AZSOMB Juvenile Guidelines and Standards Subcommittee Meeting-20260827_203017UTC-Meeting Recording

August 27, 2026,

Good afternoon. My name is Scott Naegele. I'm the chair of the juvenile subcommittee of the Arizona Sex Offender Management Board. And I'm going to go ahead and call the meeting to order at 1:30 p.m. on August 27th. Ask Major Mitchell to
Help us with the roll call.

Thank you, Chairman. Chairman Naegele is present. Mister Barney is excused. Mister Galarneau.

Present.

Miss Opheim.

Present.

Doctor Rivera.

CD **Clinical Director**
Present.

And Judge Young.

Present.

Excellent.
We do have a quorum.

Very good. It appears the first item on our agenda today is to allow for the AOC to give us a presentation about the contracts and structure of psychosexual evaluations.

Where would you like us to stand over here, next to the monitor, or probably

Wherever we can, we can both see you and the folks on the screen can too, so...
If we need to move, we can do that too.

Can I be seen if I'm standing there?
I think you can.
And I think we'll have the PowerPoint up. Right.
Yeah, they may not see you.

Yeah, they might not see us anyways. Yeah, so maybe a moot point.

All right. So my name is Steve Selover. I'm the contracts manager over the contracts and monitoring units at the AOC Juvenile Justice Service Division. I'm here with my counterpart, Brooke O'Brien.

Hi, I'm Brooke O'Brien. I'm with JJSD. I do the contract compliance monitoring. Prior to this, though, I was a probation officer with Maricopa County for 32 years and supervised this specific population. So.

Thank you for the opportunity. So yeah, we wanted to, I know the title says focuses mainly on the evaluations. We wanted to provide sort of an overview scope of the services in general that we have for this population and how that kind of works, the procurement side as well. So if you go on to the next slide. So we essentially have services that are, you can be divided into 4 main categories. So we have a delinquency prevention and an education, we have evaluations and assessments, and we have outpatient treatment, along with residential treatment and out-of-home care. So those are kind of the four umbrellas that we have over all of our services. I'm

going to go more deep into the last three, because delinquency prevention education, while it's very important and we love those services, that's like cognitive behavioral health skills, life skills, independent living skills, things like that. We don't have a specific track for that population, the JSAB population. So, but that's what that is. That's where those skills are. That's what that
category is, and that's what it's pretty much open to all youth who are eligible for that. So if you go to the next slide, it'll talk about evaluations and assessments. There's a list of what we offer as far as AOC funds, as far as evaluations, and underneath that is a list of the types of assessments that we also cover.
under AOC. So you see there we have for evaluations, we do have the psychosexual evaluation, among other ones that are up here. Down in assessments, we have a sexually abusive behavior assessment. We have the sexual interest assessment, which most people is, for most people, that's the ABLE. I know there's a couple of them out there that are used for that purpose.
And of course, there is the exceptional circumstance polygraph as well. That is also, again, these are the services that are covered by AOC funds that probation can tap into if assets and other payers aren't available to do that. Move on to the next one. Outpatient treatment, again, we have the counseling, we have day programs, day and evening reporting. Again, we have specific JSAB services that go towards
That's always fun to hear a voice. We didn't have one moment. Right, right, exactly. Everything is going so well. So the individual and group counseling, the JSAB, parent and peer support, along with
The therapeutic half day, there are, again, JSAB specific services within those types of services that we have. So we have the JSAB counseling group and individual. We have that parent education that's specifically for that population, the families of, and then the half day program as well is another one that we fund under that category. We are.
Currently, not statewide, but Maricopa County does provide victim services for youth who are in the home who are maybe victims of a JSAB situation. So they can pay for those under AOC family counseling funds. So it's just a little bit of a different funding stream, but it's basically the same.
What we're doing is we're working on a sort of a statewide version of that. So it's not just Maricopa County, but all counties can have access to that type of programming as well, because we think that's important. And the clarification process is, again, going to be part of that as far as what would go into that service.

description.
Next slide is our out of home. Care services.
which from the left here, least restrictive, to the right is most restrictive.

submit their application and come on board with us. So like I said, we don't put that third bullet there. We don't just take any service that comes to the door and is expressed interest in being an AOC contractor. We do accept those services based on need, you know, the request from the Each.
the requests from the counties who express need for those services. So whether it's a statewide need or whether it's a need from a specific county like Coconino or Yavapai, we do look at that to make sure that what we're bringing on is actually needed out in the community so they don't come on and aren't underused or not used at all.

Is it best to wait and hold questions to the end or can we ask questions as we go?
I'm fine with whatever you guys want to do it. Yeah, you can ask them now if you'd like.
And for fear of forgetting how. Exactly, I know how that. Yeah, definitely. The service that you talked about that's recently been added in Maricopa County that you're looking to add statewide with respect to victim services.
Right.
You have some contracted folks doing those services here in Maricopa County already?
Yes, so the contract is with Maricopa County, it's not with AOC. So counties, let's say AOC doesn't have a provider for a specific service. A county can contract directly with that provider.
using our criteria for the program that they bring on, but they can they still contract them. It's technically they're contracting with that program with outside of AOC, although they do use AOC funds. AOC does pass through a certain amount of funds to each county for those for that purpose.
Gotcha. Yeah.
You're doing some of that. Okay.
A lot of our outpatient therapists are seeing the victims of the group homes or kids in group homes.

I guess I didn't, I didn't. I've been somewhat away from the beaten path for a spot of time and I didn't realize that used to be back when I was running a residential treatment program. If we wanted to deliver those services, we had to figure out how to do it within scope of our own budget.

Yeah, and then it was a budget issue, I think, in prior years. Recently, we've been able to, again, kind of use that family counseling fund that the legislature also approves that, you know, that can be used for that population. So I think that was a really good idea, and we want to expand that for sure.

Joe can attest several times. I've laid it out budget-wise, like
If I have to keep a kid a year longer at the group home, then it doesn't, the budget doesn't matter of six months with outpatient, you know, so it definitely speeds us up. Not for kids longer than we need to and it gets kids longer. It really is a win, at least for our families that are using it. You see it being that one too.

And in Yavapai, we've been able to leverage like the Family Advocacy Center. They provide the victim counseling and then they will coordinate with the...
the youth's counselor and do the clarification process together. Yeah.

Anything else on that? Okay, so again, just another reminder that providers, they can provide one service or multiple services. So they come to us and, you know, we all work, we negotiate what they're going to provide to the states in general. And again, with this, additional time frame that they can, that brand new providers can come in and work with us. Current providers can also add services as well if they would like to, or not just the JSAB, but the entire probation population. Each service is guided.
by our instructions and requirements that are outlined in a service specification. So we do make sure that our providers as much as possible can follow those service specifications that go over everything like the target population they're serving, staff requirements and those types of things.
So.
we use those and follow those. And that's actually how we monitor a lot of our programs too, as we utilize those service specifications to go out and make sure that they're doing what we ask them to do. Slide.

