U.S. Department of Justice



Civil Rights Division

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Special Litigation Section - PHB 950 Pennsylvania Avenue, N.W. Washington, DC 20530

April 7, 2005

VIA FEDEX

Karen Dickerson, Esq. Deputy Attorney General Office of the Attorney General for the State of Nevada 100 N. Carson Street Carson, Nevada 89701

Re: Nevada Youth Training Center

Dear Ms. Dickerson:

As you know, the Department of Justice toured the Nevada Youth Training Center ("NYTC") from January 31 to February 2, 2005 to assess the State of Nevada's compliance with the February 26, 2004 Memorandum of Understanding ("MOU") between the United States and the State of Nevada. During that tour, the State requested that the Department provide its assessment regarding the State's compliance with the MOU.

At the outset, we wish to note our gratitude for the cooperation and assistance provided to us by the Division of Child and Family Services and the administration of NYTC, especially Administrator Jone Boseworth, Deputy Administrator for Youth Corrections Robert McLellan, Clinical Program Planner Susan Bobby, Superintendent Dale Warmuth, Deputy Superintendent Erica Olson, and Head Group Supervisor Joe Payne.

It also bears immediate mention that NYTC continues to make enormous progress in ensuring that youth housed there are safe, secure, and provided with appropriate supports and protections. The substantial improvements that have occurred at this facility in a relatively short time reflect well on NYTC's leadership and provide a tangible demonstration of the Division's commitment to meeting the needs of the youth in its custody.

We have enclosed copies of our consultants' reports. Please note that these reports reflect the opinions of our consultants and do not necessarily represent the position of the Department. Please also note that the reports contain extensive technical assistance. We wish to underscore that this assistance does not reflect noncompliance with the MOU. To the contrary, it is intended to facilitate the State's efforts to build on the significant progress that already has occurred at NYTC.

Set out below is the Department's assessment of the State's compliance to date with each of the MOU's substantive provisions. Where appropriate, we also provide technical assistance that the State may wish to consider. Finally, because it became evident during our tour that there are issues regarding the provision of special education at NYTC that warrant the State's immediate attention, we conclude this letter with a brief discussion of special education at NYTC.

As we have indicated, our consultants' reports reflect the significant progress that NYTC has made regarding the use of force and the other issues that are set out in the MOU. We endorse the assessment that:

Most impressive is the overall climate of the Center. There is a positive and relaxed atmosphere among residents and staff and the program has the appearance of being organized and directed. Clearly, the culture of the NYTC has changed dramatically. Interviews with youth and staff verify the change.¹

II.A. - Use of Force.

In broad terms, the use of force provisions of the MOU require that NYTC eliminate the inappropriate use of force, maintain staff accountability, and maintain proper staff-to-youth ratios. We interviewed over ten percent of the youth housed at NYTC during our tour. These youth consistently reported a better institutional climate, greater stability, and fewer fights, as compared with our previous tour. It is evident that use of force at NYTC is now guided appropriately by policy and training. The facility maintains a credible quality assurance ("QA") process that indicates that use of force is limited to approved purposes and techniques and is not used as punishment. The use of force reporting process indicates that there has been a significant decline in use of force incidents, 27 percent from the previous guarter.

It was also evident that the facility holds staff accountable to the use of force policy, and appropriately retrains or disciplines staff in response to the improper use of force. Further, the staff-to-youth ratios comply with the MOU's requirements. These ratios enable staff to engage in more

¹Joseph K. Mullen, MSW, <u>Report on Visit to the Nevada Youth</u> <u>Training Center</u>, 1 (Feb. 11, 2005).

constructive interventions. Accordingly, we believe that the State is in compliance with the MOU's provisions at II.A. - Use of Force.

However, we would urge the State to consider the following technical assistance regarding Youth Corrections Statewide Policy 19, governing use of force. First, if enforcement of a "lawful order" is intended to serve as a basis for the use of force, then this should be included expressly in policy provisions addressing the appropriate use of force. Second, the policy lacks clarity as to what constitutes "serious property destruction" permitting the use of force. Third, although the policy refers to a "Less Restrictive Alternative" to interventions, and references at least one category of such interventions, "Non Violent Crisis Intervention, "it does not identify other approaches that the State is using, namely "Handle With Care," "time out," and "room confinement." Fourth, the term "physical handling" used in the policy suggests that interventions other than those expressly identified and taught may be used with youth. We suggest that this phrase be removed from the policy. Our consultants offer other assistance regarding the policy in their reports, and we urge the State's consideration of these suggestions.

