OVERSIGHT OF SAFETY IN SECURE CARE FACILITIES

OFFICE OF JUVENILE JUSTICE

PERFORMANCE AUDIT SERVICES
ISSUED JUNE 6, 2018

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LOUISIANA LEGISLATIVE AUDITOR
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June 6, 2018

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report provides the results of our evaluation the Office of Juvenile Justice's (OJJ) oversight of safety in secure care facilities operated by OJJ.

The report contains our findings, conclusions, and recommendations. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of OJJ and other stakeholders interviewed for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/aa

OJJ SAFETY OVERSIGHT

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Oversight of Safety in Secure Care Facilities
Office of Juvenile Justice

June 2018

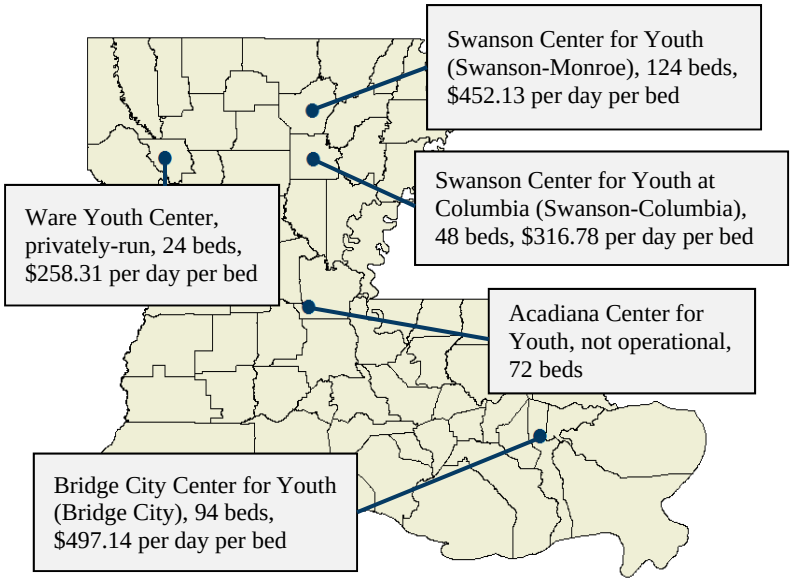
Audit Control # 40170021

Introduction

We evaluated the Office of Juvenile Justice's (OJJ) efforts to ensure its four secure care facilities are safe for its youth and employees. OJJ is responsible for the supervision and custody of adjudicated youth committed to its custody by a judge. Secure care facilities house youth with the most severe level of need and who pose the greatest risk to public safety. While this audit focuses on the safety in secure care facilities, a subsequent audit will evaluate the rehabilitation and treatment programs in these facilities. The purpose of both reports is to provide the Task Force on Secure Care Standards and Auditing (Task Force), created by Senate Concurrent Resolution 38 of the 2017 Legislative Session, with information to assist them in developing standards and procedures for the operation of secure care facilities in Louisiana. The Task Force's recommendations will include standards on topics including the safety of staff and youth in secure care facilities, treatment plans, and rehabilitative programs.

Approximately 276[1] youth are housed in four secure care facilities on a given day: three facilities for males operated by OJJ and one privately-operated facility for females. In 2016, OJJ completed a new 72-bed secure care facility for male youth, but it is not yet operational and does not house any youth. During fiscal year 2017, OJJ spent approximately $45.4 million on secure care, with an average cost per bed per day of $428.96. Exhibit 1 shows the location, bed capacity, and cost per day per bed for each secure care facility.

Exhibit 1
Secure Care Facilities, Fiscal Year 2017



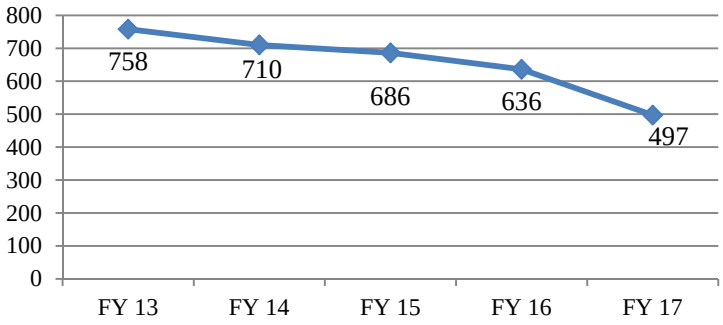
Source: Prepared by legislative auditor's staff using information from OJJ.

National best practices recommend that youth be served in the least restrictive setting, reserving secure care for high-risk youth. Overall, the number of youth served in secure care facilities throughout each fiscal year has

[1] 276 is the average daily census for fiscal year 2017 across all four facilities.

decreased 52.5% since fiscal year 2013. Exhibit 2 outlines the number of youth served in secure care facilities by fiscal year.

Exhibit 2
Number of Youth Served in Secure Care Facilities
Fiscal Years 2013 to 2017



Source: Prepared by legislative auditor's staff using data from OJJ.

OJJ's policies and procedures outline safety requirements for secure care facilities that promote public safety, as well as the well-being of staff and youth. In 2017, OJJ began participating in Performance-based Standards (PbS), a data-driven improvement model that sets national standards and compares juvenile justice agency performance to that of national averages. PbS will assist OJJ in monitoring safety through the development of improvement plans for measures that are below the national average. Thirty-six states participate in PbS. Currently, Bridge City has fully implemented PbS, and Swanson-Monroe is beginning its data collection. In addition to participating in PbS, OJJ has the following policies and practices to help ensure safety at secure facilities:

- Required staffing ratios to ensure a sufficient number of employees properly oversee youth
- Continuous quality improvement system (CQIS) audits of secure care facilities
- Collecting information on fights, use of restraints, drug testing, and contraband
- Guidelines for the use and monitoring of room confinement
- Processes for youth to file grievances

The objective of this performance audit was:

To evaluate OJJ's oversight of staff and youth safety at secure care facilities.

The issues we identified are summarized on the next page and discussed in detail throughout the remainder of the report. Appendix A contains OJJ's response to this report, Appendix B details our scope and methodology, and Appendix C shows the facility expenditures and cost per day per bed. Appendix D includes fact sheets for each OJJ facility.

Objective: To evaluate OJJ's oversight of staff and youth safety at secure care facilities.

Overall, we found that while OJJ has developed procedures, such as continuous quality assurance audits and participation in PbS, it faces staffing challenges and needs to strengthen its efforts to ensure the safety of staff and youth. In addition, OJJ does not monitor the secure care facility for females to the same degree it monitors the facilities for males. For example, OJJ does not monitor room confinement, restraints, or grievances for female youth. Specifically, we found:

- **Staffing challenges, such as high turnover, make it difficult for OJJ to maintain required staff to youth ratios, which affects the overall safety of the facilities.** Turnover in secure care facilities has steadily increased since fiscal year 2013. Bridge City has the highest overall turnover rate at 62.3%, while Swanson has a 30.6% turnover rate. In addition, secure care facilities are not always compliant with staff to youth ratios as required by the Prison Rape Elimination Act.

- **OJJ did not conduct quality assurance audits on secure care facilities from calendar years 2010 through 2015. While OJJ resumed these audits in June 2016, it did not ensure its secure care facilities corrected 205 (51%) of the 404 safety-related action items identified in the audits within six months, with 44 items unresolved for over a year.** Specifically, we found that 51.9% (120 of 231) of safety-related corrective action items identified in 2016 quality assurance audits, and 49.1% (85 of 173) corrective action items identified in the 2017 quality assurance audits were not resolved within six months.

- **From fiscal years 2013 through 2017, there has been a 52.7% increase in fights and a 111.3% increase in the use of physical restraints in secure care facilities. OJJ could better use the data it collects on fights and physical restraints to monitor these incidents and give guidance to the facilities on ways to address them.** Overall, the number of fights per youth[2] in one year increased 52.7%, from 2.06 per youth (764 total fights) in fiscal year 2013 to 3.14 per youth (867 total fights) in fiscal year 2017. The average number of times physical restraints per youth were used also increased by 111.3% over this same five-year period.

- **Since calendar year 2013, the percentage of positive drug screens increased from 2.3% in calendar year 2013 to 9.5% in calendar year 2017. Because OJJ does not collect data on why the drug tests were administered, it cannot determine if there is an increase of drugs being brought into the facility either by staff or visitors, or if youth are using drugs during furloughs.** OJJ should collect data on each drug test, including the reason (e.g., suspicion, the

[2] Because the number of secure care youth has decreased since fiscal year 2013, we calculated certain statistics based on the average per youth in order to accurately compare across fiscal years

youth just returned from a weekend furlough or off-campus trip, etc.) the test was administered.

- **While OJJ has reduced the use of room confinement as recommended by best practices, it needs to collect room confinement data in a way that it can be easily monitored and analyzed.** While the use of room confinement is lower than it was prior to OJJ implementing a "Reduce the Use" campaign in July 2017, it has increased recently at Bridge City.

- **Between fiscal years 2013 and 2017, OJJ did not address 19% of youth grievances within the timeframes set in OJJ policy. In addition, we found that there has been a 23.7% increase in the number of grievances per youth, from 1.26 to 1.56.** It is important that OJJ address grievances timely so youth are not deterred from submitting a grievance because of an inefficient process.

- **OJJ's procedures for monitoring safety at the Ware Youth Center for female youth are not consistent with its procedures for monitoring the secure care facilities for males. For example, OJJ does not monitor medical care, room confinement, restraints, or grievances at Ware.** As a result, female youth are not receiving the same protection and standard of care as males in secure care facilities. We found that Ware uses room confinement areas in its detention center for girls housed in the intensive residential facility, but OJJ does not monitor its use.

These findings are explained in more detail on the following pages.

Staffing challenges in secure care facilities, such as high turnover, make it difficult for OJJ to maintain required staff to youth ratios, which affects the overall safety of the facilities.

