State of Colorado Department of Human Services (CDHS)
Division of Youth Services (DYS)

On-Site Technical Assistance Visit
Summary Report

Consulting Team:

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July 22-25, 2019

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Introduction

In July 2019, the Colorado Department of Human Services, Division of Youth Services (DYS) contracted with the Council of Juvenile Correctional Administrators (CJCA) to provide technical assistance to Lookout Mountain Youth Services Center. Consulting services included conducting detailed analyses of agency and facility policies, procedures, and related documents as well as a four-day site visit. The purpose of the engagement was to gather feedback from a nationally recognized organization (CJCA) regarding facility operations in the areas of safety, security and programming.

It is important to note that the State of Colorado DYS currently operates ten secure facilities. The consultant team's observations and recommendations for improvement are focused solely on the Lookout Mountain Youth Services Center, and are provided in the body of this Summary Findings Report.

Background

Colorado Department of Human Services, Division of Youth Services (DYS)

The Colorado Division of Youth Services (DYS) is a division of the Department of Human Services (DHS). At the time of the visit, there were 530 youth committed to DYS. Approximately 400 are served in DYS facilities with the remainder housed in congregate care programs statewide. The Division is responsible for operating ten secure care facilities. The DYS Mission is to collaborate with our partners and to design and deliver high-quality human and health services that improve the safety, independence, and well-being of the people of Colorado.

The agency strives to achieve its Mission by providing an array of intervention, supervision, and rehabilitation programs and services, while maintaining a focused commitment to public safety. There are three main goals that assist DYS in working to achieve its mission. These include:

- Improving short-term and long-term outcomes for youth in their care
- Supporting families in the rehabilitation process
- Providing trauma informed care
- Improving the safety, security and well-being of DYS youths and employees

DYS uses a Restorative Justice Model and philosophical framework as the foundation for programmatic service delivery. There are three main facets or principles that support this model. These include Accountability, Competency, and Community Protection defined as:

- *Accountability* - When an individual commits an offense, the offender incurs an obligation to individual victims and the community
- *Competency Development* - Offenders who enter the juvenile justice system should be more capable when they leave than when they entered

- *Community Protection* - Juvenile justice has a responsibility to protect the public from juveniles in the system

DYS is responsible for all youth committed by the juvenile courts. When a juvenile is adjudicated, DYS determines their level of care (secure, community, etc.) during their commitment time. Services while in secure care facilities include comprehensive assessments, clinical programming, education, vocational training, and skills-based groups.

Council of Juvenile Correctional Administrators (CJCA)

The Council of Juvenile Correctional Administrators (CJCA) is committed to improving outcomes for youth and their families engaged in the juvenile justice system. We work with all juvenile justice leaders to provide them with education, resources, training, leadership development, research, and best practice opportunities to help them improve their systems, cultures, programs and services they provide to the youth entrusted to their care. We believe in working to ensure that only those youth posing a true and significant public safety risk should be placed in secure facilities and that when necessary, those facilities should be focused on providing the right type of educational, vocational, and treatment programs in a therapeutic and trauma-informed care environment.

The Council of Juvenile Correctional Administrators (CJCA) is a national non-profit organization, formed in 1994 to improve local juvenile correctional services, programs and practices so youth within the systems succeed when they return to the community. The CJCA mission is *"To connect, develop and strengthen youth corrections leaders so that they may implement and sustain reforms in their systems to improve outcomes for youth, families and communities."* Our underlying belief is that every youth should leave a correctional program in a better place than when he or she came into the program and/or system.

CJCA provides national leadership and leadership development for the individuals responsible for the juvenile justice systems. CJCA represents the youth correctional CEOs in 50 states, Puerto Rico and major metropolitan counties. We fulfil the organization's mission through educational activities and programs as well as research and technical assistance projects. These education activities include up to three annual meetings free for all directors offering sessions on best practices and evidence-based approaches.

Additional areas of involvement include working with the Casey Foundation on various projects, including the annual Leadership Institute meeting wherein leaders from all CJCA participating jurisdictions are invited to attend a two-day leadership training and networking opportunity focusing on relevant topics for system improvement and reform, such as developing Trauma Informed Care environments. CJCA's work also involves partnering with the Council of State Governments (CSG) Justice Center to develop and implement its comprehensive Juvenile Justice Project as well as assisting Pew Charitable Trusts (Pew) in the educational work of their state centered Public Safety Performance Project (PSPP). CJCA's national level involvement includes

developing national standards for reentry and providing technical assistance to a variety of jurisdictions throughout the country on various topics in juvenile justice.

CJCA is well known for its development of Performance-based Standards (PbS) - a data-driven improvement model grounded in research that holds juvenile justice facilities and programs to the highest standards of operations, programs and services. PbS won the 2004 Innovations in American Government Award for effectively and uniquely addressing conditions of confinement. PbS supports integration if its model through training, technical assistance, expert coaching and resources. For more information, please visit: www.pbstandards.org.

Consulting Team

The Council of Juvenile Correctional Administrators (CJCA) consulting team included the CJCA Executive Director and Assistant Executive Director- Michael Dempsey and Wendi Faulkner, respectively. A brief explanation of professional background is provided below for reference. Both individuals participated in the policy, procedure, and document analyses and conducted the onsite visit to Lookout Mountain.

Michael Dempsey, Executive Director
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Prior to joining CJCA, Michael previously served as Executive Director of the Indiana Department of Corrections, Division of Youth Services from 2009 to 2015. He began his work with the Indiana Department of Corrections as Superintendent of the Pendleton Juvenile Correctional Facility in June 2006. Prior to moving to Indiana, he served as the Superintendent of the Kansas Juvenile Correctional Complex for approximately two and a half years. He began his career in corrections with the Missouri Department of Corrections, starting as a Corrections Officer at the Missouri State Penitentiary in 1985. Since that time, Mike has held positions as a Correctional Sergeant, Lieutenant, Captain and Major. He has also held positions as Correctional Training Officer, Internal Affairs Investigator, Assistant Superintendent and Associate Superintendent.

