Juvenile Court of Memphis and Shelby County (Sheriff's Department) MOA Protection from Harm Stipulations: 8th Report of Findings and Recommendations

by

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Submitted to

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Juvenile Court of Memphis and Shelby County (Juvenile Court) MOA Protection from Harm Stipulations: 8th Findings and Recommendations Letter

This is the eighth report 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, TN, and it describes my visit to the Shelby County Sheriff's Department of Juvenile Detention Services (JDS) on September 26-29, 2016. 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.

The Juvenile Court transferred the operations of the JDS on July 1, 2015 to the Shelby County Sheriff, Bill Oldham. Chief Kirk Fields is the new detention superintendent and heads the new JDS leadership team. He has additional supervisory responsibilities for secure custody operations outside of JDS. Chief Deidra Bridgeforth and Captain Larry Weichel are responsible for daily operations. William Powell, contracted MOA Coordinator, continues to provide support, guidance, and direction. Jina C. Shoaf, Court attorney, and Marlinee Iverson, Shelby County attorney, participated in many of the monitoring meetings and discussions. Their input is valuable, and their questions are insightful.

My role as the Protection from Harm Consultant has been to provide information and assessments of the progress by JDS toward compliance with the Protection from Harm all I know I will paragraphs of the MOA (Section C). The shift from one agency to another necessitated an assessment in identification of the organization differences that required some recalibrations of the monitoring process. Chief Fields and his staff responded quickly and positively to the April 2016 discussions about the differences between an adult detention facility and a juvenile detention facility. From the start of the transition, JDS leadership endorsed its commitment to a juvenile-oriented approach, and this visit identified significant accomplishments in that new direction.

I. Assessment Protocols

The assessments used the following format:

A. Pre-Visit Document Review

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 had not made full use of document reviews before the on-site. The change of organizations provided a timely opportunity to adjust the request for documents to be forwarded and reviewed before the visit. Future monitoring should consider the development of a list of specific documents to be assembled for review before the on-site along with a list of documents to be present at a designated location for reference during visit.

An additional document reviewed before each on-site visit is the "Compliance Report" and "Substantive Remedial Measures" prepared by Powell, the MOA Coordinator. He is conversant about compliance issues and offers a pragmatic approach to what is required for compliance under the MOA paragraphs. He submitted and forwarded copies of the September 12, 2016 "Compliance Report #8" (hereafter referred to as the "Compliance Report") for review before the on-site visit. Special attention was given to pages 5-6 and 31-38, covering Protection

from Harm actions and recommendations. Powell's descriptions of the improvements implemented by Chief Fields and his team serve as a valuable and positive indicator of progress toward compliance.

B. Use of Data

The presence of a paragraph on Performance Metrics (Paragraph 4 under Protection from Harm) has resulted in improved data-collection systems necessary to make informed and accurate quality assurance decisions. To monitor 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. This should continue for the new DOJ Protection from Harm expert. Additionally, staff members from the JDS, the Sheriff's Department, and the Juvenile Court participate in a monthly telephone call with DOJ attorneys and me to review and discuss the monthly data reports. This, too, should continue for the new DOJ Protection from Harm expert. 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 meeting with Chief Fields, Chief Bridgeforth, Captain Weichel, Captain Byers, Captain Ward, DOJ Attorney Goemann, County Attorney Shoaf, and MOA Coordinator Bill Powell 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 September 27 and 28 and provided an opportunity to observe resident sleeping rooms, the general cleanliness of the facility, and physical plant status. Since the transition, the Sheriff has continued painting resident rooms, along with improving lighting. These are positive, albeit temporary, remedies.

The amount of progress that can be reasonably accomplished toward Protection from Harm compliance through the development of programs is limited by the physical plant. Issues identified from this visit alone call stark attention to an aging building that has served well beyond its intended lifespan and usefulness. The building is a constant factor in all considerations of how to enhance daily operations and programs. Recently, the cooling system failure necessitated the transfer of several youth from the South Side to the North Side, and a smaller number of youth had to be transported to the jail for sleeping purposes. This temporary sleeping arrangement required special efforts to ensure sight and sound separation from adult inmates and the ongoing supervision of youth by JDS staff. Currently, the cooling system works so well that the building is unnecessarily and uncomfortably cold. While staff members wear long sleeve shirts *and* jackets, youth can receive a rule infraction if they put their arms inside their short-sleeved surgical style shirts to keep warm.

