STATE OF NEW MEXICO
COUNTY OF SANTA FE
FIRST JUDICIAL DISTRICT

No. D101CV2007102921

The AMERICAN CIVIL LIBERTIES UNION OF NEW MEXICO,

Plaintiff,

v.

THE NEW MEXICO CHILDREN, YOUTH AND FAMILIES DEPARTMENT, DORIAN DODSON, Secretary, New Mexico Children, Youth and Families Department, and ROGER GILLESPIE, Director, Juvenile Justice Services, New Mexico Children, Youth and Families Department,

Defendants.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

1. This action is brought by the American Civil Liberties Union of New Mexico (hereinafter, "ACLU-NM") on behalf of all New Mexico youth who have been adjudicated as delinquent, challenging the failure of the named New Mexico officials and the New Mexico Children, Youth and Families Department ("CYFD") to protect the health, mental health and safety of these youth.

2. Some youth, especially those with mental and/or developmental disabilities, are inappropriately placed in CYFD's delinquency facilities because they have been unlawfully denied needed residential treatment in treatment foster homes, residential treatment centers or psychiatric hospitals, yet the CYFD facilities have little or no ability to meet their

identified residential and treatment needs. Many of these young people need behavioral health and related services which, if provided to them in a timely way in community settings, would have enabled them to avoid incarceration. But Defendants have unlawfully failed to provide them these essential community-based services, causing them to suffer great harm, as well as unnecessary, inappropriate and illegal incarceration in Defendants' facilities.

3. The youth who are housed in state run or contract facilities are routinely and unlawfully denied adequate mental health, medical and educational services by Defendants, thereby causing them to suffer great harm and excessive periods of incarceration, and making it very difficult for them to achieve satisfactory rehabilitation. These youth are also routinely and unlawfully placed by Defendants in unsafe conditions causing them to suffer physical and emotional injury and making it very difficult for them to achieve satisfactory rehabilitation. While in the facilities run by or under contract with CYFD, these youth are frequently abused and/or neglected. Denied essential services, their mental and/or developmental conditions predictably have deteriorated, and crises have developed in their lives. Consequently, their behavioral problems have become aggravated and their ability to function has regressed. This is exacerbated by physical harm these youth suffer while in these facilities. As a result of Defendants' illegal and indifferent conduct, over time the prospects for these youth becoming healthy and productive adults become more and more difficult and remote.

4. Finally, these youth are routinely and unlawfully denied parole and made to suffer extra periods of incarceration because Defendants have failed to arrange for the community-based services necessary for them to engage in their rehabilitation and remain out of trouble after they have served their periods of incarceration. They remain

unnecessarily and inappropriately confined in CYFD's detention facilities because of the illegal lack of appropriate placements and services in their communities.

5. On February 15, 2006, the ACLU-NM, on behalf of these New Mexico delinquent youth, entered into a comprehensive and binding contract or Agreement with CYFD (hereinafter, "the Agreement") to remedy these many program deficiencies and rights violations. The Agreement is attached as Exhibit 1 to this Complaint.

6. After more than 20 months, Defendants still have not implemented many important requirements of the Agreement. Defendants' non-compliance has caused these youth to continue to suffer substantial harm and deterioration. This case challenges Defendants' conduct as substantially violating the Agreement. In this case the ACLU-NM seeks to specifically enforce the terms of the Agreement and to obtain injunctive relief mandating Defendants to remedy their violations of the Agreement and to provide programs, health care and safe living conditions guaranteed by the terms of the Agreement and sufficient to assist these youth to become productive members of society.

JURISDICTION AND PARTIES

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

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

9. Plaintiff ACLU-NM is a non-profit, membership organization with members located throughout New Mexico. It represented itself and all New Mexico youth adjudicated delinquent in negotiating and signing the February 15, 2006 Agreement with Defendant CYFD.

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

11. Defendant Roger Gillespie is the Director of Juvenile Justice for the New Mexico Children, Youth and Families Department. As such, Defendant Gillespie is responsible for New Mexico's care and treatment of youth who are adjudicated delinquent, and he is responsible for implementation of and non-compliance with the Agreement.

12. The New Mexico Children, Youth and Families Department is the executive agency of the State of New Mexico responsible for the care and treatment of New Mexico's youth who are adjudicated delinquent. It is the executive agency responsible for the implementation of and non-compliance with the Agreement.

FACTUAL ALLEGATIONS

A. Background History

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

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

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

b. Mental health services were grossly inadequate. Mental health staff lacked sufficient training and experience to operate independently and lacked adequate clinical skill and supervision. A false dichotomy between "mental health" issues and "behavioral" issues prevented many residents with treatable mental disorders from receiving necessary treatment. Sufficient psychiatry time was not being provided. Residents with serious mental health needs were denied access to residential treatment in outside facilities and denied adequate services in the delinquency facilities.

c. Medical care was inadequate. Nursing staffing was inadequate and care was not available. Residents, including those with painful conditions were not being timely or adequately assessed or diagnosed, and follow-up care ordered by physicians was not being adequately provided. Medications were not adequately controlled, but inappropriately were dispensed by security staff and kept in housing units.

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

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

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

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

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

i. The lack of intensive community-based mental health services for girls was a serious problem and new services were desperately needed. The lack of alternatives to incarceration and of a basic continuum of services was particularly problematic for girls. The delinquency facilities serving girls were crowded and conditions such as medical and mental health staffing, disciplinary problems, staff reaction, etc. were growing worse.

j. Classification decisions were irrational and residents were unable to obtain parole, even when continued incarceration served no legitimate purpose. Some youth were denied parole because CYFD had failed to provide them with the treatment and services which were established at Intake as prerequisites to parole. Others were denied parole because CYFD did not provide the parole board with up-to-date mental health evaluations.

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

16. During the first half of 2005, on behalf of these youth, the ACLU-NM prepared a class action lawsuit to address what it perceived as the most pressing systemic safety, programmatic and procedural deficiencies. In August 2005, at Defendant CYFD's request, settlement negotiations were undertaken before the case was filed. On February 15, 2006, Plaintiff ACLU-NM entered into the Agreement, attached hereto as Exhibit 1, on behalf of all New Mexico youth who are adjudicated delinquent. The Agreement itself explains the reasons for the Agreement:

> Whereas the ACLU of New Mexico (hereinafter, "ACLU-NM"), in conjunction with its cooperating attorneys and the Youth Law Center of San Francisco, has prepared for filing a class action lawsuit to address what it perceives as the most pressing systemic safety, programmatic and procedural deficiencies in New Mexico's treatment of youth who are adjudicated juvenile delinquent,
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> Whereas the parties have met numerous times, have reached an agreement on the steps CYFD will take to address the issues that are the subject of the ACLU-NM's

proposed lawsuit, and desire to work together sharing expertise about solutions to problems in the future; and

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

17. The Agreement also expressly provides in paragraph 2 that the ACLU-NM is the proper party to bring any action to enforce the Agreement:

> This Agreement is a fully enforceable contract, the terms of which may be enforced like any other contract through an action by the ACLU-NM for damages, specific performance and/or declaratory and injunctive relief. ... The right of the ACLU to sue for damages under this Agreement shall be limited to attorneys' fees and costs as set forth hereinafter. The parties expressly agree there may be no punitive damages for violation of this contract.

