents had occurred in their unit during the previous few weeks. One such incident occurring only days before our tour allegedly involved a fight among two girls that started in the gym and continued later in the unit. One or more girls began "popping [i.e. opening]" the doors of other girls' cells as they passed while being escorted to the bathroom. This resulted in many girls being out of their cells at once, escalating the fight into a multi-youth disturbance. According to youth, security was called and several girls were restrained before order was restored in the unit. This incident, and others like it, could be prevented by better de-escalation techniques and other efforts to reduce non-compliant behaviors among the youth.

Many youth stated that they feared for their safety and worried about being “jumped” by other youth. These concerns were clearly evident in a review of the Grievances from March, April and May 2007. In just one two-week period in May 2007, the following issues were brought separately to the attention of the grievance officer:

- “[Youth] hit me...”
- “[Youth] threatened me...”
- “[Youth] punched me in the stomach...”
- “[Youth] hit me in the jaw...staff didn’t see it.”
- “[Youth] hit me...”
- “Keep [youth] away from me...”
- “Please change my unit. I’m scared...”

In the interviews, youth were particularly concerned for their safety in the school building (although outdoor recreation areas and the gymnasium were also mentioned) given that classroom supervision often consists of one teacher and one YCW.² In the minds of some youth this staffing pattern creates opportunities for more aggressive youth to strike out at others without detection. Further, youth reported that some staff turned a blind eye to activity that places them at risk of harm. This practice by staff can take several forms including responding in a less-than-immediate fashion to a physical altercation between youth. One girl reported that certain staff are known for their slow response to altercations. She stated that she had heard girls recently say they would wait until a particular member of the staff was working to retaliate against another girl because it was known that this member of the staff would respond slowly, allowing for the greatest amount of harm to be inflicted.

Meeting the 1:8 ratio during both waking and sleeping hours may be difficult at times because of the number of vacant YCW positions. When G4S assumed operational control of the facility, there were approximately 50 vacancies. The number of current vacant YCW positions is approximately 27, which requires a significant number of staff to work overtime. G4S staff reported the facility pays approximately 2,000 to 3,000 hours of overtime (per month) to staff in order to meet the 1:8 ratio. Staff report that working overtime can be tiresome, but provides needed supplementary income.

Meeting the targeted 1:8 ratio is particularly difficult when individual staff are assigned to protect the safety of individual youth, such as those on extreme suicide precautions or those with special needs. For example, one youth who has been at Alexander nearly one year has a full scale IQ of 47 and requires close supervision and specific instructions. Several other youth experience incontinence or enuresis. One

² We did not observe the school in operation as we arrived and toured the facility during the school’s summer break.

such youth reported being constantly taunted, teased, spit on and hit by youth, largely as a result of his occasional “accidents.” To help manage this situation, this youth was assigned a one-on-one staff person throughout much of the day. While this may have helped to protect that individual youth, it appeared that the staff person assigned as the one-on-one was drawn from the existing staff compliment on the unit rather than being specifically assigned to augment the unit staff. The deployment of regularly scheduled staff to one-on-one supervision duties clearly reduces the staffing ratio and makes it difficult to properly supervise the other youth on the housing unit.

- **Recommendation.** The precise number of staff needed to conform to generally accepted practice will vary depending on the facility’s population and the physical plant of each housing unit.
 1. Conduct a post analysis to identify the precise number of staff needed. Calculate a relief factor that compensates for staff illness, training, vacation, temporary “non-contact” assignments, 1x1 suicide precaution or other safety plan duties, etc.
 2. Allocate sufficient numbers of Youth Care Worker positions so all housing units can conform to the accepted 1:8 ratio at all times. When youth movement or staff breaks require altering the staff ratio, provide continuous support from Unit Managers or security staff until the regularly assigned staff person returns to his or her post.

Staff Training

Staff in juvenile correctional settings need to be trained in behavior management, de-escalation and the use of force to develop their skills in diffusing tensions among youth and in intervening safely in situations that escalate to physical violence. The generally accepted practice is for these topics to be a central feature of pre-service training, generally lasting between 80 and 120 hours, and to comprise a large portion of a standard 40-hour annual training curriculum. On-going training is essential for staff to refresh their skills and knowledge in de-escalating tensions among youth and to develop confidence in using a variety of physical restraint techniques when needed.

- **Observations.** When G4S assumed operational control of Alexander, all existing Cornell employees were reportedly screened to assess their qualifications for hire by G4S. Each staff person reportedly underwent a criminal background check and a drug test. Each personnel file was reviewed, and each needed to be recommended for hire by both Cornell and DYS. Facility administrators reported that those who passed this initial screening were required to complete a Transition Training, which was planned as a 40-hour curriculum. This training reportedly reviewed several “emergency issues,” and required all employees to sign a form indicating that they

would abide by the following rules: a) not taking aggressive or combative youth into offices or other areas that are out of view of surveillance cameras; b) immediately notifying Master Control when a potentially hostile situation is developing; c) committing to using the least restrictive means necessary to de-escalate and control potentially volatile situations; d) reporting all incidents of physical intervention on an incident report. Finally, the transition training reportedly included information on a variety of G4S policies and procedures, including wearing uniforms, clocking in/out, ensuring perimeter security, and serving food. It is worth noting that during the course of our tour, we became aware of several situations in which staff had violated one of the “emergency issues” that were reportedly covered during G4S’ early tenure. For example, DRC recently investigated a case in which a youth was deliberately pulled into a staff office—where there is no security camera coverage—during the course of a restraint. As will be discussed in more detail, the analysis of incident reports did not reveal a commitment among some staff to use the least amount of force necessary to de-escalate a situation—instead, many youth are taken to a prone position for behavior describe as “disobedient” or “refusing to comply with directives.” This appears to underscore the challenge faced by both DYS and Alexander administrators as they attempt to change a culture of force that has existed for many years and is common in large, secure correctional settings.

A roster of current employees was provided by the State. This roster included 79 full-time Youth Care Workers. Training records were supplied for a sample of these employees (those with employee numbers ending in 3, 6, or 9). Of the 79 YCWs, training records were received for 69 YCWs. A total of 27 of these staff had worked under the Cornell administration and had been re-hired by G4S. Approximately 30% received the entire employee orientation program shortly after G4S assumed control of the facility and 7% received re-certification training in Safe Crisis Management (SCM) and First Aid. However, 63% of former Cornell staff did not receive any additional training beyond a few hours of staff meetings or campus-wide meetings. This is particularly troubling given the volume of mistreatment and abuse allegations that emerged during Cornell’s tenure.

These data paint quite a different picture than what was presented by the Facility Administrators, and suggest that the majority of former Cornell employees did not receive training on the new philosophies, procedures, and practices put forward by G4S. This is particularly unfortunate given the obvious staff training deficiencies of Cornell. Ensuring that ALL staff have the opportunity to develop new skills, become familiar with new procedures, and to put these into practice is the only way to ensure that the quality of care at the facility improves.

The roster of 79 full-time Youth Care Workers also included 42 staff who were hired since G4S assumed control of Alexander. Approximately 90% of these staff received new employee Orientation training on or before their hire date. The remaining 10

percent (n=5 staff) either received the training at some point after their hire date, or did not receive the full complement of training.

The training materials assembled by G4S reinforce the concepts that force is to be used as a last resort, residents are to be treated with dignity and respect, and grounds a variety of behavior management skills in theoretical perceptions of adolescent development. While the topics appear to be comprehensive, the training curriculum totals only 40-hours, which is well short of contemporary standards of 80 to 120 hours of new employee training.

Facility administrators indicated their intent to switch from SCM to Handle With Care (HWC; another widely used use of force training curriculum) in mid-June 2007. Neither SCM nor HWC training currently includes a competency-based assessment of staff skill and knowledge in using the approved techniques. Finally, the suicide prevention component of the training does not currently include instruction on how to intervene in a situation where a youth is hanging by the neck (e.g., relieving pressure on the neck, using a cutdown tool, etc.). In fact, the suicide component of the training appears to only require 30 minutes to administer (based on the training records provided), suggesting that it lacks depth and detail.

All staff will reportedly receive additional training in the HWC curriculum over the coming months. Administrators report that a total of 12 HWC instructors have been certified at the facility. Training on an array of special topics has also been developed, among them, incident report writing, working with sex offenders, and gender-specific training for working with girls. Although not yet developed, G4S reports its intention to train staff in Motivational Interviewing. G4S plans to implement a 24-hour annual refresher training course, but has yet to do so. Contemporary standards suggest that at least 40 hours of refresher training should be provided on an annual basis. None of the aforementioned trainings had been scheduled at the time of our tour. It is important to note that the many well-intended plans described by G4S administrators to train staff, develop operational policies and provide generally improved oversight of operations at Alexander would be ambitious under the very best of circumstances. Achieving the stated objectives with a staff consisting largely of hold-overs from a terminated contractor will make attaining these goals all the more challenging. Further complicating the task for G4S is the constant pressure caused by a steady influx of low-risk/high-needs youth.

