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Re: Juvenile Court of Memphis and Shelby County (Juvenile Court) MOA Protection from Harm Stipulations: 4th Findings and Recommendations Letter

Dear Winsome and Richard:

This is the fourth letter to the U.S. Department of Justice (DOJ) regarding the Memorandum of Agreement (MOA) between the United States and the Juvenile Court of Memphis and Shelby County (Juvenile Court), TN, and it describes the visit to the Juvenile Court Detention Services Bureau (Detention Facility) on October 8-10, 2014. 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 slowed considerably as a result of uncertainty among staff associated with the September elections for a new juvenile court judge to replace retiring Judge Curtis Persons. The new judge is the Honorable Dan Michael, a veteran juvenile court attorney with an appreciation for current Detention Facility leadership and a commitment to resolve the Protection from Harm issues in the MOA.

The Juvenile Court staff and the leadership team at the Detention Facility remain good combinations of complementary skills and abilities. Gary Cummings, Mamie G. Jones, and Willie Walton represent a solid management team. Communication, information, and guidance provided by William Powell, Settlement Agreement Coordinator, continue to be excellent. He provides a valuable perspective, and his advice continues to be beneficial to the achievement of

compliance with Section C of the MOA. Jina C. Shoaf, Assistant Shelby County attorney, again participated in many of the meetings and discussions. Her input continues to be valuable and her questions insightful.

I. Assessment Protocols

The assessments used the following format:

A. Pre-Visit Document Review

Powell remains the MOA Settlement Agreement Coordinator. He is conversant about compliance issues and offers a pragmatic approach to what is required for compliance under the MOA paragraphs. He continues to be an excellent resource. On September 23, 2014, Powell submitted reports called, "Compliance Report #4" and "Substantive Remedial Measures" (hereafter referred to as the "Compliance Report") and forwarded copies for review before the on-site visit. Special attention was given to pages 30-36, covering Protection from Harm actions and recommendations.

B. Use of Data

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

C. Entrance Interview

No formal entrance interview occurred. First day meetings with Gary Cummings, Mamie G. Jones, and Willie Walton provided an opportunity to discuss updates of institutional goals and objectives, an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities.

D. Facility Tour

Brief walkthroughs of the facility occurred on October 9 and provided an opportunity to observe resident sleeping rooms, the general cleanliness of the facility, and any physical plant modifications or improvements.

E. On-Site Review

This visit continued the verification of practices through a review of documentation (incident reports and youth files, including medical and mental health) and data collection regarding isolation, confinement, and uses of force. Additionally, the last visit established some

baselines by youth that pertain to Protection from Harm factors. Youth perspectives will be discussed in greater detail below.

F. Staff Interviews

I interviewed 24 staff, including Judge Michael and nine (9) Juvenile Court employees, 8 (eight) Detention Facility employees, and six (6) Correct Care Solutions (CCS) staff.

G. Resident Interviews

I interviewed 11 youth, 10 youth in two five-person group interviews and one individual interview regarding personal safety precautions. The average age of these youth was 15.9 years with an average length of stay (ALOS) of 16.7 days. The individual interview 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. Administrative staff selected the youth for the interviews; all were youth of color.

H. Exit Interview

The exit meeting occurred on October 10, 2014 in the Juvenile Court Conference Room. Those in attendance included: Gary Cummings, Detention Facility Administrator; Garland Erguden, Magistrate; Dini Malone, Director of Administrative Services; Debbie Miller, Manager of Food Services; Hon. Dan Michael, Juvenile Court Judge; William Powell, Settlement Agreement Coordinator; Larry Scroggs, Chief Administrative Officer; Jina C. Shoaf, Shelby County Attorney; Pam Skelton, Director of Court Services; David White, Chief Magistrate and by teleconference Winsome Gayle and Richard Goemann, DOJ Attorneys. 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

The interview strategy for this visit attempted to include the new leadership resulting from the election of Judge Michael. The development of his leadership team had begun, and some leadership transition had occurred by the time of the on-site visit. Therefore, interviews with as many key and newly appointed lead staff were important elements of the assessment and represented much of the first day of activities. Two perceptions emerged. First, consistent with the objectives of the previous administration, everyone expressed a strong desire to improve the quality of detention services and remedy the Protection from Harm factors to make the Detention Facility an exemplary program. Second, there was, again, uniform resolve of leadership to resolve quickly and effectively address the Protection from Harm issues in the MOA.

