AZSOMB Juvenile Guidelines and Standards Subcommittee Meeting-20260416_203030UTC-Meeting Recording

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OK, we're going to go ahead and get started. My name is Scott Naegele. I'm Chair of the Juvenile Subcommittee of the Arizona Sex Offender Management Board.
So it's still getting used to rituals. Do I need to make a motion to start the meeting too, or? No, just call the meeting to order date time. Call the meeting to order, I am. I pass it back to you, Jenna, for roll call. All right, so Chairman Naegele is here. Mr. Barney, participating virtually.

BB **Blake Barney**

Yes, present.

JM **Jenna Mitchell**

Mr. Galarneau.
Present.
Dr. Morey.
Present.
Ms. Opheim. Present,
and Judge Young participating virtually.

YA **Young, Anna**

Present.

Hello there.

YA **Young, Anna**

I'm here.
Hello.

Jenna Mitchell
Hello, thank you. Have a quorum.

Okay. I think without further ado, I'm going to pass the baton to the folks at DCS and let them roll with what they've come to share with us. Can I get all of you to remind me names so that...
We know who we're talking to. Yeah, are we good over here? Do we need to sit in a hot seat anymore? Wherever you're comfortable. Yep, stand or sit. My name is Nick Pawlowski. I'm actually a member of the board, main board. So that's myself. Thanks for having us here today. Thank you. And then my colleagues are here with me.
That'll be mostly actual.
Super, yeah.
Good afternoon. My name is Marisol. I'm a DCS supervisor with placement administration. Nice to meet you. My name is Daniel Bugarin. I'm a placement coordinator for placement administration.
And then do we have somebody online as well? Yes.

Cearlock, Amelia
Yes, you certainly do. Hi, my name is Amelia Cearlock. I am the System of Care Administrator with DCSCHP.

So, so a question to you folks from DCS.
How would you like us to roll if we have questions about things that we hear you say? Do you want us to chime in as we roll along? Do you want us to hold questions and let you talk about some things? I'm certainly open, whatever works best for you.
Super.

Cearlock, Amelia
I don't necessarily have a preference, yeah.

Okay, good. I think that probably makes the most sense, but...
Then, I didnt want to be authoritative and, alright, so I I pass it to you all.

Wonderful. So again, thank you for having us. My name is Marisol. I am one of the DCS Placement Administration supervisors at the Department of Child Safety.
And then you can work. So in the sense of what we do in placement administration, there's two units for the emergency unit, where we seek for homes for any children who need a home within less than seven days. Kids who are in the hospital, there's no time frame of a discharge date.
kind of communicate with them alongside. And of course, any children who are being released from detention. Then there is a non-emergency placement unit. Those are any placements needed from 8 to 30 days. Any
Placement disruptions in general from any type of placement, foster home, high need foster care.
a higher level of care or any type of group homes. And as well as any juvenile correction release. So Daniel and I are actually adobe liaisons. We've been adobe liaisons for quite some time, so those are the kids we work alongside with.
Next.
So, one of the DCS priorities that we focus on is always finding a family-like setting placements, which is kinship. We also ask individuals who are with family, you know what, I'm so sorry, that came a little weird. So, when we ask...
Case managers of kinship has been explored when a child comes into DCS care. We also remind them or ask if there's any family-like settings or someone a child has a relationship with that may not be kinship, but we call them victim kinships. That's one of the things that we always ask first before we can even think about any other type. From there, we find we like a child to be placed in a family-like setting, which is a licensed foster home, through a DCS. If a child has behavioral health services, we ask for a very good foster home referral, which again is a family-like setting. When all those have been rolled down and we have no opportunity to take those children in a family-like setting,
We seek residential group homes, QRTP residential, I apologize, QRTP is a qualified residential treatment program that we utilize for those kids. And of course, a shelter, which is meant to be a short-term temporary placement for them when we're waiting for something when a higher level of care is needed.
or there's locations which we're going to do a lateral in another agency. Can I, can I ask Scott Naegele, can I ask a quick question? The residential group home level and the qualified residential treatment program, are those DCS license programs or are those OBH license programs?

So the only one that is not DCS will be the therapeutic foster home, and that's their behavioral health, and licensed foster home, residential group home, and QRTP as well as shelter, those are through DCS.
So in order for us to determine in what type of placement a child should be headed to, it's, and I apologize, I keep saying this in a little backwards, when DCS becomes involved,
When DCS becomes involved with any family and the child is not able to stay within the family, with a family like setting, that's when we get trained in as in the Placement Administration. And that's going to be when either the child cannot stay at home in a safely sense,
or the child cannot see with any family members.
And at that moment, the specialists or a OCWI investigator are going to submit a service request. And the service request is going to allow placement administration to gather all the information, to gather as much information to know what type of placement we're going to be seeking for that child. Again, we're going to ask one more time.
has all family like settings, all kinship been ruled down. A lot of individuals do get tired of us because we want to know if there's any kinship. A lot of the times children are connected with teachers, so we'll ask if there's anybody in school, if there's anybody anywhere else that you know could be a safe and considered to be a placement.
So when we, the information that we gather that we need, it's in order to find the most appropriate placement for the child.
I apologize. This is going to allow us to find, again, police restrict your placement.
And the information that we consider and find most important is of course the child's probation information, if the child is to be on probation, those detention release orders requirements, and then of course any recommendations for a higher level of care. If a child has been already detained, if the child is
currently in correction, a lot of the times we already have information ahead because probation officer has been communicating with DCS because we already have some understanding and idea of, you know, if they're there due to specific targets. Scott Naegele, another question, if I may.
Um...
In terms of the number of kids who present with the issues that we're all here to talk about.

What percentage of them are either on probation or have made their way to ADJC versus those that are just wards, if I'm making sense? Let's say kids that have these issues. Do you have a set of those numbers? I don't have those numbers off hand. So you can be talking about like some that are adjudicated
some that are adjudicated with these issues, and then some that have gone through the probation system and found their way to ADJC, and then those that present with the same issues, but
Are not adjudicated? Like, I guess I'm just trying to get my arms and brain around, you know, numbers and...
proportion of numbers. I think that would be, it's going to be a little bit difficult just because in placement administration, I think we're the last ones to get informed that the child is going to be leaving at home. But a child, we need to step in and find the most appropriate home for a child. I think those will be more higher up.
Are those numbers that exist? Does somebody have that data? Ohh, yeah, I can look and see like ask.

Melony Opheim, I guess, and I don't know where Scott's going with this, but I guess I kind of have somewhat similar question. I run, and for those who don't know, I run residential homes, and so not on your list was a BHRF that is licensed by ADHS, but we do have a contract with DCS. So not all of them are licensed by DCS, but we do take kids in our homes, not very frequently, but
But then I have an outpatient program. And so we deal with a lot of the QRTPs with our outpatient therapists. And what we find is that, I don't want to throw out numbers either without knowing, but a legitimate large amount of the kids in the DCS QRTPs for sexually maladaptive behaviors.
are not on probation. So I guess my one of my big questions, and I'm not sure it can be answered here, but I've always kind of wondered what happens, how do those kids get there? If a DCS hotline is called and somebody says, my son has been, you know, inappropriately touching, abusing,
assaulting my three other siblings. I just feel like sometimes it makes it to the court, sometimes it makes it to the PD, sometimes there's a call for police, and then sometimes it doesn't. So I feel like our houses, at least my experience with the group homes, is we have a lot of kids not on probation and some kids that are. Some kids go to treatment, some kids don't, some have the justice system involved, some don't. So I don't know how that kind of breaks down up at the top, and I get it sometimes

you guys are the last to know, but I don't know where it breaks down. Like why police are called sometimes, why they're not. And I get it if a county attorney or a probation decides not to charge a kid and they were there and then they left, they're still with you guys, but it feels like a lot of kids have never even seen a judge at the inside of a courtroom, you know.
So, in the criteria of QRTP, we utilize, and actually to any non-QRTP scenario, we do utilize the three things, and then Jenna goes to the next, I mean, slide. We'll look at the channels, of course, background behavior.
any pending charges, charges, or any behavioral health services executive following to that. There are not many occasions in which we get those hotline calls and we read those hotline calls, we see some concerning behaviors, there is something, but we kind of hit a wall.
You know, people who have been in the same field for an extended period of time can pick up those little hands. I'm pretty sure you guys see them. And it just...

And, and I think sometimes, too, what we'll see is like a call will go to our hotline, our hotline to get information call, and sometimes it doesn't reach their.

Child safety is going to investigate, you know, things that are allegations that are happening in the home, and if something happened outside the home, like if he was at school, he or she was at school, and then there were some allegations stayed there, different than the Department of Child Safety. I think we get involved with children that are approaching the threshold, but yet don't pass the threshold.
And that's information that we'll give when we're gathering. I want to be mindful of that too. I'm sure you're getting spaces too, so I don't want to jump the gun. No, and like Daniel said, we we receive the information in our job as placement administration is to gather everything, and we're the ones that at times
We pick up on those little of things. Then we let the case manager, the investigator, the OCWI investigator, know additional information and as we work together.

Joe Kelroy has his hand up and has a question.

Kelroy, Joseph
Hi, this is Joe Kelroy. And Scott, to your question on the number, we've been involved with DCS for a decade on the crossover youth practice model. So we have numbers who are duly adjudicated in both delinquency and dependency, but we don't have numbers just...
specific to Mel's question on how many kids have this behavior that may receive treatment or not, but are not part of a court system. So there is data, we have reports on that duly adjudicated juvenile.