All staff interviewed reported that they had received training either when they transitioned from Cornell to G4S employees, or as new G4S employees. All staff commented on the “culture change” at the facility since G4S assumed control. Most characterized this shift as the administration “looking out more for the kids,” whether by providing them with additional incentives for good behavior, attending more closely to the needs of the girls, or the administrators’ willingness to talk directly with the youth. Most also commented that G4S was committed to reducing

the frequency with which staff used physical restraints, reserving them as a response of “last resort.” all staff commented that using force was “much less acceptable” under the G4S administration than it had been under Cornell. G4S staff reported that the frequency of youth being “taken to the floor” had decreased significantly since they assumed control of the facility. In May 2006, there were 131 instances of take downs recorded in incident reports, compared to only 18 take downs recorded in May, 2007 (these data were not independently verified). Many staff felt this was a positive development, believing that proactive supervision and de-escalation skills could effectively control the vast majority of situations that arise at Alexander. However, the extent to which staff have been trained in alternative means of responding to incidents is questionable given the small proportion of staff that has been fully retrained since G4S assumed control.

Staff descriptions of G4S’ training suggested that it focused on techniques for de-escalating conflicts among youth and ways to prevent the need for physical force to be used. Several staff commented that they were hesitant to intervene in fights, not because of a lack of confidence in their own skills, but because they perceived that the staff were “never believed” if a youth made a child abuse allegation and they feared the loss of their jobs. While the fact that staff are cognizant of the consequences of alleged abuse and their perceptions that G4S takes these allegations very seriously are both very positive indicators of G4S’ commitment to protect youth from harm. It is also true, however, that staff must have confidence to intervene when needed and must not be timid when an altercation occurs.

- ***Recommendations.***

1. Align Orientation Training with contemporary standards of care (e.g., require 80 to 120 hours; include intensive training on Suicide Prevention, Child Abuse Reporting, and the Use of Force, among other topics).
2. Use real-world scenarios in physical restraint training so that staff develop confidence in their ability to intervene effectively and their knowledge of what is permissible. Rather than requiring staff to restrain a willing co-worker, some jurisdictions invite youth to assist with training and direct them to resist.
3. Incorporate a measure of skill-based assessment to certify that staff can execute techniques properly.
4. Continue to require at least 40 hours of On the Job Training in which new staff are paired with veteran staff, shadowing them throughout the day until they are ready to supervise youth independently.
5. Require all staff to participate in 40 hours of training annually so they can refresh their skills.

Programming.

The frequency of misbehavior and violence is reduced when youth are engaged in structured activities throughout the day. Not only can such activities help to prevent tensions from brewing and youth from colluding with each other, but they can also contribute to the process of discharge planning by connecting relevant programming to real world experiences in the communities to which youth will return. During the weekdays, youth should be engaged in a full day of academic instruction, and should have the opportunity to participate in a variety of programs after school. Like those that could be held on weekend days, these can be facilitated by volunteers or direct care staff and should be focused on helping youth to accomplish developmental tasks and to address their criminogenic needs. Generally accepted practices also dictate that youth should be engaged in large muscle activity for one hour on weekdays and two hours each weekend day.

- **Observations,** With the exceptions of school and recreation, programming is limited for most youth at Alexander. Alexander is intended to serve as a intake/assessment center for many youth, and thus the original planning for the facility was to defer access to treatment programming to the subsequent placement. Regrettably, however, youth frequently become stuck in the Intake status, often because service providers are not willing to work with the youth. These youth are often left to complete their commitments at Alexander with minimal programming. Fifty-seven of the youth at Alexander on the first day of our tour were designated as Intake status, seven of whom had been in Intake status since March 2007 or before.

Although required by a Consent Agreement with the U.S. Department of Justice to operate a vocational program, none was in place at the time of our tour. We were informed by school officials at Alexander that the fledgling vocational program came to an abrupt halt when the instructor died in January 2007. We are also aware of serious and long-standing inadequacies in the special education program at Alexander and reviewed findings by the Arkansas Department of Education stemming from its April 3 and 4, 2007 monitoring visit to Alexander.

One programmatic bright spot at Alexander is the Boys and Girls Clubs program that provides physical education for all Alexander youth during the school day and an after school program consisting of art, music, independent living skills and job readiness components. Youth from all housing units at Alexander have daily access for one hour to the after school program on a staggered schedule. The Boys and Girls Club is also in the final year of a multi-year Intensive Aftercare Program grant which provides targeted reentry services to youth from Pulaski and Saline Counties. These reentry services have shown promise in reducing recidivism in part by working closely with youth and their families to reenroll youth in schools, and by assisting

with employment and other needed services. Youth are seen face-to-face at least three times weekly during their first 90 days post discharge.

- **Recommendations.** Investments in structured programming will likely result in reduced tensions and fewer fights among youth, and therefore will provide greater protection from harm.
 1. Combine a discharge planning component into all programming designed to make sure the skills being taught have applicability in the home communities of youth. This would include establishing connections in home communities of youth that can both hasten and provide programmatic continuity upon discharge.
 2. Ensure that all youth, including those in disciplinary isolation, attend school for a full day each weekday.
 3. Expand high-interest, developmentally-appropriate programming to be delivered in the evenings and on weekends.
 4. Provide all youth, including those in disciplinary isolation, with at least one hour of large muscle activity on weekdays and two hours on weekend days.

Incident Reporting.

Juvenile correctional facilities need a process for reporting all fights between youth, youth assaults on staff, attempted escapes, suicide gestures, and other situations in which the youth's safety or the facility's security is at risk. The generally accepted practice is for these reports to include a detailed narrative account of the incident, statements from the youth involved and from others who witnessed the incident, statements from all staff involved, and a meaningful supervisory review that assesses the extent to which standard policies and procedures were followed. The reports should be reviewed in a meaningful way—that is, there is little point in requiring staff to document incidents if the information is not used for any purpose. At the very least, they should be reviewed for patterns across youth (to identify on-going tensions, programmatic gaps, youth who may need additional attention from mental health staff, youth who may need additional protection or a different housing assignment) as well as training opportunities for staff (in de-escalation, staying on post, proper use of force techniques, etc.). A more sophisticated use for these reports is to identify hotspots within the facility—times, places and situations that seem to provide opportunities for fights, escape, contraband—so that the environment can be manipulated strategically.

- **Observations.**

Facility administrators described the process for completing and reviewing incident reports. While some identifying information on the youth, staff, time and place is required at the top of the incident report form, the bulk of the form provides for an

unstructured narrative account of the incident. Certain critical incidents are required to be reported within an hour, but most are to be reported by the end of the shift. The Shift Supervisor is responsible for assembling the incident report packet, but facility administrators said the supervisor is not expected to critique the staff's handling of the incident. This contradicts what is stated on the form itself, which asks specifically for shift supervisors to comment on how the incident could have been prevented or anticipated by staff. While G4S intends to require that all staff present complete a witness statement, this was not Cornell's policy, has not yet been required by G4S and it was not made clear when this requirement might take effect. All incident reports reportedly include a "Marks Sheet" that is completed by trained medical staff.³ By the end of each shift, all incident reports should be faxed to staff in DYS's Internal Affairs Unit. The facility's Management Team reportedly reviews each incident from the prior day at their morning meeting. References to specific incidents and to the practice of daily incident report review were made by most of the Assistant Facility Administrators and Unit Managers, suggesting that this review does in fact occur on a routine basis. When questions arise about how a particular incident was handled, the facility-based investigator (discussed in more depth later in this report), cues up the video footage and reviews the incident. We were also told that if indicated, constructive discussions are held with staff about how they could have prevented the incident, or formal investigations of misconduct, policy violations, or abuse are initiated at that point.

All YCWs interviewed were aware of their responsibility to complete an incident report following a youth-on-youth assault, attempted escape, assault on staff or other serious incident. However, this practice appears to extend only to incidents that are actually observed by staff. When asked how they would document a youth's report that he or she had been assaulted outside the view of staff, most responded that they would only make a notation in the unit log book, but would not complete an incident report (others responded that they would only question the youth involved, but would not document the allegation in writing at all). A sound incident reporting process would require documenting ALL instances, whether observed or reported, of youth-on-youth assault. The failure to recognize the importance of reporting an incident like the one presented is of concern and suggests that facility administrators may only receive documentation on a relatively small subset of incidents occurring in the facility.

We reviewed redacted copies of approximately 450 incident reports from January 21, 2007 through April 28, 2007. This review was not intended as an exhaustive review of the volume of incidents occurring at the facility, but rather as an assessment of the quality of the incident reporting process and its ability to identify

³ A "Marks Sheet" is a standardized form that is used to identify and describe injuries. It includes an outline of a body on which staff are to identify the specific location of injuries, along with space for a narrative description of the injury.

and respond to issues that compromise youth's safety. A sub-sample of 80 reports (approximately 18%) was randomly chosen for more in-depth analysis. This analysis revealed several troubling inadequacies:

- In many situations, the amount of force used appeared excessive as youth were taken to the floor in response to rather minor rule violations (e.g., cussing or failing to comply with staff directives). These incidents suggest that staff are not working their way through the continuum, beginning with verbal commands, increasing staff presence, and attempting to encourage compliance using less restrictive means (e.g., escort, upper torso) before taking the youth to the floor. While some youth will continue to be non-compliant, in the absence of aggression or a clear threat of harm, non-physical means should be exhausted first, and then less restrictive physical means should be employed. Staff should recognize the fact that laying their hands on an agitated youth can escalate the situation, *causing* a more extreme use of force, in a situation where less invasive means could have ended the incident without physical restraint being needed.
- None of the incident reports provided youth witness statements from the youth involved in the incident or those who observed it. This is particularly problematic in a facility with a history of unprofessional and abusive treatment by staff as these statements are one of the first indicators that the incident needs to be flagged for additional review. Youth should be provided with the opportunity to give their own accounts of the incident. The information provided is often useful to staff to identify ongoing conflicts among youth and also gives important clues for better handling of future incidents with that youth.
- Not all of the incident reports included witness statements from all staff who were present. Among those that were included, many suffered from a lack of detail that prevents a clear understanding of how the incident occurred and the staff's response to it. Staff should be asked to describe the youths' behavior, their own role in the incident, and what they observed other staff doing during the incident. Each staff person should also clearly state where they were posted and how many youth they were supervising, so that staff deployment can be evaluated.
- While nearly all staff identified a specific SCM physical restraint technique (e.g., hook and carry, upper torso, etc.), they did not provide sufficiently detailed descriptions of how the technique was executed (e.g. which arm they were holding, where other staff were positioned, whether the youth struggled against the restraint or complied). In addition, many staff placed the youth in a prone position on the floor, and it is not clear from the narrative whether they properly balanced their own weight so as to ensure

that they were not placing pressure on the youth's torso. These details are essential in situations where injuries occur or youth allege abuse.

