

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

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**SUBJECT:** Summary Review

**DATE:** September 1, 2005

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) is charged with the responsibility to conduct semiannual, unannounced inspections of state operated facilities, according to Section 601.6 of Title 10 of the Oklahoma Statutes. That task includes inspections of the three juvenile centers, Central Oklahoma (COJC), L.E. Rader (Rader or LERC), and Southwest Oklahoma (SWOJC or Manitou Center), under the auspices of the Office of Juvenile Affairs. The OJSO is to ascertain compliance with established responsibilities, which may include state and federal laws, accrediting and licensing responsibilities, contractual agreements, and the policies and procedures of each facility.

In the past nine months, beginning in October, 2004, the OJSO has conducted two unannounced inspections of each of the three facilities. In October, November, and December of 2004, the OJSO completed an inspection using one specific instrument comparing the responses of about twenty percent of the resident population in each facility. The data was collected and assimilated into one report, and was published and presented to the

Oklahoma Commission on Children and Youth in the first quarter of 2005. The second series of assessments began in April of 2005, and were concluded in June, 2005. Several instruments were used to more generally assess the programs, staff, safety of residents, residents' perceptions about their treatment, facilities, records, and adherence to policy.

Additional investigations have occurred within this time period in response to complaints filed with, or other agency reports given to, the OJSO. Title 10, Section 601.6, gives the OJSO the responsibility of ". . . investigating and reporting misfeasance and malfeasance within the children and youth service system." It is the policy of the OJSO to respond to such complaints with an investigation and determination of findings.

The intent of this report is to assimilate the perceptions of the OJSO staff and the data collected by this office, by the Office of Client Advocacy (OCA), by DHS Licensing, and by the American Correctional Association (ACA) into a comprehensive assessment describing the strengths, weaknesses, and areas of concern as determined by

## Office of Juvenile System Oversight Summary Review – Oklahoma Juvenile Centers

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the OJSO Programs Manager (the author of this report) after consultation with OCCY staff who have demonstrated direct oversight contact with the state programs at COJC, Rader, and SWOJC. The report is not intended to be critical in nature; in fact, no violations, findings, or recommendations that require a response shall be included with this report. However, it is the hope of the OJSO, in a spirit of collaboration with the OJA, that this report shall provide an impetus for dialogue regarding the concerns addressed.

The report format will review each of the three facilities and identify:

- Strengths
- Weaknesses
- Facility summary with additional observations

### Central Oklahoma Juvenile Center

The Central Oklahoma Juvenile Center is located in Tecumseh, Oklahoma. This center has been serving Oklahoma's children since 1917. It has a capacity for 76 male and 40 female juveniles, ages 13 to 19 years old. The census at the time of the last visit was 74 males and 38 females. Juveniles are placed at COJC, as with each of the juvenile centers, following adjudication either as delinquent or as youthful offender. All juveniles are in the custody of the OJA.

The OJSO has observed, on numerous occasions, the involvement of facility staff and residents in the life of the local community. Juveniles have participated in intramural sports in local and distant school competition. Facility staff have donated their time in local charity events. In kind, community businesses have donated towards special projects and programs in the facility. COJC administration and staff are to be commended in these efforts.

In the first quarter of 2005, the OJSO presented a report to the Oklahoma Commission on Children & Youth comparing juvenile responses from each of the institutions, COJC, Rader, and SWOJC, representing approximately twenty percent of the total census at each facility. The report indicated the following regarding the juvenile perceptions of programs and staff at COJC:

- 72% of reporting residents said they found the school teachers to be helpful (scores ranged from a low of 72% at COJC to a high of 100% at Rader).
- COJC staff was least likely of the three institutions to use early bedtime, group punishment, or time out as disciplinary procedures.
- COJC residents reported the use of physical restraints at a higher rate than at either of the other centers (COJC – 67%; Rader Intensive Treatment Program – 60%; Rader Residential Treatment Program – 38%; SWOJC – 27%).
- 61% of COJC residents reporting indicated that they had participated in their treatment planning (scores ranged from 61% to 86%).
- COJC residents were most likely to report participation in family counseling (scores ranged from 40% to 67%).
- 61% of the youth responding reported they had regular meetings with a counselor or a therapist.
- 78% of reporting residents indicated that they had witnessed staff cursing at the residents (highest among the three institutions; scores ranged from 38% to 78%).
- Almost 40% of residents responding could not indicate a feeling of safety at the facility.
- 70% of those residents reporting assault said that a staff member had assaulted them.

