

# Treatment . . . Arkansas Style

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**An Investigation Report of the Arkansas  
Juvenile Assessment and Treatment Center**  
by Disability Rights Center  
The Protection and Advocacy System for Arkansans with  
Disabilities



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## **Preamble**

Arkansas spends more than 50 million of the state's tax dollars to provide "care and treatment" to children placed in the custody of the Department of Human Services (DHS). This does not include the millions of state and federal dollars Arkansas spends on its other various social services programs for children. Yet there is little or no oversight or accountability on whether our tax dollars are spent to purchase effective and appropriate services for some of the state's most needy. Tragic stories of children dependent upon Arkansas social services are extraordinary by any measure. Viewed in the context of the Division of Youth Services (DYS) detention practices, they reveal themselves to be the logical outgrowth of a broken system. This system, despite years of criticism and court intervention, has subjected thousands of children to continued mistreatment and deprivation. The people of Arkansas can no longer afford to continue funding this failed system.- It must be dismantled, re-designed, and replaced for the sake of our children who are depending upon us to provide them with a true opportunity for success.

## **Introduction**

The female victim in this report epitomizes the failure of Arkansas' systems to address the needs of its most vulnerable citizens. The victim was abused and neglected by her parents, and Arkansas' inability to coordinate its agencies and provide appropriate and effective services led to her incarceration and her continued abuse and neglect by a state that is required by law to provide "rehabilitative" services. The victim was "served" by multiple state systems and private for profit and nonprofit providers, including health, mental health, education, foster care, etc. It was the failure of these systems to work in concert that led to the victim's incarceration in the Arkansas Juvenile Assessment and Treatment Center (AJATC). Moreover, many separate entities, including courts, probation departments, public defenders, attorneys ad litem, case workers, community based organizations, and private nonprofit service providers were active within the juvenile justice system itself.

The incident in this report illustrates how the lack of collaboration can, through ineffective treatment, lead to the continued abuse and neglect of children in the State's custody. This child has endured sexual abuse and family dysfunction. She has been diagnosed with substance abuse, learning deficits, mental health disorders, etc., and yet records show that each service provider, rather than address the interrelated nature of her problems and treat them in an integrated holistic fashion, attempted to solve her problems in a vacuum. This lack of coordination led to this child being "bounced" from one system to another- education to mental health to child welfare to juvenile justice - and not once receiving the services she so desperately needed and deserved. While housed at AJATC, she received only four core academic courses in her educational day, not the wide array of academic choices – both required curricula and elective courses of study - found in Arkansas' public school system and required by institutions of higher education.

There are several evaluations in this child's file which indicate she should be referred for special education services. Yet DRC has been unable to find any documentation that she has been referred for or is receiving special education. As of October 25, 2007, she was confined to her cell where she was to receive all of her "educational" services. There is nothing in the law that says because a child is adjudicated delinquent he/she is entitled to less education opportunities. Ark. Code §6-10-120 ensures Arkansas' children an adequate and

equitable education system. However, children who are placed on the AJATC campus are immediately placed in an inadequate and inequitable education program without any hope of success.

There were crippling consequences at a system level as well: poor decision-making when knowledgeable experts in one agency were ignored by decision-makers in another; wasted resources as agencies and systems operated separate, parallel programs rather than achieving efficiencies by working together; and counterproductive outcomes when isolated treatment efforts failed to address the child's needs comprehensively.

**Mandating inter and intra agency collaboration and oversight are our primary recommendations.** Unless the Governor mandates that leaders of key agencies work together to devise new approaches to partnering, sharing information, devising integrated treatment plans for individual children and making joint decisions regarding what is in the child's best interest and not their own, Arkansas will continue to perpetuate the abuse and neglect of children it is charged with protecting and rehabilitating. When parents abuse and neglect children, the State removes the children from the home but when the State continues the abuse and neglect of children, we call it services. We must come together as a state, not one agency at a time, and work toward a true system of care that integrates all agencies that are charged with caring for children. It is time that Arkansas acknowledges that children's lives are more important than continuing to support a system that perpetuates the abuse and neglect of children.

### **Investigation Report**

DRC's client is a sixteen (16) year old Caucasian female with brown hair and brown eyes. She is 5' 7" tall and weighs 176 pounds. The client is no stranger to systems designed to provide treatment and rehabilitation services to youth. Nor is she unfamiliar with moving from place to place. According to one of the *Inpatient Psychiatric Evaluations* in the file, the client's parents, who never married, parted ways when the client was three (3) years old. She lived with her biological mother until the age of four (4), then went to live with her grandmother in California while her biological mother was incarcerated until she was five (5). "DHS placed the patient with the father where she was sexually molested until age 7 ½."<sup>i</sup> She was then returned to her biological mother and step-father. Her in-patient psychiatric admissions (as documented by records supplied during the course of the DRC investigation) included a July 2000 admission to Laureate Psychiatric Clinic and Hospital in Tulsa, OK, and a February 2002 admission to Brown Schools of Oklahoma.

At some point between 2002 and 2004, she returned to live with her biological father and step-mother, only to be taken into DCFS custody in Arkansas (for the first time) pursuant to a dependent/neglect case in April 2004, subsequent to her father's relocation to Arkansas. Previous to her initial adjudication as dependent/neglected, her biological father admitted her to the Summit School in Hot Springs in February 2004, until April 4, 2004. She was admitted to Ouachita Children's Center from April 15, 2004, through June 28, 2004, then to the Centers for Youth and Families from July 6, 2004, through September 27, 2004. Following discharge from the Centers for Youth and Families, she was admitted to Rivendell Behavioral Health on the same day. During 2004 and 2005, she was evaluated by the UAMS Department of Pediatrics, on July 6, 2004 and October 4, 2005. She was admitted to Living Hope (Texarkana, AR) on January 21, 2007. At that time, she was taking General Equivalency Diploma (GED) classes after having completed the ninth grade.