- A significant number of incident reports did not include Marks Sheets for all youth who were involved in the incident, suggesting that they did not receive medical attention after their involvement in an altercation or a restraint. Further, some of the Marks Sheets revealed significant delays (e.g., several hours) in the delivery of medical attention. Except during nighttime hours, medical treatment should be provided within an hour or less. In a few cases, the Marks Sheet was completed by staff, not by licensed medical practitioners.
- None of the incident reports evidenced a thoughtful review by a supervisor. Most of the incident reports were signed by a supervisor, but very few provided any comment. The few supervisory reviews that were completed did not discuss how the incident could have been prevented or anticipated (as required by the form and as required by contemporary standards of care), nor did they make any mention of the inadequacies present in the incident report packages themselves. For example, some of the staff witness statements were contradictory, yet the supervisor did not make any attempt to gain clarity.

These deficits limit the usefulness of the incident reporting process as a tool for protecting youth from harm. They do not provide the necessary details to critique the staff's execution of various physical restraint techniques or to account for the positioning and deployment of all staff in the area. They suggest that additional work is needed to ensure a commitment to using the least amount of force necessary to ensure that youth do not hurt themselves, staff or other youth. Using force is not about controlling the situation (i.e. making the youth do what the staff wants them to do)—it should be solely about protecting the youth and staff from harm. The G4S training materials subscribe to this idea, but the incident reports suggest that not all staff have adopted it as their own. Making the incident reporting process more useful toward this end will require more training and better oversight from shift supervisors who must learn to think critically about the incidents and to guide staff in the moment toward avenues that can at least anticipate, but hopefully prevent, subsequent incidents.

- **Recommendations.**
 1. Require staff to complete an incident report on ALL incidents of youth-on-youth violence, whether or not the incident was observed by staff or simply reported by youth involved.
 2. Develop key questions for staff response to ensure that all key information is included in the narrative, e.g., what precipitated the incident? How many staff were present and where were they posted? How many youth were present and what were they doing? What efforts were made to de-escalate the incident non-

- verbally and verbally, prior to using physical force? If physical force was used, specifically, what did each staff do? How did the youth respond? What happened after staff gained control of the situation?
3. Require all staff to submit written witness statements. These should account for their own actions, as well as those of the youth and other staff.
 4. Develop procedures for youth involved in or witnessing incidents to provide written statements.
 5. Require shift supervisors or unit managers to critique each incident as to how staff might have been able to prevent its occurrence, how staff responded to youth's behavior, whether the situation was controlled using the least restrictive means possible, etc.
 6. Utilize videotaped footage to verify that the incident occurred as described. This footage will also be useful in crafting prescriptions for how similar incidents could be prevented in the future.
 7. Ensure that all youth involved in the incident receive prompt treatment by medical professionals and that the provision of treatment is documented in each report using a Marks Sheet.
 8. In addition to reviewing individual reports, analyze the volume of incident reports to identify patterns among youth, staff, location, time of day, and circumstance that could be used in efforts to decrease the likelihood of similar incidents in the future. An analysis structure with this capability is reportedly used at other G4S facilities.

Medical Attention.

Generally accepted standards dictate that ALL youth involved in incidents with the potential for harm (e.g., fights, suicide gestures or attempts, accidental injuries) should receive medical attention in a timely manner, usually interpreted to be within 2 hours of the incident. Even if youth report that they are not injured, they should be assessed by a nurse or other licensed medical professional. The receipt of medical attention should be documented in two ways—on the incident report itself (or via an attachment) and in a progress note in the youth's medical chart. The nurse should inquire about what happened, assess and treat any injuries sustained. Most jurisdictions also require the nurse to photograph any injuries sustained, particularly in situations in which the youth alleges mistreatment by staff.

- **Observations.** Facility administrators and nursing staff reported that all youth are required to be assessed by medical staff following their involvement in an incident that involves an altercation or restraint. These assessments are documented on a "Mark Sheet" which is attached to each incident report (by giving it to the accompanying direct care staff before the youth leaves the clinic), with a copy placed in the youth's medical file. One of the first operational changes made once

Alexander came under G4S control was to require the “Mark Sheet” to be completed by licensed medical staff (under Cornell, direct care staff were permitted to make assessments and decisions pertaining to the medical condition of youth). All YCWs interviewed referenced the completion of the “Mark Sheet” as one of the steps involved in the incident reporting process.

The Marks Sheets attached to the incident reports provided by DYS revealed that medical treatment was provided promptly to some, but not all, youth involved in altercations or restraints. Among the 80 incident reports analyzed, some did not include a Marks Sheet for all youth involved, some evidenced a significant delay in the provision of medical treatment, and some of the Marks Sheets were completed by non-medical staff. None of the incident reports indicated that photographs of injuries were taken, which is contrary to contemporary standards of care. Prompt medical treatment following an incident or restraint is essential to limiting the harm sustained by youth involved in these situations. In situations where abuse or mistreatment is alleged, an assessment of injury by medical personnel is essential. Thus, it is essential that treatment is provided to ALL youth who are involved.

▪ ***Recommendations.***

1. Ensure that all youth receive prompt medical attention following their involvement in a critical incident, whether or not they report being injured.
2. Photograph all injuries sustained. In situations where mistreatment by staff is alleged, photograph the areas in which the youth reports injury, even if no injury is visible.
3. Document the delivery of medical treatment on the incident report itself.
4. Document the delivery of medical treatment in the youth’s medical file, to ensure that medical staff’s subsequent contacts with youth are fully informed of the youth’s history.

Behavior Management.

Adolescents exhibit a range of nuisance behaviors that, while annoying to staff, do not pose an immediate threat to the safety and security of the facility, staff or other youth. In addition, youth sometimes engage in more serious behaviors (e.g., assault, attempted escape, etc.) that require a firm and predictable response. Disciplinary isolation, considered by some an appropriate response to certain serious behaviors, is never an appropriate response to nuisance behavior. A behavior management system (BMS) that rewards youth for positive behavior and penalizes youth for non-compliance or negative behavior can be a key tool to protect youth from harm, if it is properly designed and implemented. The range of incentives should be meaningful to youth; should affect a large proportion, if not all, of the youth; and should be frequently available. The range of consequences should be proportional to the severity of the behavior, should be clearly articulated, and should be consistently and fairly applied by staff. The BMS

should be used in all sectors of the facility—in the housing units, in school, in the dining hall, and during programming and should be effective on both weekdays and weekends.

- **Observations.** The basic behavior management program at Alexander is conceptualized as a levels system where youth accumulate points and advance to different levels with progressively more privileges. The housing units use different labels for the levels (Learner, Practicing, Role Model; Pride, Gold Star, Show; Pearls, Dolls, Princess) and award differing numbers of points per day, but the concept remains the same. Youth begin the day with a maximum number of points, and points are deducted by teachers, YCWs and others in response to negative behavior and rule violations. Points are used only to advance from one level to the next, and cannot be used to purchase rewards. Privileges associated with the level vary across housing units, but are very limited in scope in all instances. Staff described the higher levels receiving progressively more TV time, recreation time, or later bedtimes, but that the behavior management program was otherwise limited in what it could provide to youth to encourage positive behavior. Recently, Saturday Activities were reportedly implemented for those who had achieved Role Model status, but the details of this program are not known.

Administrators at Alexander acknowledged that the behavior management system varies in its application from unit to unit, and lacks consistency among staff. Youth do not have any way to “earn” points based on performance, but can only “lose” points based on misbehavior. Such a design obviously lacks an incentive for youth to perform well. If, for instance, a youth loses a significant number of points early in the day, there is no incentive for them to improve their behavior in the remainder of the day in the hope of earning back lost points. All staff commented that the scope of both sanctions and rewards available through the current program were not sufficient to encourage positive behavior and to discourage negative behavior. Youth were aware of the behavior management system and could, in virtually all cases, identify their level. According to most youth, however, the system lacks meaningful rewards to be a factor in motivating good behavior. Many youth were unable to describe the difference between the first two levels, believing that the two levels share identical privileges.

Several staff were concerned that the level system unintentionally reinforced negative behavior by providing one-to-one attention to youth who misbehave and by excusing them from school if they acted out during the school day. For many youth who struggle in the classroom, their objective in acting out in the classroom is exactly this—to leave the environment that challenges them and to receive individual attention from staff. Staff noted that youth who were meeting expectations were rarely given individual staff attention as a reward, even though most staff felt this would be a compelling incentive for youth to behave. Two staff indicated that when they tried to restrict non-compliant youths’ access to recreational programming (e.g., movies or special events), they did not have

sufficient staff to hold the youth in their rooms and ended up simply allowing the youth to participate with the others.