Really quick, as someone texted, they're unable to see the slides from home. Are they supposed to be able to see them? Because of the clear? No.
Yeah, they are supposed to see them.
Yeah, they're just not seeing them on virtual. Somebody's on a virtual meeting and said that they can't see the slides.
I don't know.
Yeah, all I'm seeing is here.
Why can't they see?
Thank you. No worries.
We can make this slide deck available.
It's available. It is actually. It is already online posted. Yeah.
So. I'm going to share one more time.

I have some questions about, you talked about the instructions and guidelines for the specifications. Oh, it was there. In your outline. I want to go back to that if we might want to get through this. Sure.
and talk about how the items that are part of the current psychosexual evaluation became part of those items and why other things might not be there from a historical standpoint.

Do you want me to move on? I'm finished if you want to move on. Okay. All right. Now, Brooke's going to talk a little bit about how those services are referred out to probation and how that process works.

Yeah. So basically, for everyone here has probably been a part of that referral process at one time or another, but for the population that's viewing here that has not. All of these evaluations are going to be court ordered. So after a juvenile is adjudicated, either through a plea or the adjudication process, the probation officer by order of the court will submit a comprehensive referral packet to one of our psychologists.
And typically those psychologists are.
chosen based on geography, like for the more rural counties, we only have a certain select of evaluators that will go to that area. But generally, we have a selection of psychologists that specifically do this type of evaluation.
So the referral packet is sent to the psychologist, and then the psychologist will actually do the evaluation, which is really important because the evaluation process is

really what sets off the string of events that comes after that.
So it really is a critical part of the process because it's the foundation by which really all of the decisions are made after that regarding treatment and decision making within the case. So it's the psychosexual.

Question, if I may.
Yeah.

When you say you send out the referral and you send documentation to the people doing the evaluation,
Can you tell me what that consists of?

Yeah, and the probation department has a list of items that ideally we would like to have included. We've put those in our manual this new contract year. So we want them to have the ASIAS, any prior evaluations that they are available,
hopefully they have the ones that are available through access or DCS, any court reports, obviously the order from the court and any prior treatment reports as comprehensive as they as they can.

How about like for the kids that are special ed kids that have had
Psycho eds every three years, do those get passed on to evaluators?
They should.
They should, for sure.

Yes, they should. And that is a part of our monitoring process is that if there is documentation within the report that they're special ed or have a prior IEP, we're looking for that kind of information that's contained in the referral.
Process.

And we cannot, as judges, we can always tell what's been reviewed because the evaluator specifically lists everything that they received. And so I can tell you that I look through it and I make sure, like, if I've got a kid that has an IEP and it wasn't sent to the evaluator, then that's an important piece of information.
Yeah. And we try to.
have our vendors feel comfortable reaching back out to probation to make sure that

they're getting all of the information. And if we get feedback that they're not getting complete packets or they're just getting a service authorization form and they're not getting really what they need, we try to mediate that with the probation departments and the vendor to
to make sure that they're getting comprehensive packets.

Yeah, I asked the question only because from my perspective, as someone who does those evaluations, the more information, the better.
Absolutely.
So you can see the history up to that point in time, sure.

Yeah, so police reports are involved as well.

Yes, the police reports, very important so that they know what's being.
disclose versus what was in the actual police report. And then something else that we've added this new contract cycle is the professional consultation. So we're actually having the vendors reach out to probation and do a staffing with them so that they can get the information that's not necessarily captured in a report, have those conversations about family and things that you normally wouldn't be privy to in a report. So I think that that has helped the quality and the recommendations of the report.

I make an assumption, I guess I'm asking a question at the same time, that interviews get done with both the client, the juvenile, and with parents or guardians as part of the evaluation.

And that is something also that we have added to this service spec that there document collateral interviews and attempts to conduct those collateral interviews. So if they've made numerous attempts and they can't get a hold of a parent or a parent's not returning those, that they show documentation for that. I mean, certainly they can't control.
that, but we ask that they do those collateral interviews, which is really important. And for the most part, they're doing a good job of that. And then, so the evaluation report obviously will give us treatment recommendations in the least restrictive environment, which is the second part, and it's outpatient versus the inpatient.

As we know, all inpatient interventions have to have a recommendation from a psychologist that that is, in fact, the least restrictive environment and that the youth is not manageable while remaining in the community, which qualifies them for that level of care. And then from there, once they are in treatment, there are ongoing assessments throughout the treatment process. So our providers have the ability to conduct additional assessments throughout treatment to measure progress and risk to the community.

Thanks, Brooke. All right. Yeah, just to sort of close this out, we just wanted to mention that we try to create opportunities for sharing of information and education and technical assistance. So just a little list here of what we do in that regard. We do try to train probation officers when there's a need on various issues related to JSAB youth. We've also offered training to judges and attorneys, as well as the providers themselves. We are working on currently a provider training for the evaluators because we've brought on a few new folks since the 2024. And even since then, through our opening continuous process, where we've had some, just some expressions of need that we should probably have a training that really goes into what should be in these psychosexuals, especially evaluations. So that's one of the ones that tracks that we're working on right now. And anytime we hear another request from a provider, whether it's against JSAB or another issue, we try to provide that as much as possible. Not always us being the trainers, actually, not usually. We usually bring in experts and folks from the field, especially who can help us out with that. Ms. Opheim has helped us with some of those trainings as well. So she's really helpful when we call upon her. The last one I'll mention is that we're always trying to promote.
communication and collaboration between our providers and probation and the courts in general, as Brooke had mentioned with that new requirement that we have evaluators and probation get together. It's not a voluntary thing. It's a requirement that they at least meet over the phone or in person and have that discussion. So that, again, the evaluator knows what probation is looking for and makes it a much more, I think, smoother process in the end. And it has better, we have better outcomes when we do it that way. Last slide here is that I wanted to point out that everything we do, we try to adhere to the best practice of the Association of Treatment of Sexual Offenders, ATSA by following the statute that says we have to follow the ATSA code of ethics. We also, in our services that are offered by us, whether it's the assessment

side or the treatment side, we try to have them implement the ATSA adolescent guidelines.
And we have those requirements embedded in our services. And just to stay up on all the current information, we do attend the national conference annually, if we can, to make connections, meet more experts, and also stay up on all the latest research.
And I believe that is essentially us in a nutshell. And obviously, if you have questions, we can talk about those now. Afterwards, if you have any other questions, this is how to reach us. Both Brooke and me are on there. She's definitely got the, you know, all the knowledge about probation. I've got more than maybe the knowledge about the contracts themselves, but we make a pretty good team. So if you want to give us a call or send us an e-mail, we can definitely follow up with you if you'd like.

