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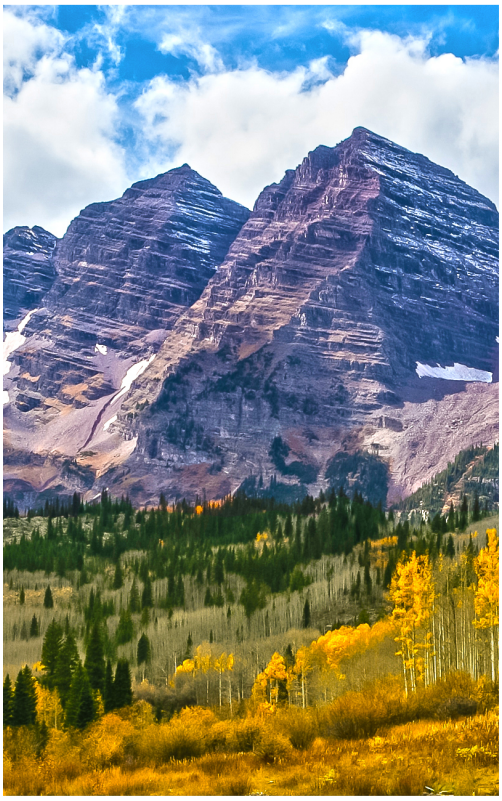
DEPARTMENT OF HUMAN SERVICES

DIVISION OF YOUTH CORRECTIONS



SEPTEMBER 2016 PERFORMANCE AUDIT

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DIANNE E. RAY, CPA
STATE AUDITOR

September 15, 2016

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Division of Youth Corrections within the Department of Human Services. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government, and Section 2-7-204(5), C.R.S., which requires the State Auditor to annually conduct performance audits of one or more specific programs or services in at least two departments for purposes of the SMART Government Act. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Human Services.

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REPORT HIGHLIGHTS

DIVISION OF YOUTH CORRECTIONS

PERFORMANCE AUDIT, SEPTEMBER 2016

DEPARTMENT OF HUMAN SERVICES

CONCERN

Our audit found that the Division of Youth Corrections (Division) could improve its management and documentation of procedures to help ensure youth and staff safety at all secure facilities. This includes the need to strengthen controls over seclusion, staff-directed timeouts, reporting of fights, assaults, and critical incidents, and oversight of the two contractor-operated secure facilities.

KEY FINDINGS

- The Division does not always use and document seclusion incidents in accordance with statute and Division policy. For example, for 13 of the 32 sampled seclusion incidents (41 percent), facility staff did not document that the emergency situations continued, and therefore, the Division could not demonstrate that the continued seclusions were necessary and appropriate.

- In practice, there are limited differences in how staff-directed timeouts and seclusion are experienced by youth and staff-directed timeouts are not a less restrictive alternative to seclusion, as they were intended to be. Both tools are used to address similar behaviors, both place the youth in isolation, and both have the same requirements for releasing youth.

- Facility staff do not consistently comply with Division requirements related to fights, assaults, and critical incidents. We found problems with 16 of the 20 fights or assaults (80 percent) and all 10 of the critical incidents we reviewed. For example, we found that reports lacked required information or contained inaccurate information and some notifications did not occur or were not timely.

- The Division does not provide the same level of oversight of the two contractor-operated secure facilities as it does with the 10 state-operated secure facilities. We found that the Division does not (1) require the contractor to provide sufficient performance data, (2) hold the contractor-operated facilities to the same standards as state-operated facilities, or (3) coordinate its monitoring of the contract facilities.

BACKGROUND

- The Division's mission is to protect, restore, and improve public safety for youth offenders aged 10 through 21.

- The Division oversees 10 state-operated secure facilities and two contractor-operated secure facilities. Secure facilities have locked doors and fencing to prevent escapes.

- In Fiscal Year 2016, the Division spent $133.7 million on state- and contractor-operated facilities.

- In Fiscal Year 2016, the Division admitted 1,369 committed youth and 6,813 detained youth to secure facilities.

KEY RECOMMENDATIONS

- Ensure that secure facilities use and document seclusion appropriately by training facility staff on documentation, notification, and meeting requirements and conducting supervisory review of incident reporting.
- Ensure that secure facilities appropriately use staff-directed timeouts by revising Division policy to clearly differentiate between staff-directed timeouts and seclusion.
- Strengthen controls related to documentation and supervisory review of fights, assaults, and critical incidents.
- Revise the contracts for secure facilities to include performance measures, at a minimum, that hold the contract facilities to the same standards as state facilities, and strengthen contract monitoring responsibilities.

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CHAPTER 1

OVERVIEW

Statute created the Division of Youth Corrections (Division), within the Department of Human Services (Department), to supervise and treat youth between the ages of 10 and 21 who are involved in the criminal justice system and have been sentenced to detention or committed to a secure facility or a less secure community-based facility, or who have been paroled [Section 19-2-203, C.R.S.]. Youth in detention are either awaiting adjudication or have completed their adjudication and are serving sentences of up to 45 days. Youth in commitment have been convicted of a crime in juvenile court and are serving longer sentences. The Division has physical custody of detained

youth and physical and legal custody of committed youth. Statute limits the number of detention beds statewide to 382; statute does not limit the number of commitment beds [Section 19-2-1201(3), C.R.S.].

EXHIBIT 1.1 shows the total number of youth admitted to a secure facility for detention or commitment, as well as the average commitment and detention daily populations, for Fiscal Years 2013 through 2016. According to Division data, the average length of service in a secure facility during Fiscal Year 2015 was 14.6 days for detained youth and 10.5 months for committed youth.

EXHIBIT 1.1
DIVISION OF YOUTH CORRECTIONS
COMMITMENT AND DETENTION POPULATION
FISCAL YEARS 2013 THROUGH 2016

POPULATION	2013	2014	2015	2016	PERCENT CHANGE
Detained Youth Admissions[1]	7,664	7,070	7,292	6,813	-11%
Committed Youth Admissions[1]	1,805	1,612	1,465	1,369	-24%
TOTAL YOUTH ADMISSIONS	9,469	8,682	8,757	8,182	-14%
Average Daily Population – Detention[2]	304	288	279	272	-11%
Average Daily Population - Commitment[2]	416	392	381	382	-8%

SOURCE: Office of the State Auditor's analysis of the Division of Youth Corrections' data.
[1] Figures are the number of times youth were admitted to detention and commitment during the fiscal year. Some youth were admitted to detention and/or commitment more than once and may have been admitted to both detention and commitment multiple times in the same year.
[2] The Average Daily Population is calculated as the average number of detained or committed youth in a secure facility during the reporting period.

The Division's mission is to protect, restore, and improve public safety through services and programs that supervise juvenile offenders; promote offender accountability to victims and communities; and build the competencies and skills youth need to become responsible citizens. According to the Division, one of its goals is to ensure all youth in its custody reside in a safe environment free from fear of harm. The Division has implemented various juvenile justice philosophies and behavior management models over the past decade, which has seen a shift in focus from punitive to rehabilitative and restorative philosophies. In 2014, the Division implemented Positive

Behavioral Interventions and Supports, a model centered around rewards for positive behavior.

SECURE FACILITIES

The Division owns and operates 10 secure facilities around the state to house detained and committed youth and owns two additional secure facilities, the Betty K. Marler Youth Services Center (Marler) in Lakewood and the Robert E. Denier Youth Services Center (Denier) in Durango. The Division contracts with one vendor to operate both the Marler and Denier facilities. All 12 secure facilities have locked doors and fencing to prevent youth from escaping the facilities' perimeters.

EXHIBIT 1.2 shows the number of detention and commitment beds at each of the 12 secure facilities, as well as the population they serve. Four secure facilities house only detained youth, three facilities house only committed youth, and the remaining five facilities house both committed and detained youth. The Division conducts an initial assessment of each youth detained and committed to the Division to determine the most appropriate placement among the secure facilities.

EXHIBIT 1.2
DIVISION OF YOUTH CORRECTIONS SECURE FACILITIES
FACILITY CAPACITY
FISCAL YEAR 2016

FACILITY	POPULATION	DETENTION BEDS	COMMITMENT BEDS	TOTAL BEDS
STATE-OPERATED				
Adams	Male & Female	30	0	30
Gilliam	Male & Female	64	0	64
Grand Mesa	Male & Female	27	40	67
Lookout Mountain	Male	0	130	130
Marvin W. Foote	Male & Female	61	0	61
Mount View	Male & Female	41	64	105
Platte Valley	Male & Female	64	39	103
Pueblo	Male & Female	28	0	28
Spring Creek	Male & Female	51	29	80
Zebulon Pike	Male	0	36	36
CONTRACTOR- OPERATED				
Betty K. Marler	Female	0	41	41
Robert E. Denier	Male & Female	9	19	28
TOTAL		375	398	773

SOURCE: Office of the State Auditor's analysis of Division of Youth Corrections' facility data.

