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December 30, 2013

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Re: Juvenile Court of Memphis and Shelby County (JCMSC) MOA Protection from Harm Stipulations: 2nd Draft Findings and Recommendations Letter

Dear Winsome and Anika:

This is the second letter to the U.S. Department of Justice (DOJ) regarding the Memorandum of Agreement (MOA) between the United States and the Juvenile Court of Memphis and Shelby County (JCMSC), TN, and it describes the visit to the JCMSC Detention Services Bureau (DSB) on November 5-7, 2013. My role as the Protection from Harm Consultant is to provide information and assessments of the progress by JCMSC toward compliance with the Protection from Harm paragraphs of the MOA (Section C).

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

I remain very positive about the response by JCMSC and DSB leadership to Section C of the MOA and the recommendations in previous communications. I am pleased with the pace of change, and the progress made to date on Section C is a key theme of this letter despite concerns about Section C paragraphs that have not yet reached compliance. Section C of the MOA asks JCMSC and DSB leadership to make substantial changes to its juvenile detention operations, which are sometimes easy to accomplish and sometimes very hard to accomplish, but hardly ever quickly accomplished.

Jerry Maness and the JCMSC staff have done a good job of assembling a leadership team at DSB that appears to be good combinations of complementary skills and abilities. Gary Cummings, Robert Stanley, and Willie Walton represent a solid management team. Each conveys in his own way a positive and enthusiastic attitude toward Section C as a motivator for change.

Communication, information, and guidance provided by William Powell have been excellent. He continues to provide a valuable perspective, both as someone who has experience dealing with other MOA circumstances and who can look at the DSB operations with a greater level of objectivity and detachment. Additionally, his advice has been generally accurate and beneficial to the achievement of compliance with Section C of the MOA.

I. Assessment Protocols

The assessments used the following format:

A. Pre-Visit Document Review

Powell remains the MOA Settlement Agreement Coordinator. He has experience with settlement agreements and DOJ through his work with the Shelby County Sheriff's Department. Powell recently retired from his employment with the Sheriff's Department, but he has a contract to continue his role as the MOA Settlement Agreement Coordinator. He remains conversant about compliance issues and offers a pragmatic approach to what is required for compliance under the MOA paragraphs. He continues to be an excellent resource. On September 23, 2013, Powell submitted a report called, "Compliance Report–Substantive Remedial Measures" (hereafter referred to as the "Compliance Report") and forwarded a copy to me for review before the on-site visit. Special attention was given to pages 31-37, covering Protection from Harm actions.

B. Use of Data

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

C. Entrance Interview

Two entrance interviews occurred on November 5, one with Powell and the other with key DSB staff. The meetings provided an opportunity for informal discussion of institutional goals and objectives, an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities.

D. Facility Tour

A walkthrough of the facility occurred on November 7 and provided an opportunity to observe the Hope School, the conditions of resident sleeping rooms, the general levels of cleanliness of the facility, and any physical plant modifications or improvements.

E. On-Site Review

More time was needed to review all of the areas in the MOA. As such, various segments of the MOA will become the focus of future monitoring visits. Progress toward compliance is rarely linear, and it seldom follows the MOA stipulations sequentially. Instead, the initial stages of monitoring often focus on those issues that reflect administration's current program or policy

development concerns, as was reflected in the first letter about ongoing access to a qualified mental health professional for youth that staff identified as needing a safety or suicide assessment. Once critical life safety issues receive attention (and the DSB suicide prevention data compare favorably with generally accepted professional practices), monitoring often spends more time during an on-site on a limited number of Section C issues as opposed to an even distribution of time on all paragraphs. For example, this monitoring visit spent more time on physical restraints. This approach can be beneficial when it allows DSB to identify in advance of the monitoring visit those issues that are ready for careful scrutiny and approval while delaying the same level of scrutiny on those paragraphs where DSB has more work to do.

F. Staff Interviews

I interviewed 11 JCMSC, DSB, and Correct Care Solutions (CCS) staff.

G. Resident Interviews

I interviewed three (3) youth, and they occurred in a room across from the control office on the living unit. The next site visit will include time for additional resident interviews.

