U. S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

January 23, 2004

The Honorable Janet Napolitano
Governor of Arizona
1700 West Washington
Phoenix, Arizona 85007

Re: CRIPA Investigation of Adobe Mountain School and Black Canyon School in Phoenix, Arizona; and Catalina Mountain School in Tucson, Arizona

Dear Governor Napolitano:

I am writing to report the findings of the Civil Rights Division's investigation of conditions at the State of Arizona's Adobe Mountain School ("Adobe"), Black Canyon School ("Black Canyon"), and Catalina Mountain School ("Catalina"). On June 6, 2002, we notified then-Governor Jane Hull of our intent to conduct an investigation of Adobe, Black Canyon, and Catalina (collectively, "the facilities") pursuant to both the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). As we noted, both CRIPA and Section 14141 give the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of children in juvenile justice institutions.

Between October 1, 2002 and January 13, 2003, we conducted on-site inspections of the facilities with expert consultants in juvenile justice, suicide prevention, education, mental health, and medical care. We visited Adobe October 1-4, 2002 and January 5-9, 2003. We visited Black Canyon School October 22-25, 2002, and January 10-13, 2003. We visited Catalina Mountain School December 3-6 and December 17-20, 2002. While at the facilities, we interviewed staff,

youth residents, medical and mental health care providers, teachers, and school administrators. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, medical and mental health records, grievances from youth residents, Internal Affairs investigations, unit logs, communication logs, orientation materials, staff training materials, and school documents. As promised at the onset of our investigation, we also conducted exit conferences with facility and central office staff at the conclusion of each tour, during which time our consultants described their initial impressions and concerns.

We commend the staff of the facilities and the central office staff of the Arizona Department of Juvenile Corrections ("ADJC") for their helpful and professional conduct throughout the course of the investigation. Staff and administrators cooperated fully with our investigation. We also appreciate the ADJC's receptiveness to our consultants' on-site recommendations.

Consistent with our statutory obligation under CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies set forth below. As described more fully below, we conclude that certain serious deficiencies at these facilities violate the constitutional and federal statutory rights of the youth residents. In particular, we find that children confined at Adobe, Black Canyon, and Catalina suffer harm or the risk of harm from constitutional deficiencies in the facilities' suicide prevention measures, correctional practices, and medical and mental health care services. In addition, we find that the facilities fail to provide required education services pursuant to the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1401 et seq., and Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794.

I. BACKGROUND

Adobe Mountain School is a 430-bed[1] secure facility for boys that also serves as the Reception, Assessment and

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[1] Adobe has a physical capacity of 544 beds, but ADJC considers its operational capacity to be limited to 430.

Classification ("RAC") center for newly-committed boys from Maricopa County. After completing a 28-day RAC process, boys are assigned to one of three secure facilities: Adobe, Eagle Point School in Buckeye, or Catalina in Tucson. Approximately 426 youth between the ages of 13 and 17 were confined at Adobe at the time of our tours. Adobe has 14 housing units, including specialized housing units for youth with sexual behavior offenses, violent offenses, substance abuse offenses, and a specialized mental health unit, Triumph.[2] Adobe also has a ten-bed Separation Unit.

Black Canyon School is a 182-bed secure facility for female juvenile offenders. It is the only facility for girls committed to ADJC custody and operates its own RAC unit. This institution confined approximately 108 girls between the ages of 14 and 17 at the time of our tour in October 2002; the population decreased to around 90 during our tour in January 2003. Black Canyon has seven housing units, including a special treatment unit for violent offenders, a substance abuse unit, a mental health treatment unit, Maya, and a parole violator unit. A ten-bed Separation Unit exists for girls who require segregation from the rest of the population.

Catalina Mountain School is a 140-bed secure facility for boys and is the initial intake location for Pima, Santa Cruz, and Cochise Counties.[3] Approximately 136 youth between the ages of 13 and 17 were confined at this facility at the time of our tours. Catalina has six housing units, including three general housing units, a violent offenders unit, a sex offenders unit, and a substance abuse unit. Catalina Mountain also has a ten-bed Separation Unit.

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[2] The Triumph Unit, located on the campus of Adobe, and the Maya Unit, located on the campus of Black Canyon, together constitute ADJC's specialized mental health program called Encanto. This program has its own superintendent and staff. It shares education, food, medical, and security services with Adobe and Black Canyon.

[3] Catalina has a physical capacity of 150 beds, but ADJC considers its operational capacity to be limited to 140.

II. FINDINGS

A. SUICIDE PREVENTION

Between April 2002 and March 2003, three youth at Adobe committed suicide, all three by hanging, and two in the same housing unit.

> On April 11, 2002, a youth was found dead in the Freedom Cottage at Adobe with a sheet tied around his neck.
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> On July 11, 2002, a youth committed suicide by hanging himself with a sheet in the Enterprise Unit at Adobe.
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> On March 23, 2003, a youth strangled himself to death with his own belt in the Freedom Cottage at Adobe.

This number of suicides in a 12-month period is extremely high for any juvenile justice facility. Indeed, according to a recent survey of 3,800 juvenile facilities throughout the United States covering the five-year period from 1995-1999, only two other facilities (.0005%) have had three or more completed suicides during a 12-month period. Our investigation revealed that the Adobe suicides are emblematic of the inadequate suicide prevention measures and practices throughout the facilities.

As a general matter, States must provide confined adjudicated juveniles with reasonably safe conditions of confinement. See Youngberg v. Romeo, 457 U.S. 307, 315-24 (1982); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979); Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9th Cir. 1987). Such constitutionally mandated conditions include the right to adequate medical care, a concept that embraces both mental health treatment and suicide prevention measures. See Hott v. Hennepin County, 260 F.3d 901, 905 (8th Cir. 2001); Hare v. City of Corinth, 74 F.3d 633, 644-45 (5th Cir. 1996) (en banc); Young v. City of Augusta, 59 F.3d 1160, 1169 (11th Cir. 1995); Horn v. Madison County Fiscal Court, 22 F.3d 653, 660 (6th Cir. 1994); Gordon v. Kidd, 971 F.2d 1087, 1094 (4th Cir. 1992); Hoptowit v. Ray, 682 F.2d 1237, 1253 (9th Cir. 1982). The State has clearly fallen well short of this constitutional obligation.

As described in detail below, the suicide prevention procedures employed at all three facilities we examined were

grossly inconsistent with generally accepted professional standards.[4] Although the facilities adequately screen youth to identify those at risk for suicide, the youth who are identified are inadequately monitored by mental health staff, inadequately supervised by direct care staff who also lack the training and tools necessary to intervene in the event of an attempted suicide, and are not safely housed.[5]

1. Inadequate Monitoring by Mental Health Staff

Generally accepted professional standards require that youth who are identified as potentially suicidal and who have been placed on suicide precaution, be monitored by mental health professionals. Appropriate monitoring is necessary to provide consistent and adequate services. Our investigation revealed that appropriate monitoring of youth on suicide precaution does not occur in any of the three facilities.

We found that youth who were initially identified as at risk for suicide were not placed on suicide precaution or seen in a timely manner by mental health staff. For example, a youth with a history of depression and self-harm, who made threats of suicide on July 13 and 17, 2002, was not placed on suicide precaution or monitored by mental health staff. On August 1, 2002, this youth was found wrapping a belt around his neck. Moreover, we found that even when mental health professionals do monitor youth, in many cases they fail to document their clinical assessments. This deficiency in the

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[4] In assessing whether the constitutional rights of the confined juveniles have been violated, the governing standard is the Due Process Clause of the Fourteenth Amendment. See Gary H., 831 F.2d at 1431-32. Accordingly, the proper inquiry focuses on whether the conditions substantially depart from generally accepted professional judgment, practices, or standards. See Youngberg, 457 U.S. at 323.

