PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: June 30, 2016

Auditor Information			
Auditor name: Charmene Griffin			
Address: 673 Covered Bridge Pkwy., Apt. E Prattville, AL 36066			
Email: gthree6@icloud.com			
Telephone number: 251-295-1200			
Date of facility visit: May 31-June 1, 2016			
Facility Information			
Facility name: AMIKIDS Acadiana			
Facility physical address: 611 Celestine La Tortue Rd., Branch, LA 70516			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 337-334-4838			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Issac Williams			
Number of staff assigned to the facility in the last 12 months: 37			
Designed facility capacity: 30			
Current population of facility: 30			
Facility security levels/inmate custody levels: Non-Secure/Low-Moderate risk			
Age range of the population: 12-18			
Name of PREA Compliance Manager: Charmona Henry		**Title:** Case Manager	
Email address: acadiana-cm4@amikids.org		**Telephone number:** 337-334-4838	
Agency Information			
Name of agency: AMIKIDS Acadiana Campus			
Governing authority or parent agency: *(if applicable)* AMIKids			
Physical address: 5915 Benjamin Center Dr.., Tampa, FL 33634			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 813-887-3300			
Agency Chief Executive Officer			
Name: OB Standler		**Title:** Executive Chief Officer	
Email address: Click here to enter text.		**Telephone number:** Click here to enter text.	
Agency-Wide PREA Coordinator			
Name: Wendel Watson		**Title:** Regional Director/PREA Coordinator	
Email address: wendell L. Watson III		**Telephone number:** 321-863-1497	

AUDIT FINDINGS

NARRATIVE

AMIkids Acadiana's parent agency, Association Marine Institute, AMI, was formed as a non-profit organization in 1969 and was the result of Juvenile Court judge Frank Orlando becoming frustrated at seeing the same young men come before his court time and again. As an experiment he would send some boys to work on a research vessel at the Florida Atlantic Ocean Science Institute where his friend, Mr. Bob Rosof was the director of a research program. While there the young men would be rewarded for their efforts and appropriate behavior while Mr. Rosof and his staff would serve as role models who helped the young men see a different future. As a result of this experiments success today over 100,000 young men and women have been given an alternative to incarceration through the programs of AMIkids.

AMIkids Acadiana is a long-term residential program founded in 2008 located in Branch, Louisiana. It serves an all-male population between the ages of 14-18 who have committed non-violent offenses and are involved with Louisiana's Office of Juvenile Justice. The students at AMIkids Acadiana are afforded the opportunity to work towards their high school diploma or GED or participate in a vocational program in food service. The food service program allows the student to earn Serv Safe Certifications from National Restaurant Associations and local restaurant associations. Job readiness skills training is also offered to prepare students for immediate or eventual success in obtaining employment.

AMIkids Acadiana takes a long-term approach to assist students with discovering their potential and obtain the tools to succeed and by identifying each student's individual issues and obtain the tools to succeed and by identifying each student's individual issues and presenting solutions to overcome learning disabilities or behavioral problems. Counseling staff consist of one LPC and one master's level Counselor.

DESCRIPTION OF FACILITY CHARACTERISTICS

The AMIkids Acadiana Campus is located in a remote location and consists of three adjoining dormitories, an administrative and educational building, a cafeteria and a workshop that was proudly under construction by students during the audit on-site visit. There is also an outdoor basketball court and area for volley ball games as well.

Two of the dorm house 12 students each while the remaining dorm houses 6. Each dorm was extremely neat and clean in appearance and had adequate space for sleeping and lounging areas for watching television. All of the area are well within sight and sound distance 0f supervising staff. Bathroom and showers facilities provide for constant site and sound supervision as well while simultaneously allowing each student an appropriate degree of privacy. There are both male and female direct care staff, however only male staff supervise showers. All female staff do announce themselves prior to entering any dorm.

Classrooms provide for an excellent learning opportunity for students in that classes are kept at a maximum of 6 students per class. Students seemed really engaged during the site visit and were more than happy to share information on the topic they were studying in class. All teachers are trained as first responders as well and the food services personnel.

Administrative and criminal investigations are conducted by the Louisiana Office of Juvenile Justice and the Acadia Parrish Sheriff's Office.