18. This Agreement, in its Appendix A, provided for concrete, comprehensive remedial steps that Defendants would implement in order to promptly remedy the many programmatic, safety and procedural deficiencies described above in this Complaint. Appendix A of the Agreement is attached as Exhibit 2. Appendix A of the Agreement is entitled "Plan of Action Concerning Services and Procedures for New Mexico Youth Adjudicated Juvenile Delinquent" and the subjects covered by Appendix A are:

I. The Timely Transition of the New Mexico Boys' School Facility at Springer to Another Use If the New Mexico Legislature Approves of the Transfer of the Facility to the Department of Corrections

II. Actions to Ensure That Youth Are Safe in CYFD Facilities

III. Actions to Ensure Appropriate Behavioral Health Services Are Provided in the Least Restrictive Settings in CYFD Facilities

IV. Actions to Develop Adequate Community-Based Behavioral Health Services to Serve Youth on Probation or Parole in Appropriate Community Settings

V. Actions to Provide Appropriate Health Care Services in Facilities

VI. Actions to Provide Female Youth Comparable Access to Services and Programs as Provided for Male Youth

VII. Classification and Placement Procedures to Place Youth in the Most Appropriate Setting in CYFD Facilities

VIII. Safeguards Concerning Parole Revocation Proceedings

IX. Implementation of an Effective System for Investigating Grievances and Serious Incidents

X. Actions Limiting Monitoring and Censoring of Communications Between Youth in CYFD Facilities and Others

XI. Establishment of an Office of Quality Assurance That Reports to the Central Office

XII. Establishment of a System for On-going Communication and Information Sharing Between the ACLU's Team and CYFD and Youth in Custody

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

> If at any time during the term of this Agreement the ACLU-NM believes that CYFD is not in substantial compliance with the Agreement, as defined in Section 13 herein, it shall give notice to CYFD and the parties shall meet in good faith to try and resolve the issue. If after a period of 30 days the parties are unable to resolve the issue, they shall engage Paul Bardacke as a mediator to attempt to assist in such resolution. If after 30 days there is no resolution, the ACLU-NM may bring suit to enforce those Sections of the Agreement with which it believes CYFD is not in compliance and/or to seek a remedy under other laws if CYFD is not implementing any term of this Agreement in a timely and appropriate manner.

20. In early 2007, Plaintiff ACLU-NM informed Defendants that CYFD was not in substantial compliance with the Agreement. The parties unsuccessfully attempted to negotiate to resolve Plaintiff's concerns and, pursuant to Paragraph 8 of the Agreement, in February 2007 engaged Paul Bardacke as a mediator to attempt to assist in resolving Plaintiff's concerns. After several months of discussions, on August 17, 2007, Plaintiff informed Defendants and the mediator that they had reached an impasse and were unable to reach a resolution. As provided in paragraph 8 of the Agreement, Plaintiff ACLU-NM brings this lawsuit "to enforce those Sections of the Agreement with which it believes CYFD

is not in compliance" and those terms it is not implementing "in a timely and appropriate manner."

B. Specific Violations of the Agreement, Appendix A

Substantial Violations of Section II of Appendix A which Requires Actions to Ensure That Youth Are Safe in CYFD Facilities

21. Youth continue to be unsafe in the facilities operated by or under contract with Defendant CYFD; many are not being protected from harm and unreasonable threats to safety have not been eliminated, in violation of Section II(A) and its subparts. Plaintiff's monitoring of grievances filed by youth in these facilities and other allegations made by youth reveal many allegations of staff abuse. Defendants condone unnecessary and improper physical assaults on youth and fail to take appropriate action to address violations of the Agreement and Defendants' own policies. For example, although a number of incidents at the Santa Fe County Juvenile Detention Center ("SFCJDC"), which is one of Defendants' contract facilities, were brought to Defendants' attention by grievances ACLU personnel filed on behalf of youth, Defendants have condoned and/or taken inadequate measures to correct this conduct.

22. The recommendations of Defendants' own expert, Dr. Eric Trupin, regarding staff training in behavior management, de-escalation and crisis management, and his recommendations on the development of a positive based Behavior Management Program have not been adequately implemented, in violation of Section II(C)(7). In addition, as a result of Defendants' failure to adequately train and discipline Juvenile Justice staff, safety and the elimination of violence in the facilities housing delinquent youth are not a priority, in violation of Section II(D) – (H). Moreover, staff ratios are still not in compliance with

Section II(C)(1) and security camera coverage was not provided as required by Section II(C)(2).

23. Despite a commitment in the Agreement to stop the practice, Defendants continue to place youth inappropriately in segregation or isolation, in direct violation of Section II(C)(5), and continue to deny these youth appropriate and required education programs, treatment, recreation and other programming while they are in segregation or isolation.

24. Defendants' failure to implement Section II of the Agreement has caused significant and permanent harm to youth in their care and custody. For example:

a. C. L. is a former male resident at Defendant CYFD's J. Paul Taylor Center ("JPTC"). In December of 2006, while a resident at JPTC, C.L. was placed in a restraint by staff when he refused to comply with a request to go to his room. When C.L. grabbed hold of a table, one staff member improperly placed his arm around C.L.'s neck. Holding a youth by his throat is never permitted by policy. Although another staff person attempted to place C.L. in an approved restraint hold, C.L. was nonetheless dragged several yards by the neck, while still holding onto the table. (Even the attempted approved restraint hold involves a level of force that is permitted by JJS policy only if a youth is assaultive, attempting to destroy property, or attempting to escape, none of which was C.L. attempting.) As a result of Defendants' actions, C.L. lost consciousness and suffered neck pain and scratches to his shoulder. In addition, he suffered severe emotional distress from being choked, dragged and injured by those entrusted to take care of him, and spent several months after the incident attempting to get CYFD to take the incident seriously enough to call law enforcement authorities to report the battery, which Defendant CYFD never did. Defendants' response to C.L.'s grievance, filed to object to this illegal and dangerous action, was merely to recommend retraining. Plaintiff and C.L. were not informed whether this retraining ever took place.

b. A.O. is a male resident at Defendant CYFD's JPTC facility. On December 30, 2006, A.O. was in a holding cell at Defendants' Youth Diagnostic Development Center ("YDDC") facility awaiting medical treatment when he was involved in a verbal altercation with a Sheriff's Deputy and YDDC staff. The facility superintendent ultimately ordered staff to use force to remove A.O. from the holding area, despite the fact that A.O. met none of Defendants' criteria for the use of force. Because of Defendants' failure to provide staff with adequate training in mental health care and proper use of force, A.O. was injured, including a laceration to the top of his head, swelling around both of his eyes, and swelling of his nose.

