

A Case Study of the Civil Rights of Institutionalized Persons Act:  
Reforming the Arizona Department of Juvenile Corrections

By

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## ABSTRACT

Research examining the long-term impacts of federal interventions under the Civil Rights of Institutionalized Persons Act on correctional institutions has been scant. The result has been a failure to understand the sustainability of reforms aimed at protecting the civil rights of confined persons. This dissertation examined the long-term reforms at the Arizona Department of Juvenile Corrections following a consent decree with the U.S. Department of Justice from 2004 to 2007. Interviews were conducted with current and former ADJC employees, juvenile justice advocates across Arizona, and county court representatives to determine how each of these groups perceived the status of the reforms at the ADJC.

The findings of the current dissertation suggest that long-term reforms following consent decrees imposed on correctional institutions are possible. At the ADJC, the methods for securing the reform required that the agency reform its culture, implement a Quality Assurance process, revamp the Investigations and Inspections unit at the agency, and consider the perspectives of external agencies. One of the primary reasons why the department has been committed to making these reforms is because of the perceived loss of legitimacy and resources that would occur if they failed to reform. Such a failure for the agency could have potentially resulted in a closure of the agency. However, the increase in punitive and preventive policies used to enforce the reforms may have negative repercussions on the organizational culture in the long term. Policy implications for future CRIPA consent decrees are outlined, limitations are addressed, and suggestions for future research are made.

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## Chapter 1

### Statement of the Problem

America's prisons and jails have long been viewed as having poor conditions. Formed in large part as a response to increasing social disorder (e.g. crime, minority group threat), institutions of confinement allowed for the spread of formal social controls aimed at both punishment and reform (Rothman, 1971). Many early institutions were founded under the guise that they would provide "benevolent reform," where criminals and delinquents would adopt ethics and values, but in reality they provided "benevolent repression" (Pisciotta, 1994). Instead of humane treatment, criminals were subject to "ineffective and brutal prisons which did not provide kindly reform" (p. 5). Rehabilitative programs (e.g. religious, job skills, educational) aimed at reform were viewed by managers merely as "tokens," as they were more focused on confinement. In the end, the reform movement failed at creating institutions that provided rehabilitation, but it did allow for the expansion of social control by way of incapacitation.

It quickly became clear that confinement had adverse consequences that conflicted with the goals of humanizing the treatment of criminals. While prisons were portrayed publicly as places of reform with minimal physical punishments, the reality was that mistreatment ran rampant in institutions. Reports indicate that the earliest institutions of confinement were wrought with harsh conditions, such as physical abuse by correctional administrators, inmate riots, crowding, poor sanitary conditions, limited amounts of food, and poor medical care (Jacobs, 1978; Pisciotta, 1994). Despite these problems, institutionalization increased because "confinement was simply too convenient a solution to social problems" (Rothman, 1971, p. xxxv). Although they typically started

out orderly, clean, and resembled early visions of ideal prisons, rarely did these conditions persist (Lewis, 1922). Beginning in the mid-19<sup>th</sup> century, institutions experienced severe declines in conditions, growing increasingly disordered, crowded, and corrupt. Subsequent efforts at correctional reform focused on rehabilitation proved ineffective, in large part because poor conditions and a focus on incapacitation undermined these efforts (Walker, 1998).

Harsh correctional conditions, resulting in the deprivation of civil rights, have continued well into the 21<sup>st</sup> century. In many respects, modern correctional facilities resemble their early counterparts with respect to the physical structure of buildings, activities provided to inmates, and inmate violence (Pisciotta, 1994; Singer, 1971). Just a few examples of the violations that have been brought to light recently include: holding inmates for days after their acquittals in Washington, D.C. (Wilber, 2011); use of excessive force towards inmates in Los Angeles County jails (Faturechi and Leonard, 2012); failure to provide air conditioning in Texas state prisons, leading to indoor temperatures over 120 degrees in one facility (Fernandez, 2012); rat and bug infestations in one Illinois prison (Rushton, 2012); and the sexual abuse of females in California prisons (Gottesdiener, 2011). When correctional institutions are plagued with poor conditions like these and deprive inmates of their civil rights, one remedy has been for the federal government to force compliance through consent decrees (i.e. negotiated settlements) and lawsuits. In order to lift a consent decree or satisfy a lawsuit, the agency must first make the necessary changes. The focus of the current dissertation is what happens after agencies come into compliance and are no longer under the watch of federal monitors. In other words, do consent decrees and lawsuits result in long-term,

sustainable changes? The following section will discuss the impact that poor correctional conditions can have on individuals, re-entry outcomes, and state responses; and will then transition into how the federal government has responded to the mistreatment of confined persons.

### **Impacts of Poor Correctional Conditions**

One conditional issue that has consistently been problematic in institutions is overcrowding. Among the 50 largest jails in the country, nearly 20% experienced overcrowding in 2010, down from 38% in 2008 (Minton, 2011). Overcrowding has been particularly concerning because it has been linked to institutional misconduct, psychological harm to inmates, and negative outcomes upon release (Huey and McNulty, 2005; Jan, 1980; Megargee, 1977; Paulus, Cox, McCain, and Chandler 1975). For example, one study of 1,400 inmates nationwide found that higher levels of prison crowding was related to increased suicides and deaths in prison (McCain, Cox, and Paulus, 1980). Other research suggests that overcrowding in prisons leads to other forms of misconduct such as riots and escapes (Jan, 1980; Wooldredge, Griffin, and Pratt, 2001). Similar findings have been found in juvenile institutions, where overcrowding contributes to suicidal behavior among juveniles, staff assaults, and escapes (Burrell, 1998; Parent et al., 1994).

Research now suggests that poor conditions during incarceration can influence reentry, although findings have been mixed. It has been argued that:

a setting less prone to encourage rehabilitation than a building which is disintegrating before the very eyes of its inmates is hard to imagine. Moreover, these old buildings were constructed with a view of imprisonment that is no

longer accepted or acceptable; they are composed of elements which increase the suffering of the individual and accomplish nothing toward his eventual resocialization. (Singer, 1971, 373)

A small body of research suggests that inmates housed in poor conditions are more likely to recidivate upon reentry (Chen and Shapiro, 2007; Jonson, 2010; Puritz and Scali, 1998a). Other factors such as too much control over inmates (Chen and Shapiro, 2007) and overcrowding (Farrington and Nuttall, 1980; Feldman, Wodarski, Flax, and Goodman, 1973) can further harm reentry. The influence of correctional conditions on reentry is especially concerning considering the increases in correctional populations over the past forty years (Petersilia, 2003; Pratt, 2009). In addition to the direct impacts on inmates, conditions of confinement can also have macro-level influences on state crime control.

In response to poor conditions of confinement, some states have made sweeping reforms. For example, in response to persistent overcrowding in California prisons, Governor Jerry Brown was forced to realign the state's prison structure. Multiple lawsuits in 2006 alleged that the state failed to provide satisfactory health care for inmates (Golaszewski, 2011). Following a judicial requirement to reduce overcrowding by 2011, the state was still overcrowded by over 34,000 inmates. To ease the burdens of overcrowding and comply with the lawsuits, the adult prison system was realigned (Turner, 2011). In other words, the burden of confining and supervising prisoners was shifted onto counties because low-level offenders were relocated back to counties. Similar correctional reforms have also been considered in Illinois (Okon, 2012) and New York (New York State Executive Budget, 2012). These severe correctional reforms highlight the seriousness of housing inmates in inhumane conditions.

Despite the negative conditions and deprivation of civil liberties reported in many correctional institutions, the nation has grown increasingly reliant on confinement to control adult and juvenile crime. Growing correctional populations over the past thirty years demonstrate the reach of social control in the United States. Since the 1980s, there has been nearly a 300% increase in the number of adults in/on prison, jail, probation, or parole (Glaze, 2011). Despite a .3% decrease in the prison population in 2010, the first decrease in prisoners since the 1970s (Guerino, Harrison, and Sabol, 2011), it is evident that correctional controls are unlikely to significantly decline in the near future. With over 7 million persons under some form of correctional supervision and an incarceration rate of 743 per 100,000 persons, no other country has a higher incarceration rate than the U.S. (Walmsley, 2011). Similarly high rates of incapacitation are also exhibited in the juvenile justice system. Although the number of confined juveniles has decreased since the 1990s, there are currently over 70,000 juveniles committed to some form of supervised care (Sickmund, Sladky, Kang, and Puzanchera, 2011). In sum, the expansion of formal social control has increasingly brought adults and juveniles into a correctional system that has resulted in centuries of depriving individuals of their civil rights, housing them in poor conditions, and negatively impacting successful reentry.

### **Responding to Deprivations of Civil Rights**

Concerns over mistreatment, abuse, poor housing conditions, and overall deprivations of civil rights have led the federal government to step in to force reforms upon adult and juvenile correctional institutions (Jacobs, 1974). In 1980, the enactment of the Civil Rights of Institutionalized Persons Act (CRIPA) allowed the U.S.

Department of Justice (DOJ) to independently initiate lawsuits against state and local facilities for confinement institutions that violated the civil rights of confined persons (Holt, 1998). CRIPA allows the Attorney General to initiate an investigation when it is suspected that there are “egregious or flagrant conditions which deprive such persons of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States causing such persons to suffer grievous harm, and that such deprivation is pursuant to a pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities” (42 U.S.C. § 1997). The DOJ can then sue those overseeing institutions that deprive individuals of civil liberties to force compliance.

In a CRIPA investigation, typically an institution is brought to the attention of the DOJ through either newspaper reports or complaints by employees, family members, or community advocates (Barczyk and Davis, 2009). If there is sufficient cause for concern that there is a pattern of persons being deprived of their rights, experts are hired to investigate conditions at the facilities (42 U.S.C. § 1997). The DOJ then has the option to either file a lawsuit to force the changes or to allow the agency to voluntarily comply and make the necessary changes (i.e. enter into a consent decree).

The responses of the Justice Department to institutions that deprive individuals of civil rights have not been without criticism (Cornwell, 1988; Dinerstein, 1984; National Council on Disability, 2005). Many of the criticisms were raised during the initial years of CRIPA and pertained primarily to the failure of the Justice Department to initiate litigation to restore the rights of inmates. Other concerns have persisted including the length of time it takes to complete investigations, the length of time to achieve compliance, sporadic monitoring during consent decrees, and the failure to provide



oversight after an agency is in compliance with the conditions of confinement. This latter point is particularly relevant, as some community advocates have expressed concerns that after a consent decree is lifted or litigation is resolved, the Justice Department no longer has the authority to oversee conditions. This means that institutional conditions may potentially decline after a federal intervention, yet go unnoticed because of a false sense of security post-reform. Because of this, it is important to examine how and why organizations maintain reforms.

Sherman (1978) posits that three questions need to be addressed when explaining how organizations become deviant and respond to reforms. These include: 1.) What conditions led to the deviance, 2.) What were the conditions surrounding the implementation of the social control against the organization, and 3.) What were the consequences of external social controls being placed on the agency? Although the first two questions are addressed to an extent in the current dissertation, the primary focus is the latter question of the outcomes of external influences on organizations. This question is examined through the lens of institutional theory. Meyer and Rowan (1977) suggest that organizations strive to appear legitimate to their external environments because they are dependent on their environment to provide needed resources for survival. These dependencies then force organizations to adopt structures and practices because of their need to appear legitimate to their environment.

In the case of CRIPAs, the initiation of a consent decree or lawsuit against a correctional institution may result, for example, in a loss of legitimacy by agencies external to the institution. Harms that may potentially result because an institution has deprived the civil rights of inmates include: loss of agency funding by state governments,

loss of grants by external agencies, being required to pay for monitors to investigate the agency, having to pay litigation fees if the CRIPA lawsuit is contested, and a decline in the number of inmates because counties are unwilling to send inmates to inhumane facilities. In correctional agencies where resources are all too often spread thin, these can serve as serious penalties that will likely be avoided in order to ensure “organizational survival.” In other words, the organization responds to coercive isomorphism, where external pressures force the institution to adopt other policies of institutions that are viewed as legitimate (DiMaggio and Powell, 1983). One way to ensure “organizational survival” would then be to agree to a negotiated settlement with the DOJ, make the changes required by the DOJ, and maintain those changes to prevent future litigation against the agency. The institution would then demonstrate to their environment that reforms are occurring to comply with federal standards of correctional care, signaling that the agency seeks legitimacy. Agencies that resist reforms may then be sued to force the changes to occur and perceptions of legitimacy may decline.

A second explanation as to why correctional institutions successfully reform because of external pressures is the impact that the resulting internal controls may have on the agency. Sherman (1978) suggested that deterrence theory could explain how in response to external forces, organizations will implement internal controls. Similar to the specific and general deterrent effects that punishments can have on individuals (Gendreau and Ross, 1981), organizations may also be deterred from deviance (Rottig, Koufteros, and Umphress, 2011; Talaulicar, 2011; Trevino, 1992). Sherman found that police departments that experienced scandals in the early 1970s respond in two ways to deter future organizational corruption—preventive (i.e. removing opportunities for corruption)

and punitive (i.e. punishing officers) controls. Specifically, he studied the effects of two preventive control strategies on deterring misconduct: changing organizational practices (i.e. internal accountability, tight supervision, abolition of corrupting procedures) and changing the environment (i.e. task and political environments). Punitive controls took the shape of detection (i.e. intelligence was gathered from citizens, police, and internal policing units), investigations, and sanctions. Police departments that implemented punitive and preventive controls were more effective than those without such controls. However, it remains unclear if a correctional institution responding to similar circumstances would have similar outcomes.

Chanin (2012) recently examined the sustainability of reforms following consent decrees with the Justice Department. He argued that sustainability is the most critical aspect of these interventions. His examination of four police departments reforming use of force practices shed light on factors that led to the institutionalization of change (e.g. leadership and commitment) and those that hindered effective reform (e.g. lack of external accountability, limited external support). Chanin posited that four factors are critical for understanding sustainability of reforms including: “the process and substance of the reform effort, as well as organizational and environmental contexts” (p. 281). In other words, the requirements outlined in the consent decree, the process of reform, organizational context, and the environment of the organization all shape the institutionalization of change in police departments.

Similarly, reforms made through CRIPA related interventions do not occur in a vacuum. Correctional agencies that are investigated and forced to reform typically have deprived inmates of civil liberties for years. Whether these problems are the result of a

poor staff culture, factors external to the agency (e.g. political climate in state, economy), the failure of administrators to effectively manage the agency, and/or other factors that result in conditions so severe that they warrant a federal investigation, it is critical to account for the background of organizations for understanding responses to consent decrees. The result is that an agency marred by failures is required to make changes quickly under the eye of federal monitors.

After a few short years, most agencies are no longer under federal monitor and are not under any external oversight. What happens behind closed doors after the cessation of monitoring could then be the full adherence to the consent decree, a complete abandonment of these reforms, or somewhere in between. In other words, it is unclear whether organizations that face CRIPA investigations will be reformed over the long term. It would only be until problems are again brought to the attention of the federal government that the cycle would begin again of forcing compliance with a consent decree, improving conditions, and then leaving an agency without oversight.

A closer examination of reforms made through CRIPA is important for multiple reasons. First, the failure to extensively examine the sustainability of reforms is concerning because institutionalizing change is arguably the most important aspect of consent decrees (Chanin, 2012). Second, in addition to the financial costs that are expended to employ litigators, conduct investigations, and proceed with litigation, there are also severe social costs for housing individuals in conditions where they are deprived of their civil liberties. Third, the protection of the civil rights of confined persons is of less concern to the public because they are perceived as more deserving of punishment (Garland, 2001; Rychlak, 1990). As a result, institutionalized persons are vulnerable to

abuse and physical coercion and are dependent on their custodians for all aspects of care (Marquart, 1986; Stojkovic, 2007; Sykes, 1958). Finally, the conditions of institutions can also impact reentry outcomes (Jonson, 2010), further justifying the importance of maintaining reforms that improve facilities. The fact that the conditions of countless correctional institutions have been subpar at the same time that the incarceration rate is increasing suggests that the maintenance of housing conditions and civil rights have been neglected in favor of expanding social control.

Prior research has examined the historical foundations of institutions, abuse directed at inmates, the deprivation of civil rights of confined persons, and the lasting harms confinement has upon reentry have been examined in depth, yet rarely are the mechanisms for changing institutional conditions addressed. Scant research exists as to how consent decrees reform criminal justice agencies (Chanin, 2012). Studies examining CRIPA have been largely historical in nature (Plotkin, Davison, and Kaufman, 1989; Puritz and Scali, 1998a), been limited to the initial formation of CRIPA in the 1980s (Holt, 1998), focused on the confinement of those with disabilities (Dinerstein, 1989; National Council on Disability, 2005), or reported on the process of implementation (Barczyk and Davis, 2009). Furthermore, none has examined the institutionalization of a consent decree resulting from CRIPA for any significant amount of time after a consent decree has been lifted. This has left a gap in the understanding of if and how changes are sustained. Filling this knowledge gap is important to those tasked with initiating lawsuits (e.g. DOJ), those responsible for monitoring the progress of an agency during a consent decree, and correctional administrators charged with overseeing the protection of civil rights to ensure that reforms are institutionalized.

The current dissertation will extend our understanding of CRIPA in two ways. In line with Chanin (2012) and Sherman's (1978) frameworks for evaluating the institutionalization of reforms in police departments this dissertation first describes the implementation of one CRIPA intervention from multiple perspectives, including correctional administrators, line level staff, community advocates, and detention administrators. The requirements outlined in the consent decree and the process of implementation will be examined from the perspective of each of these groups. Second, the current dissertation addresses those factors that encourage either sustainability of the conditions of the CRIPA or impede its institutionalization. More specifically, this dissertation addresses both external (e.g. pressures to appear legitimate, dependence upon external agencies for resources) and internal (e.g. staff culture, punitive controls, preventive controls) forces that influence sustainability of change in a correctional agency.

Few states have been subject to more than four CRIPA investigations. Arizona is one such state, with investigations having occurred in prisons, jails, and juvenile justice facilities, which makes it an attractive location to examine the sustainability of consent decrees. One agency, the Arizona Department of Juvenile Corrections (ADJC), was formed following a consent decree with the Arizona Department of Corrections (ADC) to remedy abuses of confined juveniles. To avoid a formal lawsuit, responsibility for confining and treating juveniles was shifted from ADC to ADJC. ADJC then endured years of monitoring to improve conditions and insure that the rights of juveniles were not violated. Shortly after the cessation of the consent decree and monitoring by external agents, new problems began to surface. Three youth committed suicide in ADJC

institutions and local news agencies reported that staff were sexually abusing juveniles, juveniles were held in solitary confinement for months at a time, educational services were lacking, and youth were being deprived basic rights such as using the bathroom. Taken together, the poor conditions immediately following the first consent decree suggest that the ADJC might not have fully institutionalized the changes of the consent decree. Sustaining change at the Arizona Department of Juvenile Corrections (ADJC) after federal monitoring and a consent decree are the focus of the current study.

As will be discussed in greater depth, the troubled history of the ADJC eventually led to federal involvement, the implementation of a consent decree, and an agency that was forced to change how it cared for juveniles. The question now is, was the ADJC able to effectively reform as a direct result of the CRIPA? If so, what led to successful agency reform? If not, what prevented the agency from successful reform? A case study research design was employed, consisting of a review of newspaper articles, government documents, and semi-structured interviews with 47 respondents. These included current and former ADJC employees, community advocates, and detention administrators. Participants were interviewed regarding the conditions leading to intervention, changes during the CRIPA investigation, their perceptions of conditions five years after the consent decree was lifted, and factors that influenced the implementation of changes.

The current study expands on prior research on organizational reform by directly examining the sustainability of changes made in correctional facilities as a result of lawsuits under the Civil Rights of Institutionalized Persons Act (CRIPA). The overarching questions guiding the dissertation is: Does federal involvement requiring correctional reforms produce long-term, sustainable change? If changes are made, how

are they accomplished and how deeply embedded are they within the agency? The study is couched in a framework that considers both how organizational needs to maintain legitimacy in the environment are necessary for survival and the deterrent effects of internal controls that are imposed on line level staff by management to ensure successful reforms. In regard to the latter, a specific focus is paid to the punitive and preventive methods of control that are imposed subsequent to federal lawsuits. Recommendations will be made for both the implementation of future consent decrees and future research examining sustainability of reforms.



## **Chapter 2**

### **Literature Review**

This chapter begins by examining the evolution of formal social control in the United States since the 19<sup>th</sup> century. The purpose of this section is to outline the historical roots of control and punishment to provide context for a later discussion of more modern forms of social control over individuals and organizations. It begins by addressing how incapacitation became the response to crime, eventually leading to societal dissatisfaction with conditions of confinement, followed by a formal governmental response to abuses in institutions to encourage reforms.

The chapter then shifts to the institutionalization of reforms by organizations. When changes are made either proactively or reactively in organizations, multiple factors will influence the long-term outcomes of such reforms. The impact that external and internal influences, along with the implementation of policies, have on institutionalizing reforms are addressed.

The chapter concludes by examining a specific policy aimed at reforming institutions of confinement, The Civil Rights of Institutionalized Persons Act of 1980 (CRIPA). The events leading up to the passing of the act and initial problems with implementation are addressed. Next critiques made by legal and community advocates of CRIPA are examined along with some of the proposed solutions. The chapter then addresses the limitations of previous research on CRIPA and sustaining organizational reforms.

## **Social Control: Expansion and Consequences**

Social control is the societal response to individuals who are deemed as delinquent or criminal and constrains behaviors through punishments, deterrents, incapacitation, and rehabilitation (Cohen, 1985). Forms of social control have evolved in multiple ways since the 19<sup>th</sup> century. Most notably was the decline of informal controls placed on individuals by families, religion, and communities in the early 1800s as the population grew and time was increasingly spent away from home (Walker, 1998). This shift meant that these once powerful institutions that restrained behavior were growing less influential over individual behaviors. In response to fear of the weakened influence of informal social controls would lead to crime, regulation of behaviors by the government became commonplace.

Prior to the formation of prisons, one method of formally controlling individual behaviors was physical punishment (e.g. whippings, beatings, torture, and hangings). Over time, physical punishments waned as efforts to ‘humanize’ the system took hold (Foucault, 1979). The shift towards more humane treatment of criminals was then coupled with the growing sentiment that the social institutions that controlled individuals were breaking down (Rothman, 1971). It was feared that as communities grew larger, social bonds would be weakened and lead to crime. These two national sentiments largely contributed to the desire to seek out new solutions for criminals and delinquents.

Prisons, jails, and asylums eventually became the solution to dealing with difficult populations in society (Rothman, 1971; Walker, 1998). While this has not always been the case, incapacitation has become an accepted form of crime control. One explanation for the growth of incarceration is the decline of informal social control, although it is

unclear exactly why incapacitation was thought to be the best solution to this issue. Perceptions existed that the weakened controls of families, communities, and schools in a changing society would result in social disorganization (Garland, 1990). To combat growing concerns over crime and disorder, asylums and prisons were the solution despite the crowding and inhumane conditions that typically characterized most institutions.

For the most part, a consensus has been demonstrated over time regarding the character of confinement institutions, whether they are for the mentally ill or criminals (Rothman, 1971). Rothman aptly described seven consistent similarities in institutions (i.e. prisons, mental hospitals, reformatories, and almshouses), including: 1.) they are used for punishment and/or treatment, 2.) they are similarly designed/organized, 3.) they serve to separate inmates and mentally ill from the outside, 4.) time is strictly managed, 5.) the two primary mechanisms used to transform behaviors were work and isolation, 6.) institutions typically started out ordered but over time all spiraled downward and became disorganized and crowded, and 7.) they were used to house the lower class. Among the earliest prisons developed in the United States were the Auburn and Pennsylvania Prison systems. The Auburn and Pennsylvania systems differed significantly in their forms of incapacitation. Whereas the former allowed for inmate interactions, the latter required inmates to remain in solitary confinement. Foucault (1979) argues that the initial goals of incapacitation surrounded the concept of docility. It was believed that humans could be easily transformed through discipline, thereby making them obedient and docile. Further changes to inmates' physical appearance, thoughts, and actions would also serve to reform criminals. In other words, the evolution of punishment from physical

punishments to incapacitation only served to “change the form but not the aims of social control” (Pisciotta, 1994, p. 22).

A similar expansion of social control also occurred in response to increased juvenile delinquency (Fox, 1970; Pisciotta, 1994; Platt, 1969; Schultz, 1973). A growing trend towards incapacitating juveniles was a direct result of shifts from the informal controls of families and communities to those of formal control by the government and states in the late 1890s. Platt deemed this period the “child-saving movement,” where a group of middle-class women were instrumental in reforming how states responded to juvenile delinquents. The involvement of females in juvenile justice was supported because females were viewed as the “natural caretakers” of youths and they could serve as social workers. They perceived juvenile delinquents as less responsible for their behavior because they were not as mentally developed as adults. Furthermore, it was believed that reformatories could fix behaviors that were the result of poverty and poor environments. The resulting juvenile justice system was originally formed to be separate from the adult system in order to limit the exposure of more hardened criminals to youths, prevent labeling of young offenders, and provide youths with a parental figure (Feld, 1999). However, this has changed over the past forty years in response to shifting perceptions of juveniles as hardened criminals, so-called “superpredators,” and violent offenders. As a result, responses in the juvenile justice system have also grown increasingly punitive. This has resulted in more youths housed at juvenile correctional facilities and transferred from the juvenile to adult systems.

The resulting formal social controls have since shaped the appearance of crime control today. Pisciotta (1994) states that “the rise of the adult reformatory movement

resulted in a wider, deeper, stronger, more sophisticated American network of social control” (p. 27), which has directly impacted the appearance of modern day corrections. This expanded network of social control has been clearly exhibited in the growth of incarceration and supervision since the 1970s. A related issue is the control that is present over criminal justice organizations, especially by the federal government.

### **Criticisms of Expanded Social Control**

Cohen (1985) outlines the push and pull between well intentioned reforms and the negative outcomes resulting from such reforms. He argues that social control reforms take three shapes: 1.) reform is the response to the advancing of knowledge, where increasing insight into criminal control leads to improved responses to crime, 2.) reform is the direct result of changing social conditions, and 3.) reform occurs because of the actions made by a select portion of society striving to repress the lower classes under the guise that reforms are fairly distributed in society. One issue complicating many reforms is the struggle faced by organizations when attempting to internally implement necessary changes while confronted with the external constraints placed upon them. Over the course of time, positive reforms begin to show their flaws and weaknesses, leading to new programs and policies based on more recent advances in knowledge and understanding of deviance. Cohen states that “it is not the system’s professed aims which are at fault, but their imperfect realization” (p. 18). The imperfect realization of more “humane” treatment for criminals in the 19<sup>th</sup> century laid the foundation for modern practices of confinement.

Questions have lingered as to why incapacitation became the primary mode of social control both in the United States and worldwide. As Rothman (1971) has argued, “confinement was simply too convenient a solution for social problems” (p. xxxv). This convenient solution allowed for the perpetuation of an institutional model wrought with problems because it served the needs of a society searching for a solution with what to do with the insane and criminal. Additionally, it served an economic function for states, as profits were made off of inmate labor and fines (Rusche and Kirchheimer, 1939). There was little evidence that incapacitation was rehabilitative, especially with the mechanisms for treatment that were used at the time (Foucault, 1975). Garland (2001) further acknowledges the role that societal shifts in the 1960s had on increasing crime rates and, ultimately, the use of incarceration. His examination of societal transformations in the United States and the United Kingdom argued that “late modernity,” or the “distinctive pattern of social, economic, and cultural relations that emerged in America...[which] brings with it a cluster of risks, insecurities, and control problems that have played a crucial role in shaping our changing response to crime” (viii), served to increase crime because of increased opportunities, weakened controls, and more “at risk” individuals. As a result, individuals and communities were more vulnerable to crime, and stronger crime control policies emerged that were rooted in conservative ideologies.

The tension between liberals who believed that indeterminate sentencing unfairly harmed minorities and conservatives who argued that criminals were not being treated punitively enough then came to a head following Martinson’s (1974) finding that “nothing works” in rehabilitation. Subsequent sentencing reforms to make sentences more punitive and fair led to the rise in incarceration during the 1970s and 1980s.

Additionally, concerns over the conditions of confinement (e.g. overcrowding), resulted in more prisons being constructed to alleviate problems (Schoenfeld, 2010). This led to an increase in the “state’s capacity and willingness to incarcerate” (p. 733), and ultimately contributed to mass incarceration. The convenient prison solution to merely construct more prisons allowed for formal controls of the state to expand.

The expansion of social control began to be strongly criticized by social scientists and the public in the 1960s (Austin and Krisberg, 1981; Scull, 1977). Correctional reforms had done little to change the goals and practices of incapacitation, as modern day prisons still closely resembled their predecessors in many ways (Pisciotta, 1994). Many questioned whether more recent practices in confinement were an improvement over early forms of corporal punishment that had once been perceived as cruel and unusual (Foucault, 1977; Rothman, 1971). No longer able to hide under the rhetoric that had been concealing what was really happening in prisons, the growing reality that prisons were depriving individuals of their civil rights was a large factor in the deinstitutionalization movement (Scull, 1981). Beginning in the 1950s, this movement was a direct result of the perception that treatment of the mentally ill in the community was more humane, rehabilitative, and, most importantly, cheaper. The movement also impacted the criminal justice system, as it was claimed that prisoners were being mistreated and deprived of their civil rights. Scull argues that “some of the pressure for decarceration has to be attributed to the growing willingness of courts, particularly Federal courts, to intervene in running of prisons” (p. 37). In contrast to the initial goals of deinstitutionalization efforts (e.g. community corrections, diversion programs) to reduce incarceration, this practice

actually became another clear example of the growth in formal controls in the 1960s and 1970s (Scull, 1977).

As a growing number of individuals were being brought into a failing system, there was a newfound interest in developing alternative solutions to incarceration that would lessen that nation's reliance on incapacitation. The search for alternatives to incarceration resulted in the phenomenon of net-widening nationwide (Blomberg, 1977; Decker, 1985; Mainprize, 1992). Net-widening occurs when alternatives to detention or incarceration actually result in an increased number of offenders being brought under the control of the criminal justice system by allowing more options for punishment. For example, Blomberg's (1997) evaluation of a juvenile diversion program in the early 1970s revealed that of those juveniles who would have previously been ineligible for punishment, a large number were placed in the diversion program. In other words, rather than reducing the scope of those brought into the juvenile system, the diversion program allowed for increased control over delinquents. Austin and Krisberg (1981) argue that searching out alternatives to confinement was an ironic endeavor because the funding for such programs was reliant on the government for support. Ultimately efforts to reform the system through community corrections and diversion programs served as alternatives at the same time that they served as additional options for the placement of offenders (Cohen, 1979).

A growing reliance on incarceration continued the conditional problems that had been exhibited since the earliest prisons. The following section will address such issues and explore reasons why they have continued despite their harms to inmates. This will



then lead into a review of how organizations, specifically correctional institutions, respond to formal social controls to improve conditions and restore civil rights.

### **The Reality of Confinement Conditions**

One of the primary contributors to the expansion and acceptance of formal controls nationwide has been the gap between rhetoric and reality (Feld, 1990; Giardino, 1996; Greene and Mastrofski, 1988; Morris and Hawkins, 1970; Phelps, 2011; Pisciotta, 1985). When correctional practices based on false rhetoric are legitimated or justified, future “generation[s] could resort to [them] without especial difficulty” (Rothman, 1971, p. 255). This trend has resulted in a “legitimation despite failure” of poor policies and practices in jails, prisons, and juvenile facilities that have severe ramifications for the criminal justice system. It is especially problematic when “fully and clearly defined purposes become the foundation for decisions and coherent policies” (Christy, 1994, p. 110). In other words, the creation and/or continuation of policies based upon incorrect “facts” contribute to the continuation of a system that may in fact be broken.

As the reach of formal social controls in the 1800s spread throughout the country, so too did reports of poor treatment. Pisciotta (1985, 1994) outlines some of the most notable cases of inmate abuse and inhumane conditions reported in juvenile facilities and prisons in the 19<sup>th</sup> century. The first was the Elmira Correctional Facility in Elmira, New York, which was investigated by the Board of Charities in 1893 over claims that the warden had allowed for poor conditions of confinement and had mismanaged the staff. These reports brought to light exactly how inmates were physically punished, tortured, and isolated, which was a surprise to the public who had been led astray by the warden.

It was recommended that the prison make severe changes to improve the conditions of the facility. However, the warden was opposed to this reform and was able again use rhetoric to convince the public that the prior methods were necessary (New York State Board of Social Welfare, 1894). Pisciotta's examination of the New York House of Refuge for juveniles from the 1850s to 1930s revealed similar findings regarding the gap between rhetoric and reality. His review of practices demonstrated that the juveniles were being used for "cheap labor," not treated from a parental perspective, deprived of basic necessities, and improperly classified, all of which were in contrast to the policies the facility reportedly espoused. The "brutal" conditions that were characteristic of confinement in the facility led Pisciotta to characterize it as a prison rather than a house of refuge for rehabilitating juveniles. In addition to correctional facilities, insane asylums at the time were unable to live up to the rhetoric of treatment and rehabilitation (Rothman, 1971).

Many of these inhumane conditions exist to this day. Pisciotta (1994) has argued that:

Contemporary correctional institutions continue to experience many of the same problems which undermined late nineteenth- and early twentieth- century social control efforts. Many institutions are still overcrowded, underfunded, and in poor structural condition (witness the continued use of the Auburn and Sing Sing Prisons). Correctional facilities are still plagued by the defects of total institutions, the limitations of the medical model ('tinkering science'), and the problem of prisoner resistance (violence, gangs, riots, drugs, theft, smuggling, arson, predatory sex, and suicide). (p. 153)

More recent reports confirm that factors like overcrowding, a lack of resources, and resistance of staff (Green, 2010; Massachusetts Department of Correction, 2012; Muradyan, 2008) still contribute to inmate harms like sexual abuse (Beck and Harrison,

2010; Zweig and Blackmore, 2008) and an increased suicide risk (Dye, 2010; Hayes, 2009). Facilities where inmates have experienced past violence and/or have a poor staff culture reportedly also have a greater number of inmates who fear for their safety while incarcerated (Wolff and Shi, 2009). Excessive overcrowding, which contributed to an increased risk for violence, the inability to control inmates, and deteriorating physical conditions of facilities, recently led one state to declare an emergency proclamation to improve conditions (Schwarzenegger, 2006). Although poor conditions do not characterize all correctional facilities, the culmination of reports since the 19<sup>th</sup> century are indicative of a pattern of misconduct and disorder in institutions for confinement.

The poor conditions exhibited in the Massachusetts Department of Youths Services (DYS) system famously led to the closure of the Massachusetts State Training Schools in the early 1970s in what was later termed the “Massachusetts Experiment” (Miller, 1998). Jerome Miller, the Commissioner of the DHS, was concerned over the high rates of staff abuse against youths, escapes of juveniles, improper confinement, and the failure of staff in the training schools to provide rehabilitative programs. Despite concerted efforts by Miller to reform the agency, he quickly realized he would be unable to overcome the poor culture exhibited by staff. In response, Miller closed the large training schools in favor of small, decentralized group homes across the state. While many of the group homes were unsuccessful and were eventually shut down, Miller’s “experiment” signified a growing concern over how juveniles in confinement were being treated.

It is clear that both past and present efforts aimed at controlling crime have caused new harms to confined persons, as a growing number of individuals are incarcerated and

deprived of their civil liberties while incarcerated. As a result of harsh conditions that harm confined persons, controls must then be placed on correctional facilities to maintain proper standards of care. In other words, agents of social control may have formal external controls imposed upon them to achieve compliance with national standards of care. The responses of organizations to forced reform will then shape their ability to maintain long-term changes. The following section presents an overview of social control in organizations, with a specific focus on the factors influencing restraint from deviance and that encourage the institutionalization of reforms.

### **Control in Organizations**

The previous sections have outlined the evolution of formal social controls in the criminal justice system and how the expansion of control over individuals has led to the acceptance and practice of incarceration as the response to criminal behavior. However, it has been argued that “we have been concerned with hidden deviance of individuals and not with the visible deviance of organizations” (Reiss, 1966, p. 18). The overreliance on confinement and subsequent mistreatment of inmates eventually led to federal and state responses to control organizational deviance. Reports of the deprivation of civil liberties of confined persons now demonstrate that harms to society are committed not only by individuals, but also by organizations empowered with control over criminals (Vaughan, 1983). Public dissatisfaction with criminal justice agencies then contributed to the “impotence” of the system (Austin and Krisberg, 1981). As violations of civil liberties and abuses in prisons became public knowledge, support waned for the correctional system and grew for inmates and criminals. In a direct response to the poor conditions of

confinement characterizing many institutions across the country, the federal government intervened to force the upholding of civil liberties of confined persons.

Social controls in organizations are mechanisms that regulate behaviors to encourage conformity of individuals within organizations and organizations as a whole (Ermann and Lundman, 1978). They may be exerted both externally and internally on organizations similar to the social controls that are placed on individuals (Hirschi, 1969; Sherman, 1978). Whereas individuals are controlled internally by their consciences and social environments, so too are organizations by individuals within an organization who encourage conformity. Likewise, individuals who are no longer controlled internally and who violate social norms will be punished externally by formal agencies, just as organizations may be punished for violations by outside agencies. One way that organizations can become deviant is when individuals within the organization become corrupt (e.g. corruption of officers in a police department). In response, “the organization undergoes some organizational transformation as a consequence and some of its members are removed from their office or position, even indicted and perhaps sentenced” (Reiss, 1966, p. 14).

All organizations are subject to external controls (e.g. legal, political, economic, or cultural) placed upon them that regulate behaviors and operations (Hall, 1972; Pfeffer and Salancik, 1978). Most of these external organizational controls are the direct result of dependencies that organizations have upon their environments (Jacobs, 1974).

Whether organizations willingly choose or are forced to have external controls placed upon them, this is accomplished by other organizations which “have as their primary function and purpose the control and alteration of the activities of other organizations”

(Pfeffer and Salancik, 1978, p. 39). In other words, there is an interdependence at play between two organizations that are reliant on one another for successful outcomes. The extent of control is shaped by the dependence of one organization on another for needs such as money or social legitimacy. However, public organizations are controlled by more external factors, especially legal and political controls, whereas private organizations are constrained more by financial controls (Schiflett and Zey, 1990).

Examined in more depth in the later discussion of consent decree implementation, a growing body of research now suggests that the external controls placed upon criminal justice agencies through court reforms can effectively improve conditions (Chanin, 2012; Feely and Rubin, 1998; Nathan, 2004). Recognizing the harms that continue to occur in correctional institutions, the American Bar Association (2008) recommended that, in addition to internal controls, outside oversight of correctional facilities should be provided to inform the public of institutional conditions. It is argued that by bringing issues to light, changes can be made to improve the quality of care. They state that such external oversight could come from “monitoring by citizens’ groups, accreditation, legislative oversight, media access, and special mechanisms for the prosecution of crimes committed by correctional staff” (p. 3).

The internal controls (e.g. organizational policies, managers, norms) of organizations are related to and impacted by the external controls (e.g. compliance with laws) that are placed upon them to function appropriately. This relationship can be directly influenced by either internal or external organizational changes. Sherman (1978) argues that “one possible consequence of external social control of deviant organizations is an increase in internal organizational control of deviant behavior among the

organizations members” (p. 28). Such findings suggest that the success or failure of sustaining changes within failing organizations will be dependent on the internal responses to external control. In other words, a high degree of external control may have little influence on an organization where the employees are unwilling or unable to reform.

Internal controls are those that are enforced by supervisors over both staff and inmates. Foucault’s (1975) vision of the Panopticon described this concept when he stated that:

In this central tower, the director may spy on all the employees that he has under his orders: nurses, doctors, foremen, teachers, warders; he will be able to judge them continuously, alter their behavior, impose upon them the methods he thinks best; and it will even be possible to observe the director himself. An inspector arriving unexpectedly at the centre of the Panopticon will be able to judge at a glance, without anything being concealed from him, how the entire establishment is functioning. (p. 204)

Some scholars report that the key to maintaining order in prisons comes from the top of the bureaucratic chain, starting with the warden and other correctional administrators. For example, DiIulio (1987) found that “a paramilitary prison bureaucracy, led by able institutional managers and steered by a talented executive, may be the best administrative response to the problem of establishing and maintaining higher-custody prisons” (p. 256). He argues that it is not the prison culture, institutional structure, or staffing practices that control prisons, but rather the social controls imposed by administrators. This control is gained through a variety of tactics including “training, policies and procedures, supervisory structures, and formal sanctions that can be imposed to ensure conformity” (Stojkovic, 2003, p. 219).

Not all research suggests that extensive internal control leads to conformity, instead finding it can have negative consequences (Durkheim, 1897; Reisig, 1998). For

example, Durkheim has argued that because of the integration of individuals in their social environments, their environments will serve to regulate behaviors. Applying a framework of integration/regulation to the occurrence of suicide, he argues that the overregulation of individuals can cause them to commit suicide because they feel oppressed and cannot conform to such regulation. Correctional institutions may also experience similar negative effects when they are excessively controlled. For example, in contrast to DiIulio's findings, Reisig's (1998) examination of 11 prisons using control, consensus, or responsibility models found that prisons adopting a control model had increased disorder when compared with the latter two models. These findings suggest that extensive regulation of officer behaviors by managers is potentially harmful to the successful management of prisons.

