

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

Name and Location of Facility: LE Rader Center
Sand Springs, Oklahoma

Date of Visit: December 13 and 14, 2007

Oversight Reviewer: Ellen Harwell

Oversight Review Team: April Simmons and Cliff Aldridge,
Oversight Specialists

Focus of Visit: Unannounced Routine Visit

Date: March 31, 2008

Introduction

The Office of Juvenile System Oversight (OJSO) conducted a routine, unannounced visit on December 13 and 14, 2007, of the LE Rader Center in Sand Springs, Oklahoma. The facility is a medium and maximum secure rehabilitation program for male juveniles adjudicated Delinquent or Youthful Offender who are in the custody of the Office of Juvenile Affairs (OJA). Programs include the Residential Treatment Program (RTP), Intensive Treatment Program (ITP), the Mental Health Stabilization Unit (MHSU), and the Behavioral Management Unit (BMU). The focused oversight visit consisted of staff and juvenile interviews and a review of the Caretaker Conduct Review process. The facility is licensed for 215 residents. The census the day the oversight visit began was 138.

Interviews Conducted

- Entry conference with the superintendent
- Exit conference with the superintendent
- Twenty seven residents
- Nine staff members

Documents Reviewed

- Oklahoma State Department of Health inspection report dated September 24, 2007
- Department of Human Services (DHS) Division of Child Care Facility inspection form, dated November 6, 2007

- Caretaker Conduct Reviews completed by the facility from June 2007 through December 2007, including the corresponding OCA-1 form

Findings

Juvenile Interviews

The OJSO interviewed 27 male residents. Due to program differences, findings for the RTP are reported separately from the other units. MHSU and BMU are most similar to ITP, and, therefore, ITP is combined with MHSU and BMU for reporting purposes; collectively these three programs are referred to as the Intensive Group.

Residential Treatment Program

Fourteen residents were interviewed. All the residents were 15 years of age or older. The average age of residents was 15.6, which is lower than the last oversight visit by one year. Seventy-nine percent (11 of 14) were 16 years of age or older. Twenty-nine percent (4 of 11) were 18 years of age or older compared to 39% during the previous oversight visit. Thirty-six percent (5 of 14) reported their county of residence was Oklahoma County, the most heavily represented county. Cleveland, Pottawatomie, and Tulsa Counties were the second highest reported counties at fourteen percent (2 of 14) each. Reported lengths of stay at the facility ranged from one month to two years. The OJSO noted:

- All residents reported they received a copy of resident rights upon admission.
- Eighty-six percent (12 of 14) reported receiving written notification of policies regarding visitation, mail, phone calls, gifts, and discipline.
- Seventy-one percent (10 of 14) reported the information received upon admission was also explained to them.
- All residents reported previous admissions to other facilities. Types of facilities included detention centers, jails, level E group homes, psychiatric hospitals, shelters, and foster care.
- Seventy-nine percent (11 of 14) reported they received enough food.
- Seventy-one percent (10 of 11) reported additional helpings of food were allowed if residents desired them.
- Residents were asked to rate the quality of food on a scale of one to five, with one being the worst and five being the best. Residents' ratings were as follows: 1 – 7%, 2 – 21%, 2.5 – 14%, 3 – 43%, 4 – 7%, 5 – 7%.
- Twenty-one percent (3 of 14) reported having been physically restrained within the last six months.
- Seventy-nine percent (11 of 14) reported the use of group sanctions within the last six months.
- Ninety-three percent (13 of 14) reported having an individualized treatment plan.
- Thirty-six percent (5 of 14) reported they participated in the development of the treatment plan.
- Twenty-one percent (3 of 14) were not able to recall treatment objectives.
- Fifty-seven percent (8 of 14) reported receiving individual counseling.
- Sixty-four percent (9 of 14) reported receiving substance abuse treatment.

- Fourteen percent (2 of 14) reported receiving family counseling.
- Forty-three percent (6 of 14) reported receiving Independent Living Skills counseling.
- Twenty-one percent (3 of 14) reported being required to complete sex offender treatment and stated they have received services.
- Residents were asked how many times a week group is held. Fifty percent (7 of 14) reported group is held one to three times per week. Twenty-nine percent (4 of 14) reported group is held four to six times per week. One resident reported group is held seven or more times per week, and two residents reported no groups were being conducted.
- Residents were asked who did the majority of the talking in group. One resident reported the juveniles did most of the talking. Fourteen percent (2 of 14) reported staff members did most of the talking. Seventy-one percent (10 of 14) reported both residents and staff spoke in group equally.
- Eighty-six percent (12 of 14) reported everyone was encouraged to talk in group.
- One resident reported receiving job training at the skills center.
- Forty-three percent (6 of 14) reported being taught skills to help them live on their own.
- All residents identified a career goal.
- Seventy-one percent (10 of 14) reported they had shared their career goals with staff members.
- Seventy-nine percent (11 of 14) reported having filed a grievance.
- One resident reported the grievance process does work. Fifty-percent (7 of 14) stated the process does not work. Twenty-one percent (3 of 14) reported the process sometimes works. One resident stated he was not sure. Fourteen percent (2 of 14) did not respond to the question.
- Fifty-seven percent (8 of 14) reported staff members have used curse words when addressing them.
- Sixty-two percent (9 of 14) reported witnessing staff members curse at other residents.

Supervision

Residents were asked to respond, using a Likert scale, how often direct care staff members check on them while in the dorm area. The options given were Frequently (every 15 to 20 minutes), Occasionally (every 1 to 2 hours), Rarely (every 3 to 4 hours), Very Rarely (every 5 to 6 hours), and Never. Ninety-three percent (13 of 14) of the residents reported that staff members check on them frequently. One resident reported that staff members check on residents frequently and occasionally depending on the shift.

Residents were also asked how often security officers check the living units. A Likert scale again was used. The options given were Frequently (every 1 to 2 hours), Occasionally (every 3 to 4 hours), Rarely (every 5 to 6 hours), and Never. All residents reported that security officers frequently check the living units.