Progress towards safer conditions of confinement includes the long-standing concept of humanizing the environment. Presently, the conditions of the physical plant work against humanizing efforts. For example, many toilets and showers do not work and plumbing remains an ongoing problem; the roof leaks when it rains; many locks do not work necessitating changes in youth movement patterns and fire drill responses; multiple resident room doors are warped

and difficult to open; the construction materials for resident's rooms are so old that they look dirty even when clean, inviting youth to continue the tagging of walls and doors; the distances required to conduct routine room check observations are excessive, as noted in a previous report; the configuration of space, especially recreation, is not conducive to the full range of activities normally found in juvenile detention facilities; and program space is equally deficient, to name a few.

Even if the JDS operated the best possible programs, their effectiveness would be diminished because of the noise levels. The design combines with the construction materials to create an environment that amplifies sound. Noise abatement would be costly and raises the question about the cost-effectiveness of expending substantial funds on a building that exists as an ongoing financial liability. Noise levels can also be an indicator of insufficient controls on youth behaviors. Others describe institutional noise as a characteristic of a chaotic environment, which is also linked to increased anxiety, stress, and trauma in children and youth.

Recent Office of Juvenile Justice and Delinquency Prevention (OJJDP) research suggests that positive youth perceptions of the detention experience correlate with a greater likelihood for positive post-release outcomes (participation in school and reductions in returns to detention). Factors that influence positive perceptions include environmental factors associated with humanizing efforts, e. g., safety, caring staff, positive peers, consistent discipline, fairness, and order and organization, to name a few. Areas for improvement exist in all of these areas. For example, the frequent clutter, papers, food service trays, and trash in the living units give the impression that there are challenges to cleanliness that undermine the order and organization aspect of structure.

F. Staff Interviews

I interviewed 18 staff. A complete list is available upon request.

G. Resident Interviews

I interviewed 14 youth (4 girls and 10 boys) in three (3) group interviews, one with all girls and two with boys. The average age for girls was 16.0 years and the average age of boys was 15.4 years. The self-reported Average Length of Stay (ALOS) was 83 days. 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

An exit meeting occurred on September 29, 2016 with Steve Leech, Chief Administrative Officer; Chief Fields; Chief Bridgeforth; Bill Powell, MOA Coordinator; Jina Shoaf, County Attorney; and Winsome Gayle and Richard Goemann, DOJ Attorneys. The meeting was a time for questions, clarifications, and explanations of events and impressions before issuing the report.

II. Protection from Harm: Detention Facility

A. Preliminary Comments and Observations

There have been accomplishments since the last visit. Many were noted in Compliance Report #8. Overall, there is reason to be optimistic about progress in the Protection from Harm portion of the MOA, and a continued focus on operational improvements should sustain this progress. Much of the following represents combinations of perspectives. They include:

1. Accomplishments

a. Daily Circle-Up groups occur, sometimes many times a day. The groups give youth information about the daily schedule, more specifically the upcoming activities during a given shift. This information helps youth make better transitions while reducing the amount of uncertainty about "what's next." The groups also provide a safety valve, allowing youth who are emotionally upset an opportunity to vent. This decompression also addresses the youth's need for respect, caring adults, and someone to listen.

b. Positive Behavior Management System (PBMS) is going well. PBMS under the direction of Sgt. Hunt has taken root, and staff and youth can describe positive outcomes attributed to the new approach to behavior management. All detention staff have been trained. Staff and youth acknowledge the existence of the PBMS. All youth receive a pamphlet about PBMS that they can keep in their rooms. A Youth Advisory Committee informs PBMS of important issues to youth. Bright and colorful PBMS posters are in different parts of the building. Youth discussed PBMS as a positive aspect of JDS. This likely results from the continued development of the token economy and its relationship to a fledgling but expanding commissary.

c. Contract medical services provider, Correct Care Solutions (CCS), is doing a good job, and communication between medical staff and security staff seems to have improved.

d. Hope Academy has expanded, and the school program continues to be described as a great asset.

e. Over the past nine months, the Report Card data have shown improvements in most areas but the September data show some temporary reversals that seems to be related to the increase in Average Daily Population (ADP). Supervision and documentation need to continue to improve in response to new processes put in place to address these reversals. However, increased ADP erodes the quality and quantity of supervision and documentation due to the stress and strain it places on staff and scheduling assignments.