The OJSO last visited COJC in April, 2005. The visit was general in nature, examining quality of life issues; safety; facility management; education; discipline; and treatment. In addition to chart audits, staff interviews, and facility investigation, twenty-two residents were interviewed. The following concerns were noted:

- The percentage of residents reporting regular meetings with a counselor or therapist dropped from 61% six months ago to 38% (8 of 22).
- Only three residents of twenty-two (14%) were able to say, "Yes," when asked whether the grievance procedures worked.
- The percentage of residents reporting participation in treatment planning dropped from 61% six months ago to 50% (10 of 20).

## Office of Juvenile System Oversight Summary Review – Oklahoma Juvenile Centers

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The Office of Client Advocacy (OCA) fourth quarter report to the OJSO (for the months of April, May, and June, 2005) indicated the following (names are deleted as indicated in brackets):

- A total of 41 incident reports were logged in the three-month period.
- An investigation for “Caretaker Misconduct” was confirmed on a JS (Juvenile Specialist) worker when a resident sustained “numerous injuries to the mouth and face area” following the execution of a standing restraint. “Although the restraint was authorized and [the resident] sustained injuries as a result of her struggling with [JS worker] during the restraint take down, [JS worker] contributed to this incident as he got too close to [the resident] during a confrontation prior to [the resident’s] actions and subsequent restraint.” (OCA Report to District Attorney.)
- A “Caretaker Review” investigation was confirmed for “Caretaker Misconduct” on two JS workers for the use of force by staff on a resident, “because the criteria approved for the use of force was not met and the investigator could not reasonably believe that use of force was necessary, required, or authorized.” (COJC OCA Investigation Report.)
- A “Caretaker Review” investigation was confirmed for “Caretaker Misconduct” on a JS worker and an APO (Administrative Programs Officer) when a resident was allowed to rub her arm in the presence of staff until she had an abrasion.
- A “Caretaker Review” investigation was confirmed for “Caretaker Misconduct” for the use of an unauthorized restraint. Following the investigation, the staff member was discharged.
- Of the 41 complaints, 6 were assigned to investigation by the OCA and 35 were assigned “Caretaker Review,” requiring an investigation by the facility administration and staff.
- Of the 6 OCA investigations, 1 was confirmed, 5 did not indicate a completed status.
- Of the 35 “Caretaker Review” investigations, 4 were confirmed, 7 were not

confirmed, and 24 did not indicate a completed status.

On October 4, 2004, the OJSO forwarded concerns regarding nursing practices at COJC to the Oklahoma Board of Nursing. The OJSO has received notice, dated June 1, 2005, from the Board of Nursing, that a nursing supervisor at the center was disciplined in the following manner:

- The respondent shall successfully complete a course on Nursing Jurisprudence.
- The respondent shall successfully complete a course on Medication Administration, to include controlled dangerous substances, and all state and federal laws.
- The respondent shall successfully complete a course on Patient Rights and Confidentiality.
- The respondent shall successfully develop a mandatory in-service program for all nursing staff at COJC on Nursing Jurisprudence, Medication Administration, and Patient Rights and Confidentiality.
- The respondent shall conduct the mandatory in-services on Nursing Jurisprudence, Medication Administration, and Patient Rights and Confidentiality.
- The respondent shall pay an administrative penalty to the Oklahoma Board of Nursing.

The nurse in question is no longer employed by the facility.

The OJSO has not, to date, conducted a focused review of the female program at the Central Oklahoma center. However, a quick review of the resident population suggests that many are children of color, they have had academic difficulties, and they have been victims of abuse (physical, sexual, and/or emotional). General research also tends to support that girls struggle with self-esteem, depression, suicidal ideations, and a negative body image at greater rates than their male counterparts. A number of prevalence studies done in state juvenile justice systems show females to have higher rates of mental health problems than males (National Mental Health Association: Mental Health and Adolescent Girls in the Justice System).

In contrast to the residents’ perceptions of decreasing time with a counselor or therapist, the

**Office of Juvenile System Oversight**  
**Summary Review – Oklahoma Juvenile Centers**

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OJSO suggests a focused review of the clinical program to ensure the emotional and psychological needs of residents, both male and female, be successfully addressed through individual and group counseling. Relationship management, conflict management, mutual support and mentoring opportunities, parenting skills, dating, and trauma resolution, while already considered a part of the existing milieu, might be re-evaluated and expanded as a part of the everyday routine of residents at COJC.

**L.E. Rader Center**

The L.E. Rader Juvenile Center is located in Sand Springs, Oklahoma. The maximum capacity is 215, though one unit was closed during the last inspection. The census on that day was 175. After the female population was transferred to the Central Oklahoma Juvenile Center in April, 2005, the resident population is now entirely male.

Most, if not all, of the residential units were in a state of repair, or repairs were recently completed. The walls were freshly painted and, by report of staff and residents alike, were painted by joint efforts of administration, staff, and juvenile residents. Many of the areas had been re-carpeted. Contractor timing was an apparent issue, due to paint overspill on the new carpet. (Painting was completed after the new carpet was laid.) However, the freshened appearances were pleasing and demonstrated an attempt by management to build cooperation and team-work with residents and staff.