He has extensive experience with CJCA and Performance-based Standards (PbS). He served as president of the CJCA Board of Directors for two years (2012-2014), and on the PbS Board of Directors for four years, two of those years as president. Mike was an active member of CJCA while he was director of Indiana DYS. Mike has over 30 years of experience working in both adult and juvenile correctional and detention facility settings and continues to be committed to assisting juvenile justice systems on improving conditions of confinement, reforming systems, and improving long-term outcomes for youth.

Mike holds a Bachelor of Science degree in Public Administration and Criminal Justice and has been actively involved with the American Correctional Association (ACA) as a member and certified auditor. He has served as the President/COO of Youth Opportunity Investments and

brings a unique experience and perspective in both the public and private sectors in the juvenile justice field.

Wendi Faulkner, Assistant Executive Director
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Prior to joining CJCA, Wendi Faulkner served as the Deputy Director of the Division of Facility Support for the Ohio Department of Youth Services. She was responsible for security, operations, and treatment within DYS facilities. The Division also includes oversight of Medical and Mental Health Services and the Buckeye United School District. Serving as a trusted advisor, Wendi served as a mentor to those who worked under her leadership.

With over 23 years of experience in criminal and juvenile justice, Wendi has served on numerous national and statewide policy committees and councils. During her career, she has presented to various audiences on a wide range of criminal justice topics. Her breadth and scope of the criminal justice field, specifically correctional administration, makes her not only a leader, but also a subject matter expert.

Wendi is a strong advocate of system reform, which includes encouraging systems to develop innovative and effective educational opportunities for youth. To fulfill this passion, she has served on the boards of two charter schools: Columbus Preparatory Academy and Columbus Arts and Technology Academy. Wendi was also a member of the Executive Committee for Buckeye Charter School Boards, which is charged with strengthening charter school boards throughout the state of Ohio.

Wendi earned a Bachelor of Arts degree and a Master's degree in Business Administration from Franklin University (Ohio) with a concentration in Leadership.

Methodology

The onsite TA visit to Lookout Mountain Youth Services Center was conducted between July 22nd-July 25th, 2019. The consulting team consisted of the Executive Director of CJCA, Michael Dempsey and Assistant Executive Director of CJCA, Wendi Faulkner. The facility visit ranged between five and six hours per day and included a meeting with facility leaders, a facility tour, conversations with youth and staff, and a brief review of documents related to daily operations (i.e. shift schedules, programming schedules, log books detailing perimeter checks, etc.). The purpose of the tour was to gather additional information about the program, identify any operational risks (i.e. safety and security breaches), and to determine alignment with best practices in the field of juvenile justice.

The consulting engagement focused predominantly on the secure care portions of one DYS facility:

- Lookout Mountain Youth Services Center (LMYSC)

Prior to the onsite visit the CJCA consultants conducted an extensive analysis of agency policies and procedures; facility operations manuals; copies of facility logbooks; youth and family manuals; and additional documents related to operations (i.e. quality assurance/audit reports, incident reports, Individualized Support Plans and Facility Improvement Plans).

Limitations

There are inherent limitations in this type of assessment. The team did not interview every staff member at the facility, nor did it visit the facility over an extended period of time. The limited time on-site also prevented the team from observing all operational posts involved in a 24/7 secure facility, although the team made efforts to tour and observe operations during normal business and non-business hours. Nevertheless, the review of policies, available data, and records; the extensive interviews conducted with administrators, staff, and youth; the experience of the members of the team; the observations made throughout the facility; the team members' reported experience with the PbS and JDAI standards; and the receipt of consistent information from multiple sources provided a strong foundation of information for developing this report.

In addition, it is important to note that this process inherently focuses attention on the areas of concern as well as the two main incidents in question and may not fully explore all of the strengths of the facility and agency.

Facility Description

Brief descriptions of the facility that received the onsite technical support are provided below.

All facilities are operated by the Colorado Division of Youth Services (DYS) and serve youth between the ages of 12 and 21. All youth have a history of risk and delinquent behaviors, and the majority of youth also have formal clinical mental health diagnoses.

Lookout Mountain Youth Services Center (LMYSC)

The Lookout Mountain Youth Services Center is located in Golden, Colorado. The intensive secure treatment program operates under the leadership of Kristen Withrow, DYS Associate Director and current Interim Director at LMYSC, allows for a population of 140 male juvenile offenders. LMYSC provides for the care and supervision of youth committed by the District court to the custody of the CDHS Division of Youth Services (DYS). At the time the onsite visit, there were seventy-one youth in the facility.

LMYSC offers comprehensive services to committed youth and their families. Using cognitive behavioral and social learning modalities, Lookout Mountain's programming provides an

environment where therapeutic and strength-based relationships may develop. Services consist of academic and career technology programming, recreation and medical and dental care. Spiritual growth opportunities and pastoral care are provided when requested by Youth for Christ and Straight Ahead Colorado. Treatment services are provided for substance abuse, family, mental health and offense specific treatment needs. Programming is grounded in the principles of Restorative Community Justice (RCJ).

In collaboration with regional Client Managers, Lookout Mountain utilizes a multi-disciplinary team (MDT) approach. The MDT process provides a structured setting for the development of individualized treatment plans, treatment plan review, and case related decision-making. MDT members include the youth, the family, natural community supports, the Client Manager, representatives from various facility disciplines including clinical, education, line staff and medical providers, when appropriate. The youth's case plan and their individual treatment plan guide service provision throughout their placement at LMYSC, by identifying and addressing goals, objectives, and target interventions.