c. A.C. is a male resident at Defendant's contract facility, SFCJDC. On May 29, 2007 he was unnecessarily and inappropriately restrained by SFCJDC staff, and was injured as a result. He had requested a new toothbrush because he had dropped his in the toilet the night before. He was denied a new toothbrush by staff and told to get ready for the day. A.C. refused and returned to his room where he safely remained. Some 5 minutes later, several SFCJDC staff came to his room and told him to come out. When he didn't, the staff entered his room and one took him to the floor, face first from behind. In violation of Defendants' policies, a video camera was brought to the scene only after he was on the floor. A.C. received a contusion to his face and injured his neck during the incident. Staff then denied A.C. the opportunity to file a grievance about the restraint. When Plaintiff filed a grievance on his behalf, CYFD did not find the manhandling of A.C. to be inappropriate, but only criticized the staff for failing to video tape the "take down."

d. O.S. is 17 year old male who has been in Defendants' custody since May 12, 2006. He is developmentally delayed, with a reported IQ of 74, a history of inhalant abuse, command auditory hallucinations, and behavioral issues. On or about March 22, 2007, he was battered by staff at SFCJDC who picked O.S. up by his armpits and repeatedly slammed O.S.'s head into a metal classroom door. When O.S. told the staff member not to slam his head into the door, the staff replied "don't fuck with me, boy," propelled O.S. by his armpits down the hallway, slammed O.S.'s face into the floor, and ground his face into the carpet. O.S. sustained lacerations to at least 25% of the left side of his face and chin with swelling under his left eye. After this incident, Defendants transferred O.S. to another facility (YDDC) the same day. When Plaintiff filed a grievance on his behalf, CYFD did not find the manhandling of O.S. to be inappropriate, but only criticized the staff for failing to video tape the "take down."

e. On July 30, 2007, O.S. was securely locked in his room when five staff members entered and used a chair to pin him down on his bed. The justification for entering the room allegedly was that O.S. had covered the window in his door and made threatening statements to staff. The five YDDC staff who entered his locked room and used a chair to extract him from the room, which is an unauthorized and inappropriate method, had received the explicit approval of a supervisor to use the chair. According to Defendant CYFD, it has no policies governing the procedures for extracting a youth from a room. As a result of Defendants' totally inappropriate actions, O.S. suffered bruising to his body and red and swollen eyes, as well as continued exacerbation of his mental health condition.

f. F.B. is a 20 year old male resident of YDDC. He has been in Defendants' custody since June of 2005. On or about February 22, 2007, F.B. was injured as a result of a staff restraint. F.B. collided with a concrete pillar after being grabbed by the staff member, required stitches to close a wound in his left eye, and, according to Defendants, may have injured his eye when he fell after staff restrained him for a second time.

g. R.M. is a male resident of Defendant's contract facility, SFCJDC. On July 2, 2007, R.M. was inappropriately restrained and battered by a facility staff member. Despite the fact that R.M.'s conduct did not meet any of the criteria for use of force, he was restrained by three JCO's. CYFD acknowledged that, during the restraint, one of the JCOs elbowed R.M. in the neck while holding his arm down. R.M. suffered an injury next to his right eye and the pain and humiliation of being physically retrained and elbowed in the neck.

Substantial Violations of Section III of Appendix A which Requires Actions to Ensure Appropriate Behavioral Health Services Are Provided in the Least Restrictive Settings in CYFD Facilities

25. Defendants have failed to provide adequate mental health care and rehabilitative services appropriate to the needs of the youth in CYFD facilities and have not substantially complied with Section III of Appendix A of the Agreement and its subparts.

26. Section III(Y) of Appendix A of the Agreement required CYFD to retain a qualified expert to monitor whether staffing and resources are sufficient to provide adequate mental health care and rehabilitative services to the facilities' youth and to monitor compliance with Section III. To satisfy these requirements, Defendants contracted with Dr. Pamela McPherson, who has a long history and a great deal of experience in monitoring mental health services in juvenile justice facilities, as the mental health expert. After making two visits to Defendants' facilities, Dr. McPherson made the following findings:

a. CYFD does not currently provide adequate mental health care and rehabilitative services appropriate to the needs of all youth in CYFD facilities. (Violating Agreement Appendix A, Section III A).

b. CYFD has not fully and adequately implemented all the recommendations made by Eric Trupin, Ph.D. in his report to CYFD, Review of Mental Health and Substance Abuse Services (December 2003). (Violating Agreement Appendix A, Section III B).

c. "Of major concern during my May 2007 visit were policies, procedures, protocols, and/or practices for the intake/diagnostic process and crisis intervention. These critical procedures were not available for my review in May." (Violating Agreement Appendix A, Section III C).

d. The tasks of the Director of Facility-Based Behavioral Health Services have not

been met, largely due to the position remaining vacant for months. (Violating Agreement Appendix A, Section III D).

e. Review of progress in the redesign of the initial mental health screening procedure in May 2007 revealed no progress. (Violating Agreement Appendix A, Section III F).

f. "Extensive time and resources expended during my initial 2006 tour with Dr. Cruise were aimed at the evaluation of the mental health assessment process and discussion of the corrections needed. The lack of progress evident at the May 2007 tour was shocking." (Violating Agreement Appendix A, Section III G).

g. In both Initial Intake/TDM discussions and plans mental health diagnoses educational exceptionalities and disabilities requiring ADA accommodations were not identified.

h. Security staff who have the responsibility for youth safety and rehabilitation do not have adequate information, training, and guidance to accomplish this task. (Violating Agreement Appendix A, Section III T).

i. Behavioral health treatment plans of youth with learning disorders, mental retardation, developmental disabilities and cognitive impairments do not adequately address necessary accommodations. (Violating Agreement Appendix A, Section III P).

j. Treatment plans and charts revealed no specific discharge plans. (Violating Section Agreement Appendix A, Section III U).

k. Behavioral health staff and the psychiatry service reported that security staffing levels are not adequate to allow youth timely access to behavioral health services. . . . CYFD needs to determine staffing patterns based on youth need for services and programming. (Violating Agreement Appendix A, Section III Q).

27. In addition to the above findings by Dr. McPherson during her May 2007 tour, she found that Defendants also failed to comply with the Agreement by:

a. not having adequate policies and/or procedures to make reasonable accommodations in its disciplinary process or daily programming for youth who are covered by the Americans with Disabilities Act, and

b. inadequate staff training to deal with mental health issues.

28. Due to the inadequate training and/or the indifference of Defendants' staff to the mental health needs of youth in their care and custody, youth are subjected to violence and

the threat of violence on a daily basis. The violence comes from both the staff and from fellow youth. Defendants have a duty to prevent such violence and to provide safety to the youth in its custody. Defendants have failed to adequately address the mental health needs of these youth and to provide their most basic need of safety, in violation of Sections II and III of Appendix A of the Agreement.

