Juvenile Court of Memphis and Shelby County
(Sheriff's Department)
MOA Protection from Harm Stipulation
10th Report of Findings and Recommendations

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Submitted to:

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OVERVIEW OF THE REPORT

This report is organized into sections:

A. Executive Summary (brief summary of findings and recommendations)
B. Overview of the Site Visit
C. Protection from Harm MOA Provisions Assessment (item by item review)
D. Summary and Recommendations
E. Appendix (The Appendix contains the Data Collection Matrix used to collect data on MOA Provisions, QMHP Qualifications Form, Use of Force Video/Document Review Form, Persons in Attendance at Interviews/Meetings)

ABBREVIATIONS USED IN THIS REPORT	
CCS: Correct Care Solutions	PREA: Prison Rape Elimination Act
DOJ: US Department of Justice	QMHP: Qualified Mental Health Professional
MH: Mental Health	SCHD: Shelby County Health Dept.
MIRS: Major Incident Reporting System	SCJDC: Shelby County Juvenile Detention Center
MIS: Management Information System	SCSO: Shelby County Sheriff's Office
MOA: Memorandum of Agreement	SPs: Suicide Precautions
PBMS: Positive Behavior Management System	UOF: Use of Force

A. EXECUTIVE SUMMARY

1. A site visit was conducted at Shelby County Juvenile Detention Center on October 2-5 (Monday through Thursday) 2017.

2. The sources of data for assessing compliance with the MOA involved policy/document reviews, record reviews (both electronic and paper) and interviews. This information was then reviewed in light of previous site visit reports and monthly data and reports.

3. The site visit found that all of the UOF Provisions of the MOA were in substantial compliance except for provisions c (ii) (use of unapproved forms of restraint/seclusion), c (iii) (use of restraint only when necessary), c (x) formal review of all UOF events) and d (review of incidents). These were all in compliance.

4. The site visit found that of the Suicide Prevention Provisions of the MOA, c (i) (place and timing of suicide risk assessment) was in partial compliance. Provisions c (ii) (procedures for initiating and terminating precautions), c (vii) multiple levels of precautions, and e (routine use of isolation) were in compliance; the rest of the provisions were found to be in substantial compliance).

5. The site visit found that all of the Training Provisions of the MOA were in substantial compliance.

6. The site visit found the Performance Metrics for Protection from Harm Provisions of the MOA found provision a (i) to be in substantial compliance and a (ii) to be in partial compliance.

7. The recommendations regarding UOF MOA provisions include: continuing to have detention management staff review videos of physical restraints and work with individual staff to increase de-escalation skills, a process which seems to be working effectively; cross validation of reported data is still a work in progress.

8. The recommendations regarding Suicide Prevention MOA provisions include: continuing to work at effective documentation, revise the timing/place of suicide risk/mental health assessment, simplify the system for ensuring physical plant safety, specify clearly on forms that youth on SPs are placed in a room with a camera, revise the suicide precautions order form and revise the number of descriptions of levels of risk.

9. The recommendations regarding Training and Performance Metrics MOA include: updating the current suicide prevention training to current clinical standards and incorporating it into a general presentation on adolescence and mental disorders.

10. Detention Center leadership should work to reduce the stark quality of resident rooms and the facility in general; continue to work to reduce daily population, continue work to ensure that all residents have the same consistent educational experience, increase the effectiveness of assessment for mental health disorders, clarify issues of continuing care for those residents assessed at risk and who may have a Major Mental Disorder or MMD (e.g. Depressive Disorder, Anxiety Disorder, Bipolar Disorder, Schizophrenia/Psychotic Disorder). The PBMS system needs a major overhaul and there should be increased use of CBT based (Cognitive Behavioral Therapy based) materials with established effectiveness.

B. OVERVIEW OF THE SITE VISIT

The site visit occurred Monday through Thursday, October 2-5, 2017. A matrix of Memorandum of Agreement (MOA) provisions and data for evaluating compliance was developed before the site visit. The matrix appears in the appendix. Information sources for the site visit included written reports/policies, records, and interviews/observations. To ensure that information directly and indirectly relevant to the MOA was obtained from interviews, all questions were prepared ahead of time.