[5] In July 2003, the State provided us with a summary of recent measures reportedly taken to address some of our concerns relating to suicide prevention. Although a number of these reforms have yet to be implemented or are only in the embryonic stage, we do acknowledge the State's efforts. It is our hope, as it is surely the State's, that these measures will allow the State to make significant strides in correcting its institutional deficiencies.

monitoring process places potentially suicidal youth at risk by denying them necessary mental health services.

Communication about the mental health status of potentially suicidal youth is a necessary aspect of monitoring suicidal youth. ADJC staff fail to communicate effectively among themselves regarding the management needs of suicidal youth. Communication deficiencies are particularly acute at Adobe. Adobe fails to maintain a daily listing of youth on close observation status. Incident reports describing the events which resulted in placing a youth on suicide precaution are not consistently completed. The psychiatrist at Adobe only sporadically attends the weekly treatment meetings during which each youth's status is discussed, and, at the time of our tours, had been absent from these meetings for the previous five months. Adobe mental health staff, who also service youth at Encanto (the specialized mental health unit), do not interact routinely with the Encanto direct care staff.

While communication practices are somewhat better at Black Canyon and Catalina than at Adobe, overall, the facilities all practice inadequate information management of suicidal youth. For instance, all three facilities fail to integrate the medical and mental health files of youth. We were informed that mental health staff are not permitted access to the medical files, which is where the psychiatrist's notes are placed. As a result, mental health personnel lack access to information necessary to understand fully a youth's mental health status. Further, mental health staff at the facilities informed us that they sometimes fail to keep any clinical notes regarding their interaction and assessment of suicidal youth. Mental health staff also stated that where clinical notes are maintained on youth, these notes are not retained in either the youths' medical files or a central mental health file, but in the staff person's personal files. In addition, psychology associates (masters level mental health professionals), who attend to suicidal youth, do not receive any clinical supervision, an important aspect of effective communication. These communication voids deny suicidal youth appropriate treatment.

The communication failures within ADJC are exemplified by the July 11, 2002 suicide of a youth at Adobe. On June 25, 2002, this youth was placed on close observation status based upon his high suicide ideation rating. We found no indication of any formal mental health assessment or in-person physical

assessment by a psychiatrist of this youth. While his mental health records were reviewed by a psychiatrist on June 26, there was no indication that the youth's close observation status was communicated to the psychiatrist. The youth was not seen by mental health staff until July 3, when he was seen by a psychology intern.

Between July 3 and 11, ADJC's Community Family Services Division conducted an in-home evaluation and discovered that this youth had previously threatened and/or attempted suicide. In addition, his court file, which accompanied him to Adobe, contained information regarding his attempted suicide while he was in detention. This information, which could have assisted in the addressing this youth's mental health needs, was not timely communicated to, or reviewed by, staff. On July 11, this youth committed suicide.

2. Inadequate Supervision by Direct Care Staff

In addition to appropriate monitoring by mental health professionals, potentially suicidal youth require appropriate supervision by direct care staff, who are the only staff in the facilities on duty 24 hours a day, to ensure their safety. We found that supervision of suicidal youth by direct care staff throughout the facilities was inadequate. For example, during our on-site tour, a youth at Black Canyon attempted to choke herself with her clothing. At the time of this incident, the youth was on suicide precautions that required direct care staff to check on her every 15 minutes, but the required checks had not been made for two hours.

Direct care staff at all three facilities, especially those on night duty, admitted to difficulty in consistently supervising youth on suicide precaution because of staff shortages. In some cases, we found that reports documenting suicide precaution observations by staff were filled out even though staff admitted that the observations were not actually being performed. On the Enterprise Unit at Adobe, we found suicide precaution reports that had not been completed for several hours for eight youth who were placed on suicide precaution. In other instances, we observed suicide precaution reports filled in at precise 15-minute intervals for extended periods of time. This level of precision seemed highly improbable given the other responsibilities of direct care staff and chronic staff shortages.

Further, we found that youth who are placed in exclusion (confined to their rooms for periods of time) for disciplinary purposes, were not supervised appropriately. While ADJC policy requires staff to interact with youth in exclusion every 15 minutes, direct care staff readily admitted that these checks were not regularly performed. This failure is significant because of the strong correlation between involuntary locked room confinement and suicidal behavior.[6] Indeed, two of the suicides that occurred at Adobe in 2002 involved cases in which the youth had been involuntarily confined to their rooms prior to their suicides.

Appropriate supervision by direct care staff also includes the referral of potentially suicidal youth to mental health professionals. Our investigation revealed instances where direct care staff failed to refer potentially suicidal youth to mental health professionals. For example, on September 28, 2002, upon hearing of his father's attempted suicide, a youth at Adobe informed direct care staff that he would kill himself. Later that day, the youth acted upon the threat by wrapping earphone wires around his neck. Rather than refer the youth to mental health professionals, direct care staff instructed two other youth to watch the boy to make sure he did not harm himself. No follow-up action or mental health assessment was undertaken until the youth was transferred to another facility two weeks later. In another instance, a youth who self-mutilated on July 28, 2002 was placed on 15-minute watch by direct care staff, but was not referred to mental health staff for assessment.

Adequate supervision also contemplates that direct care staff will follow the orders of mental health professionals. Our investigation revealed several instances in which direct care staff, who have no specialized mental health training, downgraded the level of suicide precaution that youth were

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[6] It is well-established in the field of corrections that there is a strong correlation between inmate suicide and isolation. See Lindsay Hayes, National Study of Jail Suicides; Seven Years Later, 60 Psychiatric Quarterly, NO. 2, 7-29 (1989). According to a forthcoming report for the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, over 50 percent of juvenile suicides occur while youth are in involuntary room confinement status.

placed on without the authority of mental health professionals.

3. Inadequate Training and Intervention Tools for Direct Care Staff

Staff training in suicide prevention measures similarly departs substantially from the generally accepted professional standards in this area. Experts all agree that staff who interact with potentially suicidal youth must be trained to detect, assess, and, if necessary, intervene to prevent a suicide. Yet our review of training records for 2002 (a year in which there were two suicides at Adobe) revealed that 61.8% of Adobe staff had received no suicide prevention training. At Catalina, 56.3% of medical and mental health staff at Catalina had not received the annual refresher training and 40% of non-medical staff had not received cardiopulmonary resuscitation ("CPR") refresher training.

The failure to have emergency equipment readily available to staff trained to use it can make the difference between life and death. We found that emergency intervention measures throughout the facilities were wholly inadequate. At Adobe, first aid kits, microshields for CPR, and rescue tools (*e.g.*, blades to cut ligature from a hanging victim's neck) were not available. During our January 2003 tour of Adobe, we found oxygen tanks, which are often vital to resuscitating a hanging victim, were stored haphazardly without indication of which ones were full and which ones were empty. Nursing staff did not even know how to operate these tanks, and the facility had no regular system in place to monitor the readiness of this emergency equipment. These deficiencies were demonstrated during the July 25, 2002 suicide by hanging at Adobe. When the youth was discovered hanging, staff reportedly did not have the appropriate rescue tool to cut the noose and had difficulty removing it from the boy's neck. Medical staff were reportedly delayed in responding without explanation. When they did arrive, the oxygen tank they brought with them to help resuscitate the youth was reportedly empty.