1. Youth Interviews

Youth interviews provided a supplemental perspective on operations, safety, and suicide prevention practices. Youth interviews also can be controversial. Detained youth are great truth tellers and prevaricators, oftentimes in the same sentence. Therefore, youth perspectives need to be one part of a larger system of information that describes what is occurring in the facility. A triangulation strategy is used that includes subjective perspectives (views of youth and staff), direct observations, and the elements of organization structure included in policy, procedure, practice, and outcomes data. 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 trigger various forms of acting-out or inappropriate behaviors by youth. Given that relationship, it is important for staff to be aware of concerns expressed by youth and to discuss if and how youth's concerns should be addressed.

Compared to the 10 youth who participated in the focus groups during the April 2014 monitoring visit, this group of 10 youth expressed greater concerns about safety, order, and organization. Much of their concern had to do with relationships with staff. These findings underscore the need for an effective and positive behavior management system grounded in healthy relationships between youth and staff. For example:

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[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.

- 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. A restriction of this nature remains contrary to generally accepted professional standards about a quantity of reading materials that are permitted in a youth's room.

  Regarding room confinement time, all youth complained that there are days during the week when there is no school or when there are staffing shortages or on the weekends when they are only out of their rooms for about two hours a day.
- 10 of the youth (100%) stated that the grievance system does not work. Grievance systems are important to the protection of residence rights while in 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.

  The Compliance Report noted that youth are informed of the grievance process during orientation, which takes place during admission to detention. Each youth is to be given a copy of the Detention Orientation Booklet to review during leisure time. However, only three youth (30%) indicated that day had received information about a grievance process at admission. The Compliance Report also noted that Detention Facility shift supervisors are required to collect all grievances from the secure grievance box daily. All grievances are logged into the grievance logbook and investigated by the shift supervisor. Youth provided confirmation of this practice but continued to maintain that grievance system is ineffective. Additional attention to the grievance system is needed to change youth perceptions.
- 10 the of youth (100%) indicated that they (a) understand the facility rules, (b) do not know of or understand a behavior management system based on incentives or rewards, and (c) believe that staff make more negative comments to them than positive comments.
- Two of the youth (20%) indicated that they (a) have feared for their safety since they have been the facility and (b) have had personal property stolen directly by force or threat.
- Four of the youth (40%) indicated that they have been beaten up or threatened with being beaten up by other youth since being at the facility.
- Eight of the youth (80%) indicated that staff members do not show youth respect while 20% indicated that staff sometimes show them respect.
- Nine of the youth (90%) indicated that staff are not good role models while 10% indicated that staff are sometimes good role models.
- 10 the of youth (100%) indicated that staff members are not fair about discipline issues.

- 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.
- Youth interviews involved the question, "If you were in charge, what would you do to make this a better place?" 100% of youth identified "food" as the first change they would make. 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. After once again verifying the youths' complaints about poor food quality (this time servings of partially frozen slices of processed turkey breast), Detention Administrator Cummings and I talked with food services manager Trisha Monteil and her supervisor, Debbie Miller, about improving the preparation and serving of food. Generally accepted professional standards prohibit the use of food as punishment, yet improperly prepared food served with what both youth and staff reported as the occasional "If you don't like this, then maybe you ought not be in here" raises legitimate questions as to where bland ends and punishment begins. The hope is that improvements in food services can be accomplished before the next monitoring visit.

The Detention Facility leadership conducts periodic youth forum activities to solicit youth perspectives. In most instances, these findings were parallel to the information gathered from the youth discussion groups.

Other indicators supported a reduced level of safety for youth and staff. For example, several individuals reported that there is increasing concern among probation staff that the level of safety in the Detention Facility has deteriorated. While the Detention Report Card data supported this perception, it is unlikely that probation officers have access to these numbers, suggesting that their concerns about safety were based on first or second hand experiences. One factor that was different from the April 2014 visit was the noise level on the units. Staff shortages have increased the frequency of strategic and rolling locked room confinements of different groups of youth to accommodate competing staff supervision demands by program and youth movement priorities. During an October 9 walkthrough on the North Side at 11:00 AM, there were 19 youth in locked room confinement and only one staff member on the unit. To communicate with one another, youth got on the floor and talked loudly under the door to youth in adjacent rooms or across or down the hall. Because of insufficient staffing, consequences for these behaviors were inconsistently enforced due to staff concerns about escalations of behaviors. This situation also encouraged youth to bang or kick the door, creating even more noise. The noise factor may be an important contributor to staff perceptions of a chaotic environment and, therefore, a reduced level of safety.