SUMMARY OF AUDIT FINDINGS

On May 31-June 1, 2016 the on-site audit was conducted at AMIKIDS Acadiana Residential Treatment Facility located in Branch, Louisiana. Initial contact was made with the Facility Executive Director and the Facility PREA Compliance Manager who also serves as the facility Case Manager. Also present was the Facility Director of Operations and Director of Treatment.

Immediately noticed were the postings of PREA information throughout the campus and a feeling of "all in" from the administrative staff to the direct care staff. This became more apparent as the interviews with both staff and students progressed. I found the students to be well informed about their right to be free from sexual abuse or harassment and free from retaliation from reporting such incidents. They were also very aware of the numerous ways to report. Both direct care and non-direct care staff also demonstrated a firm knowledge of the requirements of PREA in terms of preventing, detecting, and responding to allegations of sexual abuse or harassment. They were aware of not only their duty to report but were aware of the multiple ways to do so.

The Facility PREA Compliance Manager has done an outstanding job with both the student and staff training and it was evident. Training materials viewed for both staff and students were creative due to the materials being updated from various PREA information websites periodically. There were also tests created by the Compliance Manager to ensure complete understanding of the requirements of PREA. PREA training is also provided by OJJ personnel.

The fact that both federal and state background checks are conducted yearly on all staff is another testament to this facility and its parent agency of its dedication to keep the students they serve safe. This facility is also received record check reviews from other agencies that include DCFS, ACA, OJJ, DHH as well as their parent agency, AMIkids.

AMIkids Acadiana represents a facility whose main focus appears to be keeping their students safe. All students interviewed stated they felt safe on campus and that they felt like the staff really do care about them. The staff reiterated by saying the same, "the students' safety has to come first, TEAMWORK MAKES THE DREAM WORK!"

Number of standards exceeded: 6

Number of standards met: 33

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
AMIKIDS Policy 6.11/PREA Policy 115.311

Supporting Documentation
Facility Organizational Chart
Facility Designation of a PREA Compliance Manager

Interviews
Facility Executive Director
Facility PREA Compliance Manager

Conclusion
Policy mandates that there is a zero tolerance toward all forms of sexual abuse and sexual harassment. Policy further outlines the approach to preventing, detecting, and responding to such conduct and serves as the guide for directions to the facility to ensure PREA compliance.

The agency has a designated PREA Coordinator who oversees the agency's efforts to comply with the PREA standards. Periodic reviews of the facility's PREA files are conducted. The facility Case Manager is the designated PREA Compliance Manager.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. AMIkids Acadiana is a private facility that does not contract with other agencies or entities for the confinement of its students.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy Number 6.13, 6.13A, and 6.13B

Supporting Documentation
Staffing Plan Development Process
Viewing Mirrors placed in strategic locations in all dorms, including showers
Unannounced Rounds completed on every shift

Interviews
Facility Executive Director
Facility Director of Operations
Facility PREA Compliance Manager
Intermediate or Higher-Level Facility Staff

Conclusion:
The facility utilizes a staffing plan process that considers all factors in PREA standard 115.113. This process also includes consideration of whether adjustments are needed to the staffing plan, which is 1:6 during wake hours and 1:12 during sleeping hours, prevailing staffing plans, deployment of monitoring technology, and allocation of agency/facility resources to commit to the staffing plan to ensure compliance with the staffing plan. There have been no deviations from the facility staffing plan. Any deviations will be documented per written policy.

Unannounced rounds are conducted at the facility on each shift. Documentation provided during site visit.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy

Policy number 6.15

Supporting Documentation:
Training Curricula-Guidance in Cross-Gender and Transgender Pat Searches-The Moss Group, Inc.
Training Logs viewed during site visit

Interviews:
Random Sample of Staff
Random Sample of Residents
Transgendered and Intersex Residents –None
Facility Executive Director

Conclusion:
It is facility policy that no cross-gender pat-down searches are permitted. Only male staff conduct pat-down searches, as confirmed by through student and staff interviews, although all staff are trained on this topic by an OJJ Probation and Parole Program Specialist. This training also includes the topic of cross gender viewing. Strip searches and body cavity searches are not permitted except when performed my medical practitioner in exigent circumstances. There are no physical exams performed for the purpose of determining a resident's genital status, per facility policy 6.15. This facility has no medical staff on-site.