So, half of the equation, I guess, or a third, perhaps.

Kelroy, Joseph
I have no idea what, you know, how many kids we're talking about in child welfare that are strictly child welfare. But I do know the number of kids that have crossed into both dependency and delinquency.

Kelroy, Joseph
And I did have one question.

Kelroy, Joseph
For the speakers, could they explain what differences between a QRTP and a group home residential or residential group home from one of those earlier slides?

And.
I think I'm going to answer this extremely bad. So QRTP, it's a qualified residential treatment plan that is federally funded. So it is supposed to be a short-term plan, a short-term placement to allow the support to children to meet their behavioral goal. In the sense of SMB placements, they have the same exact look. That's the only difference with having a QRTP placement child placed in a significant home and a structure group home as in a standard residential home. With SMB, I do believe, and based on my past experience,
It doesn't matter if you're QRTP or not a QRTP, the goal is the same, is to help the

child, to support the child, to meet their criteria regardless of information, rule, any of their charges to be on treatment and attend treatment. So that is the one difference. But QRTP is supposed to be
a short-term placement goal to allow the children to reach that behavioral stabilization to step down to a family-like setting. As in an SMB, QRTP, non-QRTP, the goal is the same, to allow the children to return to the family-like setting and then into a home that there's no vacancy. But perhaps the timelines are different. Yeah. So, and I don't want to get ahead of myself because maybe you're going to talk about it, but I'd be really interested to know how you're deciding which kids go to which of those places. And once that's decided by whatever that process looks like and criteria looks like,
How do we decide what's being used to decide that they should move from that, whether that be to a lower level care or a high level of care? I'd be genuinely interested in that part of it.
Yeah, so next we'll talk about kind of like the cohort and like pretty much how they're going to end up in the homes that are going to require.
sexually maladaptive behaviors, SMB cohorts. And these are, we're going to look at, you know, the release orders, if they've been adjudicated, what are the conditions that they need to be at. And then if they haven't reached that threshold, we're going to see like the history of the child and see what the allegation was, was there anything that came from it.
Should we be looking at a pattern or to make sure that we're not, again, putting that any other children at risk? So if we have some allegations or multiple allegations of the youth possibly perpetrating on younger youth, then we want to make sure that we're getting them in a home that's licensed for only
12 and on up, so that we're not putting any of the younger victims or possible victims or other youth at risk.
And then if they've been referred to any kind of treatment, then we will also get them into an SMB cohort home. Again, that could be an SMB QRTP or SMB residential. One of the other differences between a QRTP and a residential home is your QRTPs are going to employ staff that have gone through additional training. and that are trained to work with children that are more trauma-informed care to provide for those kids. And so it's got a bit of a higher degree of structure and a higher degree of supervision in your residential homes. So that's another difference between the residential and the QRTP home. Again, as far as like

Time to get back to your question about the timeline. You know, the team, not so much placement administration, but the youth team, the whole team, they're going to be looking at, you know, having the meetings and kind of coming together to see what the progress is. And that's when the therapists and stuff wants to be part of those team meetings.
talk about the progress, where they are in their treatment, and then, you know, it's pretty much a live evaluation of, you know, is it safe to be in a different setting if needed. So that's also determined whether or not
And when you say the team, you mean the team that's in place around that child at that time, both from your side of the equation, but also from the treatment side and wherever the kid should be residing, whether that's in a foster home or whether that's. Correct. Later on, one of our colleagues is going to be presenting on that child family team.
And that's going to include the DCS worker, the staff from the group home where they're currently at, the behavioral health sites, all the therapists and whoever out to do whatever other services are involved. So a representative from that should be attending these meetings as well to provide an update of the progress. So
Scott Naegele again. Beyond the dialogue and the discussion that's going on where everybody's offering their input as to what they know about this child and their family and what are the presenting issues beyond that kind of stuff going on, what kind of a structured
process do we have in terms of using risk assessment scales or protective and risk scales to evaluate whether or not we've got the kid in the right level of care? Is any of that stuff, anything like that happen?
I do believe that a lot of this falls into also the documentation and communication that we can have for that hearing when DCS just doesn't put a note and then we choose or we flip the coin to where the child is going to go.
We gather all the information to see what would be the most appropriate, the best setting environment for that child. But is that decision making matrix, my word, is that something that has been driven by research or by empiricism in making those kinds of decisions?
Am I making sense? Yeah, I don't think I can answer that. I haven't been important or aware of any. I kind of get what you're saying. Some kind of a risk analysis guideline here gets to go by. Yeah, like, exactly. Melony Opheim I actually have quite a bit to say about this topic, but I'll let you guys go through your slides and then I just can

give some of my experiences that might answer some of yours or even just kind of what.
I've experienced on the other end, but I, I can feel like I'm stopping you, but I'll see if you guys, I apologize for that. No, I just don't wanna, I know, as we move along, if I don't, I don't articulate some of these in the moment, they're gonna be lost, so, and again, mainly our experience is when we're trying to initially find that.
placement for them, or if they're disrupting from a current placement, you know, we're going to get involved at that time. Once they are placed, then it's, you know, the child's team that's really working on it. They provide us any information, any updates. Once again, we're
Has to look for an enforcement or or what have you - that's when we get involved together.
Next slide.
Ahh.
And then and then when we go and we do figure out where we're going to put them and if we are putting them in an SMB home, another thing we're going to look at to kind of determine which of those SMB homes are going to put out, we're going to be looking at the location of the home, because we definitely want to keep, you know, everything normal that the youth would.
was going through. So we try to keep them in the same school district, same school possibly. You know, so they have a lot of their non-therapeutic support still around them that they've had. You know, it's going to be the most successful to support the youth and to progress with anything that they might be needing.
And again, we always just try to get, you know, we're going to push it, look for the family setting. I always continue to work with the families to try to make sure that we could try to develop a plan to get them back into either the same into the family home or a victim kinship or some other kinship. And then this will go ahead and pass it on to our colleague.

CA **Cearlock, Amelia**
Thank you so much. Any questions before I hop into discussing how youth in DCS custody get behavioral health services?
Excellent. Thank you for the opportunity to be able to speak today. So I wanted to provide just a little bit of a foundational understanding and try not to, I'm going to try not to get too lost into the weeds about child and family team, because certainly

that could be a very large training per se. But so wanted to again, just provide the indication. So children and youth in DCS custody receive behavioral health services through the CFT process. CFT stands for Child and Family Team. So at the time of removal, when youth are coming into out of home care, an integrated rapid response assessment referral is submitted, and then they are subsequently assessed within the 72 hours of
of that referral being received by the provider to complete the assessment. And so this assessment of needs subsequently drives the service plan and referral process for identified services. It's really the process for how youth get enrolled into behavioral health services. And this process is guided by
Arizona 12 principles. Certainly could go down a rabbit hole of all of those particular things. But then it's really just, you know, good coordination with the team and with the family and taking into account the child's needs and experiences, the family's cultural needs, that sort of thing. Also timely access to care, etc.
And then let's see, child and family team members can be, as my colleagues were indicating previously, the child, the guardian is the DCS specialist, and anyone that the child identifies as a support to them, and also family and additional caregivers, and anyone that the family might select to
to be a participant. Next slide, please.
This here is, I just wanted to sort of do a quick visual of what that CFT process looks like. So again, starts at the top with this overarching assessment, assessing for needs, and then again, subsequent referrals. So the assessment of needs at the CFT should also include identification of those strengths,
needs, cultural discovery, some of what I had just previously indicated. From there, the team works collaboratively to build the service plan for the child. That is the little green box that you're seeing on the second level here, the ISP, individualized service plan. Any service and identified need that the team
discussing should be listed on the youth service plan primarily so that we can track trends and track where services are being referred to or referred to and the progress that the youth is making in those services. So the child and family team would meet on typically a monthly basis, could be more frequent if needed, depending on, again, the youth's needs.
and discuss their status and progress in those services. Let's see, we'll get into a bit more of the, that third tier that you're seeing on there is really just indicating like these are the kinds of services that we can, that you'll see coming from the service

plan, which we'll talk about in the next few slides. So let's see.
Next slide, please.
So this is what the structure looks like of the children's behavioral health system. So every child is assigned a behavioral health home at the time that they enroll into services. And as you can see in that purple shaded box, behavioral health homes can provide a variety of services. They would be responsible for the intake in that initial assessment.
and then ongoing assessment of the youth's needs. They also provide the case management. There are also various tiers of case management, again, depending on the need of the child and their level of intensity that they might need. Behavioral health homes can typically also provide individual group and family therapy, psychiatric services, which can include medication monitoring,
if the youth needs medication. And then just ongoing coordination of care between all of the various service providers that could come into play. So as you'll see in that middle box, this is where we get more into the specific, like targeted services, I would say for the population that we're talking about here, youth with.
sexual maladaptive behavior. So that's where you'll see service referrals being submitted out from the primary behavioral health home out to a specialty provider.
Let me scroll through my notes to make sure I'm not missing anything.
And then I don't think so then. So the third the third column that you'll see there is our residential levels of care, which I have. I think my next like three or four slides are all about that. So if there aren't any questions up until this point, we can progress.
Oh, apologies. We'll get to the residential levels of care in a second. So
The different types of evaluations that occur within that can occur within the behavioral health network. There are three types of evaluations. The first two are listed here. The next one will be on the next slide. So we have psychosexual evaluation, which I am sure everyone here is familiar with. We also have listed the provider here that is within the network we utilize, Levitan and Associates.
We also have a full comprehensive psychological evaluation, and we have 3 providers for those, Cortisone, McGady, and then Levitan. And then on the next slide, there's also an option for a neuro developmental evaluation. So if they're
are some concerns about developmental delays, milestones, that sort of thing, a youth can engage in that type of evaluation. And then we've listed the providers here as well.
Next slide.