H. Exit Interview

The exit meeting occurred on November 7, 2013 in the Judge's conference room. Those in attendance included: Gary Cummings, DSB Administrator; Winsome Gayle, DOJ Attorney; Anika Gzifa, DOJ Trial Attorney; William Kissel, CCS Regional Vice President; Herbert Lane, Chief Legal Officer; Jerry Maness, Director of Court Services; Dr. Sidney Ornduf, CSC Director; Bill Powell, MOA Settlement Coordinator; Sandra Price, RN, CCS Health Services Administrator; Larry Scroggs, Chief Administrative Officer; Robert Stanley, DSB Deputy Administrator; Dr. Sara Vardell CCS Behavioral Health Manager; Willie Walton, DSB; and Linda Williams, CCS Qualified Mental Health Provider (QMHP). I highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before issuing the report letter.

I. Compliance Logic

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

1. The MOA provides the language of compliance, so we will identify and define the key requirements in each of the Protection from Harm paragraphs. JCMSC and DSB should provide an initial list of the key requirements for determining the final list of key requirements.

2. Where appropriate and necessary, JCMSC and DSB will develop new or modify existing policy and procedure that address the key requirements. The policy statements will answer the questions of "what" and "why." Linked to the vision and mission statements, policy statements will explain what will be done in a specific key requirement area. They will also explain to staff and all other readers the purpose of the policy.

Procedure statements will answer the "how" questions, explaining in some instances the step-by-step actions required to enact the policy statement. The "how" questions also include

explanations of "who," "what" (not to be confused with the "what" above, this what is a behaviorally specific description of staff actions under the procedure), "when," and "where."

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

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

II. Protection from Harm: Detention Facility

This is the second on-site visit, and the logistics and the need to reschedule the original October 7-10 visit due to the government shutdown constrained the assessment activities somewhat. For future consideration, on-site monitoring visits should be 2.5-3 days in duration.

Some of the remedies have progressed more than others, and some information supporting compliance is more fully developed than others. Given these circumstances, many remedy comments contain partial compliance evaluations but, hopefully, provide useful guidance and recommendations about achieving compliance.

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: Compliance

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

The Juvenile Court Strategic Plan for DOJ Remedial Measures, revised June 6, 2012, contains information relevant to the MOA. Regarding the restraint chair, an order from Judge Person on April 26, 2012 instructed DSB staff to remove the restraint chairs from detention. A January 17, 2013 memo documented the removal of the restraint chairs and a prohibition against pressure point tactics. An appendix to the Compliance Report contains the Judge's letter, the aforementioned memo, and a form dated May 10, 2013 which detention staff were required to sign acknowledging the prohibition against pressure point tactics.

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: As referenced above, DSB now has a data collection system that allows it to review and analyze the methods that staff views to control youth who pose a danger to themselves and others. Furthermore, the analyses of uses of force are beginning to identify those methods that comply with this agreement. The system is still too new and the reviews are continually improving such that continued expansions and improvements in the data analyses should lead to compliance.

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

FUTURE MONITORING:

Future monitoring will include monthly telephone meetings with DSB administration and the Powell to review these data analyses.

The DAT override memo seems to indicate that some youth have been detained because they did not have someone to pick them up. Continued monitoring will also focus on the use of electronic bracelets as a preferred option for low scoring youth where some level of monitoring is deemed necessary.

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

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

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

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

(iv) Require the prompt and thorough documentation and reporting of all incidents, including allegations of abuse, uses of force, staff misconduct, sexual misconduct

between children, child on child violence, and other incidents at the discretion of the Administrator, or his/her designee;

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

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

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

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

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

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

RECOMMENDED FINDING: Partial Compliance

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

From the perspective of the MOA, my interpretation is that the policy should be more positive, proactive, and youth-focused. In this regard, the policy required some modification regarding word choice and youth orientation. A substantial amount of time was spent with DSB administration on a line-by-line review of the use of force policy. The review generated consensus on alternative uses of language to expand and incorporate Positive Youth Development principles without altering the goals or staff expectations for effective and appropriate uses of force.

These modifications to the wording of the use of force policy have yet to receive JCMSC approval. Furthermore, the incorporation of the new wording into new and veteran staff training cannot occur until JCMSC approval has been secured. Copies of the approved use of force policy should be disseminated to DOJ and me for review.

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

1. Regarding staff uses of the least amount of force appropriate, the policy states in several places that the amount of force permissible is only the minimum amount necessary.

2. Regarding the use of unapproved forms of physical restraint and seclusion, the policy outlines unapproved techniques and specifically prohibits restraint and seclusion uses as punishment. The issue of seclusion requires additional monitoring. Future monitoring will include a review of seclusion related to use of force incidents.

3. Regarding those circumstances where the youth poses an immediate danger and less restrictive means have been properly, but unsuccessfully, attempted, there is a clear statement in the policy. Yet, what is missing is sufficient and compelling evidence that the circumstances for which physical restraints are used represent the immediate danger expressed in MOA. This concern will be explained further in the discussion of the "spontaneous designation" below.