Policy 6.15 allows for residents to shower, perform bodily functions, and change clothing without non-medical opposite gender staff viewing and this policy requires all opposite gender staff to announce themselves when entering resident housing or where residents are likely to be showering, performing bodily functions, or changing clothing. Signs are posted as a reminder that female staff should announce their presence as the enter housing units. This was confirmed by staff and student interviews.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.16

Supporting Documentation
Student Curricula

Interviews
Facility PREA Compliance Manager
Disabled and Limited English Proficient Residents –None

Conclusion:
Facility has procedures to provide disabled students and students with limited English proficiency equal opportunity to participate and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Procedures also prohibit the use of student interpreters, readers, or other types of student assistance except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the students' safety, first-responder duties, or the investigation of the student's allegations.
The facility has taken reasonable steps to ensure meaningful access to the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to students who are limited English proficient by attempting to establish MOU's with interpreter services and

deaf/blind services. (Some PREA information is currently available in Spanish)

Standard 115.317 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policies
Policy 6.17 and 6.17A

Supporting Documentation
Federal Background Checks, including finger printing -Yearly
State Background Checks-Yearly
Child Abuse and Neglect Registry Checks

Interview
Administrative Staff (Human Resources)

Conclusion:
The facility policy prohibits hiring or promoting anyone who may have contact with students, and prohibits enlisting the services of any contractor who may have contact with students who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution, has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, or coercion, or if the victim did not consent or refuse or, has been civilly or administratively adjudicated to have engaged in the described activity. The facility also will consider any incidents of sexual harassment in determining whether to hire or promote anyone or, to enlist the services of any contractor, who may have contact with students.

Material omissions regarding such misconduct, or the provision of materially false information shall be grounds for termination. Unless prohibited by law or Louisiana OJJ (Office of Juvenile Justice), the facility shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom an employee has applied to work.

It is the facility's policy that State and Federal Background Checks as well as Child Abuse and Neglect Registry Checks be performed on all staff members. (There are currently no contractors being utilized at this time who have contact with the students). The State and Federal Background Checks are conducted yearly and this does include fingerprinting. Motor Vehicle Registry Checks are conducted every six months on all employees as well. These records are audited by the Department of Children and Family Services (DCFS). Furthermore, no staff member is permitted to drive onto the facility grounds without a valid driver's license.

These checks were confirmed by viewing staff personnel files during the site visit. A copy of the form required to be completed by each individual owner, operator, current or prospective employee or volunteer of a child care facility was given to the auditor during the site visit. The auditor is satisfied that the facility exceeds this standard.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.18

Supporting Documentation
Mirrors placed in strategic locations
Key control
Use of radios by staff, teachers, and food services staff

Interviews
Facility Executive Director
Random Staff
Educational Staff
Food Services Personnel
Random Administrative Staff

Conclusion:
There have been no substantial expansions or modifications to the facility since August 20, 2012 nor has the facility installed any video monitoring system, electronic surveillance system, or other monitoring technology. When considering planning any substantial expansion or modification of the facility and agency consider the effect of the design, acquisition, expansion, or modification upon facility's ability to protect students from sexual abuse. The facility's ability to protect students from abuse is also considered when installing or updating video monitoring systems, electric surveillance systems, or other technology.

This was confirmed by the facility Executive Director during the onsite visit. It has not been financially possible for the facility to begin these type of upgrades but they considered. Mirrors were placed in areas to enhance monitoring of students in the dorms and shower areas and staff positioning in the dorms and schools maximize observation capabilities. Each staff and teacher, as well as food services staff, carry radios to enhance security measures on the campus. All three dorms are interconnected by one door that remains locked and can be opened by staff members should any dorm need assistance in any way. The auditor noted during the tour of the facility more than adequate key control by staff.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:

Policy
Policy 6.21, Attachment 6.22A

Supporting Documentation
Hearts of Hope Memorandum of Understanding
Acadia Parrish Sheriff's Department Memorandum of Understanding

Interviews
PREA Compliance Manager
Random Sample of Staff
Residents who Reported a Sexual Abuse -None

Conclusion:
The facility does not conduct administrative or criminal investigations. Per policy in there is an allegation of sexual abuse the Acadia Parrish Sheriff's Office (APSO), the Department of Children and Family Services (DCFS), the Office of Community Services (OCS) and the Office of Juvenile Justice (OJJ) will be contacted immediately.
There have been no incidents of allegations of sexual abuse during the audit period.