29. For all of the reasons listed in the above paragraphs, the critical mental health services that are necessary to adequately serve the needs of the juveniles in Defendants' custody are not being met. Defendants' failures, as stated above, constitute substantial violation of Section III of Appendix A of the Agreement.

30. Defendants' failure to implement Section III of Appendix A has caused significant and permanent harm to youth in their care and custody. For example:

a. K.G. is a 16 year old female CYFD client who is currently residing at Mesilla Valley RTC. She has high mental health and behavioral needs, with several mental health diagnoses, including PTSD as a result of a history of severe physical and emotional abuse. She has been in Defendants' custody since July of 2005. Although K.G. had no record of violence before her commitment, she has spent the majority of her commitment in Defendants' Sage Separation Unit due to her assaultive behavior. Plaintiff ACLU initiated grievances on her behalf in the Spring of 2006 because of Defendants' failure to provide her appropriate mental health care and their persistent segregation and isolation of her due to her mental disabilities. The ACLU repeatedly complained that she was not getting adequate mental health care and requested that she be transferred to an appropriate facility able to address her needs. The response from Defendants was that she was getting proper care. K.G. received an additional commitment to incarceration and a one year extension of her confinement due to her assaultive behavior, which was directly attributable to her inadequately treated mental health condition. Finally, a year after the initial ACLU grievance, Defendants transferred her to a treatment facility, Desert Springs, and then transferred her to Mesilla Valley when Desert Springs closed. After six months of treatment, K.G.'s condition has improved to the extent that she is now on the November parole agenda. Defendants' failure to provide K.G. with adequate mental health care caused her to develop symptoms of serious emotional disturbance that were not present prior to her incarceration. She unnecessarily spent many months in segregation and isolation, with severe emotional distress, due to Defendants' refusal to provide her the residential treatment she needed.

b. O.S. is a 17 year old who has been residing in the Loma Separation Unit at Defendants' YDDC facility for many months. He is developmentally delayed, with a reported IQ of 74, a history of inhalant abuse, and command auditory hallucinations. He has been in Defendants' custody since May 12, 2006. O.S. was initially placed in the Milagro unit at YDDC but after several weeks he was moved to the Loma Separation Unit because he allegedly threatened another resident. O.S. was then sent to Defendants' John Paul Taylor Center ("JPTC") facility on July 13, 2006 and from there he was sent to Sequoia Adolescent Treatment Center ("SATC") on August 16, 2006, because JPTC was unable to address his mental health needs or behavior. Defendants then sent O.S. back to YDDC in March 2007, after he allegedly assaulted another client. He has remained in the Loma Separation unit ever since. Plaintiff has repeatedly requested that O.S. be transferred to a less restrictive treatment setting where he could obtain the level of care and intensity of services that he needs. O.S.'s file contains notations from his treatment team, as recently as September 12, 2007, stating "Client continues to require treatment services this facility cannot provide." Despite the recognition by his treatment team of O.S.'s need for a more appropriate setting, Defendants finally responded on October 1, 2007, to Plaintiff's requests for information regarding placement attempts for O.S., by stating that he was "where he needed to be," and that there really wasn't any other suitable placement for him. Plaintiff is aware of only one other facility, other than SATC, where placement may have been attempted (Desert Springs, which is no longer in business). Defendants finally agreed that they would continue to search for alternate treatment settings where O.S., and clients similarly situated, could obtain the level of care and intensity of services needed. No progress update has been provided and O.S. remains separated from the rest of the population, with his mental health needs largely unaddressed. Defendants' failure to provide O.S. with adequate mental health care caused his condition to deteriorate and symptoms of serious emotional disturbance to develop that were not manifested prior to his incarceration. As a consequence of Defendants' refusal to address or deliberate indifference to his mental health needs, O.S. has spent many months in segregation and isolation, which has caused him severe emotional distress and exacerbated his condition.

c. A.S. is a 16 year old who is currently residing at YDDC. He has been in Defendants' custody since September 6, 2006. A.S. has a long history of residential placements since age nine. In addition to previously spending a total of 25 months at Sequoia Adolescent Treatment Center ("SATC"), he has spent several months in psychiatric hospitals. Due to his mental health condition, A.S. has been unable to control his behavior, and has received at least 19 Serious Incident Reports during the last year. As a consequence of his behavior, A.S. has spent more than half of his commitment locked down in Defendants' Loma Separation Unit. He also received an additional period of incarceration due to his behavior. On August 28, 2007, Plaintiff questioned the continuous housing of A.S. in the Loma Separation unit. Defendants responded that because "[i]t was the consensus of the mental health professionals that it had been decided that A.S.'s receptivity to treatment was minimal due to his Axis II personality disorder traits," Defendants would simply "continue efforts by CYFD-JJS staff to stabilize A.S.'s presentation for

the remainder of his commitment." Defendants have been deliberately indifferent to A.S.'s mental illness and have failed to provide him with adequate mental health care to address a known mental health condition. This lack of care and failure to secure more appropriate and less restrictive treatment has resulted in A.S. being warehoused in the Loma Separation unit for the majority of his current commitment, causing him significant emotional distress and exacerbating his condition.

d. D.W. is a 16 year old who is currently residing at SATC. He has been in Defendants' custody since July 24, 2006. Defendants recognize that D.W. has high mental health needs. D.W. has a long history of residential placements dating back to a young age. Although it was recognized that D.W. required a higher level of care than YDDC could provide, it was not until January of 2007, that D.W. was referred to SATC, which initially denied him placement, because he had run away from there during his past stay. A second attempt was made to refer him to SATC in April 2007. It was not until nine months after Defendants first attempted placement at SATC that D.W. was finally transferred there. The only other facility where placement was attempted by Defendants was Mesilla Valley, which, until recently, would not accept committed youth. D.W. was committed to Defendants' custody by the court in the hope that his commitment would enable him to receive the mental health treatment that he was previously unable to obtain. But Defendants' deliberate indifference to D.W.'s need for a higher level of treatment, evidenced by their failure to seek appropriate placement with the level of care and services he needs, has caused him to spend more than half of his commitment in a facility that is unable to meet his needs. In addition, D.W. spent over five months in Defendants' Loma segregation unit. Defendants' conduct has caused D.W. significant emotional distress and exacerbated his condition.