The variety of sanctions available is extremely limited, as the youth's level is dropped in response to nearly every instance of misbehavior. Youth reported that in response to most misbehavior, a “long form” is completed by the case manager that in the extreme could result in added custody time, but often does not result in a tangible sanction. More serious behaviors also include a period of room restriction (discussed in the next section). None of the youth or staff reported the use of any other type of sanctions—writing an essay, writing a letter of apology, tutoring a peer, campus beautification project, etc.—relying only on the loss of privileges associated with one's level. The problem with this practice is that for some youth, the rewards and sanctions available through the levels system are not particularly meaningful and do not serve as effective incentives for positive behavior. In response to major rule violations, youth are placed on MCV (major community violation status), which has relatively few privileges associated with it.

Facility administrators reported their intention to move away from the point/level system and to one that responds to misbehavior in a more interactive fashion. In other words, when a youth commits a rule violation, the youth and staff will engage in a conversation to determine the appropriate sanction. This process should result in a far more individualized system that could account for the broad range of cognitive abilities among Alexander youth. Further, it can be tied more clearly to programming, treatment and discharge planning goals and thus could become a coherent part of G4S' rehabilitative mission. However, this shift was only in the very early planning phase and has yet to be fully designed. There is currently no projected date by which implementation is anticipated at Alexander.

- **Recommendations.** Fortifying the behavior management system may lead to a reduction in the number of youth-on-youth assaults and the number of youth who fear for their safety. Program enhancements should include efforts to:
 1. Redesign the program to provide a richer and more meaningful array of rewards and sanctions to encourage positive behavior. Every effort should be made to integrate individual youth's treatment and discharge goals in the behavior management program, thereby creating meaningful incentives for achievement.
 2. Train staff to apply the system properly and consistently. Not only should training include real-world scenarios for staff decision-making, but also should help staff to utilize the system in a strength-based manner (e.g., encouraging good behavior rather than constantly threatening sanctions for negative behavior).
 3. Develop a range of incentives that can be purchased as part of a token economy with earned points. Engage youth in designing the list of items and their cost, to ensure the array is seen as both valuable and worthwhile.

Isolation.

Considerable debate exists within the juvenile justice community as to the appropriate use of isolation. Generally accepted practice is to view isolation within a juvenile correctional facility as a tool to be used sparingly to de-escalate youth who are violent, out of control, and who represent an immediate threat to the safety of youth and staff and the security of the facility. If the purpose of de-escalation is to be served, youth must be placed in a separate environment so that they can regain control, calm down and work through some of the issues that sparked the violent behavior. This type of isolation is used only when youth are agitated—after a fight or after an intense verbal altercation with staff—and should be short-term. Most youth will calm down within a couple of hours, and some even sooner. The length of stay depends entirely on the youth—how quickly they regain control, and whether they are willing to commit to letting the issue pass. However, ensuring the length of stay is commensurate with the youth’s demeanor also depends on the frequency and intensity of staff interaction with the youth. Staff should visit the youth frequently and should attempt to engage them in conversation and to counsel them to prepare for return to the general population.

Increasing numbers of jurisdictions have ceased to use isolation as a punitive sanction. Effective sanctions used in other jurisdictions include point reductions, community service, writing assignments, apology letters, losing the privilege of attending a social event, among others. Time in isolation does little to change the underlying causes of the troublesome behavior. If youth are put in isolation for swearing or being generally annoying to staff, they are not being taught to express themselves appropriately and will likely emerge from isolation even more frustrated. Fewer and fewer jurisdictions look to isolation as punishment but rely instead on sanctions that more directly address the underlying causes of the behavior. It is certainly more in line with best practice to limit the use of isolation to those situations in which the youth presents an immediate risk of harm to himself, staff, or other youth, and thus must be held in isolation until he is calm and this risk has subsided.

- **Observations.** Although G4S and facility administrators indicated their desire to alter the Alexander’s isolation practices no clear date exists by which intended modifications are to be implemented. Current practices suggest that isolation is used at Alexander in a manner that is inconsistent with contemporary standards of care. YCWs reported that isolation (also called room restriction, social separation or social isolation) was commonplace under Cornell but has become less pervasive since G4S assumed operational control. Although possibly used less frequently, there was a striking lack of consistency across staff in response to questions about when the use of isolation is authorized, procedures for placing a youth in isolation, and the documentation that must accompany its use. These varied and inconsistent responses from staff suggest that isolation is imposed arbitrarily and without the

procedures normally required to protect youth's due process rights and to ensure their safety during the period in which they are confined to their rooms.

Administrators stated that they are in the process of modifying their use of isolation, moving to a "Controlled Observation" approach to room confinement intended not to exceed 24 hours and to involve frequent interviews by staff with youth confined to their rooms to gauge their mood and ability to return safely to the general population. Administrators stated that visual checks of youth on room confinement are to be conducted every 15 minutes and documented in the unit log. They noted, however, that 15 minute checks and documentation is the "expectation" and they are aware that this practice is not being adhered to uniformly by all staff. They also noted that youth are to be released from room confinement as soon as a youth has calmed down and can safely function on the unit; and that room confinement is not to be used as a form of punishment. This too, however, was noted by administrators to be an area where they know deviation occurs. Administrators at Alexander acknowledge the importance of proper and sufficient training for staff in this area. At the time of our tour, however, no dates had been fixed by which the needed training would be initiated or completed.

In practice, we saw examples where isolation was used as punishment without any of the necessary procedures to ensure the youths' safety and welfare, or to protect their due process rights. One of DRC's clients who reported that she had been on "social separation" for two weeks was used as a case study to obtain a snapshot of the facility's practices surrounding the use of isolation. From February 21, 2007 through approximately March 4, 2007, frequent entries were noted in the Girls Unit Log indicating that the youth in question had been confined to her room for extended periods of time. Documentation was not sufficient to ascertain the reason for this confinement, who authorized it, or whether it was implemented throughout the entire period above or whether the youth was released to the general population at certain periods. Facility administrators searched the incident report files for this information, but to no avail. Whatever caused the youth's lock-down status had not been reported through the required channels. Further, contrary to facility policy (as reported by facility administrators) which requires safety/welfare checks of all youth confined to their rooms at 15-minute intervals, documentation of these checks in the log book were sporadic, at best. Many times, an entry was made indicating that the youth was on the unit (e.g., "1Youth, 1Staff on unit") but additional entries were not made to verify the youth's well-being.

In addition to placing youth in room confinement for extended periods without the standard precautions to ensure fairness, safety and the protection of their due process rights, Alexander staff also reportedly utilize group punishment, which is incompatible with contemporary standards of care. The majority of youth interviewed reported that they are frequently punished in mass for the behavior of one or two youth on the unit. Youth from all housing units provided many examples

of this practice. Several girls mentioned one girl in particular whose misbehavior is frequently the cause of group punishment. Boys from various units also mentioned the names of one or two youth whose misbehavior resulted in blanket forms of punishment for all. These challenging and often deeply troubled youth commonly become the targets of retaliation for their actions by others on their units, placing them at high risk of harm by other youth.

▪ **Recommendations.**

1. Develop procedures strictly limiting the use of isolation as a method for de-escalating youth behavior and helping them to regain control.
 - Identify the circumstances under which isolation is permitted (but not required), such as immediately after a fight with another youth, after attempting to assault or assaulting a staff member, after attempting to escape, etc.
 - Identify the frequency with which Youth Care Workers or Supervisors must meet with the youth (e.g., every 2 hours) and the types of questions to be asked to assess the youth's readiness to return to the general population. Require supervisors to document the reason for continuing isolation (e.g., making threats, history of continued aggression upon release, etc.).
 - Require staff to make frequent welfare checks of the youth while confined (e.g. at random intervals, no less than 6 per hour) and to document these observations on an Observation Form. Maintain these documents in an organized fashion so they may be audited to verify that policies have been properly implemented.
2. Develop written policies delineating minor and major rule violations and the authorized sanctions for each type of infraction.
 - Develop a range of creative sanctions for violations that do not warrant confinement.
 - Ensure that sanctions are proportional and germane to the nature of the offense itself; and
 - Grant youth the right to appeal the sanction to the Facility Administrator or designee.

Classification.

One of the key challenges in safely managing a large juvenile correctional facility such as Alexander is the diversity of offenders in the general population. Given the large number of very low-risk offenders that fill Alexander, limiting their exposure to more sophisticated delinquent youth is extremely difficult. Youth at Alexander charged with status offenses and probation violations are housed along with those accused of very serious violent crimes. Youth of all different ages, sizes, and levels of sophistication and

maturity are housed in close proximity, creating a risk of harm to those who are more vulnerable. There are few places where deviant youth are more tightly concentrated than in a correctional facility, and Alexander is certainly no exception. As discussed in the first section of this report, “external” classification systems use a set of empirically derived factors to identify the specific level of supervision that is needed by a particular youth, based on his or her risk of recidivism. Within correctional facilities, a different type of classification system is needed. “Internal” classification instruments distinguish potentially predatory youth from those who could be easily victimized, leading to housing assignments that prevent contact between these two groups and suggests supervision strategies to diminish the risks involved. An internal classification instrument is composed of a variety of factors such as the youth’s committing offense, age, size, maturity, and prior involvement in institutional misconduct to determine the appropriate classification level and housing strategy. High quality instruments are used throughout the country, but all should be locally validated to ensure they will lead to accurate decisions within a new setting, before being adopted. Without a local validation, a jurisdiction risks implementing a system that could actually *create harm* (by housing inappropriate types of offenders together) rather than mitigate it.