II.B. - Incident Review.

A reliable incident review process continues to develop at NYTC, and significant progress has been achieved since our previous tour. The facility's incident reporting format has improved. Incident reports are more consistently completed, including the youth's statement and signature. Further, it appears that the incident review team process is functioning much better. In addition to paperwork, the more fundamental element of ensuring that appropriate corrective action is implemented now appears to be occurring consistently.

Nevertheless, the facility continues to lack a person "with demonstrated competence in quality assurance management" as the MOU requires, and similarly lacks a person or persons designated to manage its quality assurance system and to perform investigations of use of force and other incidents. It continues to rely on mental health counselors who are untrained in investigations. Consequently, although the quality of documentation regarding uses of force and other incidents has improved, the quality of the investigations, themselves, is lacking. Accordingly, we believe that the State is in partial compliance with this provision of the MOU.

It remains the case that staff lack training in performing use of force and similar investigations and do not otherwise demonstrate a capacity to perform such investigations. Consequently, incident investigations do not meet generally accepted standards. We understand that the Division's budget request includes funding for a quality assurance staff person at the facility. We urge that the State also take steps to ensure that the staff conducting investigations are properly qualified.

The Incident Review provisions of the MOU include a requirement for the creation a Quality Assurance Unit. Currently, one person has responsibility for developing, implementing, and overseeing quality assurance programs at each of the Division's three juvenile justice facilities, with assistance from other Division staff during QA reviews. Notwithstanding the considerable skill and dedication of the staff person currently assigned, this is an enormous task that realistically cannot be sustained by one individual.

Nevertheless, NYTC has made significant progress. It appears that the Division and the facility are taking a comprehensive and systemic approach to Quality Assurance/Quality Improvement ("QA/QI"), and the development of a viable QA/QI system at NYTC continues. The facility has an internal QA team that reviews its compliance with a subset of the American Corrections Association Standards for Juvenile Correctional Facilities. The process includes review of primary and secondary documentation for compliance/non-compliance with each standard. When a deficiency is identified, a remediation plan is put in place to address lack of compliance with the standards. There is also an external QA team that reviews NYTC's compliance with the same standards, providing the facility with an objective "fresh eyes" analysis of compliance with standards.

In addition, leadership staff at NYTC and Youth Correctional Services have identified a number of indicators as to which data are being collected, tracked, and trended. For example, the facility has identified all use of force incidents by location where the incident occurred, day of the week, time of day, youth and staff member involved, etc. Data are being analyzed to determine if patterns of precipitating events/time/place/person or other factors can be identified. Performance improvement plans are then initiated. In light of this significant progress, we are hopeful that, with the addition of qualified QA personnel at NYTC, the State will be able to achieve full compliance with this provision.

Apart from assessing the State's compliance with the terms of the MOU's Incident Review provisions, we also offer the following technical assistance. First, it appears that the incident review process could be facilitated through further refinement, notably by consolidating seemingly redundant paperwork and avoiding repeated entry of the same data. Second, it appears that the investigation process would benefit if investigators made use of standard interview questions, in addition to questions warranted by a particular incident, to minimize the risk that relevant information is lost. Third, we encourage NYTC to conduct rigorous data analysis to identify areas of focus and track program improvement initiatives. For example, four youth in September accounted for 30 percent of the use of force incidents. An extension of the QA trend and data review to examine systemically who goes into confinement, from where, when, and length of stay in confinement, and to look at repeat offenders and their behavior patterns, may prove useful in shaping individual interventions and developing alternative practices.

II.C. - Staff Training

Record review and training observations indicate that NYTC provides appropriate competency based training in behavior management and crisis intervention to its existing staff, and to new staff before new staff may work in direct contact with youth. Record review and training observations further indicate that the facility regularly evaluates the training and training techniques through quality assurance data and revises the training curriculum based on such evaluations and staff input. Accordingly, we believe that the State is in compliance with staff training provisions of the MOU.