   The Morning Report from September 26, 2016 identified 5 youth or 8% of the count for that day who had been in detention for more than 100 days (one youth who had been in detention for 277 days). This is a 56% reduction in the percent of youth with days care greater than 100 days as compared to the Morning Report from the April 2016 monitoring visit.

f. Adjustments are underway on the Report Card that will allow more precision with how data are tracked. With the assistance of Shannon Caraway of the Juvenile Court and the diligent work of Captain Weichel, automation and data collection have shown significant progress, which will ultimately improve the accuracy, documentation, and validation of a quality assurance metric.

g. Interactive training has improved and has more of a juvenile and adolescent development focus.

h. Refresher training on Safe Crisis Management has been scheduled and should improve staff responses in use of force situations.

i. Population reduction efforts in conjunction with the court have been helpful.

j. Involvement of the CAO Steve Leech has signaled a greater focus on operational improvement and follow-up by the Sheriff's Department.

k. A training-for-trainers workshop occurred October 17-21.

l. A staffing analysis report has been completed.

m. Communications continue between the Juvenile Court and the JDS about population reductions, especially the exchange of information about youth who have been detained 15 or more days. Staff report that the meetings have a positive impact on ADP reductions but externals factors are blamed for a daily population that is substantially above the goal set by Judge Michael several years ago. Concerns remain about the average length of stay (ALOS).

n. A full-time counselor has expanded programs for youth. Increases have been noted in programming, an expansion of the Hope Academy program, additional PBMS activities, extended visits, and additional phone calls.

o. The JDS leadership team continues to speak highly of the Hope Academy. The school capacity is currently at 45; however, plans are in place and renovations are occurring to expand the Hope Academy to provide educational services to all detained youth. JDS administration reports that a new teacher has been hired.

p. The return of reading materials to residents' rooms has occurred without major incident. Additional reading materials in rooms should be considered.

q. JDS and the Health Department staff meet monthly with CCS to discuss performance audits. A contract monitor oversees performance by CCS, and her audits are discussed at the meetings with CCS, JDS, Court Administration, and Health Department staff.

2. Challenges

a. Room confinement remains an ongoing concern. The best overall strategy is expressed by the MOA, "*seclusion should 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*." Relevant professional standards, such as the Performance-based Standards Project and the revised Juvenile Detention Alternatives Initiative (JDAI) *Facility Self-Assessment Standards* recommend that locked room confinement events be resolved in the shortest durations.

b. Completing the data validation will insure confidence in the information being reported and relied upon for management purposes.

c. The documentation remains a problem. While every monitoring experience addresses documentation at some point in the evaluation of quality assurance data, too much important information related to Protection from Harm is collected by hand, data forms are inconsistently completed, and the storage and retrieval of these data are problematic. The information about certain outcomes related to Protection from Harm is not reliable.

d. The regression in the quality of food served to detained youth is a familiar concern; addressing the quantity of food to youth warrants continued attention.

e. Concerns remain about expanding the hierarchy of non-physical alternatives.

f. Items from Nurse Reddic's 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 JDS Report Card so that trends can be monitored.

g. Prison Rape Elimination Act (PREA) policies and practices have yet to be audited.

h. The high rate of staff turnover continues, and the number of new staff highlights the urgency for upgrading new staff training and annual in-service training related to juvenile specific topics. Training recommendations will be discussed in detail below.

i. Addressing and resolving youth assaults. This is a frequently occurring issue in Shelby County and other jurisdictions nationally.

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 organizational structure included in policy, procedure, practice, and outcomes data.

Safety once more was not a part of the discussions. This does not mean that safety is not a concern, rather it suggests that safety is sufficiently better that it is no longer the priority concern. This indicates progress.

Several themes emerged from the three groups when asked about what they would do to improve JDS. Many of the responses were easily resolved problems and could be linked to PBMS. Consistent with a humanizing perspective, their suggestions included the following:

a. Food: Food was a concern in the past, primarily the quantity of food. Concerns about food currently focus on quality. In response to a question about the accuracy of youth complaints about the quality of the food (everything tastes like it's boiled), one staff member stated, "They're right, the food is terrible; there's no way I would ever eat it!"