DYS Assessment Overview

Detailed analyses were conducted of local policies, procedures, and other documents related to program operations. Among the documents reviewed were facility procedures, youth orientation handbooks, unit programming schedules, agency quality assurance reports and site evaluation reports, to name a few. Valuable themes emerged though this review regarding strengths and areas for improvement for the Lookout Mountain Program. A series of recommendations are offered herein to provide DYS with more specific guidance regarding ways to enhance the operations of Lookout Mountain. For ease of reading these items have been broken out into four categories, many of which are closely related. These categories are: 1) Agency and Facility Culture; 2) Safety and Security; 3) Programming (which includes Evidence-Based Practices, assessments, etc.); and 4) Quality Assurance.

Our assessment and this report is focused and based on CDHS's current understanding of conditions at LMYSC, CDHS requested that the CJCA's review provide the necessary investigatory methods, and reference the needed industry standards and best practices, to provide a focused assessment in the identified areas.

As a result of our assessment, we found three overarching concerns which we believe represent the main contributing factors to the concerns in the conditions of confinement and recent incidents of violence at LMYSC. These overarching factors will be discussed in the following sections, but involve the following concerns:

1. Substantial drug problems within the facility;

2. Complexities around preparation and training for transformational initiatives (including overall program changes, and the recent alterations in the use of seclusion and search protocols and procedures); and
3. A lack of basic fundamental safety and security processes for a facility of this type.

As part of the agency and site assessment, CJCA met with agency leadership in order to discuss the on-going issues at LMYSC. As part of this discussion, the following issues and deficiencies were identified as having an impact on and/or part of the root causes of the issues related to safety, security, and facility programming. These include:

1. **Onsite administration (facility director and facility leadership team)** displayed a need for more intensive training in leadership skills to develop and support the competence and confidence needed to lead and operate this large long-term commitment population with oversight of approximately 250 staff and a very difficult population of youth.

2. **Administrative oversight** [redacted]

3. **Major staffing shortages** at both the direct-care and supervisory level has led to hiring less experienced staff, as is needed with this population. In addition, the supervisory positions have remained open for long periods of time. It has been equally difficult bringing in new and inexperienced staff to work with some of our most difficult youth in the deepest end of the commitment continuum, without the support and modeling needed for successful experiences.

4. **42% turnover rate of direct-care staff** last year. This alone has made it extremely difficult if not impossible to in sustain good programming.

5. **Staff hired in certain cases, that were ultimately found to be unethical, which** contributed to the dysfunction, safety and security of the facility program.

6. **Appointment of new unit managers** across all residential units without the necessary experience. These residential units could be considered stand-alone DYS youth centers when compared to other programs both in Colorado and other states.

7. **Several promotions of high-level staff from Lookout Mountain** to other parts of the Division.

8. **Increase in aggravated and violent offender sentences** with a vast majority placed at Lookout Mountain. Matching programming with the increase in sentence severity has been and will continue to be difficult.

9. **Reform efforts** currently underway take time and there may be struggles throughout the process. Larger youth centers have a more difficult time with change (more youth and more staff).

10. **Introduction of drug contraband** into the youth center have exacerbated the problems in the facility. This undoubtedly contributed to the increase in gang activity, fights, assaults, and restraints.

11. **The behavioral management program** did not have the staffing or training to maintain and implement the program as designed. The lack of program incentives and/or appropriate consequences for behaviors, resulted in staff and youth losing the foundation of rules and rewards to promote positive growth and ultimately created a very unstable environment.

12. **Physical plant issues** with bedroom windows and approachability issues with the secure perimeter fence.

Strengths, Areas for Improvement, and Recommendations

The team observed a number of important strengths at the facility. We particularly noted the following:

A. Agency and facility administrators are highly motivated, committed and open to new ideas about reforms, and are sincerely interested in raising the level of practice at the facility. The agency and facility leadership expressed great interest in learning about new approaches to the problems identified at LMYSC. Although the facility is facing a number of serious challenges, as outlined below, it is clear that there are dedicated professionals at both the agency and facility level who are committed to improving conditions of confinement, reducing incidents of violence and improving the overall culture and atmosphere of the facility.

B. There is an impressive level of commitment and caring attitudes with the direct care staff. The majority of the facility staff are at Lookout Mountain because they truly care about the youth and want to make a difference in their lives. They understand the importance of their roles and want to improve the culture and atmosphere of the facility in order to provide a safe and effective environment for treatment for the youth entrusted to their care.

C. The school at the facility is an active, engaging place that provides a supportive culture and

program for students. The school has a number of important and beneficial programs and appears to be keeping youth actively engaged in the classrooms. The education space and post-secondary options are excellent. During discussion with both staff and youth, everyone spoke highly of the education program and believed it to be one of the strengths of the facility.

D. Quality vocational programs that are relevant provide youth with skill development that can aid in their successful re-entry back to the community.

Agency and Facility Culture

The success of any initiative depends on a variety of factors and requires support from executive level administrators and high-level facility managers. Interviews with the DYS leadership and staff revealed that all leaders are committed to keeping youth safe and reforming the lives of youth. These strengths will be highlighted in subsequent sections of this report. The most successful programs have strong leadership who can support staff, motivate staff to engage in the change process, and provide a clear vision and direction for where the agency is heading.

