Juvenile Justice Associates, LLC
5 Locust Court Albion, MI 49224 517.465.7029

June 9, 2014

Winsome G. Gayle
Anika Gzifa
Trial Attorneys
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Avenue, NW
Washington, D.C. 20530

Re: Juvenile Court of Memphis and Shelby County (JCMSC) MOA Protection from Harm Stipulations: 3rd Findings and Recommendations Letter

Dear Winsome and Anika:

This is the third 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), TN, and it describes the visit to the Juvenile Court Detention Services Bureau (DSB) on April 7-10, 2013. My role as the Protection from Harm Consultant is to provide information and assessments of the progress by the Juvenile Court toward compliance with the Protection from Harm paragraphs of the MOA (Section C).

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

I remain positive about the response by the Juvenile Court and the Detention Facility leadership to Section C of the MOA and the recommendations in previous communications. The pace of change has slowed considerably as the detention facility leadership has addressed the more difficult and time-consuming changes implicit in the MOA, but continued progress thus far on Section C is a key theme of this letter despite concerns about Section C paragraphs that have not yet reached compliance. Section C of the MOA asks the Juvenile Court and Detention Facility leadership to make substantial changes to its juvenile detention operations, which are sometimes easy to accomplish and sometimes very hard to accomplish, but hardly ever quickly accomplished.

The Juvenile Court staff and the leadership team at the detention facility appear to be good combinations of complementary skills and abilities. Gary Cummings, Mamie G. Jones, and Willie Walton represent a solid management team. This is the first opportunity to work with Jones, and she appears to have quickly gained control of the responsibilities assigned to her. Each member of the leadership team continues to convey a positive and enthusiastic attitude toward Section C as a motivator for change.

Communication, information, and guidance provided by William Powell, Criminal Justice Coordinator, continue to be excellent. Powell provides a valuable perspective, both as someone who has experience dealing with other MOA circumstances and who can look at the Detention Facility operations with a greater level of objectivity and detachment. Additionally, his advice continues to be generally accurate and beneficial to the achievement of compliance with Section C of the MOA.

New to the monitoring process is Jina C. Shoaf, Assistant Shelby County attorney, who participated in many of the meetings and discussions. Her input was valuable and her questions insightful. As her understanding of the Protection from Harm stipulations increases, progress toward compliance will likely increase. Her approach to the MOA is to do what is a reasonably necessary to achieve compliance.

I. Assessment Protocols

The assessments used the following format:

A. Pre-Visit Document Review

Powell remains the MOA Settlement Agreement Coordinator. He has experience with settlement agreements and DOJ through his work with the Shelby County Government. Powell retired from his employment with the Sheriff's Department, but he has a contract to continue his role as the MOA Settlement Agreement Coordinator. He remains conversant about compliance issues and offers a pragmatic approach to what is required for compliance under the MOA paragraphs. He continues to be an excellent resource. On March 21, 2014, Powell submitted reports called, "Compliance Report #3" and "Substantive Remedial Measures" (hereafter referred to as the "Compliance Report") and forwarded copies to me for review before the on-site visit. Special attention was given to pages 4, 5-7 and 29-36, respectively, covering Protection from Harm actions and recommendations.

B. Use of Data

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

C. Entrance Interview

An entrance interview occurred on April 7, 2014 with Gary Cummings and administrative staff. The meetings provided an opportunity for 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 brief walkthrough of the facility occurred on April 10 and 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.

E. On-Site Review

More time was spent during this visit on verification of practices through a review of documentation (incident reports and youth files, including medical and mental health) and data collection regarding isolation, confinement, and uses of force. Additionally, this visit established some baselines on issues generated by youth that may influence Protection from Harm factors. These youth perspectives will be discussed in greater detail below. This monitoring visit also spent more time on physical restraints. This approach was beneficial as it provided clearer guidance and direction on critical issues in the administrative review use of force documentation and videos.

F. Staff Interviews

I interviewed 18 staff, 10 Detention Facility employees, four (4) Shelby County employees, and four (4) Correct Care Solutions (CCS) staff.

G. Resident Interviews

I interviewed 10 youth, eight (8) youth in two four-person group interviews and two in individual interviews regarding personal safety precautions. The average age of these youth was 16.2 years with an average length of stay of 18.8 days. The individual interviews occurred in a room across from the control office on the living unit, and the group interviews occurred in the classroom adjacent to the administrative offices.

H. Exit Interview

The exit meeting occurred on April 10, 2014 in Larry Scroggs' office. Those in attendance included: Gary Cummings, DSB Administrator; Winsome Gayle, DOJ Attorney; Anika Gzifa, DOJ Trial Attorney; Mamie G. Jones, DSB Deputy Administrator; Jerry Maness, Director of Court Services; Jina C. Shoaf, Shelby County Attorney; Larry Scroggs, Chief Administrative Officer; and Willie Walton, DSB Deputy Administrator. I 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 report letter.

I. Compliance Logic

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

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

2. Where appropriate and necessary, the Juvenile Court and the Detention Facility will develop new or modify existing policy and procedure that address the key requirements. The

policy statements will answer the questions of "what" and "why." Linked to the vision and mission statements, policy statements will explain what will be done in a specific key requirement area. They will also explain to staff and all other readers the purpose of the policy.

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

3. For each key requirement, there will be a performance outcome or a quantifiable indicator that the requirement has, in fact, happened or occurred. A system of performance metrics will accompany the performance outcomes, and the performance metric will provide ongoing data about "how much" the performance outcome is occurring.

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

II. Protection from Harm: Detention Facility

A. Preliminary Comments and Observations

1. Detention Facility Self-Assessment (DFSA) Report

The Juvenile Court informed DOJ that it has received the draft Detention Facility Self-Assessment Draft (DFSA) Report of February 2014. We will address the report after we receive the response by the Juvenile Court regarding the correction of factual errors or substantial progress that has occurred since the issuing of the draft report. The final DFSA will serve as another source of information and perspectives on the operations of the detention facility, some of which may have relevance to the Protection from Harm elements of the Agreement. Several perspectives on the DFSA are worth consideration:

- Like the ACA Accreditation audits, the DFSA provides an expansive discussion of the issues important to the improvement of conditions of confinement. Unlike ACA, the DFSA contains a third-party assessment of the facility from the perspective of local juvenile justice stakeholders that are more sensitive to the nature and extent of interactions between other parts of the juvenile justice system in Shelby County.
- The DFSA also provides another assessment of how well the Juvenile Court and the detention facility are doing in the reforms in JDAI and compliance with the Agreement. In this regard, the DFSA is a helpful document.
- The scope of the Agreement is sometimes restricted, and these limits often constrain the larger discussions about how other non-MOA issues influence compliance outcomes.