Next, the frequency of uses of force increased by 36% from August to September. While the rate of uses the force per 100 bed days remained relatively stable, frequency data are important because they represent the number of times that staff members actually engaged in hands-on restraint activities with youth; and youth generally respond with higher levels of anxiety, adrenaline, and stress when uses of force occur, even if they are not directly involved in the use of force event.

2. Staff Interviews

Staff identified the specific changes in use of force practices consistent with the changes in the physical restraint policies, procedures, and training. In particular, staff identified a greater emphasis on verbal interaction and de-escalation. Again, staff summarized this change as "talk down before take down." Staff generally viewed the new approach as a change for the better.

Staff get regular feedback from the QMHP following an intervention, assessment session, daily checkup, or change in status of a youth on suicide precaution. Supervisors indicated that the QMHP talks or calls them personally to discuss issues and changes and to make sure that everyone understands the intervention plan. Line staff indicated that supervisors are very good in transferring this information, particularly regarding observation intervals and who is permitted in and out of the youth's room.

Staffing remained a problem, and it was identified as such by all staff interviewed. As stated earlier, the October 9 walkthrough on the North Side at 11:02 AM revealed 19 youth in locked room confinement with only one staff member on the unit. This is an unacceptable staffing ratio under any circumstance. Given the current number of available Detention Officers and the current average daily population (ADP), a preliminary analysis of the routine Coverage and Assignment strategy revealed that about half of the available Detention Officers were needed to cover the need for staff on just one of three shifts.

3. Interview Summary

The impressions from the discussions with youth, line staff, and the data analyses yielded an overall perspective that the progress made since the last visit had "stalled." The majority of the indicators used to evaluate progress showed little or no differences over the past 6 months. To Judge Michael's credit, he immediately pointed out that staff had been in a state of uncertainty due to the recent election and that this situation likely accounted for much of the lack of progress. However, the Judge indicated his desire to move forward quickly and effectively in the resolution of the Protection from Harm stipulations.

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.

FUTURE MONITORING:

Future monitoring will include reviews of use of force policies and procedures with special emphasis on prohibition of the restraint chair and pressure point control tactics (PPCT).

Additionally, future monitoring will include interviews with youth and staff to verify the absence of behavior management practices related to both prohibited approaches.

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: As the monitoring evolves in response to progress by the Detention Facility, the interrelatedness of certain paragraphs will also ebb and flow. The monitoring is at a point where the quality of information used to "analyze the methods that staff uses to control children" has become a priority concern. There is a temporal ordering to this requirement for a competent analysis, and the first issue is competent information and data. Confidence is needed in the Detention Report Card data; and while this is a concern that will be expanded in Section 4, "Performance Metrics for Protection from Harm," the integrity of the data that inform critical Protection from Harm analyses must be improved.

Any paragraph that depends upon data, metrics, or the Detention Report Card to achieve a recommendation of compliance requires the validation of the data collection system (Section 4, "Performance Metrics for Protection from Harm") if there is to be sufficient confidence in the numbers that undergird compliance.

Second, compliance represents “the Facility” analysis versus what will be later described more narrowly as the Facility Administrator review or analysis in subsection (c) below. As such, compliance means a broadening or expansion of those staff members at various levels of the facility and agency that participate in the analysis.

Third, the system for corrective actions needs to be enhanced through forms of documented instruction (situationally-specific and individually tailored staff training or tutoring that is documented as part of the corrective action as opposed to progressive discipline) and coaching (high-performing staff members providing direct supervision of the target employee to provide immediate and specific feedback about job performance issues).

Fourth, for expediency in the resolution of these paragraphs, Judge Michael and Juvenile Court leadership should evaluate the benefit of an external assessment of the existing data system to include recommendations for improvements and guidelines for conducting an internal data validation assessment.