   Youth requested a *bona fide* commissary. As the average age and length of stay increase, access to additional food above and beyond age-appropriate dietary requirements and their accompanying caloric intake restrictions can be a powerful motivator.

b. Increasing basic services, such as, more visitations and telephone calls, better personal hygiene products, more recreational and leisure time activities, and more work assignments or chores.

c. Regarding hygiene products, youth consistently described skin problems attributed to low cost deodorants, shampoos, soaps, and lotions. Youth were particularly critical of the current hygiene products. One youth explained how, on the direction

of a staff member, he helped mix a large container of body lotion with water at a 1:1 ratio, diluting the lotion and thus providing an explanation for many youth-generated complaints about the ineffectiveness of the lotion to resolve dry skin problems.

d. All youth complained about being cold, not having enough clothes, and only having worn-out underwear. While there is a tendency to report these concerns in an exaggerated manner during an inspection visit, there were quite a few youth with new undershirts and socks.

e. Youth expressed concerns that staff would mark them as not in their rooms or engaged in an out-of-room activity when they were actually in confinement, specifically the less-than-60-minute timeout.

f. Youth and staff reported optimistically about the PBMS but complained about widespread inconsistencies among staff when distributing points. Youth were especially critical of what they called favoritism and the practice of corporate punishment, punishing the entire group based on the misbehavior of one group member.

When asked if there were someone each youth could go to in times of trouble who would help them, all youth were able to identify at least one staff member; only one staff member was male. Youth again reported a level of disrespect and profanity directed toward them by the majority of the male staff.

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 should 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 should 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 JDS is the leader in the collection and use of data for management purposes. Yet, while commendable, it is important that the integrity of the data that inform critical Protection from Harm analyses still be validated.

FUTURE MONITORING: Future monitoring should include reviews of various quality assurance data on a random basis to determine the quality of documentation.

(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: JDS made immediate changes regarding the counting of mechanical restraints following the previous visit. At this point, there is growing confidence in the JDS Report Card data. Action is still needed to increase the accuracy and documented count of frequency of Protection from Harm factors.

Physical restraints remain a problem at JDS, as they do at many juvenile detention facilities across the nation. Physical restraints occur too frequently and signal the need for continued improvement in behavior management skills by staff. Reduced ADP lessens crowding-related stressors associated with behaviors linked to physical restraints. While it is

unrealistic to expect JDS to eliminate all fights and the accompanying need for physical restraints, there are rates of physical restraint that combine with other outcomes to indicate acceptable levels of safety. When the number of youth under the supervision of one JDO exceeds that staff member's ability to supervise adequately, locked room confinement is often the default response. In these situations, physical restraint is often used to enforce commands and directives.

From the list of use of force events from August 2016, I reviewed five (5) 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 gave the list of names to the Health Services Administrator (HSA) who secured and provided the files. The medical file reviews look for documentation of a post-restraint medical exam and for any notations or reports of injury from the restraint that could prompt the nurse to file a report about suspected child abuse as a mandated reporter. All files contained evidence of a post-restraint medical exam with additional clarification regarding anything unusual about the youth's physical condition.

FUTURE MONITORING: Concerns continue to exist about the need for additional medical and mental health staff due to clear caseload requirements and the increases in the average daily population.

(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: This aspect of the monitoring visit was preempted by extra time needed on documentation, training, and data quality issues. However, conversations with JDS staff indicate that the process has improved somewhat over the previous visit.

The Compliance Report #8 includes a daily average population chart for detention prepared by Sheriff's Population Management Analyst Chris Floyd. This type of data should be regularly collected, analyzed, and disseminated.

Efforts to validate the improved data collection system continue to show progress. Recent changes include an expanded field of Protection from Harm behaviors that will allow greater precision with information relevant to youth injuries, when confinements, use of force, physical restraints, and mechanical restraints.

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 of the physical Restraint Packet and its conversion to a PDF format

and other forms of transmittal should 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 JDS 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 less than 0.01 and 0.37, respectively, since July 2015, and they continue to reflect an effective approach to suicide prevention.

The suicide prevention section of the Report Card notes a slight decrease in the rate of the Qualified Mental Health Professional's (QMHP) contacts per 100 youth, reflecting the strain on QMHP activities with an increased ADP. JDS leadership also explained that staff are overly cautious in light of the understaffing circumstances.

I reviewed five mental health files of youth listed on the monthly precaution reports (July and August 2016). The reviews focused on the QMHP documentation of timely assessments,

setting precautionary levels, daily contacts, reassessments, and release justification for youth on suicide watch. All files met the criteria in the MOA.