A Memorandum of Understanding exists between the facility and Hearts of Hope Sexual Abuse Response Center. This agency provides counseling, education, and advocacy to sexual assault victims and has an established 24-hour crisis hotline. The agency also has Sexual Assault Nurse Examiners who can provide examinations and follow-up care at no cost to the victim.

Standard 115.322 Policies to ensure referrals of allegations for investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policies
Policy 6.21 Attachment 6.22A
OJJ Youth Services Policy Number C.4.6

Supporting Documentation
Louisiana Office of Juvenile Justice Website FAQ

Interviews
Agency Executive Director
PREA Compliance Manager

Conclusion:
The policies address this standard and identifies the responsibilities of the agency and the facility. All related policies are posted on the OJJ website. There have been no allegations of sexual abuse or sexual harassment during the audit period.

Standard 115.331 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.31

Supporting Documentation
Staff Training Curriculum
Staff Training Records

Interviews
Random Sample of Staff
PREA Compliance Manager

Conclusion:
The facility training covers all topics referenced in standard 115.331 and additional PREA training is also provided by OJJ personnel. The facility Compliance Manager ensures that all staff who have contact with the students receives this training through weekly training sessions for all new employees and quarterly PREA training for all current staff as refresher training. Current staff include all educational staff and food services staff. The curriculum includes PREA tests created by the PREA Compliance Manager to ensure that the material is clearly understood by all staff. Training is tailored to the needs and attributes of the facility's students. It is an all- male facility and there is a policy in place requiring opposite gender announcing themselves prior to entering the student dorms. Training on cross gender pat-down searches is conducted and attended by all staff however facility policy prohibits opposite gender pat-down searches. Auditor is satisfied that these practices exceed the standard.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 332

Supporting Documentation
Facility Zero Tolerance Policy Statement

Interview
Facility PREA Compliance Manager
Volunteer(s) or Contractor (s) who have contact with students- None

Conclusion:
The facility has not had any volunteers or contractors who have contact with the students during the past twelve months nor were there any being utilized during the audit visit. Should the facility utilize any volunteers or contractors they are required to receive training on the agency/facility policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response.

Standard 115.333 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policies
Policy 333

Supporting Documentation
Student Handbook(Includes Youth Safety Guide from OJJ)
Random Sample of Student Files
Viewing of Posted PREA Materials

Interviews
Intake Staff
Random Sample of Students

Conclusion:
Interviews with students and intake staff confirm that PREA information is provided on day of intake and that comprehensive age-appropriate education to students is provided within ten days of intake. This was also confirmed through a review of a random sample of student files. There is PREA material available in Spanish as well. The training curriculum for the students is continuously updated due to the Facility PREA Compliance Manager/Case Manager continuously updating the material from PREA and other website resources. Students also receive PREA refresher training on a quarterly basis and some PREA training is also provided by staff from the facility's corporate office. There is also a wealth of PREA information posted throughout the campus in all student dorms, the administrative building and the educational building. Auditor is satisfied that these practices exceed the standard.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.54 and 334

Supporting Documentation
Louisiana Office of Juvenile Justice(OJJ) Statement on Website, "LA Coordinated System of Care
Emergency.Louisiana.gov
Department of Children and Family Services(DCFS) LAR 67: v.1103

Interview
Facility Director
Facility PREA Compliance Manager

Conclusion:
OJJ is responsible for both administrative and criminal investigations. The facility is responsible for reporting any allegations of sexual abuse or sexual harassment to Acadia Parrish Sheriff's Office(APSO), DCFS, and the Office of Community Services(OCS). The facility has contacted the APSO in an attempt to enter into a Memorandum of Understanding. This cannot be signed until after the current election but APSO will be contacted if there is an allegation of sexual abuse or harassment at the facility per there established coordinated response efforts.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:

Supporting Documentation
List of Counselors Qualifications/ Training Records
Mou's with Medical and Mental Health Care Providers

Interviews
Director of Treatment
Facility Case Manager

Conclusion:

There are no medical or mental health practitioners on-site. The facility does have licensed counselors on-site who receive training from the facility's PREA Coordinator and Director of Case Management from their corporate office. This training includes the topic of detecting child abuse recognition, reporting and preventing. The facility also has MOU's in place with their local medical and mental health care providers that make them aware of the facility's obligations to comply with PREA standards.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.41

Supporting Documentation
Screening Form for Risk of Sexual Victimization and Abusiveness
Random Sample of Student Files-Student Receipt of PREA Forms