One of the questions that came up, I think in the last meeting, was what the genesis of the so-called statement that the ERASOR has fallen on bad favor for some reason, and nobody could articulate where and why that was.
Sure. And I'm trying to, yeah, and I have some questions about that, but knowing where that came from to start with would probably be valuable. Yeah, and I think I was listening in on that. So I kind of thought that that question was going to be brought up. So when Judge Young sent out that request for all of the, you know, the judges and folks around the state to provide what they use in the assessments for the psychosexuals,
We also reached out to our providers who do those assessments or to do those evaluations as well. And we received some of those items on that list, especially if you don't see a county next, you know, next checked off for one, that's probably the ones that we provided input on as far as our, not us, us, but our providers, you know, did. And
So there were a couple assessments that were already on that list. I believe that probably came from the courts that we were advised that, hey, these aren't really considered valid any longer.

Where did that come from? I guess is one of, I mean, I have some commentary to say about that.
I believe there's just been some research that's been done that, and it was the ERASOR and it was the TABS, which is the Trauma Attachment Belief Scale. These providers said that those were essentially obsolete or outdated, and there were

better tools to use as opposed to those that had been replaced. We also checked in with our Tom Levercy, who's one of our consultants that we use nationally.
And we were also told by him and the creator of the ERASOR himself, I guess, Jake Worley. Yeah, who mentioned that, yes, that is true. We don't recommend this be used. There's other assessments that are more ideal to use for that population than this. And I don't know the ins and outs of that research.

What I struggle with with respect to that is this. If that's true for the ERASOR, and I debate kind of the stream of information that's passed and how that's got codified into it being outdated, if that argument is being made with the ERASOR, the same argument could be made for the JSOAP.
because they're both essentially the same kinds of instruments. They were never actuarial instruments to start with. They were empirically guided instruments. And the research that's been done on both of them collectively says exactly the same things. And that is, we should be very careful about assessing risk using these instruments and making long-standing statements about a youth. So I'm not necessarily arguing that there is or isn't merit for the ERASOR. I'm saying if it's true for the ERASOR, then it's true for the JSOAP. And I think we collectively as a subcommittee need to get some clarity around some of this issue so that we, when we pound out the structure of what we think should be in a psychosexual evaluation, that we have some consensus and it's actually driven by factual information. I'm afraid to tell you the truth, that the ERASOR falling on bad favor literally came from an Arizona ATSA training where Jim Worling himself came and gave a presentation.
And in that presentation, somebody in attendance raised their hand and they said, so Jim, are you saying we should stop using the ERASOR? And Jim said, I'm not saying you should stop using the ERASOR. I'm saying that I'll probably stop using the ERASOR because I'm going to use the PROFESOR at this point in time. But he didn't say stop using it. What he, you know, and my contention is both with the ERASOR and the J-SOAP, is that they, the structure of them, as long as we don't get carried away and start making hard and fast statements about risk, especially long-term risk, they provide a really good structure for looking at the things that we need to identify and need to focus on in treatment.
So I'm just concerned about, you know, throwing out something that gives us information about what's going on with the individual youth that I think is important for treatment purposes.

Sure. And all you're saying could be absolutely true. I'm not a psychologist. I don't know the ins and outs of all these presentations. But I think it is important for this committee to know that There is, in the community of evaluators, there is this sense that the ERASOR, for whatever reason, whether it's valid or not, it is out there that this is no longer a tool that is being considered. So I think it's important for you all to be aware of that, just so you know what the landscape looks like as far as these assessments go.

Well, I guess, as long as I'm being heard and saying, people need to understand if they're expressing concerns about that and choosing not to use it, they should be thinking the same way about the JSOAP.

Sure.

Which then would leave us with, you know, the use of the PROFESOR. I hope nobody's, you know, gotten to the point where they've decided that that's that doesn't have any merit to it.

And I know these assessments are changing. The research is constantly being done to validate these assessments.

Well, the reality with the ERASOR, at least, it's probably done.
as Jim's moved on to the PROFESOR. Whether or not, you know, Prentky and Knight, the folks that did the JSOAP, are still doing research on it, I don't have a clue at this point. My guess is, given the great big meta-analysis that Mike Caldwell did, where he analyzed, you know, juvenile services and juvenile treatment programs and assessment things, that is part of where you know, some of this discussion about the ERASOR and the JSOAP came out of is that there probably isn't a whole lot of research being done on the JSOAP either at this point in time.
So, you know, I'm just looking for broad.
Joe might have a comment here.
Yeah, Joe.

Yeah, just a thought. I mean, I like what you're saying regarding, you know, if we're looking at one way to get the creator of the ERASOR saying, yeah, I'm not going to use it no more, but JSOAP is out there and it seems like that's a fairly popular.

Well, he didn't comment, he didn't comment on the JSOAP because no question was asked him about the JSOAP. It's not his instrument. Had somebody asked the question, my guess is, and I'm not going to speak for the man. I mean, I will ask him when I see him in about a month at the ATSA conference. But my guess is he probably would have said the same thing about the JSOAP.
as he said about his own instrument, the ERASOR.
So I'm just simply saying, I think we're missing an opportunity to capture comprehensive information about individual clients if we're not careful in what we do and don't use.
Sure.
I personally, and I write caveats in my reports when I do an evaluation, I'm going to keep using all three of them.
I'm going to keep using the ERASOR. I'm going to keep using the JSOAP, and I'm going to keep using the PROFESOR, because I think they say comprehensively a more complete statement about an individual kid to the treatment providers who are going to, you know, get these evaluations in their hands and use them for treatment purposes. That's my position on that. This board collectively will decide whether or not, you know, what the structure of who he is and whatever I think will come second to what the board collectively says. But that's just my position on that. And I would be remiss if I didn't articulate that out loud. And also talk about how I think, you know, this belief about the ERASOR are not being valid. They never were valid. So it's a misnomer that they were ever valid about predicting risk in the 1st place. They weren't actuarial risk assessment scales to start with. And the attempts by other people, the folks in Iowa with the J-SORAT, to do an act, to create an actuarial risk assessment scale, for juveniles have been highly unsuccessful, and we all know why, because the dynamic nature of what it means to be an adolescent. You know, so more power to them that they tried to do that. And I think that's the reason why Prentky and Worling and colleagues didn't go down that path, because they pretty much knew that that's how that was going to play out from their wealth of knowledge about the issues to start with. And they never, and they never called their own instruments, you know, actuarial risk assessment scales, because they're not,

they're not predictive and we don't, we don't have the psychometrics that we have for the same tools used with adults.
And I don't think we ever will. So all I'm making a case for is for us to do whatever we can do in the upfront assessment to be as thorough and comprehensive as we possibly can.

