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Re: Juvenile Court of Memphis and Shelby County (Juvenile Court) MOA Protection from Harm Stipulations: 5th Findings and Recommendations Letter

Dear Winsome and Richard:

This is the fifth letter to the U.S. Department of Justice (DOJ) regarding the Memorandum of Agreement (MOA) between the United States and the Juvenile Court of Memphis and Shelby County (Juvenile Court), TN, and it describes the visit to the Juvenile Court Detention Services Bureau (Detention Facility) on April 27-30, 2015. My role as the Protection from Harm Consultant is to provide information and assessments of the progress by the Juvenile Court toward compliance with the Protection from Harm paragraphs of the MOA (Section C).

This report evaluates Section C: Protection from Harm: Detention Facility, including numbered MOA Paragraphs 1-4. Specific headings within these groups of remedies include Use of Restraints, Use of Force, Suicide Prevention, Training, and Performance Metrics for Protection from Harm.

I remain positive about the response by the Juvenile Court and the Detention Facility leadership to Section C of the MOA and the recommendations in previous communications. The Juvenile Court staff and the leadership team at the Detention Facility remain good combinations of complementary skills and abilities. Gary Cummings, Mamie G. Jones, and Willie Walton represent a solid management team. Communication, information, and guidance provided by William Powell, Office of the Shelby County Criminal Justice Coordinator and Settlement Agreement Coordinator, continue to be excellent. He provides a valuable perspective, and his advice continues to be beneficial to the achievement of compliance with Section C of the MOA. Jina C. Shoaf, Assistant Shelby County attorney, again participated in many of the meetings and discussions. Her input continues to be valuable and her questions insightful.

I. Assessment Protocols

The assessments used the following format:

A. Pre-Visit Document Review

Powell remains the MOA Settlement Agreement Coordinator. He is conversant about compliance issues and offers a pragmatic approach to what is required for compliance under the MOA paragraphs. He continues to be an excellent resource. On March 23, 2015, Powell submitted reports called, "Compliance Report #5" and "Substantive Remedial Measures" (hereafter referred to as the "Compliance Report") and forwarded copies for review before the on-site visit. Special attention was given to pages 31-37, covering Protection from Harm actions and recommendations.

B. Use of Data

The presence of a paragraph on Performance Metrics (Paragraph 4 under Protection from Harm) has resulted in efforts by the Juvenile Court and the Detention Facility to improve data-collection systems necessary to make informed and accurate quality assurance decisions. As an indicator of Detention Facility progress on performance metrics, I receive monthly several Excel spreadsheets and narrative analyses on a range of outcomes, including DAT overrides, safety and order statistics, suicide prevention, suicide screening, use of force reviews, critical incident reviews, and suicide prevention screening times. Additionally, Detention Facility and Juvenile Court staffs participate in a monthly telephone call with DOJ attorneys and me to review and discuss the monthly data reports. Even though there are data quality issues that will be discussed below, the establishment of metrics of this nature represents significant progress.

C. Entrance Interview

The visit began with a meeting with the Hon. Dan Michael, Juvenile Court Judge; others in attendance included: Gary Cummings, Detention Facility Administrator; Garland Erguden, Magistrate; Dini Malone, Director of Administrative Services; William Powell, Settlement Agreement Coordinator; Larry Scroggs, Chief Administrative Officer; Jina C. Shoaf, Shelby County Attorney; Pam Skelton, Director of Court Services; David White, Chief Magistrate, and Winsome Gayle and Richard Goemann, DOJ Attorneys. No formal entrance interview occurred with the Detention Facility leadership as a result of the schedule of interviews. The interview with the Detention Facility leadership team, Gary Cummings, Mamie G. Jones, Willie Walton, and Lawrence Weichel, provided an opportunity to discuss updates of institutional goals and objectives, an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities.

D. Facility Tour

Brief walkthroughs of the facility occurred on April 29 and provided an opportunity to observe resident sleeping rooms, the general cleanliness of the facility, and any physical plant modifications or improvements. Noise levels continued to be an issue and can be an indicator of insufficient controls on youth behaviors. Another issue suggesting the need for behavioral management improvements was what appeared to be an increase in "tagging" or gang-related graffiti in residents' rooms. The new Positive Behavior Management System (PBMS) could be a helpful tool for staff to address both issues.

E. On-Site Review

This visit continued the verification of practices through a review of documentation (incident reports and youth files, including medical and mental health) and data collection regarding room confinement and uses of force. The monitors and the DOJ team accompanied Judge Michael and several Juvenile Court staff members on a tour of evening and day reporting programs through Juvenile Intervention & Faith-based Follow-up (JIFF).

F. Staff Interviews

I interviewed 22 staff, including four (4) Juvenile Court employees, three (3) Shelby County employees, two (2) University of Memphis faculty members, 8 (eight) Detention Facility employees, and five (5) Correct Care Solutions (CCS) staff.

G. Resident Interviews

I interviewed 10 youth in two five-person group interviews. The average age of these youth was 15.9 years with an average length of stay (ALOS) of 41 days. The group interviews occurred in the classroom adjacent to the administrative offices. Administrative staff selected the youth for the interviews; all were youth of color.

H. Exit Interview

No exit meeting occurred. I met with the Detention Facility leadership team and Bill Powell to highlight areas of importance and concern, but not findings. The meeting was a time for questions, clarifications, and explanations of events and impressions before issuing the report letter.

I. Compliance Logic

Logic is a commonly used evaluation word to explain the reasoning, rules, and criteria used by organizations to make quality decisions. Logic models make sense both rationally and empirically. The same applies here. We will use a set of criteria to make compliance decisions that will satisfy common sense, will be site-specific and transparent, will be data-driven, and will include the input of Juvenile Court and Detention Facility stakeholders at a minimum. Our compliance model will contain four parts:

1. The Agreement provides the language of compliance, so we will identify and define the key requirements in each of the Protection from Harm paragraphs.

2. Where appropriate and necessary, the Juvenile Court and the Detention Facility will develop new or modify existing policy and procedure that address the key requirements. The policy statements will answer the questions of "what" and "why." Linked to the vision and mission statements, policy statements will explain what will be done in a specific key requirement area. They will also explain to staff and all other readers the purpose of the policy.

Procedure statements will answer the "how" questions, explaining in some instances the step-by-step actions required to enact the policy statement. The "how" questions also include explanations of "who," "what" (not to be confused with the "what" above, this what is a behaviorally specific description of staff actions under the procedure), "when," and "where."

3. For each key requirement, there will be a performance outcome or a quantifiable indicator that the requirement has, in fact, happened or occurred. A system of performance

metrics will accompany the performance outcomes, and the performance metric will provide ongoing data about "how much" the performance outcome is occurring.

4. The final piece of the compliance logic is the performance metric mechanism for determining not only "how much" but "how well." The performance metrics are the foundation for a quality assurance process that uses data on performance outcomes to provide feedback about the accuracy and relevance of policy and procedure, thus creating a QA feedback loop that helps to guide ongoing evaluations and improvements to the policy, procedure, and practice aspects of program operations.

II. Protection from Harm: Detention Facility

A. Preliminary Comments and Observations

The interview strategy again included many of the new leaders resulting from the election of Judge Michael. All individuals expressed optimism, and the organizational climate has improved noticeably. In particular, the appointment of Pam Skelton as Director of Court Operations has provided the Detention Facility leadership team with needed advocacy, support, communication, and action regarding Protection from Harm issues.

The responsibilities for monitoring the MOA Protection from Harm paragraphs have been structured in such a way as to maximize the input of knowledgeable "others" who have involvement with the daily operations of the Detention Facility. Therefore, independent audits of the Detention Facility operations, such as the ACA accreditation audit, supply valuable information that may not necessarily be available or accessible during the monitoring visits. Several issues identified in the February 2015 ACA Accreditation Report warrant additional evaluation and could alter slightly future on-site assessment strategies.

1. Accomplishments

There have been multiple achievements since the last visit. Many were noted in Compliance Report #5, so the following list represents combinations of perspectives.

a. At the end of the visit, the daily population was 49 youth. Detention admissions have declined compared to the same period in 2014. The reduction in the Detention Facility population has been a positive factor that has contributed to a reduction of the critical indicators on the Report Card. Fewer youth mean improved Detention Facility decision-making due to strengthened assessments, evaluations, program alternatives, and commitments to community-based programs. Continued progress at population reduction should produce additional positive outcomes for Detention Facility.

