STATE OF NEW MEXICO
COUNTY OF BERNALILLO
SECOND JUDICIAL DISTRICT

No. _____

The AMERICAN CIVIL LIBERTIES UNION OF NEW MEXICO,

Plaintiff,

v.

The NEW MEXICO CHILDREN, YOUTH AND FAMILIES DEPARTMENT, BILL DUNBAR, Secretary, New Mexico Children, Youth and Families Department, and DEBRA PRITCHARD, Director, Juvenile Justice Services, New Mexico Children, Youth and Families Department,

Defendants.

COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND COMPENSATORY RELIEF

1. This is an action for breach of contract and breach of the implied covenant of good faith and fair dealing which is brought by the American Civil Liberties Union of New Mexico (hereafter, "ACLU-NM") on behalf of all New Mexico youth who have been adjudicated as delinquent. This action challenges the failure of the named New Mexico officials and the New Mexico Children, Youth and Families Department ("CYFD") to comply with the September 3, 2009 Settlement Agreement ("2009 Agreement") reached between CYFD and ACLU-NM, which requires CYFD, *inter alia*, to protect the safety of these youth, to treat them fairly and to provide them with proper mental health treatment, substance abuse treatment and medical care. The 2009 Agreement is attached as Exhibit 1 to this Complaint.

2. Some youth, especially those with mental and/or developmental disabilities, are inappropriately placed in CYFD's secure delinquency facilities because they have been unlawfully denied needed mental health treatment while on probation, yet the CYFD facilities do

not meet their identified treatment needs. Many of these young people need mental health treatment and/or substance abuse treatment which, if provided to them in a timely way in community settings, would have enabled them to avoid incarceration. However, Defendants have unlawfully failed to provide them these essential community-based services, causing them to suffer great harm, as well as unnecessary, inappropriate and illegal incarceration.

3. The youth who are housed in state-run or contract secure facilities are routinely and unlawfully placed by Defendants in unsafe conditions causing them to suffer physical and emotional injury and making it very difficult for them to achieve satisfactory rehabilitation. These youth are also routinely and unlawfully denied adequate mental health, substance abuse, medical and educational services by Defendants, thereby causing them to suffer great harm and excessive periods of incarceration, and making it very difficult for them to achieve satisfactory rehabilitation. While in the facilities run by, or under contract with, CYFD, these youth are subjected to abuse and/or neglect. Consequently, their behavioral problems become exacerbated by threats of harm and actual physical harm they suffer while in the facilities. As a result of Defendants' illegal and indifferent conduct, the prospects for these youth ever becoming healthy and productive adults become more difficult and more remote.

4. Finally, these youth are routinely and unlawfully denied parole, now called "supervised release," and made to suffer extra periods of incarceration because Defendants have failed to provide needed services within the secure facilities and also failed to arrange for the community-based services necessary for them to engage in their rehabilitation and remain out of trouble after they have served their periods of incarceration.

5. On September 3, 2009, ACLU-NM, on behalf of these New Mexico delinquent youth, entered into the 2009 Agreement to remedy these and other program deficiencies and rights violations.

6. After more than 14 months, Defendants still have not implemented many important requirements of the 2009 Agreement, and their non-compliance is causing these youth to continue to suffer substantial harm.

7. Moreover, Defendants have also knowingly and deliberately attempted to conceal their non-compliance. Their bad faith is another basis for the Court awarding remedial relief to the youth in CYFD's custody. Defendants are equitably estopped from asserting either that the 2009 Agreement terminates on December 31, 2010 or that the Court is without jurisdiction to award ACLU-NM damages and equitable relief. Due to CYFD's non-compliance and their bad faith, ACLU-NM seeks to specifically enforce the terms of the 2009 Agreement and to obtain injunctive relief:

A. mandating Defendants to comply with the 2009 Agreement by providing the programs, services, mental and medical health care and safe living conditions required by the 2009 Agreement; including establishing a plan to address the needs of incarcerated youth over the age of eighteen and of "high risk" youth;

B. compensating the youth who are the beneficiaries of the 2009 Agreement for CYFD's non-compliance;

C. awarding liquidated damages for those violations of the 2009 Agreement which were deliberate or in bad faith; and

D. awarding reasonable attorneys' fees and costs.

8. Alternatively, should the Court choose not to specifically enforce the terms of the 2009 Agreement and grant equitable relief and damages, ACLU-NM seeks to vacate the 2009 Agreement and return ACLU-NM and CYFD to the positions they were in prior to September 3, 2009: in litigation regarding noncompliance with the original February 15, 2006 agreement.

JURISDICTION AND PARTIES

9. This Court has jurisdiction over this matter because all parties are New Mexico residents and all events occurred within the State of New Mexico.

10. This action arises under the common law and statutes of the State of New Mexico.

11. Plaintiff ACLU-NM is a non-profit, membership organization with members located throughout New Mexico. It represented itself and some of its constituents, all New Mexico youth adjudicated delinquent, in negotiating and signing the September 3, 2009 Agreement with Defendant CYFD.

12. Defendant Bill Dunbar is the Secretary and chief executive officer of the New Mexico Children, Youth and Families Department. As such, Defendant Dunbar is responsible for New Mexico's care and treatment of youth who are adjudicated delinquent, and he is responsible for implementation of and non-compliance with the 2009 Agreement.

13. Defendant Debra Pritchard is the Director of Juvenile Justice Services for the New Mexico Children, Youth and Families Department. As such, Defendant Pritchard is responsible for New Mexico's care and treatment of youth who are adjudicated delinquent, and she is responsible for implementation of and non-compliance with the 2009 Agreement.

14. The New Mexico Children, Youth and Families Department is an executive agency of the State of New Mexico responsible for the care and treatment of New Mexico's

youth who are adjudicated delinquent. It is the executive agency responsible for implementation of and non-compliance with the 2009 Agreement.

FACTUAL ALLEGATIONS

A. Background

15. In 2003, ACLU-NM was contacted by parents of youth adjudicated delinquent who asked for ACLU-NM's assistance regarding the lack of mental health treatment and the abuse of their children in CYFD custody. ACLU-NM authorized its cooperating attorneys to investigate CYFD's treatment of youth who have been adjudicated delinquent and placed in Defendants' care, custody, and treatment. Thereafter, CYFD entered an agreement by which ACLU-NM's attorneys and law students working with them would operate as ombudsmen to aid youth in protecting their legal rights and to gather information to assist the State to improve its services for children and youth. Later, the UNM School of Law took over managing the ombudsman program.

16. ACLU-NM's monitoring of conditions for these youth in Defendants' care and custody in 2003-2005 revealed the following very serious and illegal deficiencies which were formally brought to Defendants' attention at the time:

A. Staff did not ensure basic safety for the residents, who were subject to assault by other youth and verbal and physical abuse by staff. Rather than separating residents who assault others from the general population, residents who do not feel safe in the other housing units were the ones routinely housed in segregation.

B. Mental health services were grossly inadequate. Mental health staff lacked sufficient training and experience to operate independently and lacked adequate clinical skill and supervision. Sufficient psychiatry time was not being provided. Residents with serious mental health needs were denied access to residential treatment in outside facilities and denied adequate services in the delinquency facilities.

C. Medical care was inadequate. Nursing staffing was inadequate and care was not available. Residents, including those with painful conditions, were not being timely or adequately assessed or diagnosed, and follow-up care ordered by physicians

were not being adequately provided. Medications were not adequately controlled, but were inappropriately dispensed by security staff and kept in housing units.

D. Security staff behaved unprofessionally, cursing at and/or threatening youth. Staff excessively and improperly used physical force, seclusion and restraints and refused to allow phone calls.

E. Residents were inappropriately kept in isolation for lengthy periods, in cells that were unduly harsh and without meaningful structured activities, including education. The improper idleness and harsh conditions harmed the mental condition of many youth.

F. There was no functional grievance system. The disciplinary hearing officer acted as the grievance officer, despite CYFD acknowledging that having one person perform both roles was a conflict of interest which compromised the grievance system. Many youth reported that there was no point in filing a grievance and that they believed they would be subjected to retaliation if they filed one.

G. Adequate systems were not in place to track incidents and injuries. A tracking system had not been established to account for traumatic injuries to residents, to follow up reported uses of restraints and to ensure that trauma to mentally ill youth was addressed. Furthermore, most of the time there was no restraint report in the medical records when a resident was restrained. Frequently, the residents who were reported as restrained were on the active mental health caseload.

H. The lack of intensive community-based mental health services directly caused the unnecessary and inappropriate incarceration of youth with serious mental health needs due to the unavailability of needed treatment.

I. The lack of intensive community-based mental health services for girls was a serious problem and new services were desperately needed. The lack of alternatives to incarceration and of a basic continuum of services was particularly problematic for girls.

J. Classification decisions were irrational and residents were unable to obtain parole, even when continued incarceration served no legitimate purpose. Some youth were denied parole because CYFD had failed to provide them with the treatment and services which were established at Intake as prerequisites to parole.

17. In late 2004, on behalf of New Mexico youth who have been adjudicated delinquent, ACLU-NM gave CYFD notice of its intention to sue CYFD because of the persistent violations of the rights of these youth as outlined above.

18. During the first half of 2005, on behalf of these youth, ACLU-NM prepared a class action lawsuit to address what it perceived as the most pressing systemic safety, programmatic and procedural deficiencies. In August 2005, at CYFD's request, settlement negotiations were undertaken before the case was filed. On February 15, 2006, ACLU-NM entered into an agreement ("2006 Agreement") on behalf of all New Mexico youth who have been adjudicated delinquent which settled the unfiled lawsuit.

19. In 2007, ACLU-NM sued CYFD for its failure to comply with the 2006 Agreement.

20. In September 2009, CYFD settled that lawsuit and entered into the 2009 Agreement to rectify its violations of the 2006 Agreement.

21. The 2009 Agreement itself explains the reasons for the second Agreement:

> Whereas in 2005 and early 2006 the ACLU of New Mexico (hereinafter, "ACLU-NM"), in conjunction with its cooperating attorneys and the Youth Law Center of San Francisco, prepared for filing a class action lawsuit against the New Mexico Children, Youth and Families Department (hereinafter, "CYFD") to address what it perceived as the most pressing systemic safety, programmatic and procedural deficiencies in New Mexico's treatment of youth who are adjudicated juvenile delinquent,
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> *****
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> Whereas the parties have met numerous times, have reached an agreement on the steps CYFD will take to address the issues that are the subject of the ACLU-NM's pending lawsuit, and desire to work together in the future by sharing expertise about solutions to problems; and
>
> Whereas the parties desire to resolve the issues between them at this time without the necessity of further litigation

22. The 2009 Agreement also expressly provides in paragraph 2 that ACLU-NM is the proper party to bring this enforcement action:

> This Agreement and all agreed upon amendments or appendices are a fully enforceable contract, the terms of which may be enforced like any other contract through an action by the ACLU-NM for damages, specific performance and/or

> declaratory and injunctive relief, subject to the enforcement deadline limitation set forth in paragraph 1, above. However, nothing in this Agreement shall create in any individual any right to sue for damages or for specific performance as a third party beneficiary of this Agreement. The right of the ACLU to sue for damages under this Agreement shall be limited to attorneys' fees and costs as set forth hereinafter. The parties expressly agree there may be no punitive damages for violation of this contract.

23. The 2009 Agreement, in its Appendix A, provided for concrete, comprehensive remedial steps that Defendants would implement in order to promptly remedy the many programmatic, safety and procedural deficiencies set forth above in the Complaint. The 2009 Agreement required CYFD to implement a fundamental reform of its secure facilities by contracting with a consulting organization, Missouri Youth Services Inc., to train staff, coach staff and their supervisors and to consult with CYFD's leadership to implement 'the Missouri Model" of youth corrections services, called here in New Mexico "Cambiar New Mexico."

24. Appendix A of the 2009 Agreement is entitled "The Way Forward" ("TWF") and the subjects covered by Appendix A are:

I. Quality Assurance
II. Safety and Security
III. Behavioral Health
IV. Medical
V. Other Issues

25. The mechanism for implementing the 2009 Agreement, and for establishing plans and procedures for the required reforms, was the Technical Assistance Committee ("TAC"). Paul DeMuro, a nationally recognized expert in juvenile justice issues who had been consulting with ACLU-NM, then-CYFD Secretary Dorian Dodson, and Dr. Pamela McPherson, a psychiatrist who is an expert in behavioral health services for youth involved in juvenile justice, were the leaders of the TAC. Paul DeMuro was the principal author of The Way Forward. The 2009 Agreement authorized the TAC to draft similar plans to address six other areas of juvenile

justice. The TAC was also charged with providing on-going technical assistance and advice to CYFD with respect to juvenile justice issues.

26. Paragraph 8 of the 2009 Agreement specifically authorizes this litigation. It provides:

> If at any time during the term of this Agreement the ACLU-NM believes that CYFD is not implementing or otherwise complying with the terms of this Agreement, it shall give notice to CYFD and the parties shall meet in good faith to attempt to resolve the issue with the TAC team's assistance. If the parties and the TAC team are unable to resolve the issue, the parties may engage Paul Bardacke as a mediator to attempt to assist in such resolution. If there is no resolution, the ACLU-NM may bring suit to enforce those terms of the Agreement with which it believes CYFD is not in substantial compliance and/or seek a remedy under other laws if it believes in good faith that CYFD is not implementing or otherwise complying with any term of this Agreement in a timely and appropriate manner. Under no conditions shall CYFD be liable for the actions or inactions of the TAC in its performance of any duty under this Agreement or the appendices attached thereto.

27. During meetings in July and September 2010, and in correspondence during December 2010, ACLU-NM informed Defendants that it was clear that CYFD was not in compliance with the 2009 Agreement. CYFD has failed to resolve ACLU-NM's concerns.

28. In July 2010, the medical expert, Dr. Robert Greifinger, authored a report disclosing that CYFD had deceptively concealed information from him during his May 2010 medical audit, necessitating another audit of medical care. In November 2010, Dr. Greifinger, together with the mental health expert, Dr. Pamela McPherson, and CYFD's own medical director, Dr. Linda Smoker, issued a joint report concluding that CYFD had made misrepresentations during the May 2010 audit and that CYFD is not in compliance with their obligations under the 2009 Agreement.

29. On November 23, 2010 Paul DeMuro issued a report ("the November 23, 2010 DeMuro report") finding that CYFD is not in compliance with several features of the 2009 Agreement.

30. A new violation of the 2009 Agreement is imminent. During November 2010, CYFD directed the staff at the J. Paul Taylor Center secure facility in Las Cruces ("JPTC") to break up the existing educational program at JPTC, and to prevent the continued implementation of Cambiar New Mexico during the school day, by preventing youth who live together in each housing unit from staying together during the school day. (ACLU-NM has also learned from youth in CNYC and YDDC that they continue to attend at least some of their classes with youth from other housing units, indicating that CYFD has apparently also failed to fully implement Cambiar New Mexico in YDDC and CNYC.)

31. As provided in paragraph 8 of the 2009 Agreement, ACLU-NM brings this lawsuit "to enforce those terms of the Agreement with which it believes CYFD is not in substantial compliance" and those terms it is not implementing or otherwise complying with "in a timely and appropriate manner."