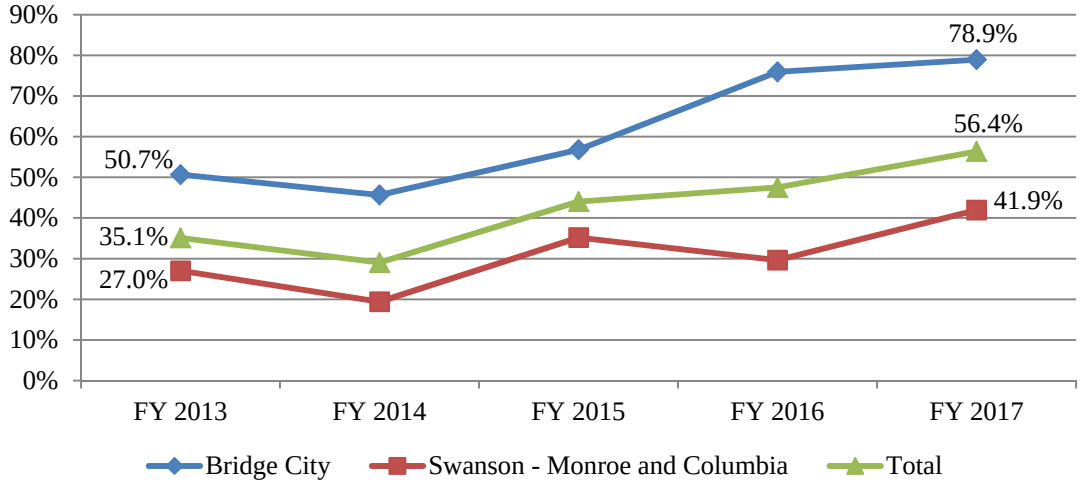
Best practices state that staffing practices such as staff-to-youth ratios and turnover directly impact staff ability to monitor youth, maintain safety, and provide quality interactions. Appropriate staffing is necessary to ensure proper supervision and a safe environment for youth and staff.[3]

Turnover in secure care facilities has steadily increased since fiscal year 2013. Bridge City has the highest overall turnover rate at 62.3%, while the Swanson facilities[4] have a 30.6% turnover rate. According to OJJ, recruiting and hiring quality candidates is a challenge, along with staff retention. Research[5] indicates that high rates of staff turnover can destabilize a facility, contributing to misbehavior and violence. Bridge City, in particular, has seen high turnover in Juvenile Justice Specialist (JJS) positions and facility director positions,

[3] National Institute of Corrections, *Desktop Guide to Quality Practice for Working with Youth in Confinement*
[4] Swanson-Monroe and Swanson-Columbia are both included in Swanson's staffing numbers.
[5] National Institute of Corrections, *Desktop Guide to Quality Practice for Working with Youth in Confinement*

with 95% turnover in JJS staff in fiscal year 2017 alone. In addition, Bridge City has had frequent turnover in management positions, particularly in the facility director and deputy director positions. Exhibit 3 shows the turnover rate by facility by fiscal year.

Exhibit 3
Secure Care Turnover
Fiscal Years 2013 to 2017



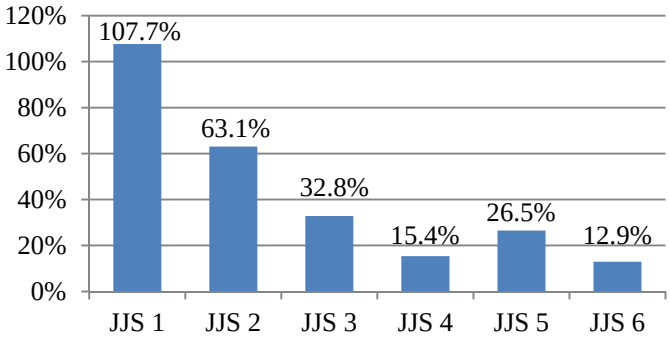
Source: Prepared by legislative auditor's staff using data from OJJ and Civil Service.

OJJ should explore recruitment and retention strategies, including actively recruiting from local universities. For example, Missouri works with local colleges and universities to recruit employees through job fairs, have youth speak to classes, give classes tours of the facilities, and offer internships and part-time positions for college students.

For fiscal years 2013 through 2017, more than half of the turnover has been with staff that directly supervises youth. The JJS Staff 1 position had a turnover rate of 107.7% (488 employee separations), and the JJS 2 turnover rate was 63.1% (198 employee separations) for all secure care facilities. JJS staff is responsible for monitoring youth movement, searching youth, participating in treatment activities, and maintaining a safe and therapeutic atmosphere. High turnover rates in the JJS positions result in staff not being able to develop meaningful relationships with the youth. According to the National Institute of Corrections, high turnover rates result in inexperienced staff who are less effective at managing youth and preventing violence, as they are less familiar with the individual youth, security procedures, and de-escalation techniques. JJS 4 through 6 are supervisory positions and have much lower turnover rates. Exhibit 4 shows the turnover rates by JJS position. High turnover is a challenge nationally, often because of low salaries and the difficult nature of the job. In Louisiana, JJS staff salaries start at $26,416 per year, which is comparable to other states. JJS staff is required to have completed high school, but are not required to have a college degree. According to OJJ management, it is difficult to recruit and retain high quality staff because of the challenging nature of the job and low salaries.

Secure care facilities are not always compliant with staffing ratios as required by the Prison Rape Elimination Act (PREA). PREA, a federal law passed in 2003 designed to protect individuals from prison rape, requires a 1:8 staff to youth ratio during waking hours and a 1:16 ratio during sleeping hours.[6] Having more staff supervise youth can help prevent behavior problems before violence escalates,[7] and higher ratios of staff to youth help create supportive and positive relationships between staff and youth which leads to better employee retention and better outcomes for youth.[8] However, we found that OJJ facilities are not always compliant with these staff to youth ratios. High staff turnover and high numbers of staff not reporting to work contribute to facilities not meeting PREA staffing ratios. For the month of October 2017, 57.3% of shifts (43 of 75) at Swanson-Columbia had at least one dorm out of compliance with the PREA staffing ratio, and 50% of shifts (25 of 50) at Swanson-Monroe had at least one dorm out of compliance.[9]

Exhibit 4
JJS Turnover by Position
Fiscal Years 2013 through 2017



Source: Prepared by legislative auditor's staff using data from OJJ and the Department of State Civil Service.

Bridge City does not collect enough information to accurately determine compliance with PREA staffing ratios and may be calculating staffing ratios incorrectly. According to Bridge City management, it is always compliant with PREA ratios; however, unlike the Swanson facilities, it does not track compliance with PREA during each shift. The Swanson facilities include a notation on each shift packet[10] regarding which dorms were not compliant with PREA staffing ratios and include which staff was assigned to which dorm. Bridge City, on the other hand, does not indicate on its shift packets if dorms are PREA compliant, nor does it accurately list which staff are assigned to which dorm.

> "[Bridge City] also needs more staff because less than 4 months after I started I was left alone on the unit every time I came to work with 12 youth."
>
> **Source:** Staff survey from a 2017 quality assurance audit of Bridge City.

In addition, the way facilities calculate staffing ratios is inconsistent. Specifically, the Swanson facilities only include JJS staff in the ratio calculation and do not include group leaders, which are dorm supervisors, unless the group leader was specifically assigned to fill in for JJS staff. However, Bridge City does include group leaders in its ratio calculation. PREA states that the staff to youth ratio should only count staff who are actively supervising youth and are primarily responsible for the supervision and control of youth in the facilities. As the roles of

[6] Juvenile justice facilities were required to come into compliance with these ratios by October 1, 2017.
[7] National Institute of Corrections, *Desktop Guide to Quality Practice for Working with Youth in Confinement*
[8] According to the June 2016 PbS Blueprint.
[9] This information is based on self-reported information from the facilities. Swanson-Columbia has 8-hour shifts, while Swanson-Monroe had 12-hour shifts.
[10] Staff at each facility submits a shift packet after each shift documenting what took place during the shift, such as staffing information, unusual incident reports, and perimeter checks.

group leaders are the same in each facility, OJJ should clarify which staff should be included in the staffing ratio calculations.

Recommendation 1: OJJ should explore strategies to recruit quality candidates, such as working with local universities.

Summary of Management's Response: OJJ agrees with this recommendation and states that it will continue to participate in career days at local universities, job fairs, and Louisiana's Civil Service Resource Center to assist in filling vacancies. Additionally, OJJ will continue to use local advertising efforts as well as social media to recruit appropriate staff. See Appendix A for OJJ's full response.

Recommendation 2: OJJ should clarify how to calculate PREA staffing ratios and ensure that facilities are compliant with these ratios.

Summary of Management's Response: OJJ agrees with this recommendation and states that effective April 2018, each OJJ secure care facility must verify their staffing ratios for each shift through daily reporting to administration. See Appendix A for OJJ's full response.

Recommendation 3: OJJ should require Bridge City to document staffing ratios by dorm in order to accurately calculate staffing ratios.

Summary of Management's Response: OJJ agrees with this recommendation and states that effective April 2018, all facilities are required to submit daily reports indicating staffing ratios for each shift per dorm. See Appendix A for OJJ's full response.

OJJ did not conduct quality assurance audits on secure care facilities from calendar years 2010 through 2015. While OJJ resumed these audits in June 2016, it did not ensure its secure care facilities corrected 205 (51%) of the 404 safety-related action items identified in the audits within six months, with 44 items unresolved for over a year.

The National Institute of Corrections states that an ongoing system of quality assurance, especially one that focuses on correcting deficits, provides additional assurance of safe conditions of confinement. OJJ's current Continuous Quality Improvement Services (CQIS) process involves auditing each secure care facility annually, with a six-month follow up, to assess the day-to-day operations of the facility, as well as the youth and staff climate. Quality assurance audits address compliance with areas such as safety procedures, including youth counts, searches, and room confinement; physical plant safety, including maintenance, cleanliness, and controls around tools and hazardous materials; and compliance with treatment delivery.

Starting in calendar year 2010, OJJ's prior administration discontinued quality assurance audits of secure care facilities. OJJ did not resume these audits until June 2016. In lieu of quality assurance audits, facilities were required to submit outcome measure reports. However, according to OJJ management, this process did not work well because the required reports were too complex and OJJ headquarters staff was not physically present to review operations. As a result, OJJ resumed quality assurance audits. During calendar year 2016 and 2017 quality assurance audits, OJJ found 447 violations related to youth and staff safety in its secure care facilities. Exhibit 5 summarizes these violations.

Exhibit 5
Calendar Year 2016 and 2017 Quality Assurance Audit Violations

Violation Category	Examples of Violations	CY 2016	CY 2017
Key Control	• Discrepancy in keys with the key control database • Incorrect tag number on key	13	8
Lack of documentation	• Failure to conduct and document perimeter fence checks • The Safety Officer and HR Liaison did not ensure accident incident reports were submitted within the 48-hour timeline	62	47
Maintenance	• Failure to have proper washing temperatures recommended by ACA standards • Failure to have a work order to repair ceiling tiles and broken lights	28	20
Physical Plant	• Cracks in the sidewalk not painted bright yellow • Should pressure wash building to remove green algae	12	10
Emergency Preparedness	• The Evacuation and Safety Plan not posted • The location of the fire extinguisher not marked	43	30
Time Out Control	• Placement in time out exceeded 59 minutes • Staff do not have an up-dated copy of the Seriously Mental Illness list	8	1
Lack of Supervision	• Does not have two staff present during high traffic times • JJS staff is not present in the classroom to engage and supervise youth	27	20
Hazardous and Tool Control	• The facility has not established, conducted, documented, and maintained tool control • The facility has not established, conducted, documented, and maintained FTC Control of Chemicals	25	14
Food Control	• Gross contamination - not separating raw animal foods with different cooking temperatures • Does not seal raw food until ready for use	3	1
Cleanliness and Organization	• Lack of cleanliness	53	22
Total		**274**	**173**

Source: Prepared by legislative auditor's staff using data from OJJ.

