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**Re: Juvenile Court of Memphis and Shelby County (JCMSC) MOA Protection
from Harm Stipulations: Draft Findings Recommendations Letter**

Dear Winsome and Anika:

This is the first 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 (JCMSC), Tennessee, and it describes the visit to the JCMSC Detention Services Bureau (DSB) on April 8-10, 2013. My role as the Protection from Harm Consultant is to provide information and assessments of the progress by JCMSC toward compliance with the Protection from Harm paragraphs of the MOA. I appreciate the comments and observations provided by DOJ to earlier communications about the issues discussed below.

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

I. Assessment Protocols

The assessments used the following format:

A. Pre-Visit Document Review

Mr. William Powell is the MOA Settlement Agreement Coordinator. He has experience with settlement agreements and DOJ through his work with the Shelby County Sheriff's Department. Powell is conversant about compliance issues and has a pragmatic approach to what is required for compliance under the MOA paragraphs. He is an excellent resource to DSB, DOJ, and me. On April 1, 2013, Powell submitted a report called, "Synopsis of Substantive Remedial Measures" (hereafter referred to as Powell's Synopsis) and forwarded a copy to me for review before the on-site visit. Special attention was given to pages 32-39, covering Protection from Harm actions.

Additional documents reviewed included the Hayes Report. In a proactive action, JCMSC contracted with the nation's leading authority on in-custody suicides, Lindsay Hayes from the National Center for Institutions and Alternatives (NCIA). Hayes conducted a thorough review of DSB operations and provided a comprehensive report with critical recommendations for improving suicide prevention. The report is an excellent resource, and components of it will guide the compliance process. Other documents included (a) the first draft of a suicide prevention plan with policies and procedures and (b) the current policy and procedure manual.

B. Use of Data

The presence of a paragraph on performance metrics insures that the MOA will prompt the improvements to the JCMSC and DSB data-collection system necessary to make informed and accurate quality assurance decisions.

C. Entrance Interview

Two entrance interviews occurred, one with Bill Powell on April 8 and the other with Judge Person and his key staff on April 9, 2013. The meetings provided an opportunity for introductions, informal discussion 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

A walkthrough of the facility followed the April 9 entrance interview. The tour was a due diligence activity based on notes from an exhaustive facility tour in 2010. The walkthrough provided an opportunity to observe the Hope School, the conditions of resident sleeping rooms, the general levels of cleanliness of the facility, and any physical plant modifications or improvements completed since 2010. During the tour, I discussed with Facility Director Gary Cummings the rationale surrounding routine environmental scans for suicide risks. The Hayes Report did not emphasize the idea of noting physical plant suicide risks, such as clothing and towel hooks, plumbing, and exposed pipes. While physical plant improvements in these areas are important, I emphasized to Facility Director Cummings that the best suicide prevention strategy is an alert and aware direct care staff; and by conducting routine environmental scans for suicide risk factors, the administration continually sensitizes direct care staff to the locations of these risks, thus making them more aware of areas that require ongoing and increased supervision levels.

E. On-Site Review

The site visit was brief and required additional time for meetings and assessment activities. Very little information was reviewed on-site. This will likely be different for upcoming site visits.

F. Staff Interviews

I interviewed 10 JCMSC and DSB staff. In addition to group meetings with four staff, I interviewed two Senior Detention Officers, two Probation Counselors B, the staff trainer, and one Facility Director, and one Assistant Facility Director.

G. Resident Interviews

There were only informal interviews with youth, and they occurred in the dining area and day room of the living units. The next site visit will include time for resident interviews.

H. Exit Interview

The exit meeting occurred on April 10, 2013 in the office of Judge Person. The two Monitors and I expressed our appreciation for the cooperation and hospitality of the DSB and JCMSC staff. We then highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before issuing the draft reports.

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 JCMSC and DSB stakeholders at a minimum. Our compliance model will contain four parts:

1. The MOA provides the language of compliance, so we will identify and define the key requirements in each of the Protection from Harm paragraphs. JCMSC and DSB should provide an initial list of the key requirements for determining the final list of key requirements.