Any changes in the following policies/documents were reviewed:

1. Use of Force (UOF)

2. Policy on Mandated Reporting
3. PREA Policy
4. Suicide Prevention Policy
5. Training Curricula
6. QMHP Credentialing Summary

The following electronic records were reviewed:
1. Videos of UOF incidents
2. Previous suicide attempt/history flag in MIS

The following paper records were reviewed:
1. UOF Incident Reports
2. Report Card data
3. Log of Supervisory Review of UOF Incidents
4. Log of Suicide Risk Screenings
5. Completed Suicide Risk Assessments
6. Documentation of communication between MH staff and security on suicide/mental health issues
7. Training Session Attendance Lists
8. Physical Plant Inspection Documents
9. Log of Responses to Suicidality
10. Resident clinical files of those put on suicide precautions
11. Random selection of resident clinical files of those not put on suicide precautions
12. Documentation of follow-up after wrongful conduct identified in UOF incidents

The site visit schedule was as follows:

Monday, October 2

Initial meeting and introductions, introductory meeting with detention management, tour of the facility, HOPE Academy meeting, and review of Physical Plant Inspection logs; focus groups with residents.

Tuesday, October 3

Review of a sample of clinical charts of residents placed on suicide precaution and a sample of charts from residents not placed on suicide prevention; review QMHP credentialing of staff hired since the April site visit; security log review for MH referrals, log of responses to suicidality; focus groups with staff and residents.

Wednesday, October 4

Meeting with CCS staff and Health Dept. representatives; review of training curriculum and training attendance documentation; review of program change implementation after the June visit to the Youth Center of the High Plains in Amarillo, Tx; review of mandated reporting and PREA policy; review of Major Incident Report System, System/Data Verification; focus groups with staff and residents.

Thursday, October 5

Meeting with Court Expediter; meeting with the Settlement Coordinator.

C. PROTECTION FROM HARM MOA PROVISIONS ASSESSMENT

1. Memorandum of Agreement: Use of Force

Recommended Finding	MOA Use of Force Provision (a)
Provision Terminated	(a) No later than the Effective Date, the Facility shall continue to prohibit all use of a restraint chair and pressure point control tactics.

This provision was terminated per DOJ letter of April 3, 2017 from Steven H. Rosenbaum, Chief, Special Litigation Section.

Recommended Finding	MOA Use of Force Provision (b)
Substantial Compliance	(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.

The current UOF policy and monitoring via camera review and incident report indicate that UOF procedures are used that cause minimal harm to the resident or staff; the provision is in substantial compliance.

Recommended Finding	MOA Use of Force Provision (c)
	(c) Within six months of the Effective Date, JCMSC shall ensure that the Facility's use of force policies, procedures, and practices:
Compliance	(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;
Compliance	(ii) Prohibit the use of unapproved forms of physical restraint and seclusion;
Compliance	(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;
Substantial Compliance	(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
Substantial Compliance	(v) Limit force to situations where the Facility has attempted, and exhausted, a hierarchy of pro-active non-physical alternatives;
Substantial Compliance	(vi) Require that any attempt at non-physical alternatives be documented in a Child's file;
Substantial Compliance	(vii) Ensure that staff are held accountable for excessive and unpermitted force;
Substantial Compliance	(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;
Substantial Compliance	(ix) Require mandatory reporting of all child abuse in accordance with Tenn. Code. Ann. § 37-1-403; and
Compliance	(x) Require formal review of all uses of force and allegations of abuse, to determine whether staff acted appropriately.

In light of c (i), videos and accompanying subsequent documentation were reviewed for the months of July and August. Since the last site visit through August, there have been only 10 recorded incidents of UOF. The question of incidents and restraints was posed to residents in interviews; their responses were not always in line with reported data. UOF data does not have any outside validation. The rate of UOF incidents/100 youth has also shown a significant drop (from an average the first quarter of this year at .30 to .04 in August). This provision is in compliance.

With regard to c (ii), no use of unapproved forms of physical restraint and seclusion were identified. Wrongful conduct has dropped to zero as have reported violations of policy or protocol. In terms of c (iii), restraint and room time have dropped significantly. Use of room time beyond one hour has dropped to zero. This data was not always in line with that reported by youths in interviews, however, and external validation of this data is still a work in progress. This provision is in compliance.

In terms of c (iv) assaults per 100 person days of youth confinement and assaults per staff per 100 person days of youth confinement continue to be below last year's data. For 2016 the latter was .78 and the former was .06, while in July/August of this year the data were an average of .43 and .02 respectively. Regarding provisions c (v), c (vi) and c (vii), the UOF policy and related documentation and reports indicate substantial compliance.

For c (viii), the UOF policy was reviewed, as were incident reports. The Report Card indicates that 100% of all medical evaluations were completed. Regarding c (ix) the UOF policy was reviewed as well as the PREA policy. These policies are substantially compliant with this provision. In terms of c (x), all detention management personnel have been reviewing videos of UOF incidents, including Chief Fields and Asst. Chief Bridgeforth. Detention management reported using these reviews to help staff increase their behavior management skills and ability to pre-emptively de-escalate acting out behavior. This provision is in compliance.

