

An Interim Report on the Conditions at the Arkansas Juvenile Assessment and Treatment Center



Aerial Photo of Arkansas Juvenile Assessment and Treatment Center in Alexander.

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

The opinions contained in this report do not necessarily reflect those of our federal partners.

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Introduction

For many years, Arkansans have struggled with how to address the needs of children involved with our state's juvenile justice system. The Arkansas Juvenile Assessment & Treatment Center (AJATC) has had a troubling history of problems. These problems were first brought to light in June of 1998, thanks to a series of articles published in the Arkansas Democrat Gazette on the conditions in facilities for juvenile offenders. In 2001 the United States Department of Justice (DOJ) issued a findings letter to Governor Huckabee pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997(a)(1), in which DOJ concluded that certain conditions at AJATC violated the constitutional and/or statutory rights of juveniles confined at that facility. Recently, AJATC was once again in the news due to an increase in the number of reported assaults at the facility.



The most recent allegations were reported in the Arkansas Democrat Gazette beginning June 12, 2014. This series of articles noted that in 2013, there were 327 reported assaults – an increase of 98 percent over the figures reported in 2012. This dramatic increase in reports of violence at the facility prompted Disability Rights Center of Arkansas (DRC) to increase its monitoring efforts

to ensure that all youth being served at the Center were safe and receiving services necessary for a successful transition to the community.

In 2006, Arkansas began a comprehensive study of its juvenile justice system and in 2009 developed a five year plan for reform. The strong commitment of the Governor, the administration, courts and stakeholders led to the downsizing of secure juvenile facilities and the growth of community programming. Additionally, the number of beds at AJATC was reduced by 43. Unfortunately, much of the reform activity has plateaued. Based on the US Census, from 2001 to 2011, states began to decrease the use of detention centers by 30.6%, while Arkansas saw an increase of 37.5%. From 2007 through 2011, Arkansas saw an increase of 100%. (“Why Detention is Not Always the Answer”, Arkansas Democrat Gazette, 2014).

The solution to the current concerns about AJATC is to not pull back on reform or return to discredited models. We hope this report and the recommendations made within will help to move the discussion in the direction of creative and positive next steps toward a truly effective and humane juvenile justice system.



Rehabilitation is beginning to look a lot like punishment.

Arkansas Juvenile Assessment and Treatment Center (AJATC)

AJATC is a secure facility for adjudicated Arkansas juveniles ages 10 to 17; the current census is 100 youth, 85 boys, and 15 girls, with a capacity of 143. The facility is an old “training school” built in 1905. The Department of Youth Services (DYS), an agency in the Department of Human Services (DHS), has overall responsibility for AJTAC, which is funded primarily by state appropriations. The facility is accredited by the American Corrections Association (ACA).

The campus consists of six living units, a cafeteria, a gymnasium, a chapel and medical, administrative, and educational buildings. AJATC functions as the central intake and assessment unit for all juvenile offenders throughout Arkansas.

The average length of stay at AJATC is five to eighteen months; however, during our monitoring and reviewing of records, DRC staff identified youth who had been there for as long as three years. The length of stay at AJATC is determined by the youth's "LOS Matrix." This matrix is compiled by DYS and takes into account the offense, behavior, etc. of the youth.

Youth report being abused by staff during their stay:

One youth, who was thirteen years old when committed to AJATC, and was originally given a sentence of three-to-five months for disorderly conduct, has now been incarcerated at AJATC for three years. He has seen several extensions of his sentence while incarcerated for threats he has made to harm himself. Staff has noted the youth has "unraveled" and that his adverse behaviors have increased as a result of his unusually long stay. During interviews with DRC staff, he has stated that he is aware that his behavior is what is keeping him at AJATC, but no one is listening to his pleas for help. He states that he has been abused by staff while in a restraint hold, has had his head banged into walls, and has been slapped and hit in the face by staff, all in areas where there are no cameras to record incidents. When asked if he reported the abuse, he replied that he has filled out grievance paperwork, but has not been apprised of any outcomes. He currently remains incarcerated due to behaviors.

DRC was told that the cost per youth to be housed, fed, and educated at AJTAC is \$81,958 per year. Approximately 40% of the youth are receiving special education services through the facility. They are not segregated according to the severity of their offense, although there is a high-risk dorm that keeps the more serious sex offenders separated from the other youth.