So these are, I understand that there was some question about providers within the network, who was out there and who was doing the treatment. So this here is, these are the specialty providers that I referred to in that like sort of beige colored column that was in the middle on the previous slides. So we have 6 providers within the network who provide group individual and family therapy.
to address youth with sexually maladaptive behaviors. These behaviors can or services can also potentially include intensive wraparound programming if that is something that would be beneficial to the youth. And you can see here on the slide the providers. So we have Arizona Center for Change, Grossman & Grossman, Mojave Mental Health, Resolution Group, U-Turn.
Shout out Mel, and then Casa de Los Menus.

Really quick, Amelia, is that just Maricopa County or is that how just, I mean, I guess a lot of your slides specific just to our area or I just wonder, are those kind of statewide or over certain counties or do you kind of have that information?

CA **Cearlock, Amelia**
Yep.
To me.
Statewide.
It is statewide, yes.

Okay.

CA **Cearlock, Amelia**
Yeah, yeah, I...

That's it for the whole state, yes.

CA **Cearlock, Amelia**
I'm so sorry. Repeat that one more time.

Just that those are the providers for this outpatient programs for that population for the whole state.

Cearlock, Amelia
Correct.

Okay.

Cearlock, Amelia
Yes, specific to sexually maladaptive behaviors, yes. Yep.
And then the next slide is provider specific for youth with sexually reactive behaviors. So we have encourage empowerment, Grossman and Grossman, Casa de Los Ninos, and then the resolution group.
And then next slide is where we'll get into the higher levels of care. So behavioral health levels of care that we were referring to before. So for youth who are displaying more intense behaviors than can be treated with outpatient services, the health plan offers residential levels of care to address those needs.
So we have the behavioral health inpatient facility, BHIF. You may also have heard it called previously the RTC or residential treatment center. The sort of mid-level is behavioral health residential facility, BHRF. Oftentimes those names get confused between which one is the highest level, which one is not because of the word residential. I hear it often. It's confusing.

Yeah.

Cearlock, Amelia
And then we also have TFC, the therapeutic foster care. And then let's see, it is important to note that the health plan does require prior authorization before admitting into those levels of care, because we need to confirm that youth are meeting the medical necessity criteria for admission for those settings. And then in the next few slides,
We'll dive in just a little bit more into each of those levels of care. Perfect. So TFC is sort of the lowest level, I'll do air quotes around level of residential services offered. And I say that because it's not necessarily a youth must do a TFC and have exhausted that before going to the next level of care, right? Like they don't need to work through each of the levels up.

Cearlock, Amelia

or down in either in either direction. So just wanted to provide that indication. But a TFC as had previously been referenced, their family settings where youth are residing with caregivers who have received specialized training to meet their needs. There's also a component that's important to remember for matching for this. We don't We're not placing youth into settings where caregivers are not equipped and haven't received the appropriate training to be able to meet their needs. So there's really an interview process and opportunity for the family to decide to meet the youth. Maybe not to meet the youth, but sometimes interviews do occur, but to really weigh out whether or not they are a good match.
for treatment for the youth and vice versa. Youth in TFC receive all of their services on a community basis. So they continue to maintain services with their behavioral health home for psychiatric monitoring, outpatient therapy, that sort of thing.

Yeah,
A question, if I may.

Cearlock, Amelia

Yeah.
Sure.

Scott here. My question is this: when
You're seeking to find a therapeutic foster home for a child with one of these types of issues.
Can you can you tell can you tell the board, the subcommittee, what what access to what degree do the do the potential foster parents have access to the client's file and all of the information in the client's file? And does that include whatever psychosexual evaluation that was
Was was done.

Cearlock, Amelia

I think that it should, as long as the department has been, I think typically we get a court order for that to be released to us, especially if it hasn't been, if it's not a

psychosexual evaluation that was completed within the behavioral health system, because we do from time to time see evaluations that are completed
through like the probation referral process. And so in those situations, we need to ensure that it has been court ordered, released to DCS for treatment purposes. And then once that happens, then yes, it should go into the youth's file and be a part of the supporting documentation when completing those referrals and that sort of thing.
Did that answer the question?

I think so. I have other questions about the psychosexual. We can come back to that.

CA **Cearlock, Amelia**
Okay.

CA **Cearlock, Amelia**
I think the next slide is touching on behavioral health residential facility. If you can switch to the next one. Thank you. Thank you. So this is the second highest level of care in the behavioral health residential facility. Youth will receive group and individual therapy within the treatment milieu within the BHRF setting.
Depending on the provider agency, there may youth may also attend school in the community. If it's a facility such as YDI, there may be youth would be receiving school services or go to school on site. It sort of just depends on the setting and also may receive psychiatric services in that.
particular setting, but for the most part, BHRF settings, youth are attending school in the community and or in whatever, you know, school setting the BHRF is arranging.
And let's see. One of the things it's important to keep in mind, so there is
set medical necessity criteria that the health plans are looking for when making determinations for each of these levels of care. And so one of the things, one of the pieces of criteria for BHRF is youth must demonstrate significant risk of harm to self or others. We're specifically looking at the last 90 days of
the time that that prior author referral is being received by the health plan. So what have those significant severe behaviors looked like during that period of time? And

then, because we're also indicating that youth who are being placed into BHRF for treatment need 24-hour supervision by an on-site BHT.

Cearlock, Amelia

behavioral health tech. But also not so severe behaviors that they need the highest level of care, which would require monitoring by a psychiatrist or a nurse practitioner, which we'll actually hear about on the next slide if you want to transition.

So BHIF is the highest level of care just down from an acute care setting, right? So not necessarily a hospital setting, but behavioral health inpatient youth who admit to these settings are displaying behaviors that do require 24-hour supervision to manage.

their psychiatric disturbance that's playing out for them that's causing significant risk of harm to themselves or others. These youth do require 24-hour access to a psychiatrist or nurse practitioner to help manage their behavioral health symptoms that are putting themselves or others at risk.

This setting is like all encompassing. Youth are going to school there. They're again seeing the psychiatrist or nurse practitioner. They're receiving all of their therapeutic services within that milieu as they're working on their targeted treatment goals.

And then this last slide, nope, that was perfect. You can transition to the next one. Thank you. So just a few sort of reminders or nuances. So just wanted to indicate. So when exploring these out of home treatment settings as possible interventions to address youth needs, we often, not often, but we do take into account their treatment history.

Cearlock, Amelia

and their response to those previous interventions when reviewing those packets for these higher levels of care. So approval also indications, so approval for higher level of care will not be given as an alternative to incarceration or to address runaway, address or prevent runaway behaviors.

That's even though the BHIFs do have the ability to have locked doors or some of them may have tall fences around them, elopement can still occur and does still occur from those settings. Let's see, admission to these levels of care are not emergent, so it's important to keep that in mind.

Youth may be in the community while waiting for these treatment settings to be identified. And so there may be a need for the team to plan alternative services and

increase those outpatient services while waiting for youth to admit to these settings, because it can take a little bit of time while planning for that. And I think that might be my last
Oh no, the last slide is, if you want to go to the next one. This is the providers for BHIF and BHRF. So BHIF, we have Casa Grande Academy and YDI. And then BHRF, we have Back to Life, Progressive Health Alliance, U-Turn Foundation, and YDI also has a BHRF setting.
What is it for me, but I know that there might be some, I know that there's questions and I hope that I can answer the psychosexual questions that are going to pop up.

Yeah.

Scott Naegele here. I guess I'd be interested in what the psychosexual evaluations have within them as far as the protocol that's being used. I mean, literally, what do they consist of? What's in them?
in terms of the different kinds of measures and psychometric testing.

CA **Cearlock, Amelia**
Oh, that is a that is a wonderful pop quiz that I don't know that I feel confident to be able to to be able to just rattle that off the top of my head, unfortunately.
I was going to take a look at.

Judge Young, go ahead.

YA **Young, Anna**
If you want, I can grab one and I can list all the tests that they do, because it's a pretty standard battery of tests that they do. I just had one this morning.

CA **Cearlock, Amelia**
Yeah, that's what I was going to do is see if I could wrangle one on my side.

And this.
Would have been done by.
I'm sorry, and this would have been done by somebody that's doing this the screenings for DCS.

Young, Anna
Yeah.

OK, that'd be great.

Young, Anna
Yeah, I'll grab it. I'll be right back.

Cearlock, Amelia
Thanks, Judge Young.

To.
Only.
Oh, I know. I'm just saying it's not typically that you go through the CHP or emergency care or the behavioral health, you know what I mean? It's a matter of who's requesting it. So DCS is always the request. Not a question for the DCS folks. Didn't didn't I did I hear correctly that you have a list of providers that are doing psychosexual evaluation?
Did I hear that right? Yeah, no, no, yes, but on requesting the documentation, even as we have to send out the in order to review.

Cearlock, Amelia
Yes.

So, the placement administration, maybe a little bit way lower on answering that that question.
But.
I guess a piece of this is coming back to me when I'm trying to get my head around the scope of the problem in terms of numbers and where kids are ultimately landing and who then is
charged with driving the process from assessment to determining placement to the kinds of treatment that kids are getting. That's where my head is coming back to. I mean, I don't know how large or small the scope of the problem is as it relates to DCS only kids.