The school, teachers, and principal continue to receive high marks by the residents. The juveniles report pride in their scholastic accomplishments, and many are on schedule to complete their high school requirements or G.E.D. requirements while in the institution. The pictures of graduating students are displayed in the halls and in classrooms. The juveniles also reported that their teachers are helpful. In a survey concluded in December, 2004, by the OJSO, of 35 Rader juveniles, 100% reported “always helpful,” (the highest average response among the three juvenile centers.)

In October of 2004, Mr. Jimmy Martin was named as Superintendent of L.E. Rader by the administration of OJA. Under Mr. Martin’s direction, the OJSO has received cooperation and collaboration from the administration at Rader. During the two most recent exit conferences following OJSO inspections, Mr. Martin responded with near immediate compliance, correcting noted deficiencies and violations with either corrective repair or plans of action. Procedures were changed, such as the inclusion of family participation in the treatment plan and the addition of a fruit/salad bar to improve juvenile’s access to additional food servings on request.

Mr. Martin has also demonstrated collaborative efforts by working closely with the OJSO regarding residents with persistent, problematic issues that may require additional resources for treatment. The cooperative effort has recently provided assistance and direction for the out-of-the-state placement of a young man who has a history of self-mutilation, violence, and non-compliance. The collaboration included the resources of the Oklahoma Health Care Authority (OHCA), the OJA Juvenile Services Unit (JSU), and the OJSO.

In the spring of 2005, the administration at Rader re-designated one of the residential units as a combined facility housing a behavioral management program, a crisis management program, and a mental health stabilization program. The behavioral management program is new to Rader, and is designed to focus on juveniles with sufficient behavioral acting out that they are determined to be too disruptive for the general program. The Mental Health Stabilization Unit (MHSU) is now almost two years old, and demonstrates efforts to provide stabilization to residents with suicidal ideations, self-mutilating behaviors, and/or other mental health diagnoses.

The Crisis Unit is designed for short-term intervention, where juveniles may de-escalate (staff most often use the term: “cool off”) following a crisis or inappropriate acting out event. Policy requires an immediate evaluation once the inappropriate behaviors cease. On the most recent visit, the Crisis Unit was sparsely furnished, exceptionally warm, and one of the four rooms had a leaking toilet with marks of water damage to the room immediately apparent. The OJSO observed

**Office of Juvenile System Oversight**  
**Summary Review – Oklahoma Juvenile Centers**

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staff attempting to “de-escalate” a juvenile with questions and directive advice.

The leaking toilet was not a rare event. The site investigation revealed numerous plumbing problems and concerns. Furthermore, DHS licensing reports for the recent period continue to document plumbing issues and facility maintenance problems. It is apparent to the OJSO that facility maintenance needs increased attention. In a letter, dated August 29, 2005, addressed to the OJSO, Mr. Martin explained: “We continue to encounter plumbing leaks throughout the facility. Most of these leaks are due to the age of the buildings and constant use within the housing units. To help repair leaks, we are in the process of establishing a contract with a local plumber. We will utilize this person, as needed, for immediate response as we encounter plumbing repair needs.”

In a fair assessment of the program at L.E. Rader, three issues should be considered:

1. Rader was monitored and reviewed by the American Correctional Association in September, 2004, and in March, 2005. Though areas of non-compliance were indicated in 2004, the facility was determined to be in compliance in the March, 2005 report.
2. DHS Division of Child Care monitoring reports for the periods including 2004 and 2005 documented “numerous, repeated and serious areas of non-compliance.” The February 23, 2005, report included the following observations (the list is not all-inclusive of the report):
  - Lights inoperable or dim
  - Missing floor tiles – broken floor tiles
  - Protective gloves observed with what appeared to blood inside them
  - Holes in carpet – seams coming apart
  - Dirty microwave oven, no thermometer in refrigerator
  - Holes in walls
  - Gang graffiti
  - Toilets inoperable, toilets broken, toilets overflowing

The ITP (Intensive Treatment Program) unit was of special concern in this monitoring report, dated February 14, 2005:

“The conditions of this unit do not appear to have improved since the last visit. Instead they appear unsafe and hazardous due to the lack of trained staff on the unit, resident staff ratio and other listed areas of non-compliance.”

The DHS Program Field Representative (PFR) documented the following events of February 14 in the supplemental information log of the monitoring report (abbreviated by the author of the OJSO report):

“The female staff member was on the unit alone. . . Eleven male residents were counted. . . The male staff member had taken two boys to the laundry. However, one resident yelled that the staff member was ‘on a smoke break.’ Chaos ensued . . . [Rader staff accompanying the PFR] went to call security. . . The female staff appeared to be dazed. She kept repeating that she is new and didn’t have any help. . . Residents completely disregarded direction from staff. . . The unit was completely out of control. . . [Rader staff accompanying the PFR] once again went to call security. . .