So, my point on that was...
How do we train to that, right? Yeah. How do we train clinicians to do assessments to be calculated in their use of these things?

I can tell you what my thoughts are about that.
Well, I don't know if it, you know, I mean, it's something we have to grapple with as a subcommittee and make some decisions about. So it's a worthy question, and I think a worthy question to be answered.
asked and answered in the moment. I think that we try to not be so prescriptive that we rule out the possibility of somebody deciding to use all three of them if they want to use all three of them. But at a minimum, they have to use the PROFESOR and maybe even the JSOAP. Do you know what I'm saying? I mean, so, you know, I think we don't get so prescriptive that we say you must, but we say pick as many of the following as you see appropriate for your purposes, but you have to pick one, and it has to be the PROFESOR at this point, because it's the one that's the furthest out there with respect to current research supporting its use. We're going to learn more and more about, you know, and Jim's real clear about the PROFESOR. He says, it's not a risk assessment scale. That's not what it is. And he's real clear about that. It's an information gathering thing that has the support of research.
And these are the kinds of things that you need to be mindful of if you're going to work with and treat kids and families with these issues. I mean, that's pretty much what he would say about it. So that's my answer, but, you know, we have to grapple with that. And that's one of our tasks to continue the discussion today, post, you know, your guys' presentation.
But one more question.

Yeah, of course.
Why is the ABLE not part of the psychosexual evaluation? Just as a standard thing. It's carved out, is it not? I mean, if I'm wrong about this, then I have misinformation.

Several of our evaluators do utilize the ABLE with the evaluations, the psychosexual evaluations.
It’s part of some people's,

yes,

but not other people's.

That's my understanding.

And I go, why is that?

It's a separate service authorization.
So if you want to get both, you've got to get both. It's not all inclusive. Somebody just told me that the rate increased, which is awesome if it did.

Yeah, that's it did.

Yeah, awesome, because it was just hard to cover the cost of getting the test. Yeah, which is why a lot of people don't do that.

Nobody's going to do it if they're not going to get compensated for it.

I think that some people just look at it, maybe a disagreement with you, that not every kid you need to know about their sexual interest.

We should have, we should, and we will have a discussion about that. I think that, I think knowing the answer to that is an important piece of the equation. Because then you can, in the absence of concerns, as evidenced by the results of the ABLE or the LOOK, you know whether you need to focus on those things in a hard and significant way, or you don't need to focus on those things. Now, a whole bunch of our kids don't have deviant sexual interests. We know that.
But for me, I'd like to be a little bit more objective about determining, you know, whether that is or isn't the case for a given kid. So I just asked the question, you

know, my position, again, I guess, is that it should be part of the psychosexual evaluation, the rate stuff and contract stuff and the
That's a secondary discussion. It's a real discussion because it determines whether or not people make it part of it or not. If they're not going to get compensated for it, I can see why they wouldn't. Because here's the deal. At this point, it costs, if you buy 50 of them at once, which not everybody can afford to buy 50 of them at once, prepaid, they cost you 90 bucks a shot, just to administer the test. And never mind the time involved and then the time writing a report and all that stuff. But if you pay for it test by test, it's more than 90 bucks. I think it's $110 per test. So that's the cost to the consumer, utilizer of the test. I've been fortunate enough that I can
buy 50 at once and pay, you know, it just went up from 79 to 89. That was the first increase they had in a while, but it is that much if you buy 50 at once. So.

We've had this discussion too, Scott, but we're just all praying that they update their slides, that they update their process.
And we've given the feedback probably three different years in a row at ATSA that, you know, woman from the 1975s in jazzercise out there.

We need to be able to argue why that's not as relevant as we think it is relevant. I mean, I can do that too, but we can explain that, but we keep we keep looking at both. Here's what I know that's great. It's a great point.
And here's where I think it becomes problematic while we're on this subject, just so everybody who's here can be part of this discussion. The kids that don't have... hands-on offenses, but have been arrested for, you know, exhibitionism, voyeurism, online use of child pornography. Those slides don't do much for those kids as a group because they're so outdated and old. So we're not, I fear that sometimes we're not getting what we want from the ABLE with respect to that subgroup of juveniles. So you have a good point. You didn't realize it, but you're probably making an argument for using the LOOK because the slides are more updated and there's seven categories of males and females. So they have more age
demarcations in the LOOK than they do in the ABLE. So there's a couple arguments for it. Now, you're not going to get any historical information from the LOOK because it doesn't have a questionnaire. It has only the viewing component. But, you know, so for these kids who have those kinds of issues, perhaps part of the

discussion is to to look at using the LOOK rather than be ABLE for some of those kids.

We're just trying to get through our prepaid test. We're not leaving any of the tables.

I don't blame you for that.

But I would, I mean, and I'm not counter arguing you, but every one of our kids has had some relationship with porn. So either way, if they're not deviant or online or exhibitionism,
Even if it's a hands-on victim, they've got a relationship with some kind of tech and pictures.

No, you're right. But my experience having administered that test about 3,000 times now is it's that group, it is true for adults too. They, you know, I get the results back and I ask adults who have gotten arrested for online child pornography use,
What's with your not rating any of the slides as sexually arousing to you? Those slides are tired. I mean, the things that they've seen online compared to the pictures that are in the ABLE assessment are so benign, it doesn't even pique their curiosity.
So, but yeah.
Are we using is any of the evaluators using the LOOK?
I haven't heard. I think it's no, it's really the ABLE.

So I'm not pitching. I'm not campaigning. I mean, I use them both. I use them both.
The one good thing I will tell you about the LOOK is
You don't pay for every test that you run. You buy the software, you pay an annual renewal fee, and you can run as many tests as you choose to run from, you know, your one-time purchase fee for the year. So there is a clear advantage to doing that. People used to do that 15 years ago.

OK, any other questions?
Thank you very much. Thank you for your time. Thank you guys for the presentation and the answer to it.
You're certainly welcome to stay and listen to the rest of the dialogue too. Our next item, I think we've really, in this room, I think we've really addressed the next item

and that is
No, I take that back. No, yeah, the discussion of potential recommended option of revised juvenile guiding principles. We took a vote in this room last time.

Yeah, we approved the guidelines last time, but my understanding is that there were some typographical errors that were fixed.

Yes, ma'am. And that, Chairman, you had asked to see those again before they went to the larger board at the next time.

In my review, suggest that they were.
And the consistency issues, you know, in terms of the way we were talking about things was tightened up. So I think we're in a position to take those to the full board and have a discussion and take a vote on adopting those guidelines at the full board. That's my recollection.