The institutional responses to disparate leadership styles based on control are outlined in depth in Jacobs' (1978) review of the Stateville Correctional Center in Illinois from the 1920s to the 1970s. Opened in the early 1920s in response to the overcrowding and poor conditions in another Illinois prison, Stateville was characterized early on as employing correctional officers with little experience, providing no organizational goals for staff, having weak internal controls over staff, and having flexible rules for inmates. In response, the institution during this time "experienced one of the most violent and unstable periods in its history" (p. 201). The later appointment of Warden Joe Ragen from 1936 to 1961 resulted in more rigidity through his authoritative and totalitarian leadership style, where both staff and inmates were required to give him "absolute loyalty." He sought full control over correctional officers, by hiring from distant cities and forcing officers to live in barracks, in essence segregating them from their



surrounding areas. Because Ragen only provided the basic necessities to inmates, all other extras were allotted to them based on a reward system. The inmate society during Ragen's administration was characterized as being highly competitive for jobs and luxuries. At the time, these rewards served as incentives for inmates, as they provided mobility and more freedoms within the institution.

Following Ragen's tenure as warden, Jacobs (1978) outlines the shifting political and social climate in the 1960s, which served to challenge how prisons were being managed. Although the physical isolation of inmates prevented their direct involvement in these reforms, they were impacted by the growing perception that inmates' rights needed to be upheld. Jacobs notes that prior to this time, it was believed that convicted inmates were severed of their rights and they had little legal recourse to bring about change. The passage of the Civil Rights Act of 1964 eventually led to "federal and state courts...scrutiniz[ing] every aspect of the prison regime and...issu[ed] injunctions and declaratory judgments affecting discipline, good time, living conditions, health care, censorship, restrictions on religion and speech, and access to the courts" (p. 9). As a result, later management styles were characterized as being professional and formalistic. These changes were demonstrated with the hiring of experts and professionals for treatment, the implementation of grievance systems for inmates, and the formal relationships between officers and inmates.

The very nature of institutions for confinement means that power is wielded over inmates. The dynamics of such a relationship can oftentimes result in opportunities for misconduct and corruption by the more dominant group. Vaughan's (1983) review of large corporations where employees engaged in misconduct outlines the harm that arises

when opportunities for misbehavior exist. She argues that organizations can “provid[e] normative support for illegality, provid[e] mechanisms for carrying out illegal acts, and minimize the risk of detection and sanctioning” (p. 67), even though initial intentions for such opportunities were for legitimate reasons. Other factors that may directly lead to corruption include the size and age of the organization. For example, large organizations may allow for physical isolation, making it more difficult to detect illegal behavior. Organizations that are confronted with employee misconduct, corruption, and opportunities for deviance may respond by creating internal controls. The following section will discuss two forms of internal controls, punitive and preventive, which can be placed on organizations to prevent future misconduct.

### **Deterrence through Punitive and Preventive Controls**

Internal controls in institutions are shaped by both preventive and punitive control policies (Igbinovia, 1985; Mohamed and Man, 2010; Sherman, 1978). Whereas the former focuses on the removal of opportunities that may corrupt line level staff, the latter deals with detecting and punishing officers. Sherman’s review of police departments experiencing post-scandal reforms is one of the first and most extensive studies to directly examine how the institutionalization of changes in criminal justice organizations are shaped by preventive and punitive controls. His case study of four police departments rocked by scandal in the 1970s and their attempts at reform will be examined in more depth as it sheds light on organizations that were able to effectively reform, factors that influenced sustainability, and those that were unsuccessful at institutionalizing changes. While both punitive and preventive control methods are

implemented with the goal of deterring misconduct, Sherman (1978) contends that punitive controls are more in line with deterrence theory, as they punish deviance. The following section will briefly review deterrence theory as it relates to organizational misconduct and will then provide a more in depth review of how both forms of control serve as deterrents.

Some of the earliest perspectives on crime and punishment argued that offenders rationally weighed the costs and benefits of crime, subsequently deciding whether or not to offend (Beccaria, 1775). In essence, if the costs were not worth the benefits of offending, criminals would be deterred from crime. Deterrence may then occur when an increase in punishments results in decreased offending. Because of this perception, deterrence, in addition to retribution, rehabilitation, and incapacitation, became one of the primary justifications for punishment. Punishments may deter individuals in two ways, generally and specifically (Gibbs, 1975). Whereas general deterrence occurs when the general population is deterred from crime after observing the punishments of others, specific deterrence occurs when individuals are deterred from crime after they are punished. In theory, the most effective way to deter crime is by creating punishments that are severe, certain, and swift, however, research on their deterrent effects is mixed. For example, some research suggests that sanctions and punishments do lead to reduced recidivism (Mendes and McDonald, 2001; Sherman and Berk, 1984; Tittle, 1980), especially when punishments are given out swiftly and with high certainty (Bailey, 1976; Darlauf and Nagin, 2011; Loughran, Pogarsky, Piquero, and Paternoster, 2011; Nagin and Pogarsky, 2001; Tittle and Rowe, 1974). In contrast, others find that incarceration can actually cause offenders to commit future crimes (i.e. deviance amplification)

(Farrington, 1977; Matsueda, 1992), does not serve as a deterrent (Cullen, Jonson, and Nagin, 2011; Morris and Piquero, 2011; Payne, 1973), and the severity of punishment may have no influence at all (Brennan and Mednick, 1994). The impact of punishments on deterring crime may also extend to organizations that are faced with similar controls.

While deterrence theory has traditionally been considered from an individual perspective, it has also been applied to individuals within organizations to determine the compliance of individuals to departmental policies and regulations (Hu, Xu, Dinev, and Ling, 2010; Trevino, 1992). In fact, criminologists have argued that deterrence theory “would apply to work settings where actors contemplating noncompliance with organizational rules could be expected to take into account their perceptions of threats of organizationally-imposed, socially imposed, and self-imposed punishments” (Grasmick and Kobayashi, 2002, p. 23). For example, one study of employee theft found that certainty and severity did impact employee deviance, but that younger employees were less deterred by sanctions than older employees (Hollinger and Clark, 1983).

The application of deterrence theory may be extended past the criminality of individuals and those within organizations to consider how organizations as a whole may be impacted by specific and general deterrents (Braithwaite and Makkai, 1991; Sherman, 1978). More specifically, many organizations are required to be compliant with laws and regulations placed upon them by external agencies, therefore policies may be in place to deter non-compliance of organizations. For example, Braithwaite and Makkai’s review of nursing homes that violated the civil rights of individuals (e.g. residents were undernourished, had bed sores) showed that the certainty of detection led to greater organizational compliance, while other deterrence oriented variables were not influential.

This issue was recently questioned in Chanin's (2012) examination of law enforcement agencies that were sanctioned following misconduct when he suggested that future research should examine the effectiveness of agency-wide versus individual efforts to deter misconduct. One study that has been particularly noteworthy concerning criminal justice reforms and how organizations deter future deviance has been Sherman's (1978) examination of police agencies experiencing scandals.

Criminal justice organizations plagued by corruption employ a variety of policies to establish and instill preventive internal controls that serve to deter deviance (Sherman, 1978). These include: "internal accountability, tight supervision, and abolition of procedures encouraging corruptions" (p. 120). First, departments that change internal accountability policies allow for a greater number of employees, including both line level and top level administrators, to become responsible for themselves and others. Administrators employing internal accountability tactics do so under the notion that it will encourage staff to report misconduct. Sherman argues that "a prerequisite of internal accountability is a clear communication of standards in which the employees will be held accountable" (p. 121).

Second, departments attempting to rein in corruption will likely tighten supervision by monitoring work time and/or "product." For example, Sherman's review of the Oakland police department's reform indicated that efforts to tighten supervision included increased documentation by supervisors of cases, progress reports of detectives' activities, and changing procedures for property seizures. In contrast, the New York Police Department took a different technique by becoming more decentralized and moving the mechanisms for controlling corruption further down the bureaucratic chain.

The final method of improving internal controls is that of removing practices that encourage corruption. Corrupting “procedures either imply levels of productivity that are all but impossible to achieve by legitimate means, or the procedures may create pressure for a de facto financial contribution from officers which they often try to ‘earn back’ in corrupt ways” (Sherman, 1978, p. 122). In other words, when officers are encouraged to perform duties that require them to go above and beyond their duties (e.g. paying for gas out of pocket), they may attempt to recoup these losses illegally. Sherman found that only two of the police departments attempted to remove corrupting procedures.

In response to scandals, organizations will also frequently implement punitive controls to deter future misconduct. Those that are unable to effectively control staff misbehaviors will be doomed to fail (Sherman, 1978). In the case of the agencies investigated by Sherman, punitive control policies “were attempts to increase the detection and punishment of corrupt acts in order to deter all officers in each department from engaging in corrupt acts” (p. 146). Detection of inappropriate behaviors may be done proactively or reactively, being brought to light through reports from outsiders, officers, or administrators. Although he notes that it is uncommon for police departments to have internal policing units, all four of the departments he examined had adopted some form of internal policing. For the most part, these policing units dealt with incidents and complaints in a reactive fashion. While Sherman concluded that internal controls were more effective at reforming agencies than were external controls, he found that both punitive and preventive controls were critical to change. Such findings suggest that the removal of opportunities for corruption coupled with establishing deterrents for deviance will encourage long-term reforms.

The preceding section has discussed how attempts to impose formal social controls on the population have ultimately resulted in the necessity for organizational controls to be placed upon the very agencies tasked with controlling individuals. The following section will examine factors shaping the sustainability of organizational reforms. A specific focus is paid to how pressures to maintain legitimacy in the institutional environment will result in change.

### **Sustaining Change in Organizations**

The ability for organizations to make successful and effective reforms is shaped in large part by forces external to the agency, such as shifts in administration, policies, politics, and budgetary constraints (Austin and Krisberg, 1981; Berkhout, Hertin, and Gann, 2006; Dunphy, 1996; Hannan and Freeman, 1977; Weick and Quinn, 1999). For example, Cohen's (1985) model of organizational convenience suggests that, despite the best intentions of agencies to produce the most beneficial changes, they frequently result in organizations considering their own needs. Cohen argues that "on the one hand there are goals, objectives, strategies, ideals and intentions. On the other, there is a series of powerful organizational constraints and constraints on organizations—technology, budgets, inter-agency competition, public opinion, system interdependence, political interference, etc" (p. 94). These factors all occur in conjunction with one another to impact the implementation of programs and policies. Cohen's model suggests that a multitude of both internal and external forces may serve to impede implementation and lead to frustrations among employees.

Despite agency concerns for effective operation, the reliance of organizations on external environments for resources and legitimacy results in the conformity to the rules and norms adhered to by institutional environments (Meyer and Rowan, 1977). Meyer and Rowan's Institutional Theory argues that although they are a hindrance to efficiency, "institutionalized products, services, techniques, policies, and programs function as powerful myths, and many organizations adopt them ceremonially" (p. 340). In other words, the overreliance that organizations have on their environments causes them to adopt practices that may actually be harmful for them. Organizations that are then able to conform to the values of their environments are much more likely to survive. Meyer and Rowan suggest in response to these contrasting necessities, organizations will remain "in a loosely coupled state" (p. 359) where there is a gap between policies and practices in the organization. This is beneficial to the organization because it can then be assumed that the policies are working, when in fact practices may not reflect a strict adherence to policy.

This ceremonial adoption of similar practices and procedures results in isomorphism, or the practice where organizations change to resemble other successful organizations in order to obtain legitimacy, power, and resources (DiMaggio and Powell, 1983). Pressures from the institutional environment subsequently result in three types of isomorphic changes: coercive, mimetic, and normative. Coercive isomorphism occurs when change is the result of pressures from external organizations to adopt policies and practices that are perceived as legitimate. DiMaggio and Powell suggest that in organizations where dependence is high on external agencies, it is likely that



organizations will strive to appear similar in “structure, climate, and behavioral focus” (p. 154).

In contrast, mimetic isomorphism occurs when there is organizational uncertainty. The organization will then look to similar organizations to imitate practices that have been successful. Being able to mimic other successful organizations can in turn reduce the expense associated with implementing impractical solutions.

Finally, DiMaggio and Powell outline how normative isomorphism is the result of change occurring to achieve professionalism in the institutional environment. For example, as the acceptance of formal education (e.g. college degree, certificate) in a field grows, the organization may only hire those who have obtained a degree or training. As certain practices become legitimized in the environment, the organization will then seek to adopt those practices that make them appear professional.

The dependence of organizations on external agencies has been demonstrated in numerous studies of police (Crank, 2003; Dover and Lawrence, 2010; Katz, 2001; Willis, Mastrofski, and Weisburd, 2007), but relatively few studies in corrections research (Ogle, 1999; McGarrell, 1993). However, Ogle suggests that corrections can be considered from an institutional perspective because they closely resemble one another in regards to goals and technology. She finds that they have established legitimacy and are believed to be necessary for social order. One factor that has been found to particularly impact correctional institutions is the relationship that exists between the agency and external agencies like police departments and courts (Christy, 1994). The constant ebb and flow of persons sentenced to correctional facilities is out of the hands of correctional administrators, yet they are forced to make accommodations when these populations are

high and may struggle when populations are low. These issues are coupled with the fact that oftentimes criminal justice agencies are competing with one another for resources (Austin and Krisberg, 1981), suggesting that those that appear to have low levels of legitimacy will get fewer resources.

The current section has examined change from an institutional theory perspective. Two important mechanisms of change that have been employed in criminal justice agencies are lawsuits and consent decrees, which can require law enforcement agencies and correctional facilities to abide by a national set of norms. Lawsuits may also be viewed from the perspective that they are a form of program being applied to an institution. To explore this possibility further, the following section examines the implementation science literature and applies it to correctional reforms. The section will then shift into a more in depth review of specific consent decrees that have shaped the criminal justice system.

### **Consent Decrees: Implementation and CRIPA**

The focus of social scientists on the implementation of programs is a newly emerging field that has been limited primarily to case studies (Glasgow et al., 2006; Proctor et al., 2009). One of the primary goals of practitioners in the field has long been to provide evidence-based programming, while the implementation of programs has received considerably less attention. The problem is that oftentimes programs and policies are implemented inappropriately, under poor conditions, and can take years to institutionalize, all of which may serve as barriers to reform (Boren and Balas, 1999; Sherman, 1978; Tansella and Thornicroft, 2009). For example, Botvin, Baker,

Dusenbury, Tortu, and Botvin's (1990) study of the implementation of a substance abuse prevention program in New York schools found that teachers covered between 27% and 97% of materials, suggesting the program was inadequately carried out in numerous locations. Implementation research now suggests the importance of evaluating the success of programs in their implementation, not just their outcomes (Holt, 1998; McHugh and Barlow, 2010).

While practitioners tend to agree that there is a gap between what should be done in program and policy implementation and what is actually done, the way in which this gap is bridged is more complex. Gottfredson (2001) fully outlines these issues in an examination of the implementation of programming in schools to prevent delinquency, crime, and drug use. She suggests that eight factors will influence the success of implementation including: the organizational capacity (e.g. past success in program implementation, staff morale), leadership, resources, organizational support (e.g. training), program structure (e.g. quality control, standards), integration of program into school day, program feasibility, and level of school disorder. In some schools, implementation is more challenging (e.g. schools that are disorganized, that have low parental involvement, where schools where administrators and parents differ in culture, and where delinquent peer groups are more prevalent). In other words, implementation of delinquency programs may have a higher success rate in schools where there are fewer problems in the first place. It is also unclear if and how implementation models vary across groups under treatment (Proctor et al., 2009). Proctor and colleagues contend that consideration should be given to multiple levels in the process of change including: political/policy influences, environmental factors, culture of the organization, and

individual behaviors. Among these four levels, they argue that the most influential level for successful policy or program implementation is that of cultural support and willingness to change of those within the organization.

Research is now also beginning to examine the implementation of policies and programs in correctional settings (Castellani, 1992; Lin, 2000; Rudes, Lerch, and Taxman, 2011; Taxman and Friedmann, 2009). In an examination of juvenile correctional facilities experiencing reforms, Barton (1994) argued that the most important factors in implementing successful policy changes include: clear objectives, theoretical foundations to programs, adequate resources, legislation, leadership, a sentiment among relevant parties that the program/change is necessary, incentives for compliance, and outside oversight. He claims that it is necessary to have both political support and the ability of an organization to carry out changes to institutionalize reforms. It is necessary that employees are able to “adapt the policy to their working realities” (p. 147) or else changes will be ineffective.

While much of prior implementation research has focused on program implementation, a growing body of literature is examining the implementation of consent decrees in law enforcement agencies and correctional facilities (Bazemore, Dicker, and Nyhan, 1994; Dale and Sanniti, 1993; Holt, 1998; Kupferberg, 2008; McMickle, 2003; Stone, Foglesong, and Cole, 2009). Consent decrees are the result of an agreement between two parties in an effort to avoid formal litigation (Goldberg, 1962). In the criminal justice system, consent decrees commonly occur between the federal government and law enforcement or correctional facilities to resolve issues such as discrimination, racial profiling, civil rights violations, excessive use of force, failure to

provide treatment, and other abuses. Civil litigation that results in agencies experiencing such problems is often time consuming and financially costly for both defendants and plaintiffs (Anderson, 1986). As a result, both parties frequently enter into consent decrees whereby defendants are required to remedy specific violations.

Appendix 1 presents research examining the implementation and institutionalization of consent decrees in the criminal justice system. There have been few evaluations of agencies after consent decrees have been remedied and those that have focused primarily on law enforcement agencies. For example, one study recently focused on the process and sustainability of implementing consent decrees among police departments (Chanin, 2012). Chanin examined four police departments—Pittsburgh Police Bureau, Washington D.C. Metropolitan Police Department, Cincinnati Police Department, and Prince George's County Police Department—that were required to make changes to their use of force policies and response to citizen complaints. He examined four areas that influence sustainability including: the initial problem, the proposed solution, environmental context, and the agency implementing the change. Approaching change from both an implementation and institutionalization perspective, Chanin found that both police leadership and commitment to changing the issues outlined in the settlement agreement were the most important factors in institutionalizing the reforms. Consistent with Barton's (1994) conclusions regarding the importance of employees adopting changes to sustain organizational changes, Chanin makes a similar argument regarding the role of officer commitment to consent decrees. Factors that hindered the internalization of consent decrees included: poor leadership, limited external support, turnover of administrators, failure to reevaluate agency after reforms, and no external

accountability. Although consent decrees occur because of concerns by outside organizations, Barton and Chanin both indicate that the institutionalization of changes cannot come from external pressures, but internal willingness to change. Such findings highlight the importance of considering consent decrees from an implementation perspective because poorly implemented reforms can harm the sustainability of changes made under consent decrees.

The implementation of one consent decree at the Broward (FL) Detention Center received much attention in the early 1990s because of the expansive reforms the agency experienced (Barton, Schwartz, and Orlando, 1994; Bazemore, Dicker, and Nyhan's, 1994; Dale and Sanniti, 1993). In 1988, reforms were made at the center in response to a class-action lawsuit brought against the state for overcrowded facilities, failure to provide adequate numbers of treatment staff, limited education, violence among youths, and sexual assault of minors (Uhler, 1989). One examination of the conditions of the Center indicates that the agency did in fact make the changes required in the consent decree (Dale and Sanniti, 1993). Their examination of the institution showed that improvements had been made to mental health care, housing conditions, crowding levels, and food quality. However, Dale and Sanniti suggest that one critical aspect of maintaining the consent decree was that the agency went above and beyond what was required in the consent decree. In addition to facility improvements, reforms also had an impact on intake criteria, alternative programming, and services upon reentry, three aspects that were not required to be changed under the consent decree. These changes allowed for the appropriate placement of juveniles both in the center and in alternative programs. In contrast, Bazemore, Dicker, and Nyhan (1994) examination of the impact that the reform

had on staff in the Broward Detention Center and a comparative center that experienced no reform suggested other changes were necessary for institutionalization. Correctional officers in the facility that experienced the reforms treated youths less punitively, however, there were no significant differences in organizational factors like trust in supervisors, commitment to the agency, or job stress. These findings suggest that the reforms made post-litigation did not influence officers' perspectives, which is likely because additional factors (e.g. wages) also influence perceptions of the organization. Effecting such change is necessary for sustaining reforms in the long term, as officer attitudes and behaviors shape the organization.

Implementation is further influenced because employees in organizations are commonly resistant to major changes and are weary of outside critiques (Klein, 1979; Pisciotta, 1994). It has been argued by some that continuity, as opposed to change, is important to organizations for both bureaucratic and political reasons (Holt, 1998; Nathan, 1986). This is particularly true when there is a shift in leadership and long time employees do not respond well to inevitable changes to the organization. They may demonstrate resistance to reform because staff fear changes may result in their own harms (e.g. being fired) (Trice and Beyer, 1993). Employees who are dissatisfied with the changing organization are left with few options other than to quit, attempt to counter shifting policies, or merely tolerate them (Schmidt and Abramson, 1983). However, the perspectives of such employees are rarely accounted for under shifting administrations. Consideration of employee perspectives is particularly important in reforming agencies, as they contribute significantly to the organizational culture, ultimately shaping the sustainability of change.

Organizations experiencing major changes frequently struggle because of deeply embedded cultural beliefs (Trice and Beyer, 1993). Schein's (1993) review of prior conceptions of culture in organizations led him to formally define culture as "a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid, and therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems" (p. 18). The primary agents shaping organizational culture are the "operatives," or those working in the criminal justice system (Garland, 1990). Once a culture has been established, social controls in place offer either rewards or punishments that will then maintain the culture (Stojkovic, Kalinich, and Klofas, 2003). Subcultures may also have developed within organizations which will impact reform efforts. One example noted by Stojkovic and colleagues is the relationship in correctional institutions between officers and treatment providers. As both are employed to serve very different functions, this can create tension among agencies experiencing sweeping changes.

The current section has addressed findings from research focused on the implementation of consent decrees. The next section will examine the latter area in more depth with respect to the institutionalization of changes in correctional facilities after a lawsuit or consent decree. Initial responses to investigations and reforms in institutions of confinement will be discussed and will then transition into a specific mechanism for changing prison conditions.



## **Responding to the Civil Rights of Confined Persons**

In response to reports of abuse and deprivation of civil liberties in prisons, investigations aimed at reform have occurred since the mid-1800s. One of the earliest investigations occurred in New York in response to reports of crowding and poor management, which was supported by the New York Prison Association and the governor of New York (Pisciotta, 1994). Pisciotta outlines the 1867 investigation of juvenile and adult correctional facilities across the state whereby investigators concluded that there should be a greater emphasis on rehabilitation and education than punishment. It was not until the 1970s that the Justice Department became an active participant in civil rights litigation when their involvement was requested in litigating for the rights of the mentally ill (Dinerstein, 1989; Holt, 1998). Up until that time, investigations of abuse were limited to underfunded prison advocacy groups, thereby reforms were inadequate (National Council on Disability, 2005). It was not until there was a growing concern over cruel and unusual punishment in prisons that the courts took action. Then in the 1970s there was a growing focus on prison conditions as a whole and defendants' rights. Unsurprisingly, the increase in investigations and formal oversight of prisons was unwelcomed by correctional administrators (Austin and Krisberg, 1981).

The federal government has become actively involved in the rights of confined persons since the passage of The Civil Rights of Institutionalized Persons Act (CRIPA). CRIPA, which is enforced through the Special Litigation Section of the Civil Rights Division of the DOJ, has had a long and storied history since it was enacted in 1980. Although the federal government had been involved in legislation for the rights of confined persons since the early 1970s (e.g. *Wyatt and Stickney*), it did not have the

authority to initiate lawsuits independently (Dinerstein, 1984). Instead, the DOJ could only become actively involved in litigation after an outside agency or group had already filed a suit. In most cases, this involvement was welcomed as the Justice Department had the resources to both litigate and monitor compliance of defendants. Nevertheless, those at the DOJ grew concerned over their inability to initiate their own lawsuits, especially for failing institutions that were powerless. Subsequent efforts by the Justice Department in *United States v. Solomon* and *United States v. Mattson* to file suits against institutions for the mentally retarded were rejected on the basis that they had no authority to instigate lawsuits (National Council on Disability, 2005).

Beginning in 1977, the DOJ advocated for a statute to be passed in Congress that would formally permit the department to initiate lawsuits (National Council on Disability, 2005). This received much support from advocates who recognized the value of having an agency with an abundance of resources advocating for confined persons. However, the Congressional debates over CRIPA were heated (Holt, 1998). The impetus for CRIPA stemmed from Senate bill S. 1393 and House bill H.R. 9400. Opposition from Republicans and Democrats on the grounds that CRIPA would allow for greater federal control over the states resulted in the bills never being voted on. Later bills, H.R. 9400 and S. 10, were presented in 1979 and received bipartisan support. The National Association of Attorneys General opposed the bills because “they viewed [them] as strong-arm tactics by the Justice Department in the course of institutional litigation in their states” (p. 17). These arguments led to revisions of the bills to limit the power of the Justice Department, including notification that a lawsuit could occur, informing agency of issues to be addressed, and the opportunity for informal conciliation. Although

unwanted by many supporters of the bill, the modifications were agreed to in order to allow the bill to pass. The result was that the Justice Department had less discretionary powers than were originally sought, but for the first time could advocate for the civil rights of confined persons independently.

Passed in 1980, CRIPA allowed the DOJ to file lawsuits against state and local institutions of confinement that had been suspected of a pattern of depriving individuals of their civil liberties and/or housing individuals in poor conditions (42 U.S.C. § 1997). These included jails, prisons, juvenile correctional facilities, mental health facilities, and nursing homes. Under the act, when reports of abuses are made to the Justice Department, it is the discretion of the Attorney General to launch an investigation. After giving seven days notice to the institution, the Attorney General will investigate conditions if the institution agrees to cooperate, which occurs in most situations. One representative from the DOJ stated that “if we can verify violations [without gaining access], we issue a findings letter, and then we start to negotiate on the issues we found. If we still encounter resistance, we’ll file a complaint. We’d never sign an agreement without access to an institution, and once we gain access we can always issue a second findings letter” (National Council on Disability, 2005, p. 18). Consultants who carry out the investigation then inform the state’s Governor and Attorney General of their findings, recommendations, and remedies to the reported issues. The institution is then given 49 days to improve and remedy the issues described in the findings letter. Defendants may enter into consent decrees with the Justice Department, whereby they are subsequently monitored and inspected until they are compliant with the findings. If the defendants are

uncooperative and unwilling to reach a conciliation, the Justice Department will file a lawsuit to force changes.

The Justice Department has favored the use of consent decrees or conciliation in favor of litigation because they are less costly, public, and entail less confrontation (Cornwell, 1988). Discussed above in regard to the responses of reforming institutions, the reasoning behind the federal government relying so heavily on consent decrees is the result of “organizational convenience” (Cohen, 1985). In other words, while formal litigation may better serve to bring institutional reforms, constraints on the Justice Department prevent litigating in every case of civil rights violations. Despite the fact that consent decrees are negotiated, the government typically has the upper hand, because “once a defendant has indicated a willingness to compromise, the government is in the superior position in fixing the precise terms of the decree” (Goldberg, 1962, p. 1). Getting defendants to agree to a consent decree is also preferred by the defense because it allows for a remedy to problems that may not have been achieved if a lawsuit was lost.

Despite the establishment of CRIPA under President Carter, it was not until President Reagan’s administration in 1981 that the first lawsuits were initiated (Holt, 1998). This was because of the limited time between the enactment of CRIPA and the end of the Carter administration, as well as amount of time that it took to file a lawsuit following an investigation. However, the number of new investigations decreased by over 40 percent in the first year of President Reagan’s administration. When CRIPA was first proposed, it was estimated that there would be between 7 to 10 lawsuits per year, which would be approximately 40 lawsuits per presidential term. However, Holt

contends that it took six years into Reagan's administration for the number of lawsuits to reach those early yearly estimates.

The involvement of the federal government in protecting the civil rights of confined persons was minimal and received extensive criticism under Reagan (Dinerstein, 1989; Holt, 1998). Some have attributed the lax enforcement at the time to William Bradford Reynolds, the Assistant Attorney General for the Civil Rights Division of the DOJ. The lenient enforcement in the early years of CRIPA was attributable to the "procedural safeguards" in the Act, which allowed the federal government to negotiate, as opposed to litigate, with institutions. Although Reynolds had claimed that CRIPA was being enforced effectively in its early days, the Reynolds/Reagan era of CRIPA was approached much differently than it had been during the inception under Carter.

In contrast to the perspective under Carter that CRIPA would be used to force institutions to maintain humane conditions, Reynolds and Reagan had a much different vision as to how the federal government should oversee the civil rights of confined persons. In regard to general civil rights, Reagan had advocated for a decreased role of the federal government, as it was seen as an "intrusion" in people's lives. Reynolds then stated in testimony at a hearing before Congress in the early 1980s that they "must be always mindful that it is, in the final analysis, the responsibility of State officials to operate and maintain these facilities" (Plotkin, Davison, and Kaufman, 1989, p. 418). Under the advisement of Reynolds, CRIPA would only serve to make minimal changes to ensure safety, while other issues like overcrowding were neglected. Similar to the current practices of CRIPA, Reynolds did advocate for resolving cases through conciliation as opposed to formal lawsuits (Holt, 1998).

## **Critiques of CRIPA**

By the mid-1980s it was becoming clear that little was being enforced under CRIPA, allowing poor conditions to be prolonged (Cornwell, 1988; Dinerstein, 1989; National Council on Disability, 2005). At congressional hearings, it was suggested that the rights of mentally impaired persons were being neglected because of the Section's failure to file any lawsuits under CRIPA. In response, the Assistant Attorney General claimed that negotiations with institutions had been successful, thereby making it unnecessary to formally sue noncompliant organizations. Similar to Cohen's (1985) perspectives on organizational convenience, Reynolds argued that oftentimes litigation was stalled to allow for conciliation, which more quickly improved harsh conditions and prevented conflicts with state governments. Cornwell (1988) contested these claims stating that Reynolds offered no proof that litigation was in fact time consuming and the involvement of the Justice Department was believed to encourage speedy resolutions. His review of multiple conciliations under CRIPA also showed that they were not always "quick and effective remedies" as had been suggested by Reynolds. Others also strongly criticized the reliance on informal resolutions because they were unenforceable, as opposed to formal litigation (National Council on Disability, 2005).

The growing dissatisfaction with the direction that Reynolds was taking CRIPA was highlighted when a lengthy consent decree with multiple prisons in Michigan was drafted by attorneys from the Justice Department (Plotkin, Davison, and Kaufman, 1989). Reynolds took it upon himself to revise the consent decree to a five page agreement that he argued would help the prisons reform more quickly and made the original agreement voluntary. As a result, the Special Litigation Section of the Justice Department

experienced an exceptionally high rate of turnover among their legal staff. Plotkin and colleagues report that some staff even declared that the Justice Department was no longer committed to ensuring the civil rights of institutionalized persons.

One former litigator in the Special Litigation Section of the DOJ contends that Congress had been initially supportive of the changes that were to be made under CRIPA, however, those providing oversight severely limited the potential of the act (Dinerstein, 1989). Dinerstein outlined numerous criticisms of the implementation of CRIPA during the 1980s including: 1.) the Justice Department reversed decisions in critical cases, 2.) the failure to litigate against any department during the initial years of CRIPA, 3.) investigations frequently took too long, 4.) the apparent disregard for protecting certain civil rights, 5.) the failure to adapt responses to differing conditions, 6.) the failure to maintain relationships with advocacy groups, 7.) the loss of staff, and 8.) neglecting other problems resulting from CRIPA.

Although more recent literature regarding the implementation of CRIPA has been limited, it is apparent that concerns over CRIPA have persisted at the national level. For example, advocates continue to raise alarm over the length of time that it takes to resolve cases, as this allows poor conditions to persist (National Council on Disability, 2005; Puritz and Scali, 1998a). Criticisms regarding the prevalence of investigations have also occurred (Barczyk and Davis, 2009). The fact that each year there are on average over 4,500 letters and phone calls<sup>1</sup> to Congress regarding civil rights violations in institutions,

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<sup>1</sup> The Department of Justice publishes an annual report regarding activities related to the Civil Rights of Institutionalized Persons Act. An equivalent report of activities by the Department of Justice through the enforcement of the Violent Crime Control and Law Enforcement Act of 1994, Omnibus Crime Control and

yet the number of new investigations a year only ranges from 2 to 27 is concerning because many cases may be slipping through the cracks. Because of this disparity, “advocates may have lost faith in the effectiveness of CRIPA and have chosen other means of vocalizing their complaints” (p. 196). While these critiques have surrounded the initial stages of implementing CRIPA, other concerns surround the later stages of implementation.

One factor that may serve to shape the frequency of investigations is the political party in control of the White House (Schlanger, 2006). Schlanger argues that the appointment of Republican or Democratic judges will directly influence the regulation of institutions. Typically, liberal judges are more likely to support consent decrees or litigation against a facility and conservative judges are not. An examination of the average number of lawsuits filed or consent decrees entered into lends support this perspective (See Table 1). During the Reagan and first Bush administrations, the average number of cases filed was less than four, but this increased to an average of six cases being filed under the Clinton administration. Filings then decreased again under George W. Bush. As of the writing of this paper, Barack Obama was still president, so it is unclear how many cases will be filed. Currently under his administration there has been an average of 3.33 cases filed per year. It is important to note that during the second Bush administration, relatively few cases were filed until his last month in office, when

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Safe Streets Act of 1968, and Title VI of the Civil Rights Act of 1964 reporting on the number of complaints regarding abuses by law enforcement officers is not published (Conduct of Law Enforcement Agencies, 2012). In fact, Fyfe (2002) points out that it is difficult to obtain similar data for complaints against the police because “one would have to study every federal and state civil and criminal court in the country” (100). One very dated comment by the Justice Department suggested an average of 2,500 complaints are made to the Justice Department each year for police misconduct (Lewis, 1991).



Table 1. CRIPA Lawsuits/Consent Decrees Filed by Fiscal Year by President

President	Year	# of Cases	Average Number of Cases Per Year During Administration
Reagan- Republican	1981	0	3.71
	1982	1	
	1983	2	
	1984	3	
	1985	5	
	1986	7	
	1987	5	
	1988	3	
Bush- Republican	1989	3	3.00
	1990	3	
	1991	3	
	1992	3	
Clinton- Democrat	1993	1	6.00
	1994	10	
	1995	9	
	1996	4	
	1997	6	
	1998	6	
	1999	7	
	2000	5	
Bush- Republican	2001	0	5.13
	2002	3	
	2003	1	
	2004	6	
	2005	5	
	2006	6	
	2007	5	
	2008	13	
Obama- Democrat	2009	2	3.33
	2010	3	
	2011	5	

six cases were filed in one month. This mass of filings has been criticized by advocates who claim that “the terms of these last-minute settlements are inexcusably weak and that the agreements don’t do enough to make sure the states fix their problems” (Shapiro, 2009).

Concerns have also been raised over the implementation of CRIPA because the Justice Department only provides sporadic monitoring while overseeing institutions, provides no oversight after the conditions of confinement have been met, and has little authority aside from civil rights violations inside facilities. With regard to the former, Cornwell (1988) argues that this is problematic because “the decrees fail to provide for any independent monitoring body to ensure compliance; instead, they leave these responsibilities to the federal government” (p. 853). Regarding more general correctional reforms, Barton (1994) states that in order for changes to be sustained, institutions must allow outside groups the ability to provide oversight, a practice that may be unwanted by institutions. Finally, some critics have claimed that CRIPA does not address more national issues with improper confinement. For example, the National Council on Disability’s report examining the success of CRIPA suggested that there are other important issues outside the authority of the Justice Department that should be addressed, including the improper placement of certain individuals in prisons (e.g. those with mental health issues). Similar arguments may also be extended to the placement of juveniles in the adult criminal justice system (Johnson, Lanza-Kaduce, and Woolard, 2011; Winner, Lanza-Kaduce, Bishop, and Frazier, 1997). Others contend that practices like placing individuals in the community or in the “least restrictive environment” are not addressed through consent decrees focused on improving institutional conditions (Cornwell, 1988).

Finally, although not directly related to the implementation of consent decrees, one macro-level criticism has been raised over correctional reforms to maintain humane conditions (Feely and Rubin, 1998). Schlanger (1999) has argued that “by promoting the comforting idea of the ‘lawful prison,’ the litigation movement may have smoothed the way for ever-harsher sentences and criminal policies” (p. 1998). This phenomenon was then coupled with the expansion of prisons in response to overcrowding (Schoenfeld, 2010). In other words, the modernization of prisons and appearance that they are safe and humane have led to judges increasingly using incapacitation as the solution to crime (i.e. a form of net-widening). This potentially false perception arguably became a contributor to increased prison populations. Schoenfeld contends that the result has been long-term reforms that are misaligned with the initial goals of the litigation movement of the 1970s.

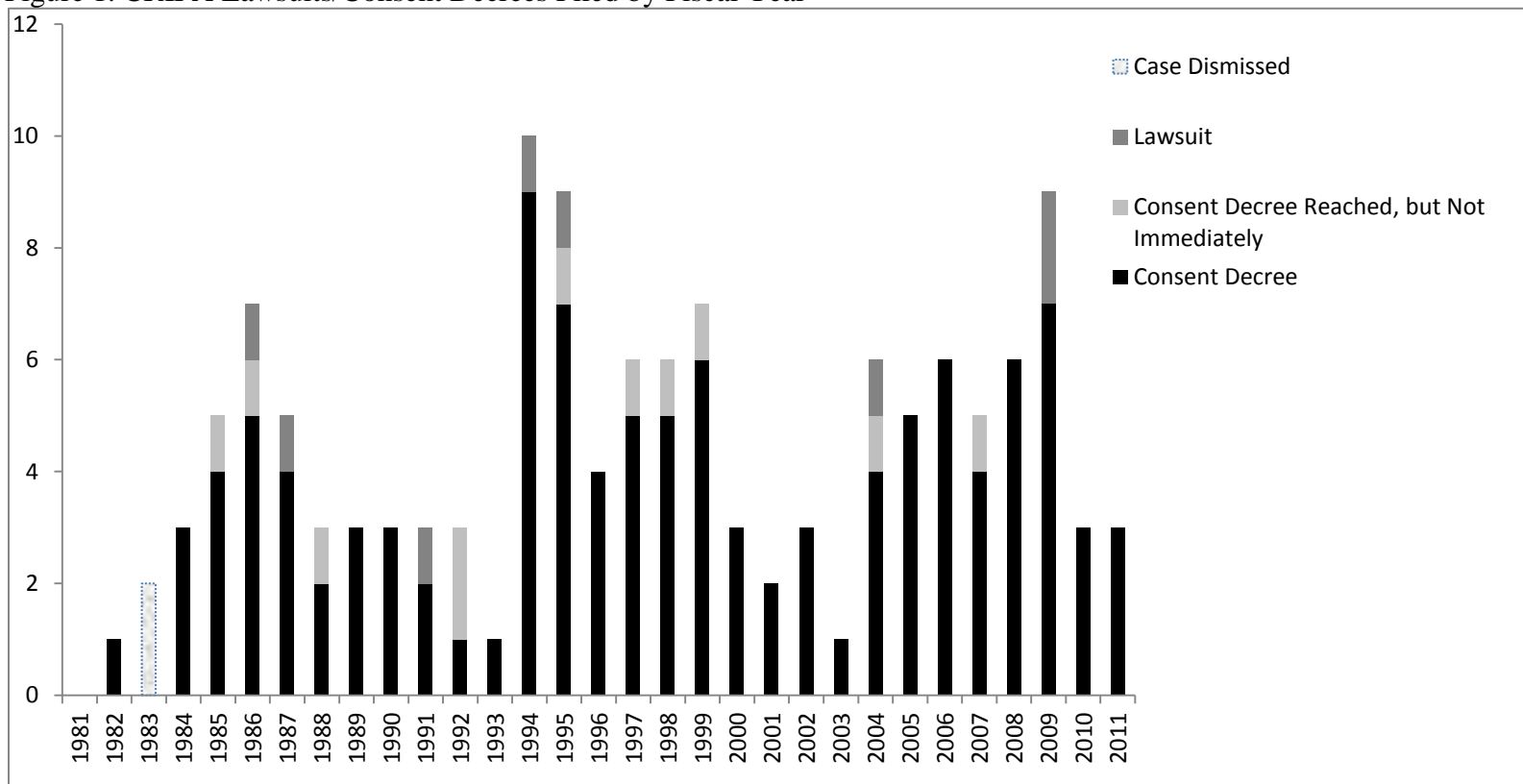
In light of the past and present issues that have been raised with reforming institutions through CRIPA, multiple solutions have been presented by corrections and legal advocates. Suggestions for improvement have included enforcing more timely case resolutions, shorter conciliation periods, formal litigation if effective reforms are not achieved quickly through conciliation, and greater involvement of outside agencies (Cornwell, 1988). Critics have also advocated for greater involvement from community organizations to provide some form of oversight and/or support (National Council on Disability, 2005).