B. 2009 Agreement Does Not, and Should Not, Terminate on December 31, 2010.

32. The 2009 Agreement Does Not Terminate on December 31, 2010.

A. ACLU-NM acknowledges that the parties agreed that the initial date on which the 2009 Agreement would terminate was December 31, 2010, as set forth in Paragraph 1 of the 2009 Agreement. ACLU-NM notes, however, that in the very same sentence the parties added that this termination date could be "extended by mutual agreement of the parties."

B. Under the 2009 Agreement, many of Defendants' obligations are identified with specific deadlines by when Defendants must satisfy those obligations. The parties chose December 31, 2010, because that is deadline by when Defendants agreed to satisfy the last of their obligations:

> Preparation for Cambiar training in the Albuquerque facilities will begin in July 2009, with all training and complete implementation in all units by December 2010 (sooner if resources allow), barring extenuating circumstances. [TWF, p. 7]

C. ACLU-NM specifically agreed to December 31, 2010 as the termination date for the 2009 Agreement because that permits it to monitor CYFD's complete implementation of The Way Forward. This termination date was not arbitrary, but rather was chosen specifically to coincide with the last of CYFD's obligations under the 2009 Agreement.

D. The reason why the parties agreed that the initial termination date of December 31, 2010 could be "extended by mutual agreement of the parties" was made clear in several places in the 2009 Agreement:

> If any unforeseen circumstance occurs which might cause a failure to timely carry out any requirement of this Agreement, CYFD shall notify the TAC team and the ACLU in writing within 20 calendar days of the time that CYFD becomes aware of the unforeseen circumstance and its impact on CYFD's ability to timely perform under this Agreement. [Agreement, ¶ 11]

> As the Department moves forward, this Plan will be updated as appropriate by the TAC to reflect both improved understanding and changing realities ….. This Plan is an evolving document, and CYFD has used its best efforts to include reasonable dates for achieving the various objectives contained in this Plan. In the event that CYFD anticipates that it will be more than two weeks late in achieving an objective with a state completion date, … it will provide written notice to the TAC stating the reasons why the objective will not be achieved by the date set forth in the Plan and the date on which CYFD believes it will achieve the objective. The TAC will decide the date that is appropriate. [TWF, P. 1]

> This document … provides a method to identify and develop specific measurable outcomes and data points that are necessary to track CYFD's progress in

> implementing the specific requirements of this rewritten agreement. The outcomes of this Plan will be tracked by an enhanced quality assurance and continuous quality improvement process that is described in this document. This Plan also establishes timelines for each outcome contained herein. [TWF, P. 1]
>
> This Plan details the Department's Quality Assurance process and the manner by which the Quality Assurance process will report on the progress of implementing the specific provisions contained in this Plan…. This Plan will, for the topics discussed, identify the issue being addressed; what the Department has done and will do to address the issue; and anticipated outcomes, target dates, and related quality assurance measures designed to track the anticipated outcomes. [TWF, P. 2]

E. CYFD has agreed to fully implement all of its obligations under the 2009 Agreement by the deadlines in the 2009 Agreement or as any of those deadlines have been extended by mutual agreement of the parties. ("CYFD agrees to implement fully all the actions set forth in this Agreement (and any amendments or appendices thereto) in accordance with all timelines ….; Agreement, ¶ 5)

F. During the term of the 2009 Agreement, CYFD announced on numerous occasions that it would not be able to satisfy certain of its obligations according to the deadlines established by the 2009 Agreement. Each time the parties met and mutually agreed upon extensions of those deadlines, when ACLU-NM could have chosen to immediately sue for breach of contract and specific performance. It is further evidence of CYFD's bad faith that it now maintains that the 2009 Agreement still terminates on its original date of December 31, 2010, in spite of these extensions granted by ACLU-NM, at least two of which (full implementation of Cambiar New Mexico and unit-based management) were extended well past December 31, 2010. ACLU-NM withdrew its 2007 lawsuit against Defendants in exchange for the precisely negotiated obligations set forth in the 2009 Agreement. ACLU-NM did not negotiate simply for whichever of its obligations CYFD might choose to or be able to satisfy before the end of 2010.

33. The 2009 Agreement Should Not Terminate on December 31, 2010.

A. Defendants have misrepresented material facts, and conducted themselves in bad faith, prior to and during the term of the 2009 Agreement, as noted below in Sections C and D.

B. ACLU-NM has reasonably relied to its detriment upon Defendants' actions and conduct. Among other things, in reliance on Defendants' actions and conduct, ACLU-NM agreed to dismiss its pending lawsuit regarding the 2006 Agreement and has agreed to numerous extensions of the deadlines for Defendants' obligations under the 2009 Agreement.

C. Defendants' assertion that the 2009 Agreement terminates according to its original termination date of December 31, 2010 would prejudice ACLU-NM by, among other things, not permitting ACLU-NM to fully monitor Defendant's complete implementation of its obligations under the 2009 Agreement and thus undermining ACLU-NM's ability to enforce those obligations.

D. Therefore, Defendants' are equitably estopped from asserting that the 2009 Agreement terminates on its original date of December 31, 2010.

C. Defendants Misrepresented Material Facts Prior to Formation of 2009 Agreement

34. The misrepresentation of material facts prior to the entry of the 2009 Agreement, and the bad faith by CYFD, officials are important bases for the Court to now grant equitable remedial relief to ACLU-NM and the youth in CYFD's custody. At the time that ACLU-NM entered into the 2009 Agreement, it was unaware that a number of CYFD personnel had misled ACLU-NM and its counsel about facts material to the 2009 Agreement.

35. Misrepresentations by CYFD Underlying Dr. Greifinger's April 2009 Report

A. In his report dated April 25, 2009, the designated neutral medical expert Dr. Greifinger found CYFD in substantial compliance with the 2006 agreement with respect to medical services based, in part, on Continuous Quality Improvement ("CQI") information provided to him by CYFD: "The minutes of the quality improvement committee for the past three months demonstrate appropriate self-criticism and they contain action plans."

B. After entering into the 2009 Agreement, ACLU-NM obtained evidence that CYFD had deceived both ACLU-NM and Dr. Greifinger, by providing them with fabricated documents which falsely misrepresented that CYFD was conducting Quality Improvement Committee meetings for the purpose of identifying and correcting deficiencies with respect to the medical and psychiatric care provided to youth held in CYFD's delinquency facilities. Fraudulent minutes of non-existent committee meetings were given to ACLU-NM and Dr. Greifinger to create the false impression that CYFD was conducting such meetings periodically and that CYFD was taking effective corrective actions to address identified deficiencies in the medical and mental health care it provided to youth.

C. ACLU-NM received information that the minutes of Quality Improvement Committee meetings, which had been provided to Dr. Greifinger and the ACLU-NM were fabrications. After Dr. Greifinger's April 2009 report was issued, an employee complained about the fraud to CYFD administrators. In response to that complaint, Deputy Director of Juvenile Justice Services Michael Bronson inaccurately replied: "The CQI meetings were reconstructed in May right before the Dr. Greifinger audit, the results of his most recent audit determined that the medical department did hold the required

CQI meetings and met all ACLU obligations." Defendant Debra Pritchard, CYFD's Director of Juvenile Justice Services, later confirmed Bronson's incorrect determination, finding the nurse's complaint unsubstantiated.

D. When ACLU-NM transmitted to Dr. Greifinger in October 2009 the evidence that they had obtained, Dr. Greifinger investigated the allegations, and concluded in his October 15, 2009 report:

> In my last report, I noted that the minutes of the quality improvement committee for the past three months demonstrated appropriate self-criticism and action plans. ***During the week of my visit, it became apparent that*** some performance measurement has been carried out, but ***there had not been any quality improvement committee meetings during the 2009 calendar year. The minutes that had been presented were not minutes at all, but rather were summaries of problem identification and action steps taken by the nurse administrator, written from memory, in retrospect. My prior recommendations for training the nursing leadership on chart review and integration into the quality improvement activities were not followed***. . . .
>
> A staff member's complaint about erroneous minutes was ignored by a Deputy Secretary of CYFD….
>
> CYFD is not in compliance with this element of this Agreement….
>
> ***The quality management program needs a complete overhaul***…. [Emphasis added.]

D. Defendants Have Continued to Misrepresent Material Facts Since Entering Into 2009 Agreement

36. Moreover, since the 2009 Agreement was signed in September 2009, Defendants and other agents of CYFD have continued to mislead ACLU-NM and its counsel, deliberately attempting to conceal their non-compliance with the 2009 Agreement. CYFD's ongoing misrepresentations and concealment of facts material to the issue of CYFD's compliance with the 2009 Agreement, and the bad faith by CYFD officials, are important bases for the Court to now grant equitable remedial relief to ACLU-NM and the youth in CYFD's custody.

37. Misrepresentations by CYFD Underlying Dr. Greifinger's May 2010 Report

A. CYFD has continued to make material misrepresentations to Dr. Greifinger and to the ACLU. In May 2010, Dr. Greifinger conducted his next audit of medical care, as provided in the 2009 Agreement. He initially authored a report finding that CYFD had achieved substantial compliance with the commitments it had made to the ACLU with respect to medical care.

B. However, in late July 2010, the medical expert was contacted by an attorney representing a CYFD employee, who disclosed that during Dr. Greifinger's May 2010 audit several high-ranking CYFD employees, including Defendant Pritchard, had engaged in a cover up to conceal from Dr. Greifinger the truth regarding various deficiencies in medical care and to conceal that CYFD's quality management system for improving medical care was still not operating in the way that CYFD was claiming.

C. On August 21, 2010, Dr. Greifinger issued a revised report regarding his May, 2010 audit of medical care. The report stated:

> On the basis of the information that I have obtained through documents and review of records since July 29, 2010, it is clear to me that ***the basis for my report, dated May 17, 2010, was flawed, due to deliberate suppression of information on significant deficiencies in medical care at SJDC [San Juan Detention Center] and the withholding of quality assurance information and activity***. Based on facts that I have obtained and reviewed, I find that ***the medical care for each of the nine clients in custody of SJCJDC during April and early May was deficient. This is the finding I would have made in my May 17, 2010, had I been presented with the information I have now***. This finding of non-compliance with the Agreement, in my role as medical expert for the parties, would have led to a return visit to assess compliance with the Agreement. ***Further, the quality management process at CYFD did not legitimately incorporate problems that had been identified and failed to verify whether the identified problems had actually been corrected. The CYFD is not compliant with the Agreement regarding medical care for youth in custody***. I affirm the withdrawal of my report, dated May 17, 2010, based on a misrepresentation of a material fact. [Emphasis added.]

D. In response to the withdrawal of the May 2010 Report, a November, 2010 medical audit was conducted. That audit disclosed that CYFD has not performed the medical CQI studies that they told Dr. Greifinger in May 2010 would be performed during 2010 and that contract facilities housing youth committed to CYFD's custody have been excluded from any CQI or quality assurance processes.

38. Misrepresentation Regarding Practice of Restraints After Three Strikes in April 2010

A. In a memorandum to all facility staff dated April 27, 2010, Defendant Pritchard declared:

> There is NOT a "three strikes" directive allowing for use of force in our facilities, where uncooperative clients are to be given three chances to comply and if they do not, force can then be used against them…. This type of "use of force" to gain client compliance is not allowed under current JJS policy and procedure governing use of force. [Emphasis in original.]

B. However, for at least several months prior to this memorandum, Defendant Pritchard was copied on a least several grievances by youth alleging that they had been subjected to this very practice: they had been physically restrained by staff after their third refusal to follow orders by the staff. In addition, several of these same youth told ACLU-NM that Defendant Pritchard was present in the unit when they were subjected to restraints following their "third strike."

C. It is therefore inconsistent, and indeed disingenuous, for Defendant Pritchard to disclaim knowledge of a practice that she acknowledges violates JJS policy and procedure when she was aware of the practice and may very well have been present for its implementation.

39. Misrepresentations to Legislative Finance Committee in ACLU-NM's Presence in May 2010

A. During the Legislative Finance Committee hearings in Las Cruces on May 12, 2010, Defendant Pritchard stated that "87.7% of clients that completed their supervised release since July 1, 2009 were successful." ACLU-NM questioned CYFD regarding this figure, requesting the basis for this calculation.

B. CYFD responded that the basis for its 87.7% figure could be found on the PowerPoint slide used by Defendant Pritchard at the LFC hearing. That slide made the identical conclusion to that noted above, underneath three graphs indicating the total number of clients during that time period released to family, released to community programs, and released to reintegration centers, respectively, and the proportion of clients in each of the three categories whose release was either completed or revoked.

C. ACLU-NM made its own calculation of the success of clients placed on supervised release since July 1, 2009 based on documents earlier provided by CYFD, and the result flatly contradicted the 87.7% figure provided by CYFD to the LFC.

40. Misrepresentation Regarding Modified Programming of J.M. in June 2010

A. ACLU-NM met with CNYC client J.M. on June 4, 2010. She told them that she had been, and continued to be, locked down in her room on "modified programming" since May 30 after receiving two incident reports on May 27. She was not told how long she would be on the program, of what the program consisted, or how she might complete the program. She did not have her hearing for the two Incident Reports ("IRs") until June 4. She did not want to be locked in her room, and was growing increasingly depressed as she had spent the vast majority of a week sitting in her room.

B. On June 7 ACLU-NM requested from CYFD documentation of her IRs, the hearings, and her modified programming, in a letter that also set forth what ACLU-NM learned as stated in the preceding paragraph. The next day, June 8, J.M., as well as one other girl on her unit who was also presently on modified programming, were abruptly and without explanation removed from such programming by order of the CNYC Superintendent.

C. On June 10 Defendant Pritchard addressed this issue herself, stating:

> After talking to our staff as part of our own investigation into the issue, the assigned therapist and the case manager provided the following details on [J.M.]: She was and is in her room between one and one and a half hours a day (besides sleeping time)…. She has been attending school which is now on break…. [W]e will provide you with the documentation you request so that you can review it as we are to see what happened."

D. ACLU-NM reviewed the documents provided by CYFD and performed its own review of J.M.'s files, and found no evidence that she either attended or was suspended from school. In addition, even if she did attend school, CYFD's own documents make clear that J.M. was only otherwise out of her room for 30 minutes on the morning shift and 30 minutes on the evening shift (her "30/30"). ACLU-NM later learned that at least 6 other CNYC clients had been placed on such programming since January 1, 2010, with five of them on such programming for between 5 and 32 days, during which time they also only received their 30/30 out of their rooms.

41. <u>First Misrepresentation Regarding Access to Youth in August 2010</u>

A. Under the 2009 Agreement, ACLU-NM members "are authorized to interview any youth for purposes of monitoring the implementation of this Plan" and "may also review any information pertaining to the needs of adjudicated youth (in either

redacted form or with a youth's consent as to documents in which youth are personally identified)," including all information in a youth's files.

B. On August 2, 2010, ACLU-NM requested copies of documents it had identified and marked for copying while reviewing the files for three youth on July 21 (K.B.) and 27 (J.M. and S.C.).

C. CYFD responded the next day that its delay in providing copies of the documents was because "a couple of the clients first stated verbally that they wished to rescind their HIPAA releases and asked that we hold their records, and then (while we were seeking to document that) they withdrew their requests and authorized release."

D. In response to ACLU-NM's request to know who were these clients and the circumstances of their supposed refusal to permit access by ACLU-NM to their records, CYFD responded that "apparently [J.M.] and [K.B.] told [the grievance officer] and/or [the CNYC Superintendent] last week that they didn't want the ACLU to file grievances for them or have access to their records. When we asked them to put that in writing, they changed their minds. If you need more specifics than that, you should ask the girls."