Correct. Yep. Just wanted to give you that chance to see that final version with those corrections made before it went to the larger board. So
Apologies for those errors.

And thank you for me. I don't know if it helps others, but for the two versions, the thing with all the lines drawn.
The red line and the clean version. Yeah, it helps me immensely be able to track things. You can thank Ashlesha for that. Thank you for that.

The second issue under old business was to continue the discussion about psychosexual evaluation reports.
I mean, I don't know that we're coming out of here today with a final recommendation, but I just want to further the conversation. And I asked last time for everybody to kind of take a look at that list of measures and measurements, and maybe we can begin to cross some of them off in our quest to get tighter parameters around things.
Because I think that there are, and I said this the last time, I just think that there's a whole bunch of things on there that are not germane to doing a psychosexual evaluation.

And like I said, I think a lot of them that aren't necessarily germane are things that are covered by a regular psychological evaluation that kids are undergoing.

So you're not.

I think that some of the counties were.
Maybe conflating the two.
Gotcha.
So are you saying that we collectively could make a decision about what under the, first thing we have to decide is, are these categories that we've got everything put under consistent with perhaps what ATSA is saying? And then
And then taking a look at the list of things that we have under each one of these categories and keeping or crossing off so that we can kind of, I think, appropriately narrow the scope of what we're asking people statewide to do.

Can I ask a clarification question?
Please.
To what end? I mean, I mean, where would this work product ultimately go as far as the proposal goes? Because, you know,
the court administers the funding for psychosexuals. And so we don't have the authority to make changes to the way the court does things. And so to what end are we working?

Well, I think...
Because I thought of what the question you're asking. I mean, I would hope that I would hope that the process alone, vis-a-vis the people that are sitting in the room currently and gave us a presentation, that we collectively could move to a place where there's some consensus.
about what this looks like so that it so that whatever we outline and we think is what it should look like for lack of a better way of putting it and why that there's that the folks that are entering into contracts with people to do it there's agreement about that.
So it just makes sense to start from the perspective of the way it exists currently and whether changes need to be made to that rather than starting from the position

where we're looking at every assessment known to man and then drilling down the list.
Say that, say that again. I'm not, I mean, go ahead.

So what we've got is we've got this exhaustive list of assessments that different counties are seeing in a various number of realms. But then we've also got the AOC and how they're administering the contracts and how they're paying for the service. So does it make more sense to just look at what they're doing right now and see whether that meets our needs, rather than going from the direction of looking at everything, add to or subtract up to what's already existing.

Sure, because we don't have that list in this in this presentation. We we have we have talked about instruments, but we don't I don't I don't know what that list is.

May I guess I could ask the AOC in the room.
Is there anything that, I don't want to say forbidden, but anything you discourage or you wouldn't want in a psychosexual? You guys don't ever say do not use blank.
Like a specific assessment.

Right.

I don't believe so.

Which is why there's so many. But is there any that you say you have to at least use, and I believe the PROFESOR is one of them that I can think of, that you need to use at least this. And then obviously there's all the information Brooke was saying that you get, you know.

I believe by calling out an assessment by name is the JSOAP that's in there. I don't know if PROFESOR is.

PROFESOR is not the JSOAP, but it just says you have to use at least one of them.
And it provides the JSOAP as an example.
not that you have to use a JSOAP.

And I think it goes along the lines of what Mr. Naegele was saying about not being restrictive in terms of what tools that they're using. And so we don't, we're not restrictive in that, but we do require them to use assessment tool or a assessment.

So you're not restrictive, but then in some reason, that's how you get kind of vague. So just somewhere in between where you're not restrictive, but you say at least these five things, or we hope these have it. And people know what they like. People know, probation officers typically have a preferred person to do their evaluation because they like what they get from it, you know.
But maybe there's always some doctor that they like a lot, but they wish they had this in it that they don't, you know.

I think one of the tasks I believe that we as a subcommittee need to answer is what are the categories of assessment? Personality assessment, measure of intelligence, measures of psychosexual functioning, sexual knowledge,
those kinds of things. We've started a discussion about whether or not an objective measurement of sexual interest is important at Jump Street or isn't. We've started that discussion in this room today. I mean, I've already articulated where I stand on that. So we've got four categories there. I mean, polygraph would go in the same category as the ABLE would because it's a physiologic assessment, just like the ABLE is.

But you have to have another court order for the polygraph.

Right.
And so the evaluator would not be able to just choose that.

No, but if it were available under, it is available under certain, that they could make a request for it. Exactly. And that's what. In addition to what they're already doing.
Yeah.
So I guess what I'm saying is, I capture what.
you were trying to articulate. We come up with the categories and we do have, we try to seek to have them mirror what's already being done. And then we try to figure out what are acceptable measures under each of those categories.

And I think that's how it's organized right now with the AOC contract, isn't it? That it's, you're going to do the the consultation with the probation officer. You're going to collect the documents, you're going to list the documents that you've reviewed. You're going to note the collateral information that you received from like a parent or guardian, probation officer, things like that. You're going to do some kind of measure of intelligence.
And so you guys break it down by category of what you're requiring your contracted vendors to do, right?

Yeah, yeah, they assess the, there are certain sections that we feel that, and this is our opinion, this is I think again community, but this is, and maybe as well, I didn't create these guidelines myself.
But yes, we do outline what we expect because this is what probation is looking essentially trying to get. And you know, those recommendations, they want those tied to, like, to make sure they match, you know, or they align with what was done to collect that information. So
It all makes sense.

When I get psychosexuals on juveniles and I'm reviewing them, a lot of times it doesn't really matter who the provider is. They are set up very similarly and they have same categories of assessments done.

It is my sense, and I don't have a complete grasp of what's going on in every outlying county, that that's more true for the three larger counties in the state. It's less true for some of the other counties, because I've seen some of those evaluations, and I would guess that Mel probably has in the treatment setting too, but I don't, there's
There's less standardization, I think, when when it when it goes when it goes that way, but...
I mean,
I think all of our outlying counties are using the providers from Maricopa. It really isn't a whole lot of other. We don't have any. I mean, we don't have really rural providers doing these. I know the doctors are coming up and they're seeing my kids a lot of times in Yavapai County.

I mean, sometimes families are bringing it into the valley to see us.
Yeah.
That's good for me to know. I've been clear about that.

Yeah. I mean, you guys can probably say how many you have, right? You've just added a few, I've heard. A lot of new doctors, yeah.

