

**OKLAHOMA COMMISSION ON CHILDREN AND YOUTH
OFFICE OF JUVENILE SYSTEM OVERSIGHT**

Name and Location of Facility: L. E. Rader Center
Sand Springs, Oklahoma

Dates of Visit: May 31, June 1, and June 8, 2006

Oversight Reviewers: Ellen Harwell, April Simmons, Jenifer K. Cooks, and
Cliff A. Aldridge, Oversight Specialists

Focus of Visit: Biannual Visit for 2006

Date: December 4, 2006

General Information

The Office of Juvenile System Oversight (OJSO) conducted a routine, unannounced visit of the L. E. Rader Center on May 31, June 1, and June 8, 2006. The focus of the visit was to assess compliance with established responsibilities and facility policy and procedures.

Persons Interviewed

- Thirty juveniles
- Nine staff members

Documentation Reviewed

- Files on eight residents
- Ten staff files
- Facility policy and procedures
- Office of Juvenile Affairs Rules
- American Correctional Association (ACA) Standards
- Most recent inspection reports by the Oklahoma State Department of Health, the Division of Child Care of the Department of Human Services, and the Office of the Oklahoma State Fire Marshal

Areas Toured

- Entire facility

Overview

Resident Interviews (instrument attached)

Thirty residents were interviewed to assess their perceptions of safety, program services, the rights of residents, discipline practices, and other residential issues. The residents were randomly selected. The average age of the residents interviewed was 16.6, as compared to 16.3 during the previous oversight visit. Twenty-three of the interviewees were 16 years of age or older. Tulsa County and Oklahoma County were the highest reported home counties.

The OJSO noted:

- Eighty percent (24 of 30) reported receiving a copy of the Resident's Rights.
- Forty-three percent (13 of 30) reported that program information and rules were explained to them upon admission.
- Thirty-three percent (10 of 30) reported being enrolled in special education classes in the community.
- Seventy-three percent (22 of 30) reported that the teachers were helpful to them.
- Thirty percent (9 of 30) reported they received enough food to eat.
- All interviewees reported that additional servings of food were not allowed.
- Thirty-seven percent (11 of 30) rated the food as 1 on a scale of 1 to 5. The second highest percentage, thirty percent (9 of 30), rated the food as 3 on the same scale. No one rated the food as 4 or 5.
- Eighty percent (24 of 30) reported the use of group punishment.
- Fifty percent (15 of 30) reported having been physically restrained.
- Sixty-seven percent (20 of 30) reported receiving individual counseling.
- Forty-seven percent (14 of 30) reported receiving family counseling.
- Seventy-three percent (22 of 30) reported receiving substance abuse treatment.
- Three percent (1 of 30) reported the grievance process worked.
- Sixty-three percent (19 of 30) reported having been physically assaulted at the facility.
- Fifty-three percent (16 of 30) reported they felt safe at the facility.

Staff Interviews (instrument attached)

Nine staff members were interviewed. The interview questions pertained to the staff perceptions of program services, the rights of residents, discipline policies, and other residential issues. Most staff members reported prior experience in working with children; two staff members reported no prior experience. Staff members voiced repeated requests for additional training regarding gangs.

The OJSO noted:

- Seventy-eight percent (7 of 9) reported having been injured during a restraint.
- Forty-four percent (4 of 9) reported seeing a resident injured during a restraint.

- Eighty-nine percent (8 of 9) reported that residents were not allowed additional servings of food. Three staff members reported that the juveniles did not receive enough to eat.
- Thirty-three percent (3 of 9) believed their input was valued by administrative staff.

Resident Files

Eight resident files were reviewed. The OJSO noted:

- Documentation did not indicate receipt of the Resident Handbook by the residents in four files reviewed.
- The final treatment plans for three residents were not signed by the parents/custodians, nor were the reasons for lack of participation documented.

Staff Files

Ten staff files were reviewed. The OJSO noted:

- One of the three references contained in one personnel file was obtained prior to the staff member's date of hire.

Observational Tour

The OJSO conducted a tour of the entire facility and noted:

- Discovery Cottage, Apollo Cottage, Viking Cottage, Unit 4, the Behavior Management Unit, Mercury Cottage, and Venus Cottage contained unlabeled bottles of chemicals.
- Friendship Unit, Room F2, had gang writing on the wall.
- One room on Unit 3 contained candy wrappers, a two-liter Sprite bottle, a calculator, and a rolodex. All items were confiscated by staff at the time of the visit.

Summary

Staff members repeatedly reported working long hours or double shifts, due to a perceived staff shortage. The residents stated that staff members were not actively monitoring the sleeping areas, reportedly resulting in the residents feeling less safe. Residents reported they would like additional staff coverage and increased monitoring by security. Criticism of the quantity and quality of food (as evidenced by ratings of 3 or less on a scale of 1 to 5) was expressed by staff and residents.

Findings

1. Four resident files lacked documentation of the residents' receipt of the Resident Handbook. Department of Human Services licensing standards, Section 154, Social services, (e), Resident's records, (1), (J), states, "The facility maintains a written

record for each resident The [resident] record includes signed documentation that the resident and parents or custodian have been provided written copies of the facility's policies on resident's rights, grievance procedures, behavior management policies, trips away from the facility, use of volunteers and frequency of reports to the parent or custodian." L.E. Rader Center policy, procedure number RC50100.01, (II), (S), states, "The juvenile will be introduced to the rules and regulations of the unit as well as receiving the Juvenile Handbook and having the handbook reviewed with them by designated staff."

2. Final treatment plans for three juveniles were not signed by the parents/custodians, with no reasons given for the lack of participation. Department of Human Services licensing standards, Section 154, Social services, (b), Service planning, (1), Comprehensive service plan, (A), states, "The facility involves the resident and parents or custodian in the development of the service plan. If the parents or custodian do not participate in the development of the service plan, the reason for non-participation is documented in the service plan." At the same cite, paragraph, (b), Service planning, (1), Comprehensive service plan, (B), (vi), states, "The service plan identifies and includes the names and signatures, with the date, of those participating in developing the service plan."
3. One personnel file contained verification of only one reference obtained prior to employment. Department of Human Services licensing standards, Section 153.1, Personnel, (g), Employment requirements, (1), References, states, "The facility obtains a minimum of three references for all staff prior to employment."
4. Gang writing was located on the wall of Friendship Unit. Department of Human Services licensing standards, Section 157, Physical facility and equipment, (j), Sanitation and safety, (7) states, "Floors, walls, ceilings, doors, and windows are maintained in good condition."

EH:js

