Juvenile Court of Memphis and Shelby County (Juvenile Court)
MOA Protection from Harm Stipulations:
7th Report of Findings and Recommendations

by

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Submitted to

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This is the seventh 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 (Juvenile Court), TN, and it describes the visit to the Shelby County Sheriff's Department of Juvenile Detention Services (JDS) on April 4-7, 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 Detention Facility on July 1, 2015 to the Shelby County Sheriff, Bill Oldham. Chief Kirk Fields is the new detention superintendent and heads the new Detention Facility leadership team. He has additional supervisory responsibilities for secure custody operations outside of JDS. Daily operations are the responsibility of Chief Deidra Bridgeforth and Lt. Larry Weichel. William Powell, contracted MOA Coordinator, continues to provide support, guidance, and direction. 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.

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 necessitated conversations to identify and assess those differences that could prompt recalibrations of the monitoring process. In the previous report, dated December 17, 2015, I discussed the differences between a juvenile detention facility operated by a juvenile-oriented parent agency versus an adult-oriented parent agency. During this visit, the differences were identified and explained using examples from existing practice. From the start of the transition, JDS leadership enthusiastically endorsed its commitment to a juvenile-oriented approach without understanding fully what it entailed. This visit compared and contrasted the differences in the approaches, and JDS leadership seemed to understand the differences. This marks a significant accomplishment and has hopefully set JDS in a 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 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.

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 March 10, 2016 "Compliance Report #7" (hereafter referred to as the "Compliance Report") for review before the on- site visit. Special attention was given to pages 32-39, covering Protection from Harm actions and recommendations. Powell's presentation and description of use of force data from the Detention Report Card highlighted differences in the numbers before and after the transition to the Sheriff's Department. While measured and descriptive, the comments called attention to important use of force issues and elicited local news media coverage.

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, Sheriff's Department, 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 meeting with Chief Fields; Chief Jailer Robert Moore; Chief Bridgeforth; Lt. Weichel; Sgt. Michelle Hunt; Dr. Audrey Townsel, CCS Regional Operations Manager; Richard Goemann, DOJ Attorney; Jina Shoaf, County Attorney; and 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 April 4-7 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 continued the painting of resident rooms, 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.

F. Staff Interviews

I interviewed 20 staff, including 14 Sheriff's employees, one (1) Juvenile Court employees, two (2) Shelby County employees, and three (3) Correct Care Solutions (CCS) staff.

G. Resident Interviews

I interviewed 10 youth in two (2) five-person group interviews, all boys. The average age of these youth was 16.7 years with a self-reported Average Length of Stay (ALOS) of 91 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. Both the average age and ALOS of interviewees were the highest since the monitoring started.

H. Exit Interview

An exit meeting occurred on April 8 with Steve Leech, Chief Administrative Officer; Ross Dyer, County Attorney; Chief Jailer Moore; Chief Fields; Chief Bridgeforth; Lt. Weichel; Debra Fessenden, Winsome Gayle and Richard Goemann, DOJ Attorneys; and Bill Powell. 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

Comparisons between the detention Report Card data before and after the transition to the Sheriff's Department have generated attention. Because some of the comparisons reflected deterioration in Protection from Harm indicators, representatives of the Sheriff's Department noted that not all of the Report Card comparisons were unfavorable. Instead, many of the post-transition outcomes revealed some improvements. In fairness, the detention Report Card data comparisons in Tables 1 and 2 at the end of the report contain indicators of change that reflect both areas of accomplishment and concern. The tables are of similar size and represent an analysis of variance of averages in each category over the nine-months before and after the transition. First, the accomplishments:

1. Accomplishments

There have been accomplishments since the last visit. Many were noted in Compliance Report #7, so the following list represents combinations of perspectives. They include:

a. Communications between the Juvenile Court and the Detention Facility about population reductions continue, especially the exchange of information about youth who have been detained 15 or more days. Meetings appear to have had a positive impact on ADP reductions but substantial concerns remain about the effects on ALOS. JDS administration reports reductions in ALOS while the data reveal a statistically significant increase. This will be discussed more in this report.