e. L.C. is a 19 year old, who currently resides in the SEG 5 unit at Bernalillo County Metropolitan Detention Center, after being arrested for heroin possession. She is diagnosed with PTSD and engages in self-mutilation and assaultive behavior. L.C. was paroled to UNM's Children's Psychiatric Center (CPC) in the summer of 2006. However, she was told by CPC staff that they wanted her to leave because they were not able to handle or treat her behavior. While in Defendants' custody, L.C. attempted suicide on August 21, 2006, by ingesting cleaning fluid and bleach. After returning to Defendants' custody from the hospital, L.C. was punished for this suicide attempt. L.C. has a history of drug abuse and is a recipient of federal SSI benefits for her disabilities. L.C.'s parole was revoked on July 28, 2006. The reason given for revoking her parole and returning her to incarceration was that she was not "medication compliant." After being returned to Defendants' custody at YDDC, L.C. did not receive adequate mental health care. When Plaintiff ACLU initiated a grievance regarding her lack of needed treatment, Defendants failed to take any action. She was eventually discharged by Defendants at the end of her commitment without the necessary transitional services and discharge planning to which she was entitled. In fact, L.C. reports she was not supplied with any services, but was simply discharged to her mother. L.C. also reports that she was subsequently kicked out of her mother's home and was living on the streets for six months.

f. C.A is a former resident at Defendant's YDDC facility. She arrived at YDDC on February 16, 2007. In the eight months she was in custody she did not receive adequate individual therapy or family therapy. Her treatment plan states she should have received individual therapy once a week. Since June 2007, Defendants failed to provide her the weekly sessions she needed and she received only one therapy session in August and two in September. Since arriving at YDDC, she consistently requested to participate in family therapy to facilitate her successful return home at the end of her commitment and to enable her to be approved for parole. Family therapy was added to her treatment plan in May 2007. However, Defendants provided C.A. with only one or two family therapy sessions in the ensuing five months, denying C.A. the treatment she needs and impeding her ability to end her incarceration. The lack of consistency and continuity of therapists in the housing unit in which C.A. lived negatively impacts the ability of youth to receive the rehabilitative services to which they are entitled. Defendants' own documentation indicates that the services identified as necessary in each youth's treatment plan are not provided consistently.

31. Section III(V), requires Defendants to develop and implement at each facility, daily, including weekends, adequate structured programming which: a) begins when the youth wake up and continues until they go to bed, including an appropriate mix of educational, rehabilitative, recreational, and leisure activities (including outdoor activities), b) shall be designed to ensure that youth are not confined in locked cells or unable to participate in programming except in narrowly defined circumstances, and c) shall also be designed to modify behaviors and provide rehabilitation appropriate to the needs of the youth committed to each facility, as determined by the youth's plan of care. CYFD has failed to provide appropriate educational, rehabilitative, and recreational activities that comply with Appendix A, Section III(V). Beginning in September of 2006 and continuing to the present, Plaintiff has filed some 30 grievances with Defendants which detail specific violations of Appendix Section III(V). Even when Defendants agreed with the grievance, they failed to take necessary action to remedy the violations, including actions that their own staff had recommended. This has resulted in significant and permanent harm to youth

in their care and custody, as youth have not been able to participate in programming, have been confined to their cells, and have not been provided rehabilitation appropriate to their needs.

Substantial Violations of Section IV of Appendix A which Requires Actions to Develop Adequate Community-Based Behavioral Health Services to Serve Youth on Probation or Parole in Appropriate Community Settings

32. Defendants have failed to develop adequate community-based behavioral health services to serve youth on probation or parole in appropriate community settings and have not substantially complied with Section IV of Appendix A of the Agreement and its subparts. The state-funded behavioral health system for children and youth has substantially deteriorated since the Agreement was entered in February of 2006. Due to the actions of the State's Behavioral Health Purchasing Collaborative, which is co-chaired by Defendant Dodson, and its contract managed-care company, ValueOptions New Mexico, access to residential treatment has become much more limited for youth on probation or parole. At the same time, access to community-based non-residential services has also been curtailed. Some community-based services for youth on probation or parole, including Family Stabilization, Psychiatric Intensive Outpatient treatment and Psychosocial Rehabilitation services have been eliminated altogether. These developments, combined with Defendants' failure to implement the Agreement's requirements to improve the mental health services provided to youth on probation or parole, have resulted in Defendants' failure to substantially comply with Section IV of Appendix A of the Agreement.

33. Section IV(F) of Appendix A of the Agreement requires CYFD to retain a qualified mental health professional to "monitor whether the services CYFD operates or

funds are sufficient to provide adequate mental health care and rehabilitative services to these youth in the community and to monitor compliance with Section IV of this Agreement." To satisfy these requirements, Defendants contracted with Dr. Pamela McPherson to serve as the qualified mental health professional monitor.

34. Section IV(B) of Appendix A of the Agreement requires, *inter alia,* "The Director [of Community-Based Behavioral Health Services] shall: (1) Develop and implement policies and/or procedures to ensure that where mental health care and rehabilitative services are operated or funded by CYFD such services are at least adequate for youth."

35. Defendants' failure to fulfill this obligation is described in Dr. McPherson's mental health audit report, in which she states: "While some policies and/or procedures are in place to ensure that mental health care and rehabilitative services that are operated or funded by CYFD are at least adequate for youth, additional auditing/QA measures, as noted in Section A, and data analysis are necessary to implement meaningful policies and/or procedures."

36. Section IV(B) of Appendix A of the Agreement also obligates Defendants to: "2. Develop and implement an adequate quality assurance program for community-based behavioral health services operated or funded by CYFD, which shall include, but not be limited to, staff training and oversight of mental health care and rehabilitative services provided by CYFD to these youth in the community."

37. The mental health monitor's audit report found non-compliance, stating: "The auditing conducted by the State of New Mexico's Human Services Department, Behavioral Health Services Division for the Behavioral Health Purchasing Collaborative does not offer sufficient detail to highlight trends for youth on probation or parole. ... it is critical that CYFD work with the Behavioral Health Purchasing Collaborative to ensure auditing capture the

details necessary to understand the trends for youth on probation and parole or entering secure facilities or develop this capacity internally."

38. Defendants are also violating Section IV(B)(3) of Appendix A , which requires: Within 90 days of the hiring of the Director of Community-Based Behavioral Health Services, [the Director shall] develop and present to the ACLU team for review and comment a comprehensive plan that includes specific implementation time lines and describes in detail what CYFD will do to improve the mental health services provided to youth on probation or parole. ... CYFD shall begin to implement all aspects of this plan no later than 90 days after its approval by the ACLU."

39. The required plan is not being implemented in a timely manner. Also the plan required Defendants to expand community based behavioral health treatment services described under Sections IV(D) and IV(E) of Appendix A. The services required by Section IV(E) have diminished, not expanded.

40. Section IV(C) of Appendix A of the Agreement provides: "CYFD shall provide or contract for sufficient case management services to provide these youth with competent behavioral health case management services utilizing evidence-based, generally accepted treatment approaches. " Case management services are not being provided to youth on probation or parole who need them.

41. Section IV(D) of Appendix A of the Agreement provides: "JJS and Protective Services shall work together to provide appropriate care to youth committed to JJ custody who also qualify for protective services, including, but not limited to, family preservation and other voluntary services." Defendants' Protective Services Division is not adequately working with their Juvenile Justice Division, and family preservation and other voluntary protective services are not being provided to youth who need them.