2. Youth Interviews

This was the first visit that included multiple interviews with detainees. Youth interviews provide another perspective on operations, safety, and suicide prevention practices. Youth interviews also are controversial. Detained youth are great truth tellers and prevaricators, oftentimes in the same sentence. Therefore, youth perspectives need to be one part of the larger system of information that describes what is actually occurring in the facility. A triangulation strategy is used that includes subjective perspectives (views of youth and staff), direct observations, and the elements of organization structure including policy, procedure, practice, and outcomes data. Within the context of peer deviance contagion,[1] the input of detainees is critically important in the assessment of the social climate, which has a direct relationship on those environmental factors that precede and, some would say, trigger various forms of acting out or inappropriate behaviors by youth. Given that relationship, it is important that staff be aware of concerns expressed by youth and discuss if and how those concerns should be addressed.

There were two (2) focus groups with four (4) detainees per group plus two (2) individual interviews with youth related to suicide precaution or other mental health observations. In response to basic protection from harm questions, the youth provided the following responses:

- 10 of the youth (100%) indicated that staff asked them about suicidal thoughts, suicidal ideation, and suicidal history at intake.
- 10 of the youth (100%) could identify Ms. Ivy, the QMHP; all had positive comments about her; and those youth who identified as a possible safety or suicide risk were positive about her contacts with them.
- 10 of the youth (100%) complained that they spend too much time in their rooms and that they are not allowed to have reading materials in their room. This restriction on reading materials in the room was verified with administration. A restriction of this nature is contrary to generally accepted professional standards about a quantity of reading materials that are permitted in a youth's room.

  Regarding room confinement time, the same youth complained that there are times on the weekend when they are only out of their rooms 1 hour a day. This allegation was not been verified, and a review of room confinement practices on the weekend will be a part of future monitoring.
- 10 of the youth (100%) stated that the grievance system does not work. Grievance systems are vitally important to the protection of residence rights while in detention; and while there is currently little other evidence to indicate that the system is effective, in facilities where the conditions of confinement are exemplary, youth evaluate the grievance system as highly effective.
- 100% of youth indicated that they (1) understand the facility rules, (2) do not know of or understand a behavior management system based on incentives or rewards, (3)

[1] Kenneth Dodge, Tom Dishion, and Jennifer Lansford edited a book of readings on the iatrogenic effects of congregate living conditions with incarcerated youth in 2006 called *Deviant peer influences in programs for youth: Problems and solutions*. The book summarizes research on what the authors called "peer deviance contagion." The primary challenge in addressing this phenomenon is the absence of regular and systematic feedback from youth in the facility regarding issues pertaining to safety and other conditions of confinement.

have not feared for their safety since they have been the facility, (4) have not had personal property stolen directly by force or threat, (5) have not been beaten up or threatened with being beaten up since being at the facility, and (6) believe that staff make more negative comments to youth than positive comments.

- 50% indicated that staff members do not show youth respect while 50% indicated that staff *sometimes* show youth respect.
- 50% of youth indicated that staff are not good role models while 50% indicated that staff are *sometimes* good role models
- 50% of youth indicated that staff members are not fair about discipline issues while 50% indicated that staff are *sometimes* fair about discipline
- Two youth (20%) indicated that they had been in a fight since coming to the facility. Similarly, the same two youth indicated that they had been physically restrained as a result of the fight. One of the youth indicated that he thought staff was trying to hurt him during the restraint process.
- When asked if there was a Detention Officer with whom they could talk if experiencing difficult times, emotional or personal crisis, or trouble and frustration with life in detention, only three (3) youth (30%) indicated that there was someone that they could talk to. The remainder of the youth was critical about the approach that staff takes toward them, particularly staff on the afternoon/evening shift.

Youth interviews involved the question, "If you were in charge, what would you do to make this a better place?" 100% of youth identified "more food" as the first change they would make. The complaints about food became more specific, and several youth asked me to look at the menu to see how often they receive either a cheese sandwich or peanut butter sandwiches for the supper or evening meal. The Agreement does not address food, but hunger-related behaviors could be easily linked to emotional dysregulation, disruptive behaviors, and circumstances that lead to staff uses of force. A check of that Wednesday's evening meal confirmed that dinner was two peanut butter sandwiches, a small bowl of vegetable soup, and a piece of cornbread or sweetbread. Review of the Detention Facility menu by an independent dietitian indicated that it was not possible to determine an adequate caloric content without further investigation, but the menu was itself described as a cause for concern and further monitoring.

3. Staff Interviews

There were two (2) focus groups with three (3) veteran staff in each group. Six (6) staff were interviewed. Even though the new Safe Crisis Management training was only partially completed, those staff members who had been through the training program had very positive things to say about it. The same applied for the new NCIA suicide training delivered by CCS.

When discussing the differences with today's detention program and population, staff were quick to identify more youth with mental health issues but also to praise the CCS contract staff for providing greater on-site access to mental health counseling. Staff also suggested that there are greater numbers of detainees who are low performing in education.

As the visitations continue and the progress toward compliance takes shape, additional factors will come into play and require discussion, consideration, and explanation regarding

whether they have a relationship or influence on compliance activities. Several of these related topics are addressed in this section.

B. Section C Comments and Recommendations to DOJ

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

1. Use of Force

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

RECOMMENDED FINDING: Substantial Compliance

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

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 the detention facility staff to remove the restraint chairs from detention. A January 17, 2013 memo documented the removal of the restraint chairs and a prohibition against pressure point tactics. An appendix to the Compliance Report contains the Judge's letter, the aforementioned memo, and a form dated May 10, 2013 which detention staff were required to sign acknowledging the prohibition against pressure point tactics.

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: As referenced above, the detention facility now has a data collection system that allows it to review and analyze the methods that staff use to control youth who pose a danger to themselves and others. The Detention Report Card is a compilation of data into spreadsheets that allow quick access to important information that can be used to track performance trends. The analyses of uses of force trends are beginning to identify those methods that comply with this agreement.

There was a disruption in data analysis following a recent staff turnover. This visitation and review of the data collection system resulted in recommendations for findings consistent

with the perspectives expressed by Powell in the Compliance Report. Specifically, policies must be in place to guide data collection and analysis so it is not dependent on one individual and can be continuously done in times of staff transition. Review processes should be established to monitor and review performance to insure proper implementation of policies and procedures. Plans for validating data, insuring suicide prevention activities are effective, and data sharing with staff should be completed.

I believe the intent of the paragraph is that compliance represents "the Facility" analysis versus what will be later described more narrowly as the Facility Administrator review or analysis. As such, compliance means a broadening or expansion of those staff members at various levels of the facility and agency that participate in the analysis.

FUTURE MONITORING:

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: Powell noted in the Compliance Report that the revised use of force policy is a good policy. It delineates for staff a use of force continuum, itemizes approved methods of restraint, and provides guidance to staff in dealing with situations involving the use of force. Powell accurately noted that the key to the compliance with the Agreement will be the extent to which staff understands and implements the policy (presumably through continued training and instruction) and supervisors conduct or provide proper reviews and guidance that also complies with the policy (again presumably through continued training and instruction). This visit confirmed Powell's perspectives and recommendations.