b. A full-time counselor has been hired to expand programs for youth. Increases have been noted in programming that includes groups (circle up, therapeutic community), an expansion of the Hope Academy program, additional activities, extended visits, and additional phone calls.

c. The Positive Behavior Management System (PBMS) under the direction of Sgt. Hunt has been implemented, and 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. During the visit, bright and colorful posters about the PBMS were mounted 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 an expanding commissary.

d. Substantial progress has been made in the development of an acceptable data collection system. While additional action is necessary, progress to date represents a notable accomplishment. This issue will be discussed in greater detail below.

e. The Detention Facility 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.

f. The improvement in the quality of food services to detained youth by the Sheriff is commendable; addressing the quantity of food to youth warrants continued attention.

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

h. 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.

i. During this visit, we noted reductions in the daily population numbers from the previous monitoring visit. The Juvenile Court and JDS meet regularly to identify youth who can be released. The April 2016 Report Card data reveal another reduction in the average daily population. One interview included discussions with Chris Floyd, who displayed a solid understanding of population management issues and how to expedite detainee releases. This level of understanding could be use by the Sheriff's Department to inform JDS administration about the tasks necessary to expediting releases. Additionally, she could be helpful to the Juvenile Court in the development of the expediter position description and the selection of the individual to perform the expediter functions. It is always better when resources for essential information can be found within the system. The risk management implications for protecting the rights and well-being of incarcerated youth creates a powerful rationale for strengthening the population management team.

j. April 2016 Report Card data also reveal encouraging reductions in physical restraints, mechanical restraints, use of room confinement and segregation, and the average duration of room confinement in hours.

2. Challenges

a. The use of room confinement remains a substantial concern for achieving compliance. The best overall strategy is expressed by the MOA, "*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." Relevant professional standards, such as the Performance-based Standards Project and the revised JDAI Facility Self-Assessment Standards, target the percentage of locked room confinement events resolved in short durations. The U.S. District Court intervention at the Cook County Juvenile Temporary Detention Center in Chicago provided evidence that resolution of locked room confinement can be accomplished more quickly than the recommendations in the standards. It seems reasonable with this administration to reduce significantly the average time needed to resolve room confinements.

b. A related issue affecting ADP is the unacceptably high Average Length of Stay (ALOS). Juvenile detention is supposed to be a temporary or short-term custody experience, but the Morning Report from April 4, 2016 identified 18 youth or 27.3% of the count for that day who had been in detention for more than 100 days (one youth who had been in detention for 215 days) as compared to 5.7% of the count on April 27, 2015 (the date of the monitoring visit one year ago). Additional comparisons of the April 2015 visit data with the April 2016 data reveal a 98% increase in ALOS from 33.9 days to 67.0 days, which is statistically significant ($p < 0.0001$). These comparisons suggest that substantial problems exist in the timely and efficient resolution of legal and the case management issues.

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

d. The documentation is a substantial problem. While every monitoring experience addresses documentation at some point in the evaluation of quality assurance data, this issue existed before the transition to the Sheriff's Department and would have appeared in a monitoring report regardless. 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 unreliable.

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

f. 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.

g. 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.

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 November 2015 monitoring visit, this group of 10 youth was similar in racial distribution (100% youth of color), older, and detained about the same amount time. The November 2015 group was same average age (16.7 years old) but there was a 3% increase in the self-reported average length of stay to 93.1, an ALOS unacceptably high. 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 JDS.

Safety was not a part of the discussion, which is a marked change in youth interviews at JDS. This does not mean that safety is not a concern, rather it suggests that safety is sufficiently better that it is no longer a priority concern. This indicates progress.

Several themes emerged from the two groups:

- Youth complained about the delays in the legal process. They specifically mentioned that psychological testing takes over 30 days to complete. They were also animated about the perception that good behavior is not reported to the court.
- Showers: Youth complained that they sometimes do not get a shower each day. Others complain that showers occur before recreation. Several expressed concerns about privacy and how some youth shower in their underwear.
- Too much time in locked room confinement: Youth complained once more about an alleged 22/2 program on the weekends. The investigation of this allegation is discussed later in this report. Youth also identified the "Red Card" as a special disciplinary status associated with a 23/1 program for at least three days and the use of handcuffs and shackles during the one-hour out of room. This also warrants further investigation.