- **Observations.** Alexander does not use any type of objective internal classification instrument. The housing units were characterized as follows:
 - Dorm 1: sex offender unit; 18 single cells
 - New Dorm: older boys, general population; 48 beds in open dormitory setting (four 12-bed pods)
 - Boys Intake: intake unit, younger boys; 18 single cells
 - Girls Intake: sole housing unit for girls; 12 rooms that can be double/triple/quadruple bunked
 - House of Hope: sanction unit; 15 single cells
 - JUMP: sanction unit; 24 single cells (3 6-bed pods)

Most of the DYS and G4S administrators commented that Alexander was not being used as originally intended. The facility is designed as an Intake and Assessment center, intended to admit boys and girls once committed to DYS custody, complete a 30- to 45- day assessment process, and transfer the youth to an appropriate placement. While this quick turn-around reportedly does occur for a small segment of youth, the population includes many youth for whom suitable placements cannot be located (e.g., those who are developmentally disabled; those with significant cognitive deficits; those who have failed at prior non-secure placements). These youth often languish at Alexander for months, sometimes years, even though Alexander was not intended as a long-term placement. Further, the sex offender programs are located at Alexander which suggests at least some intention to provide ongoing programming. This heterogeneous youth population presents a significant challenge for housing decisions. While the Alexander is large and has multiple housing units, most are

somewhat specialized, leaving very little flexibility in terms of bed assignments. For example, one girl reported a scenario that perfectly illustrates this point: she was concerned for her safety because one of the girls in her four-person room had made unwanted sexual advances toward her. She wanted to be moved to a different room, but could not because the combination of offenses (sex offenders must be housed in a single room), medical needs (girls with injuries, weight problems, and other chronic conditions that required their assignment to a lower bunk), and alliances/tension among the other girls left very few choices within the single housing unit for females.

The threat of unwanted sexual advances or of having to witness consensual sexual activity among roommates was a common complaint among the youth interviewed. When questioned about the issue, staff appeared to be at a loss for effective strategies to combat the behavior, stating that it occurs at night when youth are in their rooms/on their bunks (and not as well supervised as during the day), and that they are very limited in their ability to re-assign beds in response to these complaints. A more structured and strategic housing assignment process could provide staff with additional tools to manage this behavior more effectively.

The dormitory setting of New Dorm also presents a security challenge. While particularly vulnerable or predatory youth could be shuffled among the four pods, there are few options for boys to be housed separately, unless they are sex offenders or have some sort of disciplinary issue taking them to House of Hope or JUMP. Particularly in the dormitory setting, youth of all different sizes, levels of maturity, and histories are all housed together, with no formal distinction between those who are potentially vulnerable and those who are potentially predatory. Bed assignments may be posted on individual doors or individual rooms, but no historical record of these assignments is kept, which limits the ability to adequately investigate allegations of inappropriate sexual contact or other forms of assault. The failure to use an objective process to assess each youth's potential for violence within Alexander and to house them accordingly creates a serious risk of youth-on-youth violence.

▪ ***Recommendations.***

1. Develop/adopt and validate objective internal classification instruments to guide housing decisions. The validation should be conducted by qualified researchers who examine the statistical relationship between the items on the instrument and the youth's involvement in institutional misconduct.
2. Classify all youth upon admission, and re-classify them after they have been housed at the facility for a specified period of time (e.g., 30 days) or after they have been involved in a major rule violation.
3. Develop a housing plan that identifies the type of youth that may be placed in each room in each unit. For example, dormitory beds closest to the control

- center should house those who are potentially aggressive and those who may need more intensive supervision (e.g., those on suicide precautions).
4. Maintain and audit housing assignment sheets to verify that classification procedures have been implemented as designed.

Measures Designed to Protect Youth from Self-Harm

Adequate policies and procedures need to be established and implemented in all juvenile correctional settings to identify, supervise, and protect youth who indicate a risk of self-harm. Youth in correctional settings are known to be at higher risk of suicide than their counterparts in the community. In fact, young people with behavioral health problems who are confined in secure correctional settings tend to get worse, not better.

Youth in secure confinement express the risk of self harm in various ways and staff must be trained to identify and to respond to them in developmentally-appropriate ways. Their responses will vary somewhat with the individual needs of youth, but in general, will include a combination of enhanced supervision and mental health treatment to address the underlying issues. Adolescents who experience suicidal feelings typically do better when fully-integrated into normal program activities and when their positive relationships with others are sustained. The risk for suicide may be present upon admission and must be identified using a validated and developmentally-appropriate suicide risk assessment instrument. Because the risk for suicide may develop during the period of incarceration, staff must be trained to identify warning signs and to refer youth for assessment by qualified mental health professionals.

In general, all ideation, gestures, and attempts should trigger suicide precautions. Once the risk is identified, the generally accepted practice utilizes multiple levels of precautions with increasingly intensive levels of supervision. The welfare of those at lower risk is commonly assessed approximately every 15 minutes (and documented accordingly), while those at higher risk are assessed approximately every 5 or 10 minutes. Some youth may be placed under constant visual observation and/or one-to-one supervision if suicide is thought to be imminent. Observations should be made in a random and unpredictable fashion, not at predetermined intervals, commonly articulated as “check at random intervals, no less than 6 per hour.” In addition to differences in the intensity of supervision, the levels of precautions also typically differ in terms of the required proximity of staff to youth (e.g., those at great risk must be within arm’s length) and whether enhanced supervision is required during both waking and sleeping hours.

Typically, any staff person should be able to place a youth on suicide precautions, with the default being the most intensive level of supervision. Only a qualified mental health professional should reduce the level of precautions, and only in response to a clinical

risk assessment. Youth originally maintained on the highest levels of precautions should be gradually stepped down to lower levels of supervision before being taken off suicide precautions altogether. Finally, mental health professionals should provide direct care staff with specific instructions about any restrictions on activities or possessions that are needed to ensure the youth's safety. The youth's person and environment should be searched regularly to ensure the youth has not obtained any implements that could be used to harm himself.

- **Observations.** Clerical staff in charge of maintaining the suicide precaution documentation described a process that, by design, is compatible with contemporary standards of care. All ideation, gestures or attempts should be documented on an incident report, which is forwarded to the Unit Manager. The youth is automatically placed on 1x1 supervision and clothed in a blue uniform to enhance visibility, and the psychologist and unit therapist are immediately notified. The youth is assessed by a qualified mental health professional (QMHP; masters-level, licensed) within 24 hours. If the youth remains on precautions for longer than 24 hours, the youth is assessed by the psychiatrist. Two levels of precautions are available: *Close Observation* which features 15 minute safety checks by unit staff; and *Continuous Observation* which features 1x1 supervision within arm's-length, with behavioral ratings documented at 5 minute intervals. These observations are documented on a Precaution Tracking Form. A list of youth on suicide precautions is updated each morning and is circulated to a variety of facility staff (Facility Administrator, medical staff, psychologist, psychiatrist, and unit staff). These youth are also discussed each morning at the Management Team meeting. The list of youth on suicide precautions includes the youth's name, housing unit, date/time placed on precautions, date/time taken off precautions and includes warnings about any items that are prohibited to ensure the youth's safety. Again, our ability to verify adherence to the procedures described was limited to a relatively small number of DRC clients and therefore lacks what we consider to be a thorough audit of actual practice.

As described by G4S officials, the policy includes most of the components of a sound suicide precaution strategy. However, confusion exists among staff about the supervision requirements of the two levels—most explained them somewhat differently and were uncertain about the differences between them. Staff also reported (and administrators confirmed) that emergency “cut-down” tools are not available at the facility and staff have not been trained to properly release a youth who is found hanging by the neck. For obvious reasons, this is a critical omission in training and one that could have dire consequences.

The translation of policy into practice was assessed by reviewing a collection of suicide precaution forms for six DRC clients. Observation forms could not be located for three of the six youth, suggesting that they were either never completed or that document storage procedures need to be enhanced. Those that were located were

in large part complete, meaning that observations were documented throughout the period of time that precautions were indicated on the Suicide Precautions observation form.

However, in both policy and practice, the concept of conducting welfare checks at random intervals is absent. Staff record observations at exact 5- and 15- minute intervals, and are not required to record the actual time at which checks are conducted. Further, the observation forms that were provided were in complete disarray, suggesting that no formal auditing process occurs to ascertain the extent to which staff are fulfilling their supervision responsibilities.

Given the history of successful suicides by hanging at Alexander and the deeply troubled youth who make up part of the facility's population, consistent adherence to suicide prevention protocols is essential. The widely inconsistent patterns of practice among staff that emerged from our review are troubling, especially in light of the approximate 30 minutes devoted to administering suicide prevention training as determined by our review of training records.