E. ACLU-NM spoke with both J.M. and K.B., and neither of them confirmed the story ACLU-NM had been told by CYFD.

42. Second Misrepresentation Regarding Access to Youth in August 2010

A. On August 9, 2010, ACLU-NM requested the opportunity to review the files of S.D., a former CNYC resident, to investigate allegations of mistreatment.

B. On August 16, Defendant Pritchard responded by implying that CYFD would refuse to provide ACLU-NM access to S.D.'s files because the files might be sealed: "I do not know if her file has been sealed…. I need to check."

C. On August 17, CYFD added:

> [S.D.] discharged from CYFD custody on May 14[, 2010]. I think that once a client discharges from CYFD custody, we are under no obligation to continue to provide documents that relate to events that may or may not have occurred while they were in our care ….

D. On August 18, ACLU-NM renewed its request:

> Yes, I knew that CYFD had already discharged [S.D.] from its custody at the time I made my request on August 9 to review her files. However, I am surprised and disturbed that you present [S.D.'s] discharged status as a basis for refusing to comply with my request to review her files. Under The Way Forward, "[m]embers of the ACLU team may also review any information pertaining to the needs of adjudicated youth," provided that such information "may not be used for any purpose other than monitoring the implementation of this Plan or discussions with and/or reported to CYFD or the TAC." As I stated in my request, I wish to review [S.D.'s] files "[i]n order to better determine whether her concerns, in fact, implicate CYFD's implementation of The Way Forward."
>
> Since The Way Forward became effective a year ago, CYFD has never refused to comply with a request by the ACLU for copies of a client's documents or access to a client's files simply because CYFD had discharged that client from its custody. In fact, CYFD has recently complied with at least two such requests made on behalf of clients whom CYFD had discharged from its custody. Why has CYFD now changed its practice with regard to the ACLU's access to clients and information under The Way Forward?
>
> Please let me know when [S.D.'s] files will be ready for my review, or whether the ACLU will need to take further action to enforce CYFD's compliance with The Way Forward.

E. The next day, August 19, CYFD completely and abruptly reversed its unprecedented and unfounded position, and simply stated, without further ado: "Your request to review [S.D.'s] file has been approved; please contact Josefina Sandoval to make arrangements."

43. <u>Misrepresentation Regarding Violations of Separation Policy in August 2010</u>

A. CYFD implemented its new procedure on separation, Procedure 21.18, on August 23, 2010. Under the Procedure, "Separation may not continuously last for more than 8 hours." ACLU-NM discovered, after reviewing client files at CNYC, that at least five CNYC clients had been separated for much longer than 8 hours. On November 5, ACLU-NM made the following request to CYFD:

> According to the documentation you provided, these five clients were on continuous separation for the following durations of time starting on October 4: [A.G.] (nearly 1 full day), [B.L.] (at least 2 full days), [S.C.] (nearly 3 full days), [C.C.] (nearly 3 full days), and [F.M.] (at least 5 full days). According to the procedure on separation, Procedure 21.18, as well as the Separation Checklist & Log designed to document any instance of separation, "Separation may not continuously last for more than 8 hours." Please explain when, if ever, it is appropriate to maintain a client on separation longer than 8 hours, and please explain why each of these clients was maintained on separation much longer than 8 hours.

B. As part of its response, CYFD told ACLU-NM and the TAC that "[t]hese clients were not separated for much longer than 8 hours. 98% of the time clients' acting-out issues are addressed within the 8-hour period set in policy."

C. Since August 23, 2010, according to documents provided to ACLU-NM by CYFD, 21 clients have been separated from their peers. Of those 21, 11 clients have been separated from their peers in excess of the 8-hour time limit established by JJS procedure. This proportion of youth on separation within the 8-hour time limit is 48%, and not 98%. Before December 6, when questioned about this number by both ACLU-NM and the TAC, neither Defendant Pritchard nor other CYFD personnel could explain how they had arrived at the number 98%.

D. On December 6, JJS Deputy Director Bronson finally explained that the figure of 98% "was not a calculated figure but an estimate over the last 2 years, not just since the new policy was released." However, not only does that belated response fail to

explain how CYFD estimated the figure to be 98%, and fail to explain why CYFD bases its estimation on a 2-year period, but it wholly fails to explain why CYFD initially responded with its figure of 98% when the question clearly involved, and only involved, separation of youth since the August 23, 2010 effective date of the new procedure on separation, Procedure 21.18.

E. As part of his December 6, 2010 defense of CYFD's implementation of its new separation procedure, Mr. Bronson proceeded to place the many failures of the separation procedure and its implementation on the shoulders of the same youth CYFD had chosen to subject to the procedure and its failed implementation: "These clients were either unwilling or unable" to commit to returning to normal programming; "[t]heir behaviors and their lack of ability to make a commitment not to harm self or others determined that." Unfortunately for Mr. Bronson, his assertion finds no support in any of the separation documentation requested and reviewed by ACLU-NM. At best, as Mr. Bronson pleads, at least "these policies are well-intentioned …."

44. ACLU-NM could have brought this action earlier had not Defendants misrepresented their progress under the 2009 Agreement and concealed their violations. The Court could have easily granted effective injunctive relief within the original timeline of the 2009 Agreement, before December 31, 2010, if not for Defendants' deceptions. Accordingly, equity requires injunctive relief, to remedy Defendants' misrepresentations.

E. Specific Violations of the 2009 Agreement, Appendix A

Substantial Violations of Section I of Appendix A ("Quality Assurance")

45. The November 23, 2010 DeMuro report states:

> Lack of accountability & Lack of a clear & coherent management structure. Key policies, programs and procedures are not consistently implemented and

monitored. Many staff at all levels are not held accountable – unless and until (or after) a major problem occurs. Data is not used to inform decision-making. When a problem is uncovered, CYFD often finds itself in a reactionary posture, explaining or justifying its actions. There seems to be inadequate emphasis on cross-discipline team building and communication throughout the agency. Although a major policy can be developed and promulgated at the top of the organization, key managers at all levels throughout the organization are simply not routinely held accountable for implementing those same policies. As a result, key staff can and often do work at cross-purposes. . . . [M]any Behavioral Health staff, particularly at JPTC, have resisted the unit based management approach. The educational leadership staff have also resisted unit based management.

46. The November 23, 2010 DeMuro report states:

Silos/turf issues. Although the agency claims to have adopted the Missouri model of unit-based (team) management in the youths' living units, there is little evidence of close cooperation and coordination among major program areas and staff, particularly among the leaders of education, behavioral health and the juvenile justice managers. In effect these areas are "siloed", so problem solving and decision making is "vertical" with each discipline reporting up its own chain of command. Rather than teamwork and problem solving occurring at the living unit and mid-management level, there is a tendency to blame staff in the other silo.

47. The November 23, 2010 DeMuro report states:

Grievances/abuse investigation – keeping youth safe. The revised settlement restructured both the abuse investigation process and the grievance process within the agency. In addition the state added additional resources (with new grievance officers being hired and with Child Welfare protective services investigators being deployed to investigate allegations of abuse) in order to ensure that youth and staff in the institutions had access to an effective grievance and abuse reporting process. These policy reforms were not aimed at making it easy for youth or making it difficult for staff. A safe institution demands the timely and objective handling of legitimate grievances (for example, a youth not getting her medication) and the timely investigation and resolution of abuse allegations. Although these new policies have been in place for some time, the agency has failed to implement them consistently. In all probability, the current litigation will not be finally resolved unless and until CYFD can document that it has fully implemented these grievance and abuse reporting procedures.

48. The November 23, 2010 DeMuro report states:

Use of data; need for an effective QA/QI process. In addition to revising the grievance and abuse investigation process, the revised settlement called for a dedicated and enhanced Quality Assurance/Quality Improvement process (a

> number of staff were assigned to this effort). In all honesty, currently, the QA/QI efforts have been less than satisfactory. There is little sense of urgency. For example, the agency finds it difficult to track two person and prone restraints, check the accuracy and timeliness of special incident reports or effectively monitor the medical program in its contracted facilities. In addition there is little connection between the QA/QI process and ongoing quality management.

49. After speaking with CNYC youth and staff, ACLU-NM learned that in or about September 2010 that CYFD had conducted an investigation into allegations by youth in one of its units that they had been retaliated against by unit staff for filing grievances and speaking with the grievance officer. Youth complained that staff were keeping them in their rooms longer than necessary. CYFD confirmed that the youth had complained and that the grievance officer had reported "that administrators were unresponsive and potentially interfering with the grievance process when she reported the grievances." CYFD also confirmed that, as a result of its investigation of these alleged abuses, the Facility Superintendent had been demoted and the Unit Supervisor had been fired.

50. Youth remain unwilling to use the grievance process for two reasons. First, staff commonly call youth a "snitch" if the youth files a grievance. Second, the grievance process does not afford effective remedies when a youth tries to use it.

51. Fifteen months after the 2009 Agreement was signed, the Office of Quality Assurance has only completed two Continuous Quality Improvement ("CQI") studies, although the 2009 Agreement listed more than twenty that should be conducted before the end of 2010.

52. The November, 2010 medical audit disclosed that CYFD has not conducted the medical CQI studies that were scheduled to occur during 2010.

53. Contract facilities housing youth committed to CYFD's custody have been excluded from any CQI or quality assurance processes. The San Juan contract facility has no CQI program of any kind.

Substantial Violations of Section II of Appendix A ("Safety and Security")

54. The November 23, 2010 DeMuro report states:

> [A]lthough a new policy had been established for reporting and investigating allegations of abuse, key staff – including high level staff – did not adhere to the agency's abuse reporting policy when a girl (SC) recently alleged that staff had sexually abused her. Despite the policy reforms, there is clear evidence of CYFD often mishandling investigations of major allegations by youth (e.g., the allegations by CNYC youth of sexual abuse by a staff, deployment of shields at JPTC, allegations by YDDC youth of sexual abuse by his two roommates, and altercation between youth and JPTC Superintendent.) Many youth report that staff "discourage" them when they are about to file a grievance. Recently when new policies and procedures were developed for the A2D unit, an audit of the unit uncovered the fact that many of these policies and procedures were simply not followed. As has been noted, when a thorough investigation of the SC abuse allegation was finally conducted, it was evident that high- ranking staff failed to follow the agency policy regarding reporting abuse. In addition, this investigation documented that staff in the girls unit routinely did not follow policy or good practice guidelines (e.g., male staff supervising girls without female staff being present; male staff engaging in physical "horse-play" with girls).

55. CYFD often does not initiate Incident Reports when incidents occur. Investigations commonly are not conducted until ACLU-NM learns of an incident and demands an investigation. For example:

A J.L.: He alleged to staff that he had been sexually abused by his two roommates, but a Serious Incident Report ("SIR") was not completed until at least four days after ACLU-NM inquired into the incident and three months after he made the allegation; and

B A.V.: He alleged that he seriously injured his hand after being confronted and provoked by the facility superintendent, but an SIR and three other incident reports (including one by the facility superintendent) were not completed until at least four days after ACLU-NM inquired into the incident and 27 days after he made the allegation.

56. During a meeting on September 27, 2010, CYFD acknowledged that it had no data to show how often restraints were conducted, but staff stated that they "feel" that there have been fewer of those occasions. Paul DeMuro expressed ongoing concerns related to data regarding prone two-person restraints, whether the reported decrease in serious incidents were the result of manipulation of the data, and whether CYFD's former restraint system did a better job at the beginning of training. Defendant Pritchard acknowledged that shields have been employed at JPTC and at YDDC, although staff who deployed them had not all been trained on their use.

57. During a meeting on September 27, 2010, Defendant Dunbar acknowledged that only $250,000 has been requested to continue implementation of Cambiar. ACLU-NM stated that this planned 50% reduction in annual funding was not sufficient.

58. CYFD's own personnel reviewed the implementation of Cambiar at JPTC in August and found serious deficiencies in its implementation. CYFD acknowledged ongoing concerns with how "siloing" negatively impacts implementation and effectiveness of Cambiar.

59. During a meeting on September 27, 2010, Defendants admitted there are problems with incident reporting. Defendant Pritchard acknowledged that facility superintendents need to more regularly review incident reports. She added that, while superintendents are required to analyze all reports of an incident and then create a summary report, these summaries are often not done well.

A. On November 18, 2010, ACLU-NM personnel spoke with the hearing officer for YDDC and CNYC regarding client F.M. at CNYC. The hearing officer reported that the seven IRs F.M. had received from August 10 to October 19, 2010,

would all be dropped because she had been unable to schedule a hearing for those IRs within the 7-day limit established by JJS procedure.

B. Later that same day, ACLU-NM requested documentation from CYFD of all IRs received by youth in JJS custody since August 1, 2010. On December 2 CYFD provided a responsive spreadsheet that included the following information for the 479 IRs received by youth in JJS custody between August 1 and November 22, 2010: date of incident; date client notified; date of hearing; hearing disposition; and reason for disposition.

C. Under JJS procedure, a youth who has received an IR must be provided a hearing within 7 days of the incident. According to the CYFD spreadsheet:

i. The hearings for 262 of the IRs occurred more than 7 days after the incident; meaning, CYFD failed to hold a timely hearing as required under JJS procedure for 54% of the IRs;

ii. The hearings for 171 of the IRs occurred two weeks or more after the incident; meaning, CYFD failed to even hold a hearing within 2 weeks for 35% of the IRs;

iii. 234 of the IRs were dismissed or dropped; meaning, 48% of the IRs were dismissed or dropped entirely; and

iv. 120 of the hearings were held on November 30, 2010; meaning, 25% of the hearings were held on a single day, 12 days after ACLU-NM made its request regarding the same, and 2 days before CYFD provided its response.

60. CYFD has failed to properly classify and place youth with high needs. About a year ago, a specialized segregation unit for female youth was hurriedly created to deal with

several female clients whose needs the facility was not adequately addressing in the other two female units. Those clients spent the majority of their time locked down in their cells, with very little therapeutic intervention. The unit was then abruptly shut down on or about March 26, 2010. During 2010, several male youth with high needs were subjected to lengthy periods of lock-down in the Camino Nuevo facility. Current practices regarding lock downs do not comply with the procedures established pursuant to the 2009 Agreement.

61. Modified Plans of Care. Since January 1, 2010, at least 7 CNYC youth were placed on "modified programming." While on such programming the clients were locked into their cells, and allowed no more than 30 minutes out of their cells during the day shift and 30 minutes during the evening shift, in violation of JJS procedure. There is no evidence that these clients attended school or that they were suspended from school during their programming. ACLU-NM learned of this and inquired about it with CYFD on June 7. The two clients who remained on modified programming at that time were abruptly and without reason removed from such programming the very next day, June 8, by order of the CNYC Superintendent. CYFD later informed ACLU-NM that CYFD would no longer employ such programming.

A. Examples of 5 clients who were placed on such programming for between 5 and 32 days: J.M., S.C., K.B., B.Q., and S.D.

62. "Safety Unit" (A2-D) at CNYC. Procedure 21.8, effective August 23, 2010, established a Safety Unit in CNYC's A2-D Unit, and provides for the following:

> [Section 7.2] Youth will be placed in this unit only after a rigorous referral and screening process is completed …. In no case may approval for a move to this unit be given after the fact ….
>
> [Section 9.1] Only a Unit Manager, Facility BH staff person, or Facility Superintendent can refer a client who meets the criteria for placement in this unit, by making a formal request for an Executive MDT, who will recommend which youth should be admitted into the safety unit.