When asked about what they would do to improve JDS, many of the responses were easily resolved problems and could be linked to PBMS. They include:

- Food: Food has been a concern in the past, primarily the quality of food. Concerns about food currently focus on quantity. 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.
- Increases in basic services, such as, more visitations and telephone calls, better personal hygiene products, more reading materials in rooms, and more work assignments or chores.

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; none were male. Youth consistently 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 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 leads 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 moves towards resolution, the integrity of the data that inform critical Protection from Harm analyses must be validated.

Quality documentation is the foundation of any quality assurance performance metrics. JDS documentation is unacceptable and unreliable. For example, a review of all Youth Observation Logs from March 12, 2016 were so incomplete that it was impossible to determine the amount of time youth spent in locked room confinement. Here, on a critically important Protection from Harm metric, documentation was so poor that no verification existed of mandatory room checks. The absence of documentation lends additional credibility to the claims of youth that confinement on the weekends is a 22/2 (22 hours in the room and two hours out of the room for meals and recreation) type of isolation. Youth further alleged that middle management supervisors (Sergeants) do not provide consistent supervision of JDOs, allowing the perception among youth that there are two sets of rules, one enforced by male staff and another enforced by female staff. Youth believe that female staff are fairer across the board.

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.

FUTURE MONITORING: Future monitoring will 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: DOJ received complaints about the use of shackles on JDS youth before the April visit. The complaints noted the vulnerability of youth in situations where the shackles seem to be inconsistent with the risk of harm in the situation. The discussion about shackles also included ancillary complaints of excessive confinement, specifically 23/1 programs for youth on disciplinary action.

Mechanical restraints were a problem before these complaints were registered. There are multiple factors related to mechanical restraints that need immediate attention and correction. First, the Detention Report Card data show an increase in the use of mechanical restraints when comparing uses between juvenile court operations and Sheriff's Department operations. Even though these are small numbers, nonetheless the increase requires explanation.

In searching for the reason for the increase in the use of mechanical restraints, a review of policy led to a statement that "mechanical restraint is a use of force." Therefore, all uses or applications of mechanical restraints require a report and documentation. This means that the use of shackles for transportation or court appearances must be documented and counted in the Report Card.

Attempts to count the number of mechanical restraints in March were quite difficult, as most were not reported on the Detention Report Card since they were not defined as a physical restraint incident. JDS uses multiple forms to document various activities, and there needs to be a consolidation of these forms in order to streamline data analysis. The result is that mechanical restraints are substantially undercounted. An informal "blanket" policy exists about the use of mechanical restraints for transportation and court appearances. A blanket policy raises concerns when a use of force occurs without consideration of the individual youth's behavior. At this point, there is no way to determine what percentage of actual uses of mechanical restraints the Report Card data represent. Immediate action is needed to resolve the lack of an accurate and documented count of frequency of mechanical restraint usage.

Physical restraints remain a problem. They occur too frequently and signal the need for improvement in behavior management skills by staff. The reduction in the ADP has lessened crowding related stressors associated with behaviors linked to physical restraints, so these numbers are, indeed, beginning to decrease. The challenge is sustaining the reduction in physical restraints to the point that they are not problematic. 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 combined with other outcomes to indicate acceptable levels of safety.

In situations where 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 March 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 provided the list of names for the file review to Health Services Administrator (HSA) Crosby who secured and provided the files. The medical file review looks 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 presenting physical condition.

Youth raised contradicting accounts of the handling sick call request process, which could influence these Protection from Harm concerns, some stating that staff checked the request and filed a form and others stating that youth themselves fill out the sick call request form. HSA Crosby noted potential health-related privacy violations if security staff acted as intermediaries between youth and medical.

FUTURE MONITORING: Discussions with QMHP Richards and HSA Crosby raised concerns about the need for additional medical and mental health staff due to caseload requirements and an increased 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.