	MOA Use of Force Provision (d)
Compliance	(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.

All videos were reviewed by detention management personnel and used to assist individual staff in skill improvement. This provision is in compliance.

2. Memorandum of Understanding: Suicide Prevention

Recommended Finding	MOA Suicide Prevention Provision (a)
	(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:
Partial Compliance	(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.
Compliance	(ii) Procedures for initiating and terminating precautions;
Substantial Compliance	(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;
Substantial Compliance	(iv) Suicide risk assessment by the QMHP
Substantial Compliance	(v) Housing and supervision requirements, including minimal intervals of supervision and documentation;
Substantial Compliance	(vi) Interdisciplinary reviews of all serious suicide attempts or completed suicides;
Compliance	(vii) Multiple levels of precautions, each with increasing levels of protection
Substantial Compliance	(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;
Substantial Compliance	(ix) Requirements for mortality and morbidity review; and
Substantial Compliance	(x) Requirements for regular assessment of the physical plant to determine and address any potential suicide risks.

The suicide prevention policy was reviewed, as well as logs for the evidence of suicide screenings. A random set of 10 clinical files of youth who were put on suicide prevention were reviewed, as were a sample of files from those youth not having been on placed on suicide precaution.

With regard to provision a (i), the obtained description of how the suicide risk screen is administered is not line with this provision. Staff indicated that the screening instrument was administered while the youth "was standing against the wall by the elevator in the intake area." This is not a confidential environment. Any suicide risk assessment needs to be done at the same time as the mental health screening in an appropriate environment with established rapport with the youth. Otherwise, the accuracy of the obtained data may be questionable.

In terms of Provision a (ii), data indicated compliance, although there is some concern about whether suicide precautions were the most appropriate response to the clinical presentation of some youth. With regard to a (iii, iv and v), the suicide prevention policy and chart review demonstrates substantial compliance. Credentials of QMHPs hired since the last site visit were reviewed in light of the current Tennessee Statute regarding that nomenclature. No suicide attempts have been documented; provision a (vi) appears to be in substantial compliance per policy.

With regard to a (vii), a review of the sampled medical charts revealed significant improvement in clinical documentation. While the use of levels is clear from the documentation and is in compliance with the provision, there is some question whether the way in which the levels of are defined is supported by empirical evidence. For example, the use of a level described as "no risk" is contrary to clinical practice and empirical findings with regard to suicide. There also did not appear to be a guiding principle to determine what restrictions belong to what level of intervention, the absence of which further compromises the clinical integrity of these levels.

Attendance lists and logs were reviewed for provisions a (viii- x). Training is done annually; there was no reason for any morbidity reviews. These provisions are in substantial compliance.

Recommended Finding	MOA Suicide Prevention Provision (b)
Provision Terminated	(b) Within 60 days of the Effective Date, JCMSC shall ensure security staff posts are equipped with readily available, safely secured, suicide cut-down tools.

This provision was terminated per DOJ letter of April 3, 2017 from Steven H. Rosenbaum, Chief, Special Litigation Section.

Recommended Finding	MOA Suicide Prevention Provision (c)
Provision Terminated	(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.

This provision was terminated per DOJ letter of April 3, 2017 from Steven H. Rosenbaum, Chief, Special Litigation Section.

Recommended Finding	MOA Suicide Prevention Provision (d)
Substantial Compliance	(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.

The suicide prevention policy and reviewed documentation indicated substantial compliance. This provision was terminated per DOJ letter of October 26, 2017 from John H. Gore, Acting Assistant Attorney General, Civil Rights Division.

Recommended Finding	MOA Suicide Prevention Provision (e)
Substantial Compliance	(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.

Documentation review indicated substantial compliance.

Recommended Finding	MOA Suicide Prevention Provision (f)
	(f) Within nine months of the Effective Date, the following measures shall be taken when placing a Child on suicide precautions:
Substantial Compliance	(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.
Compliance	(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.
Substantial Compliance	(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.
Substantial Compliance	(iv) Only a QMHP may raise, lower, or terminate a Child's suicide precaution level or status.
Substantial Compliance	(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.

Any changes to the suicide prevention policy were reviewed, as well as Report Card data on the wait time from admittance to screening, and average wait time for arrival of a QMHP. With regard to f (i) Report Card data indicates time well within the provisions and is in substantial compliance. Regarding f (ii), when records were reviewed, risk was assessed and the provision is in compliance. Regarding f (iv), although in substantial compliance, I recommend that QMHPs more assertively match the level of suicide risk to the level of suicide precautions. Not all youth assessed at the highest risk level presented symptoms at that level.