   Communications between the Juvenile Court and the Detention Facility about population reductions have improved with new leadership, especially the exchange of information about youth who have been detained 15 or more days. The information exchange permits greater accuracy in the identification of risk and needs and allows the Juvenile Court to make better decisions about step down activities and alternatives to incarceration.

b. The Report Card data show a decrease in disciplinary locked room confinement. The frequency of disciplinary confinements has decreased, but caution remains as the length of disciplinary confinement events has increased.

c. There have been improvements in the institutional climate as measured by resident perceptions of safety. The Report Card indicated that only 7% of youth feared for their safety during the March 2015 survey of youth. When asked what might be contributing to this outcome, Detention Facility leadership indicated that youth feel safer around staff due to the change in operational philosophy. Additionally, new staff have been trained to be more interactive in resolving conflicts by talking to youth and verbally working through problems. Detention Facility leadership believes the newer staff will sustain the changes associated with Protection from Harm compliance.

d. The Positive Behavior Management System (PBMS) will be implemented very soon. Detention staff were in the last week of in-service, which included the PBMS. The system will include a token economy that uses multiple point categories to assess the amounts of appropriate behavior by youth through several periods during the day. The accumulation of points will allow for movement through a level system (with increasing access to privileges) and the purchase of food, the most notable is a honey bun.

e. The Detention Facility leadership team speaks very highly of the Hope Academy. There is good communication with school's director, Mr. Smith, and the school capacity is currently at 45. The development of the education program is a notable accomplishment; however, a detention education program must have capacity for all detainees to attend school on any given school day. Further expansion of the Hope Academy is important so that it has the capacity to provide educational services to all detained youth.

f. The Detention Facility recently experienced an accreditation audited by the American Correctional Association (ACA) on its *Standards for Juvenile Detention Facilities* and received an excellent report. This is an important accomplishment, and it should be seen as a source of great pride among staff. In any reform effort, change applies to all aspects of a detention facility. One key aspect is an organizational structure that includes a range of administrative and operational variables that must be organized, standardized, and formalized. ACA Standards are the best definition of this organizational structure, which serves as the infrastructure for effective facilities. These structural components include essential policies and procedures that support programs, services, and staff training.

g. The University of Memphis validated the DAT and affirmed the decisions of the Juvenile Court as measured by low numbers of failures to appear (FTA) and reoffending for those youth diverted from secure detention. The validation study also identified several areas where improvements to the DAT should yield continued reductions in the Detention Facility population. The validation report identified several critical issues relating to domestic violence, overrides, and collateral scoring factors, along with useful recommendations for addressing these issues. The DAT analysis followed the JDAI guidelines developed by David Steinhart. The data indicated that the DAT was effective compared to JDAI outcomes about failures to appear and rates of reoffending.

h. Detention Facility and the Health Department staff meet monthly with the Correct Care Solutions (CCS) medical provider to discuss performance audits. A contract monitor oversees performance by CCS, and her audits are discussed at the meetings with CCS, Detention Facility, Court Administration, and Health Department staff. These audit items (Sick Call-Blended, Medical Administration Audit, 7-Day Health Assessment, and Use

of Force Medical Care Audit) should be incorporated in the Detention Facility Report Card so that trends can be identified and discussed with both security and medical staff.

i. The call-in program has been implemented which is expected to further decrease admissions to Detention.

2. Challenges

a. Data validation must be done to insure confidence in the information being reported and relied upon for management purposes.

b. Use of locked room confinement continues to be a Protection from Harm concern. Room confinement issues identified in the February 2015 ACA Accreditation Report warrant additional scrutiny and could alter future on-site monitoring strategies.

c. Admissions declined 6% in January/February 2015 yet the average number of bed days increased by 69%. This statistic presents a number of implications for Detention that need attention from creation of more pre-disposition alternatives to enhanced programming within the Detention Facility.

d. There is a concern that the hierarchy of non-physical alternatives is not used to the extent intended.

e. The Positive Based Management System is a large undertaking that will require a "culture shift" in the Detention Facility staff.

f. Items from the health care audits (Sick Call-Blended, Medical Administration Audit, 7-Day Health Assessment, and Use of Force Medical Care Audit) should be incorporated into the Detention Facility Report Card so that trends can be monitored.

g. PREA policies need to be finalized and implemented, staff trained, and performance audited.

h. Transition teams and a transition plan should be established immediately to prepare for the movement of Detention to the Sheriff's Office.

i. The refusal by the Juvenile Court to improve the quality of food services to youth in detention is unacceptable.

j. Reading materials in rooms. Detention facilities must balance competing priorities of juvenile rights and privileges and the legitimate security functions of operating a facility responsible for youth and public safety. Anecdotal evidence from youth and staff suggests that the destruction of the sprinkler heads decreased following the removal of books from the resident rooms. The Juvenile Court believes an implied cause-effect relationship exists. But the decision is still problematic.

k. The high rate of staff turnover. When combined with the number of existing JDO vacancies, the demands upon recruitment and selection are substantial. The problems do not get easier when a new staff member is hired and must be trained and oriented before assuming responsibility as an independent worker (see discussion on pages 10-11). The challenges of recruitment, selection, training, and retention are commonplace, but the frequency of these issues in the Juvenile Court may warrant a different approach. When ongoing problems of this nature exist, particularly if not posting positions consistently,

questions of efficiency arise. How much more efficient Human Resources can become requires attention at the highest levels of Juvenile Court operations.

l. Keeping ACA Accreditation in perspective.

3. Youth Interviews

Youth interviews provided a supplemental perspective on operations, safety, and suicide prevention practices. Youth perspectives need to be one part of a larger system of information that describes what is occurring in the facility. A triangulation strategy is used that includes subjective perspectives (views of youth and staff), direct observations, and the elements of organization structure included in policy, procedure, practice, and outcomes data. Compared to the 10 youth who participated in the group interviews during the October 2014 monitoring visit, this group of 10 youth proved to be remarkably similar in racial distribution and age (the mean age for both groups was 15.9 years). This group expressed fewer concerns about safety, order, and organization. Much of their concern had to do with relationships with staff. These findings underscore the need for the Positive Behavior Management System and for strengthened relationships between youth and staff. For example:

- 10 of the youth (100%) indicated that staff asked them about suicidal thoughts, suicidal ideation, and suicidal history at intake.
- When asked, "On a scale of 1-10, with 10 being the highest, how safe do you feel in this facility?" youth rated their safety at 8.2 or a 95% increase over the safety perceptions of youth in the October 2014 interviews.
- 10 of the youth (100%) complained that they spend too much time in their rooms and that they are not allowed to have reading materials in their room. A restriction of this nature remains contrary to generally accepted professional standards about a quantity of reading materials that are permitted in a youth's room.

  Regarding room confinement time, all youth complained that there are days during the week when there are staffing shortages or on the weekends when they are only out of their rooms for about two hours a day.
- 10 of the youth (100%) stated that the grievance system does not work. Grievance systems are important to the protection of residence rights while in the Detention Facility; and while there is currently little other evidence to indicate that the system is effective, in facilities where the conditions of confinement are exemplary, youth evaluate the grievance system as highly effective.
- Youth interviews involved the question, "If you were in charge, what would you do to make this a better place?" 100% of youth identified "food" as the first change they would make. Having enough staff to keep youth out of their rooms and engaged in programs also received unanimous endorsement.

Another response is noteworthy. Youth self-reported their lengths of stay, which worked out to an average of 40.9 days or an increase of 145% over the self-reported ALOS of interviewees in October 2014. Self-report information may not be precise, but it is another independent indicator of the concern about how long youth remain in the Detention Facility.

B. Section C Comments and Recommendations to DOJ

JCMSC shall provide Children in the Facility with reasonably safe conditions of confinement by fulfilling the requirements set out below (see MOA page 27)

1. Use of Force

(a) No later than the Effective Date, the Facility shall continue to prohibit all use of a restraint chair and pressure point control tactics. (See MOA page 28)

RECOMMENDED FINDING: Substantial Compliance

COMMENT: This paragraph remains in substantial compliance. In the interviews with staff and youth, no one mentioned the existence of a restraint chair or use of pressure point tactics. Each interviewee stated clearly that these two approaches were strictly prohibited. I found no evidence of a restraint chair anywhere in the facility or any evidence of pressure point control tactics.