Of the event, Mr. Martin reported (in the supplemental information log of February 14, 2005):

“Unit IV will be reassigned an additional unit manager to immediately address the problems noted. [Rader staff member] will be directed to go to Unit IV, as will I, and get the rooms and juveniles into compliance. Disciplinary actions will be taken on those staff members in non-compliance of staffing ratios.”

3. The policies and practices of Rader are currently under investigation by the U.S.

## Office of Juvenile System Oversight Summary Review – Oklahoma Juvenile Centers

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Justice Department - Civil Right's Division. Their report, dated June 8, 2005, specifically addresses the practices of Rader between January 1, 2003, and May 30, 2004. The findings of the investigation may be generally described as:

- The State failed to provide adequate supervision and monitoring to ensure that juveniles at Rader are not subjected to inappropriate sexual relationships with staff or other residents.

Several examples were provided indicating sexual relationships occurred both between juveniles and between female staff and juveniles. The report states: "Documents produced by the State indicated that numerous sexual relationships developed between female staff members and male youth. It appears that in some instances other staff members were aware of these relationships and brought them to the attention of supervisors and administrators. However, administrators and supervisors failed to take prompt, appropriate action."

- The State failed to provide youth at Rader with reasonably safe conditions including protection from assault by other youth.

The report states: "Many of the assaults and injuries at Rader occurred because staff failed to adequately supervise youth. Other assaults and injuries occurred because staff lacked the knowledge and/or training to safely intervene once fights occurred. . . . Disturbingly, and in a gross departure from sound practices, it appears that in some cases the staff either actively encouraged a fight to occur or had knowledge that a fight would occur and allowed it to happen . . . the lack of supervision makes it possible for an excessive quantity of contraband to be introduced into the facility . . . In an institutional setting, contraband is often

used either as a weapon or as currency. According to documents provided by the State, contraband appears to be readily accessible to juveniles at Rader, and regularly used as a weapon, potential weapon, or currency in the facility."

- The State failed to protect youth at Rader who engage in suicidal and self-injurious behavior.

The report states: "In 2003 and 2004, youth at Rader made at least 12 suicide attempts at the facility. In each case, staff failed to take adequate precautions to protect the youth from harm . . . From January 1, 2003 to May 30, 2004, there were over 35 documented reports of youths punching walls or furniture, banging their heads against floors and windows, or beating themselves with objects. In most cases, it appears that staff at Rader are not monitoring adequately children who have a repeated history of engaging in self-abusive behaviors."

- The State failed to monitor adequately the distribution of psychotropic medication to mentally ill youth at Rader.

The report states: "Based on a review of documents produced by the State, we found that students regularly hoard medication and either share it with or sell it to other youth. In addition, the nursing staff, at times, appear to provide youth with the inappropriate type or dosage of medication.

- The State failed to protect youth at Rader from excessive use of force by staff.

The report states: "Staff at Rader physically restrain youth with great frequency . . . Our review of documents produced by the State indicates that Rader staff employed force that was

**Office of Juvenile System Oversight  
Summary Review – Oklahoma Juvenile Centers**

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disproportionate to the threat posed by the youth.”

On July 22, 2005, the Oklahoma Attorney General’s office responded by letter to the U.S. Department of Justice referencing the investigation of the L.E. Rader Center. The document states, “[The investigative] letter contains incomplete and inaccurate information which has led him [U.S. Attorney General] to make an inaccurate assessment of the L.E. Rader Center.”

The Oklahoma response to the Department of Justice findings reflected the “outcome of applicable investigations by various entities.” Those entities were listed, and include the American Correctional Association, the OJA Advocate General’s Office, the Oklahoma Department of Human Services, the OJA’s Office of Public Integrity, and the Oklahoma Commission on Children and Youth. Each allegation (as indicated by the U.S. Department of Justice) is presented with the accompanying response taken by the facility. The type of investigation is described, whether by caretaker review, or by an investigation by the DHS Office of Client Advocacy (OCA), or by the Office of Public Integrity, or by other oversight agency. The Oklahoma response further states: “In summary, the evidence shows that the State of Oklahoma is not subjecting juveniles at the L.E. Rader Center to egregious or flagrant conditions or depriving them of their rights under the Constitution or laws of the United States. The isolated incidents cited . . . do not establish a pattern and practice of civil rights violations.”

Three additional observations are indicated due to the issues raised by the Justice Department’s report:

1. Approximately 23 Rader staff and administration have recently completed a one day course on “Reducing the Use of Restraint and Seclusion” presented by facilitators from the Child Welfare League of America.