Who have these issues?
But more to follow, I guess.
It's OK.
Judge Young.

Young, Anna
Sure. Yeah, so there's a clinical interview, then there are collateral interviews, which include family members, and then they do the Kaufman Brief Intelligence Test, second edition. Then they do the wide range test of achievement, that RAT to determine reading level.
And there's the Millen Adolescent Clinical Inventory Second Edition, that's the MACI Two. Then the Abel, Becker, and Kaplan Adolescent Cognition Scale. They do the ASIC, which is the Adolescent Sexual Interest Card Sort. The Phase Sexual Attitudes Questionnaire.
Don't always see it, but this one has the PTSD checklist, the civilian version, trauma symptom checklist for children, the TSCC, the ABLE assessment for sexual interest, and then the JSOAP, the Juvenile Sex Offender Assessment Protocol, second edition. And those are the standard battery of tests and protocols that I see in all the psychosexual I get.
both on the dependency side and on the delinquency side.

I'm fairly confident I could tell you who your evaluator was because they consulted me previously about the protocol, but you don't have to comment. I think that that's pretty comprehensive. I will say for the record, more comprehensive than I anticipated, especially given that there is an able assessment in there.

Cearlock, Amelia
Yes.

Young, Anna
Yeah.
Yeah, and there are a couple different providers that I see the reports from, depending on which system the kids are involved in. And it's pretty standard, those

tests.

Glaringly absent though is polygraph testing, but that's a whole other discussion. Blake has his hand up. Blake.
Yeah.

Blake Barney
Yeah, Blake, Barney, I guess one of the things that I'm thinking about through this whole process is how often does DCS review their approved providers and what is the protocol for them to become or to maintain approved providers status?
with DCS because sometimes there's certain things that change. So I don't know if it's similar to a probation contract where it's four years and then after four years, they do everything else or they do the contract submission again. So I'm just curious that process.

Cearlock, Amelia
That is another, that is another tough hitter.

Cearlock, Amelia
So Mercy Care provides the provider network for DCSCHP and they are who directly contract with the providers. I would need to check, I don't know off the top of my head what that contract period looks like.
I'm sorry, I can't answer that.

Melony Opheim. I could answer. We have an audit every year, but every five years is our contract. So people are showing up and checking us out often from DCS. But the biggest thing to remember is that DCS pays us for the kids to live there. DCS licenses my DCS home, but they're not the ones providing the treatment. So a lot of times when they're talking about CHIP and Mercy Care,

Cearlock, Amelia
Thanks.

It's like another entity is kind of paying the outpatient provider to see the therapy. So therapy and residential and room and board are two separate things. So a lot of times they get mixed up. And that's why I'm saying DCS doesn't often request psychosexual. It's usually the Mercy Care and the JFCS. There's a different provider and access provider requesting it. At the request of DCS. It could be the DCS is involved.

CA **Cearlock, Amelia**
We.
Right.

But I'm not sure DCS pays for those or they never seem like they're owed only by DCS, like probation owns are psychosexual, they pay for them. But we don't typically get DCS saying, oh here, we ordered a psychosexual, unless it goes through one of their behavioral health homes. So it kind of gets not convoluted, but some of those, I mean, maybe Joe would know the answer, but I,
I could have swore, is it McGrady? He's on an AOC contract as well, for a second, so some of those overlap.

CA **Cearlock, Amelia**
Yes.

So, one of the things I'm hearing, perhaps...
as a challenge is securing the authority for the release of information to be able to move those to the people who need them to be able to.
to do their work. Sounds like that's a challenge. Is that is that a fair statement to make? No. No.
Just now, we're able to share that information because. Are you talking more about the placement initially? Yes, we're usually going to pass these guys, like they've already had their psychosexual by the time they're deciding where to place. I can bring up a different topic though that I think maybe you're adjusting and it just looks like there's an evaluation involved.
And I've been excited to have DCS here, and I know way back. And Nicholas, I'm at a board meeting now, and Amelia, I know we've had correspondence before. But I have two or three things I'd like to address, and I'm going to say it as easy or hopefully as

simply stated as I can.
But I do have some, not necessarily concerns, but some questions as to placements. For example, I'm glad you went over the CFT process. I brought my Access CFT packet. It's 18 pages. I know well what the CFT is supposed to and why. I mean, I know the creator of it from years back at Access.
I know why it was created and it was a lot to have a team decision process. I, and I don't want to make this personal, but it's very personal. If anybody has talked to me, I didn't lose my voice for this, but I often lose my voice for this. It's very personal to me because we are trying to help kiddos. I was asked and approached by the DCS director years ago to open a QRTP.
My response was, I will, because I have nowhere for my BHRF kids to get abandoned to go. So I would love to have a continuum of care with my treatment, my schools, my jobs, my churches, all the stuff that our kids get used to being in our BHRF, move them to a DCS QRTP. That didn't last very long. I didn't,
really agree with some of the stuff that was happening with the QRTPs. I think the biggest thing was nobody asked me anything about sexual maladaptive behaviors when I got licensed. I thought that was kind of odd. So I said, you know what, let me just do the standard DCS SMB group home. I always was transparent about wanting some of my own kids to continue in my own care.
And not that I'm not taking other DCS kids, but why wouldn't I take the kids we're already involved with? I have probably lost over the last five, I don't know how many you guys have been doing QRTPs, five, six years now, probably 30 kids where I have been stopped by placement taking a kid, either from my own care or from a YDI treatment perspective.
So just this week, three days ago, there's been a team, CFT team, family, DCS, three other people involved with mentors and all the stuff that goes around wrapping around a kid, including of course, the DCS YDI team. Slotted to come to the, to ask and wanted the aftercare that comes with the freeway DCS SMB.
the house. And the DCS person called me and said, okay, let's get you this kiddo. The court's ready to order it, but they haven't yet, but everybody's on board. It sounds like it's a great fit. I said, great, we actually have a bed. Let's get him in. And then it was just shut down. It was, nope, he's got to go to a QRTP. So I'm very interested in how that happened.
That's how, and I'm not blaming placement, but there's some people or an entity out there that suddenly gets a kid's name. They've never met the child. Sometimes they

drew the CALOCUS that didn't come up and maybe it's not being used anymore. But a Cal locus after two years of being at YDI is not going to be the same as somebody who knows the kid and has been watching the progress of the kid. So suddenly there's a CALLOCUS that says, nope, they need a QRTP.
And I'm pretty sure I heard you say that really, or maybe it was my soul that said, they really are kind of the same level of care. It's kind of apples and oranges. And depending on who you ask, it depends. Like the QRTPs that my outpatient therapists are dealing with, half those kids aren't going therapy. The staff aren't aware of what to do with a kid with SMB issues. There's a lot of training lacking, at least from our experience with the kids.
we're dealing with. But again, 5 out of 10 kids are getting therapy at the QRTPs and other five aren't supposed to or don't have to. They're given the option. So my house is not an option. I have a lesser group home, if you will. It's not a QRTP, but I don't know. I don't know how this happens. I don't know how placement really does happen. And
And it used to be like, oh, well, there's five people at the placement team and they decide and don't ask any questions and there's a CALOCUS involved. But I feel bad for the teams. I've gotten therapists calling me upset. I've gotten families calling me crying because they thought they were deciding. And then at the last minute, in a matter of hours, somebody else decides that that's not where they're going and they get to go to a different kind of group home.
And it's frustrating. That's just kind of one of my issues. And as far as level of care, and I totally appreciate your slides, Amelia, and like this is what a BHRF looks like, and this is what a DCSSMB and this is what a QRTP might look like. But I'm very concerned and I have a big, huge question. It was typed and then I reiterated it with my pen.
that I don't know when kids get reassessed back to evaluation protocols. We have, and this is kind of a caveat, I know it's just my talking of my experience and I thought my therapist is going to come today, not that she can talk, but she is very upset because there are three kids in a group home plotting a rape against a staff. When I found out who these three kids were,
One of them we said, absolutely not. We're not going to see him outpatient. He probably belongs in a BHIF. And we recommended that a year and a half ago. He's still there at a QRTP with no treatment. The other kid, we had him an outpatient. We discharged him because he had very, very high risks at school and in the home trying

to act out. Now these kids are trying to approach a staff.
and have continued to write out their plot and their planning. When we discharged him, we thought something would happen and that kid would have to go to at least another provider, if not a higher level of care. And he's still there. It's been six months. So I think a lot of, I don't know how your system works with that.
But it's like it doesn't get back to you guys that, hey, I mean, the group home is like, well, we're still getting paid. We still have to take the kid to a therapist every week, you know, and it's one less ride we have to give them. So I'm worried that the, kind of, I'm worried that the care for some of the QRTPs in particular that we work with, and there's three,
Maybe four of them.
is that the feedback doesn't get, you know, when we have a PFDA, when we have probation, we have them to go back to and say, hey, kid is acting out. We can't, we don't want him at our group home anymore. He's not amenable to our treatment. He needs YDI. And I worry that DCS doesn't have a lot of that.
back and forth with the group home managers who may just fall on them, not telling you guys. But there's some very risky kids that are just living in these homes with no therapy and not a lot of reassessment, if you will. And then we're dealing with it because we have kids telling us they're scared to go home to their QRTPs. And then we're trying to move them to our home where we feel like he'll be safe. And then I get in trouble because we're trying to steal kids. So I have a couple of issues.
Those are just the two I'm going to throw out there. But I do worry that the system is just seeing some of these kids and the treatment, whether they're not getting treatment at all. I've been told if a DCS kid comes to me, he doesn't have to go to treatment. And that's sad to me because that's why he's there. But we had a kid. I think if I said his name, all four of you would know it.
He's had several offenses sexually and never been caught by the law, never been reported. Nobody's ever filed charges. And yet he continues to have predatory behavior. And I was told if he came to my house, he could choose to go to treatment to talk about therapy or not. And that's just not how I operate. And I know I operate different because I've been on the behavioral health side.
But I don't know, just kind of throwing it out there that these are a couple of the really big glitches. When I have a CFT team decide they want to come here, but then they can't, I don't, nobody can explain how that gets, how that gets solved somewhere upstream, you know, from a kid, from a standpoint of somebody who's