- **Recommendations.** Adequate policies and procedures must be designed to identify, respond to, and ultimately prevent attempts by youth to harm themselves. The following recommendations focus on the role of direct care staff, although mental health staff will play an essential role in the assessment and treatment of suicidality. Their role should be fully articulated and relevant training should be required as well.
 1. Continue to assess suicide risk upon admission. Ensure that youth who score in the warning range are placed on precautions and are promptly referred to and seen by a qualified mental health professional (QMHP).
 2. Develop and implement policies and procedures and secure the tools needed to intervene appropriately when a youth has hung him or herself. Ensure that all staff have quick and easy access to cut-down tools, yet control access to them so they cannot be used as a weapon by other youth.
 3. Incorporate the concept of observation at random intervals into policy and practice.
 4. Include the issues listed above in the curriculum for mandatory pre-service and annual staff training.
 5. Maintain all risk assessments and observation forms in a manner that will permit a regular audit of these documents to verify that policies and procedures are being followed. Streamline the document maintenance procedures to ensure that the majority of documents are stored in a central location so they can be audited most easily.

Measures Designed to Protect Youth From Harm by Staff

Youth can be harmed by staff both intentionally and accidentally. If staffing levels are not sufficient to safely manage out-of-control behavior by youth, and/or if staff are not trained to use physical and mechanical restraints properly, the risk of accidental injury increases. In addition to physical harm, youth also have a right to be protected from offensive and degrading language by adults in whose care they are placed. Regrettably, limits on our access prevented us from rendering firm conclusions as to actual practice in this key area. Given the many alleged incidents of abuse of youth by staff at Alexander in the recent past, however, reaching supportable conclusions as to the potential for youth to be harmed by staff is particularly important.

- **Observations.** Well over half the youth interviewed reported experiencing various forms of physical and/or verbal abuse by staff. This was viewed by most youth as a relatively common occurrence, although it was noted by several youth that in their opinions abuse by staff is less common now than when the previous contractor operated Alexander. Youth reported that many of the staff known for their harsh treatment of youth have either quit or been terminated by G4S administrators. Nonetheless, several youth reported either witnessing or being subject to physical restraints by G4S staff that involved inflicting intentional pain above and beyond what is necessary to safely accomplish the restraint. Youth described recent incidents where staff would drive the points of their elbows and knees into the backs and necks of youth during the execution of physical restraints. Others reported having seen staff punch or slap youth. Other youth described a practice permitted by some staff where youth are allowed to take “body-shots” at one another. This practice, which is said to occur less since G4S has assumed control of the facility, involves youth striking each other with closed fists in the torso outside the view of security cameras. One youth described being paid by staff with Popeye’s Chicken to beat up other youth.

During our tour of the facility, we spoke with many youth, some of whom were DRC’s clients and some who were not. Most youth interviewed reported that staff frequently use profane language and sometimes racial slurs when addressing youth. A youth in the JUMP unit described a member of the staff telling youth that their sisters and/or mothers are “whores.” This, he said, was done to humiliate and provoke youth into a physical confrontation. Facility administrators admit that profanity is an issue on the campus and report they have recently terminated at least three staff for using profanity. The facility’s many security cameras have an audio feature that has been very useful in identifying the offending staff and holding them accountable.

As previously noted, Alexander is home, largely by default, to many youth who experience a wide range of very serious physical, mental and emotional impairments

that cause them to become targets of abuse by other youth as well as by staff. Interviews were conducted with at least three boys who experience incontinence and/or enuresis. These conditions have caused these boys to be singled out among both their peers and staff for humiliation as well as alleged physical and verbal abuse. One boy with a history of a congenital gastro-intestinal disorder described a recent occasion where he had an “accident” in which he soiled his pants. Staff loudly and publicly made fun of the youth’s situation, “That boy stinks. You shouldn’t do that in your pants,” which resulted in incessant taunting, teasing and various forms of physical abuse by other youth on the unit. This was corroborated by other youth.

Another boy with a long history of schizophrenia with visual and auditory command hallucinations, multiple serious suicide attempts and a history of sexual abuse, also recently soiled himself. He reported that two staff became angry with him and attempted to rub his face in the excrement. Once aware of the incident, Alexander administrators attempted to intervene by assigning a one-on-one staff member to this youth during part of the day and by instructing the staff alleged to be involved to stay away from the youth. Unfortunately, according to this youth, the one-on-one staff member is not available to him while he is in school or on weekends, limiting the effectiveness of this precaution. Furthermore, one of the staff members allegedly involved in this incident sat next to the boy at a basketball game earlier on the day of our interview. According to the youth, his one-on-one staff was seated elsewhere watching the game. The boy reported being scared when the identified staff member sat next to him. He reportedly told the staff member that he was not supposed to be near him. The staff member just laughed and said, “Now what are you going to do?” The boy moved to a different location away from the staff member.

This same youth described an earlier incident where another youth on his unit placed something over the window of his cell, thereby blocking the light and darkening the cell. The youth in his room became very frightened and began to bang and cry for help from staff. Staff were reportedly slow to respond to his cries and banging. As his fear escalated, the boy began to experience command hallucinations instructing him to bite himself. He ultimately bit deep into his arm in several places drawing blood. It was reported by this youth that one member of the staff was “written-up” as a result of this incident.

Finally, several of the dorms on the Alexander campus are configured with “dry” cells, requiring youth to be allowed out of their rooms by staff at night to use the bathroom. Youth complained that some members of the staff are slow to respond to requests to use the bathroom. Some youth viewed this as a form of intentional punishment; others saw it as a reflection of disinterested and uncaring staff. In either case this slow response has on occasion contributed to youth urinating on the floor of their cells, which only serves to increase tensions between youth who share rooms, as well as between youth and staff who have to ensure the floor is cleaned.

Avenues for Youth to Report Mistreatment.

Youth should have free access to a confidential process for reporting mistreatment, abuse or neglect. Whether this process takes the form of written grievances or a telephone hotline, staff should be required to provide access upon request. Although access does not necessarily have to be granted immediately, it should certainly be provided as soon as possible. A very limited number of facility staff should have access to the grievances so that youth can be assured of their privacy. Once received, all grievances should be logged so that an auditor may track compliance with protocol and timelines. Staff assigned to handle grievances should investigate matters by speaking directly with the youth; talking to staff involved, including those from medical, food services, or whichever service area was implicated in the grievance; providing youth with a written resolution; and disciplining staff as appropriate or referring the matter for further investigation. All of these steps should be accomplished in a reasonable time frame—generally, youth should be contacted within 48 hours and the matter should be resolved within 72 hours thereafter in most cases. Obviously, more complicated issues, those requiring staff discipline or further investigation, may take longer to resolve.

Youth should also be provided with the opportunity to express concerns about their treatment during the incident reporting process. The generally accepted practice is for all youth involved in incidents to provide a written statement shortly thereafter. If the youth initially refuse to write a statement, they should be provided with the opportunity again after they have calmed down. Youth who have difficulty writing or who have limited English proficiency should be offered assistance from an impartial staff person or counselor. Youth should write their statements independently, to limit the opportunities for collusion among the youth involved. If any of these statements alleges excessive force, mistreatment, or outright abuse, the incident should be reported to Child Protective Services and investigated accordingly.

Many jurisdictions provide an additional avenue for youth to voice their concerns by requiring medical staff to conduct a confidential interview with youth when they are brought to the clinic following an incident. Medical staff should record the youth's statement verbatim, and the supervisor reviewing the incident report package should be alert to claims of mistreatment and abuse and should react accordingly.

- **Observations.** The grievance system is well-used by youth: in February, 114 grievances were submitted, 72 in March and 105 in April. Approximately 50 percent of the grievances submitted in March, April and May, 2007 were reviewed (the names of youth and staff were redacted to protect their privacy). A significant number of grievances related to issues of safety—youth reported feeling threatened by particular youth or having been assaulted by a youth undetected by staff. Most of these were addressed within a reasonable period of times (48 hours or less) by the

Assistant Facility Administrator speaking directly with the two youth involved. A significant number also alleged mistreatment, verbal abuse, or physical abuse by staff. In all cases, the youth was contacted to gather information, but whether or not the complaint was taken further (e.g., reported to the Child Abuse Hotline, investigated by any of the agencies responsible for doing so) could not be discerned. It is essential that all allegations of mistreatment, verbal and physical abuse are reported, investigated and resolved with appropriate disciplinary measures when warranted.

While the assigned Grievance Officer clearly takes the responsibility seriously, and contacts the youth quickly to learn more about the issue, the grievance process suffers from a paucity of information about how the issue was ultimately resolved. Many of the responses to the complaints indicate what the Grievance Office (or Unit Manager if so designated) “will” do or “plans” to do, without ever verifying what if anything was actually done and how the issue was addressed.

Most youth interviewed were aware of the existence of a grievance system and many had confidence in the system as an avenue to report concerns ranging from alleged abuse or unfair treatment, to complaints about the food. Not only could most youth describe the process, where to obtain grievance forms and where to deposit them, but they could also name the member of the staff charged with responding to grievances. While not all youth interviewed had filed a grievance, many had and most saw it as a legitimate means of voicing concerns. The grievance system is one that was seen by most youth as having improved considerably since G4S assumed operational control of the facility.

In addition to the grievance system, many youth interviewed knew or had fairly good relations with one or more members of the Alexander administration and felt they could raise issues of concern directly with them. Youth tended to know members of the Alexander administration by name, including the Facility Administrator and Assistant Facility Administrators, all of whom were observed circulating through the facility at irregular hours throughout our tour. There appeared to be a fairly high degree of trust between youth and the facility administrators. Interestingly, the level of trust did not seem to extend as broadly to the YCWs and other line staff. Although there were certainly exceptions, many youth had trouble identifying members of the staff as individuals they trusted. Case workers, trackers and teachers also received a very mixed review from youth. Some were seen as helpful individuals who had the youths’ interest at heart, others, however, were seen as in it for the pay check with little regard for the youth.