FUTURE MONITORING: The use of force Restraint Packet review will 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 0.01 and 0.59, respectively, since January 2014, 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 QMHP contacts per 100 youth, reflecting the strain on QMHP activities with an increased ADP. Detention Facility leadership also explained that staff are overly cautious in light of the understaffing circumstances. Subsequently, the average length of a suicide precaution is longer than in the past.

I reviewed five mental health files, five files of youth listed on the monthly precaution reports (February and March 2016), and five different medical files. The review of the files focused on the presence of 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 Detention Facility staffs.

Several issues in the meeting with Dr. Audrey Townsel, CCS Regional Operations Manager, related to quality and continuity of care. Emerging health concerns include reentry medication (a seamless transition between detention and the community regarding medications for youth), adolescent sleep problems (a concern noted in a 2010 OJJDP publication about needs of detainees), and sex education regarding sexually transmitted infections. Additionally, the Shelby County Health Department will assume the primary responsibility for the CCS contract for juvenile detention, and we recommend the July 2016 contract be ADP-based like the existing precedence set by the CCS contract with the Jail (201 Poplar).

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 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 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: Non-Compliance

COMMENT: Previous monitoring reports have noted youth allegations of routine locked room confinement on the weekends. They describe weekend confinement as a 22/2 program where youth are confined for 22 hours and out of their rooms for two hours for recreation and showers. Youth claim that they eat most of their meals in their rooms. During previous

monitoring visits, detention superintendents denied that such a practice exists on the weekends. They have, however, referenced extra or extended confinements on the weekends and on non-school days when there were insufficient staff to cover the shifts. This visit targeted the documentation of the amount of locked room confinement on the weekend. Lt. Weichel retrieved several boxes of unsorted Youth Observation Logs from March 2016. A Youth Observation Log contains documentation of the 15-minute room check and a status/location indicator. We identified and retrieved Youth Observation Logs for each youth in custody on March 12 and 13.

As stated above, Youth Observation Logs from March 12, 2016 were so incomplete that it was impossible to determine the amount of time youth spent in locked room confinement on that day. The review of the Youth Observation Logs for March 13, 2016, however, revealed a clear pattern where JDO staff documented confinement nearly identical to the pattern of confinement youth repeatedly claimed occurs on the weekends. Specifically, the Youth Observation Logs from March 13, 2016 indicated that youth were only out of their rooms an average of one hour and 34 minutes or a 22.4/1.6 program. That is, youth were out of their rooms less than 2 hours of the day that Sunday. Best practice calls for 14 hours of planned activities out of the room.

There were no youth on suicide prevention status on March 13, 2016, according to documents provided by JDS. The March 2016 suicide prevention statistics indicated that one youth was placed on suicide precaution on Friday, March 25 and released from suicide precaution on Monday, March 28; but this information was discovered in a post-visit review of documents, so there were no evaluations of the Youth Observation Logs from that weekend. However, the implication is precarious, for if these March 13 room confinement findings are in any way indicative of a common weekend isolation practice as youth have repeatedly claimed, youth on suicide precaution would likely have been confined over the weekend; and this paragraph would then automatically be in non-compliance. This practice of confinement needs to end immediately.

FUTURE MONITORING: The next monitoring visit will again 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. Additionally, monitoring will focus on the "Red Card" and allegations of a 23/1 program for at least three days and the use of handcuffs and shackles during the one-hour out of room.

(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 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. The March 15, 2016 Clinical Nurse Monitor Report data on use of force from September 2015 raised a concern about the communication between security and medical. Given the recent personnel transitions related to medical and clinical monitoring, communication between security and medical will remain a focus of monitoring.

(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 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: I tested the system by asking an Intake Officer to pull up the file of the 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 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; however, as will be discussed below, there is reason to believe that substantial progress will occur before the next monitoring visit regarding data quality. Furthermore, many of the critical indicators for Protection from Harm, specifically the amount of time youth spend in room confinement, have been trending downward since the April visit.

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 will include progress of the data committee as it moves toward a validation of the revised the Report Card.

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 issues expressed in the MOA 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. Training records confirmed that all staff members were current on these two training requirements.