She was committed to DYS on September 7, 2006, for violation of probation and fleeing. During the time the client was at DYS' residential program in Mansfield, her father was arrested on drug charges and DCFS once again entered her life almost concurrently with a request from the Mansfield program to transfer the client back to AJATC. The February 7, 2007 *Request for Disruption Staffing* submitted by the Mansfield program

underscored the tenuous hold the client had on her relationship with her father. “To the best of my knowledge, [client name redacted] has no idea of the pending Dependency/Neglect petition to remove custody from her father. It is my fear that when she inevitably finds out about it, her behavior will continue to deteriorate even further.” The client was returned to DCFS custody in February 2007, again being adjudicated dependent/neglected on March 21, 2007. Response to DRC’s initial request on September 5, 2007, for the DCFS file was delayed for several days because the client had not been entered into DCFS’ database system, despite the fact that she had been in DCFS custody for the second time since February 2007. Excluding court appearances and one AJATC staffing on June 11, 2007, for which he was present by telephone, the client’s DCFS case worker documented one contact, on June 14, 2007, related to his client. It was a phone call not to or from the youth, but from her G4S Case Manager. The *Contact Sheet* noted, “[G4S Case Manager name and phone number redacted] of DYS called. [Client name redacted here and misspelled in original] is turning somewhat towards violence.”<sup>ii</sup>

Documents contained within both the DYS and DCFS case files, and requested by DRC during the course of its investigation into the client’s allegation of abuse, numbered more than 1,000 pages and noted Axis I diagnoses of “Sexual abuse of a child, victim,”<sup>iii</sup> “History of Physical/Sexual Abuse of a Child,”<sup>iv</sup> as well as “. . . history of physical abuse from stepmother and sexual abuse from stepbrother,”<sup>v</sup> combined with a diagnosis of “Child Maltreatment Syndrome – Multiple.”<sup>vi</sup> She has been diagnosed most recently with bi-polar disorder and conduct disorder, although she has a history of additional diagnoses of attention deficit, hyperactivity disorder (ADHD), physical and sexual abuse of a child (victim), post-traumatic stress disorder, and borderline personality disorder. (Although requests were made for a copy of her *DYS Assessment*, none was provided to DRC.) Despite the wealth of information about the client’s issues about feeling abandoned by people she loved, and her history of mental illness, DRC found no evidence that any of the state agency or direct care staff has ever read the entire case history of DRC’s client in an effort to provide her with effective assessment and treatment services.

These system failures made what happened to the client during the Labor Day weekend of 2007 all the more egregious.

### **Summary of Allegations/Incident**

On the morning of September 4, 2007, DRC Quality Assurance Team Leader Dee Blakley received a voice mail message from the client left on the previous Friday, August 31. In the recording, the client was crying and upset to the degree that it was difficult to understand everything she said, but Blakley determined that the client wanted to talk to Blakley about “them violating my rights.”

Blakley went to Arkansas Juvenile Assessment and Treatment Center (AJATC) on the afternoon of September 4, 2007, to follow up on the voice mail message. The G4S Internal Investigator informed Blakley the visit would have to take place in the dorm because the client was clothed in a suicide smock. When Blakley arrived at the dorm, she was provided with a room in which to talk with the client.

Blakley asked the client why she had been placed on suicide precautions. The client responded that she had received a letter from her younger sister on Thursday, August 30, informing her of the suicide of one of the client’s close friends. She stated that this news was too much on top of everything else she was going through and she just wanted to “give it all up.” It was then that Blakley learned that the client had been placed in the custody of the Division of Children and Family Services (DCFS), and her father was no longer in contact with her – in fact, he was no longer even in Arkansas.<sup>vii</sup>

The client told Blakley she had been placed on suicide precautions on August 31, 2007. She stated that on September 2, 2007, she was wearing the standard two piece blue suicide garment and her panties. The client

said she had wrapped the top to her two piece suicide garment around her head while in her cell, and this was observed by staff. As a result, she was told to change into a suicide smock, a quilted shift that closed at the shoulders with Velcro. She refused, and according to the client, two male program staff were summoned by the female Assistant Facility Administrator (AFA) #1 to remove the top to her suicide garment. The client told Blakley she fought the male staff but her top was removed anyway and she was dressed in the quilted suicide smock. The client could not recall who dressed her, but according to the written statement of AFA #1, attached to *DYS Incident Report B758*, AFA #1 dressed the client in the suicide smock.

The client stated that shortly afterward, and while in her cell, she tore the front half of the elastic waistband out of her panties and wrapped it around her neck, tying it but not tying twice to form a knot. Again, this was observed by staff, and the client was told to remove her panties and give them to AFA #1. She said she told AFA #1 that she was having her menstrual cycle, but AFA #1 still insisted she must remove her panties. The client was extremely upset during the incident as well as the recitation of it because, she alleged, her panties had been removed from her while she was facedown on the floor in her cell, in the presence of the male program staff who had earlier removed her top. She said she could not see who removed her panties because she was facedown on the floor. The client further alleged that she had no sanitary napkin during the night and menstrual blood had soaked through the suicide smock during the night. She said she was not allowed to shower until the afternoon of the following day, September 3.

During her conversation with the client, Blakley noted significant bruising to the client's arms and asked the client when the bruising had occurred. The client told Blakley the bruises occurred as a result of successive restraints on September 2, but it was the bruises on her upper, inner thighs that bothered her the most. She showed Blakley the bruises, then asked if it was a violation of her rights to have her panties taken off by staff with men in the room.