[Section 9.3] On the day a youth's referral for admission is reviewed by the Executive MDT, the referring person/designee, the youth, the youth's family or guardian, and a representative from the youth's MDT must meet with the Executive MDT. Information at the meeting must a minimum include: current Plan of Care, current Treatment Plan (if any), input from education and medical …"

[Section 9.4] The Executive MDT will be required to complete an Executive MDT Safety Unit Criteria Form.

A. Youth were first assigned to the Safety Unit on August 30. CNYC facility staff, as well as A2-D unit staff, reportedly first learned of the new unit the following day via an email from Defendant Pritchard. Unit staff received inadequate training regarding how to properly implement the new safety unit. ACLU-NM learned that A2-D had been used as a secure unit of sorts before it was abruptly converted to normal programming in early August of this year. Then, weeks later, and just as abruptly, the email from Defendant Pritchard notified staff that A2-D had again been converted, this time to was to a secure unit.

B. Dr. McPherson visited the Safety Unit in late September, reviewed documentation, spoke with youth and staff, and then noted the following concerns in her report to the TAC:

i. The Executive MDT assigned youth to the Safety Unit who were already on A2D already;

ii. A2D staff were not included in the discussion regarding assignment to the Safety Unit, and other managers, supervisors, and other facility staff were not consulted for referrals;

iii. The Executive MDT Safety Unit Criteria Forms did not contain adequate information to justify placement on the Safety Unit and were incomplete;

iv. The Criteria Forms clearly document that at least three of the youth did not need to be on the Safety Unit, but there was not another bed available;

v. Safety Unit staff had not seen the completed Executive MDT Safety Unit Criteria Forms and did not know where to find them;

vi. Some staff felt the Safety Unit could be operating just as successfully as a regular unit;

vii. Staff had questions and concerns about the Safety Unit procedure but did not feel they could voice these concerns;

viii. The referral forms were nowhere near appropriate: No form had a plan of care or supporting documentation or psychiatrist's statement attached (Dr. Davis did write notes in the medical chart - some of them say the youth could be on another unit if there was space); only one youth had a strengths and needs assessment or functional behavior assessment; no family was invited; the signatures for manager, supervisor, education and medical were blank on every form; and Deb [Pritchard] had signed the JJS Deputy Director line crossing out deputy; and

ix. There seems to have been pressure to get the Safety Unit up and running before the TAC meeting.

C. Paul DeMuro, in his October 2 email to Defendant Dunbar, observed:

> It is with a great deal of reluctance that I sign … the TWF Safety Unit addendum. In light of Dr. McPherson's very recent review of the actual implementation problems at the Safety Unit (A2D) that has been shared with the TAC, I trust that you understand my reluctance…. [T]he issues that Pam uncovered underscore the serious 'governance' problems within the Department.

63. Separation of Youth Under "New" Procedure. Procedure 21.18, effective August 23, 2010, establishes the guidelines and protections regarding placement of a client on separation, and provides for the following:

> [Section 7.1] Separation can be imposed only for the safety of a client, other clients, or staff …."
>
> [Section 8.5] The supervisor notifies education services staff as early as possible to provide education assignments and tutoring for a client in separation who is also suspended when no schoolwork has been provided by education."
>
> [Section 8.6] Staff provides all regular programming, including recreational activities and education, consistent with the evaluation of medical services and behavioral health services staff for as much time as possible while a client is separated."
>
> [Section 8.6.1] A client must be suspended from school in order to be kept in separation during school hours."
>
> [Section 9.1] Staff documents client behavior in any separation—and the decision for continuing separation or the return of the client to regular activity and programming is in writing."
>
> [Section 9.6] Separation may not continuously last for more than 8 hours.

A. On October 15, 2010, in its final TWF Addendum regarding interventions for High-Risk Youth Safety, CYFD stated that it "recognized that locking a youth in a cell (isolation) does little if anything to help effect positive change in a youth; indeed, there is much evidence to indicate that isolation only increases a youth's alienation and acting out."

B. Since August 23, 2010, the effective date of Procedure 21.18, according to documents provided to ACLU-NM by CYFD, 21 clients have been separated from their peers. Of those 21, 11 clients have been separated from their peers in excess of the 8-hour time limit established by JJS procedure. CYFD told ACLU-NM and the TAC that "98% of the time clients' acting-out issues are addressed within the 8-hour period set in policy." ACLU-NM reviewed documentation of all instances of separation provided by CYFD, and concluded that the number is no more than 48%. When questioned about this

number by both ACLU-NM and the TAC, CYFD could not explain how it had arrived at the number 98%. CYFD Deputy Director Bronson later explained to ACLU-NM on December 6 that, in fact, the figure of 98% "was not a calculated figure but an estimate over the last 2 years, not just since the new policy was released."

C. According to documentation provided by CYFD, the following five youth were among those youth whom CYFD separated from their peers for periods of time much greater than 8 hours: A.B. (at least 1 full day), A.G. (at least 1 full day), B.L. (at least 2 full days), S.C. (nearly 3 full days), C.C. (nearly 3 full days), and F.M (over 5 full days).

64. Reporting and Investigation of Allegations of Abuse and Neglect. Defendants have not conducted proper investigations of allegations of abuse and neglect of JJS clients. They have failed to coordinate the respective duties and authority of CYFD investigations, ERB investigations, and State Police investigations, the sharing of information among these three investigations, and the various and seemingly impermissible ways in which the findings and conclusions of one investigation may depend upon those of another investigation.

A. May 2010 Allegation by J.L. in YDDC of sexual abuse by his two roommates.

i. On May 13, 2010, J.L. alleged to staff that he had recently been sexually abused by his two roommates on two occasions. CYFD began its own investigation, but permitted the State Police to take over the investigation. The two roommates were moved to CNYC's Sexual Offenders unit, where they remained until June 9.

ii. CYFD failed to timely complete an SIR.

> The SIR was not completed due to the investigation by the State Police and lack of communication by all agencies….
>
> [A]n SIR should have been completed irrespective of a State Police investigation. In this case it was not, simply due to an oversight. One was completed this week to correct that …. Appropriate action is being taken against staff who failed to complete the SIR.

iii. When ACLU-NM inquired after learning about the incident several months after J.L. made the allegation, CYFD had still not obtained a copy of the State Police Report. CYFD told ACLU-NM that its own investigation of the allegations depended on the State Police investigation, and that CYFD would adopt the findings and conclusions of the State Police investigation. And yet CYFD assured ACLU-NM that the matter had been resolved.

B. July 2010 Incident in JPTC between A.V. and Facility Superintendent.

i. On July 27, 2010, the JPTC Superintendent held a group meeting of A.V.'s unit to address an assault on a staff earlier that day. At some point during the meeting, the Superintendent and A.V. exchanged heated words. A.V. then immediately stormed out of the group to his room, slammed the door, and punched his wall. He was taken 30 minutes later to medical, where he complained of extreme pain. X-rays were taken and his hand was splinted.

ii. CYFD failed to timely complete an SIR. "The SIR was completed on 8/23. It should have been completed 7/27, and that delay is part of the ERB investigation."

iii. On October 13, eleven weeks after the incident, in response to an ACLU-NM request for documentation of all findings and conclusions by CYFD regarding this incident, CYFD responded: "IT IS STILL UNDER INVESTIGATION." Nineteen weeks after the incident, ACLU-NM must assume

that the CYFD investigation is still underway, as it has not received a single document responsive to its request.

iv. When ACLU-NM inquired whether there had been any investigation of the incident by Protective Services, CYFD simply responded: "No…. The client dropped the grievance and there was no physical abuse to be investigated." When ACLU-NM pointed out that, under JJS policy and procedure, physical abuse is not the only basis for a mandatory referral to Protective Services, CYFD, again simply, responded: "It was referred to PS and was screened out."

C. September 2010 Incident at JPTC Involving At Least Three Clients and Access to Hand Sanitizer.

i. On September 18, 2010, three JPTC clients (A.L., A.P., and J.C.) allegedly obtained hand sanitizer, got intoxicated, and assaulted staff. J.C. was restrained by JPTC staff using two shields obtained from Southern New Mexico Penitentiary. Although CYFD insisted that both of its staff had been trained in the use of such shields, CYFD's records show that one of the staff had not been so trained.

ii. On September 27, ACLU-NM inquired as to when CYFD anticipated completing its own investigation and producing a report on the incidents. CYFD responded on October 4: "Unknown at this time; everything has been sent to ERB, who is currently conducting an investigation."

iii. On October 20, ACLU-NM requested that CYFD provide, as soon as they are available, the results of CYFD's investigation of the incident, including all findings and conclusions. CYFD responded on November 2:

> The ERB investigation is not yet concluded; we will follow up by sending you notice of the result when it is. Beyond that, as noted in our email to you of 10/28, CYFD cannot share information on individual personnel investigations or actions, as they are confidential.

iv. Eleven weeks after the incident, ACLU-NM must assume that the ERB investigation is not yet concluded, and that therefore the CYFD investigation is not yet concluded, as ACLU-NM has not received either notice of the result of the ERB investigation or the findings and conclusions of the CYFD investigation.

D. May 2010 Allegation by S.C. in CNYC of Sexual Abuse by Staff.

i. S.C. told ACLU-NM that she had been sexually abused by a regular unit staff in May of 2010. Several weeks after her abuse she mentioned the allegations to a client, who relayed them to another client, who relayed them to a staff member. Shortly after that the CNYC Superintendent held a meeting with all of the girls on the unit. Each was called in to the multi-purpose room, the site where some of the alleged sexual abuse occurred. Present at each of these meetings was the Superintendent, the alleged perpetrator, and one girl. The Superintendent asked each of the girls whether she knew of anything sexual going on between a girl on the unit and the alleged perpetrator. The Superintendent asked S.C. whether there was anything sexual going on between herself and the alleged perpetrator. S.C. was intimidated and said no. S.C. told a staff a few days later that the rumors were true. S.C. was never provided any documentation or

status reports regarding the investigation. The Superintendent's preemptive investigation of allegations was highly unprofessional and inappropriate.

ii. ACLU-NM brought it to the TAC's attention on September 17 and requested an investigation of CYFD's investigation. CYFD has not provided ACLU-NM with the results of the subsequent investigation, but ACLU learned that the CNYC Superintendent was demoted shortly after ACLU-NM brought this issue to the TAC's attention.

Substantial Violations of Section III of Appendix A ("Behavioral Health")

65. In November 2010, the TAC issued a report describing its review of the behavioral health services provided by CYFD to the youth incarcerated in its juvenile justice facilities.

66. The November 2010 TAC report states:

> Youth placement issues are an ongoing concern for the CYFD JJS administration. Specific issues include: 1. Delays from initial MDT placement decision to youth placement. 2. Bunking youth on units other than his assigned unit. 3. Placement of youth on special units (A2D) in violation of Procedure 21.8 Client Programs (Safety Unit)…. [With regard to the third issue, the report adds:] In September 2010 I reviewed documentation [Executive MDT Safety Unit Criteria Form] for youth on A2D [the Safety Unit]. Eight youth were assigned to the unit. (One of the eight was at MDC.) Not one form was complete; yet they were all signed by the psychiatrist, director of behavioral health services, superintendent and JJS Deputy Director. Three forms had notations that the youth could function in regular programming. The explanation given was that the census did not allow the youth to be transferred…. Youth care and BH staff had not been adequately oriented to Procedure 21.8 Client Programs (Safety Unit).

67. The November 2010 TAC report states:

> The treatment planning process is being conducted according to policy/procedure at YDDC, CN, and the JPTC. These practices must be extended to the reintegration centers and the San Juan Juvenile Detention Center.

68. The November 2010 TAC report states:

> Overall, behavioral health treatment is being conducted according to policy/procedure at YDDC, CN, and the JPTC. Where lapses occur, they are staff specific and being addressed through education and, where necessary, employee disciplinary practices…. These practices must be extended to the reintegration centers and the San Juan Juvenile Detention Center.

69. The November 2010 TAC report states:

> In June and July of 2010 the Office of Quality Assurance conducted a review of the Suicide Assessment and Prevention Procedure. This review was limited to the procedure followed by behavioral health staff…. Of the 24 items reviewed, 10 were in full compliance, thirteen items required modification of documentation practices or the procedure, and one item required additional training of staff…. This review did not include JJS procedures…. While OQA and BH response to the review was adequate, the documentation provided to the TAC and the discussion of the review by CYFD JJS administration and the TAC exhibited a disconnect between the review and the JJS administration. OQA noted that youth on watches are observed by YSC staff. The only task for the YSC conducting the watch is to ensure that the youth is safe and document youth activity at regular intervals. Under items 6 , 17, and 19 OQA noted difficulties with verifying YSC practices. While BH did modify the form used for documentation, there was no evidence in the TAC binder or TAC discussion that CYFD took any action to ensure that YCS received training on the new form or were in fact documenting separation and completing observations as required.

70. The November 2010 TAC report states, regarding its recommendations for future reviews:

> 1. All JJS procedures governing the assessment and prevention of suicide should be reviewed during the same review period. While discipline specific reviews will be acceptable for many procedures, suicide prevention demands a comprehensive, or 360 °, review. 2. CYFD JJS administration must take necessary actions in response to OQA reviews. 3. Reviews and procedures must be extended to the reintegration centers and the San Juan Juvenile Detention Center.

71. The November 2010 TAC report states: "The BH monitor's review of records did not reveal documentation of special MDTs as indicated by CYFD policy."

72. The November 2010 TAC report states:

> Ongoing monitoring of BH and medical care cannot change the culture, JJS practices, or governance of the facilities…. Sadly, the successes of the TAC have been limited. The TAC can offer expert guidance to CYFD administration and

> the CYFD JJS but the TAC cannot ensure adequate system or facility governance…. New Mexico must institute a system to ensure adequate governance of the facilities. Governance challenges are at the heart of the ongoing complaints issued by the ACLU. Defendants have been aware that most JJS clients need substances abuse treatment, but the staffing and the services provided by CYFD to these clients have not been adequate.

A. Example of CNYC clients S.C., B.L., A.G., C.C., and B.Q. CYFD has evaluated each of these clients, determined that they have behavioral health needs, and identified specific behavioral health therapies and programming as part of their commitments with CYFD. Unfortunately, during the summer of 2010 and as late as October and November of this year, these clients were not receiving these therapies and programming.

73. Under the 2009 Agreement, "Each unit has a behavioral staff member assigned to the unit. This staff will function as an active member of the unit teams." For youth in the Ivy cottage, whether classified as Intake or Ivy, this is clearly not being provided. The last response from CYFD indicates that they do not intend to comply with this requirement. This refusal, together with the delays in getting youth placed, means that the youth housed, sometimes for months, at the Ivy unit are being denied the behavioral health component required by The Way Forward.]

A. In light of youth reports in Intake and Ivy that a counselor was not presently available in the unit, ACLU-NM in September 2010 asked what counseling and other mental health services are available to youth in Intake and Ivy. CYFD responded:

> They did have a full time therapist assigned to the unit, but she is no longer with us and we are in the process of attempting fill this position. The clients do receive individual counseling and some groups are held with the clients by a mental health staff on some occasions.