FUTURE MONITORING:

Future monitoring will include reviews of use of force policies and procedures with special emphasis on prohibition of the restraint chair and pressure point control tactics (PPCT). Additionally, future monitoring will include interviews with youth and staff to verify the absence of behavior management practices related to both prohibited approaches.

(b) Within six months of the Effective Date, the Facility shall analyze the methods that staff uses to control Children who pose a danger to themselves or others. The Facility shall ensure that all methods used in these situations comply with the use of force and mental health provisions in this Agreement. (See MOA page 28)

RECOMMENDED FINDING: Partial Compliance

COMMENT: The Report Card data contain a great deal of important management information on security issues including Use of Force, and the Compliance Report accurately notes that the Detention Facility is ahead of the rest of the Juvenile Court in the collection and use of data for management purposes. Yet, while commendable, it is important that greater confidence exists in the Detention Report Card data; and while this concern will be expanded in Section 4, "Performance Metrics for Protection from Harm," the integrity of the data that inform critical Protection from Harm analyses must be improved.

Any paragraph that depends upon data, metrics, or the Detention Report Card to inform a recommendation of compliance requires the validation of the data collection system (Section 4, "Performance Metrics for Protection from Harm") if there is to be sufficient confidence in the numbers to support compliance. Second, compliance represents “the Facility” analysis versus what will be later described more narrowly as the Facility Administrator review or analysis in subsection (c) below. As such, compliance means a broadening or expansion of those staff members at various levels of the facility and agency that participate in the analysis. Third, the system for corrective actions needs to be enhanced through forms of documented instruction (situationally-specific and individually tailored staff training or tutoring that is documented as part of the corrective action as opposed to progressive discipline) and coaching (high-performing staff members providing direct supervision of the target employee to provide immediate and specific feedback about job performance issues). Fourth, for expediency in the resolution of these paragraphs, Judge Michael and Juvenile Court leadership have been advised of the benefit

of an external assessment of the existing data system to include recommendations for improvements and guidelines for conducting an internal data validation audit.

The lack of responsiveness by external funding sources does not excuse the Juvenile Court for not having conducted a data integrity audit. The onus is squarely on the Juvenile Court to make this happen soon.

FUTURE MONITORING:

Future monitoring will include information from the monthly telephone conferences with Juvenile Court, Detention Facility administration, and Powell to review these data integrity and quality developments.

(c) Within six months of the Effective Date, JCMSC shall ensure that the Facility's use of force policies, procedures, and practices:

(i) Ensure that staff use the least amount of force appropriate to the harm posed by the Child to stabilize the situation and protect the safety of the involved Child or others;

(ii) Prohibit the use of unapproved forms of physical restraint and seclusion;

(iii) Require that restraint and seclusion only be used in those circumstances where the Child poses an immediate danger to self or others and when less restrictive means have been properly, but unsuccessfully, attempted;

(iv) Require the prompt and thorough documentation and reporting of all incidents, including allegations of abuse, uses of force, staff misconduct, sexual misconduct between children, child on child violence, and other incidents at the discretion of the Administrator, or his/her designee;

(v) Limit force to situations where the Facility has attempted, and exhausted, a hierarchy of pro-active non-physical alternatives;

(vi) Require that any attempt at non-physical alternatives be documented in a Child's file;

(vii) Ensure that staff are held accountable for excessive and unpermitted force;

(viii) Within nine months of the Effective Date ensure that Children who have been subjected to force or restraint are evaluated by medical staff immediately following the incident regardless of whether there is a visible injury or the Child denies any injury;

(ix) Require mandatory reporting of all child abuse in accordance with Tenn. Code. Ann. § 37-1-403; and

(x) Require formal review of all uses of force and allegations of abuse, to determine whether staff acted appropriately. (See MOA pages 28-29)

RECOMMENDED FINDING: Partial Compliance

COMMENT: Again, the Report Card data contain a great deal of important management data on Use of Force. The Use of Force data show that the rate of Use of Force for 2015 is roughly the same as that in 2014.

Of the 10 use-of-force events from March 2015, I reviewed the medical files for each youth to ensure that the post-restraint medical exam occurred in a timely fashion and was

documented appropriately. I provided a list of names of individuals for the file review, and Health Services Administrator (HSA) Crosby secured and provided the files. All were in order except one. That file (incident 030315A) had no blue sheet (the original of the medical form is blue) nor copy of the blue sheet. After checking the contents twice to make sure that I was not overlooking the form, I mentioned the missing blue sheet to the HSA. She indicated that it was not possible for a medical exam to have occurred and not be in file. I showed her the Restraint Packet copy of the blue sheet included in the documentation with JC-142. Later, the HSA showed me the original blue sheet and stated that she found it in the file. Regardless, the follow-up medical exam is sufficiently important that *all* documentation must be verifiable.

One item of particular concern is the "% of time Hierarchy of non-physical alternatives used." A low percentage in this item suggests either a staff failing to attempt non-physical de-escalation techniques in response to problem behavior or the presence of a high number of spontaneous acts by youth, which require an immediate physical intervention by staff. While the failure to use non-physical alternatives is clearly problematic, a high number of spontaneous acts by youth requiring physical interventions could also be problematic. That situation could indicate staff are not responding to tense environments in a timely and appropriate way thus allowing youth to quickly escalate to violence or it could be indicative of poor staff/youth relationships where youth may try to resolve problems themselves rather than relying on help from staff. In any event, this Use of Force indicator is one that bears closer monitoring.

Regarding the documentation of attempts at non-physical alternatives in a youth's file, there is a clear statement in the policy. Incident Statement JC-142B requests a list of the nonphysical alternatives, and this form goes in the youth's file. The file review indicated a lack of documentation of the attempts at non-physical alternatives. This does not mean that no non-physicals were used, especially in the absence of audio; however, the documentation does not support the use of non-physicals. Discussions with Jones, Walton, and Weichel stressed the importance of providing feedback to staff about how to increase their documentation on incident reports that describe non-physical alternatives.

Critical Factors in Achieving Compliance

There are multiple factors that work against the Juvenile Court in its efforts to achieve compliance with the use of force paragraphs. They exist as obstacles to the progress made by the Detention Facility and have the potential, when taken together, to undermine the order and structure necessary to create a safe living environment for both youth and staff. These factors are considered separately but are interactive.

1. Staffing

Staffing remains a priority concern and the absence of an adequate number of JDOs available to work all three shifts during the week has an adverse impact on Protection from Harm concerns. The staffing challenge is not simply about the number of authorized positions approved as part of the annual budget. Instead, the attention on staffing numbers has to do with the availability of qualified individuals to work a shift. By qualified, most detention practitioners mean an employee who has successfully completed the hiring process, has been through the mandatory pre-service training, and who has acquired some appropriate job experience. Many in detention believe that it takes a new JDO approximately 18 months to two years to acquire sufficient experience to be competent and reliable in performing the job duties.

A second major variable affecting staffing availability is leave status, in particular FMLA and OJI at the Juvenile Court. This is above and beyond the routine or normal use of sick and vacation leave factored into staffing estimates as part of the Replacement (*R*) factor.

The third variable is the number of unfilled or vacant positions, and this shifts attention away from the facility to Human Resources and raises questions about how to achieve greater efficiency in shortening the time between the designation of a vacancy and a new employee participating in the mandatory pre-service training.

A discussion of staffing that includes these variables presents a different picture of staffing adequacy than is often times conveyed to the Juvenile Court. Using personnel data provided by the Detention Facility as of April 27, 2015, the following availability findings are noteworthy:

a. There were 60 Lead JDO (six) and JDO (54) positions allocated, but there were 14 vacancies (23%).

b. 20 (33.3%) (19 JDO and one Lead JDO) were unavailable because of leave status.

c. Counting vacancies and leave, 26 (43.3%) of Lead JDO and JDO staff were available to fill the shifts.

d. When factoring in job tenure and experience, the "availability" drops to 40% when considering those staff members with less than six months of experience; and "availability" drops to 23% when considering those staff members with less than a year experience.

e. If we convert the leave hour usage from the April 27 personnel data to 8-hour shift equivalents, the total hours per week that staff were unavailable due to leave status was 7.6 shifts that needed to be filled with a replacement staff member in order to meet the Coverage and Assignment strategy.