Another example of staff unpreparedness to respond to an emergency occurred on October 23, 2002 at Black Canyon. DOJ investigators and our suicide prevention consultant were coincidentally visiting a housing unit when a youth attempted to choke herself with her clothing. After the initial alarm was raised, security staff responded promptly. However, when

the nurse responded, she was not directed to the victim by staff. Indeed, staff generally appeared uncertain as to what actions to take, and our suicide prevention consultant had to alert the nurse to the location of the victim.

4. Unsafe Housing of Suicidal Youth

Generally accepted professional standards further require that potentially suicidal youth be housed in living quarters that are suicide resistant. Suicidal youth are housed in two places in the facilities -- the Separation Units and the living units. While Separation cells were largely free of potential suicide hazards, we found physical features throughout the remainder of the facilities' housing units that pose substantial risks to suicidal youth. For example, the Alpha, Challenge, Crossroads, Enterprise, January, Nova, Phoenix, and Separation Units at Adobe have ventilation grilles and ceiling vents that are potentially dangerous because sheets or other objects could be anchored to them. Nova and January also have exposed bolts attached to the desk that present a similar risk. The Estrella, Genesis, Hope, Oasis, and Encanto units all have horizontal bars on the room windows that provide sufficient space between the bars and the glass to allow for the anchoring of a sheet or other material. Indeed, this was the anchoring device utilized by the youth who committed suicide in April 2002.

At Black Canyon, four of the seven functioning housing units have dangerous suicide risk physical plant issues similar to those at Adobe. For instance, the Recovery and Success units have room doors containing grilles with large gauge openings, and the Maya and Pride units have rooms with both wall and ceiling ventilation grilles with large openings. Large gauge openings pose risks for tying off hanging devices.

At Catalina, five of the seven functioning housing units have rooms with dangerous anchoring points. The Chiricahua, Crossroads, and Recovery units have rooms with ceiling ventilation grilles with large gauge openings, as well as holes in the bunk bed platforms that could be utilized as anchoring devices. All five housing units have rooms with window grilles with large gauge openings in the doors.

B. JUVENILE JUSTICE

Youth are denied constitutional protections because the facilities fail to: (i) protect youth from sexual and physical abuse; (ii) provide adequate due process protections before isolating youth; and (iii) maintain safe and sanitary living conditions.

1. Sexual Abuse at Adobe

Our investigation revealed that sexual abuse of youth by staff and other juveniles occurs with incredibly disturbing frequency at Adobe, and that ADJC management does not effectively address this serious problem.[7]

Several examples are illustrative. In December 2002, a female staff member admitted to internal investigators that she had engaged in sexual acts with a youth, including oral copulation, sexual touching, and sex talk over a period of months. It appears that facility management failed to detect these alleged acts, which occurred over an extended period of time. In April 2001, an internal investigation revealed that another female staff member wrote at least 12 sexually explicit letters to a youth.

In February 2002, a male staff member was accused repeatedly of inappropriate sexual contact with youth, including touching boys on their buttocks. Reportedly, 13 boys and five staff members voiced complaints about this behavior and three youth filed formal grievances within a one month period. In response to one of the grievances, a unit supervisor responded that he had spoken to this staff person three times and that "it is his lifestyle and personality to be physically affectionate." Youth Grievance dated 2/21/02. In response to a written request for an investigation by the youth rights advocate, Adobe's Assistant Superintendent stated that the matter had been taken care of and that "usually when something like this is found out it goes to the

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[7] It is difficult to assess the full extent of the sexual abuse occurring at Adobe, in part because of the dysfunctional grievance system and ineffective abuse investigation processes described below.

manager . . . ."[8] Despite the seriousness of these complaints, the allegations were never investigated by a neutral party. Rather, the staff member was simply counseled. At the time of our tour, this staff member continued to work directly with youth. We notified management of this matter.

In addition to sexual abuse committed by staff, our investigation revealed many examples of youth-on-youth sexual violence. Documentation revealed that sexual intimidation is occurring in the facilities. In numerous interviews during our tours, youth revealed their fears and concerns about being sexually intimidated by other youth.

An incident report from October 2002 reveals that a youth informed a staff member that youth were threatening him to perform sexual acts or risk being beaten up or raped. In another case, an Internal Affairs investigation includes strong evidence that three Adobe youth attempted to place a pepper shaker in the anus of another youth. Another investigation disclosed that a youth engaged in sex with other youth in exchange for their friendship or for such items as soap. Incident reports also indicate a prevalence of sexual activity among the girls at Black Canyon, including the characterization of some youth as "sexual predators." These reports highlighted the fact that much of the sexual activity consisted of inappropriate actions between "girlfriends" due to competition among the girls for affection. We found no evidence of any action taken by the facilities to address these reports.

2. Physical Abuse

Equally disturbing to us, our investigation revealed that some Adobe staff physically abuse youth, and that other Adobe staff purposefully do not intervene to protect juveniles from attacks by fellow youth. These practices not only harm youth but make efforts to rehabilitate them extraordinarily difficult. They also are obviously unconstitutional. See Redman v. County of San Diego, 942 F.2d 1435, 1441 n.7 (9th Cir. 1991) (en banc); White v. Roper, 901 F.2d 1501, 1503 (9th Cir. 1990).

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[8] This deficient practice of referring serious complaints from a unit back to the same unit for resolution is discussed in detail below.

Interviews conducted with both staff and youth during our tour of Adobe revealed that a sizable number of unit and security staff physically abuse youth by hitting them or slamming them to the ground in an overly-aggressive fashion. We also found that some staff exposed youth to entirely unnecessary risks of physical injury. For example, in September 2002, Mr. U., a staff person from the RAC unit, required youth under his supervision to crawl on their stomachs through a drainage ditch in order to receive their "responsibility time" (free time) later that day. Two youth received minor injuries in the activity.[9] On the very day we toured Adobe, we even observed a staff member slap an Encanto youth hard on the side of his head because he was moving "too slowly" back to the housing unit after dinner.

Our investigation also revealed numerous allegations of physical abuse that were never investigated and, in fact, remain unresolved to this day. One youth at Adobe reported that staff literally assaulted him for failing to return a pencil that was given to him by another staff member. Another Adobe youth reported that a correctional officer put his knee on the youth's head while the youth, who was offering no resistance whatsoever, was lying down on the bed of the small pick-up truck used to transport individuals to disciplinary confinement. We found no evidence that these allegations of abuse had been investigated.

Our review also revealed staff complicity in a number of fights between youth. Youth at Adobe reported that, at times, staff allowed youth to fight with each other and, incredibly, permitted and even encouraged youth to enforce physical discipline on other youth. A report dated August 20, 2002 stated that during a group session with the entire cottage present, a staff member allowed two youth to beat another youth. In another instance, a youth reported that he was "brutally assaulted" in September 2002 by two youth who were permitted by staff to run into his room. This grievance was never resolved. In a further incident, a youth received a serious eye injury that an Internal Affairs investigation determined was the result of a staff member "setting-up" and allowing a youth-on-youth fight. It was further determined

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[9] Mr. U. was demoted. Mr. U's initial has been fictionalized here; his identity will be provided by separate cover.

that the involved staff member was setting up other fights between youths, allowing them to occur and watching them.

3. Dangerous Lack of Supervision

Sexual and physical assaults are more likely to occur because the facilities lack sufficient staff to supervise youth adequately, thus exposing youth to danger. ADJC Policy 4002.05 calls for a minimum of three staff for up to 48 juveniles during the day and one staff at night. Our review indicates that none of the three facilities meet the ADJC's own staff-to-youth target ratios. Moreover, the prescribed ratios deviate substantially from generally accepted professional practices. Many states require one staff per eight youth during waking hours, and one staff per 16 youth at night. Indeed, at Adobe, we observed one staff person supervising an entire cottage of 20-28 youth in the afternoon and another single staff person supervising 48 youth during the overnight shift. Documentation that room checks were being done regularly during the night could not be provided.