Interviews
Staff Responsible for Risk Screening
Random Samples of Residents

Conclusion:
The facility policy requires that an objective screening instrument be used to ascertain the information required by the PREA standard. It was confirmed during on-site visit that this screening takes place within 72 hours of the student's arrival at that the assessment instrument is an objective screening instrument. A random sample of student interviews also confirmed that they are ask questions, usually upon the day of their arrival, that they are askedquestions, usually upon the day of their arrival, that they are asked questions related to all 11 items prescribed in PREA standard 115.341.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The following was considered in determining compliance with the standard:

Policy
Policy 6.42

Supporting Documentation
Copy of Screening Form Used
Samples of Completed Forms from Random Sample of Student Files

Interviews
Facility Director
PREA Compliance Manager
Staff Responsible for Risk Screening
Director of Treatment
Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) –None
Residents in Isolation -None
LGBTI Residents –None
Student One-On-One Log Viewed

Conclusion:
This standard is addressed in policy 6.42. The information gathered from the screening form is used to help determine housing placement of all students. Policy prohibits students being house on identification status nor will they consider this status as an indicator of the student being sexually abusive. The assigning agency does consider whether to assign a transgender or intersex students to a facility for male or female students, whether a placement would ensure the student's health and safety, and whether the placement would present management or security problems.

This facility does not use isolation at any time. If and when there is a need for a student to be isolated this facility assigns one staff member to that student as one-on-one. If extra staff are needed they will be called in to assist if any additional coverage is needed. This student will remain on one-on-one until the situation is determined to be safe by the administrative review team. This student will not be denied daily large-muscle exercise and any legally required educational programming or special education services as well as, continue to have access to other programs and work opportunities to the extent possible.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policies
Policy 6.51, Proc. #1, A-D
Policy 6.51, Proc. #4
Policy 6.51, Proc. #5, A-C and, #6

Supporting Documentation
Visual Inspection of PREA Materials Posted on Campus
Student Grievance Form

Interviews
PREA Compliance Manager

Random Sample of Staff
Random Sample of Residents
Residents who reported a Sexual Abuse –None

Conclusion:

Policy 6.51 addresses all ways, internally or to a public or private entity, that students can report sexual abuse or harassment, retaliation by other students or staff for reporting such incidents, and staff neglect or violation of responsibilities that may have contributed to such incidents. Students may submit a grievance form. There is no time limit in which the student must submit a grievance form. The student may also talk with any staff member, educational or food services staff, or facility counselors.

The students also have multiple ways to report to a public or private entity. Both the OJJ and Hearts of Hope have hotline numbers that students may use. These numbers are posted in all dorms. Students may also report to outside medical and mental health staff. (The facility has MOU's their medical and mental health service providers.) Students may also report incidents of sexual abuse or harassment to their probation officers during their visits and to their parents. This facility is also monitored by their parent agency as well as ACA, DHH, and by Louisiana PREA personnel who may also accept reports from the students.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:

Policies

Policy 6.54/ 334

Supporting Documentation

Grievance Form Reviewed

Interviews

Facility Executive Director
Facility PREA Compliance Manager
Random Staff Interviews
Random Student Interviews
Residents who reported a sexual abuse -None

Conclusions:

The facility considers any report or grievance of this nature as a potentially criminal offense and is required by policy to immediately notify the local sheriff's office and OJJ when a report or grievance is received. OJJ will then perform an administrative investigation. Random interviews of staff and student verify their knowledge of this procedure and staff are empowered to begin the process themselves if they feel there is an imminent threat to a students' safety.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policies
Policy 6.51, Proc. 2, A-B, Proc. 3
Policy 6.53, Proc. 3-5

Supporting Documentation
MOU with Hearts of Hope
Notification from Sheriff's Office
Visual Observation of Posted Materials

Interviews
Facility Executive Director
Facility Compliance Manager
Facility Director of Operations
Random Sample of Residents
Residents who Reported a Sexual Abuse –None

Conclusion:
The facility has an MOU with a local rape crisis center that makes available a toll free number for reporting as well as the OJJ. An MOU with the local sheriff's office expects to be formalized after the current election. MOU's are also in place with local medical and mental health service providers as another way for students to report allegations of sexual abuse or harassment. Students were able to confirm these ways of reporting. Student also has access to their probation officers during the probation officers' regular visits to the facility as a way of reporting as well.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.54

Supporting Documentation
Visual Observation

Conclusion:
Third party reporting forms and pamphlets are available at the facility's check in desk and visitor's area. This information is also available

on the facility's parent agency, AMI, website and third party reporting forms have been distributed to the facility medical and mental health services providers.