During the onsite visit, interactions with facility leaders and staff indicate they are committed to their work and to helping youth in their care. The majority of staff appeared to embrace the evidence-based practices philosophy and a strengths-based approach to working with youth. Youth interviews revealed that youth feel some staff care about them and are helping youth turn their lives around. Staff described wanting their role to be more of a mentor and articulated they want to be active advocates for youth to achieve their goals. Research shows establishing appropriate and healthy relationships with youth is a hallmark of a good program and perhaps, the most critical factor in preventing assaults and the unnecessary use of isolation.

Lookout Mountain is currently working to strengthen their leadership/management teams. In addition, there appears to be issues with the current pay structure and the agency may benefit from looking at their higher classifications and adjusting their pay scale accordingly. DYS should consider increasing their efforts to demonstrate support for staff by formally acknowledging them through “thank you” emails and/or acknowledgments during monthly staff meetings. Other facilities throughout the country have worked to increase the cohesiveness of their leadership team by reading a leadership books as a team and meeting weekly to discuss each chapter. The consultants applaud DYS for recognizing the role a strong leadership team plays in a program’s success. Therefore, focusing on a high level of cohesiveness provides the foundation for achieving the facility and agency’s mission and ultimately will lead to more positive outcomes for youth. The DYS leadership team should consider requiring all facilities to develop specific plans to enhance teamwork among their respective leadership teams.

Although culture change takes time (often several years), facility site visits revealed there is a need to increase demonstration and/or awareness of the evidence that positive changes and

improvements are being made (i.e. safety security measures, increased quality assurance mechanisms, implementing evidence-based practices, etc.). The majority of facility units appear to be unstable. Youth interviews revealed they do not understand the daily routine and expectations as well as how they progress through the program (i.e. behavioral management system, achieving SMART case plan goals, etc.) and believe everything is based on staff emotions of the day.

Most juvenile facilities have a formal process for gathering youth input, which is an indication of a healthy facility environment. In terms of grievances, the agency should have a policy that describes the formal process for filing a grievance in a way that youth understand and may utilize. Part of the intake process (if not currently occurring) should include providing youth with an example of grievance form, a description of their rights and a clear explanation of the process for filing a grievance. Equally as important, Lookout Mountain would benefit from a formal process in place to gather youth input on a regular basis. There was mention of a quasi-youth council which meets regularly to provide input into the program and discuss unit issues (and solutions) but no evidence could be found of these occurrences. The consultants would encourage increased levels of youth involvement and encourage the facility to create a formal mechanism for youth input outside of the grievance process. This process creates ownership on behalf of youth and will foster better engagement in treatment while youth are in DYS care.

There appears to be a breakdown or no evidence to demonstrate that the facility has or is working toward more positive relationships with their local communities. This is typically seen in facilities having an active volunteer program, bringing healthy role models to the facility to donate their time with youth. It is understood that the screening process currently in place in Colorado is prohibitive, however effort to develop and maintain a volunteer program has shown to be helpful in the rehabilitation of youth in Juvenile Justice. Community support is a critical factor in a program's success.

The agency is in the process of standardizing the operational procedures across the division. This standardization will increase efficiency across the system, provide clear guidance/expectations to staff, and allow for continuity for those youth who may reside in several facilities throughout their stay with DYS. The consultants applaud the agency for devoting the time and resources to this investment.

Areas for Improvement and Recommendations

As previously mentioned, the agency is implementing a number of significant changes including additional evidence-based treatment models in the facility; quality control mechanisms; and safety and security measures. As expected, some facility staff are embracing these changes while others struggle. As a result, staff fears for safety have increased. It is important that the agency recognizes these fears and takes steps to discuss them with staff and determine appropriate steps to alleviate these fears. There is a feeling of unrest and uneasiness within the overall atmosphere of the facility, this unrest and fear for safety most certainly impact the relationship between staff and youth and contributes the number of incidents of violence. This is typical for all systems undergoing change.

The following areas for improvement have been identified and recommendations for enhancement have been provided. The agency and facility leaders will need to prioritize these recommendations based on perceived value/impact on the agency's overall mission and key goals.

Recommendation: Increase support for facility managers and direct care staff through regular site visits. DYS has experienced difficult times in the past year that have included issues around retention. These crisis situations often lead to staff feeling overworked and not supported by upper management. While most facility managers stated they felt support by the DYS Executive Team, the suggestion was offered to increase the Executive Team's presence at the facilities through regular site visits. It is important that these site visits not be conducted only in response to serious incidents but also as part of routine "check-ins" to take advantage of opportunities to praise the good work being done with youth. These positive visits will demonstrate support for facility leadership, mid-level managers, and direct care staff and consequently increase staff morale.

In addition, when a post-incident visit must occur, the Executive Team should be aware of its communication style and messaging. Consistent with the agency's trauma-informed care and strengths-based approach, the team should highlight what facility staff did well in handling the significant event (i.e. staff using de-escalation strategies; staff "tapping out" and asking another staff to step in when s/he was not effective in de-escalating youth, etc.). While it is important to provide constructive feedback, it is critical for leadership to remember that significant incidents are traumatic for both youth and staff and staff are doing their best with the skills they have. The Executive Team is encouraged to make a concerted effort to find opportunities to praise managers and direct care staff.

Recommendation: Increase cohesiveness among all levels of facility staff through open dialogue during regular monthly meetings, specific team building exercises, activities, retreats, etc. Consider implementing cycle-trainings that include staff from the different sites and/or programs, this would allow an opportunity to build comradery and support, while obtaining necessary training. This will increase understanding and support for one another as well as breakdown any myths that currently exist (i.e. certain unit are the "gang" units while others do not hold youth accountable, etc.)

Recommendation: Develop specific strategies for overcoming staff resistance to change and increasing staff engagement or "buy-in." This work can be done using a brainstorming exercise with facility staff during a monthly meeting and developing a formal action plan on how to implement these strategies (i.e. lead, specific activity, target dates, etc.)