Yeah, we also have a few agencies that have several that, but you know, they cannot do them.
or Zoom or anything. Those are the one of our few services that has to be done in person. So if we do have a person from Maricopa County working with a kid up in Page or Flagstaff, they have to travel there.
Yeah.
Yeah.
Part of what I'm trying to argue for is there's a whole bunch of measures on this list, especially in this 4th category on this handout that we have, that
I just don't know why they're there. We're doing a psychosexual assessment. We're not doing a neuropsychological. We're not doing an assessment of depression. We should be gathering some of that from our clinical interview. We should be gathering that from our personality testing. If those issues exist, then
evaluators should be talking about the need for more thorough assessment in a specific area, not necessarily doing those assessments in the context of a psychosexual evaluation.
And I think if we start from the point of the AOC contract, I think that will clarify that a lot for us as far as what is actually being done, because it's what they're paying for. And so it very well could be that maybe some of these kids are getting neuropsychologicals done as well as psychosexuals. And so that's why.
the response from the judges and the probation chiefs were we're seeing all of these assessments, not necessarily that's part of the psychosexual.
I get it that this is not a this is not a pure sample of what people do who do psychosexuals is.
Right.
But are we going to leave this? This is going to be our list for psychosexuals or are we going to?
You know, I guess, let me throw something out. I guess if there's something missing

from the list that you guys don't see, I think it would be helpful that we could consider that, you know, within the scope of work as far as our service specification. But if there are tests or evaluations that have question marks, we can reach out to those providers that we contract with and say, hey, could you tell us a little bit more why you use this tool? Because I think we need the collaboration with the provider versus a room trying to figure out which assessments are best.

If there's a way for me to say this and say it respectfully.
I'm not sure that all of the providers actually know what should be included in the psychosexual evaluation and using that as the point of departure for gathering information. If my contention is accurate, then your analysis is faulty because they're only talking to you about what they know about. For example, we don't have
on an ongoing basis in your contract specs, the use of a measurement that can tell us where somebody's at pre-treatment, intermediate treatment, post-treatment. We don't have a metric in there other than using the PROFESOR to do that. But for the client to engage a text that can tell us about whether or not they're making progress You know, not just from our observations, that's not part of what's routinely happening. There's 2 instruments that could be used for that, the MIDSA and the MSI juvenile version. So those are two instruments that are not on your list. The LOOK is not on your list. And
I'm not championing using the ERASOR, but the ERASOR is not on the list either, so...

Would, Scott, would it be safe to say that in the answers, because I would be very interested in this also?
If the answer from the evaluator was given, I think we would have some insight as to whether or not it's tied to psychosexuals, or is it just some test from a psychological standpoint that's being used, because that's what they know.
I, I guess I would, I would think we see some differentiation, right, or no?

What about doing it this way? What about reaching out to the contractor providers and say, can you give us a list of what you regularly do during your psychosexual evaluations that you're providing to courts? I think that's what.

Well, we didn't ask every provider. That's the difference, I think, in what you're saying. We didn't get a huge sample.

Yeah. So yes, there are probably other ones out there that we didn't capture on this because there are other psychologists who do these and we just haven't. Yeah. I think we could entertain that question out to them for sure.
I mean, that might be a good place to start and ask the people who are doing the evaluations what tests, what assessments they're using.

Specifically for psychosexual,

because the problem is, you know, some of these responses were from judges, and some of them were from, you know, probation chiefs. And honestly, when I read through the list that I got from some of the counties, I'm like, oh, that's what I see in a regular psychosexual. That's what I see in a neuropsych. Yeah.
not just in a standalone psychosexual evaluation. Yeah.

So, we could, we could do that, yeah.

Yeah, I, like, like, you know, in the end, I think...
We come, we come to a better place if we're, if we're all, you know, having this kind of discussion and looking at...
Kind of.
what needs to be there and what could be there, leave enough flexibility for people to make decisions about that. You know, people, you know, I mean, people are going to make decisions based on what their testing costs are and things like that and how much stuff they do. You know, for somebody that routinely does these, lots of them. It doesn't take me much more time to score somebody on an ERASOR JSOAP and PROFESOR than it does if I just do one of them, you know what I mean? Because I'm already conceptualizing the whole body of work in that framework, you know what I mean? So by the time I sit down to score somebody on the instruments, I've largely got it, you know?
I may have to go look at my notes and some testing data and stuff to answer, you know, three or four questions in each one of them, but so I think, you know,
Yeah, I think that's a piece of it too. All right, so can we get from you guys like your, how you, what in the structure, you must, you have listed instruments that people can be using, right? Are those, do you have those?

I mean, I texted my guy two months ago and we started talking about it, what do you use? And he gave me his 10 things, you know.
Sometimes this, but most of the time.
Do you mean the AOC specs?
Oh, I have them. It's not with me, yeah. But they're not, they're not, like they said, they're not totally restrictive on you have to use this 10 or 15.

No, and to be clear, I'm not saying, I'm saying we agree on the categories. We come up with a list of measurements in those categories, and we say things like,
must use at least one of the following. Please feel, you know, I mean, you know what I'm saying? So that we get some consistency from county to county to county and from evaluator to evaluator to evaluator.

And my understanding is that's how it's set up right now, right? You guys have the categories.

Yes, we have the format that's consistent. We don't, again, as we've said many times, we don't call out specific assessments that need to be used.
Because they need to do an assessment for this, for intelligence or whatever, and then they get to choose which one they use.
I don't even know if we get that in the weeds.
Your categories might be like history and recommendations and more of the
Yeah, we require them to utilize a, I think we call it a battery of tests that are evidence-based, all that, to perform on during the rally. So they can't just do an interview, basically, and say, here you go, they have to actually legalize these. instruments, you know, but we don't.

But it might be helpful to have these categories, intelligence, education, sexual.
But you can see that's also contributing to the laundry list.
Of course, yeah.
Yeah, absolutely.
So I just think, you know, I mean.
I like the categories idea, just pick one of these five.
For this.
We've all seen psychosexuals where there's really nothing sexual in it.

It's A qualified psychological evaluation. What, and you go, what measure did you use that helps us set?
Yeah, I'm not the same, because the ones I see are paid for by the AOC, and so the providers are, they're giving me the categories and they're giving me the assessments and they're giving me all the data.
Whereas in smaller counties, you're getting a doctor who's going to just do all of it. in town, you know, and not specific. I don't, you're not even saying that in rural county.
I mean, Yavapai is a rural county. I can tell you my providers come from Maricopa.
No, I'm just saying he might be seeing a doctor or a provider somewhere that has nothing to do with AOC. That's what you did.
Right, exactly.
And that's a different, that's a different ball of wax. I mean, if someone chooses to pay for their own evaluation, they're certainly able to do so. Right, but there should be certain.
But the more consensus we have about this and the more we have agreement about the structure, I'll call it that, for lack of a better way of putting it, the more pressure that puts on anybody who's going to do evaluations like this, and they're going to be an outlier if they're functioning the way Ben just articulated.
And that's a problem. And now we've kind of encouraged in an indirect sort of way somebody to bone up on what they're doing.
Because as somebody said, these have significant implications for these kids for the potentially for the rest of their lives. And what people are saying about them ought to be anchored in something that there's consensus about.
Okay.
So I ask this of the subcommittee for our next gathering.
Are these categories the categories we want, or do we want to adjust them and come back and have a discussion about it? And then I want people to think about, if they would please, what needs to be under those categories as possibilities for that category.