FUNDING

The Division is primarily funded with state general funds and receives appropriations for Division administration, institutional programs, and community programs. The institutional programs appropriation covers the 10 state-operated secure facilities, including personnel, operating, educational, and medical costs for youth housed at these facilities. The cost to operate and provide services for youth in the two contractor-operated secure facilities, Marler and Denier, is included in the community programs appropriation. This appropriation also outlines funds for contract costs associated with housing and treating youth who are not sentenced to a secure facility, parole services, and Senate Bill 91-94 programs, which are alternatives to incarceration for pre-adjudicated and adjudicated youth aimed at reducing admissions to secure facilities.

In Fiscal Year 2016, the Division reported that it employed 987 full-time-equivalent (FTE) staff, of which 868 are assigned to work in the 10 state-operated facilities and 119 are Division administration and staff in regional offices who oversee community-based programs. In its Fiscal Year 2015 and 2016 budget requests, the Division stated that it needed more direct-care staff for secure facilities to address increases in the number of fights and assaults occurring at the facilities and to comply with the federal Prison Rape Elimination Act of 2003 (PREA).

PREA, which is administered by the federal Department of Justice, requires secure youth corrections facilities to maintain direct care staff-to-youth ratios of 1:8 during waking hours and 1:16 during sleeping hours by October 2017. The Division was authorized to and did hire an additional 53 FTE for Fiscal Year 2015, and an additional 22 FTE for Fiscal Year 2016. However, as of March 2016, the Division estimated that its staff-to-youth ratios averaged 1:10 during waking hours and 1:20 during sleeping hours and that it needed about 200 additional direct care staff to meet the PREA ratio requirements.

EXHIBIT 1.3 shows the Division's FTE and expenditures for Fiscal Years 2013 through 2016:

EXHIBIT 1.3
DIVISION OF YOUTH CORRECTIONS
EXPENDITURES (IN MILLIONS)AND FULL-TIME EQUIVALENTS
FISCAL YEARS 2013 THROUGH 2016

	2013	2014	2015	2016[4]	PERCENT CHANGE
Division Administration	$1.6	$1.6	$1.7	$1.8	12%
Institutional Programs[1]	$65.0	$65.2	$68.6	$74.4	14%
Community Programs[2]	$54.0	$53.4	$54.6	$53.8	(.30)%
Other[3]	$3.3	$3.6	$3.8	$3.7	13%
TOTAL	$123.9	$123.8	$128.7	$133.7	8%
Full-Time Equivalents	925	908	934	987	7%

SOURCE: Office of the State Auditor's analysis of data from the Colorado Financial Reporting System (COFRS), the Colorado Resource Engine (CORE), and the Division of Youth Corrections.
[1] Includes personal services for Division staff who work at facilities, facility operating costs, and educational and medical services.
[2] Includes personal services for Division staff who oversee community programs, payments to contractors for community programs, Marler and Denier facility payments, and Senate Bill 91-94 programs.
[3] Includes worker's compensation and Office of Information Technology costs.
[4] For Fiscal Year 2016, the Division reports that the expenditure amounts are estimated until year-end close is completed.

AUDIT PURPOSE, SCOPE, AND METHODOLOGY

We conducted this audit pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government, and Section 2-7-204(5), C.R.S., the State Measurement for Accountable, Responsive, and Transparent Government (SMART) Act. The audit was prompted by a legislative request for a performance audit of the Division. Audit work was performed from October 2015 through August 2016. We appreciate the assistance provided by the management and staff of the Department of Human Services and Division of Youth Corrections during this audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the

evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The primary purpose of the audit was to assess the Division's controls for ensuring that all fights and assaults that occur in state- and contractor-operated facilities and seclusion incidents are handled in accordance with Division policy and are timely and accurately documented and reported. We also reviewed the Division's processes for evaluating its staffing needs in state-operated facilities, managing financial transfers between institutional and community program line items, use of vacancy savings, and pots appropriations, which include employee costs such as health and dental insurance and retirement contributions to the Colorado Public Employee Retirement Association (PERA).

The key objectives of the audit were to assess:

- The sufficiency of the Division's controls to ensure that all fights and assaults that occur in state- and contractor-operated facilities, and all seclusion incidents are handled by staff in accordance with Division policy and are timely and accurately documented and reported.

- The effectiveness of the Division's processes for evaluating its staffing needs in state-operated facilities.

- The sufficiency of the Division's controls to ensure that its financial management activities related to transfers between institutional and community program line items, its use of vacancy savings, and its use of the pots appropriations comply with state requirements and are appropriately documented.

To address the audit objectives, we performed the following audit work:

- Reviewed applicable state statutes, Division written policies and procedures, the Department's contracts to operate the Marler and

Denier facilities, and progress reports submitted by the vendor that operates these facilities.

- Analyzed seclusion, fight, assault, critical incident, and average daily population data for Fiscal Years 2013 through 2016.

- Analyzed Division expenditure data for Fiscal Years 2013 through 2016.

- Reviewed compliance audits of the 10 state-operated and two contractor-operated secure facilities conducted by the Department's Quality Assurance staff for Fiscal Years 2014 through 2016.

- Conducted site visits at one contractor-operated and two state-operated secure facilities.

- Interviewed Division and Department management and staff and management and staff of the two contractor-operated facilities.

- Conducted an online survey of 620 facility staff who directly care for youth in the 10 state-operated and two contactor-operated secure facilities.

- Analyzed the Division's calculations for determining the number and allocation of staff, hiring processes, and vacancy and turnover information at the 10 state-operated secure facilities for Fiscal Years 2015 and 2016.

- Analyzed the Division's financial management activities related to its authority under the Long Bill to transfer funds between its institutional programs and community programs line items and the Division's allocation of centrally appropriated indirect costs or pots, which includes the State's contributions for employee health and dental insurance and PERA.

We relied on sampling to support our audit work and selected the following samples:

- A random sample of 32 seclusion incidents out of 180 that were recorded in the Trails database from the 10 state-operated and two contractor-operated secure facilities between October 1, 2015, and December 31, 2015.

- A random sample of 20 fights or assaults out of 169 that were recorded in Trails between August 1, 2015, and December 31, 2015.

- A random sample of 10 critical incidents out of 81 that were recorded in Trails between August 1, 2015, and December 31, 2015.

When samples were chosen, the results of our testing were not intended to be projected to the entire population. The samples were selected to provide sufficient coverage to test controls of those areas that were significant to the objectives of this audit.

We planned our audit work to assess the effectiveness of those internal controls that were significant to our audit objectives. Our conclusions on the effectiveness of those controls, as well as specific details about the audit work supporting our findings, conclusions, and recommendations, are described in CHAPTER 2.

CHAPTER 2

SAFETY IN SECURE FACILITIES

The Department of Human Services (Department) is designated by statute as the single state agency responsible for supervising and treating detained and committed youth [Section 19-2-202, C.R.S.]. As such, the Department has authorized the Division of Youth Corrections (Division) to establish and operate the facilities necessary for the care, education, training, treatment, and rehabilitation of those juveniles legally committed to its custody. As part of this responsibility, the Division must ensure that secure facilities provide a safe environment for the youth placed in its custody.

During the audit we assessed the Division's controls to appropriately manage the fights, assaults, and critical incidents that occur in secure facilities. Specifically, we reviewed the Division's administration in three key areas: (1) managing and documenting seclusion and staff-directed timeout incidents, fights, assaults, and critical incidents; (2) oversight of the contractor-operated secure facilities with respect to safety; and (3) processes for evaluating staffing needs and developing staffing plans and allocations, specifically as it relates to safety and complying with the Prison Rape Elimination Act of 2003 (PREA). In addition, our audit work included reviewing the Division's transfer of funds between its institutional programs and community programs pursuant to its authority in the Long Bill.

Overall, we found that the Division could improve its management and documentation of seclusion, staff-directed timeouts, and the reporting of fights, assaults, and critical incidents, as well as its oversight of the two contractor-operated secure facilities with respect to how they manage fights, assaults, and critical incidents. Our audit work did not identify any findings or recommendations related to the Division's staffing methodology and allocation or its transfer of funds between programs.

Finally, we conducted an online survey of Division staff who directly care for youth in the 10 state-operated and two contractor-operated secure facilities. The survey asked questions about safety, training, and compliance with Division policies and procedures related to seclusion, fights, assaults, and critical incidents. We sent surveys to 620 staff at the state-operated and contractor-operated facilities and received 259 responses, or 42 percent of the staff surveyed. The survey results did not identify any new concerns, but did support some of our findings.

SECLUSION

The Division is responsible for ensuring that youth reside in a safe environment and that youth rights are protected. Seclusion is a method that facility staff use to keep the environment safe when youth

behavior threatens safety. The Division defines seclusion as placing a youth alone in a locked room during an emergency situation and the youth is not permitted to leave the room until the emergency ends and the youth commits to safe behaviors. According to statute, an emergency is defined as "a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm" [Section 26-20-102(3), C.R.S.]. Staff can use seclusion when youth display behaviors that place themselves, other youth, or staff at risk of injury or harm. For example, staff will often place a youth who was the perpetrator of an assault in seclusion until the youth has become calm and agrees to behave safely. Division policy prohibits staff from using seclusion as punishment.