Review of medical charts support substantial compliance with provisions f (iii, iv). Documentation review and interviews with mental health and detention staff support substantial compliance with provision f (v).

Recommended Finding	MOA Suicide Prevention Provision (g)

Substantial Compliance	(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.

Review of medical charts indicated substantial compliance with provision (g). This provision was terminated per DOJ letter of October 26, 2017 from John H. Gore, Acting Assistant Attorney General, Civil Rights Division.

Recommended Finding	MOA Suicide Prevention Provision (h)
Substantial Compliance	(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.

Review of medical charts indicated substantial compliance with provision (h). This provision was terminated per DOJ letter of October 26, 2017 from John H. Gore, Acting Assistant Attorney General, Civil Rights Division.

Recommended Finding	MOA Suicide Prevention Provision (i)
Substantial Compliance	(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.

In the MIS system indicated a flag appears upon admission if there is history of suicidality from a previous admission. Provision (i) is in substantial compliance. This provision was terminated per DOJ letter of October 26, 2017 from John H. Gore, Acting Assistant Attorney General, Civil Rights Division.

Recommended Finding	MOA Suicide Prevention Provision (j)
Substantial Compliance	(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.

Documentation supports substantial compliance with provision (j)

3. Memorandum of Agreement: Training

Recommended Finding	MOA Training Provision (a)
	(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.
Substantial Compliance	(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.
Substantial Compliance	(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. The Administrator shall review and, if necessary, revise the suicide prevention training curriculum to incorporate the requirements of this paragraph.

Review of training curriculum indicates substantial compliance with all sections of provision (a). This provision was terminated per DOJ letter of October 26, 2017 from John H. Gore, Acting Assistant Attorney General, Civil Rights Division.

4. Memorandum of Agreement: Performance Metrics for Protection from Harm

Recommended Finding	MOA Performance Metrics for Protection from Harm Provision (a)
	(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:
Substantial Compliance	(i) Review of the monthly reviews of use of force reports and the steps taken to address any wrongful conduct uncovered in the reports
Partial Compliance	(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

Section a (i) is in substantial compliance as reviews are being done by all detention management personnel. Section a (ii) is in partial compliance. The effectiveness review has shown significant improvement; further work is needed however on clarifying the risk levels and the response to a youth at a particular level. The review also needs to ensure that the community standard of practice in these areas is followed.

Recommended Finding	MOA Performance Metrics for Protection from Harm Provision (b)
Substantial Compliance	(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 Provision VI of this Agreement.

All required reports and documents were available for review indicating substantial compliance. This provision was terminated per DOJ letter of October 26, 2017 from John H. Gore, Acting Assistant Attorney General, Civil Rights Division.

D. SUMMARY AND RECOMMENDATIONS

D1. Use of Force

- The reduction in physical restraints has continued since the last site visit. Staff report that these reductions have occurred because of increased communication with the youth as an incident begins to emerge. Reducing the number of residents under supervision into smaller groups has also reduced behavioral acting out.
- The ongoing review of UOF events by detention management appears to have been effective in reducing physical restraints and also increasing effective communication between detention staff and residents. The process of review with particular officers appears to be effective by assisting the officer(s) involved in the take down by giving them the opportunity to self-assess their performance.
- Interview data with staff and report card data indicate that youth are no longer being placed in their rooms following an incident or for behavioral reasons for substantial lengths of time. Interview data from residents was less consistent. Data validation procedures are still not clear; there should be an internal quality assurance system that provides checks on the accuracy of collected, entered and reported data.
- To sustain reductions in the use of physical restraints and involuntary room time, detention center management must develop a cohesive vision or plan for alternative behavior management tools. Without a comprehensive alternative, staff will eventually fall back into old patterns of controlling unwanted youth behavior. The detention center has begun introducing isolated elements of a behavior management system and management's enthusiasm for these new, more positive tools is to be commended. But behavior management systems use several components that are designed to work together for the benefit of residents and staff. Introducing one component without the others is not only likely to fail, it may actually increase behavior problems and staff frustration. During focus group interviews, some staff pointed out that by curtailing involuntary room time for residents and the use of force, the facility had gone from one management system (albeit punitive) to no system at all. It is recommended that the detention center develop a comprehensive positive behavior management system and to that end, hire, at least as a half time position, someone with training in behavioral science whose entire function is program construction and implementation.