We found that 51.9% (120 of 231)[11] of safety-related corrective action items identified in the calendar year 2016 quality assurance audits were not resolved within six months. In addition, 49.1% (85 of 173) corrective action items identified in the calendar year 2017 quality assurance audits were not resolved within six months. For example, no steps were taken in a six-month period to address broken light fixtures, establish and maintain tool control,[12] and ensure that laundry temperatures were high enough to meet Department of Health guidelines. One reason for the large number of uncorrected violations may be due to the fact that quality assurance audits were halted for six years, and facilities likely had long-standing issues that went undetected or unresolved. However, since the quality assurance audits started again in calendar year 2016, the number of violations identified has decreased by 36.9% over a one-year period.

We also found that 44 of the outstanding corrective action items from the calendar year 2017 audits were unresolved repeat violations from the calendar year 2016 audit or had been an ongoing issue for at least a year. Quality assurance audits in 2017 identified 69 violations that were repeat violations from the initial 2016 audits, and 44 still remained unresolved during the 2017 corrective action follow up. For example, the first quality assurance audits that resumed in 2016 cited facilities for not documenting formal rounds, not documenting pat down searches, not conducting routine searches, and staff providing false documentation. These same issues were identified again in the calendar year 2017 audit. These are major issues that could have been ongoing for the years the facilities were not being audited by OJJ. Despite these safety issues, there are limited consequences for noncompliance, and these facilities are unlikely to be shut down because OJJ does not have any alternative secure care placement options.

Recommendation 4: OJJ should ensure that facilities resolve safety-related issues identified in quality assurance audits within the required timeframes.

Summary of Management's Response: OJJ agrees with this recommendation and states that although numbers of corrective action items between calendar year 2016 and 2017 showed a significant decrease, it is preferred that all corrective actions be completed. Some corrective actions, however, are due to aging physical plants and may have a significant cost effect. OJJ will continue to work with secure facilities, auditing corrective action items, conducting periodic repairs meetings and tracking major repair projects through Central Office. See Appendix A for OJJ's full response.

[11] In 2016, 43 of the corrective action items were not addressed by the subsequent audit; therefore, we could not determine if the issues had been resolved within six months.
[12] Tool control is a process to safely store and account for tools so that they are not used inappropriately.

From fiscal years 2013 through 2017, there has been a 52.7% increase in fights and a 111.3% increase in the use of physical restraints in secure care facilities. OJJ could better use the data it collects on fights and physical restraints to monitor these incidents and give guidance to the facilities on ways to address them.

Youth fights and violent behavior create unsafe situations and often disrupt effective rehabilitation.[13] We found that since fiscal year 2013, the number of youth housed in secure care has steadily decreased; however the number of fights and the use of physical restraints have increased. Although the use of physical restrains increased, OJJ rarely used mechanical restraints on youth and does not allow the use of chemical restraints, which is in line with best practices. While OJJ collects electronic information on fights and use of restraints, OJJ could better use the data to monitor these incidents and provide guidance to the facilities on ways to address them. OJJ runs quarterly data reports on the number of fights, and according to OJJ, in April 2018 it began using them to provide guidance to facilities. One reason for the increase in incidents could be because OJJ has been using secure care for higher-risk youth, leading to a higher concentration of violent youth. In addition, high turnover in the facilities, as discussed earlier, an increased need for training, or ineffective treatment programs could also contribute to more fights.

Physical restraints include techniques, or "holds," where staff use their bodies to gain control of the youth.

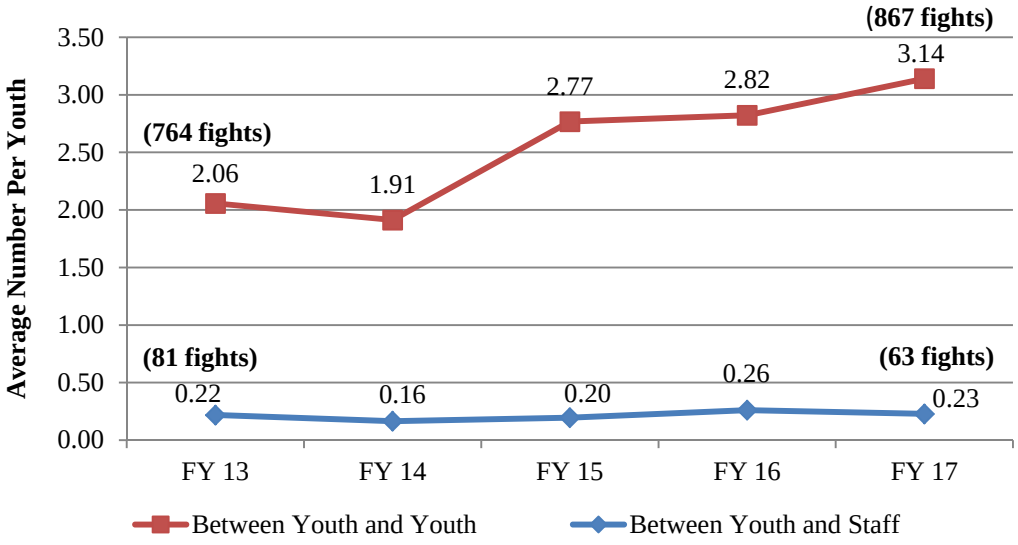
Mechanical restraints include handcuffs and leg irons.

Chemical restraints include pepper spray or sedation, which are not used in secure care.

Although the youth population has decreased between fiscal years 2013 and 2017, all facilities had an increase in the average number of fights per youth. Violent behaviors disrupt treatment and education services and may also indicate that youth are not receiving effective rehabilitation services.[14] Overall, the number of fights per youth in one year increased 52.7%, from 2.06 per youth (764 total fights) in fiscal year 2013 to 3.14 per youth (867 total fights) in fiscal year 2017.[15] The largest increase was Bridge City, which increased 121% in the average number of fights per youth. Exhibit 6 shows the average number of fights per youth by fiscal year, including the average number of fights involving staff and youth.

[13] According to the June 2016 PbS Blueprint.
[14] Our second report evaluates the effectiveness of rehabilitation programs.
[15] In order to account for the lower population numbers, we calculated the average number of instances per youth for these areas, which allows for better comparison across fiscal years.

Exhibit 6
Average Number of Fights per Youth
Fiscal Years 2013 to 2017



Source: Prepared by legislative auditor's staff using data from OJJ.

According to OJJ, the rise in fights may be caused by frequent fighters, a small number of youth who often instigate fights in the facilities. However, we found that while the number of youth that are frequent fighters has increased in all three facilities, these youth are also engaging in more fights per year. The increase in frequent fighters disrupts facilities, leads to a higher number of fights, and may also indicate that these youth are not receiving treatments or programs that effectively address this high-risk behavior.

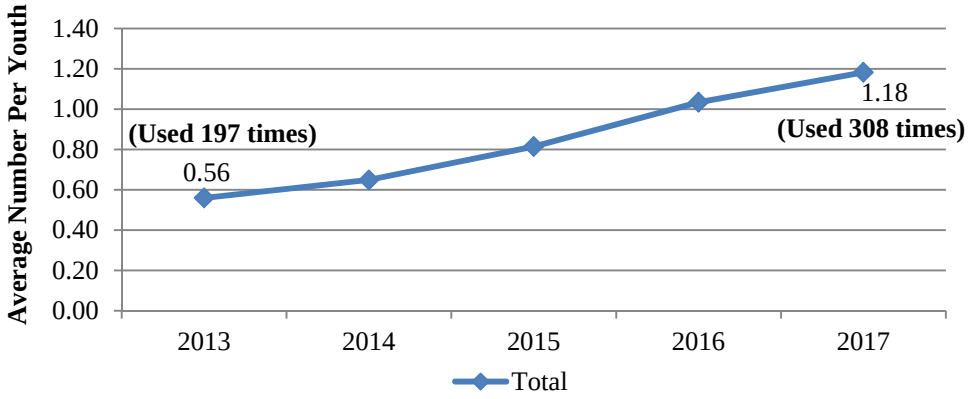
As the average number of fights per youth has increased, the average number of times physical restraints were used has also increased. OJJ could better use its data to provide guidance to facilities on how to reduce the use of restraints, such as more training in de-escalation techniques. Physical restraint use increased by 111.3%, from 0.56 average instances per youth (197 instances total) in fiscal year 2013 to 1.18 average instances per youth (308 instances total) in fiscal year 2017. Physical restraint is a use of force that involves the application of approved techniques by a staff member to physically restrain a youth whose behavior is out of control or unsafe. Staff is trained in Safe Crisis Management (SCM) techniques, which provide them with the ability to prevent or safely control dangerous situations. After staff uses physical restraints on a youth, the youth must be seen by a medical professional who evaluates the youth and documents the incident.

According to OJJ policy, restraints should be used in the least intrusive manner to protect youth from causing harm to others or themselves. Research has shown that high restraint use has negative impacts on the facility climate and results in higher rates of injuries.[16] The rise in the use of physical restraints could be due to an increase in fights or an increase in staff turnover. Staff reported in multiple quality assurance audit surveys that they wanted more training in SCM

[16] According to the June 2016 PbS Blueprint.

and de-escalation techniques. Mechanical restraints, such as handcuffs, were rarely used (a total of 17 times) during fiscal years 2013 through 2017. Exhibit 7 shows the average number of times physical restraints were used by staff per youth by fiscal year.

Exhibit 7
Average Number of Times Physical Restraint Was Used Per Youth
Fiscal Years 2013 to 2017



Source: Prepared by legislative auditor's staff using data from OJJ.

As OJJ already collects electronic data on fights and the use of restraints, it could use this data to monitor trends at each facility. Increases in the number of fights and use of restraints could help OJJ identify areas that need improvement, such as rehabilitation programming, staff training, staffing levels, or problems in the overall facility culture. For example, a higher rate of physical restraint use could indicate that staff needs additional training in de-escalation techniques to help prevent situations from resulting in fights.

Recommendation 5: OJJ should formalize a process to regularly provide data-driven guidance to facilities regarding fights and the use of physical restraints in secure care facilities.

Summary of Management's Response: OJJ agrees with this recommendation and states that these two indicators (fights/restraints) have a direct correlation. Reduction in altercations automatically results in the lowering of physical restraint use. OJJ produces a quarterly report that has the number of fights, location, and time of day for each facility. OJJ's Assistant Secretary has incorporated review of this report in regular meetings with facility leadership. See Appendix A for OJJ's full response.