These factors create substantial stress on Coverage and Assignment, and they create situations where overtime increases and staff experience job burnout. Depending upon the Detention Facility population, these staffing availability challenges translate into important budget factors related to overtime hours.[1]

Conversely, a second and more cost-effective way to address the staffing issue is through the reduction in the average daily population (ADP). The Juvenile Court understands this approach, and the recent reduction in ADP reflects the implementation of JDAI reform strategies. The concern is the increase in the average length of stay (ALOS) and how it can offset the positive effects on ADP of reduced admissions to detention. Discussions with Juvenile Court Administration about ALOS included consideration of the one youth that had been in

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[1] Using (a) Miller and Liebert's staff prediction strategy in the *Staffing Analysis Workbook for Jails* (1988), (b) the Detention Facility staffing roster and vacancies as of April 30, (c) computation of the accumulated Detention Facility weekly hours of FMLA or workers comp leave, (d) a conservative estimate of the Replacement Factor (1.7), (e) a population of 56 youth (six girls), (f) a staffing ratio of 1:8, and (g) an estimated mean JDO hourly rate of $18, Coverage and Assignment is short 12.7 shifts per week or the equivalent of approximately 101 hours of overtime weekly. Annualized, overtime expenditures could amount to nearly $95,000, again, a conservative estimate particularly if overtime is *not* paid at time-and-a-half.

custody over 240 days during this visit; however, most facilities have a statistical ALOS outlier, and the increase in ALOS seems more indicative of generally longer stays in detention for all other youth. Other reasons for ALOS increases might include delays due to requests for psychological evaluations, the absence of parental supports, difficulties surrounding the enforcement of subpoenas, and DA filings of "notices" on more cases than necessary to get some type of plea offer. Attention by the Juvenile Court to ALOS is important in Detention Facility population management.

As the Juvenile Court acquires resources to add more detention alternative beds, there are still questions about a formal expediter position. Juvenile Court administrators should refer to guidance from Mark Soler, a leading national expert on detention population management. One area of concern is the proposed transfer of detention operations to the Sheriff's Department, which would mean that the Juvenile Court would retain a gatekeeper function for detention. Under this arrangement, an expediter could be beneficial for Detention Facility population management.

2. PBMS

PBMS should have an additional positive impact on the reduction of use of force and room confinement. Systems of this nature provide a way to resolve minor inappropriate behaviors before they escalate to situations requiring use of force or confinement. However, there are always initial implementation problems, especially in facilities where such a behavior management system has not been previously used. Detention Facility leadership has already identified the existence of a veteran group of line staff who do not want to change the philosophy and assumptions about working with youth in detention. They refer to situations where supervisors' decisions have been contrary to the intentions of leadership, and these decisions could sabotage the positive impact of PBMS on the use of force Report Card data.

"First-generation problems" are inevitable and mean that those youth and staff who are familiar with the old system will be tempted to revert to old ways when things are not going well or when the new approach does not show immediate results. They are the result of an inconsistent application of the behavioral principles, and inconsistency in any reward system generates complaints of unfairness from youth, which can be a powerful triggering event for acting-out behaviors. Training and intention supervision are required to minimize negative impact of first-generation problems. Patience will be needed until the system is fully implemented.

3. Food

It remains difficult to understand why food is still such a problem. Experience in over 250 juvenile facilities convinces me that the failure to resolve this issue goes beyond "You will never be able to serve food that teenagers like and still stay within nutritional guidelines." Conventional wisdom continues to suggest that teenagers who are fed well and active (physical exercise) are less likely to be engaged in mischief and are more likely to be tired enough at the end of the day to get a good night's sleep. As applied to the youth in the Detention Facility, this wisdom seems to be even more relevant.

There was an endorsement of this thinking by Judge Michael at the last visit, and the assumption was that if Judge Michael were in support of improving food services, the situation would improve. To the contrary, however, reports from youth and staff, the minutes of

Committee A, and even the American Correctional Association's Audit Report contain documentation that problems persist. Beyond the consistent criticism of the food by youth and staff, the conservative and extremely tolerant ACA Visiting Committee was moved to describe *unprofessional* behavior on the part of kitchen staff toward youth and wrote that the staff were "sometimes *rude* to the detainees" (p. 7). The Juvenile Court seems to invite pushback about why it feeds its youth in this manner. And, multiple sources continue to suggest that the reason for the poor food quality may have more to do with the ideological biases of some employees within the Juvenile Court who vocalize that "If they don't like the food, they shouldn't be here." The hope is that this unprofessional approach is limited to the kitchen staff, for if this philosophy is more pervasive, it undermines the implementation of the PBMS.

4. Reading Materials in Rooms

The blanket decision to remove the reading material from all resident rooms applies to every youth and thereby unfairly penalizes youth who have not shown a destructive inclination. Denying access to reading materials during locked room confinement impedes the youth's efforts for education and self-improvement. Some Juvenile Detention Officers (JDO) argue that a pervasive gang influence would ensure that even the youths most unlikely to damage a sprinkler head would be under so much gang-related peer pressure that he or she would surely pass a book to a gang member intent upon mischief and disruption through breaking the sprinkler head. It is difficult to evaluate this perspective since there has been no assessment of the nature and extent of gang activity and its influences in the Detention Facility. However, the staff argument calls attention to gaps in the supervision of youth; and given the stark nature of youth rooms, contraband item as large as a book should be easily discoverable. Finally, in regards to room confinement practices, Mark Soler wrote in *Representing the Child Client* (Soler et al., 1990:2-102) that "children should be allowed to have books, writing materials and articles of personal hygiene," and this statement is footnoted to multiple case law decisions. He was also instrumental in the wording of the updated *Juvenile Detention Facility Assessment: A Guide to Juvenile Detention Reform* (JDAI, 2014:103) regarding access to books while youth are in room confinement. The DOJ opposition from a Protection from Harm perspective to this across-the-board policy that penalizes the innocent remains unchanged.

FUTURE MONITORING: Missing from this information is documentation about the use of non-physical alternatives. As will be discussed regarding the review of restraint packets, there is video evidence that staff are refraining from initiating use of force too quickly. The assumption is that non-physical alternatives are being used, but there is no consistent reference to them in the documentation. There will be a greater review of restrain packets, especially the video.

(d) Each month, the Administrator, or his or her designee, shall review all incidents involving force to ensure that all uses of force and reports on uses of force were done in accordance with this Agreement. The Administrator shall also ensure that appropriate disciplinary action is initiated against any staff member who fails to comply with the use of force policy. The Administrator or designee shall identify any training needs and debrief staff on how to avoid similar incidents through de-escalation. The Administrator shall also discuss the wrongful conduct with the staff and the appropriate response that was required in the

circumstance. To satisfy the terms of this provision, the Administrator, or his or her designee, shall be fully trained in use of force. (See MOA page 29)

RECOMMENDED FINDING: Partial Compliance

COMMENT: I reviewed the 10 Restraints Packets from restraint events in March 2015. The use of force activities ranged from full physical restraints with the youth on the floor to simple escorts where staff took a hold of the youth's arm for movement and direction purposes. The Detention Facility definitions of use of force activities are consistent with the definitions from the Performance-based Standards Project, which also serves as the frame of reference for other critical incident definitions.

The documentation contained in the JC-142 forms was consistent with the video. Discussions occurred with Jones, Walton, and Weichel about an expanded role for documentation and the need for greater description regarding staff behaviors before the use of force. Discussions also included suggested modifications to the form regarding the different justifications for the use of force. The recommendation was to remove from the form a justification called, "Enforce rules and regulations" because force should not be used to enforce directives. The PBMS is intended to address these types of minor inappropriate behaviors.

This is the first occasion where use of force documentation and videos were transmitted confidentially for off-site review before the monitoring visit. These restraint documents and videos represent a snapshot or a first look at existing physical restraint practices, but more information is needed about staff use of force behaviors and the consistency of the administrators' reviews. Nonetheless, the preliminary reviews were generally positive and indicated that Detention Facility management has a good understanding of use of force events and their sequence. Video reviews indicated that staff seem to have a satisfactory understanding of the use of force policies and techniques.

FUTURE MONITORING: The use of force Restraint Packet review will include relevant documentation regarding an incident (this usually includes multiple incident reports from the staff members directly involved and a report by the shift supervisor), a post restraint medical evaluation form, documentation of an administrative review and plans of action, relevant video footage from all applicable cameras, and documentation describing any future or ongoing corrective action. The use the physical Restraint Packet and its conversion to PDF and other forms of transmittal will be the topic of continued discussions on the monthly teleconferences.