Blakley asked the client if photographs had been taken of her bruises. The youth told Blakley a *Marks Sheet* had been completed, but no photographs had been taken. Blakley asked her if she would consent to a female staff taking photographs of the bruising if Blakley remained in the room. The client agreed and Blakley asked the Facility Investigator to bring the digital camera from his office for photos to be taken. Photos of the client's bruises were taken by a female security officer with Blakley present in the room. To see photographs of the bruising, go to <http://www.arkdisabilityrights.org/DYSOct2007ReportAD1.pdf>.

After concluding her visit with the client, Blakley was provided with copies of the photographs that were taken. She also visited with AFA #1 about the incident. To Blakley's amazement, AFA #1 admitted that the client's top had been removed by male staff at her direction, and the client's panties had been forcibly removed – by AFA #1 – in the presence of the same male staff, although she vehemently denied that the client was on her menses at the time. AFA #1 completed an *Incident Report* detailing her role in the incident subsequent to her conversation with Blakley.

Investigation of this allegation was not the first contact DRC has had with this client. She has been known to DRC since her admission to AJATC and has been frequently characterized by AJATC staff as a needy, grasping, attention-seeking troublemaker who is fully capable of complying with program rules and guidelines as long as she gets her own way. "If she gets her way, she's compliant. If she doesn't get her way, then sometimes she's going to be, um, not be compliant, and sometimes she will be combative. And with respect to treatment, sometimes verbally aggressive, saying what she will do and she will not do. Sometimes she's able to be verbally de-escalated – it just depends on how she's approached."<sup>viii</sup>

During her discussion with AFA #1 on September 4, Blakley had asked AFA #1 if she could see why the client had been upset to the point of suicide after receiving news of the death of a close friend. AFA #1 told Blakley, "That's what she said it was then – with [client name redacted], it's always something. . ."

Therapist #2, who had performed a *Self Harm Assessment* on the client on September 5, didn't know what had triggered her desire to harm herself, and she didn't ask her.

Blakley: Were you aware of any precipitating factors to her being placed – to making the threats and any attempt – gestures that she may have made?

Therapist #2: No.

Blakley: Okay, so as far as you know, she just all of the sudden became suicidal?

Therapist #2: Yes.

Blakley: Did you review the clinical record about the reasons for her being placed on suicide precautions or this just came from your visits with her?

Therapist #2: No. Just from my visits with her. . .

Blakley: But she didn't tell you that on Thursday prior to being placed on precautions on Friday, that she had received a letter from her sister, informing her of the suicide of a close friend?

Therapist #2: No. . . I didn't want to go into detail with her being that I'm not her primary therapist. . . for her to open up that can of worms with me. . .so I'm just checking in with her, being that I was here on the unit.<sup>ix</sup>

AFA #1 and Therapist #2 are not the only staff at AJATC who failed to investigate and identify the underlying issues of this client's "neediness." Her Case Manager duly noted in a 5/29/07 *Progress Note*, "[B]eing seen by [Contract Psychiatrist name redacted] discussing why she went on suicide precaution. [Client name redacted] reported she doesn't have anyone to talk with." From a 7/9/07 *Progress Note* in which the client's mood is described as *hopeless*, the Case Manager reported, "No place to go after discharge. Dad out of state. Wants to go to another program for a few week to assist with depression. Believe she is on the wrong medication. Reports right knee messed up." There was no indication in the form of other *Progress Notes*, or notes in her medical or mental health charts of follow-up by the Case Manager, or referral to the client's clinical staff for discussion about these issues.

A review of therapy notes with the client's Primary Therapist paints a more complete picture of the very real issues of abandonment faced by this youth. A July 20, 2007, individual therapy note states, "[S]adness, isolation, need to belong." On July 14, again during an individual session, "[C]ontinues to acknowledge feelings of neediness, alienation, sadness. Will continue to attempt to support but my perception is that she is 'stuck' in this needy field."<sup>x</sup>

From an undated note: Client "presents as a solitary figure on field. She is aware of Dad's relocation, mother's rejection of her, and she feels belittled by grandmother. . . Unity with peers is very unsatisfactory." From a twenty (20) minute session on June 20, 2007, ". . . initially continues to focus on depression, anger re: father's behavior. Session stopped due to lack of available space." On June 14, 2007: "[R]emainder of session focused on self-esteem and abandonment issues. Acknowledges feelings of hurt with accompanying camouflage. Knows behaviors of aggression [are] inappropriate behavior." According to the client's Primary Therapist, the "neediness" she referred to in her own clinical notes was not neediness manifesting in attention seeking behavior, but rather a need to have at least one significant relationship that would give the client something "to hang onto."<sup>xi</sup>

The client's Primary Therapist explained during her DRC interview that the client's deep-seated need to be part of a relationship, due to the loss of her natural family, led her to try and establish relationships with inappropriate people, including staff, and for all the wrong reasons. The Primary Therapist said that the client was trying to sort through her feelings when she realized that her biological father was not an appropriate parent figure, adding, "I'm sure she always kind of knew it in her head, but now, she's admitted it."<sup>xii</sup> The Primary Therapist characterized the loss of the client's relationship with her father as an "overwhelming" loss. She also told DRC that the client needed to be allowed to appropriately grieve that loss.

Other staff familiar with the client also agreed that the client had grief issues. Therapist #2 was asked about that during her DRC interview.

Blakley: Do you see [client name redacted] as a child who's grieving the loss of a relationship?

Therapist #2: Yes, I do. I do.<sup>xiii</sup>

Knowing that the client had serious issues with feeling alone and abandoned by the people closest to her, it is very difficult to understand why on August 30 she was given a letter announcing the suicide of a friend to read alone with no therapeutic support available to help her process the resulting emotion. DRC's interview with the client's Case Manager, who scans all incoming and outgoing mail, did not provide answers to that question.