In contrast to the claims by some academics, service providers, and those employed by the Justice Department, others argue that conciliation serves both the needs of institutions and the federal government (National Council on Disability, 2005). More

recent interviews of Justice Department staff suggest that there is less dissatisfaction with conciliation than there was in the 1980s. Some employees found that conciliation was a preferred method because litigation can be risky. As was stated by one spokesperson, “you spend lots of time convincing them that they have problems. During that long period of time reform is not happening. And you’re forcing the state to spend money on litigation instead of reform” (p. 24). Furthermore, institutions are given deadlines to follow for reform during conciliation, which means they do not have an unlimited period of time to demonstrate a reform has occurred. The Justice Department has also recently revised its policy regarding pre-set deadlines for terminating settlements, which means institutions must now be in compliance before a settlement is ended (Department of Justice Activities Under the Civil Rights of Institutionalized Persons Act, 2009). Figure 1 shows that there is in fact a growing trend towards conciliation over time, as 79%, 75%, 91%, 92%, and 100% of investigations resulted in conciliation during the Reagan, Bush, Clinton, Bush II, and Obama administrations, respectively.

Since the inception of the act in 1980, the Justice Department has investigated nearly 500 prisons, mental health facilities, jails, and juvenile correctional facilities (Department of Justice Activities Under the Civil Rights of Institutionalized Persons Act, 2008, 2009, 2010, and 2011; National Council on Disability, 2005). These investigations have resulted in about 140 lawsuits and consent decrees between the DOJ and institutions (See Figure 1). Figure 1 identifies cases in which consent decrees were reached quickly, cases where consent decrees took longer than one year, cases where a lawsuit was filed (i.e. a consent decree could not be reached), and cases that were dismissed. The distinction between immediate consent decrees and those occurring after one year was

Figure 1. CRIPA Lawsuits/Consent Decrees Filed by Fiscal Year



Sources: National Council on Disability (2005); Department of Justice Activities Under the Civil Rights of Institutionalized Persons Act (2004, 2005, 2006, 2007, 2008, 2009, 2010, and 2011)

Note: The chart identifies cases in which consent decrees were not immediately reached between agencies and the DOJ. This distinction was made because many institutions were slow to agree to a consent decree with the DOJ. Although a consent decree was eventually made, in some cases it took multiple years to reach this agreement.

made because many institutions were slow to agree to a consent decree with the DOJ. Although a consent decree was eventually made, in some cases it took multiple years to reach this agreement, suggesting that these “agreements” may not have been amicable. It is also clear that the overwhelming majority of cases were resolved through consent decrees, with 122 cases resolved through consent decrees, 9 through lawsuits, and 2 cases were dismissed.

Since 2000, 95 findings letters have been given to agencies that outline violations of civil rights and 46 cases have been filed. Conditional improvements have addressed areas such as mental health, medical care, suicide prevention, education, physical abuse, sexual abuse, excessive use of solitary confinement, and physical conditions of institutions. Despite the critiques that the Justice Department has faced, especially in the earliest years of implementation, there is little doubt now that the enforcement efforts under CRIPA have improved institutional conditions for thousands of confined persons across the country (Daly, 2010; Rubin, 2009). For example, the Baltimore County Jail was monitored by the DOJ in 1971, 1976, and 2000 because of reports that juveniles and adults were not adequately separated, inmates were deprived of mental and medical health services, and constitutional rights were being violated (Department of Legislative Services, 2012). As a result of the lawsuits against the jail, it was proposed that a separate detention center for juveniles be built to remedy these issues. Reports of improved institutional conditions are typical, as departments that either enter into consent decrees or are sued by the DOJ are legally required to make the necessary improvements.

## **Arizona Department of Juvenile Corrections**

The Arizona Department of Juvenile Corrections (ADJC) is one such agency that was forced to reform following a consent decree after a CRIPA investigation. Because the agency has endured two agency changing lawsuits, it is useful for examining the factors that led up to a federal intervention, the implementation of the intervention, and the institutionalization of the intervention. The first occurred in 1987 and was a class action lawsuit, *Johnson v. Upchurch*, against the Arizona Department of Corrections (ADC). After a brief respite from monitoring following the expiration of the *Johnson v. Upchurch* consent decree in 1997, the department faced a second consent decree in 2004 following a CRIPA investigation.

As will be addressed in depth in this dissertation, the failure to reform after the initial consent decree strongly shaped departmental responses during the second consent decree. There were clearly failures in the department prior to the consent decree under CRIPA, but it was not until the second federal intervention that these failures were realized and addressed. Since the resolution of the CRIPA consent decree in 2007, the ADJC has experienced multiple issues that could potentially negatively impact the sustainability of the changes made under CRIPA. These factors, which are further examined in the current dissertation, include severe budget cuts in 2010, an announcement by the Governor of Arizona that the agency would be closed, and rumors of privatizing the agency (Brewer, 2011; Reinhart, 2010).

## **Limitations of Prior Research**

After an institution or agency has remedied the issues outlined by the DOJ, the Justice Department no longer has the authority to monitor the conditions of confinement. In other words, after the requirements of the consent decree are met, the Justice Department has no legal recourse to ensure that the changes are maintained. This means that only until new reports are made to Congress regarding improper care that the federal government will become aware of improper conditions and can again require that changes be made. Multiple reports have addressed the process of filing a CRIPA suit and issues in achieving compliance with consent decrees. However, no studies to date have systematically examined a correctional organization after the conditions of confinement under a CRIPA have been met and the agency is no longer under a consent decree.

Of the research examining the implementation of consent decrees and litigation under CRIPA, the majority has been limited to the 1980s (Cornwell, 1988; Dinerstein, 1989; Holt, 1998; Plotkin, Davison, and Kaufman, 1989). Criticisms in early research were directed primarily at the sitting Assistant Attorney General for the division for his failure to litigate against institutions that violated the civil rights of confined persons. Considering that over 30 years has passed since the enactment of CRIPA, nearly 25 years has passed since a new Assistant Attorney General took over the division, and the number of investigations in the division has quadrupled since the late 1980s, there is cause to believe that significant changes have been made in the process of implementing change.

More recent examinations of CRIPA have been limited in their scope. For example, the most comprehensive study to address the process of investigations and



institutionalization of changes was limited in two ways (National Council on Disability, 2005). First, although the National Council on Disability addressed all types of agencies overseen by the Justice Department, there was a specific focus on the institutionalization of rights of disabled persons who were confined. This group represents only a small portion of individuals that CRIPA protects. Second, this report, while comprehensive, relied primarily on interviews with current and former representatives from the Justice Department. Although valuable, they fail to consider the perceptions and experiences of those working directly in and with the reformed agencies. Other studies have been primarily descriptive or have relied on official reports from the Justice Department to derive their conclusions (Barczyk and Davis, 2009; Puritz and Scali, 1998b). This has left a gap in the literature where the opinions of those experiencing change both within and outside a reformed agency are not considered.

Achieving compliance with CRIPA lawsuits or consent decrees is only a small fraction of these correctional reforms. Following years of change and federal monitoring, agencies that have fulfilled the requirements of CRIPA are left with no outside oversight or official guidance. The real challenge in these cases is ensuring that long-lasting reforms have been made in protecting the civil rights of confined persons once federal oversight is lifted. To explore this issue, the following section will examine the methods and data used. Then, attention will be paid to the external factors (e.g. pressures to maintain legitimacy in the institutional environment) that shaped the ADJC's responses to the consent decree during implementation and following the cessation of the consent decree. Internal factors (e.g. agency culture, punitive controls, and preventive controls) also will be explored for their influence both during and post-CRIPA. Finally,

conclusions will be discussed along with policy recommendation for the implementation of future consent decrees.

## **Chapter 3**

### **Methodology**

#### **Research Questions**

Hundreds of correctional institutions (i.e. jails, prisons, juvenile facilities) nationwide have been forced to reform in order to ensure that the civil rights of inmates are upheld (See Figure 1). Arizona is one of the few states that have been subject to four CRIPA investigations. Following these reforms, the federal government no longer has the authority to ensure that agencies remain compliant with the civil rights of institutionalized persons. In other words, changed agencies may subsequently revert back to practices that deprived inmates of their constitutional rights. The current dissertation addresses this issue and examines how changes under CRIPA are sustained once monitoring ceases. Three questions are specifically addressed that guide the dissertation. Does federal involvement in forcing correctional reforms result in long-term, sustainable changes? If changes are made, do they occur because the organization strives to maintain legitimacy by the institutional environment? In contrast to the concerns of administrators to maintain legitimacy, the dissertation also asks, does change occur because employees are deterred from practices that deprive inmates of their civil rights?

The responses of an institution to a CRIPA investigation will shed light on how future investigations should be conducted and changes maintained. A case study methodology was adopted, as it allowed for an in depth contextual analysis of institutional reforms. The following section will examine the participants, data collection strategies, methodology, data analysis, and methods to ensure reliability and validity in

the dissertation. Background information will also be provided regarding the state of Arizona (e.g. demographics, politics) and the ADJC (e.g. demographics, population, budgets) to provide additional context as to how the ADJC became the subject of two federal investigations, lawsuits, and reforms.

### **Research Setting**

The research setting of the current dissertation is the state of Arizona. It is important to first consider the location in which the reform is occurring, as the unique characteristics of Arizona could influence the sustainability of the reform (Scharf, 2012). In 2011, there were approximately 6.5 million persons living in Arizona and 25% of the population was under the age of 18 (U.S. Census Bureau, 2012). The majority of the population is white (85%), with an additional 5% black, 5% Native American, and 3% Asian. Thirty percent of the population identifies themselves as being Hispanic or Latino. Arizona has a high foreign-born population compared to other states, with over 14% of residents being foreign born. The foreign-born population is predominantly from Latin America (68%). The percent of foreign-born persons in Arizona has increased nearly 65% from 3.4 million to 5.6 million residents being foreign born. Discussed below, these shifting demographics have impacted crime control responses against certain people in the state.

The majority of Arizonans reside in Maricopa County (60%), followed distantly by Pima (15%), Pinal (6%), Yuma (3%), Yavapai (3%), and Mohave (3%) Counties. This uneven distribution will be discussed in more depth throughout the case study, as it has greatly impacted the operations of the ADJC. For example, a facility in Pima

County, the only facility not in Maricopa County, was closed in 2011 in part because there were not enough juveniles from Southern Arizona being committed to ADJC. The unemployment rate in Arizona in 2012 was approximately 8.2%, which was only slightly higher than the national unemployment rate of 8.1% (U.S. Bureau of Labor Statistics, 2012). Industries employing the greatest number of persons included education/health care (21%), retail (12.2%), professional/scientific services (11%), and arts/entertainment (10%)<sup>2</sup> (U.S. Census Bureau, 2011a). In 2011 nineteen percent of families reported that they are living below, however in families with a female head of household (i.e. no husband is present), 29% of families were in poverty. This is in contrast to only 15% of families nationwide reporting living in poverty (U.S. Census Bureau, 2011b). This high rate of poverty in Arizona is concerning when considering the strong linkages between living in impoverished neighborhoods and juvenile delinquency (Farrington, 1994; Peebles and Loeber, 1994).

Arizona had the 18<sup>th</sup> highest violent crime rate in the United States in 2010, with a rate of 408 incidents per 100,000 and the 8<sup>th</sup> highest property crime rate, with 3,534 incidents per 100,000. Juveniles accounted for 15% of arrests in the state and about 7 juveniles per 1,000 were arrested (Arizona Department of Public Safety, 2011). The number of juveniles referred to court had remained stable from 2000 to 2007, but then decreased by 15% from 2007 to 2010, with just over 41,000 juvenile referrals in 2010 (Arizona Criminal Justice Commission, 2011). Somewhat different patterns have been exhibited among the number of juveniles committed to the ADJC. More specifically, 926

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<sup>2</sup> This data comes from the U.S. Census' American Community Survey from 2006-2010 (U.S. Census Bureau, 2010). The recession in 2008 may have impacted the distribution of occupations.

juveniles were committed to ADJC in 2003, but the number of commitments was in the 800s from 2004 to 2006. Then again in 2007 the number of commitments reached 926, yet declined ever since to a new low of 751 in 2010. Multiple events occurred across Arizona that may have directly impacted some of these trends. Most notably, in 2003 and 2004, multiple suicides occurred in ADJC facilities and the CRIPA investigation began in 2004. It is possible that patterns of committing juveniles may have shifted over this time due to county judges' concerns over safety of the juveniles they were sending to the state. This theory is given more credibility because in 2007 the number of commitments increased in the same year that the CRIPA investigation ended. The number of commitments remained the same in 2008, but then declined in later years. The more recent declines occurred during the Great Recession starting in 2008. Declining resources on the part of juvenile courts may have resulted in less juveniles subsequently being brought into the system.

Arizona is a fairly typical conservative, Western state. Arizona has been nationally recognized as being tough on crime and has been increasingly becoming more punitive towards undocumented immigration (Lynch, 2010). Most notably, Arizona's response to immigration has been in national headlines because police officers have been granted increasing freedom to question drivers regarding immigration statuses (Eagly, 2010). The tough on crime stance in the state has also been demonstrated in the treatment of jail detainees by Sheriff Joe Arpaio (Attwood, Mini, and Papa, 2011). For example, the sheriff has been known to house jail inmates in tents with no air conditioning, provides them with pink underwear, still uses a "chain gang," and has racially profiled against Hispanics in the community (Romero, 2011). Practices in

Arpaio's jails have continued despite research conducted in the agency suggesting that extremes in punitive treatment result in "defiant responses" by inmates (Griffin, 2006). The harsh treatment went so far that the jails were subject to a CRIPA investigation in 1997 due to the use of excessive force by correctional officers and lack of adequate medical care (Madison, 2006). The agency was also subject to investigations under the Violent Crime Control and Law Enforcement Act of 1994 and the Civil Rights Act of 1964 again in 2008. This investigation was later closed in 2012 without a lawsuit being brought against the agency, although no reason for the dismissal has been given (Montini, 2012). In contrast, Pima County stands as a notable exception to the conservatism in the state, as is evidenced by the liberal stance of most residents and the push to treat criminals in their communities. This is evidenced by the fact that Pima County residents account for 15% of the population, but only 8% of the population at the ADJC.

Although a more in depth review of the Arizona Department of Juvenile Corrections is presented in Chapter 5, it is important to briefly examine the demographic characteristics of the institutions and juveniles. During the time of data collection in 2011, the ADJC housed 399 youths, although the operational capacity was 403 and the design capacity was 623 (Just the Facts, 2011). An additional 461 juveniles were supervised in the community. Prior to commitment, 50% of juveniles had been referred to juvenile court 10 or more times (See Table 2). Juveniles were typically committed to ADJC for less serious offenses, including: property (33%), drug (12%), public order (11%), and parole violations (11%). Only 25% of juveniles were committed for a crime against another person. Offenses committed by juveniles tended to be

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Table 2. Demographic Characteristics of Juveniles (n=399) and Institutions in 2011

		% of Juveniles
Age	17	50
	16	28
	15	19
	14	4
	13	1
Gender	Male	86
	Female	14
County	Maricopa	58
	Yuma	11
	Pima	8
	Pinal	6
	Cochise	5
	Mohave	4
Race/Ethnicity	Hispanic	49
	Caucasian	28
	African American	12
	Native American	6
Offenses	Property	33
	Crime against person	25
	Drug	12
	Public order	11
	Parole violation	11
	Other	6
	Weapon	3
Seriousness of Offense	Misdemeanor	29
	Parole violation	12
	Felony	59
Programming Offered	New Freedom	100
	Sex Offender	11
	Mental Health	6
	Substance Treatment	40
# of Prior Referrals to Juv. Court	1-3	10
	4-6	17
	7-9	24
	10-12	16
	13 or more	34
Risk Level	High	33
	Medium	28
	Low	40



felonies (59%) and misdemeanors (29%). Once committed to ADJC, all juveniles received treatment under the “New Freedom” program, while 40% of juveniles received substance abuse treatment, 11% sexual offender treatment, and 6% mental health treatment. Most juveniles (61%) were considered to be medium or high risk within the institution.

Juveniles who were held at ADJC were typically Hispanic males from Maricopa County. Eighty-six percent of juveniles were male and nearly 50% of juveniles were Hispanic, followed by Caucasians (28%), African Americans (12%), and Native Americans (6%). This breakdown was not very representative of the population in Arizona, as only about a third of residents in Arizona are Hispanic and 5% are African American. The majority (78%) of juveniles was 16 years or older, while only .5% of the population was under 14 years of age. Nearly 58% of juveniles were sent to ADJC from Maricopa County, followed by 11% from Yuma, 8% from Pima, 6% from Pinal, 5% from Cochise, and 4% from Mohave Counties. In other words, while the majority of juveniles are housed relatively close to home (i.e. Maricopa County), there is a large percentage of juveniles who are placed in ADJC from geographically distant counties. Although the ADJC has attempted to alleviate the strains of being housed long distances from home to an extent (e.g. video conferencing), the reality is that most families from outlying counties are unable to make the long commute. As will be discussed in later chapters, this distance has also provided severe challenges to parole officers across the state tasked with supervising juveniles in their communities and connecting them with community resources.

At the start of data collection in June 2011, the ADJC operated three safe schools; Adobe Mountain School (AMS) for boys and Black Canyon School (BCS) for girls were in Phoenix and Catalina Mountain School (CMS) for boys was in Tucson. A fourth facility in Buckeye, Eagle Point School, had closed in early 2010. CMS closed in October 2011 and many juveniles and staff were transferred to AMS and BCS. The number of new juvenile commitments to the ADJC has been steadily decreasing since early 2001. From 2001 to 2010, the population decreased by 40%, with the population being nearly 900 in 2001 and dropping to 535 by 2010. The percent of juveniles returned to custody (i.e. percent of juveniles who recidivated) was 33% in 2008 (A.R.S. § 41-2802).

The estimated budget for the ADJC in 2011 was approximately \$57 million, a substantial decrease from the budget of \$84 million the agency operated with in 2007 and 2008 (A.R.S. § 41-2802). The budget includes annual salaries for youth corrections officers (YCOs) ranging from \$30,857 to \$57,892 (Arizona State Service, 2007). A portion of the budget also includes training of new YCOs, which is comprised of a 32 day academy and 8 additional days of on the job training (Arizona Department of Juvenile Corrections, 2008). The budget cuts faced by the ADJC beginning in 2010 are not surprising when it is considered that these occurred around the time of the Great Recession. However, many in Arizona were concerned when Governor Jan Brewer announced in the budget for Fiscal Year 2011 that the budget for the ADJC had been eliminated (Brewer, 2011). In the budget, it was stated that in light of the budget crisis, “it is appropriate to reconsider [ADJC’s] mission, scrutinize the probability of achieving desired outcomes, and seek to minimize duplication of functions” (p. 22). The Governor

further argued that the ADJC no longer housed the serious and violent offenders that it had before transfers to adult court were prevalent. In other words, juveniles committing relatively minor offenses and those with mental health issues were inappropriately and unnecessarily being taken out of their communities and placed in state custody.

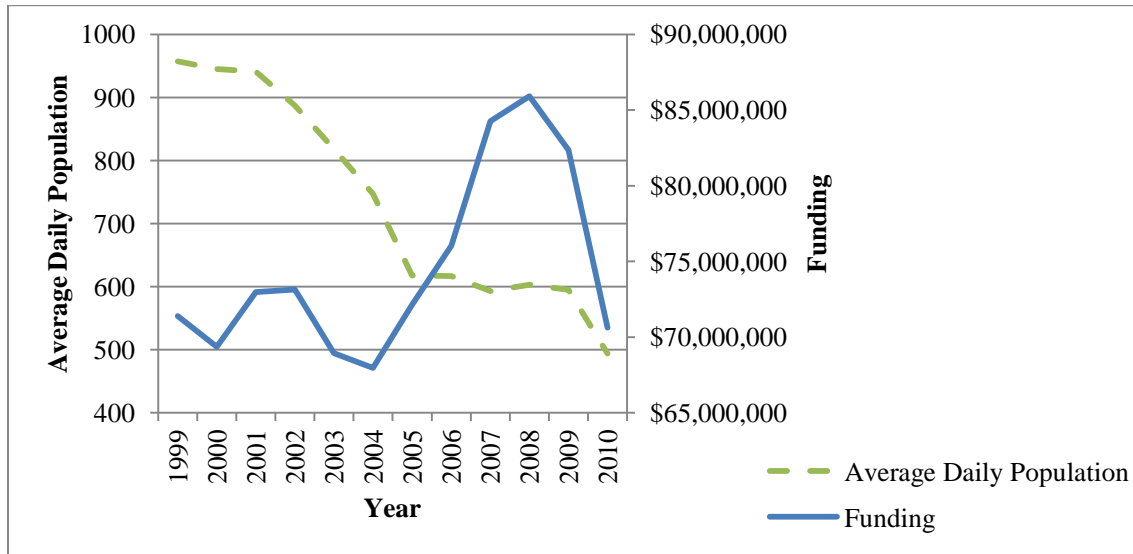
Furthermore, the cost of running the state agency had been increasing at the same time that the average daily population was decreasing (see Figure 2). This gap between state spending and the declining need for custody were further used to justify the closure of the agency.

In their annual reports, the ADJC outlines the vision, mission, and role of the agency. The vision of the ADJC is to provide “safer communities through successful youth.” The mission is to “enhance public protection by changing the delinquent thinking and behaviors of juvenile offenders committed to the department.” Lastly, the role of the agency is to be

Responsible for juveniles adjudicated delinquent and committed to its jurisdiction by the county juvenile courts. It is accountable to the citizens of Arizona for the promotion of public safety through the management of the state’s secure juvenile facilities and the development and provision of a continuum of services to juvenile offenders, including rehabilitation, treatment, and education. (Arizona Department of Juvenile Corrections, 2011a, p. 5)

This vision of the ADJC is still in effect because the Governor announced in 2011 that the ADJC would not be closed. The implications of both budget cuts and the potential for closure will be discussed in more depth in later sections.

Figure 2. ADJC Facility Population vs. Budget



### Study Participants

After identifying an initial sample of participants from a variety of sources (e.g. government websites, newspapers), snowball sampling was used to identify additional participants (e.g. former employees) (Biernacki and Waldorf, 1981; Wright, Decker, Redfern, and Smith, 1992). Snowball sampling was employed because it was important to contact employees who had differing levels of experiences and roles within the agency. For example, some employees had worked in multiple safe schools (e.g. transferred from Catalina Mountain School in Tucson to Adobe Mountain School in Phoenix), while others had a greater involvement in the CRIPA investigation than others (e.g. long time employees vs. recent hires). Using a semi-structured questionnaire, 47 interviews were conducted with individuals intimately familiar with juvenile corrections across the state of Arizona. Twenty-seven interviews were completed with current and former employees of ADJC, 12 interviews were conducted with court officials from 7 counties across the state, and 7 individuals who were identified as community advocates for

juvenile justice were interviewed. In all, 75 individuals were contacted for interviews for a response rate of 61%. Of those that did not participate, 7 declined to be involved and 22 did not respond to repeated emails or phone calls. Among those who declined to participate, one individual stated that just discussing the problems at ADJC would bring up too many negative emotions.

### **Data Collection**

Data collection for the current dissertation consisted of interviews, reviews of documents, and reviews of newspaper articles (See Table 3). After multiple visits (e.g. tours of the safe schools) to ADJC and negotiations over the content of the project, full access was granted to interview all willing employees. This access was not without its challenges. First, in order for the ADJC to agree to allow interviews of employees, the research team was required to also investigate any influences that CRIPA may have had on the operations of the community corrections aspects of ADJC. Although the focus of the current dissertation is the operation of institutions of confinement, it is also important to address how the ADJC's growing focus on treatment in communities impacts the institutions. A second issue that arose was the changing of agency directors right as data collection was set to begin. In the same week that full approval was given for interviews with ADJC employees, the director that had granted the access resigned. The timing of these events may suggest that the approval to begin interviews was artificial and merely done for appearances, although this is unclear. Fortunately, the incoming administration of the ADJC remained supportive of the project and agreed to allow interviews to begin.

Table 3. Data Collection

Type of Data	# of Interviews/ Documents	Date of Interview	Document Dates
<i>Interviews</i>			
Current ADJC Employees	23	10/2011-3/2012	
Former ADJC Employees	4	9/2011-12/2011	
Community Advocates	7	6/2011-11/2011	
Court Representatives	12	7/2011-10/2011	
<i>Documents</i>			
ADJC Documents	43		1/2003-8/2012
Newspapers	96		7/1990-8/2011
Government Documents	41		12/1989-9/2012

Interviews of juvenile corrections officials, county court employees, and community advocates for corrections were conducted in Arizona between June of 2011 to March of 2012. Typically, participants were sent an initial email requesting their participation in the project (see Appendix 2). It was made clear that the project was being independently conducted through Arizona State University (ASU) and was in no way a new investigation of the agency. Non-respondents were sent two more emails in the weeks following the initial email, which were then followed by phone calls. Included in the requests for participation was a statement outlining that all information shared between the interviewer and participant was voluntary and that they could stop the interviews at any time. They were informed that all information would be confidential and their names and/or positions would not be identified. Although reports would be

given to ADJC administrators, participants were assured that their unique responses would not be identifiable in the report. Signed informed consent forms were not collected; however, passive consent was obtained through the information letters.

Each interview lasted between 45 and 75 minutes and they were held in locations selected by participants, typically their place of employment. Participants were assured that their identities would remain confidential and that no names or titles would be identified. Open-ended questioning was used in order to determine what participants thought and felt about the ADJC's response to CRIPA. During most of the interviews, field notes were taken regarding anything of note that occurred before, during, or after the interviews took place. In some cases, these were conversations that occurred in the hallways between officers about what they thought about their jobs or frustrations that they may have had with how the agency was operating. In the cases where field notes were not taken, interviews occurred at locations outside of correctional or detention facilities (e.g. coffee shops and libraries).

Interviews were not tape recorded; instead notes were taken with pen and paper. This method was used to make participants feel more comfortable and willing to speak freely with interviewers. At the time of the interviews, the agency had been experiencing hundreds of layoffs and it became clear throughout the project that many participants were still cautious of losing their jobs. Efforts were made to write down most quotes verbatim, but naturally, this was not always the case. For this reason, some of the quotes presented throughout the paper may contain *slight* variations from their original statements, however the researchers made all attempts to report these as closely as possible to their original statements. Following each interview, both field and interview

notes were transcribed as soon as possible, typically within two to three hours after the interviews took place.

Due to the fact that most employees at the ADJC had been with the agency during one or more lawsuits, severe budget cuts, recent layoffs, and a threat of closure, it was recognized that administrators and line staff may be leery of participating fully with interviews. In order to allay these fears, multiple steps were taken. First, the project was described to participants. They were reassured that the interviews were going to be used for a dissertation, and in no way were a reflection of any new problems within the agency. Although they were informed that the ADJC would be receiving a copy of the final paper, they were again told that identifying information would not be included in the project. Multiple participants feared that despite these assurances, that the information they gave would make it possible for an insider to identify their interviews. For example, one participant stated that based on the dates of employment, identification would be possible. In such cases, participants were informed that their responses would be included with many other responses and that specific identifiers (e.g. dates of employment) would not be included. Second, in nearly all interviews, I discussed my professional background for participants. More specifically, I informed them that while I was currently a graduate student at ASU, I had been previously employed as a juvenile correctional officer in California. I believed that by divulging my background as both a student and former correctional officer, participants would be more forthcoming than if I was in a more “intimidating” position that could jeopardize their jobs (e.g. correctional administrator). I believe that these reassurances and background allowed participants to become comfortable with divulging information. Additionally, all of the employees



interviewed at the Central Office (i.e. a building off-site of the “Safe Schools” where ADJC administrators work) were made aware that I had been granted the use of an office at the building. It was believed that the fact I had an ADJC sanctioned office would increase my legitimacy with administrators.

Interviews were conducted with both current and former employees of the ADJC (i.e. administrators, line staff, treatment providers, and educators), judges, detention/probation administrators, and community advocates. As a result, although the purpose of the interviews was to answer specific questions regard the sustainability of CRIPA, interviews were highly tailored based upon individual positions (Appendices 3 and 4). For example, a former correctional officer would have very different experiences and knowledge than would a judge making decisions on committing a juvenile to ADJC. This meant that while questions were asked regarding similar topics, the wording of the questions would vary (e.g. “Has your agency (e.g. detention) made any changes in sending juveniles to the ADJC because of conditions at the ADJC?” versus “How has life at the ADJC changed for youths/staff since the investigation?”).

Participants were informed that there were six broad areas that were being examined. The first was the conditions leading to the CRIPA investigation and the process of the investigation. The second issue examined was the changes that took place during the CRIPA investigation and how the institutions were changed while the agency was being monitored. The third purpose was to determine how the agency had maintained the changes made during CRIPA after monitoring ceased. In 2008, the United States began experiencing the effects of the Great Recession. Because of this, the fourth purpose was to examine how the agency was able to maintain the previous changes

in spite of the recession. County courts made the decision on whether or not to place a juvenile on probation in their respective counties or to refer them to the ADJC. It was expected that juvenile courts may modify their referral practices based upon their perceptions of conditions at the ADJC. Changes in referrals would then also directly impact the management of the safe schools, so the fifth purpose of the study was to examine how the six juvenile courts that send the most juveniles to ADJC perceived and responded to changes. The final purpose of the study was to examine how changes may have resulted to juveniles supervised under community corrections. This last purpose was not one of the original purposes of the current study, but was a required area of study in order to gain the cooperation of the ADJC. Because this latter purpose has little relation to civil rights while confined, this dissertation does not address the issue.

## **Documents**

In addition to the interviews with relevant juvenile justice actors, numerous documents were reviewed to shed light on the historical context of the agency and how this shaped the implementation of the changes post-CRIPA. The primary purpose of the documents was to fill in the gaps from the interviews, serve as a method to confirm the information provided in the interviews, and provide further insight into both the process of implementation and sustainability of change. These documents included 96 newspaper articles from 1992 to 2011, 41 government documents pertaining to the agency, and 43 reports/documents found online that were created by those within Arizona's juvenile corrections agency.

One of the “richest” sources of data that served to guide both the interviews and analysis were articles in a local paper, the *Phoenix New Times*, which published dozens of articles surrounding the conditions of the ADJC over the past twenty years. Although some of the research participants later discounted the accuracy of some of the paper’s reports, it was nevertheless the impetus for the CRIPA investigation, suggesting there was validity in the reports. Other newspaper articles were gathered from the *Arizona Republic*, the *Arizona Daily Star*, and the *Arizona Daily Sun*. Word searches were conducted directly through Arizona newspaper websites using the search terms of “ADJC,” “Arizona Department of Juvenile Corrections,” and “Arizona Juvenile Corrections”. Only articles that did not directly discuss the agency were excluded. For example, articles that discussed a crime committed by a juvenile who was then sent to the ADJC, but included no additional information regarding agency functions, were excluded. Some articles were no longer accessible directly through newspaper websites, so these were accessed through Lexis Nexis.

The second source of document data were documents obtained directly from the ADJC website. The agency publishes multiple reports through the website including an annual report, a five-year strategic plan, a program overview, institutional handbooks, a history of the agency, and organizational chart. Additional documents were located through the Arizona State Library, Archives and Public Records, which included ADJC newsletters and older reports that had been distributed throughout the agency. The research department at the ADJC also maintains a repository for documents related to the CRIPA investigation. Open access to this repository was restricted for confidentiality

reasons; however, it is believed that the majority of documents included in the repository were found elsewhere (e.g. reports by CRIPA monitors).

The third source of document data were other government documents obtained from outside government agencies. These included the Department of Justice's annual publication of "Department of Justice Activities Under the Civil Rights of Institutionalized Persons Act," semi-annual reports made by the DOJ regarding progress at the ADJC during monitoring, and a Sunset Review of the ADJC by the Arizona Auditor General. Additional documents not directly pertaining to CRIPA or the ADJC, but more general juvenile justice issues in Arizona were also examined. This was because the functioning of juvenile detention has a direct influence on state corrections. For example, documents from the Arizona Juvenile Justice Commission (AJJC) were collected, as they included funding decisions that impacted the ADJC. Other types of documents included presentations made by ADJC representatives at conferences or juvenile justice meetings. For example, at one meeting for the Arizona Children's Executive Committee, an ADJC representative discussed how the agency responded to juveniles released on community corrections.

### **Researcher's Bias**

Qualitative researchers have suggested that one way to maintain internal validity in qualitative research is to present researcher biases upfront (Creswell, 1994; Merriam, 1988, 1995). My perception of juvenile correctional institutions has been highly shaped by both my personal experiences as a juvenile correctional officer and my knowledge gained from courses examining juvenile justice and organizational theory. In regard to

the former, before starting the doctoral program, I was a juvenile correctional officer in California. My training for the position consisted of 8 weeks of training regarding policies, institutional operations, suicide prevention, responses to juveniles with mental health issues, physical restraints, and separation (i.e. solitary confinement). In other words, I had been trained in all of the areas that had been raised as issues in the CRIPA at the ADJC. Based on statements made by employees at the ADJC, this training was very similar to the training experienced by correctional officers at the agency. Many of the issues brought up by participants were issues that I had personally confronted (e.g. suicidal juveniles). In addition to professional experience, my training in graduate school has also addressed many of the issues that were raised during data collection. More specifically, I have taken courses in corrections, juvenile justice, and organizational management, all of which informed various aspects of the project.

I do not believe that these potential biases were harmful to data collection, and in fact, I believe they were useful in data collection. More specifically, I was mindful throughout data collection not to project my personal experiences on participants. Aside from the initial mention of my background, very rarely was it brought up at later points in interviews. However, there were some cases where my background was used to establish rapport with the participants. For example, a juvenile had committed suicide at the ADJC two years prior to data collection. This was an extremely difficult subject for many of the officers and employees to discuss. In one instance, when a participant was asked about the incident, it was obvious to the interviewer that the question was ill received. I then disclosed that a juvenile at the agency I was employed at had committed suicide, so I was aware that it could happen without any staff misconduct or wrongdoing. The participant

then responded that he was glad I was able to sympathize with the traumatic event. This, and other examples, were used frequently to suggest to participants that I was not passing judgment or blame, and was only attempting to determine the situation of the agency.

### **Case Study Research Methodology**

Adopting a qualitative research methodology was crucial for the current project because it focused on understanding the process of reforming an agency over multiple years. In particular, qualitative research aims at “understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (Merriam, 2009, p. 5). To explore the responses of an agency reforming following a consent decree, a case study research design was used. A case study was an appropriate method because of the broadness of the area being studied, the importance of the context in which such decisions were taking place, and the multiple data sources (Yin, 2003).

Case studies provide context to research projects by examining both historical and chronological aspects of an issue that may not be captured in quantitative research (Creswell, 2006). Furthermore, qualitative research is able to contextualize a case study in a broader framework and develop themes to help analyze the data. Case studies are particularly advantageous over other methods because they allow for multiple forms of relevant data to be collected (Neale, Thapa, and Boyce, 2006), which “can strengthen the evidence for case studies” (Yin, 2012, p. 182). Using an intensive case study method, it was possible to develop a deeper understanding of both the research setting and theoretical explanations to explain outcomes (Cunningham, 1997).

## **Data Analysis**

Data analysis is arguably the stage in qualitative research that is most different from quantitative studies (Maxwell, 1996). It is suggested that “the core of qualitative analysis lies in these related processes of describing phenomena, classifying it, and seeing how...concepts are interconnect[ed]” (Dey, 1993, p. 31). Initial themes were developed to explore the process of CRIPA implementation and sustainment. During the review and coding of the interviews, field notes, and document review, these were further developed and expanded. The qualitative software program Dedoose v. 4.2.79 was used to assist in the organization of the data. The coding of all relevant documents in the Dedoose program allowed for the identification of patterns across the multiple data sources. Two general analytic strategies were used at the onset to examine how the agency reformed following the consent decree—relying on theoretical propositions and thinking about rival explanations (Yin, 2003).

Yin (2003) suggests that two of the three most valuable strategies for analyzing case study data are to rely on theoretical propositions and to consider rival explanations. The former is useful for organizing the case study around a theory and identifying explanations other than the theoretical proposition. In the current dissertation, institutional theory was drawn upon to explain how a correctional department responds to a potential lawsuit. As has been previously argued, criminal justice organizations rely on financial support, resources, and perceptions of legitimacy from external agencies in order to survive. As a result, they are forced to comply with the rules and beliefs instituted by such agencies (Dacin, Goodstein, and Scott, 2002; DiMaggio and Powell, 1983; Meyer and Rowan, 1977). In other words, conforming to the rules and norms of

the external agencies results in organizations being “rewarded for establishing correct structures and processes” (Scott and Meyer, 1983, p. 149). The current dissertation proposes that the changes made during CRIPA were shaped in large part by the organization’s reliance on external agencies for funding, legitimacy, programming, and the juveniles that are sent to the agency.

To further examine the proposition that the ADJC produced long term reforms as a direct result of conforming to the demands of external environments, two rival explanations were considered as to how the ADJC institutionalized change—the deterrent impact of punitive and preventive controls. Although these controls were the result of the CRIPA investigation, it is important to consider them separately from institutional concerns. More specifically, punitive (e.g. punishments against officers) and preventive (e.g. removing opportunities for officer corruption) controls were directed specifically at line level staff, who likely gave little consideration to the external pressures that are felt more by correctional administrators. Yin suggests that this strategy is useful in case studies, as it allows for the consideration of the influence of additional independent variables. In this case, the dependent variable would be the sustainability of change, while the independent variables would be the external influences of the organization environment, CRIPA monitoring, and the internal influences of punitive and preventive controls. These analytic strategies were used to examine how an institution changes as a direct result of a CRIPA investigation, competing explanations for sustaining reform, and barriers that may compromise the reforms process.



## **Reliability and Validity**

Qualitative research has long received criticisms because of perceptions that there are inherent difficulties in producing valid and reliable findings. The major issue in applying concepts of reliability and validity to qualitative research is that they are derived from quantitative methods. Merriam (1995) presents some of the questions that have been asked of qualitative researchers including: “How can you generalize from a small, non-random sample?” and “If somebody else did this study, would they get the same results” (p. 51). In response, Merriam argues that these are inappropriate questions to be asking for assessing reliability and validity of qualitative research because the purpose of qualitative studies is to understand phenomena, build theory, and provide a fresh outlook on issues. Similarly, Eck (2006) argues that case studies and randomized controlled experiments both have value in evaluations. Instead of discounting the value of case studies because of threats to internal validity, Eck suggests that they are in fact valuable because they are less expensive, they can begin after program implementation, they help explain the results of unique interventions, and they can be used without controls or comparisons with other similar programs. In other words, Eck makes the argument that case studies are more useful than a study that didn’t occur because of potential threats to validity.

One of the overarching questions of ensuring reliability and validity, or rigor, is what is the tradeoff in reaching reliable and valid findings? In most cases, the methods to obtain reliability and validity are in stark contrast to the very essence of qualitative methods. As Sandelowski (1993) argues, being forced to abide by rigid methods in order to achieve requirements like replicability, prohibits the artistry and flexibility of

qualitative research. Quantitative methods generally require threats to validity to be dealt with at early stages of research by setting up control groups, performing randomization, and other designs. On the other hand, qualitative studies are rarely afforded the luxury to set up experimental controls or use other methods to tackle threats to validity early on. As many qualitative studies are conducted in such a way as to allow for adaptability based upon issues confronted in the field, the rigidity required by quantitative methods is not worth the cost. While the solutions to threats to validity developed by qualitative researchers (e.g. triangulation, member checks, ruling out threats over time) may appear less formal and rigorous, they allow for both flexible methods and validity.

Many suggestions have been made to ensure internal validity in qualitative research studies (Merriam, 1988). These include triangulation (i.e. multiple sources of data used to confirm findings), peer and colleague examinations (i.e. obtaining feedback from colleagues on findings), researcher presenting biases at the beginning of the study, and submersion in research (i.e. obtaining data over a long term). Each of these suggestions were observed and practiced during data collection. First, triangulation was accomplished by relying on multiple forms of data (i.e. government documents, newspaper articles, and interviews) when coming to conclusions. Second, informal meetings frequently occurred and email exchanges occurred nearly each week during data collection between researchers to discuss findings that were emerging. Third, researcher's potential biases were addressed earlier in the current chapter. Finally, interviews occurred over a 10 month period and articles were collected over a 20 year period, allowing for a more in depth understanding of the agency and how it responded to CRIPA.

Case studies have also been criticized for the difficulties in generalizing findings past the case being examined, which threatens external validity (Creswell, 1994; Yin, 2003). Flyvbjerg (2006) has argued that social scientists view case studies as being useful for informing future research, but that they criticize case studies for limited generalizability. Flyvbjerg instead suggests that they can allow for both depth and generalizability when multiple case studies are conducted. Although conducting multiple case studies was not feasible in this case, generalizability was improved by providing a rich description of the case study, allowing for future replications (Lincoln and Guba, 1985; Schoenfield, 1993). Yin also suggests that comparing qualitative with quantitative methods is inappropriate in this case because “survey research relies on statistical generalization, whereas case studies rely on analytical generalization” (p. 37). In other words, the generalization occurring in a case study is to a theory and not a larger population.

Finally, the reliability of qualitative research ensures that future researchers could replicate the same case study again based upon the data collection methods described by the first researcher (Yin, 2003). The main concern with reliability is that the initial researcher(s) thoroughly documented their methods for data collection in order to “minimize errors and biases in a study” (p. 37). Yin suggests that documentation should include an overview of the project, procedures used in the field, questions used in the case study, and providing a guide for the case study that is incorporated into the case study protocol, all of which were included in earlier sections of the current dissertation.