At Catalina, the staffing deficiency is similarly acute. There, we observed during the overnight shift that there was only one staff person to supervise both the ten-bed Separation Unit and the 22-bed Agave Unit, which share a common building. Youth who are at acute risk for suicidal behavior and those segregated from the general population for disciplinary reasons are housed in Separation; older youth with more serious behavioral problems are housed in Agave. The one staff person on duty at the time of our tour literally had to dart between these two units to attend to youth in both units and readily admitted that it was not possible for him to supervise the youth adequately.

The absence of adequate supervision is clearly resulting in harm to the youth. For example, an April 2002 Internal Affairs investigation found that a youth received a serious eye injury when he was assaulted by another youth. The only staff member on duty at the time was on a bathroom break when the fight occurred. The lack of supervision is particularly dangerous on the overnight shift. Youth are double-bunked and fights, assaults, and other "acting out" occur in the absence of appropriate supervision. Adobe staff reported that fights are commonplace in the youth rooms at night and often go unreported. A lack of supervision also allows youth to victimize other youth. Staff in the Triumph cottage at Adobe

related that sexual "acting out" was "rampant" among youth there. One youth complained of being sexually propositioned by his roommate. A review of Internal Affairs investigations of youth-on-youth sexual assaults demonstrated that these victimizations occur regularly.

4. Inadequate Grievance and Abuse Investigation Systems.

Both the grievance system and abuse investigation process at all three facilities are extremely dysfunctional. These deficiencies incubate the dangerous institutional environment described above, where incidents of sexual and physical abuse are not appropriately reported or investigated, and where youth are not protected adequately from harm.

a. Inadequate Grievance Systems

The Constitution mandates that incarcerated individuals have readily available access to the institution's grievance process. See Bradley v. Hall, 64 F.3d 1276, 1279 (9th Cir. 1995). Based on our interviews with youth and staff in all three facilities, it is apparent that the grievance system does not operate fairly. Youth and some staff reported that youth are frequently prevented from speaking with "youth rights" staff, and that, in some cases, at the discretion of staff, written grievances are not accepted. When youth are permitted to submit written grievances, youth rights staff simply collect the grievances, assign a tracking number, and return the completed forms to the cottage supervisor for handling. The obvious problem with this approach is that many grievances include allegations of abuse against the very cottage staff for whom the supervisors are responsible. Not surprisingly, youth widely reported that this process made them reluctant to file a grievance out of fear of retribution.

Furthermore, throughout the facilities, grievances are not responded to in a timely fashion. At Catalina, a review of 150 grievances filed between September and November 2002 revealed that nearly one third had not been addressed. Among these were the denial of access to an asthma inhaler and allegations of inappropriate racial comments made by a staff person. Similarly, grievances at Adobe and Black Canyon were not addressed in a timely fashion. Youth throughout the facilities reported that the grievance system was "a joke" and that they rarely received responses to any grievances they

filed. Youth rights staff also expressed frustration with the process for grievance resolution and the lack of response from other ADJC personnel.

b. Inadequate Abuse Investigations

Youth who witness or experience potential abuse at one of the facilities may file a grievance.[10] At the same time, staff who witness potential abuse are required to report the matter to the facility superintendent. There are several problems -- both systemic and practical -- with this abuse investigation system.

As an initial matter, two administrative screening processes must be utilized before an objective investigation even begins. Once a grievance is submitted, the superintendent makes a case-by-case determination as to whether the allegation will be investigated by his/her own facility staff or referred to the Deputy Director of the agency for investigation. If the matter is referred to the Deputy Director, a second inquiry is conducted to determine whether an Internal Affairs investigator will be assigned to investigate the matter. Unfortunately, there are no written criteria to determine which allegations of abuse are to be investigated by Internal Affairs or by institution staff. Determinations are made on a case-by-case basis, a wholly subjective, time consuming, and cumbersome process.

In addition, it appears that incidents that should be referred for investigation by Internal Affairs are not being referred. For instance, in June 2002, a new staff member completing on-the-job training at Black Canyon reportedly "threw" a girl to the ground, slapping her several times, and choking her. This incident was reportedly witnessed by numerous youth who provided consistent accounts of the events, and the incident was reported to facility administrators by the youth rights advocate. Nonetheless, we could locate no documentation to indicate that an independent investigation of this matter had been conducted by Internal Affairs.

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[10] Very few abuse investigations are generated by youth grievances apparently because youth lack faith in the grievance system and fail to utilize it.

Investigations that are undertaken are generally very untimely, often occurring weeks or even months after an alleged incident. This is problematic because it allows for the possibility of further harm to youth by an abusive staff member while waiting for a formal finding. In a case involving allegations of sexual misconduct that allegedly occurred during the months of November and December 2001, and were reported in January 2002, the investigation was not completed until March 2002. Despite the seriousness of the allegations, there was no indication whether the involved staff member was relieved of direct contact with youth during the time it took to complete the investigation.

There is also no system in place allowing youth a direct method by which to report abuse other than by filing a grievance. Under the present system, youth grievances are collected by the youth rights staff and returned to the housing unit supervisor for resolution. This practice necessarily involves a staff person with supervisory responsibility for the housing unit in the resolution of a grievance. Objectivity in this situation is highly questionable, particularly where the allegations may include physical or sexual abuse. For example, from September 6, 2002 to October 26, 2002, 15 youth grievances alleging abusive use of force in Encanto were made. One particular staff member was repeatedly identified by youth for allegedly aggressive take downs and verbal threats. The Director of Encanto, however, only responded to two of the grievances and both responses noted that the Director would seek resolution by bringing the involved youth and the staff member together. The other grievances had no resolution or outcome noted.

5. Inappropriate Use of Disciplinary Confinement

The facilities employ three different disciplinary measures that result in the disciplinary confinement of youth. First, youth can be confined to their rooms, either individually or with roommates, in a practice known as "exclusion." Second, entire housing unit populations can be locked in their rooms in a practice known as "large group." Third, youth can be placed in Separation Units, which are single-celled housing units where youth are placed in isolation in individual, locked rooms.

While the facilities provide adequate due process protections as they relate to the initial placement in Separation Units, youth are kept in isolation for extended and inappropriate periods of time that fly in the face of generally accepted professional standards. For example, over the explicit objections of mental health staff, one Catalina youth was confined in a Separation Unit for 33 days. Four other youth were confined in a Separation Unit for more than 18 days, again over the objections of the mental health staff.

Another disturbing practice is the decision to lock entire unit populations in their rooms because of the misbehavior of two or three youth. This practice is known as "large group." Clinical staff can authorize "large group" lock downs, which consist of locking every youth in a particular cottage in his room for several days or weeks with very limited time outside their room or cottage. We do not suggest that these lock downs are facially unconstitutional or unwarranted in all circumstances. But the State's institutions appear to ignore completely the adverse psychological side effects of prolonged isolation and, more importantly, seem to have adopted no standards governing when such lock downs may be validly employed.

Our review of Adobe documentation revealed that staff have almost unfettered discretion to impose lock down. A review of lock down practices in the Freedom Unit at Adobe revealed numerous lock downs of the entire unit, during which time youth acted out in their rooms, engaging in sexual behavior and fights. In another unit, youth rights staff reported that youth were locked down for more than 14 consecutive days. Despite objections raised by the youth rights staff, lock down continued in this unit, during which time youth were limited to only ten minutes of exercise per day and were not permitted to attend school, eat in the dining hall, or attend religious services. Notably, one of the suicides discussed earlier involved a youth whose unit had been locked down for over 30 days in a "large group" status.