Blakley: If she, [client name redacted] writes a letter to her sister, you scan it before it goes out?

Case Manager: Yes.

Blakley: And then if [client name redacted] receives a letter from her sister -

Case Manager: That is correct.

Blakley: - you scan that before it is given to her?

Case Manager: That is correct.

Blakley: So were you aware of the letter that she had received on August 30th about the death-

Case Manager: Yes.

Blakley: - of a friend?

Case Manager: Yes.

Blakley: Okay, and how was that letter handled?

Case Manager: It was handled the same way I do – I scanned it. I didn't think it was inappropriate and um, it was logged and given to her.

Blakley: Okay. Was any staff with her or available to her as she read the news contained in the letter?

Case Manager: Yes, usually the residents read the letters either in the day area um, and I'm assuming that's where she was reading the letter. I know that she didn't read the letter in my presence.

Blakley: Okay, do you know what if any kind of reaction she – were you present when she read the letter?

Case Manager: No ma'am.

Blakley: Do you know any staff who might have been present when she was reading the letter -

Case Manager: No ma'am.

Blakley: - who could tell me what kind of reaction she might have had to it?

Case Manager: No, I don't.<sup>xiv</sup>

The clinical record also revealed that, although she was seen by numerous mental health professionals during her seven (7) day suicide precautions, only two (2) clinical staff explored with the client the reason for the her suicidal ideations and gestures – her Primary Therapist and Therapist #3.<sup>xv</sup> In a *Progress Note* dated 9/3/07 at 3:00 p.m., Therapist #3 noted, “[Client name redacted] stated that her sister called her and told her that her best friend had died. Sister called her on Wednesday. She states that she doesn't know how to deal with her feelings tearfully. . . She states that she hasn't been to the bathroom since 8:30 and really needs to go. We called security over to let her go to the bathroom and get a shower.”

The client was scheduled to see the Contract Psychiatrist on Tuesday, September 4. His *Physician's Note*, dated 9/4/7, stated, “Child Psychiatry – Patient not seen due to unstable behavior per staff – on suicide precautions – will continue and see on 9/6/7.” Therapist #3 wrote on her 9/4/07 *Progress Note*, “I was told by staff that [Contract Psychiatrist] refused to see [client name redacted] today to assess her because of her continued acting out behaviors. I encouraged her to behave appropriately so that she can come out [of] suicide precautions. She asked if she could come out of the suicide smock and I told her ‘no,’ which she reacted to by getting angry and sulking. Told her [Primary Therapist] would probably see her tomorrow. Asked her to talk to [Primary Therapist] about things she is distressed about. Talked to her about the stages of grief and told her it's normal to be angry and depressed when we lose someone we love.”

When Blakley visited the client again on September 6, 2007, the client was sitting in the day room of the girls' dorm, supervised by two female staff and still wearing the quilted smock. In response to Blakley's questions, the client stated that she had not been provided any education materials or homework from school for the dates of September 4-6, 2007 and guessed she would have to make up the work when she was released from suicide precautions.

### **Systemic Concerns**

#### ***A. Failure to Provide Appropriate Mental Health Treatment***

For the past nineteen (19) months, the members of DRC's Quality Assurance Team have been intensively monitoring care and treatment at the facility, which for the sake of simplicity, we will call “Alexander.”<sup>xvi</sup> During the entire duration of the intensive monitoring, failure to provide appropriate mental health treatment has been the single most pervasive and egregious rights violation found at the program.

If AFA #1 had seriously been concerned about the lethal potential for the client to use the partial elastic waistband of the panties to injure or kill herself, a number of other alternatives could have been employed to assure that did not occur. Admission to an acute psychiatric inpatient treatment program could have been

sought and secured. AFA #1 could have contacted clinical staff by telephone to inquire as to the advisability of forcibly removing the client's panties and further, whether it would be clinically advisable to remove them in the presence of male staff. One-on-one staff could have been assigned to remain in the room with the client to ensure she did not use clothing to attempt to hang or strangle herself.

The facts being what they were, the client would likely not have been successful in either killing or seriously injuring herself with the elastic waistband of the panties. On September 18, 2007, DRC conducted an informal and unscientific experiment with the same type of panties worn by the client, obtained from the program on September 17, 2007. DRC QA Team Leader Dee Blakley, with two (2) other DRC staff as witnesses, tore the front waistband elastic from the panties in less than two (2) minutes. Blakley then tied the elastic around her neck and pulled tightly on each end, holding the elastic tied around her neck for a total of five (5) minutes. When she released her hold on the elastic and removed it, a red line was immediately visible around her neck. Within one (1) hour of the experiment, the red line had faded significantly, and within three (3) hours, there was no visible mark at all. Twenty-four (24) hours after the experiment, no bruising or mark of any kind could be detected. Blakley experienced no faintness or loss of consciousness at any time during the experiment.<sup>xvii</sup>

Another reasonable alternative to the forcible removal of the client's panties could have been attempted. The client's Primary Therapist could have been contacted to come to the program and attempt to de-escalate her. However, as the facts later demonstrated, the client's Primary Therapist did not even know of the suicidal ideations nor that her patient had been placed on suicide precautions until she arrived at the program on Saturday, September 1 to provide individual therapy for another female youth, and heard someone screaming so loudly it disrupted her therapy session through a closed door. "I could hear somebody screaming. And they were screaming in this manner, 'Aaaagggggggghhhh. . .' So I came out of that office and said to whoever staff was there, 'Who is that screaming? And what is wrong?' And they said, 'That's **your** client, one of **your** girls. . .' And I said, 'Okay, so which one is it?' And they were kind of like, 'Well, you should know. . . it's so-and-so,' being [client name redacted]. . . So I said, 'I'd like to talk with her.' I said, 'Nobody told me she was on suicide and nobody asked me to talk with her, but since I'm here, and she's screaming, I'd like to talk with her. . .' I think they said something like 'she can't come out the room,' so I said, 'Then I'm just going to have to go there.'"<sup>xviii</sup>

