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Re: Juvenile Court of Memphis and Shelby County (Juvenile Court) MOA Protection from Harm Stipulations: 6th Findings and Recommendations Letter

Dear Winsome and Richard:

This is the sixth 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 Shelby County Sheriff's Detention Services Bureau (Detention Facility) on October 5-8, 2015. 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.

Following months of discussions between the Juvenile Court and the County, the Juvenile Court transferred the operations of the Detention Facility on July 1, 2015 to the Shelby County Sheriff, Bill Oldham. My role as the Protection from Harm Consultant remains the same, to provide information and assessments of the progress by the Detention Facility toward compliance with the Protection from Harm paragraphs of the MOA (Section C). The shift from one organizational structure to another meant that this visit would necessitate continued open conversations to identify and assess those differences that might prompt recalibrations of the monitoring process. Here are some of the differences:

1. An accepted best practice in juvenile justice is to locate the operation of a juvenile detention facility within a youth-serving parent agency. The branch of government is sometimes a factor, but juvenile detention is thought to be best operated by the juvenile court, the children and family services agency at the local or state level, a designated youth services or youth corrections division of a social services agency at the local or state level, but not local law enforcement. Therefore, the transfer of juvenile detention to the Sheriff has attracted attention within the juvenile justice community nationally. The challenge for all involved in the MOA is to mitigate, even overcome, the obstacles

inherent in law enforcement agencies. One American Correctional Association publication characterizes these obstacles as (a) adult-oriented (making assumptions about youth behaviors largely on experience with young adults) as opposed to a youth-oriented and developmentally appropriate approach, (b) use of isolation, locked room confinement, or special management units as primary tools for discipline, (b) training and staff development by didactic methods such as lectures, (c) reliance on authority and the role of the guard instead of relationships to gain compliance with rules, (d) making compliance to rules and immediate behavior control the focus of staff interventions, (e) implementing mental health strategies that focus on fixing the youth rather than empowering them to build on their own strengths, and (f) seeing the family and the community as only tangential to the mission or even as an obstruction, to name a few. An effective transition to a juvenile model will be a function of how well the Sheriff resolves the operational problems that routinely occur in these obstacle areas.

2. Assets available to the Sheriff for immediate action on transition issues include:

   (a) A history of positive relationships and good communications with the previous Detention Facility leadership team and supervisory staff, many who remain in their pre-transition positions,

   (b) The existence of youth-oriented program elements to build upon,

   (c) Availability of technical assistance services,

   (d) The Juvenile Court's progress in several key areas (medical and mental health services, suicide prevention, and staff training) has made even more discernable those MOA paragraphs where the lack of progress has made much clearer the remaining compliance priorities:

      - The well documented negative effects of large changes in the daily population on staffing adequacy and youth supervision (there has been an approximate 65% increase in the number of youth in the detention facility since the Sheriff assumed responsibility for detention),
      - Use of force (there has been a 36% increase in the rate of physical restraints and a 303% increase in the use of mechanical restraints since the Sheriff assumed responsibility for detention),
      - Locked room confinement issues (there has been a 12% increase in the use of disciplinary locked room confinement and a 30% increase in the average duration of room confinement since the transfer of the facility to the Sheriff), and
      - Absence of a validation of quality assurance data.

   (e) Bill Powell, who can clarify the practical implementation challenges of adaptations of youth-oriented programs and services from Jail East to the Detention Facility and who understands the nature and extent of the remaining compliance tasks.

3. Before the first questions were asked about Protection from Harm issues, we noted a daily population number that was significantly different from anything we had experienced in previous monitoring visits. Despite numerous explanations for the increase, which was nearly two times greater than the daily population figures from the previous monitoring visit, this constitutes an immediate and significant "red flag," which

should signal to the Sheriff that "business as usual" is no longer a compliance option. The crowding, social density, spatial density, and staffing literatures are replete with dismal outcomes for youth in facilities with similar population management situations. The Sheriff understands that population management is largely an external function, but the risk management implications for protecting the rights and well-being of incarcerated youth becomes substantially greater in the absence of gatekeeper authority and safeguards. Population management obstacles affect multiple Protection from Harm factors, making compliance a more difficult and tenuous proposition.

4. The Transition Plan reflected a change in communications. The new procedural delays in discussing and producing the Transition Plan seemed to circumvent Bill Powell, deny DOJ and me the opportunity for comment, and missed some opportunities to improve the document. The basic contents of the Plan need strengthening regarding specificity about action items, such as more information about timelines, identification of lines of authority and responsibility, and evaluation criteria that mark the Plan's accomplishment. Augmenting these elements would convey better the importance of the transfer.

Chief Kirk Fields is the new detention superintendent and heads the new Detention Facility leadership team. Former superintendent Gary Cummings remains an employee of the Juvenile Court and served as the transition liaison during this visit. Additionally, Mamie G. Jones remains with Juvenile Court. The Deputy Detention Superintendent is Willie Walton, and Larry Weichel serves as Lead Supervisor. Communication, information, and guidance provided by William Powell, Office of the Shelby County Criminal Justice Coordinator and Settlement Agreement Coordinator, continue to be helpful. He provides valuable perspectives, and his ability to identify expedient pathways to compliance is beneficial. Jina C. Shoaf, Assistant Shelby County attorney, and Debra Fessenden, Sheriff's attorney, participated in many of the meetings and discussions. Their input was valuable and their questions were insightful.

A substantial number of important changes have occurred following the transfer of detention operations to the Sheriff. These changes are sufficient to amend past monitoring dynamics and justify a realignment of future Protection from Harm assessment strategies to address these changes. The adjustments to future assessment protocols will be discussed in the sections below where they apply. However, moving forward in partnership with the Sheriff, the objective of the monitoring will continue to be avoiding pitfalls, removing obstacles, solving problems, and strengthening assets that lead to compliance.