never met the kid or doesn't know anybody in the team, you know?
Scott Naegele. I think part of what I'm hearing is part of where some of my questions are coming from, and it's not accusatory. I'm just, I'm wanting to understand what the structured way and what are we using as that structure, whatever that might be, to make
The types of decisions that that we're having, we're having articulated now, and I think...
From my, from my perspective.
We as a system, not just the DCS part of the system, but we collectively as a system, we need to get to the place where we are using what we have available to us with respect to research and science to help guide making these decisions. And then we need to ensure
that we have people that are properly trained in the utilization and scoring of these instruments so that we have solid inter-rater reliability amongst the ranks, no matter where those are being done, so that we can be making decisions that aren't personal, that aren't
that aren't subjective, that aren't bothersome, that are that are that are that are truly objective in orientation.
I have ideas about that. We're just trying to gather as much information as we can collectively from the different parties that are doing a piece of this work with these kids and their families. And, you know, while I have a long history of having worked with juveniles and juvenile families and running a residential treatment program. I've been away from that arc for a spot of time. So for me, personally, asking you all to come was about trying to get up to speed again to see what's the same, what's different, how are we making decisions so that I, in a meaningful sort of way, can contribute.
to this subcommittee's work. I mean, that's really where I'm coming from. So, when I when I ask in in is is is starting to get to know me a bit, I got to see the landscape. I got to see, I got to see it all.
to be able to start making decisions about how we need to structure ourselves and how we need to get buy-in, perhaps at some point in time from the legislature to help us do what we're all trying to do. And I don't question anybody's integrity in terms of trying to do the right thing for kids.
But I think that we end up getting in, may I say, ******* matches around things, that if we did things in a more systematic and structured way, we wouldn't have to get into

those moments in time, at least not as much. There's going to be differences of opinion no matter what we do here. But
The more we can have an overarching structure, no matter which system of care the kid belongs to, that we're doing things, you know, similarly, I just I just think that's where it's at.
Do others have questions?
About.
Anything the folks who see us are trying to share with us.
Or do you guys have things that you want us to know? I mean, I don't want to pretend that I got it, because I don't. Well, just kind of address the QRTP thing. I work in a QRTP unit, so our...
structure is every six months we need to do if a child is still remaining in a QRTP. We need to make a review and assessment to see if they are still needing that QRTP. One of the requirements to be in a QRTP is to be doing behavioral health services. So what we do is every so long, I've got the exact timeline.
providers are providing placement administration with reports, exhibit one reports that kind of break down everything, services that they're supposed to be attending or what they have. Sometimes they list the services that they refer to, but they're not really putting down what their engagement is. At that six months when we're doing that assessment,
feel like we just don't have enough information, or if we need more information, or if we have information to say that, yes, you know, we've done a review and it still continues to be QRTP to be needed, then we do that at that point. If we do see that there's evidence that there is no services involved or they're not engaged or we find out behavioral health has been closed out, which they shouldn't be,
Then we request that CFT. We attended ourselves, like I said, as a placement coordinator to QRTP. I attend them, request what's going on. And if they still are refusing services, then we ask that they submit a placement referral so that we can get that child out of that QRTP and get them into another appropriate. Again,
We will also work with behavior health if higher level care is needed, or we even assess that a higher level care may be needed. You know, we kind of make sure that behavioral health is seeing that, you know, everyone let the case manager know, because you know they are guardian, we kind of guide them through to make those suggestions if needed, if them are already making those suggestions.
And again, we do have to remind our managers that...

If a child is needing services, they need to make sure that they're having those conversations and let them know that they need to be giving services and they can't just be at the home, not giving services.
And everybody in the home, but yes, that kind of answers something that we do have. Melony Opheim .Are you a contact for me then? Because I really don't have a lot of contacts and I don't want to blow anybody up or bother anybody, but if somebody's just not getting treatment for six months and they're still in a home. approaching our kids or, you know, sexual and misappropriate behaviors every day, can we reach out to you saying, hey, maybe it's the home not getting a hold of you. Maybe it's somebody or the case manager or I just, I don't know who to call when we see it. And I mean, I'm sure you guys have systems in place, but if they're not happening, I'm gonna be a tattletale, but I also don't like kids, you know, taking the whole.
group home down with them.
Because they might have a little bit more.
You know, a better connection, but yes, with the high needs case manager with more of those mental. No, the system of care coordinator, yes, yes, yes, you're more than welcome to always reach out. I mean, if he gives you his info, it's fine. You know, we even have a QRTP inbox through our email.
general question, you go to the QRTP inbox, email that we do. And the hard part is when we discharge it because they're too risky, unfortunately, we just hear about them or we see them when we show up to the home still, but we don't have a lot of say because at that point we're done with the team. Sometimes we worry about that kid just not getting.
Sometimes we'll come in involved with that, because neighbor health has been submitting those referrals for higher level care. They keep getting out of state analysis, in state analysis, but now comes down to the kid either right now, safety hazard. Then we have to try to assess where is the best place that we can set up and...
Just trying to take the information that we have and try to get them to. And Scott Naegele, I can't help but believe that in some instances, because
We haven't we haven't agreed upon the structure of how we articulate our concerns and our arguments about what Kid X needs and haven't systematically done that in the same way across the board. You know what I'm saying?
The formal documentation that is specific to these issues that hindering work.

To get those kids.
What they need?
Some of what we have to do is create this in a way that it's not easy for people to refuse to work with us and to take the kids, you know what I mean?
And it's where I can get that word for the set of requirements for a higher level of carries, exactly.
Getting denials from this, and I say, for those, like...
And part of what I'm saying is we have at our disposal, if we choose collectively to use them, some risk scales that have been researched in a protective scale.
Maybe it's only the next.
You.
but we've now communicated, now we've created a language that we have to begin to communicate around the concerns that we're all sitting in this room, you know, talking about and trying to see responses to. We just have to just have to figure out how to foster some acceptance.
of that. I was happy to hear that whoever the evaluator was used to JSO. Now I will tell you not to make things more funny and less.
But the creator of the...
of the eraser, which is the analogous instrument to the JSO. He at this point in time himself isn't even using his own instrument anymore because he's created another instrument called a professor. Now, that, so there's lots to talk about here. I know why.
I know why he did that, and I know why he's moved that way. Now, I, on the other hand, continue to use the JSO, the eraser, and the professor, because I think they add their additive collectively to helping us understand what's going on with an individual kid.
And here's the reality. Once you scored the kid baseline, it ain't, there's a way to automate this. It ain't that hard to go back and score them again at every six months intervals. If we've created a system that's fairly fluid, you know, that takes somebody 10 or 15 minutes to do it in a go.
And if you've used the instruments enough, you begin to really understand them inside and out. And it's not as cumbersome, because that's going to be one of the things that people are going to say. Well, I don't have time to do this. Well, look at all the time we're wasting.
trying to, which ends up being at odds with each other in terms of, you know, trying

to make something happen. I mean, you know, as I've said before, perhaps I'm naive, but I think we can get to the place where there's a way to do this that makes it more seamless for everybody.
We have virtual board members that have questions. Blake and Judge Young both have their hand up. Judge Young.

Young, Anna
I had to turn my camera off. I was losing your audio a little bit and I was hoping that was helping, but I just wanted to make sure that everybody knew that there's actually a juvenile rule on QRTPs. It's rule 335 and it requires judges to evaluate a child's placement in QRTP, including whether or not they're getting the therapeutic services that they're supposed to be being provided.
at every hearing. And so that might be a good thing for the subcommittee to take a look at too, is that's juvenile rule 335. That's all I had.

Thank you. Melony Opheim, that's awesome, Judge. I would only go back to our initial conversation of that. I don't know the percentage, but I think it's a very high percentage of kids in the QRTPs are not seeing judges. And so they've kind of just, they're not in that juvenile justice system. They're just in the dependency system.

Young, Anna
No, I'm talking about dependency. It's in the dependency rules, Mel. So, yeah, so the kids, so the kids who are just juvenile justice involved, those kids are not going into QRTP. The only kids that are going into QRTP placements are the kids who are in DCS custody, because QRTP is a DCS placement. It's not in the behavioral health continuum of care.

Melony Opheim
Oh, okay. All right.
At.

Young, Anna
The kids who are not involved with DCS, those are the kids that we see in the BHIFs

and the BHRFs and the therapeutic foster homes, because it's, you know, the QRTP is not available to kids who are just juvenile justice involved.

Melony Opheim.
Right, right. That makes sense. I guess I'm just wondering if those kids are seeing anybody every six months, but yeah. And I probably would be involved all those, especially if they're not our kids, they're not doing treatment, so.