In addition to the abusive practices noted above, we found other troubling examples of disciplinary confinement. For instance, at Adobe in March 2002, a youth was placed for several days straight on "Security Status" in locked room isolation. Log notes indicate that the youth was permitted to talk only with certain designated staff and, even then, only for five minutes in the morning and five minutes in the

evening, at which points he could "request toilet paper." The log also denotes that the youth's day was to be spent in silence, yet offers no explanation or justification for such treatment. This condition of confinement raises serious constitutional questions in that it potentially precluded this youth from alerting staff about, and securing necessary treatment for, serious medical issues. See LeMaire v. Mass, 12 F.3d 1444, 1458-59 (9th Cir. 1993).

Although disciplinary practices were not as extreme at Black Canyon, we observed some inappropriate isolation practices there as well. For example, a girl who spoke Spanish and very limited English and who was very upset about the recent death of her mother was confined in the Separation Unit for three consecutive days. There was no documented justification for her isolation and, when we asked facility staff about this incident, no explanation whatsoever was offered. Unfortunately, this incident was not unique. Large group lock downs lasting as long as ten days were reported in the Maya Unit at Black Canyon, and some girls reported that during these times they received virtually no opportunity to shower.

6. Unsanitary Living Conditions

At Adobe and Catalina, most of the rooms for boys lack toilets. Moreover, due to staff shortages at night, youth often are not allowed out of their rooms to use the restroom unless additional security staff are present. As a consequence, youth frequently have no access to bathroom facilities and must relieve themselves in their rooms. Shockingly, youth reported urinating and defecating in laundry bins and plastic bottles. During one evening tour at Adobe, we observed youth emptying their laundry bins in the toilets and rinsing them out; other youth were observed darting from their rooms to the bathroom to relieve themselves when security arrived and their doors were unlocked.

Grievances and interviews with youth revealed numerous complaints about a lack of access to toilet facilities at night. One youth was told by staff to "hold it" for two and one-half hours; reportedly, he ultimately relieved himself in a plastic bottle in his room. Another youth indicated that one night when he requested to go to the bathroom, it took nearly an hour and a half before someone arrived. In another instance, a youth stated that the night staff member would not

call security for a bathroom break, so the youth was forced to defecate in a plastic bin in his room. Staff at Catalina reported that the odor that results from these unsanitary practices is particularly pungent in the summer months.[11]

7. Inadequate Security at Catalina

Juveniles confined at ADJC facilities are entitled to reasonable safety. Security practices at Adobe and Black Canyon were acceptable and comport with generally accepted professional practices. Security practices at Catalina, however, were significantly deficient. During our tours, we observed that there was virtually no screening of visitors. There was no operating metal detector and visitors were not required to sign a log or subjected to any type of search. Our investigation also revealed a fair amount of contraband at Catalina.

Key control was incredibly lax. Indeed, during our tours, we were provided with two sets of master keys that opened almost all facility doors. At the conclusion of our tour, we were asked to return *four* sets of keys even though we only had *two* sets to return. This discrepancy was apparently not reconciled. The failure to screen visitors for contraband and to control the possession of keys places youth at an unreasonable risk of harm.

C. EDUCATION

Turning to the education provided to the confined youth, the facilities are in clear violation of the statutory rights of residents with disabilities by failing to provide these juveniles adequate special education instruction and resources.

1. Inadequate Special Education Services

In states that accept federal funds for the education of children with disabilities, as does Arizona, the requirements of the IDEA apply to juvenile correctional facilities. See 20 U.S.C. § 1412(a)(1)(A); 34 C.F.R. § 300.2(b)(1)(iv). The deficiencies in special education services we observed at

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[11] Youth at Catalina have recently been issued plastic urinals like those utilized in hospital settings.

three Arizona facilities result from inadequate screening and identification of students for special education services, inadequately developed Individualized Education Plans ("IEPs"), inadequate special education staffing, a lack of related services[12] for special education students, and the lack of Section 504 plans for students with disabilities.

a. Inadequate Screening and Identification

The IDEA requires that all children with disabilities who are in need of special education and related services be identified, evaluated, and served. The IDEA requires that schools conduct a full and complete an assessment of students suspected of having disabilities and that the assessment be done by an appropriate evaluation team that includes specialists in the areas of the students' suspected disabilities. Proper screening should include systematic observation of students, interviews, and an assessment of entering students to determine either a prior history of special education or the necessity of a referral for special education eligibility.

Youth who enter the facilities we examined are not sufficiently screened for identification of special education needs. The primary test that is administered to all incoming students is the Test of Adult Basic Education ("TABE"). This test is intended for use with an adult population and is an inadequate tool for assessing the educational needs of youth.[13] Moreover, the TABE can only determine the grade level at which someone is functioning; it cannot assess individual skill deficiencies. Thus, it is an inappropriate and inadequate

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[12] Related services are defined in the IDEA to include supportive services as are required to assist a child with a disability to benefit from special education. Examples of related services include psychological services; physical therapy and occupational therapy; recreation, including therapeutic recreation; counseling services, including rehabilitation counseling; and social work services in schools. 20 U.S.C. § 1401(17).

[13] The youngest age for which the TABE is normed is 17, and the average age of youth committed to ADJC is 15 and a half.

assessment tool for meeting the requirements of the IDEA. At the time of our tour, program administrators were developing a different process to screen and identify students eligible for special education services. The development of this new process, however, was hampered by a lack of adequate personnel and delays in receiving school records.

At the time of our visits, 19% of students at Adobe were identified as eligible for special education services, 27% at Black Canyon, and 37% at Catalina. Program administrators consistently estimated the true prevalence of students eligible for special education services in ADJC to be between 35-40%. Key education staff acknowledged that Adobe had under-identified the number of youth in need of special education services.

b. Inadequate Individualized Education Plans

The IDEA requires that each youth classified as eligible for special education services have an Individual Education Plan (IEP) that: (i) states the student's present level of performance; (ii) specifies short term instructional objectives that are measurable and within the individual student's capabilities; (iii) sets objective criteria and a timetable for measuring achievement; (iv) outlines the special education and related services to be provided; (v) describes the extent to which the student will be able to participate in the general education program; and (vi) sets forth projected dates for the initiation and duration of services. The facilities fail to develop adequate IEPs for each youth determined to be eligible for special education services. Facility IEPs were not individually tailored to address the special education needs of youth. Rather, the IEPs had generic and broadly stated goals and objectives, making progress on these goals difficult if not impossible to assess. Nor were related services described in the IEPs.[14]

The IDEA also establishes safeguards to protect the rights of children with disabilities, including parental participation and consent in the IEP process. For the special education student whose parent cannot be located, a surrogate may be appointed to advocate for the child. At ADJC, rather

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[14] As discussed below, our review found no evidence that any youth actually received related services.

than appoint a surrogate when a youth's parents cannot or will not participate in the IEP process, the facilities simply have adults who have never even met the youth sign the IEP.

c. Inadequate Special Education Staff

To the extent that general education teachers do try to address the goals and objectives of IEPs, they are hampered by a shortage of qualified special education staff, particularly at Adobe. At the time of our tour, Adobe had a total student population of 426. Eighty students had been identified as needing special education services. These 80 students were served by just three special education teachers, each of whom carries a caseload from 16 to 36 students. To achieve the 1:8 teacher to student ratio that is required by ADJC policy, and commonly viewed as adequate, seven additional teachers would be required. Although most special education students are served in general education classrooms, a number of classroom teachers we interviewed informed us that they receive no consultation from special education teachers for their students on consultative IEPs. The high demands placed on the limited number of special education teachers make it difficult for them to provide meaningful consultation to general education teachers. As discussed in further detail below, the lack of substitute teachers when regular classroom teachers are absent also compounds the difficulty in providing adequate instruction to special education students.