B. In light of youth reports in Intake and Ivy that a therapist was available to them, at best, only on an infrequent and inconsistent basis over the last several months, ACLU-NM in November 2010 asked when a counselor will be placed on the unit again and what efforts CYFD is making to ensure continuity of behavioral health services for both Intake and Ivy clients in the Ivy cottage. CYFD responded on December 6, 2010:

> In the intake unit we have the Clinical Supervisor for YDDC working with the line staff to identify counseling that needs to occur. She also checks in with the unit 2-3 times per week. Diagnosticians are also meeting with the clients. They are all counselors, and a Substance Abuse counselor is providing Substance Abuse groups in that unit. If a youth is identified as needing immediate services, they are provided. At this time is it not likely that a therapist will be permanently assigned to the intake unit, as our method for identifying and providing short-term intervention is effective and appropriate given the allocation of resources. The standard for assignment of mental health counselors for juvenile correction facilities is 'Juvenile facilities: The minimum psychology staff ratio in facilities for juvenile offenders is 1 full-time qualified mental health care professional for every 60 to 75 juveniles in general population and 1 full-time qualified mental health care professional for every 20 to 25 juveniles in a special management unit.' This is taken from STANDARDS FOR PSYCHOLOGY SERVICES IN JAILS, PRISONS, CORRECTIONAL FACILITIES, AND AGENCIES, International Association for Correctional and Forensic Psychology [ECF], Third Edition, 2010. We clearly not only meet but far surpass these standards."]

C. CYFD has clearly failed to meet its obligations under the 2009 Agreement.

Substantial Violations of Section IV of Appendix A ("Medical")

74. On August 21, 2010, Dr. Greifinger issued a revised report regarding his May, 2010 audit of medical care. The report stated:

> On the basis of the information that I have obtained through documents and review of records since July 29, 2010, it is clear to me that the basis for my report, dated May 17, 2010, was flawed, due to deliberate suppression of information on significant deficiencies in medical care at SJDC [San Juan Detention Center] and the withholding of quality assurance information and activity. Based on facts that I have obtained and reviewed, I find that the medical care for each of the nine

> clients in custody of SJCJDC during April and early May was deficient. This is the finding I would have made in my May 17, 2010, had I been presented with the information I have now. This finding of non-compliance with the Agreement, in my role as medical expert for the parties, would have led to a return visit to assess compliance with the Agreement. Further, the quality management process at CYFD did not legitimately incorporate problems that had been identified and failed to verify whether the identified problems had actually been corrected. The CYFD is not compliant with the Agreement regarding medical care for youth in custody. I affirm the withdrawal of my report, dated May 17, 2010, based on a misrepresentation of a material fact.

75. On November 9, 2010, Dr. Greifinger, Dr. McPherson and Dr. Smoker jointly issued a report of their audit of medical care. It stated:

> It is our opinion that the quality measurement program, CQI, does not comport with current professional standards. The purpose of CQI is to provide meaningful, critical analysis of medical services in order to promote the delivery of quality health care. While the initial design of the CQI program was sound, it has not been implemented as designed. The lapse of leadership by an HAS, until recently, has contributed to the deficiencies found in the CQI program. The CQI program has not conducted performance measurements as scheduled. When studies were conducted they lacked sufficient scope and depth to play an ongoing role in self-critical analysis and quality improvement.

76. The Greifinger, McPherson and Smoker report found that Patient Care and Medication Administration is problematic:

> It is our opinion that CYFD should work with the appropriate state agencies and the governor's office, if necessary, to remedy the accounting quirk that risks patient safety and medication diversion through the use of stock medications. It is our opinion that CYFD has an obligation to ensure that youth receive prescribed medication. CYFD should explore the various reasons that patients have disrupted continuity of medication and implement remedies, to the extent possible. Remedies should be formalized as a procedure that can be monitored for compliance.
>
> A. Youth sometimes do not get their prescribed medication due to CYFD's ineffective system for distributing medication.

77. The Greifinger, McPherson and Smoker report stated, regarding Direct Patient Care at the San Juan Detention Center:

> It is our opinion that the case of the facility administrator's interference with physician's orders is egregious. It is a fundamental tenant [sic] of correctional medicine that appropriately ordered medical care not be denied by non-physicians for purposes that are punitive or for the convenience of staff. It is our opinion that the deficiencies identified during the August re-evaluation … should not be characterized as 'minor.' While easily corrected, courts have consistently found that administration of medication without informed consent and the failure to conduct AIMS testing are potential grounds for medical malpractice. It is our opinion that thee are deficiencies in the medical care at San Juan, including medical record-keeping; consents for psychotropic medication; AIMS testing; access to dental care; training and supervision of nursing staff on physical assessment, documentation; and appropriate referral for care; and follow-through on outside diagnostics. CYFD youth at San Juan continue to be at risk of harm until these deficiencies are remedied. It is our opinion that CYFD should develop and implement a procedure for oversight of medical and behavioral health care at all contract facilities. This plan should be made clear in the contract between the State and receiving facility. The care for youth at San Juan needs intensive administrative and clinical supervision, at least monthly, until the deficiencies are remedied, and then ongoing oversight on a quarterly basis.

78. The Greifinger, McPherson and Smoker report stated, regarding Direct Patient Care at the JPTC:

> It is our opinion that the deficiencies identified above indicate that nursing staff at JPTC need additional training on physical assessment and documentation. The ongoing supervision of individual nursing staff should include peer review of nursing skills including physical assessment and documentation. When indicated, the supervisor should note actions taken in the personnel file. All documentation in the medical chart must be legible. When an individual displays a pattern of barely legible documentation, this deficiency must be addressed in supervision.

79. The Greifinger, McPherson and Smoker report stated, regarding Direct Patient Care at YDDC [Youth Development and Diagnostic Center]:

> It is our opinion that the deficiencies indentified above indicate that at least one nurse needs additional training on physical assessment, timely referral, and documentation. The ongoing supervision of individual nursing staff should include peer review of nursing skills including physical assessment and documentation. When indicated, the supervisor should not actions taken in the personnel file. All documentation in the medical chart must be legible. When an individual displays a pattern of barely legible documentation, this deficiency must be addressed in supervision. It is our opinion that the pattern of failure to notify non-psychiatrist physicians of their patients' medication refusals does not comport with currently accepted professional standards. The HAS should

develop a procedure to ensure physicians are notified of medication refusals. The procedure should be monitored for compliance.

80. The Greifinger, McPherson and Smoker report stated regarding Direct Patient Care at CNYC:

> It is our opinion that CNYC nursing does not consistently comply with the use of force policy requiring a nurse to assess each youth subjected to force. A nurse must evaluate each youth subjected to use of force and thoroughly document the assessment. The documentation of positive and negative findings … is critical. Detailed suggestions for clarifying the Incident/Injury Documentation Form were given in writing to the health services administrator during the tour. It is our opinion the failure to obtain documentation or review available documents for off-site diagnostic procedures and consultations does not comport with currently accepted professional standards. The HAS and the medical management team should develop a procedure to track and respond to diagnostic procedures and consultations. The procedures should be monitored for compliance. It is our opinion that the pattern of failure to notify non-psychiatrist physicians of their patients' medication refusals does not comport with currently accepted professional standards. The HAS and the medical management team should develop a procedure to ensure physicians are notified of medication refusals. The procedure should be monitored for compliance.

81. The Greifinger, McPherson and Smoker report stated regarding Direct Patient Care at CYFD's non-secure facilities, Carlsbad, Eagles Nest, and Albuquerque Reintegration Center:

> No opinion is offered regarding the medical care at the reintegration centers. While there were isolated examples of excellent attention to the medical needs of youth at the Carlsbad facility, the lack of standardization of medical documentation prevented us forming conclusions. It is our recommendation that CYFD should develop a standard policy and procedure for the reintegration center medical charts. The standards for NM group homes should be followed. The medical information forwarded to the reintegration center from the JJS secure facility should be standardized. A log in each record should document the date and purpose of medical/dental visits. Any documentation of the visit should be filed. Medication use should be documented on a medication administration record. Privacy should be maintained in a manner similar to group home practices in New Mexico, with medical records separate from the custody record, where appropriate.

Substantial Violations of Section V of Appendix A ("Other Issues")

82. The 2009 Agreement required CYFD to work with the TAC, under Paul DeMuro's leadership, to develop plans and procedures by December 21, 2009 to address six other elements of CYFD's juvenile justice system, "Other Issues." None of those six plans was completed during 2009. Moreover, CYFD unilaterally decided to forego altogether the required plan to address the needs of older youth, those over the age of eighteen. Although over 60% of the youth in CYFD's secure facilities are over eighteen, CYFD has never established the required plan to address their needs.

A. Specialized services to address the unique needs of female youth remain inadequate and not comparable to those provided to male youth.

B. "Supervised Release" replaced "parole" as the nomenclature for the status of youth who can be released from a secure facility to complete their term of commitment under the supervision of a Juvenile Probation and Parole Officer ("JPPO"). CYFD's methods of deciding which youth will appear before a panel to decide who will receive supervised release is capricious; the panel's decisions regarding which of those youth will be released is not rational; and CYFD procedures for revoking a youth's supervised release deprive youth of their liberty without procedural due process of law. Youth who do not receive needed treatment while incarcerated are denied release because they did not complete treatment which CYFD does not make available to them.

i. Example of A.L. at JPTC. Placed on the September 2010 Supervised Release Panel agenda. He was later improperly removed from that agenda. Upon his grievance and follow-up questioning by ACLU-NM, he was placed on the October 2010

agenda. At that hearing he was denied early release for reasons that his classification officer and ACLU-NM consider unfair and inappropriate.

COUNT I – DECLARATORY JUDGMENT

83. All allegations set forth above are incorporated herein.

84. As set forth above, based upon the multiple areas in which Defendants are in substantial non-compliance, ACLU-NM seeks a declaration that Defendants misrepresented material facts in the formation of the 2009 Agreement, that they have breached the 2009 Agreement, that they have breached the implied covenant of good faith and fair dealing with respect to the 2009 Agreement, and that, as a result, they are equitably estopped from asserting either that the 2009 Agreement terminates on December 31, 2010 or that the Court is without jurisdiction to enforce the 2009 Agreement or to award damages or equitable relief.

COUNT II - SPECIFIC PERFORMANCE

85. All allegations set forth above are incorporated herein.

86. Pursuant to New Mexico law, ACLU-NM seeks specific performance of the 2009 Agreement.

87. ACLU-NM seeks specific performance requiring that Defendants comply with the 2009 Agreement by taking appropriate action to comply. In particular, Defendants should be compelled to comply with each section in which they are found to be in substantial non-compliance by the neutral experts.

88. Furthermore, ACLU-NM seeks injunctive relief to remediate the Defendants' non-compliance and to lead to future compliance.

COUNT III – BREACH OF COVENANT OF GOOD FAITH AND FAIR DEALING

89. All allegations set forth above are incorporated herein.

90. The implied covenant of good faith and fair dealing imposes on CYFD and its agents the duty to refrain from doing anything which would render performance of the contract impossible by any act of their own, and also the duty to do everything that the contract presupposes that each party will do to accomplish its purpose.

91. Defendants have breached the covenant, depriving ACLU-NM and the youth in CYFD's juvenile justice system of the benefits of the 2009 Agreement by interfering with and failing to cooperate with ACLU-NM, the TAC and its members, and with Dr. Greifinger in the performance of the 2009 Agreement.

RELIEF REQUESTED

92. Defendants have acted intentionally, knowingly, in bad faith, with reckless disregard or with deliberate indifference to the rights of Plaintiff ACLU-NM, and the New Mexico youth who have been adjudicated delinquent and are in defendants' care and custody, guaranteed by the 2009 Agreement. Their acts and omissions were a direct cause of the injuries suffered by ACLU-NM and the New Mexico youth who have been adjudicated delinquent and are in defendants' care and custody. The injuries caused by Defendants' material breach of the 2009 Agreement were foreseeable at the time they entered the 2009 Agreement and Defendants reasonably could have expected these injuries would be a consequence of their breach.

93. As a direct result of Defendants' joint and several failure to comply with the terms of the 2009 Agreement, ACLU-NM and the New Mexico youth who have been adjudicated delinquent who are in Defendants' care and custody have suffered and will continue to suffer immediate and irreparable harm unless this Court grants them preliminary and permanent

injunctive relief specifically enforcing the terms of the 2009 Agreement, remediating the violations of the 2009 Agreement and granting such additional injunctive relief as is necessary to promptly achieve compliance with the terms of the 2009 Agreement, including but not limited to the hiring of sufficient highly qualified professionals as are necessary to ensure prompt compliance with the 2009 Agreement. Plaintiff has no adequate remedy at law.

WHEREFORE, Plaintiff prays for judgment against Defendants and each of them as follows:

1. For an injunction commanding:
    a. specific performance and specifically enforcing the terms of the 2009 Agreement;
    b. ordering Defendants to make whole both ACLU-NM and the youth who have been denied the benefits of the 2009 Agreement;
    c. prohibiting CYFD from breaking up the groups of youth who live together during their school days;
    d. requiring CYFD to afford ACLU-NM the same access to residents of their facilities, to the facilities themselves, to CYFD staff and to documents and other information which is currently in effect; and
    e. such additional remedial actions as are necessary in order to achieve prompt compliance with the terms of the 2009 Agreement, including but not limited to implementation of Cambiar New Mexico and the hiring of sufficient qualified professionals as are necessary to ensure prompt compliance with the 2009 Agreement;
2. For a declaration that Defendants are in breach of the 2009 Agreement, and that they have breached the implied covenant of good faith and fair dealing;

3. For contract damages in an amount to be determined by the trier of fact, jointly and severally;

4. Alternatively, vacate the September 3, 2009 Agreement and return ACLU-NM and CYFD to the positions they were in prior to September 3, 2009: in litigation regarding noncompliance with the original February 15, 2006 agreement.