Juveniles adjudicated delinquent by a juvenile court prior to their 18th birthday may be retained in the juvenile justice system until the age of 21. A juvenile court judge may order a youth committed to AJATC for a misdemeanor, including something as minor as throwing a chair or saying a curse word to a teacher.

History of service providers since the State of Arkansas relinquished day-to-day operational control of AJATC in 2001

I. Cornell Interventions, Inc.

In 2001, DYS turned over operational responsibility of AJATC to Cornell Intervention, Inc., a for-profit corporation. Cornell was contracted to provide on-site management of what was then known as the Alexander Youth Services Center and a DYS maximum-security facility known as JUMP (Juvenile Upward Mobility Program). “Under the initial two-year contract, the state was to pay Cornell about \$13 million to do a better job, presumably, than the state could do at almost twice the cost.” [June 17, 2001, *Arkansas Democrat-Gazette*].

The total amount paid to Cornell from July 1, 2002, through June 30, 2007, for this contract totaled \$55,525,778.00. From July 1, 2006, through June 30, 2007, the contract amounted to \$10,135,502.00

II. G4S Corporation

In October 2006, the contract with Cornell Interventions, Inc. was cancelled by the state of Arkansas. On June 30, 2007, it awarded a contract for the operation of the facility to the G4S Corporation. According to their website, “G4S, formerly known as Wackenhut Corporation, is a leading provider of security solutions. G4S offers a unique combination of personnel, project management, risk management, and technology solutions; G4S focuses on advancing the safety and security of businesses and governments, ensuring the security of key assets – people, property, products and reputation.”

G4S operates twenty-seven Youth Services Facilities – one in Arkansas, one in Tennessee, and twenty-five in Florida. Services provided by G4S at AJATC include mental health, substance abuse, and sex offender treatment services.

The initial contract between G4S and DYS was for one year, beginning July 1, 2008. After approval by DYS and the Arkansas Department of Finance and Administration (DFA), a review by the Legislature, an appropriation of necessary funding, and receipt of all necessary federal reviews and approvals the contract was extended for an additional six years. The contract will expire June 30, 2015.

DRC Monitoring Visits

I. Disability Rights Center

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DRC advocates and attorneys renewed monitoring of AJATC in June 2014 as a result of the increase in reported assaults over the past year. As of this report, DRC Advocates have conducted seventeen monitoring visits. DRC has requested and reviewed incident reports, G4S and DYS policies, and the DYS/G4S contract. DRC has also conducted interviews with over fifty youth at the facility. The goal of the investigation was to ensure that youth at the facility are safe, that the state is adequately investigating reports of assault and abuse and that G4S is operating in accordance with the DYS contract and other applicable policies and regulations.



The facility is largely old and outdated. Several of the cells contain antiquated deadbolt locks despite a recommendation by DOJ 10 years ago to install an electronic locking system.



By contrast, the education building, called the “new school,” is clean and up-to-date with spacious decorated classrooms, a library and relevant technology, including smart boards. The cafeteria is nicer than the living units but not as up to date as the school. The youth eat all meals in the cafeteria. The gymnasium is adequate but not exceptional. The local Boys and Girls Club, operates on site and provides a number of activities for the youth. The dorms are barren, with a minimal amount of furniture and decoration in the communal areas; the cells consist of metal bunk beds with very thin mattresses and blankets and no other belongings, aside from papers (artwork, cutouts from magazines, etc.) hanging on the walls and perhaps a few books.



Some cell walls are well-covered with inspirational mottos or photos of sport figures/celebrities, but there are very few photos of family members. In order to acquire items to decorate their cells, the youth have to exhibit positive behaviors. A quick glance at a cell's walls inform a visitor about the inhabitant's compliance with the program.



The medical facility is open from 6 am to 10 pm during the week. If a youth needs acute care and/or hospitalization, they are sent offsite. AJATC employs seven nurses and one nurse practitioner. The facility contracts with an emergency doctor from Pine Bluff to provide care. In the past, the facility contracted with a psychiatrist who visited the campus one day per week and saw fourteen to fifteen youths per day. As this report went to print, DRC received additional information from G4S that the psychiatrist has enhanced his service from one day per week to two. The psychiatrist now sees seven to eight youths per day. However, it is reported that 85% of the youth at the facility are prescribed psychotropic medications and need psychiatric services; therefore, even these increased services fail to provide the necessary level of care.