2. Where appropriate and necessary, JCMSC and DSB 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

This is the first on-site visit; and while it could have included more time, the logistics and the need to change schedules constrained the assessment activities somewhat. For future

consideration, the next on-site should be 2.5-3 days in duration. Next, the initial assessment visit is intended more as an opportunity to meet face-to-face with the key stakeholders, to listen to their concerns and goals, to establish some guidelines for communication, and to establish some initial agreement about compliance. Therefore, in-depth assessments of each paragraph regarding compliant status did not routinely occur on this visit, but will be the focus of upcoming visits. Some of the paragraphs have progressed more than others, and some information supporting compliance is more fully developed than others. Given these circumstances, many paragraph comments contain no compliance evaluations but will instead provide some guidance and recommendations about achieving compliance.

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)

COMMENT: Despite the caveat at the beginning of this section, this paragraph appears to be in compliance. In the interviews with staff, 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.

The Juvenile Court Strategic Plan for DOJ Remedial Measures, revised June 6, 2012, contains information relevant to the MOA. Regarding the restraint chair, an order from Judge Person on April 26, 2012 instructed DSB staff to remove the restraint chairs from detention. The tour of the detention facility on April 9, 2013 included numerous out-of-the-way locations within the facility, including the basement and supplemental storage rooms. A reasonable effort was made to locate any remaining restraint chairs in the facility based on recall of the thorough tour of the facility in 2010.

A January 17, 2013 memo documented the removal of the restraint chairs and a prohibition against pressure point tactics. The appendix to the Powell Synopsis contains the Judge's letter, the aforementioned memo, and a form dated May 10, 2011 which detention staff were required to sign acknowledging the prohibition against pressure point tactics.

FUTURE MONITORING:

Future monitoring will include a review 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 confirm the absence of practice related indicators of 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)

COMMENT: The analyses and assurances described in the paragraph are to be complete by June 17, 2013. Further review of this paragraph is pending receipt of the June 17 report.

Judge Person provided us with the annual number of detention admissions from 2001 through 2012, showing a 69% reduction in admissions during that time. Population reductions are associated with lower rates of uses of force, so careful monitoring of detention admissions is important. The Detention Assessment Tool (DAT) is an important element in controlling the number of youth in detention. The JCMSC describes itself as the only detention center within the State of Tennessee using objective decision-making to guide intake counselors on which youth meet criteria for secure detention pending a detention hearing.

I was asked by DOJ to review David Steinhart's review of the Shelby County DAT. Before preparing my response, I read Bill Powell's minutes from the May 2 Committee A meeting where it noted that someone remarked that the JDAI Consultant was extremely critical of the DAT. However, I found Steinhart's review of the DAT to be balanced and accurate. He acknowledged and praised the places where the DAT was appropriate and consistent with JDAI principles. He commended Shelby County's reductions in the detention population.

Steinhart is a leading authority on objective detention screening instruments so, in that regard, Shelby County had the best set of eyes reviewing the DAT. His observations and recommendations were precise and specific. There hardly seems to be any question that JCMSC will have a more effective and improved screening instrument if it were to implement the suggestions in Steinhart's review.

The Committee A minutes referenced earlier may have reflected some of the frustrations associated with the nature and extent of the changes required by JCMSC to achieve compliance with the MOA. It is difficult to operate an effective juvenile court system, especially one that includes juvenile detention, so aspiring to be the best while also being satisfied with efforts and products that are not first-rate makes the task even harder. While much of what is required in the protection from harm paragraphs is within reach, it will still take a Spartan effort to achieve these requirements, and these efforts will not be without criticism, constructive or otherwise.

The Steinhart review of the DAT is an excellent example of the very high quality of work that emanates from JDAI.

FUTURE MONITORING:

Future monitoring will include a review of the June 17 report, an analysis of the appropriateness of its recommendations, and a response to the recommendations.

(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)*

COMMENT: The policy and procedure development required in the paragraph are to be complete by June 17, 2013. Further review of this paragraph is pending receipt of the June 17 report.