D2. Suicide Prevention

- The documentation on the charts that were reviewed has improved significantly since the last site visit.
- It is suggested that instead of physical plant review logs going forward a more effective and efficient system should be used that simply identifies when changes to physical plant occur in those areas where continuous staff supervision of youth is not possible (e.g. sleeping rooms and shower facilities). These changes should indicate that they have been checked so as to be suicide resistant (e.g. breakaway shower curtains, clothes hooks).
- Some charts indicated that youth were administered as many as four suicide risk instruments in addition to the Columbia measure; one instrument was used twice in two different clinical forms. This does not add clarification but only provides confusion.
- In some cases the basis for the suicide risk level was overstated or later found to be fictitious, e.g. the resident stated suicidal information for hoped-for secondary gain. The latter situations, with resulting unnecessary time on suicide precautions, may have been avoided by more time taken at the assessment of this particular resident.
- All youth on suicide precautions are now housed in rooms with a camera that is under constant observation which is good practice. This significantly reduces the likelihood of a lethal act and can reduce the need for the frequency of visual checks. Checks should be documented in the control center to ensure relatively constant observation. Camera observation, however, is extremely intrusive and restrictive and should only be used when clinically appropriate.
- The time and place when the suicide screening tool is administered as described is clinically inappropriate; this information should be gathered as part of the overall mental health assessment, in an area conducive to more privacy and after having established rapport with the youth.
- The use of the Columbia Screening tool to determine the placement on SPs and removal from SPs is not clinically appropriate. That decision must be made by a clinician who has made a careful clinical assessment for the presence or absence of imminent risk.
- Some of the daily "check-ins" with residents on SPs are recorded to have lasted only a few minutes. No other treatment was recorded except for these check-ins and a few minutes is clinically insufficient given the assessed seriousness of the youth's clinical presentation. After a few days of checks when the youth is removed from SPs, there appears to be no evidence of any continuing care or on-going treatment.
- The current Suicide Precautions Order Form has significant problems: There is no empirical evidence to support the descriptions of the suicide risk levels and they do not follow the current community standard of care. Level 4 (No Risk) should be restated as "low risk." No human behavior has a zero probability of occurrence. Describing anyone as having "no risk" is clinically inappropriate and can be dangerous.
- There appears to be standard "boilerplate" that is added to the end of the "Comments" section of the suicide precaution order form. In some cases these additions were confusing when read with the material entered above them in the section on the form. There needs to be a more thorough proof reading of this form to ensure that all statements are accurate and form a coherent narrative.
- There does not appear to be consistent connections between risk levels and restrictions. Placement in a camera room must be required with suicide precautions as well as only having a suicide smock in the room. Standard practice in mental health limits suicide precautions to those individuals who are at "imminent risk" of suicide and requires that this assessment be made. It is not clear that this is being done or documented. The definition of imminent risk requires all five conditions: 1) Suicidal ideation; 2) articulation of a specific plan for suicide; 3) articulate means/steps to achieve that plan; 4) clear and unfettered access to those means; 5) full, 100% intent to take one's life. It is the community standard of practice to assess for imminent risk and document that process.
- Often youth with suicidal ideation alone are placed on SPs; that is not standard clinical practice, since suicidal ideation by itself is not a good predictor of eventual suicide. A less intensive level of intervention would suffice.
- It is suggested that the risk levels be modified to the following which is more in line with current clinical thinking, research and practice: 1) Suicide Precautions (youth is at imminent risk); 2) Mental Health Alert (ideation but not all components of imminent risk); 3) Low Risk (not currently expressing ideation). A "finer" differentiation is not possible; suicide is a rare event and psychometrics limits predictability/risk assignment. The Alert status may also be used for other behavioral presentations (e.g. manic episodes, cutting or other self-harm, or difficulties with psychotic symptoms).

- The current standard for clinical practice does not recommend and advises against using any suicide risk measures/screening tools or other tools designed to identify a level of risk. The assessment must focus on the immediate situation of the youth and what he/she perceives as impacting his/her mental status and capacity for managing him/herself safely and effectively.
- More flexibility in restrictions can be used with a youth on Alert status rather than on SPs.

D3. Training

- The training curriculum on UOF meets MOA standards.
- The training curriculum on suicide prevention meets MOA standards, but is quite dated and does not reflect the most current clinical practice on suicide risk assessment and intervention. To be effective, suicide training should be done in the context of training on adolescence and mental disorders.

D4. Performance Metrics from Protection from Harm

- Video reviews of UOF incidents appear to be effective in keeping UOF minimal and only when absolutely required.