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 though somewhat underutilized resource. On September 16, 2015, Powell submitted reports called, "Compliance Report #6" 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 32-39, covering Protection from Harm actions and recommendations.

The review of documents before the on-site visit is a better way to review certain types of information that are important to compliance recommendations. Previously, the visits have not made full use of document reviews before the on-site. The change in organizations provided a timely opportunity to adjust the request for documents to be forwarded and reviewed before the visit. Additionally, the request for specific documents to be assembled and present in a designated location for reference during visit has also been adjusted. Currently, a list of both types of documents exists, has been reviewed and approved by DOJ, and will be the basis for information gathering and review as the process moves forward.

B. Use of Data

The presence of a paragraph on Performance Metrics (Paragraph 4 under Protection from Harm) has resulted in efforts 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 have participated in a monthly telephone call with DOJ attorneys and me to review and discuss the monthly data reports, and Chief Fields and Debra Fessenden have given assurances that these monthly telephone calls will continue. Even though there are data quality issues that will be discussed below, the establishment of metrics of this nature represents significant progress.

C. Entrance Interview

The visit began with a private meeting with Chief Kirk Fields, then a second meeting that additionally included Chief Jailer Robert Moore, Gary Cummings, Willie Walton, and Lawrence Weichel to discuss the transition and 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 6 and 7 and provided an opportunity to observe resident sleeping rooms, the general cleanliness of the facility, and any physical plant modifications or improvements. Since the transition, the Sheriff has completed the painting of rooms on half of the building, along with improvements in lighting. These are positive indicators. Noise levels continue to be an issue and can be an indicator of insufficient controls on youth behaviors. Recent research indicates that the more positive the perceptions of the detention experience, the greater the likelihood for positive outcomes (participation in school and reductions in returns to detention). Factors that influence positive perceptions include safety, staffing, peers, discipline, fairness, and order and organization, to name a few. Areas for improvement exist in all of these, particularly order and organization as represented by the frequent clutter, papers, food service trays, and trash in the living units that continue to be a concern and give the impression that there are cleanliness challenges. The new Positive Behavior Management System (PBMS) could positively influence all of these factors.

E. On-Site Review

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

F. Staff Interviews

I interviewed 24 staff, including 13 Sheriff's employees, four (4) Juvenile Court employees, two (2) Shelby County employees, two (2) University of Memphis faculty members, and three (3) Correct Care Solutions (CCS) staff.

G. Resident Interviews

I interviewed 15 youth in two (2) five-person group interviews with boys and one (1) five person group interview with girls. The average age of these youth was 16.3 years (16.6 years for boys and 15.6 years for girls) with a self-reported average length of stay (ALOS) of 42 days (58 days for boys and 11 days for girls). 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. Both the average age and average length of stay of male interviewees have increased since the last visit.

H. Exit Interview

An exit meeting occurred on October 8 with Chief Moore, Chief Fields, Gary Cummings, Willie Walton, Larry Weichel, Pam Skelton, Debra Fessenden, and Bill Powell. The meeting was a time for questions, clarifications, and explanations of events and impressions before issuing the report letter.

II. Protection from Harm: Detention Facility

A. Preliminary Comments and Observations

The transition to the Sheriff generated some changes in Detention Facility staffing, so the interview strategy again focused on the new leaders along with perspectives from core leadership regarding the status of the transition. The responsibilities for monitoring the MOA Protection from Harm paragraphs have been structured in such a way as to maximize the input of knowledgeable "others" who have involvement with the daily operations of the Detention Facility. Therefore, independent audits of the Detention Facility operations, such as the ACA accreditation audit, supply valuable information that may not necessarily be available or accessible during the monitoring visits. Several issues identified in the February 2015 ACA Accreditation Report warrant additional discussion and could alter slightly future on-site assessment strategies.

1. Accomplishments

There have been multiple achievements since the last visit. Many were noted in Compliance Report #6, so the following list represents combinations of perspectives.

a. Communications between the Juvenile Court and the Detention Facility about population reductions remain good following the changes in leadership, especially the exchange of information about youth who have been detained 15 or more days. The information

exchange permits greater accuracy in the identification of risk and needs and allows the Juvenile Court to make better decisions about step-down activities and alternatives to incarceration.

b. The Positive Behavior Management System (PBMS) has been implemented, and all detention staff have been trained. Staff and youth acknowledge the existence of the PBMS, but with mixed reviews. The system includes a token economy that uses multiple point categories to assess the amounts of appropriate behavior by youth through several grading periods during the day. The accumulation of points allows for movement through a level system (with increasing access to privileges) and the purchase of food.

c. The Detention Facility leadership team continues to speak highly of the Hope Academy. There is good communication with the school's director, Mr. Smith, and the school capacity is currently at 45. The development of the education program is a notable accomplishment; however, a detention education program must have capacity for all detainees to attend school on any given school day. Discussions have begun about an expansion of the Hope Academy to provide educational services to all detained youth.

d. The improvement in the quality of food services to detained youth by the Sheriff is commendable.

e. The return of reading materials to residents' rooms is commendable. Detention facilities must balance competing priorities of juvenile rights and privileges and the legitimate security functions of operating a facility responsible for youth and public safety. No evidence exists from youth and staff that there has been a rash of sprinkler head destructions following the return of books to the resident rooms. The Sheriff should be commended on the decision.

f. The Detention Center received a notice of accreditation by the American Correctional Association (ACA) on its *Standards for Juvenile Detention Facilities*. This is an important accomplishment, and it should be seen as a source of great pride among staff. ACA Standards are the best definition of organizational structure, which serves as the backbone for effective facilities. These structural components include essential policies and procedures that support programs, services, and staff training.

g. Detention Facility and the Health Department staff meet monthly with the Correct Care Solutions (CCS) medical provider to discuss performance audits. A contract monitor oversees performance by CCS, and her audits are discussed at the meetings with CCS, Detention Facility, Court Administration, and Health Department staff.

h. The call-in program has been implemented which is expected to further decrease admissions to Detention. So far, the admissions data do not support this expectation.