d. Lack of Related Services

The facilities fail to provide necessary related services to help special education students benefit from their educational experiences. Few of the IEPs that we reviewed indicated any related services, although the need for such services was readily apparent. At Catalina, two youth with IEPs had recently attempted suicide, but neither was receiving any special therapy. Another teenage youth at Catalina, who had reading and math skills at the third grade level, a history of both antagonizing other youth and being disruptive and defiant to his teachers, and who had spent considerable time in school detention, was also receiving no related services. When queried, special education teachers indicated

that Limit and Lead[15] is the only "related service" that students with disabilities receive. While Limit and Lead may provide some structure to ADJC's rehabilitative program, it does not qualify as a related service. Moreover, given that this program is geared to the seventh grade reading level, its benefit to students eligible for special education services is suspect. Further, our investigation revealed that 14 youth at Catalina required speech therapy, a related service commonly provided to special education students, but there was no indication that any were receiving such services.

e. Lack of 504 Plans

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination against persons with a disability by any agency receiving federal funds. The protections of this law, which apply to state prisons, see Pennsylvania Dep't of Corrections v. Yeskey, 524 U.S. 206 (1998) (holding that the terms of Title II of the Americans with Disabilities Act, the relevant provisions of which are identical to Section 504, are applicable to the states), are extended to any person who (1) has a physical or mental impairment that substantially limits one or more of such person's major life activities, (2) has a record of such impairment, or (3) is regarded as having such impairment. The law requires that an accommodation plan be developed for students who qualify for services under Section 504.

Throughout the facilities, we could find no student for whom a Section 504 accommodation plan was provided, although many youth would qualify for such plans. There is no formal process or identified coordinator to facilitate development or implementation of Section 504 accommodation plans and, as a result, accommodation plans are not developed for students, which reduces their potential benefit from the education program.

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[15] Limit and Lead is the primary treatment program at the facilities and consists of a curriculum designed to "change delinquent thinking." ADJC's version is modified from the Limit and Lead therapeutic program originally designed for treatment with sexual offenders that is discussed in greater detail below. The program includes reading and writing components.

f. Failure to Provide Accommodations for Youth with Disabilities.

As discussed above, the core component of the treatment program at use in the facilities is the Limit and Lead treatment curriculum. This program consists of four different levels. To be released from custody, youth must progress through the different levels. While the treatment program includes workbooks that are written at a seventh grade reading level, data supplied by the school superintendent at the time of our tours indicated that a sizeable percentage of the youth at Adobe and Black Canyon, and nearly half of the youth at Catalina, read below the seventh grade level. The following chart summarizes the data:

Facility	Youth who read below the 7th grade level	Youth who read below the 2nd grade level
Adobe	28%	10%
Black Canyon	38%	3%
Catalina	48%	6%

Thus, many students are unable to read the required treatment program materials independently. Moreover, treatment staff, who are not trained or expected to make accommodations in instruction or materials for youth with reading difficulties, did not appear prepared to help those students struggling to read. Thus, students with reading difficulties, including many students receiving special education services, are significantly challenged to complete the treatment program successfully. Because completion of the program is a prerequisite for release from the facilities, the failure to provide accommodations for disabled youth has particularly adverse consequences.

D. INADEQUATE MEDICAL CARE

Juveniles in the facilities are entitled to adequate medical care. See Sharp v. Weston, 233 F.3d 1166, 1172 (9th Cir. 2000). However, the medical services actually provided to youth at Adobe, Black Canyon, and Catalina is grossly

deficient and exposes youth to significant risks of harm. The deficiencies result from inadequate nursing care, dangerous medication administration practices, inadequate quality assurance and infection control programs, inadequate pharmacy services, and inadequate dental care services at Catalina.

1. Inadequate Nursing Care

Generally accepted professional standards dictate that nurses document a description and assessment of an individual's medical problem in the progress notes in the medical chart. The taking and documenting of vital signs (heart rate, blood pressure, respiratory rate, and body temperature) are among the most basic of nursing practices; the failure to obtain such basic information significantly limits the ability of a medical practitioner to assess a youth's medical condition and places the youth at risk of harm. Moreover, appropriate documentation serves as a record of treatment received and the efficacy of any treatment given. Absent appropriate medical documentation, it is nearly impossible for health care staff at the facilities to ascertain whether appropriate medical treatment is being rendered. Our review of nursing care throughout the facilities demonstrated substantial deficiencies. The following examples are illustrative.

At Adobe, the medical record of one particular youth reveals four separate, serious errors in nursing care in a six-week period. Notes indicate that, when the youth was seen by a nurse in August 2002, he expressed suicidal thoughts. Yet there was no documentation of the youth's mood, mental status, sleep patterns, past mental health issues, or history of prior suicide attempts. In the area where an assessment should have been documented, a line was drawn, indicating that no assessment was done. The absence of an assessment of a youth verbalizing suicidal ideation demonstrates a lack of basic, clinical nursing knowledge. In September 2002, the youth was seen following a "take down" by security, at which time he complained that he "sees stars." Once again, however, there was no neurological exam noted or vital signs documented. The youth was also seen for a sore throat but, while the nurse's note indicated swelling of his tonsils and a strep culture was ordered, no vital signs were obtained and the strep was not taken for almost two weeks. Ultimately, the results were positive for strep, a painful and highly contagious condition.

Additional examples of deficient nursing care include:

- A youth was seen by medical staff because he hit his head on a door on two occasions in September 2002, resulting in lacerations. Although it is standard medical practice to obtain vital signs and conduct a neurological check in such cases, the nursing notes for N.O. lacked any vitals or neurological exam.

- A youth was seen for a possible hand fracture. Nursing notes indicate that a re-evaluation would occur in one to two days, but there was no follow-up entry documenting that the follow-up occurred.

- A youth was seen on November 2, 2002 for vomiting that morning. Although obtaining vital signs on a youth experiencing vomiting is basic nursing care, none were obtained.

- A youth was seen for headache and blurred vision following an injury to his right eye. No vital signs or neurological check was noted.

- A nurse's note dated June 5, 2002 stated that a youth's mother reported that he was allergic to Lithium. This information was not added to his medical staffing sheet under "Allergies" so that medical providers would be immediately alerted to this allergy, which could have life-threatening side effects.

Because adolescent girls experience significant changes in their bodies as they go through puberty, monitoring them for regular menstrual cycles is a standard medical practice, as the absence of menses could be brought about by various conditions including pregnancy, emotional disturbances, medications, poor nutrition, weight loss, anemia, or tuberculosis. Our review indicated the absence of a system for monitoring menses. For example, a youth was admitted to Black Canyon on December 5, 2002. Her medical record indicated that she had had a miscarriage on July 19, 2002, but had not had a regular menses since that time. On December 24, 2002, she was referred due to an abnormal Papanicolaou (pap) test. On January 7, 2003, the medical record indicated that she was having "long periods" and bleeding heavily, but there was no indication that her menses was being monitored.

Another youth was admitted to Black Canyon on February 10, 2002. A health care request dated in July 2002 from W.S. stated that she was having pains in her breasts and that she had not had her menses in over a year. Until the girl submitted a sick call request five months after her arrival at the facility, medical staff were not aware of this condition.

Nursing coverage at the facilities is provided from 5 a.m. until 10 p.m. During the overnight shift, the Director of Nursing provides medical consultation, as needed, by phone. Unit staff are not trained to take basic vital signs, and, during the night, decisions regarding whether medical attention is sought are made by unit staff. The absence of medical staff during the overnight shift, coupled with the lack of training for unit staff, places youth at serious risk.