4. Regarding prompt and thorough documentation and reporting, there is a statement in the policy.

5. Regarding the attempted, and exhausted hierarchy of pro-active non-physical alternatives, there is a clear statement in the policy, even though this aspect will require additional work through the use of force review process in order to identify the presence of the hierarchy in the documentation and video reviews.

6. Regarding the documentation of attempts at non-physical alternatives in a youth's file, there is a clear statement in the policy. Incident Statement JC-142B should include a list of the nonphysical alternatives, and this form goes in the youth's file.

7. Regarding staff accountability for excessive and unpermitted force, there is a clear statement in the policy.

8. Regarding the immediate medical evaluation, there is a clear statement in the policy. See the information below confirming the presence of the post restraint medical evaluation in the 13 files reviewed as a part of this monitoring visit.

9. Regarding mandatory reporting of all child abuse in accordance with Tenn. Code. Ann. § 37-1-403, there is a clear statement in the policy.

10. Regarding the formal review of all uses of force and allegations of abuse to determine whether staff acted appropriately, there is a clear statement in the policy.

What is missing is sufficient and compelling evidence that staff understand the policy; however, and assessment of this understanding must wait until the revised policy has been approved and implemented through training.

FUTURE MONITORING:

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

(d) Each month, the Administrator, or his or her designee, shall review all incidents involving force to ensure that all uses of force and reports on uses of force were done in accordance with this Agreement. The Administrator shall also ensure that appropriate disciplinary action is initiated against any staff member who fails to comply with the use of force policy. The Administrator or designee shall identify any training needs and debrief staff on how to avoid similar incidents through de-escalation. The Administrator shall also discuss the

wrongful conduct with the staff and the appropriate response that was required in the circumstance. To satisfy the terms of this provision, the Administrator, or his or her designee, shall be fully trained in use of force. (See MOA page 29)

RECOMMENDED FINDING: Partial Compliance

COMMENT: The Compliance Report refers to three (3) documents, two (2) spreadsheets of information compiled on the use of force and an analysis of these uses of force events. These documents and their analysis will be discussed in detail under the Performance Metrics section.

File reviews were conducted on 13 of the 17 physical restraint incidents for October. Incidents Reports (JC-142B) were in the files, and the quality of the documentation was acceptable. One of the DSB forms asks staff to classify the reason for the use of physical force. One option is that the youth's behaviors created a spontaneous and imminent danger to safety, which justified the use of physical force. 13 of the 13 files were designated as "spontaneous."

Concerns exist with the "spontaneous" designation. For example, if administration automatically approves the "spontaneous" designation during a restraint review, then staff members are exempt from documenting and demonstrating the use of de-escalation strategies and techniques. Stated differently, beginning the documentation of a restraint event at the point of the "spontaneous" designation does not account for the antecedent events that more than likely contributed to the "spontaneous" outburst of dangerous behaviors; therefore, the exploration of various options by staff to have intervened earlier and, perhaps, averted a restraint does not routinely occur. Based on the "spontaneous" designation phenomenon, the recommendation for the Administrative Review of restraints was to evaluate the video 10-15 minutes before the initiation of the restraint.

A common problem in the review and analysis of a restraint event is the assumption that a restraint is only involved with the use of physical force. Whereas, the word "restraint" means to constrain or reserve feelings and behaviors (in this instance both); holding back, controlling, or checking; along with the implementation of a state of restraint that deprives liberty or involves confinement. Most facilities do not routinely consider a restraint as a continuum of actions on the part of staff to change and reduce the threat of danger and to help the youth restore emotional regulation. In part, the emphasis on de-escalation as a verbal or nonphysical precursor to physical intervention is based on a better and more expansive classification of violence or danger. An excellent resource on this concept is Chicago-based community psychiatrist Carl Bell. Through his violence reduction efforts in the public schools, the local communities, and the juvenile justice system, Dr. Bell teaches youth and adults to recognize and respond to three different expressions of violence: 1) potential violence where circumstances and environmental factors are conducive to violence, 2) impending violence where participants' behaviors indicate that violence could occur soon, and 3) emergent or imminent violence where aggressive or dangerous behaviors are occurring and demand an immediate response from staff (a "spontaneous" designation). If the analysis of the interventions only includes emergent or imminent danger without considerations of potential and impending dangers, then the opportunities for de-escalation will be substantially diminished; and the skills of staff to respond in such a way that restraints are avoided will not be adequately developed.