Standard 115.361 Staff and agency reporting duties

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policies
Policy 6.54
Policy 361, Proc. 1-5

Supporting Documentation
Facility Written PREA Incident Response Reporting Plan

Interviews
Facility Executive Director
Facility Compliance Manager
Facility Director of Treatment
Random Sample of Staff

Conclusion:
Both facility policies address this standard and the requirement that all staff report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or harassment that occurred in the facility. There is also a facility coordinated response plan that is comprehensive in its explanation of each staff member's responsibility concerning this plan. Staff are also required by policy to report any retaliation against a student or staff who reported any such incident, as well as, staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical and mental health service providers of the facility are required to follow mandatory reporting laws including informing the students of their duty to report at the initiation of services. The facility has memorandums of understanding in place with these service providers. The facility Executive Director or his designee shall promptly report the allegation to the appropriate agency office, student's legal guardian, unless prohibited from doing so by official documentation, or the student's caseworker or the student's attorney or other legal representative within 14 days of receiving allegation. The facility utilizes investigators provided by the OJJ. Staff interviews confirmed their thorough knowledge of this policy and the auditor is satisfied that the facility exceeds this standard.

Standard 115.362 Agency protection duties

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.62

Supporting Documentation
Facility Written PREA Incident Response Reporting

Interviews
Facility Executive Director
Facility Director of Operations
Facility Director of Treatment
Facility PREA Compliance Manager
Random Sample of Staff
Conclusion:
There were no incidents in which the facility learned that a student was subject to a substantial risk of imminent sexual abuse during the past 12 months. The staff are trained and empowered to take immediate action should they learn of any student's risk of imminent harm of any nature by providing one-on-one "continuous site supervision" until it is determined by the incident review team there is no longer a threat to the student. This was confirmed by onsite interviews by administrative staff and direct and non-direct care staff. The auditor is satisfied that the facility exceeds this standard.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.63, Proc. 1-4

Interviews
Facility Executive Director
Facility PREA Compliance Manager

Conclusion:
The facility policy covers and addresses the contacts to be made and the process to report an allegation that a student was sexually abused while confined at another facility. Policy requires that this notification be made no later than 72 hours after receiving the allegation and that

this notification is documented. There have been no allegations that a student was abused while confined at another facility during the past 12 months and no allegations of sexual abuse that the facility has received from other facilities in the past 12 months.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.64

Supporting Documentation:
Staff Training Logs

Interviews
Random Sample of Direct Care Staff
Random Sample of Non-Direct Care Staff
Residents who Reported a Sexual Abuse –None

Conclusion:
The facility procedures address all stated actions in the standard. It was confirmed during onsite interviews that all staff, direct and non-direct care staff receive first responder training and were well versed in what their responsibilities were. Staff training logs were viewed during on-site visit as well. There have been no allegations that a student was sexually abused during the past 12 months.

Standard 115.365 Coordinated response

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policies
Policy 6.22
PREA 365

Supporting Documentation
Facility Written PREA Incident Response Reporting Plan
Random Staff Interviews

Interview
Facility Executive Director
Facility Director of Operations
Facility Director of Treatment
Facility PREA Compliance Manager
Random Staff Interviews

Conclusion:
The facility written coordinated plan is very thorough and specifically outlines the facility's actions of first responders and administrative staff. This includes notifications, contact with local authorities, and victim advocate agency providing SANE/SAFE staff and follow up services.

On-site interviews confirmed that both direct care and non-direct care staff are extremely knowledgeable of their responsibilities concerning the facility coordinated response. Each person interviewed was able to state comfortably and confidently the steps that would be taken in responding to an incident of sexual abuse. These steps included when to notify local authorities, facility administrative staff, OJJ, Hearts of Hope, local medical and mental health service providers. Each person was also aware of all memorandums of understandings that exist between the facility and these service providers. Furthermore, each person's first response to insure the safety of the possible victim by "never leaving that students side" until help was provided. The auditor is satisfied that the facility exceeds this standard.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:

Interview
Facility Executive Director
Facility Compliance Manager

Conclusion:
This standard is not applicable. The facility does not maintain any collective bargaining agreements.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.67: Proc. 2-6; Attach. A