2. Challenges

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

b. The Report Card data for July through October 2015 revealed a 12% increase in the use of disciplinary locked room confinement since the transfer of the facility to the Sheriff. The frequency of disciplinary confinements typically increases as the population increases. Use of locked room confinement continues to be a Protection from Harm

concern. Room confinement issues identified in the February 2015 ACA Accreditation Report warrant additional scrutiny and could alter future on-site monitoring strategies.

c. The Report Card revealed a 30% increase in the average duration of room confinement since the transfer of the facility to the Sheriff. The use of room confinement remains a substantial concern for achieving compliance.

d. Other Protection from Harm indicators revealed increases that are causes for concern. For example, since the transfer of the facility to the Sheriff, there has been a 58% increase in suicidal behaviors without injury, a 31% increase in the rate of assaults of youth on youth, a 36% increase in the rate of physical restraints, and a 303% increase in the use of mechanical restraints. These data suggest an across-the-board deterioration in Protection from Harm indicators since the transfer of the facility to the Sheriff.

e. The population at the time of the visit was 81 youth (only two were White), which is a 65% increase over Judge Michael's projected capacity goal of 49 and a 108% increase over his target capacity of 39. The overall bed usage has increased by 66% since the transfer of the facility to the Sheriff. Coverage and Assignment has now become a significant concern with staffing adequacy as the primary focus of attention. Since this represents a significant deviation from what has been represented to the DOJ as the intended operational strategy, the Sheriff inherits a situation with heightened urgency to implement remedial Protection from Harm measures related to staff deployment in the absence of a staffing plan.

f. The concern remains that the hierarchy of non-physical alternatives is not used to the extent intended.

g. The Positive Based Management System is a large undertaking that requires a "culture shift" in the Detention Facility staff. As of this visit, the implementation seems to have stalled. There needs to be a consolidation of targeted behaviors, a reassessment of the point values, but most importantly a commitment to provide sufficient and reliable incentives as the basis for strengthening positive behaviors.

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

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

j. The high rate of staff turnover continues. Since the transfer of the facility to the Sheriff, the Report Card reveals a 126% increase in the percentage of staff reporting that they fear for their safety. While Chief Fields has access to Sheriff's Deputies to fill emergency vacancies on the shift, these replacement staff must be trained and oriented before assuming responsibility as independent workers. The challenges of recruitment, selection, training, and retention are commonplace, but the increase in the average daily population (ADP) in the Detention Facility may warrant a different approach.

k. The departure of Gary Cummings and the appointment of Chief Fields as superintendent of the Detention Facility mark a change in the leadership, which predictably signals some type of change in the organizational culture. How this change affects monitoring remains to be seen.

3. Youth Interviews

Youth interviews provide a supplemental perspective on operations, safety, and suicide prevention practices. Youth perspectives need to be one part of the larger system of information that describes what is occurring in the facility. A triangulation strategy is used that includes subjective perspectives (views of youth and staff), direct observations, and the elements of organization structure included in policy, procedure, practice, and outcomes data. Compared to the 10 youth who participated in the group interviews during the April 2015 monitoring visit, this group of 15 youth was similar in racial distribution (100% youth of color), older, and detained about the same amount time. However, the 15 youth include five girls, so by removing these five girls we can make a comparison of the 10 boys from the April 2015 monitoring visit with the 10 from the November 2015 visit. From this perspective, there was similar racial distribution (100% youth of color); however, the November 2015 group was older by four percent but there was a 40% increase in the self-reported average length of stay. While the November 2015 group expressed fewer concerns about safety, order, and organization, their primary concerns were about the lack of things to do, too much time in the rooms, frustrations with the PBMS because of sporadic and questionable incentives, and staff who play favorites.

Another response is noteworthy. Male youth self-reported their length-of-stay, which averaged 57 days and is another increase in the self-reported ALOS of interviewees. Self-report information may not be precise, but it represents youth perceptions of time and is another independent indicator of the concern about how long youth remain in the Detention Facility.

4. Staff Interviews

The focus group with JDO staff was important as one indicator of how the transition is going. The majority of concerns were as expected, issues relating to the changes in organizational structures and, therefore, different ways of doing things. In particular, staff protested the amount of documentation required by the Sheriff. Parenthetically, this is a good sign of progress on the transition, as JDO staff need to improve the quantity and quality of their documentation. What can be derived as critical points for further investigation are staffs' concerns about the lack of effectiveness of the PBMS, safety and security concerns surrounding special management status, and improved consistency of supervision. To some extent, all of these issues pale in comparison to their concerns about the lack of adequate staffing as a result of the increases in the daily population.

B. Section C Comments and Recommendations to DOJ

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

1. Use of Force

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

RECOMMENDED FINDING: Substantial Compliance

COMMENT: This paragraph remains in substantial compliance. In the interviews with staff and youth, no one mentioned the existence of a restraint chair or use of pressure point tactics. Interviewees stated 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 inquiries about of use of force policies and procedures with special emphasis on prohibition of the restraint chair and pressure point control tactics (PPCT). Additionally, future monitoring will include interviews with youth and staff to verify the absence of behavior management practices related to both prohibited approaches.

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

RECOMMENDED FINDING: Partial Compliance

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

Any paragraph that depends upon data, metrics, or the Detention Report Card to inform a recommendation of compliance requires the validation of the data collection system (Paragraph 4, "Performance Metrics for Protection from Harm") if there is to be sufficient confidence in the numbers to support compliance. Second, compliance represents “the Facility” analysis versus what will be later described more narrowly as the Facility Administrator review in subsection (c) below. As such, the pathway to compliance means that more staff members at various levels of the facility needed to be involved in the review and analysis of the data in the Detention Report Card. Questions such as, "What do these numbers mean to you about how the facility is operating?" need to be examined at multiple levels of the Detention Facility staff. Third, the system for corrective actions needs to be enhanced through use 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, an approved external assessment of the existing data system to include recommendations for improvements and guidelines for conducting an internal data validation audit would be beneficial.