As stated earlier, DRC's initial motivation for renewed monitoring of the facility was our concern over the rise in the number of assaults. As reported in the media, the rise in assaults has been attributed by DYS and the DHS leadership to a new definition of assault, as outlined in the Performance-based Standard (PBS) model utilized by DYS at AJATC. When PBS was implemented, the facility was informed that all "non-assault causing incidents" were now to be labeled as assaults. Examples of "non-assault causing incidents" under this new definition include: a youth who engages in horseplay with other youth, a youth who throws a shoe into another youth's room without striking them, and a youth who attempts to fight another youth but is stopped by the staff.

Youth reported to DRC staff that retaliation is a concern, so the level of reported abuse by staff may be even higher than current data reveals:

One youth states that he has experienced both verbal and physical abuse by staff, i.e. name calling and restraints that left bruises on his face and arms. When asked if he reported these incidents, he stated that he did not because he feared retaliation from staff if it was reported back that he “snitched.”



A former employee who was terminated for assaulting a youth was re-hired by the facility only to be fired again for assaulting another youth. This former staff person was allegedly threatening the youth “off-camera” meaning areas of the facility not visible on the security cameras, which are primarily halls and bedrooms.

During monitoring, DRC became aware of inconsistencies on the part of staff with regard to adhering to youth daily schedules. Youth reported that they can predict whether or not the schedule will be followed based on which staff is on duty. Not adhering to the schedule usually means the youth are kept in their cells. When this issue was brought to the attention of the facility administrators, DRC was assured this would be addressed with all unit supervisors.

Another concern is the limitation imposed on the youths' access to family and attorney phone calls. While DRC was meeting with the youth, advocates were told that they were allowed one ten-minute phone call per week. All phone calls took place in a case manager's office, with the case manager seated next to the youth. While DRC understands the need for security, we are alarmed about the inability of the youth to make private calls to their attorneys and families. When reviewing policies obtained by DRC, those policies state that the youth will have unlimited calls to parents/guardians, legal counsel, and officials. It also states that youth shall receive a reasonable degree of privacy but will be supervised to ensure that they don't use profane language or make unauthorized calls. Each call is to be documented on the phone log.

During DRC monitoring visits, advocates were informed by youth that staff frequently would "reward" youth for punching, slapping or bothering another youth per the staff order. If the youth complied with the order, the youth was "rewarded" with a candy bar. These particular incidents were not reported by youth to facility or State authorities. The State should immediately investigate these allegations and, if substantiated, bring the practice to an immediate end and appropriately discipline any staff person who is involved in or condoned this behavior.



Review of incident reports

All facilities must have well-functioning and reasonably impartial systems to investigate complaints and incidents. It is generally agreed that some combination of internal and external review is most efficient and optimal. Most managers agree that an internal investigation capacity is important to the administrators' ability to be informed about conditions in their facilities. Those managers also recognize that there are some investigations that are best handled by external agencies due to the nature of the incident and to eliminate any concerns about conflict of interest or command influence.

As DRC continued our monitoring of the facility and reviewing incident reports, the question that came up repeatedly was, "how and when are cases reported to the Arkansas State Police or the Child Abuse Hotline?" and "Who investigates the incident reports?" The answer to these questions was difficult to find. If DRC had difficulty determining the process, we can only imagine how the process is perceived by the youth who are trying to file a report.

During our monitoring and interviewing personnel, DRC found that once an incident is reported, it is sent to a statewide database. The provider, in this case AJATC, is responsible for completing a narrative description, who was involved and whether or not the injury occurred that required reporting to the hotline. AJATC is then responsible for contacting a DYS worker on the AJATC campus for further investigation. When the DYS worker receives incident reports, they are provided to the DYS caseworker for the affected youth.

While the internal process is on-going, a DYS Internal Affairs Coordinator reviews all the incident reports that come through the state database to determine whether or not further investigation is required, including a call to the hotline or Arkansas State Police. The DYS Internal Affairs Coordinator will, if necessary, travel to facilities across the state if further investigation is warranted.

As for reporting to the Arkansas State Police and the hotline, per the Child Maltreatment Act, all DYS providers are mandated reporters if they perceive that the assault requires reporting.

Further, DRC learned that when a youth reports an assault, G4S conducts an administrative review to determine accuracy. While G4S reports to the appropriate agencies responsible for investigating assaults, DRC is concerned that there is insufficient follow up by G4S and DYS of allegations of assaults. Of particular note is that, except when a youth reports the incident, the youth appears to not be given any forum for voicing what happened to him or her. This means that any review, particularly when conducted by DYS, is conducted without input from the victim. Youth interviewed by DRC stated that filing a complaint/grievance is a "waste of time." According to several youth, reporting only leads to retaliation and further abuse. One youth did

state that the presence of DRC has made a difference, as staff seems to be on their “best behavior” when observers are present.