Similar to the development of data collection and performance metrics, the existence of an administrative review of use of force incidents is another mark of substantial progress towards

compliance. While there is more to accomplish and monitor regarding the administrative review, several observations are noteworthy:

1. Regarding the administrative review, a restraint review process exists; and it provides the first level of quality assurance regarding the use of physical restraints. Only one video was reviewed due to an insufficient amount of time, so a more thorough review will occur on the next visit.

2. Regarding the administrative assurance of appropriate disciplinary action, there was some mixed response encountered during the monitoring visit. While the documentation of substantial but appropriate disciplinary action occurred for a supervisory staff member, there were indications of two (2) instances in the use of force monthly summary where staff did not follow policy and procedure; and verification of disciplinary action for these instances did not occur. Future monitoring will address this issue.

3. Regarding the administrative review identification of any training needs, future monitoring will spend more time identifying the training needs that emerge from the administrative review and verify a training or coaching follow-up activity. For this part of the stipulation and number 4 below, see the discussion in the Performance Metrics section below about the need for an analysis of the inappropriate uses of force.

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

5. Regarding the training of administrative staff in use of force, DSB administration indicated that not all administrative staff had been fully trained in the use of force technique.

FUTURE MONITORING:

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

2. Suicide Prevention

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

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

behavior by family members and/or close friends; and suicidal issues or mental health diagnosis during any prior confinement.

(ii) Procedures for initiating and terminating precautions;

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

(iv) Suicide risk assessment by the QMHP;

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

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

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

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

(ix) Requirements for mortality and morbidity review; and

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

RECOMMENDED FINDING: Partial Compliance

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

Several factors are noteworthy regarding Powell's assessment. First, the policies are improved. Second, the data (which will be discussed in greater detail later) provide another indicator that suicide prevention has substantially improved. Third, the involvement of CCS as the contracted health and mental health provider seems to be a substantial contributor to these improvements.

The monitoring visit included a meeting with Mr. William Kissel the CCS Regional Vice President for Jail Operations, the division that provides the contracted services to DSB. The meeting was very productive, and CCS appeared quite capable of meeting the needs of the suicide prevention and post-restraint medical follow-up remedies of the MOA. In particular, there was impressive that Kissel was a Certified Correctional Health Professional (CCHP) through the National Commission on Correctional Health Care (NCCHC) and a member of the Academy of Certified Health Professionals. While not required under the MOA, reliance on NCCHC standards is a valuable asset.

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

Regarding the CCS 24/7 nursing services, a review of the 13 restraint files revealed that the nursing staff did a careful examination of each youth following the physical restraint.

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

Since the monitoring visit, CCS replaced this QMHP. According to information provided by DSB administration, a replacement QMHP provides the same services. This monitoring visit looked at the quantity and quality of the QMHP function, an assessment in the delivery of treatment services that is a function of the skill set of the individual, so the replacement of the first QMHP will require the next monitoring visit to include a similar review of the new QMHP's performance of these responsibilities.

There are advantages and disadvantages to any contract for services; and because turnover of key staff is common among all agencies, a common assumption is that staff turnover should not necessarily be a variable in compliance determinations. The concern here is the presence of a settlement agreement with the US Department of Justice, which, from the perspectives of Protection from Harm, creates increased scrutiny on the quality of services during changes in staffing. Despite the newness of the contract, there appears to be mutual agreement that the expectation is to establish and sustain an acceptable level of services even during times of staff turnover. The key is the continuity of care. While CCS has a very positive reputation and will very likely provide services at DSB in excess of those required by the MOA, this is the first monitoring visit with CCS and sustained quality of care has not yet been established. Furthermore, successful experiences with contracted health services for adult inmates do not automatically equate to the same level of success with children and adolescents. Therefore, at this initial stage of the monitoring of CCS services, due diligence requires another assessment of the replacement QMHP until CCS demonstrates at DSB a sustainable continuity of care following the replacement of a key service provider.

The recent change in the critical QMHP position further suggests the need for a contract monitor. The JCMSC should consider the appointment of a CCS contract monitor who is not employed at DSB.

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

1. Regarding the intake screening, information collection forms are appropriate and address those areas identified in the agreement. Despite a superficial review of these factors, several issues remain unanswered. There was no opportunity to observe an actual screening event to ensure that the activity occurred according to the agreement.

2. Regarding the procedures for initiating and terminating precautions, there was evidence in the youth files of both the initiation and termination of precautions consistent with the expectations and the policy and the MOA.