## **1. Qualifications of the contractor's Director of Clinical Services**

Without question, serious deficiencies exist in the ability of DYS and its contractor to provide quality mental health services to adjudicated youth housed at AJATC. At the time of DRC's September 17, 2007, request for credentials on all licensed clinical staff, the new Director of Clinical Services at AJATC did not even possess a license in the state of Arkansas to practice psychology, making it unlawful under state law for him to supervise the delivery of mental health therapy services to adjudicated youth, which is in and of itself a clinical practice. He is licensed in the state of Florida and has applied for a provisional Arkansas license to practice psychology.

## **2. Confidentiality of Group Therapy Sessions**

The online version of *The American Heritage® Stedman's Medical Dictionary*, found at <http://www.kmle.com/>, defines "group therapy" as "a form of psychotherapy that involves sessions guided by a therapist and attended by several clients who confront their personal problems together. The interaction among clients is considered to be an integral part of the therapy." The same website dictionary defines "psychotherapy" as "the treatment of mental and emotional disorders through the use of psychological techniques designed to **encourage communication of conflicts and insights into problems**, with the goal being personality growth and behavior modification." (Emphasis added.)

The Gestalt Process therapy group conducted by the client's Primary Therapist was apparently the only girls' therapy group that was not conducted under the watchful eye of video and audio camera surveillance.<sup>xix</sup> The therapist who conducted the Gestalt Process group said she had been told by the new Director of Clinical Services, "You will never have a room [for therapy] that is not being recorded and taped. That day just doesn't exist any more."<sup>xx</sup> The Case Manager said topics covered in the girls' *Survivors of Abuse* group therapy were physical, emotional, psychological, and sexual abuse. As confirmed by DRC interviews of Therapist #2 and the Case Manager for the client, all other group therapies for the girls are held in the day room of the girls' dorm. Blakley inquired about the absence of confidentiality in such a setting.

Blakley: Do you think the presence of the camera has a chilling effect on the things that the girls might be willing to disclose?

Therapist #2: Huh uh, because we do not, uh, encourage them to share anything they do not want anyone else to share. That's why they have written homework assignments in confidential homework folders. Don't share anything that you don't want anyone else to know."<sup>xxi</sup>

During his September 25, 2007, interview with Blakley, the Director of Clinical Services was unsure how many of the therapy groups were "process" groups, as opposed to being purely psycho-educational in nature. She also asked if he had observed any of the group therapies.

Director of Clinical Services: Out of the curriculum you are probably talking about, I would say that, you know, very few of them are actually process groups at this point. . . We are still very much in a process of, um, identifying and implementing what I believe to be much better quality of services. . ."

Blakley: Ok, so the answer to the question - are there **no** process groups out here?

Director of Clinical Services: No, there are some, there are some. I would have to get back with you to let you know exactly who's doing what at this point, because I just don't know that off the top of my head.

Blakley: Have you observed any of the groups in action?

Director of Clinical Services: No, I have not.

Blakley: Just sat back on the periphery and observed?

Director of Clinical Services: Not at this point. . . I will be - more than they care to know, actually. . .<sup>xxii</sup>

When questioned by Blakley about whether the girls' *Survivors* group was a process group, he responded that it was "more process oriented." Blakley asked if he had concerns about confidentiality and efficacy of process groups subjected to video and audio surveillance.

Blakley: The *Survivors* group has been characterized as a process group. . . do you have any concerns about confidentiality during such a group?

Director of Clinical Services: Yes. I - the- I asked the - it is a question that I have asked and am still trying to get clarification from the State on that, because I don't - quite frankly I don't - I'm not 100% positive of the answer of that. This is a unique setting for me in terms of - I'm very used to facilities having cameras, um -

Blakley: Uh huh –

Director of Clinical Services: But to be in a facility that has both camera and sound, um -

Blakley: Uh huh -

Director of Clinical Services: That's new to me and it is a question that I asked as well. . . what I have been told is that, uh, you know part of the process for the girls is that they are reminded that, in fact, that these – you know, that the cameras **are** there and they in fact are being recorded and that they need to be knowledgeable about that.

Blakley: So then what happens to the group therapy dynamic? I mean, why call it a group?

Director of Clinical Services: Is it a group – yes. Is it possibly an issue? Yes, that's why I'm asking the question. . .

Blakley: Could the group simply not be moved to an area that's not monitored so that concern wouldn't be -

Director of Clinical Services: Could it? Yeah, I think so, but on this – it's my understanding – and though you know this better than I do – is that, you know, there's a not a lot of areas on this campus that aren't monitored.<sup>xxiii</sup>

### **3. Failure to Provide Access to and Confidentiality of Individual Therapy Sessions**

According to the client's Primary Therapist, the June 14 and June 20 individual therapy sessions for DRC's client were cut short when 1) AFA #1 sent for the client to spend some one-on-one time with her, and 2) the Case Manager returned to her office, which was being used for the session and would not leave the office, breaching the client's confidentiality during the session with the therapist and making both too uncomfortable to continue. In both instances, the client was unable to have a full individual therapy session with someone with whom she had established an appropriate and therapeutic bond.

In addition, the Primary Therapist reported to DRC in her interview that on another occasion when she was having an individual session with the client on the girls' dorm, a new employee orientation was underway on campus, and five (5) new male staff were brought into the room where the session was underway. The session stopped because rather than excuse themselves and leave the room, the new employees simply lined up around the room to watch and listen.