Regarding the revised youth use of force policy, staff interviewees had a general understanding of the changes in the policy, but more training and review are needed before they can provide specific descriptions of the changes and be reasonably assured that this knowledge will influence on-the-job behaviors. However, most staff accurately described use of force as a continuum starting with verbal de-escalation. One staff member described the process as "talk down before takedown."

Comparisons of the revised use of force policy with the specific concerns in this paragraph yield the following observations:

1. Regarding staff uses of the least amount of force appropriate, the revised policy language explicitly states in several places that the amount of force that is permissible for use by staff is only the minimum amount of force necessary to control the situation.

2. Regarding the use of unapproved forms of physical restraint and seclusion, the policy outlines unapproved techniques and specifically prohibits restraint and seclusion uses as punishment. The issue of seclusion also received additional monitoring.

   The Isolation and Confinement Log for March 2014 was consistent with the physical restraint document reviews of 17 use of force events regarding any room confinement resulting from the use of force and a follow-up disciplinary hearing. The amount of time prescribed in the disciplinary form was consistent with the amount of time noted on the Isolation and Confinement Log. The amounts of confinement are too long, and the Detention Facility should consider a better positive behavior management system and an enhanced schedule of activities as one strategy for the reduction in the amount of room confinement.

   Embedded in the Self-Assessment Standards is the commonly held notion that isolation and room confinement are usually harmful experiences that need to be carefully monitored, controlled, and, if possible, reduced to the point of elimination. Historical evidence, studies from related fields, and contemporary reports from practitioners would support the JDAI assertion that a consensus exists among practitioners and policy advocates nationally that every facility should implement programs and activities that help to eliminate the need for room confinement, except in routine program circumstances such as sleeping hours or brief periods during shift change.

3. Regarding those circumstances where the youth poses an immediate danger and less restrictive means have been properly, but unsuccessfully, attempted, there is a clear

statement in the policy. Yet, what is missing is sufficient and compelling evidence that the circumstances for which physical restraints are used represent the immediate danger expressed in the Agreement. This concern will be discussed again under "spontaneous designation" below.

4. Regarding prompt and thorough documentation and reporting, there is a statement in the policy.
5. Regarding the attempted, and exhausted hierarchy of pro-active non-physical alternatives, there is a clear statement in the policy, even though this aspect will require additional work through the use of force review process in order to identify the presence of the hierarchy in the documentation and video reviews.
6. Regarding the documentation of attempts at non-physical alternatives in a youth's file, there is a clear statement in the policy. Incident Statement JC-142B should include a list of the nonphysical alternatives, and this form goes in the youth's file.

   Of the documentation for the 18 physical restraints from March, none contained the hierarchy of non-physical alternatives that were attempted or considered in form JC-142B as required by policy. This needs to be addressed by staff before the next monitoring visit.
7. Regarding staff accountability for excessive and unpermitted force, there is a clear statement in the policy.
8. Regarding the immediate medical evaluation, there is a clear statement in the policy. See the information below confirming the presence of the post restraint medical evaluation in all files reviewed as a part of this monitoring visit.
9. Regarding mandatory reporting of all child abuse in accordance with Tenn. Code. Ann. § 37-1-403, there is a clear statement in the policy.
10. Regarding the formal review of all uses of force and allegations of abuse to determine whether staff acted appropriately, there is a clear statement in the policy.

There is growing evidence that staff understand the revised policy; however, an assessment of this understanding will continue during future visits.

FUTURE MONITORING:

Future monitoring will include a review of the revised use of force policy, modifications to the use of force training related to the revised the use of force policy, and verification of changes in use of force practice because of the implementation of the revised policy. Changes in the behaviors of staff should be verifiable through use of force reviews. Future monitoring will continue to include a review of seclusion and other forms of confinement related to use 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. (See MOA page 29)

RECOMMENDED FINDING: Partial Compliance

COMMENT: Three (3) documents and two (2) spreadsheets of information compiled on the use of force and an analysis of these uses of force events are part of the information in this section. These documents and their analysis will be discussed in detail under the Performance Metrics section.

File reviews were conducted on 18 physical restraints from March. Incidents Reports (JC-142B) were in the files, and the quality of the documentation was acceptable. One of the Detention Facility forms asks staff to classify the reason for the use of physical force. One option is that the youth's behaviors created a spontaneous and imminent danger to safety, which justified the use of physical force. 17 of the 18 files were designated as "spontaneous."

There was one " planned" physical restraint that involved the use of the shield, handcuffs, and shackles. The situation also included multiple incidents of restraint activity. The "planned" use of force was in a youth's room, so there was no video to evaluate the application of force. In response to being off-camera, administrators in other facilities have modified policy, procedure, and use of force training to emphasize the need for use of force activities to be on camera. Even though this is inherently problematic, formal messages need to be sent to staff that off-camera or in-room restraints are unwanted. An off-camera restraint does not provide staff or youth with sufficient safeguards. Off-camera restraints are frequently viewed by youth as the place where staff can apply excessive force without fear of corrective action by administration. Likewise, in situations where the monitoring of use of force has resulted from abuses and use of force applications, off-camera restraints generate similar concerns.

Concerns remain with the "spontaneous" designation. For example, if administration automatically approves the "spontaneous" designation during a restraint review, then staff members are exempt from documenting and demonstrating the use of de-escalation strategies and techniques. Stated differently, beginning the documentation of a restraint event at the point of the "spontaneous" designation does not account for the antecedent events that more than likely contributed to the "spontaneous" outburst of dangerous behaviors; therefore, the exploration of various options by staff to have intervened earlier and, perhaps, averted a restraint does not routinely occur. Based on the "spontaneous" designation phenomenon, the recommendation for the Administrative Review of restraints was to evaluate the video several minutes before the initiation of the restraint.

Similar to the development of data collection and performance metrics, the existence of an administrative review of use of force incidents is another mark of substantial progress towards compliance. While there is more to accomplish and monitor regarding the administrative review, several observations are noteworthy:

1. Regarding the administrative review, a restraint review process exists; and it provides the first level of quality assurance regarding the use of physical restraints. Deputy Directors Walton and Jones and Shift Supervisor Weichel observed six (6) physical restraint videos with me. On several of the videos, the resolution or

quality of the images was so poor that no one could identify accurately the different youth. On one video, the equipment skipped the time period in question, so no video was available. It is understandable that this might happen, once. Otherwise, the videos revealed some discrepancies between the manner in which staff are trained to conduct physical restraints and staff behaviors on the video. Two (2) videos raised serious concerns about the use of unapproved techniques, i. e., headlocks. It must also be noted that these restraint reviews occurred immediately before the staff training on physical restraints using Safe Crisis Management (SCM). Therefore, future monitoring visits will expect to see evidence of the implementation of the Safe Crisis Management techniques.