The Division has developed policies and procedures that govern the use of seclusion in state- and contractor-operated secure facilities. In October 2015, the Division updated its seclusion policy for state-operated secure facilities to allow seclusions for only as long as the emergency continues and to add additional notification requirements based on the duration of the seclusion. The policy generally limits seclusion to no more than 4 hours, but seclusion can be longer than 4 hours if the emergency continues. When youth are placed in seclusion, facility staff must document the reasons for the seclusion, check on the youth at least every 15 minutes, and document whether the emergency is continuing. Once facility staff believe the emergency is over and the youth commits to behaving safely, the youth should be removed from seclusion. Each seclusion incident is required to be entered into Trails, the Division's electronic case management database.

EXHIBIT 2.1 shows the total number of seclusion incidents in the 12 secure Division facilities during Calendar Years 2014 and 2015, and the average length of time these incidents lasted. As the exhibit shows, the total number of seclusion incidents increased 9 percent from Calendar Year 2014 to 2015, while the duration of the average seclusion incident decreased by nearly half.

EXHIBIT 2.1
DIVISION OF YOUTH CORRECTIONS
NUMBER AND AVERAGE DURATION OF SECLUSION INCIDENTS
CALENDAR YEARS 2014 AND 2015

FACILITY	NUMBER OF SECLUSION INCIDENTS		PERCENT CHANGE	AVERAGE SECLUSION LENGTH IN HOURS		PERCENT CHANGE
	2014	2015[1]		2014	2015[1]	
Platte Valley	23	82	257%	5.4	3.3	-39%
Gilliam	15	48	220%	3.1	3.5	13%
Lookout Mountain	138	290	110%	3.9	1.9	-51%
Pueblo	78	92	18%	5.0	3.9	-22%
Spring Creek	274	307	12%	5.2	3.9	-25%
Marvin W. Foote	156	171	10%	3.9	5.0	28%
Mount View	236	221	-6%	13.8	4.2	-70%
Zebulon Pike	60	50	-17%	10.4	6.3	-39%
Betty K. Marler	136	90	-34%	2.9	1.6	-45%
Robert E. Denier	7	4	-43%	13.1	4.3	-67%
Adams	100	55	-45%	9.5	1.9	-80%
Grand Mesa	118	49	-58%	8.1	5.9	-27%
TOTAL	1,341	1,459	9%	7.0	3.8	-46%

SOURCE: Office of the State Auditor's analysis of data provided by the Division of Youth Corrections.
[1] The Division of Youth Corrections issued a new seclusion policy that went into effect October 1, 2015 limiting seclusion incidents to 4 hours or less, unless the emergency continues.

WHAT WAS THE PURPOSE OF OUR AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of our audit work was to determine whether secure facilities use and document seclusion in accordance with statute and Division policy. We reviewed statutes and Division policy to determine when staff should use seclusion and how seclusion incidents should be documented. We selected a random sample of 32 seclusion incidents that were recorded in the Trails database from the 10 state-operated and two contractor-operated secure facilities between October 1, 2015, and December 31, 2015. We selected our sample from this time period because October 1, 2015, is when the Division's new seclusion policy went into effect. For each sampled seclusion incident, we

reviewed electronic Trails data and hard copy documentation that the Division had on file, including incident reports and room check sheets. We also interviewed Division and facility management and staff to understand when and how seclusion should be used and documented. Finally, we surveyed all secure facility direct care staff on issues related to facility safety and seclusion. We received responses from 259 facility staff, or about 42 percent of those surveyed.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

Overall, we found that secure facilities are not always using seclusion and documenting seclusion incidents appropriately and accurately, in accordance with statute and Division policy.

REASONS FOR CONTINUED SECLUSION WERE NOT DEMONSTRATED. We found that for 13 of the 32 sampled seclusion incidents (41 percent), facility staff did not document that the emergency situations continued for the entire duration of the seclusion. Statute [Section 26-20-103, C.R.S.] and Division policy 14.3B state that seclusion shall only be used in an emergency, or to prevent the continuation of an emergency, and must end once the emergency has ceased. Division policy 14.3B also requires staff to document the reasons why they believe that an emergency is continuing. As a result of the lack of documentation, we could not determine if the continued seclusion was necessary and appropriate. Specifically, we found:

- One sampled seclusion incident where the Division could not provide the room check sheet, and therefore, we could not determine if the continued seclusion of the youth was necessary and appropriate. Specifically, we were unable to confirm any details related to the seclusion, including the length of time the youth was secluded, how frequently staff checked on the youth, the behaviors the youth exhibited to warrant the continued seclusion,

whether the appropriate notifications were made, or the reasons the seclusion was ended. Division policy 14.3B requires that all seclusion incidents be documented on the room check sheet, including "a description of the emergency, outlining the facts demonstrating that the juvenile is a serious, probable, and imminent danger of bodily harm to self or others…" According to the Division, the facility could not find the room check sheet for the seclusion incident, which was 3 hours and 50 minutes in length according to the Trails data entry for this incident. The incident report indicated that the youth was placed in seclusion as a result of a fight.

- Twelve room check sheets (38 percent) did not show that the emergency continued for the duration of the seclusion. The youth in 10 seclusion incidents were held in seclusion from 24 minutes to 2 hours and 24 minutes past the time when the room check sheet no longer indicated that the emergency continued and warranted further seclusion. For example, in one seclusion incident, staff noted that the youth was "quiet" for 24 minutes, was let out to use the bathroom, then was returned to the seclusion room for an additional 2 hours, during which time staff noted that the youth talked with staff and slept for 40 minutes. In another seclusion incident, staff noted on the room check sheet that the youth was "sitting on bed" for 30 minutes, "standing by the door" for an additional 10 minutes, then staff did not check on the youth for an additional 25 minutes, in violation of Division policy requiring staff to check on youth every 15 minutes. According to the room check sheet, the youth then spoke with staff, who placed the youth on "sleeper status" since it was the time all of the youth normally go to bed for the night. We could not determine whether the youth's seclusion ended at the time that he was placed on sleeper status or if the youth was removed from the seclusion room and taken to his regular sleeping room. Finally, in two seclusion incidents, the room check sheets indicated that the youth were not released until 25 minutes after they had indicated they were ready to process out of seclusion.

SOME NOTIFICATIONS AND MEETINGS DID NOT OCCUR. We found that for 19 of the 32 sampled seclusion incidents (59 percent), facility staff did not make all of the notifications and conduct all of the meetings required by Division policy. Ten seclusion incidents had more than one problem. Specifically:

- For 12 seclusion incidents (38 percent), the shift supervisor did not meet with the staff involved in the incident within the first 15 minutes of the seclusion, as required by Division policy 14.3B. We could not determine when or if the supervisor met with staff.

- For 10 seclusion incidents (31 percent), the shift supervisor did not meet with the youth within the first 15 minutes, as required by Division policy 14.3B. For one of these seclusion incidents, the supervisor met with the youth about 1 hour after the seclusion began. For the remaining nine incidents, we could not determine when or if the supervisor met with the youth.

- For six seclusion incidents (19 percent), facility staff did not notify the facility director within the first 15 minutes of the seclusion, as required by Division policy 14.3B. For four incidents, the notifications occurred 23 minutes to 4 hours and 40 minutes from the start of the seclusion; in two of these incidents, the notifications occurred after the seclusion ended. For the two remaining incidents, we could not determine when or if the facility director was notified.

- For five of the 22 seclusion incidents in which behavioral health staff should have been notified (23 percent), facility staff did not notify them. According to Division policy 14.3B, if the seclusion of a committed youth lasts more than 15 minutes, the shift supervisor or lead worker shall notify available behavioral health staff, and work with them to develop an individualized action plan for the youth to end the seclusion. For one incident, the behavioral health staff was notified 2 hours and 28 minutes after the seclusion began, and for the remaining four incidents, we could not determine if behavioral health staff were notified at all.

- For two seclusion incidents (6 percent), facility staff did not immediately notify the shift supervisor of the youths' seclusion, as required by Division policy 14.3B. We could not determine when or if a supervisor was notified.

- For one of the nine seclusion incidents that lasted 2 or more hours (11 percent), facility staff did not notify the youth's legal guardian within 12 hours of the 2-hour mark, as required by Division policy 14.3B. The Division could not determine whether the guardian was contacted at all.