42. Section IV(E) of Appendix A of the Agreement provides: "CYFD shall work closely with the Purchasing Collaborative and the Single Entity to improve access to needed psychiatric hospitalization, residential mental health care and intensive in-home treatment for youth on probation or parole who need those services whenever they require them." As described above, access to these services has decreased, not improved.

43. Defendants' failure to implement Section IV of Appendix A of the Agreement has caused significant and permanent harm to youth in their care and custody.

a. I.C. is a 17 year old who is currently residing at YDDC. He spent eight months in Defendants' custody between May 16, 2006 and February 23, 2007, when he was paroled. At his parole hearing, he was identified as having high needs by his treatment team. He was referred to residential treatment facilities, but not admitted. He was paroled to his parents on February 23, 2007. No home study was completed for this placement. Plaintiff is not aware of any transitional services that were arranged for I.C. prior to his parole. At his parole hearing, his treatment team indicated that YDDC had nothing more to offer him. Defendants' failure to provide proper placement for I.C., and their failure to provide any transitional services or discharge planning, was a significant reason for his lack of rehabilitation, which led directly to his subsequent re-commitment to Defendants' custody. In August of 2007 I.C. appeared before the parole board. Defendants' Protective Services Division reportedly closed their file on him and provided no assistance to him, so when he appeared before the parole board, Defendants made no protective services available to him.

b. M.B.'s incarceration was extended an additional six months due to Defendants' failure to obtain needed treatment in a location outside its facilities. He appeared before the parole board in April 2007. He was referred to many residential treatment facilities but he was unable to obtain a placement. As a result, his incarceration was continued past his mandatory parole date. Defendants' Protective Services Division did not assist him to obtain needed treatment or release from incarceration.

c. K.L. is an 18 year old youth with a history of substance abuse problems. She appeared before the parole board in April 2007. Defendants failed to obtain needed residential treatment for her and she was paroled home, although this was not an appropriate placement because the clinical staff who worked with her had determined she needed residential treatment.

d. R.A. has bipolar disorder. Defendants failed to obtain placement for him in a residential treatment facility. In January of 2007, he was paroled home, but Defendants failed to set him up with any services. Defendants failed to contact him

or his family to help R.A. get treatment. Defendants simply gave him 30 days of medication and sent him home.

e. L.F. went before the parole board in April of 2007. Defendants referred him to a residential treatment facility, but ValueOptions, the state's Single Entity for determining funding, did not approve funding for his placement. L.F. was paroled home.

f. In September 2007 J.F. appeared before the parole board. There was a two month waiting list at the residential treatment facility that agreed to provide him with treatment, so he was placed into the Albuquerque Boys Reintegration Center to wait two months for the needed treatment.

44. Thousands of youth on probation or parole are being unlawfully denied the benefits of the requirements of Section IV of Appendix A of the Agreement.

Substantial Violations of Section V of Appendix A which Requires Actions to Provide Appropriate Health Care Services in Facilities

45. Defendants have failed to provide appropriate health care to youth in Defendants' facilities and have failed to substantially comply with Section V of Appendix A of the Agreement and its subparts. Many youth are not timely screened for medical conditions needing routine care, and routine and acute medical care are either unreasonably delayed or denied altogether, causing and/or exacerbating long-term health problems for many youth in Defendants' care and custody, in violation of Section V of Appendix A of the Agreement.

46. Pursuant to Section V(D), CYFD was required to contract with a highly qualified medical expert to monitor and evaluate whether services, policies and procedures provided by CYFD are sufficient to provide adequate health care services (including, but not limited to, dental care) to youth in JJS facilities and, if not, to assist the CYFD Director of Facility Medical Services to draft a medical care plan to correct deficiencies. This medical expert also has the responsibility to monitor compliance with Section V of Appendix A of the

Agreement. To satisfy these requirements, Defendants contracted with Dr. Robert Greifinger as the medical expert.

47. Dr. Greifinger has made several on-site visits to Defendants' facilities in New Mexico and consulted regularly with Defendants as to the status of medical services for youth in their facilities. He has also repeatedly proposed steps that Defendants must take to address non-compliance with Section V of Appendix A of the Agreement.

48. The First Report by Dr. Greifinger (Dec. 18, 2006) exposed major areas of noncompliance with Section V as to the health care administered to youth in Defendants' care and custody. Dr. Greifinger concluded:

> 1. The policies, procedures, protocols and/or practices necessary for adequate medical care are not being provided by qualified professionals using generally accepted treatment approaches. This is primarily a result of inadequate staffing, policies, guidelines, training and supervision.
>
> 2. EPSDT standards are not being met.
>
> 3. Youth are referred to qualified medical professionals, but they are often not seen, seen late, or lost to follow-up.
>
> 4. Health care for acute illness is incomplete.
>
> 5. Health care for prevention and chronic care is incomplete and does not comport with nationally-accepted guidelines.
>
> 6. Because of vacancies and the way physician time is scheduled, there is insufficient duration and scope of service.
>
> 7. EPSDT screens and immunization are not performed nor are records maintained.
>
> 8. There is inadequate space at YDDC, a negative work environment because of staffing.
>
> 9. Management processes are deficient, especially documentation, collegial review (although the physician was reviewed once at YDDC), staffing, physician on-call, intake screening, dental care, discharge planning, scheduling and reporting.
>
> 10. There is no functioning quality management program.

11. Treatment planning for medical illness is non-existent.

12. There is no discharge planning documented for medical conditions.

49. At the time of Dr. Greifinger's first report, Defendants were providing medical care in all their facilities through a contract with a private medical services provider called Wexford Health Services, Inc. As a result of many complaints made by Plaintiff and many others throughout New Mexico about the extremely poor quality of care provided by Wexford and in response to Dr. Greifinger's first report, Defendants ended their contract with Wexford as of July 1, 2007.

50. Instead of contracting with another private provider for operation of all medical services in its facilities, Defendants took direct responsibility themselves for the provision of all medical and dental services to all youth in their facilities as of July 1, 2007. Despite the change in approach, Defendants continue to fail to provide appropriate health care to youth in their facilities, in violation of Section V of Appendix A. Many youth are still not timely screened for medical conditions needing routine care, and routine and acute medical care are still either unreasonably delayed or denied altogether, causing and/or exacerbating long-term health problems for many youth in Defendants' care and custody.

51. The Second Report by Dr. Greifinger (July 19, 2007) confirmed the continuation of major areas of noncompliance with Section V as to the health care administered to youth in Defendants' care and custody. Dr. Greifinger concluded:

> 1. The policies, procedures, protocols and/or practices necessary for adequate medical care are not being provided by qualified professionals using generally accepted treatment approaches. This is primarily a result of inadequate staffing, policies, guidelines, training and supervision.
>
> 2. EPSDT standards are not being met.