2. Suicide Prevention

(a) Within 60 days of the Effective Date, JCMSC shall develop and implement comprehensive policies and procedures regarding suicide prevention and the appropriate management of suicidal Children. The policies and procedures shall incorporate the input from the Division of Clinical Services. The policies and procedures shall address, at minimum (See MOA pages 29-30:

(i) Intake screening for suicide risk and other mental health concerns in a confidential environment by a qualified individual for the following: past or current suicidal ideation and/or attempts; prior mental health treatment; recent significant loss, such as the death of a family member or a close friend; history of mental health diagnosis or suicidal behavior by family members and/or close friends; and suicidal issues or mental health diagnosis during any prior confinement.

(ii) Procedures for initiating and terminating precautions;

(iii) Communication between direct care and mental health staff regarding Children on precautions, including a requirement that direct care staff notify mental health staff of any incident involving self-harm;

(iv) Suicide risk assessment by the QMHP;

(v) Housing and supervision requirements, including minimal intervals of supervision and documentation;

(vi) Interdisciplinary reviews of all serious suicide attempts or completed suicides;

(vii) Multiple levels of precautions, each with increasing levels of protection;

(viii) Requirements for all annual in-service training, including annual mock drills for suicide attempts and competency-based instruction in the use of emergency equipment;

(ix) Requirements for mortality and morbidity review; and

(x) Requirements for regular assessment of the physical plant to determine and address any potential suicide risks.)

RECOMMENDED FINDING: Compliance

COMMENT: The two primary indicators in the Safety and Order section of the Detention Facility Report Card are "Suicidal Behavior with Injury by Youth per 100 Bed Days" and "Suicidal Behavior without Injury by Youth per 100 Bed Days." These rates have averaged 0.00 and 0.86, respectively, over the past six months, and they continue to reflect an effective approach to suicide prevention.

The suicide prevention section of the Report Card noted an increase in QMHP contacts or the rate of QMHP calls per 100 youth. Detention Facility leadership explained this increase as staff being overly cautious in light of the understaffing circumstances. Subsequently, the average length of a suicide precaution almost tripled between February and March 2015.

The contract services provided by CCS have been responsive to the MOA, and the CCS services were in full operation at this assessment: (a) there was a 24/7 nursing presence, and CCS provides the QMHP staff designated by the Agreement; and (b) at the meeting with the CCS contracted service providers, there was open satisfaction with the increased communications with County, Juvenile Court, and Detention Facility staffs.

I reviewed six (6) files selected at random from the names of youth on the March 2015 list of precaution orders. All the required documentation were in the file; the case notes were legible, understandable, and appropriate; dates, times, and signatures were accurate; daily progress notes were complete; release justification forms were present and complete; and psychiatric notes were available. The files indicate that QMHP activities occur as outlined in the Memorandum of Agreement.

The CCS team provided an overview of the accomplishments in medical and mental healthcare services since the last visit. These included a 100% on all healthcare standards from the ACA accreditation audit, an activity therapist who provides group activities on Saturdays and Sundays, monthly meetings with the County contract auditor for healthcare, creation of a use-of-force audit tool; stabilization of the RN nursing staff; addition of a LPN position with

administrative skills; weekly group on health education; and initiation of a third Tuesday meeting with the Detention Facility leadership to discuss operational issues. A request was made and accepted by CCS that Ms. Jina Shoaf, Shelby County Attorney, participate in future third Tuesday meetings. These improvements in communication have been impressive. Furthermore, the overall quality of medical and mental health care has improved substantially through the contract with CCS.

An important suicide prevention strategy is to have youth out of their rooms and actively engaged in constructive activities. The activity therapist conducts activities from a life skills curriculum, which has been requested for review. As of yet, there is no way of knowing what these activities include or accomplish. CCS reports that the activity therapist is responsible for two groups a day on Saturday and Sunday. She also submits a report and makes occasional notes in the youth's charts. Interviews with 10 youth made no mention of the weekend activities by the activity therapist.

A proposal exists to conduct a tele-behavioral health assessment with a handheld device, e.g., an iPad, on those occasions when the QMHP is on call. Confusion exists about the status of the proposal and who is offering support or concern about it. This needs to be resolved.

Concerns have arisen about medicine administration or med passes due to incidents of "cheeking" pills and the danger of contraband implications. Cheeking meds means that the youth did not swallow the medication, instead kept it in his/her mouth. Given the presence of psychiatric medications, these pills become contraband and are a tradable commodity to acquire extra food. CCS questioned who has the responsibility for making sure that the youth takes the medicine and pushed for a dual responsibility between the nurse and the supervising JDO. This is not a responsibility for juvenile detention line staff. This is the responsibility of medical.

The file review raises some issues that require continued monitoring by CCS and the contract monitor. For example, in two files, the times of the QMHP assessment had been changed. The time on the form reflected the gap between the nurse's assessment of the youth and the QMHP assessment. Because the nurse had been on the scene almost immediately, her assessment resulted in a precaution level recommendation, which was later confirmed by the QMHP. Having a nurse on the scene quickly is highly beneficial, and a nurse-generated precaution about immediate supervisory requirements strengthens suicide prevention strategies. However, the QMHP assessment represents an additional and important level of suicide prevention as outlined in the Memorandum of Agreement. Because these examples occurred during the work hours of the QMHP, questions arose regarding tardiness and continuity of care; and both warrant follow-up.

In the files of two youth (40%), Precaution Order Forms indicated that notification to the supervisor of the precaution level designation had been "attempted." This is unacceptable. It is the responsibility of the QMHP to ensure that Detention Facility staff have immediate access to the information in the Precaution Order, and the best way to ensure that this happens is for the QMHP to hand a copy of the form to the supervisor. This element of suicide prevention is so important that the failure to remedy this problem will adversely affect compliance.

FUTURE MONITORING:

Several factors represent substantial threats to continued compliance, and they will constitute focal points for future monitoring activities. These issues include:

- Electronic medical record records need to be a priority for the health care unit. This is something that should be the responsibility of the Juvenile Court and the Detention Facility to implement with guidance from CCS.
- Previous conversations with CCS regarding how to use new technologies to enhance emergency mental health services led to a productive discussion about tele-mental health options. Through the use of handheld devices that permit a video discussion with a youth presenting issues requiring a QMHP's assessment, the QMHP could see and talk to a youth to provide an immediate determination of his or her mental status for purposes of levels of supervision and possible emergency referral in accordance with appropriate tele-mental health protocols. If the youth were not in crisis, a face-to-face assessment with the QMHP would occur within an appropriate amount of time according to the protocols. While the concept has strong appeal, recommendations for approval of tele-mental health options would have to follow a review of a draft CCS tele-mental health policy, which has not been completed, so there is as yet no recommended practice.
- The activity therapist's reports.
- Effectiveness of med passes.
- A review of timeliness issues of the QMHP assessments.
- Review of percentage of Precaution Order Forms delivered directly and immediately to the Detention Facility Supervisor.

(b) Within 60 days of the Effective Date, JCMSC shall ensure security staff posts are equipped with readily available, safely secured, suicide cut-down tool. (See MOA page 30)

RECOMMENDED FINDING: Substantial Compliance

COMMENT: Here is another paragraph that remained in compliance. The cut-down tool was part of the Code Blue Pack, a blue pouch like container located in the staff offices. I verified the presence of three Code Blue Packs while conducting the facility tour.

FUTURE MONITORING:

Future monitoring will continue to include a check of each security staff post to ensure that all contain a Code Blue Pack with the appropriate equipment.

(c) After intake and admission, JCMSC shall ensure that, within 24 hours, any Child expressing suicidal intent or otherwise showing symptoms of suicide is assessed by a QMHP using an appropriate, formalized suicide risk assessment instrument. (See MOA page 30)

RECOMMENDED FINDING: Substantial Compliance

COMMENT: The file reviews supported the provision of these services through CCS, so continued compliance is recommended.

FUTURE MONITORING:

Future monitoring will continue to include a review of those youth who identify as suicidal through self-disclosure or staff identification and the response by the CCS QMHP. This will include file reviews along with interviews with youth, direct care staff, and the CCS QMHP.