3. Regarding the communication between direct care and mental health staff, there is a need for additional monitoring in this area. While the evaluations of this element revealed a working level of information exchange, it was a biased sample that included only those

who were responsible for the information sharing. Missing is information representative of a daily practice reflective of good communications between direct care and mental health staff from the perspective of staff at different levels.

4. Regarding the suicide risk assessment by the QMHP, the information provided during the monitoring visit indicated that the existing QMHP conducted a competent suicide risk assessment. The change in personnel will require a revisiting of this stipulation

5. Regarding the housing and supervision requirements, the policy addresses this subject; but the monitoring visit did not assess its implementation. Comment here is pending and will be the focus of future monitoring. Missing is a review of the practice to verify that the requirement is being implemented in compliance with the MOA.

6. Regarding the interdisciplinary reviews, the policy addresses this subject; but the monitoring visit did not assess its implementation. Missing is a review of the practice to verify that the requirement is being implemented in compliance with the MOA.

7. Regarding the multiple levels of precautions, the policy addresses this subject; but the monitoring visit did not assess its implementation. Missing is a review of the practice to verify that the requirement is being implemented in compliance with the MOA.

8. Regarding the annual in-service training, the policy addresses this subject; but the monitoring visit did not assess its implementation. Missing is a review of the practice to verify that the requirement is being implemented in compliance with the MOA.

9. Regarding the mortality and morbidity review, the policy addresses this subject; but the monitoring visit did not assess its implementation. Missing is a review of the practice to verify that the requirement is being implemented in compliance with the MOA.

10. Regarding the regular assessment of the physical plant, the policy addresses this subject; but the monitoring visit did not assess its implementation. Missing is a review of the practice to verify that the requirement is being implemented in compliance with the MOA.

FUTURE MONITORING:

Future monitoring will include an ongoing review of the policy and procedure; an observation of key individuals conducting a confidential intake screening; ongoing review of CCS suicide prevention services; more focused reviews of communication between direct care and mental health staff, housing and supervision requirements, multiple levels of precautions, interdisciplinary reviews, mortality and morbidity reviews and regular assessments of the physical plant; and a review of the Performance Metrics regarding how much and how well the suicide prevention elements have been implemented.

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

RECOMMENDED FINDING: Compliance

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

FUTURE MONITORING:

Future monitoring will 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: Partial Compliance

COMMENT: There was not enough time to conduct an extensive document review of the DSB response to youth expressing suicidal intent, but a file review was conducted on two youth who identified suicidal issues at intake and admissions, specifically looking at the QMHP notes and entries. The services provided complied with the MOA. This monitoring visit looked at the quantity and quality of the QMHP function, so the presence of a new QMHP will require the next monitoring visit to repeat the current review of the new individual's performance of these responsibilities.

FUTURE MONITORING:

Future monitoring will 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 a file review 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: Recommendation Pending

COMMENT: The assessment of this paragraph was limited by the decision to address other issues during the time available for monitoring on this visit. The issues expressed in the MOA are present in the DSB policy. One recommendation was that DSB work to comply with PbS Health 4 Standard: Suicide Screening within an Hour of Admission.

Concerns existed about the expectation that DSB staff conduct a suicide screening within one hour of a youths admission to the attention. Problems have occurred in achieving this goal because DSB administration interpreted the "one hour within the time of admission" to be the time between the youth's arrival at intake (the taking of custody by DSB) and the decision and transfer of the youth upstairs. In most cases, this was more than an hour after the youth was delivered to intake. The strategy following this monitoring visit will be to conduct the screen in intake within the first hour. If the youth is not admitted, any concerns about suicide issues can be identified, properly monitored while the youth is in the intake area, and referred to the probation officer and/or community-based QMHP for follow-up.

There was an informal working agreement about the status of youth in intake. While they have not been counted as an admission because they have not been formally processed (a decision has not been made to detain) and they have not been physically escorted upstairs to

detention, nonetheless DSB has custody; and these intake youth are not allowed to leave the building, which means they are detained. Therefore, all of the MOA requirements should apply to youth in intake.

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: This is another area of Section C that was limited by the decision to address other issues in the time available for the monitoring visit. The issues expressed in the MOA are present in the DSB policy, but there were unsubstantiated allegations during the latter part of the monitoring visit that youth on suicide watch have been placed on varying types of isolation. There was no investigation of the routine use of isolation based on time constraints and the timing of the allegation. Further review is required to assess this provision.