5. For pre-judgment and post-judgment interest;

6. For attorneys fees and costs; and

7. For such other and further relief as the Court deems just and proper.

Respectfully submitted,

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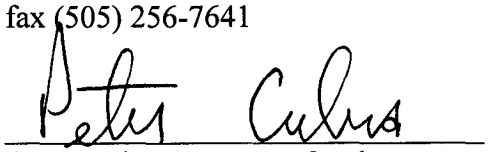

Cooperating Attorneys for the
American Civil Liberties Union of New Mexico

Youth Law Center Attorneys:
Alice Bussiere
Maria Ramiu
200 Pine Street, Suite 300
San Francisco, CA 94104
(415) 543-3379
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CERTIFICATE OF SERVICE

I hereby certify that on the 15th day of December 2010, I emailed a copy of the foregoing to:

Gary King
Attorney General
State of New Mexico
408 Galisteo St.
Santa Fe, NM 87501
gking@ago.state.nm.us

Chris Romero
Acting General Counsel
Children, Youth and Families Department
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Peter Cubra
Counsel for Plaintiff

AMENDED AGREEMENT BETWEEN CYFD AND THE ACLU-NM CONCERNING SERVICES AND PROCEDURES FOR NEW MEXICO YOUTH ADJUDICATED JUVENILE DELINQUENT

Whereas in 2005 and early 2006 the ACLU of New Mexico (hereinafter, "ACLU-NM"), in conjunction with its cooperating attorneys and the Youth Law Center of San Francisco, prepared for filing a class action lawsuit against the New Mexico Children, Youth and Families Department (hereinafter, "CYFD") to address what it perceived as the most pressing systemic safety, programmatic and procedural deficiencies in New Mexico's treatment of youth who are adjudicated juvenile delinquent,

Whereas on February 15, 2006, the parties entered into an Agreement Between CYFD and the ACLU-NM Concerning Services and Procedures for New Mexico Youth Adjudicated Juvenile Delinquent (hereinafter, the "2006 Agreement"),

Whereas on November 20, 2007, the ACLU-NM filed suit against CYFD alleging that CYFD was in violation of certain provisions of the 2006 Agreement, which allegations CYFD denies,

Whereas CYFD believes that it continues to improve its Juvenile Justice services and procedures in a way that is in the best interests of these New Mexico youth,

Whereas the parties have met numerous times, have reached an agreement on the steps CYFD will take to address the issues that are the subject of the ACLU-NM's pending lawsuit, and desire to work together in the future by sharing expertise about solutions to problems; and

Whereas the parties desire to resolve the issues between them at this time without the necessity of further litigation,

Now, therefore, the ACLU-NM and CYFD hereby agree as follows:

1. The effective date of this amended Agreement and all appendices thereto (hereinafter, "this Agreement") is the date on which the first signature on this Agreement by a CYFD official occurs. This Agreement shall terminate on December 31, 2010, unless extended by mutual agreement of the parties. All rights and obligations established by this Agreement shall terminate when this Agreement terminates. A court may not enforce this Agreement after the expiration of the term of this Agreement, whether or not the action was filed prior to the termination date of this Agreement, nor may a court reform this Agreement nor provide relief of any kind or nature extending beyond December 31, 2010 under any circumstances whatsoever. This Agreement supersedes and otherwise replaces the 2006 Agreement between the parties, and all obligations established by the 2006 Agreement are hereby extinguished upon the effective date of this Agreement.

2. This Agreement and all agreed upon amendments or appendices are a fully enforceable contract, the terms of which may be enforced like any other contract through an action by the ACLU-NM for damages, specific performance and/or declaratory and injunctive relief, subject to the enforcement deadline limitation set forth in paragraph 1, above. However, nothing in this Agreement shall create in any individual any right to sue for damages or for specific performance as a third party beneficiary of this Agreement. The right of the ACLU to sue for damages under this Agreement shall be limited to attorneys' fees and costs as set forth hereinafter. The parties expressly agree there may be no punitive damages for violation of this contract.

3. The ACLU-NM agrees to dismiss its pending lawsuit (*The American Civil Liberties Union of New Mexico v. The New Mexico Children, Youth and Families Department, et al.*, NM Dist. Ct., 1st Jud. Dist. No. D-0101-CV-2007-02921) and further agrees that it will not file any suit as to any CYFD juvenile justice services or policies addressed in this Agreement (including any amendments or appendices thereto) so long as this Agreement is in effect and the ACLU-NM believes CYFD is implementing the terms of this Agreement in a timely and appropriate manner.

4. Definitions. Throughout this Agreement (including any amendments or appendices thereto) the terms "youth" means anyone adjudicated in New Mexico to be a juvenile delinquent and held in a CYFD facility, unless a different meaning is specifically indicated, and "ACLU" or "ACLU team" means the ACLU-NM cooperating attorneys, the attorneys from the Youth Law Center of San Francisco, and their support staff who are working on this project, as listed in Appendix B to this Agreement. Appendix B may be modified from time to time by the ACLU, which shall notify CYFD in writing of any modifications. The term "TAC" means the Technical Advisory Committee established pursuant to Appendix A of this Agreement.

5. For good and valuable consideration which CYFD hereby acknowledges receiving, CYFD agrees to implement fully all the actions set forth in this Agreement (and any amendments or appendices thereto) in accordance with all timelines, except for the limited circumstance provided in paragraph 7, below, and subject to paragraph 11, below. All plans, policies and procedures required by this Agreement which are approved in whole or in part shall automatically become a part of this Agreement. The parts which are approved shall be added as addenda to this Agreement when they are approved in whole or in part through the process set forth in paragraph 6, below.

6. Whenever CYFD proposes to adopt a new plan, policy, procedure or other document that will have a substantial impact on this Agreement or its appendices, the following process shall be followed by the parties to this Agreement:

(a) CYFD shall mail or deliver a copy of the document to be reviewed simultaneously to all members of the TAC team and Daniel Yohalem, Philip B. Davis, Peter Cubra and Alice Bussiere at the addresses set forth in Appendix B;

(b) the ACLU team shall provide one set of comments and recommended changes or a statement that there are no comments or changes to the TAC team and CYFD's General Counsel (currently Frank Weissbarth) within 20 days of receipt of the document;

(c) the version of the document adopted by the TAC shall be implemented by CYFD.

7. The ACLU-NM acknowledges that CYFD's ability to comply with certain provisions of this Agreement is dependent in part on the New Mexico Legislature making available sufficient resources for such compliance. CYFD shall make its best efforts to obtain sufficient funding to fully effectuate this Agreement. In the event that despite these best efforts the Legislature does not provide CYFD with the funds and other resources (e.g., FTE) necessary for implementation of this Agreement the TAC team will work with ACLU-NM and CYFD to negotiate in good faith to tailor the actions to be taken with the funds and resources available to support such actions. CYFD may raise insufficiency of funds and resources as a defense to any action brought by the ACLU-NM to enforce this Agreement, but this shall not prevent the ACLU from rebutting that defense and/or seeking a remedy under other laws.

8. If at any time during the term of this Agreement the ACLU-NM believes that CYFD is not implementing or otherwise complying with the terms of this Agreement, it shall give notice to CYFD and the parties shall meet in good faith to attempt to resolve the issue with the TAC team's assistance. If the parties and the TAC team are unable to resolve the issue, the parties may engage Paul Bardacke as a mediator to attempt to assist in such resolution. If there is no resolution, the ACLU-NM may bring suit to enforce those terms of the Agreement with which it believes CYFD is not in substantial compliance and/or to seek a remedy under other laws if it believes in good faith that CYFD is not implementing or otherwise complying with any term of this Agreement in a timely and appropriate manner. Under no conditions shall CYFD be liable for the actions or inactions of the TAC in its performance of any duty under this Agreement or the appendices attached hereto.

9. The TAC shall meet with the ACLU-NM every three months for the duration of this Agreement and every six months during 2011 and prior to those meetings shall provide the ACLU and CYFD with information in writing on CYFD's progress and compliance with the terms of this Agreement. CYFD shall provide the ACLU-NM a copy of all documents it provides to the TAC for purposes of the TAC's quarterly meetings, including but not limited to status reports, TAC meeting agendas and TAC meeting minutes. The Secretary of CYFD may have his or her general counsel present at the TAC meetings with the ACLU.

10. Fees and Costs

(a) CYFD shall pay the ACLU-NM team attorneys' fees, expenses and costs in the total amount of $500,000 (in addition to the $10,000 remaining to be paid

under the parties' prior Agreement) and ACLU and its counsel shall make no further claim for fees and costs for the litigation entitled *The American Civil Liberties Union of New Mexico v. The New Mexico Children, Youth and Families Department, et al.*, NM Dist. Ct., 1st Jud. Dist. No. D-0101-CV-2007-02921, or for past monitoring or for future monitoring under the Agreement.

(b) Except as provided in subparagraph 10(a), above, this provision shall not be evidence that a claim for fees is or would be applicable to any lawsuit that could have been, or may in the future be, brought by the ACLU-NM.

(c) Except as provided in subparagraph 10(a), above, in the event that the ACLU-NM brings a court action to enforce this Agreement, as provided for in paragraphs 2 and 3 of this Agreement, and the ACLU-NM prevails in such litigation, the ACLU-NM's attorneys fees and costs for such action shall be determined by the Court, applying the standards of the Prison Litigation Reform Act, 42 U.S.C. Section 1997 e(d)(3), unless another federal statute is also applicable to the lawsuit.

11. Unforeseen Circumstances. If any unforeseen circumstance occurs which might cause a failure to timely carry out any requirements of this Agreement, CYFD shall notify the TAC team and the ACLU in writing within 20 calendar days of the time that CYFD becomes aware of the unforeseen circumstance and its impact on CYFD's ability to timely perform under this Agreement. The notice shall describe the cause of the failure to timely perform and the measures taken to prevent or minimize the failure. CYFD shall implement all reasonable measures to avoid or minimize any such failure

12. This Agreement includes and incorporates Appendices A ("The Plan") and B (ACLU team addresses), attached hereto.

13. ACLU Contract with Paul DeMuro. ACLU shall enter into a contract with Paul DeMuro to perform all his duties as a permanent member of the TAC and the parties agree that payment to DeMuro on that contract shall be paid out of the $500,000 payable in fees and costs to the ACLU and its counsel as set forth in subparagraph 10(a) above. The ACLU shall allocate at least $110,000 of the $500,000 to payment of the contract with DeMuro, or any successor in the event that DeMuro leaves the TAC prior to the expiration of this Agreement. In the event that the ACLU files suit to enforce this Agreement, any unexpended portion of the $110,000 shall be refunded to CYFD. In the event that no suit is filed, at the expiration of this Agreement, any unexpended portion of the $110,000 allocated to the DeMuro contract shall be retained by the ACLU to cover claims for uncompensated fees.

Notwithstanding his employment as an independent contractor for ACLU, DeMuro retains absolute and total independence to act as he determines necessary in regard to the services he performs pursuant to his contract.

(a) Nothing in his contract shall be construed to empower ACLU to exercise control over DeMuro's independence in regard to his investigations, observations,

statements, conclusions or recommendations, whether written or oral, and without limitation, in the course of his work undertaken pursuant to the terms of his contract.

(b) Nothing in this contract shall be construed to prevent DeMuro from having unlimited and unfettered communication with representatives of the ACLU-NM team or with anyone else of his choosing who has information regarding youth involved in New Mexico's delinquency system or expertise deemed useful to him in fulfilling his duties as a TAC member.

(c) Nothing in this contract shall be construed to prohibit or limit DeMuro from serving as an expert consultant and/or expert witness for ACLU-NM at ACLU's and DeMuro's sole discretion in the event of any litigation contemplated or brought by the ACLU-NM concerning conditions or rights of youth incarcerated in CYFD facilities at the sole cost of ACLU-NM. If at any time the ACLU reasonably believes that they will pursue litigation and DeMuro agrees to become the ACLU's expert consultant or witness, the ACLU shall notify CYFD and DeMuro shall immediately resign from the TAC. If DeMuro resigns from the TAC, another person mutually selected by the parties shall take his place; if the parties are unable to agree on a replacement, the TAC, including DeMuro, shall select the replacement TAC member.

AGREED:

For the ACLU-NM:

Daniel Yohalem
Philip B. Davis
Peter M. Cubra
Alice Bussiere

Date: Sept. 3, 2009

For CYFD:

Dorian Dodson, Secretary

Date: 9/3/09

Frank Weissbarth, General Counsel

Date: 9/3/2009

APPENDIX A

THE WAY FORWARD

Preliminary Note:

This document (hereinafter referred to as "Plan") addresses the principal objectives originally covered by Appendix A of the February 15, 2006 Agreement (the 2006 Agreement) between CYFD and the ACLU; and provides a method to identify and develop specific measurable outcomes and data points that are necessary to track CYFD's progress in implementing the specific requirements of this rewritten agreement. The outcomes in this Plan will be tracked by an enhanced quality assurance and continuous quality improvement process that is described in this document. This Plan also establishes timelines for each outcome contained herein. This Plan is designed to supersede and replace Appendix A of the 2006 Agreement and this Plan is hereby incorporated in the 2009 Agreement.

This Plan also establishes the Technical Advisory Committee (hereinafter referred to as the TAC) that will routinely review CYFD's progress implementing this Plan by monitoring specific outcomes and data points generated by CYFD's Quality Assurance staff. Furthermore, on an on-going basis, the TAC will help establish target dates and quantifiable outcomes for the major provisions of this Plan, review progress and help resolve problems.

It is important to note that this Plan is a goals-based, evolving document, detailing what the Department believes is the best possible way to meet the needs of the youth in the Department's care while recognizing that a perfect system may not be truly achievable and that circumstances change over time. As the Department moves forward, this Plan will be updated as appropriate by the TAC to reflect both improved understanding and changing realities, and then approved by the Secretary of CYFD and Paul DeMuro. This Plan is an evolving document, and CYFD has used its best efforts to include reasonable dates for achieving the various objectives contained in this Plan. In the event that CYFD anticipates that it will be more than two weeks late in achieving an objective with a stated completion date, for reasons including but not limited to all consequences related to budgetary limitations or shortfalls, foreseen or unforeseen, it will provide written notice to the TAC stating the reasons why the objective will not be achieved by the date set forth in the Plan and the date on which CYFD believes it will achieve the objective. The TAC will decide the date that is appropriate.

CYFD's most important role is to ensure the safety and security of the community, department staff, and the youth in CYFD's care. Fulfilling this role requires the Department to establish a culture of child- and family-centered teamwork at all levels, from line workers to senior administration; and to establish accountability at all levels through a rigorous quality assurance and continuous quality improvement process. CYFD is actively working to achieve both these goals, and to embed them within the Departmental infrastructure as a permanent, sustained effort.

As part of the effort to achieve these goals and embed these efforts, , CYFD is in the process of adapting the innovative Missouri model to meet the needs of the Department, its staff, and the youth in its care, and implement this adapted model – Cambiar New Mexico – in its facilities. Both safety/security and behavioral health play significant roles in the Cambiar rollout.

This Plan details the Department's Quality Assurance process and the manner by which the Quality Assurance process will report on the progress of implementing the specific provisions contained in this Plan. This Plan also addresses issues of safety and security; finally, this Plan addresses issues regarding the role of behavioral health staff in four specific areas:

1. As an integral part of the intake, assessment, and treatment planning processes
2. As an integral part of daily programming and service delivery
3. As an integral part of immediate and appropriate response to critical incidents
4. As an integral part of daily unit and behavioral management

This Plan describes the role of the TAC in implementation and sustainability. This Plan will, for the topics discussed, identify the issue being addressed; what the Department has done and will do to address the issue; and anticipated outcomes, target dates, and related quality assurance measures designed to track the anticipated outcomes.

I. Quality Assurance

As provided in Section II, below, CYFD's Quality Office of Quality Assurance (OQA) will no longer investigate grievances, including grievances involving alleged neglect or abuse of youth in CYFD JJS facilities. Instead, OQA will devote its full resources to quality assurance (QA) and continuous quality improvement (CQI) activities. Following the separation of grievance and abuse processes from OQA, an initial draft of the inspection processes in this area contained within this Plan can be developed within 60 days, with a complete report on the targets established in this Plan 60 days later.