However, we strongly urge the State to place ongoing emphasis on its training initiatives. It is imperative that staff are provided with policy-driven, quality-assurance-tested techniques for youth management that they can trust and effectively implement. Unless staff are proficient in such techniques, there is a great risk that confrontations needlessly will result in injuries to staff or youth or that staff will lose confidence in approved methods and resort to inappropriate interventions, such as excessive force.

It was apparent during our latest visit that staff were eager for training that would enhance their ability to manage and interact with youth safely and constructively. It was also apparent that such training is warranted; having turned from a "hands-on" approach to youth management, NYTC has not yet developed an adequate array of alternatives. Our review of use of force incidents indicates that, with proper training, many incidents had the strong potential of being diffused before force was necessary. Accordingly, we would urge the facility to expand its curricula around nonphysical interventions and, in this regard, carefully consider the training recommendations made in Mr. Mullen's report. Finally, we suggest that the State consider placing special emphasis on training regarding the safe implementation of prone restraints and on establishing control before it is necessary to implement prone restraints. We are encouraged that the Division is seeking additional funding for a training officer at each of its facilities.

II.D. - Grievances.

Juvenile Grievance Procedure policy P-9 establishes a clear explanation of the grievance process, and the policy is provided to all youth upon admission to the facility during their orientation. There is documentation that they have received the policy with an explanation of how the procedure works. The grievance policy is also provided to a youth's parent or guardian. Grievance forms were readily available to youth. Every youth we asked could explain how to obtain the form and how to submit a grievance.

The latest QA report available to us documents a substantial increase in the use of the process by youth at the facility. The number of grievances filed has increased from 19 in the previous quarter to 48 in the most recent quarter available to us. The number of grievances filed that were upheld totaled 25, or 52 percent. The increased volume appears to reflect increasing confidence by youth in the viability of the process. In this regard, we noted a discernible difference in language in the responses to grievances. We found increasing evidence of respect for the youth and an increasing acceptance regarding the validity of the youth's point of view. Many more responses, as compared with our July review, noted an intent to address the underlying problem, rather than persuade the youth that there was no basis for his grievance. Significantly, only two grievances filed addressed misconduct, and no grievances were filed that alleged staff abuse.

The Deputy Superintendent assigns all grievances to the appropriate staff and tracks the response to grievances to assure that they are completed in a timely manner. If the youth disagrees with the response to his grievance, he can appeal to the Superintendent at NYTC or to the Deputy Administrator. In addition, grievances are now also considered in the incident team review meetings. Youth consistently reported their belief that the grievance process is fair and responsive to their complaints. Accordingly, we believe that the State is in compliance with these provisions of the MOU.

We would suggest that the State consider additional steps to ensure that grievances are appropriately resolved. Some grievance responses indicate that "[Staff person] needs to be counseled about [a particular issue]." Yet there was no documentation that such follow-up occurred. There should be a file for each grievance that catalogues, by number, what the grievance was, what the response was and documentation of what follow-up occurred. These files should then be subject to the rigors of the QA/QI process previously described. It is also recommended that youth be made more aware of their right to appeal a response to a grievance and that a separate form be

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developed for this purpose, rather than just checking a box (I agree/disagree with action taken).

II.D - Time Out/Room Confinement.

The use of confinement appears to be the option of first choice rather than as a last resort. Of the dozens of use of force incidents reviewed, the vast majority resulted in room confinement. This is contrary to the MOU's objectives as to time out and room confinement. It reflects that the facility, having successfully turned from force as the primary means to manage behaviors, must still develop appropriate alternatives, in the form of behavioral interventions and sanctions, that are effective in managing behaviors. Room confinement can be an appropriate tool. However, we found examples where, following an incident, youth regained and maintained their composure until they were placed in room confinement, whereupon they became physically or verbally challenging. Such examples reflect a counterproductive use of room confinement and underscore the need for alternative interventions.

The facility's statistics re-enforce this point. In the 3rd quarter of 2004, NYTC had its lowest youth census of the year. Nevertheless, the QA report indicates that incidents that have resulted in placement into confinement have increased almost 32 percent from the first quarter of the year. By contrast, the number of serious incidents requiring use of force declined significantly over the first 3 quarters.