E. APPENDIX

1. Data Collection Matrix
2. QMHP Qualifications Summary Form
3. Use of Force Video/Document Review Form
4. Personnel in Attendance at Interviews/Meetings.

Data Collection Matrix

Shelby County -- MOA: Protection from Harm with Data Sources (rev. 031417)

1. Use of Force	Report	Records	Interview/Observation
(a) No later than the Effective Date, the Facility shall continue to prohibit all use of a restraint chair and pressure point control tactics.	Review Use of Force Policy	View random set videos of Jan-Mar Use of Force Incidents for evidence of use of chair View random set of Jan-Mar reports for evidence of use of chair	Interview residents for evidence of use of chair
(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.	Review Use of Force Policy		
(c) Within six months of the Effective Date, JCMSC shall ensure that the Facility's use of force policies, procedures, and practices:	Review Use of Force Policy		
(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;	Review Report Card: UOF 02 Total N of UOF UOF 03 UOF/100 youth UOF 04 % Time Non Phys alt used UOF 08 Non-Phys Alt Documented	View random set of videos of Jan-Mar Use of Force Incidents to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions View random set of Use of Force incident reports Jan-Mar to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions	
(ii) Prohibit the use of unapproved forms of physical restraint and seclusion;	Review Use of Force Policy Review Report Card: UOF 17 Wrongful conduct UOF 18 Violations of Pol/Prot	View random set of videos of Jan-Mar Use of Force Incidents to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions View random set of Use of Force incident reports Jan-Mar to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions	Interview residents regarding use of restraints
(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;	Review Use of Force Policy Review Report Card: UOF 7b % Inv room confinement	View random set of videos of Jan-Mar Use of Force Incidents to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions View random set of Jan-Mar Use of Force incident reports to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions	Interview residents regarding use of restraints
(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	Review Use of Force Policy Review Report Card: SAO 5 Assaults/Youth/100 days SAO 6 Assaults/Staff/100days	View random set of Use of Force incident reports Jan-Mar to determine quality and appropriateness of documentation based on provision iv criteria	Interview residents regarding use of restraints
(v) Limit force to situations where the Facility has attempted, and exhausted, a hierarchy of pro-active non-physical alternatives;	Review Use of Force Policy	View random set of Jan-Mar Use of Force Incident Reports to determine appropriate use of hierarchy vis-à-vis antecedent conditions	Interview residents regarding use of restraints
(vi) Require that any attempt at non-physical alternatives be documented in a Child's file;		View random set of Jam-Mar Use of Force incident reports and child's detention file determine appropriate use of non-physical alternatives	
(vii) Ensure that staff are held accountable for excessive and unpermitted force;		View random set of Jan-Mar videos of Use of Force Incidents for evidence of excessive force	Interview residents regarding perceived institutional response to appropriate/inappropriate use of force.

1. Use of Force	Report	Records	Interview/Observation
		and compare to incident report of same situation	
(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;	Review Use of Force Policy Regarding Medical Evaluation after incidents Review Report Card: UOF 16 % Med Eval Completed	Review child's file and incident report	
(ix) Require mandatory reporting of all child abuse in accordance with Tenn. Code. Ann. § 37-1-403; and	Review Policy on Mandated Reporting Review PREA policy		
(x) Require formal review of all uses of force and allegations of abuse, to determine whether staff acted appropriately.		Review Log of Supervisory Review of Uses of Force Incidents	
(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.		Review documentation from Administrator that Log of Supervisory Reviews of Uses of Force has been reviewed and appropriate action has been taken.	

2. Suicide Prevention	Report	Records	Interview/Observation
(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:	Review Suicide Prevention Policy		
(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.		Check intake log for evidence of suicide screenings Review random set of Jan-Mar suicide risk assessments and ensure assessment done by QMHP	
(ii) Procedures for initiating and terminating precautions;	Review Suicide Prevention Policy		
(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;		Review security logs to establish that referrals were made	
(iv) Suicide risk assessment by the QMHP		Review QMHP credentials to ensure compliance with Tennessee statute	
(v) Housing and supervision requirements, including minimal intervals of supervision and documentation;	Review Suicide Prevention Policy		
(vi) Interdisciplinary reviews of all serious suicide attempts or completed suicides;		Review files of suicide attempt incidents	Interview mental health staff to determine if incidents occurred and the resulting follow up
(vii) Multiple levels of precautions, each with increasing levels of protection	Review Suicide Prevention Policy		
(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;		Review attendance lists for training	
(ix) Requirements for mortality and morbidity review; and		Review any relevant records	
(x) Requirements for regular assessment of the physical plant to determine and address any potential suicide risks.		Review inspection logs of physical plant	
(b) Within 60 days of the Effective Date, JCMSC shall ensure security staff posts are equipped with readily available, safely secured, suicide cut-down tools.			Observe during walk-through
(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.	Review Report Card: SP 02 Total N QMHP contacts	Review log of response to suicidality Review selected case files	