In addition to the measures identified in this Plan for OQA tracking, it is the Department's intention to continue efforts to ensure that quality assurance measures and outcomes become an integral and vital part of the total management culture and programming within the Department's JJS facilities and programs. Quality Assurance activities will include the following:

- Monitoring compliance with CYFD policies and procedures in all facilities, with emphasis on those policies and procedures that relate to issues of safety, healthcare, and behavioral health services. This shall include a schedule of inspections conducted by the appropriate means, including staff interviews, client interviews, case sampling, and other best practices methods for determining compliance.
- Producing an annual audit plan identifying risks within the facilities and using statistically valid sampling techniques to determine policy and/or procedure compliance. This audit plan will include, but is not limited to, adequacy of youth disciplinary practices including documentation, incidents, injuries, seclusion and restraint, use of force, grievance procedures, and implementation of classification criteria, plans of care, and counseling and rehabilitative services.
- Conducting quality assurance reviews of facilities. These reviews will be provided to management for use in evaluating, achieving, and maintaining high-quality programs in the facilities. Management, in turn, will establish and implement any necessary corrective action plans and plans of improvement within 30 days.

To support these and other quality assurance activities, an inspection process will be developed by the OQA for presentation to the TAC by November 30, 2009 for each of the key areas listed below:

A. *Corrective actions*

Monitoring the timeliness and adequacy of corrective actions taken by the Department in response to substantiated grievances, substantiated abuse allegations and other issues requiring corrective action identified through OQA's auditing activities

B. *Management Accountability*

Background Screening of Employees
Risk Management
Provision of an Abuse-Free Environment
Certification Training
In-Service Training Requirements
Case Reviews
Special Diets

C. *Youth Management and Disciplinary Treatment*

Personal Property (where staff takes possession of youth's personal property during admission and safeguards it until return)
Classification and Orientation
Grievance Process
Abuse Investigations (numbers, type and results of investigations), which depending on the nature of the investigation break out as a sub-category of the Grievance Process, Incident Reporting, or Provision of an Abuse-Free Environment
Behavior Management System
Confinement, Use of Force, and Restraint Incidents
Youth Disciplinary Practices Including Documentation
Separation/Segregation Practices
Classification and Placement

D. *Mental Health and Substance Abuse Treatment*

Screening/Initial Assessment
Specialized Mental Health Assessment
Treatment Planning
Case Management
Mental Health Counseling
Management of Psychotropic Medications
Crisis Services
Youth Development Programs

E. *Healthcare Services*

Designated Health Authority
Healthcare Admission Screening
Health Related History/Comprehensive Assess.
Screening, Evaluation, Treatment for STD
Sick Call
Medication Administration
Pharmaceuticals: Storage, Security, Access,
Inventories and Disposal
Infection Control
Chronic Illness Treatment Process
Episodic/Emergency Care
Authority for Evaluation and Treatment and Notification of Care
Pregnant Girls and their Neonates

F. Safety and Security

Key Control
Room Checks
Fire Prevention
Toxic, Caustic, Flammable, Poisonous Items
Vehicle Inspections
Tool Control
Supervision of Youth
Escapes

G. Programming

Recreation and Activities
Academic and Vocational Education
Religious Activities
Gang Management
Transition
Community Facility Programs
Behavior Management
Work Programs

H. ADA Compliance

Procedure for the identification of youth with disabilities as defined by ADA
Procedure for monitoring and reporting reasonable accommodations in the following areas:

Grievance Procedures
Physical Plant Access
Medical Issues
Program Access

II. Safety and Security

CYFD shall provide reasonable safety to youth in its custody and eliminate unreasonable threats to the safety of youth in their facilities.

- Grievance System

CYFD shall implement an effective system for abuse investigations and grievances and ensure timely and appropriate corrective action is taken in response to abuse allegations or grievances that are substantiated in whole or in part, as necessary.

Currently, routine grievances, defined as complaints about or issues regarding the quality of life for youth within the facilities (food, clothing, visits, telephone calls, etc.), are handled by the facility grievance officers. Serious and/or non-routine grievances are handled by the quality assurance team, including abuse and neglect reports. This use of the quality assurance staff is problematic on two levels – first, it compromises the QA staff's ability to objectively collect, analyze, and report data; second, it typically takes priority over data collection, analysis, and reporting, resulting in a failure to take full advantage of the otherwise rich data produced. To correct this, new grievance officer positions (one at YDDC, one at Camino, and a half-time at JPTC) will be identified and staff retrained to fill these positions to address and resolve all grievance issues by December 31, 2009. After a three month period, JJS will evaluate the need and adjust positions accordingly. These staff will report directly to the Deputy Director of JJS Facilities. The Department will develop and promulgate a new Grievance Policy and Procedure practice guide which will be reviewed and approved by the TAC and will train the staff in these new positions to carry out the grievance function by December 31, 2009. In addition to resolving all grievances, by December 31, 2009 the Grievance Resolution staff will develop an ongoing brief monthly report, identifying the number of grievances per month, the outcome of those grievances as well as other pertinent information. OQA will assist with the development of this report and monitor its use.

In addition to providing report development assistance, OQA will monitor the grievance process, tracking number and nature, findings, and resolution, and trends or spikes. Analysis will be based on statistical data as well as the review of an appropriate sample of grievances and interviewing a number of youth and staff involved in the filing and resolution of grievances in the month prior to analysis. These changes will be implemented by December 31, 2009. Over time, it is anticipated that there should be an overall drop in grievances as the result of implementing a fair system, and providing guidance to staff to handle grievances in a reasonable time frame.

- Youth Safety System

As with non-routine and/or serious grievances (discussed above), allegations of staff abuse are also currently handled by the quality assurance team, with the same counterproductive effect on their ability to focus on their core responsibility: producing objective, quantifiable data and analyses that can be used for management and CQI. This undercuts the efficient and reliability of the abuse reporting system. To resolve this issue, the Department will make best and highest use of other staff and resources. First, the Medical staff, already trained in the detection and reporting of abuse, will be the primary referral source of allegations of abuse. Second, at least two Protective Services (PS) investigators will be assigned, depending on analysis of actual abuse complaints, to investigate allegations of abuse originating from the facilities. The total number

and location of assignment will be made following establishment of a baseline determined in consultation with the TAC, by examining the existing grievance data by facility, including the number of substantiated allegations of abuse. The PS investigators will continue to operate under the Protective Services chain of command, thereby ensuring their objectivity and independence in these investigations. As medical staff members see all injuries, it is anticipated that they will do the bulk of the reporting; training on staff expectations concerning reporting will be conducted to ensure all staff, from line to administration, are clear on their responsibilities. Reporting will be done using the existing Statewide Central Intake system established to screen all cases of abuse and neglect in New Mexico. Appropriate adjustments to the juvenile justice databases and tracking systems will be made to ensure adequate and appropriate monitoring of cases, case progression, and outcomes. Medical staff has previously received, and will continue to receive, training on recognizing and identifying abuse. However, the Department will ensure that by end of September 2009 all staff (particularly the behavior health staff) are made aware of their legal responsibilities as mandated reporters to report all allegations of abuse, and are provided with the Statewide Central Intake number.

OQA will monitor the new abuse and neglect allegations process, tracking number and nature, findings, and resolutions, and reporting on trends or spikes, including the frequency of unsubstantiated allegations. Medical conducts their own CQI process; the OQA reports will track their process and its outcomes as well. This system change will be implemented by December 31, 2009. CYFD anticipates improved reporting and improved capacity among staff for identifying and addressing abuse and neglect issues, compared to a baseline developed from the existing grievance data. In addition, the Department will work with the Employee Relations Bureau to identify appropriate actions to take with staff that has substantiated allegations of abuse. Staff with multiple allegations of abuse, defined as at least three allegations within a nine-month period, will be identified to senior management for appropriate actions.

- Restraints, Isolation, Hands-on Crisis Management

A complete policy governing the use of restraints and hands-on crisis management, isolation, and lockdowns has been completed as part of the 2006 Agreement; these polices and procedures have been resubmitted to the plaintiffs' attorneys for review. All use of restraints and hands-on crisis management is documented and submitted to the OQA team, as is use of disciplinary isolation.

Until the staffing and unit size issues are resolved on all units, in the event of under-staffing on units with more than 12 youth, alternative sequence programming/schedule may be proposed by unit staff and used with written permission from the facility superintendent or the Deputy Director of Facilities, provided that all youth are out of their rooms every two hours (except for normal sleeping hours) on a rotating basis and receive an equal amount of time outside of room confinement in any given 24 hour period. This alternative sequence schedule will only be approved for 24 hours; if the program is proposed to be repeated for more than 24hours, written approval for each additional 12 hours must be obtained in advance from the facility superintendent or the deputy director, and signed off on by the Secretary.

Every effort will be made to address the short staffing problem. Barring extenuating circumstances such as an unexpected surge in committed youth, by January 2010, it is

anticipated that all units will have 12 or fewer youth, and alternative sequence programming will be completely phased out.

OQA staff within each facility will monitor daily use of restraints and use of force, reporting aggregate data with notable incidents called out to the OQA supervisor, Unit Supervisor, Facility Superintendent, JJS Director, and JJS Deputy Director for Facilities; and also monitor and track hands-on crisis management, disciplinary lockdowns, and alternative sequence programming (until their use is abolished), tracking number and nature, time and resolution of situation. Using this data and a Quality Assurance approach, the Department anticipates a decrease in all these events.

Current restraint training is designed for youth under age 18. As 64% of facility residents are 18 or over, restraint training options are currently being reviewed to identify and select a more appropriate package for dealing with the reality of the facility population. A new restraint program will be selected and implementation will begin by January 2010, following review by the TAC (the current system must remain in place until all staff are trained in the new system). Parallel with new restraint training will be a change in procedure designed to phase out the use of handheld cameras except as authorized with specific youth either identified by the Department or the Plaintiffs, with approval of the TAC, and in specific situations – i.e., use of restraint chair. Handheld cameras, in addition to adding a layer of complexity, carry a high risk of escalating a crisis situation rather than de-escalating. Their removal, combined with changing procedures to clear an area of all non-staff witnesses when a crisis management issue arises, is anticipated to result in improved de-escalation and decreased use of restraints. OQA will track the use of handheld cameras and the amount of time and number of staff required to de-escalate a crisis situation against incidents where no camera is present. CYFD anticipates being able to resolve incidents in a fairer and more timely fashion with these changes.

- Unit Reduction

As part of the Cambiar rollout, and to support the development of a positive, therapeutic milieu by encouraging the ready interaction/engagement of staff with youth, all units will be reduced to 12 youth or fewer by January 2010, barring extenuating circumstances. Supporting this shift will be an analysis of resource/staff deployment versus needs within juvenile justice facilities, and a consequent redeployment of staff resources in order to ensure their most efficient use. Among other things, this redeployment will support the Department's efforts to limit the number of youth in every unit to 12, and to decrease the use of overtime, resulting in a more balanced workload for all staff and a correspondent reduction in stress, tension, and turnover. OQA will track the redeployment of staff and size of each unit and the use of overtime, and work with Human Resources to track EEOC and other staff complaints and grievances, and the turnover rate across the facilities. CYFD anticipates a reduction in these measures, as well as a reduction in incidents.

- Cambiar Implementation and Training

Preparation for Cambiar training in the Albuquerque facilities will begin in July 2009, with all training and complete implementation in all units by December 2010 (sooner if resources allow), barring extenuating circumstances. Specific training for mid and upper level facility managers will begin first to facilitate understanding of the model by managers prior to line staff training, and will be completed by September 30 2009. As part of this implementation, the

structured daily programming will continue and be improved, as will all disciplinary proceedings. This will include familiarization of all staff and youth with the Cambiar program and integration of the Cambiar program with all activities at YDDC, Camino Nuevo, and JPTC on a 24/7 basis. Beginning in September 2009, OQA will use data generated by the existing incident reporting system to monitor and analyze negative behavior and the efficacy of the Cambiar program in addressing such behavior.

- Unit Based Management

Implemented as part of the Cambiar rollout is unit-based management, including security and safety elements, behavioral health and behavioral management, and cross-training. By reducing unit sizes, implementing daily schedules and routines, clarifying and communicating exactly what is expected of staff and youth, integrating behavioral health staff into the units, and ensuring a consistent team composition for every unit, the Department intends to implement current and new policies and practices that make youth and their safety, well being and rehabilitation the central focus for everything that happens. Unit based management will be fully implemented by July 2010, barring extenuating circumstances. OQA will use the inspection process to monitor compliance with related policies and procedures as they are documented and implemented.

III. Behavioral Health

CYFD shall provide adequate mental health care and rehabilitative services appropriate to the needs of all youth within their facilities in the least restrictive setting in its facilities that is appropriate to their needs. Behavioral health staff members will be integrated into the unit teams and play significant roles within the new model as members of the team.

<u>The Behavioral Health Role in Intake, Assessment, and Treatment Planning</u>

- Intake and Assessment: General

Trained diagnostic staff members administer a timely comprehensive assessment of every youth to identify previously diagnosed or potential behavioral health or substance abuse issues. This process also seeks to identify physical and learning disabilities in order to determine how best to treat each youth. Youth with a mental health diagnosis and/or a resulting functional impairment that is secondary to the diagnosis are identified as members of the target population who will receive individualized behavioral health services. Those youth not having a behavioral health diagnosis will receive appropriate group therapy interventions, i.e., generalized substance abuse counseling, life skills training, etc. by staff outside of behavioral health. Youth Information Sheets are being compiled for each youth with special needs and sent to the unit so that staff working with that youth will have specific information and understand how to best work with that youth.

- Intake and Assessment: Classification System

The Classification Procedure has been completely rewritten to include detailed descriptions of how each youth will be assessed and classified. The procedure was reviewed by Dr. McPherson and minor changes have been made to comply with her comments. All of the processes described in the new procedure are currently being followed, which has already resulted in improvements. Youth are getting to their placements much sooner, their placements are appropriate and they are being moved far fewer times.

- Intake and Assessment: Critical Needs

Intake staff conducts an immediate critical needs assessment upon the arrival of a client at the facility. If behavioral health critical needs are present, behavioral health staff is immediately notified and address the issues appropriately. Following the critical needs assessment, behavioral health staff, along with medical staff and education staff, reviews all available data and conducts appropriate diagnostic screening. Following diagnostic screening, a preliminary plan of care and, where appropriate, behavioral health treatment plan is drafted; these plans are then reviewed and finalized during the multi-disciplinary team meeting, including the client and the client's parents and/or guardians if appropriate (e.g., child is under 18, court has not ruled otherwise, etc.). These plans determine what access to services and treatment are best for the child's needs and strengths, and this access is matched against available placements. Regardless of placement, services and treatment are laid out in the plan(s) and are provided. OQA will track and report upon the development of these plans, placement, access to and delivery of services, outcomes and changes in needs, and actions taken to achieve goals contained within the plans. These activities are on-going within the facility.

- Assessment and Planning: High Needs Youth

Judges continue to commit high needs youth to juvenile justice facilities so that they will receive services that the judges determine are unavailable in the community. These youth are those whose safety and physical and/or mental health needs require an unusually high concentration of staff and programming resources. The Department will take all reasonable steps to identify these youth as early as possible and develop a treatment plan which makes every reasonable effort to safely and effectively treat those behavioral health disorders which are amenable to evidence-based interventions. In the cases of suicidal or self injuring youth, the Department will take measures to ensure their safety in the facility and develop long term plans for their placement and aftercare including inter-agency agreements to support these long term plans. Because each high needs child is unique, there is no timeline for this, except that development of placement plans will begin the day the child is admitted to the facility. Where possible, the Department will identify these youth before they reach the point of commitment, and work to connect these youth with available resources as appropriate to strive for an environment that balances meeting their treatment needs and providing for public and staff safety. OQA will monitor and report upon behavioral health treatment plans and fulfillment. These activities are on-going within the facility.