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: Previous Compliance Report noted that the revised use of force policy is a good policy, delineating for staff a use of force continuum, listing approved methods of restraint, and providing guidance to staff in dealing with situations involving the use of force. Powell accurately noted that compliance with the Agreement will depend on the extent to which staff understand and implement the policy (presumably through continued training and instruction) and supervisors conduct or provide proper reviews and guidance that also comply with the policy (again presumably through continued training, instruction, and coaching). (See the comments in subsection (b) above.)

Regarding the resulting "practice" from the revised use of force policy, staff interviewees as previously noted identified specific changes in use of force practices that place a greater emphasis on verbal interaction and de-escalation or as staff describe "talk down before take down." Staff generally viewed the new approach as a change for the better. Additionally, the review of IR #091414A with Jones and Walton revealed a situation where staff members engaged in a sufficient amount of de-escalation (talk) that a physical restraint was avoided.

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 amounts of locked room confinement were too long, and the Detention Facility should consider a positive behavior management system and an enhanced schedule of activities as one strategy to reduce the amount of room confinement. The Juvenile Detention Alternatives Initiative (JDAI) Self-Assessment Standards call for programs and activities to reduce locked room confinement. According to youth interviews, the new CCS recreational specialist has not had an impact on reducing locked room confinement. The relative newness of this position may account for these perceptions. Even more problematic was the relationship between periodic

insufficiencies in staffing and the use of locked room confinement to accommodate too few staff. The Detention Report Card data revealed a 151% increase in the average duration of room confinement since April 2014.

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. The file review indicated a lack of consistency in the documentation of attempts at non-physical alternatives.

With one exception, the file review confirmed the presence of the post restraint medical evaluation.

FUTURE MONITORING:

Future monitoring will shift to a review of a stratified, non-random sample of use of force or physical restraint packets 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 analysis will be contingent upon the development of a standard definition of a use of force or physical restraint packet. 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 were part of the information in this section. These documents and their analysis will be discussed in detail under the Performance Metrics section.

The Compliance Report noted that use of force incidents are reviewed (the incoming shift supervisor, a detention officer lead, a detention officer and a juvenile services specialist conduct a video review, complete the use of force review checklist and forward the results to the Detention Facility manager); and data are compiled and analyzed to identify issues associated with uses of force. Discussions have been held about data validation, data integrity, and data sharing with staff. Plans exist for validating these data, and it is important to insure these plans are implemented so that there is confidence in the numbers being reported.

File reviews were conducted on seven randomly selected incidents from July through September 2014. 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; six (6) of the six (6) files that contained a use of force were designated as "spontaneous."

Concerns remained with the "spontaneous" designation to the extent that the "spontaneous" designation may 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. Feedback from Jones and Walton indicated that their review of pre-restraint video has not been uniformly productive. For this reason, the shift to a pre-visit review of physical restraint packets will allow for additional discussion about the environmental context or antecedents to the physical restraint.

The Detention Facility should also 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:

As described above, future monitoring of restraint activities will review a stratified, non-random sample of use of force or physical restraint packets. A use of force or restraint packet should include at a minimum all relevant documentation regarding the incident (this usually includes multiple incident reports from the staff members directly involved and a report by the shift supervisor), a post restraint medical evaluation form, documentation of an administrative review and plans of action, relevant video footage from all applicable cameras, and documentation describing any future or ongoing corrective action. The further development of the physical restraint packet and the requirements for its conversion to PDF and other forms of transmittal will be the topic of continued discussions on the monthly teleconferences.

2. Suicide Prevention

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

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

(ii) Procedures for initiating and terminating precautions;

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

(iv) Suicide risk assessment by the QMHP;

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

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

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

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

(ix) Requirements for mortality and morbidity review; and

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

RECOMMENDED FINDING: Compliance

COMMENT: Even though many detention administrators believe it is bad luck to talk about the absence of serious suicidal behaviors, the two primary indicators in the Safety and Order section of the Detention Report Card are Suicidal Behavior with Injury by Youth per 100 bed days and Suicidal Behavior without Injury by Youth per 100 bed days. These rates have averaged 0.03 and 0.81, respectively, over the past six months, and they reflect an effective approach to suicide prevention.