Safety

Residents were asked about physical and sexual assaults and the presence of dangerous contraband at the facility. The OJSO noted:

- Fifty percent (7 of 14) reported seeing residents in possession of dangerous contraband. Items included cigarettes, tobacco for dipping, money, pornography, and alcohol. Residents were asked if they wanted the OJSO to report specific allegations regarding assaults or contraband. Two residents stated yes and reported an incident that the OJSO confirmed had previously been reported to the Department of Human Services Office of Client Advocacy.
- Thirty-six percent (5 of 14) reported being physically assaulted by other residents.
- All residents denied being physically assaulted by staff members.
- One resident reported being sexually assaulted by another resident. This resident reported to the OJSO that the incident had been reported and investigated.
- All residents denied being sexually assaulted by a staff member.

Residents were asked how often they felt safe at the facility. Using a Likert scale (Very Frequently, Frequently, Occasionally, Rarely, Very Rarely, and Never), the responses were as follows: Very Frequently 36% (5 of 14), Frequently 36% (5 of 14), Occasionally 21% (3 of 14), and Rarely 7% (1 of 14). Residents were asked what contributed to their feeling of safety. The options were staff, facility police officers, peers, or their ability to keep themselves safe (self). Residents could choose more than one and reported the following: Staff 21% (3 of 14), Police Officers 21% (3 of 14), Peers 14% (2 of 14), and Self 86% (12 of 14).

Residents were also asked what contributed to feeling unsafe. Their options were staff, facility police officers, and peers. Residents could choose more than one. Seventy-nine percent (11 of 14) reported peers as the reason for feeling unsafe. One resident reported staff members were the reason for feeling unsafe. One resident reported that everyone contributed to feeling unsafe. When asked how to improve safety at the facility, forty-three percent (6 of 14) requested additional staff members on the living units.

Intensive Group

Residents of ITP, MHSU, and BMU were combined to form the Intensive Group. Programming, supervision, and unit schedules of MHSU and BMU are more similar to ITP than RTP. Thirteen residents were interviewed. All the residents were 15 years of age or older. The average age of residents was 16.8. Ninety-two percent (12 of 13) were 16 years of age or older. Twenty-three percent (3 of 13) were 18 years of age or older. Reported length of stays at the facility ranged from two months to two years and two months. The OJSO noted:

- Eighty-five percent (11 of 13) reported they received a copy of resident rights upon admission.

- Ninety-two percent (12 of 13) reported receiving written notification of policies regarding visitation, mail, phone calls, gifts, and discipline.
- Sixty-two percent (8 of 13) reported the information received upon admission was also explained to them.
- All of the residents interviewed reported previous admissions to other facilities. Types of facilities included detention centers, jails, other medium secure facilities, level E group homes, level D+ group homes, psychiatric hospitals, adventure programs, shelters, and foster care.
- Sixty-nine percent (9 of 13) reported they received enough food.
- Fifty-four percent (7 of 13) reported additional helpings of food were allowed if residents desired them.
- Residents were asked to rate the quality of food on a scale of one to five, with one being the worst and five being the best. Residents' reports were as follows: 2 – 23%, 2.5 – 8%, 3 – 38%, 4 – 23%, 5 – 8%.
- Thirty-one percent (4 of 13) reported having been physically restrained in the last six months.
- Forty-six percent (6 of 13) reported having been placed in solitary confinement.
- Sixty-nine percent (9 of 13) reported the use of group sanctions in the last six months.
- Seventy-five percent (10 of 13) reported having an individualized treatment plan.
- All residents reported they participated in the development of the treatment plan.
- Seventy-seven percent (10 of 13) reported receiving individual counseling.
- Sixty-two percent (8 of 13) reported receiving substance abuse treatment.
- Sixty-two percent (8 of 13) reported receiving family counseling.
- Twenty-three percent (3 of 13) reported receiving Independent Living Skills counseling.
- Fifteen percent (2 of 13) reported being required to complete sex offender treatment and stated they had received services.
- Residents were asked how many times a week group is held. Seventy-seven percent (10 of 13) reported group is held one to three times per week. One resident reported group is held four to six times per week.
- Residents were asked who did the majority of the talking in group. One resident reported that residents did most of the talking. Sixty-nine percent (9 of 13) reported both staff members and residents talk equally in group. Fifteen percent (2 of 13) reported staff members did most of the talking.
- Ninety-two percent (12 of 13) reported that everyone is encouraged to talk in group. One resident did not answer the question.
- Fifteen percent (2 of 13) of residents reported receiving job training at the skills center.
- Twenty-three percent (3 of 13) reported being taught skills to help them live on their own.
- Ninety-two percent (12 of 13) identified a career goal. Seventy-five percent (9 of 12) reported they had shared their career goals with staff members.
- Seventy-seven (10 of 13) reported having filed a grievance.

- One resident reported the grievance process does work. Sixty-nine percent (9 of 13) reported the process does not work. One resident reported the process sometimes works. Fifteen percent (2 of 13) did not respond to the question.
- Fifty-four percent (7 of 13) reported staff members have used curse words when addressing them.
- Sixty-two percent (8 of 13) reported witnessing staff members curse at other residents.

Supervision

Residents were asked to respond, using a Likert scale, how often direct care staff members check on them while in the dorm area. The options given were Frequently (every 15 to 20 minutes), Occasionally (every 1 to 2 hours), Rarely (every 3 to 4 hours), Very Rarely (every 5 to 6 hours), and Never. All residents reported that staff members check on them frequently.

Residents were also asked how often security officers check the living units. A Likert scale again was used. The options given were Frequently (every 1 to 2 hours), Occasionally (every 3 to 4 hours), Rarely (every 5 to 6 hours), and Never. All residents reported that security officers frequently check the living units.

Safety

Residents were asked about physical and sexual assaults and the presence of dangerous contraband at the facility. The OJSO noted:

- Sixty-two percent (9 of 13) reported seeing residents in possession of dangerous contraband. Items included cigarettes, tobacco for dipping, lighters, pornography, alcohol, marijuana, tattoo guns, pencils, pens, spoons, shanks, pills, a box cutter, razor blade, and other nonspecific street drugs. Residents were asked if they wanted the OJSO to report specific allegations regarding assaults or contraband. There were no specific allegations regarding assaults or contraband reported to OJSO and no requests for OJSO to report assaults or contraband.
- Thirty-one percent (4 of 13) reported being physically assaulted by other residents.
- Thirty-eight percent (5 of 13) reported being physically assaulted by staff members.
- All residents denied being sexually assaulted by other residents or staff members.