Recommendation 6: OJJ should identify and address frequent fighters to help decrease the number of fights in facilities.

Summary of Management's Response: OJJ agrees with this recommendation and states that the Behavioral Health Treatment Unit was implemented in September 2017 to address the programming needs of a subpopulation of youth who repeatedly violate facility rules and engage in aggressive and defiant behaviors that jeopardize their safety as well as the safety of other youth and staff. In addition, frequent fighters will

continue to be audited through the quarterly treatment review process. See Appendix A for OJJ's full response.

Since calendar year 2013, the percentage of positive drug screens increased from 2.3% in calendar year 2013 to 9.5% in calendar year 2017. Because OJJ does not collect data on why the drug tests were administered, it cannot determine if there is an increase of drugs being brought into the facility either by staff or visitors or if youth are using drugs during furloughs.

OJJ policy states that the use of illegal substances and alcohol by youth presents a serious threat to youth health, public safety, and the security of a facility. In addition, the PbS standards direct the facilities to prevent contraband (drugs, weapons, cell phones, etc.) from entering the facilities, with the goal of providing a safe environment for youth and staff.

While OJJ has seen an increase in the number of positive drug screens since calendar year 2013, it does not collect data on why drug tests were administered. The percentage of drug screens that tested positive for illegal substances increased from 2.3% (12 tests total) in calendar year 2013 to 9.5% (83 tests total) in calendar year 2017. Since calendar year 2013, OJJ has consistently been performing more drug screens on youth in secure care. According to OJJ policy, youth are drug tested at random, due to suspicion, or when returning from a furlough or off-campus trip. However, OJJ is not documenting the reasons for the drug test. As a result, OJJ cannot determine the main reason for the increase in positive drug screens. OJJ should collect data on each drug test that includes the reason the test was administered, such as suspicion, the youth just returned from a weekend furlough or off-campus trip, etc.

It is important for OJJ to determine the root cause of the rise in positive drug screens. For example, in a 2017 quality assurance audit staff survey, one staff stated that another staff was bringing cigarettes and drugs for the youth, and quality assurance audits repeatedly found that staff was not always conducting or documenting youth searches. It is possible that higher positive drug screens could indicate that there are more drugs entering into secure care facilities from visitors or OJJ employees. For example, OJJ reported that one staff member was sneaking contraband into the facilities using re-sealed chip bags. On the other hand, if positive drug tests are a result of more youth going on furloughs or off-campus trips, then those youth may need additional re-entry planning so they can effectively deal with pressures in the community.

According to OJJ staff surveys, **29% (61 of 212)** of sampled staff stated that youth receive contraband from staff.

Source: 2016 and 2017 quality assurance audit reports.

Recommendation 7: OJJ should include the reason for drug screens when they aggregate drug screen information so it can determine the cause of the rise in positive drug screens.

Summary of Management's Response: OJJ agrees with this recommendation and states that effective May 1, 2018, OJJ began to collect data concerning the number of drug screens, reason for conducting, location of youth tested, etc. This data will be reviewed monthly in meetings between the Assistant Secretary and Regional Directors/Facility Directors. See Appendix A for OJJ's full response.

While OJJ has reduced the use of room confinement as recommended by best practices, it needs to collect room confinement data in a way that it can be easily monitored and analyzed.

Room confinement is defined as any time a youth is physically or socially isolated from other youth.[17] Nationally, juvenile justice agencies have been moving away from using room confinement, and 10 states have banned punitive solitary confinement. Research has shown that putting youth in confinement has negative public safety consequences, does not reduce violence, and may actually increase recidivism. It has also shown that facilities that use minimal room confinement are safer and have healthier staff to youth relationships, which lead to reduced recidivism rates.[18] OJJ policy states that the use of room confinement should not be used as punishment. If it is necessary, the length of time should not exceed 59 minutes, and youth in room confinement for Behavioral Intervention should not exceed 72 hours.[19] In July 2017, OJJ implemented a "Reduce the Use" campaign to lower the use of room confinement. Prior to this, Swanson-Monroe routinely housed youth in the Victory and Cypress units, where youth were held in individual cells for months at a time. These units have since been closed.

Although OJJ has implemented a "Reduce the Use" campaign, the use of room confinement has increased recently at Bridge City. While the use of room confinement is still lower than it was prior to this campaign, it is starting to rise again. It is important for OJJ to monitor room confinement use so that it does not continue to increase. Bridge City's room confinement use was lower than the national average in the 2017 PbS report. For example, from April to October, Bridge City's average duration of room confinement improved from 36.3 hours to 7.35 hours, respectively, while the national average was 15.39 hours. We requested room confinement documentation from December 2017 to February 2018, and according to the documentation, the length of time youth spent in room confinement has been increasing and is greater than the October 2017 numbers reported to PbS for Bridge City. In contrast, Swanson-Monroe has had fewer instances of room confinement; however, its average length of time in confinement is higher than Bridge City's. Swanson-Columbia does not use room confinement. Exhibit 8 shows the room confinement usage for December 2017 through February 2018.

[17] Room confinement can also be called solitary confinement, isolation, or seclusion.
[18] *Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation.*
[19] Staff directed time out is used for "cooling off" when youth behavior is out of control. If youth behavior's remains out of control or is threatening the safety of other youth or staff, then the youth may be placed in Behavioral Intervention, which is when youth are confined to a room separate from other youth.

Exhibit 8 Room Confinement Use December 2017 through February 2018			
Month	**Average length in confinement**	**Max length in confinement**	**Total Instances Used**
Bridge City Room Confinement Use			
October 2017*	3.5 hours	19.1 hours	29
December 2017	4.1 hours	22 hours	10
January 2018	6.4 hours	26.9 hours	25
February 2018	13.4 hours	43.3 hours	23
Swanson - Monroe Room Confinement Use**			
December 2017	16.6 hours	20.8 hours	3
January 2018	32.8 hours	32.8 hours	1
February 2018	14.4 hours	40.9 hours	12

*We used the data from the October 2017 PbS data collection to calculate overall room confinement statistics. PbS data is normalized to compare across states by using 100 person-days. The numbers in this chart do not account for the 100 person-days.
**As of October 2017, Swanson-Monroe had not yet begun participating in PbS.
Source: Prepared by legislative auditor's staff using information from OJJ room confinement forms. We did not test the reliability or completeness of these forms.

In addition, we found that OJJ needs to collect room confinement data in a way that it can be easily tracked and analyzed. OJJ does not currently collect room confinement information in a way that is easily aggregated and analyzed. Staff document required 15-minute youth checks in a log book and use a series of forms to document the reason why a youth is placed in room confinement, what steps were attempted to prevent room confinement, medical and mental health checks, and 15-minute checks on youth. However, quality assurance audits in 2016 and 2017 found that staff were not always completing all of the required paperwork and were falsifying 15-minute checks on youth when they were not being conducted. In addition to ensuring staff complete all required room confinement paperwork accurately and honestly, OJJ should consider streamlining the process. For example, OJJ could redesign forms to make it easier to aggregate information such as the number of room confinement instances and the length of time in confinement. Ensuring that all room confinement use is documented is important for OJJ to know how often the practice is used and whether it is in accordance with current OJJ initiatives.

Recommendation 8: OJJ should streamline room confinement documentation and ensure staff complete required documentation.

Summary of Management's Response: OJJ agrees with this recommendation and states that it approved a new policy on May 25, 2018, that outlines the specifics as it pertains to room confinement use within the facilities and has forms attached and gives specific instructions on the completion/storage of these forms. In addition, now that all facilities are participating in PbS, OJJ will be able to compare all use of Behavioral Intervention (or "room confinement") to the national field average. See Appendix A for OJJ's full response.

Recommendation 9: OJJ should regularly track and monitor room confinement use.

Summary of Management's Response: OJJ agrees with this recommendation and states that facility Directors are charged with monitoring the use of room confinement. CQIS will also audit this function annually and conduct annual reviews of corrective action. Room confinement data is also reviewed through the PbS process. See Appendix A for OJJ's full response.

Between fiscal years 2013 and 2017, OJJ did not address 19% of youth grievances within the timeframes set in OJJ policy. In addition, we found that there has been a 23.7% increase in the number of grievances per youth, from 1.26 to 1.56.

Article 912 of the Louisiana Children's Code states that youth committed to the custody of the Department of Public Safety and Corrections (the agency OJJ is under) have the right to file a grievance concerning their care, custody, and control and have it resolved through the administrative remedy procedure outlined in 22:I:325 of the Louisiana Administrative Code. An effective grievance process is important because it helps youth to express complaints safely and provides them with a venue for reporting abusive situations.[20] If a grievance alleges abuse or sexual abuse, OJJ's Investigative Services section, which is independent from the facilities, investigates the allegation.

Examples of Youth Grievances

- Youth requesting to be reassigned to another dorm or facility because they do not feel safe
- Milk served during mealtimes is spoiled or meat is undercooked
- Staff treating youth inappropriately, such as verbal abuse, allowing youth to fight, or not allowing youth to use the restroom

Source: Prepared by legislative auditor's staff using grievance data from OJJ.

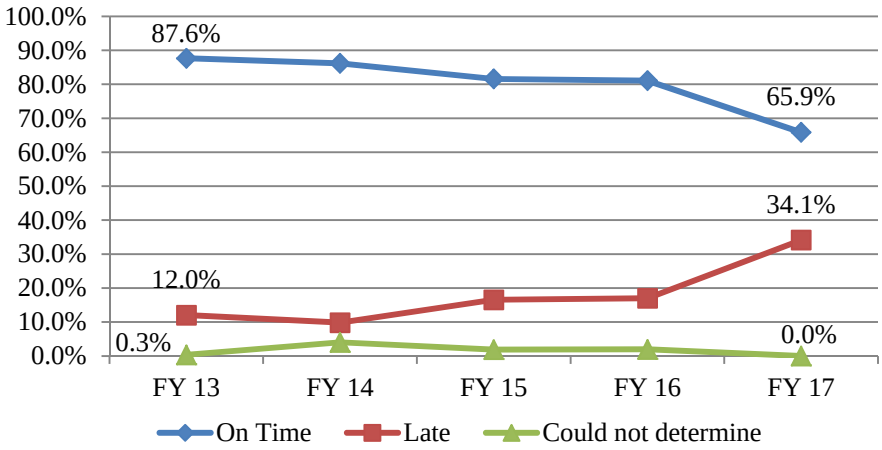
Between fiscal years 2013 and 2017, the most common types of grievances were about food, housing conditions, requests for transfers, and complaints about staff. In addition, youth indicate their desired solutions on the grievance form, such as fixing the air conditioner, being transferred to another dorm, requesting a pair of shoes, requesting a haircut, or requesting staff be reassigned. Between fiscal years 2013 and 2017, 41.4% (758 of 1,828) of grievances were resolved with the youth's request being denied, and 40.5% (740) of grievances were resolved with the youth's request being granted fully or in part.[21]

[20] According to the June 2016 PbS Blueprint.