As noted in the Compliance Report, the suicide policies were revised; and those policies were attached in the 2nd Compliance Report, which was submitted September 23, 2013. There were two policies: The first was the Suicide Prevention policy, the second was a policy addressing Suicide Crisis which described what should be done in the event of an actual or attempted suicide. On August 1, 2013 Correct Care Solutions (CCS) was retained as the contract medical and mental health provider. CCS provides mental health staff that play a critical role in suicide prevention. Furthermore, staff were trained on a new suicide prevention curriculum developed by Lindsay Hayes, a nationally recognized expert in suicide prevention. This training took place in March and April 2014. A mock suicide drill occurred; the review of the drill revealed numerous areas for improvement, which should be part of the next mock drill before the April 2015 visit. Mock suicide drills and critical incident reviews should be regularly conducted and documented with the aim of improving performance and insuring understanding and adherence to policies. There is continued agreement with Powell's 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 have been responsive to the MOA, and the CCS services appeared to be in full operation as of this assessment:

- There is a 24/7 nursing presence, and CCS provides the QMHP staff designated by the Agreement.
- At the meeting with the CCS contracted service providers, there was open satisfaction with the increased staffing stability, including an announcement of 100% staffing.
- Random reviews of five mental health files from the 17 youth placed on suicide precautions in September revealed that all required information was in the file; all the documents were satisfactorily completed; and follow-up with detention staff both supervisory and line staff

revealed positive feedback about the information transmitted to them following assessments and checkups by the CCS QMHP.

The October visit revealed the need to enhance and expand even more the programming for youth, particularly recreation and other types of physical activity. The same situation has been part of the goals identified by CCS, which rearranged its budget to include a contract for a recreational or occupational therapist. There was little opportunity to assess the impact of the recreation worker, and this component will be part of the next monitoring visit.

Contract Monitoring. Since the April 2014 monitoring visit, Toyetta Reddic, RN, has served as the Shelby County Contract Monitor. I received copies of her Clinical Contract Monitor Report covering Seven-Day Health Assessments, Sick Call-Blended, and Medical Administration Record from January through August 2014. Of primary concern were the findings for April through August. For all three indicators, CCS healthcare services were at or above 80% in goals achieved. A review of the CCS quality improvement worksheets indicated a comparable level of compliance with the 10 assessment activities associated with juvenile health assessment. The only concern of the health assessment data was the medical record regarding PPD (purified protein derivative) TB tests. This needs further attention by CCS and Nurse Reddic.

This monitoring visit also included a meeting with Nurse Reddic to discuss her contract monitoring activities. We discussed the review of the medical examination following a physical restraint and the need to conduct some random reviews of the time that elapses between a sick call request and the youth being seen by a QHCP. Pregnant detainees create a challenge in all detention facilities, but there needs to be additional attention paid to this healthcare problem for female detainees. Finally, concerns existed about the transfer of important medical and mental health information from CCS to detention services staff. These issues also need to be resolved.

FUTURE MONITORING:

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

- The increased census or ADP at the detention center threatens the ability to provide mental health and suicide prevention services at the current levels that support a recommendation of compliance. CCS has identified an ADP service requirement that will exceed its ability to provide services.
- Electronic medical record records need to be a priority for the health care unit. This is something that should be the responsibility of the Juvenile Court and the Detention Facility to implement with guidance from CCS.
- Previous conversations with CCS regarding how to use new technologies to enhance emergency mental health services led to a productive discussion about tele-mental health options. Through the use of handheld devices that permit a video discussion with a youth presenting issues requiring a QMHP's assessment, the QMHP could see and talk to a youth to provide an immediate determination of his or her mental status for purposes of levels of supervision and possible emergency referral in accordance with appropriate tele-mental health protocols. If the youth were not in crisis, a face-to-face assessment with the QMHP would occur within an appropriate amount of time according to the protocols. While the concept has strong appeal, recommendations for approval of tele-mental health options

would have to follow a review of a draft CCS tele-mental health policy, which has not been completed, so there is as yet no recommended practice. Powell has noted that a tele-mental health proposal was submitted to Larry Scroggs on 7/29/14 for review and approval.

Regarding the regular assessment of the physical plant, the policy addresses this subject; but the monitoring visit did not assess its implementation. Due to time constraints, a review of the documentation to verify that the requirement was implemented in compliance with the Agreement did not occur but will occur next visit.