An example of the dangerous management of serious medical issues during the overnight shift due to the absence of a trained nurse on-site coupled with the lack of training of unit staff is illustrated most acutely by an incident from June 29, 2002. That night, a youth at Black Canyon slipped and hit her head. She was seen by medical staff just before the overnight shift began. The medical staff recommended that the youth be checked by unit staff every 30 minutes. At 11:30 p.m., one and one-half hours after medical staff had left the facility, the youth was found disoriented and difficult to arouse. The on-call medical provider instructed that a female unit staff perform breastbone thrusts to rouse her. Such an over-the-phone medical consult ordering chest thrusts is a clinically unacceptable practice and a potentially dangerous treatment for the youth. Once the chest thrusts were done, the youth became more alert, but within 25 minutes began vomiting and shaking. The youth was then transported to the community hospital. Our review revealed no documentation that the youth was checked every 30 minutes. Moreover, because unit staff lacked training to take vital signs, they were unable to provide that relevant information to the on-call medical provider.

In still another case, a youth at Catalina sustained a cut over his eye. Because there were no medical staff on-site, the on-call nurse was notified, but did not respond for more than an hour and a half.

Even when nurses are supposed to be on-site, nursing directors in all three facilities reported that they are

frequently short-staffed and must rely upon registry nurses who are often unfamiliar with the facilities' policies and procedures.

2. Dangerous Medication Administration Practices

Generally accepted medical practices, not to mention basic logic, advise that prescribed medication should be taken only by the person to whom the medication is prescribed, only in the dose prescribed, and, if administered by a health professional, appropriately documented. Medication administration practices at the youth facilities in Arizona, however, are woefully inadequate.

As part of our on-site investigation, we observed nurses administering medication to youth in all three facilities. Nursing staff did not uniformly follow the "watch/swallow" procedure designed to assure that youth actually take their prescribed medications. Several examples illustrate deficiencies in medication administration and the risk posed to youth. After a youth at Black Canyon swallowed some unknown medication, a search of her housing unit revealed pink pills in the cushion of her unit's day room. This youth was transported to the hospital where she had her stomach pumped. Another youth at Black Canyon was found in her room in the fetal position crying. She disclosed to staff that she had swallowed ten pills that she had obtained from another youth. She was also transported to the hospital for treatment. At Catalina, a youth informed staff that he had "cheeked" his anti-depressant medications with the intent of stockpiling it for subsequent use or disseminating it to other residents. Another youth reported that he was having trouble breathing after snorting the contents of a capsule given to him by another youth. At Catalina, numerous incident reports also documented that youth had hoarded psychotropic medications and later gave/sold them to other youths.

Youth are also at risk of harm at the facilities because they do not always receive the medications prescribed to them. A review of 30 medical records from Catalina revealed that in 19 cases, there was no documentation that medications were given as ordered. A similar pattern was evident at Black Canyon, where a review of 30 medical records revealed an absence of documentation for 20 youths. Standards of nursing practice dictate that medications be administered as prescribed and appropriately documented.

3. Inadequate Dental Care at Catalina

With the exception of Catalina, the facilities are meeting their obligation to provide adequate dental care to youth. At Catalina, dental services are provided on an irregular basis and used only generally for emergency dental needs or initial admission exams. At the time of our tour, there was a significant backlog of youth in need of dental procedures. The Director of Nursing informed us that numerous youth had been placed on antibiotics to prevent infection while awaiting needed dental services. It was unclear when these services would be provided. At the time of our December 2002 tour, at least 15 youth required follow-up dental care that had not been scheduled.

4. Lack of a Quality Assurance Program

Quality assurance protocols are standard in institutional healthcare settings and necessary for monitoring, tracking, identifying trends, and/or recognizing need for corrective actions. The facilities have no quality assurance program in place for nursing care. As noted above, medication errors occur with some frequency in the facilities, yet when questioned, the Directors of Nursing were either unaware of the rates of medication errors or grossly underestimated the rate. In addition, nursing directors do not conduct regular chart audits. One nursing director had completed only five chart audits in the last year; the other two had completed none. As a result, the deficiencies in nursing care discussed herein are not identified or corrected.

5. Inadequate Infection Control Program

Generally accepted medical practices require that facilities like Adobe, Black Canyon, and Catalina have an infection control program to track incidents of communicable diseases and ensure effective responses to infections. The absence of a program, given the close quarters of a juvenile justice facility, puts youth and staff at risk of illness. Our review revealed that the facilities lack an infection control program.

6. Inadequate Pharmacy Services

Pharmacy services throughout the facilities fail to comport with generally accepted professional standards. ADJC

employs a single pharmacist who is based at Black Canyon and fills prescriptions for Adobe, Black Canyon, and Catalina. There is no indication, however, that this pharmacist performs any functions other filling prescriptions.

It is, for example, standard practice for pharmacists to participate on a facility's Pharmacy and Therapeutics ("P&T") Committee.[16] Yet our investigation revealed no functioning P&T Committee in the facilities and no review of medication errors by the pharmacist. The purpose of a P&T Committee is to ensure safe medication practices and the committee's responsibilities typically include reporting and monitoring adverse medication reactions and errors, making decisions on the facility formulary, developing and reviewing treatment guidelines and protocols, developing medication policies and procedures to meet regulatory standards, and conducting drug use evaluations of requests for off-label medications. Clearly, the P&T Committee serves a vital purpose in the overall management of medication issues, particularly in monitoring and correcting medication errors. The virtual complete absence of a functioning committee in the facilities fails to ensure safe medication practices and places youth at risk of harm.

The pharmacist is also generally responsible for maintaining the inventory of emergency medical kits. But we observed that the medical boxes did not contain an inventory list, as required by professional standards, and that in one kit, some medication had expired. Our review revealed no evidence that these boxes were checked within the six months prior to our tour.

E. MENTAL HEALTH/REHABILITATIVE SERVICES

Mental health services, to which incarcerated individuals are constitutionally entitled, see Sharp, 233 F.3d at 1172, are inadequate to address the individual needs of the youth at each of the three facilities. The shortfalls are seen in the areas of rehabilitative services, including inadequate group and individual therapy; interventions; interdisciplinary communication; and discharge planning.

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[16] We found evidence of only one P&T Committee meeting, conducted on January 10, 2002.

1. Inadequate Rehabilitative Services

Youth in juvenile justice facilities are entitled to adequate rehabilitative services, including individualized treatment. See Sharp, 233 F.3d at 1172 (quoting Ohlinger v. Watson, 652 F.2d 775, 778 (9th Cir.1980)). Without a program of individual treatment juveniles are much more likely to become long-term wards of the State and simply "warehoused" in the facility. Arizona fails to meet its constitutional obligations in this area.

The programs at both Adobe and Black Canyon consist largely of standardized group therapy in which little attempt is made to address the individualized needs of the youth. Therapeutic groups, led by a qualified group leader with formal training and supervision in group dynamics, can be a highly useful tool for developing skills. From our observations of group sessions and interviews of group leaders, however, it was painfully apparent that, while the facilities' staff were well meaning, they did not have sufficient training to lead groups in a therapeutic manner.