The review of one physical restraint packet raised an unusual coincidence. In the review of the video, I stopped the video in order to ask why the lead staff member was not attending to a fight between two (2) youth as the priority locus of intervention but instead was restraining a different youth from approaching the area in which the fight was occurring. Later, during one of the focus groups with detainees, one youth alleged that some staff actually like to see youth fight. He further alleged that staff would delay breaking up a fight in order to see who wins. The other youth in the focus group agreed. This type of allegation often represents the anger and frustration of youth toward staff members who set clear limits and hold them accountable. In other words, these allegations need corroboration from other perspectives or other sources of information. However, this restraint review video creates a reasonable suspicion to believe that there may be something to the allegation that some staff members will allow youth to fight. This is a very serious allegation and warrants a thorough investigation.

2. Regarding the administrative assurance of appropriate disciplinary action, there was some mixed response encountered during the monitoring visit. While the documentation of two (2) instances of unapproved uses of force occurred in the restraint video reviews, future visits will seek verification that disciplinary action for these instances did occur.

3. Regarding the administrative review's identification of any training needs, future monitoring will spend more time identifying the training needs that emerge from the review and verify a training or coaching follow-up activity. For this part of the stipulation and No. 4 below, see the discussion in the Performance Metrics section below about the need for an analysis of the inappropriate uses of force.

4. Regarding the administrative action on wrongful conduct and appropriate responses, a review of a corrective action indicated that the detention facility administration is proactive in addressing use of force situations where an inappropriate response occurred.

5. Regarding the training of administrative staff in use of force, the Detention Facility administration indicated that all administrative staff had been fully trained in the use of force technique.

The Detention Facility should consider the development of a chart or form on Excel spreadsheet that provides summary data about the 1) level of comparability between documentation and

video, 2) coherence between the list of nonphysical alternatives and video, and 3) a list of individuals and issues for coaching or follow-up, etc.

FUTURE MONITORING:

The evaluation of the administrative review process will be in relationship to the five (5) components discussed above. In each of these areas, there needs to be more evidence of compliance with the Agreement; but there is a clear acknowledgment that the absence of evidence may be a function of the abbreviated monitoring, insufficient communication with the detention facility administration and Powell regarding these factors, or the need to further develop and collect data on each.

Future reviews of restraint activities will consider a stratified, non-random sample of restraints based on the complexity of the restraint (for example, notation of multiple restraint techniques and multiple staff members involved), the length of the restraint, preliminary indications of injuries to youth or staff or referrals of staff for investigation, and the date of the incident with dates closer to the monitoring visit having a higher priority. The sample of restraints may contain multiple problems, which will provide an opportunity to evaluate the systemic responses to the correction and remediation of difficult circumstances. The mark of a competent protection from harm strategy is the ability to resolve appropriately the majority of the most difficult and challenging uses of force situations since it is unrealistic to expect a facility to eliminate all inappropriate uses a force. Nonetheless, a competent facility should be able to demonstrate effectiveness in the majority of these situations.

2. Suicide Prevention

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

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

(ii) Procedures for initiating and terminating precautions;

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

(iv) Suicide risk assessment by the QMHP;

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

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

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

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

(ix) Requirements for mortality and morbidity review; and

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: The Compliance Report accurately notes that the suicide prevention policy now includes two (2) policies, one on the suicide prevention and the other on addressing suicide crisis. There is continued agreement with Powell's earlier assessment that the suicide prevention activities at the detention facility have moved from a "point of weakness to a point of strength."

The contract services provided by CCS appear responsive to the MOA, and the services appeared to be in full operation based on this assessment. There is a 24/7 nursing presence, and CCS provides all the QMHP staff designated by the Agreement. There has also been a continued decrease in the use and reliance on Mobile Crisis (MC), which staff described as beneficial.

Several additional factors are worth reiterating. First, the policies are improved. Second, the data (which will be discussed in greater detail later) provide another indicator that suicide prevention has substantially improved. Third, the involvement of CCS as the contracted health and mental health provider seems to be a substantial contributor to these improvements. For example, CCS has been quick to offer assistance with training in areas such as HIPPA compliance and suicide prevention. A suicide screening instrument has been proposed and implemented to help the detention facility staff do an immediate screening of youth entering Detention Facility custody.

CCS provides a QMHP in the building seven (7) days a week, along with on call services. The monitoring visit included an interview with the QMHP, which involved a discussion of suicide assessment strategies, approaches to suicide prevention intervention, general counseling strategies, and a review of professional experiences. The general assessment of the QMHP also included interviews with two youth who had been on suicide watch and had interacted with the QMHP. Affirmatively, all files contained routine or daily assessments by QMHP, all had a mental health assessment conducted by QMHP and all had a psychiatric evaluation when indicated. Finally, a file review was conducted on these youth specifically looking at the QMHP's notes and entries. In the final analysis, the services provided complied with the Agreement.

As of this monitoring visit, CCS has replaced two QMHPs, so this monitoring visit looked again at the quantity and quality of the QMHP function and an assessment of the delivery of suicide prevention services. According to information provided by the detention facility administration, each replacement QMHP provided the same services. This visit also included a discussion with Makendra Ivy, the current QMHP, and Dr. Sara Vardell, CCS psychologist. Their responses to questions about mental health services related to suicide were excellent and indicated a solid understanding of the issues associated with suicide prevention in detention. They discussed multiple strategies to address various types of depression and self-destructive tendencies, a comprehensive system of setting precautions for youth at-risk, methods of

assessment, ongoing assessments, and removal from risk status. All of these systems appeared to be appropriate. Furthermore, interviews with youth and file reviews verified their comments.

The monitoring visit included another meeting with William Kissel the CCS Regional Vice President for Jail Operations, the division that provides the contracted services to the detention facility. The meeting was again very productive, and CCS appeared quite capable of meeting the needs of the suicide prevention and post-restraint medical follow-up remedies of the Agreement. The conversation included concerns about the continuity of care and a commitment that the issue would be successfully resolved. Some of the concern over contract staff centered on the difficulties and inconveniences associated with the need to be on-call and then to be physically present at the facility within a two-hours if a youth were in crisis.

Kissel discussed numerous options for addressing this concern, and one included the use of personal devices (iPads) as a way to conduct distance or tele-mental-health assessments. Any recommendations to move in this direction would also include a requirement that a youth is seen face-to-face within 24 hours. Kissel suggested that he could provide a recommendation and sample policies and procedures for DOJ consideration. This approach seems to be a reasonable strategy to resolve the problems associated with on-call status. Therefore, we look forward to receiving the draft proposal as soon as it is available since resolving this issue is a priority concern.