Also, we note that the State's policies do not require verification that periodic assessments of the youth's attitude and behavior while in confinement, as called for in the MOU, are performed, particularly the presence or absence of factors affecting a youth's release.

For these reasons, we believe that the State has not yet achieved compliance with these provisions of the MOU. As the facility develops additional interventions for challenging behaviors, we can expect to see this area corrected.

II.F. - Screening and Censoring Mail.

The facility's policy regarding the screening and censoring of mail appropriately implements the MOU's requirement prohibiting the censoring of mail critical of the facility. None of the youth with whom we spoke expressed any concerns regarding the management of their mail. Additionally, our file review revealed no basis for concluding that the policy was not being implemented correctly. In fact, only one grievance related to mail, and the grievance response indicated that the youth's position was inconsistent with the policy. Accordingly, we believe that NYTC is in compliance with the MOU's provision regarding the screening and censoring of mail. We would urge that the State consider the technical assistance offered in Mr. Platt's report indicating that it is appropriate to screen mail for materials that advocate, or are designed to facilitate, the committal of criminal acts.

II.G. - Mental Health and Safety.

The MOU requires the State to ensure that decisions regarding the administration, alteration, or termination of psychotropic medications for youth at the facility are based upon an appropriate mental health assessment of the youth. The MOU also requires that the State ensure that toxic substances are safeguarded appropriately.

Record review indicates that psychotropic medications are managed consistent with appropriate mental health assessments. Also, policy YCS P-11 sets out the requirement that the facility "maintain youth on the medications the youth was taking upon arrival until the youth can be evaluated by a qualified health care professional, or consultation with the youth's prescribing physician has occurred." The facility also has issued an institutional directive addressing "Control and Use of Flammable, Toxic, Caustic Materials," that requires direct and constant supervision of any juvenile having access to hazardous materials. No violations with this directive were apparent during our review. Accordingly, we believe that the State is in compliance with the MOU's provisions regarding Mental Health and Safety.

Although not expressly addressed in the MOU, we trust that the State will continue to enhance the facility's suicide protections. In this regard, we note that NYTC can enhance suicide prevention by addressing window covers, grilles, and appurtenances in the Reception & Classification cottage rooms.

Finally, we offer the following suggestions as technical assistance. There appears to be a strong need for a full-time, on-site psychologist to perform psychological assessments, expand substance abuse programs to meet the population's needs, and provide oversight of the facility's mental health counselors. Further, consistent with developing alternatives to physical interventions, the State should consider implementing a systemwide model of cognitive behavioral intervention.

II.H. - Transportation of Youths

We believe that the State remains in compliance with the MOU's provision that "[s]taff are prohibited from handcuffing youths together during transportation."

Special Education

Officials at the facility's school acknowledged during the tour that the school currently does not comply with federal and State educational requirements. In particular, it is evident that youth requiring special education services mandated by the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400, <u>et seq.</u> (2004), are not receiving those services. School officials acknowledged that 30 of 39 youth requiring special education services were not receiving them in accordance with federal law. In addition, school officials reported that there was a lack of current Individual Education Plans ("IEPs"), a failure to schedule and conduct mandatory multi-disciplinary staffings, a failure to have proper multi-disciplinary professionals attending staffings, a lack of mandated educational psychological services, and the absence of an effective screening process to identify special education services.

We understand that school officials are working to address these shortcomings, including establishing special education staffing schedules, identifying multi-disciplinary staff for the IEP progress case reviews, contracting for school psychological services, and instituting measures to obtain IEPs and provide parental notification. However, it is apparent that the school will not be able to meet its IDEA obligations without more resources. In this regard, we understand that the current NYTC budget request includes an additional special education teacher.

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We would be pleased to discuss any of the foregoing comments or our consultants' reports with you; the attorney assigned to this matter, Benjamin Tayloe, Jr., can be reached at (202) 514-8103. We appreciate the State's significant efforts regarding the implementation of the MOU and the State's demonstrated commitment to the welfare of the youth in its custody. We look forward to continuing to work with the State to achieve the MOU's successful implementation.

Sincerelv.

Shanetta Y. Cutlar Chief Special Litigation Section

Enclosures