In addition, the facility is monitored by an Ombudsman employed by the Public Defender Commission. The Ombudsman is independent of DHS and ensures that youth are free from abuse/neglect and are receiving appropriate treatment. Within the DYS system, the Ombudsman is responsible for thirteen residential programs around the state. While the current Ombudsman has been in this role for a number of years and seems to be very knowledgeable and invested in his role, it is not feasible for one individual to effectively advocate for this many youth. It is clear DYS does not have adequate personnel to properly investigate all allegations.

As part of DRC’s monitoring protocol, incident reports are randomly reviewed and documented. DRC Attorneys reviewed the reported number of Controlled Observations and Restraints for all of calendar year 2013 and January through June 2014. According to G4S policy, AJATC uses controlled observation (seclusion) whenever a youth is actively exhibiting one or more of the following behaviors and has been non-responsive to verbal intervention, counseling, directives, and/or prompts from staff:

1. The youth is exhibiting active aggression toward others.
2. The continuation of the youth’s acutely aggressive or violent behavior is likely to result in immediate injury or imminent harm to others or substantial damage to property.
3. The youth is physically out of control and less restrictive methods of dealing with the youth are ineffective or are deemed inappropriate; and staff need to quickly regain control and re-establish order within the program, because if the out of control behavior continues, safety and security are likely to be significantly compromised.
4. In the event the youth presents an imminent risk to escape based on an assessment of behavior, interviews, and/or other information.

A youth on any type of suicide watch is not to be placed behind a locked door at any time. Prior to all controlled observations, staff members are to immediately notify the Shift Supervisor if a youth exhibits behaviors that warrant a Controlled Observation. Once notified, the Shift Supervisor will notify the appropriate individual for authorization to place the individual into Controlled Observation. If a youth is sent to Controlled Observation, a staff person of the same sex is to conduct a visual check of the youth to determine if observable injuries are present that would make that placement inappropriate. Those injuries, if present, are noted on the mark sheet. The Controlled Observation does not mean the loss of regular meals, clothing, sleep, medical, and/or mental health care services.

When DRC requested documentation regarding the use of Controlled Observations and Restraints over a 16 month period, as reported by the facility, AJTAC provided the following documentation:

2013

Month	Controlled Observation	Restraint
Jan	5	6
Feb	12	9
Mar	13	8
Apr	7	9
May	11	13
June	4	10
July	12	22
Aug	25	21
Sept	50	16
Oct	26	12
Nov	16	20
Dec	12	21
Total	193	167

2014

Month	Controlled Observation	Restraint
Jan	34	21
Feb	23	21
Mar	30	17
Apr	16	26
May	20	45
June	15	35
Total	138	165

However, when DRC was on site and asked for actual incident reports, as reported by youth during the same 16 month period, DRC found the following:

2013

Month	Controlled Observation	Restraint
Jan	1	0
Feb	1	4
Mar	0	3
Apr	0	1
May	2	14
June	5	13
July	3	15
Aug	7	16
Sept	9	23
Oct	4	24
Nov	4	20
Dec	2	7
Total	38	140

2014

Month	Controlled Observation	Restraint
Jan	5	21
Feb	3	7
Mar	0	3
Apr	1	9
May	1	13
June	0	7
Total	10	60

Based on our review of over 450 actual incident reports, it is clear that discrepancies exist between the numbers of controlled observations and restraints noted on the incident reports and those provided by G4S to DRC. This begs the question of the integrity of staff reporting accurate information on assaults. DRC has learned that physical interventions and controlled observations are noted on separate reports. As this interim report was going to press, DRC requested the additional documentation on the number of Controlled Observations and Restraints. However, the inadequacies in data reviewed by DRC thus far suggest that the State needs to develop a better data collection system. Notably, out of the 100 youth of the facility, many had been involved in a controlled observation and/or restraint over eight times. Two youth had been placed in controlled observation/restraints at least nineteen times.

A youth serving time for a probation violation stated that her refusal to comply with a staff person ended in an assault. She stated that she told the staff person that she did not want to be moved to another living area, due to her dislike of persons living in that area. The altercation began with the staff person striking her in the face open-handed, and the youth hitting back. She stated she did not report this incident because it was her word against that of a staff member.