Less restrictive alternatives not documented. We found that for 18 of the 32 sampled seclusion incidents (56 percent), the room check sheets did not document that facility staff attempted less restrictive alternatives prior to the youth being placed in seclusion, or that staff concluded that less restrictive alternatives would not be appropriate. Statute provides that agencies that use seclusion as a form of restraint, shall do so "(I) after the failure of less restrictive alternatives; or (II) after a determination that such alternatives would be inappropriate or ineffective under the circumstances" [Section 26-20-103(2), C.R.S.]. In addition, Division policy 14.3B requires the shift supervisor to document the less restrictive alternatives attempted or why, under the circumstances, such alternatives would be inappropriate or ineffective.

Facility director reviews did not occur or were not timely. We found that for three of the 32 sampled seclusion incidents (9 percent), the facility director either did not review the incident reports at all, or did not review them in a timely manner. According to Division policy 5.1, the facility director or designee is responsible for ensuring that required data is entered, verified, and corrected, if needed, in an accurate and timely manner. The policy does not define "timely." In one seclusion incident, the facility director did not review the incident report at all, and in two incidents, the facility directors did not review the incident reports that documented how the fights in those two incidents led to seclusion until 31 and 78 days after the incidents. The Division agreed that for these two incidents, the facility

directors should have reviewed the incident reports sooner than 31 and 78 days; however, the Division did not specify a timeframe for when the reviews should have occurred.

TRAILS DATA NOT ENTERED ACCURATELY. We found that for four of the 32 sampled seclusion incidents (13 percent), some data entered into Trails were not accurate. Specifically, for two sampled seclusion incidents, the Trails data indicating the time that the seclusion began conflicted with the time written on the room check sheets. For example, in one seclusion incident, the Trails data indicated that the seclusion started 28 minutes later than the start time on the room check sheet and in another incident, the start time in the Trails data was 10 minutes later than the start time on the room check sheet. According to the Division, the room check sheets are the actual records of the seclusion and therefore accurately reflect the seclusion incident and the Trails data for the start times for these two incidents was entered in error. In addition, two of the incidents we sampled were erroneously entered into Trails as seclusion incidents but documentation provided by the Division showed that the youth were not secluded during the time noted in the Trails data. The Division could not explain the errors in Trails. Division policy 5.1 states that all data must be entered into Trails accurately and within 24 hours after the event. The policy also requires that each facility implement quality control procedures for data review on a regular basis and that each facility director verify that all data is entered accurately within 24 hours of when the event occurred. Additionally, Division policy 14.3B requires staff to enter an incident report into Trails and states that the shift supervisor is responsible for the oversight and monitoring of seclusion incidents and must ensure that documentation is complete and accurate.

WHY DID THESE PROBLEMS OCCUR?

Department management reported that it believes that a lack of adequate staff at facilities contributed to the problems we found. During our review of the Division's staffing resources, we did not identify any weaknesses with the Division's processes for evaluating its

staffing needs, and the Division continues to seek additional funding for staff through the annual budget process. In addition to a lack of adequate staff, we identified the following factors that contributed to the problems we found:

INSUFFICIENT TRAINING. According to the Division, it has not provided sufficient training to ensure that facility staff place youth in seclusion only in an emergency situation and appropriately document, review, and notify facility management of seclusion incidents. The Division reports that all facility staff were trained when the current seclusion policy went into effect in October 2015. We recognize that our sample included incidents that occurred within the first 3 months of the Division's implementation of the new policy and that staff may have been adjusting to the changes. However, the problems we found indicate that the initial training may not have been sufficient. In addition, our survey of facility staff showed that about 8 percent of survey respondents reported that the training they have received related to the updated seclusion policy was not sufficient. Additional training is needed to ensure that staff understand the policy's requirements and how to apply those requirements in practice.

INADEQUATE SUPERVISORY REVIEW OF SECLUSION DOCUMENTATION. Currently, Division policy does not describe the purpose of supervisory review of seclusion documentation or what it is supposed to include, nor does it require that supervisors sign off on room check sheets once they have been reviewed. As a result, supervisory review of the room check sheets in our sample was inconsistent. All but two of the room check sheets in our sample had been signed by a supervisor as reviewed. However, it is not clear what those reviews covered and it does not appear that they were effective given the problems we identified with proper use and documentation of seclusion. For the two room check sheets in our sample that had not been signed by a supervisor, we could not determine if they had been reviewed. Finally, two of the room check sheets were signed by the supervisor who had also secluded the youth and completed the form. A thorough and independent supervisory review can be an effective control to ensure that policies are applied correctly and to identify areas in which staff

may need additional training or guidance. In addition, statute requires agencies to establish a review process for the appropriate use of seclusion [Section 26-20-107, C.R.S.]. At one of the secure facilities in our sample, the room check sheets for the seclusion incidents included notations by the supervisor that staff did not document reasons for continued seclusion and discrepancies between the seclusion start time recorded in Trails and on the room check sheet. This supervisory review approach should be considered a best practice and could be established as part of the Division's standard practices to help ensure its use in all of the Division's secure facilities.

WHY DO THESE PROBLEMS MATTER?

When facility staff do not accurately and completely document the circumstances surrounding a seclusion incident, the Division cannot ensure that secure facilities are complying with statute and Division policy and are only using seclusion during emergency situations, and only for as long as the emergency exists. The use of seclusion has been shown to have a negative effect on youth and should only be used in emergencies, and for a limited amount of time, as required by statute. As a result, many states, including Colorado, have implemented limits on the amount of time youth spend in seclusion, and the federal government has prohibited the use of seclusion altogether for youth in federal facilities. The Division implemented significant changes to its seclusion policy in October 2015 to protect youth's rights and to prevent seclusion from being used as a punitive measure. According to the Division, it added notification requirements to its seclusion policy to ensure that facility management is aware of each seclusion and can be involved in helping to end the seclusion as soon as possible, which is the intent of statute and Division policy.

In addition, the General Assembly passed House Bill 16-1328 during the 2016 Legislative Session, which codified much of the Division's seclusion policy in statute and requires the Division to report twice per year aggregate information on the total number of youth held in seclusion, the number of seclusion incidents, the average length of time in seclusion per incident, and a summary of the race, age, and gender

of the youth held in seclusion. It is important that facility staff comply with all of the requirements surrounding the use of seclusion, as well as documentation and notification requirements, to protect the rights of youth in the secure facilities, create a safer environment for staff and youth, and fulfill statutory reporting requirements for seclusion.

RECOMMENDATION 1

The Department of Human Services should ensure that Division of Youth Corrections (Division) secure facilities use and document seclusion in accordance with statute and Division policy by:

A Training facility staff on how to properly document seclusion incidents and the notification and meeting requirements associated with seclusion.

B Implementing a supervisory review process for seclusion incidents that describes the purpose of the review, when it should occur, what it should include, how it should be documented, and how to address deficiencies in staff's compliance with seclusion requirements.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: OCTOBER 2016.

The Department agrees to train staff on how to properly document seclusion incidents. DYC Policy 14.3B has been revised and a new seclusion form has been created which incorporates all requirements of policy in the order that staff is to complete them. Trainings will be provided to all staff involved in the administration and use of seclusion on how to properly document seclusion incidents and the notification and meeting requirements associated with seclusion.

B AGREE. IMPLEMENTATION DATE: OCTOBER 2016.

The Department agrees to amend the supervisory review requirement for seclusion and train supervisory and direct care

staff on this review so that all staff involved in the administration and use of seclusion understand the required elements of the seclusion documentation. The new seclusion form will help supervisors identify deficiencies and to inform feedback to staff on those deficiencies. Additionally, DYC Policy 14.3B has been revised to specify the purpose, elements, and timing requirements of the supervisory review process.

STAFF-DIRECTED TIMEOUTS

The Division uses a variety of behavioral management tools to ensure safety at youth facilities. One tool that the Division uses is staff-directed timeouts, which is a tool for staff to direct a youth to spend time away from others when staff believe the youth's behavior could become a risk to safety. As discussed in RECOMMENDATION 1, seclusion is another tool the Division can use in emergency situations to deal with youth who display behaviors that create a serious, probable, and imminent threat of bodily harm to themselves or others. According to the Division, a staff-directed timeout is intended to be a less restrictive alternative to seclusion.

WHAT AUDIT WORK WAS PERFORMED, WHAT WAS THE PURPOSE, AND HOW WERE THE RESULTS MEASURED?

We reviewed statutes and Division policy related to staff-directed timeouts and evaluated the Division's use of staff-directed timeouts for the 10 incidents in our random sample of 32 seclusion incidents in which staff-directed timeouts were used prior to seclusion. The two main purposes of our audit work were to evaluate:

- Whether staff consistently used staff-directed timeouts in accordance with the Division's timeout policy.

- Whether, in practice, staff-directed timeouts are a less restrictive alternative to seclusion, which is their purpose, according to the Division.

EXHIBIT 2.2 shows the policies for staff-directed timeouts and seclusion. Seclusion is included to show where the policies are similar and different.