The visit revealed an opportunity to enhance and expand the programming for youth, particularly recreation and other types of physical activity. The same situation was part of the goals identified by CCS as it evaluates its services to the detention facility, and discussions occurred regarding a proposal to shift some of the hours in the CCS contract to include a contract for a recreational or occupational therapist.

Regarding the CCS 24/7 nursing services, a review of the 16 restraint files revealed that the nursing staff did a careful examination of each youth following the physical restraint. Medical files also contained mental health information. Medical staff expressed concerns about the adequacy of medical files due to problems with staff turnover, suggesting that some of the files would or may not contain all of the required information or that some of the information was available but had not been placed in the file. Either way, some concerns were noted. The primary concern had to do with the documentation of two (2) youth on a precaution list where the notice of the precaution, the daily contact notes, the removal rationale, the follow-up assessment, and the individual treatment plan were not in the file. Again, much of this has to do with the transition of staff and the gap in staffing continuity.

Contract Monitors. The recent changes in the critical QMHP position affirmed the need for a contract monitor. This visit included an interview with the contract monitor and her trainee, who will have responsibility for the detention facility. I met with Mary Knox, BSN, Shelby County Contract Monitor, and Toyetta Reddic, Clinical Monitor Trainee. Both are County employees assigned to contract monitoring. Both have an excellent grasp on health care issues, and they regularly look at data quality control, continuous quality improvement, sick call, health assessments, risk management, grievances, and corrective action plans. Based on their discussions, I am requesting copies of the monthly MSRT notes, especially the Q1 Committee. For future monitoring, I will sit with Toyetta Reddic and observe her conduct a file review.

There is agreement that the goal is to establish and sustain an acceptable level of services even during times of staff turnover. The key is the continuity of care. While CCS has a very

positive reputation and will very likely provide services at the detention facility in excess of those required by the Agreement, this is just the second monitoring visit with CCS providing contracted services and the range and quality of services show substantial improvements, and continuity of care is minimally acceptable. Therefore, monitoring of CCS services will focus on sustainable continuity of care.

The following are observations and comments about the suicide prevention policies and procedures:

1. Regarding the intake screening, information collection forms are appropriate and address those areas identified in the agreement. Despite a review of these factors, several issues remain unanswered. There was no opportunity to observe an actual screening event to ensure that the activity occurred according to the agreement.
2. Regarding the procedures for initiating and terminating precautions, there was evidence in the youth files of both the initiation and termination of precautions consistent with the expectations and the policy and the Agreement.
3. Regarding the communication between direct care and mental health staff, there is a need for additional monitoring in this area. While the evaluations of this element revealed a working level of information exchange, it was a biased sample that included only those who were responsible for the information sharing. Missing is information representative of a daily practice reflective of good communications between direct care and mental health staff from the perspective of staff at different levels.
4. Regarding the suicide risk assessment by the QMHP, the information provided during the monitoring visit indicated that the existing QMHP conducted a competent suicide risk assessment.
5. Regarding the housing and supervision requirements, the policy addresses this subject; but the monitoring visit did not assess its implementation. Comment here is pending and will be the focus of future monitoring. Missing is a review of the practice to verify that the requirement is being implemented in compliance with the Agreement.
6. Regarding the interdisciplinary reviews, the policy addresses this subject; and the monitoring visit assessed limited implementation of these reviews. Additional reviews of the practice will verify compliance with the Agreement.
7. Regarding the multiple levels of precautions, the policy addresses this subject; and the monitoring visit did assess its implementation through the file reviews. Reviews of the practice will continue to verify compliance with the Agreement.
8. Regarding the annual in-service training, the policy addresses this subject; and the monitoring visit assessed its implementation.
9. Regarding the mortality and morbidity review, the policy addresses this subject; but the monitoring visit did not assess its implementation. A review of the practice or a mock review will need to occur to verify compliance with the Agreement.
10. Regarding the regular assessment of the physical plant, the policy addresses this subject; but the monitoring visit did not assess its implementation. Missing is a

review of the practice to verify that the requirement is being implemented in compliance with the Agreement.

FUTURE MONITORING:

Concerns remain about the CCS staff turnover issues. In a recent conference call, a court representative mentioned something about the return of Health Services Administrator Nurse Price. If she does not return, Nurse Price's departure would heighten the concern about the CCS contract. Beyond the continuous CCS lead staff turnover, the presence of an approved and qualified supervisor for medical staff is an issue. The court staff acknowledged that the nurse from the Corrections Center who is providing interim supervision a couple days a week has no experience working with juveniles. In situations like these, adult-oriented practitioners sometimes advise staff on what to do with children and adolescents based on their experience with how adult inmates are handled. Additionally, a tendency sometimes arises where those who are accustomed to responding to adults may be less receptive to different healthcare requests from children and youth. In light of these issues, future monitoring will continue its focus on the quantity, quality, and continuity of services provided by CCS.

Future monitoring will continue to include an ongoing review of the policy and procedure; an observation of key individuals conducting a confidential intake screening; ongoing review of CCS suicide prevention services; more focused reviews of communication between direct care and mental health staff, housing and supervision requirements, multiple levels of precautions, interdisciplinary reviews, mortality and morbidity reviews and regular assessments of the physical plant; 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)

RECOMMENDED FINDING: Substantial Compliance

COMMENT: Here is another paragraph that remained 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 three Code Blue Packs while conducting the facility tour.

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

COMMENT: The file review supports the provision of these services through CCS, so an initial compliance is recommended. The compliance is tenuous because of the turnover issue with CCS QMHPs. As a result, monitoring will continue to review the timely provision of these services to sustain a compliance recommendation.

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: The additional concern that existed about the expectation of the Detention Facility staff to conduct a suicide screening within one hour of a youths admission to the facility appears to be moving to a successful resolution through the use of the new suicide screening tool. Columbia Suicide Severity Rating Scale is an adequate and appropriate tool for the initial screening of youth for potential suicide risks.

The agreement about the status of youth in intake is that while they have not been counted as an admission because they have not been formally processed (a decision has not been made to detain) and they have not been physically escorted upstairs to detention, nonetheless the detention facility has custody and these intake youth are not allowed to leave the building, so they are detained. Therefore, all of the Agreement requirements apply to youth in intake.

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: This is another area of Section C that was reviewed this visit. The issues expressed in the Agreement are present in the Detention Facility policy, but there had been unsubstantiated allegations during the latter part of the previous visit that youth on suicide watch have been placed on varying types of isolation. There was no evidence in this investigation of the routine use of isolation of youth on suicide precautions.