YA **Young, Anna**
They have to be.
Yeah, per dependency rules, statute and rules, judicial officers have to be doing review hearings of every dependency case at least every six months. And I can tell you, we teach people to do that much more frequently. And so if you have a kid who's placed in QRTP, you're doing a review of that QRTP placement,
at every subsequent hearing after the kids placed.

And is that just up to the case manager, DCS case manager, kind of to make sure, I mean, was it up to the judge, the, the, I mean, I guess is it up to the courts to kind of get them back in to see that?

YA **Young, Anna**
That's on the dependency side.
Well, the judge is having the hearing, and so the judge is getting the information at every review hearing.
Okay.
Maybe at something.
And then Blake.

BB **Blake Barney**
Yeah, Blake Barney. So.
I'm hearing a lot of things that appear that the system is flawed. There's no such thing as perfection. So we know there's flaws in every system. However, as the board, I am curious what at least one DCS spokesperson has to say about
what the board can do to help them, what they would like us to do to work in unison with them, and how we can be partners in helping with this whole process. Because

there's obviously ideas that we have as board members, but I'm curious from the other side, what DCS
spokespeople would like to see from the board or how they would like us to help them. So that's kind of my thoughts right now.

Thank you.
Well, I definitely like that idea about universal risk assessment that, you know, everyone's being used, that everyone understands and can really articulate the risk rather than us just trying to say what this allegation or this charge or, you know, whatever that means. I think having something that work, you know, a whole team from no matter what.
where it's coming from, everyone can really utilize everything else.
I appreciate the question. I think I want to kind of go back on something that Daniel was saying too that I think is really important. Like the evaluation component and figuring out what a kid needs as far as treatment and placement and finding a placement that will take the kid are two very different issues.
And I think both need to be addressed. And so, you know, we could get it perfect to where we are great on our validations. We know exactly what, you know, and then going out and finding, you know, approved or qualified people that are working in these facilities or even a facility at all that will house this population, which I will work on getting.
Actual not reported, but you know, those are two different issues, and so you know, the resource, the definition of the problem and actually addressing, you know, the problem, throwing resources at it, those are two things that I need to be kept in mind, because at the end of the day, no matter what data we have on this kid and recommendations we have.
like they have to live somewhere. And so like tonight, right? They have to be somewhere tonight. And I know when I started at DCS, that meant, you know, I might be having sleepover with the kid in my office because kids got to sleep somewhere. And I think we've come a long way since then. And so I also want to point that out that while there are still flaws, there has been progress in a lot of areas.
over the last 16 years or so that I've been here. But yeah, I think that's, I think that's a very important thing to just also keep in mind where like everything takes time. You know, the evaluation takes time. You know, getting approval through insurance takes time, getting approval from a judge takes time, and in the meantime, the kids got to

be somewhere. So
That's the reality that DCS pretty much faces, not just with this. I truly appreciate you saying that out loud. I want to comment on that if I can. Sure. I think that I think. That there want the problems that you just articulated are are are one are in part at least one in the same.
And what I mean by that is, is if we have a structure that we're talking about in terms of, you know, using to kind of track progress or lack thereof, whichever the case may be, and we have an expectation that the people who are providing the care for the kids come along for the ride,
and we create criteria and guidelines and structure that they must adhere to, that they must follow if they want to be in the game, so to speak, and then ways to evaluate whether or not they're doing what they need to do to train their staff. staff and to support their staff to be able to do those things. That's what I mean when I say I think in part that they're one of the same, they're one of the same thing. We have three different languages that we're speaking and we're trying to forge some sort of agreement. Then it becomes who can yell the loudest more than it becomes
Are we are we are we having the same conversation? Do we really all want the same thing? That's just me from 30 years of experience working in the behavioral health field in the state of Arizona. And I think that, you know, there are no panaceas and we're not going to create one out of this group, but
we can certainly go a long ways in doing a lot better than we are currently, especially if we continue to remember that we're all on the same blood and team.
You just have to try to come back to that when things get difficult. I think the other thing too that I want to throw out there to keep in mind, just this budget, no one ever likes to talk money, but budget is always a important thing. Like, you know, if DCS is having to pay for, you know, like if...
I guess if qualification level, you know, prizes, then that will bring with it probably higher contracts in order for to pay for it and DCS's budget doesn't tend to go up. And so that's just another like housing to pay for it. Keep in mind as well.
All true, but should not prohibit us from trying to build it as we should.
Um...
Does anyone have any other questions for the folks from DCS before we move on to the next item on the agenda with the remaining time that we have?
I mean, I don't, Melony Opheim. I don't want to keep beating it, but my issue is not

an assessment. My issue is not an evaluation. I'm still talking about team processes, therapists, qualified therapists working with kids for a year, year and a half, recommendations, which I feel are clinical. They don't want to be a whole assessment to know a kid's doing great.
and then recommendations of the placement. And I still, maybe you guys can't answer it right now, but I don't know why.
That's not always heard. Or what happens after a placement is recommended and then it gets shut down and not really an explanation. I don't know. Maybe talk to somebody else. It's just super frustrating. You're having a continuum of care. That was my own, my own. I had our kids as well as other kids. And that has nothing to do with evaluation. These are kids that are doing well or aren't doing well, but my place has been.
recommended by a CFT and a family team and everybody involved. And then there is somebody who trumps it basically and negates it and says, no, they're going to go to a different home. So that's, I wish I didn't bring it up, but it happened two days ago, so it's fresh, but it's happened again over 20 times. So it's, I don't.
I don't know if I was doing something wrong. I don't know the difference between the two. QRTP versus my house. But I can't really get straight answers. And when somebody's in a CFT saying, well, what's the difference? Why can't they go to the freeway house? They said congregate care. There's not a lot of answers besides that's not where they're going. So information gets frustrated with it. The therapists get frustrated that are working with the kids.
So, but I just I just want to point out that has nothing to do with an evaluation. Like, we're not having to reassess anybody at that point. So sometimes, and I've had a kid that got court ordered, so we took him and then DCS says, we're not paying, we don't, we don't, the court order means nothing to us. I mean, their words didn't ending all. So then I get frustrated like,
am I not supposed to take a kid that got court ordered? So then I even have justice system in DCS kind of going like, well, we didn't say he'd go there. So then I don't know what to do. I don't know who to take and who not to take. I kind of, it kind of falls in my lap a lot as far as like, which system am I listening or guided by. And then I don't want to not get paid for six months, which is what's happened with the kid.
I guess, so it's, I mean, we're just trying to do right by the kids.
So if you have, if we have custody of a child and you're on a CMT and there's a bit of a struggle, you don't mind them. OK, usually it's preemie, you know what I mean?

Like, they're just calling me like, hey, do you have a bed? This kid want them to go to U-turn and I'm like, yeah, for sure. And then it just kind of gets stopped. Somebody's on right away.
Okay, connected. I've been told by placement.
I mean, I got written up a couple weeks ago by a placement and I got a VPN saying we took a kid that we didn't, and I'm like, well, we really didn't. But the statement with Future does this often, they take the kids without asking us or requesting from us. So the second that happened with a kid getting court ordered from someplace else, I immediately contacted placement, just a generic placement email saying, Hey, this gave out court order. DCS showed up yesterday. We had a...
So I'll get to the...
I don't want to. Recommendation
And.
Yeah.
Ben Galarneau.
I have a question: who does make you know who who writes?
So when the referral party comes in, then it is gathering the information placement administration. Then we also communicate and say, it says right here, Miss Nell, that it will be in the child's best interest. Do you have a bed? No, it will go somewhere else. But when it is during a CMT team meeting, then it would be on a team meeting. If a placement administrator is a coordinator, I'm sorry, is involved, then they're the ones listening. But sometimes the information doesn't make it the whole way. And we're going to work on a referral based on what we see. I mean, in the case of the kid this week, it was three months worth of he's going to go to U-turn. The DCS case manager called me. She was excited. He's coming tomorrow.
And then she called me back and she pretty much had cancellation emails like, cancel, cancel, he can't come. They said no. And then she talked about the placement. So then I don't know who those people are, but the CFT was on board, the DCS was on board, DCS, the supervisor was on board, but someone on the placement team said no. So I don't know. And we have two teams, emergency and. Not an emergency, so sometimes I can decide which team that goes to, the time frame, any placement needed, it takes 2 days to 30, that's not an emergency, so nonetheless. If they're YDI, it's not an emergency, but I don't know, maybe we can shuffle around, I don't know. OK.

And sometimes, yeah, placement administration is in a loop, you'll have a supervisor talk about when they're going to send the kids, they start talking to the placements.

Cearlock, Amelia
Did we lose the primary meeting folks?

Young, Anna
I think we did. I don't see them logged in anymore.

Cearlock, Amelia
Perfect.
Okay, I thought that was.

Young, Anna
I'm hoping they're, yeah, I'm hoping they're gonna log back in. I sound it looked like they were having like some kind of issue because we were using sound and then the whole thing froze and then now they're gone, so...

Blake Barney
Yeah, it appears.

Cearlock, Amelia
Yeah.
Yeah.
Yes, okay.

Blake Barney
Yeah, I'm not sure if it's Jenna or Ashlesha that's doing it, but my guess is that they're probably working on straightening it out right now.

Young, Anna
Yeah, I emailed Jenna just to let her know that we were having issues.

Cearlock, Amelia
Okay, cool.