EXHIBIT 2.2
DIVISION OF YOUTH CORRECTIONS
COMPARISON OF SECLUSION AND TIMEOUT POLICIES

	SECLUSION	STAFF-DIRECTED TIMEOUT
WHAT TRIGGERS ISOLATION	Emergency – serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm.	Staff observe behaviors or attitudes that lead them to believe the youth is escalating and posing a risk to safety and security.
MANNER OF ISOLATION	Youth is placed alone behind a locked door.	Youth is placed away from others, in the open unless doing so will compromise safety or not meet the needs of the youth, in which case the youth may be placed alone behind a locked door.
PROCESS USED TO END THE ISOLATION	Staff determine when seclusion should end, which must occur when the triggering emergency no longer exists, but only when the youth commits to safe behavior.	Staff ask the youth if he or she is ready to be released from timeout. If the youth requests to be let out, staff must process with the youth to determine if they are ready to commit to safe behavior.
LENGTH OF ISOLATION	Generally not to exceed 4 hours, unless the emergency continues.	Not to exceed 1 hour. If the youth does not commit to behaving safely at the 1-hour mark, the youth may be placed in seclusion.
MONITORING OF ISOLATION	Must check every 15 minutes.	If timeout is behind a locked door, must check at least every 15 minutes and ask the youth if he or she is ready to be let out of the timeout.
NOTIFICATIONS OF ISOLATION	Specified facility and Division management and the youth's parents or guardians must be notified within specified deadlines.	Supervisors must be notified within a specified deadline.

SOURCE: Office of the State Auditor's analysis of data provided by the Division of Youth Corrections.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY AND WHY DID IT OCCUR?

For our sample, we found that staff used staff-directed timeouts in accordance with the following applicable policies:

- The timeouts lasted no longer than 1 hour.

- Staff talked with youth when the youth requested release from timeout to determine if they were ready to commit to safety and therefore could be released.

- Staff checked with the youth at least every 15 minutes for the duration of the timeouts.

However, we found that, in practice, there are limited differences in how staff-directed timeouts and seclusion are experienced by youth and that staff-directed timeouts do not appear to be a less restrictive alternative to seclusion. For example:

STAFF TEND TO USE TIMEOUTS AND SECLUSION TO ADDRESS SIMILAR BEHAVIORS. All of the staff-directed timeouts in our sample were initiated for essentially the same reasons as the seclusions in our sample—because of a youth-on-youth or youth-on-staff assault, or in instances where the youth threatened or refused to obey staff. Division policies do not make a clear distinction between the types of behaviors that warrant a staff-directed timeout versus seclusion. Both policies reference the concepts of behavior that is, or is likely to be, a threat to the safety of the youth or others, without further definition. The policies also do not provide examples of the types of behaviors that should trigger the use of each tool. According to our interviews with eight Division and Department managers and staff, the lack of clarity in the Division's policy has led to confusion about which behavioral management tool is appropriate for a particular situation. This confusion was reflected in our sample, where for two of the staff-directed timeout incidents (20 percent of the sample), the Division stated that facility staff should have placed the youth in seclusion rather than a timeout because of the nature of the events that led to the timeout.

STAFF USE THE SAME RESTRICTIVE METHOD TO ISOLATE YOUTH IN TIMEOUTS AND IN SECLUSION. All of the staff-directed timeouts in our sample took place behind a locked door, which makes them just as restrictive as seclusion. The Division's staff-directed timeout policy states that timeouts "*shall* [*emphasis added*] take place in an open

area" which is, by definition, less restrictive, "unless doing so will compromise safety or not meet the needs of the youth." The policy currently allows significant discretion on the part of facility staff to decide whether to place youth in timeout in an open area or behind a locked door. Division staff report that most timeouts occur behind locked doors to ensure that the youth remains isolated until ready for release and that the physical layout of most facilities provides limited options for a timeout in the open. If youth are placed in timeout in an open area of the facility, staff would need to monitor them continually to ensure contact with others is prevented. The Division reports that facilities lack staffing resources to monitor youth in this way.

REQUIREMENTS FOR RELEASING YOUTH FROM STAFF-DIRECTED TIMEOUTS ARE AS RESTRICTIVE AS FOR SECLUSION. For all of the timeouts in our sample, the youth were not released until staff believed the youth were ready and the youth agreed to commit to safe behaviors, regardless of the youth's request to end the timeout. Division policy states that one of the key distinctions between a staff-directed timeout and seclusion is that a juvenile who is not afforded the ability to request release from a locked location is in seclusion, not in timeout. However, if the request is not honored until staff determine that the youth is ready to commit to safe behavior, the ability to request has no effect and release is based upon the same conditions as release from seclusion.

In addition, we found that the Division does not track staff-directed timeouts that occur behind a locked door and therefore, does not have a way to monitor facilities' use of this tool because staff do not enter information related to the timeout in Trails or any other electronic system. Instead, staff must complete a hard copy room check sheet to document when the timeout started and ended, the reason for the timeout, that the required monitoring checks occurred, and the supervisor's notification. With only a hard copy record of the timeout, Division management has no efficient way to monitor how often staff-directed timeouts behind a locked door are used, for what purpose, and their duration to determine if staff are using them appropriately.

WHY DO THESE PROBLEMS MATTER?

Because of the significant similarities we found between staff-directed timeouts and seclusion, the value of having both of these tools is unclear and, at a minimum, the goal of providing opportunities for less restrictive behavior management is not met. Further, staff-directed timeouts have fewer controls associated with their use than seclusion–requirements for notifications and documentation are much more limited. First, when youth are placed in timeout behind a locked door, staff are not required to notify facility management, as they are for all seclusions, and management does not have a means of comprehensively assessing how timeouts are being used. As a result, management is not in a position to ensure timeouts are handled appropriately and end as soon as possible. Additionally, facility staff do not have to document that there is an emergency to justify a staff-directed timeout, only that they believe the youth poses a safety risk, which may be easier to justify. Finally, when a staff-directed timeout occurs behind a locked door, from the perspective of the youth, the treatment is the same as seclusion. Therefore, having policies and practices that do not clearly distinguish between the two tools, and that tend to promote the use of locked-door timeouts, appears contrary to the movement to less restriction.

RECOMMENDATION 2

The Department of Human Services should ensure that Division of Youth Corrections (Division) secure facilities appropriately use staff-directed timeouts as a behavioral management tool and that timeouts are not used either when seclusion is the appropriate tool or as a means to effectively extend seclusion by revising Division policy to clearly differentiate between staff-directed timeouts and seclusion, including when, where, and how they should be used, and implementing an electronic means of tracking timeouts that occur behind a locked door.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

AGREE. IMPLEMENTATION DATE: OCTOBER 2016.

The Department agrees that while it complied with policy on Staff Directed Time Outs, there is not a clear difference between Staff Directed Time Outs and Seclusions. DYC Policy 14.3 has been revised to clearly differentiate Staff Directed Time Out as a milieu management tool in which youth will not be behind a locked door. As the Department is removing Staff Directed Time Outs from behind a locked door, the recommendation to electronically track these time outs is no longer applicable.

REPORTING OF FIGHTS, ASSAULTS, AND CRITICAL INCIDENTS

Division policies require staff to document certain events involving actual or threatened violence that occur in secure facilities. Specifically, Division policy requires that the following types of events be documented in Trails:

- **FIGHTS**, which are defined as any aggressive physical contact between youth with the intent or result of harm and in which the youth are mutually participating.

- **ASSAULTS**, which are defined as any intentional act of aggression initiated by a youth with the intent to harm in which the other party or parties do not participate or retaliate; assaults can be youth-on-youth or youth-on-staff.

- **CRITICAL INCIDENTS**, which are defined as serious life, safety, or security incidents or a potential safety or security concern to the youth, facility, or community. A fight or assault can be classified as a critical incident if, as a result of the fight or assault, either the youth or staff receive external medical care or if law enforcement is called.

EXHIBIT 2.3 shows the total number of fights, assaults, and critical incidents that occurred in the 12 state- and contractor-operated secure facilities from Fiscal Years 2013 through 2016. As the exhibit shows, the total number of fights and assaults increased 42 percent and the total number of critical incidents increased 108 percent.

EXHIBIT 2.3
DIVISION OF YOUTH CORRECTIONS
NUMBER OF FIGHTS, ASSAULTS, AND CRITICAL INCIDENTS
FISCAL YEARS 2013 THROUGH 2016

TYPE OF INCIDENT	2013	2014	2015[1]	2016	PERCENT CHANGE
Fights	392	428	548	493	26%
Assaults					
Youth-on-Youth	297	411	480	464	56%
Youth-on-Staff	120	129	198	189	58%
Total Fights and Assaults	809	968	1,226	1,146	42%
Critical Incidents[2]	283	330	372	588	108%

SOURCE: Office of the State Auditor's analysis of data provided by the Division of Youth Corrections.
[1] A Division policy change in 2015 expanded the definition of critical incidents.
[2] According to the Division, critical incidents can include fights and assaults if they meet the criteria for classification as a critical incident, which may result in an incident being double counted.