The Isolation and Confinement Log revealed several instances where a youth was confined, but there was not a corresponding use of force involved. Four (4) of these instances were further investigated because of youth having been on a suicide concern and because of substantial confinement times without a corresponding use of force incident. The review of the instances with suicide implications revealed that the use of confinement was consistent with the

agency policy and procedures and did not violate the suicide precaution policies. The others revealed serious misbehaviors that resulted in confinement as a sanction from the disciplinary hearings. Again, there were no links to suicide precaution status in any of these instances. Ongoing review is required.

FUTURE MONITORING:

Future monitoring will continue to include a review of the confinement and isolation practices to ensure that the records do not reveal youth on suicide precautions 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)

RECOMMENDED FINDING: Partial Compliance

COMMENT: The issues expressed in the Agreement are present in the Detention Facility policy, and the majority but not all of the requirements of this paragraph were present during this visit. Comments and observations are outlined below:

1. Regarding the QMHP evaluation within two hours, a file review was conducted on the two youth who identified suicidal issues that intake and admissions, specifically looking at the QMHP notes and entries to determine the time of the evaluation. The documentation complied with the Agreement. This monitoring visit looked at the quantity and quality of the QMHP function, so the presence of a new QMHP will require the next monitoring visit to repeat the current review of the new individual's performance of these responsibilities.
2. Regarding the extent of the risk of suicide, the file review of the two youth produced QMHP notes and entries describing the extent of the suicide risk and suggesting regular monitoring. The documentation complied with the Agreement. This monitoring visit looked at the quantity and quality of the new QMHP. Under this Subsection, 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 Agreement. Future monitoring will also address the ITP.

3. Regarding the QMHP reassessments, the file reviews of youth produced QMHP notes and entries describing daily assessments, rationale for removal of the precautionary supervision, and periodic reassessments. The documentation was also in the youth's medical file indicating that all required documentation complied with the Agreement.

   Individual interviews were conducted with youth on suicide precaution or other mental health observations. Youth described Ms. Ivy is a very nice person who "gives me hope." This is an important aspect of the QMHP provider in response to suicide crises. A review of the progress notes and paperwork regarding suicide precautions yielded positive results. The notes were up to date, comprehensive, and informative. The corresponding medical and psychiatric notes were also available in the file.

4. Regarding the changes to a youth's suicide precaution level or status, eight (8) medical charts were reviewed for documentation regarding suicide cautions, QMHP assessment, recommendations to staff regarding behaviors that can moderate a youth's crisis, individualized treatment plans, QMHP rationale for the removal of a precaution status, and routine, daily, or follow-up assessments. All documentation was appropriate.

   So far, staff indicated in their interviews that relevant information is provided frequently, but it seems far too soon to indicate compliance until a pattern of regular exchanges of relevant information is established. The relationship between the CCS QMHP and detention officers appears positive and in line with compliance expectations.

In response to the anticipated increase in the need for services to address the greater proportion of youth with specialized needs, the CCS contract appears to be a satisfactory strategy to address these challenges. The addition of a QMHP and on-call mental health services has substantially increased the protection from harm safeguards regarding dangerous, self injurious, and suicidal behaviors associated with mental health problems and other needs of youth. The CCS contract also provides a level of medical and health care coverage that complements mental health services. The addition of the CCS contract is an appropriate response to the increased demands that will likely occur in Shelby County's detention population. Only the continuity of care and regular communication by the QMHP with Detention Officers need greater consistency

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: The file review of the youth on suicide precautions produced QMHP notes and entries describing daily assessments, rationale for removal of the precautionary supervision, and periodic reassessments. The documentation was also in the youth's medical file indicating that all required documentation complied with the Agreement. As mentioned above, the next monitoring visit will repeat the current review of the new QMHP staff member regarding these responsibilities.

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: The assessment of this paragraph was limited by the decision to address other issues during the time available for monitoring on this visit. The issues expressed in the Agreement are present in the Detention Facility policy; however, there was insufficient time available to verify this reporting requirement.

FUTURE MONITORING:

Future monitoring will include a review of the data to verify 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.

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: During this review period there was an interruption in compiling and analyzing data due to the retirement of a staff member responsible for this work. It was apparent that this dependency upon a single staff member limited the ability of the Detention Facility to analyze their work and also brought into question the ability of the detention facility to insure the quality of the data compilation and analysis. It is important that policies be developed to insure administrative staff knows how to compile and analyze data and that this work continues to be done in times of staff transition.

See the comments below about the Performance Metrics.

FUTURE MONITORING:

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

3. Training

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

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

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

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

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

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: The issues expressed in the Agreement are present in the Detention Facility policy and verified in the content and quality of the training. The monitoring included reviews of training records and discussions with staff about the new suicide training curriculum. While the review of staff training records provided a picture of the quantity of training that occurs, future monitoring will need to focus on timing aspects (the annual occurrence of this curriculum and its refresher), and how staff apply the training in their daily routine.

The review of staff training records yielded the following observations:

1. Regarding the use of force curriculum, there was no assessment of the curriculum and its relevance to the Agreement; and an evaluation of verbal de-escalation is not included. A random selection of 15 employee training records indicated that all have had the 16-hour CPI use of force training.

The review of Suicide Prevention Training yielded the following observations:

1. Regarding the description of the environmental risk factors for suicide, individually predisposing factors, high risk periods for incarcerated youth, warning signs and symptoms, known sources of stress to potentially suicidal youth, the specific risks posed, and coping mechanisms or activities that may help to mitigate the risk of harm, the CCS psychologist addressed this concern; and elements for a revised training curriculum have been developed. Future monitoring visits will continue to assess the improvement to information sharing as a result of the new training.
2. Regarding the discussion of the Facility's suicide prevention procedures, liability issues, recent suicide attempts at the Facility, searches of youth 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, the review of the 15 employee training records indicated that all had the required suicide prevention training.

On Wednesday, April 9, I observed a part of the morning session of the suicide prevention training using the NCIA training curriculum by Lindsay Hayes. Ms. Ivy was the trainer and the session was informative and interactive. Hayes structured the presentation of materials in such a way that staff are asked to respond to "fact or fiction" statements and circumstances. Staff responses indicated how many of the common assumptions about institutional suicide were not borne out in Hayes' national suicide research data. The point for staff was that making assumptions about what youth will do in certain situations at certain times can be problematic and that their vigilance needs to be heightened at all times. In addition to the CCS QMHP providing training for detention officers, Dr. Tucker Johnson, Office of Clinical Services (OCS) psychologist, also provides training on the signs and symptoms of mental illness, retardation, and chemical dependency. These programs strengthen the annual in-service training offering.

A sample of 15 employee training records was drawn from the file of staff training records. All had the suicide prevention refresher training of eight (8) hours each. All had verified sign in sheets from the training sessions for each topic. Walton has also prepared and administered competency posttests for suicide prevention and use of force training, and a review

of selected posttest exams revealed satisfactory understanding of the training topics as evidenced by the scores on the exam.