Residents were asked how often they felt safe at the facility. Using a Likert scale (Very Frequently, Frequently, Occasionally, Rarely, Very Rarely, and Never), The responses were as follows: Very Frequently 38% (5 of 13), Frequently 8% (1 of 13), Occasionally 8% (1 of 13), Vary Rarely 23% (3 of 13), and Never 15% (2 of 13). Residents were asked what contributed to their feeling of safety. The options were staff, facility police officers, peers, or their ability to keep themselves safe (self). Residents could choose more than one and reported the following: Staff 31% (4 of 13), Police Officers 15% (2 of

13), Peers 23% (3 of 13), and Self 46% (6 of 13). Fifteen percent (2 of 13) reported never feeling safe. One resident did not respond to the question.

Residents were also asked what contributed to feeling unsafe. Their options were staff, facility police officers, and peers. Residents could choose more than one and reported the following: Staff 38% (5 of 13) and Peers 54% (7 of 13). Thirty-eight percent (5 of 13) stated that no one at the facility made them feel unsafe.

STAFF INTERVIEWS

The OJSO interviewed nine staff members. The interview questions pertained to the staff members' perceptions of the rights of residents, discipline policies, and other residential issues. Length of employment ranged from six months to 23 years. The OJSO noted:

- Staff members were asked about their highest level of education. Eighty-nine percent (8 of 9) reported having a high school diploma. One staff member reported earning an associates degree.
- Thirty-three percent (3 of 9) reported no prior experience working with juveniles.
- All reported current training in first aid, CPR, and the behavioral intervention technique used by the facility.
- Fifty-six percent (5 of 9) were able to state how many training hours are required every year.
- Eighty-nine percent (8 of 9) reported having been involved in a restraint.
- Fifty-six percent (5 of 9) reported being injured during a restraint.
- Forty-four percent (4 of 9) reported seeing another staff member be injured during a restraint.
- Fifty-six percent (5 of 9) reported seeing a resident injured during a restraint.
- Fifty-six percent (5 of 9) stated additional training would assist them. Areas in which additional training was requested included information about the behavior of sex offenders, coping skills and dealing with the youths' behaviors, cultural information, updates on gang behavior, and additional refresher courses for the Care and Custody Management System (CCMS).
- Sixty-seven percent (6 of 9) reported they get enough information about the residents to provide appropriate care.
- Eighty-nine percent (8 of 9) reported that they eat the same food as the residents when eating together.
- Thirty-three percent (3 of 9) reported that residents may have additional servings of food.
- All but one staff member reported the use of group punishment is not allowed for the actions of a few.
- Sixty-seven percent (6 of 9) believed that administrative staff members worked well with the direct care staff members.
- Forty-four percent (4 of 9) believed their input is valued by administrative staff members.

- Eighty-nine percent (8 of 9) reported that recreation is offered at least two or more times per day. One staff member reported recreation is offered at least one time per day.
- Interviewees were asked to classify the morale of staff members as low, medium, or high and reported the following: Low 44% (4 of 9), Medium 33% (3 of 9), High 11% (1 of 9).
- Interviewees were asked to classify the morale of residents as low, medium, or high and reported the following: Low 11% (1 of 9), Medium 67% (6 of 9), and High 11% (1 of 9).

Safety

Using a Likert scale (Always, Usually, About half the time, Seldom, and Never), staff members were asked if co-workers treated them with respect. Responses were as follows: Always 22% (2 of 9), Usually 56% (5 of 9), and About half the time 11% (1 of 9). The same scale was used when staff members were asked if they felt their co-workers were willing to put forth as much effort as necessary to get work done. Responses were as follows: Always 11% (1 of 9), Usually 67% (6 of 9), and About half the time 11% (1 of 9). Staff members were asked, "Do you feel safe while at work?" Fifty- six percent (5 of 9) stated they always feel safe at work. Thirty-three percent (3 of 9) stated they usually feel safe at work.

Staff members were asked how often security officers completed checks of the living units. All responded that security officers check the living units at least every hour.

CARETAKER CONDUCT REVIEWS

Alleged Incidents of abuse, neglect, and caretaker misconduct are reported to the Department of Human Services Office of Client Advocacy. Depending upon the specific allegations, the Office of Client Advocacy may investigate allegation(s) of caretaker misconduct or ask the facility to complete a Caretaker Conduct Review (CCR). During the current oversight visit, the OJSO requested to review Caretaker Conduct Reviews completed between January and December 2007. The facility provided this information to the OJSO on February 5, 2008.

The OJSO reviewed 183 CCRs. Of the 183 CCRs reviewed, 147 were not completed within 30 days as required by policy. The most delinquent case was FY-07-15979 which was reported to the OCA on February 5, 2007, and completed on October 9, 2007.

Ten Caretaker Conduct Reviews were randomly selected to determine their compliance with OAC 340:2-3-37 sections (c) through (f). Case specific findings and information concerning these ten CCRs are attached to this report in a confidential attachment to be reviewed by the facility. The attachment is not electronically published because the case specific information is not public record. General concerns and violations are noted below.