FUTURE MONITORING:

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

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

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

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

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

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

(v) Following each daily assessment, a QMHP shall provide direct care staff with relevant information regarding a Child on suicide precautions that affects the direct care staff's duties and responsibilities for supervising Children, including at least: known sources of

stress for the potentially suicidal Children; the specific risks posed; and coping mechanisms or activities that may mitigate the risk of harm. (See MOA pages 30-31)

RECOMMENDED FINDING: Partial Compliance

COMMENT: The assessment of this paragraph was limited by the decision to address other issues during the time available for monitoring on this visit. The issues expressed in the MOA are present in the DSB policy, but not all of the requirements of this paragraph were subject to scrutiny and evaluation during this visit. Comments and observations about those aspects that received some review are outlined below:

1. Regarding the QMHP evaluation within two hours, a file review was conducted on the two youth who identified suicidal issues that intake and admissions, specifically looking at the QMHP notes and entries to determine the time of the evaluation. The documentation complied with the MOA. This monitoring visit looked at the quantity and quality of the QMHP function, so the presence of a new QMHP will require the next monitoring visit to repeat the current review of the new individual's performance of these responsibilities.

2. Regarding the extent of the risk of suicide, the file review of the two youth produced QMHP notes and entries describing the extent of the suicide risk and suggesting regular monitoring. The documentation complied with the MOA. This monitoring visit looked at the quantity and quality of the QMHP function, so the presence of a new QMHP will require the next monitoring visit to repeat the current review of the new individual's performance of these responsibilities. Under this Subsection, the writing of appropriate orders and regular monitoring is where Lindsay Hayes' recommendation for the development of an Individualized Treatment Plan (ITP) attaches to the MOA. Future monitoring will also address the ITP.

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

4. Regarding the changes to a youth's suicide precaution level or status, the file review of the two youth produced QMHP notes and entries clearly indicating that the authority to change a youth's status was the purview of the QMHP. The documentation complied with the MOA. As mentioned above, the next monitoring visit will repeat the current review of the new QMHP staff member regarding these responsibilities.

5. Regarding the QMHP providing direct care staff with relevant information, assessment of this paragraph was limited by the decision to address other issues during the time available for the monitoring visit.

   As noted previously, the Shield of Care training does not do an adequate job of addressing these three issues: known sources of stress for the potentially suicidal youth, the specific risks posed, and coping mechanisms or activities that may mitigate the risk of harm. The CCS psychologist has addressed this concern, and elements of a revised

procedure have been developed. Future monitoring visits will assess the improvement to information sharing.

FUTURE MONITORING:

Future monitoring visit will repeat of the current review for the new QMHP staff member regarding the responsibilities 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: Partial Compliance

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

FUTURE MONITORING:

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

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

RECOMMENDED FINDING: Recommendation Pending

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

FUTURE MONITORING:

Future monitoring will 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: Recommendation Pending

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

FUTURE MONITORING:

Future monitoring will include a review of the data, including the performance metric, which ensures that the documentation or record keeping has been completed in a timely fashion. Discussions have begun about an expanded management information system, including the delineation of categories of incident data that include but move beyond the suicide attempt and ideations requirements of this paragraph. The intent is to rebuild the management information system in such a way that it is consistent with selected standards from the Performance-based Standards Project (PbS).

(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 Compliance Report indicated that while the current information system needs some improvements it represents "a huge leap forward" in the ability of DSB administration to understand and analyze critical incidents. The critical incident review policy is important because it provides a structured way to review important decisions surrounding critical incidents, including a framework for identifying and replicating appropriate and positive staff behaviors. The Compliance Report accurately identifies the potential of the self-harm data as a powerful management tool. Compliance is near; needed is a sufficient number of administrative reviews to generate sufficient confidence in the process to warrant full compliance.

See the comments below about the Performance Metrics.

FUTURE MONITORING:

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

3. Training

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

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

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

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

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

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

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

RECOMMENDED FINDING: Partial Compliance

COMMENT: The assessment of this paragraph was limited by the decision to address other issues during the time available for monitoring on this visit. The issues expressed in the MOA are present in the DSB policy; however, there was insufficient time available to verify the content and quality of the training. The monitoring included time to review training records and to discuss different training topics and curricula, so the following comments do not reflect primary source information. While the review of staff training records did provide a picture of the quantity of training that occurs, future monitoring will need to focus on the quality aspects of the training, specifically how staff apply the training in their daily routine.

The review of staff training records yielded the following observations:

1. Regarding the use of force curriculum, there was no assessment of the curriculum and its relevance to the MOA; and an evaluation of this nature is not included in the MOA. A random selection of five (5) Detention Officer training records for 2013 indicated that all have had the 16-hour CPI use of force training.