3. Youth are referred to qualified medical professionals, but they are often not seen, seen late, or lost to follow-up.

4. Health care for acute illness is incomplete.

5. Health care for prevention and chronic care is incomplete and does not comport with nationally-accepted guidelines.

6. Because of vacancies and the way physician time is scheduled, there is insufficient duration and scope of service.

7. EPSDT screens are not performed nor are records maintained. Immunizations are being done.

8. The space at YDDC is improved; however, there is tension between health care and custody staff and a negative work environment because of staffing.

9. Management processes are deficient, especially documentation and scheduling. There is no functioning quality management program.

10. Treatment planning for medical illness is non-existent.

11. There is no discharge planning documented for medical conditions, yet.

52. Defendants' failure to implement Section V of Appendix A of the Agreement has caused significant and permanent harm to youth in their care and custody. For example:

a. B. L. is a female residing at NMGS. She has diagnoses of Type 1 diabetes and serious emotional disturbance, and she has previously experienced diabetic comas. On 9/25/07, 9/26/07, 9/27/07, and 9/28/07 she complained repeatedly to nursing staff of chest pains, dehydration, high blood sugar, low blood sugar, vomiting, weight loss, clamminess, headache and dizziness. After Defendants failed to adequately respond to her complaints, she was brought to UNM Hospital on the morning of 9/28/07. UNM-H determined that her blood sugar was dangerously high and admitted her to the hospital. B.L.'s condition was so severe that she was not able to return to YDDC until October 2. At YDDC Defendants are still not managing her medical condition adequately. In addition, although B.L. is substantially overweight as a result of diabetes, Defendants are not providing her needed assistance in managing her diet. B.L. is at serious risk of death if she does not begin to receive proper medical and mental health care.

b. L.S. is a female former resident at Defendant's NMGS. When she was admitted to the NMGS in July 2006, she informed medical staff that she had a needle embedded in her right foot and was experiencing considerable pain and discomfort from it. Despite medical staff confirmation via X-ray the next day and L.S.'s

continued complaints about the untreated condition, Defendants did nothing to address her painful condition until January 2007, over six months later. Indeed, Defendants had L.S. treated in January 2007 only after the ACLU learned of her situation and initiated a grievance on her behalf. Defendants' failure to ensure that L.S.'s medical condition was treated promptly caused her considerable pain and discomfort for over six months and put her at risk of serious infection. Moreover, L.S.'s mental health needs also suffered during this period as result of Defendants' neglect of her medical condition. When Plaintiff initiated a grievance on her behalf about her treatment, Defendants found her grievance to be "unsubstantiated."

c. L.C. is a 19 year old, who currently resides in the SEG 5 unit at Bernalillo County Metropolitan Detention Center. On July 29, 2006, while in Defendant's custody, she requested medical attention, but was not seen by medical staff until two days later, on July 31st. This delay was due to CYFD's medical contractor, Wexford, failing to provide any nursing staff for the facility on the day L.C. requested attention, which also resulted in no clients in YDDC receiving their medications that day. Due to Defendant's failure to provide any nursing staff for a whole day, L.C. and every other resident of YDDC were denied their medications and were put at serious and substantial risk of harm if they had had a medical emergency.

d. E. R. is a male resident at Defendants' JPTC facility. He broke his finger while playing basketball on 12/9/06 at YDDC, and had surgery with pins inserted on 12/29/06. The pins were supposed to be extracted three weeks after the operation was completed, but Defendants did not allow him to have the pins removed until late March, over a month after they were supposed to be removed. This denial of adequate medical care caused E.R.'s finger to be visibly misshapen, and he still experiences pain in the tip, such that he requires a consultation by an orthopedic specialist. E.R. will likely never fully recover from Defendants' medical negligence.

e. J.C. was a resident at Defendants' YDDC facility. He was seen by a dentist for tooth pain on July 14th, 2006, at which time X-rays were ordered. The X-rays were never taken, and J. C. continued to complain of tooth pain throughout the summer. On September 18, 2006, J.C. finally had X-rays taken. As a result of Defendant's actions, J.C. needlessly suffered for over 2 months with excruciating tooth pain.

Substantial Violations of Section VI of Appendix A which Requires Actions to Provide Female Youth Comparable Access to Services and Programs as Provided for Male Youth

53. Defendants have failed to provide female youth comparable access to services and programs as provided for male youth, in violation of Section VI of Appendix A of the Agreement and its subparts.

54. The only secure facility available for female youth, regardless of their offenses, needs and levels of risk, is the high risk/security New Mexico Girls' School ("NMGS"). A

few committed girls have been placed in a reintegration center in Alamogordo, but Defendants have failed to provide females with options comparable to the lower risk programs, such as the camp program at CYFD's Camp Sierra Blanca, or the work, vocational, or community service programs that the males have outside of the YDDC/NMGS facility in Albuquerque. The entire system does not offer comparable programming, residential options and services to females.

55. Defendants have failed to assess the needs of the female CYFD population, or to reassess the available community based services and determine what services are actually being provided, or to assess the actual capacity of the community programs to serve the CYFD juvenile justice population, including the current or historic utilization rates and the appropriateness of the services to meet the needs of the female CYFD population. Defendants' analysis does not provide adequate information to determine what services are actually being provided and whether these programs have been used by CYFD youth or are appropriate to meet the needs of girls in Defendants' care and custody and to enhance community based services for girls.

56. Defendants have failed to enhance the "step-down" options to provide females with access to comparable step-down programs as are provided to boys, which include, but are not limited to: opportunities for females to reintegrate into their communities (where they come from or intend to go upon release); reintegration services that extend beyond the walls of the facility into the community; reintegration services that extend beyond just a school program; and step-down services for girls committed to Defendants' custody. La Placita is the only Reintegration Center serving females. It is 200 plus miles away from NMGS (which in itself raises the issue of whether females will have the opportunity to reintegrate into their communities), and the services offered do not provide females access

that is at all comparable to the community access that males have in other reintegration centers. In contrast, the step-down options for males committed to CYFD, offer vocational, work and community service programs and provide family counseling and reunification services.