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 MOA; and (b) at the meeting with the CCS contracted service provider, there was open satisfaction with the increased communications with County, the Sheriff, and the JDS staffs.

FUTURE MONITORING: This aspect of the MOA remains in compliance because of the quality of services provided by CCS. Future monitoring should 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 with an increased population, hence the increased demand for services. The ability of the existing CCS contract to meet the increasing needs of the current JDS 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 should 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 should 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 should 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 JDS staff conduct suicide screening within one hour of a youth's admission to the facility. 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 should 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: Previous monitoring report noted a pattern of JDO staff-documented confinement such that youth were only out of their rooms an average of one hour and 34 minutes or a 22.4/1.6 program. Detention leadership responded immediately to change these practices regarding the amount of time youth spend in confinement on the weekends. There was a substantial commitment from Chief Fields before the previous visit's closeout that the amount of time youth spend out of their rooms on the weekend would significantly increase. The Chief was true to his word. Using the same assessment strategy (collecting and reviewing all Room Observation Logs for every youth in custody on randomly selected weekend days), the amount of time youth spend out of their rooms on the weekends as indicated by the Room Observation Logs showed a 360 percent increase.

FUTURE MONITORING: Monitoring should audit the amount of confinement time documented in JDS logs and the coherence of these findings with reports from random samples 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 JDS policy, and all of the requirements of this paragraph were satisfactorily present during this visit. The five file reviews verified all of the required actions of the QMHP for those used on suicide precautions.

FUTURE MONITORING: Future monitoring should continue to review the QMHP job performance outlined in this section of the MOA. Additionally, monitoring should include 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 should 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 JDS policy; however, there were no documented incidents or discoverable events that warranted reporting.

FUTURE MONITORING: Future monitoring should 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: I tested the system by asking an Intake Officer to pull up the file of two different youth who had been released but had been on a suicide precaution while in JDS. The classification system again alerted the Intake Officer that the youth had been on suicide precautions. This paragraph is in compliance.

FUTURE MONITORING: Future monitoring should 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: 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. JDS leadership also includes middle management and line staff in the discussion and interpretation of these data. Compliance Report #8 includes what appears to be an outlier-driven increase in the average time on suicide precautions, given that the data reflect a single incident youth in June 2016. The recommendation in Compliance Report #8 is important. The average time on suicide precautions should be routinely monitored at the monthly Medical Services Review Team (MSRT) meetings with Detention and CCS staff.

FUTURE MONITORING: Future monitoring should 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.

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.

The Administrator shall review and, if necessary, revise the suicide prevention-training curriculum to incorporate the requirements of this paragraph. (See MOA pages 31-32)

RECOMMENDED FINDING: Compliance

COMMENT: The shift toward a juvenile philosophy of detention operations has begun, and detention decision-makers at all levels are giving greater consideration to their responsibilities of providing a secure detention experience that is developmentally appropriate for children and adolescents while simultaneously maintaining security and public safety. Evidence of this new and appropriate structure can be seen in the new 16-hour juvenile-specific training program recently implemented by Chief Bridgeforth.

Changing staff perspectives on youth misbehaviors and how to resolve them became important parts to changing the institutional culture; and training interventions are consistently identified among best practice recommendations as a critical part of these transformations. The same applies here. Two significant events were scheduled to occur that can accelerate the development of juvenile-specific skills among staff. First, through funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Carol Brooks and Rick Quinn delivered a 40-hour training-for-trainers workshop on a juvenile-specific curriculum, allowing Chief Bridgeforth to develop a cadre of certified trainers upon which to build a stronger and better internal training department. As the JDS moves beyond reliance from the Sheriff's Academy, it will be better able to reinforce juvenile-based knowledge, skills, and competencies.

Preliminary evaluations of the 40-hour training-for-trainers workshop are already available, and multiple staff have described it as one of their best training experiences. There were 18 staff members who participated. All were engaged from Day 1 through Day 5 of the training. The training taught a new model to facilitate learning, helping training staff identify learning styles with an easily administered assessment tool. The training clarified how people perceive and process information and taught training staff to learn, recognize, and teach in a way that each participant can perceive and process the information effectively. The instructors used the Instructional Therapy Into Practice Model (ITIP), which incorporates all adult learning styles and leads to greater training effectiveness. Participants were engaged, interacting and giving positive feedback, and thinking about how to use their new skills in class. One staff member said, "It is a hidden secret to training, like finding a golden egg."