During the review, a DSB administrator expressed sensitivity to providing staff with a restraint strategy (and training for skill development in that strategy) that is comprehensive and safe. During a video review, administration raised a question about a perceived inadequacy of the current restraint training by Crisis Prevention Institute (CPI) regarding circumstances when staff need to take a youth to the floor. Administration noted that CPI does not train staff on such a technique, so staff members are permitted to use their own particular type of takedown maneuver. Administration expressed concerns that the current situation represents too little control over staff actions that have the potential for injury to youth and staff. As long as DSB uses some form of a sitting, supine, or prone restraint, a better way to move the youth to the floor is needed to increase the safety to youth and staff. Nothing in the MOA suggests a DOJ involvement in the selection, qualifications, or assessment of restraint approaches, but there is enough concern about youth and staff safety to support a recommendation that the JCMSC

reevaluate the capacity of the current provider to respond to this type of training and skill development.

Suicide Prevention Training

1. Regarding the description of the environmental risk factors for suicide, individually predisposing factors, high risk periods for incarcerated youth, warning signs and symptoms, known sources of stress to potentially suicidal youth, the specific risks posed, and coping mechanisms or activities that may help to mitigate the risk of harm, the CCS psychologist addressed this concern; and elements for a revised training curriculum have been developed. Future monitoring visits will assess the improvement to information sharing as a result of the new training.

2. Regarding the discussion of the Facility's suicide prevention procedures, liability issues, recent suicide attempts at the Facility, searches of youth who are placed on suicide precautions, the proper evaluation of intake screening forms for signs of suicidal ideation, and any institutional barrier that might render suicide prevention ineffective, the review of the five (5) Detention Officer training records for 2013 indicated that all had the required suicide prevention training.

CCS indicated its plan to evaluate the suicide prevention curriculum developed by the National Center on Institutions and Alternatives' (NCIA) Lindsay Hayes. Because Hayes is viewed as the authority on suicide prevention, because he is a consultant with the JCMSC, and because DOJ uses his perspectives as the generally accepted professional standard on suicide prevention, the adoption of the NCIA suicide prevention curriculum would have the support of the PH Consultant. The recommendation would be that the curriculum be implemented if CCS deemed it appropriate.

3. Regarding the mock demonstrations, a video exists of a mock demonstration; however, the review of this video did not occur because of lack of time.

4. Regarding the certification in CPR and first aid of all detention staff, the review of the five (5) Detention Officer training records for 2013 indicated that all were current in CPR and first aid training.

FUTURE MONITORING:

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

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

4. Performance Metrics for Protection from Harm

(a) In order to ensure that JCMSC's protection from harm reforms are conducted in accordance with the Constitution, JCMSC's progress in implementing these provisions and the

effectiveness of these reforms shall be assessed by the Facility Consultant on a semi-annual basis during the term of this Agreement. In addition to assessing the JCMSC's procedures, practices, and training, the Facility Consultant shall analyze the following metrics related to protection from harm reforms:

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

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

RECOMMENDED FINDING: Partial Compliance

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

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

1. Regarding the monthly reviews of use of force reports, the monthly data spreadsheets include frequencies and rates on use of force, seclusion, documentation and recording, the hierarchy of nonphysical alternatives, documentation of nonphysical alternatives, and medical evaluations. Supplemental information includes information from the PbS Standards for Safety, Order, and Health. These 13 standards provide definitions for youth and staff behaviors that are important to the protection from harm elements of the MOA. Several concerns need to be addressed regarding the monthly use of force reports:

   The current system does not address the identification, classification, and correction of any wrongful conduct uncovered in the review of the data. This information is important to continuous quality improvement by identifying patterns and other variables that can be instructive to administration and staff regarding improper uses of force. This information is currently collected, and it needs to be reported through the existing MOA Performance Metrics system.

   There are data collection and reporting challenges with several of the PbS standards that need to be resolved. These include an accurate assessment and reporting of Safety 13 (percent of youth who report that they fear for their safety), Safety 14 (percent of staff who report that they fear for their safety), Order 9 (average duration of isolation and room confinement and segregation/special management unit in hours).

   The narrative analysis of the monthly data should include a more representative group of detention staff if, as reported, the analysis is done only by DSB administrators. The best analyses of the data result from the input of multiple perspectives, so it is worth considering the responses of supervisors, intake workers, detention officers, teachers, nurses, and QMHPs. This is not to imply that there should be another series of meetings regarding use of force data, but DSB would do well to consider a short, multidisciplinary

discussion of the implications in the data. In other words, a response is needed from multiple sectors to the question, "What do these numbers mean?"