57. Defendants have failed to provide females who need residential mental health treatment with those services.

58. Defendants' failure to implement Section VI of Appendix A of the Agreement has caused significant and permanent harm to youth in their care and custody. For example:

a. K.G. spent the majority of her commitment in the Sage Separation Unit at YDDC, receiving little or no treatment for her mental health condition, because Defendants failed to provide female JJS clients with access to the level of services that are provided at SATC for committed male clients. It was only after the concerted efforts of the ACLU, over the period of a year, that K.G. was eventually transferred to Desert Springs RTC in the spring of 2007. Defendants' failure to provide K.G. with a comparable level of care afforded to male JJS clients has caused her to develop serious emotional disturbances and has caused her great anguish. She did not display any of the uncontrollable assaultive behavior that caused her to be segregated and isolated in the Sage Separation Unit prior to being in the custody of Defendants, and has not displayed those behaviors since leaving Defendants' custody.

b. I.C. is a 16 year old, currently residing at YDDC . She has been in Defendants' custody for over a year and is committed until age 21. I.C. has been a model client, and there is a consensus among her treatment team that she should be placed in a less restrictive setting such as a step-down facility/RTC. The consensus among I.C.'s treatment team is that she would benefit from placement at the CYFD-run La Placita girls RTC. She was previously housed in Defendants' LFA Girl's Reintegration Center, which was closed in the summer of 2006, and converted by Defendants to the ABRC facility for male JJS clients. After LFA was closed, I.C. was transferred back to YDDC, where she remains. Currently there is no RTC which accepts committed JJS females operated by the Defendants. Defendants' failure to provide comparable RTC facilities for female JJS clients has caused I.C. to spend over a year in a more restrictive environment than is recommended by her treatment team. In addition, this failure has prevented I.C. from receiving the benefits of a facility designed to transition youth back into the community.

c. L.C. has paroled to CPC, because Defendants did not offer females a facility comparable to SATC which admits committed male JJS youth. She was sent back to YDDC, because CPC was not able to provide the level of services that L.C. required, and that is provided for committed male clients at SATC. Defendants' failure to provide L.C. with a comparable level of mental health care that is afforded to male JJS clients with high mental health needs exacerbated L.C.'s condition, as evidenced by her suicide attempt. Defendants' failure to provide any type of transition plan, or services upon her discharge is a significant contributor to her relapse and subsequent incarceration.

d. All female youth housed in the Sage segregation unit at NMGS are receiving a maximum of 45 minutes of education instruction per day, rather than the six hours of education mandated by law. In addition, while in the Sage unit, these female youth are not permitted to attend education classes at the education building.

Substantial Violations of Sections IX and XI of Appendix A which Require Implementation of an Effective System for Investigating Grievances and Serious Incidents and Establishment of an Office of Quality Assurance

59. Defendants have failed to establish an effective office of quality assurance and failed to implement an effective system for investigating grievances and serious incidents, in violation of Sections IX and XI of Appendix A of the Agreement and their subparts.

60. The Agreement provides that CYFD will implement and operate an effective system for investigating grievances and serious incidents, as well as for conducting audits and monitoring facility compliance with CYFD policies and procedures. Defendants' Office of Quality Assurance ("OQA") is responsible for carrying out such investigations and monitoring functions. But the OQA has failed:

a. to complete many grievance investigations within 5 business days, in violation of Section IX(B)(5),

b. to review, investigate, and respond (by appropriate personnel) to uses of force resulting in injury, uses of mechanical restraint, and uses of isolation in excess of 12 hours, in violation of Section IX(B)(8),

c. along with the Defendant Gillespie, to ensure that prompt corrective and remedial actions are taken as to grievances that are upheld in whole or in part and as to unauthorized or inappropriate uses of force, in violation of Section IX(B)(9),

d. to adequately monitor compliance with CYFD policies and procedures in all facilities with an emphasis on issues of safety, medical and mental health services, in violation of Section XI(B)(1),

e. to adequately conduct audits of Defendants' facilities and other quality assurance activities, in violation of Section XI(B)(2),

f. to evaluate each facility and program operated by Defendants and their contractors and recommend specific corrective action plans to Defendant Dodson, in violation of Section XI(B)(5), and

g. to adequately report on the implementation and adequacy of the safety, medical and mental health programs required by the Agreement so Defendant Dodson can take necessary actions to remedy deficiencies, in violation of Section XI(B)(6),

h. to provide aggregate data on grievances, uses of force, personnel actions, youth safety, characteristics of youth at each facility, youth progress while in custody in basic skills such as reading, math, social skills, acquisition of job skills, and, for youth discharged, recidivism, in violation of Section XI(B)(8).

i. to implement the requirements set forth in subparagraphs d - h, above, through the following measures, in violation of Section XI(D)(1-14):

i. inspecting institutional, medical and educational records, unit logs, incident reports, use of force reports, major disciplinary report, documentation of room checks by line staff, etc.,

ii. interviewing staff, administrators and youth at each facility

iii . interviewing the parents and other care givers of youth confined in JJS facilities, and attorneys and other individuals with relevant information,

iv. inspecting the physical plant of the facilities housing youth,

v. interviewing juvenile court judges, public defenders and other officials having regular contact with the facility or its youth,

vi. regular communication with UNM Law school ombudsman personnel,

vii. determining whether the facilities are in compliance with CYFD policies and/or procedures, including but not limited to adequacy of documentation, relating to: suicide prevention, use of force, serious grievance procedures, serious incident procedures, use of mechanical restraints, youth-on-youth violence and conditions in security units,

viii. using statistically valid sampling techniques to determine the facilities compliance with CYFD policies and/or procedures, including but not limited

to adequacy of documentation, relating to: youth disciplinary practices, routine grievance procedures, implementation of classification criteria, and implementation of Plans of Care, including but not limited to, implementation of classification criteria and counseling and rehabilitative services,

ix. conducting unannounced, periodic site visits at each JJS facility.

x. tracking the implementation of all activities required by the Agreement.

61. Defendant CYFD Secretary Dodson and Defendant CYFD have failed:

a. to adopt an effective plan of correction whenever, through audits, investigations or other quality assurance activities, the OQA finds substantial noncompliance with the requirements of JJS policies, procedures and/or the Agreement, in violation of Section XI(E), and

b. to evaluate the cost effectiveness of programs and to make appropriate program changes to best accomplish the goals of JJS, in violation of Section XI(B)(8).

62. As described throughout this Complaint, Defendants' failure to implement Sections IX and XI of Appendix A of the Agreement has caused significant and permanent harm to youth in their care and custody. By failing to adequately investigate, monitor, and remedy safety, health and mental health issues in the facilities housing youth, Defendants have placed these youth at high risk for threats and the occurrence of physical violence and subjected them to deteriorating health and mental health, all of which Defendants have a duty to prevent.

RELIEF REQUESTED

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

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

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

1. For an injunction requiring specific performance to enforce the terms of the Agreement, ordering Defendants to make whole both the ACLU-NM and the youth who have been denied the benefits of the Agreement, and such additional remedial actions as are necessary in order to achieve prompt compliance with the terms of the Agreement, including but not limited to the hiring of sufficient highly qualified professionals as are necessary to ensure prompt compliance with the Agreement,

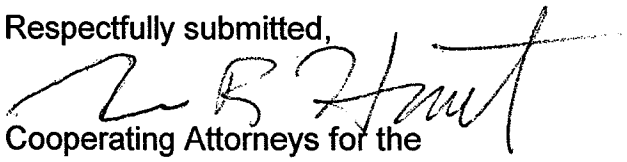
2. For contract damages in an amount to be determined by the trier of fact, jointly and severally,

3. For pre-judgment and post-judgment interest,

4. For attorneys fees and costs pursuant to paragraph 12(d) of the Agreement, and

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

Respectfully submitted,



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