Areas of Concern

1. Thirty-six percent of residents in the Residential Treatment Program reported they participated in the development of their individualized treatment plan. Twenty-one percent could not convey to the OJSO issues identified on their treatment plans.
2. In the Residential Treatment Program, reported treatment services in family counseling and substance abuse were low compared to the previous oversight visit. The reported percentage of family counseling dropped from 50% to 14%. The reported percentage of substance abuse treatment dropped from 94% to 64%.
3. Reported treatment services for residents in the Intensive Group declined in the areas of family counseling, independent living services, and substance abuse. The reported percentage of family counseling dropped from 62% to 33%. The reported percentage of independent living services dropped from 23% to 8%. Substance abuse treatment dropped from 62% to 42%.
4. Both the RTP and the Intensive Group had high percentages of residents who reported having filed a grievance and low levels of satisfaction with the process. Seventy-nine percent of residents in the Residential Treatment Program and 77% of residents in the Intensive Group reported having filed a grievance. Only one resident in each program reported the grievance process worked.
5. Juvenile witnesses and/or victims were interviewed for a CCR over the telephone in four of the ten CCRs selected for review. Residents do not have access to private phone conversations. Interviewing residents regarding the actions of other juveniles and/or staff members placed those juveniles at risk and compromised the integrity of the CCR.
6. Most CCRs were not confirmed although the facility process failed to meet the objective policy criteria stated in OAC 340:2-3-37.
7. None of the 10 CCRs selected for review were signed by the person who completed the report or the person who reviewed the report. Five of the 10 reviews had initials with typed names on the report sent from the facility to the Office of Client Advocacy (OCA-7). OAC 340:2-3-37 (e), (11) states, "...either on a cover memo or at the end of the report, the signature and date signed by the person who conducted the CCR, and the signature of the person who reviewed and approved the report."

Violations

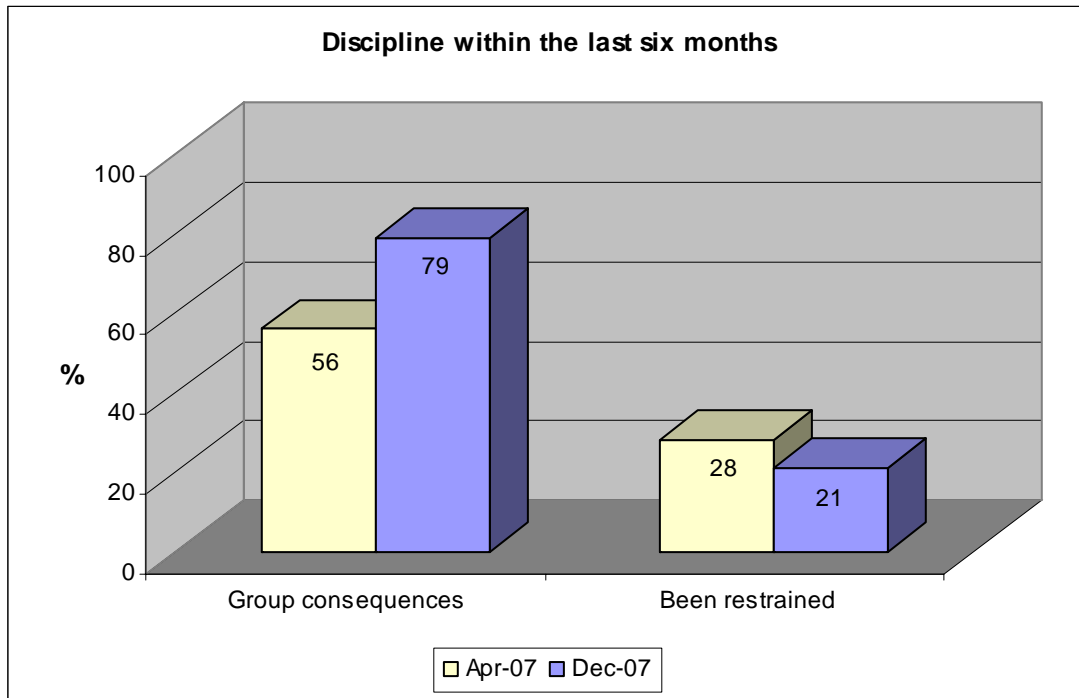
1. Eighty percent (127 of 183) of Caretaker Conduct Reviews completed by the facility failed to meet the 30-day time frame for completion. OAC 340:2-3-37 (f) states, "The final written report is submitted to the advocate general within 30 calendar days from the date that OCA intake notified the administrator that an allegation is referred for CCR."
2. None of the CCRs selected for review contained written statements from those interviewed. OAC 340: 2-3-37 (c), (3), (A-D) states that the CCR includes:
 - ...obtaining written statements and conducting interviews with:
 - (A) each alleged victim;
 - (B) each eyewitness;
 - (C) other persons with knowledge relevant to the allegation; and

- (D) each accused caretaker;
3. One CCR reviewed met the criteria for requesting that the Department of Human Services (DHS) Office of Client Advocacy (OCA) initiate an investigation in lieu of a CCR. OAC 340:2-3-37 (d) states:
“If at any time during the CCR information is learned that gives cause to believe that a client was the victim of caretaker misconduct resulting in a serious injury, abuse or neglect, the administrator immediately discontinues the CCR and contacts OCA intake to report the new information warranting an OCA investigation.”
 4. One CCR reviewed did not contain a statement of whether or not photographs were taken of an injury sustained by the youth. OAC 340:2-3-37 (3), (2) states that the CCR report contains “a statement of any injury sustained by the alleged victim(s) and, in cases involving an injury, a statement whether photographs were taken of the injury and if so, the date they were taken.”