The training discussions revealed that training delivery is also a concern. When asked for the lesson plans on the training, staff largely produced PowerPoint files, sometimes including the handouts from the PowerPoint slides. Questions about adult learning styles, Instructional Theory into Practice (ITIP), and training-for-trainers certification ended the training discussions. JDS training staff needed specific examples of a juvenile specific training approach, so the meeting moved to another office where trainers could review complete curriculum materials, including lesson plans, trainer notes, participant handouts and activities, and PowerPoint slides. The training materials were developed by the National Juvenile Detention Association's (NJDA) Center for Research and Professional Development through funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). All curriculum materials were in Microsoft Word format so that trainers could make the curriculum JDS specific by modifying certain training activities to meet the particulars of JDS and by using the "replace function" to identify Shelby County as the proprietor of the materials.

Interactions with the trainers were positive and enthusiastic. Because JDS does a good job of providing training, there is a base from which to build, substitute, or supplement new training materials. The key to this transition is the training-for-trainer's technical assistance so that current JDS trainers can deliver the new curriculum materials to new and veteran staff with greater effectiveness.

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. With the commitment to add more juvenile specific training workshops, future monitoring will 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. Perhaps, the most important progress on this paragraph was the meetings about data collection and data quality. As a follow-up to several telephone conversations that included Shannon Caraway, Information System Manager, a meeting was held with key individuals (list provided upon request) in the training room so that participants could see projections of data tables from the existing data collection system. Caraway's belief that the existing system had the capacity to produce the types of reports that would be required to meet the data and quality assurance requirements of Paragraph 4 under Protection from Harm was cause for a new enthusiasm not previously experienced on the data quality issue. Her concern was the identification of the proper data and the type of reports.

Input from Eric Bennett, Network Administrator, and Chris Floyd, Jail Population Management Analyst, added substantially to the discussion. When factoring the skills and resources of Caraway, Bennett, and Floyd, the next action was to convene a group of JDS staff to identify the behaviors to be coded for entry into the data collection system. Continued work on this aspect of the quality assurance metric will be a focus of the future technical assistance.

After the data meeting, the designated JDS staff participated in a nominal group technique designed to brainstorm, evaluate, and rank the various uses and types of data to be the core of the quality assurance metric. The results of the nominal group were recorded, transcribed, and disseminated for future action. This also represents a major goal of the upcoming technical assistance. The data meeting and the nominal group provided substantial cause for optimism that this part of the MOA can be quickly and effectively resolved.

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.

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 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 JDS logs and the coherence of these findings to reports from youth and staff as an initial validation of the data collection system.

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

RECOMMENDED FINDING: Compliance

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

III. Summary

Numerous circumstances exist that were present before the transfer of the Detention Facility to the Sheriff. Critical Protection from Harm factors, such as ADP, ALOS, and uses of force, require clear plans of action. In response to these inherited issues, the Sheriff's Department had been mostly reactive, sufficiently so as to justify a rethinking of the approach to monitoring. With the exception of suicide prevention, there was a sense of needing to start over on basic assumptions about juvenile facility operations related to Protection from Harm. As a result, part of the strategy for this monitoring visit was to confront areas of Protection from Harm where JDS administration mistakenly believed it was moving in the right direction. The Sheriff's Department had moved confidently, recounting its success in resolving a DOJ conditions lawsuit in the adult detention facility. Sometimes, the Sheriff's staff appeared defensive and other times dismissive of monitoring assessments that disagreed with its actions.

Steve Leech, the Sheriff's Chief Administrative Officer, assumed the leadership of the Sheriff's MOA team between the previous visit and this visit; and the tone of monitoring changed. Leech requested information, ideas, examples, and materials that could help staff understand the differences between adult and juvenile detention facilities. What resulted was a substantially different monitoring visit where added technical assistance and disseminating of information occurred. A new optimism now also exists among JDS leadership, which predicts more substantial changes. Evidence exists that immediate action has already been taken to

[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.

restrict the use of mechanical restraints and locked room confinement. So far, the responsiveness to recommendations is at a high level.