In sum, the current study will rely on a case study methodology to examine the sustainability of a consent decree in the Arizona Department of Juvenile Corrections. A

review of the ADJC in chapters two and three has provided only a brief glimpse of the agency reforms from 2004 to 2007. Although the reforms were portrayed to an extent in newspaper articles covering the suicides and CRIPA monitor reports suggesting the agency was making successful changes, these documents provided only a brief glimpse of the process of long-term organizational reform. By employing a case study method, this dissertation is able to provide a more in depth contextual analysis from the perspectives of multiple actors in the criminal justice system of the sustainability of CRIPA reforms. Chapter four examines in detail how the agency responded to each of the areas that were reformed under CRIPA and how changes made in those areas have been sustained. Chapter five outlines how the agency worked to reform the culture following the consent decree. Chapter six then presents two rival explanations for correctional reform. First, chapter six addresses reform from an institutional theory perspective and will examine if pressures to maintain legitimacy in an institutional environment have encouraged the sustainment of change. Then, internal correctional change will be examined to determine how punitive and preventive controls implemented during CRIPA have encouraged sustainability by deterring misconduct. Finally, chapter seven will present conclusions and discuss policy implications for the implementation of future consent decrees.

## Chapter 4

### Long Term Reforms Following CRIPA

Providing treatment and rehabilitation to confined populations, especially juveniles, is difficult to accomplish. More specifically, suicide prevention, health care, and security of juveniles have been found to be particularly challenging to provide in institutions nationwide (Guarino-Ghezzi and Loughran, 2006; Parent, 1993; Parent, Lieter, Kennedy, Livens Wentworth, and Wilcox, 1994). These challenges have been further complicated in facilities where juveniles face abuse by staff and find it difficult to file grievances against abuse. In fact, relatively few institutions have been found to be in full compliance with national standards of care. Despite these difficulties, institutions are obligated to provide a minimum standard of care and prevent the deprivation of civil rights of inmates (Puritz and Scali, 1998a). Institutions that are found to exhibit a pattern or practice of abuses can now be sued by the federal government under the Civil Rights of Institutionalized Persons Act.

The current chapter examines the changes at the Arizona Department of Juvenile Corrections that occurred following a consent decree under the CRIPA. The semi-annual reports by the CRIPA Consultants Committee<sup>3</sup> demonstrated that the ADJC was able to come into full compliance of the Memorandum of Understanding within a three year

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<sup>3</sup> The terms CRIPA monitors, investigators, and consultants committee are used interchangeably throughout this dissertation.

Table 4. Progress of the ADJC in Achieving Compliance with the MOU

	Substantial Compliance	Partial Compliance	Non- Compliance	Not Rated	# of Issues Evaluated*
3/15/2005	23	91	9	13	136
9/15/2005	55	70	1	0	126
3/15/2006	107	19	0	0	126
9/15/2006	118	10	0	0	128
3/15/2007	120	3	0	0	123
9/15/2007	120	0	0	0	120

\*The total number of issues that fell into compliance does not total 136 during each report because areas where the agency was found to be in substantial compliance over an 18 month period were terminated from the agreement. Furthermore, some of the issues were combined or separated over the course of monitoring.

Source: Arizona Department of Juvenile Corrections (2009)

period (Table 4). In March of 2005 the agency was in substantial compliance<sup>4</sup> with 23 of the identified issues in the MOU, but by September of 2007 they were in compliance with all 120 issues that were required to be resolved. The first semi-annual report demonstrated that the consultants overall were very satisfied with how the ADJC was responding to the investigation. For example, they reported that “at the conclusion of site visits...debriefings were held with Director Branham and his leadership team. The team was completely receptive to recommendations of the Consultants Committee and in many cases instituted remedial measures prior to the termination of the visit” (Hayes, Kraus, Leone, Van Vleet, 2005, 1). The committee reported that this cooperation by the ADJC director and staff continued until the final report in September of 2007.

The DOJ outlined several areas that needed improvement, including suicide prevention, juvenile justice, special education, medical care, and mental health care.

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<sup>4</sup> Substantial compliance was defined by the consultants as being in “compliance with all components of the rated provision” (Hayes, Kraus, Leone, Van Vleet, 2005, p. 2).

Each section will present specific issues noted in the initial investigation by the CRIPA monitors, the first semi-annual report in 2005 by the monitors, the sixth semi-annual report in 2007 by the monitors, performance audits in 2009 by the Arizona Auditor General examining conditions at the ADJC, perspectives of ADJC staff that were interviewed for the dissertation, and documents describing current conditions of the institutions.

## **Suicide Prevention and Treatment**

### **Reforming Suicide Prevention and Treatment During CRIPA**

Following the completed suicides of juveniles in 2002 and 2003 at ADJC facilities, the U.S. DOJ entered into a Memorandum of Agreement (MOA) with the ADJC to make over 120 specific changes. Many of these changes related directly to the prevention of and response to suicide. To satisfy the MOA, the ADJC improved training, building structures, and policies in order to prevent juveniles from committing suicides. In response to an audit of the ADJC by the Arizona Auditor General (AG), the director of the ADJC outlined the changes that were made. These included: “all four facilities were retrofitted and remodeled to reduce the opportunity for juvenile suicide, the Department implemented a comprehensive new suicide prevention program,...the Department developed and implemented or revamped virtually all of its secure care operations and programming,...[and the Department] revamped both its Pre-service Academy and the delivery of in service training” (Branham, 2009, pg. 1). Interviewees participating in the present study confirmed that each of these reforms did in fact occur.

The most notable and visible change to preventing future suicides was the retrofitting of the institutions. Specifically, the agency “suicide proofed” lights, doors, vents, and beds to prevent future incidents. Limitations on what juveniles could have in their rooms were also imposed. For example, juveniles were no longer allowed to wear belts or bring plastic bags into their rooms. All of the participants spoke positively of the retrofitting, with the exception of one community representative. This participant felt that other states have been successful at keeping low suicide rates without modifying the structure of the institutions. For example, in Missouri, staff have been able to keep juveniles safe because of changes in staff and training. One article about the retrofitting echoed this sentiment by stating that “you can’t suicide-proof a kid, not even with fancy vents and bunk beds fused to the cinder block wall of the cell” (Silverman, 2009).

In addition to modifying building structures, the department also provided more intensive training to prevent suicide and changed how it responded to potentially suicidal juveniles. Following the CRIPA, new employees were trained in how to make appropriate room checks, how to identify risk factors for suicides, the importance of starting “red folders” for juveniles (i.e. used to monitor juveniles under suicide watch), and were informed about the history of the agency and the CRIPA intervention. Refresher trainings are also given to all correctional officers each year, as was suggested in the MOA. As a result of CRIPA, the department began closer monitoring of suicidal juveniles through more consistent room checks and better documentation.

Due to changes at the administrative level in quality assurance, the ADJC has maintained a closer adherence to these room checks than it had in previous years. Discussed in more depth in Chapter 6, the department’s initiation of a COMPSTAT



program has allowed for increased supervision of staff to ensure compliance with policies for monitoring juveniles. Although monitoring of suicidal juveniles was mandated prior to CRIPA, the investigators noted numerous incidents where room checks would exceed the maximum time limits. The current supervision levels for juveniles who are a danger to themselves are constant supervision, 10 minute room checks, and 15 minute room checks, depending upon the severity of the threat. The department has also improved documentation of suicidal juveniles. Juveniles at risk of suicide are placed on a “red folder,” which signals to officers the enhanced monitoring of the juvenile. As noted in the final report by the CRIPA monitors, staff placing a juvenile under suicide watch must “document the initiation of the precautions level of observation, housing location, and conditions of the precautions” (Hayes, Kraus, Leone, and Van Vleet, 2007, p. 13). Overall, officers and monitors reported a high level of satisfaction with the changes made post-CRIPA and the adherence to the revised policies. Exceptions to these practices are discussed below.

The only lingering issue related to suicide prevention that was noted in the final CRIPA report by the DOJ monitors was that once juveniles were removed from suicide precautions, their Continuous Case Plans (CCPs) should be revised to reflect changes in future treatment. However, the report notes that the department has only achieved “‘paper’ compliance with CCPs, [and] the consistency of quality treatment planning for youth discharged from suicide precautions remains uneven” (Hayes et al., 2007, p. 5). This has led to poor implementation of methods to reduce suicidal behaviors. Very few participants discussed this as a major concern of suicide prevention in the agency. While some recognized that the CCPs were ineffectively written and carried out prior to CRIPA

or that staff shortages prevented effective case management, no participants expressed any concerns directly related to poor case management following removal from suicide precautions.

### **Sustaining Reforms in the Treatment of Suicidal Juveniles**

To examine more recent conditions at the ADJC, the Arizona Auditor General's (AG) audit of the ADJC in September of 2009, a part of the decennial sunset review, was assessed. Following a lengthy audit, they concluded that the issues relating to suicide addressed in the CRIPA report (i.e. inadequate training for suicide prevention, inadequate assessments/treatment, inconsistent communication, unsafe facilities, placing suicidal juveniles in isolation, poor interventions, and inadequate follow-ups) greatly improved as a direct result of the investigation. Changes that were noted in the report include: increased training for suicide prevention (e.g. annual trainings, reviews of policies), better monitoring of juveniles, improved communication between units, improvements in rooms to prevent suicides, trainings on how to intervene in potential suicides, and follow up of all suicide attempts. At the time of the report, it was noted that since the three suicides in 2002 and 2003, the ADJC had not had a completed suicide. Despite these positive improvements noted in the report, there were multiple suggestions made by the AG as to how the ADJC could continue reforming. Through departmental audits from April 2008 to March 2009, the AG found that treatment plans did not always address youths with suicidal behaviors, suicidal juveniles were inappropriately placed in separation, suicide-proof smocks were commonly used before mental health assessments at Catalina Mountain School (not addressed in this report because CMS had closed by the

time interviews at ADJC began), and 51% of eligible juveniles for a suicide incident report did not have a report completed.

Overall, it appeared based upon reports from both those employed by the ADJC and those external to the agency that improvements had been made in suicide prevention and responses to suicidal juveniles. Then in December of 2009 the *Phoenix New Times*, a local weekly newspaper that published articles about the abuses at ADJC and ultimately led to the CRIPA investigation, published a new article—*Suicidal Tendencies: The Arizona Department of Juvenile Corrections is a Bloody Mess* (Silverman, 2009). In the article, incidents of suicide attempts or cutting were reported on February 14<sup>th</sup>, April 3<sup>rd</sup>, April 4<sup>th</sup>, April 14<sup>th</sup>, May 17<sup>th</sup>, and September 21<sup>st</sup> of 2009. These attempts are unsurprising, as the Auditor General reports that from January of 2007 until mid-2009, there was about one serious suicide attempt per month. While the *New Times* article acknowledged the report, it stated that “the report was largely glowing, leading the *Arizona Republic*, the state’s newspaper of record, to hand out high-fives in a story headlined, ‘Arizona’s Juvenile Jails Free of Suicides Since ’03.’ The story and the audit didn’t mention how close some of the calls were.” The article cites multiple examples, including a boy who was unconscious after strangling himself with his pants, a girl who tied a shirt around her neck to choke herself, and a boy with a towel around his neck who “was turning red and then blue.” As will be discussed later in this chapter, Silverman notes that the ADJC has improved since CRIPA, but that “the agency is clearly unable to provide adequate care for seriously mentally ill kids.”

## **Completed Suicide of Juvenile Following CRIPA**

Unfortunately, the ADJC experienced a completed suicide in May of 2010, only five months after the *Suicidal Tendencies* article was published. Multiple participants both internal and external to the ADJC reported on the suicide and confirmed many of the details that had been released in Silverman's (2010a; 2010b) articles immediately after the incident. The male juvenile who committed suicide was reportedly a Native American and homosexual, two factors that could potentially predispose the juvenile to suicide. It was also reported that he had additional risk factors for suicide including family issues, alcoholism, mental health problems, and prior suicide attempts. Multiple participants stated that the juvenile had made comments while at ADJC about suicide, but the juvenile said "he wouldn't try to commit suicide because they watched him so well." The juvenile was on close observation "just because," although he never made any direct threats. Despite these general concerns, he was not on a red folder, which would have resulted in more intensive supervision. The justification for this was that "it wasn't like he threatened to kill himself a couple of days before he did it...it had been a while." This incident highlights the point made by the Auditor General that suicidal behaviors were not always addressed in treatment plans.

Shortly before the juvenile committed suicide, it was reported that he had received adult charges for an assault, meaning that he would be transferred into the adult system. Some speculated that the potential for transfer "may have impacted his decision because of adult charges. The outcome for his going to court was he was relieved, but there is some question about if he was happy about this outcome or just faking it." Days prior to the suicide, the juvenile was transferred from a mental health unit to a unit for

violent and assaultive juveniles. This was a unit that he was unfamiliar with where he did not know the staff well. It was reported that it was policy that if juveniles are moved from one unit to another, mental health staff were required to have a meeting with the staff in the unit. This was “kind of done, but wasn’t a formalized review. We don’t move many kids from a special unit to another and this problem highlighted exactly why we don’t do this... In hindsight he should have never been taken off of a red folder ever.”

On the night of the incident, the juvenile used a plastic bag to cover his face and ultimately suffocated himself. Although the Youth Correctional Officer (YCO) working the night shift in the unit checked on the juvenile multiple times that night, the officer failed to follow protocols and training because he never checked whether the juvenile was breathing or that the juvenile’s face was visible. Instead he merely counted the number of juveniles in the unit rather than shining a light on their faces. In fact, the YCO admitted that he had not observed the juvenile’s face that night when questioned by administrators. The window on the door of the room the juvenile occupied was also reported to be heavily scratched, which made it even more difficult to view the juveniles. The juvenile was deceased for nearly six hours before it was realized that he was not breathing.

The majority of those interviewed reported that the third shift YCO had been negligent in ensuring the safety of the juveniles that night, but not all officers felt this way. Those that perceived negligence reported that the officer “should have seen it sooner.” Most felt confident that the suicide prevention/detection practices in place were effective and best practice, and that this incident was an “individual lapse and not necessarily indicative of the system as a whole.”

## **Long Term Reforms in Suicide Prevention**

As a result of the incident, the officer working that night was first placed on leave and ultimately resigned from his position. The suicide also had many long-term effects on the agency. First, it demonstrated to staff that they always needed to be vigilant of suicides. It was apparent that because the agency had gone so long without a suicide that concerns had waned over the risk of suicides. One of the COMPSTAT meetings (discussed in depth in chapter six) during data collection highlighted this point. In a meeting in October 2011, areas where the department was out of compliance included: staff could not see into some windows because of scratches, a welfare check occurred after 23 minutes for a level 3 juvenile, and one juvenile had been inappropriately put on suicide watch. With regard to the juvenile being placed on suicide watch, it was reported that a red folder to indicate the juvenile needed to be closely monitored was not started when the juvenile was placed in separation, as it should have been. What this meant was that the juvenile was being checked at appropriate intervals according to protocols, but that timesheets were not completed to document these. At the meeting, it was reported that there was a breakdown in communication between the mental health staff and YCOs. When it appeared that staff were blaming one another for the lapse, one administrator stated that “everyone should take ownership... This is especially concerning considering where the agency has been that there would be a problem with tracking a suicide.” In order to address the issue immediately, one administrator announced that in the future, the psychologist who recommends having a level (i.e. increased monitoring of suicidal juveniles) should obtain the name of the officer starting the red folder so that a similar incident did not occur again.

Other long term changes have included: juveniles now must see a psychologist before and after they visit court, staff meetings must occur if a juvenile is going to be moved from one unit, superintendents can no longer move juveniles to a different unit without first consulting with clinicians or mental health professionals, staff have high end flashlights to observe juveniles through windows, staff must see juveniles moving under their blankets, juveniles can no longer have anything over their necks at nighttime, glass on the windows was changed, managers and security now do occasional room checks during the third shift, juveniles cannot have plastic bags, and lights in the hallways are now kept on. One ADJC employee noted that many of these policies after the suicide weren't necessarily new, but that they hadn't always been followed after CRIPA. As a result, "the suicide really opened our eyes again." For the most part, the adherence to old and new policies for suicide prevention has been received well within the department. One exception to this is not all YCOs have responded well to managers being required to do room checks during the night shift. It is reported that some of the night shift felt undervalued and that the importance of their roles was being overlooked in the department.

Staff varied greatly in their perceptions over how preventable the suicide in 2010 was. On one hand, some employees suggested that not all suicides can be prevented and placed the majority of the blame on the juvenile. In one interview when a correctional officer was asked to describe the incident, the response was that "a kid took a plastic bag and put it over his head... what else do you want to know?" With additional probing this participant then admitted that he heard the plastic bag over the juvenile's head was visible and that the night staff did not see the juvenile in time. The participant went on to say

that the department “already had a really good suicide prevention program in place and that they didn’t need to change what they were doing.” Others felt that even with the best of care, treatment, and supervision, juveniles will commit suicide. For example, one respondent stated that

I had the feeling of what more can you do because we had put so much into suicide prevention. The suicide was very hard on staff and they felt responsible. It wasn’t a problem with the policy/training. The problem was with people not doing what they were supposed to be doing. The administration can’t watch everyone all the time. This comes down to human beings doing what they are supposed to do. Staff are not paid well and they have difficult jobs. It is also hard to keep people alert.

In contrast, other staff felt that multiple factors led to the suicide, not just the desire of the juvenile to commit suicide. These factors included: the negligence of the YCO working the unit that night, the scratched windows that made it difficult to see in the room, and moving the juvenile from one special unit to another. With regard to the latter point, multiple staff questioned the decision of the assistant superintendent and movement coordinator to remove the juvenile from a unit he was reportedly comfortable in to a unit for violent juveniles. As one staff reported, “moving him was just a way for them to be assholes to a kid who was being an asshole... They were not talking to people who knew the kid the best...[this] is an awful practice.” Based upon these responses, it was evident that line staff were holding both the individual officer and administrators responsible for the suicide.

One issue that was also noted in the Auditor General’s report was that “suicidal juveniles were inappropriately placed in separation.” Surprisingly none of the respondents expressed concerns over this issue. In fact, one ADJC employee felt as if it



was a positive practice and allowed juveniles to be removed from stressful situations.

More specifically

They would receive a referral for self harm and would then see a mental health professional and go to a facility run by a mental health team. There would be a concentration of mental health professionals in the unit. The juvenile would then be away from the distractions of their units and could be monitored on camera. The health unit was also adjacent to them, so if there was a problem they could be rushed there right away.

Although this respondent believed that separation was beneficial for suicidal juveniles, multiple respondents did express concerns over the excessive use of separation in the department. These concerns arose as a direct result of CRIPA ending and the lack of monitoring of this practice because “during CRIPA we were watched like hawks.” This participant did not specify exactly what these concerns were over; just that staff say juveniles are being “admitted for things they should not be there for.”

Although the suicide in 2010 was a glaring misstep in an agency that had sought to improve practices since 2004, overall ADJC employees appeared satisfied with the extent of changes in suicide prevention and felt that a closer adherence to policies had successfully reduced the number of incidents at the agency. Changes to physical structures of buildings, policies, and training all contributed to an overall improved perspective in the departmental response to suicide. The following section will further examine changes that had a direct impact on suicide prevention (e.g. grievances, use of separation) and how juvenile justice has been maintained following the cessation of the consent decree.

## **Juvenile Justice**

At the close of the CRIPA investigation in 2007, the CRIPA investigators appeared very satisfied with how the department responded to the recommendations to improve juvenile justice in the facility (i.e. grievances, sexual abuse, physical abuse, supervision, abuse investigations, disciplinary confinement, and unsanitary living conditions). In their final report, the investigators declared that “ADJC has developed an administrative infrastructure that would allow the agency to provide services to youth while protecting them from harm. The development of this infrastructure, over the last 3 years, has been very impressive and is a major accomplishment for Director Michael Branham, his leadership team, and all staff throughout the agency” (Hayes et al., 2007, p. 14). In every juvenile justice issue where civil rights were deprived prior to CRIPA, the ADJC was in substantial compliance with each required change by the end of the consent decree. The following section will examine each of the aspects of juvenile justice in more depth.<sup>5</sup>

### **Grievances**

During the initial investigation, the CRIPA investigators found so many issues with the juvenile grievance system that they categorized the grievance process as “dysfunctional,” while the juveniles described it as “a joke.” Two specific issues were noted with how the ADJC handled juvenile grievances. The first was that grievances

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<sup>5</sup> An 8<sup>th</sup> juvenile justice issue was identified in the CRIPA investigation, but is not addressed in the current report. There was reportedly inadequate security at the Catalina Mountain Facility, but this facility closed prior to data collection and was not discussed in interviews.

made by juveniles are reviewed by the cottage supervisor where the juvenile is housed. This means that “many grievances include allegations of abuse against the very cottage staff for whom the supervisors are responsible” (Acosta, 2004, p. 15). This process resulted in many juveniles being unwilling to report issues to staff. Second, many juveniles were either not allowed to submit grievances or the grievances they filed were responded too slowly. In fact, the investigators found that one-third of grievances over a three month period at one facility had not been resolved.

During their first semi-annual review in 2005, the DOJ investigators noted that the agency was in partial compliance with the majority of recommendations for grievances. Although a grievance system had been implemented and efforts were made to inform juveniles of the new process, some criticisms remained. Issues noted by the investigators included: officers were not accepting of the Youth Rights Specialist (YRS) in charge of collecting the grievances, officers occasionally tore up grievances, the YRS was not included in facility meetings, officers were unaware as to how the grievances had been resolved, the YRS was not included in resolution meetings, juveniles were still unsure of the grievance policies following orientation, there was a failure to verify the status of grievances with juveniles, and juveniles were not informed of the “resolution of their grievance.” The department acted quickly to remedy the grievance issues noted in the investigators’ report. In fact, in the sixth semi-annual review in 2007, the CRIPA monitors did not address any inadequacies in the grievance system. Because the agency had been in full compliance in all grievance related areas for an 18 month period, monitoring had been terminated. The Auditor General’s 2009 Sunset report did not shed

any new light on changes in the grievance process, but did report that in 2008, 98% of juveniles “felt satisfied with the outcome” of the grievance.

This satisfaction with the response of ADJC to the juvenile grievance process was further reflected in interviews with ADJC employees and community representatives. Although participants suggested that prior conditions and the use of grievances prior to CRIPA were poor, they had improved significantly as a result of CRIPA. For example, one participant described how juveniles were placed in separation for long periods of time, exercise was limited, and that policies were not being enforced. These problems had become so “normalized that kids weren’t even complaining about the conditions... it was toxic at the time.” Because of this, “kids weren’t using the grievance system, which can be a problem if kids don’t believe grievances will be heard.” This participant further described how none of the juveniles who committed suicide prior to CRIPA had filed grievances. Before CRIPA, staff misconduct was occurring daily. Respondents note that as a result of the grievance system that was put in place, juveniles can report if staff misconduct is ever a problem. The grievances are also now numbered, so staff can no longer just rip up grievances that they did not agree with.

During the time of data collection, it appears as if the reports of staff misconduct are much lower than they had been prior to CRIPA. At one staff meeting in October 2011, it was reported that there had not been any staff misconduct grievances filed in the previous 6 months in any ADJC facilities. At the boys’ facility, there was an average of 2.92 grievances per week for other issues, which was down 11.76% from previous weeks. In contrast, the girls’ facility only had an average of 1.21 grievances per week, which was

up 12.5% from previous weeks. The grievances that were made in the facilities were primarily for issues pertaining to food and property, not staff misconduct or abuse.

Although the grievance process has been met with much satisfaction, the agency is in the process of changing to an automated system. It was reported that “one problem is that they have so many different systems where information goes that it can get cumbersome and fragmented. They need to streamline their reporting systems...to have information consolidated.” Having an effective and efficient grievance process has a direct impact on maintaining civil rights of confined juveniles, especially with respect to sexual and physical abuses that may occur while institutionalized.

### **Sexual and Physical Abuse**

During the CRIPA investigation, numerous incidents of alleged physical and sexual abuse were uncovered. It was found that “sexual abuse by staff and other juveniles occurs with incredibly disturbing frequency at Adobe, and that ADJC management does not affectively address this serious problem” (Acosta, 2004, p. 11). Issues cited in the report include at least two female employees who engaged in relationships with juveniles, a male employee who was too affectionate with the male delinquents, and sexual violence occurring between juveniles. Similarly, juveniles were physically abused by both staff and other juveniles. In some cases, staff would allow and encourage juveniles to fight with one another. The physical abuses occurring from staff were highlighted when a juvenile was hit in front of the DOJ investigators. They report that “we even observed a staff member slap an Encanto youth hard on the side of his head because he was moving ‘too slowly’ back to the housing unit after dinner” (p. 13). Many

of the incidents of abuse were never investigated. Despite these incidents of abuse noted in the investigation, the DOJ monitors noted difficulties in obtaining the full scope of abuses because of poor monitoring and investigations of abuse.

In the first report by the CRIPA consultants on the status of the agency changes, they found the ADJC had made significant improvements to protect incarcerated juveniles from harm. They found that the

State has made significant efforts to improve the policies, procedures, and practices for the reporting and investigation of allegations of abuse of a youth made by any person, including youth... The State shall continue to make all reasonable efforts to ensure that all youth are protected from harm and that all allegations of abuse, including but not limited to physical and sexual abuse, are investigated in a timely and thorough manner by ADJC's Investigations and Inspections Unit (I&I), and other appropriately trained investigative personnel, as designated by the ADJC director.

The process of I&I and the impact that it has had on ADJC operations will be discussed in more depth in chapter 6, but it should be noted that the process brought about a more systematic way to report and investigate cases of abuse, as well as monitor correctional officers.

Overall the investigators were satisfied with the steps the ADJC was taking to improve the agency. There were a few notable exceptions where the department was only reported to have partial compliance with the changes. Related to the grievance issue reported above, juveniles were unclear on how to report instances of abuse following an orientation to the institution. Other issues that were noted included: "minor differences in processing" incident reports, failure to track referrals to CPS, failure to include documentation of injuries in incident reports, limited number of staff completing crisis intervention training, and the failure to evaluate training using quality assurance data. In

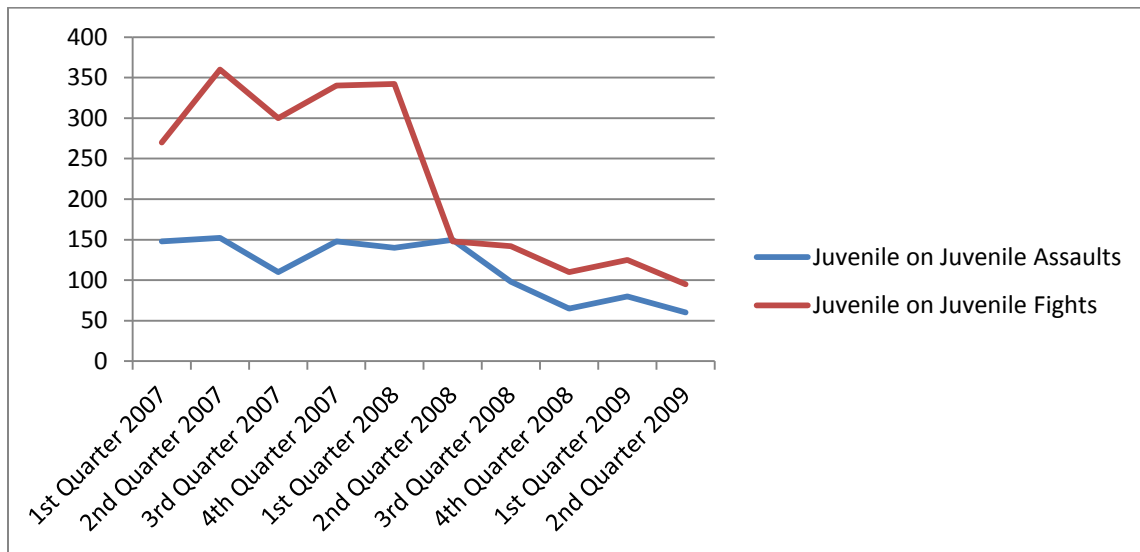
the final report by the CRIPA monitors in 2007, it was reported that the ADJC was in substantial compliance with all recommended suggestions to protect juveniles from physical harm. The monitors found that allegations of abuse were being effectively investigated by the I&I division and they believed incidents of abuse would decrease as the agency continued changing.

**Sustaining Reforms in Sexual and Physical Abuse.** In line with the beliefs of the CRIPA monitors that incidents of violence at the ADJC would significantly decrease as the agency continued to reform, data presented by the AG suggests that this did in fact happen (Figure 3). As reported in the AG report, juvenile on juvenile assaults and fights both decreased substantially from 2007 to 2009. Nevertheless, the AG still recommended that the ADJC continue to be aware of violence in the facilities and “assess whether its actions and practices are having a positive impact on reducing violence, and adjust when necessary if it finds these actions and practices no longer help to sustain reduced levels of violence” (Office of the Auditor General, 2009a, p. 25).

The AG report also indicates that, consistent with recommendations made by the CRIPA monitors, the ADJC has continued to monitor, investigate, and take action against employees that physically or sexually harm incarcerated juveniles. They report that in 2008, there were 329 investigations of misconduct, with 21% of the investigations being substantiated. In 2008, 13% of the 78 employees who were fired from the ADJC were found to have either sexually or physically abused juveniles. Legal actions were being taken against three of the staff who were fired in 2008.

No specific reports of juveniles being physically abused by staff were reported after the CRIPA investigation ended. However, multiple participants from the county

Figure 3. Juvenile-On-Juvenile Violence by Quarter First Quarter 2007 through Second Quarter 2009



Source: Office of the Auditor General (2009)

courts that send juveniles to the ADJC reported concerns over fighting and physical harm. Many were concerned about juveniles being sent to the ADJC because they feared the juveniles would be assaulted by other juveniles. For example, one participant noted that the ADJC

Touted they cleaned up and it was a state of the art facility, yet they just had an officer and juvenile commit suicide and kids are still afraid of fights. These issues have all occurred after the monitor was lifted. These were not publicized, so it is possible that they are keeping these new issues private because they were supposed to have changed.

Other county representatives had lesser fears over the issue of fighting and believed these were just “kids fighting” and that these were understandable because the kids were just using fists and not shanks.

During interviews, reports of sexual abuse on the extent of sexual abuse were sketchy at best. However, many participants believed sexual abuses occurred both during and after the CRIPA investigation. For example, one participant noted that during the



investigation a female delinquent had been engaging in a sexual relationship with an officer and that “everyone including the kids knew about this.” The reported decreases in sexual relationships were likely impacted by the legal action that would be taken by the administrators if abuse was discovered. One participant noted that during training, the director told the class that “if you have sex with the kids I will see you serve prison time.” That participant reported that he no longer hears of problems related to abuse. Following the CRIPA investigation it was reported that there is a greater focus on appropriate boundaries with juveniles.

Others reported that occasionally relationships still occur and that they continue to be punished punitively in the department. While numerous participants reported some instances of sexual abuse following the CRIPA investigation, the details on the incidents were vague. Specific information seemed to vary from person to person, suggesting that rumors of abuse were being talked about, yet were not officially discussed in the department. Also, in most cases where participants would mention a case of sexual abuse, they would discuss one or two incidents. No participants made statements along the lines of, “that happens all the time.” Instances of abuse that were discussed included a teacher who had a sexual relationship with a juvenile after he was released but still on parole and an officer who had a relationship with a female juvenile around 2009.

Participants from the counties also had general concerns over sexual violence at the ADJC. One respondent stated that “one kid in [juvenile hall] was making sexual advances towards a female guard. When the kid was confronted on this, he said something to the effect of, ‘Well that happens at Adobe Mountain and it’s not a big deal’...The kid just said it so nonchalantly, like it was no big deal to make sexual

advances, which made me think that it was true.” This participant went on to say there was a report in 2010 of a female staff at ADJC having sexual relations with a minor, and feels that the issue of sexual relationships should be examined at the ADJC. Another described an incident in 2010 or 2011 of “finding out about a kid who had been physically and sexually assaulted only after the mother had told the kid’s lawyer, who then contacted the county.” One participant also expressed concerns that there were “sexual grooming behaviors,” where juveniles were “grooming” other juveniles.

**National Survey of Youth in Custody.** Because juveniles were not interviewed during data collection, it is difficult to have a clear understanding of the extent of sexual abuse in the facilities. However, the National Survey of Youth in Custody conducted in 2008 and 2009 by the Bureau of Justice Statistics demonstrates that the ADJC did in fact have relatively high rates of sexual misconduct against juveniles both by staff and other juveniles in the facilities (Beck and Harrison, 2010). Juveniles were surveyed in state facilities with a population over 90. In facilities with a population over 240, a random sample of males was collected and all females were surveyed. The total sample for the survey was 26,551 confined juveniles. Nationwide, 12% of juveniles surveyed reported experiencing a sexual victimization in the previous 12 months in the facilities.

In Arizona, three facilities were surveyed regarding sexual victimization: Adobe Mountain School (AMS), Catalina Mountain School (CMS), and Eagle Point School (EPS) (Table 5). Although these surveys capture the majority of juveniles housed at ADJC, they fail to capture the female population at Black Canyon School. Nevertheless, the overall percentages of juveniles reporting sexual victimization either by staff or other juveniles were 17% (AMS), 24% (CMS), and 24% (EPS). These figures decreased

Table 5. Sexual Violence in Youth Correctional Facilities

	All Facilities in Survey	Adobe Mountain School	Catalina Mountain School	Eagle Point
Number of youth sampled	25896	276	98	162
% of juveniles reporting sexual victimization	12.1	16.9	23.8	23.5
% of youth reporting victimization by another youth	2.6	5.6	4.8	0
% of youth reporting nonconsensual sexual acts by another youth	2	2.9	4.8	0
% of youth reporting staff sexual misconduct	10.3	14	19	23.5
% of youth reporting staff sexual misconduct, excluding touching	9.2	14	19	23.5

Source: National Survey of Youth in Custody (2010)

dramatically when examining only juveniles who were reportedly victimized by other juveniles, with 6% (AMS), 5% (CMS), and 0% (EPS) of juveniles reporting some form of sexual victimization. In contrast, 14% (AMS), 19% (CMS), and 24% (EPS) of juveniles reported sexual misconduct by staff. When comparing these figures with the other 196 facilities surveyed, it is apparent that victimization occurs at a relatively high rate. When examining the overall percentages of sexual victimization nationwide, the median was 11% and the average was 12%. AMS was in the top 70<sup>th</sup> percentile and CMS and EPS were in the 75<sup>th</sup> percentile of facilities with sexual victimizations nationwide. Although an in depth analysis of how and why each of the facilities differed is beyond the scope of the current dissertation, it is concerning to note that the

percentages of sexual violence were so high in a facility that had been under a consent decree, in part, to reduce sexual victimization one year prior.

One notable example of the ADJC failing to protect juveniles comes from the State of Arizona's Board of Behavioral Health Examiners (AzBBHE) credentialing meeting in December 15, 2009. At this meeting, the decision was made to suspend an ADJC therapist's license for two years and receive training on sex offender grooming behaviors (Board of Behavioral Health Examiners, 2011). In the AzBBHE's action tracking report in 2010, the details of the case are outlined as follows:

For approximately 9 years, the professional was the primary therapist for approximately 16 youth incarcerated in a juvenile sex offender program. The professional indicated that there were 5 youth that she suspected had been victimized by Youth K, and 2 youths who felt victimized by Youth K. The professional disclosed specific incidents where it appeared that Youth K sexually victimized 2 youth. The professional acknowledged that she did not file an incident report ("IR") regarding these incidents and others where she suspected that Youth K had engaged in inappropriate sexual conduct with other inmates. The professional indicated that she responded to incidents involving Youth K by confronting the youths involved, discussing the issue in group, giving Youth K extra help, a disciplinary action, and offense cycle paperwork, and providing individual counseling. The Arizona Department of Juvenile Corrections ("ADJC") found that the professional's failure to report sexual misconduct incidents involving Youth K violated multiple ADJC policies. (p.6)

Although no participants at the ADJC made mention of this incident, it is clear that the failure of the therapist to make an incident report of a juvenile having sexual contact with other juveniles is a clear violation of ADJC policies. Documentation from the AzBBHE did not outline the dates in which this negligence occurred, it is very likely that the incident took some place near the end of the CRIPA monitoring or post-CRIPA monitoring. Overall, it is apparent based upon participant responses that occurrences of sexual and physical abuse have decreased since the CRIPA investigation began, there is

concerning evidence that it has persisted since the end of the consent decree. The next section shifts into the issue of confinement, which the ADJC has struggled to remedy since its inception in 1990.

## **Confinement**

The CRIPA monitors investigation of the ADJC in 2004 found that officers had been inappropriately confining juveniles. More specifically, juveniles were held in separation units (i.e. solitary confinement) or held in their rooms for extensive periods of time. In some cases, entire units would be confined to their rooms as part of “large group” exclusions. The investigators noted that “over the explicit objections of mental health staff, one Catalina youth was confined in a Separation Unit for 33 days. Four other youth were confined in a Separation Unit for more than 18 days, again over the objections of the mental health staff” (Acosta, 2004, p. 18). Many of these lockdowns and separations were done without reason or documentation and in some cases led to juveniles “engaging in sexual behavior[s] and fights.” For example, a juvenile “who was very upset about the recent death of her mother was confined in the Separation Unit for three consecutive days. There was no documented justification for her isolation and, when we asked facility staff about this incident, no explanation whatsoever was offered” (p. 19).

In the first semi-annual report in 2005, the CRIPA monitors found that the agency was in significant compliance with the recommendation to have a due process hearing within 24 hours of a juvenile being placed in separation. They also determined that the majority of juveniles placed in separation are there less than 24 hours. However, the

agency was only in partial compliance of the requirement to implement best practices in separation and the development of policies that do not harm youth. One issue of note was the failure to rewrite separation policies that had been written in the 1990s, although it was acknowledged that these were slated to be rewritten prior to the next semi-annual report. The investigators were also concerned over the use of “slow down,” which was a practice used at Adobe Mountain where uncooperative juveniles were placed in a chair outside their rooms. This way they could be supervised while the group was also supervised. Some officers advocated for the practice as a “group management tool,” but the monitors remained concerned that “the use of such techniques needs to be continually reviewed since the use of exclusion or separation has, in the past, created management problems for this agency” (Hayes et al., 2005, p. 41). They report further concerns that practices like “slow down” are used for “staff convenience rather than group management.”

By the time of the sixth semi-annual report in 2007, the ADJC had come into substantial compliance with all requirements of the MOA. The investigators noted that visits to the separation units showed the officers were now following proper protocols and procedures. They further believed that the adherence to these policies was now plausible because of the efforts to now monitor separation. One issue that did appear to be a concern was that some juveniles were deemed “frequent fliers,” who accounted for the bulk of the time that separation was used for. They noted that this practice is concerning, as it is unclear if placement in separation is an appropriate response to misbehavior.

**Current Perceptions of the Use of Separation.** Another issue related to separation that concerned the DOJ investigators had been the practice of sending suicidal juveniles to separation, as this can lead to feelings of alienation. In the final CRIPA report, it was noted that only juveniles with the most serious risk of suicide would be placed in separation. Furthermore, separation was only supposed to be initiated after the juvenile had been seen by a mental health professional who decided on placement. The Auditor General's review of separations from March 2009 to May 2009 found that this practice was no longer being followed. Instead, the majority of juveniles with suicidal issues were immediately sent to separation because the mental health professional was either occupied with another juvenile or was not at the facility. When a mental health professional was not available for an evaluation, staff felt the juvenile would be safer in separation where constant monitoring would be standard. The auditors also found that many of the staff did not actually know that the proper procedures were to first allow the juvenile to speak with mental health staff. Instead they would immediately send the juvenile to separation.

Overall, ADJC employees were supportive of the new policies for placing juveniles in separation. Although some initially believed that the use of separation was acceptable because that was how they were trained, they later acknowledged the problems associated with long-term separation. In regard to the practice of large group exclusions, the ADJC reportedly no longer practices this form of confinement (Arizona Department of Juvenile Corrections, 2007a). Not a single participant remained concerned over the length of time that separation was being used for. Staff report that most juveniles are in separation for less than 24 hours and that it is a time for juveniles to

cool off. However, some did acknowledge the issue of juveniles who were “frequent fliers,” who were repeatedly going back to separation. In other words, even though the duration of separation has shortened significantly since CRIPA, there are still some juveniles who spend a lot of time in separation.

Some of the participants agreed with the use of separation for a variety of reasons, and were dissatisfied that the usage of separation had been limited following CRIPA. As noted in the earlier section detailing suicides, one participant noted that separation was useful for suicidal juveniles because they had more resources. Some educators were also concerned that separation could no longer be used for most problematic juveniles. Prior to the budget cuts, educators had the option of sending disruptive youths to Alternative Education (AE), but this was no longer an option. This means that teachers have extremely limited options in how they can respond to class disruptions. One participant discussed an incident where juveniles were yelling across a classroom to one another. Because they were not causing physical harm to themselves or others, they could not be placed in separation. This results in challenges for teachers who have standards to teach but are unable to conduct lesson plans because of interferences. The following section will further examine the challenges of providing education to an incarcerated population and how the ADJC responded to the requirements of CRIPA.