2. On October 4, 2004, the OJSO forwarded concerns regarding the nursing practices of a Registered Nurse and nursing supervisor at Rader to the Oklahoma Board of Nursing. The OJSO has received notice, dated June 1, 2005, from the Board of Nursing, that a nursing supervisor at Rader was disciplined in the following manner:

- The respondent shall successfully complete a course on Nursing Jurisprudence.
- The respondent shall successfully complete a course on Medication Administration, to include controlled dangerous substances, and all state and federal laws.
- The respondent shall successfully develop a mandatory in-service program for all nursing staff at Rader on Medication Administration, to include controlled dangerous substances, and all state and federal laws.
- The respondent shall conduct the mandatory in-service on Medication Administration, to include controlled dangerous substances, and all state and federal laws.

According to a report from Mr. Martin, the nurse is engaged in a plan of compliance.

3. The Office of Client Advocacy (OCA) fourth quarter report to the OJSO (for the months of April, May, and June, 2005) indicated the following (Quotes are from OCA reports to the District Attorney. Names are deleted as indicated in brackets.):

- One investigation was confirmed for “Neglect.” A JS (Juvenile Specialist) worker “allowed [a resident] to take a container of bleach to his room unsupervised. [The resident] poured some of the bleach in a cup and drank it.”
- An investigation for “Caretaker Misconduct” was confirmed on two JS workers when a resident, while on 1:1 supervision level, managed to get on the roof in an attempt to go AWOL. The JS workers “acknowledge they were aware [the resident] was on suicide precaution,

## Office of Juvenile System Oversight Summary Review – Oklahoma Juvenile Centers

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but they deny being aware of its additional supervision responsibilities.”

- An investigation for “Caretaker Misconduct” was confirmed on two JS workers for allowing residents to watch a video tape with nude scenes. “Staff was not aware of the content of the tape.”
- An investigation for “Caretaker Misconduct” was confirmed regarding the staff’s unauthorized use of force, cursing, and locking a resident in his room until the oncoming shift informed him the doors are to remain unlocked.
- An investigation for “Neglect with Injury” was confirmed regarding three JS caretakers when “for approximately 25 minutes [a resident] was unaccounted for even though he was on close observation.” The resident was allowed to go to his room unsupervised “and carve into his wrist for approximately 13 minutes. He was then able to go the bathroom for approximately 12 minutes.”
- Of the 64 complaints, 14 were assigned to investigation by the OCA, 48 were assigned “Caretaker Review” by the facility, one was a duplicate complaint, and one was assigned to Rader administration for review.
- Of the 14 OCA investigations, 3 were confirmed, 3 were not confirmed, and 8 did not indicate a completed status.
- Of the 48 assigned “Caretaker Review,” 2 were confirmed, 15 were not confirmed, and 31 did not indicate a completed status.

### Rader Summary

Of the three institutions, Rader seems to most exemplify the decreases in funding attributed to budget cuts in the last two to three years. According to the most recent ACA report, direct line staff employees are salaried at little more than \$16,000 a year and suffer from a high turnover rate. The OJSO has monitored units, with as many as 16 residents, that have been staffed with no more than two

employees who shared a total of four months on-the-job experience between them. As DHS licensing reports indicate, the facility appears to be in constant need of repair. The OJSO has inspected several units with recent updates, including new carpet and a fresh coat of paint, but leaking roofs, plumbing and other structural maintenance continue to provide content for findings of non-compliance.

The fence around the perimeter of the campus continues to be a security issue, but it is the understanding of the OJSO that funds have been approved for the purchase of a new, more restrictive fence. Mr. Martin was reported to state, in the ACA investigative report of April 1, 2005, that the fence may possibly “[free] up five security positions to be moved into programming and direct supervision . . . this will improve the staff’s ability to provide programming and recreation.”

Mr. Martin has been very cooperative with the staff of OJSO. Problematic juveniles have been identified, and OJSO has attempted assistance in two instances, at administration’s request. During the most recent OJSO investigation in March, 2005, many of the concerns raised by oversight staff were almost immediately addressed and corrected. As previously mentioned, Mr. Martin has encouraged 23 of his line staff, security, and administrative employees to attend training for the reduction of the use of restraints and seclusions. He reports that the incidents of seclusions and restraints have decreased since the training.