#### ***B. Failure to Consider the Whole Child***

This case highlighted once again how little information is shared about a youth among the staff who are supposed to be in "direct care" of the youth. Therapist #2 was of the opinion that the reason a dependent-neglect petition had been filed against the client's father was because of the client's behavior. She indicated no knowledge at all that the client's father was alleged to have been in and out of jail over a period of years and incapable of providing her with proper and appropriate supervision, or that the client had been physically and sexually abused while in her father's care. Therapist #2 had not read any of the clinical notes of the client's Primary Therapist, nor had her Case Manager, although both had authorization to access them. Blakley asked the Primary Therapist if any other staff ever sought her out to get insight into DRC's client.

Blakley: Do any of the other staff seek you out to say, [Primary Therapist name redacted], can you explain why it is that she seems to need to be the center of attention? Does anybody ever come to you and ask you that?

Primary Therapist: Well. . . actually, no, actually no.

Blakley. Okay.

Primary Therapist: But sometimes, I seek them out and say that. . .

Blakley: That there are reasons?

Primary Therapist: Yes.<sup>xxiv</sup>

This investigation included an extensive review of documents related to the client – well over 1,000 pages that not only included documentation about the incidents themselves, but notes from the clinical and medical file as well as the client’s entire DCFS file. There is no evidence that any of the state agencies or direct care staff, from the DYS case tracker to the DCFS case worker, to the G4S case manager or the Director of Clinical Services at AJATC, has ever read the entire case history of DRC’s client in an effort to provide her with effective assessment and treatment services. It is entirely likely that the only person who had read all the documents and obtained the full picture about the very real issues and traumas of the client is Dee Blakley from DRC. As late as October 1, 2007, the Director of Clinical Services at AJATC told Blakley he had not yet reviewed the clinical file of the client.

During his September 25, 2007, interview with DRC, Blakley asked the Director of Clinical Services who was responsible for reviewing all documentation on youth to ensure that all areas of need were included in the comprehensive treatment plan.

Blakley: Is there any person in this dad-gummed place who is responsible, once they get a kid on their caseload – whether you’re a case manager or you’re a therapist, or you’re a schoolteacher – is there a person who is responsible for taking every document we’ve got on the kid, and looking at them and getting a well rounded picture of the kid, and going “Yo folks, we’ve missed some stuff here that should be in the treatment plan?”

Director of Clinical Services: Uh huh.

Blakley: Or is that a happen-chance thing?

Director of Clinical Services: Um, well let me answer that two ways. I can’t speak for the history here. . . I can tell you this – one of the things that, um – “yes” is the answer to your question.

Blakley: And who would that person be?

Director of Clinical Services: Right now. . . actually, the case manager and the therapist.<sup>xxv</sup>

There is already a mechanism in place at AJATC to assess the needs of the whole child. It’s called the Multi-Disciplinary Services (MDS) staffing and is held shortly after a youth arrives on the AJATC campus. The focus of the meeting should be, in the opinion of AJATC’s Director of the Clinical Services, a needs assessment.

Director of Clinical Services: What the MDS staffing appears to be – and I think quite frankly should be – is really a needs assessment meeting. It’s a needs assessment conference.

Blakley: And see, that’s what I thought it was supposed to be too, but those suckers always start off sounding to me like a re-adjudication of the kid. “What did you do?”

Director of Clinical Services: Yeah.

Blakley: “What did you do wrong?”

Director of Clinical Services: And so part of – one of the things that you know, one of the things that I have kind of continued to – my mantra right now is that we are going to control those things that we can control -

Blakley: And is the MDS staffing one of those things?

Director of Clinical Services: It is now -

Blakley: Or is that a DYS deal?

Director of Clinical Services: Well, that’s a really interesting question, um, because when I first came here – um, I was led to believe that that was a DYS meeting. . . since that time, I’ve met with [DYS staff name redacted] and, you know, we’ve chatted about that meeting specifically, because it seemed like I was getting different answers from different people, depending upon who I was talking to. . . I think we left that meeting with a much better understanding now that. . . we need to use that meeting as a needs assessment meeting.<sup>xxvi</sup>

The children in DYS custody at AJATC are more than the sum total of their offenses, and issues that follow them into the assessment and treatment center should be properly identified and incorporated into their treatment plans if anyone reasonably expects them to be able to succeed at the “corrections” type of treatment provided.

### ***C. Failure to Identify, Investigate, Report and Remedy Allegations of Abuse, Neglect and/or Exploitation of Youth***

During the course of the DRC investigation of this allegation, Blakley met with the G4S Internal Investigator, G4S Youth Services Vice President for Quality Assurance, and AFA #2 on September 14, 2007, to discuss why the program still lacked written policies or procedures for the conduct of internal investigations several months after an Internal Investigator position was created and staff hired. The G4S Youth Services Vice President for Quality Assurance told Blakley that a former G4S Youth Services Vice President had told the Internal Investigator just to use his experience in law enforcement to decide when and how to conduct internal investigations.

Part of the discussion in the September 14 meeting centered on how the Internal Investigator, who stated DRC had called the current incident to his attention, would be notified that there was a need to investigate an incident. Blakley pointed out a checkbox on a new document attached to the fronts of the incident reports she had received on the female youth. The document in question was called *Internal Incident Compliance Checklist*, and the question was, “Does the incident require further investigation?”

Despite the documentation of nine (9) separate *Incident Reports* detailing the self destructive and combative behavior of this female youth on suicide precautions, including an attached *Marks Sheet* that diagrammed thirty-two (32) bruises on the youth (*Incident Report B766*), AFA #2 saw no need to note on any of the *Internal Incident Compliance Checklists* that further investigation was needed. No box was checked at all on *Incident Reports B752* or *B755*, and the other seven (7) had the “no” box checked.