[21] The remaining 18.1% (330) of grievances were withdrawn, cancelled, or had blank requests. It is important to note that the solutions youth requested may not always be the appropriate way to handle a situation; therefore, denial of the request does not necessarily mean the grievance was not resolved.

We found that between fiscal years 2013 and 2017, 19% (297 of 1,562) of youth grievances were not addressed within the timeframes set in OJJ policy. According to OJJ policy, facilities have 30 days to address youth grievances.[22] We found that 54.1% were up to 14 days late, 20.7% were 15 to 30 days late, and 25.2% were more than 30 days late. Exhibit 9 shows grievance timeliness compliance for fiscal years 2013 through 2017.

Exhibit 9
Grievance Timeliness Compliance
Fiscal Years 2013 through 2017



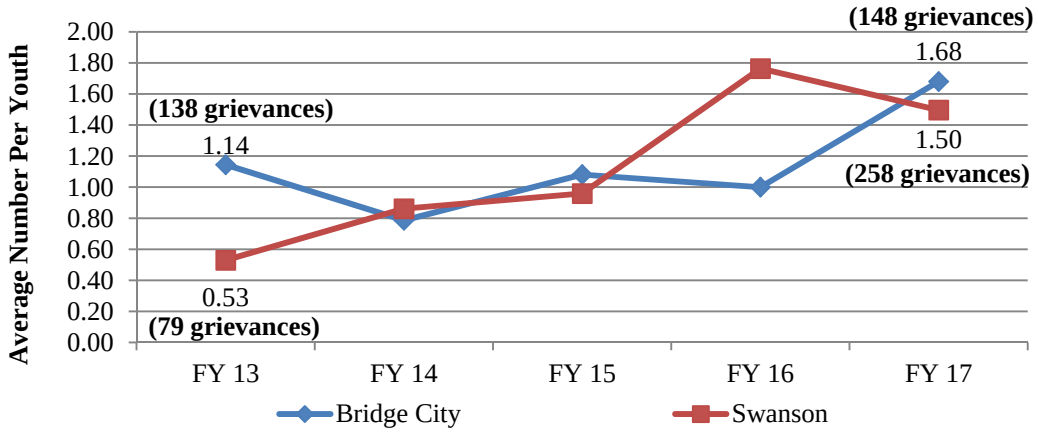
Source: Prepared by legislative auditor's staff using data from OJJ.

The average number of grievances reported by youth has increased by approximately 23.7% since fiscal year 2013. We found that the average number of grievances reported by youth increased from 1.26 grievances per youth (a total of 340 grievances) in fiscal year 2013 to 1.56 grievances per youth (a total of 406) in fiscal year 2017. According to PbS, a large number of grievances may indicate that a facility has an open, healthy environment where youth feel safe to express their needs, or it may indicate a facility has significant problems. Each dorm has grievance forms and a locked box for youth to submit grievances. During site visits to each facility, the audit team observed the forms and lock boxes.

When we spoke with youth in the facilities, many stated that they did not submit grievances because they did not trust the system. Because of the increase in the number of grievances, it is important that OJJ address these grievances timely so youth are not deterred from submitting a grievance because of an inefficient process. Exhibit 10 shows the total number of grievances and the average number of grievances per youth per secure care facility from fiscal years 2013 to 2017.

[22] If granted an extension, facilities have 44 days maximum to address grievances in Step One of the process. Our analysis only includes Step One because there were so few Step Two grievances.

Exhibit 10
Average Number of Grievances Per Youth
Fiscal Years 2013 to 2017



Note: Swanson includes Swanson-Monroe and Swanson-Columbia**.** In addition, Jetson Center for Youth had 166 grievances during FY13 and FY14.

Source: Prepared by legislative auditor's staff using data from OJJ.

Recommendation 10: OJJ should ensure that youth grievances are addressed according to the timelines set in policy.

Summary of Management's Response: OJJ agrees with this recommendation and states that the timeliness of youth grievance processing was isolated mainly to one facility and was due to staff turnover in that position. The CQIS process monitors deadlines of grievances and will continue to do so. The Facility Director is also charged with monitoring timelines of grievance processing. Additionally, the Family Liaison position has been moved to the local/regional level. This position is charged with assisting in the youth grievance process. See Appendix A for OJJ's full response.

OJJ's procedures for monitoring safety at the Ware Youth Center for female youth are not consistent with its procedures for monitoring the secure care facilities for males. For example, OJJ does not monitor medical care, room confinement, restraints, or grievances at Ware. As a result, female youth are not receiving the same protection and standard of care as males in secure care facilities.

OJJ contracts with Ware to house females needing secure care. Ware is located in Coushatta, Louisiana and houses up to 24 females. Ware is the only facility in the state that houses females. OJJ monitors the facility according to its contract monitoring policy for

community-based services,[23] which includes group homes and non-residential programs. However, Ware is not considered a group home or non-residential program. It is a secure care facility reserved for the highest-risk youth. As a contracted provider, Ware is licensed as a child residential facility by the Department of Children and Family Services (DCFS), which monitors the facility's compliance with child residential regulations. DCFS is required by law to conduct annual facility and complaint inspections.

OJJ does not include Ware in its CQIS quality assurance auditing process, nor does it currently collect and analyze enough information from Ware to monitor the overall safety of female youth and staff like it does for the secure care facilities for males. OJJ has processes in place to collect data that can be used to monitor the overall safety of youth and staff at the three secure care facilities that house male youth including the number of fights, use of restraints, drug test results, use of room confinement, and grievances. However, OJJ does not collect this type of information for the youth housed at Ware. As a result, OJJ cannot fully evaluate youth safety at Ware. According to OJJ, it has not included Ware in its CQIS quality assurance auditing process because it is concerned about the contract price increasing. In addition, OJJ conducts quarterly audits on medical and mental health services provided at the secure care facilities for males; however, OJJ does not include Ware in these audits.

While DCFS licensing visits do include reviewing areas such as room confinement and the grievance process, the department focuses more on licensing requirements, such as employee background checks, required staff training, and physical building requirements, than the overall quality of services. DCFS does not currently forward its findings to OJJ, but its findings are available on the DCFS website. OJJ should monitor Ware at the same level as the other secure care facilities since these youth are under OJJ's custody, not DCFS's custody.

Ware uses room confinement areas in its detention center for females housed in the intensive residential facility, but OJJ does not monitor its use like in other secure care facilities. During our site visit to the facility, Ware management stated that they did not have room confinement in the intensive residential (i.e., secure care) facility. However, we found that females housed in the intensive residential facility were taken to the Ware Detention Center, which is a separate licensed facility on the same campus, for room confinement and suicide watch. During our visit, there was a youth in room confinement for suicide watch who had been there for six days. OJJ was aware that youth from the secure care facility were brought to the detention center; however, it does not monitor its use.

We found that out of 48 unusual occurrence reports for Ware in 2017, 32 (66.7%) resulted in a youth being taken to room confinement. Unlike OJJ's procedures at secure care facilities for males which include monitoring the use of room confinement, neither OJJ's monitoring policy nor its auditing tool include similar monitoring procedures for Ware. In addition, because Ware does not have a room confinement area, DCFS was not aware that Ware staff brought youth to the detention center. DCFS's licensing specialist investigated this issue and informed Ware that it cannot use the detention center for room confinement for females in

[23] Monitoring consists of monthly file reviews to evaluate compliance with certain policies. However, indicators of safety such as the prevalence of room confinement, grievances, altercations, and contraband are not reviewed.

secure care, because the intensive residential facility and the detention center are separate licensed facilities and youth should not be moving between the two.

In addition, Ware only retains video footage for one week, as compared to the other facilities that keep video for approximately two months, which makes it difficult to monitor what actually takes place at the facility. For example, we requested video footage of the intensive residential facility and room confinement area in the detention center. However, since it took more than two months for Ware to provide us with video footage, we could not use this video to review the timeframe we requested. Also, we could not use the footage for the week they sent us because the administration knew we would be reviewing it; therefore we could not ensure the video footage would represent normal uses of the intensive residential facility and room confinement area in the detention center.

Recommendation 11: OJJ should begin collecting, analyzing, and monitoring safety information from Ware, including the number of fights, use of restraints, drug test results, use of room confinement, and grievances.

Summary of Management's Response: OJJ agrees with this recommendation and states that Ware Intensive Residential Unit is considered a quasi-governmental facility with which OJJ maintains a contract for the placement of females in that facility. Ware is monitored by DCFS Licensing, as well as OJJ Program Specialists, who make monthly visits to monitor program compliance with OJJ policy and Standard Operating Procedures (SOP) for that facility. As the contract for Ware is re-negotiated, OJJ will put more stringent monitoring and data requests in place. See Appendix A for OJJ's full response.

Recommendation 12: OJJ should consider including Ware in its CQIS audit process.

Summary of Management's Response: OJJ agrees with this recommendation and states that the Secure Care Standards Task Force has been mandated through legislation to develop standards for monitoring of all secure facilities within the state. Once recommendations are received from this body, OJJ will work with the facility and licensing to amend the Ware contract to meet the auditing needs of the new standards. See Appendix A for OJJ's full response.

Recommendation 13: OJJ should consider requiring Ware to maintain video footage longer than one week.

Summary of Management's Response: OJJ agrees with this recommendation and states that OJJ maintains a contract with Ware Intensive Residential to house females. This matter will be considered upon renegotiation of the contract with Ware and revision of Standard Operating Procedures. See Appendix A for OJJ's full response.

APPENDIX A: MANAGEMENT'S RESPONSE

JOHN BEL EDWARDS, Governor
JAMES BUECHE, PH.D, Deputy Secretary

Office of Juvenile Justice

May 25, 2018

Daryl G. Purpera, CPA, CFE
Louisiana Legislative Auditor
P. O. Box 94397
Baton Rouge, LA 70804-9397

Dear Mr. Purpera:

Please accept the attached as our response to the performance audit report of the Office of Juvenile Justice (OJJ) entitled *Oversight of Safety in Secure Care Facilities*. OJJ concurs with all of the findings cited in your report.

The secure facilities within OJJ house youth who have the highest level of risk and need. OJJ is committed to providing the appropriate treatment for these youth in a safe and secure environment for both staff and youth. Therefore, the feedback and recommendations provided by your audit staff concerning our oversight of safety are greatly appreciated.

OJJ would like to express our thanks to your staff for their professionalism and cooperation with the agency while conducting this audit. We will consider all factors outlined in the recommendations provided by your office as we continue to make improvements in the oversight of safety within the Office of Juvenile Justice secure facilities.