After careful consideration, the OJSO encourages OJA and Rader to re-evaluate the direction of the programs offered in the facility. Despite continued efforts at increasing security, the negative behaviors and extreme acting out of the juvenile residents continues. With increasing diagnoses of mental health disorders (to be addressed later in this report), Rader administration may consider re-emphasizing a culture of treatment that focuses on clinical interventions, utilizing therapeutic groups and individual counseling. The goals of individual and group counseling are well within the treatment goals of juveniles in our training schools. While custody and protection are understandably paramount, helping residents identify their motives, feelings, thoughts, actions, and perceptions, will offer the resident more control and may actually decrease old

## Office of Juvenile System Oversight Summary Review – Oklahoma Juvenile Centers

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patterns of behavior. Concentrated therapy in individual and group sessions may provide many of the juveniles a relief from symptoms as personal issues are uncovered and/or discovered that have proven to be distracting or indirectly causing acting out symptoms.

The OJSO is aware of the valiant efforts of the social services staff, and wants to encourage their interventions with unanimous support. An increase in clinical staff, with associated abilities to develop an improved therapeutic milieu and an increase in the number of group and individual sessions may produce many of the same results as money spent in increases in security.

### Southwest Oklahoma Juvenile Center

Southwest Oklahoma Juvenile Center (SWOJC or Manitou Center) is a medium secure juvenile facility for male juveniles adjudicated by the courts and placed in the custody of the Office of Juvenile Affairs. Resident admissions first occurred on August 5, 1996, making the Manitou center the newest of the state's three juvenile institutions. At the time of the last OJSO site visit, June 16, 2005, the resident population was 75 with a capacity for 78 beds. As might be expected, the facility appeared considerably newer and in a better state of repair than COJC or Rader. At the time of the visit, administration was removing the only swimming pool, an above ground vinyl pool, following the recommendations of the health department. The OJSO also observed heightened security (nearly double the typical staffing scheduled) because of recent gang activity on the campus.

The first quarter OJSO report of 2005, referred to earlier in this document, offers the following comparisons of residents' perceptions of daily life at Manitou:

- 73% of reporting residents said they found the school teachers to be helpful (scores ranged from 72% at COJC to 100% at LERC).
- SWOJC residents reported the least use of physical restraints (COJC – 67%; Rader Intensive Treatment Program – 60%; Rader Residential Treatment Program – 38%; SWOJC – 27%).

- 83% of SWOJC residents reporting were able to recall that they had participated in their treatment planning (scores ranged from 61% to 86%).
- 40% of the youth responding reported they had regular meetings with a counselor or a therapist.
- Of the three institutions, SWOJC residents were most likely to report an awareness of the grievance procedures (scores ranged from 94% to 100%).
- Only 7% of the residents responding (one resident) reported an assault by staff (scores ranged from 7% to 63%).
- 80% of residents responding could indicate a feeling of safety at the facility (scores ranged from 44% to 80%).

The Office of Client Advocacy (OCA) fourth quarter report to the OJSO (for the months of April, May, and June, 2005) indicated the following:

- A total of 36 incidents were logged in the three-month period.
- An investigation for “Caretaker Misconduct” was confirmed on a new JS (Juvenile Specialist) worker for the use of inappropriate techniques and “unintentional excessive or unauthorized use of force” (SWOJC Caretaker Conduct Review Investigative Findings report) to remove a juvenile from beneath a table.
- A “Caretaker Review” investigation for “Caretaker Misconduct” was confirmed on a JS worker. The JS worker did not maintain a line of sight on a juvenile placed on close observation. While unobserved, the juvenile was able to assault another resident.
- A “Caretaker Review” investigation for “Caretaker Misconduct” was confirmed on a JS worker. The JS worker did not maintain a line of sight on a juvenile placed on close observation. While unobserved, the juvenile was able to “elude staff and hide under a bed during a moment of inattention.” (SWOJC Caretaker Conduct Review Investigative Findings report)
- A “Caretaker Review” investigation for “Caretaker Misconduct” was confirmed on four JS workers. A juvenile, while on suicide watch, secured a weapon. The

## Office of Juvenile System Oversight Summary Review – Oklahoma Juvenile Centers

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juvenile was considered a “risk of escape and self-harm.” (SWOJC Caretaker Conduct Review Investigative Findings report.) No injuries were reported.

- An investigation for “Caretaker Misconduct” for the “unauthorized use of force” (SWOJC Caretaker Conduct Review Investigative Findings report) to re-direct a juvenile was confirmed on a JS worker. There were no reported injuries.
- Of the 36 complaints, 3 were assigned to investigation by the OCA, 32 were assigned “Caretaker Review,” and one was assigned for administrative review.
- None of the 3 OCA investigations indicated a completed status.
- Of the 32 “Caretaker Review” investigations, 5 were confirmed, 11 were not confirmed, and 16 did not indicate a completed status.