G4S’ Internal Investigator was not tipped off to the need for an investigation, since he is not provided copies of the incident reports or *Internal Incident Compliance Checklists*. The Internal Investigator only receives a copy of a database report of daily incidents upon which there was no column for noting if AFA #2 did in fact check “yes” in answer to the Checklist question, “Does the incident require further investigation?”

As part of the extensive review of documentary evidence, DRC obtained and reviewed a copy of G4S’s internal investigation report. Documented in that report are statements that reveal the client’s panties were forcibly removed from her body twice, once by AFA #1 on September 1, with male staff present in the cell, and again on September 2 by a combination of three female staff while the client was being restrained by a male staff in what was called a “sitting upper torso” restraint. The report further stated, “Nurse [#1] was in the room observing and examined the panties and pad and determined that [client name redacted] was not on her cycle and they left them off.”<sup>xxvii</sup>

No attempt was made by the G4S Internal Investigator to determine why, after having subjected the female client to the forcible removal of her panties on September 1, they were given back to her only to be forcibly removed again the next day. The report documented Nurse #1 examining the panties *and pad* – which DRC inferred to mean a sanitary napkin – and this inference is consistent with what the client told Dee Blakley on September 4, that “she had no sanitary napkin during the night and menstrual blood had soaked through the suicide smock. . .” Her allegation of not being allowed to shower until the afternoon of September 3 was corroborated by the Progress Note of the same date, made by Therapist #3.

*DYS Incident Report #B766* was the incident report relevant to this event. There is no documentation of the removal of the panties from the client, and some of the staff referenced in the internal investigation report failed to complete witness statements, i.e., two of the three female staff reported by the internal investigation who forcibly removed the client’s panties, one who assisted in the forcible removal of the panties and failed to note that on her report, and Nurse #1 who, according to the internal investigation report, examined the panties and sanitary pad.

The conclusion of the internal investigation was that no abuse occurred. There was no attempt in the internal investigation report to identify an antecedent for the attempts of the youth to engage in self-injurious behavior, nor was there a recommendation for revision of her comprehensive treatment plan to try and avoid future occurrences of self-injurious behavior. There was no finding that several staff, including AFA #1, violated G4S policy by failing to complete required *DYS Incident Reports* on a timely basis - or even at all - during the period of time covered by the internal investigation.

## **Findings**

### ***A. Primary Findings***

DRC finds that state agencies and their contracted service providers failed to work in cooperation and concert with one another to provide the client services to which she was entitled.

DRC finds that the Memorandum of Understanding (MOU)<sup>xxviii</sup> between DCFS and DYS has no practical effect of ensuring the agencies work collaboratively to coordinate services to meet the individual and unique needs of children in their custody.

DRC finds that DYS failed to “coordinate communication between the various components of the juvenile justice system,” in violation of ACA § 9-28-203(a)(1).

DRC finds that the State of Arkansas failed to “ensure the provision of an adequate and equitable system of education” to adjudicated juveniles housed at AJATC, in violation of Article 14, § 1 of the Arkansas Constitution and ACA § 6-10-120(2).

### ***B. Secondary Findings***

DRC finds that DYS failed to appropriately observe and assess the client to “ensure appropriate recommendations for intervention, services and placement,” in violation of ACA § 9-28-203(b)(6)(A).

DRC finds that the client was subjected to abuse by DYS as defined by ACA § 9-27-303(3)(A)(iii).

DRC finds that the client was subjected to neglect by DCFS as defined by ACA § 9-27-303(36)(A)(i) and (ii).

DRC finds that DCFS failed to “see that the juvenile is protected, properly trained and educated,” in violation of ACA § 9-27-353(a).

DRC finds that the female client’s rights to dignity and privacy were violated on September 1, 2007, when male staff were instructed to forcibly remove a portion of her clothing and were further instructed to stand by in the room while her panties were forcibly removed by AFA #1.

DRC finds that the female client was subjected to psychological abuse on September 2, 2007, when her panties, presumed previously by AFA #1 to pose a lethal hazard to her safety, were returned to her and then forcibly removed again.

DRC finds that the female client’s rights to dignity and privacy were violated on September 2, 2007, when a male staff physically restrained her in a sitting upper torso restraint while her panties and a sanitary pad were forcibly removed by three (3) female staff.

DRC finds that despite AJATC’s assertions that the client had to be restrained in order to protect her from harming herself, the client was physically abused by AJATC.

DRC finds that AFA #1 failed to seek the advice of clinical staff to determine whether the forcible removal of clothing by and in the presence of male staff was clinically contraindicated.

DRC finds that AFA #1 made a clinical decision with respect to the removal of the client’s clothing that she is unqualified by training, education or licensure to render.

DRC finds that AFA #1 failed to complete a *DYS Incident Report* regarding her direct participation in at least two physical interventions with the client and only did so once DRC had begun an investigation into the allegation of abuse.

DRC finds that two staff involved in the incident occurring on September 2, 2007 at approximately 8:15 p.m. failed to complete incident reports detailing their involvement in the incident documented in *DYS Incident Report #B766*, and one failed to fully document her involvement in the forcible removal of the client’s panties and sanitary pad.

DRC finds that the client's Primary Therapist was not notified of the client's placement on suicide precautions and only became aware of the need to speak with her client by accident.

DRC finds that the client's right to confidentiality during her individual therapy sessions was breached on two separate occasions and further, that the breach of confidentiality also prevented her from being able to complete the sessions.

DRC finds that right to confidentiality of the female youth at AJATC during group therapy sessions is continuously breached due to the presence of audio and video surveillance equipment in the room where group therapy sessions are conducted.

DRC finds that during the course of the DRC investigation, the Director of Clinical Services at AJATC was not credentialed in the state of Arkansas to serve in that capacity.