Recommendation: Create a formal communication plan around the agency policy on staff recognition. If DYS chooses to implement this recommendation it will be critical to gather ideas from all levels of staff to include direct care staff on what they view as meaningful rewards and ways to communicate. This discussion should also include ideas on the frequency of formal recognition.

Recommendation: The agency should create and/or re-create youth and family program manuals to ensure all language is reflective of the agency's trauma-informed care approach. For example, one manual describes restraints as a "take down" which may be perceived as punitive or at the very least physically violent. Language should reflect a staff's responsibility and effort to protect youth from harm and do so without violence.

Recommendation: It is suggested that all facilities develop a communication plan to further explain the agency mission, core principles, agency treatment philosophy and approach, and juvenile rights in the youth and family manuals. If the facility also has a facility-specific mission statement, it is suggested that they include both the agency and facility missions in these handbooks. This reminds staff and youth that the facility is part of a larger DYS system - a network of facilities which operate together with the same goals in mind.

Recommendation: Develop a comprehensive plan detailing strategy for promoting staff wellness and retention. This planning process should include input from staff at all levels of the agency, especially direct care staff. This is an important exercise to support staff retention.

Safety and Security

DYS has a third-party quality assurance process that requires facility staff to "spot check" staff supervision, youth-to-staff interactions, and safety security breaches by reviewing several hours of video. In addition, DYS may wish to consider implementing a regular practice of reviewing video segments in staff meetings (particularly following an incident) to identify and discuss what went well, areas for improvement, team training needs, and lessons learned. This practice is in line with programs who have demonstrated positive youth outcomes.

As previously mentioned, DYS should require staff to review a youth's rights and responsibilities with youth at intake and have youth sign a form acknowledging their understanding of their right to file a grievance. This is the first of several critical pieces to ensuring a safe environment for youth in DYS care. Facility tours indicated that not all units have formal locked grievance boxes nor could staff or youth articulate the process. The grievance boxes should be checked by designated facility managers daily. Having a formal mechanism by which youth may anonymously report any harm they may be experiencing (i.e. bullying, abuse, harassment, etc.) is a critical component to youth safety. Interactions with youth verified they understood their rights and that facilities provide timely responses to youth grievances/suggestions (usually within a few days of grievance being filed).

[redacted]

Areas for Improvement and Recommendations:

Recommendation: Hire a permanent new director with proven experience in a secure long-term commitment program similar to LMYSC.

Recommendation: Evaluate on-site leadership and their ability to appropriately function in their assigned position.

Recommendation: Identify a formal supervision protocol to support and engage staff and to have a means for staff to immediately bring concerns and receive assistance in operationalizing solutions.

Recommendation: Maintain the current reduction in the number of youth from 148 to the current census of approximately 75-96 youth. This is important as it relates to staffing ratios, staff vacancies and turnover rates.

Recommendation: Consider implementing the Diana Screening tool across the division. This instrument screens for vulnerability of new hires to cross boundaries and pose a risk of sexually victimizing youth.

Recommendation: Consider reviewing and increasing minimum qualifications for direct-care staff.

Recommendation: Consider changing position description for the unit managers from a Youth Services Counselor III to a Program Manager I.

Recommendation: [redacted]

Recommendation: Re-establish routine meetings, such as the Youth Advisory Council meetings and staff Roundtable meetings, to increase the voice and participation of all that live and work at Lookout Mountain.

Recommendation: Evaluate legislation for aggravated offender sentences.

Recommendation: Staff training has been reduced over recent years, to include reducing the number of training hours for new hires from 120 hours to 80 hours. Some of the classes removed from the training curriculum are critical to the success of new staff, particularly direct care staff. As such, agency leadership should thoroughly review both the new hire and annual training curriculums and lesson plans in order to ensure the training is providing adequate and meaningful training for staff.

Recommendation: Review the salary structure for YS3's and provide salary adjustments to ensure salary is commensurate with their positions and not less than their subordinate staff.

Recommendation: [redacted]

Recommendation: [redacted]

Recommendation: [redacted]

Recommendation: Ongoing evaluation protocols for assessment of staff appropriate professionalism and boundaries. Have a supervision protocol to help determine which staff are appropriate to remain employed in direct care services at Lookout Mountain.

Recommendation: Facility leaders should eliminate safety hazards on the living units and increase the "homelike" feel of the units (make them more welcoming and warmer). Many units were cluttered with excess items and objects which pose significant safety and security hazards. During the onsite visit, many of the units appeared dreary (lack of color). In addition, observations revealed that many units did not have a recorded cleaning schedule. Facility leadership should work closely with their teams to gather ideas on how best to address these issues. These recommendations should be considered among the agency's highest priorities. Many units were cluttered with excess items and objects which pose significant safety and security hazards.

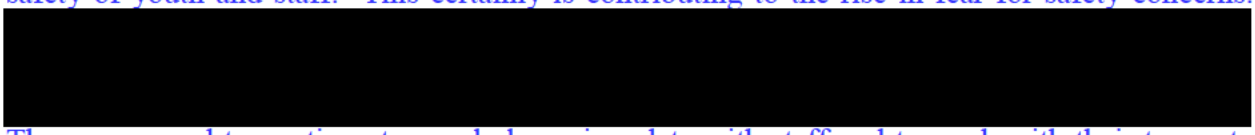
Recommendation: DYS should ensure all units have formal post orders to provide guidance and direction for staff working throughout the facility. Although all staff receive on-the-job training, some staff may not handle a crisis as effectively as others which may lead to staff forgetting steps in the response process. It is critical that staff react immediately, consistently, and effectively to all situations that may arise. Creating post orders will provide staff with guidance needed during crisis situations. Staff must be appropriately and regularly trained on crisis and emergency management response.