When a fight or assault occurs, facility staff are required to complete a report in Trails. The fight or assault report should describe the details of the incident, including the youth and staff involved; witnesses; whether staff used physical management to restrain the youth; whether staff used mechanical restraints, such as handcuffs or shackles; the date and time that the incident occurred and when the report was created; and the date of supervisory review. According to the Division, these fight or assault reports are used to ensure that incidents are addressed and documented appropriately, including that injuries were documented, staff and youth received necessary medical care, and staff used Division-approved physical management techniques. Physical management is a system of physical and mechanical restraints that facility staff use to subdue or control youth. For example, when a fight or assault occurs, staff use specific physical techniques to restrain the youth so that he or she can be placed in handcuffs, a type of mechanical restraint.

The reports also help the Division track the number of fight and assault incidents, and this information is reported to Division management, senior Department management, and the General Assembly. According to the Division, the incident report is typically

completed by staff who directly care for the youth and were involved in the incident.

When a critical incident occurs, staff are required to complete an additional report in Trails—a critical incident report, which explains why the incident was considered critical. Division policy classifies critical incidents into the following two categories:

- **CATEGORY 1 –** These critical incidents are the most serious and include incidents such as an escape from a secure facility, a suicide attempt that requires admission to a hospital, transporting a juvenile to a hospital for a life-threatening emergency or for an unscheduled visit, or when the police are called to the facility, such as when a youth in the Division's custody receives a citation or is arrested for an alleged new crime of violence that occurs within the facility.

- **CATEGORY 2** – These critical incidents are less serious and include incidents such as assaults that may result in police contact with less serious charges being filed, a scheduled admission to a hospital, a suicide attempt that does not require admission to a hospital, an allegation of child abuse, or if a facility is locked down for more than 4 hours.

Division management reported that critical incident reports are used to ensure that critical incidents are addressed appropriately, including verifying that staff and youth received necessary medical care. The reports also help the Division track when police are called to facilities and to alert Division management of any law enforcement investigations involving youth. According to the Division, the critical incident report is generally completed by a supervisor. The incident report and critical incident report together are intended to document the actions staff took to address the critical incident.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of our audit work was to determine whether facility staff followed Division policies and procedures related to fights, assaults, and critical incidents. We reviewed Division policies and procedures to understand requirements for managing fights, assaults, and critical incidents, including how each of these incidents should be documented. We selected a random sample of 20 fights or assaults and 10 critical incidents that were recorded in Trails between August 1, 2015, and December 31, 2015. For each sampled fight, assault, or critical incident, we reviewed the documentation that the Division had on file, including the fight or assault report or critical incident report in Trails, as applicable, and any hard copy documents associated with the incident. Finally, we surveyed all secure facility direct care staff on issues related to fights, assaults, and critical incidents. We received responses from 259 facility staff, or about 42 percent of those surveyed.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND HOW WERE THE RESULTS MEASURED?

Overall, we found that facility staff are not consistently complying with Division requirements related to fights, assaults, and critical incidents. We identified problems with 16 of the 20 sampled fights or assaults (80 percent) and all 10 of the sampled critical incidents. These problems are described below:

Fights and Assaults

Reports lacked required information. We identified 13 fight or assault reports that were missing information required by the Division. Two reports were missing multiple items. Specifically, we identified:

- Nine reports that were missing or contained conflicting information about injuries. Division policy 9.4 requires that facility staff include information in the report on any injuries sustained during the incident.

- One report that did not provide justification for the use of handcuffs, as required by Division policy 9.4.

- Three reports that were missing the dates and times that staff had written the fight or assault reports, or the names of staff and youth witnesses present at the time of the incidents, both of which are required to be documented according to Division policy 14.3A.

- Two reports where the debriefing meeting reports were incomplete, with one missing supervisor signatures and the other missing notes on what staff could have done differently to prevent or improve handling of the incident. The debriefing meeting form indicates that signatures and comments on handling of the incident should be documented.

Incidents did not comply with Division physical management requirements. We identified six fight or assault reports where the sampled incidents did not comply with the following Division requirements related to physical management. Two reports had more than one problem:

- **Debriefing meetings.** We found two incidents where the debriefing meetings were held late—one 27 days after the fight or assault and one 6 days afterward. Division policy 9.4 requires that a debriefing meeting occur within 3 days following any fight or assault incident where physical management is used. We also found one incident where the debriefing meeting did not include a certified physical management instructor, as required by Division policy 9.4. Finally, no debriefing meeting was documented for two incidents. According to the Division, the meetings were held, but we could not verify this.

- **NOTIFICATIONS.** We found three incidents in which the facility directors were not notified according to Division policy 9.4, which requires that the facility director be notified when any type of physical management is used. In these cases, the incident reports did not reflect any notification and the Division confirmed that the notifications did not occur.

REPORTS CONTAINED INACCURACIES. We identified two fight or assault reports that did not contain accurate information about the incident. Specifically, one incident was classified as a youth-on-youth assault, but according to the narrative description in the report, the two youth were engaged in a fight. The Division stated that this incident should have been categorized as a fight, and that it was incorrectly categorized as an assault. For the other incident, the times recorded in the incident report for when staff took the youth to a seclusion room and removed the youth's handcuffs were inaccurate and conflicted with the times recorded on the room check sheet. According to the Division, these were data entry errors in Trails.

CRITICAL INCIDENTS

CRITICAL INCIDENT REPORTS LACKED REQUIRED INFORMATION. We found that for nine sampled critical incident reports, staff did not complete the outcomes/follow-up section of the report. For example, in two critical incidents, staff had contacted the police after the youth had assaulted staff, but the results of the law enforcement investigation were not documented in the critical incident reports. Division policy 9.8 requires staff to enter any new information that becomes available after the critical incident report is initially created in Trails and to enter the final disposition of the incident once it is obtained.

CLASSIFICATIONS WERE INCORRECT OR MISSING. In three sampled critical incident reports, staff did not classify the incidents appropriately, according to Division policy 9.8. Specifically, staff classified two incidents as Category 2 critical incidents, when they should have been classified as Category 1 because of the severity of the

situations, while staff did not classify one incident at all. All three critical incidents involved youth assaulting staff members and resulted in staff injuries. As a result of the incorrect or missing classifications, the notifications required for a Category 1 critical incident were not performed or were not performed within 30 minutes of the incident, as required by Division policy 9.8.

NOTIFICATIONS DID NOT OCCUR OR WERE NOT TIMELY. In two sampled critical incidents, staff either did not perform all of the required notifications or did not notify management in a timely manner. Specifically, in one Category 1 critical incident, notifications to facility directors and Division management did not occur at all; Division policy 9.8 requires that these notifications occur within 30 minutes of the incident. For one Category 2 critical incident, Division management were notified 27 hours after the incident, rather than within 24 hours, as required by Division policy 9.8.

Finally, we identified one incident from our seclusion sample that met the criteria for a critical incident, but was not reported as a critical incident. A youth at a contractor-operated facility attempted suicide but did not require hospitalization, which met the criteria for a Category 2 critical incident. Staff did not complete a critical incident report or the notifications required by Division policy.

WHY DID THESE PROBLEMS OCCUR?

INEFFECTIVE SUPERVISORY REVIEW. Division policy requires facility administrators to review fight or assault and critical incident reports in Trails to ensure that they are accurate, and to then correct any issues identified and lock the reports to document the review and prevent changes from being made. However, the policy does not describe the purpose of the reviews, or explain what actions administrators should take to correct inaccurate information. The problems we found related to reports lacking required information, incidents not complying with physical management requirements, inaccurate data, notifications not occurring, and misclassifications, all indicate that the supervisory reviews are either not identifying these problems, or if problems are

identified, that they are not being corrected prior to locking the reports. Further, the policy does not establish a deadline for completing the reviews and we found that some of the reviews occurred weeks after the incidents occurred. For example, one critical incident report related to a youth-on-youth assault resulting in police contact was not reviewed until 29 days after the incident. According to the Division, while it does not have a specific timeframe for facility administrators to review critical incidents, it agreed that the review was not timely for this critical incident. In addition, two of the sampled critical incident reports were not locked in Trails, indicating they had not been reviewed. Finally, we could not determine whether supervisors who reviewed the fight or assault and critical incident reports in Trails also reviewed other hardcopy documentation, such as debriefing reports, to ensure that all documents consistently reported the details of the incidents.

Inadequate training. The Division reported that many of the problems we found with incomplete, inaccurate, inconsistent, or missing documentation or data; incorrect classifications; and missing or untimely notifications, occurred because staff lacked adequate training. Currently, the Division provides training to new staff on how to enter information into Trails. We reviewed some of the Division's training materials related to incident report writing, which directs staff to complete injury, witness, and physical management information in Trails. However, the problems we identified indicate that the current training is not sufficient and additional training is needed to ensure that staff understand all of the requirements related to fights, assaults, and critical incidents. Our survey of facility staff showed that 17 percent of survey respondents reported that the training they received related to reporting and documenting critical incidents was not sufficient, while 11 percent reported that the training they received on handling fights and assaults was not adequate.