There is also a lack of adequate and appropriate individual therapy at Adobe and Catalina. For example, a youth at Adobe attempted suicide by cutting both of his arms. After treatment in the emergency room, he was placed in the Separation Unit, but he received no individual therapy. Another youth struck himself with a pipe from the sink, yet there was no indication that he received any individual therapy. After one youth's godfather died, and communication logs indicated that he was upset over the death, staff were merely instructed "to keep him busy" rather than providing him an appropriate therapeutic intervention. At Catalina, we found a youth who was in the Separation Unit for cutting himself, who reported to us that he did not have a regular therapist with whom to talk. While this youth stated that he had received a few visits from a mental health staff person while in the Separation Unit, he noted that he did not know this person and, therefore, would not be able discuss his problems with her. This youth appeared to be extremely depressed and in need of individual therapy.

The psychology associates and psychologists we interviewed reported that individual therapy is not a treatment supported by the facilities' administration. Rather, the facilities rely on Limit and Lead, a therapeutic

program originally designed for treatment with sexual offenders. Mental health staff reported that much of the Limit and Lead program is inappropriate for the youth, and one psychologist reported that this program actually undermined the limited individual therapy that was provided. Mental health staff throughout the facilities reported their belief that youths' therapy needs were not being met.

Clinical staffing shortages at the facilities exacerbate a "one size fits all" approach to the therapeutic program. The wide variety of girls assigned to the Pride Unit exemplified the deficiency.[17] Residents of Pride Unit included girls who were almost 18 years old and, therefore, close to mandatory release. Others were younger and sexually aggressive, or younger and physically aggressive. Still others were lower functioning girls who had spent, in some cases, years at Black Canyon without advancing through the level system necessary for their release. Girls with disparate needs received therapy together and, not surprisingly, to little effect.

2. Inadequate Mental Health Interventions

The facilities claim to provide a therapeutic milieu, but in reality do not. Milieu therapy is a treatment mode in which the staff deliberately plan and structure a youth's interpersonal and physical environment. The purpose of a therapeutic milieu is to create the structure necessary for the development of independence, responsibility, and a healthy sense of self, traits which delinquent youth often lack. The staff in a therapeutic milieu use every interaction with youth as an opportunity to encourage growth. Our review of records, interviews with staff and youth, and on-site observations revealed the absence of a therapeutic milieu in the facilities.

Staff spend most of their time responding to incidents and crises, focusing attention on youth who injure themselves. Some staff reflected unsympathetic attitudes inconsistent with

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[17] We understand that following our tour of Black Canyon, the Pride Unit was closed and youth were re-assigned to other housing units. While this change in environment may have some salutary effect, we have not been apprized of substantive programmatic changes.

any therapeutic approach. One staff member stated that a youth had been saying he wanted to kill himself for months, but the staff member did not take the threats seriously because the youth had not made any attempt so far. Another staff member stated that if a youth was serious about killing himself, he should get a knife or a rope and "just do it." Yet another staff member told a youth who had recently made a suicidal gesture that he "needed to be a man and take it." In light of the three suicides that have occurred at Adobe since April 2002, these attitudes are nothing short of alarming.

3. Inadequate Interdisciplinary Communication

Communication among the various disciplines at the facilities is fragmented. No formal system exists for information to cross all areas to ensure that consistent care is provided. Medical records, mental health records, and treatment notes are not integrated. There is no sequential documentation of events. This deficiency deprives the treating psychiatrist of feedback from professional and non-professional staff to remain informed of the status of the symptoms being treated, medication refusals, injuries, changes in behavior, medication side effects, or educational issues.

4. Inadequate Discharge Planning

Discharge planning is an essential component of a rehabilitative plan because this helps to identify the individual treatment goals for a youth. Our investigation revealed inadequate discharge planning throughout the facilities. Discharge plans consisted of the date of the last physical examination, any medications the youth was taking, any chronic illnesses (*e.g.*, asthma), and the need for any follow-up medical appointments. Discharge plans failed to consider information regarding a youth's mental status, educational level, placement, or progress summary. The discharge summaries provided extremely limited information about a youth's treatment at the facility and are inconsistent with professional standards of treatment.

5. Psychiatric Services

Psychiatric services at the facilities were generally adequate. Appropriate psychiatric evaluations were being conducted and clinical justifications for most diagnoses were evident. We noted one area of deficiency regarding the

monitoring of youth on atypical antipsychotic medications. Youth taking these types of medications should be regularly evaluated for Tardive Dyskenisia, a serious potential side effect of neuroleptic (antipsychotic) medication that is manifested by involuntary, rhythmic movements of the tongue, mouth, jaw, or limbs. Screening for this irreversible side effect should be conducted and documented through the use of the Abnormal Involuntary Movement Scale ("AIMS") or the Dyskenisia Identification System, Condensed User Scale ("DISCUS"). Our review of medical charts of youth receiving atypical antipsychotics did not show that the AIMS or DISCUS were regularly conducted.

III. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional and statutory rights of the youth confined at Adobe, Black Canyon, and Catalina, these facilities should implement, at a minimum, the following measures:

1. Ensure adequate housing, monitoring, and documentation of youth identified as potentially suicidal. Ensure that current environmental conditions which pose risks for potentially suicidal youth are eliminated.

2. Ensure that all staff who are in contact with youth are adequately trained in suicide identification, prevention, supervision, and intervention.

3. Develop and implement procedures to ensure that interdisciplinary communication occurs between all direct care staff and mental health staff who are in contact with potentially suicidal youth.

4. Ensure that there are sufficient numbers of adequately trained direct care and supervisory staff to safely supervise youth and protect youth from harm. Ensure that there are adequate staff to permit youth to use the bathroom facilities in a timely manner.

5. Develop and implement adequate grievance procedures to ensure youth have access to a functional and responsive grievance process.

6. Ensure that investigations of abuse are conducted thoroughly and in a timely fashion by appropriately trained investigators. Develop and implement a policy for youth to directly report allegations of abuse independent of the grievance process.

7. Develop and implement policies that eliminate the use of disciplinary confinement without adequate due process protections.

8. Ensure that appropriate remedial security measures are implemented at Catalina Mountain School to address security lapses.

9. Provide adequate special education services in all facilities, including complying with all requirements of the IDEA.

10. Comply with all requirements of Section 504 of the Rehabilitation Act and the Americans with Disabilities Act.

11. Provide adequately trained staff, resources, and quality assurance programs to ensure access to adequate medical care, including dental services at Catalina.

12. Develop and implement appropriate an appropriate quality assurance program for medical care.

13. Develop and implement an effective infection control program.

14. Ensure that professional standards for medication administration are followed by all medical staff, including pharmacy services for the regular review of medication regimens for youth, regular inventorying of medications, and regular Pharmacy & Therapeutics meetings.

15. Ensure that adequate mental health services are provided to all youth, including appropriate individual and group therapy and that appropriate interdisciplinary communication to facilitate mental health treatment occurs.

16. Ensure that appropriate discharge planning is conducted.

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During the exit interviews at our on-site tours, we provided State officials with preliminary observations made by our expert consultants. State officials and facility staff reacted positively and constructively to the observations and recommendations for improvements. The collaborative approach the parties have taken thus far has been productive. We hope to be able to continue working with the State in an amicable and cooperative fashion to resolve deficiencies previously noted. In addition, due to the State's cooperation in this matter and State officials' expressed desires to improve conditions in these facilities, we will send, under separate cover, reports from our consultants that provide their more detailed findings and recommendations to address the inadequacies they found in the operation of the facilities. Although the expert consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, the observations, analyses, and recommendations of our consultants provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that 49 days after receipt of this letter, the Attorney General may institute a lawsuit pursuant to CRIPA to correct noted deficiencies. 42 U.S.C. § 1997b(a)(1). Accordingly, we will soon contact State officials to discuss in more detail the measures that must be taken to address the deficiencies identified herein.

Sincerely,

R. Alexander Acosta
Assistant Attorney General

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