Recommendation: DYS should work with local law enforcement to develop procedures to have a drug dog onsite to patrol the parking lot and stand by the door on random visitation days and during various work shifts and shift change.

Recommendation: As part of the incident review process and to supplement review of video footage, the agency should consider requiring regular review of facility video in all-staff meetings a minimum of quarterly (in addition to post-incident reviews). These reviews serve to identify what went well, areas for improvement, team training needs, and lessons learned. This is an important process for ongoing professional development.

Recommendation: DYS should consider formalizing the practice of regular video review (not only after incidents) into agency policy and/or the program operations manual. The policy/procedure should explain when to conduct these reviews, what to look for (the positive and negative actions taken), how to use the information obtained from these video observation sessions, and how this information will be documented.

Recommendation: Continue to formally address staff fear for safety concerns and the use of isolation. At the time of the onsite visit several facilities had identified the goal of decreasing the use of isolation and fear for safety concerns of staff. Although most facilities are currently below the national average on isolation and seclusion, staff fear for safety is a major concern. Staff routinely voiced concerns that the mandate to reduce seclusion became more important than the safety of youth and staff. This certainly is contributing to the rise in fear for safety concerns.



The encouraged to continue to regularly review data with staff and to work with their teams to identify barriers and strategies to successfully reduce the use of isolation while working to provide staff with appropriate training to ensure for their and youth safety (i.e. alternatives to isolation, documentation, etc.). Staff need additional training and skills to respond to behavior incidents in a different manner while ensuring for the safety of all.

Observations and discussions during the site visit provided evidence that many units struggle to maintain adequate staffing levels, presenting safety and security concerns. Staff shortages are mainly due to a statewide turnover. The facility managers are back-filling these positions by serving as direct care staff. This inadequate staffing pattern puts undue stress on managers and direct care staff; limits a program's ability to operate as designed; and diminishes staff's ability to respond effectively to youth needs. For DYS facilities to achieve the agency mission of youth reformation, it is critical that all staff positions be filled. Doing so will allow staff to effectively supervise serious mental health youth, ensure treatment groups are conducted daily, and respond to emergency situations without leaving a mandatory post.

Recommendation: [redacted]

Recommendation: [redacted]

Recommendation: [redacted]

Recommendation: The agency should revise its grievance procedures and the youth and family manuals to align with federal Department of Justice PREA (Prison Rape Elimination Act) standards. The revised policy and program manuals should clearly state:

- Youth are not required to talk with the staff member who is the subject of the grievance
- Youth may submit a grievance anonymously or on behalf of another youth
- A parent and/or guardian may file a grievance on behalf of a youth and describe how a third-party report is made
- Designated facility staff must check the locked grievance boxes a minimum of once daily (including weekends)
- How submitted grievances are resolved – i.e. with grievances that allege sexual abuse, a thorough investigation will be conducted and a written response provided to youth by the YS3's within 48 hours but no later than five calendar days
- Staff are prohibited from asking youth about the contents of the grievance
- Staff must provide the tools necessary for youth to file a grievance and are not allowed to refuse youth the right to file a grievance
- The facility will provide stamps for letters to advocacy agencies as needed (no maximum limit)

Recommendation: DYS should secure an agreement with a local advocacy or rape crisis center to provide support to youth who may be victims of sexual abuse and/or assault. Once this Memorandum of Understanding is secured, youth and family manuals should be updated to provide this contact information (i.e. mailing address and telephone number). Federal PREA standard 115.351 requires facilities to youth to *"report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward*

resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request." And, signage is posted throughout the units to provide instructions.

Recommendation: Ensure all units have a locked grievance box on the living units and in the school classrooms. This will ensure youth can submit a grievance at any time throughout the day and on weekends. And, ensure proper communication is provided to youth and staff on the process.

Recommendation: Adopt and implement a vulnerability risk tool to measure risk for sexual victimization and/or perpetration for all youth at intake. This safety information should be used to make bedroom assignments. It is recommended that DYS revise existing policy and/or procedures to reflect this new practice.
(I think that a lot of this is done at the assessment unit. Maybe check on this in case it is already happening.)

Recommendation: Revise agency policies, procedures, and facility youth manuals to more clearly describe how strip searches are conducted to ensure privacy and meet security concerns. It is important to explain in the youth and family manuals that searches are done with two staff – one staff member conducts the search, while the other watches the staff (and cannot see the exposed youth).

Recommendation: [redacted]

Recommendation: [redacted]

Recommendation: The agency should consider developing a weekly room confinement report to be reviewed by DYS leadership each week (to include all room confinement). This will ensure all facilities operate consistent with agency expectations and use room confinement only in limited and exigent circumstances. Consider establishing a monthly metrics report which focuses on PbS critical outcome measures so that the data for these measures can be reviewed monthly.

Recommendation: Consistent with federal PREA standards, DYS should consider implementing ongoing education about zero tolerance for sexual abuse and sexual harassment. The facility may consider having youth watch a video at intake and lead a discussion monthly. One video to consider is one created by the Idaho Department of Juvenile Corrections

(https://youtu.be/TRqJd_tZh1A). Included in these regular discussions with youth should be the youth's right to contact an advocacy center and/or the State of Colorado sexual abuse hotline number. This contact information should be displayed on zero tolerance posters throughout all facilities.