FUTURE MONITORING:

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDED FINDING: Partial Compliance

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

From the list of use-of-force events from August 2015, I reviewed eight (8) medical files of the physically restrained youth to ensure that the post-restraint medical exam occurred in a timely fashion and was documented appropriately. I provided a list of names for the file review, and Health Services Administrator (HSA) Crosby secured and provided the files. All were in order. One item of continuing concern is the "% of time Hierarchy of non-physical alternatives used." A low percentage in this item suggests either a staff failing to attempt non-physical de-escalation techniques in response to problem behavior or the presence of a high number of spontaneous acts by youth, which require an immediate physical intervention by staff. While the failure to use non-physical alternatives is clearly problematic, a high number of spontaneous acts by youth requiring physical interventions could also be problematic. That situation could indicate staff are not responding to tense environments in a timely and appropriate way thus allowing youth to quickly escalate to violence or it could be indicative of poor staff/youth relationships where youth may try to resolve problems themselves rather than relying on help from staff. In any event, this Use of Force indicator is one that bears closer monitoring.

Regarding the documentation of attempts at non-physical alternatives in a youth's file, there is a clear statement in the policy. Incident Statement JC-142B requests a list of the nonphysical alternatives, and this form goes in the youth's file. The file review indicated a lack of documentation of the attempts at non-physical alternatives. This does not mean that non-physical alternatives were not used, especially in the absence of audio; however, the documentation does not support the use of non-physical alternatives. Discussions with Mr. Walton and Mr. Weichel stressed the importance of providing feedback to staff about how to increase their documentation on incident reports that describe non-physical alternatives.

FUTURE MONITORING: Missing is documentation about the use of non-physical alternatives. As will be discussed regarding the review of restraint packets, there is a need to verify through video evidence and the corresponding documentation that staff are using SCM techniques appropriately and that they are refraining from initiating use of force too quickly. The assumption is that non-physical alternatives are being used, but there is no consistent reference to them in the documentation. The upcoming change in the monitoring process by adding a list of documents for review in advance of the next monitoring visit will permit a more comprehensive review of restraint packets, particularly the video before the on-site.

Critical Factors in Achieving Compliance

There are multiple challenges to compliance with the Use of Force paragraphs. They exist as obstacles to the progress made by the Detention Facility and have the potential, when taken together, to undermine the order and structure necessary to create a safe living environment for both youth and staff. These factors are considered separately but are interactive.

1. Inappropriate Uses of Approved Techniques

This is a red flag, which means it has the potential to change the current finding to noncompliance if the issues in this paragraph are not resolved immediately. A growing Protection from Harm threat exists for youth.

It is important to start the explanation of this issue by noting that previous reviews of physical restraint events, including the video of the event, produced no evidence that concerns existed about the application of approved physical restraint techniques. The approved restraint techniques are from Safe Crisis Management (SCM), which has a good reputation among juvenile justice agencies as an appropriate and safe program for crisis management, including uses of force. From the outset of the monitoring, there was some confusion about SCM. First, representatives of SCM questioned the level of supervision provided to Detention Facility staff during and after a physical restraint event. Second, Juvenile Court administration reported that a Detention Facility representative went through the SCM training-for-trainers program as opposed to SCM providing its trainers for the initial all-staff training on SCM, which seems to be the preferred strategy. However, this approach is more costly than having a facility trainer complete a training-for-trainers program and then training staff. According to SCM, a lot of information about the proper use of the techniques may not the presented due to the differences in the participant groups; that is, a group of trainers from various different facilities being trained as trainers may not present the same types of issues and concerns as a group of JDOs from a single facility. Third, feedback from staff suggests that there is not a uniform or consistent application of SCM principles. Finally, there is no evidence in the medical records that the proper use of SCM is linked to an increase in the rate of injuries to youth as the result of physical restraints.

That said, from the list of use-of-force events from August 2015, I reviewed four (4) discrete restraint events; and three of the applications of use of force were unacceptable because they deviated substantially from the approved SCM techniques, hence violating Detention Facility policy and procedure. Two examples of to-the-floor restraints were done with unapproved techniques that resulted in facedown, prone restraints. The second major violation of standard practices that falls within the area of expertise of the Sheriff was the inappropriate staff supervision through improper positioning of staff. Two videos showed youth nearly unsupervised. In fairness to staff, however, this happened during the transition when directives and expectations were new, so there may likely have been some inconsistencies. What remains a point of continued concern on the part of Protection from Harm is the question about how the unusually high numbers of detained youth may be undermining adequate supervision. In the past, staffing inadequacies have resulted in youth being confined to their rooms for the majority of the shift.

2. Staffing

Staffing remains a priority concern and the absence of an adequate number of JDOs available to work all three shifts during the week has an adverse impact on Protection from Harm concerns. The stresses of the increased population have reached the point where some of the duties assigned to the JDOs cannot be accomplished acceptably in the time allotted for their completion. For example, on October 8, Chief Fields and I went to the North Side and accompanied JDO Kimbrough on one of his standard, 15-minute room check tours. Because Chief Fields and I were observing him, the assumption was that he did not stop to talk to youth as he might have during an otherwise routine room check tour. By all conservative estimates, the tour took 16 minutes and seven seconds to complete. The size of the North Side living unit is so big and the number of youth in locked room confinement so great that by the time JDO Kimbrough completed this 15-minute room check tour, he was already late in starting the next 15-minute tour. Given this scenario, something has to give; and it is usually the nature and quality of supervision that suffers.