The OJSO last visited Manitou in June, 2005. The visit was general in nature, examining quality of life issues; safety; facility management; education; discipline; and treatment. In addition to chart audits, staff interviews, and facility investigation, twenty residents were interviewed. In a trend demonstrated by each of the institutions, the percentage of residents reporting regular meetings with a counselor or therapist at Manitou dropped from 40% in December, 2004, to 30% (6 of 20), the lowest reported among the three centers. As mentioned, security staffing had been increased following incidents of gang activity at the facility. Administrators, staff and security were quick to respond. Residents were limited to their units, but school continued by distributing the teachers and maintaining classes among the units. Problematic juveniles were separated quickly and assigned one-to-one security. Despite the activity as recent as two or three days past, the facility was quiet and well-managed.

The response plan, however, demonstrated the concerns of the OJSO. While staff and security had been increased, there was no evidence of increased therapeutic intervention or increases in therapeutic staff. The readers of this document are well aware of the many opportunities afforded a clinician following this adolescent behavior: consequences of

destructive acts; trust issues; relationship issues; anger management issues; narcissism; issues surrounding self-esteem; consequences of irrational behaviors; the list of behaviors, insights, and “aha” moments is nearly endless. The OJSO does not deny that therapeutic interventions followed the weekend of gang acting out behaviors. But observations of responses to negative behaviors were generally seen to be of a custodial nature.

### Overall Conclusions

According to Section 7301-1.2 of Title 10, the intent of the legislature relating to juveniles alleged or adjudicated to be delinquent is to “promote the public safety and reduce juvenile delinquency.” Among the eight specific directions, the state is to “give juveniles access to opportunities for personal and social growth,” and, “provide a system for the rehabilitation and reintegration of juvenile delinquents with society.” Provisions are also described to allow placement of juveniles in mental health and substance abuse treatment centers.

Recent data, gathered from interviews with juvenile center residents, reviews of clinical records, and observations of programmatic materials, suggests a movement within the culture of state institutions from “rehabilitation” towards a custodial approach of incarceration. These concluding remarks do not attempt to prove, argue, or debate the observations of the OJSO. Rather, as stated in the beginning of this document, the OJSO would like to stimulate dialogue regarding the consequences of juvenile care that includes or deletes any parts of the milieu issues of rehabilitation, recovery, and custody.

Rehabilitation might be discussed in the context of the treatment plan (or service plan) that is prepared for each resident upon admission to a state juvenile center. Ideally, the treatment plan, developed in consultation with the juvenile, clinical staff, assigned field staff, and family, outlines treatment goals that prepare the individual for personal growth and a successful return to the individual’s environment outside the confines of OJA custody (“reintegration of juvenile delinquents with society”). The treatment plan, or plan of rehabilitation, is based on a thorough evaluation of the juvenile’s problems. The goals and

**Office of Juvenile System Oversight**  
**Summary Review – Oklahoma Juvenile Centers**

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objectives are measurable, clearly defining the desired behavior and consequences of that behavior. The plan is regularly revised, by policy, by the social worker, juvenile and other clinical staff, reflecting the progress (or lack of), and revised goals. Daily behaviors, as noted by line staff and clinicians, are reflected in daily logs, progress notes, school reports, incident reports, and therapy reports generated through individual and group therapies. The clinician plays the primary role in the treatment plan, assimilating the reports into a concise evaluation of the juvenile's progress.

Recovery, though a term not found in the statutes describing the work of state juvenile centers, is clearly a part of the rehabilitation process. Arguably, for many adolescents, recovery is a precursor to rehabilitation. The establishment of mental health services on a juvenile center campus is testimony to the reality of the need for recovery services. Recovery, for the purposes of this discussion, may be defined as the "development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Oklahoma Evidence-Based Practices Implementation Project). Currently, few specific statewide standards exist to address the mental health needs of adjudicated youth.

The OJSO staff and administration find the philosophy of mental health remedial care (recovery) evidently missing in the treatment planning, goals and interventions of the juvenile residents. Most direct-care staff, when interviewed, had great difficulty describing the treatment plan (service plan) of an individual in their care, with the exception of rote goals and objectives that appear on every plan (and speak mostly to rehabilitation). The juvenile instruments used in the most recent facility visits indicated that almost 42% (29 of 70) of the residents interviewed (all centers combined) were unaware of their participation in the treatment plan, though some could be prompted to recall "that meeting" where goals and objectives were discussed, but rarely re-visited.

In a milieu where physical health treatment is timely and adequately addressed, more than several youth may be forced to suffer and decompensate with little therapeutic intervention. Many juveniles, when interviewed, could not recall an "individual

counseling session" in the last week (or more) with a staff clinician. When clinical staff are interviewed, they often report regular weekly contact with their residents. However, many admit to short meetings, sometimes 15 minutes or less, in less than formal environments, such as the day room. The residents appear to be able to distinguish these informal conferences to the purposeful, clinical and private individual counseling sessions that identify behaviors, interventions, and outcomes.