### **Education**

Following the CRIPA monitors’ investigation of the ADJC in 2004, they determined that “the facilities are in clear violation of the statutory rights of residents with disabilities by failing to provide these juveniles adequate special education



instruction and resources” (Acosta, 2004, p. 20). Six specific issues were noted including: poor screening of juveniles with special education needs, failure to provide individualized education plans, an insufficient number of special education teachers, related services were not provided (e.g. speech therapy), accommodation plans are not given to juveniles with mental impairments as is required by the Rehabilitation Act of 1973, and the department did not accommodate for the reading levels of special education youths in treatment programming.

In the first semi-annual report, the monitors reported that the ADJC had “made great strides to improve special education” and was in substantial compliance with multiple parts of the Memorandum of Agreement. The department made significant steps to hire special education staff and assist teachers in obtaining special education certificates, but by the first report there were still over 30 vacancies for special education positions. Other areas where the ADJC had made progress, but was only in partial compliance with the MOA included: all special education students need access to newly developed vocational classes, fostering involvement of parents with educational programming, and filling vacancies because this “will make it difficult to achieve compliance and maintain compliance” (Hayes et al., 2005, p. 48). The department was also out of compliance with developing protocols to communicate with local schools for juveniles upon reentry.

By the final report in 2007, the CRIPA monitors found that the department had been committed to creating sustainable changes and that the department had successfully hired an adequate number of staff, had developed and improved policies, and was better able to communicate with schools for the exchange of records. The issue of maintaining

an appropriate level of staff was an issue highlighted throughout the CRIPA agreement, and the monitors concluded that “sustaining compliance in this area requires on-going vigilance by central office administrators as well as school principals. ADJC education staff has demonstrated good attention to this provision of the Settlement Agreement” (Hayes et al., 2007, p. 30). One way that this has been accomplished is the department grew committed to retaining teachers by providing incentives, “staff development activities,” and modifying the school schedule.<sup>6</sup>

As noted above, there were six specific issues that the CRIPA monitors stated needed to be addressed with regard to education. Most of these issues were not touched on by the participants, instead the primary concerns of those at the ADJC concerned classroom sizes and ratios. These ratios particularly have impacted special education juveniles. For example, there are over 100 special education juveniles at the facilities, but only four teachers to provide special education to them. Special education students are placed in the same classrooms as other students, so the department uses a team teaching method where both teachers participate. Because resources are spread thin, special education teachers are typically only available in math and English classes. In many classes, the number of special education in a class makes it difficult to maintain quality.

Others report more general issues with class sizes. For example, one participant noted that classrooms

Are sometimes so crowded that you can hardly walk through them with all of the desks. It is also a safety concern that teachers don't want to walk through...Kids

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<sup>6</sup> The Auditor General did not address issues of education of confined juveniles in their 2009 report.

are now disengaged with the larger classes and it makes it more difficult when there are fights in the classrooms. The department says that the maximum classroom size is 20, but this is clearly not the case.

Others report that these classroom sizes allowed for mentorship and a true focus on teaching. Some classes now have up to 30 juveniles at one time.

In addition to classroom sizes, some participants report that the co-ed classes that were implemented as a result of budget cuts have been particularly challenging. While some participants felt this was a beneficial practice because it taught juveniles to engage with those of the opposite sex, it has also made providing education more difficult. Many of the girls in the facility reportedly have low self esteem and came from backgrounds of abuse, so when they are in classrooms with males they may go into a “protective mode because it is males that previously sexually assaulted them.” The girls can also be disruptive and in some cases have fought with the boys in class. It is apparent that many of the problems currently occurring in education surround the inability to maintain low ratios of teachers to students. Although many of the concerns that arose about education during CRIPA have since ceased, this has persisted and appears to be worsening over time.

### **Mental Health**

Providing mental health treatment at ADJC has been a challenge as evidenced by concerns raised in both *Johnson v. Upchurch* and CRIPA. During the initial DOJ investigation at the ADJC, numerous inadequacies in mental health care included “inadequate group and individual therapy, interventions, interdisciplinary communication, and discharge planning” (Acosta, 2004, p. 31). Most notably, the

investigators found that individualized treatment of juveniles was neglected in favor of group therapy. This was even more concerning when it was “painfully apparent that, while the facilities’ staff were well meaning, they did not have sufficient training to lead groups in a therapeutic manner” (p. 32). One reason for the limited use of individual therapy is that the program used at the time was designed for sex offenders, which are not representative of the general population of ADJC. The limited staff and resources resulted in a “one size fits all” method that had been very ineffective. A second issue was that the agency was not providing a therapeutic milieu (i.e. “staff deliberately plan and structure a youth’s interpersonal and physical environment” (p.33)), as had been claimed. The failure of staff to recognize suicidal behaviors, and in some case to encourage suicidal behaviors, suggested that the therapeutic approach had not been implemented. Third, these issues were exacerbated by the fact that there was poor communication between staff responsible for treatment. Fourth, discharge planning documentation was very limited and did not include “information regarding a youth’s mental status, educational level, placement, or progress summary” (p. 34). Finally, the CRIPA investigators noted overall satisfaction with psychiatric services, but did note that there was little monitoring following the use of a medication that had serious side effects.

The first semi-annual report showed that the ADJC was in substantial compliance with only one area of the mental health requirements of the MOA—hiring a Deputy Director tasked with overseeing mental health treatment. The investigators determined that the ADJC was in partial compliance with the three remaining areas. First, the department was lacking in implementing appropriate mental health and treatment for juveniles. The investigators remained concerned because officers with little to no

experience in mental health care were running therapy groups, there was a lack of Spanish speakers to provide therapy to Spanish speaking juveniles, therapy sessions were rarely conducted because psychology associates were given too many responsibilities, separation was being improperly used, mental health professionals were being supervised by those with no mental health experience, there was poor documentation, and juveniles in restraints were not assessed by nurses. Furthermore, the department had yet to fully develop and implement a program for quality assurance to monitor mental health treatment. Nevertheless, the CRIPA monitors recognized that the ADJC was making important steps to remedy many of these issues.

By the final semi-annual report in 2007, the CRIPA monitors had found that the ADJC was in substantial compliance with all of the previous recommendations made regarding mental health treatment and rehabilitation. The department was able to come into compliance with the requirements of the MOA because of new staff being hired, improved intakes and assessments, and better monitoring of juveniles on psychotropic medications. They concluded that “the complexities of everything that has gone into these treatment plans are quite impressive...As time progresses, using the information at hand to develop well-structured plans regarding education, mental health, behavioral interventions and transitions to the community should be the ultimate goal. The current plans are currently going in that direction” (Hayes et al., 2007, 44). One issue that did raise some concerns was that there had been much turnover in mental health staff, which could potentially lead to inconsistencies in treatment or derail the progress that had been made.

## **Recent Perceptions on Providing Mental Health Treatment**

The Arizona Auditor General's Performance Audit of the ADJC's rehabilitation and treatment programs found that the ADJC was using best practices, but they concluded that their "delivery needs improvement" (Office of the Auditor General, 2009b). More specifically, "treatment programs do not adhere to program design," "treatment frequency and duration do not meet expectations," "customized elements of core treatment program not provided," "poor behavior management disrupts treatment," and "specialty treatment not consistently provided to all who should receive it" (p. 12). For example, in "only one of the eight core treatment groups auditors observed had juveniles who substantially cooperated and participated. No group was without disruptive behaviors, and four were significantly disruptive, with constant discussions, shouting, or other negative behavior that distracted treatment...During one core treatment process group, juveniles talked back, ignored redirection, and called the group leader a 'loser'" (p. 16). In most units, staff were unable to redirect juveniles who were overly disruptive, which made treatment extremely difficult. Several recommendations were made so that the ADJC could continue providing quality care for juveniles. These included: "department needs to follow treatment programs' designs," "department should develop adequate program guidelines," "department should enhance staff training," "qualified professionals should deliver treatment," and "better monitoring and evaluation of treatment delivery" (p. 20). Many of these issues parallel those that were raised during the CRIPA investigation, including the poor delivery of services and inappropriately trained staff providing treatment.

Mental health treatment at ADJC also received criticism from ADJC employees, county court representatives, and juvenile justice advocates because of concerns that providing mental health treatment in correctional facilities is inappropriate. In other words, the overall disdain for mental health services at ADJC was not directly related to the quality or quantity of services; instead it was the result of more general perceptions of where juveniles are best rehabilitated. Many suggest that the placement of certain juveniles in the ADJC has been the result of few mental health treatment options in the state of Arizona. One such option for housing and treating juveniles with severe mental health issues was the Arizona State Hospital (ASH), but this facility close in 2009. Following the closure of ASH, participants questioned whether juveniles were being inappropriately placed at ADJC. For example, one participant suggested that

we need some kind of ASH-like facility. Our youth here would overrun staff at a hospital because they commonly have the unique combination of substance abuse, mental health issues, and delinquency. ASH didn't have the staff for corrections whereas here [at ADJC], they are less focused on medicine and more on corrections. This is a disadvantage because they don't have a full medical staff at ADJC. For example, they can't do sedation in case a kid gets out of control. Here they can be restrained. There is now a criminalization of the mentally ill....So without ASH, youth don't have a lot of other options and ADJC becomes the treatment provider of choice. This becomes the place of last resort. Do I believe some of those youth should be here? No, but there are no other options in the community. Here they give safety and security their due.

One ADJC administrator echoed this same sentiment in a local news article by stating that "it's not an appropriate place for these kids. Those kids that are significantly mentally ill, they end up decomposing here...You're seeing the justice system becoming almost the new asylums."

Despite the overall reticence that many juvenile justice practitioners have about juveniles being treated in a correctional facility, the ADJC still must provide quality

services aimed at rehabilitation. Interviews for the current study revealed mixed feelings towards how the CRIPA reforms to mental health have been sustained. One concern that was raised in the Attorney General's report was that treatment materials for the mental health programs were not actually being used in therapy. It was found that "none of the nine housing units auditors reviewed provided the expected, customized core treatment" (Office of the Auditor General, 2009b, p. 14). This sentiment was expressed by numerous participants who are currently employed at the ADJC. One such program is New Freedom, which is supposed to be provided to all juveniles, while more specialized treatment is given to at risk populations (e.g. sex offenders, drug addicts). New Freedom provides workbooks and activities to juveniles focused on self-discovery, self-awareness, skill building, and reintegration.

The program was criticized by both juveniles and staff because it was repetitive, expensive (i.e. staff had to make copies of each of the 174 packets for juveniles to complete), boring, and was written at a 6<sup>th</sup> grade level that insulted some of the juveniles. As a result of these issues, the department is getting rid of the packets. What the department "tries to do now is differentiate between the letter of the law and the spirit of the law and look at the theme of the packet. They will then talk and journal about an idea so they can digest information." They now have the chance to "take the best of those packets and use those as a base and pull in other resources." Some like this new flexible approach because it is less repetitive and can be more customized.

Shortly after the consent decree was lifted on the ADJC, the Great Recession occurred. As a result, multiple staff, especially those in more specialized positions (e.g. therapists, clinical staff, psychologists), either quit or were laid off. The response of the



ADJC to the recession and shifting roles will be discussed in more depth in the next chapter, but it is important to note that the loss of certain positions made it difficult for the agency to provide all services. For example, substance abuse treatment had “languished for a bit” when they lost a key staff member that provided services. At one point, the agency was providing mental health treatment to Catalina Mountain through video conferencing with Adobe Mountain staff. Although the juveniles were not complaining over this, some staff reflected the importance of providing personal interactions. These budgetary constraints may also be impacting treatment for females as well. One participant noted that the “mental health girls are getting lost in the shuffle” mostly because the boys are getting more resources. Related to this issue, multiple respondents noted that the training of staff in the mental health unit is inadequate.

It is apparent that the ADJC has been doing the best they can to provide mental health services in a less than ideal environment. The department has also struggled to keep qualified and trained staff in light of severe budget cuts. Recent reports have criticized the department for its failure to maintain enough mental health professionals and the lack of adherence to well developed treatment programs. At the same time the department was reforming mental health, sweeping changes were also made in medical treatment at the ADJC. The next section will examine the initial problems and current status of health services.

### **Physical Health**

Finally, the CRIPA investigators’ initial investigation revealed that the ADJC was providing inadequate medical care to confined juveniles. Medical treatment was

described as “grossly deficient and exposes youth to significant risks of harm” (Acosta, 2004, p. 25). First, the investigators found that nurses were inadequately documenting vital signs and basic information regarding health, which are standard nursing practices. One example of this practice was a juvenile who had reported “seeing stars” after being restrained by staff. This juvenile never had vital signs or a neurological exam documented, making it unclear whether or not these practices occurred or not.

Medical staff were also not available for seven hours during the night shift, with the director being on call during that time. The monitors concluded that “the absence of medical staff during the overnight shift, coupled with the lack of training for unit staff, places youth at serious risk” (Acosta, 2004, p. 28). The problem with this situation was highlighted in an incident at Black Canyon School in 2002 when a girl fell and hit her head. Medical staff during the day suggested that the girl be checked every 30 minutes. Later that night,

The youth was found disoriented and difficult to arouse. The on-call medical provider instructed that the female unit staff perform breastbone thrusts to rouse her. Such an over-the-phone medical consult ordering chest thrusts is a clinically unacceptable practice and a potentially dangerous treatment for the youth. Once the chest thrusts were done, the youth became more alert, but within 25 minutes began vomiting and shaking. The youth was then transported to the community hospital. Our review revealed no documentation that the youth had been checked every 30 minutes. Moreover, because unit staff lacked training to take vital signs, they were unable to provide that relevant information to the on-call medical provider. (P. 28)

Some of these issues also spill over into the day shift, as it is reported that short-staffing has occurred.

The monitors also found that the distribution of medicine has been “woefully inadequate.” In numerous cases, juveniles were not observed swallowing their

medications by nurses, which made it possible for them to “cheek” their medications. This allowed them to later barter the pills and in some cases resulted in juveniles overdosing on a stockpile of medications. Poor documentation of medication distribution also made it unclear what medicines had or had not been given out.

Other issues that were noted included inadequate dental care at Catalina Mountain, the lack of a quality assurance program to monitor staff, and the lack of an infection control program. Furthermore, the department only employed one pharmacist based at Catalina Mountain who was not involved in a Pharmacy and Therapeutics Committee. The monitors argue that a committee is important for management of medication because they are responsible for “reporting and monitoring adverse medication reactions and errors, making decisions on the facility formulary, developing and reviewing treatment guidelines and protocols, developing medication policies and procedures to meet regulatory standards, and conducting drug use evaluations” (Acosta, 2004, p. 31).

By the first semi-annual report in 2005, the monitors determined that the medical system was in substantial compliance in half of the noted issues in their investigation. The monitors appeared highly satisfied with the direction the medical staff was taking in ensuring documentation. In fact, one of the monitors acknowledged that there were likely documentation procedures in place that he had not reviewed, suggesting that this issue could have been over emphasized in the initial investigation. The department had also reportedly implemented system “for the pharmacist to document alerts to the physicians regarding information about any youth’s medication issues” (Hayes et al., 2005, p. 54).

One issue that remained a concern was the employment of an adequate number of nurses. This included the lack of a nurse manager at Catalina Mountain. The reason for these deficiencies was that the

reimbursement for staff nurses were below what their counterparts at the state hospitals received and as such, even though they had positions available which potentially could care for their shifts, these positions were not filled. In addition, strong concern as expressed as when they were able to get agency nurses to fill in, they could only fill in half of the needed spots due to the cost of agency nurses. (Hayes et al., 2005, p. 52)

However, it was noted that recent salary increases and bonuses served as incentives to fill these positions. A second issue of concern was that nurses needed to adopt better practices for handing out medications, as they were not maintaining confidentiality or warning about side effects. Third, one issue that had recently been remedied was the practice of males performing pap smears on females, as a female doctor was assigned to complete all pap smears. Also, the monitors reported no concerns with dental and that juveniles were being seen consistently. Finally, the department still needed to establish a system for quality assurance.

By the final report, the monitors had declared the ADJC was in substantial compliance with all of the required changes to medical care. The review of the progress made in medical care was positive. They found that “after interviewing a multitude of staff, reviewing pertinent files, reviewing policies and procedures, there has been wonderful growth and stability regarding medical service and service delivery. There are some staffing concerns which continue to be addressed in a consistent manner” (Hayes et al., 2007, p. 36). These problems had been somewhat remedied by the end of the consent decree. For example, Black Canyon and Catalina Mountain were only allocated 280

hours per week for nurses. The actual number of hours worked in these facilities exceeded the original about by about 100 hours, so an “outside evaluation” had been tasked with determining the appropriate number of hours. Furthermore, the department had been able to hire an additional nurse and a new medical director to help fill in staffing gaps. The department was also able to finally provide 24/7 nursing care in the facilities.<sup>7</sup>

Research participants had overwhelmingly glowing reviews of the medical treatment of juveniles at ADJC. In fact, participants could only point to relatively minor issues with medical care (e.g. juveniles are removed from class for medical treatment), and none pointed to the serious issues that had been identified during CRIPA. Nurses are now available 24 hours a day, 7 days a week, as was suggested in the MOA. When asked about the quality of medical treatment, typical statements were: “medical is doing a good job,” “nurses do a good job and see kids quickly after they have a sick call,” and “I have no concerns over medical care. Similar statements were made about dentistry at the agency. One issue discussed by one participant was that there is not a full medical staff at ADJC, so they are unable to do certain practices that are available at mental health facilities (e.g. sedation). Nevertheless, this was not one of the issues raised in CRIPA and appears to be more a limitation on legal abilities than on performance.

Others raised concerns that the budget cuts have made it difficult to hire and retain medical staff. For example, when the Governor of Arizona was considering closing the ADJC many medical staff left for more secure jobs, including the pharmacist.

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<sup>7 7</sup> The Auditor General did not address issues of medical treatment of confined juveniles in their 2009 report.

As a result the department hired a temporary pharmacist who became so frustrated with the computer system that he quit. The department was able to hire a pharmacist after this, but it was reported that the department has had to do some “creative things” to keep everything functioning properly. Compared with many of the other areas reformed under CRIPA, the changes made in medical appear the most successful and well received.

### **Examining Why Change Occurs**

The current chapter has examined five general areas that were reformed in response to the CRIPA intervention at the ADJC. Since the end of the consent decree between the DOJ and ADJC ended in 2007, the department has overwhelmingly been able to comply with the bulk of modifications that were required in the Memorandum of Understanding. Despite the positive reform over the past ten years, there have also been important deficiencies that have marred the ADJC’s progress. These include sexual abuses by staff and juveniles and the completed suicide of a juvenile in 2010. The following chapters will examine why the department has been able to maintain these changes, with direct comparisons made between the first consent decree in 1990 and the second in 2004. Chapter 5 will specifically focus on the cultural transformation that occurred during CRIPA and has continued to this day. To provide context to more recent changes, an in depth examination of the formation of the agency is first conducted. Specific issues to be discussed will include the conflicting ideologies guiding the department, how the recent fiscal crisis has impacted the agency, and the current direction of the ADJC. Chapter 5 will highlight deficiencies that have resulted in many of the problems noted throughout the current chapter.

## Chapter 5

### Reforming Institutional Culture through CRIPA

Correctional institutions have historically been plagued by poor conditions and the deprivation of civil liberties. Many facilities where conditions have become so severe have been forced to reform under federal lawsuits. One area that is frequently examined when making such reforms is the culture of the organizations. Maintaining a strong institutional culture is essential for ensuring the safety of officers and inmates and contributes to the rehabilitation of inmates. Correctional facilities that have been successful at maintaining reforms “require an organizational culture that is committed to ‘change rather than stability’” (Johnson, 1996, 259). Such changes must occur on the part of both leadership and line level officers. However, forcing institutional cultures to reform through litigation has been particularly challenging because of difficulties in pinpointing cultural aspects that have led to abuses (Brooks, 1996). An important aspect that has shaped many prison cultures is the philosophy of either treatment or rehabilitation that guides institutional management.

One such institution is the Arizona Department of Juvenile Corrections, which was under a consent decree with the U.S. Department of Justice from 2004 to 2007. The ADJC has had a long and storied history with considerable conflict. Appendix 5 presents a timeline of this history from when juveniles were monitored under the adult system, to the first consent decree under *Johnson v. Upchurch*, the second consent decree under CRIPA, and the subsequent reforms of the agency. As a result of the CRIPA consent decree, the agency set about to reform nearly all aspects of the department, from responses to suicidal juveniles to mental health treatment. During this time, the agency

was monitored by four Federal investigators who determined if the ADJC was in compliance with over 100 required changes. Once the ADJC was in compliance with all aspects of the consent decree, the consent decree had to be lifted. This meant that beginning in 2007, the ADJC was no longer being monitored by the federal government or any other agency that it was responsible to. In other words, the ADJC could potentially begin depriving juveniles of their civil rights, just as it had following the *Johnson v. Upchurch* consent decree. In order to prevent a third lawsuit from occurring, ADJC administrators during the time of CRIPA set out to fully reform the culture of the agency. The current chapter examines the culture of the agency over time to determine if meaningful changes have occurred. First, the culture of the ADJC prior to the CRIPA intervention will be studied, and will then transition to how the culture changed during the intervention, and will conclude with how the culture reformed after the monitoring ceased.

### **Formation of the Arizona Department of Juvenile Corrections**

The early foundation of the ADJC began in 1901 with the formation of the Territorial Industrial School in Benson, AZ and later a school in Fort Grant, AZ in 1927 (ADJC History, 2009). During this period, responsibility for delinquent and criminal juveniles was given to the Superior Courts. With the establishment of the ADC in 1968, juvenile corrections came under the jurisdiction of the adult system. The facilities that would eventually be used by the ADJC to house boys and girls were subsequently built, with Catalina Mountain School of Tucson opening in 1967, Adobe Mountain of Phoenix



in 1972, and Black Canyon of Phoenix in 1988. These facilities are referred to as “Safe Schools” by the ADJC.

Public reports of misconduct and violence at the juvenile facilities were rare until the late 1980s. One notable exception was the murder of Officer Paul Rast in 1975 by three juveniles at Adobe Mountain School (ADC Staff Killed in the Line of Duty, 2012). However, it was not until the reported mistreatment of a young boy named Matthew Johnson in 1986 that brought the Arizona Department of Corrections into a national spotlight for the handling of juveniles (*Johnson v. Upchurch*, 1986). The *Johnson v. Upchurch* suit lodged against the Superintendent of Catalina Mountain and others at the ADC ultimately led to a class action lawsuit. The suit alleged that solitary confinement cells were being used for months at a time, there were poor conditions in the confinement cells, staff denied services and treatment to those in solitary confinement, staff improperly used handcuffs, staff were using cruel and harsh punishments, youths were denied appropriate medical treatment, educational services were inadequate, and youths were inappropriately placed based upon their needs. For example, some of the plaintiffs in the suit reported that they were confined for so long in their cells and had been denied use of the restroom that they were forced to urinate and defecate on the floors. Those in separation, or solitary confinement, were also frequently denied the same educational resources as other youths, denying them the ability to complete the Graduate Equivalency Degree Examination.

It was clear that the agency was going to lose the lawsuit (Bortner and Williams, 1997). One of the solutions brought forth by ADC administrators and the Governor to remedy the lawsuit was to separate the juvenile system from the ADC, a decision that

was eventually approved. The separation from the adult system also occurred in part because of the difficulty in providing resources to juveniles when the primary focus of the ADC was that of adult corrections. As was reported by those employed at the ADC and community advocates who were involved with the decision to separate the agencies, both financial and staff resources would frequently be diverted from juveniles to adults. For example, one employee noted that the “juvenile side was only a tiny portion of the agency and they weren’t providing proper training for officers to be working with juveniles. One problem was an officer could work on the adult side for a few days, then would work on the juvenile side for a couple of days.” The director of the ADC and the Governor of Arizona, Rose Mofford, were supportive of the decision to separate the agencies.

### **Culture of the ADJC Prior to CRIPA**

The events following the separation of the juvenile and adult correctional systems in Arizona contributed to a negative departmental culture. The first director of the agency was appointed from the ADC and many of the officers who had once primarily worked in the adult prisons were allowed to transition to the juvenile system (Christian, 1993). Prior to the formation of the ADJC, all staff received similar training which resulted in juveniles being treated like “mini adults.” For the present study, approximately one-fourth of the participants expressed concerns over this practice because they had heard rumors that the bad administrators and officers had been “dumped” on the ADJC “to get them out.” Many felt that the correctional environment of the first officers and administrators of the ADJC had carried over, allowing for a

culture where juveniles were readily subjected to abusive conditions. One ADJC employee noted that following the split “it was a strange mixture and some of the clinical staff had begun to buy into what the more crime control staff were putting out there.”

Shortly after the establishment of the Arizona Department of Juvenile Corrections on July 1, 1990, the agency changed its name to the Department of Youth Treatment and Rehabilitation in mid-1991. During this time, John Arredondo from the Texas Youth Commission (now named the Texas Juvenile Justice Department) was appointed as director to continue the department’s new focus on treatment and rehabilitation. The second director began to take action towards meeting the requirements of the *Johnson* consent decree. Christian (1993) reports that under the advisement of Arredondo, the Governor’s Task Force overseeing the reforms “began to enjoy a true partnership with the Department for the first time” (p. 14).

However, his methods of bringing rehabilitation to the ADJC were strongly criticized. On the one hand, some believed that Arredondo was bringing much needed programming and treatment to the agency, while others felt that his methods were extreme and ineffective. The strategy Director Arredondo adopted was to improve individual units by devoting resources to specific units. An ADJC employee at the time noted that “he rewarded those who shared in the ideals of his team and the new system” with resources, remodeling their units, and a van. Some units and staff reportedly began to adopt a philosophy of rehabilitation because they observed the benefits they would receive. However, not all employees were as accepting of this practice. One long time employee noted that Arredondo’s strategy resulted in animosity between the staff who were the “chosen ones” and those who did not receive the rehabilitative programs.

Another tactic used by Arredondo to make the ADJC less corrections oriented and more rehabilitative was to take officers out of uniforms and have them wear polo shirts. This practice was also met with disdain from many officers. Juvenile justice advocates characterized Arredondo as doing an “impossible job” because he did not receive external support from the governor or internal support from employees.

Some of the methods used for rehabilitation were poorly received by many employees whose punishment and treatment philosophies contrasted with the director. A county representative noted that

The culture of the officers was one of the major reasons why Arredondo was not successful at providing a rehabilitative model. Arredondo would be confronted by small groups of people who had links to the legislature saying that he was running the institution poorly and that he shouldn't be coddling the kids. There was the feeling that next the kids would be having color TV's in their cells and other luxuries. He came in with the concept that the state was sincere about instituting reforms, but was confronted with an impossible culture that did not want such reforms.

Others described the agency as being split and corrections oriented. Some of the officers reportedly reviled treatment providers and believed that treatment was “stupid.” Despite a push from juvenile justice advocates to bring more rehabilitative services to the agency, the director of the ADC who still had a strong influence on the ADJC and the ADJC superintendent of facilities disapproved of the new direction.

One of the most blatant examples of the clash between the methods used by “old” and “new” employees was the controversy over a play that was performed for the juveniles (Sowers, 1994; Swenson, 1994). In late 1993, a church group was permitted to enter the “safe schools” with real weapons and allowed to perform a graphic play depicting multiple criminal acts including gang and sexual violence. After ten employees

raised issue over the play to the director and Governor of Arizona, one correctional officer was suspended for complaining about the incident. The inappropriate suspension of the officer, concerns over weapons in the facilities, and the director's requests for more state funding, led the Governor to encourage the resignation of the director. Following Arredondo's resignation, Eugene Moore from Arizona's adult prison system was appointed as director in 1994.

The move from a director who was, for the most part, focused on the rehabilitation of juveniles to a director experienced with the confinement of adults signified a growing focus in Arizona on treating juveniles from an adult perspective geared towards punishment. The changing sentiment towards juveniles in Arizona was solidified in January of 1995 when, "a bill renaming Arizona's juvenile justice agency was approved...changing the Department of Youth Treatment and Rehabilitation back to the Department of Juvenile Corrections [because] Governor Fife Symington wanted a name that reassures the public its safety is uppermost" (Noyes, 1995, p. 1B). The Governor also wanted the "'automatic transfer' of juveniles, which would send all teens accused of violent crimes to adult court...and suggested moving juvenile justice from the court system to the executive branch" (p. 1B). Voters in Arizona approved of the punitive treatment of juvenile offenders by allowing for more transfers to adult court in 1996 (ADJC History, 2009).

By the mid-1990s, the direction of the ADJC was questioned by both employees of the agency and counties that placed juveniles there. Many raised concerns about the multiple changes in the name of the agency. However, ADJC employees appeared less concerned with the name change and referred to the name as "a window dressing" and

stated that the “name doesn’t matter.” In contrast, county and community representatives made statements along the lines of “these changes formally and informally signaled the shift from a rehabilitative to a crime control model” and “a new message was put in place that there was a new way for the department to be run.” One ADJC employee noted that “a number of factors contributed to this including: internal issues with directors, the national outcry against juveniles in the 1990s, partly symbolic, and the newly appointed director, Eugene Moore, had received direction from the governor’s office to bring back to the middle.”

These shifts in both departmental administration and ideologies were occurring as federal monitoring resulting from the *Johnson v. Upchurch* consent decree was playing out. Signed in 1993, changes required under the consent decree included: improvements to risk assessments instruments, adherence to maximum capacities of institutions, increased programming (e.g. substance abuse, sex offender treatment), implementation of a “continuum of care,” and the evaluation of treatment effectiveness (Christian, 1993). To achieve compliance with the consent decree, the Governor of Arizona diverted resources to the agency, federal monitors evaluated the “safe schools,” and agency administrators began implementing the required changes.

In late 1994, “the monitors said the state ha[d] met population reduction standards in the past 18 months, but they remained concerned about officials’ commitment to provide juveniles with a full range of treatment” (Federal Monitors: State’s Youth Correctional Facilities Improving, 1994, p. 3A). These concerns were not unfounded, as numerous reports during the time the agency was under the consent decree indicated that the agency had failed to resolve the issue of overcrowding. Reports suggested that the

“safe schools” were so overcrowded that a federal judge announced population caps, fines were imposed on the agency, and the ADJC was eventually forced to begin releasing juveniles to comply with the caps (Cook, 1997; Federal Judge: No More Juveniles to be Put in State’s Juvenile Centers, 1996; Juvenile Corrections Plans to Defy Judge’s Order on Population Cap, 1997; McKinnon, 1997). Less than two months after the department was fined for overcrowding, the population was reduced and the ADJC became in compliance with the consent decree (Dougherty, 1996). The consent decree was then allowed to expire in 1997 and the ADJC was no longer under federal monitoring (Rotstein, 1997).

### **Failure to Reform Leads to Federal Investigation**

Immediately following the resolution of the consent decree in 1997, few reports were made regarding poor conditions at the ADJC. Of those that referenced continued problems, issues apparently stemmed from overcrowding, as the agency sought alternatives to confining youths in the “safe schools” (Cook, 1998a). One such alternative that was met with much controversy included housing youths in an adult prison in Tucson (Cook, 1998b; Correction Plan Irks Judge: Proposal Would Temporarily House Juveniles in Prison, 1998). Other reports suggested that the agency was making positive reforms by opening facilities for parole violators to be re-evaluated at the safe schools (ADJC History, 2009) and had reduced recidivism rates (Few Juvenile Delinquents are Back in Custody a Year Later, 1999). During that time, the Arizona Legislature allowed for the elimination of an advisory board that was created during the consent decree to monitor the agency (Silverman, 2001a).

Eight months after the *Johnson* consent decree expired, ADJC's Deputy Director, David Gaspar, was appointed as the next director of the ADJC (ADJC History, 2009). At the time of his appointment, Director Gaspar had a 20 year history of working in corrections and had been involved in mental health treatment in Tucson. This experience was lauded as important in an agency that was seeking to reform. As reported by the ADJC, "Director Gaspar continued the ambitious reform agenda that led to completion of *Johnson v. Upchurch*" (ADJC History, 2009).

In contrast to the perspective of Director Gaspar put forth by the ADJC, the overwhelming majority of respondents participating in the current study strongly felt that his direction harmed the agency. For the most part, current and former ADJC employees, county court representatives, and community advocates perceived Director Gaspar as an ineffective leader who was unaware of what was occurring within the agency. Statements like, "it was rare to see him come out of Central Office," "I would rarely see him," and "it was a big event for the director to go out to the facilities" were typical. Many were hopeful that the Director's experience with rehabilitation and corrections would set the agency on the right path to continue reforming and providing humane conditions for juveniles. Very quickly perceptions of Gaspar shifted, as he became viewed as "a snake oil salesman who was giving the perception he would focus on rehabilitation but was not."

Opinions were mixed about how much responsibility was placed upon Gaspar's shoulders for the CRIPA consent decree. On one hand, some believed Gaspar was the primary reason why conditions at the ADJC quickly declined following *Johnson v. Upchurch*. Some felt that the short time between Gaspar being appointed director and



juveniles committing suicide suggested a correlation and not a causal relationship. Part of the reason for the disenchantment with Gaspar was that what he was saying publicly about the success of the facilities didn't always coincide with how juveniles were reportedly being treated behind the fences. Participants felt that they had been "snookered" and "bamboozled" because Gaspar would report that no problems occurred at the ADJC and that it was a model agency. For example, one participant noted that "the CRIPA hit the judges and others by surprise. They felt they had been snookered by Gaspar. It was commonplace to have ADJC meet with the judges. At the meetings Gaspar had said they had made so much progress, they were now a model agency, and how they had such a great system." Because Director Gaspar had put so much faith in the leaders of institutions and rarely visited the facilities himself, he too had a limited perception of the institutional conditions. He had assumed that officers would correctly carry out their responsibilities, but the quick decline in conditions indicated this was not occurring.

Gaspar's lack of knowledge of what was really happening made some participants feel slightly sympathetic towards him because he had good ideas that were never able to get off the ground. Some county representatives also speculated that there was a poor institutional culture that pre-dated Gaspar's term as director that made it difficult for him to gain the support of his staff. For example, it was speculated that "the majority of the problems [were the result of] the culture, but Gaspar also should shoulder some of the responsibility for the problems that happened under his watch. He did make efforts to change the culture...but Gaspar was faced with a culture that didn't want to change."

The lull in reports of abuse and poor conditions at the ADJC was short lived. Four years after the consent decree was lifted and federal oversight vanished, countless reports began surfacing of serious problems at the agency. A series of articles published in the *New Times*, a local Arizona newspaper, by Amy Silverman revealed that problems had persisted with little public attention despite a reform that had lasted nearly a decade (Silverman, 2001a, 2001b, 2001c, 2001d, 2001e, 2001f, 2001g, 2002a, 2002b, 2002c, 2002d, 2002e, 2003a, 2003b, 2003c, 2004, 2006, 2009, 2010a, 2010b, 2010c). Silverman (2001d) reported that advocates who had raised concerns previously “assumed all was well under Gaspar, whose extensive background in corrections and mental health treatment made him a natural to lead the agency” (p. 2). Following a lengthy investigation, Silverman found that the “ADJC no longer follows the practices put into place by a federal court order in 1993 that were designed to ensure that proper conditions are maintained for youth in detention” (p. 1). These failures included youths being held in separation for long periods of time, youths being kept in their rooms for long periods of time, poor mental health services, increased staff-to-youth ratios, improper use of violence by staff upon youths, sexual abuse by staff, and poor supervision. One internal memo uncovered in the investigation revealed that in 1999, less than two years after the consent decree was lifted, a youth rights ombudsman for the agency informed the director of the excessive use of solitary confinement and improper housing. Silverman concluded that “in many cases, children detained in Arizona are treated more harshly than their adult counterparts in the state” (p. 2). Silverman’s series of reports once again brought the ADJC to the attention of the Justice Department.

Concurrent to the release of the Silverman articles, many ADJC administrators, legislators, and individuals from the Governor's office were reporting that the agency was still in compliance with the court order. For example, one member of the AZ Senate Judiciary Committee had claimed that "nothing's wrong at the ADJC, [which he knows] because he's toured Adobe Mountain School" (Silverman, 2001, p. 3). An ADJC administrator made similar claims, stating that the agency had improved tremendously after *Johnson*, in large part because millions of dollars were invested in the agency, and that the department had continued to experience improvements (Silverman, 2001f). The director of the ADJC in early 2000 further acknowledged the increased use of mental health and substance abuse programming and the hiring of new employees. The positive reforms that were touted by the agency and government even led to the nomination of the director of ADJC for the American Correctional Association Board of Governors, where it was stated that the ADJC was a model for juvenile justice programs (Candidates for the 2002 ACA Election, 2002).

By late 2001, the abuses uncovered in the Silverman articles raised concerns with community advocates and monitors from the *Johnson v. Upchurch* case, with one monitor stating that "I think they need an outside agency to come in once again and review procedure" (Silverman, 2001d, p. 1). The concerns that had been raised since *Johnson* came to a head in April of 2002 when the first of three juveniles within a one-year period committed suicide at the ADJC. Already on the verge of a federal investigation because of the *New Times* series, the three suicides led to the DOJ investigation under CRIPA. Following investigations by consultants in late 2002 and early 2003, the DOJ concluded that "certain serious deficiencies at these facilities violate

the constitutional and federal statutory rights of the youth residents” (Memorandum of Understanding, 2004, p. 2). The ADJC subsequently entered into a consent decree with the DOJ to remedy these issues.

The fact that the ADJC was placed under federal monitoring within just a few years after reforms under another consent decree suggests that changes were either not adequately made or were not effectively institutionalized into the departmental culture. Christian (2010) argues that one reason for the lack of effective reform was because, “the legislation...aimed at treatment...passed in Arizona because we had a lawsuit. We had not changed the hearts and minds of our citizens” (p. 42). Similarly, many ADJC employees reported that the culture of the agency had changed very little. During the initial years of the ADJC, it was evident that an institutional silo mentality had developed across the agency. There was reportedly minimal communication occurring between the various service providers in the institutions (e.g. mental health, education, line staff). ADJC employees expressed frustrations that these silos had developed and remained following the *Johnson* consent decree, but there appeared no remedy to mend the distance between staff. One potential solution would have been to implement a system of checks and balances to ensure that staff had to comply with changes in policies and practices, but this was not the case.

One ADJC employee stated that reports of abuse began surfacing quickly after the *Johnson* consent decree ended. The reason the reforms to the agency had been unsuccessful was because the ADJC

Didn't change the culture of the agency. Staff never really accepted a new way of business. Once they stopped being under the monitor, they didn't have a system in place to monitor the agency. Many of the issues would get to the

superintendent and were not passed on to inspections and investigations. There were no checks and balances at all and what was happening in the institutions was all a matter of trust that it was going right. There was not a lot of emphasis on procedure.

Additionally, background checks were not being done on incoming employees, leading to a poor quality of officers who were hired to supervise juveniles. In fact, there was reportedly a joke in the department that “you could just tackle someone outside the fence and if they were breathing you could hire them.”

### **CRIPA Forces ADJC to Reform Culture**

During the time the CRIPA investigators were conducting tours of the ADJC in October of 2003, Governor Janet Napolitano replaced Director Gaspar. Napolitano was reportedly very concerned about the CRIPA and treatment of juveniles, so she “made it a priority to fix the ADJC.” As a result, she heavily invested resources into the agency and formed a task force of community advocates and correctional experts. The goals of the task force were to “provide oversight to the Department of Juvenile Corrections on the implementation of the recommendations in response to the CRIPA report and advise the Department on broader juvenile justice system issues, including cross system integration, youth reentry into the community, and the possible formation of an external review process for youth committed to ADJC.” She also decided not to fight the CRIPA lawsuit and willingly set about to make the changes within the agency. Multiple administrators were hired from outside of Arizona because of their experience with correctional reforms and juvenile justice.

A search committee made up of ADJC employees and community advocates decided upon hiring Michael Branham as Interim Director and Dianne Gadow as Deputy Director. Although Director Branham had planned on staying with the agency until a new director was officially appointed, he eventually accepted the position of Director. Director Branham was reported by the ADJC to be “the guiding force behind the department’s organizational culture change. This transformation is the foundation in building a solid organization which provides a safe and secure environment while addressing treatment, education, and rehabilitative needs for youth committed to ADJC.”

Prior to his tenure as Director, Branham had a thirty-year career in law enforcement and had minimal correctional experience (Arizona Department of Juvenile Corrections, 2011a). He was also the Executive Director of the Arizona Criminal Justice Commission (ACJC). This commission serves

As a resource and service organization for Arizona’s 480 criminal justice agencies on a myriad of issues...[It also] works on behalf of the criminal justice agencies in Arizona to facilitate information and data exchange among state-wide agencies by establishing and maintaining criminal justice information archives, monitoring new and continuing legislation relating to criminal justice issues and gathering information and researching existing criminal justice programs. (Arizona Criminal Justice Commission, 2013)

This means that his experiences were not just limited to law enforcement, but that he had the capability of dealing with a variety of situations and was familiar with legislators and policy makers. These skills and relationships helped him considerably in responding to the challenges of the CRIPA.

The overwhelming perspective among respondents participating in the current study was that someone so committed to law enforcement would not be able to transition into a correctional setting with juveniles. On the one hand, these fears were confirmed

when Director Branham began using policing type strategies to gain control of the agency. For example, drug sniffing dogs were brought in to search for drugs among juveniles. On the other hand, many participants quickly began changing their perceptions of the Director, as they were able to see positive changes associated with his more punitive methods. For example, he was described as being “a perfect fit at the time to bring structure, organization, and focus to the agency.” Strategies used by the Director to change the culture of the agency will be discussed in depth in Chapter 6, but it is important to note here that the reception of these strategies was mixed.