Blake Barney
I was just about to send a message, so I was going to ask if anybody did before I hit send. Thanks, Judge Young. Appreciate it.

Cearlock, Amelia
Yeah.

Young, Anna
No problem.

Jenna Mitchell
And.
This is Jenna Mitchell. Can you hear me?

Young, Anna
Yeah, we can hear you now.

Jenna Mitchell
Okay, we lost connectivity. I called in on my phone. We're taking a 5 minute break so I can do a reboot on the computer and reestablish connectivity. So for subcommittee members and members of public, we'll take a 5 minute break and then we'll resume.

Young, Anna
Okay.
Jenna, it's Judge Young. I need to log off at 3.15. I've got court hearings. I've actually got healthy boundaries court this afternoon.

Jenna Mitchell
Okay.
OK. Thank you, ma'am. Thank you.
All right, so I'm turning the recording on.

We're back after some technical delays. So, but what I want to do now with the time, with the time that we have left, we're re-recorded again, but the time we have left is

maybe to start going through what people learned from their research.
regarding the issue of guiding principles, so that we can make a decision about whether or not we want to write our own, or whether we want to just adopt something that somebody else has already done. But until we kind of go through what we learned, it's already that. So
Peter, can you go first? Sure, yeah, we can start. Peter, Morey.
So I was assigned Washington, Tennessee, Rhode Island.
And I sent late to Major Mitchell to get it all sent out to you. Just kind of quickly to try to save the time. Tennessee doesn't really have much.
Well, actually, their sex offender, they're coming from the standard of sex offenders are highly manipulative and so.
program, basically. So not a whole lot of rehabilitation.
Did you even find it, the sex offender management board? There's not much mention to see. Yeah. And so I'll just kind of skip to the best one, so that's probably what we want.
Consider they have a pretty detailed and thorough sex offender management.
I...
Juveniles, core guiding principles, juveniles are fundamentally distinct population from adults, and their policies have to reflect the ongoing grade knowledge, which is something we're considering.
They recognize that most youth who offended.
Have to treated, and they also has a, so it, so increase the level of their pending, which is also something that we discussed.
Risk and the protective factors need to be considered together, and obviously at least restrictive placement governance, and...
Their treatment plan follows the youth from the institutions.
It doesn't restart any transition points, so it's cumulative. I also put the chart into that, that will, so you can see when it gets to you.
Again, my fault on that.
The problem with Washington, and I think we're going to run into it, is their sex offender management board was put together with all of these in 2011 volunteer board similar to what we have. It fell apart and scattered. So I think the lesson from this to learn
Is we need to think about things that are going to be.
Lasting, again, have to think about, OK, how do we like today? We're discussing, and

I that can mention this to Scott in break.
We have, you know, three or four different languages being spoken just between the residential facilities. Mental health and law and medicine and law speak different languages. So how do we create something that's going to create those pathways that's going to last that is going to keep
You can take .
Accusation through assessment to whatever, if there's any sort of dependency or tentative system through rehabilitation, so...
Kind of overwhelming. Sorry, I'm just kind of processing everything I just heard, but...
It was overwhelming from the time I saw what Colorado did since, you know, it became overwhelming to me. Yeah, yeah, so...
Ohh.
I think Washington's worth looking at. Pennsylvania is.
Okay, probably the second best. Again, great principles of falls apart on application. Tennessee is kind of what we want to avoid. And Rhode Island, the juvenile side is stronger than the adult side. Public safety and victim protection are the main.
Guiding principles, multidisciplinary team, they spent.
Emphasize individualized treatment.
Caregiver is an active participant. I'm just notified so they involved the planning and progress.
Victim really drives the reunification process, so they don't automatically get reintroduced. There's the victim voice in there.
And, uh...
providers, again, independently licensed, Medical certified, but standard qualifications where that I'm liking where we have some sort of certification proposed by the board. In this state, they do actually have a sexting carve out. where a juvenile treated sexting as a status offense, not delinquency adjudication, but no registration and Deliberately kept out of.
If I may, Scott Naegele.
We have some ground to cover discussions to have regarding the registration issue as it relates to juveniles.
And I'm not sure that today obviously is not the place and the time to start to delve into that, but that's something that I want for us, you know, to come out of here where whenever that is. Sure. I'll give us some recommendations about that issue. Because reality is, is the recidivism rates for kids that have successfully completed

treatment as a group are really pretty low. And if the issue is, is risk, and that's what registration is all about,
then it's inconsistent with what we know from recidivism data. Yeah, and one thing I want to point out with the Rhode Islands.
The difference from Washington is all of them have their consensus and management focused on the highest risk individuals, so they're not stratifying the risk; they're kind of like, "Okay, this is a bad kid benefactor. Rhode Island is Intentionally, kept the population is small, so they can kind of have a lot of services by...
I think.
Because they have such a concentration on the high level of offenders, their registration just kind of follows with that, if that makes sense. But I think Washington State is probably more like.
Looking at, what would be worth considering to create the cyber?
Um...
But I think also...
Like I said, it's worth.
Keeping in mind, if for some reason.
Or?
To make these recommendations have some to stay empowered.
So, becomes.
Ben.
Yeah.
Yeah, uh, Kentucky, Maryland, and Louisiana
Looking for this stuff is difficult right off the bat.
A lot of these places had they had some assemblance of a board.
I have been updated.
None of them had an like.
Theoretical philosophical state about guidance.
a lot of those. Kentucky and Louisiana had policies. And Kentucky's policy said something to the effective treatment should be based on guiding principles that are consistent with an evidence-based framework that supports effective care. And then kind of lists the things that, you know, they should do things like family therapy.
Comprehensive assessments.
Maryland did the same kind of thing. It said their guiding principles should be.

was the comprehensive assessments, family-focused care, multiple by system therapy, collaborative management, and specialized training. And Louisiana. Individual program planning for youth adjudicate for sex offense shall include its primary objectives to actually the public reduction of risk that demonstrate reduced behaviors relating to delinquent behavior.
An enhancement of abuse, growth, and development, so they just kind of give up. It was very...
Why?
The request.

Of us, he must be a.
Well, Scott, what I what I what I found when I started to do research for the states that I was charged with doing was is is that the original Intel that I got in terms of doing a cursory search about how many states actually have sex offender management boards, it was 16 or 17 states.
As I dug into this more, what I'm finding by virtue of making phone calls to people is there aren't even sex offender management courts in some of those 16 and 17 states. The state of Texas does not have a sex offender management Board. Because I talked to a gentleman, it took me
about 30 minutes of conversation with him to realize that really what he was was the guy that was one of the people that's in charge with certain counties registration process.
But the registration process wasn't emanating out of any overarching sex offender management board, because they don't have one. So it turned into a conversation where you can't garner any information that doesn't exist. And it also, I think, speaks to just how big
If, if, if we, the state of Arizona, are going to do this in a meaningful way, how big the task at hand is and how many different layers there are to it? Yeah, Peter Morey.
Kind of the same thing in Washington City. As I was saying, this was a 2011 construct that kind of got, okay, we've got it, we're not going to think about it too much anymore. And the board gets reconvened at the legislature's pleasure. So it's not really a standing thing. Well,
I mean, having said that, I know that myself, Dr. Blades, Chairwoman Goulden, and the folks from DPS are going to have a gathering later this month to talk about the importance of us being clear about what's, what are our mandates.

and making sure that we're demonstrating that we're engaging in a process that's answering some of those mandates. Answering some of those mandates is part of what's going to get us to last beyond four years. So the extent to which we address the task at hand, obviously, is going to influence
Whether or not we have viability down the road, so, well, and I, Peter, I think I think one of the things to impress with that is that...
This whole subject area, adult and juvenile.
and policies and, frankly, society with it is a dynamic construct. It's not something that's one and done to.
If we can impress the dynamism, that there needs to be some maintenance.
On.
No, do you want to talk any more about Colorado? Everybody kind of knows I like the cream of the crop. I do have a contact there. Joe Kelroy knows the guy as well. You know, he's helped us out in Arizona more than anybody else. And his feedback, and I know I've talked to Joe about it, that it's not been easy. It's been an up and down and
They're still around, but it's been a lot of kind of back and forth and conversations, which I suspect we're going to have as well. So yeah, probably sticking to the task at hand. Delaware was kind of a wash. Utah has a new board, 2023, mostly mostly talking about registration. And so I need to delve into it a little more of one of the board members from the
The big board had told me they'd give me a contact. I didn't get that from Jenna. Maybe she didn't give it to Jenna, but I'll try to touch base with her again, but I'd like to look into theirs more. I thought Idaho, I thought Idaho kind of had something too, but maybe we just pick our three or four states, look and see what they got, how they overlap, what we want to get rid of, what we want to add to, but I don't want to make it.
too more complicated. It sounds like they have found more dead ends than anything. I would just say that, as you know, I don't agree with everything Colorado has done, but they always act. I mean, when they have the school, especially with juveniles, when they have school involved and advocates involved, probations involved, and they're all sitting at a table talking about this kid, that's pretty impressive.
I would love to get to a point that I wouldn't have to worry about DCS. It would be kind of like we're all at the table and everybody's deciding and there's not a lot of behind the door decisions making about kids. So how about if I propose this in the