Another problem that may lead to the under-reporting of actual incidents is the presence of observation blind spots in cells and hallways. One report DRC reviewed involved a youth who alleged that she was physically abused by staff in her cell. She stated staff was saying she was biting them, but that they were banging her head on the floor, which caused her mouth to bleed. When DRC Advocates reviewed the video, there was no way to determine what took place due to the incident occurring in a “dead area.”

- While every incident report is signed by a supervisor and undergoes administrative review at the facility, there appear to be inconsistencies in the reports. Some examples of inconsistencies include:
 - Noticeable time differences between staff statements when compared to the actual time of the incident.
 - A staff member being identified in one report as a participant in the incident, but not named in any of the other incident reports. This staff person also did not complete an incident report.

When DRC addressed these issues with the facility administrators, they were defined as “clerical” errors. DRC was told that AJATC administrators are confident that all reports are accurate. While it is expected that discrepancies will exist between staff recollections, any review conducted on an incident should identify and attempt to resolve the discrepancies.

While conducting monitoring visits, DRC learned that youth are frequently transferred to other Juvenile Detention Centers across the state for “time out” or “cooling off” periods. While it was reported that AJATC utilized this transfer only ten (10) times this year, DRC spoke with more than 10 youth who reported being transferred to another facility for “time out.” While on paper this practice appears to be helpful to ease tensions, DRC is very concerned about the impact of transfers to the youth and the receiving facility.

DRC Recommendations

In developing recommendations for the Governor, State Department of Youth Services Director and others involved in providing care and treatment of youth at AJATC, DRC reviewed previous reports and recommendations that have been developed. While the contractor is different, many

of the problems and recommendations identified in 2006 remain the same. The recommendations are as follows:

General

- Provide state funding and access other funding sources for new community-based services, and assure a comprehensive, coordinated approach for all troubled youth, avoiding duplication of services among interrelated programs and programming. Note – this recommendation was previously identified in 2006 and continues as a recommendation.
- The internal transfer of some youth from less to more restrictive settings needs to be reviewed.
- The state Department of Youth Services needs to allocate additional resources to fully staff the Ombudsman program. The current Ombudsman system is inadequate to ensure the health and safety of the youth.
- Internal investigations within the Department of Youth Services need to be strengthened. The State should consider reassigning existing staff to field positions to conduct follow-up investigations.
- The State needs to develop a classification plan for youth entering the system and educate judges on alternative placement.
- The State should reconvene the Task Force that was developed in 2009 to review how to improve the provision of juvenile justice services to youth.
- The recommendations provided in the Task Force Report's five year plan that ended in 2014 need to be re-evaluated and strengthened.

Mental Health Services

- Provide adequate mental health care to all juveniles who require these services.
- Ensure all direct care staff are trained in trauma informed care.
- The number of psychiatrists contracted with and/or employed by G4S must be increased to effectively provide services to the 85 youth.

Incident Reports

- The incident report process needs to be reviewed to minimize reporting inaccuracies, up to and including retraining staff on incident report writing.
- Administrative reviews of incidents should note discrepancies between reports and reconcile these discrepancies by investigating, if necessary.
- Youth who are part of the incident report should be allowed to provide a written statement.

- Every individual who witnesses an incident should submit a written statement or report. While this should be occurring per G4S policy, it does not happen.

Educational Supports

- Developing a plan to ensure youth who have finished their G.E.D/High school diploma continue to be active on campus and are not simply restricted to their units.

Health and Safety Issues

- Camera placement needs to be assessed and corrected to minimize “dead areas”.
- Youth who have been identified as a “security risk” should have weekly risk assessments conducted to reassess ability to be active on campus.

Rights Issues

- G4S should comply with the terms of their contract with DYS with respect to allowing youth to make phone calls. Barring specific security concerns or court-imposed restrictions, youth should be able to make calls more often and for a greater length of time. Additionally, DYS should consider alternative methods for families who may not be able to accept collect calls.

Conclusion

DRC monitored AJATC and provided recommendations in 2007, but we are seeing the same areas of concern that were identified seven years ago. Therefore, DRC strongly encourages the State to:

- Study juvenile services in other states with more progressive programs and implement services that are community based rather than institution based.
- Re-allocate funding from the Arkansas Juvenile Treatment and Assessment Center to other programs throughout the state with a demonstrated track record of effectively and safely providing services to at risk youth.

It is our sincere hope that the State of Arkansas will give serious consideration to each finding and create an environment that provides actual rehabilitative services, allowing the youth to grow into productive members of society.