Additionally, the Sheriff's Department has sponsored a detention staff member to attend a training for trainers workshop on safe crisis management with special emphasis on de-escalation skills.

The MOA issues were present in JDS 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.

FUTURE MONITORING: Future monitoring should 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. With the commitment to add more juvenile-specific training workshops, future monitoring should

continue to assess and support for developmentally appropriate juvenile-oriented training materials.

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: There has been a breakthrough on the data integrity audit and its importance in verifying reductions in uses of force. A review of the data metrics plan revealed substantial improvements largely attributable to the excellent work of Shannon Caraway and Captain Weichel. The key Protection from Harm behaviors have been identified, along with the subcategories of behaviors. The system appears to be ready to be tested with real data.

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 should produce a beneficial analysis of use of force. Further, a substantial challenge related to Protection from Harm is room confinement data. While there are many operational issues associated with the use of locked room confinement in juvenile detention, the juvenile justice community and the leadership of JDAI have 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.[1] In light of the participation in JDAI and the existence of the MOA, use of confinement is a legitimate concern.

FUTURE MONITORING: The current monitoring emphasis on room confinement issues should likely have a strong influence on future compliance strategies. The next monitoring visit should include multiple audits of the amount of confinement time documented in JDS logs and the coherence of these findings to reports from youth and staff as an initial validation of the data collection system that includes Bill Powell.

[1] Page 97 – Staff do not place youth in room confinement for fixed periods of time; Page 98 - Staff do not place youth in room confinement for longer than four hours.

(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 JDS has created, prepared, completed, and provided all necessary documentations to conduct a monitoring review.

III. Summary

Steve Leech, the Sheriff's Chief Administrative Officer, assumed the leadership of the Sheriff's MOA team prior to the April visit, and the progress toward compliance improved in much the same way that Pam Skelton energized detention staff for the juvenile court before the transition of detention to the Sheriff's Department. A new optimism again exists among JDS leadership, which predicts more substantial changes. So far, the responsiveness to recommendations is once more at a high level.

A. Documentation

Documentation must improve.

B. Staffing Analysis

The staffing analysis is an important document moving forward. It identifies for the Sheriff's Department some of the critical staffing issues in secure programs for youth. In particular, the staffing analysis provides an improved perspective on staffing levels, and the recommendations in the staffing analysis should be implemented.

C. Average Daily Population (ADP)

Despite seasonal fluctuations in the daily population, mechanisms are in place that fill the role of a detention expediter. There is a daily review by both JDS and Juvenile Court staff regarding the status of youth who can be released more quickly or those youth who seem to be on a protracted stay. The ADP is such an important and expensive variable that even temporary or sustained increases in the number of youth in custody have substantial implications. As a result, a contingency plan exists for how detention will alter its staffing and programs to maintain basic levels of service during periods of time when the ADP increases.

D. Recommendations

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

1. Continue and expand current efforts to reduce the average length of stay (ALOS).
2. Enhance and expand the momentum generated by the recent training-for-trainers workshop through the continue development of juvenile-specific training presented by the newly trained JDS trainers.
3. Continue the progress on the resident management information systems with Shannon Caraway and others. Pilot test a new data-reporting prototype to enhance, supplement, or replace the Report Card.
4. Implement the revised policy on locked room confinement.

5. 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.
6. Complete a juvenile-detention-focused staffing plan based on the findings of the staffing analysis to guide budgeting and safeguard Protection from Harm. The pre-transfer absence of such a staffing plan has placed the Sheriff at a substantial disadvantage.
7. Improve the grievance system and other measures of assessing youth perceptions so as to reduce the gap between youth and staff perceptions detention effectiveness.
8. Continue programming and activity enhancements as part of the Positive Behavior Management System (PBMS). Under the direction of Sgt. Michelle Hunt, the PBMS has the potential for an even greater positive impact on reducing use of force and use of confinement. PBMS is only in its infant stages of development despite what many staff think is an overdeveloped approach to rewards and incentives. A wise move would be to provide Sgt. Hunt with substantially greater support in the areas of resources, activities, and personnel.
9. Future monitoring needs to include verification of the documentation practices of staff when youth are involved in a timeout, a cool-off, and other type of involuntary confinement.