The staffing challenge is not simply about the number of authorized positions approved as part of the annual budget. Instead, the attention on staffing numbers also has to do with the availability of qualified individuals to work a shift. By qualified, most detention practitioners mean an employee who has successfully completed the hiring process, has been through the mandatory pre-service training, and who has acquired some appropriate job experience. Many in detention believe that it takes a new JDO approximately 18 months to two years to acquire sufficient experience to be competent and reliable in performing the job duties.

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

The third variable is the number of unfilled or vacant positions, and this shifts attention away from the facility to Human Resources and raises questions about how to achieve greater efficiency in shortening the time between the designation of a vacancy and a new employee participating in the mandatory pre-service training. These factors create substantial stress on Coverage and Assignment, and they create situations where overtime increases and staff experience job burnout. Depending upon the Detention Facility population, these staffing

availability challenges translate into important budget factors related to overtime hours. We will observe carefully how the Sheriff addresses these issues.

Conversely, a second and more cost-effective way to address the staffing issue is through the reduction in the average daily population (ADP). The recent increase in the ADP challenges the health of the JDAI reform strategies in Shelby County. The concern is twofold, the increases in admissions and average length of stay (ALOS). This situation continues to draw attention to the need to create, fund, and staff an expediter position. The Sheriff would do well to solicit guidance from Mark Soler, one of the very best national experts on detention population management. The crux of the issue is that the transfer of detention operations to the Sheriff means that the Juvenile Court retains the gatekeeper function for detention, a situation that the Sheriff already understands through its operation of the jail. Still, in keeping with (a) the commitment to acknowledge the differences between secure custody for children versus adults and (b) the commitment of Shelby County to the JDAI detention reform efforts, an expediter could be beneficial for Detention Facility population management.

3. PBMS

PBMS should have a positive impact on reductions of use of force and room confinement. Systems of this nature should provide a way to resolve minor inappropriate behaviors before they escalate to situations requiring use of force or confinement. However, there appear to be some initial implementation problems.

"First-generation problems" are inevitable and mean that those youth and staff who are familiar with the old system will be tempted to revert to old ways when things are not going well or when the new approach does not show immediate results. However, there are some systemic problems with the behavior management system; and while staff report getting excellent advice from Dr. Tucker Johnson, additional technical assistance may be needed to resolve some of the implementation problems. In the interim, the Sheriff would do well to focus on the following:

a. Strengthen access to incentives. There needs to be a variety of available reinforcers following sustained appropriate behaviors by youth. Whether a "store" for point redemptions or a commissary, the "cupboards" were bare when Mr. Walton and I toured the secure location of the reinforcers. Inconsistency in a reward system (the promise of a reinforcer or food when none exists or no comparable alternative is available) generates complaints of unfairness from youth, which can be a powerful disincentive for cooperation and a triggering event for acting-out behaviors.

b. Reduce the complexity of the PBMS. Both youth and staff offered a general explanation of how the point system works, but both indicated that it had become too complicated. A review of the point sheet identified several areas where behavioral categories could be consolidated. Additionally, a simple point system often uses dichotomous variables for the awarding of points, i.e., either a yes or no determination. In situations where staff are supposed to evaluate behavior on a sliding scale depending on the quality or quantity of responses, the number of points available on the scale should always be an odd number so that the middle number becomes the expected behavior.

c. Re-training of JDO staff may be needed until the system is fully implemented. Training and intentional supervision could help to minimize the negative impact of first-generation problems.

4. Education Services

Access to education services through the Hope Academy influences use of force activities in two general ways. First, participation in school provides youth with helpful and remedial experiences that increase the likelihood of their reconnection with public schools upon release from detention and help to develop within youth an orientation to future outcomes. Second, school provides a constructive activity that occupies time that would otherwise be spent with mostly nothing to do or in locked room confinement. With a population of 81 youth, as many as 36 detainees would not have participated in educational services. There is reason to believe that a substantial portion of the 36 youth who do not receive Hope Academy educational services qualify as special education students (emotional disability) and are entitled to a free and appropriate education under the law.[1]

(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: See subsection 1 above on page 11 as a preface to these comments. From the list of use-of-force events from August 2015, I reviewed with Chief Fields, Mr. Walton, and Mr. Weichel four (4) discrete restraint events. The JC-142 forms documented the sequence of events but the descriptions of what transpired did not match the video. Documentation described the nature and sequence of events but omitted essential information that was revealed on the video, i.e., an unauthorized use of SCM techniques. Additionally, no documentation appeared describing the two, facedown restraints. Discussions occurred with Chief Fields, Mr. Walton, and Mr. Weichel about the reason for what seemed to be a significant change in physical restraint behaviors from previous video reviews. Fortunately, in each case where an unapproved technique was used, there seemed to be a plan of action in place to correct the behavior. Documentation was also provided if individuals involved had been through a formal counseling session.

[1] Beyond potential violations of generally accepted professional standards, the findings from Professor Linda Teplin's Northwestern University Juvenile Project, which is the field's best estimates of the proportion of juvenile detainees with diagnosable mental health issues, and the recommendations in the OJJDP and Youth Law Center publication regarding the implications of the Individuals with Disabilities Education Act (IDEA) to juvenile justice settings. Additional relevant information is available in the DOJ/DOE Guidance Letter available online.

The Restraint Packets (use of force documentation and videos) needs to be transmitted confidentially for off-site review before the monitoring visit. These restraint documents and videos represent a snapshot or a first look at existing physical restraint practices, but more information is needed about staff use of force behaviors and the consistency of the administrators' reviews. Up to this point, the preliminary reviews of the physical restraint packets have been generally positive and have indicated that Detention Facility management has a good understanding of use of force events and their sequence. Video reviews had indicated that staff seemed to have a satisfactory understanding of the use of force policies and techniques. All of this requires another look because of these videos.