interest of us kind of making a decision about what our guiding principles are? Let's not make a decision today.
let's take between now and our next meeting to familiarize ourselves individually a little bit more with what Colorado's are, a little bit more what Idaho's are, perhaps the Washington one, and come back and decide whether or not we want to meld them together in some sort of meaningful way or
we just adopt what Colorado's got as ours. I don't think we're going to be at a loss. The question. I'll just add, I have previously distributed the Colorados to you. I have them up on the board for you. I know the adult subcommittee has reviewed them as have you and made a decision to move.
make a recommendation yesterday to the larger board. So I don't know if you all want to, you know, maybe entertain that thought of you've had them, you've reviewed them. Do you want to, are you prepared to move forward with those? Yeah, proposing that we not make a final decision today. That we collectively take take individual times and look.
more closely at these three or four states, and that we come back together the next time and we make a decision about whether we melt them in some fashion, if there's something from one of the other states that's additive to what Colorado did, then we do that and then we make a decision until we
adjourn that next meeting. I'm aware of the fact that we have folks in ADJC are going to come give us a presentation last next time.
We confirmed that today. So we'll have the benefit of the same kind of process we did today at the outset of our meeting. We're still working on trying to get the folks from Maricopa County Juvenile Court to come and do the same thing. And I had a conversation with Chief Meaux about
About that, and he was gonna get back to me about that.
So I my recommendation is we table one last time the discussion about guiding principles until our next meeting. I was going to ask you what final decision are they coming up with or what did you were you kind of going out there to us to possibly make a decision on?
Yeah, a couple of you are on that subcommittee, so maybe you would want to speak to that. There are a few of us actually that are on that subcommittee that are also this group. In yesterday's similar meeting to this one, we did make a decision collectively to adopt the Colorado guidelines as the guidelines as it relates to
Adult side of this, they can be tweaked, but that's just like a an initial, this is what

we're gonna call, yeah, yes, as far as the adult side, yeah, Peter Morey, I think probably in the interest of...
I, I agree with tailoring it, um, however I think it probably would us.
identify three or four states today and say, okay, they want to take this seriously. We'll have a decision for you next time. So they don't hear, well, we're still looking around. So I think we've done that. I think we have Colorado, we have Idaho, we have Utah.
and Washington.
And if we all agree to just take, you know, some time between now and our next subcommittee meeting to look at those closely and make a decision about if there. I mean, I think from my perspective, the point of departure is what Colorado has written.
If there are things that are in these other, call them guiding principles, I know that everybody's using that language, but it's missing in the Colorado stuff, then we can have a discussion about adding them to the Colorado stuff. But I think, I think,
I don't think that you they've done it, and they did it well. Sure, I just wanted to I think are we missing something.
Yes.
And I'll just add for the record that Judge Young did have to log off for court and Blake Barney has his hand up.
Hello, Blake.

Blake Barney
Hey guys, Blake Barney, so.
I mean, I, you know, I tried to, full disclosure, I use ChatGPT to help me organize all of this information that's on the background materials, but
I haven't done enough research into Utah, but I do know when it comes to Illinois, they've done a pretty good job. They've been around for quite some time. I think 20, 28 years, I was like 98, 97, 98, something like that, that they developed their board.
So shortly after,
Colorado.
And they've got like, you know, like it says on the handout here, the best for juvenile specific rehab and family integration. So.
Again, I'm not saying we shouldn't use Utah, but between Idaho, Hawaii, and Illinois, Illinois has the best for the rehab specific for juveniles. So we may consider that one.

And Idaho is great. It's very clinical. It's very structured. So if we want to go that route, we can certainly have
Idaho included. And then the other aspect of all of this is Hawaii is a sex offender management team. They refer to them as boards, but they're not technically. They are sex offender management teams, so they call them SMTs. So I think we eliminate Hawaii from this, but
there are certain things, you know, in the handout that we could take from it. And when it comes to coming up with our guiding principles, we can certainly adopt another state's principles.
Or we could look at it as, here's kind of a grab bag of all of these different things that seem to work really well in these states. Let's figure out what's going to work the best in Arizona. And we as the experts should know likely what is going to be the most beneficial for juveniles in the state of Arizona that
may not be the same as Idaho or Illinois or Utah or Washington or, you know, any other state because Arizona has its specific aspects that juveniles are going to experience here that they might not in Utah or Idaho or Illinois or any of those places. So
You know, my two cents on it is I'm happy to keep doing the research and looking into them, but let's not exclude Illinois.
yet because I think that they do have a good rehab.
model for juveniles specifically.

So can Blake, hey, it's Scott Naegele. Can I ask you and Peter to do a couple of things and something Peter may have already done it, but is to make sure that we get those to the to Jenna so that she can put them up so that we all have easy access to them so that we don't have to go look again ourselves to find what you've already discovered.
So if we can, if we can do that, you know, here in the next day or two, if it hasn't already been done, because I'll readily admit that I need to get in the practice of looking at what's already been put up on the website for us to have access to. I'm very much still getting used to the ritual here. And
And I've not been as good as I should have been at looking what's already been put up there. But if we can get it there, it'll make it easier for all of us to be able to do what I'm asking everybody to do between now and the next meeting. Sorry, Peter,

Morey a quick question. I agree with what Blake's saying.
And I would, I mean, Washington's good on paper, but again, their system kind of fell apart. If Illinois has a more dynamic system, that might be worth looking at. The question I have, though,
Because Blake's talking about the rehabilitation and we're talking about the core guiding principles and sort of feel like we're getting a little beyond, we're making it a little bit more difficult on ourselves than we need to at this point. So are we looking just at the guiding principles kind of like, yes, yeah, yes, is the answer to that, because I agree with the rehabilitation.
Is that something necessary? But I took, I'd like to clarify, I took what you said to mean that the way they've written their guiding principles is in and around the use of a rehabilitation model. Am I missing what you said?

Blake Barney
No, that's accurate. It's written off of a family integration and rehabilitation model, so that that's basically their main focus when it comes to juveniles and the sex offender management board is family reintegration, if possible, and the rehabilitation of juveniles.
Within the sex offender management or sex offender treatment realm.
So that's why I was, you know, considering them. And my information is on the handout from page like 183 to 192. So it's the very last stuff that's on there. And it's all broken down because again, I use ChatGPT to help me
organize it. So it's all broke down and tells you the differences and the similarities between each state. So if you get a chance to look at that, hopefully that helps clarify as well.

Yes, so you've already done it is what you're saying. You've already you've already passed it along to staff. Yeah. And Peter Morey, Blake, I'll join your confession. I used to Claude.

Blake Barney
Yes.

So, so it sounds like we we we we know what we're going to do with the guiding

principles by the time we finish the next meeting. And we have a plan to report back to the larger board with respect to that.
In the absence of having more time, I don't know that it makes any sense to try to bite off the last item that's on the agenda for today's meeting. So with everybody's agreement, I say we leave that for the next time as well. I want to recommend Melony Opheim I want to recommend it the county attorney.
Possibly the office come and talks about how a kid makes it probation or not on probation or some other different version or it makes sense to me to give everybody else preferred because it would have been nice to have some other people be able to. Yeah, so if county attorney Maricopa, I mean, I don't know if those still on there is he involved with Maricopa coming, but
The probation specifically, as well as the county attorney's office might be a... Well, as I said, we're still waiting to hear back from ADJCC, so I haven't heard anything since I had a meeting with the chief. Chief is on the phone. He's been on the call today. Oh, okay. Yeah. So I'm going to entrust that you'll get back to me and let me know. Yeah, I just thinking it would be a good, robust conversation if the county attorney's.
Peter Morey I know also the juveniles defense .
column, juvenile defense body has some serious concerns about the use of polygraphs. So that's important. And that's important, and just to be clear, item B on today's agenda, which we're going to carry over to next time, is a piece of that. And I'm told, though,
because I readily confessed a second ago that I've not been as good at looking at what's been posted on the website. All of the documents related to item D on the agenda are in fact available to everybody to access and see. Some of them are fairly long, some of them are less so, but they're all relevant.
to the work with juveniles and the discussion about polygraph. Yeah.

Blake Barney
And Blake Barney again. Hey guys, I think it's also important that we have Judge Young available for that as she's, you know, the juvenile court justice representing the board and with our subcommittee now. So I think that it would be a really good thing for her to be present for that conversation as well.

So, it sounds like we're in agreement that we move that last item to the next

meeting's agenda, and we may sorry.
Ohh, never mind.
Are there any other things regarding the things we've been speaking about today that we need to tidy up before we offer adjournment for today?
Melony Opheim , I would just ask if there's anything else you guys wanted to know about DCS. I mean, I'm obviously in the thick of things with the system itself, but I didn't know if you guys thought it went or didn't go or just if you got the information you wanted or just kind of. I mean, getting with the other, getting the information with respect to the scope of the.
Problem, and where do where do our kids in Arizona sit in the system, and where are they?
In terms of numbers.
Of them, and how many of them are not indicated, and those kinds of things will be helpful to me in trying to play a part. I think Nick is on our board, so we can kind of see if he's on it. I believe he's on it, so...
So with that in mind, can I get a motion to adjourn today's meeting? Got a motion to adjourn. Peter Morey.
Ben Galarneau. Second.
I adjourn. All in favor? All in favor? Aye. Opposed?

Blake Barney
Aye
Also, sorry.
Thank you. See you next time, Blake. That's the delay, Blake, you opposing so the closing of our meeting.

Blake Barney
Yes, I will be there in person next month. Sorry, guys, I've got a meeting back immediately after this. So I'll see you there next week or next month for sure.

Yeah.
So, yeah, see you Monday.

Blake Barney
Alright, see you guys.

◉ stopped transcription