Two opportunities for staff and program development presented themselves at this first site visit. A traditional area for improvement among juvenile detention personnel is the development of a thorough and comprehensive organizational structure, including well-developed policies and procedures. Bill Powell is a good resource in this regard because adult facilities are much farther ahead of juvenile facilities in terms of organizational development and policies and procedures. A high value-added activity by the DSB leadership would be continued development of policy and procedure skills. To assist in this process, I provided examples of complete policy and procedures manuals from two facilities that are accredited by the American Correctional Association (ACA). References to ACA standards come with some qualifications. The standards represent a comprehensive description of the necessary elements of an organizational structure required to successfully coordinate a juvenile facility. On the other hand, the ACA standards are not as instructive regarding how to operate a successful juvenile facility as evidenced by the congressionally mandated *Study of Conditions of Confinement*, and a number of ACA accredited institutions and agencies have been the target of DOJ investigations and successful youth advocacy litigations.

I mention this because the outdated (published January 1992) but still extremely relevant *ACA Guidelines for the Development of Policies and Procedures: Juvenile Detention Facilities* provides a clear and simple distinction between policy and procedure. On page *ix*, ACA explains the terms policy and procedure. "Policy" answers the "why" and "what." The policy states the facility's philosophy and therefore determines its present and future decisions. It is the definitive statement of the facility's position on an issue of concern to the administration or to the operation of the facility. For DSB, the "why" issues are twofold. The policy should be linked to the agency/facility mission statement as the initial explanation of why the policy exists. Next, DSB has an MOA that supplies other reasons why a policy exists. There is no rule that states that DSB cannot cut-and-paste the words in the MOA into its policy statements. In fact, to do so strengthens the connection between Judge Person's commitment to comply with the MOA and the corresponding change or reform in policy. "Procedure" answers the question "how." A

procedure is a detailed, step-by-step description of the sequence of activities necessary for achieving a specific policy.

Here is where Bill Powell can be extremely helpful. Independent of his knowledge of juvenile facility operations, he has a very good sense of the things that need to be included in the articulation of a procedure. I have great confidence in his understanding of these mechanisms, and I encourage DSB to draw heavily on him for technical assistance regarding policy and procedure development.

FUTURE MONITORING:

Future monitoring will include a review of the June 17 report, an analysis of the appropriateness of its recommendations, and a response to the recommendations.

Additionally, there will be a review of the policy and procedure required by this paragraph, which will include each subsection and will look for appropriate statements, descriptions, definitions, limits, and other relevant factors related to each particular subsection.

(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)

COMMENT: The expectation is that the review and its accompanying procedures required in the paragraph will be in the aforementioned June 17 report.

FUTURE MONITORING:

Future monitoring will include a review of the June 17 report, an analysis of the appropriateness of its recommendations, and a response to the recommendations. This will initiate the discussions and process regarding the building of a reliable and a usable database for quality assurance purposes.

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:

(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. (See MOA pages 29-30)*

COMMENT: The recommendations about policy and procedure development mentioned above also apply here. The February 17, 2013 Suicide Prevention policy needs considerable work before it can be approved as meeting the expectations of this paragraph.

The Powell Synopsis (page 33) contains an accurate list of five (5) areas for needed improvement. These areas include: greater clarity in staff expectations, responsibilities, and supervision; improved adequacy and timeliness of intake screening and assessment; clarification of communications about suicide issues and the roles of the Office of Clinical Services (OCS) and Mobile Crisis (MC); individualized treatment plans; and completion of the section on mortality-morbidity reviews.

Included in the Suicide Prevention Policy should be all of the key recommendations from the Hayes Report. Powell accurately notes that several of the Hayes recommendations have been completed, including staff training on suicide prevention, a mock suicide drill, and definition of various levels of observation. However, Powell again identifies five (5) additional areas where Hayes' recommendations warrant attention since the failure to implement these recommendations will create impediments to achieving compliance. These include: adequate screening of all youth entering the facility; clarifying roles of detention and clinical services; development of individualized treatment plans; written policies clearly indicating activities for youth on suicide precautions; and development of multidisciplinary mortality-morbidity review teams.

A tension exists between DSB and OCS because OCS considers forensic psychology to be its primary responsibility, not clinical psychology. OCS draws a clear distinction between the two and appears reluctant to assume the responsibilities for the suicide prevention functions identified in the MOA as falling to a Qualified Mental Health Professional (QMHP). This is a problem for the JCMSC. The MOA only requires JCMS to ensure that these activities are

completed effectively by a QMHP. The delay on the part of JCMSC to resolve this issue causes frustration among DSB staff and places youth at increased risk of harm.