- Assessment and Planning: Services

Based on individualized clinical assessment and assigned target population level, youth will receive adequate behavioral health services under the care of appropriate professionals. These services will include, but not be limited to:

- Necessary psychiatric evaluation prior to medication;
- Regular medication management and monitoring of medication efficacy and side effects as laid out in department policy and procedure;
- Participating in treatment team meetings;
- Providing counseling and therapy when needed;
- Timely assessments, evaluations and prompt treatment;
- Adequate documentation of treatment;
- Maintaining accurate information in the youth's treatment plan concerning medication, including monitoring schedule, medication or medical action description, counseling or therapy to be provided, ability to provide necessary treatment, treatment monitoring and review where appropriate, current diagnosis;
- Full disclosure to youth on any medication proposed, including risks, benefits, side effects, and goals; and disclosure of same to parents/guardians when appropriate and indicated by law; and,
- Adherence to CYFD policy/procedure/practice on prescription, distribution, and monitoring of psychotropic medications.

OQA will track and report upon evaluations, prescribed medications, dosage and delivery, subsequent re-evaluation, and treatment documentation. These activities are on-going within the facility.

The Behavioral Health Role in Daily Programming and Unit Management

Each unit has a behavioral staff member assigned to the unit. This staff will function as an active member of the unit teams. The Behavioral Health staff will model the positive peer interaction with other staff that is the foundation of unit management and Cambiar NM. Specifically, the Behavioral Health staff will:

- model appropriate care;
- provide guidance and information to unit staff on working with mental health and developmental disabilities;
- provide information and direction on recognizing and responding appropriately to normal versus abnormal behavior and development;
- help create plans of care needed for each youth to ensure that they can benefit from the program provided and help ensure plans of care or treatment plans and interventions take into account any disability the youth may have, particularly for youth who have frequent discipline or behavior management problems;
- in the event of critical incidents follow up with the client and staff where necessary;
- participate fully in the Cambiar training and play an active role in the implementation of the positive peer culture created by Cambiar; and
- participate in unit staff meetings.

The Behavioral Health Role in Critical Incidents

As active members of the unit team, behavioral health unit staff will support security staff in, or, at the request of security staff, take lead responsibility for, de-escalation and management of crisis situations and critical incidents (i.e., suicidal gestures/attempts, self-harming behaviors, physical restraints, and/or isolation in excess of four hours).

The Department policy of notification in the event of critical incidents is to notify behavioral health and medical staff first. In the event of behavioral health unit staff not being present, on-call behavioral health clinical staff will assist in de-escalation and management as appropriate. Regardless of the presence of behavioral health unit staff, on-call behavioral health staff will respond according to Department policy for identifying level of severity within an appropriate response time. This policy will be developed and implemented by December 2009; QA will track and report upon reports, severity levels, and response times.

IV. Medical

CYFD shall continue to contract with Dr. Greifinger as provided for in Section V(D) of Appendix A to the 2006 Agreement to fulfill the monitoring and reporting requirements of that section. Since the last review by the medical expert indicated that the Department's medical services had been significantly improved and that no major medical issue needed to be addressed, the medical expert will conduct one more review of the medical services during 2009. Unless new and significant medical issues are identified in this review, no further external reviews of the medical program will be conducted.

V. Other Issues

Transition Plans

CYFD recognizes the importance of the need for a plan of care for each youth and is committed to having a plan implemented as soon as possible after admission. The services that each client receives will be based on that plan. The plan of care will include provisions for each youth's successful reintegration into the community and started on July 1, 2009. Once full staffing levels are achieved, each facility will have a full-time Facility Transition Coordinator (FTC) who meets with each youth during the Central Intake Process. For those youth who fall within the highest need level of two or three of the Behavioral Health Target Population, a Regional Transitional Coordinator (RTC) will also be assigned. Transition planning will begin on the day of entry into the facility. Following the full diagnostic screening, the initial multi-disciplinary team, including the youth and, where appropriate, the youth's parents or guardians, will develop a plan of care including a tentative release date and, where appropriate, behavioral health or medical treatment plan. These plans identify the youth's strengths and needs; and the youth's involvement in programming, education, and services is as a result of these plans. These plans are regularly updated and reviewed by the MDT, and form the basis for the transition plan that will support the youth's return to the community. For those youth who are on medication or require specialized medical services, the Medical Transition Coordinator will ensure that the youth has an

appropriate supply of medications and follow-up appointments in the community to which he or she is returning, in accordance with CYFD policy.

OQA will track and report upon the development of these plans, placement, access to and delivery of services, outcomes and changes in needs, and actions taken to achieve goals contained within the plans.

TAC Responsibilities

The TAC consists of both Department decision makers and outside experts on juvenile justice corrections and rehabilitation as both permanent and pro tem members. All decisions of the TAC shall be by consensus of its core members. The Secretary of CYFD, Dorian Dodson, and Plaintiffs' experts, Paul DeMuro and Pamela McPherson, M.D., will serve as the core members of the TAC. CYFD will contract with Dr McPherson to assess behavioral services, to fulfill the monitoring and reporting requirements herein concerning behavioral health, and to serve on the TAC. Paul DeMuro will also serve on the TAC to assist CYFD to fulfill the monitoring and reporting requirements herein. The TAC will report to both CYFD and to the ACLU. The TAC will identify the other permanent and pro tem members as needed. The TAC will support the research, identification, and adoption of new policies and procedures necessary to carry out the purpose of this Plan; will investigate allegations concerning violations of this Plan and report back as part of the mediation and review process; and will be receive timely notification from CYFD in the event of extenuating circumstances that may cause CYFD to alter deadlines or make other changes to any item contained within this Plan. Through 2010, the TAC will conduct quarterly meetings in person, with ad hoc meetings and conversations via electronic means whenever necessary, to assess data, trouble-shoot issues, update and adjust responsibilities, goals and expectations, and mediate disagreements. The TAC will review and agree on major outcomes and data that need to be collected and analyzed to monitor the implementation of this Plan. On an on-going basis, the TAC will review outcomes and timelines and will, when necessary, modify timelines and/or data collection strategies. Although the TAC will stay in existence to the end of 2011, its role during 2011 will be limited to review of the Department's sustained activities relative to this Plan. During 2010 the TAC will meet at least quarterly; in 2011 it is anticipated that the TAC will meet twice. In the event that any of the three core members of the TAC resign from or are otherwise unable to continue to serve on the TAC, the parties shall agree on a replacement.

Communications; Monitoring; ACLU Access to Clients and Information; Records Requests

CYFD shall continue to abide by the procedure concerning monitoring and censoring of communications by youth that are set forth in CYFD Juvenile Justice Services Procedure 8.14.5.31 (amended July 2009 to renumber consistent with NMAC policy; originally numbered 8.14.5.18), COMMUNICATIONS, as originally amended January 2006.

Members of the ACLU team are authorized to interview any youth for purposes of monitoring the implementation of this Plan. Members of the ACLU team may also review any information pertaining to the needs of adjudicated youth (in either redacted form or with a youth's consent as

to documents in which youth are personally identified). This information includes, but not limited to, documents concerning programs and services, written policies and procedures; cumulative records of youths; disciplinary reports; isolation logs; grievance reports and corresponding investigatory reports; use of force reports and corresponding investigatory reports; significant incident reports and corresponding investigatory reports; quality assurance audits, investigations and plans of correction; contracts; medical logs; and mental health case load documents pursuant to the New Mexico Mental Health and Developmental Disabilities Code, or other applicable state or federal law. Members of the ACLU team may also, upon request, obtain a copy of a reasonable number of documents. The information provided to the ACLU shall be requested pursuant to the procedure in this Plan ("see below; Records Requests") and may not be used for any purpose other than monitoring the implementation of this Plan or discussions with and/or reporting to CYFD or the TAC.

ACLU Monitoring Role

Once the changes outlined under 'Youth Safety System' above have been made and the TAC has so certified, and no later than that date, the ACLU's role will be to monitor CYFD's implementation of this Plan rather than to act as an advocate for individual youth's needs, except as they relate to the implementation of this Plan. As such, any concerns for an individual youth's needs should be raised with the CYFD liaisons as outlined below. If an ACLU monitor wishes to personally advocate for or intervene on behalf of a youth, the monitor may become that client's attorney/legal representative. As an attorney/legal representative for an individual youth, an ACLU team member shall have the same access to the youth and the youth's records as any other attorney representing the youth, but shall not have access as a monitor under this Plan. In addition, if, after or during a facility monitoring visit, a youth interview or document review concerning youth, the ACLU identifies specific issues of concern related to youth care or needs under this Plan, the following procedure shall be followed:

1. If the concern can be addressed through a client grievance, the ACLU shall encourage the youth to file a grievance or assist the youth with completing and filing a grievance. CYFD shall treat such grievances in the same manner as all other grievances. The ACLU may not file a grievance on behalf of a youth or on its own behalf, but it may assist a youth in preparing a grievance to be filed by the youth.

2. If the concern cannot be addressed through the grievance process for reasons such as it being obviously systemic in nature, the client refusing to file a grievance for good reason, the grievance being more easily addressed informally, or the grievance being urgent enough to require immediate resolution, the ACLU will bring the concern to the attention of the JJS Director/Deputy Director, CYFD Office of General Counsel, and/or the CYFD Secretary within 72 hours. CYFD shall promptly investigate the concern, and report the results to the TAC and the ACLU. If necessary, CYFD and the ACLU shall work cooperatively to remedy any issues. At any time after CYFD completes its investigation, either party may ask the TAC to intervene to assist with resolution. Once the TAC has intervened, only the TAC may make further records requests pursuant to the concern.

Similarly, once the changes outlined under 'Youth Safety System' above have been made and the TAC has so certified, and no later than that date, at any time after a records request has been made by the ACLU, CYFD may reasonably inquire as to the purpose of the request to ensure that the request relates to monitoring of the implementation of this Plan rather than representation. If CYFD believes that the request is not reasonably related to implementation of this Plan, CYFD may refuse the request. The TAC may be requested by either party to mediate a dispute related to the validity or reasonableness of a records request.

Access

In requesting approval to have access to JJS facilities for monitoring purposes, members of the ACLU team will specify the intended scope of the visit, including date, time, sites, and youth to be visited. Members of the ACLU team will be permitted to speak privately with youths at the facilities. Members of the ACLU team will not interrupt therapy or counseling sessions, educational programming, other programming, or in any other way disrupt the orderly operation of the facility. At the discretion of the Director, members of the ACLU team may be accompanied by an employee escort, but the escort shall not listen in on any private discussions with youth and shall not interfere with members of the ACLU team in the performance of their activities.

CYFD's primary liaisons with the ACLU team are the Division Director of JJS, CYFD's General Counsel, and the CYFD Secretary, or their designees. As such, all inquiries concerning implementation of this Plan shall be directed through these CYFD employees and no others.

Oral communication

1. All CYFD personnel who are not within CYFD's central office management team and all personnel contracted to provide services to JJS clients on behalf of CYFD are permitted but not required to speak to ACLU-NM personnel regarding any matter that is not confidential or privileged. CYFD and contract personnel shall be notified in writing by CYFD that: a) CYFD is placing no limitation on their communicating with ACLU-NM personnel, and b) no youth "release of information" form is required for CYFD personnel to discuss youth-specific information that is not confidential or privileged.

2. CYFD personnel within CYFD's central office management team may but are not required to discuss with ACLU-NM personnel any matter that is not confidential or privileged. However, communication with the JJS Director for Facilities (currently Debra Pritchard), the ACLU Project Manager (currently Christine Tessmann), and the Director of the Office of Quality Assurance (currently Raymond Sedillo) regarding either access to information or regarding individual youth grievances is permitted without limitation except as to information that is confidential or privileged.

Records Requests

Records requests by the ACLU shall be made for the sole purpose of monitoring the implementation of this Plan. A records request shall be made in writing to the ACLU Project Manager (currently Christine Tessmann) with a copy to the CYFD General Counsel (currently Frank Weissbarth). The ACLU shall make each request with sufficient specificity to enable CYFD to determine what records the ACLU is requesting, and shall transmit each request to CYFD in a separate writing. The ACLU shall transmit all applicable releases to CYFD together with the request. Any follow-up request made by the ACLU concerning a specific request shall be made in writing and refer to the original request.

CYFD shall provide the ACLU with copies of documents that are not confidential or privileged pursuant to the Children's Code, including but not limited to the Delinquency Act and the Children's Mental Health and Developmental Disability Act, HIPAA, FERPA, or any other legally recognized basis of confidentiality or privilege, in accordance with the following procedure and without a release. CYFD shall provide the ACLU with copies of documents that are confidential or privileged in accordance with the following procedure if the ACLU provides CYFD with a current release from the youth to whom the documents pertain, permitting CYFD to provide copies of the requested documents to the ACLU for the purpose of monitoring or enforcement of this Agreement:

Following receipt of a request, CYFD shall either:

1. respond to the request within five business days of receipt of the request and any applicable releases, if required, by providing the ACLU with copies of the requested records or an opportunity to inspect the records in the case of a request to inspect records in a medium other than print; or

2. notify the ACLU in writing within three business days of receipt of the request that it is (i) unable to respond to the request within five business days, (ii) the reason why a response cannot be provided within five business days, and (iii) the date on which CYFD will provide the ACLU with copies of the records or with access to the records, in the case of a request to inspect records in a medium other than print. In the event of a dispute arising under this section, the TAC shall work with the parties to achieve a mutually acceptable resolution.

As used herein, the term "record" means a single, identifiable document in any medium. A JJS client's "file" typically contains numerous records and a request for a copy of a JJS client's file shall be construed as a request for copies of the number of individually identifiable records in the file.

Within 30 days of the date this Plan is signed by CYFD, the CYFD Secretary shall issue a memorandum to CYFD staff accurately describing this Plan, as well as the role and responsibilities of members of the ACLU team. CYFD shall provide members of the ACLU team with an opportunity to comment upon the memorandum prior to its dissemination. CYFD

shall also disseminate an accurate notice describing the role and responsibilities of members of the ACLU team, which will also be posted in all units of JJS facilities.

Additional Topics

This Plan will be revised and expanded to include:

(1) Gender-specific (girls') issues; [NOTE: Issues to include both institutional and community based interventions for girls. The drafters of this Plan intend to begin working on this issue immediately. Their intention is to incorporate the section on girls in this Plan as soon as possible.]

The following issues will be addressed in September, or as soon as reasonably feasible thereafter, as determined by the TAC:

(2) Community-based Behavioral Health Issues over which CYFD has control;
(3) Supervised Release Issues;
(4) Appropriate Interventions for older youth (ages 18 to 21) both in the facilities and the community.
(5) Interventions for severely high-risk youth.
(6) Classification [Section VII of Appendix A]

Draft language for the additional topics listed as (1) through (6), above, will be completed by the TAC and presented to the parties for review by December 31, 2009. The parties shall have 20 days to submit comments on the draft language to the TAC. After reviewing the parties' comments, the TAC will decide upon the content of each new section to be added to this Appendix A, without the necessity for agreement by the parties.

AGREED:

For the ACLU-NM:

Daniel Yohalem
Philip B. Davis
Peter M. Cubra
Alice Bussiere

Date: Sept. 3, 2009

For CYFD:

Dorian Dodson, Secretary

Date: 9/3/09

Frank Weissbarth, General Counsel

Date: 9/3/2009