I'd like to see what the AOC is able to gather from the providers who are doing psychosexuals under the contract.
as far as their feelings about the categories, their feelings about the assessments within the categories.

Hopefully, hopefully we get those by the time we came back together the next time.
Yeah, I mean, that would be optimal. Absolutely. Yeah.
Look at us. Look at us. It's on the website, right? Oh, you need titles. Dr. Davis' description. Okay, okay, I see that. All right, all right. Yeah, no, let me find it. If you want to send that to us, I'll be sure.
One down, 17 to go.
All right. Moving on. Everything else that follows hereafter on this list, other than E, which is call for future agenda items, was me trying to think about things that I think we need to begin to think about. So
Discussion of standard procedure to evaluate juveniles who have committed sex offenses, which we're talking about now. Discussion of guidelines and standards, that's what we already talked about. Discussion of home reunification of juveniles who have committed sex offenses, safety assessment, placement determined. And I guess I just want us to get
really systematic about thinking about.
What needs to be in place for kids to go back home? I think that everybody sitting at this table probably has...
some ideas about that, but I'm not sure that there's consensus about that. So, and frankly, like I said, these other items on here were, because Jenna was asking me for items for the meeting, and I didn't know what else to put on the agenda for us moving forward. So,
I think that input from probation about things like safety planning and things like that might be helpful as far as what gets put in place before kids can go home. because they and the treatment providers are really working together to come up with how that transition goes and what the rules are for the transition.
I know it's happening. I just I just also know that it's not been ever really concretized so that it can be done uniformly with the same set of concerns being
Evaluated in each in each individual case.
So, um...
Yeah.
Are there other items that we need to put on the agenda for our next meeting?
I would have one.
Thank you. We have continued to look at recidivism and we have now bounced our juvenile data off the adult system. So we have more.
I'm happy to hear that.

So we'll my data analyst.
take force and will present at the next subcommittee.
I'm happy to hear that and I and I and I was thinking a lot about that when when the folks from Maricopa County were here and talking and I'm sure that I didn't make any friends by by talking about how we don't really have any recidivism data because I because my sense was is recidivism data was was was being conceptualized as while we had the kid on probation, did he commit another offense? And that's not the recidivism data that I'm talking about. What you just articulated is more in line with what I'm talking about.
So we can share that at the next meeting. Yeah. So super. Maricopa operates.
We'll see if we can get what we've done in their system, if they can do it in their system, because their system is a little bit easier than our system, because they have one case management system where we have multiple. So thank you for that. I'm going to dovetail something off of that, if I could, just to get us
us collectively thinking about something.
I, I think that we have, if...
If we can make this enough of a priority, I think we can go probably even beyond what you're talking about being able to present and tracking people when they leave the state and things like that. We'd have to gain access to FBI databases and things like that. But that's how some of the actuarial risk assessment tools were created in the 1st place.
was to have solid data, tracking data, so that we could determine what were risk factors and what weren't risk factors based on what was present in Kid X's history, 20 years down, you know what I'm saying? And perhaps we could even entice some doctoral students, you know, at one of the PhD programs locally with their professors' assistants to take on some tasks like this, because that's how some colleagues of mine did a re-analysis of the static 99 about 15 years ago, is they got somebody at the university level to support that, and they got a doctoral student to to take it on as their doctoral dissertation. And I think it would be magnificent if we could do, if we could figure out how to do something that reaches even beyond, Joe, what you're talking about, coming to talk to us about. Because we know that our kids don't all stay in Arizona.
they leave and they go to other parts and some of them get in trouble and most of them don't, but knowing that would be helpful to, are we doing what we're

supposed to be doing or do we need to modify what we're doing?
So thank you for that.

Sure. I have one suggested agenda item also. It's more of a question probably than anything else, but maybe it's just I'm not a provider, so I don't understand it. But having been in probation as a PO for 17 years and coming here and working kind of at the administrative level with the Supreme Court.
I've never understood how someone could be in outpatient treatment for, say, nine months. And then, because most of the treatment,
From my understanding, it's fairly.
Consistent with how a kid progresses through different.
Parts of the treatment, and then eventually gets to the end, and when a kid goes from outpatient to inpatient.
a residential, it seems like they start over. They don't bring with them the treatment knowledge that they have into that program. And then, I mean, because a brand new kid coming into residential doesn't have all that knowledge of language. Right.
This is what you and I were trying to do in one of the detention centers, was to orient kids to that process so that it gets them over that initial bump of whatever it is. And I don't see that happening here. Thus, a kid stays in residential for
you know, almost the same time a kid would that doesn't have any prior health. It started there in the 1st place. Yeah. So I don't know if it's just a...

So is your question like a kid who's in outpatient then has to go up a level and go to more restrictive?
Let's say he's, whatever reason, yeah, he's now going back to court. The court says, hey, I want
to residential, he's sitting in detention.

I can say that because I came from a lockdown facility before I started mine 26 years ago, that I didn't want kids to start over. I had kids coming from the BHIF level one at the time, from the unlocked BHIF, you know, the new leaf situations, and then all of a sudden, like 10 years into my agency, I started getting kids and I'm like, oh, this is the YDI kid at my place.
So I have kids that are way more intense and kids that are like kind of stepping down from someplace. So I've always had the philosophy and kind of our motto is we start

where the kids at. That doesn't always mean that they learn something where they were. If we can't, if they can't decide or express what consent is in their first group, we're kind of already on the fence of how much that nine months was at.
outpatient or even in the IF, sometimes we're like, okay, I feel like we're not going to let him just out the door because he says he finished and got to watch and whatever it might be. We got to kind of go where the kid is. But I hope that we don't just start them all over. We don't try. Nothing worse than the kid just like, I'm already done and having to start over again. But it's very individualized. And I
take pride in our therapists doing that, but I see how other kids get stuck. We don't do a lot of the cookie cutter, this is your level, this is what you got to do, because then it would probably just like, oh, you're starting away from scratch. If you can show us you learned all that beginning level stuff in a month, you're on your way to going wherever the thing is next.

I think it's a great question, because the same
I think the question gets asked in the adult system when you guys get discharged from a treatment program and somebody else has to take them on, the same kind of stuff unfolds and is discussed. I think a piece of it, I think it's a great question and people should expect to be able to answer that question. Treatment providers like Melanie just, you know, very quickly answered the question.
I mean, I think they should have the answer to those questions. I mean, what are you going to do to assess whether or not this kid needs to start over from Jump Street, or we can take into account, you know, what does that look like? How are you doing that? How are you making those decisions?