2. Suicide Prevention	Report	Records	Interview/Observation
(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.	Review Suicide Prevention Policy	Review security log	
(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.	Review Suicide Prevention Policy		interview MH staff interview security staff
(f) Within nine months of the Effective Date, the following measures shall be taken when placing a Child on suicide precautions:	Review Suicide Prevention Policy		
(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.	Review Report Card: SP 12 Avg Time adm/screening SP 13 Avg wait time for QMHP	Review screening documentation and relevant files/logs	
(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.	Review Suicide Prevention Policy	Review screening documentation and relevant flies/logs	
(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.	Review Suicide Prevention Policy	Review selected MH files	
(iv) Only a QMHP may raise, lower, or terminate a Child's suicide precaution level or status.	Review Suicide Prevention Policy	Review selected MH files	
(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.	Review Suicide Prevention Policy		Interview MH staff Interview security staff
(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.	Review Suicide Prevention Policy	Review selected MH files	
(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.	Review Suicide Prevention Policy	Review selected incident reports Review MH file	
(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.	Review Suicide Prevention Policy	Check for presence of flag in Information Management System for future intakes	
(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.			interview with administration

3. Training	Report	Records	Interview/Observation
(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.		Review training curriculum Review training attendance records	
(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.		Review training curriculum Review training attendance records	

(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. The Administrator shall review and, if necessary, revise the suicide prevention training curriculum to incorporate the requirements of this paragraph.		Review training curriculum Review training attendance records	

4. Performance Metrics for Protection from Harm	Report	Records	Interview/Observation
(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:	Ensure monthly report card data is being collected and is accurate		
(i) Review of the monthly reviews of use of force reports and the steps taken to address any wrongful conduct uncovered in the reports	Ensure monthly report card data is being collected and is accurate	Review f/u from selected incident 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	Review Report Card: SP 09 N on SP SP 10 Avg Time on SP	Review selected MH files	
(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 Provision VI of this Agreement.	Ascertain presence of relevant reports	Ascertain presence of relevant document files	

2. QMHP Credential Verification Form

QMHP Verification (Tennessee Code: Title 33)

Instructions: Please check the state QMHP criteria that are met for each QMHP on staff

Name:		Degree:		Work Title:	

✓	Category	✓	Category
	Psychiatrist		Licensed master's social worker with two years of mental health experience
	Physician with expertise in psychiatry		Licensed clinical social worker
	Psychologist with health service provider designation		Licensed or certified marital and family therapist
	Licensed psychological examiner		Licensed professional counselor
	Licensed senior psychological examiner		Licensed Nurse with a master's degree in nursing who functions as a psychiatric nurse
	Licensed Physician's Asst with a master's degree and expertise in psychiatry as determined by training, education or experience		

Name:		Degree:		Work Title:	

✓	Category	✓	Category
	Psychiatrist		Licensed master's social worker with two years of mental health experience
	Physician with expertise in psychiatry		Licensed clinical social worker
	Psychologist with health service provider designation		Licensed or certified marital and family therapist
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	Licensed Physician's Asst with a master's degree and expertise in psychiatry as determined by training, education or experience		

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Name:		Degree:		Work Title:	

✓	Category	✓	Category
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	Physician with expertise in psychiatry		Licensed clinical social worker
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	Licensed psychological examiner		Licensed professional counselor
	Licensed senior psychological examiner		Licensed Nurse with a master's degree in nursing who functions as a psychiatric nurse
	Licensed Physician's Asst with a master's degree and expertise in psychiatry as determined by training, education or experience		

3. Use of Force Video/Document Review Form

VIDEO REVIEW	Date:	Time:	Location:
Antecedent Conditions			
Event			
Child in immediate danger	Y N		
Force Used/Physical Restraint			
3. Inappropriate Use Force	□ Slapping, punching, kicking, hitting □ Risk of LOC/harm to neck □ Pinning down with knees to torso, neck/head □ Choking or similar that restricts breathing □ Use of other youth or untrained staff □ Use of pressure point/pain compliance/joint manipulation (non-CPI)	□ Securing youth to another youth/fixed object/restraint device □ Striking with hands, elbows, knees, feet or other body part □ Dragging/lifting by hair/ear/mechanical restraints □ Lifting arms behind back while in restraints □ Placed down in prone position with continuous observation	
5. Hierarchy exhausted	□ 0 Office Present/No force used □ **I Verbal direction/warning** (at least 1 verbal attempt; at least verbal warnings) □ **II Supervisor/CM/MH staff involved** □ **III Passive removal (CPI transport)** □ **IV Use of** physical force		
Medical Examination Conducted	Y N		
6. Summary	Y N Least amount of force used appropriate to the harm posed by child Y N Use of unapproved forms of physical restraint Y N Documentation complete		