This positive outlook for moving toward compliance with the Protection from Harm paragraphs has been tempered by the necessary reporting of several inevitable discoveries of problems that are symptomatic of facility change. The more a facility improves Protection from Harm, the more it sees and resolves the myriad problems that were largely hidden but sustained by unacceptable staff practices. This visit was no exception. Therefore, the hope is that identification of substantial problems strengthens the commitment to resolve them.

A. Documentation

Current documentation practices are unacceptable. It is the “canary in the coal mine,” a reliable indicator of more serious problems. The more serious problem is supervision. The cardinal sin is when supervision breaks down to the point that leadership does not know what is happening with youth on the units. These issues existed when the Juvenile Court administered the detention facility, but the recommendation to transfer detention to the Sheriff's Department drew support, in part, from the presumption that jailers would bring a better organizational knowledge and structure reflective of an ACA accredited adult facility, especially an improved system of staff supervision. Therefore, the unexpected discovery of the March 13 confinement practice suggests the presence of inadequately supervised staff, a lack of sensitivity to youth complaints, an insufficient responsiveness to monitoring reports, and a confounding and inadequate system of documentation. Middle manager supervision of JDOs needs improvement and has allowed the perception among youth that there are two sets of rules, one that is presented to the public as the official detention culture and the other that reflects the behaviors of staff on those shifts other than 8:00 AM and 5:00 PM Monday through Friday when administration is present.

B. Staffing Analysis

In conversation with the contracted staffing analyst, there was a demonstrated knowledge of the NIC materials for conducting a staffing analysis. The analyst also discussed multiple experiences with corrections and the Sheriff's Department. What was not mentioned was information about direct experiences in a juvenile facility or prior experiences conducting staffing analysis for juvenile facility or references to juvenile-specific issues in making staffing determinations. As a result, the Sheriff's Department’s staffing analysis is an individual who, while appearing competent in conducting a staffing analysis for an adult facility, has no direct experience in a juvenile facility. Neither was any rationale presented to explain how the staffing gaps between adult and juvenile operations will be successfully bridged. Fortunately, this visit marked the beginning of the end of the assumptions that adult attention translates perfectly to juvenile detention. As a result of a new understanding and cooperation, a commitment was made to work with the Sheriff's staffing analyst to make the results more juvenile specific. Background materials have been forwarded to the JDS for sharing with the staffing analyst. Issues related to the staffing analysis findings will be a topic for technical assistance this summer.

C. Training

New JDO staff receive training consistent with commonly accepted best practices for adult facility personnel. For example, the description of job shadowing or O.J.T. (on-the-job training) includes no specific objectives, tasks, or experiences that a new employee is to complete under training coach or mentor supervision. An underlying assumption exists that there are no difference between juvenile and adult detention skills. When the content of training relies more heavily on what works with adults, a fundamental problem exists. The adult-bias problem is currently being resolved as the Training Department moves to more juvenile-specific training curricula.

Only Chief Bridgeforth stated that she has NIC trainer certification from 2004. Lt. Talley received certification as a trainer by the Sheriff's Department. None of the pre-service instructors at the JDS holds certification as a trainer. As such, the recommendation is that the Sheriff's Department pursues certification of the JDS staff trainers through a 40-hour training-for-trainers program from a nationally recognized certifying organization. Discussions relating to trainer development and training delivery prompted JDS administration to seek technical assistance support from OJJDP for delivery of a 40-hour training-for-trainers program. We have noted a non-responsiveness by OJJDP to some requests from Shelby County for training and technical assistance, so an alternative approach is recommended because training, especially trainer development, is a critical part of the culture change process.

IV. Recommendations

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

1. End the practice of 22/2 locked room confinement.
2. Improve documentation.
3. Adopt and implement Peters and Waterman’s Management by Walking Around (MBWA) as a daily JDS leadership practice.
4. Continue and expand current efforts to reduce the average length of stay (ALOS).
5. 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.
6. Revise the policy on locked room confinement.
7. Certify JDS staff trainers through a 40-hour training-for-trainers program from a nationally recognized trainer certifying organization for juvenile justice.
8. 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.
9. Complete a juvenile-detention-focused staffing plan 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.
10. Improve the grievance system and other measures of assessing youth perceptions so as to reduce the gap between youth and staff perceptions detention effectiveness.
11. Continue programming and activity enhancements as part of the PBMS.