I can tell you that's why I have an outpatient program. Fifteen years ago, before I started right of way, I had it for the substance abuse kiddos and the victims.
but I did not have it for the SMB. And my 2 therapists at the group home said, I'm so sick of hearing calls for my kid that he's having to learn everything over with the new outpatient therapist. I'd rather have him. I know where he's at. He just needs three months of adjusting to home. You know, now that he's moved home. So our.

I just don't see that in the reports necessarily. It doesn't get like verbalized or

In our reports, like a treatment provider report or in a either or.

I think they're coming in and they've had nine months of treatment, outpatient, here they are. We've taken that into consideration and this is what we're going to do. I guess that's what I'm looking for.

Maybe it's our wording. It looks like they're starting brand new, but we're really going where we're at. Yeah, I know you think that way.
But we're not putting it in our reports?
I just don't know if I see it across the board. Like Scott, you're talking about, can we get some uniformity with some of this stuff? I would think on a continuum, I think we can with risk. How does that how does that fit?

I think we can, Joe, is the answer to the question.
And I think it starts with some of this slow-moving, painful kind of trudging through things and trying to work with each other to create that structure. But I think we can.
I mean, you do it naturally.
as a program because of all your experience, but that doesn't mean you shouldn't have the same expectation of other treatment providers who may have come into the mix in more recent times.

Or maybe a treatment program who only does outpatient services.
Yeah. Yeah. I can see it as a training. Because we're taking her own kids.
No, but it is a good thing for us to spend some more time
thinking about and operationalizing and trying to put down in black and white so that it could be shared with, you know, as many people as possible. I think it does make sense.

It really comes down to assessment. You get a new kid, where's he at? And I got to be honest, we get a lot of our own kids from outpatients, especially in the East Valley that come straight to the group homes because they've had four months of spinning their wheels. They haven't come to group, the group home they're in doesn't get into our group, the outpatient group, or they're just struggling at home or they just aren't, they're not progressing and that's why we get the referral. Like he needs a group home to get structured and settle down so he can be out in nine months

instead of spinning his wheels and outpatient going out every night, you know.
So they might not look like they have much under their belt. This is what I'm trying to say is that when they come to this direction, there's usually a reason and they don't have a lot of, you know, points in the, and I've already learned this category. They're not always coming in stars.
How often does it happen where they start an outpatient and go to inpatient? Is that, is there a high percentage?
Probably half of my referrals are from my outpatient therapist that are like, I'm struggling with this kid. I don't want him going to another DCS group home. Can you guys take him to BHRF? And then it's a matter of talking to somebody, funding it and paying for it. But probation is usually on board. They can see the kid struggling. A lot of times it's just environment. We have a lot of kids that cannot either get to or are not doing well in outpatient treatment because of their home environment. They're only coming to us five hours a week, but if the rest of their week is chaos, they're not going to get very far.
Is that a result of initial assessment?
I used to complain a lot about initial assessments. I mean, way back, like Magellan days, I remember being on committees where I said they need to go wherever they need to go to begin with.
Like if a treatment, because a lot of people get denied. When we say, when my doctor used to say this kid needs a level 1 slash BHIF, and then we're getting the referral, like why would we take a kid that a doctor that said needs a higher level of care? Well, funding, money, whatever it may be. But then when he fails, and if he goes to outpatient and he fails, and we got a lot of kids that like, well, he can't get into YDI yet, can you take him outpatient? I'm like, that's not good for the kid.
or the team to see him do well for two weeks and say, see, he doesn't need outpatient or inpatient. But I'm like, they need to go. That's why we put a lot of stock right back to full circle psychosexuals telling us where they need to go to begin with. Because then you have a kid that fails outpatient, then they get to us and they struggle, struggle, and then they're in outpatient. It's not good for the kids to have three strikes. You know, it's not, it's like you just would have started at the higher level.
spun his wheels for a minute and then got better and come to us and go, I'm all about higher level and then backwards, if that's what's necessary. Now, if a kid doesn't need it, it doesn't need it. I've always complained that my BHRF and the

other ones in town are apples and oranges. My BHRF kids go to homecoming. They can play sports. They can get jobs when they're ready.
The other BHRF is in the middle of Phoenix. They're not going to Central High School and they're not getting jobs at the Circle K. It's like those two, they're just, they're not the same level. So if I get a referral for a kid that looks like he needs a higher level, I say, this is too much for us. He's not going to do well here. Go to the other BHRF. Now, I'm not sure that they always look at it and go like, oh, this kid could probably be in a high school. He should go to the other one.
But if we put them in the right place at the beginning, I've always been a really big advocate for the right place to start with. It'll eliminate.

You just said something that's really valuable in all of it, and that is don't take kids that are not ready for your level of care. We try. But a lot of times people pay for that. I mean, I can remember way back to my AYA days.
When I got there and I had this, I didn't know what I had, this group of kids in two houses. And the first thing that I did was get really, really succinct about who could we manage in our program, and then drawing a real dark line about not taking anybody that was over the line.
And it was the most effective thing that I ever did in running a residential treatment program was to get clear about what our admission criteria were and to not deviate from it when it was clear that the kid didn't meet the admission criteria.

And we used to probably say no to 75, 80% of the kids that come our way because they're not. So you're doing that.
I mean, they're not. I can have five, and I have complained about empty beds over the last couple of years, but it's not worth taking kids that are only going to, or I don't want to set kids up to fail in two months, so it's not it's not worth that.
Well, we strongly encourage assessment at the front end and I don't like any placement selling or sold to take.
People just take them, because if they're in the wrong place, we're gonna, they're not making progress, yeah, yeah, so yeah.
So, yeah, we we can talk about that some more, too, yeah.
Any other things that we need to ask for for future agenda items? And you don't have to articulate them right now. I mean, as long as they get to Jenna by the

deadline for our next meeting. But please do think about that. Makes my life easier. I know that.

I don't necessarily want to quit talking about DCS, but I'm sure other people would like me to quit talking about DCS, so I just...
Throw it out there.
I don't know if we're done, if there's not much resolution to some of it, but every month I could come with more stories of just mistreatment or misplaced kids in some of these places.
I know there's much for an agenda item, just be on the record, I guess.
Unless there's something else.
Somebody make a motion for us to adjourn for today.
So moved.
Second?
Second.
So we are adjourned. It is 2. I'm sorry. I'm not good at this protocol stuff. All those in favor of adjourning the meeting at this time? Say aye.
Aye.
Anybody opposed?
We are done.

◉ stopped transcription