Although Branham’s direction was initially questioned, the overall perspective gleaned from interviews was that he had very effectively instilled long-term changes within the department and was successful at changing the agency. While some participants were critical of individual aspects of Branham’s changes, his efforts were generally well received and reportedly led to the elimination of the consent decree in 2007. In multiple instances, participants would give interviews that were highly critical of the decisions Director Branham had made. However, they would then finish with a statement about how they didn’t want to appear overly critical of the Director and that they felt most of the changes were done well and that he was well respected. As was evident in Chapter 4, an extensive reform occurred at the ADJC following CRIPA, which was very much attributable to the direction that was taken by Branham.

One decision made by Director Branham that was received with overwhelming support was his firing of staff who were found to have abused juveniles. As stated earlier, only minimal background checks were done on employees and many line staff had been previously employed in the adult correctional system, resulting in a pattern of

abusive and inappropriate staff being tasked with supervising juveniles. It was reported that staff who were hired prior to CRIPA would never have been hired after CRIPA. In an effort to root out employees who contributed to the negative culture of ADJC, the Director had investigators review all old complaints of abuse. In cases where the abuse was substantiated, the staff were fired. In many cases, staff were prosecuted if they had abused kids in the past. One administrator reported that upwards of 200 out of approximately 1,200 employees were fired, and that he eventually stopped counting the number of firings that occurred.

Over a three year period, staff were fired “for contraband, sex with kids,...a whole spattering of excessive force, and sexual harassment.” Current employees felt that this was the correct step to take in order to reform the culture once and for all because “they had brought in new blood who weren’t tied to the past.” During the previous lawsuit, new policies were implemented, yet the staff who were implementing the policies remained the same. Furthermore, the Director reportedly conducted background checks after the fact on all employees and fired those that did not meet the appropriate standards. To then effectively change the culture, the Director initiated more formal hiring practices and more extensive training.

In contrast to Director Gaspar, Director Branham made frequent visits to the Safe Schools and was more knowledgeable about what was occurring at the institutional level. Some staff were initially concerned that the Director was observing them on these visits and that he was going “overboard.” Because of their experiences with the previous directors, staff “had gotten relaxed thinking the director wouldn’t show up.” These fears appeared to fade away over time because “there was a general feeling that he had the



right to check on the facilities at any time.” The fact that Branham visited the facilities was even more surprising when he would visit in the middle of the night and on holidays. Others reported that Branham “was around all the time and would sit and talk to see what was going on.” Branham further encouraged communication between administrators and line level staff by implementing a zero tolerance policy for abuses. A website was used to have a direct line of communication between the line staff and the Director, which further eliminated abuses that were occurring. It was perceived that Branham had a true “open door policy,” which allowed for staff to convey any of their problems.

To further improve departmental culture, Branham set out to provide greater transparency between the department and the external environment. At the beginning of CRIPA, the lack of transparency was particularly evident with the monitoring done by the Governor’s task force. It was reported that as the CRIPA investigation progressed over time, the “agency was much more open, transparent, and the task force had more access to kids...Mike really did open it up and make it a transparent process.” The CRIPA monitors also found this transparency to have emerged in the agency and declared that if the ADJC was to continue the reforms, transparency would have to remain.

Another strategy adopted by Director Branham that will be discussed further in the next chapter was improving communication between departments, administrators, and line staff. More specifically, interdepartmental meetings increased in frequency. One administrator noted that “directors of different units (e.g. medical, education, housing, psychology) met together as a team so there was a coordinated effort...Before there had been a lot of autonomy—they shared the same kids, but didn’t share information.”

Currently formal meetings are held five days a week between administrators and specific juveniles are discussed in these meetings.

Despite all of the changes that occurred within the agency, there was some degree of pessimism exhibited among staff about how sustainable the changes would be. Administrators reported that it was relatively easy for the entire department to comply with the CRIPA at the time because “you really have to do your best when being watched.” As was outlined in chapter 4, the Department of Justice investigators reported that ADJC was in compliance with all aspects of the Memorandum of Agreement by 2007 and was no longer going to have any official external oversight. One question that lingered in the minds of many within the ADJC was whether they would be able to maintain the changes when there was no one looking over their shoulders.

### **Maintaining Reforms Following Cessation of Monitoring**

In their final report, the CRIPA monitors noted that “the ADJC is much safer now than when this process began. This is due to the outstanding effort of Director Branham and his staff to come into compliance with the MOA provisions and the institutional culture change created by the monitoring of the settlement agreement. The most difficult part of this process is just beginning.” The difficulties of this change were echoed in the responses of participants for the present study who were employed by the ADJC and county courts. Although the overall perspective of participants was that the ADJC had changed the culture and had been more focused on sustainability than the agency was during *Johnson v. Upchurch*, the degree of satisfaction with reforming the culture varied. In particular, two outlooks stood out—the agency had made sustainable changes because

they were focused on the long-term outcomes of the agency and the CRIPA changes had been good for the agency but would be difficult to sustain.

Following the end of monitoring, “staff were extremely aware of CRIPA ending,...[but] there was no dramatic change because there was such a focus on the main points of CRIPA.” Although Director Branham himself reportedly felt that it was difficult to change cultures, he was taking steps to actually make it possible for the ADJC to reform. Most notably was the improvement in quality of staff who were employed by the agency. The removal of staff who had physically or sexually abused juveniles or who failed subsequent background checks, along with the hiring of well trained staff who had a greater awareness of the importance of treatment and rehabilitation, signaled a shift in the behaviors of staff overall. Furthermore, modifications in separation policies have all but eliminated the long-term use of separation, which was one of the most concerning issues during CRIPA.

These improvements strongly contributed to the ability of the ADJC to adhere to the requirements of CRIPA following the cessation of the consent decree as was evidenced in chapter 4. However, perceptions of the extent of cultural reform varied between line staff and ADJC administrators. Most notably, administrators pointed to the improvements in communication between departments and staff and how this has eliminated “camps” within the agency. They suggested that openness within the department will prevent future fallbacks from CRIPA.

In contrast, many line staff remained critical of the agency even after the reforms made because of CRIPA. Many expressed fears that the changes made under CRIPA had not been fully institutionalized into the agency. They also felt it would take longer than

four years to have long-term meaningful cultural change. In fact, this was one of the biggest concerns of Director Branham during his time with the agency. Although in some cases this led to frustrations among the staff, Branham maintained the perspective that they always needed to be concerned about CRIPA, even after the DOJ left. ADJC employees believed that Branham was both “satisfied and dissatisfied with the progress they had made by the end of CRIPA. Branham never believed they were finished... The real push was for fixing the department to make it better and Branham wanted people to think that they would have done the same things even if the feds hadn’t been there.” As a result, he continued to bring in programming for juveniles, continued with investigations of staff who had reportedly abused kids, and remained a consistent presence at the facilities. The efforts that Branham made to change the culture were in large part because he did not want the agency to endure a third lawsuit. As a result, Branham maintained the perspective that changing the ADJC was a continuing process and they could never become lax in their roles. The following section will examine lingering concerns of the ADJC including the perseverance of the conflict between rehabilitation and control, harm to the agency culture following severe budget cuts, and a new direction of the agency over the past two years.

### **Conflict Between Rehabilitation and Control Philosophies**

The cultural reform of the ADJC was made difficult because of conflicts that arose between director Branham and other administrators who were focused on bringing rehabilitation to the agency. Following the *Johnson v. Upchurch* consent decree, the ADJC experienced a time of turmoil, where it was unclear if the goal of the agency was

to provide rehabilitation to juveniles or to provide them with punishment and control. When the agency was under a second consent decree from 2004 to 2007, this issue was raised again. On the one hand, crucial aspects of the Memorandum of Agreement forced the ADJC to provide rehabilitation to juveniles. On the other hand, the director who had been appointed to lead the change of the agency was from a law enforcement background and had a crime control mentality. In order to achieve compliance with CRIPA it was clear that both crime control (i.e. for both juveniles and staff) and rehabilitation were crucial to reforming the agency. While Director Branham was primarily tasked with instilling control aspects of the agency, Deputy Director Dianne Gadow was hired to fulfill the rehabilitative aspects of the CRIPA agreement. Although her hiring was very expensive for the department, her presence was important for the reforms because she had previously been involved in organizational reforms related to juvenile justice.

In theory this pairing seemed like an ideal match where the ADJC would be reformed to provide treatment in a safe and professional environment. In reality, it became evident that this pairing would evoke conflict between departmental divisions that had conflicting goals. Although Branham and Gadow were both vying for the director position, it was speculated by some that Branham's friendship with Governor Napolitano was what ultimately garnered him the position. In the end, Branham became director and Gadow was the deputy director whose primary focus was on treatment. With regard to the dynamics of this relationship, one county court representative noted that:

The theme was that the ADJC was bringing in experts to the highest levels of ADJC, but this wasn't translating into rehabilitation. Branham was more punitive and had a paramilitary approach, while the mid level employees who were brought in were rehabilitation oriented, but the line staff still had a punitive culture. The paramilitary approach has been shown to be ineffective. I am not

saying people were lying about providing treatment, but I thought people didn't know how to do rehabilitation and ran into problems with the state because they didn't want to appear too lenient. What you have because of pressure from CRIPA is that ADJC recognized they needed to bring in treatment oriented professionals, but the head of the agency sets the tone.

In other words, as rehabilitation was being tested and tried at the ADJC, there were difficulties in getting a full commitment from all employees because the Director was really the one who made the decisions in the agency.

Branham received a tremendous amount of respect and recognition for his part in reforming the ADJC and bringing it into compliance with the MOA. However, others also pointed to Gadow and the Director of Clinical Services, Kellie Warren who had also been hired to bring increased treatment to the agency, as being two key players in ending the consent decree. When asked why Gadow ultimately left the ADJC, participants reported that this was in large part a result of the conflicts with Branham. It was observed that “once through CRIPA, the two philosophies didn't mesh and Gadow could not make an impact anymore. Branham's priority was compliance and these kids are criminals and that's the way they should be treated.”

The gap in philosophies between the two highest ranking persons at the ADJC resulted in tensions that were evident to many within the agency. One ADJC employee described how Branham and Gadow had very different perspectives on who the juveniles were that they were treating. “Gadow was very kid oriented and believed the [juveniles] can change and just need to be redirected...Branham was from a policing standpoint—he believed they were criminals and they should be treated accordingly.” Gadow herself alluded to the clash between treatment and control in institutions during a speech at the National Prison Rape Elimination Commission. She outlined how

One of the things that we have really been struggling with and working hard and focusing on in Arizona is actual agency cultural change. Many times, because your agencies are in different systems, the mentality—and it's impacted also by your legislature and your governor—but the mentality more is of lock the youth up, security is the major focus, and if that kind of a culture is the only thing that's prevalent within your institution, it doesn't matter how beautiful the building is or how much money you put forth, that's what it's going to be... We're working very hard to change the culture and expectations down to our staff members who in many instances consider themselves guard. (196)

Similar issues arose when Kellie Warren who had been the Assistant Director for Programs and Institutions was appointed Deputy Director in 2007. Another ADJC employee described how

Warren had a different philosophy about how to run the facilities and this led to ongoing conflict all the time. Branham would attack Warren's divisions. This was a problem because Warren would tell staff to do things one way, while Branham would tell them to do it another way, and this led to conflict. [In contrast] there was a good balance happening during CRIPA between rehabilitation and crime control.

Despite these reported conflicts that endured following the end of the consent decree, no participants stated that these had persisted after Branham and Warren left the agency in 2011, suggesting that this is no longer an issue within the agency.

### **Responding to Budget Cuts**

Following the ending of the consent decree between the ADJC and DOJ in 2007, the future of the ADJC was once again questioned in 2010 as budget cuts began to severely impact the agency. In 2007, the Arizona Executive Budget for ADJC reached its peak at nearly \$80 million being allotted to the ADJC. By 2011, only \$51 million was given to the ADJC in the Executive Budget. The 36% reduction in budgets resulted in the layoffs of both line level and administrative staff, the closure of two safe schools, and

the consolidation of resources in the department (e.g. boys and girls began to attend school together). The strains of the budget cuts culminated in 2010 when the Governor of Arizona, Jan Brewer, announced that the ADJC would be closing and juveniles in state care would be released back to their respective counties. In other words, this would result in the layoffs of all ADJC employees. The effect of these struggles has had a direct impact on the roles of employees in the agency. The following section will examine this issue in more depth, as the budget cuts had the potential to eliminate the progress made at the ADJC during the CRIPA intervention.

One repercussion of the budget cuts has been the loss of valuable staff resulting in employees being forced to adopt multiple roles in the institutions and Central Office. Institutional employees expressed concerns that their time is being stretched too thin, and as a result, are unable to provide appropriate care for juveniles. For example, in one news article in 2010, an individual reported on the struggles faced by her husband who is a line level officer at the ADJC, stating that

He is asked to work an 8 hour grave shift, come home and sleep for 5 hours at best, and then is expected to go back to work for another 8 hour swing shift. Scheduling is inconsistent at best, routinely changes without warning and leaves guards, at the very least, tired and agitated. Not the best combination for taking care of mentally ill children... They treat there [sic] employee's [sic] as if they are criminal's [sic] as well. I have had calls in the middle of the night, just 30 minutes after my husband has returned from work, from management instructing him to come back in.

In the Arizona Legislature's performance audit of the ADJC in 2009, concerns were raised regarding the adherence to the staff-to-juvenile ratios that had been outlined in the CRIPA MOU (Office of the Auditor General, 2009a). In order to come into compliance with CRIPA, the ADJC had to maintain a staff-to-juvenile ratio of 1:12 in the



mornings and night and a 1:8 ratio in the afternoons. However, the Legislature's report reveals that staffing ratios for the night shift reached as high as 1:33 and exceeded the 1:12 ratio 45% of the time during a 2 week period in 2009. The report suggested that the ADJC needed to either hire more staff or use other means to avoid staff shortages.

Interviews in 2011 and 2012 suggest that the ADJC have followed both of these suggestions, albeit at the expense of staff and juveniles. Caseworkers and other institutional staff report that they are pulled from their duties to fill in for line level officers. This prevents them from building solid relationships with the juveniles, which causes them difficulties when they need to provide treatment. Staff feel that this time to get to know the juveniles has been replaced with paperwork and supervision. One ADJC employee states that "staff are expected to be line staff and expected to be caseworkers and expected to be unit managers. Too many things get in the way of me doing my actual job." In contrast, a couple of staff reported they enjoyed the opportunity to work line level positions because this gave them time to observe the juveniles, which could be beneficial when providing casework. Attempts to make the agency more efficient (e.g. layoffs, elimination of overtime) have made it increasingly difficult to have enough line officers to cover officers who call in sick to work, resulting in other strategies to ensure enough officers are supervising the juveniles.

Nearly all individuals in administrative positions at the ADJC reported they have had to take on the responsibilities of laid off employees. In many cases, the adopted roles were dissimilar to the original responsibilities. In contrast to the perspectives of institutional employees reported above, employees at Central Office appeared more accepting of their newly adopted roles. For example, one employee reported that the

department is “now doing more with a lot less,...[but] they are still focused on doing the right thing with kids.” Others believed that their newly adopted roles helped them to be more efficient in their work, even though it has been stressful on the employees. The reductions in budget have reportedly made jobs more difficult, but the implementation of the Investigations and Inspections unit, continued training of line staff, reminders of staff and juvenile boundaries, a focus on efficiency, holding employees accountable, and the continued focus on culture change among staff have made this possible.

### **Current Direction of the ADJC**

One final issue to address in the culture of the ADJC is the current direction of the agency. In July of 2011, Arizona Governor Jan Brewer appointed Charles Flanagan to be the Director of the ADJC. Prior to his appointment, Director Flanagan was the Deputy Director of the Arizona Department of Corrections (ADC). This was concerning to both ADJC employees and county court representatives because of the problems that resulted when ADC officers were transferred to work with juveniles. Perceptions of the direction taken by Director Flanagan have been mixed, as some perceive him as a welcomed change from Director Branham and others strongly disagree with the direction he is taking the agency. Specific issues that will be discussed include the treatment of line staff and reforms to education.

For example, one participant reported that Flanagan has been transparent and inviting. As a result, the employee felt that Flanagan was less likely to fire staff who reported problems in the agency, as had been feared under Branham. Other line staff praised Flanagan because of his experience in corrections. One employee noted that “it is

refreshing to have someone who knows something about corrections in charge...he's really helping us. It is good to talk to someone who has the same language as you...I also like that he is cutting down on central office people and getting us staff." This statement was reflected by many line staff who had been fearful of losing their jobs during the budget cuts, but saw Director Flanagan as someone who wanted to downsize Central Office instead of line staff.

Juvenile justice advocates and county court representatives also had somewhat of a positive perspective of Flanagan because he has been more focused on providing treatment to juveniles in the community. It was reported that due to the budget cuts across Arizona, Flanagan was hired because he had experience with keeping correctional costs low. One way that he has been able to accomplish this is by investing more resources into community corrections than those in the institutions. Furthermore, some juvenile justice advocates felt that Flanagan was very oriented towards programming, so it would be unlikely that he would make severe cuts to this part of the ADJC.

In stark contrast to the few ADJC employees who were optimistic about Flanagan's appointment, many have become concerned over his treatment of staff. Multiple participants reported being fearful of being laid off, that the director was overly critical, and does not value all staff. One area in particular where ADJC employees note that Director Flanagan has been particularly harsh is his handling of education for juveniles. Generally, most reported that the agency has been effective at maintaining compliance with the CRIPA requirements, even in spite of recent budget cuts, but that education has been hurt by the budget cuts. While part of the concern in education has to do with the budget cuts causing class sizes to increase, another aspect directly involves

the management of the schools. One participant described recent changes that pre-dated Flanagan's arrival at the agency, but have persisted. Prior to the closure of the school at Black Canyon School, class sizes were approximately 10-15 juveniles per class, but now some classes have close to 30 juveniles in one class. This employee notes that:

The department really supported education then and there weren't too many behavioral problems...it was really the ideal of teaching where they had small classes, there was a focus on kids passing classes, and a lot of mentorship. They kept boys separate from girls and had very small class sizes...The reality now is that education is no longer a priority and the educational system at ADJC is disrespected. There are still some isolated pockets of the teams that you used to see, but not anymore.

These concerns about how education is viewed at the ADJC have persisted with the hiring of Director Flanagan. For example, one employee reported that Flanagan is "tearing people apart with the negative environment. He says the things we are doing are wrong. This has created a negative environment for some staff... He is always saying that we are slacking, not doing a good job of directing kids, and their appearance is poor." At the same time that he is being critical of staff, many report that he has yet to observe the schools fully, so they feel as if they are being unfairly judged. This judgment of staff so early on in the director's tenure has reportedly made some staff feel insecure that they are not doing anything right, so they are "walking on eggshells" around the new director. Furthermore, concerns of layoffs have instilled fears that central office staff can paint the employees at the Safe Schools in a poor light to avoid being laid off themselves. In other words, one employee notes that "central office staff may be saying things to the director to ensure that if layoffs do happen, they will still be employed at central office." Some ADJC employees believe that educators are now being pushed to the brink and will eventually start quitting as a result.

Staff also reportedly became very concerned when there were rumors of charter schools being brought to the agency by Director Flanagan. Many questioned why it was necessary to have charter schools when there was a fully functioning school already in place. It was speculated that this was another cost saving tactic (e.g. online classes) that would result in the loss of teachers at the agency. As a result, an anonymous letter was sent to the director asking what was going on with the schools. Director Flanagan reportedly responded that they were planning on providing vocational programming through charter schools as a supplement to the existing services. Despite the director's reassurances that the charter schools were going to be an addition to services as opposed to a replacement, fears have remained that they will eventually replace the ADJC schools. Somewhat ironically, after the efforts the director made to cut the education budget, one employee noted that Flanagan was trying to require teachers to wear uniforms and only abandoned the plan when it was found to be too costly.

### **Ensuring Reforms Are Sustained**

The current chapter has examined the changes in ADJC culture following its formation in 1990 to today. This is an important aspect of the agency to examine how the changes made during CRIPA are able to be sustained. The next chapter examines why administrators and line staff appeared more committed to ensuring the reforms following CRIPA than they had been after *Johnson v. Upchurch*. First, chapter 6 will explore the possibility that the ADJC reformed because of concerns that valuable resources would be lost if they did not appear legitimate by external agencies. Responses of counties as a result of the CRIPA investigation are also briefly examined. The chapter will then

examine a second reason why the culture and agency made more progress during the second reforms—the Investigations and Inspections unit. A detailed examination of the punitive and preventive controls that were implemented following the CRIPA will be used to demonstrate these had a direct impact on reforms.

## Chapter 6

### Competing Reasons for Why Culture Changed

Based upon the results in Chapters 4 and 5 there is clear evidence that after the second lawsuit, the agency changed numerous aspects of management and culture. The question now is why did the agency and culture change? One possibility that will be explored in the current chapter is that the agency reformed either for rational reasons or because of a desire to maintain legitimacy by the institutional environment. On the one hand, the agency could have reformed management and culture because employees realized the changes would be beneficial to the treatment of juveniles and keeping them safe (e.g. suicide prevention, rehabilitative programs). On the other hand, institutional theory suggests that when organizations depend on their external environments for resources, they will reform to avoid losing critical resources. In the case of the ADJC, the agency may have reformed because of a dependency on external agencies for resources (e.g. financial, juveniles). Because they could potentially have lost those resources if the agency failed to reform, this may have led to the institutionalization of changes. Related to this issue, there will be a review of how counties and community advocates perceived the ADJC, as this directly impacts their responses to the agency.

A second possibility that will be examined is that the agency reformed because of the implementation of a formal checks and balances system. Prior to CRIPA, investigations of staff were inconsistently conducted and were minimally investigated. In response to this issue, Director Branham developed a more thorough and active Investigations and Inspections (I & I) unit. This unit served to investigate both staff and juvenile issues. The current chapter will first examine whether employees reformed for

rational reasons or to maintain legitimacy. It will then explore how counties and juvenile justice agencies around the state responded to the CRIPA investigation. Chapter 6 will then examine the reformation of the original I & I unit, the impact that it has had on the agency, and perceptions of staff of the unit to determine if the CRIPA reforms have been maintained because of punitive and preventive controls placed on the agency.

### **Motivations of Reforming the ADJC**

**Reforming the ADJC is Necessary to Improve Treatment.** The overwhelming majority of ADJC employees interviewed for this study acknowledged that the practices at the ADJC prior to CRIPA were harmful to juveniles and that the DOJ was not targeting them unnecessarily. The agency had reportedly been cutting corners, was hiring staff who were abusive to juveniles, had a high turnover rate, was unable to provide effective programming and education, was unable to prevent suicide, and was not conducting background checks. The facilities were described by many as being “prison like,” as opposed to providing the treatment that was expected of a juvenile facility. However, many administrators seemed unaware of problems that were occurring within the agency until the *New Times* released a series of articles documenting abuse. While these were described as highly sensationalistic, they indicated that problems were occurring within the agency that they were failing to address.

Despite the recognition that abuse, deprivation of civil rights, and policy violations were pervasive in the agency, practically no ADJC employees expressed that this was their impetus for reforming the agency. Multiple employees felt that their hands were tied because of policies, so they made no effort to make any changes to practices



until they were forced to do so because of CRIPA. Separation (i.e. solitary confinement) was one area in particular where the ADJC was found to have abusive policies. When asked about this, one employee was troubled that “people bring that up as a way to say officers were doing their jobs in correctly. Separation was used the way the policy was read. They got dogged on that because revamping separation was not a priority for those creating policies...It was wrong to pass judgment on the staff when they were following policy.” Similarly, another employee stated that he had felt their use of separation prior to CRIPA was used appropriately, but “that was because I never thought there was another way. I didn’t know punishment to change behaviors was a bad idea.” This failure to recognize abusive policies was a likely contributor to the failure of many line staff to seek alternative means of treating juveniles.

However, there was one exception to the agency failing to reform for rational reasons. Multiple ADJC employees suggested that reforms were occurring in education a few years prior to the CRIPA investigation. During the time of *Johnson*, the school received accreditation, which brought the school into adherence with national standards. Then around 2001 and 2002, the agency began to have a greater focus on giving juveniles the appropriate courses to help them pass their GEDs and training them for “low level jobs” that they would be able to advance in. To further advance the school, new administrators were hired, including a principal and vice principal. Also, it was recognized that the department had been poorly monitoring the progress of juveniles in school, had poor screenings, and were inadequately conducting Individualized Education Program (IEP) meetings. A database to monitor this progress was being set up prior to the CRIPA investigation. It was reported that “CRIPA made some of these changes, but

it was the superintendents around the same time who were the primary reason for the changes.” With these exceptions in education, it was apparent that few changes were made just because they were best practices for juveniles. An alternative explanation, that the reforms occurred because staff feared they would lose valuable resources if they continued in the same direction, is explored below.

**Reforming the ADJC is Necessary to Maintain Resources.** Although few respondents suggested that the agency began reforming for rational reasons, some did make direct links between the changes made at ADJC because of CRIPA and concerns over appearing legitimate. Institutional theory outlines how organizations that are perceived as illegitimate in their institutional environments are forced to adopt accepted norms into their organizational structures. If an organization fails to adopt the myths that are valued by the institutional environment, they could potentially lose valuable resources. The loss of legitimacy in the institutional environment was evident at the ADJC during the time of CRIPA. Administrators of the ADJC stated that the Governor of Arizona had taken a particular interest in the reforms of the agency. For example, one ADJC administrator felt that the agency changed because Governor Napolitano was particularly concerned about the agency. During CRIPA, “they got a lot of attention from Napolitano and there were a lot of eyes on the agency. They were all motivated to do well and Napolitano was vested in the lawsuit. Many new staff were hired because they wanted to get out of the CRIPA.” The fact that the Governor was responsible for determining the bulk of the ADJC budget suggests that there was a large financial motivation for ensuring the reforms occurred.

Concerns of the ADJC over maintaining legitimacy in the institutional environment were also expressed by employees who recognized that they were dependent on a steady flow of juveniles being sent to the agency. As is discussed in more depth below, as a direct result of the conditions at ADJC and the investigation, some counties began sending fewer juveniles to the state. In 2004 and 2005, the ADJC had the lowest number of commitments in its history. As a result, the new administration of ADJC grew concerned that counties did not perceive the ADJC facilities as safe and intervened to prevent any more resources being lost (i.e. kids being sent to ADJC). One participant described how when

The agency finally did break (i.e. CRIPA report was released), the director had to work hard to reestablish trust. Judges felt bamboozled. The director was more committed with courts and counties and would make the rounds. He said they were going to be open and would allow outsiders to come into the facilities. Pima was one of the counties that came out and still does. A lot of the judges wanted tours. No one had asked before CRIPA and they were under no obligation to let in outsiders.

This practice was confirmed by various county representatives. One that was particularly pleased with the director's response following CRIPA stated that

He did a great job talking with the counties about what they had been able to do, so Maricopa County judges really believed ADJC was a great place. This became problematic because counties began sending inappropriate kids, as judges believed they could get better treatment at ADJC. Eventually the director had to start talking to judges and telling them not to send over inappropriate kids, especially those who were misdemeanants.

It is evident that the Director recognized that unless he was able to reestablish confidence in the county courts that the ADJC was a safe and rehabilitative place for juveniles, they would find other ways to take care of the juveniles.

In addition to the links that were made between maintaining legitimacy and the CRIPA reforms, there were other indicators that the ADJC was generally concerned with perceptions of legitimacy. This was particularly evident in the decision to keep Catalina Mountain School (CMS) open. Multiple respondents felt that CMS in Tucson continued operations after it was no longer cost efficient because it made the agency appear legitimate. Located over 100 miles southeast of Phoenix, CMS was the last remaining facility for housing juveniles outside of the main facility in Phoenix. A primary function that CMS served was to house juveniles from Southern Arizona closer to their families and communities, rather than moving them to Maricopa County, and for the safety of juveniles from rival gangs. Although this was the “rational” perspective that was presented to the public, it is apparent that the real reasons for maintaining the facility were much less sincere. One participant stated that Director Branham:

Had taken money from the community corrections side and given it to the central office and Catalina Mountain. There were 72 kids at Catalina and they were running on a \$7.8 million budget. Branham was saying he was keeping Catalina open to keep rival gang members separated, to maintain a presence in Southeast Arizona, and to have kids closer to home for visitation. However, few kids had visitors and many kids at the facility were not from Southeast Arizona. The facts belie what the director was really doing. I believe he really kept the facility open and to keep the ADJC large. He also wanted to have an influence in Southeast Arizona so that Terry Goddard would elect Branham to a secure position if he became governor. His job needs to be about doing the right thing.

Similar sentiments were expressed by other participants who were concerned that CMS was merely kept open for political reasons and appearances, not because it was better for the juveniles. For example, one respondent stated that when the ADJC debated between closing CMS and another facility, Eagle Point School, in 2009, he felt that

Catalina should have been the Safe School to close. The primary reason for this was because of the dated facilities at CMS and the inability to hire staff. He further stated that

For the number of kids there it didn't make sense. Pima County sends few kids there and these are usually only their highest risk. Half of the kids, at most, there were from Pima. The director had said that they were keeping the facility open for the politicians in the south... The director said they needed a presence so families could visit, but this was a hollow argument because they sent the girls up to Black Canyon School and other families all over the state had to drive to see their kids.

Although CMS was kept open to make the agency appear legitimate, it ultimately proved too costly to maintain. As a direct result of the fiscal crisis in 2011, the decision was finally made to close CMS and relocate some of the juveniles and staff to the Safe Schools in Phoenix. During a public meeting outlining the closure, ADJC staff argued that the most cost efficient and best decision for juveniles was to close CMS. Part of this related to the supposed misinformation that had been given to the public regarding the cost per day of incarcerating juveniles at ADJC. While it was publicly stated that it only cost about \$250 per day for each juvenile to be housed at ADJC, compared to the national average of \$150 per day, the administration in 2011 claimed that it cost over \$300 per day per juvenile. This was the direct result of "unnecessary layers of supervision." It was further argued that maintaining CMS was not "sound fiscal or correctional practice" because it was the most costly facility at ADJC and resulted in the decentralization of services for juveniles. Coupled with the declining population of incarcerated juveniles in the state, maintaining the facility had grown to be an unnecessary expense.

The primary motivation of closing CMS was to reduce the costs of housing juveniles. However, the ADJC also reported that the closure would be positive for juveniles because it would result in the concentration of resources in one facility. Among

the improvements would be to: “expand core programs options, expand substance dependence programs, expand and make available to all youth a broader range of career technical educational opportunities, add a skills for work unit and fire science program, and make mental health and sex offender programs available to all eligible youths.” If this were in fact the primary motivation for closing the facility, then this decision would have been made for rational reasons.

### **Responses of Counties to an Illegitimate Agency**

Although only a few ADJC employees suggested that reforms occurred because of pressures to maintain legitimacy, those external to the agency believed that this one of the reasons why the agency reformed. Although the responses of counties to CRIPA reforms are not the focus of the current dissertation, it is important to briefly examine their perceptions of ADJC because they have a direct influence on the management of ADJC. More specifically, it became blatantly obvious through interviews with representatives from the seven counties that sent the largest number of juveniles to ADJC that there were severe concerns over how juveniles were being treated at the ADJC. The following section examines how these concerns changed as a direct result of the CRIPA intervention.

Prior to the CRIPA, practically no court representatives painted the ADJC as a legitimate institution where juveniles could be sent to reform and receive treatment. Instead, the overall perspective of ADJC pre-CRIPA was that the agency was failing for multiple reasons. These included the staff who were hired at the ADJC, the lack of a

clear focus on rehabilitation or punishment, and the mistreatment of juveniles. One of the biggest concerns of external agencies was who was being employed at the ADJC.

Discussed in Chapter 5, juvenile court employees were concerned about the staffing of the agency following the *Johnson v. Upchurch* consent decree. More specifically, many employees believed that ADC staff carried with them punitive attitudes that did not mesh well with the generally rehabilitative stance of juvenile corrections. They also felt that the shifting focus of the agency from control to rehabilitation made it difficult for those internal and external to the agency to determine what the overall goal of the organization was.

By 2000, it was apparent that many of the changes made under the *Johnson* consent decree had not been sustained. This reportedly was concerning to those in juvenile detention who took part in placing juveniles in ADJC custody. One article reported that 30 community advocates had written to the then Governor of Arizona because of the poor conditions at ADJC (Silverman, 2001d). In this article, one of the initial federal monitors of the ADJC reportedly said that “I think they need an outside agency to come in once again and review procedure...that would be my advice to the governor.” Although these advocates pushed the governor to initiate an external review of the ADJC, this did not occur.

In multiple interviews, representatives from county courts suggested that during the suicides and start of the CRIPA investigation, judges from numerous counties sent less kids to ADJC because they were fearful for the juveniles’ safety. Statements such as, “many judges stopped sending kids there because they were being sent to die,” “there was almost like an informal agreement between the courts that they were not going to

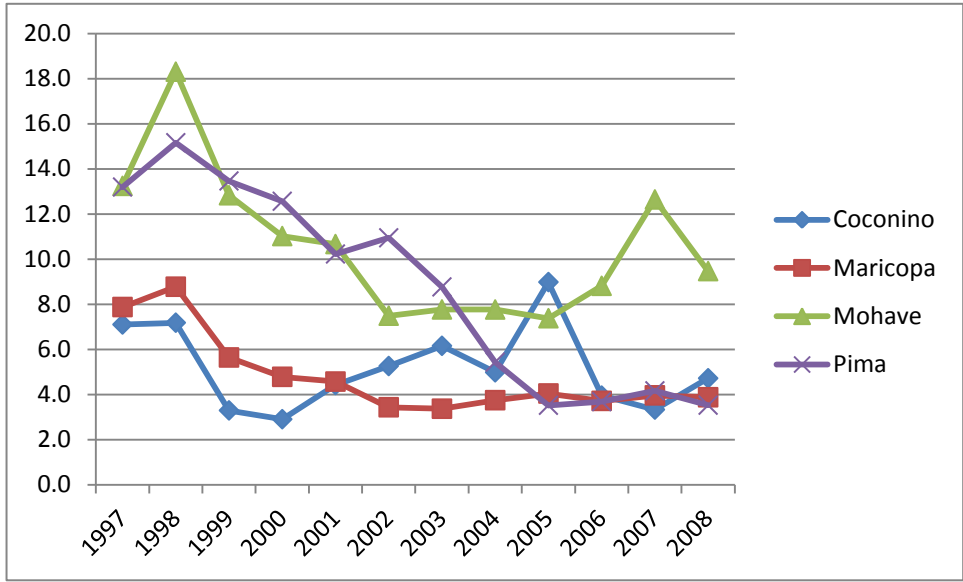
send kids to ADJC,” and “prior to the CRIPA there was a higher rate of commitment, but this has been decreasing in recent years because of reports of harm and fighting” suggest that as a direct result of counties becoming more aware of abuses, their perspective that ADJC was a legitimate resource had completely diminished.

Overall, it appears that many of the counties that had previously sent the most juveniles to ADJC had fewer commitments following the reports of abuses and suicide risks in 2002 and 2003 (Figure 4a and 4b). Figure 4a shows that Maricopa, Mohave, Pima, and Coconino counties were already sending fewer juveniles to the ADJC prior to the CRIPA. Following the reports, Mohave and Maricopa committed even fewer juveniles than they had in nearly 10 years. Respondents in the current project had reported that Pima County was the most concerned county and actively sent investigators to the facilities because of these fears. These responses were confirmed with the data because in 2002 Pima County committed about 11 juveniles per 10,000 juveniles in the county, but when the CRIPA investigation occurred, they were only committing about 5 juveniles per 10,000. Coconino County did not follow any of these trends, and actually had higher commitment rates following the CRIPA. Figure 4b shows that Pinal, Yavapai, and Yuma Counties also committed considerably fewer juveniles beginning in 2002. The total rate of commitments for these seven counties further demonstrates that there were in fact fewer juveniles being sent to the ADJC following CRIPA.

Although multiple counties sent fewer juveniles to ADJC following the suicides and CRIPA investigation, many of these counties had been experiencing declines in the number of commitments prior to these events. In other words, they would have likely sent fewer juveniles to the ADJC during this time, even if they had not experienced the

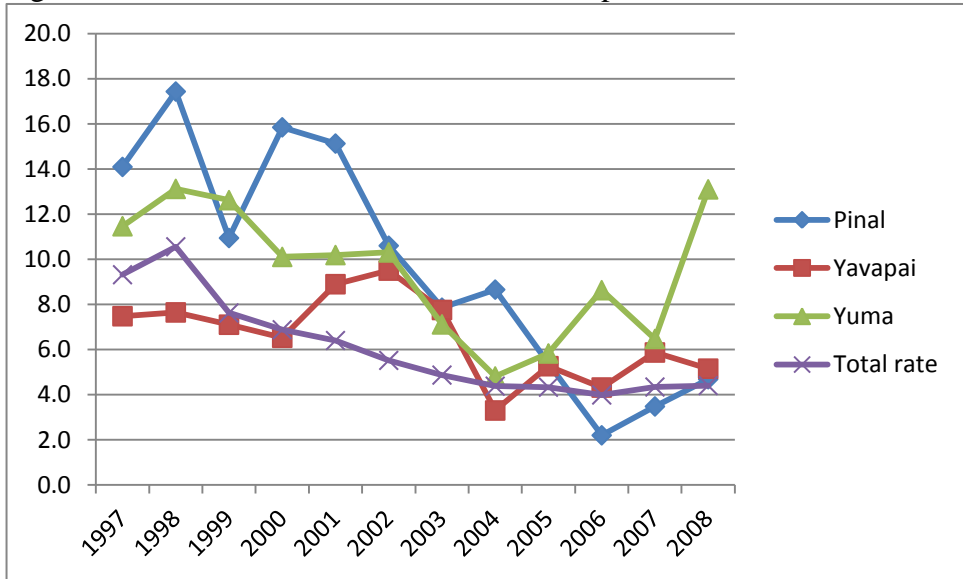


Figure 4a. Number of Commitments to ADJC per 10,000 Juveniles in County



Source: ADJC Annual Report (2008; 2007; 2006; 2005; 2004; 2003; 2002; 2001; 2000; 1999; 1998; 1997)

Figure 4b. Number of Commitments to ADJC per 10,000 Juveniles in County

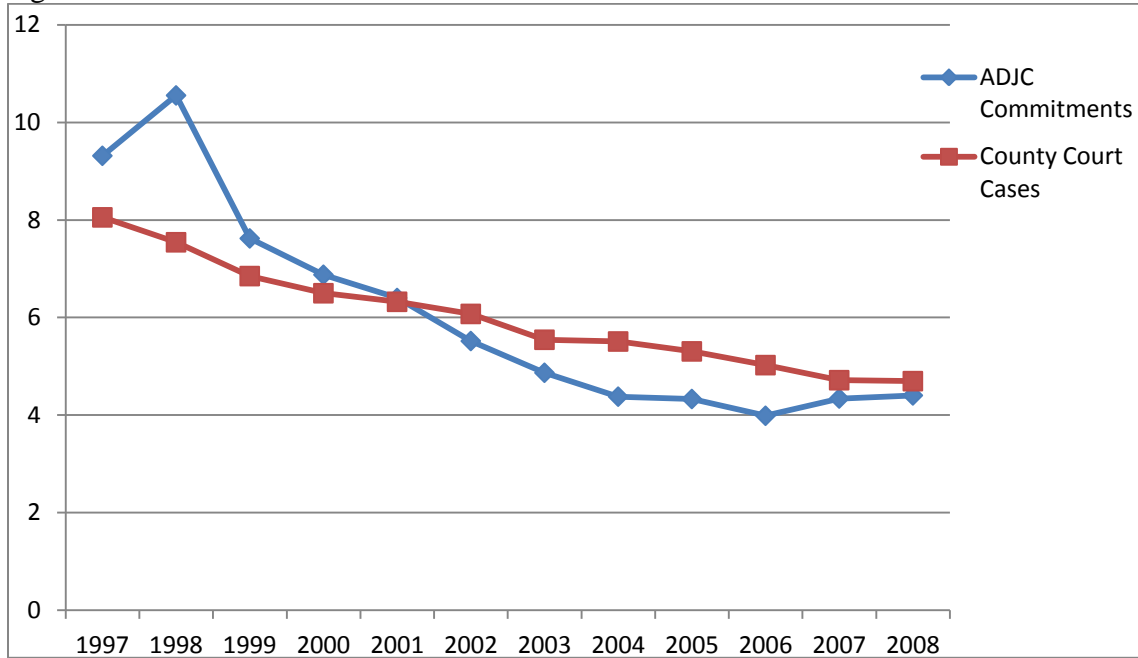


Source: ADJC Annual Report (2008; 2007; 2006; 2005; 2004; 2003; 2002; 2001; 2000; 1999; 1998; 1997)

CRIPA consent decree. This pattern shows consistency with the crime declines experienced nationwide in the 1990s and 2000s (*see* Zimring, 2007). However, an examination of the number of commitments to ADJC from the seven counties discussed above (i.e. Maricopa, Pima, Pinal, Yuma, Yavapai, Coconino, and Mohave) versus the number of juvenile court cases lends support to the notion that courts were concerned about the conditions at the ADJC (Figure 5). Although ADJC had been experiencing a decline in commitments and county courts were dealing with fewer cases of juvenile delinquency since 1997, the decrease in the number of commitments to ADJC was more severe. This suggests that both the conscious decision by judges across Arizona to send fewer juveniles because of reported abuse and suicide risks and the overall decline in juvenile offending contributed to a lower population. These counties were responding rationally, as they perceived the ADJC to be an illegitimate agency that was unsafe for juveniles and was failing to accomplish its goals. As discussed above, in direct response to these decisions, the ADJC had to make reforms and reestablish trust with counties in order for them to continue committing juveniles.