Unclear policy. While Division policy states that all sections of the critical incident report form must be completed, the Division reported to us that staff do not need to complete some of the sections because the details of the incident are captured in the incident report. Ensuring

that the written policy accurately reflects expectations for completing critical incident reports, including the entry of dispositions, can help prevent confusion among staff and promote complete critical incident reporting.

WHY DO THESE PROBLEMS MATTER?

When facility staff do not comply with Division requirements related to fights, assaults, and critical incidents, including accurately and completely documenting the facts surrounding these incidents, the Division cannot ensure that facilities are handling these incidents appropriately. Fight or assault and critical incident reports are facility and Division management's primary mechanism for monitoring these serious incidents and their outcomes. Additionally, inaccurate and incomplete reports impair management's ability to use this information to identify trends or areas of concern and make informed decisions about any changes that might be needed.

Recent statutory changes have also increased the importance of fight or assault and critical incident reports and supporting documentation being complete and accurate. In 2015, the General Assembly passed House Bill 15-1131, requiring the Division to provide, upon request, information related to critical incidents involving intentional physical acts of aggression, such as fights and assaults, and attempts to harm or gain power by blows or the use of weapons. In addition, House Bill 16-1328, which was passed during the 2016 Legislative Session, increases the Division's documentation requirements for emergency situations that lead to seclusion, such as fights and assaults, and establishes a working group that will be reviewing incident reports when seclusion lasts more than 4 hours.

Finally, fight and assault incidents often require staff to use physical management to control the situation. Physical management is one of the higher risk activities in facilities, and it is important for debriefing meetings to occur and incident reports to be accurate for Division management to ensure that staff used physical management correctly and that youth and staff's injuries and medical treatment are

documented. Incomplete and inaccurate reports may increase the risk that legal action may be taken against the Division, with allegations of excessive force or child abuse.

RECOMMENDATION 3

The Department of Human Services should improve Division of Youth Corrections (Division) facility staff's compliance with fight, assault, and critical incident requirements by:

A Strengthening controls related to supervisory review of fights, assaults, and critical incidents to specify review requirements such as the scope, purpose, and timing of reviews, how they should be documented, and how to address deficiencies within Division written policies and procedures.

B Providing additional targeted training, as necessary, for staff on the requirements related to fights, assaults, and critical incidents.

C Clarifying policies and procedures related to what information about critical incidents must be reported in Trails.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: OCTOBER 2016.

The Department agrees to strengthen controls related to supervisory review of fights, assaults, and critical incidents. A checklist for supervisors to use when reviewing Incident Reports has been created. The checklist specifies review and documentation requirements as well as guides feedback to staff on deficiencies. The Department's Quality Assurance team will monitor the timing of these reviews by including a random sampling of supervisory reviews in their monitoring process.

B AGREE. IMPLEMENTATION DATE: OCTOBER 2016.

The Department agrees to provide additional, targeted training as

needed on report requirements for fights, assaults, and critical incidents. Report Writing Training was conducted in July 2016 with all relevant staff, which addressed how to properly fill out an Incident Report in Trails.

C AGREE. IMPLEMENTATION DATE: OCTOBER 2016.

The Department has reviewed the current policy and believes that it already contains appropriate requirements for Critical Incident reporting and will clarify these requirements through training. Training will be conducted with all supervisory and direct care staff on what information needs to be included in a Critical Incident Report in Trails.

CONTRACT MONITORING

The Division oversees facilities that house detained and committed youth. The Division owns and operates 10 secure facilities throughout the state and owns two additional secure facilities, the Betty K. Marler Youth Services Center (Marler) in Lakewood, Colorado, and the Robert E. Denier Youth Services Center (Denier) in Durango, Colorado. The Division contracts with a vendor, Rite of Passage, to operate the Marler and Denier facilities. According to the Division, Marler can house up to 41 youth and is designated for committed females who have the highest treatment needs. In Calendar Year 2015, Marler housed an average of 35 females per month. Denier houses males and females, up to nine in detention and 19 in commitment, to serve youth in southwestern Colorado. In Calendar Year 2015, Denier housed an average of three youth in detention and 11 committed youth per month.

WHAT WAS THE PURPOSE OF OUR AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of our audit work was to determine whether the Division provides sufficient oversight of the contractor-operated secure facilities to ensure that these facilities comply with state requirements related to secure juvenile facilities. We reviewed statutes, regulations, annual compliance review reports conducted by Department Quality Assurance (QA) staff, job descriptions for Division staff with contract monitoring responsibilities, and Division policies and procedures related to contractor-operated facilities to determine how the Division oversees the Marler and Denier facilities. We also analyzed the Division's contracts with Rite of Passage for Fiscal Years 2015 and 2016 to understand the reporting requirements and performance measures for the Marler and Denier facilities and reviewed monthly

progress reports submitted by Marler and Denier during Calendar Year 2015. Finally, we interviewed Marler and Denier facility management and staff, QA staff, and Division staff with contract monitoring responsibilities for the two facilities.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

We used the following criteria to determine whether the Division provides sufficient oversight of the contractor-operated secure facilities.

THE DIVISION IS RESPONSIBLE FOR THE CARE AND TREATMENT OF YOUTH. Several sections of statute discuss the Division's responsibilities for the youth in its custody. Specifically:

- Section 19-2-202, C.R.S., designates the Department as the single state agency responsible for the oversight of the administration of juvenile programs and the delivery of services for juveniles and their families.

- Section 19-2-403, C.R.S., authorizes the Department to establish and operate facilities necessary for the care, education, training, treatment, and rehabilitation of those juveniles legally committed to its custody.

- Section 19-2-410, C.R.S., states that the Department shall enter into contracts as necessary with private providers for the care and treatment of juveniles and that placement of juveniles in any public or private facility shall not terminate the Department's legal custody.

STATE AGENCIES MUST MONITOR CONTRACTS. Statute states "each governmental body administering the personal services contract shall, within existing resources of the governmental body, designate at least one person within the governmental body responsible for monitoring …whether and to what extent the contract was completed according

to the performance schedule specified in the contract, satisfaction of the scope of the vendor's work as specified in the contract, and whether and to what extent the vendor met or exceeded budgetary requirements under the contract" [Section 24-103.5-101(3), C.R.S.]. The Division, as a state agency, is responsible for evaluating Rite of Passage's performance under its contracts to care and treat youth who have been placed at the Marler and Denier facilities.

CONTRACTS MUST CONTAIN PERFORMANCE MEASURES. Statute [Section 24-103.5-101, C.R.S.] and State Fiscal Rule 3-1 require that contracts contain performance measures and standards; accountability standards requiring regular vendor reports on achievement of the specified performance measures and standards; and monitoring requirements specifying how the agency will evaluate performance, including progress reports, site visits, inspections, and reviews of performance data.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND WHY DID THESE PROBLEMS OCCUR?

Overall, we found that the Division provides greater oversight of the state-operated secure facilities than it does for the contractor-operated secure facilities, as described below.

THE DIVISION DOES NOT REQUIRE THE CONTRACTOR TO PROVIDE SUFFICIENT DATA TO EVALUATE THE QUALITY OF SERVICES. We identified two areas where the contracts do not require the Marler and Denier facilities to report data that would allow the Division to either evaluate the quality of required services or evaluate the contractor-operated facilities on the same measures as state-operated facilities.

First, the contracts to operate the Marler and Denier facilities do not contain performance measures that would help the Division assess whether the core services required under the contract, including education and medical and mental health treatment, are provided and

effective, or whether the contractor has met staffing requirements. For example, although the contractor is required to provide educational services to the youth in its facilities, the contracts do not establish measures to assess the effectiveness of the education provided to youth, such as data on the youths' educational progress. Similarly, the contractor is required to provide mental health treatment to youth, and according to the Division, many youth in its custody have been diagnosed with mental health or substance abuse disorders and need treatment. However, the current contracts do not contain overall goals for the mental health treatment that is provided or measures to hold the contractor accountable for the quality or efficacy of mental health services.

Second, the contracts do not require Marler and Denier to report on certain performance measures that are evaluated in the Department's C-Stat, which is a performance monitoring tool in which Department programs report on key program metrics. Specifically, the Marler and Denier facilities are not required by their contracts to report three C-Stat measures that are applied to the state-operated secure facilities, as shown in EXHIBIT 2.4.

EXHIBIT 2.4
DIVISION OF YOUTH CORRECTIONS
C-STAT MEASURES FOR STATE-OPERATED AND CONTRACTOR-OPERATED SECURE FACILITIES

DEPARTMENT C-STAT MEASURE	STATE-OPERATED SECURE FACILITIES	CONTRACTOR-OPERATED SECURE FACILITIES
Committed or Detained Youth Who Escape or Walkaway	X	X
Timely Initial Placement for Committed Youth	X	X
Family Engagement	X	X
Fights and/or Assaults	X	
Youth Injuries	X	
Staff Injuries on the Job as a Direct Result of Youth Contact	X	

SOURCE: Office of the State Auditor's analysis of the Department of Human Service's C-Stat data.