Sincerely,

James Bueche, Ph.D., LCSW
Deputy Secretary

JB:et

attachments:
OJJ Response to Recommendations
Checklist for Audit Recommendations

cc: Karen Leblanc, CIA, MSW

OJJ Response to Legislative Auditor
Performance Audit - Oversight of Safety in Secure Facilities
May 25, 2018

For clarity, OJJ would like to offer two comments about the exhibits contained in the introductory portion of the above referenced report. Exhibit 1 shows cost per day per bed to include costs associated with OJJ's medical contract with Correct Care Solutions. Although we do not disagree with this method of calculation, we have previously given testimony utilizing cost per day per youth, excluding medical.

Exhibit 2 outlines the number of youth served in secure care facilities. This way of portraying youth served differs from OJJ's usual way of reporting, which is by legal status.

Recommendation #1: OJJ should explore strategies to recruit quality candidates, such as working with local universities.

Concur. OJJ will continue to participate in career days at local universities, job fairs, and Louisiana's Civil Service Resource Center to assist in filling vacancies. Additionally, OJJ will continue to use local advertising efforts as well as social media to recruit appropriate staff.

Recommendation #2: OJJ should clarify how to calculate PREA staffing ratios and ensure that facilities are compliant with these ratios.

Concur. Current staffing ratios are calculated to meet PREA requirements and facilities are now staffed at a level to meet those standards. Effective April 2018, each OJJ secure facility must verify their staffing ratios for each shift through daily reporting to administration.

Recommendation #3: OJJ should require Bridge City to document staffing ratios by dorm in order to accurately calculate staffing ratios.

Concur. Effective April 2018, all facilities are required to submit daily reports indicating staffing ratios for each shift per dorm.

Recommendation #4: OJJ should ensure that facilities resolve safety-related issues identified in quality assurance audits within the required timeframes.

Concur. Although numbers of corrective action items between calendar year 2016 and 2017 showed a significant decrease, it is preferred that all corrective actions be completed. Some corrective actions, however, are due to aging physical plants and may have a significant cost effect. OJJ will continue to work with secure facilities, auditing corrective action items, conducting periodic repairs meetings and tracking major repair projects through Central Office.

Recommendation #5: OJJ should formalize a process to regularly provide data-driven guidance to facilities regarding fights and the use of physical restraints in secure care facilities.

Concur. These two indicators (fights/restraints) have a direct correlation**.** Reduction in altercations automatically results in the lowering of physical restraint use. OJJ does not use chemical restraints, and only uses mechanical restraints when transporting youth.

Therefore, physical restraint is the only method of restraint allowed to deal with youth who are fighting, destroying property, etc.

OJJ produces a quarterly report that has the number of fights, location, and time of day for each facility. OJJ's Assistant Secretary has incorporated review of this report in regular meetings with facility leadership.

Altercation data is also monitored and compared twice a year to the national average, through PbS. OJJ is pleased that PbS data indicates Bridge City Center for Youth and Swanson Center for Youth at Columbia are well below the field average for the use of physical restraints.

Recommendation #6: OJJ should identify and address frequent fighters to help decrease the number of fights in facilities.

Concur. The Behavioral Health Treatment Unit was implemented in September 2017 to address the programming needs of a subpopulation of youth who repeatedly violate facility rules and engage in aggressive and defiant behaviors that jeopardize their safety as well as the safety of other youth and staff. The therapeutic model replaced room confinement used in previous programming. It consists of a dormitory housing unit with an open sleeping bay designed to facilitate treatment of behaviorally challenged and/or disruptive youth who require a more intensive level of supervision and therapy.

The Behavioral Health Treatment Unit adheres to a "best practices" model and is based on current research and expert opinion on effective behavioral management of incarcerated juveniles. The program is designed to motivate these youth to alter antisocial and aggressive patterns of behavior, adopt pro-social values, and demonstrate self-control skills that will permit them to return to mainstream facility programming.

Frequent fighters will also continue to be audited through the quarterly treatment review process.

Recommendation #7: OJJ should include the reason for drug screens when they aggregate drug screen information so it can determine the cause of the rise in positive drug screens.

Concur. Effective May 1, 2018, OJJ began to collect data concerning the number of drug screens, reason for conducting, location of youth tested, etc. This data will be reviewed monthly in meetings between the Assistant Secretary and Regional Directors/Facility Directors. OJJ is committed to reducing contraband through various avenues. We have increased our efforts to detect contraband through the use of additional searches, detection dogs and investigations.

Recommendation #8: OJJ should streamline room confinement documentation and ensure staff complete required documentation.

Concur. On May 25, 2018, Youth Services Policy B.2.21 "Behavioral Intervention Rooms" was approved. This is a new policy that outlines the specifics as it pertains to room confinement use within the facilities. The policy has forms attached and gives specific instructions on the completion/storage of said forms. There is also a Behavioral Intervention (BI) logbook that will be maintained. Additionally, now that all facilities are

participating in PbS, OJJ will be able to compare all use of BI (or "room confinement") to the national field average. Initial PbS data indicates OJJ's use of room confinement is not excessive.

Recommendation #9: OJJ should regularly track and monitor room confinement use.

Concur. Facility Directors are charged with monitoring the use of room confinement. CQIS will also audit this function annually and conduct annual review of corrective action. Room confinement data is also reviewed through the PbS process. Should the use of BI exceed the national field average, through the PbS process, the facility will develop a Facility Improvement Plan to address. This was done last year at BCCY with positive results. Additionally, initial PbS data indicates OJJ's use of room confinement is not excessive as compared to juvenile systems in other states.

Recommendation #10: OJJ should ensure that youth grievances are addressed according to the timelines set in policy.

Concur. The timeliness of youth grievance processing was isolated mainly to one facility and was due to staff turnover in that position. The CQIS process monitors deadlines of grievances and will continue to do so. The Facility Director is also charged with monitoring timelines of grievance processing. Additionally, the Family Liaison position has been moved to the local/regional level. This position is charged with assisting in the youth grievance process. With all these things in place, OJJ anticipates prompt improvement.

Recommendation #11: OJJ should begin collecting, analyzing, and monitoring safety information from Ware, including the number of fights, the use of restraints, drug test results, the use of room confinement, and grievances.

Concur. Ware Intensive Residential Unit is considered a quasi-governmental facility with which OJJ maintains a contract for the placement of females in that facility. Ware is monitored by DCFS Licensing, as well as, OJJ Program Specialists, who make monthly visits to monitor program compliance with OJJ policy and Standard Operating Procedures (SOP) for that facility. As the contract for Ware is re-negotiated, OJJ will put more stringent monitoring and data requests in place. It is anticipated that, with this, and through SOP revision and revision of the monthly monitoring tool, the suggested recommendations will be met.

Recommendation #12: OJJ should reconsider including Ware in its CQIS audit process.

Concur. The Secure Care Standards Task Force has been mandated through legislation to develop standards for monitoring of all secure facilities within the state. Once recommendations are received from this body, OJJ will work with the facility and licensing to amend the Ware contract to meet the auditing needs of the new standards.

Recommendation #13: OJJ should consider requiring Ware to maintain video footage longer than one to two weeks.

Concur. As stated above, OJJ maintains a contract with Ware Intensive Residential to house females. This matter will be considered upon renegotiation of contract with Ware and revision of Standard Operating Procedures.

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our performance audit of the Office of Juvenile Justice (OJJ). We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This audit primarily covered the time period of July 1, 2013, through June 30, 2017, although some analyses include information from fiscal year 2018. Our audit objective was:

To evaluate OJJ's oversight of staff and youth safety at secure care facilities.

We conducted this performance audit in accordance with generally-accepted *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. To answer our objective, we reviewed internal controls relevant to the audit objective and performed the following audit steps:

- Researched and reviewed relevant state and federal statutes and regulations related to OJJ
- Researched juvenile justice-related audits and practices in other states and studies conducted by local and national organizations
- Interviewed OJJ staff and juvenile justice stakeholders, such as the Louisiana Center for Children's Rights, the Department of Child and Family Services, and the Louisiana Department of Education, and participated in the Task Force on Secure Care Standards and Auditing
- Conducted site visits of all four secure care facilities, including some unannounced visits. During these visits, we interviewed youth and staff
- Obtained and analyzed JETS data for youth in OJJ custody during fiscal years 2013 through 2017 using Excel and Audit Command Language
- Obtained and analyzed other sources of OJJ data, including data on fights, youth grievances, and drug tests, as well as room confinement tracking logs
- We conducted reliability testing on data on key fields in OJJ's JETS data system, fights, grievances, and youth code of conduct violations. We found minor data reliability errors; however, none of these would affect our overall findings and conclusions

- Obtained and analyzed staffing data from the Division of Administration's Business Objects tool to calculate turnover rates for secure care facilities
- Obtained and analyzed OJJ continuous quality improvement services audits from 2016 and 2017
- Obtained and analyzed OJJ's monthly audits of Ware Youth Center
- Obtained and analyzed facility expenditures, including medical contract costs and Ware Youth Center contract costs
    - We calculated the average cost per bed per day using secure care expenditures and medical contract costs divided by the total bed capacity for the facility. We calculated the medical contract costs per facility based on the percent of youth housed at the facility for the fiscal year. We used the total bed capacity in our calculation because it costs OJJ the same amount regardless of whether the facility is at capacity or not.
- Discussed the results of our analyses with OJJ management and provided OJJ with the results of our data analyses

APPENDIX C: FACILITY EXPENDITURES

Secure Care Facility Costs and Capacity Fiscal Years 2013 to 2017				
Fiscal year	**Total Facility Expenditures***	**Average Daily Census**	**Total Daily Capacity**	**Cost per Day per Bed****
Overall				
FY 13	$54,166,346.11	371	403	$367.99
FY 14	$52,860,611.96	352	451	$320.90
FY 15	$49,001,117.54	348	346	$387.74
FY 16	$42,502,071.35	345	348	$334.38
FY 17	$45,436,433.08	276	290	$428.96
Bridge City Center for Youth				
FY 13	$13,342,679.25	121	132	$276.74
FY 14	$13,624,527.99	121	132	$282.59
FY 15	$17,477,741.53	133	132	$362.51
FY 16	$16,150,023.21	130	132	$334.97
FY 17	$17,068,610.34	88	94	$497.14
Swanson Center for Youth - Monroe				
FY 13	$23,953,934.35	145	160	$409.89
FY 14	$18,262,173.27	118	160	$312.49
FY 15	$22,231,495.56	151	142	$428.64
FY 16	$18,280,012.07	149	144	$347.56
FY 17	$20,477,196.66	129	124	$452.13
Swanson Center for Youth - Columbia				
FY 13	-	-	-	-
FY 14	$5,477,910.51	43	48	$312.45
FY 15	$5,178,403.55	46	48	$295.37
FY 16	$5,550,647.22	45	48	$316.60
FY 17	$5,553,709.15	44	48	$316.78
Ware Youth Center Intensive Residential				
FY 13	$2,390,967.00	19	24	$272.75
FY 14	$2,390,967.00	23	24	$272.75
FY 15	$2,515,967.00	17	24	$287.01
FY 16	$2,264,370.00	21	24	$258.31
FY 17	$2,264,370.00	16	24	$258.31