Recommendation: Develop a detailed response protocol for allegations of sexual abuse and provide formal training to all staff. This protocol should include separating the victim and perpetrator; preserving the scene (and evidence); contacting the rape advocacy center; transporting youth to hospital for a SANE exam (Sexual Assault Nurse Examiner), etc. Having a detailed protocol ensures allegations of sexual abuse and sexual assault are handled effectively and ensures the safety of all staff and youth.

Programming

Evidence-based practice literature in juvenile justice have shown programs that have the greatest impact on youth (reducing the likelihood to recidivate) are those that have structured treatment activities between 35 and 50 hours per week (including school hours). Onsite visits revealed that the facility is not conducting treatment groups throughout the week and on weekends. Suggested treatment groups include the below and /or other evidence-based groups that are appropriate to the population and support the individual treatment plan (provided only to serve as examples and are not an all-inclusive list):

- Dialectical Behavior Therapy (DBT) – 1 ½ hours, 1x week
- Thinking for a Change (1 ½ hour, 1 x week)
- Seeking Safety (1 ½ hours, 1x week)
- Relapse Prevention (1 ½ hours, 1 x week)
- Why Try (1 hour, 1 x week)

All direct care staff need to be formally trained on these treatment groups. In addition, direct care staff are to be responsible for co-facilitating these groups. Research shows that staff involvement in programming increases a sense of purpose and commitment to the program and ultimately, improves staff morale.

All units should be required to conduct regular fidelity checks of treatment groups. These fidelity assessments include group observation, completing a fidelity form, and providing the group facilitator with feedback. The fidelity check would include areas such as how well the facilitator was prepared; did the facilitator follow the manual; did they demonstrate appropriate listening skills; pacing of the group; whether facilitator used verbal praise, tangible reinforcers, and appropriate punishers to discourage inappropriate behaviors; did the facilitator teach the new skill by first explaining the skill, modeling the skill, and then having youth practice/role play the skill (providing youth feedback). Ensuring treatment is a recipe for success in terms of producing positive youth/program outcomes.

DYS should develop specific programming guidelines for Lookout Mountain (i.e. wake up, group at 6 AM; school, etc.) as well as detailed descriptions of the transition and aftercare processes (i.e. how to assess aftercare needs; transition team meetings; aftercare planning; specific steps and responsibilities of staff; documentation requirements, etc.). In addition, the agency manual should outline the criteria for what a youth must do to "complete" the program and includes several checklists to ensure quality services are provided (i.e. intake checklists, fidelity forms, monitoring sheets that track generalizing of skills in the youth's high-risk areas etc.).

Similarly, a review of current team meeting structure revealed the agency may want to revise their policy to be more comprehensive and trauma focused. All plans should include client strengths and weaknesses; SMART goals that reflect each of the risk need assessment domains; and a tentative discharge plan. Consistent with the individualized treatment approach, DYS should consider using a *Specialized Intervention Form (SIF)* to help organize strategies for youth who are struggling. The SIF outlines specific youth behaviors; expected behavior change; and strategies/interventions that will be used to support youth moving in the right direction. The SIF plans reviewed were clear, comprehensive, and provided specific examples of expected behaviors and support strategies. In addition, youth should be included in the team meetings and group report outs should not be used to learn of progress or lack thereof.

Interviews with staff and facility leaders indicate there is not a strong relationship with the local community. The consultants would encourage DYS to incorporate numerous volunteers regularly participating in facility activities and donating time to work with youth on a weekly basis. Examples of volunteers include individuals from local churches, Wild Life Foundation volunteers, yoga instructors, musicians, and actors from a local improvisation theater, to name a few.

Areas for Improvement and Recommendations

Recommendation: The agency may consider adopting or creating additional assessments/questionnaires to measure other responsivity factors such as personality characteristics, hobbies, and interests for both staff and youth. Assessing staff professional skills, goals, and personal hobbies coupled with having youth complete a short questionnaire inquiring about their interests, hobbies, and personality characteristics will allow the program to more effectively match youth to their staff advocate. Doing so, will help establish a working relationship between two individuals with shared interests. In addition, understanding staff's professional goals and interests will allow the program to support staff in achieving these goals by providing them personal growth opportunities (i.e. co-facilitating specific treatment groups).

Recommendation: The behavior management system is not working as it should and is ineffective in reducing incidents of violence and/or providing adequate incentives to improve youth behaviors. In fact, it was discovered the previous facility director discontinued the behavior management system all together. The BMS needs to be reinstituted and staff re-trained on the program. DYS should offer several incentives to encourage youth progress in treatment, facilities should continue

to work with youth and staff to increase the number and types of reinforcers/incentives. Youth needs are ever-changing and incentives must be individualized. Ideas to consider are an individual lunch with the facility Superintendent (takeout from a favorite restaurant); special hair products; one day to wear his favorite personal t-shirt; first choice seat selection during movie night, etc.

Recommendation: The agency should work to create a program schedule with meaningful activities that does not require youth to be in their rooms during shift change, shower time, and/or during other regular operational activities. Room confinement time seems to be significant as it relates to these operational confinement periods. This is another area where community volunteers could be helpful. Research shows separation from the group on a regular basis can trigger trauma and lead to acting out behaviors. Finally, the PbS data related to the daily activity logs, needs to be tracked more efficiently and in a manner, which ensures data integrity.

Recommendation: Due process is lacking or is non-existent within the youth disciplinary process. Due process has been replaced with the "intervention and sanctions" process. Agency leadership should review and restore due process to the disciplinary procedures. Finally, there is a lack of consequences for youth, particularly those involved in serious incidents, such as a staff assault. The agency needs to review the disciplinary sanctions and consequences to ensure adequate sanctions for serious offenses.

Recommendation: It is suggested that the agency immediately reinstitute Religious Services. The consultants were told that Religious Services were placed on hold for several weeks. However, this is a constitutional right and needs to be the highest priority.