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

2. Suicide Prevention

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

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

(ii) Procedures for initiating and terminating precautions;

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

(iv) Suicide risk assessment by the QMHP;

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

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

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

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

(ix) Requirements for mortality and morbidity review; and

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

RECOMMENDED FINDING: Compliance

COMMENT: The two primary indicators in the Safety and Order section of the Detention Facility Report Card are "Suicidal Behavior with Injury by Youth per 100 Bed Days" and "Suicidal Behavior without Injury by Youth per 100 Bed Days." These rates have averaged 0.00 and 0.61, respectively, since January 2015, and they continue to reflect an effective approach to suicide prevention.

The suicide prevention section of the Report Card noted a slight decrease in QMHP contacts or the rate of QMHP calls per 100 youth, but this was without rate information for September when the number of admissions jumped. Detention Facility leadership also explained that staff are overly cautious in light of the understaffing circumstances. Subsequently, the average length of a suicide precaution almost tripled between February and March 2015.

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

I reviewed four (4) files selected at random from the names of youth on the August 2015 list of Precaution Orders. All the required documentation was in the file; the case notes were legible, understandable, and appropriate; dates, times, and signatures were accurate; daily progress notes were complete; release justification forms were present and complete; and psychiatric notes were available. The files indicate that QMHP activities occur as outlined in the MOA.

An important suicide prevention strategy is to have youth out of their rooms and actively engaged in constructive activities. The activity therapist conducts activities from a life skills curriculum. CCS reports that the activity therapist is responsible for two groups a day on Saturday and Sunday. She also submits a report and makes occasional notes in the youth's charts. Interviews with 15 youth made some mention of the weekend activities by the activity therapist.

A proposal has been approved to conduct a tele-behavioral health assessment with a handheld device, e.g., an iPad, on those occasions when the QMHP is on call. Hopefully, there will be some discussion about the effectiveness of this strategy at the next monitoring visit.

FUTURE MONITORING: This aspect of the MOA remains in compliance because of the quality of services provided by CCS. Future monitoring will continue to include file reviews as described above. Even considering the successive compliances with this paragraph, substantial caution remains about the ability to sustain the quality of care in the face of the increased population, hence the increased demand for services. The ability of the existing CCS contract to meet the increasing needs of the current Detention Facility population warrants continued monitoring.

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

RECOMMENDED FINDING: Substantial Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Substantial Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

COMMENT: The concern that existed about Detention Facility staff conducting a suicide screening within one hour of a youth's admission to the facility continues to be 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 not 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 MOA 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: We consistently refer to the work of Lindsay Hayes as best practice on appropriate responses to suicidal ideations, gestures, behaviors, and self-harm. In addition to his research and studies, other ways of knowing about suicide prevention strategies consistently recommend the elimination of routine locked room confinement (isolation) for youth on any type of suicide precautions. There has been insufficient progress so far by the Detention Facility to bridge the gap between routine confinement practices and the first line of Paragraph (e) indicating Shelby County's commitment to prohibit the routine use of isolation for youth on suicide precautions.

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

> Additionally, any detainee placed on control status or *confined as a result of being on observation or precautions* are still allowed out of the room for large muscle activity and meals and school. As a result, they are not confined for more than ten *continuous* hours. (emphasis added)
>
> Due to this fact, programming and required activities prevent confinement for more than 10 hours, and both structural and fiscal constraints, this facility is requesting a waiver request for this standard.

The statement, "any detainee placed on control status or confined as a result of being on observation or precautions are still allowed out of the room for large muscle activity and meals and school," raises a Protection from Harm concern about the use of room confinement for youth on suicide precautions. The Waiver Request statement implies that youth "on observation or precautions" (terms associated with the CCS mental health Precautions Order Form) are confined.

Generally accepted professional practices call for the minimum use of locked room confinement because of the risk locked room confinement presents to Protection from Harm and safety.[2] The culture change anticipated with the PBMS has begun to show some improvements. Youth make references to certain incentives and activities that are signs of a growing emphasis on the reinforcement of appropriate behaviors. These instances need to be expanded with an increased understanding on the part of staff about the connection between relationship building, a strengths-based approach, and positive youth development. What prevents greater evidence of the anticipated culture change is the reluctance on the part of many staff to relinquish control and sanctions as a primary way of having a safe and uneventful shift. Reports from youth and staff continue that some youth are in locked room confinement even during programming hours and

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

especially on weekends. Weekends are associated with less structure and fewer things to do, resulting in youth behaviors that are also "less structured or more excitable," according to some JDO staff. The high ADP and the accompanying stress on staffing the shifts aggravate these situations. Locked room confinement continues to provide what JDO staff believe is the necessary structure and order to reduce inappropriate behaviors and maintain safety in the absence of adequate staffing. Likewise, it would be advantageous if staff knew that their practice violates the "*JCMSC shall prohibit the routine use of isolation for Children on suicide precautions*" part of this paragraph.

The frequent failures to have an adequate number of available personnel to staff the shift seem to worsen the use of confinement. As sometimes occurs in other secure custody facilities, the default position in response to perceived staff shortages is an across-the-board locked room confinement as a way "to protect safety and security." This perspective is not unique to the Detention Facility, but the safety concern has been heightened recently by local media reports of Juvenile Court administration statements that the current resident population is more violent and, therefore, a greater risk of assault and injury to staff. The Report Card noted that only 10% of staff feared for their safety, and this perception may be moderated by the ability of staff to use locked room confinement preemptively as a safety intervention strategy when they believe there are insufficient numbers of staff assigned to the shift. Unfortunately, this approach sometimes acquires a life of its own and reinforces in the minds of some staff the argument that locked room confinement is the best way to safeguard safety issues. To the extent that these staff work the weekends and this extended or "all day" confinement actually occurs, the practice would exceed the 10-hour criterion identified by ACA in its noncompliance of Standard #3-JDF-2C-02. More importantly, independent of a waiver from ACA, the practice is in non-compliance with this paragraph.