The U.S. Department of Health and Human Services estimates that one in five youth detained nationwide are estimated to suffer from a serious emotional disturbance (SED) (U.S. Department of Health and Human Services et al., *Mental Health: A Report of the Surgeon General*, 1999.) For example, in a given population of 175 youth at Rader, 35 may be expected to suffer from SED. The Department also reports that the rate rises to 63% of the detained population when primary diagnoses of substance abuse and disruptive behavior are included. Again, of 175 youth, 110 juveniles might be expected to suffer from some mental health disorder.

Current research seems to suggest that youth are being placed in juvenile centers presenting with numerous and various mental health and emotional needs that could benefit from acute mental health care. One might argue about the appropriate placement of such youth in institutional juvenile centers, but the placements occur on a regular, if not normative, basis. Left untreated, data suggests that these disorders may manifest into aggressive behaviors that place staff and other juveniles at risk. James Gilligan suggests that institutional care is a place where those suffering from mental health and emotional disorders learn to survive by manifesting violent and aggressive behaviors, turning non-violent individuals into violent ones (James Gilligan, M.D., *The Last Mental Health Hospital*, *Psychiatric Quarterly*, vol. 72, No. 1, 2002.) According to researcher Joseph Penn, the incarceration of these youth may be linked to increased rates of suicidal and homicidal ideation (Joseph V. Penn, et al. *Suicide Attempts and Self-mutilative Behavior in a Juvenile Correctional Facility*, *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 76-69, 2003.)

## Office of Juvenile System Oversight Summary Review – Oklahoma Juvenile Centers

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Arguably, the existence of the mental health disorder in a child or adolescent may have contributed to the offensive behavior that caused the initial arrest. Once entangled in the juvenile system, the untreated mental health problems manifest such juvenile behaviors that the adolescent cannot adjust to the system. The consequences are often punitive, allowing the youth to fall deeper into a juvenile system that neither has the capacity or the time to implement a mental health treatment plan that might return the youth to his or her community and out of the at-capacity institution.

Historically, OJA has encountered difficulty obtaining mental health services outside the facilities. Even when a mental health disorder has been diagnosed, and the behaviors of that individual have exhausted the resources of the facility, other public and private resources are often denied, potentially due to limited financial resources or to the extreme behaviors demonstrated by the individual. Private or non-profit facilities are often hesitant to admit juveniles with extensive histories that may include suicidal attempts, self-mutilating behaviors and aggressive behaviors due to risk of injury to staff, or to fears of litigation, or to financial restrictions. By the time all resources have been exhausted, facility administration may resort to such restrictive environments for the juveniles that the milieu may actually contribute to further acting out.

What the three juvenile centers provide, by intentional plan and observable effort, is custodial care, presumably to “promote the public safety.” Custodial care staff is substantially disproportionate to clinical care staff. Yet, in contrast to the efforts to improve security, as evidenced by funding for a new fence, the addition of new cameras for monitoring purposes, and increases in security staffing, custodial care continues to be problematic. Assaults, gang activity, self-injurious and mutilating behaviors, sexual acting-out, the use of restraints, crisis management units, behavioral management units, and excessive use of force may serve as reminders that unmet needs (requiring recovery and rehabilitation) may produce undesirable consequences. Direct care staff are rarely trained in clinical interventions, and are not routinely included in treatment planning. Paradoxically, treatment staff are rarely included in the debriefing processes that follow crisis events, such as the use of restraints or

seclusions. Such events are generally left to police officers and line staff to process, and only rarely are they able to identify clinical behavioral markers that serve as precursors to aggressive or violent activity.

It is the contention of the Office of Juvenile System Oversight that administrative decisions have been made to reach a state of custodial care for residents assigned to the juvenile centers at L.E. Rader, Central Oklahoma, and Manitou, versus a remedial treatment-driven culture that utilizes intensive individual and group therapies and focuses on recovery and rehabilitation. The Oklahoma Commission on Children & Youth is aware of systemic issues that may have contributed to this present state: a lack of coordinated mental health resources in the community; a lack of funding for community services; and a lack of training, education, and understanding at all levels of the juvenile system. The OCCY has committed to the development of resources in these areas. The State of Oklahoma is presently engaged with the creation of community systems of care programs that might divert children with SED from the juvenile justice system and better serve those who come into contact with the courts. However, the systemic issues only account for the over-representation of these youth in the juvenile justice system.

The OJSO has requested and is now requesting, as a result of the review of the data herein, examined within a context of custodial, rehabilitative, and recovery care, a collaboration of agency resources to re-address the rehabilitative and recovery efforts occurring within the state juvenile centers.

The Office of Juvenile System Oversight would like to thank Mr. DeLaughter, his administrative staff, the juvenile center superintendents, and facility staff for their considerable cooperation in the development of this report.