Secure Care Facility Costs and Capacity Fiscal Years 2013 to 2017				
Fiscal year	**Total Facility Expenditures***	**Average Daily Census**	**Total Daily Capacity**	**Cost per Day per Bed****
Jetson Center for Youth				
FY 13	$14,404,903.64	82	87	$453.32
FY 14	$13,105,033.19	48	87	$412.41
FY 15	$1,597,509.90	-	-	-
FY 16	$257,018.85	-	-	-
FY 17	$72,546.93	-	-	-

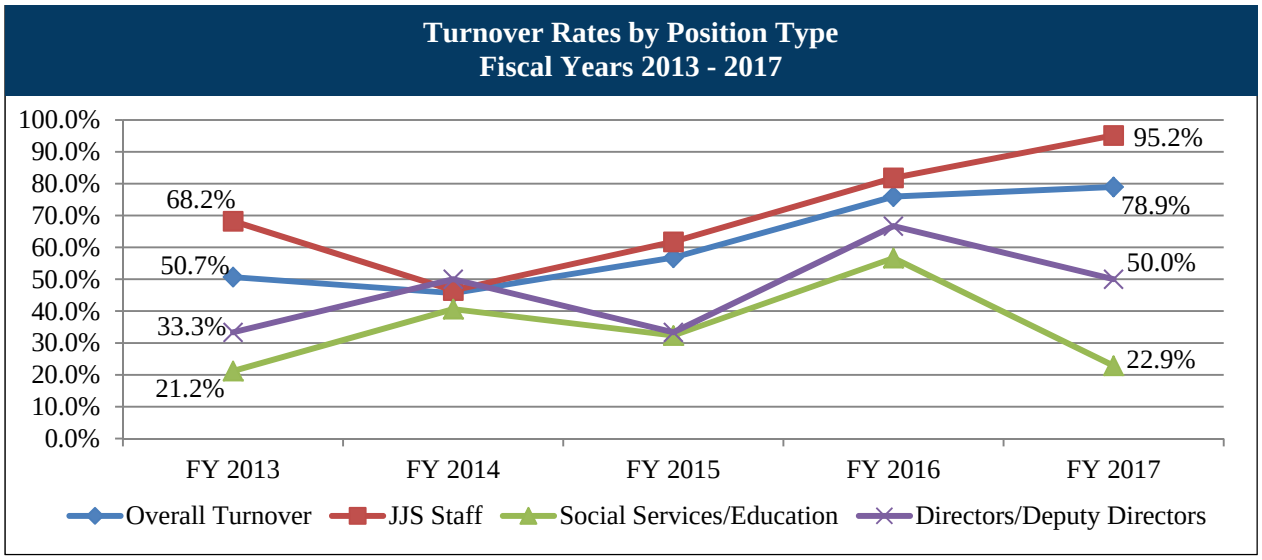
***Facility expenditures include medical contractor costs.
****The cost per bed per day was calculated by dividing the total expenditures by the facility daily capacity.
Source: Prepared by legislative auditor's staff using OJJ data and expenditure information.

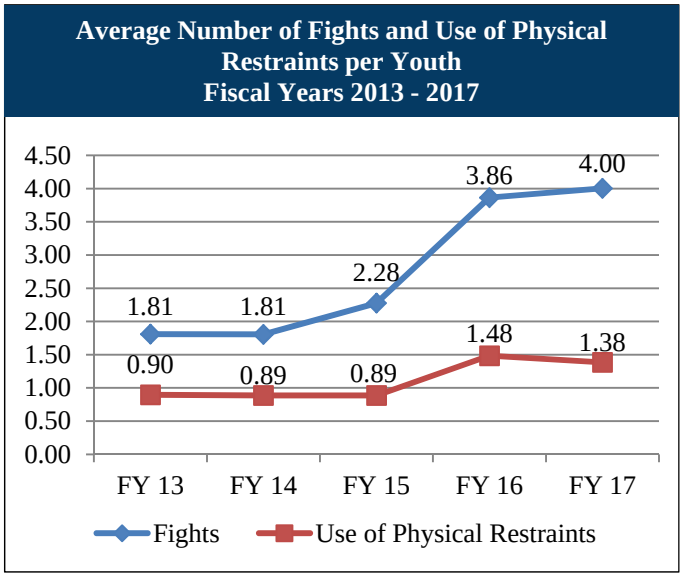
APPENDIX D: FACILITY FACT SHEETS

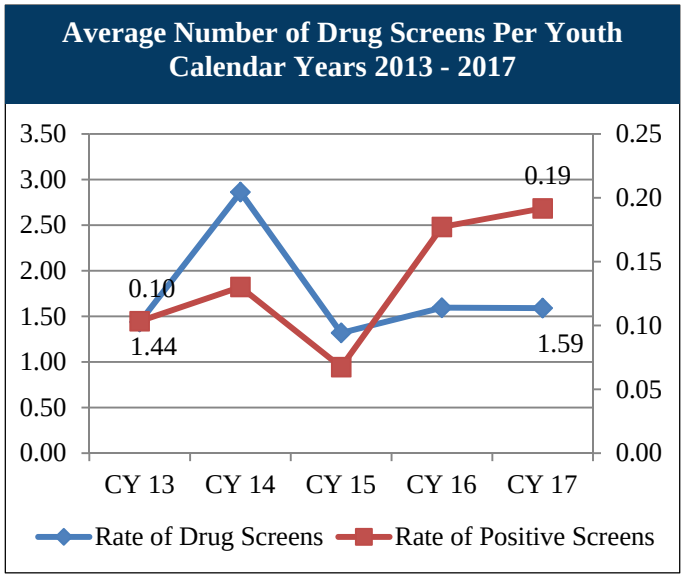
Bridge City Center for Youth

Average Annual Census for FY 17: **88**

Average Cost per Bed per Day for FY 17: **$497.14**







Bridge City Room Confinement Use			
Month	**Average length of stay**	**Max length of stay**	**Total Instances Used**
October 2017 (PbS data collection)	3.5 hours	19.1 hours	29
December 2017	4.1 hours	22 hours	10
January 2018	6.4 hours	26.9 hours	25
February 2018	13.4 hours	43.3 hours	23

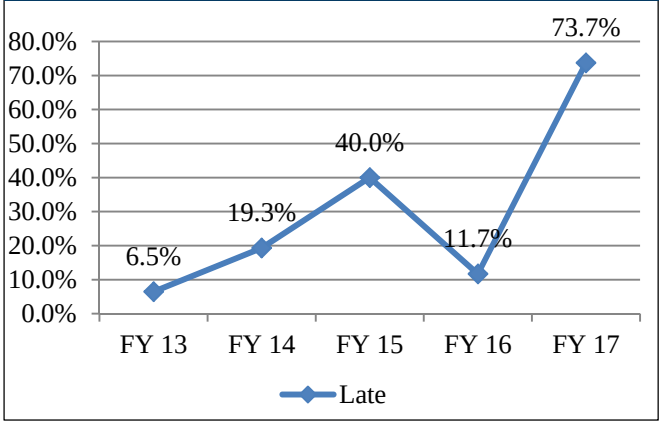
Source: Prepared by legislative auditor's staff using OJJ data, Business Objects data, and OJJ quality assurance audits.

Bridge City Center for Youth

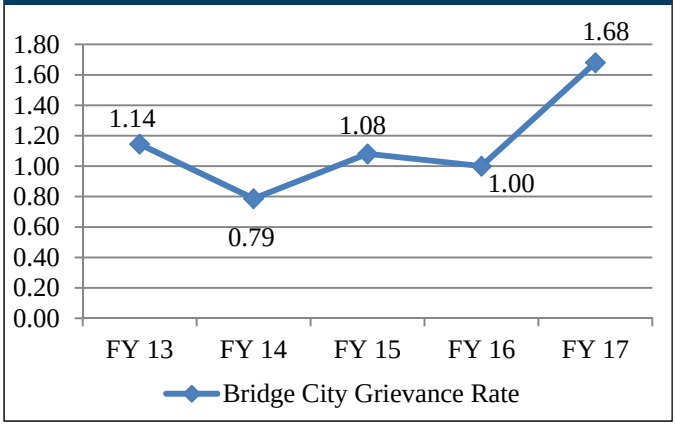
Average Annual Census for FY 17: **88**

Average Cost per Bed per Day for FY 17: **$497.14**

Percent of Grievances Addressed Untimely Fiscal Years 2013 -2017



Average Number of Grievances per Youth Fiscal Years 2013 -2017



Calendar Years 2016-2017 Bridge City Corrective Action Items				
Violation	**Example(s)**	**CY 2016**	**CY 2017**	**Total**
Emergency Preparedness	• Failure to have a working flashlight	10	7	17
Key Control	• Lack of keys being stamped and numbered • Discrepancy with keys in comparison to the key control database	3	2	5
Lack of documentation	• Youth were on the Seriously Mental Illness (SMI) list however the section on the form was incomplete • Staff falsely documenting rounds	39	22	61
Lack of Supervision	• Facility continues to be non-compliant in performing preventive maintenance	8	8	16
Maintenance	• There is no sidewalk to the Vo-Tech building and rain increases flooding	19	5	24
Physical Plant	• Placement in time out exceeded 59 minutes • Bridge City is not set up to accommodate a Behavior Management Unit	2	1	3
Time Out Control	• Discrepancies were found in the perpetual inventory	3	0	3
Hazardous and Tool Control	• Gross contamination - not separating raw animal foods with different cooking temperatures	10	1	11
Food Control	• The main laundry area needs to be cleaned and organized, and lacks proper paper products and soap	3	0	3
Cleanliness and Organization	• Lack of cleanliness	31	6	37
Total		**128**	**52**	**180**

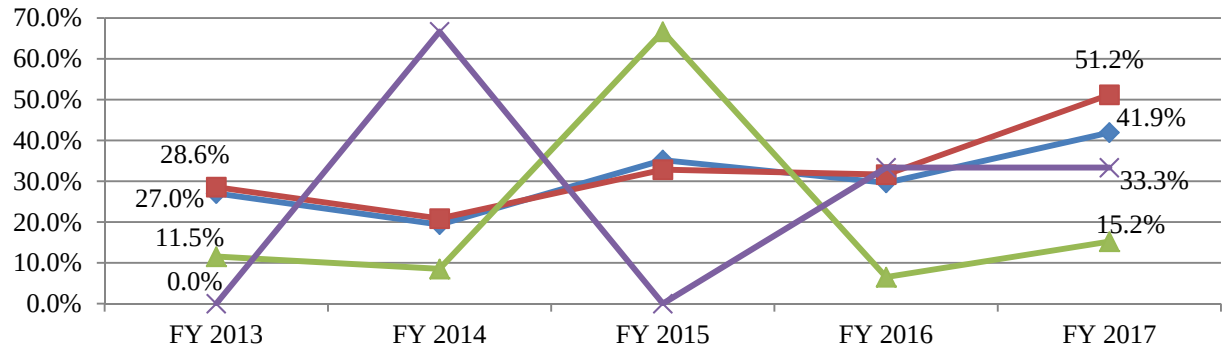
Source: Prepared by legislative auditor's staff using OJJ data, Business Objects data, and OJJ quality assurance audits.