DSB Intake staff should be trained and qualified to administer the MAYSI-2.

FUTURE MONITORING:

Future monitoring will include an ongoing review of the policy and procedure; an opportunity to observe or visit with the key individuals conducting the screening and assessment practices; and a review of the performance metrics regarding how much and how well the suicide prevention elements have been implemented.

(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)

COMMENT: Here is another paragraph that is already in compliance. The cut-down tool is part of the Code Blue Pack, a blue pouch like container located in the staff offices. I verified the presence of two Code Blue Packs while conducting the facility tour. The Powell Synopsis indicates that DSB has been operating in compliance with this paragraph since December 3, 2008.

FUTURE MONITORING:

Future monitoring will 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)

COMMENT:

Several deficits exist at the outset. The e-mail notification system currently in use does not provide weekend contacts by OCS. There is not a backup system in place. Finally, DSB staff report that MC does not use a suicide risk assessment instrument that comports with this paragraph.

The March 22, 2013 memo covers this stipulation; however, the implementation is the source of the problem. The same concerns arise in other paragraphs, so it is as good a place to discuss it as any. Three factors come into play.

First, the JCMSC has requested funding by July 1, 2013 for contract services with a medical and mental health provider that will fulfill the QMHP requirements, but information about the approval of the funding is forthcoming. Therefore, the QMHP issue defaults to Mobile Crisis (MC). The adequacy of the Mobile Crisis interventions is the second problem. Staff describe MC activities as inconsistent, and their confidence in the 24-hour assessment varies depending upon who handles the call and does the assessment. Third, OCS has some legitimate concerns about inadequate resources to provide 24/7 on-call coverage.

This is another paragraph where an insufficient amount of information is available to make a compliance determination with the notable exception that these important services are not being provided currently at the level required in the MOA.

FUTURE MONITORING:

Future monitoring will include a review of the policy, procedure, and practice, including the performance metric, which ensures that the assessment has been completed in a timely fashion.

(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)

COMMENT:

The informal practice indicates that direct care staff do a good job of providing as much information as they have available to whomever has the QMHP function. Full articulation of the notification and the transfer of information processes will be in the Suicide Prevention Policy, which at this point is in need of revision. It is likely that there will be changes in the policy covering how the anticipated contract services for medical and mental health will occur. Therefore, an assessment or evaluation of this paragraph is pending.

FUTURE MONITORING:

Future monitoring will include a review of the policy, procedure, and practice, including the performance metric, which ensures that the relevant information has been conveyed to the appropriate parties in a complete and timely fashion.

(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)

COMMENT:

The March 22, 2013 memo covers this stipulation; however, the implementation is the source of the problem. A complete statement of the prohibition on isolation as a suicide precaution will be in the suicide prevention policy, which at this point is in need of revision. Therefore, an assessment or evaluation of this paragraph is pending.

FUTURE MONITORING:

Future monitoring will begin with the review of the confinement and isolation practices to ensure that the records do not reveal the youth on suicide precautions while in isolation.

(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)*

COMMENT:

The Powell Synopsis reports that these measures are due to be implemented by September 17, 2013. In the interim, discussions with Robert Stanley have identified issues that should be converted into checklists for policy development and training delivery.

Under Subsection (ii), the writing of appropriate orders and regular monitoring is where Lindsay Hayes' recommendation for the development of an Individualized Treatment Plan (ITP) attaches to the MOA.

Under Subsection (v), the Shield of Care training does not do an adequate job of addressing these three issues: 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 Dr. Dooley's comments below.

FUTURE MONITORING:

Future monitoring will include a review of the September 17 report, an analysis of the appropriateness of its recommendations, and a response to the recommendations. This will initiate a review of the performance metrics regarding how much and how well the suicide prevention elements have been implemented.

- (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)*

COMMENT:

This is another paragraph that is pending the revisions to the Suicide Prevention Policy.

FUTURE MONITORING:

Future monitoring will include a review of the policy, procedure, and practice, including the performance metric, which ensures that the follow-up assessment has been completed in a timely fashion.