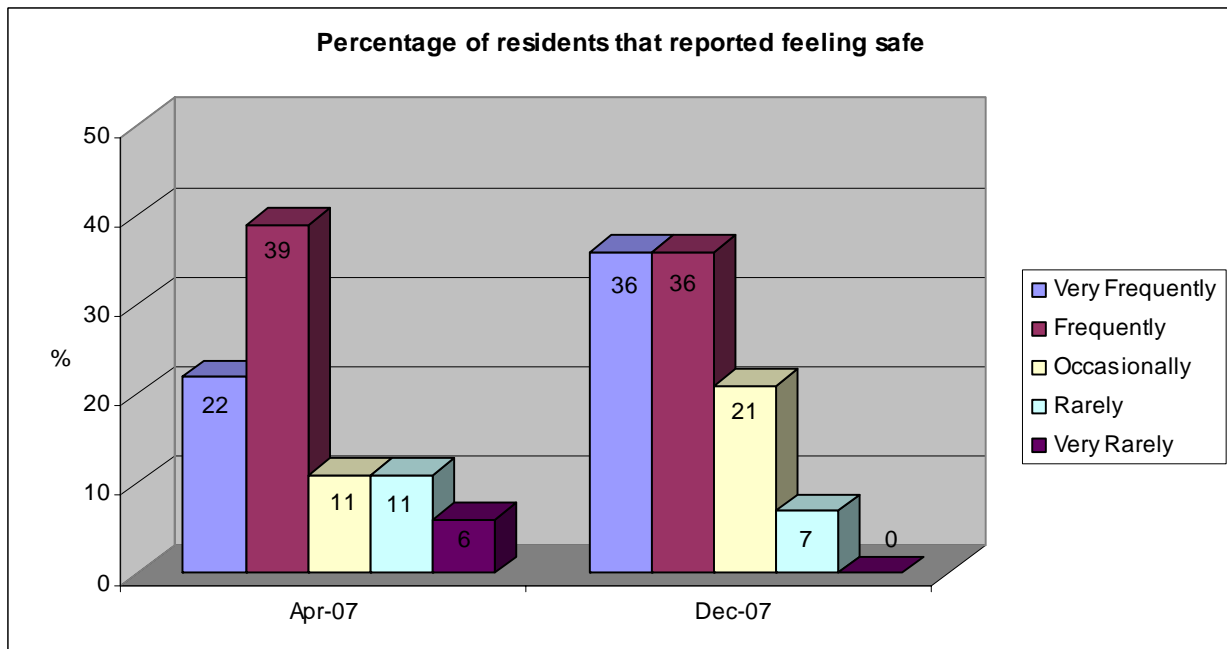
Summary

The following is a comparison of residents' self reports from the last two oversight visits. The current oversight visit was the second time data was obtained as two separate programs. Differences were noted between the RTP and the Intensive Group. A comparison will be made between these two groups as well.

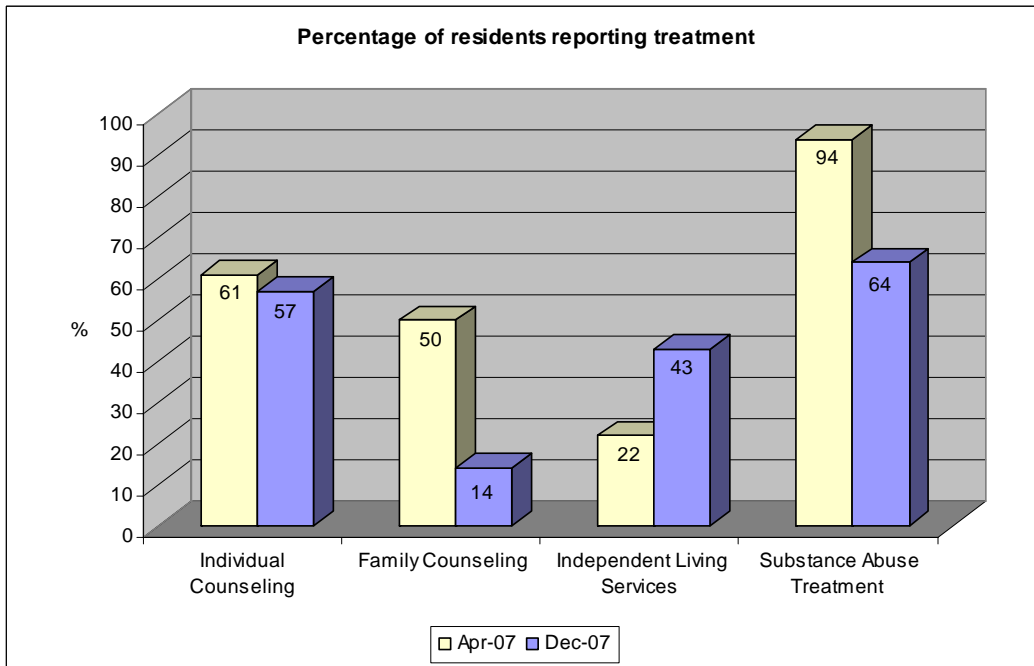
Residential Treatment Program



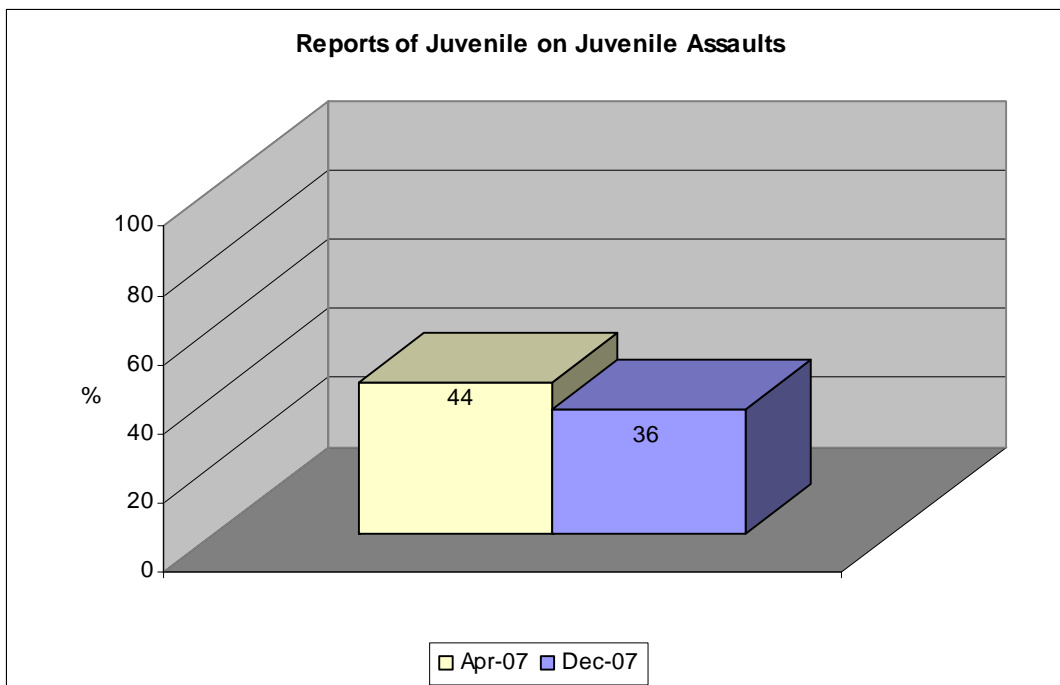
Resident responses to group consequences was at its lowest in April 2007. This low appeared after a revision to this question as outlined in previous OJSO reports. A rise was seen during the current oversight.