(d) JCMSC shall require direct care staff to immediately notify a QMHP any time a Child is placed on suicide precautions. Direct care staff shall provide the mental health professional with all relevant information related to the Child's placement on suicide precautions. (See MOA page 30)

RECOMMENDED FINDING: Compliance

COMMENT: The concern that existed about Detention Facility staff conducting a suicide screening within one hour of a youth's admission to the facility has been successfully resolved through the use of the new suicide screening tool. Columbia Suicide Severity Rating Scale is an appropriate tool for the initial screening of youth for potential suicide risks.

The youth in intake, while they have not been counted as an admission because they have not been formally processed (a decision has not been made to detain) and they have not been physically escorted upstairs to detention, are in custody, so all of the Agreement requirements apply to them.

FUTURE MONITORING:

Future monitoring will continue to include a review of the suicide screening time data along with a review of those youth placed on suicide precautions as the result of direct care staff recommendations.

(e) JCMSC shall prohibit the routine use of isolation for Children on suicide precautions. Children on suicide precautions shall not be isolated unless specifically authorized by a QMHP. Any such isolation and its justification shall be thoroughly documented in the accompanying incident report, a copy of which shall be maintained in the Child's file. (See MOA page 30)

RECOMMENDED FINDING: Partial Compliance

COMMENT: The documentation regarding locked room confinement needs review and improvement to be able to provide evidence of the practices regarding isolation of youth on suicide precautions. This is again a data quality issue that will be discussed at greater length in Section 4: Performance Metric.

Regarding the Non-Compliance on ACA Standard #3-JDF-2C-02 in the recent Accreditation Report (pages 19-20) related to "The cells are less than 80 sq. ft. when juveniles are confined more than 10 hours a day," the Juvenile Court's response contain in the Waiver Request read:

> Additionally, any detainee placed on control status or *confined as a result of being on observation or precautions* are still allowed out of the room for large muscle activity and meals and school. As a result, they are not confined for more than ten *continuous* hours. (emphasis added)

> Due to this fact, programming and required activities prevent confinement for more than 10 hours, and both structural and fiscal constraints, this facility is requesting a waiver request for this standard.

The statement, "any detainee placed on control status or confined as a result of being on observation or precautions are still allowed out of the room for large muscle activity and meals and school," raises a Protection from Harm concern about the use of room confinement for youth on suicide precautions. The Waiver Request statement implies that youth "on observation or precautions," terms associated with the CCS mental health Precautions Order Form, are confined. Additionally, the QMHP struggled to explain the relationship between suicide prevention and room confinement in the interview that Bill Powell observed. The statement seems to denote a conceptual and safety-related disconnect between suicide risk and locked room confinement that is at the heart of this paragraph.

Generally accepted professional practices call for the minimum use of locked room confinement because of the risk locked room confinement presents to Protection from Harm and safety. Nowhere is this spelled out more clearly than in Lindsay Hayes' national survey[2] of suicides in juvenile detention facilities. The research, sponsored by the National Juvenile Detention Association, the Counsel for Juvenile Correctional Administrators, and the Office of Juvenile Justice and Delinquency Prevention, revealed a hazardous association between locked room confinement and suicidal behaviors; and this link also existed for youth not on a suicide watch precaution.

Next, and of equal concern is the implication in the ACA Accreditation Audit Report that youth are confined more than 10 hours a day. The Waiver Request focuses on 10 *continuous* hours, which raises more concerns. The qualifier of "continuous" seems to acknowledge that youth may be confined more than 10 hours a day. Even though the Juvenile Court points to programming and required activities as an argument against the noncompliance finding, I have witnessed multiple exceptions to the "programming and required activities" that have occurred during monitoring visits that exceeded the additional 1.5 hours of confinement: (a) when the Detention Facility population exceeded the Hope Academy capacity, not all youth attended school and it was not unusual for the youth to spend school time in their rooms; (b) youth from other counties reported not being placed in the Hope Academy, so they were confined for the entire school day; (c) when school was not in session, youth were divided into groups to participate in recreation and leisure time activities while the other group remained in room confinement; (d) youth continue to report the use group punishment, meaning that when a disciplinary confinement occurs, it is likely that the entire group will be program confined, to name a few. Additionally, taking youth to breakfast for 15 minutes and then returning them directly to locked room confinement is a very weak argument against "continuous" confinement especially considering that taking youth to shower during disciplinary confinements is not classified as a disruption or discontinuation of the confinement event.

The culture change associated with the PBMS will have to address the traditional and existing approach to behavior management as discussed above. This traditional philosophy depends upon control and sanctions, and the primary staff objective is having a safe and

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[2] Hayes, L. M. (2009, February). Characteristics of suicide in juvenile confinement. *OJJDP Juvenile Justice Bulletin*. Washington, D.C.: U. S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

uneventful shift in the perceived absence of adequate sanctions and consequences for inappropriate youth behaviors. One staff member talked articulately about the need to establish and safeguard a "milieu of control." To do so, he explained, some youth need to be in locked room confinement even during programming hours and especially on weekends. Weekends are associated with less structure and the fewer things to do, resulting in youth behaviors that are also "less structured or more excitable." Locked room confinement allegedly provides the structure and order that reduces some of the excitement and inappropriate behaviors. Also, understaffing aggravates the use of confinement whenever there are not enough individuals working to shift to be able to exercise the amount of control staff believe necessary to prevent problems from occurring. Recent reports in the media indicate that the Juvenile Court believes that the current resident population is more violent and, therefore, staff are at greater risk of assault and injury. The Report Card noted that 35% of staff feared for their safety. Again, these factors combine to make a compelling argument in the minds of staff that locked room confinement is the best way to accommodate the absence of a full staffing complement on their shift. To the extent that they occur, the additional locked room confinement likely exceeds the 10 hours identified by ACA as the basis for the noncompliance of Standard #3-JDF-2C-02.

These situations are aggravated because a preliminary search of confinement documentation did not generate sufficient evidence to confirm or deny the Juvenile Court's Waiver Request. If these types of confinement occur routinely, it is highly problematic, further underscores the need for a data integrity audit, heightens the growing concerns about the Detention Facility's use of isolation, and calls for a verification of the 15-minute room check.

FUTURE MONITORING:

The monitoring process will shift based on these room confinement issues, especially as it relates to the potentially dangerous combination of room confinement and precautionary watches. The next monitoring visit will audit the amount of confinement time documented in the Detention Facility logs, the accuracy of the required room checks, and the coherence of these findings to reports from youth and staff for random sample of used on suicide precautions, mental health precautions, and personal safety watches.

(f) Within nine months of the Effective Date, the following measures shall be taken when placing a Child on suicide precautions:

(i) Any Child placed on suicide precautions shall be evaluated by a QMHP within two hours after being placed on suicide precautions. In the interim period, the Child shall remain on constant observation until the QMHP has assessed the Child.

(ii) In this evaluation, the QMHP shall determine the extent of the risk of suicide, write any appropriate orders, and ensure that the Child is regularly monitored.

(iii) A QMHP shall regularly, but no less than daily, reassess Children on suicide precautions to determine whether the level of precaution or supervision shall be raised or lowered, and shall record these reassessments in the Child's medical chart.

(iv) Only a QMHP may raise, lower, or terminate a Child's suicide precaution level or status.

(v) Following each daily assessment, a QMHP shall provide direct care staff with relevant information regarding a Child on suicide precautions that affects the direct care staff's duties and responsibilities for supervising Children, including at least: known sources of stress for the potentially suicidal Children; the specific risks posed; and coping mechanisms or activities that may mitigate the risk of harm. (See MOA pages 30-31)

RECOMMENDED FINDING: Compliance

COMMENT: The issues expressed in the Agreement were present in the Detention Facility policy, and all of the requirements of this paragraph were satisfactorily present during this visit. The file reviews verified all of the required actions of the QMHP for those used on suicide precautions.

FUTURE MONITORING:

Future monitoring visit will continue to review the QMHP job performance outlined in this section of the Agreement. Additionally, future monitoring will include an evaluation of the ITP; a review of the status of information sharing; a review of the supervision issues (a check on the practice of how often and how well staff are conducting monitoring and room checks of youth on suicide watch); and a review of the amount of confinement time accumulated by youth on suicide watch.

(g) JCMSC shall ensure that Children who are removed from suicide precautions receive a follow up assessment by a QMHP while housed in the Facility. (See MOA page 31)

RECOMMENDED FINDING: Compliance

COMMENT: The file reviews of the youth on suicide precautions contained QMHP notes and entries describing daily assessments, rationales for removal of the precautionary supervision, and periodic reassessments. The documentation was also in the youth's medical file indicating that all required documentation complied with the Agreement. Juvenile Court should consider adding the follow-up assessment to the monthly monitoring conducted by Nurse Reddic.