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

RECOMMENDED FINDING: Substantial Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

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

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: The issues expressed in the Agreement were present in the Detention Facility policy, but there was evidence of excessive routine uses of isolation of youth on suicide precautions without the specified QMHP authorization. The amount of room confinement has increased, and it is a problem. While this is not intended to open a debate about the elimination of locked room confinement since such a discussion is outside the four corners of the MOA, the best research on suicide prevention points to a rather dangerous relationship between locked room confinement and suicidal behaviors.

The Compliance Report confirmed that Detention Facility Supervisors have been instructed to start with the least amount of locked room confinement and only approve these confinements to correct the youth's behavior. However, the Detention Report Card indicated that the average duration of locked room confinement between April and September 2014 increased by 151%. There were multiple factors that contributed to this substantial increase, not the least of which were the increases in the ADP and the staff shortages.

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: Compliance

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

A compliance recommendation is tenuous as there are multiple hazards that jeopardize the ability of the Detention Facility and CCS to maintain the current level of quality and service. The greatest threat to compliance is the ADP. As the number of youth increases, services are strained. CCS staff acknowledge that there is a threshold at which they will not be able to provide the level of services to sustain compliance. The staff shortages also aggravate the ability to safeguard youth on suicide precautions.

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: Regarding the access to information about a re-admitted youth's previous history of suicidal behaviors or ideations either outside the facility or during a previous stay in detention, the intake officer was unable to produce the information on the computer that indicated a previous suicide precaution status during a prior stay in detention. The issue was discussed with a QMHP, and there seemed to be some problems with the system regarding data entry and access. This needs to be fixed.

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: This paragraph depends upon data, metrics, or the Detention Report Card, which have not been validated (see Section 4, "Performance Metrics for Protection from Harm"), so there is insufficient confidence in the numbers and the information to support compliance.

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

FUTURE MONITORING:

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

3. Training

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

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

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

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

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

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

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

RECOMMENDED FINDING: Compliance

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

There are several factors that could threaten this compliance recommendation. First, regarding the mock suicide demonstration, a video existed of a mock demonstration; however, the review of this video revealed multiple areas for improvement. Another mock demonstration should be conducted, videoed, and forwarded to me along with a narrative that identifies the problems from the previous mock suicide demonstration and explains how the correct procedures occurred. Second, the staffing shortage has a direct impact on staff training and quality assurance. Whenever a primary concern is the amount of staff turnover, additional emphasis is placed on staff training as the primary vehicle for preparing staff to work with detained youth.

FUTURE MONITORING:

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

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

4. Performance Metrics for Protection from Harm

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

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: The Compliance Report is a good indicator of progress made by the Detention Facility in the development of performance metrics. There has been a substantial step forward in the ability of management to use data as a tool for quality assurance and continuous quality improvement, but efforts to implement and analyze a validation of the system has stalled. I appreciate the efforts put forth by the Detention Facility leadership to develop the management information system and to analyze regularly its uses of force and suicide prevention interventions. The monthly teleconference has been an important part of this progress.

Data integrity is the foundation of a quality assurance program that will provide accurate information to the Juvenile 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 Juvenile Court have reliable and objective outcomes measures for critical decision-making.

Even before the election campaign, the Juvenile Court had been slow to address the data integrity questions regarding quality assurance. To expedite the process so that data quality does not continue to be an obstacle that slows Detention Facility progress toward compliance, the recommendation is that the Juvenile Court contract with a juvenile justice data quality expert to conduct a assessment of the existing data system, to make recommendations for improvements, and to establish the guidelines for conducting a data validation assessment by Bill Powell.

Next, 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. At the time of the monitoring visit, no information was provided to me or DOJ regarding whether a critical incident review following the multiple admissions and multiple DAT overrides associated with the "Kroger" incident had occurred. This letter should serve as a request for the findings of the critical incident review of the "Kroger" incident. The policy in

existence appeared sufficient to guide the process. Most importantly, critical incident reviews require multiple sets of eyes from multiple different disciplinary perspectives.

At the institutional level, monthly reviews occurred for use of force incidents. These reviews have become more inclusive in terms of the individuals who provide a perspective on the appropriateness of the documentation and the restraint video. In addition to the current group of reviewers, consideration should be given to physical restraint trainers, Bill Powell, and Juvenile Court administration for involvement on a regular or periodic basis. It is important for the leadership of the Juvenile 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.