DRC finds that AJATC failed to develop and implement an internal investigation system that has the capacity for effective identification, reporting, investigation, and remedial action of allegations of abuse, neglect, or exploitation of adjudicated juveniles.

DRC finds that DCFS' database did not contain the information that the client was in DCFS custody.

## **THE PLAYERS**

**Disability Rights Center, Inc.** (DRC) is the federally authorized and funded non-profit organization serving as the Protection and Advocacy System (P&A) and the Client Assistance Program (CAP) for individuals with disabilities in the state of Arkansas. DRC is authorized to protect human, civil, and legal rights of all Arkansans with disabilities consistent with federal law.

**Arkansas Juvenile Assessment and Treatment Center** (AJATC), serves as the primary intake and assessment center for youth committed to the Division of Youth Services (DYS).

**G4S Youth Services** is the for-profit juvenile corrections company that assumed operation of AJATC in January 2007, pursuant to a contract with the Arkansas Department of Human Services, Division of Youth Services.

The Arkansas Department of Human Services, **Division of Children and Family Services** (DCFS) has as its mission, to "protect children; maintain families, if this is appropriate, with the child's health and safety always considered paramount; provide quality services within available resources which enable families to maximize their potential and increase their abilities; preserve and enhance human dignity and worth; prevent or reduce the need for services.

The Arkansas Department of Human Services, **Division of Youth Services** (DYS) has as its mission, "providing effective community-based prevention, diversion, and graduated sanction programs; providing leadership for coordination, collaboration, and improvement of the Arkansas juvenile justice system; providing supervision and effective treatment for juvenile offenders in the community; operating safe and secure juvenile correctional facilities in a manner consistent with best practices in the field and with effective treatment programming for the population served in the community."

Other contracted DYS residential providers are Consolidated Youth Services and South Arkansas Youth Services. The contractors operate the following residential programs: Dermott Juvenile Correctional Facility, Colt Juvenile Treatment Center, Harrisburg Juvenile Treatment Center, Mansfield Juvenile Treatment Center and Mansfield Juvenile Treatment Center for Girls, Dermott Juvenile Treatment Center, and Lewisville Juvenile Treatment Center.

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<sup>i</sup> *Inpatient Psychiatric Evaluation*, date of admission, 6/13/00. Laureate Psychiatric Clinic and Hospital, Tulsa OK.

<sup>ii</sup> DCFS *Contact* sheet, dated 6/14/2007.

<sup>iii</sup> *Progress Report*, The Centers for Youth and Families, dated 9/21/04.

<sup>iv</sup> *Discharge Summary*, The Brown Schools of Oklahoma, 3/11/02.

<sup>v</sup> *Arkansas Foster Care: Project for Adolescent And Child Evaluations (PACE)*, UAMS Department of Pediatrics, 7/6/04.

<sup>vi</sup> *Id.*

<sup>vii</sup> The client's biological mother has not been involved in her life for quite a few years.

<sup>viii</sup> Interview of Therapist #2, 9/17/07.

<sup>ix</sup> *Id.*

<sup>x</sup> The client's primary therapist practices Gestalt therapy. The "field" is a clinical word related to Gestalt therapy.

<sup>xi</sup> Interview of Primary Therapist, 9/13/07.

<sup>xii</sup> Interview of Primary Therapist, 9/13/07.

<sup>xiii</sup> Interview of Therapist #2, 9/17/07.

<sup>xiv</sup> Interview of Case Manager, 9/18/07.

<sup>xv</sup> The client's 9/1/07 *Self Harm Assessment* noted in three different sections her disclosure about her friend's suicide as a precipitating factor for her statements and gestures of self harm. However, the clinical staff who completed the assessment did not note on the assessment document any attempts he made to discuss the feelings of the client about the news she had received, nor was there an accompanying *Progress Note* about any such discussion.

<sup>xvi</sup> DRC acknowledges the number of name changes that the program has undergone since February 2006, culminating with the most recent name change to Arkansas Juvenile Assessment and Treatment Center (AJATC).

<sup>xvii</sup> During the first minute, Blakley experienced a sensation of pounding in her head, but was able to breathe and talk, as well as maintain her standing position. Between minutes three (3) and four (4), she experienced a feeling of numbness in her chin and below her bottom lip, but still was able to breathe and talk, as well as remain standing.

<sup>xviii</sup> Interview of Primary Therapist, 9/13/07.

<sup>xix</sup> DRC used the past tense in this sentence because it was learned during the course of this investigation that the oral contract between the contractor and the client's Primary Therapist had been terminated.

<sup>xx</sup> Interview of Primary Therapist, 9/13/07.

<sup>xxi</sup> Interview of Therapist #2, 9/17/07.

<sup>xxii</sup> Interview of Director of Clinical Services, 9/25/07.

<sup>xxiii</sup> *Id.*

<sup>xxiv</sup> Interview of Primary Therapist, 9/13/07.

<sup>xxv</sup> Interview of Director of Clinical Services, 9/25/07.

<sup>xxvi</sup> *Id.*

<sup>xxvii</sup> *Alexander Juvenile Correctional Facility Management Investigation Review Form*, Case # **ALX-09-01-10C**, page 4.

<sup>xxviii</sup> See "Agreement Between The Division of Children and Family Services The Division of Youth Services," signed by Roy Kindle and Doyle Herndon on 7/22/02 and 7/23/02, respectively.

The contents of this Investigation Report are solely the responsibility of the grantee and do not necessarily represent the official views of the funding agencies that are the U.S. Dept. of Health and Human Services/Administration on Developmental Disabilities and Center for Mental Health Services, and the U.S. Dept. of Education/Rehabilitation Services Administration, Health Resources and Services Administration.