FUTURE MONITORING:

Future monitoring will include file reviews to verify that follow-up assessments have been completed.

(h) All staff, including administrative, medical, and direct care staff or contractors, shall report all incidents of self-harm to the Administrator, or his or her designee, immediately upon discovery. (See MOA page 31)

RECOMMENDED FINDING: Compliance

COMMENT: The issues expressed in the MOA were present in the Detention Facility policy; however, there were no documented incidents or discoverable events that warranted a reporting activity.

FUTURE MONITORING:

Future monitoring will continue to include a review of the data, including file reviews to ensure that the reporting function has been completed in a timely fashion.

(i) All suicide attempts shall be recorded in the classification system to ensure that intake staff is aware of past suicide attempts if a Child with a history of suicidal ideations or attempts is readmitted to the Facility. (See MOA page 31)

RECOMMENDED FINDING: Compliance Pending

COMMENT: On the previous visit, the intake officer was unable to produce the information on the computer that indicated a previous suicide precaution status during a prior stay in the Detention Facility. The issue was discussed with a QMHP, and there seemed to be some problems with the system regarding data entry and access. A previous report requested that this issue be resolved, and staff reported that it had been. However, the process was not tested due to a lack of time. Therefore, compliance is pending verification at the next monitoring visit.

FUTURE MONITORING:

Future monitoring will include a review of the data to verify that intake staff is aware of past suicide attempts if a youth with a history of suicidal ideations or attempts is readmitted to the Facility.

(j) Each month, the Administrator, or his or her designee, shall aggregate and analyze the data regarding self-harm, suicide attempts, and successful suicides. Monthly statistics shall be assembled to allow assessment of changes over time. The Administrator, or his or her designee, shall review all data regarding self-harm within 24 hours after it is reported and shall ensure that the provisions of this Agreement, and policies and procedures, are followed during every incident. (See MOA page 31)

RECOMMENDED FINDING: Partial Compliance

COMMENT: The Report Card represents the monthly statistical document used for the administrative review and analysis of the Protection from Harm factors listed above. Detention Facility leadership also includes middle management and line staff in the discussion and interpretation of these data. Yet, the utility of these monthly analyses and the their impact on safety depends upon the quality of the Detention Report Card metrics, which have not been validated (see Section 4, "Performance Metrics for Protection from Harm"). Therefore, there is presently insufficient confidence in the numbers and the information to support compliance.

To repeat, the Compliance Report accurately notes that the Detention Facility is ahead of the rest of the Juvenile Court in the collection and use of data for management purposes. This is commendable, but it is becoming increasingly important that achieving and sustaining competent quality assurance information to advise critical Protection from Harm decision-making requires a higher level of confidence in the data being reported. Detention Facility data have not yet reached that level of confidence.

FUTURE MONITORING:

Future monitoring will continue to include a review of the Administrator's Review process, including the performance metric, which ensures that suicide-related documentation has been completed in a timely fashion. Additionally, the review of this remedy will include an assessment of how well the Administrator's review is conducted.

3. Training

(a) Within one year of the Effective Date, JCMSC shall ensure that all members of detention staff receive a minimum of eight hours of competency-based training in each of the categories listed below, and two hours of annual refresher training on that same content. The training shall include an interactive component with sample cases, responses, feedback, and testing to ensure retention. Training for all new detention staff shall be provided bi-annually.

(i) Use of force: Approved use of force curriculum, including the use of verbal de-escalation and prohibition on use of the restraint chair and pressure point control tactics.

(ii) Suicide prevention: The training on suicide prevention shall include the following:

a. A description of the environmental risk factors for suicide, individually predisposing factors, high risk periods for incarcerated Children, warning signs and symptoms, known sources of stress to potentially suicidal Children, the specific risks posed, and coping mechanisms or activities that may help to mitigate the risk of harm.

b. A discussion of the Facility's suicide prevention procedures, liability issues, recent suicide attempts at the Facility, searches of Children who are placed on suicide precautions, the proper evaluation of intake screening forms for signs of suicidal ideation, and any institutional barrier that might render suicide prevention ineffective.

c. Mock demonstrations regarding the proper response to a suicide attempt and the use of suicide rescue tools.

d. All detention staff shall be certified in CPR and first aid. (See MOA pages 31-32)

RECOMMENDED FINDING: Compliance

COMMENT: The issues expressed in the Agreement were present in the Detention Facility policy and verified in the content and quality of the training. All staff members interviewed indicated that they have had the 8-hour training on suicide prevention, the 8-hour training on physical restraint, and the two-hour annual refresher on suicide prevention and the two-hour annual refresher on physical restraints. Administration confirmed that all staff members were current on these two training requirements.

FUTURE MONITORING: Future monitoring will continue to include a review of the updated and revised training curriculum, especially the schedule of training and the ability to conduct new staff training requirements in an effective and timely fashion.

The Administrator shall review and, if necessary, revise the suicide prevention-training curriculum to incorporate the requirements of this paragraph. (See MOA page 32)

4. Performance Metrics for Protection from Harm

(a) In order to ensure that JCMSC's protection from harm reforms are conducted in accordance with the Constitution, JCMSC's progress in implementing these provisions and the effectiveness of these reforms shall be assessed by the Facility Consultant on a semi-annual basis during the term of this Agreement. In addition to assessing the JCMSC's procedures, practices, and training, the Facility Consultant shall analyze the following metrics related to protection from harm reforms:

(i) Review of the monthly reviews of use of force reports and the steps taken to address any wrongful conduct uncovered in the reports;

(ii) Review of the effectiveness of the suicide prevention plan. This includes a review of the number of Children placed on suicide precautions, a representative sample of the files maintained to reflect those placed on suicide precautions, the basis for such placement, the type of precautions taken, whether the Child was evaluated by a QMHP, and the length of time the Child remained on the precaution; and (See MOA pages 32-33)

RECOMMENDED FINDING: Partial Compliance

COMMENT: The concern continues to grow about a completed data integrity audit and its importance in verifying reductions in uses of force.

Protection from Harm concerns are suicide prevention, use of force, and use of locked room confinement. Thus far, attention has been on the suicide prevention efforts, which appeared to be in good shape, and use of force where progress is occurring. The development of the Restraint Packet review that includes the restraint documentation and video coverage of the restraint event for this monitoring visit has initiated a productive and beneficial analysis of use of force. As this process continues, the focus on a thorough evaluation of the use of force event will alert staff that these events are monitored and reviewed. Detention Facility leadership has demonstrated the ability to dissect the use of force event in such a way as to identify strengths and areas where changes in staff behaviors could produce better outcomes. The positive impact of an improved Restraint Packet review process should be indicated in future use of force Report Card data. Again, verification of the improvements in suicide prevention and use of force reviews depends upon the existence of a valid quality assurance process, and the data integrity audit is the key.

The next substantial challenge related to Protection from Harm data is room confinement. While there are many operational issues associated with the use of locked room confinement in juvenile detention, the juvenile justice community including the leadership of JDAI has been instrumental in identifying the dangers associated with the isolation of adolescents. The new *JDAI Standards for Facility Self-Assessment* recommend reducing to a minimum the use of room confinement.[3] In light of the Juvenile Court's participation in JDAI and the existence of the Memorandum of Agreement, use of confinement is a legitimate concern.

Several words are used to describe confinement: locked room confinement, in the room, isolation, disciplinary confinement, and program confinement. From the Protection from Harm perspective, the focus is on those times when the youth is in his/her room with the door locked.

[3] Page 97 – Staff do not place youth in room confinement for fixed periods of time; Page 98 - Staff do not place youth in room confinement for longer than four hours.

Locked room confinement is generally divided into sleeping and program time. Juvenile detention facilities routinely lock youth in their rooms for sleeping, and sleeping hours are identified on the daily schedule as the period between "bedtime" and "wake up." Staff must check youth in their rooms for sleeping purposes at routine and staggered intervals of 15 minutes.