- **Recommendations.**

1. Take steps to prevent the occurrence of abuse in the first place by properly training and deploying staff. Utilize Alexander’s videotape and audiotape resources to conduct random observations of staff interactions with youth to

ensure that staff conform to expected standards of professionalism, in both their words and actions. Given that DYS administrators have desktop access to audio and video footage, periodic monitoring of G4S operations is an important quality assurance mechanism.

2. Enhance the current Grievance system by requiring staff to indicate the specific actions taken, and the results of these actions on each grievance form, rather than stating only what the staff anticipates doing to resolve the issue.
3. Ensure that all allegations of staff mistreatment and abuse are reported to the proper authority, are investigated, and are resolved with appropriate disciplinary measures.
4. Ensure the incident reporting policy and practice require youth involved in the incident to submit their own statements in writing. Provide a second opportunity to submit a statement to those youth who initially refuse. Alternative means should be available to those who do not read or write or those with limited English proficiency.
5. Develop a process for confidential interviews of youth by medical staff following their involvement in an incident in which force is used. Upon transport to the clinic, nurses should hold a confidential interview with youth to gather information about the incident. The nurses should copy the youth's statement, verbatim, into the progress notes and should also clearly indicate whether the youth has alleged mistreatment by staff, affirm that the allegation was reported to Child Protective Services and make an assessment of whether the youth's statement conflicts with or is corroborated by the type of injury sustained. Formalize this process in local policy and train staff accordingly.
6. Attend to the quality of interactions between youth and staff and the overall culture at Alexander so that youth might become more comfortable expressing their concerns directly to staff.

Reporting Allegations of Abuse to the Proper Authority.

When an allegation of abuse is made, it must be reported to the proper authorities to investigate the veracity of the allegation. All staff working at a correctional facility are mandated child abuse reporters by state law. As such, they must report all instances of alleged abuse, no matter how credible, to the state Child Protective Services agency, law enforcement, or both. In most states, direct care staff are not required to actually call the agency themselves, but rather to report the allegation immediately to the facility director or designee who makes the call to the agency. However, they must do so without filtering information or making subjective decisions about which are serious enough or credible enough to be reported.

- **Observations.** Facility administrators reported that Arkansas child abuse reporting mandates identify local law enforcement as the agency to handle abuse allegations

of youth in state custody. The State Police operate a Hotline for this purpose that is staffed 24-hours per day. Once reported, the hotline indicates its intention to accept or screen out the allegation for investigation. In the Q1 of FY 2007, the Hotline received a total of 45 calls from all DYS facilities, and accepted only 25 of them for investigation. Facility administrators reported that State Police contacts have made them feel as if the police believe Alexander should report only a subset of the allegations they receive, that there are some (e.g., those without injury) that will not be accepted for investigation and therefore Alexander staff should not “overuse” the Hotline. Facility administrators have properly decided to continue to report ALL allegations of abuse to the Hotline, as required by law.

All staff interviewed were aware of their responsibility to report allegations of mistreatment and abuse on an Incident Report and to notify their shift supervisor or other facility administrators. However, the extent to which all allegations of abuse were reported and investigated could not be discerned from the data available for review.

- **Recommendations.** All youth deserve to have their concerns handled appropriately. When these issues rise to the level of mistreatment, definitive action must be taken to initiate the investigation process.
 1. Report ALL allegations of misconduct or abuse to the State Police Hotline. Misconduct and abuse include verbal mistreatment, threats and actual physical violence, and sexual misconduct. Hold all staff to these standards and disciplined them appropriately.
 2. Document the date/time Hotline calls were made and develop a tracking system to provide quick information on the status of all cases.

Placing Accused Staff in Non-Contact Positions Pending the Outcome of Investigation

The generally accepted practice requires staff to be placed on non-contact status pending the outcome of a child abuse investigation. By immediately moving accused staff to a position in which they do not have direct contact with youth, the facility protects youth from harm and protects itself from liability if the staff person were to commit additional misconduct pending the outcome of the initial investigation. Obviously, since many allegations are unfounded, it is vital that child abuse investigations be completed in a timely manner so that wrongly accused staff can be relieved of the stress involved and can return to their normal posts.

- **Observations.** Facility administrators reported that when an allegation is made, the first action taken is to review the videotape for the date/time/location of the event in question. If audio or video evidence suggests that staff may be culpable or may

not have followed required procedures, administrators assert that he or she is removed from duty immediately or called at home and told not to report for their next shift. Because we did not have access to the volume of incident reports and hotline calls, we could not assess the extent to which the practice follows the prescribed policy. Those staff who were interviewed believed that they would be placed on non-contact status if they were named in a child abuse allegation.

- **Recommendations.**

1. Continue the practice of immediately reviewing videotape footage of the date/time/location in question to gain an immediate sense of the severity of the allegation.
2. Place all staff accused of misconduct or abuse on non-contact status, either moving them into positions in which they do not have direct contact with youth or placing them on administrative leave.

Child Abuse Investigations and Staff Discipline.

All allegations of abuse should be investigated at some level. State Police may choose to screen out those in which no injury was sustained, but these should still be investigated at the agency and facility level to determine whether any staff misconduct occurred. These investigations should be timely; should involve interviews with all parties involved; should utilize supplementary sources of information from log books, videotapes, etc.; and should form conclusions that are reasonable given the evidence. If substantiated, staff should be disciplined accordingly.

- **Observations.** Although the State Police have accepted a few allegations for investigation they have not shared the full-text of these investigations with facility staff. They provide only a short statement of whether sufficient information existed for criminal charges to be brought. Obviously, the failure to share such vital information places youth at risk of harm from staff. While the evidence may be insufficient to file charges, the evidence flowing from an investigation can highlight issues related to policy, practice, training, etc. that have a tangible impact on the ability to protect youth from harm.

Each allegation of mistreatment or abuse is also investigated by the Internal Affairs Unit of DYS, according to facility administrators. It is not known whether IAU accepts all allegations for investigation, who completes the investigations, the quality of the investigatory protocol or whether this protocol leads to reasonable conclusions—DYS refused to allow access to these investigations. Without this information, we can make no conclusions about the adequacy of these measures to protect youth from harm by staff. At any rate, the potential for duplicity and miscommunication between DYS and G4S highlights the critical need for coordination and a free exchange of information about youth housed at Alexander.

To supplement the State Police's investigations and those completed by DYS/IAU, the facility recently hired a retired state police officer to serve as a facility-investigator. At the time of our tour, he had been on staff for only a few weeks, and thus had yet to formalize the procedures, protocols and practices that should come to define his role. However, we were provided access to one of his investigations and had the opportunity to review several videotapes showing staff response to various types of incidents. These videotapes reportedly serve as an important source of information about the culture of the facility, areas in which staff need additional training, and for identifying staff who violate the codes of professional conduct so that appropriate discipline can be imposed.

Since G4S assumed operational control of Alexander, a total of 11 staff were terminated in response to employee misconduct:

- Verbal abuse/use of profanity (most of these were in the month prior to our tour, and were based on evidence gathered via the audiotaping function of the surveillance cameras);
- Excessive use of force (in January, 2007; staff "threw a youth into a wall");
- Violating youth confidentiality;
- Inappropriate use of force (using physical force when there was no threat to safety or security);
- Falsifying company records (duplicating treatment plans); and
- Sleeping while on duty.

• ***Recommendations.***

1. Develop a clear division of labor among the facility-based investigatory process, DYS/IAU investigations, and those completed by the State Police. While the lines of responsibility should not overlap, full and complete information must be freely shared among the three agencies to ensure that developing patterns (across staff, youth, times, places, etc.) are identified and prevention strategies are developed.
2. Use the facility-based investigatory process to review incidents, supplement investigations by State Police and IAU, and to determine whether staff violated policy or employee rules of conduct. Discipline or exonerate staff, as appropriate.
3. Ensure the facility-based process meets generally accepted investigatory standards in terms of the quality of the written product, the individuals interviewed and the sequence of those interviews, the collection and preservation of evidence, and the adequacy of the factual basis for all conclusions.
4. Develop the necessary interagency linkages with State Police to ensure that allegations from the facility will be taken seriously and investigated properly.

When possible, ask State Police to expedite their investigation processes so staff can either be returned to post, disciplined, or terminated, as appropriate.

5. Obtain copies of all State Police and IAU investigations and review for any violations of policy or employee codes of conduct. These issues are typically not addressed by criminal investigations and thus must be examined by a facility-based process. Discipline staff as appropriate.

Conclusion

The issues raised in this report as to the risks faced by youth confined at Alexander are intended to help guide DHS and DYS in their efforts to ensure the safety of all youth in committed status. As noted in the Introduction, although the majority of our comments address G4S operations, DYS is ultimately responsible for the performance of its private providers. As detailed herein, Alexander poses a series of especially complex and costly problems that must be corrected for the safety of youth in its care to be ensured. But Alexander should not be seen as a separate problem that exists in isolation of the much needed systemic overhaul of juvenile justice statewide. Viewing this report and its recommendations against the backdrop of SR31 may help to spark new and more creative thinking by stakeholders in pursuing the mandates of the Senate Resolution.