More residents reported feeling safe in the current oversight visit when looking at those that reported Very Frequently and Frequently; however, in April 2007, 11% did not respond to the question and therefore were not represented.



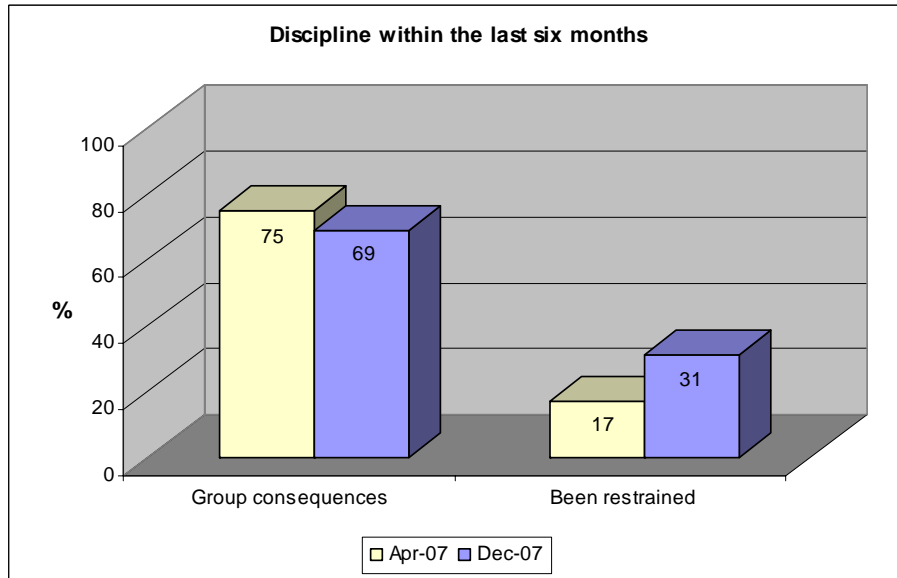
The percentage of residents who reported receiving independent living skills increased while family counseling and substance abuse services declined. Although it is possible for these services to fluctuate slightly based on the needs of the population, the size of the decrease in reported services was a concern.



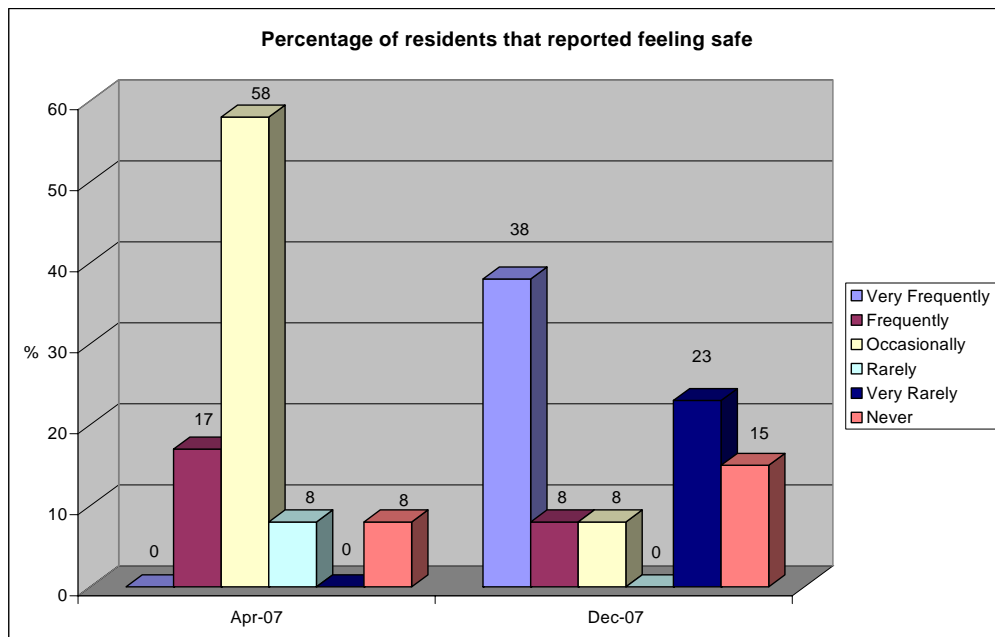
There was a decline in the reports of juvenile on juvenile assaults from the previous oversight visit to the present visit. All but one resident reported that staff members check on them at least every 15 to 20 minutes. All residents reported that security officers check the living units at least every one to two hours.

Intensive Group

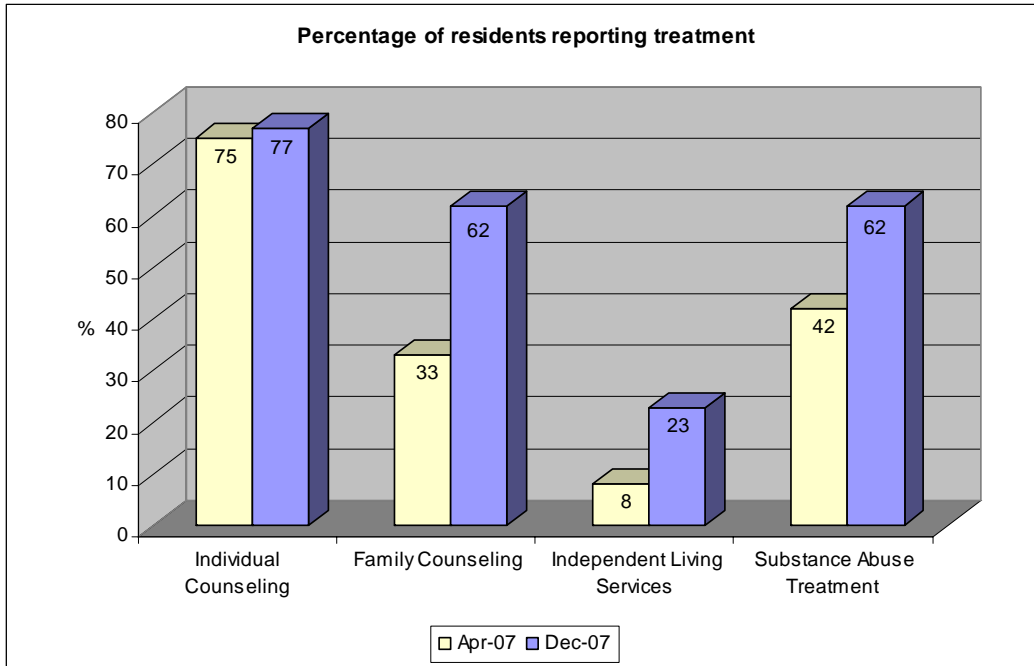
This is the second oversight visit in which the OJSO evaluated the facility as two separate programs; therefore, a comparison of the Intensive Group between the current and past visit follows:



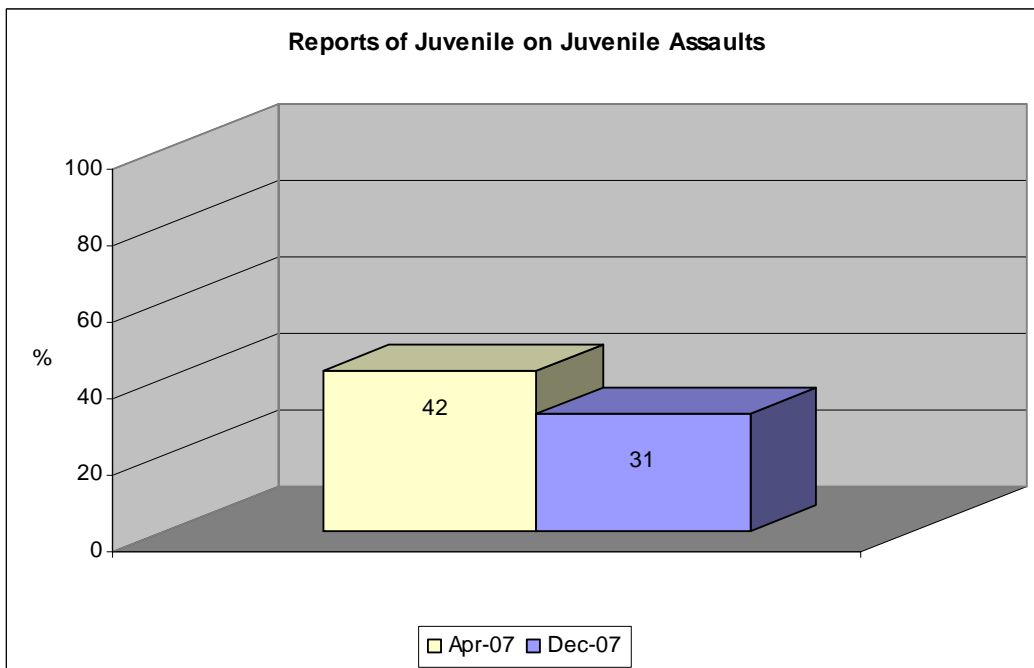
Residents' reports of group consequences declined in the current oversight visit. A larger percentage of youth reported having been restrained in the last six months compared to April 2007.



A greater percentage reported feeling safe very frequently and frequently. Very rarely and never also showed a greater percentage in the current oversight visit compared to April 2007.



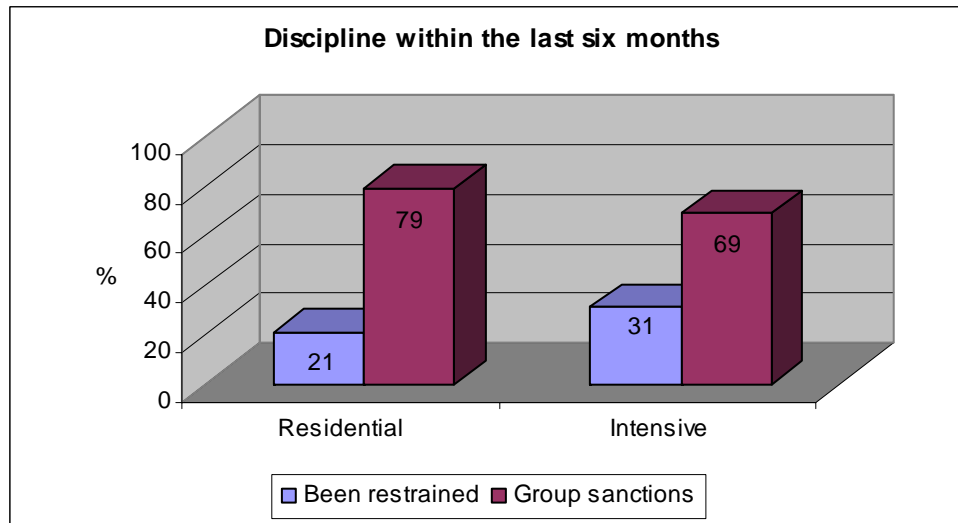
The percentage of residents who reported receiving individual counseling remained about the same. Services in the remaining areas all increased more than what would be expected from fluctuation of the needs of the population.