Interviews
Facility Executive Director
Designated Staff Members Charged with Monitoring for Retaliation
Residents who Reported Sexual Abuse –None

Conclusion:
The facility policy addresses the facility's efforts to protect students and staff who report sexual abuse or sexual harassment or cooperates with sexual abuse or harassment investigations from retaliation by other students or staff. The facility's Director of Operation and the facility's PREA Compliance serve as the designated staff members to monitor for retaliation. The monitoring continues 30, 60, and 90 days after the report and will continue to monitor after 90 days if initial monitoring indicates a continuing need.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.42

Supporting Documentation
AMIkids does not use segregated housing or isolation to protect residents who are alleged to have suffered sexual abuse.
Interviews
Facility Executive Director
Facility Director of Operations
Facility PREA Compliance Manager
Facility Director of Treatment

Conclusion:
On-site interviews confirmed that no student who alleges to have suffered sexual abuse will not be placed in isolation or segregated housing. Dormitory changes may be made for the safety, security and well-being of an alleged victim. An alleged victim will not be housed in the same area as the alleged perpetrator. A student who is alleged to have suffered sexual abuse will be placed on one-on-one supervision with a staff member until circumstances no longer pose a threat to the student's safety and well-being. The student will not be denied daily access to large muscle exercise, or legally required education or special education services.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.21, Attachment 6.22

Supporting Documentation
Department of Children and Family Services(DCFS)- LAC 67: V,1103
Letter from Acadia Parrish Sheriff's Office (APSO)

Interviews
Facility Executive Director
Facility PREA Compliance Manager
Facility Director of Operations
Residents who reported a Sexual a Sexual Abuse –None
Conclusion
This facility does not conduct criminal or administrative investigations. Policy requires that when an allegation of sexual abuse or sexual harassment is made the Acadia Parrish Sheriff's Office (APSO), DCFS, the Office of Community Services (OCS), and the Louisiana Office of Juvenile Justice (OJJ) be notified. OJJ will work in conjunction with APSO during the investigation and conduct the administrative investigation utilizing OJJ trained investigators. Interviews confirm that the facility will cooperate with outside investigators and endeavor to remain informed about the progress of the investigation.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy

Policy 6.72

Interview
Facility Executive Director
Facility PREA Compliance Manager

Conclusion:
The AMIkids shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. The interview with the facility Executive Director and PREA Compliance Manager confirmed this policy.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.73, Attach. 6.73A

Supporting Documentation

Facility Resident PREA Allegation Status Notification Form
Investigative Services Form A.1.4(d)

Interviews
Facility Executive Director
Facility PREA Compliance Manager
Residents who Reported a Sexual Abuse –None

Conclusion:
Following an investigation, the facility or the Louisiana OJJ informs students as to whether an allegation has been determined to be substantiated, unsubstantiated or unfounded. Interviews with the Facility Director and Facility PREA Compliance Manager confirmed this process. During the past 12 months there were no notifications to students made pursuant to this standard.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.76

Interviews
Facility Executive Director

Conclusion:
Staff are subject to disciplinary sanctions up to termination and criminal prosecution for violating AMIkids Agency policy addressing sexual abuse and sexual harassment. Termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. All criminal violations of the sexual abuse and sexual harassment policies would be reported to the appropriate law enforcement agency and to any relevant licensing bodies. In the past 12 months there have been no staff member from the facility reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.77

Interview
Facility Executive Director
Facility PREA Compliance Manager

Conclusion:
Interviews with the Facility Director and the Facility PREA Compliance Manager confirmed that any volunteer or contractor who engages in sexual abuse would be prohibited further contact with the residents. All criminal violations of the sexual abuse of residents will be reported to the appropriate law enforcement agency and to any relevant licensing bodies. There have been no incidents of contractors or volunteers having to be reported to law enforcement for engaging in sexual abuse of students during the past 12 months.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.78

Interviews
Facility Director

Conclusion:
The facility policy addresses all aspects of this standard. Students are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the student engaged in student-on student sexual abuse. The facility does not utilize isolation as a disciplinary sanction but one-on-one supervision by an assigned staff member. Facility does allow the process to consider the whether the student's mental health status contributed to the behavior when determining what type of sanction should be imposed. The facility will offer counseling or other interventions designed to address and correct underlying reasons or motivations for abuse. A facility may discipline a student for sexual contact with a staff member only upon finding the staff member did not consent to such contact. A report made in good faith will not constitute false reporting if an investigation does not establish sufficient evidence to substantiate an allegation. The facility prohibits sexual activity between students.