(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)

COMMENT:

Again, this is pending the revision of the Suicide Prevention Policy.

FUTURE MONITORING:

Future monitoring will include a review of the policy, procedure, and practice, including a file review 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)

COMMENT:

Discussions have begun about a management information system, including the delineation of categories of incident data that include but move beyond the suicide attempt and ideations requirements of this paragraph. The intent is to rebuild the management information system in such a way that it is consistent with selected standards from the Performance-based Standards Project (PbS).

FUTURE MONITORING:

Future monitoring will include a review of the policy, procedure, and practice, including the performance metric, which ensures that the documentation or record keeping has been completed in a timely fashion.

(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)

COMMENT:

See the preceding comments. Additionally, there is a monthly report that classifies information about self-harm, suicide attempts, and successful suicides. DSB administration is in the process of modifying the data collection process and will include those changes into the system developed for addressing the performance metrics.

FUTURE MONITORING:

Future monitoring will 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 paragraph will include an assessment of how well the Administrator's review is conducted, if a review has occurred.

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)

COMMENT:

Training has occurred using the Shield of Care training curriculum developed by the State of Tennessee. I have reviewed the training materials, and it is a good training program that covers most of the issues outlined in the paragraph. There have been some concerns expressed about who will do the training in the future and whether there should be a change in the training curriculum. For example, Dr. Barbara Dooley does consulting with DSB. She is a master trainer who has been affiliated with the training and technical assistance services of the National Partnership for Juvenile Services (NPJS). Regarding the suicide prevention training, Dr. Dooley has recommended that DSB training staff use the suicide prevention curricula developed by the now defunct Center for Research & Professional Development at Michigan State University. I can arrange access to these curriculum materials; however, it would be better to postpone this action until we have had an opportunity to review the new suicide prevention training curriculum developed by Lindsay Hayes at NCIA.

As mentioned earlier, I have had discussions with Robert Stanley regarding how to ensure that all of the training stipulations in the paragraph are translated into checklists for trainers and participants. An opportunity to review what he has accomplished has not yet occurred.

FUTURE MONITORING:

Discussions have begun about the tracking of staff training activities and better ways to verify staff attendance and complete participation in the training. Future monitoring will continue these discussions and activities.

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)*

COMMENT:

There were several conversations with DSB leadership regarding performance metrics. We looked at three different systems, including existing monthly data collection at DSB, the Shelby County Jail Report Card, and PbS. We identified several PbS standards for use in the data collection process.

I appreciate the diligence DSB put forth in attempting to find the Performance-based Standards materials through a public domain. DSB exhausted attempts to secure these documents, which were created by public funds. I sent PDF documents that contained this information. These documents were dated 2006 and represented materials that were available without charge at the time through PbS. While there may have been some changes or updates to these materials, my recent review of them indicated that they still remain relevant.

The target standards (the ones labeled as Safety, Order, and Health) were discussed in another of the PDF documents, along with some of the performance measures to consider from a quality assurance perspective. Also included was a glossary document, and the purpose for including it was so DSB would have a resource by which to define and describe certain common elements of detention practice. If DSB has any questions about the meaning of a word, phrase, or term, it should look first to this glossary document. Additionally, I provided DSB with the Youth and Staff Climate Surveys. There is no recommendation that DSB include any of these

elements at this time. Rather, when DSB has time, we will review them and talk some more about the use of these survey instruments.

(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)

COMMENT:

This is pending the completion of the data collection system.

II. SUMMARY AND RECOMMENDATIONS

Recommendation: I discussed with DSB leadership the development of a policy and procedure committee with Bill Powell as an advisor. The purpose of the committee would be to identify those policies and procedures that are directly relevant to the MOA, including the Suicide Prevention Policy, and to review and revise them as one of the initial steps in implementing the requirements of the MOA.

Recommendation: There should be regularly scheduled telephone conferences with the Protection from Harm Consultant, DSB leadership, the JCMSC supervisor of DSB, and Bill Powell.

DSB leadership is competent, caring, and enthusiastic. I have great expectations that DSB, with the advice, guidance, and support of Bill Powell, will move quickly toward the resolution of the Protection from Harm paragraphs.

Sincerely,



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