(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

Efforts by staff to make the changes necessary in response to Section C of the Agreement have slowed, perhaps regressed a bit, during the lead up to the election. Now that a new judge is in place and a new leadership team has emerged, the expectation exists that progress toward Section C compliance will be robust in the time between this visit and the next monitoring visit.

The use of force paragraphs are the most challenging by far. There currently appears to be four correctable factors exerting an adverse influence:

- The ADP at the Detention Facility was 78.3 for the month of September, which is a 40% increase from August and 81.3% increase since the previous on-site visit in April. Changes of this magnitude in the social and spatial density generally have an adverse impact on use of force indicators.
- Not surprisingly, the frequency of uses of force increased by 36% from August to September. While the rate of uses of force per 100 bed days stayed the same, the parallel percentage increase in the frequency of uses of force draws attention to the influence of the increased ADP. Frequency data are important because they represent the number of times that staff members actually engage in hands-on restraint activities with youth. Physical restraint activities represent a risk of accidental and serious injury to youth and staff. As the frequency of these events increases, so, too, does risk increase.
- The current ADP has exceeded the capacity of the Hope School, denying certain youth access to essential educational services.
- Staffing remained a critical problem. The inability to get new staff members hired and trained remained an obstacle to achieving staffing adequacy. In addition to being understaffed, the ability to have enough individuals to staff each shift satisfactorily was

aggravated by the number of employees on some type of leave or restricted duty. Inquiry into the routine Coverage and Assignment strategy revealed that approximately half of all available direct care staff were needed to staff just one of the three shifts.

The staffing crisis underscored the need for a competent staffing analysis. Information from the on-site visit continued to suggest that a staffing analysis is needed to realign the current and problematic Coverage and Assignment strategy. Additionally, before making its determination about support for the acquisition of the operation of the Detention Facility, the Sheriffs Transition Committee should have an accurate staffing analysis that clearly reflects a Coverage and Assignment strategy that is consistent with best practices for a developmentally appropriate juvenile detention operation and the implications contained in the MOA. The present Detention Facility Coverage and Assignment strategy is in need of realignment, and current staffing assumptions about the post-transfer detention needs are presently misleading. It would be more helpful in the decision-making process if the necessary changes in the Coverage and Assignment plan were available in advance of a final decision to transfer the facility to the Sheriff's Department (see recommendation below).

There are two workable strategies for resolving the staffing crisis at the Detention Facility. The more expensive approach is to increase the number of staff on each shift in order to maintain the staffing ratio identified in the Coverage and Assignment strategy so that it increases as the ADP increases. The other approach, which is substantially more cost-effective, is to reduce the ADP. By reducing the number of youth in the facility, the number of staff required to meet staffing adequacy is also reduced while still maintaining the staffing ratio consistent with the Coverage and Assignment strategy. Judge Michael understands both approaches. In our meeting, we discussed the mathematics of population management (total admissions x average length of stay = total days care), such that admissions and average length of stay (ALOS) provide two avenues for reducing ADP. On the admissions side, we discussed the opportunity to reduce admissions by addressing the number of DAT overrides that did not have a public safety rationale. On the ALOS side, we discussed the opportunity to reduce ADP by addressing the systemic issues surrounding the number of youth who are released within 96 hours of admission.[2]

Finally, the environmental context of the detention center as reflected through its behavior management and daily operational approach represents an opportunity to increase substantially the appropriate behaviors of youth and, therefore, to reduce the uses of force through the implementation of a positive behavior management program. There are multiple options available for positive program development, including JDAI programs recommendations, and these resources need to be more thoroughly investigated. In the interim, Detention Facility staff should work to increase its knowledge and understanding of behavior management program principles. One resource is Dr. Tucker Johnson. While this is not a recommendation that Dr. Johnson's involvement is or should be part of an overall compliance strategy, she does have the knowledge to assist in the short-term in the identification of appropriate programs, program materials, and training strategies.

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[2] 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 an opportunity for the Juvenile Court to rethink its detention criteria, as many of these youth likely did not require secure custody.