Data integrity is an ongoing concern. Do the numbers reflect accurately the behaviors that have occurred over the past month? There are multiple ways to approach data integrity, some more complicated than others. However, the first validation of the numbers comes from sharing them with multiple staff from varying perspectives. Second, a validation study can be conducted where an individual takes one or more of the data categories and searches files, logs, incident reports, youth and staff interviews, and other agency documentation to verify that the number of events in the documentation and inquiry equal the number reported in the data. Consistent with the procedures of the American Correctional Association, most agencies conduct these types of quality assurance activities themselves, using skilled facility staff or staff from allied agencies to conduct the validation study. JCMSC should consider a request of Powell to conduct a preliminary validation of the data, provided his contract allows this level of additional activity.

2. Regarding the effectiveness of the suicide prevention plan, the monthly data include suicide prevention information broken down according to the total number of Mobile Crisis calls, the number of youth on suicide precautions, the average time on suicide precaution (in hours), and an accounting of the amount of time on the admission screening and responses by Mobile Crisis. Additionally, the monthly data include rates for the PbS standards Safety 6 (suicidal behavior with injury) and Safety 7 (suicidal behavior without injury), and Health 4 (percent of youth presented for admissions that had a suicide prevention screening completed by trained or qualified staff in one hour or less).

   Missing from the Performance Metrics are data on the Para. 4, a, ii specified data collection categories related to the review of the effectiveness of the suicide prevention plans. For example, a representative sampling of files to reflect those youth placed on suicide precautions, the basis for such placement, the type of precautions taken, and whether the youth was evaluated by a QMHP. Additionally, these behaviors are not summarized in the monthly narrative.

   As stated above, the analysis of the monthly suicide prevention plan data should include a larger and more representative group of staff. The sharing of this information with CCS is important, and an exchange of information can be an important first step in the validation of numbers said CCS will keep its own statistics. Similarly, the above recommendations for validation apply to the suicide prevention metrics.

A final recommendation applies to both the use of force and the suicide prevention plan data, which is the use of the data to initiate discussions with staff about individual and shift level job performance. For example, Detention Officers probably do not know that the DSB rate of suicidal behaviors without injury to youth is at or below the PbS Field Average, meaning that the current level of suicide prevention is as effective as many of the better operated juvenile detention facilities nationally. Starting a discussion with staff about the strengths identified by the numbers can lead to meaningful and thoughtful discussions about other rates, such as Safety 11 (assaults on youth) where the DSB rate is almost twice the PbS Field Average. The numbers provide for internal comparisons and external points of reference to expand continuous quality

improvements and program development. However, they need to be a focus of discussion among all staff.

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

RECOMMENDED FINDING: Compliance

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

II. SUMMARY AND RECOMMENDATONS

There has been a great effort by staff to make the changes necessary in response to Section C of the MOA.

There has been an improved quality in the policies and procedures. This is a particular reference to the suicide policy. Regarding the use of force policy, some modifications were made in it. For both of the policies, the critical issue is the practice or evidence that staff are doing their jobs in a manner consistent with the policy and procedure.

Recommendation: Section C of the MOA requires policy, procedure, and practice related changes that have implications to the PREA standards. It would be helpful if JCMSC identified a PREA coordinator for DSB and the MOA.

Recommendation: As a part of the JCMSC involvement with the Juvenile Detention Alternatives Initiative (JDAI), a conditions of confinement assessment will occur at DSB after the new year, perhaps January, using the JDAI Juvenile Detention Self-Assessment Standards. The report of findings will become one of the necessary documents for future monitoring review as specified in Paragraph 4, b above. There has been no communication between the JDAI Coordinator Ken Scroggs and me regarding the relationship between the goals and objectives of the JDAI Self-Assessment and current DSB initiatives to comply with the MOA. There should be a conversation between Ken Scroggs and me (and DOJ attorneys, if necessary) before the self-assessment review.

Recommendation: Discussions with administration and line staff suggest that a contributor to the high levels of youth-on-youth assaults and physical restraints is staffing adequacy challenges. As a part of the Section C Protection from Harm improvements to programs and practices, a comprehensive staffing analysis would be beneficial.

Recommendation: There should be regularly scheduled telephone conferences with the Protection from Harm Consultant, DSB leadership, the JCMSC supervisor of DSB, and Bill Powell. For the record, the first of these telephone calls occurred on December 5, 2013. The next call is scheduled for January 9, 2014.

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

Sincerely,

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