INCIDENT REPORT	Date:	Time:	Location:
Incident Report narrative matches video	Y N		
Incident Report in child's file	Y N		
Medical f/u documented	Y N		

Notes:

4. Persons in Attendance at Interviews/Meetings.

Initial Meeting
Deidre Bridgeforth, Asst Chief SCJDC
Debra Fessenden, SCSO Policy
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Kirk Fields, Chief SCJDC
Robert Gatewood, Attorney Health Dept.
John Jones, Asst. County Attorney
Jina Shoaf, Attorney Juvenile Court
Hon. Paul Summers, Settlement Agreement Coordinator
Audrey Townsend, Regional Operations Manager, CCS
Ann Ward, Shift Captain SCSO
Lawrence Weichel, Captain SCJDC
Stan Wofford, Sr. Vice President, CCS

Use of Force Review Meeting
Michael Beyers, SCSO Juvenile Court
Debra Fessenden, SCSO Policy
Kirk Fields, Chief SCJDC
Richard Goemann, DOJ
Jina Shoop, Attorney Juvenile Court
Ann Ward, SCSO Juvenile Court

Review of Hope Academy
Michael Byers, SCSO
Debra Fessenden, SCSO Policy
Kirk Fields, Chief SCJDC
John Jones, Asst. County Attorney
Eugene Lockhard, School Principal
Jina Shoop, Attorney Juvenile Court
Ann Ward, SCSO Juvenile Court
Lawrence Weichel, Captain SCJDC

Review of CCS and Health Department
Hannah Bernard, CCS attorney
Kirk Fields, Chief SCJDC
August Geeten, CCS Dir. of Mental Heath
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Robert Gratewood, SCHD Asst. County Attorney
John Jones, Asst. County Attorney
Aduakobong Ikpe, CCS RBHM
Judy Martin, SCHD Chief of Nursing
Sheba Randle, SCHD Nursing Coordinator
Tayetta Reddic, Nurse Monitor
Jina Shoaf, Attorney Juvenile Court
Audrey Townsel, CCS Regional Operations Manager
Lawrence Weichel, Captain SCJDC

Review of Training Curriculum/Training Attendance Lists and Review of Program Development/Amarillo Visit
Deidre Bridgeforth, Asst. Chief
Debra Fessenden, SCSO
Kirk Fields, Chief
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Thachenko Grandberry, Juvenile Court Officer
Teresa Harris, Interim SA SCSO
Kevin Henderson, SCSO
Michelle Hunt, Sgt, Juvenile Detention Center
Timothy Ruben Juvenile Court Officer
Lawrence Weichel, SCSO

Review of Mandated Reporting Policy and PREA Policy
Deidre Bridgeforth, Asst Chief SCJDC
Kirk Fields, Chief, SCJDC
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Teresa Harris, Interim SA SCSO
Lawrence Weichel, SCSO

Review of System Data/Verification
Deidre Bridgeforth, Asst Chief SCJDC
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Lawrence Weichel, SCSO

Review of Court Case Expediting
Debra Salter, Juvenile Court Expediter
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Pam Skelton, Juvenile Court

Review of Detention Population Management
Deidre Bridgeforth, Asst. Chief
Michaele Byers, SCSO Juvenile Court
Debra Fessenden, SCSO
Kirk Fields, Chief
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Kevin Henderson, SCSO Juvenile Court
Jina Shoaf, Attorney Juvenile Court
John Jones, Asst. County Attorney
Ann Ward, SCSO Juvenile Court
Lawrence Weichel, SCSO

Review of Site Visit with Settlement Coordinator
Richard Goemann, DOJ
Bernard Glos, Protection from Harm Monitor
Pam Skelton, CAO Juvenile Court Administration
Hon. Paul Summers, Settlement Agreement Coordinator

Confidential Meeting with Detention Residents and Detention Staff
Focus group meetings were held with detention staff and detention residents; Richard Goemann (DOJ) was present for some meetings with residents and all meetings with staff. The attendance was as follows

Detention Staff: 2 meetings, 28 total participants
Detention residents: 7 meetings, 55 participants