Similar to counties, juvenile justice advocates and groups that make funding decisions for ADJC expressed concerns over CRIPA. Much of these concerns centered on the rhetoric that Director Gaspar portrayed to the public. One participant characterized the director as a “snake oil salesman” who portrayed that the department was running well. Another advocate stated that “[the director] had been putting money into education, cultural diversity, etc, so we thought that all of these things were working. ADJC would positively report on the treatment, partly because we decided on the money they would receive. [The director] had been reporting that... ADJC was reducing

Figure 5. Number of Commitments to ADJC versus Number of Juvenile Court Cases



Note: Only the seven counties that sent the highest number of juveniles were included in this graph. Both ADJC commitments and juvenile court cases were per 10,000 juveniles. Also, the number of county court cases was normalized by dividing the number of cases each year by 30.

Source: ADJC Annual Report (2008; 2007; 2006; 2005; 2004; 2003; 2002; 2001; 2000; 1999; 1998; 1997); Juveniles Processed in the Arizona Court System (2008; 2007; 2006; 2005; 2004; 2003; 2002; 2001; 2000; 1999; 1998; 1997)

recidivism to about 15%.” Despite the ability for the director to hide the reality of ADJC in many areas, the issue of suicides was very much public knowledge due to the *New Times* articles detailing each of the suicides. In order to excuse the fact that three juveniles had committed suicide while confined in the “Safe Schools,” the director reportedly gave off the perception that the suicides weren’t “that big of a deal” because suicides do occur in that type of population. At one point, Gaspar was even reported as saying that he “wouldn’t run an institution that I wouldn’t let my own child live in.” While that may have been true for him, it became evident that both those within and external to the ADJC would be unlikely to share the same sentiment.

In hindsight it became clear, as one participant stated, that “we had been clowned. [They] had been sitting there telling us that the agency was running great when it wasn’t.” To demonstrate the success of the agency, the director would cite reports from external agencies and awards the agency was receiving in the early 2000s. During one site visit, one award was on display for the “Innovations in American Government Award” for ADJC’s success in “Performance Standards in Juvenile Corrections” from 2004—the same year that the CRIPA investigation began.

As a direct result of the changes made through CRIPA, the perceptions of those in the environment improved. As noted by one respondent, “department policies, practices, and culture appear to have improved above and beyond the first lawsuit.” This suggests that the changes that should have been institutionalized during the first lawsuit had been able to stick following the second lawsuit. Another stated that “the ADJC was willing to let us take tours...and would encourage us to come out.” For the most part, those from counties viewed the changes made during and after CRIPA to be positive for the agency and juveniles. Most perceived the ADJC as being safer, providing more services to juveniles, and having an improved departmental culture. This is not to say that relations between counties and the ADJC are always amicable, but in the areas addressed by CRIPA, it does appear that there is more satisfaction with the agency than there had been prior to CRIPA.

Despite the improved perceptions of the ADJC in several counties, many remain concerned. These concerns directly relate back to the fact that ADJC was formed under a lawsuit, was forced to improve the quality of care of juveniles, improved this care for many years, and then following the end of the consent decree in 1997, endured a second

lawsuit in just a few short years. This led to much cynicism as to whether the agency was capable of long-term reforms. In other words, many had the perspective that they had seen these changes before. One participant raised concerns that the changes were only going to last a short period because they were not required after CRIPA ended. He stated that Director Branham had good intentions, but “a lot of changes were made that would look good on paper and satisfy the requirements of CRIPA.” Pima County had remained concerned that the changes were not made after CRIPA, so they entered into an informal agreement with the ADJC that would allow court representatives to observe the ADJC facilities at any time. As a result, they still send court representatives to the facilities to ensure that staff are not abusing them.

Others met the reforms with cynicism because they did not agree with the direction the director was taking the agency. As reported in Chapter 5, Director Branham was from a law enforcement background and had limited experience with juveniles or corrections. This meant that some of the methods he used to institutionalize change were from a law enforcement, not juvenile corrections, perspective. Many complained that the “director brought in his ‘law enforcement friends’ and they kept track of incidents.” Furthermore, many of those external to the agency did not view the investigative focus the agency was taking as legitimate. This was evidenced by numerous court representatives being critical of the director bringing in drug sniffing dogs, which was viewed as being a practice that does not lead to juvenile rehabilitation.

In sum, it is evident that some of the reforms of the agency can partially be attributed to a desire of the agency to appear legitimate. Although some internal to the ADJC acknowledged that the CRIPA investigation was fully justified because of the

harms that were occurring to the juveniles, it is difficult to go so far as to claim the organization initially changed because of rational reasons. If this were the case, it would have been evident that changes were being made long before the CRIPA investigation began. It appears as if the *Johnson* lawsuit was able to remedy the problems during the time they were being monitored, but this changed quickly after the consent decree ended. When the suicides and reports of poor conditions began around 2002, the agency demonstrated that it had failed to reform for rational reasons. It was only when the CRIPA investigation occurred and there was a decline in resources to the agency, did they step up and make attempts to reform. One of these reform efforts was the implementation of punitive and preventive controls. The following section will examine how these controls have had an impact on the agency to determine if they too have impacted the agency reforms.

### **Implementing Punitive and Preventive Controls at the ADJC**

Following the CRIPA consent decree, ADJC administrators developed a strategic plan to guide the organizational changes over a three year period (Arizona Department of Juvenile Corrections, 2007b). Two specific areas of change were outlined as being critical to the reform: achieving a continuum of services and having an organizational culture change. One aspect of cultural reforms that was required by the CRIPA monitors was the implementation a Quality Assurance Team (QA) and the revamping of the Investigations and Inspections Unit (I&I) in the agency. The following section will examine how these units were created, how they have been received by administrators

and line level staff, and will conclude with the current situation in these units following budget cuts in 2010.

**Creation of QA and I&I Units at the ADJC.** Prior to CRIPA, the ADJC had no Quality Assurance unit and the previous investigative unit was found to be lacking. Many ADJC employees pointed to this issue as a primary contributor to the agency enduring a second federal lawsuit. Following the *Johnson v. Upchurch* lawsuit, the agency was not committed to providing any form of “checks and balances” to ensure policies were adhered to and that discipline was carried out. Further contributing to the lack of investigations in the agency, many employees reported that information was not free flowing in the agency. More specifically, “before the CRIPA and Branham, the information in the agency was controlled primarily at the facility level, which meant that the administration wasn’t always aware of problems. The flow of information used to be from the superintendent determining if the report should go higher up.” Staff misconduct was also frequently handled by the same staff who had been involved in the incident itself. When issues did reach the investigations unit, the investigators had no experience in corrections, which further harmed the investigations.

As a direct result of CRIPA, the agency became more committed to providing QA and professionalizing the practice of Investigations and Inspections to monitor both juveniles and staff. To head the revamped I&I Division, Director Branham hired a law enforcement consultant (Arizona Department of Juvenile Corrections, 2004). The unit was responsible for “investigat[ing] all allegations of staff and youth misconduct and audit[ing] all agency operations to ensure compliance with departmental policy and procedure” (27). In contrast to the reporting practices following the *Johnson* consent

decree, specific types of issues are automatically reported to I&I (e.g. threatening or intimidating remarks) who report directly to the Director. This prevents the director from being out of the loop, as occurred previously in the agency. The Investigations branch of the unit is responsible for criminal investigations, professional standards, and the canine unit, while the Inspections branch is responsible for ensuring compliance with “departmental and national standards, procedures, and policies” (27).

The Memorandum of Agreement between the DOJ and ADJC stipulated that I&I and QA must work closely together in all of their tasks. Both units were responsible for monitoring compliance of policies, audits, investigations of abuse, and implementation of programming. Furthermore, it was required that the units create a quality assurance program. The program would allow the units to conduct extensive audits, including: “inspection[s] of institutional, medical, and educational records, unit logs, incident reports, use of force reports, major disciplinary reports, documentation of room checks by line staff, etc.; interviews with staff, administrators, and youth at each facility; where appropriate, interviews with the parents or other care givers of youth confined in the facilities; inspection of the physical plant; determination of compliance with the facilities’ policies” (Memorandum of Agreement, 2005, p. 13).

One of the biggest concerns during CRIPA was the speed with which changes were being made. Relative to other CRIPA consent decrees, the ADJC’s three-year monitoring period was very short. ADJC, county, and community representatives were all concerned that it is difficult to institutionalize change in such a short period of time. In order to ensure that the ADJC would be able to sustain changes after CRIPA monitoring ended, the department instituted a quality assurance process. Although it was



reported that quality assurance initially did not have a “great start,” it was eventually formalized “as they were focusing on their own sustainability.” In order to formalize the QA process, each aspect of the MOA was broken down into individual issues that could more easily be monitored. The breakdown of the MOA was then called the Unique File Numbering Ratings (UFN), and identified nearly 140 specific issues that needed to be monitored in the agency. In order to ensure that the requirements of the CRIPA have been sustained, the ADJC now has twice yearly audits by QA and compliance is checked daily.

In June of 2007, the ADJC began using a new method of monitoring the institutions through a police management tool. By adopting Computer Aided Statistics (COMPSTAT), the department has been better able to monitor the QA issues outlined by the UFN (Office of the Auditor General, 2009a). Using this tool, the I&I unit is able to identify “hotspots” of violence within the facilities. Every two weeks departmental administrators meet to discuss issues that were identified in the COMPSTAT that are related to juvenile violence and staff misconduct. One ADJC report describes these meetings as follows: “During the Central Office COMPSTAT meeting each facility Superintendent presents his or her top problem areas as well as successes...Applause and congratulations are regularly given to unit staff who have reduced violence. Current and proposed intervention strategies to reduce assaults are discussed and input is provided by all disciplines” (Dempsey and Vivian, 2009, p.2).

**Reception of Reforms in QA and I&I.** Although the ADJC revamped its I&I and QA units to comply with the consent decree, not all ADJC employees were supportive of how these units were created. As reported above, Director Branham had

previously been a law enforcement officer, so part of his strategy to reform the agency was to bring in investigators with law enforcement experience, some of whom he had been friends with previously. Many criticized this move because they felt that a law enforcement perspective would not necessarily translate into effective management of a juvenile correctional facility. For example, one county court representative stated that one of Director Branham's "first official acts was that he sent out an email saying that they had purchased drug sniffing dogs and then there was a contest for naming them. This isn't really in line with juvenile corrections." The following section will outline how both administrators and line staff at the ADJC responded to the reforms that placed stronger preventive controls on the agency. First, the response to cameras being installed in the units will be examined. Then the section will address how improvements in I&I and the adoption of COMPSTAT have helped the agency sustain the CRIPA changes. Finally the section will address multiple critiques of the reforms in preventive controls including how the agency has become focused on minor issues, has lead to attacks against line staff, has prevented them from doing their jobs, and the challenges that will be faced in the unit as a result of budget cuts.

Overall, ADJC staff working in the facilities and Central Office both reported that the cameras have been a positive addition to the facilities that have made them safer and ensured staff were not abusing the system. These include allowing teachers and line staff to corroborate stories of fights, "flashers," and vandalism. The general perspective about the monitoring of staff was that it was really only those employees who needed to have increased supervision who raised concerns that the cameras were an invasion of privacy. For example, one employee stated that "for the staff who aren't doing anything wrong

they don't need to be concerned... for people who let things go and don't keep a good watch, they have fear, but I don't think it is unfair." Others find that the cameras have been better at monitoring staff than they have been at monitoring the juveniles. Prior to the cameras being installed, there was no way to determine if staff were really conducting their jobs properly. Following their installation, numerous staff were found to have been falsely conducting room check because they were logging the checks in the computer, but not physically conducting the checks.

In contrast to the support that was expressed by facility and Central Office employees for the installation of cameras, the perspectives of I&I, QA, and COMPSTAT were clearly opposing. More specifically, Central Office employees expressed an overall positive sentiment towards the preventive controls, while facility employees tended to express dissatisfaction with the level and types of controls that were brought to the agency. In regard to the former, Central Office employees praised I&I, QA, and COMPSTAT for being primary contributors to the agency not slipping back to the harmful practices that had led them to the two lawsuits. It was only when Director Branham was hired and "took the proverbial bull by the horns," by implementing preventive controls that the agency was able to reform. The methods of control adopted by Director Branham (e.g. hiring police officers, strong investigative focus) were reportedly rarely used in other juvenile correctional agencies, but were necessary for the ADJC during the time of CRIPA.

As a result of I&I, QA, and COMPSTAT, the agency is now able to tackle important problems before they occur. Most notably, the department developed an automated quality assurance system that shows when facility staff are out of compliance

with policies by highlighting the incident in red in the computer system. This is viewed by administrative staff as a beneficial tool for the agency because it allows the entire institution to see when they are out of compliance with policies. By being able to identify when staff are correctly or incorrectly performing specific duties (e.g. line movements, pat downs, welfare checks), they can work to correct improper practices. One administrator reported that “compliance is checked day by day. The COMPSTAT is good for looking at trends. We now try to catch problems as they go along. For example, a few months ago, a couple of kids hadn’t been assessed right away. This was caught immediately and the psychologist was disciplined.” Similar to the findings made about the installation of cameras, administrators felt that facility staff who adhered to the rules and policies of the agency would have no reason to fear checks by QA and I&I.

Using the COMPSTAT system, the investigators and superintendents began to meet with one another to develop plans to address issues within the facilities. This eventually evolved to include administrators from other units (e.g. education, mental health), who now meet every other week to discuss issues from the COMPSTAT. This collaboration has contributed to the elimination of the silos that existed between units prior to CRIPA. For example, one administrator noted that “when something would happen their first reactions would be, ‘thank God it’s you and not me,’ then it became, ‘how can we work together as a team.’” These meetings have resulted in more of a coordinated effort to treat juveniles, as opposed to the responses prior to CRIPA, when each unit dealt with the same juveniles but did not share information with one another.

Despite the acceptance of preventive controls by administrators, those working in the facilities were much less tolerant of the changes in control. First, many facility staff

were cynical about the praise given to I&I and COMPSTAT following the CRIPA. One line staff reported that they “don’t like I&I and they question why they get such good salaries. They don’t really understand the ins and outs of correctional officer duties because they have never been in those positions.” Similar criticisms were levied towards the COMPSTAT program because many staff didn’t feel that it was a revolutionary tool that had changed the agency. Many felt that there was a program very similar to COMPSTAT prior to its implementation, but that it was just less sophisticated. However, the investigators took credit for developing the program, but the agency reportedly already “had all that” before COMPSAT. One of the most critical respondents stated that “they spent millions for this and I feel like I could tell them where the problems were. You have a unit filled with violent kids and you have a program telling you there are high rates of violence there. You guys are not brilliant. I could tell you without all of these programs who the problem kids are.”

A second criticism that was made by numerous line staff was that the COMPSTAT and I&I have forced the department to be focused on very minor issues. One employee stated that “QA has their days when they can be extreme... they can drive me nuts sometimes because they look at such little things.” For example, staff reported that “if YCOs clock in one minute before they are supposed to or clock out late they will be written up” and “you can get in trouble for the carpets not being vacuumed.” This has been criticized by some staff who feel that the supervisors should be the ones taking the blame and not the line YCOs. This way, the supervisors are held accountable and the line staff can then be reprimanded by their supervisors. This sentiment was also expressed for more serious violations, with staff stating that “you can’t keep firing YCOs. They need

to look at what processes didn't work and not just look at the line staff." Some now feel that the concern that line staff now feel to make sure that they are in full compliance in all areas has resulted in them neglecting more important aspects of their jobs (e.g. therapy, groups, crisis intervention).

The third and most prevalent issue that arose among line staff and a few Central Office staff was the direction that the COMPSTAT had taken. Initially, the COMPSTAT had "meant not to target specific employees but it was going that way because by the process of elimination they could figure it out." Typical statements that were made included: "they point out all of the things we have done wrong and not the things done right," "line level staff are held accountable through COMPSTAT, but the leadership isn't held accountable," "people could be abused in COMPSTAT and some got publicly humiliated," and "they run that bus over someone and back up and do it again." For an individual who is pinpointed in the COMPSTAT, their name remains highlighted for 24 hours and any problems stay in their files for six months, making it difficult to achieve promotions. Similarly, line staff feel that even when they are performing their jobs correctly, misbehaviors among juveniles can occur that make them look poorly in the COMPSTAT. Multiple officers stated that whenever fights occur, one of the first questions that is asked of them is "where were you?" Because they feel that many situations are out of their control, they have clearly become dissatisfied with the blame that has been placed upon them.

As a direct result of the attention given to policy violators in the COMPSTAT, some staff are fearful to report incidents. One employee felt that morale in the agency was "awful." When asked if this was the result of the proposed closure of the agency, the

employee stated that “we are over the closure now. Part of it is because of COMPSTAT and them being so stat driven. Things are going on that are shady. Now they hold staff responsible for a lot of issues and not the kids...A lot of the time staff won’t report things because they don’t want to deal with the repercussions...they just never know what the next day is going to bring.” Many line staff now feel that the reliance on I&I and COMPSTAT to monitor the agency has now led to the facilities being run from downtown. They now face high levels of scrutiny that had not occurred previously.

**Maintaining Preventive Controls Following Budget Cuts.** Following the budget cuts in 2010, the threat to close the agency, and dozens of laid off employees, the impact that these changes will have on I&I has been questioned. On the one hand, many attribute the success of the ADJC to the controls that were placed on the agency by I&I and consider it a necessary presence in the agency. On the other hand, as the number of incarcerated juveniles has decreased and the department has come to terms with budget reductions, questions have been raised over how large the unit needs to be. The following section will examine each of these perspectives in more depth to shed light on how the agency will proceed in light of recent changes.

As evidenced above, many of the administrators at the ADJC attributed a large portion of the agency reforms to the increased monitoring by I&I. Because of this, some Central Office employees expressed concerns about how the agency would sustain the changes if the unit were to be drastically cut. For example, one administrator felt that the changes made during the time of CRIPA were effective and necessary for the agency, but felt it was unlikely that all future directors would find it necessary to employ so many costly investigators. Following the CRIPA, this employee believed that “there was a lack

of ownership on the part of people doing things because someone else was checking on them. They need to create ownership.” This sentiment was echoed when the Arizona Auditor General audited the ADJC in 2009. Following their audit, they concluded that the monitoring of I&I had helped to improve the facilities, but recognized that a variety of factors could impact the long term presence of the I&I unit. “These threats include changes in funding, department management, staffing levels, and the size of the juvenile population. Therefore, the Department should continue to monitor the level of violence within its secure facilities, assess whether its actions and practices are having a positive impact on reducing violence, and adjust when necessary if it finds that these actions and practices no longer help to sustain reduced levels of violence” (Office of the Auditor General, 2009a, p. ii). Despite the benefits that internal monitoring by I&I have brought the agency, many at the ADJC question the need to have such a large unit.

Staff at both Central Office and the facilities believed that an appropriate direction for the agency was to retain the I&I unit, but that cuts within the unit were necessary. Similar to the respondents who were concerned about cutting I&I, these employees also felt that the controls placed upon the ADJC by I&I were needed to reform the agency. However, they raised questions how about many investigators were actually needed. For example, statements like “the agency is really fat,” “how many cops do we need,” and “how come you need 15 people doing investigations?” were typical. Those in the institutions were supportive of Director Flanagan’s direction, as he had been cutting staff from Central Office (e.g. investigative positions) and was bringing more officers to the institutions. Under Director Branham, there were nearly 40 employees in the I&I unit because he believed that punishing officers and preventing future misconduct was



essential to reforming the culture of the agency. In contrast, Director Flanagan has advocated for a smaller I&I unit. The unit now has less than 30 employees, as they have been losing staff through layoffs and attrition.

Many held the perspective that the agency had just hired too many I&I employees during the time of CRIPA. As a result, they indicated that the layoffs when the budget was reduced were partially the fault of the ADJC. One Central Office employee was particularly critical of Director Branham's strategy and felt that:

this type of law enforcement focus is negative. I give Branham credit that this was initially needed, but this was not a long term strategy. Branham had defended the agency from change, but he failed because when he lost money he was unable to adapt and those in the government became unhappy. There was a lot of money given to Branham in the wake of CRIPA. He should have used that money to make the necessary changes within the agency, but then he needed to figure out ways to cut the budget, but he did not want to do this.

Some employees now feel that the direction of the agency needs to be one where they continue cultural reforms and are less dependent on oversight to maintain the CRIPA changes. They now seem to be somewhat optimistic that the changes that have been made (e.g. increased training, setting boundaries, holding staff accountable, cultural reforms) are extensive enough to reduce the size of the inspections unit without slipping back to conditions that would warrant a third lawsuit. The following section will examine one of these changes in more depth, the implementation of punitive controls, as they have a direct impact on the sustainability of the CRIPA reforms.

**Implementation of Punitive Controls at the ADJC.** As a result of the preventive controls that were implemented following CRIPA, it has been easier for the department to identify and punish staff misbehaviors. Prior to the CRIPA investigation, it was reported that there has been little follow up for discipline. Director Branham

disagreed with this practice and would make sure that investigations were followed through or would punish employees when he felt they were misbehaving.

The reporting of abuse and misconduct was made easier following the CRIPA. In fact, the “ADJC has policies, procedures, and 24-hour management team members in place to render immediate assistance to employees and juveniles who report harassment, discrimination, retaliation, misconduct, and other incidents that poses a threat to a safe and secure working and living environment” (Arizona Department of Juvenile Corrections, 2011b, p. 2). There are multiple policies and procedures by which reporting can be reported under. Most notably is “Project Zero Tolerance,” which was started by Director Branham. Through the use of an email address and phone number, employees, family members, or others who are aware of abuses are encouraged to report them to the director. Other departmental policies have been adopted to ensure equal opportunities for employees, protection from sexual harassment, allow for employee grievances, investigations of all complaints, protection of juveniles from sexual abuse, incident reporting, juvenile rights, and juvenile grievances.

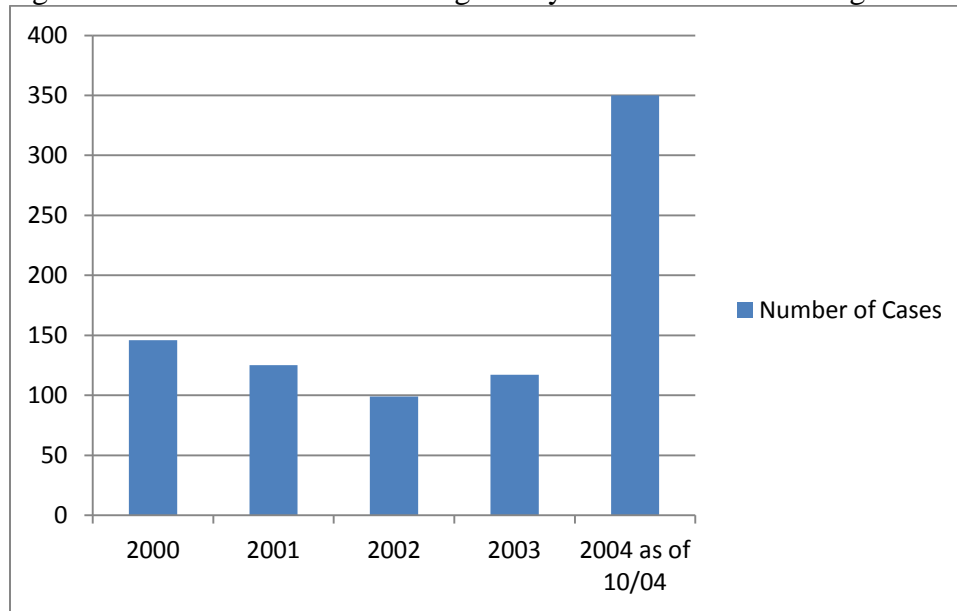
In some cases, before initiating formal discipline towards employees, the department may handle an issue informally through either a letter or verbal communication. The department’s Non-Discrimination Policy Statement outlines how employee grievances can be resolved informally. More specifically, employees who are aware of discrimination, violations of personnel rules, or other issues that harm employees are given the “opportunity to attempt informal resolution of conflicts and concerns through communication and teamwork” (Arizona Department of Juvenile Corrections, 2011b, p. 5). In cases where an issue cannot be resolved informally, the

department will formally respond to the issue. Formal investigations include interviews with those involved in the incident. Substantiated findings of misconduct by an employee can result in sanctions from training to termination. In cases where an employee is suspended for 40 hours or longer, the employee will be notified within 3 to 5 days if they will be fired.

Following the hiring of Director Branham, the number of cases investigated by the Investigations and Inspections Unit tripled (Figure 6). In the four years prior to the CRIPA consent decree, there was an average of 122 cases investigated per year. In 2004 there were over 350 cases that were investigated, which included investigations into past misconduct. Director Branham reportedly felt it was crucial to conduct investigations and remove abusive staff in order to reform the culture of the agency. After the implementation of the I & I unit, one ADJC employee noted that there has been an increase in disciplinary issues in the agency. However, this is likely the result of the agency now having the tools to confirm problems and reports of abuse.

Another form of punitive controls that have been placed on the agency following the CRIPA investigation was the firing of abusive staff. As mentioned in Chapter 5, Director Branham fired officers who were found to have abused juveniles in the past and had them prosecuted. This included abuses against juveniles that had been made in the initial *New Times* articles. This practice continued for the duration of Director Branham's term with the agency, suggesting that abuse was no longer going to be tolerated in the agency. In other words, after the CRIPA monitoring ended, firings for abusive behaviors were still going to be the norm in the agency. To conduct the

Figure 6. Number of Cases Investigated by I&I Before and During CRIPA



Source: Arizona Department of Juvenile Corrections, 2003

investigations, Director Branham hired many of his friends who had formerly been law enforcement officers to review old files and substantiate claims of abuse. In addition to abuses, employees who were inadequately doing their jobs (e.g. letting juveniles color in class) were also fired from the agency. These practices set a tone in the agency that employees who were abusing juveniles or not doing their jobs would face serious repercussions. Staff who committed the most egregious forms of abuse were formally prosecuted. The knowledge that staff will face punishments has made employees more likely to report problems, as they believe their complaints will be responded to.

The extent to which Director Branham took the firings seriously is demonstrated in the firing of an ADJC officer in 2006 for “making inappropriate and unprofessional comments, making racially discriminatory comments, insubordination, and dishonesty” in front of other officers (Fuller v. ADJC, 2008, p. 2). On appeal it was found that the

officer had not actually made radically discriminatory comments; however, his firing was upheld because he had in fact made inappropriate comments. The officer had argued that his firing was arbitrary because other employees would not have received such a punishment. One factor that made this case different than other employees' cases was that this officer had two previous offenses on his record where he had failed to monitor juveniles. For the two prior offenses he was reprimanded and informed that a third offense could result in a dismissal. For these reasons, his appeal to the Arizona Superior Court affirmed the original decision of the trial court that his firing was an appropriate response.

## **Conclusion**

The current chapter has demonstrated that there are likely two reasons why the ADJC has sustained many of the requirements of the CRIPA consent decree, even when confronted with drastic budget cuts. First, counties expressed grave concerns that juveniles were being placed in abusive conditions while at the ADJC. In response, counties committed fewer juveniles to the agency and instead treated them in their communities. If this practice had continued over a long period of time, the ADJC would have been faced with severe budget reductions by the governor who was particularly interested in the agency reforming. Second, as Director Branham recognized that the agency was losing legitimacy in the eyes of various agencies across the state, he implemented both punitive and preventive controls that would finally prevent the deprivation of juveniles' civil rights. While administrators have found these to be effective in ensuring the safety and security of juveniles, line staff feel that these controls

have attacked them and prevented them from providing rehabilitation. Chapter 7 will provide direct linkages between these reasons for reform and the changing culture of the agency. The chapter will then discuss policy implications, limitations, and future research on the sustainability of reforms following CRIPA interventions.

## **Chapter 7**

### **Discussion**

#### **Introduction**

Deprivations of civil rights of persons in prisons, jails, and juvenile correctional facilities have persisted for centuries (Pisciotta, 1994). Such deprivations include but are not limited to: overcrowded facilities, unsanitary conditions, inmate rioting, physical and sexual abuse by officers, and failure to provide rehabilitation. One recent mechanism for responding to these abuses has been to take legal action against the responsible institutions through the Civil Rights of Institutionalized Persons Act (CRIPA). Through CRIPA, the Department of Justice has sued or entered into over 130 consent decrees, some of which were directed at multiple facilities (e.g. Arizona Department of Juvenile Corrections had one consent decree that covered three facilities). Over 70 facilities for confining juveniles have been under a consent decree or lawsuit with the DOJ since 1980. In order to comply with a consent decree or lawsuit, the facility must come into adherence with all areas found to violate the civil rights of inmates. Once compliance has been achieved, the federal government ceases to have any authority to improve institutional conditions.

At issue here is that an institution could revert back to abusive conditions after federal monitoring has ended. The limited research available in this area suggests that in order to sustain consent decrees, an agency must have a commitment on the part of employees who desire to reform (Barton, 1994; Chanin, 2012). Furthermore, it is important to determine why agencies have reformed, as these motivations will have a direct impact on maintaining long-term reforms. One possibility is that an agency will

reform for rational reasons, like providing job skills training because the agency is committed to rehabilitating offenders. In contrast, according to the institutional perspective, an agency may reform because of concerns that the agency will no longer appear legitimate to those in the institutional environment, and as a result will lose critical resources (Meyer and Rowan, 1977). A second possibility is that institutions can accomplish reforms because of punitive and preventive controls that are placed on employees to ensure compliance with policies (Sherman, 1978).

To determine how agencies are able to sustain reforms following CRIPAs, the current dissertation explored the responses of the Arizona Department of Juvenile Corrections (ADJC) after the agency was monitored under the CRIPA from 2004 to 2007. The current chapter presents major findings and discusses them in context with prior literature. It then examines policy implications, limitations, and directions for future research.

### **Maintaining Reforms Following a Consent Decree**

When organizations become so deviant that they warrant formal social controls to achieve reform, it is crucial that they sustain long-term changes (Reiss, 1966). A small body of research has examined the outcomes of police departments following consent decrees and even fewer studies have documented reforms in correctional institutions after consent decrees have been lifted. The majority of studies find that consent decrees have been successful at reducing officer misconduct and reforming conditions of correctional institutions, including juvenile facilities (Dale and Sanniti, 1993; Davis, Henderson, Mandelstam, Ortiz, and Miller, 2005; McMickle, 2003; Stone, Foglesong, and Cole,



2009). More specifically, they are typically successful at remedying the issues outlined in the consent decrees, but have been less able to impact cultures. Furthermore, in departments where consent decrees have failed, relationships between the department and community are poor (i.e. community policing is unable to be institutionalized), leadership is deficient, and there is high turnover.

Following the consent decree at the ADJC, there are several areas where the department has been able to maintain long-term reforms and others where they have had less success. Most notably, the training and monitoring of staff has improved, juveniles are no longer held in solitary confinement for weeks at a time, physical conditions of the institutions have made it easier to prevent suicides, juveniles now have an outlet to grieve abusive staff and conditions, juveniles are provided with better medical treatment, and juveniles are better monitored in school progress. The agency had struggled in improving many of these services, even after the *Johnson v. Upchurch* consent decree. However, following CRIPA the ADJC has been more successful at improving many of the key areas of care.

Areas where the department has still struggled include providing a sufficient number of teachers, completely preventing suicide, preventing sexual abuse, and adhering to programming materials for mental health treatment. The most notable issue following the cessation of the consent decree was the completed suicide in 2010. Many of the factors that contributed to this specific incident have since been remedied (e.g. restrictions placed on moving juveniles from one unit to another, plastic bags are not allowed in rooms). More importantly, the officer on duty that night was fired because of his disregard of policies on the night of the suicide. These changes are likely to prevent

future suicides, but one change in the organization following CRIPA will have a much more substantial impact on suicide prevention. In a national survey of confined youth, Hayes (2009) found that one of the biggest contributors to completed suicides was being held in solitary room confinement during the daytime. After CRIPA, solitary confinement is rarely used and when it is, juveniles are under heavy monitoring (e.g. frequent room checks). Despite these challenges, the overall picture of the ADJC is that they have made significant improvements to the treatment and confinement of juveniles in their custody. There have been some glaring exceptions (e.g. completed suicide in 2010, sexual victimization) that have marred this progress, but the agency has adopted policies and been committed to maintaining conditions that do not deprive juveniles of their civil rights.

Although the ADJC was required to reform as a result of a federal consent decree, the fact that they have been unable to sustain every aspect of the consent decree six years after monitoring ended is not surprising. The challenges faced by the agency to provide services like rehabilitation, education, and mental health, especially during a time of severe budget cuts, are not unique to the ADJC (Guarino and Loughran, 2006; Parent et al., 1994). Deficiencies in juvenile facilities are “widespread,” especially when providing services in some of the most notable areas of the ADJC reform (e.g. mental health, preventing suicide, physical health). Providing treatment in institutions is further complicated by the preoccupation that exists in juvenile correctional facilities with maintaining security (Bortner and Williams, 1997). Research suggests that an environment where juveniles are confined can itself lead to increased mental health problems, making it even more challenging to provide treatment (Kashani, Manning,

McKnew, Cytryn, Simonds, and Wooderson, 1980). Juvenile justice advocates have also been highly critical over the confinement of juveniles, as it has been associated with worse outcomes (e.g. limited employment options, worsened mental health, difficulties enrolling in school) post release (Holman and Ziedenberg, 2006). In sum, the ADJC has been able to tackle many of the structural and policy oriented reforms, but has faced challenges when addressing issues that are more inherent to correctional institutions.

Large institutions for confinement have recently been coming under fire as the benefits of small regional institutions and community placements have been recognized (Butts, 2011; Lee, Bright, Svoboda, Fakunmoju, and Barth, 2011). For example, juveniles placed in diversions programs in the community have reduced recidivism rates when compared to juveniles held in detention (Shelden, 1999). In fact, Jerome Miller's (1991) decision to close the large juvenile state institutions in Massachusetts and transition to small local facilities was in direct response to the inability to successfully reform conditions of confinement in the large institutions. States like Utah and Missouri have also experienced tremendous success following consent decrees in delivering a regionalized model (Huebner, 2012; Krisberg, 2005).

Most notable has been the success of Missouri after it developed a regionalized model that allowed juveniles to remain closer to their homes. The "Missouri Model" has been praised for the incredibly low recidivism rates (8%), has not reportedly had major conditional problems over the past 35 years, and has not had a completed suicide (Nelson, Jolivette, Leone, and Mathur, 2010). The treatment provided to juveniles in Missouri occurs in small group settings and the progress of treatment is monitored closely. Juveniles are also given job training, education, and counseling, all in a "non-

punitive environment” where the focus is rehabilitation (Vestal, 2008). The focus on treatment continues into the community as caseworkers work with families, schools, and staff to coordinate a successful reintegration back into the community (Huebner, 2012).

Participants in the current dissertation raved over the operations of the Missouri juvenile justice system and questioned why similar services were unable to be provided in Arizona. The failure to obtain a commitment on the part of the ADJC, the governor, counties, and the public to initiate a reform has pushed Arizona even further away from ever providing a decentralized model. The closure of the two facilities outside of Phoenix over the past three years indicates that the state is now dedicated to consolidating services in a centralized facility.

In sum, it is evident that the CRIPA consent decree has had long-term effects on influencing the conditions of the ADJC. Juveniles now have more quality education, receive more timely and thorough medical care, have more protections from suicide attempts, are able to effectively grieve problems, and have better living conditions. However, these improvements do not mean the agency has maintained all of the areas of CRIPA (e.g. preventing suicide, maintaining low ratios of staff to juveniles). The inherent problems associated with juvenile correctional facilities, especially a large centralized facility, and budget cuts prevent this from being the case.

### **Reforming Culture through Consent Decrees**

One of the most difficult challenges facing organizations that are experiencing reforms is responding to cultures (Schein, 1993). Nevertheless, research indicates that in order to implement policy changes, culture is one of the most critical areas to address

(Chanin, 2012; Proctor et al., 2009). In the case of the Arizona Department of Juvenile Corrections, the culture of the agency has in fact been one of the most difficult areas to reform. Following the *Johnson v. Upchurch* lawsuit, officers were still supportive of practices that were harmful to juveniles (e.g. physical abuse, separation) and had little communication with one another. To make matters worse, the director of the agency was unaware of what was occurring in the facilities, making it possible for abuses to go unpunished. These struggles of the agency are not unique to Arizona, as cultures have historically been difficult to reform.

Studies of police reforms suggest that if officers are unsupportive of agency reforms, any subsequent changes in the culture will be unsuccessful (Chanin, 2012; Ikert, 2007). This was evident at the ADJC following *Johnson*, as the failure to reform was in large part because employees never became fully committed to the changes. The uncertainty of the direction of the agency led to confusion as to what the officers should have even been committed to (i.e. rehabilitation or control). Furthermore, the orientation of officers who had been hired from the adult system resulted in a culture where officers had mixed goals and were pitted against one another.

In order to obtain long-term cultural reforms, multiple strategies must be adopted by an agency, including: 1.) having a strategic vision, 2.) having a commitment from management, 3.) management must also adopt the cultural change, 4.) changing the organization to allow for the change (e.g. different management style), 5.) socializing new employees into the culture and firing employees who violate policies, and 6.) developing “ethical and legal sensitivity” (e.g. internal review, supporting ways for employees to raise complaints) (Cummings and Worley, 2009). It is because of an

adherence to these strategies that the ADJC was much more successful at reforming the culture following the second consent decree. More specifically, a director was hired with clear ideas on reforming the agency. These included the firing of abusive staff, hiring of professionals with experience in juvenile justice and investigations, improving the communication between institutional level staff and administrators, improved communication between administrative staff, hiring and training line level staff who had no ties to the ADJC's abusive past, and maintaining a long term commitment towards reform. As a result, the culture of the ADJC has improved above and beyond any changes that were made following the first consent decree.

The finding that Director Branham had been so influential at successfully reforming the agency was surprising to many because of his policing background and lack of experience in corrections. However, one theme that emerged from the interviews was that Branham was successful because he was able to be a true leader for the agency. When considering his success from this perspective, it becomes much clearer as to why and how he was able to take the "bull by the horns." An extensive body of research has demonstrated the importance of effective leadership in reforming organizational cultures (Daniel and McIntosh, 1972; Fiedler and Chemers, 1967; Leithwood, Jantzi, and Steinbach, 1999). For example, Schein (2006) suggests that "leadership is touted over and over again as a critical variable in defining the success or failure of organizations, [so] it becomes all the more important to look at the other side of the leadership coin—how leaders create culture and how culture defines and creates leaders" (p. xi).

Studies of leadership in police departments provide further evidence of why leadership is a critical element of effective management (Beito, 1999; Couper and Lobitz,

1991; Mastrofski, 2002; Schafer, 2009a). More specifically, the leadership style adopted by supervisors can have a direct influence on subsequent employee behaviors (Dickson, Smith, Grojean, and Ehrhart, 2001; Prenzler, 2010). For example, Huberts, Kaptein, and Lasthuizen's (2007) study of varying police leadership styles suggests that the supervisory style adopted can have a direct impact on specific types of unethical officer behaviors. In police departments where supervisors adopted a role modeling leadership style, officers were less likely to engage in inappropriate interpersonal relationships. In contrast, in departments where supervisors adopted a strict leadership style, officers were less likely to commit offenses like fraud, corruption, and abuses of resources. Similar research suggests that police leaders characterized as having poor communication, lacking interpersonal skills, lacking integrity, being unable to respond to problems, and egotistical are considered to be ineffective by their subordinates (Schafer, 2009b). Despite Branham's lack of experience in corrections, the skills he gained from a career in law enforcement and heading the Arizona Criminal Justice Commission likely served as a much needed source of leadership for the ADJC.

Despite the observed changes in culture following the CRIPA consent decree, the extent of these cultural reforms is questionable. Critics of institutional reforms argue that improving prison cultures through litigation is extremely difficult for three reasons: 1.) Consent decrees are not always enforced, 2.) Those enforcing the consent decree take a "hands off" approach because they will feel that prison administrators are more knowledgeable, and 3.) Litigation can only target conditions of the facilities and not cultural reforms (Brooks, 1996). With regard to the first two points, these did not occur in the enforcement of the CRIPA consent decree with the ADJC. The CRIPA monitors

were highly active in enforcing the changes outlined in the Memorandum of Agreement and made numerous site visits to ensure that compliance had occurred. The monitors that were hired also had extensive backgrounds in critical areas that needed to be reformed (e.g. suicide, education), suggesting that they would be unlikely to adopt a hands off approach.