Standard 115.381 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.81

Supporting Documentation
Facility Risk Assessment Form
Memorandum of Understanding with Hearts of Hope

Interviews
Staff Responsible for Risk Screening
Facility Director of Treatment
Residents who Disclose Sexual Victimization at Risk Screening-None

Conclusion:
If the screening indicates a student has previously perpetrated sexual abuse or discloses prior sexual victimization the student will be offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Unless the student is under the age

of 18 medical and mental health practitioners obtain informed consent from students before reporting information about prior sexual victimization that did not occur in an institutional setting. In the past 12 months there have been no students who disclosed previously perpetrating or prior victimization of sexual abuse.

Interviews with the Staff Responsible for Risk Screening and the Facility Director of Treatment confirmed that information obtained during the intake screening is strictly limited and only used in informing security and management decisions about treatment plans, housing, bed, work, education, and programming assignments, or as otherwise required by Federal, State, or local law.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.65, Attach. 6.22A

Supporting Documentation
Memorandum of Understanding with Hearts of Hope

Interviews
Facility Director of Treatment
Facility Director of Operations
Facility PREA Compliance Manager
Hearts of Hope Director of Education
Random Staff Interviews
Residents who Reported a Sexual Abuse –None

Conclusion:
Facility policy clearly states procedures established to ensure that any student who is a victim of sexual abuse shall receive timely and unimpeded access to emergency medical treatment and crisis intervention services at no financial cost to the student. Services will also include timely access to emergency information and services concerning sexually transmitted infection prophylaxis.

Interviews with the Director of Education at Hearts of Hope confirmed that all **services** provided to students **a**re free. Interviews also confirmed that facility staff are well aware of their duties as first responders and are confident in their ability to take steps to protect the victim.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.83

Supporting Documentation
Memorandum with Hearts of Hope
Hearts of Hope website: www.theheartsofhope.org

Interviews
Facility Director of Treatment
Facility PREA Compliance Manager
Residents who Reported a Sexual Abuse -None

Conclusion:
The policy provides for the facility to offer medical and mental health evaluations and treatment to all students who have been victimized by sexual abuse in prison, jail, lockup or a juvenile facility. These services provided shall be consistent with the community level of care. Treatment shall be free of charge and the facility shall attempt to conduct a mental health evaluation of all none student-on-student abuser within 60 days of learning of such abuse history. Treatment shall include referrals for continued care following a student's transfer to, or placement in, other facilities, or release from custody.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.86

Supporting Documentation
Incident Review Form

Interviews
Facility Director
Facility PREA Compliance Manager

Conclusion:
In the past 12 months there have been no criminal or administrative investigations of alleged sexual abuse completed at the facility. The facility does have designated personnel that make up the Facility Incident Review Team. According to policy, incident reviews are conducted within 30 days of the conclusion of a criminal or administrative investigation. The review team considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; whether the incident was

motivated by race, ethnicity, gender identity, lesbian, gay, bisexual, transgender or intersex status or perceived status or gang affiliation; examine the area where the incident occurred to assess whether physical barriers enabled abuse; assess adequacy of staffing levels; assess the need for monitoring technology; and prepare a report of its findings and ant recommendations to the facility parent agency.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 3.87

Supporting Documentation
2015 Survey of Sexual Victimization, State Juvenile Systems Summary Form

Conclusion:
The Agency completes a PREA Report and the Survey of Sexual Victimization, State Juvenile Systems Summary Form annually, as required the U.S. Department of Justice.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.88

Supporting Documentation
AMIkids Acadiana Website

Conclusion:
The facility addresses this standard through agency annual reports made available on the agency's website. The agency reviews data

collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following was considered in determining compliance with the standard:
Policy
Policy 6.89

Supporting Documentation
AMIkids Acadiana Website

Conclusion:
AMIkids securely retains sexual abuse data for 10 years after the date of initial collection. The Agency PREA Coordinator submits an Annual PREA Report for publication on the Agency's website. All personal identifiers are redacted.

AUDITOR CERTIFICATION
I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☐ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☐ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Charmene D. Griffin June 30, 2016

Auditor Signature Date