Arkansas is not alone in re-examining its juvenile justice system. Many states throughout the South and across the country are struggling with the very same issues that confront Arkansas relative to the operation of large, costly and ineffective secure institutions, over-reliance on institutional confinement of low-risk youth, and establishing a flexible continuum of non-residential community-based services that more effectively address the needs of public safety and the rehabilitation of youth who do not require secure correctional confinement. We urge Arkansas' Governor, juvenile justice officials, legislators, policy makers, youth advocates, service providers and other stakeholders in communities throughout the state to unite in their embrace of the opportunities presented by new and willing DHS/DYS leadership and by SR31 to fundamentally remake juvenile justice in the state. SR31, passed in March, 2007 by the Arkansas Legislature, created an interim legislative committee to identify needed reforms of the state's juvenile justice system. The resolution requires the committee to develop ways to reduce unnecessary reliance on large correctional facilities and to promote a continuum of community care so that youth committed to DYS may be served in the least restrictive setting possible, consistent with public safety.⁴ As described throughout this report, there are many safer, more effective and less costly alternatives to the largely failed models that depend on institutions to improve the behavior of youth. Abandoning the troubled Alexander facility in favor of small, secure and therapeutic facilities, complimented by a vibrant network of neighborhood-based services for youth and families is an approach that would benefit the youth and communities of Arkansas, both in terms of public safety and improved outcomes.

As immediate steps that can be taken to ensure the safety of youth in Alexander while broader, systemic reform plans are developed, we recommend that DYS and G4S develop immediate plans to rectify the following conditions so that youth committed to Alexander are no longer at risk of harm:

⁴ The full text of SR31 is included in the Appendix of this report.

1. Reduce the exposure of low-risk youth to confinement at Alexander by applying a validated external risk assessment instrument to help identify youth who can be safely managed in their home communities
2. Accelerate the thoughtful and well-planned discharge and subsequent supervision of youth currently in secure confinement by systematically targeting misdemeanants, probation violators and other non-violent offenders for the development of individualized, community-based plans into which you can be discharged with an assurance that supervision and support will be available to guide their success.
3. Develop a willing cadre of non-residential, neighborhood-based service providers who operate diverse and culturally competent programming in or near the home communities of DYS youth, and who are committed to working with challenging youth and willing to enter into “no eject – no reject” policies as part of their service contracts.
4. Examine models of “fiscal realignment” developed in several other states that encourage local jurisdictions to treat low-risk youth locally rather than committing them to DYS for assignment to Alexander.
5. Ensure that staff ratios at Alexander are met consistently and that they represent the number of staff actually deployed to supervise youth at any given time. Ensure that all staff provide vigilant, pro-active supervision designed around positive interaction with youth and efforts to identify and de-escalate tensions before they develop into violent confrontations.
6. Ensure all staff have dependable access to the full G4S training curriculum. New employees should receive at least 80 hours of training on all topics, along with 40 hours of on-the-job training before they are assigned to supervise youth independently. Existing employees should receive a 40-hour refresher course annually, focusing heavily on behavior management and de-escalation, the use of force, suicide prevention, and child abuse reporting.
7. Develop a process for supervisory review and critique of all incidents. Not only should supervisors certify the incident report is complete, but should also provide guidance on how the incident could have been prevented or anticipated and whether staff followed the use of force policy or could have responded with less restrictive interventions.
8. Develop additional incentives, rewards and programs to encourage positive behavior among youth. Tie these rewards to developmentally-appropriate skills, problem-solving strategies and behaviors that youth should be expected to master.

- 9.** Develop procedures to protect the safety of youth placed in isolation, including room check procedures, supervisory oversight, contact with mental health staff and documentation.
- 10.** Continue to hold staff accountable for upholding G4S core tenets and for treating all youth with dignity and respect.
- 11.** Develop a series of timelines by which staff training, new policy implementation and other planned initiatives and improvements at Alexander are to be satisfactorily completed. As noted throughout our report, G4S has verbally committed to a great many training, policy and operational enhancements that will improve the safety of youth in confinement at Alexander. Ensuring accountability as to the timely completion of these enhancements is in the interest of all.

Appendix A

The Division of Youth Services (DYS) contracts with G4S Youth Services, LLC (G4S) for the operation of the Alexander. We reviewed many documents including:

- Arkansas Division of Youth Services *Juvenile Operational and Facilities Master Plan*, produced by KMD Justice/Chinn Planning Design Team, August 2006;
- Arkansas Department of Health and Human Services, Division of Youth Services, Statistical Report FY 2006;
- Arkansas Division of Youth Services, Task Force Meeting February, 2007, PowerPoint presentation;
- Arkansas Department of Health and Human Services, Organizational Chart
- Survey of Arkansas Community-Based Resources, produced by Stacy Moak, January, 2007;
- Settlement Agreement between the United States Department of Justice and the State of Arkansas, Division of Youth Services and the Arkansas Department of Human Services;
- Monitoring Report on Special Education Services at Alexander prepared by the Arkansas Department of Education, June 8, 2007;
- *It's Not Punishment, It's Rehabilitation*, report produced by the Disability Rights Center, November 2006;
- *Study of Intake and Assessment Process at Alexander Juvenile Correctional Facility (Alexander)*, report produced by Gail Browne, G4S Youth Services, LLC, April 2007;
- *Examination of Risk Assessment and Classification Systems: A Technical Assistance Report*, report by Robert DeComo, National Council on Crime and Delinquency, February 2006;
- Materials pertaining to two investigations of alleged abuse initiated by the Disability Rights Center in 2006-2007;
- Youth Grievances from March, April, and May, 2007;
- Training curricula for direct care staff;
- Rosters of direct care staff, along with dates of hire, and training completed to date for a sample of staff;
- Copy of the complete training curriculum for direct care staff;
- Incident reports generated from the date G4S assumed operational control in January through April, 2007 (with youth names redacted); and
- List of all youth placed on suicide precautions from January through April, 2007.

We also interviewed a large number of staff and youth including:

- Director of the Department of Human Services
- Director of the Division of Youth Services
- G4S Headquarters staff

- DYS Clinical Director and staff
- DYS Intake staff and trackers
- Facility administrator, and 3 Assistant Facility Administrators (AFAs)
- Facility-based Investigator
- Case Managers
- Chief of Security and Physical Plant
- Facility-based Training Officer
- Clerk responsible for maintaining documentation on suicide precautions
- Direct care staff, one from each of six housing units
- Nurse
- 22 boys from each of the five boys' housing units
- 8 girls from the single girls' housing unit

Appendix B

State of Arkansas
86th General Assembly
Regular Session, 2007

By: Senator Broadway

SENATE RESOLUTION

REQUESTING THE SENATE INTERIM COMMITTEE ON CHILDREN AND YOUTH AND THE HOUSE INTERIM COMMITTEE ON AGING, CHILDREN AND YOUTH, LEGISLATIVE AND MILITARY AFFAIRS TO STUDY WAYS TO IMPROVE THE STATE'S JUVENILE JUSTICE SYSTEM FOR YOUTH COMMITTED TO THE DIVISION OF YOUTH SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Subtitle

REQUESTING A STUDY FOR WAYS TO IMPROVE THE STATE'S JUVENILE JUSTICE SYSTEM FOR YOUTH.

WHEREAS, there is cause to evaluate needed reforms of the state's juvenile justice system to more effectively and efficiently serve youth committed to the Division of Youth Services of the Department of Health and Human Services and to identify best practices that will reduce unnecessary reliance on large juvenile correctional facilities and promote the development of an appropriate continuum of community-based treatment alternatives in the least restrictive settings possible consistent with public safety; and

WHEREAS, an interim study proposal is required for the retention of independent expert consultants to assist the Division of Youth Services of the Department of Health and Human Services to conduct comprehensive needs and risk assessments of juveniles incarcerated at the Alexander Juvenile Correctional Facility and other facilities of the Division of Youth Services of the Department of Health and Human Services to identify gaps in existing community-based alternative placements and services necessary to more effectively and efficiently serve juveniles committed to the Division of Youth Services of the Department of Health and Human Services in the least restrictive settings possible consistent with public safety; and

WHEREAS, there is a pressing need to develop a juvenile justice reform plan by no later than twelve (12) months from the effective date of this interim study proposal that incorporates the evaluations, assessments, and recommendations of the independent experts provided for by this interim study proposal and other stakeholders, including the Juvenile Justice Center of the University of Arkansas at Little Rock, the Department of Education, the Division of Behavioral Health of the Department of Health and Human Services, the Division of Developmental Disabilities Services of the Department of Health and Human Services, Arkansas Advocated for Children and Families, the Arkansas Disability Rights Center, the Juvenile Ombudsman Division of the Public Defender Commission, the Division of Children and Family Services of the Department of Health and Human Services, the Administrative Offices of the Courts, and families and youth; and

WHEREAS, there exists an urgent need for construction, renovation, acquisition, purchase of equipment, maintenance, and other operating expenses to implement the reform plan provided for in this interim study proposal and to replace the facilities where conditions of confinement support ceasing operation with facilities that meet contemporary juvenile justice national best practices. These treatment services, programs, and centers shall incorporate best practices for the provision of rehabilitative and other services for juveniles and be consistent with applicable standards of accreditation from the American Correctional Association.

NOW THEREFORE,
BE IT RESOLVED BY THE SENATE OF THE EIGHTY-SIXTH GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

THAT the Senate requests that the Senate Interim Committee on Children and Youth and the House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs study ways to improve the state's juvenile justice system for youth committed to the Division of Youth Services of the Department of Health and Human Services.