Tables

Table 1. Changes in Detention Report Card Data Categories Reflecting Progress Toward Compliance

Detention Report Card Data Category	% Change
Total Number of DATs Completed	-10.01%
Number of DATs Release Eligible	-18.04%*
Total Number of DATs Overridden	-43.10%
Percentage of Release Eligible DATs Overridden	-29.42%
Percentage of Total DATs Overridden	-36.61%
Number of Overrides that were for Youth of Color	-46.95%
Number of Overrides that were for Males	-54.01%*
Number of Overrides that were for Females	-2.70%
% of Total Male Youth Admitted who were overridden	-73.76%*
% of Total Female Youth Admitted who were overridden	-41.68%
% of DATS overridden for Danger to Community for Youth of Color	-1.17%
% of DATS overridden for Danger to Community for Males	-33.80%**
DATs overridden for Parent Refused to pick up	-74.14%*
% of DATS overridden for Parent Refused to Pick Up for Youth of Color	-62.26%**
% of DATS overridden for Parent Refused to Pick Up for Males	-9.15%
% of DATS overridden for Parent Refused to Pick Up for Females	-18.16%
DATs overridden for Unable to Locate Parent	-96.49%*
% of DATS overridden for Unable to Locate Parent for Youth of Color	-88.24%**
% of DATS overridden for Unable to Locate Parent for Males	-93.72%**
% of DATS overridden for Unable to Locate Parent for Females	-46.87%
Total Number of Youth Admitted to Detention	-8.55%
Total Number of QMHP Calls/Contacts	-19.19%
Rate of QMHP calls per 100 youth	-30.30%*
Number of Youth Cleared with Restrictions	-13.19%
Number of Youth Transported for Psychiatric Care	-100.00%
Rate of youth on Suicide Precautions per 100 youth	-31.07%*
Number of Youth Placed on Suicide Precautions	-20.20%
Average Time on Suicide Precaution (in hours)	15.34%
Average wait time for the QMHP (in hours)	-76.75%
Suicidal behavior without injury per 100 person--days of confinement	-30.63%
Hierarchy of Non-Physical Alternatives Used	44.74%
Percent of interviewed youths who report that they fear for their safety	-28.26%
Percent of staff who report that they fear for their safety	-56.04%
% of youth with suicide screening by qualified staff in one hour or less of admission	0.00%

Note: ** represents statistical significant at the 0.01 level, whereas * = 0.05 level of significance.

Table 2. Changes in Detention Report Card Data Categories Reflecting Areas for Continued Attention

Detention Report Card Data Category	% Change
Percentage of overrides that were for Females	97.53%*
DATs overridden for Danger to Community	32.61%
% of DATS overridden for Danger to Community for White Youth	62.28%
% of DATS overridden for Danger to Community for Females	227.86%**
DATS overridden for Threat of Bodily Harm	80.00%
% of DATS overridden for Parent Refused to Pick Up for White Youth	322.75%*
Number of Bed Days	18.30%
Total Number of Use of Force	84.95%*
Use of Force Rate per 100 youth	53.74%*
Number of Restraint and Room Confinement	90.34%*
Number of Documentation and Reporting	84.95%*
Hierarchy of Non-Physical Alternatives Waived due to Active Physical Aggression	95.27%*
% of Times Hierarchy of Non-Physical Alternatives Used	-39.08%
Medical Evaluations Completed	85.95%*
Wrongful conduct uncovered	200.00%
Violations of Policy or Protocol	200.00%
Injuries to youth per 100 person-days of youth confinement (non-assaultive)	238.33%
Injuries to youths by other youths per 100 person-days of youth confinement	20.00%
Assaults on youth per 100 person-days of youth confinement	61.97%
Assaults on staff per 100 person-days of youth confinement	100.00%*
Physical restraint use per 100 person-days of youth confinement	55.55%*
Mechanical restraint use per 100 person-days of youth confinement	143.45%*
Average duration of locked room confinement unit in hours	16.03%

Note: ** represents statistical significant at the 0.01 level, whereas * = 0.05 level of significance.