Swanson Center for Youth – Monroe

Average Annual Census for FY 17: **129**

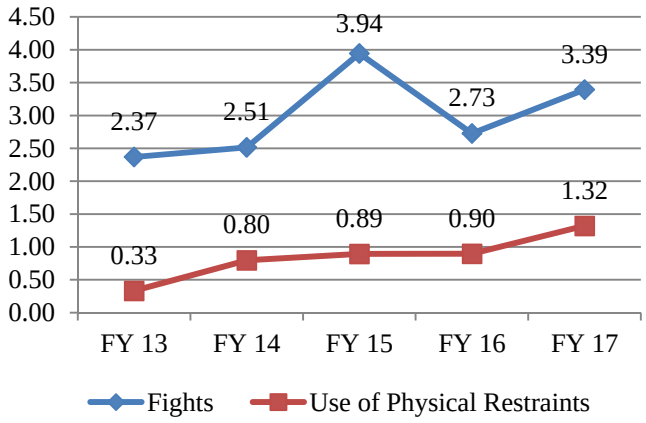
Average Cost per Bed per Day for FY 17: **$452.13**

Turnover Rates by Position
Fiscal Years 2013 - 2017

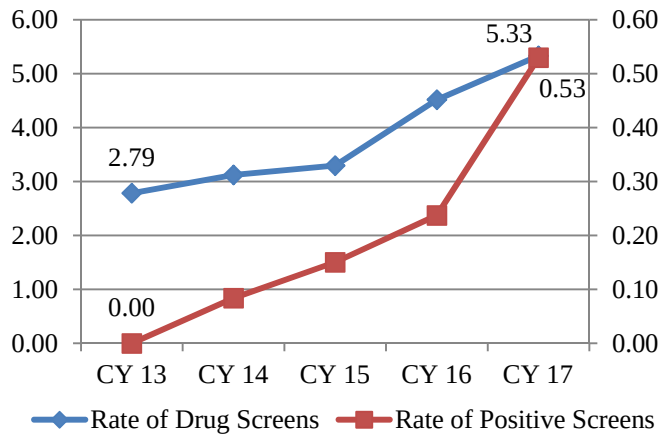


Note: Includes Swanson-Columbia.

Average Number of Fights and Use of Physical Restraints per Youth
Fiscal Years 2013 - 2017



Average Number of Drug Screens Per Youth
Calendar Years 2013 - 2017



Swanson - Monroe Room Confinement Use			
Month	**Average length of stay**	**Max length of stay**	**Total Instances Used**
December 2017	16.6 hours	20.8 hours	3
January 2018	32.8 hours	32.8 hours	1
February 2018	14.4 hours	40.9 hours	12

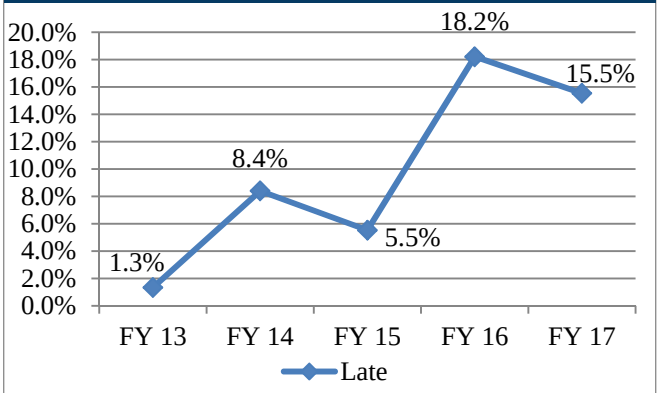
Source: Prepared by legislative auditor's staff using OJJ data, Business Objects data, and OJJ quality assurance audits.

Swanson Center for Youth – Monroe

Average Annual Census for FY 17: **129**

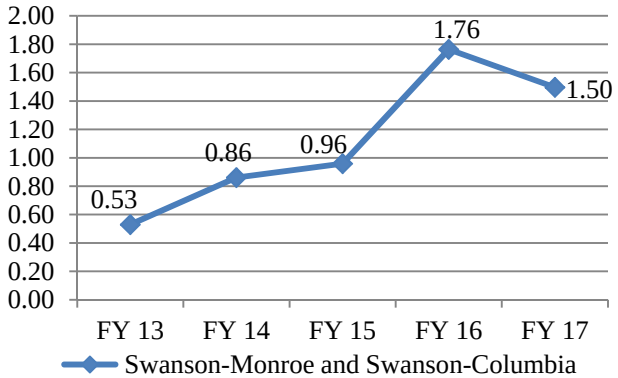
Average Cost per Bed per Day for FY 17: **$452.13**

Percent of Grievances Addressed Untimely Fiscal Years 2013 - 2017



Note: Includes Swanson-Columbia

Average Number of Grievance per Youth Fiscal Years 2013 -2017



Calendar Years 2016-2017 Swanson-Monroe Corrective Action Items				
Violation	**Example(s)**	**CY 2016**	**CY 2017**	**Total**
Emergency Preparedness	• Facility should purchase signs to designate the location of all fire extinguishers	29	21	50
Key Control	• Each key on ring should be stamped identical to identifying number	7	4	11
Lack of documentation	• The Safety Officer should review and complete Post Accident Investigation reports • The Weekly Building Inspection should be conducted, documented, and submitted	16	21	37
Lack of Supervision	• Should have two staff present during high traffic times • JJS staff should be present in the classroom to engage and supervise youth	17	7	24
Maintenance	• Work orders are being closed prior to the work being completed • Should issue a work order to repair plumbing	7	14	21
Physical Plant	• Should pressure wash building to remove green algae	7	7	14
Time Out Control	• Should store combustibles in a flammable cabinet with an inventory and SDS sheet	5	1	6
Hazardous and Tool Control	• Should seal raw food until ready for use	14	11	25
Food Control	• Constant reporting of cleaning issues on building inspections	0	1	1
Cleanliness and Organization	• Lack of cleanliness	20	16	36
Total		**122**	**103**	**225**

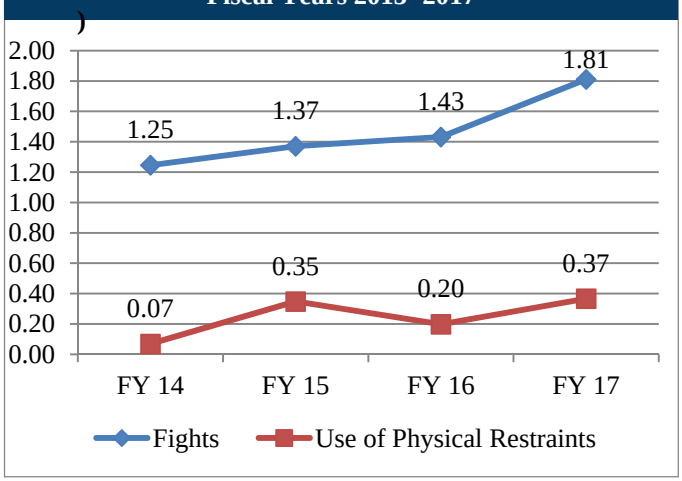
Source: Prepared by legislative auditor's staff using OJJ data, Business Objects data, and OJJ quality assurance audits.

Swanson Center for Youth – Columbia

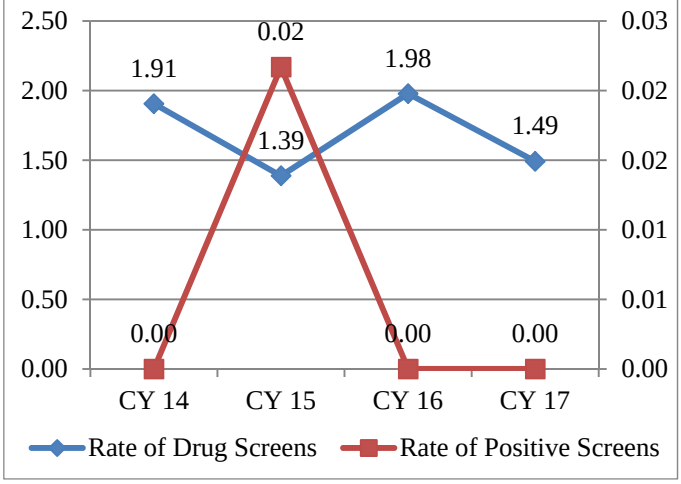
Average Annual Census for FY 17: **44**

Average Cost per Bed per Day for FY 17: **$316.78**

Average Number of Fights and Use of Physical Restraints per Youth Fiscal Years 2013 -2017



Average Number of Drug Screens Per Youth Calendar Years 2013 - 2017



Calendar Years 2016-2017 Swanson-Columbia Corrective Action Items				
Violation	**Example(s)**	**CY 2016**	**CY 2017**	**Total**
Emergency Preparedness	• The Horticulture tool storage area lacks a fire extinguisher, first aid kit, and blood spill kit	4	2	6
Key Control	• Incorrect Tag# on key	3	2	5
Lack of documentation	• Incomplete UORS for all perimeter checks	7	4	11
Lack of Supervision	• Water fountain and exhaust fan are broken	2	5	7
Maintenance	• Sidewalks and pavement area are cracked and uneven and should be painted bright yellow	2	1	3
Physical Plant	• Chemical inventory should be updated	3	2	5
Hazardous and Tool Control	• Rooms are cluttered and unorganized	1	2	3
Cleanliness and Organization	• Lack of cleanliness	2	0	2
Total		**24**	**18**	**42**

Note: Swanson-Columbia's information regarding turnover and grievances are included in Swanson-Monroe's charts on the previous pages. Swanson-Columbia does not have room confinement.

Source: Prepared by legislative auditor's staff using OJJ data, Business Objects data, and OJJ quality assurance audits.