Program time locked room confinement usually occurs for two reasons. First, there are routine and emergency situations that occur when youth will need to be in their rooms for specific purposes related to deployment of staff. The most frequent temporary locked room confinement is for shift change or a time when the oncoming and outgoing staff have an opportunity to share information about the previous shift. These types of events normally last less than 30 minutes. Another form of program-related locked room confinement has to do with a medical emergency where youth need to be isolated. The second classification of program locked room confinement is disciplinary confinement or confinement that results from a hearing on a youth's misbehavior. In both instances of program time locked room confinement, staff are expected to check on the status of the youth every 15 minutes, unless the youth is on a special room check interval designated by a QMHP as a personal safety watch or as a special mental health/suicide watch.

Preliminary reviews of the documentation related to locked room confinement reveal several areas for attention and improvement. For example, the 15-minute room checks for the night shift are noted in a separate log, but there is no information in the log about which rooms were checked or the general status of the youth. This activity by staff can be reviewed using the surveillance cameras in the units, and this type of review will be part of the next visit. Also, references to program confinement are difficult to understand. In particular, the use of program confinement on the weekends is hard to track leading to uncertainties about room checks. There are, in addition, different perspectives on the amount of time that youth spend out of their rooms on the weekends. Data collection needs to be improved in order to identify more accurately the amount of program-related locked room confinement.

FUTURE MONITORING:

The monitoring process shift based on room confinement issues will likely have strong influence on future compliance strategies. The next monitoring visit will include multiple audits of the amount of confinement time documented in the Detention Facility logs, the accuracy of the required room checks, and the coherence of these findings to reports from youth and staff as an initial validation of the data collection system. An independent, external data quality assessment remains a top priority for developing a plan to validate data integrity and to use these performance metrics to outline measurable compliance objectives.

(b) JCMSC shall maintain a record of the documents necessary to facilitate a review by the Facility Consultant and the United States in accordance with Section VI of this Agreement. (See MOA page 33)

RECOMMENDED FINDING: Compliance

COMMENT: the Detention Facility has created, prepared, completed, and provided all necessary documentations to conduct a monitoring review.

III. Summary and Recommendations

The Detention Facility leadership team continues to be a good mix of committed and talented individuals. Much of the progress identified during this visit can be attributed to the productivity of the leadership team and the Director of Court Operations. As opposed to the last visit when progress was characterized as "stalled," the Director of Court Operations has been active in her support of the Protection from Harm issues and related aspects of Detention Facility operations. The level of support provided by the Juvenile Court is an important part of future progress.

The monitoring continues to reveal progress toward compliance with the MOA. The summary statements from the Compliance Report are also very relevant here. Tremendous progress has been made in the area of Protection from Harm even considering how this progress has slowed recently. Over the past two years, staff members are better trained and a wealth of new and relevant information is available to help analyze their work performance. Medical and mental health services are available and vastly superior to what was provided before the Agreement. Detention staff have made substantial progress in producing reports that make better use of improved data. They were quick to adopt new and innovative training for staff including training on use of force, suicide prevention, and HIPPA. Suicide prevention continues to be a strength. The Detention Facility Report Card continues to provide information to track performance trends. Policies and procedures have been revised, and training occurs on a regular basis. The winnowing of MOA issues means that the more challenging paragraphs remain, and the intent of this report is to focus more precisely on these remaining issues.

An area where delay has Protection from Harm compliance implications is Section 4: The Performance Metric and the necessary data integrity audit. This is now a key component of compliance, and its completion deserves greater importance and urgency. Postponing this audit is unacceptable. The same applies to the staffing analysis. However, the data related to the performance metric raise other issues regarding the possible transfer of information between different information technology (IT) systems. Because two different computer and data analysis systems exist between the Juvenile Court and the Sheriff, there will need to be some reconciliation of the data. In situations where the critical incident numbers are generated by hand, there is a pressing need for these processes to be automated. There is no reason why statistical reports should be generated by hand in this day and age, yet the Report Card is not part of an automated data collection system.

DAT 2

According to Juvenile Court Administration, the first DAT was developed in 2004 and implemented in 2006. I have not seen the minutes of the original committee that developed the DAT, so we have no knowledge of the language used to establish the shared values, goals, or expected outcomes that serve as the additional measures of DAT effectiveness other than references to the JDAI goals and objectives. Particularly, we do not know if these original goals specifically addressed reductions in racial and ethnic disparities in the Detention Facility admissions, the development and expansion of continua of detention alternatives and alternatives to detention, and the cost-benefits to taxpayers of reductions in ADP. In a meeting with the validation study's authors, Drs. Burraston and Turner from the criminal justice department at the University of Memphis, we discussed the value of a psychosocial validation strategy and the need to have further evaluation activities focus on the coherence between the goals and

objectives of the Juvenile Court with respect to Detention Facility population reductions and the DAT scoring system. The effectiveness of a risk assessment-driven objective detention screening tool has financial implications because daily population numbers drive staffing decisions, and personnel costs (including benefits and overtime) are the largest part of the Detention Facility budget. The discussions were very productive, and a summary of the meeting was provided to Jina Shoaf, Shelby County attorney assigned to the Memorandum of Agreement.

ACA Accreditation

As mentioned above, ACA Standards provide a support system or skeleton of an effective detention operation. Accreditation means that all of the important pieces of that skeleton are present in good form. The challenge is realizing that the skeleton, while a necessary part, is not a necessary-and-sufficient component as ACA might contend. Instead, improved conditions of confinement include, but are not limited to, organizational structure. Protection from Harm safeguards are, in general, more responsive to the social structure, the social climate, and performance-driven quality assurance measures than to the organizational structure.

The seminal conditions of confinement research of our professional lifetimes is the congressionally mandated Study of Conditions of Confinement.[4] Before the Study, the widely held assumption was that changing or improving a facility's policies, procedures, and the corresponding staff development or staff training on these new policies and procedures would result in a new practice that would meet standards or other expectations, which was thought to include compliance with court-ordered reforms. This commonly held belief was a part of the ACA rationale to practitioners to adopt standards and accreditation.

The Study of Conditions of Confinement reviewed multiple variables related to conditions while simultaneously assessing the institution's compliance with professional standards and introduced the coherence test to the juvenile detention and corrections field. In other words, if a strong causal relationship is presumed to exist between one variable (the cause) and another variable (the effect), then anyone should be able to see evidence of this connection, even in the absence of sophisticated statistical analyses. The Study's findings were significant, and they resulted in a realignment of professional standards and standards evaluations in juvenile confinement facilities. The Study found that there was no coherence or no relationship between increased standards compliance and improved conditions of confinement. The Study debunked the idea that quality policy (policy, procedure, and training) equals quality practice. The Study indicated that practice was the essential element in the improvement of the conditions of confinement and that the only way to assess practice was through the development of performance metrics. There needed to be performance-based outcomes that would indicate the nature and extent of the changes put forth by in the policies and procedures. The performance-based recommendations provided the foundation for data-driven decisions as a core element of JDAI. Standards compliance only takes reform so far. Protection from Harm reforms call for evaluation strategies using performance metrics beyond the scope of ACA accreditation assessments but required in this Memorandum of Agreement.

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[4] Parent, D., Leiter, V., Kennedy, S., Livens, L., Wentworth, D., & Wilcox, S. (1994, August). Conditions of confinement: Juvenile detention and correctional facilities (Research report). Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Recommendations

Several general recommendations arose from this visitation and warranted special attention by the Juvenile Court and the Detention Facility:

1. Further delays in conducting the data quality audit substantially threaten the recommended partial compliance finding for Section 4 (Performance Metrics for Protection from Harm).
2. The amount of locked room confinement is becoming a substantial Protection from Harm problem along with representing a risk management concern for the Juvenile Court. A plan of action is needed to measure accurately and to continue the reduction in the amount of locked room confinement.
3. The Detention Facility staff need to strengthen current actions to improve the grievance system so as to reduce the gap between youth and staff perceptions of its effectiveness.
4. Programming enhancements should continue for mental health and other youth. The CCS activity therapist's curriculum materials need to be shared with DOJ and me.
5. The amount of time the Detention Facility, through the directives of the Juvenile Court, denies youth access to reading materials should be re-evaluated.
6. The finding of understaffing or an absence of staffing sufficiency underscores previous recommendations for a staffing analysis.

The Detention Facility leadership continues to be competent, caring, and enthusiastic. I remain optimistic that under the new judicial leadership team, the Detention Facility, with the advice, guidance, and support of Bill Powell, will continue to make progress toward the resolution of the Section C Protection from Harm paragraphs.

Sincerely,

David W. Roush, Ph.D.
Juvenile Justice Associates, LLC