Recommendation: Section C of the Agreement requires policy, procedure, and practice-related changes that have implications to the Prison Rape Elimination Act (PREA) Standards. PREA standards and audit expert Steve Jett conducted an on-site review and assessment of Detention Facility PREA readiness on September 23-25, 2014. A revised draft of the PREA standards exists, but the Detention Facility PREA Coordinator indicated that the policies and procedures would not be finished before the end of December. There was an American Correctional Association audit scheduled for November 17-21, 2014. Powell and a Juvenile Court team should jointly review these policies before forwarding them to DOJ for review.

Recommendation: An interview with the JDAI coordinator Kimbrell Owens was part of this monitoring visit. The discussion focused on the DAT, the nature and extent of overrides, and the availability of detention alternatives to the Juvenile Court. JDAI is the leader nationally on the identification and implementation of a continuum of detention alternatives that can address the issue of overrides and other options to reduce the number of admissions annually. A request for additional technical assistance in these areas should be made to JDAI.

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 2013 report, the assessment of the impact of these new staff has been difficult due to the ongoing strain on staffing adequacy resulting from the increased ADP and the increase in the number of staff on leave or restricted duty. The need for a staffing analysis remains a priority recommendation. Discussions with administration and line staff continued to suggest that a contributor to the current levels of youth-on-youth assaults and physical restraints are the staffing adequacy challenges, which have been aggravated by the increased ADP.

I met with the Sheriff's Transition Team to discuss some of the critical variables to be considered regarding a possible transfer of the operations of the Juvenile Detention Facility to the Sheriff. Several of the key points included fundamental differences between adult inmates and juveniles regarding health care, mental health care, education, recreation and other leisure time activities, and juvenile rights. While a noteworthy and positive aspect of the Shelby County Jail is it accreditation by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC), many differences between adult and juvenile detention still exist that are not always obvious to the public and adult corrections officials. One example that prompted discussion was the Individuals with Disabilities Education Act (IDEA) and the requirements for special education services. Another important distinction is the difference in the Coverage and Assignment strategies for juvenile detention staff members. A best practice Coverage and Assignment plan for juvenile detention would identify and define the numbers, types, and responsibilities of staff posts, especially those that are distinctly different for juvenile facilities. Included in this detailed description would be the noticeably smaller supervision or caseload ratios for detention officers, recreational specialists, psychologists, and social workers/counselors. These factors help to explain the substantially higher per diem cost of operating juvenile detention as opposed to adult detention.

The Compliance Report noted that the Office of Juvenile Justice and Delinquency Prevention (OJJDP) agreed to provide technical assistance for the staffing analysis. The technical assistance request was submitted to OJJDP's National Training and Technical Assistance Center (NTTAC), but, as of this monitoring visit, there has been no official decision from OJJDP. Information from OJJDP's National Center for Youth in Custody (NCYC)

suggested a substantial misunderstanding about the staffing analysis request that may have contributed to the delay in decision-making. To reiterate, a staffing analysis is a priority, and it should occur as soon as possible.

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

1. The amount of locked room confinement is excessive. A plan of action is needed to reduce the amount of locked room confinement.
2. The Detention Facility staff need to review and improve the grievance system so as to reduce the gap between youth and staff perceptions of its effectiveness.
3. Programming enhancements should continue for mental health and other youth.
4. The restriction on a book (reading material) in the youth's room should be re-evaluated.
5. A strong, positive behavior management system would have a positive impact on Protection from Harm issues. A behavior management action plan along with an implementation outline is needed.
6. The finding of understaffing or an absence of staffing sufficiency underscored earlier recommendations for a staffing analysis.
7. The regularly scheduled meeting with staff by the facility administrator for discussion and recommendations about new policies should continue; the new monthly meetings to discuss outcomes data could be expanded to include other policy discussions.

The summary statements from the Compliance Report were also very relevant here. Tremendous progress has been made in the area of Protection from Harm even considering how this progress has slowed recently. Over the past two years, staff members are better trained and a wealth of new and relevant information is available to help analyze their work performance. Medical and mental health services are available and vastly superior to what was provided before the Agreement. Detention staff have made substantial progress in producing reports that make better use of improved data. They were quick to adopt new and innovative training for staff including training on use of force, suicide prevention, and HIPPA. Key areas for improvement continue to be the validation of data and the use of data to improve daily operations.

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

Sincerely,

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