1. Regarding the mock demonstrations, a video exists of a mock demonstration; however, the review of this video did not occur because of lack of time. If the mock demonstration can be forwarded to me either via e-mail attachment or USB drive, a review could occur prior to the next visitation.
2. Regarding the certification in CPR and first aid of all detention staff, the review of 15employee training records indicated that all were current in CPR and first aid training.

FUTURE MONITORING:

Future monitoring will continue to include a review of the updated and revised training curriculum, especially the training elements provided by the CCS psychologist. It will also include the valuation of the Safe Crisis Management (SCM) use of force training regarding a standard technique for physical restraints of the youth that cannot be accomplished in a standing position. Future monitoring will also assess the improvement to information sharing as a result of the new training.

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

4. Performance Metrics for Protection from Harm

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

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: The Compliance Report is complimentary of progress made by the detention facility in the development of performance metrics. This is a substantial step forward in the ability of management to use data as a tool for quality assurance and continuous quality improvement. I appreciate the diligence the Detention Facility put forth in the development of this management information system and the analyses of uses of force and suicide prevention interventions.

Data integrity is the foundation of a quality assurance program that will provide accurate information to the court regarding key indicators about the status of detention operations, information that will drive continuous quality improvement, and information that can be used to fuel sustainability efforts following the DOJ departure. Because detention is a complex and sometimes confusing phenomenon, it is important that the court have reliable and objective outcomes measures for critical decision-making. This assessment marks the starting point in the progress toward the reliable system. The first monitoring visits focused on the identification of concepts and the issues surrounding data collection. This visit used the information to demonstrate the discrepancies in definitions of behavior and data collection.

The court was advised that the improvement in the integrity of data collection would result in a change in the Report Card with the likelihood of problem indicators increasing, sometimes significantly. There will be a need to respond to these changes in a way that explains that the change is a function of the data collection versus a significant deterioration in the detention operations. Every facility that cleans up its management information system goes through a process where there is an increase in key indicators due to increased reliability and validity.

The expectation is that the data collection system will continue to evolve over the next six months. In addition to the monthly conference calls, detention staff should involve Bill Powell, CSS mental health staff, CSS medical staff, and Shelby County's contract monitors in the discussion process regarding common definitions of events and consolidated event reporting strategies. Once these challenges have been resolved, then the system will go through a process of validation, and the recommendation is that Bill Powell conducts the first evaluation validation. Following a successful validation by me, a recommendation for compliance will advance.

A Critical Incident Review policy was created to provide guidance reviews and to ensure that the "lessons learned" are incorporated into new policies, procedures, training, and practices. There were two issues regarding critical reviews that required discussion. The critical incident review following the bomb threat was one example of how the process can be improved through the formalization and standardization of a comprehensive critical review policy. The policy in existence appeared sufficient to guide the process, but the implementation of it revealed there is room for improvement. Most importantly, critical incident reviews require multiple sets of eyes from multiple different disciplinary perspectives. Initially, the more players involved, the better. As the review process matures, leaders will be able to identify those individuals who provide new and important perspectives and those whose perspectives are redundant to those in the court. At that point, a restructuring or reconstituting of the review committees might be advisable. In any event, the gaps in the review conducted following the bomb threat suggests that unless a critical self-examination is done, many opportunities for improvement will likely be missed.

At the institutional level, monthly reviews occurred for use of force incidents. These reviews also need to be more inclusive in terms of the individuals who provide a prospective on the appropriateness of the documentation and the restraint video. In addition to the detention facility administration, consideration should be given to representatives from shift supervisors, physical restraint trainers, Bill Powell, and court administration for involvement on a regular or periodic basis. It is important for the leadership of the court and the detention facility to participate periodically in a use of force review to see how youth and staff behave in crisis situations and to evaluate first-hand the appropriateness of the use of force responses by staff. The review of the six uses of force incidents during this monitoring visit yielded a substantial list

of issues for follow-up. Some of these issues require coaching while others require corrective action. This list of the physical restraints will be a topic of discussion at the next monitoring visit to evaluate the quality and quantity of follow-up.

Several areas exist where the performance metrics require additional development and improvement for compliance:

- Regarding the monthly reviews of use of force reports, the monthly data spreadsheets include frequencies and rates on use of force, seclusion, documentation and recording, the hierarchy of nonphysical alternatives, documentation of nonphysical alternatives, and medical evaluations. Supplemental information includes information from the PbS Standards for Safety, Order, and Health. These 13 standards provide definitions for youth and staff behaviors that are important to the protection from harm elements of the Agreement. Several concerns need to be addressed regarding the monthly use of force reports:
- The current system does not address the identification, classification, and correction of any wrongful conduct uncovered in the review of the data. This information is important to continuous quality improvement by identifying patterns and other variables that can be instructive to administration and staff regarding improper uses of force. This information is currently collected, and it needs to be reported through the existing MOA Performance Metrics system.
- There are data collection and reporting challenges with several of the PbS standards that need to be resolved. These include an accurate assessment and reporting of Safety 13 (percent of youth who report that they fear for their safety), Safety 14 (percent of staff who report that they fear for their safety), Order 9 (average duration of isolation and room confinement and segregation/special management unit in hours).
- The narrative analysis of the monthly data should include a more representative group of detention staff if, as reported, the analysis is done only by the detention facility administrators. The best analyses of the data result from the input of multiple perspectives, so it is worth considering the responses of supervisors, intake workers, detention officers, teachers, nurses, and QMHPs. This is not to imply that there should be another series of meetings regarding use of force data, but the Detention Facility would do well to consider a short, multidisciplinary discussion of the implications in the data. In other words, a response is needed from multiple sectors to the question, "What do these numbers mean?"
- Data integrity is improving but is an ongoing concern. Do the numbers reflect accurately the behaviors that have occurred over the past month? There are multiple ways to approach data integrity, some more complicated than others. However, the first validation of the numbers comes from sharing them with multiple staff from varying perspectives. Second, a validation study can be conducted where an individual takes one or more of the data categories and searches files, logs, incident reports, youth and staff interviews, and other agency documentation to verify that the number of events in the documentation and inquiry equal the number reported in the data. Consistent with the procedures of the American Correctional Association, most agencies conduct these types of quality

assurance activities themselves, using skilled facility staff or staff from allied agencies to conduct the validation study. the Juvenile Court should consider a request of Powell to conduct a preliminary validation of the data, provided his contract allows this level of additional activity.

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

RECOMMENDED FINDING: Compliance

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

III. Summary and Recommendations

There has been a great effort by staff to make the changes necessary in response to Section C of the Agreement. There has been an improved quality in the policies and procedures. This is a particular reference to the suicide policy. Regarding the revised use of force policy, the critical issue is the practice or evidence that staff are doing their jobs in a manner consistent with the policy and procedure.