The Division's contracts require the Marler and Denier facilities to submit monthly reports containing certain data, such as the timeliness of placing committed youth at a facility, number of escapes, number of youth served, number of critical incidents, and number of staff vacancies. While these data are important, they do not provide a complete assessment of the contractor's performance or indicate whether the youth housed at Marler and Denier reside in a safe environment.

THE DIVISION HAS NOT HELD CONTRACTOR-OPERATED FACILITIES TO THE SAME STANDARDS AS STATE-OPERATED FACILITIES. Specifically, the Division does not require both contractor- and state-operated secure facilities to follow the same policies, and there are key differences between the two sets of policies. For example:

- The state-operated policies require staff to notify the Division Director within 30 minutes for Category 1 critical incidents, but the contractor-operated policies do not require Division Director notification for Category 1 critical incidents.

- The state-operated policies require that new staff complete 144 hours of training during their first year on the job, but the contractor-operated policies require only 120 hours of training for new staff.

- The state-operated policies allow facilities to impose a lock-down and place all youth behind locked doors for 30 minutes for staff to debrief after an incident, but the contractor-operated policies allow facilities to lock down for up to 1 hour.

- The state-operated policies allow facilities to place youth in a staff-directed timeout for up to 59 minutes, but the contractor-operated policies limit staff-directed timeouts to 30 minutes.

The Division could not explain why it has different policy requirements for state-operated versus contractor operated secure facilities; further, we noted that the Division has not consistently

updated the contractor-operated policies. For example, although the Division updated its seclusion policy for state-operated facilities in October 2015, the seclusion policy for contract facilities has not been updated since 2012. Another Division policy for behavioral programs and major rule violation hearings was updated in August 2015 for state-operated facilities but has not been updated since August 2012 for contractor-operated facilities.

Further, it is not clear which policies contractor-operated facilities should follow. The contracts for the Marler and Denier facilities state that their staff must follow Division policies, but the contracts do not specify whether those are the contractor-operated policies or state-operated policies. To further the confusion, QA evaluates contractor-operated facilities for compliance with both state-operated and contractor-operated facility policies. Contractor-operated facility staff stated during interviews that they are not always clear on which policies they should follow. During our audit test work for fights and assaults, critical incidents, and seclusion, the Division reported to us that we should use the contractor-operated facility policies as criteria for our test work.

THE DIVISION DOES NOT COORDINATE THE RESULTS OF CONTRACTOR MONITORING. Currently, contract monitoring responsibilities for the Marler and Denier facilities are spread among many different Division and Department staff, as follows:

- Department QA staff have the primary responsibility for evaluating the Marler and Denier facilities' compliance with Division policies. According to the Division, QA staff determine the monitoring schedule, conduct onsite visits, and provide technical assistance to the facilities, if needed.

- The Division reported that its staff with expertise in secure facility operations accompany QA staff in the onsite visits.

- Other Division and Department staff review the medical, mental health, and education services provided at Marler and Denier.

- Other Division staff are responsible for verifying the number of days youth are housed at Marler and Denier during a month before approving payments to the contractor.

- Since the Marler facility is on the same campus as a state-operated facility, the Division reported that staff from the state-operated facility sometimes conduct unannounced site visits to Marler, but do not document these visits.

The Division has not developed a mechanism for consolidating all of the monitoring information from these staff efforts to comprehensively assess the contractor's performance and compliance with the terms of the contracts and tie payments to performance. Part of the fragmentation of monitoring efforts and lack of coordination is due to organizational changes made by the Department in 2015 that resulted in contract monitoring responsibilities not being clearly assigned among Division and Department staff.

Further, it is not clear who has primary responsibility for working with the contractor to resolve areas of non-compliance. QA staff reported that they will provide technical assistance to facilities and test some of the problem areas at their next onsite visit or annual review of the facilities and issue a repeat finding if the problem continues. According to the Division, some of its staff also work with the contractor on problem areas; however, this assistance has not been formalized as part of their job responsibilities and there does not seem to be a consistent process for providing the assistance. Finally, the Division staff responsible for authorizing contractor payments are not responsible for the ongoing performance monitoring of the contract facilities, and there is no process for providing performance data to these staff for consideration before authorizing payments.

WHY DO THESE PROBLEMS MATTER?

When the Division does not provide sufficient oversight of the contractor-operated secure facilities, the Division is not fulfilling its responsibility to ensure that all youth placed in its custody receive the same level of supervision and treatment to build skills and competencies to become responsible citizens. In addition, the Division cannot ensure that the State is receiving full value for the $4.2 million it spends annually for the Marler and Denier facilities.

The Department's C-Stat states that all youth in the custody of the Division should reside in a safe environment free from fear of harm. Statute and the Division's mission do not differentiate between youth placed in contractor-operated facilities and youth placed in state-operated facilities. Youth detained and committed at the Marler and Denier facilities are in the Division's physical and/or legal custody, and the Division is responsible for their safety and care. However, when the Division does not collect or review data tied to the specific performance expectations for the contractor, such as data on youth educational progress, mental health treatment and outcomes, or staff training, the Division is inhibited in its ability to ensure the quality of the contractor's services or compare them to the state-operated facilities and ultimately ensure that the youth in all secure facilities are treated the same.

In addition, the lack of sufficient and coordinated oversight may be contributing to the high number of QA noncompliance findings at the contractor-operated facilities and overall contract noncompliance. In their three most recent annual QA compliance reviews, the Marler and Denier facilities had among the highest number of total findings, with 204 and 179 findings, respectively. Comparatively, nine of the 10 state-operated facilities had between 40 and 172 findings during the same 3-year period; one state-operated facility had 236 findings. These findings covered all areas of the facilities' operations, such as staff supervision of youth, documentation of incident reports, and use of seclusion. Further, the Marler and Denier facilities often have repeat findings from one year to the next. For example, Marler's Fiscal Year

2016 compliance review included a repeat finding that youth were left unsupervised in the living units and a repeat finding that incident reports did not document the specific physical management method used. In Denier's Fiscal Year 2014 through 2016 annual compliance reviews, QA staff cited repeat findings of noncompliance with Division policy for the use of seclusion, including using seclusion "for extended periods of time without justification" and incomplete and inaccurate seclusion documentation; incomplete incident reports; and youth not receiving the minimum required monthly individual and family counseling sessions.

In addition to QA findings, Division staff have identified problems with other services provided at Marler and Denier. According to monitoring reports of education services at both the Marler and Denier facilities from 2014 through 2016, Division staff identified noncompliance with contract requirements for education, including teachers and administrators who did not have Colorado teaching licenses and missing student education files. Comprehensive and coordinated monitoring is needed to ensure that youth placed in contractor-operated facilities receive the same oversight as youth placed in state-operated facilities.

RECOMMENDATION 4

The Department of Human Services should improve the Division of Youth Corrections' (Division) oversight of contractor-operated secure facilities by:

A Revising the contracts for secure facilities to include performance measures and accountability provisions that allow the Division to assess the sufficiency of the core services the contractor provides, such as education and medical and mental health treatment, and align the contractor's performance to state-operated secure facilities' performance.

B Revising Division policies to hold contractor-operated secure facilities to, at a minimum, the same standards and requirements as state-operated secure facilities.

C Coordinating contract monitoring responsibilities among Department of Human Services staff so that the responsibility for ensuring that the contractor is meeting all contract requirements and performance measures is clearly assigned and contractor payment is tied to performance.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: JULY 2017.

The Department agrees to amend the contracts for contractor-operated secure facilities to include additional performance measures and accountability provisions. During the next contract extension negotiations, the Department will make amendments to the contracts for contractor-operated secure facilities. Under these amendments, in addition to auditing contractors each year on the

existing approximately 300 audit standards, the contracts for contractor-operated secure facilities will contain new performance standards and accountability measures covering core services provided by the contractor.

B AGREE. IMPLEMENTATION DATE: MARCH 2017.

The Department agrees to review and revise policies in order to hold contractor-operated facilities at the minimum to the same policy standards as state-operated facilities. As part of this process, the Department will phase out the "C" series of policies, applicable only to contractor-operated secure facilities, leaving one set of policies laying out standards and requirements for State- and contractor-operated secure facilities.

C AGREE. IMPLEMENTATION DATE: NOVEMBER 2016.

The Department agrees to coordinate contract monitoring responsibilities and will identify a specific position to oversee the monitoring of the secure contractor-operated facilities. This position will monitor requirements and performance measures of the contracts and coordinate any needed corrective actions, up to and including actions affecting contractor payment if performance is not satisfactory pursuant to the terms of the contracts.

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