Recommendation: Work to enhance family engagement practices. Family engagement is an important element for facility and youth success. Families have extraordinary strengths and help create healthier facility environments.

Recommendation: It is suggested that all facilities adopt the practice of providing monthly training refreshers during all-staff meetings. Power Point presentations and corresponding talking points could be developed for and used by Leadership or designees each month. Topics to consider include adolescent brain development, verbal de-escalation, teaching youth skills, positive youth development, staff positioning, etc. These trainings should include experiential learning exercises whenever possible.

Recommendation: Continue to devote resources to implementing vocational certification programs for youth in DYS facilities (i.e. plumbing, carpentry, etc.). Trade certifications greatly increase the likelihood a youth will find employment and consequently, continue to engage in prosocial activities. The agency is in the process of increasing the vocational opportunities at Lookout Mountain. The consultants would encourage including vocational programs such as welding, robotics, landscaping, and construction (i.e. sheet rocking, tiling, flooring, etc.) as well as for DYS to continue to explore vocational programs that will allow youth to earn certification in specific trades.

Recommendation: DYS should ensure that a formal structure exists requiring active youth participation in the treatment planning process. Youth engagement may include youth advocating for level advancement and/or presenting to the treatment team evidence of behavioral progress. These expectations should be clearly described in the youth and parent manuals.

Best practices show programs with the best outcomes are those in which youth are actively involved in the development and tracking of their treatment goals. At the time of the onsite visit, some facilities required youth to be actively engaged in advocating for their behavior level and privileges, while others did not.

Recommendation: Facilities may benefit from additional training and guidance on how best to work with gang-affiliated youth. During the onsite visit, staff identified this as an area of need.

Recommendation: DYS should reconsider whether the implementation of their current model is the best model given the facility make-up. It should also be noted that both staff and youth are confused about the model and it appears to be having a negative impact throughout the facility. Staff reported that the model was introduced poorly and was implemented poorly. Staff and youth are confused as to which behavioral model they are supposed to be following and which rules apply.

Recommendation: Ensure all youth and family manuals are written using language that is easily understood by most individuals and not simply a mirror image of agency procedures. All manuals should clearly explain the program's philosophy; type and purpose of treatment groups; the behavioral level system and daily ratings; privileges and consequences; and other important program information.

Quality Assurance

DYS has had a solid system of risk controls to ensure programs operate consistent with agency expectations for several years. The system includes:

- Audits conducted by the State of Colorado Department of Human Services, Quality Assurance/Quality Improvements division; and

Quality Assurance/Quality Improvement (QAQI) oversight has been in place for several years. In reviewing some of the recent audit reports, there were non- compliant findings cited, however nothing collectively was cited as a findings or brought forward to the degree of what we are seeing now.

DYS also uses Performance-based Standards (PbS) at Lookout Mountain to continuously monitor and improve program outcomes. PbS is a data-driven improvement model that closely examines areas of safety, security, order, health and mental health, justice, programming, reintegration, and

family and social supports. PbS professionals provide training, technical assistance, and expert coaching to assist DYS facility leaders in improving programing and youth outcomes. More than 200 facilities in 32 states voluntarily participate in PbS.

The agency's primary internal audit is conducted by the State of Colorado Department of Human Services Research and Evaluation Bureau of Quality Assurance. The purpose of the audit is to determine a facility's compliance with agency policies and procedures in the key areas of programming, safety security, youth case plan documentation, staff training, facility inspections and searches, to name a few.

Recommendation:

- Although all DYS facilities participate in Performance-based Standards and collect isolation data twice a year, the consultants encourage DYS to require its facilities to collect, report, and discuss isolation and other critical outcome measures a minimum of monthly. This will ensure facilities adhere to agency expectations and assist in maintaining a culture of using isolation as a last resort. Most importantly, by establishing a monthly critical outcomes measure report, agency and facility leadership will be better able to monitor these outcomes and to respond to them in a more efficient and effective manner.
- Create an automated report to capture isolation, use of restraint, assaults, fights, youth without incident, and other critical incident measures and data points regularly and share this information with staff to reduce uninformed myths about the facility.

Conclusion

The State of Colorado DYS clearly has committed leadership and is supported by a dedicated team of facility leaders and staff members. The agency is working diligently to create a firm foundation for success that adjusts to the recent legislative and agency changes that have been substantial and have significantly effected operations in the DYS facilities. With the dedicated and caring staff; evidence-based treatment and consultations in decision-making; with a highly developed system of risk controls/quality assurance, the key pieces are in place for agency and program success.

While the recommendations in this findings report are extensive, they are intended to assist the facility in improving agency and facility operations and most importantly to decrease risk to youth and staff and improve long term outcomes for youth entrusted to the care of the Colorado DYS.

In concluding, it is important to note that the current situation and level of violence at LMYSC can be corrected. The overall environment and current conditions were brought on by several agency level and legislative factors over the course of several years. The impact of the legislative changes, including the elimination of seclusion and the restrictions placed on the agency around "strip" searches, without alternative responses in place, played a crucial role in the downturn of the facility. However, these were not the only issues impacting the sudden change in the environment

and the increase in the level of violence. The current conditions and level of violence developed as a result of a culmination of these and the other issues raised in this report. It was the totality of these circumstances that resulted in what we see today, the level of violence, the severe drug problem, the unsafe conditions, the culture, the atmosphere, staff turnover and the overwhelming feelings of anxiety and fear for safety.

The consultants encourage the DYS to identify those recommendations most critical to the agency and facility mission and develop a prioritized implementation/corrective action plan to enhance the good work currently being done. The level of commitment to improving conditions and providing care and treatment for youth is commendable.

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