The summary statements from the compliance report are also very relevant here. Tremendous progress has been made in the area of protection from harm. Staff members are better trained and a wealth of new and relevant information is available to help analyze their work performance. Medical and mental health services are available and vastly superior to what was provided before the Agreement. Detention staff have made substantial progress in producing reports that make better use of improved data. They were quick to adopt new and innovative training for staff including training on use of force, suicide prevention, and HIPPA. Key areas for improvement continue to be the validation of data and the use of data to improve daily operations. Turnover in some key positions with CCS remains a cause for concern as it relates to the continuity of care, which was addressed earlier

Recommendation: Section C of the Agreement requires policy, procedure, and practice related changes that have implications to the PREA standards. A draft of the PREA standards exists. Powell and a PREA expert, such as Steve Jett, should review these policies. Discussions occurred with Greg Dixon, the PREA coordinator and ACA coordinator. He is in the process of preparing the PREA standards, which will be used to prepare for the required PREA audit. Shelby County has contacted Steve Jett to provide information and to conduct the audit. Jett is an excellent resource and can be of substantial assistance in developing the PREA policies and procedures.

Recommendation: As a part of the Juvenile Court involvement with the Juvenile Detention Alternatives Initiative (JDAI), a conditions of confinement assessment occurred at the detention facility at the beginning of 2014 using the JDAI Juvenile Detention Self-Assessment Standards; and the report has been shared with DOJ. This visit included a meeting with the JDAI coordinator Kimbrell Owens, who provided excellent information about any possible overlap between the goals for detention expressed by the JDAI local committee and protection from harm issues in the Agreement. This recommendation shall be considered fully implemented and will be eliminated from future reports.

Regarding comments to me apologizing about access to the DFSA report prior to the filing of a response by the Juvenile Court, I am pleased that a sense of trust exists between the detention facility leadership and the DOJ monitoring that is positive and proactive regarding relevant actions and information that moves the detention facility closer to compliance with the Agreement, as opposed to actions that might give the impression that monitoring is largely a way to identify issues where the detention facility is not in compliance. Situations such as these are easily misinterpreted, but this level of transparency is highly important to keeping the monitoring relationship positive and collaborative. Sharing information is a valuable component of achieving compliance.

Recommendation: As a part of the Section C Protection from Harm improvements to programs and practices, a comprehensive staffing analysis would be beneficial. Even in light of the additional staff (Detention Officers) provided to the detention facility following the November report, there has been no assessment of the impact of these new staff because all of them are involved in training to qualify them for full participation on their assigned shift. Therefore, there was no way to determine if the additional staff will sufficiently moderate the staff shortages noted in the previous report. The need for a staffing analysis remains. Discussions with administration and line staff continue to suggest that a contributor to the levels of youth-on-youth assaults and physical restraints is staffing adequacy challenges.

Another example of practices that affect staffing needs is intake. There were 118 youth admitted to the detention facility in March. The management information system also notes the average length of stay for the month, which provides a record of how long each youth stayed in detention. Of the 118 admissions, 58 (49.2%) were released within 96 hours. Many in the juvenile justice system believe that this statistic indicates areas where the court can expedite decision-making and, therefore, reduce the time demands on staff regarding admissions and releases.

The rationale for keeping the staffing analysis on the list of recommendations is based on post-reform detention or what present outcomes suggest will be the impact on the DSB detention population after the implementation of JDAI. Anticipating significant accomplishments through the JDAI reform, the detention facility should experience substantial reductions in the numbers of youth in custody, an availability of secure beds, the expansion of community-based alternatives to incarceration, and the increased capacity in the community to provide both non-secure custody options and an expanding range of treatment services (medical, mental health, substance abuse, etc.).

The challenges associated with the reform efforts will be more available beds (a reduced average daily population), greater numbers or a greater proportion of youth with substantial chronic and acute needs (mental health issues, trauma and PTSD, depression, suicidal behaviors, substance abuse, fetal alcohol syndrome, ADHD, learning disabilities, not to mention the litany of physical health issues). Also, detention will likely see an increase in the numbers or an increase in the proportion of youth that are gang involved, which the research consistently shows is associated with increases in criminal behaviors or behaviors associated with violence, intimidation, bullying, and peer deviance contagion.

To safeguard the staff, the individual youth, and the larger group of youth, two general strategies have been used in different facilities. The first is an increase in the number of direct care staff available on the shift. In other words, the enhancement of the staffing ratio allows the

facility to use relationship building skills as a way to de-escalate potential violence. The other option is to redesign the daily living program to include behavior management and relationship-building expectations that are more helpful and problem solving oriented. Even though the evidence surrounding the effectiveness of this approach is consistently positive, the transition from a traditional attention approach to a more helpful detention program requires substantial training and time for these changes to appear in the social climate or institutional climate. This approach might better be viewed as a long-term strategy. Therefore, the short-term strategy is to make sense of the staffing ratio so that it is complementary to the protection from harm and safety expectations of the court, which would benefit greatly from a systematic staffing analysis.

The reduction in beds is often accompanied by a reduction in staff, especially detention officers. Some of the reductions in different or jurisdictions around the country have been so significant that they have resulted in the closing of the detention facility and contract agreements with a nearby detention facility for the few youth that still require secure custody. In difficult budget times, it is tempting to reduce the staffing complement in line with the percent reduction in the average daily population. The caution in taking this approach relates to the assumption that the post-reform detention population will remain largely the same, thereby justifying a pre-reform staffing pattern as appropriate. If, however, an agency believes that its post-reform detention will be different, then the rationale for a different staffing pattern makes sense.

Recommendation: Several general recommendations arise from this visitation and warrant special attention by the Juvenile Court and the Detention Facility:

1. Performing suicide screening in the hallway outside Intake may not provide sufficient privacy or confidentiality.
2. Programming enhancements should continue for mental health and other youth.
3. The restriction on a book (reading material) in the youth's room should be re-evaluated.
4. A strong, positive behavior management system would have a positive impact on Protection from Harm issues.
5. The finding of understaffing or an absence of staffing sufficiency supports earlier recommendations for a staffing analysis.
6. The regularly scheduled meeting with staff by the facility administrator for discussion and recommendations about new policies has merit; the new monthly meetings to discuss outcomes data could be expanded to include theses policy discussions.

Recommendation: There have been regularly scheduled telephone conferences with the Protection from Harm Consultant, the detention facility leadership, the Juvenile Court supervisor of the Detention Facility, and Bill Powell. For the record, the first of these telephone calls occurred on December 5, 2013 and have occurred monthly since then. These call have been productive and will be an important and monthly part of future monitoring. Therefore, this recommendation has been fully implemented and will be eliminated from future reports.

The detention facility leadership continues to be competent, caring, and enthusiastic. I remain optimistic that the detention facility, with the advice, guidance, and support of Bill Powell, will continue to move quickly toward the resolution of the Section C Protection from Harm paragraphs.

Sincerely,

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