The documentation regarding locked room confinement continues to be a priority need for review to be able to provide evidence of the practices regarding isolation of youth on suicide precautions. This is again a data quality issue that will be discussed at greater length in Paragraph 4: Performance Metric. These situations are aggravated because a preliminary search of confinement documentation did not generate sufficient evidence to confirm or deny the Juvenile Court's Waiver Request. If these types of confinements occur routinely, they are highly problematic, further underscore the need for a data integrity audit, heighten the growing concerns about the Detention Facility's use of isolation, and call for a verification of all confinement events and durations.

FUTURE MONITORING:

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

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

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

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

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

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

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

RECOMMENDED FINDING: Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Compliance

COMMENT: On the previous visit, an Intake Officer was unable to produce the information on the computer that indicated a previous suicide precaution status for a youth that occurred during a prior stay in the Detention Facility. However, at this monitoring visit, Mr. Walton and I tested the system by asking an Intake Officer to pull up the file of the three different youth who had been released but had been on a suicide precaution while in the Detention Facility. In all three instances, the classification system alerted the Intake Officer that the youth had been on suicide precautions. This paragraph is in compliance.

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 and attempts is readmitted to the Facility.

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

RECOMMENDED FINDING: Partial Compliance

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

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

FUTURE MONITORING:

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

3. Training

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

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

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

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

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

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

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

RECOMMENDED FINDING: Compliance

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

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

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

4. Performance Metrics for Protection from Harm

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

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

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

RECOMMENDED FINDING: Partial Compliance

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

Data-driven Protection from Harm concerns are suicide prevention, use of force, and use of locked room confinement. Thus far, there has been substantial progress on suicide prevention efforts and related Protection from Harm trainings. The development of the Restraint Packet review that includes the restraint documentation and video coverage of the restraint event for the next monitoring visit will produce a beneficial analysis of use of force.

As this process continues, the thorough evaluations of uses of force (physical restraints and the locked room confinements) will support compliance recommendations. Detention Facility leadership has demonstrated the ability to dissect the use of force event in such a way as to identify strengths and areas where changes in staff behaviors could produce better outcomes. The positive impact of an improved Restraint Packet review process should be indicated in future use of force Report Card data. Again, the major obstacle to resolving the remaining Protection

from Harm factors is the existence of a valid quality assurance process that permits a confident assessment of the nature and extent of uses of force. The data integrity audit is the key.

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

Previous partial reviews of the documentation related to locked room confinement revealed several areas for attention and improvement. For example, the 15-minute room checks for the night shift were noted in a separate log, but there was no information in the log about which rooms were checked or the general status of the youth. To address this issue, Mr. Walton, Mr. Weichel, and I reviewed the video for a designated night shift (September 17, 2015) on the North Side and a designated night shift (October 2, 2015) on the South Side. Video footage was of sufficient quality to identify the specific staff member and to distinguish recording and observation behaviors. The review on the North Side was particularly commendable with every 15-minute room check occurring according to policy and procedure and properly noted in the logbook. The South Side review was acceptable with minor correctable actions noted. In summary, the Detention Facility conducts the required 15-minute room checks in accordance with generally accepted professional standards. New room check forms, which are taped to the resident's room door, provide data about the status of the youth through the use of a checklist of numbered activities, behaviors, or conditions. The new form is helpful, but entering the data on the forms into a computer-based spreadsheet would enhance the usefulness, access, and storage of these data.

The different perspectives on the amount of time that youth spend in their rooms on the weekends are a red flag. Data collection needs to be improved in order to identify more accurately the amount of locked room confinement.

FUTURE MONITORING:

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

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

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[3] Pag 97

RECOMMENDED FINDING: Compliance

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

III. Summary

Numerous changed circumstances exist at the Detention Facility, and they were present from the beginning of the monitoring visit. While not altogether the result of the transfer of the Detention Facility to the Sheriff, they are sufficient to warrant a rethinking of the approach to monitoring. Other critical Protection from Harm factors, such as the significant increases in ADP, ALOS, and uses of force, have affirmed this assumption. With the exception of suicide prevention and staff training, there is a sense of needing to start anew on the use of force, physical restraint, and data quality concerns.

The new Detention Facility leadership team under the Sheriff seems to be a good mix of committed and talented individuals. Much of the progress identified during the previous visits could be attributed to the leadership of the former Detention Facility administrative team and Pam Skelton, Director of Court Operations. This visit found some familiar faces on the new detention leadership team, but again there had been a slowing of compliance progress on use of force and data quality, perhaps due to the range of issues associated with the transfer of operations from one organization to another. Now, with additional changes to the leadership team, the pace of change becomes an important factor. The Sheriff's staff asserted an excellent level of support, assuring a continuation of the open and cooperative relationship with DOJ established by the Juvenile Court.

The monitoring continues to endorse the progress toward compliance with the MOA. The summary statements from the 6th Compliance Report also apply. Tremendous progress has been made in the area of Protection from Harm: (a) staff members are better trained and a wealth of new and relevant information is available to help analyze their work performance; (b) medical and mental health services are available and vastly superior to what was provided before the MOA; (c) safeguards regarding suicidal and self harm behaviors meet and exceed generally accepted professional standards through the provision of timely services by a qualified mental health professional; (d) the Sheriff hypothetically brings a set of "fresh" eyes that have already identified areas of benefit regarding conditions of confinement, staff supervision, and the reintroduction of reading materials to residence rooms; (e) the approach to data collection and analysis could meet the expectations outlined in Paragraph 4, the Protection from Harm paragraphs of the MOA (Section C); (f) improved food services; (g) initial implementation of the potentially influential Positive Behavior Management System; and (h) there continues to be a responsiveness to recommendations in these reports. The Detention Facility Report Card continues to track performance trends. Policies and procedures have been revised, and training occurs on a regular basis. The winnowing of MOA issues means that the more challenging paragraphs remain, and the intent of this report is to focus more precisely on these remaining issues. For these reasons, there is guarded optimism surrounding the Detention Facility staff.