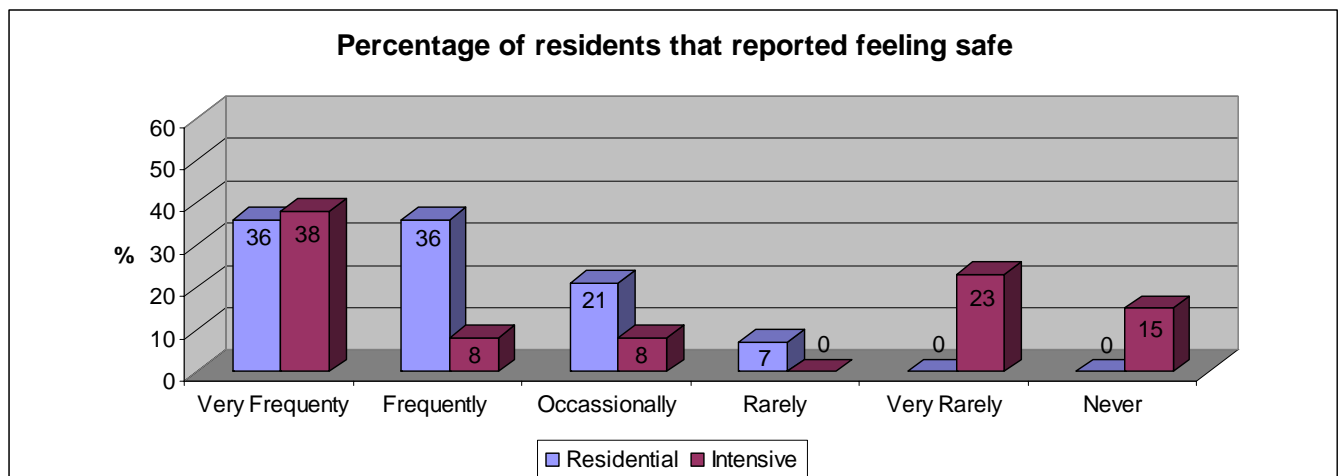
There was a decline in the reports of juvenile on juvenile assaults from the previous oversight visit to the present visit. All residents reported that staff members check on them at least every 15 to 20 minutes. All residents reported that security officers check the living units at least every one to two hours.

Residential Treatment Program Compared to the Intensive Group

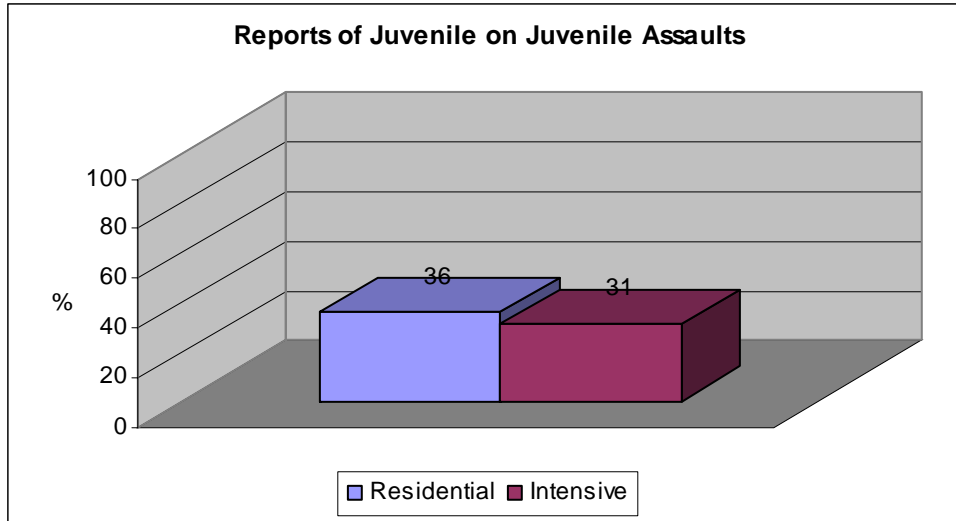
Below is a summary of comparison of the Residential Treatment Program and the Intensive Group for the current oversight visit.



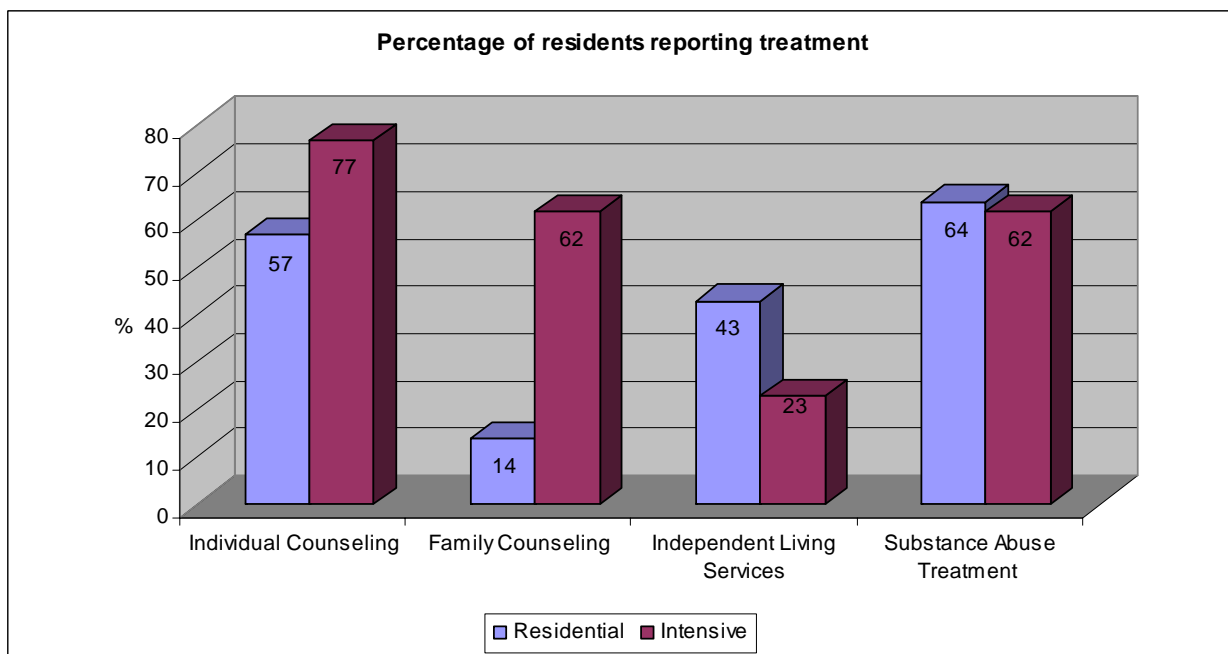
Resident reports of restraints and group sanctions in the past six months are not substantially different in the Residential Treatment Program and the Intensive Group.



A greater percentage of youth in the Residential Treatment Program reported feeling safe frequently or very frequently than youth in the Intensive Group.



The percentage of juveniles reporting juvenile on juvenile assaults for the Residential Treatment Program and Intensive Group were almost equal.



The Intensive Group reported a greater percentage of individual counseling and family counseling. Reported independent living services were lower for the Intensive Group. Substance abuse services were almost equal.