Brooks' final contention is that "litigation has improved the culture of prisons by improving conditions and improving services, [but] litigation cannot address the cultural problems" (p. 175) that led to institutional problems. In the case of the ADJC reform, this is not necessarily the case. As Brooks suggests, the litigation was able to improve conditions and improve services, which did improve the staff culture. This was evidenced by staff reporting more favorable working conditions following the CRIPA and less abuse committed by their co-workers. However, the litigation was able to improve some of the cultural conditions, above and beyond improving institutional conditions. More specifically, the firing of abusive staff set a new tone in the agency that allowed for a greater commitment to rehabilitation of juveniles and an overall improvement in the satisfaction of employees towards their jobs. While it is true that litigation cannot improve management style and communication, having dedicated administrators to root out individuals that contribute to an abusive culture following litigation can have an impact.

### **Organizational Reforms to Maintain Legitimacy**

Organizations are dependent on external agencies for resources and legitimacy. Institutional theory indicates that it is because of this dependency that organizations will



adopt practices or policies to make them appear legitimate in their institutional environments (Meyer and Rowan, 1977). The result is that organizations are not adhering to these norms for rational reasons (e.g. make the agency more effective). Instead, organizations will adopt these practices ceremonially because they will in turn be rewarded with resources from the institutional environment (e.g. financial support). The result is that organizations that are dependent on their environments will begin to resemble one another (i.e. isomorphism) (DiMaggio and Powell, 1983).

In the criminal justice literature, institutional theory has predominantly been applied to police department management (Crank, 2003; Crank and Langworthy, 1992; Katz, 2001), but rarely to correctional facilities. However, because of the dependency that correctional facilities have on their environments for resources, this is a critical area to explore (McGarrell, 1993). For example, Ogle (1999) suggests that there is conflict faced by private prisons to maintain legitimacy in the institutional environment and keep costs of incapacitation low, which can be difficult to accomplish at the same time. In the case of the ADJC, there were clear pressures on the agency to appear legitimate to the environment. The abuses and failure to prevent suicides caused public outcry from correctional leaders and juvenile justice advocates throughout the state. Once the governor of Arizona became aware of these abuses, she publicly expressed concerns and took an active role in ensuring the agency reformed.

Crank and Langworthy (1992) state that when organizations fail to adhere to the institutional myths, “crises are resolved ceremonially through a ritual that combines the public degradation of the department and the removal and replacement of the disgraced police chief by a new chief with a ‘legitimizing’ mandate” (p. 338). This process was

clearly evidenced in the reforms at the ADJC following CRIPA after the department was publicly shamed in countless news articles. As a result counties that sent juveniles to the ADJC reduced the number of commitments because they no longer perceived the agency as legitimate and able to treat delinquents. The director of the ADJC was quickly ousted following the CRIPA report detailing abuses and was replaced with a director who openly outlined his plan to bring legitimacy to the agency. Not only did the director detail how he was going to come into compliance with the CRIPA, he went a step further by vowing a cultural overhaul through the firing of abusive employees, retraining of officers, punishment of policy violators, and increased supervision of staff.

Organizations that are reforming to achieve legitimacy may do so by becoming more similar to other organizations that are perceived as legitimate (DiMaggio and Powell, 1983). The three forms of isomorphism outlined by DiMaggio and Powell are: 1.) Coercive isomorphism- the type of change that results from political factors, pressures to maintain legitimacy, and government mandates, 2.) Normative isomorphism- the type of change that results from organizations adopting practices for professionalism (e.g. requiring degrees), and 3.) Mimetic isomorphism- organizations that are unsure of best practices to adopt will mimic other successful organizations. The source of isomorphism that primarily guided the reforms at the ADJC was coercive isomorphism. More specifically, the ADJC felt tremendous pressures to reform all aspects of the agency because the federal government could potentially sue to force those reforms. Even though they never were formally sued by the DOJ, the coercive powers of the consent decree to reform clearly contributed to the changes. Mimetic isomorphism also had the potential to impact overarching reforms to juvenile corrections in Arizona. More

specifically, following the CRIPA, multiple ADJC administrators and representatives for the Governor visited facilities in Utah and Missouri to observe model juvenile justice institutions. The ADJC director expressed optimism towards the small regionalized models adopted in these states, but felt that during the CRIPA was an inappropriate time to completely revamp the structure of the institution. The sentiment expressed by ADJC administrators was that, although it was best practice for juveniles, the primary focus had to be getting out of the CRIPA. As noted above, the closure of multiple ADJC facilities indicates that the agency is far from adopting a decentralized model.

Part of the reason why the ADJC has been able to “survive,” even after the budget of the agency was cut and the Governor planned to close the agency, is because the practices now adhered to by the ADJC are viewed as legitimate. Counties do not have the resources to provide long-term housing, mental health treatment, education, rehabilitation, and supervision, but they perceive the ADJC as having the ability to accomplish these valued norms of juvenile corrections. Similarly, Crank and Langworthy (1992) suggest that it is for these reasons that police departments have been able to survive—police departments have incorporated “ceremonial displays of legitimacy...into their organizational structure[s]” (p. 360). Departments that have lost legitimacy and do not subsequently reform are then at an increased risk of organizational death (Maguire and King, 2007; Weed, 1991).

When considering the long-term sustainability of the CRIPA reforms, it is likely that the ADJC will remain committed to the practices that were adopted. Theoretically, the ADJC did not have to maintain the reforms that were made during CRIPA because the DOJ was no longer monitoring the agency. Although there was no longer a consent

decree that the ADJC had to adhere to, administrators realized they needed to continue to appear legitimate by the institutional environment. Following *Johnson v. Upchurch* those in the institutional environment had been concerned that the ADJC had abusive practices and began committing fewer juveniles to the ADJC. If the ADJC failed to adhere to the institutional myths adopted during the second consent decree, it is possible that even fewer juveniles would have been committed to the agency, potentially resulting in the organizational death of the ADJC<sup>8</sup>.

### **Outcomes of Implementing Punitive and Preventive Controls**

DiIulio (1987) argues that “poor prison conditions are produced by observable, and it appears, remedial defects in the way that prisons are organized and managed” (p. 235). Administrators running prisons with informal methods of controlling inmates and staff are frequently unable to maintain orderly institutions (Useem and Kimball, 1987). In contrast, DiIulio finds that prison administrators who adhere to a control model of management can more effectively manage safe institutions. This model is characterized by staff being required to closely adhere to policies and administrators who are committed to order maintenance and supervision of staff. As a result of strict policies, supervision, and punishments, administrators are then able to effectively control staff misconduct (Stojkovic, 2003).

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<sup>8</sup> This was a very real possibility because in 2011, the ADJC was in danger of being closed when the Governor of Arizona announced that the entire budget for the agency had been cut. This did not occur because of pressures from county courts and juvenile justice advocates across the state who still viewed the agency as legitimate.

One potential outcome of formal controls being placed on organizations by external agencies is that they will develop stronger internal controls (Sherman, 1978). Sherman suggests three ways that employees in corrupt organizations can be deterred from misconduct: developing standards so that employees can be held accountable for violations, increased supervision of employees, and removing opportunities for corruption. Following the CRIPA investigation, ADJC administrators grew highly committed to developing a managerial approach that closely resembled DiIulio's control model to finally be able to control staff. The recognition that the culture of the ADJC had failed to reform following the first consent decree led the department to enforce new methods of cultural change. The revamping of an Investigations and Inspections unit, creation of a Quality Assurance program, and initiation of COMPSTAT all set the tone that the department was more committed to deterring misconduct.

It was evident that the director during CRIPA perceived that previous reforms in the agency had not been sustained, due in large part to the poor culture of the agency. As a result, misconduct was no longer going to be accepted in the agency. By punishing staff who violated policies, monitoring employees through cameras, and more closely supervising officers, the department was able to effectively deter much of the misconduct that had occurred in the agency prior to CRIPA. The control model persisted after the CRIPA monitors left, as administrators remained committed to maintaining control of line staff. Although staff oftentimes felt as if they were going overboard, the clear outcome was that institutional staff were finally adhering to policies and training and juveniles were finally receiving appropriate programming.

One concern is that a control model may not be the most effective model for an agency that is geared towards providing rehabilitative treatment towards juveniles. In contrast to the findings of DiIulio, subsequent research has demonstrated the institutional harms associated with control models. For example, research suggests that “job autonomy and participation in decision making are associated with enhanced occupational outcomes including higher job satisfaction, stronger commitment to the institution, greater effectiveness in working with inmates, and less job-related stress” (Wright, Saylor, Gilman, and Camp, 1997, p. 525). Jail employees who are granted more discretion and control in their responsibilities have also exhibited lower turnover rates (Stohr, Lovrich, Menke, and Zupan, 1994). In addition to making staff less satisfied with their jobs, control models of management have also been associated with increased disorder in prisons (Reisig, 1998), line staff imposing increased levels of control over inmates (Hepburn and Crepin, 1984), and difficulties in providing rehabilitation (Craig, 2004).

The findings of the current dissertation confirm these arguments against DiIulio’s position. Line staff repeatedly expressed how the controls that were placed on them following CRIPA have left them frustrated and made their jobs more difficult. They report feeling targeted and singled out when any of their misbehaviors were reported to the agency. Although the overall culture of the agency had reformed and the officers were working under better conditions, the punitive and preventive controls that were placed upon them were a sore spot in the cultural reforms. While many acknowledged that the monitoring made them better, they also felt that it prevented them from providing some of the most critical elements of their jobs (e.g. counseling).

The resulting frustrations have contributed to the persistently high turnover rates that have plagued the agency since its inception. In 2007, the turnover rate of line level officers was 56% and in 2009, the turnover rate of correctional officers was 50% (Arizona Department of Juvenile Corrections, 2012a). As a result of the high turnover in 2009, the department began to develop a “succession planning program to mitigate the loss of institutional knowledge” (p. 4). By 2012, the turnover rate of line officer was 26%, suggesting that the agency has done a better job at officer retention (Arizona Department of Juvenile Corrections, 2012b). They also continue to remind staff in training about the problems that occurred during CRIPA (e.g. suicides, sexual violence) to ensure that these do not become widespread problems again.

The formal controls that were implemented by ADJC administrators following CRIPA have had both positive and negative effects on the agency which can impact the sustainability of the reforms. On the one hand, investigations, inspections, and quality assurance have caused staff to be more cognizant of actions that deprive juveniles of their civil rights (e.g. denying youths the opportunity to grieve conditions, holding juveniles in solitary confinement over a long period of time, physical abuse). The fears of punishment have also deterred staff misconduct, as officers are aware they can easily be monitored through security cameras. Sherman (1978) argues that being able to effectively implement both punitive and preventive controls are critical for establishing sustainable reforms. However, officers may become burnt out because they do not feel they are trusted to do their own jobs. The ADJC has consistently had extremely high turnover that can partially be attributed to the management tactics. It is important that the ADJC is able to find a balance between the control practices that have benefitted them

over the past six years, while also doing so in such a manner that staff no longer feel attacked and singled out when misconduct does occur.

### **Policy Implications**

CRIPA consent decrees have received criticism over their ability to provide thorough monitoring of institutions. Most notably, Cornwell (1988) criticized CRIPA because “the consent decrees it has negotiated may appear, at first blush, to remedy alleged violations, but the failure to provide for effective enforcement both within and outside of the institution substantially undermines their utility” (852). More specifically, CRIPA has limited authority over treatment that occurs outside of institutions (e.g. parole). Furthermore, once an institution has come into compliance with a consent decree, the consent decree then ends and the DOJ has no authority to monitor or enforce reforms. In other words, there is no requirement that the agency must face any form of monitoring following the cessation of the consent decree. Although not negotiated under CRIPA, the failure of the *Johnson v. Upchurch* consent decree highlights this point well. In the case of the ADJC, the agency overall has adequately maintained the requirements of the CRIPA consent decree. However, there are clear areas where the agency has slipped (e.g. suicide prevention, education). During the negotiation of the consent decree, the DOJ could make one of the requirements of the consent decree be that an external agency must monitor the agency for a set period of time. The inability to really enforce this requirement likely prevents the DOJ from making this a requirement.

In the police literature, there is some evidence that external oversight can improve police legitimacy and reduce misconduct (Walker, 2001). Similar research suggests that



outside oversight can ensure sustainable reforms in juvenile correctional facilities (Barton, 1994). However, the way the CRIPA is currently written prevents any external monitoring following the end of the consent decree because once compliance is reached, the DOJ has no legal authority to force changes. In the future, the CRIPA legislation should be reformed to include external oversight for a select period of time as a requirement. These could be infrequent visits by local volunteers with direct knowledge of correctional practices (e.g. judges). If an institution were found to be quickly reverting back to practices that deprived inmates of their civil rights, the DOJ would then be granted the authority to reactivate the consent decree. In other words, it would not take reports to the DOJ by newspapers, family members, or prisoners that they are being abused at the facilities to initiate a new investigation. This practice would also increase the amount of time that the institution would feel the pressure from the federal government to maintain the changes. Chanin (2012) suggests that continued oversight in police departments “has the potential to reduce slippage or the loss of focus that naturally coincides with the absence of a legal mandate and/or the passage of time” (p. 347). It is likely that this would similarly impact a juvenile corrections institution, but this remains to be seen.

### **Limitations**

The current project was a useful first step at examining how correctional facilities are able to maintain long-term reforms following consent decrees through the Civil Rights of Institutionalized Persons Act. However, there were several limitations that could be addressed in future research. First, the current study focused on one institution

that was experiencing a reform under CRIPA. Over 130 correctional agencies have been under federal monitoring through CRIPA, so subsequent research is needed to determine how unique the changes and challenges at the ADJC are. It is possible that the responses based upon the type of institution (e.g. juvenile corrections, prison, jail) may impact the methods of reform. Limited research has found that consent decrees have had success at reforming juvenile detention facilities (Bazemore, Dicker, and Nyhan, 1994; Dale and Sanniti, 1993), but none has examined the process of state juvenile institutions reforming over a long period. State institutions versus county institutions tend to be physically larger, have more employees, house more violent offenders, and provide treatment over a longer period, suggesting that their processes for reform would be much different from county institutions. Similarly, the orientation of the institution (e.g. rehabilitative, crime control), may require differing responses to sustain reforms. Related to this issue, similar research examining criminal justice reforms has compared reforms that occurred in multiple cities to more thoroughly examine the process and outcomes of interventions (Chanin, 2012; Sherman, 1978), suggesting the importance of comparing the current findings with other institutions.

Second, the measurement of cultural reforms was indirect and imprecise, as it was measured through the interviews with ADJC employees. In contrast to quantitative research where variables are precisely measured using data, qualitative research consists of interviews and document reviews that do not allow for the precise measurement of concepts (Merriam, 1988). However, the advantage to qualitative research is that it allows for an in depth investigation of a nuanced issue. Because “precise measuring instruments and strictly defined variables [in qualitative research] somehow limit the

inquiry with the demarcations of the instruments and the definitions” (Ebrahim, 2013, p. 199), research participants were allowed to guide their perceptions of culture (e.g. crime control oriented, rehabilitative, punitive). Future quantitative research with clearly defined measures of culture are important to examine the process of cultural reforms in more depth.

Finally, this project is also limited because two important groups with insight into the reforms were not able to be interviewed: confined juveniles and the monitors who oversaw the reforms. First, research suggests that correctional officers and inmates hold differing views towards the criminal justice system (Alpert and Hicks, 1977; Crouch and Alpert, 1980). More specifically, these studies suggest that officers have more positive views about the criminal justice system, while inmates tend to be more critical of those employed in the criminal justice system. Extending this perspective to officer versus inmate views of prison conditions and treatment, it is wholly possible that officers presented relatively optimistic views of conditions. Capturing the perspectives of juvenile delinquents would provide important insight into the reception of the reforms. Second, because CRIPA monitors are constrained under a non-disclosure agreement following their service, their insights were unable to be captured for the current project. It would have been useful to compare their perspectives of the conditions immediately following both consent decrees. This would have provided insight as to how the agency was responding differently to the second consent decree and the long-term impact of the reform efforts.

## **Future Research**

One factor that has contributed to the maintenance of reforms at the ADJC is the high level of internal controls that were imposed upon employees. The high degree of internal monitoring adopted by the ADJC was criticized by respondents as being inappropriate for juvenile corrections (i.e. not appropriate for an agency focused on rehabilitation). Others suggested that future directors may not be as committed to internal controls and could adopt new tactics. In other words, the ADJC may be unique in the high degree of internal controls that were implemented following the consent decree. Other agencies may adopt different tactics following consent decrees or lawsuits to make changes sustainable. Future research should examine other tactics implemented by departments facing CRIPA interventions to determine effective methods for maintaining reforms.

The primary focus of this dissertation has been on how agencies are able to sustain changes after consent decrees are lifted. A related issue that is critical to understanding and improving DOJ responses to civil rights violations is to explore why some institutions face difficulties in having consent decrees lifted. For example, the case of *United States v. Commonwealth of Puerto Rico*, aimed at improving the conditions of juvenile justice facilities, has not been resolved since 1994 (U.S. Department of Justice, 2011). Other institutions have been under CRIPAs since the mid-1980s. Brooks (1996) argues that one of the reasons why facilities might not reform is because “unlike fining a corporation, when one branch of the government fines another branch of the government, there is not the same personal stake in the pecuniary loss” (p. 175). Future research should explore if there are unique characteristics of institutions that make them more

difficult to reform (e.g. institution is large, political orientation of the community in which the institution is embedded within) and suggest policy implications to improve these. These findings could guide future consent decrees to ensure that compliance with civil rights are met as quickly as possible.

Future research should also examine how relationships between external agencies and the community influence the long-term changes in the agency. Of the limited research examining the sustainability of reforms following consent decrees in juvenile facilities, one critical aspect of these reforms has been the involvement of judges, counties, and other community actors (Dale and Sanniti, 1993). Police departments have also had more success following consent decrees when they have the support of external agencies and the community (e.g. community policing) (Chanin, 2012).

The current dissertation briefly examined the impact that the loss of legitimacy by the institutional environment had on the number of juveniles sent to the ADJC following the consent decree. However, the interactions between counties and juvenile justice agencies are more extensive than just the number of commitments. More specifically, there is an exchange relationship occurring where counties *temporarily* send juveniles to state agencies. The decision to commit juveniles is impacted by perceptions of conditions, but also by the appropriateness of placement, financial considerations, and rehabilitation are typically considered. Similarly, there is always the expectation that the juveniles will eventually return to their counties, so having thorough and effective communication between counties and the state is critical for reentry. For example, if counties were frequently committing juvenile misdemeanants who utilize state resources, but who are better able to be treated in their communities, this could impact the ability of

the state to provide effective services to all juveniles. This type of scenario would require that a relationship exist between state and county agencies to examine alternatives to confinement. Furthermore, it is critical that the general public perceives the agency as legitimate, as they have a direct influence on the legislature, which can in turn impact funding decisions for the agency.

## **Conclusion**

This study showed that correctional facilities that are forced to reform under the Civil Rights of Institutionalized Persons Act face challenges in the long-term sustainability of change. Strategies that aide in the institutionalization of changes include reforming organizational culture and implementing internal controls over employees. The ability of the ADJC to sustain so many important changes six years after the consent decree was lifted indicates that these strategies positively affected the agency. Agencies are also encouraged to reform because of pressures to appear legitimate in the institutional environment to avoid the loss of resources. However, the adoption of highly punitive and preventive controls may have adverse effects on employees that could harm progress of the culture, the reform, and contribute to high officer turnover. For an organization that has faced historically faced so many challenges, it is critical to maintain the support of the officers who have direct supervision over the confined juveniles. Overall, it is evident that the CRIPA is able to improve the conditions of correctional facilities, but achieving a long-term full adherence to required reforms has proved difficult.

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42 U.S.C. § 1997 et seq.

APPENDIX 1

CONSENT DECREE IMPLEMENTATION STUDIES



Source	Focus of Study	Agency	Impetus for Consent Decree	Major Findings
McMickle (2003)	Police-Racial Profiling	Pittsburgh Police Department, Steubenville Police Department, State Police of New Jersey, and Los Angeles Police Department	DOJ	McMickle reviews the responses of four police departments that entered into consent decrees with the DOJ for racial profiling. While McMickle found that some improvements were made because of the consent decrees, she finds the DOJ has multiple limitations. These include: the DOJ only acts after local and state attempts to reform have failed, the Civil Rights Division is limited in resources (e.g. litigators), and findings of investigations are rarely publicized.
Davis, Henderson, Mandelstam, Ortiz, and Miller (2005)	Police-Misconduct	Pittsburgh Bureau of Police	Class-Action Lawsuit	Davis and colleagues examined the changes made after the Pittsburgh Bureau of Police entered into a consent decree with the American Civil Liberties Union and the National Association for the Advancement of Colored People. The consent decree was in response to reported misconduct, including excessive force, ineffective supervision of officers, improper searches/seizures, and other abusive practices. Overall it was concluded that the consent decree effectively reformed the agency. Specifically, the reforms improved police accountability and

				productivity and reduced misconduct. However, many officers were dissatisfied that the agency had entered into a consent decree. In response, there was less interaction with the public, which harmed community policing strategies.
Kupferberg (2008)	Police-Racial Profiling	Los Angeles Police Department, New Jersey State Troopers, and New York Police Department	DOJ	Kupferberg's review of three police departments that entered into consent decrees with the DOJ found that there were no significant reductions in racial profiling four years after each department entered into a consent decree. However, they argued that consent decrees were valuable for collecting data on profiling and informing the public of these practices.
Stone, Foglesong, and Cole (2009)	Police-Misconduct	Los Angeles Police Department	DOJ	Stone and colleagues examined the consent decree between the LAPD and the DOJ in 2000, which arose in part because of the Rodney King beating. They concluded that the department had made and sustained significant improvements, which was exhibited by increased satisfaction by the public, less frequent use of serious force, increased quality in police stops (e.g. an increased number of cases with felony charges filed by the D.A. ), and increased use of technology to combat crime.

Chanin (2012)	Police-Pattern or Practice of Illegal Conduct	Pittsburgh Police Bureau, Washington D.C. Metropolitan Police Department, Cincinnati Police Department, and Prince George's County Police Department	DOJ	Chanin reviews the implementation of consent decrees and their sustainability in four jurisdictions. The endurance of changes across the four jurisdictions varied widely. In Cincinnati, where complaints against the police decreased along with the officer use of force, internal accountability and a greater involvement of the community and officers were key to reforming departmental culture. In contrast, law enforcement in Prince George's County was unsuccessful as is evidenced by excessive use of force and officer corruption. Jurisdictions where consent decrees were unsuccessful were characterized as having little external support, high turnover, little community involvement, poor leadership, no post-reform evaluation, and poor external accountability.
Dale and Sanniti (1993)	Corrections-Changing Juvenile Detention	Broward County Regional Juvenile Detention Center	Class-Action Lawsuit	Dale and Sanniti found that the consent decree to improve conditions at the Broward County Regional Juvenile Detention Center improved as a direct result of the intervention. Improvements includes: elimination of overcrowding, improved food quality, increased quality of mental health services, and improved housing conditions. In contrast to formal litigation,

				they argue that the negotiated consent decree allowed for changes in the community as well. By forming relationships with county administrators, the Center was able to provide a continuum of services upon release and create alternative detention programs.
Bazemore, Dicker, and Nyhan (1994)	Corrections-Officer Attitudes	Broward County Regional Juvenile Detention Center	Class-Action Lawsuit	Bazemore and colleagues found that litigation did influence officer attitudes towards treatment and rehabilitation, but failed to improve the "organizational climate" among detention staff. They conclude that additional factors like wages and relationships with colleagues are more influential on organizational commitment and trust in supervisors.

APPENDIX 2  
INFORMATION LETTER

## School of Criminology and Criminal Justice

411 N. Central Ave., Suite 600, MC: 4420, Phoenix, AZ 85004-0685  
(602) 496-2369 Fax: (602) 496-2366 <http://www.ccj.asu.edu>

<Insert Date>

<Insert Contact Information >

Dear <Insert Name >:

I am a professor in the Department of Criminology and Criminal Justice at Arizona State University. I am conducting a research study to examine the investigation of the Arizona Department of Juvenile Corrections (ADJC) under the Civil Rights of Institutionalized Persons Act (CRIPA). The investigation allows us to examine both the short and long term changes in the institution that resulted after the investigation. We propose a study plan with six purposes: 1.) Understand the processes leading to federal intervention; 2.) Understand the resulting changes in the *immediate* months after the CRIPA investigation; 3.) Understand the status of ADJC's progress prior to the current financial crisis; 4.) Understand the status of services and quality of care after a reduction of funding for the agency, 5) Understand how selected juvenile court jurisdictions perceive and respond to the changes and 6.) Understand changes to those supervised under community corrections.

It is our goal to interview a wide group of people, including administrators of the ADJC regarding this project. I look forward to holding interviews with those who have insight into the investigation. I am inviting your participation, which will involve an interview of approximately one hour at your location of employment or other desired location. You will be asked to provide your opinion on the ADJC investigation, how you are involved in the investigation, and the long term effects of federal involvement. Human Subjects protections require that I tell you that you have the right not to answer any question, you have the right to stop the interview at any time, your participation in this study is voluntary, and if you choose not to participate or to withdraw from the study at any time you may do so. The possible/main benefits of your participation in the research are providing input as to impact that the CRIPA investigation had on the organization of ADJC and treatment of youths. An evaluation of ADJC is important because it provides necessary insight into the process and outcomes of federal interventions of correctional facilities. There are no foreseeable risks or discomforts for your participation.

All information obtained in this study is strictly confidential. The results of this research study may be used in reports, presentations, and publications, but the researchers will not identify you. Because confidentiality is of the utmost importance when conducting research, names and specific titles/positions of participants will not be reported. Instead of directly identifying persons by name, more general terms will be used in the report to

describe the interviews (e.g. a representative from the Arizona Department of Public Safety).

If you would like to participate in the study, or would like additional information, please contact Melanie Taylor at [mtaylor9@asu.edu](mailto:mtaylor9@asu.edu) so that we may schedule a time to meet with one another. Privacy is very important to us, so future reports will not bear any names, contact information, or other identifying information.

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788. Please let me know if you wish to be part of the study.

Sincerely,

A handwritten signature in black ink that reads "Scott H. Decker". The signature is written in a cursive, flowing style.

Scott H. Decker  
Professor and Director  
School of Criminology and Criminal Justice  
Arizona State University

APPENDIX 3

INTERVIEW PROTOCOL: ADJC



## Interview Protocol ADJC

### Background Information

1. Please identify your specific job and responsibilities?
2. How long have you been in this job?
3. What is your history of involvement with ADJC?
  - a. Juveniles?
  - b. Other relevant experience?

### Opinions on ADJC:

1. Why do you believe the investigation occurred?
2. Describe your perceptions of the ADJC prior to the investigation.
  - a. In ADJC secure facilities?
  - b. In community corrections?
3. What changes have you seen occur to the agency over time?
  - a. In ADJC secure facilities?
  - b. In community corrections?

### Opinions on the CRIPA Investigation:

1. What has been your role in the investigation?
2. When did you learn about the investigation? How did you learn about it?
3. How did the ADJC respond to the investigation?
  - a. In ADJC secure facilities?
  - b. In community corrections?
4. Did you have the opportunity to express your opinions during the investigation?
5. What are some notable changes that were a direct result of the federal intervention?

### Opinions on Changes Post-CRIPA

1. How have these changes been sustained?
  - a. In ADJC secure facilities?
  - b. In community corrections?
2. What are the pros/cons of the investigation? Can you be specific? Do you think it was a good idea?
3. What areas still need to be improved upon?
4. How has the potential for closure and budget shortfalls affected the progress made by the ADJC after the investigation?
5. How has life at the ADJC changed for youths/staff since the investigation?
6. How are others at your agency/department responding to the intervention?
7. How have juveniles reacted to the investigation?
8. Since the intervention, have there been changes in the services juveniles have been receiving? Any additional programs?
  - a. What services are lacking currently?
  - b. How have special populations (e.g. sex offenders, those with mental illnesses) been treated since the investigation?
9. What will the long term consequences/benefits of the investigation be for juveniles and staff?

### Additional Questions

1. How has the potential closure of the ADJC impacted the agency?
2. Are there any other issues you would like to raise?
3. Any other suggestions on who to discuss CRIPA investigation with?

APPENDIX 4

INTERVIEW PROTOCOL: COUNTIES AND COMMUNITY

## Interview Protocol- County Corrections/Community Advocates

### Background Information

1. Please identify your specific job and responsibilities?
2. How long have you been in this job?
3. What is your history of involvement with ADJC?
  - a. Juveniles?
  - b. Other relevant experience?

### Opinions on ADJC:

1. What is the relationship between <INSERT AGENCY NAME HERE> and the ADJC? - Is communication frequent between the two agencies?
2. How does communication usually occur between your agency and ADJC?
3. Were you or others in the department aware of conditions in ADJC prior to the CRIPA investigation?
  - a. Did they raise concerns over any issues?

### Opinions on the CRIPA Investigation:

1. What are some notable changes that were a direct result of the federal intervention?
2. What changes have you noticed since the consent decree was lifted in 2007?
  - a. How have these changes been sustained?
  - b. What areas still need to be improved upon?
3. Did you/your agency have the opportunity to express your opinions during the investigation?
4. At meetings and committees you have been involved in, what sense do you get as to how CRIPA has affected juvenile justice in Arizona?
  - a. What have you heard the conditions at the agency are currently like?
5. Are there any concerns that juvenile courts have had over sending certain juveniles to ADJC in light of the investigation (e.g. those with mental health issues)?

### Opinions on Changes Post-CRIPA

1. Has the <INSERT AGENCY NAME HERE> made any changes in sending juveniles to the ADJC because of conditions at the ADJC?
2. Since the intervention, have there been changes in the services juveniles have been receiving? Any additional programs?
3. What services are lacking currently?
4. How have special populations (e.g. sex offenders, those with mental illnesses) been treated since the investigation?

### Additional Questions

1. How has the potential closure of the ADJC been received by <INSERT AGENCY NAME HERE> county probation?
2. Are there any other issues you would like to raise?
3. Any other suggestions on who to discuss CRIPA investigation with?

APPENDIX 5

TIMELINE OF THE ARIZONA DEPARTMENT OF JUVENILE CORRECTIONS

## **Historical Timeline for the Arizona Department of Juvenile Corrections**

### **1901**

- Territorial Industrial School created in Benson, AZ to confine juveniles

### **1927**

- Fort Grant School was formed

### **1968**

- Arizona Department of Corrections takes over jurisdiction of juveniles

### **1967**

- Arizona Youth Center opened in Tucson (Renamed Catalina Mountain in 1980)

### **1972**

- Adobe Mountain opens for girls

### **1974**

- Adobe Mountain begins to house boys and girls

### **1975**

- A correctional officer is killed at Adobe Mountain by juveniles

### **1986**

- A juvenile files a civil rights lawsuit that leads to the *Johnson v. Upchurch* consent decree (April, 6)

### **1987**

- *Johnson v. Upchurch* becomes a class action lawsuit (July, 27)

### **1988**

- Catalina Mountain opens

### **1989**

- Governor Mofford creates a commission to examine the agency (September, 22)

### **1990**

- The ADJC is formed after separating from the ADC (July, 1)
- The first director, Carol Hurtt, is appointed from the ADC
- Fifteen juveniles escaped from the ADJC; One is killed after crashing a stolen car (July)

### 1991

- Name of agency changed from the ADJC to the Department of Youth Treatment and Rehabilitation
- The director reports that the agency is facing challenges with the budget and is trying to focus money on the most troubled juveniles (April, 5)
- Director Hurtt resigns and Eugene Moore is hired as interim Director
- John Arredondo from the Texas Youth Commission is appointed director (October 30)

### 1993

- The state enters into a consent decree to resolve *Johnson v. Upchurch*; is required to make 109 reforms throughout the agency (May, 5)
- A play using real guns was performed at Black Canyon School (November, 13)

### 1994

- A guard is suspended after writing a complaint to the director and Governor about the play stating that the play was inappropriate (January, 3)
- Governor of Arizona fires Director Arredondo and he is replaced by Eugene Moore (January, 6)
- Federal monitors for *Johnson v. Upchurch* consent decree report that the state is coming into compliance, but believe the agency may not be able to provide adequate treatment to juveniles (December 11)

### 1995

- Department changes its name back to the ADJC (January, 19)

### 1996

- Federal Judge Bilby orders that the ADJC cannot accept any more juveniles because they are over capacity (April, 10)

### 1997

- Bilby again orders the ADJC to comply with population caps (January 17)
- The ADJC announces that they will not comply with the population caps set by the federal judge (January 19)
- Bilby sets a hearing to examine the ADJC being in contempt of the *Johnson* consent decree (February 7)
- ADJC begins to release juveniles to comply with population caps (February 15)
- ADJC continues to release juveniles to comply with population caps (February 19)
- ADJC receives nearly half a million dollars in fines because of overcrowding (March 21)
- Judge Bilby agrees to postpone the fine (April 1)

- Judge Bilby allows the consent decree to expire and does not require the agency to pay fines (May 5)
- A grand jury reports the ADJC released 13 dangerous juveniles early (October 3)
- Director Eugene Moore retires and Deputy Director David Gaspar is appointed director (December)

### 1998

- The ADJC proposes to have juveniles housed at the Arizona State Prison Complex in Tucson (March 25)
- Bilby criticizes ADJC's attempt to house juveniles in state prison facility (April 1998)
- ADJC begins to house 15 boys at the prison facility (June, 9)

### 1999

- ADJC reports their recidivism rates has been decreasing (May, 13)
- A youth rights ombudsman at the ADJC writes a memo to the ADJC director that conditions for juveniles were unsanitary and unsafe (May, 19)

### 2000

- Black Canyon is used solely to house the female ADJC population; Units are opened that are specifically designed for parole violators (March)

### 2001

- A juvenile at the ADJC was reportedly punched by an officer (January)
- The *New Times* releases the article "The Kids are Not Alright"; Arizona community leaders ask Governor Hull to create a task force to review conditions at the ADJC (July, 5)
- The parent of the juvenile who was punched by an officer write a letter of complaint to Governor Hull (October)
- The *New Times* releases the article "Learning Disorder" documenting the failing education system at the ADJC (December, 13)
- The *New Times* releases the article "The Kids are Still not Alright" where one of the *Johnson* monitors says that another investigation of the agency is needed and that the agency is hiding its problems (December, 20)

### 2002

- Freedom and Hope cottages at the ADJC are on lockdown for over one week; A youth rights advocate reports that the juveniles are being deprived of their civil rights in numerous ways (e.g. not providing juveniles with exercise, overcrowding, high temperatures) (March)
- Director Gaspar is a candidate for the 2002 American Correctional Association Director election (April, 1)
- A male juvenile commits suicide at the ADJC; The juvenile had been in his cell for a week and made reports about inappropriate touching by staff (April, 11)



- The Department of Justice informs Arizona that it will be investigating the ADJC (June, 2)
- Director Gaspar informs staff that they will be investigated (June, 18)
- The *New Times* releases the article “Federal Inquiry: Justice Department Examines Conditions At State Youth Facilities” (June, 22)
- The Tempe chapter of Amnesty International met to discuss violations at the ADJC (June, 26)
- A second male juvenile commits suicide (July)
- Governor Hull reports that the ADJC may receive a 10% budget cut (August, 30)
- DOJ consultants conducted on-site investigations of ADJC facilities (October, 1-4)
- Janet Napolitano is elected as the Governor of Arizona (November, 5)
- Director Gaspar reports that the proposed budget cut to the ADJC of 5% will result in the early release of juveniles and failure to provide them with community care (November, 15)

### **2003**

- DOJ consultants conducted on-site investigations of ADJC facilities (January, 13)
- A third male juvenile commits suicide at the ADJC (March, 23)
- The *New Times* releases the article “Suicide Watch” about the dangers of suicide at the agency and the DOJ investigation (April, 3)
- The Girl Scouts and Catholic Social Service DIGNITY Programs partnered with ADJC to provide programs for girls on prostitution and drug diversion (July, 9)
- Director Gaspar retires and is replaced by Interim Director Michael Branham (September, 30)
- DOJ consultants conducted on-site investigations of ADJC facilities (October, 22-25)
- DOJ consultants conducted on-site investigations of ADJC facilities (December 3-6 and 17-20)

### **2004**

- The DOJ releases its findings letter to Governor Napolitano outlining the deprivations of civil rights at the ADJC (January, 23)
- The *New Times* releases the article “Juvenile Offenses” about the findings of the CRIPA report (January, 29)
- An ADJC officer is arrested for having sexual relations with a juvenile inmate (February, 26)
- Napolitano wrote a letter to Alexander Acosta, the Assistant Attorney General. In it she states that she is committed to reforming the ADJC. She states how they are currently making changes and she has formed a task force to provide oversight. (March, 10)
- Michael Branham is named as director (March, 11)
- Governor Napolitano and CRIPA monitors tour ADJC to review changes (March, 22)

- A former ADJC officer pleads guilty to having sexual relations with a juvenile inmate (July)
- The Governor of Arizona tours Catalina Mountain School (August, 16)
- Governor Napolitano suggests she wants to avoid a lawsuit with the federal government (August, 17)
- Arizona negotiates with the DOJ over consent decree (September)
- Memorandum of Agreement to reform the ADJC is signed (September, 15)
- A second officers if found guilty of sexual assault (October)

## 2005

- The first semi-annual CRIPA report finds that the ADJC is in substantial compliance with 23 provisions, partial compliance with 91 provision, non-compliance with 9 provisions, and did not rate 13 provisions (March, 15)
- Dateline runs a story on the ADJC, with a partial focus on the CRIPA (August, 4)
- The second semi-annual CRIPA report finds that the ADJC is in substantial compliance with 55 provisions, partial compliance with 70 provision, and non-compliance with 1 provision (September, 15)

## 2006

- The third semi-annual CRIPA report finds that the ADJC is in substantial compliance with 107 provisions, partial compliance with 19 provision, and non-compliance with 0 provisions (March, 15)
- The ADJC is sued by a juvenile who was solicited by an officer (April, 12)
- The fourth semi-annual CRIPA report finds that the ADJC is in substantial compliance with 118 provisions, partial compliance with 10 provision, and non-compliance with 0 provisions (September, 15)
- The *New Times* releases the article “Teenage Wasteland” about the potential for a permanent oversight committee

## 2007

- Juvenile Detention Task Force established to review AZ Auditor General’s Performance Audit Report (February, 13)
- The fifth semi-annual CRIPA report finds that the ADJC is in substantial compliance with 120 provisions, partial compliance with 3 provision, and non-compliance with 0 provisions (March, 15)
- The American Friends Service Committee in Arizona released “Buried Alive: Solitary Confinement in Arizona’s Prisons and Jails.” This report strongly criticized the ADJC for their use of solitary confinement. (May)
- The ADJC responded to the “Buried Alive” report, claiming that many of the allegations made in the report were either false, or no longer true, as their policies had changed.
- The DOJ files to dismiss the consent decree with the ADJC (September, 14)

- The sixth semi-annual CRIPA report finds that the ADJC is in substantial compliance with 60 provisions, partial compliance with 0 provision, and non-compliance with 0 provisions (September, 15)
- DOJ announces that the ADJC is now in full compliance with CRIPA (September, 21)

## **2008**

- Representatives from the National Associations for Child and Teenage Protection in France visited ADJC to learn how they can be successful at providing a tough on crime approach along with rehabilitation. (February, 7)
- An ADJC employee is assaulted by juveniles trying to escape the safe schools (September, 4)
- Therapy dogs are being used in the mental health unit at Black Canyon (September, 17)

## **2009**

- A male juvenile at Adobe is found unconscious while trying to hang himself (February, 14)
- A female juvenile at Black Canyon was found trying to commit suicide by strangling herself with a shirt, but was prevented from doing so by staff intervention (April, 3)
- A male juvenile tried to commit suicide by tying a towel to his feet and neck, but was prevented from doing so by staff intervention (April, 4)
- A female juvenile is found cutting herself with staples (April, 14)
- A male juvenile is found cutting himself with a staple and hitting his head against bars (May, 17)
- Mental health unit for juveniles at the Arizona State Hospital is closed because it was reportedly being used less frequently (September, 11)
- Auditor General releases performance report about the ADJC (September, 17)
- A female juvenile left in the bathroom alone is found with severe cuts (September, 21)
- The Arizona Republic releases the article “Arizona’s Juvenile Jails Free of Suicides Since ‘03” (September, 29)
- Eagle Point School and units at Adobe Mountain and Catalina Mountain are closed (December, 30)

## **2010**

- Arizona Governor Jan Brewer announces proposal to close the ADJC (January)
- Arizona counties report that closing the ADJC would make it difficult for them to provide services to juveniles (March)
- An ADJC officer commits suicide (May)
- A male juvenile at the ADJC commits suicide after being transferred from a mental health unit to a unit for violent juveniles (May, 25)

- At an Arizona Juvenile Justice Commission meeting it is announced that the ADJC will likely not be closing, but could still be privatized (September, 16)
- Joint House-Senate hearing resulted in the recommendation to keep ADJC open (December, 6)

### **2011**

- A boy at Catalina Mountain School was ordered released after he was reportedly assaulted while in custody (March, 5)
- Brewer announced that Branham was stepping down and that the Deputy Director of the Arizona Department of Corrections, Charles Flanagan, would be appointed as Director (June 10)
- Director Flanagan announces that Catalina Mountain School will be closing in an effort to cut down on costs (July, 12)