An area where delay has Protection from Harm compliance implications is the Performance Metric and the necessary data integrity audit. This is now a key component of compliance, and its completion deserves greater importance and urgency. Postponing this audit

is unacceptable. The same applies to the staffing analysis. However, the data related to the performance metric raise other issues regarding information technology (IT) systems. In situations where the critical incident numbers are generated by hand, there is a pressing need for these processes to be automated. There is no reason why statistical reports should be generated by hand in this day and age, yet the Report Card is not part of an automated data collection system.

A. ACA Standard #3-JDF-2C-02

The findings from the ACA Accreditation and appeals processes are not binding on this Protection from Harm monitoring. While the DOJ monitoring has always reserved the right to use external resources as important information for compliance determinations, any assumption that an ACA finding supersedes Protection from Harm considerations is erroneous. Furthermore, there has been no response to the previous challenge that the confinement-related concerns identified in the ACA Standard #3-JDF-2C-02 Non-Compliance in the last Accreditation Report (pages 19-20) related to "The cells are less than 80 sq. ft. when juveniles are confined more than 10 hours a day" does, in fact, affirm previously documented concerns about too much use of room confinement at the Detention Facility. Addressing this confinement concern requires substantial discussion regarding compliance with the MOA, since the present level of confidence in the Report Card confinement data, which ACA did not know at the time of the appeal, cannot reliably support the Juvenile Court's appeal rationale.

B. DAT 2

A common characteristic of JDAI sites is a substantial reduction in the ADP of the jurisdiction's detention center. JDAI involvement typically includes the development of a core group of juvenile justice stakeholders and decision-makers who develop and implement an objective detention screening tool (DAT) grounded in the jurisdiction's key values and an adequate continuum of alternative services for the youth who do not qualify for detention using the objective screening instrument. It has been over a decade since the DAT was constructed. According to Juvenile Court Administration, the first DAT was developed in 2004 and implemented in 2006.

We have no knowledge of the language used to establish the shared values, goals, or the expected outcomes that serve as the additional measures of DAT 2 effectiveness other than references to the JDAI goals and objectives; or if these original goals specifically addressed reductions in racial and ethnic disparities in detention admissions, or the development and expansion of the continua of detention alternatives and alternatives to detention, or the cost-benefits to taxpayers of reductions in the ADP. The effectiveness of a risk-driven objective detention-screening tool has financial implications because daily population numbers drive staffing decisions and the concomitant personnel costs (including benefits and overtime) that are the largest portion of the Detention Facility budget.

There are two types of alternatives, alternatives to detention and detention alternatives. Alternatives to detention are often grouped with prevention activities since the purpose of these programs is to move youth farther away from situations that warrant secure detention. The Neighborhood Captains program and School-Based Auxiliary Probation are alternatives to detention. From a detention population management or reduction strategy, it is the detention alternative that is the workhorse. Youth involved in the system need custody options that

provide the necessary structure and supervision to prevent reoffending and failures to appear in court but do not require secure custody.

The current spike in the ADP is one indicator of DAT problems, many of which are aggravated by the lack of alternatives. As a JDAI site, the Shelby County detention alternative cupboard is surprisingly bare. With the exception of 15-20 electronic monitoring options, there are no pre-adjudicatory detention alternatives available. There are no home detention or shelter options that could form the basis of a step down strategy. The Juvenile Court is looking at the Juvenile Assessment Center in Dade County, Fl; and while the Court looks, analyzes, considers, evaluates, and promises, what is the Sheriff to do with the excessive number of youth currently detained? These are some reasons why the assessment and validation of DAT 2 may have be too narrowly conceived.

IV. Recommendations

Several general recommendations arose from this visitation and warrant special attention by the Sheriff and the Detention Facility:

1. This MOA is better served by improving communications and taking advantage of TA.
2. Further delays in conducting a DOJ approved data quality audit substantially threaten the recommended partial compliance finding for Section 4 (Performance Metrics for Protection from Harm). Although the Sheriff has only recently assumed control, this issue is approaching a crisis point and may require additional conversations with the parties.
3. Concerns exist about the use of unapproved physical restraint techniques that constitute an excessive use of force. This situation requires additional monitoring as it is the first time physical restraint videos have documented this level of unacceptable behavior by staff.
4. The amount of locked room confinement is a substantial Protection from Harm problem along with representing a risk management concern for the Sheriff. A plan of action is needed to measure accurately and to continue the reduction in the amount of locked room confinement.
5. The Sheriff should reconsider the creation, funding, and staffing of a juvenile detention expediter position.
6. While the Juvenile Court works to address the recent increases in the number of detained youth, the Sheriff should develop a contingency plan for how to maintain the level of programs and services outlined in the MOA when the number of youth detained in the facility exceeds the capacity of existing, budgeted resources, particularly JDO staff, contracted services by CCS, and educational services by the Hope Academy.
7. The Sheriff should conduct a juvenile-detention-focused staffing plan to be proposed, approved, and implemented for budgeting purposes as a safeguard for Protection from Harm. The pre-transfer absence of such a staffing plan has placed the Sheriff at a substantial disadvantage.

8. The Sheriff needs to strengthen current actions to improve the grievance system so as to reduce the gap between youth and staff perceptions of its effectiveness.

9. Programming enhancements should continue for mental health and other youth. The CCS activity therapist's curriculum materials need to be shared with DOJ and me.

I appreciate the commitment of Chief Fields, Chief Moore, and Debra Fessenden to move the Detention Facility to compliance as quickly as possible. I remain optimistic that, with the advice, guidance, and support of Bill Powell, the Detention Facility will continue to make progress toward the resolution of the Section C Protection from Harm paragraphs.

Sincerely,

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