M. T., et al, v. Forrest County Mississippi

Monitoring Compliance Report:

Draft Date: October 13, 2012

Report Date: November 9, 2012

Submitted by:

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INTRODUCTION:

"On April 20, 2011, Plaintiffs filed suit challenging the conditions of confinement at the Forrest County Juvenile Detention Center. Plaintiffs and the Defendant, without any admission on behalf of either," (See Agreed Order) agreed that it was in the best interest of all parties to resolve the matter amicably without further litigation and cost to the taxpayers of Forrest County, Mississippi. On October 12, 2011 at Agreed Order was signed by Judge Keith Starrett in the United States District Court for the Southern District of Mississippi, Hattiesburg Division, elucidating the provisions of that Agreed Order. That Agreed Order requires that the "Defendant shall contract with an independent monitor who will be responsible for documenting the Defendant's compliance with the terms of this agreement and for providing and/or arranging technical assistance and training regarding compliance with this Agreed Order." The parties were to attempt to mutually agree on the selection of an independent monitor.

The parties were unable to reach an agreement regarding the selection of an independent monitor in this case. On March 6, 2012 a hearing was held before Judge Starrett at which testimony was taken and statements were presented by both parties. Judge Starrett selected me, Anne M. Nelsen, as independent monitor in this matter at that time.

The Agreed Order requires the monitor to "file with the Court and provide the parties with reports describing the Defendant's steps to implement this Agreed Order and evaluate the extent to which the Defendant has complied with each substantive provision of this agreement. Such reports shall be issued quarterly, unless the parties agree otherwise. The reports shall be provided to the parties in draft form for comment at least two (2) weeks prior to their submission to the Court." I made quarterly, on-site, monitoring visits to the Forrest County Juvenile Detention Center (FCJDC) on March 27-30 and June 26-29, 2012 and reports were submitted to the Court and to the parties subsequent to those visits. My third monitoring visit was made to the FCJDC September 25-28, 2012. This report describes my assessment of compliance with the Agreed Order, to that date, based on my site visit, interviews, and review of documents and videos.

The staff of the FCJDC, and the key management employees responsible for its operation, were again welcoming and open during my visit. I was given unlimited access to the facility and to staff and youth detained. I was able to be present at the facility during both day shifts (6:00 a.m. to 6:00 p.m.) and night shifts (6:00 p.m. to 6:00 a.m.) I did submit a written request for documents one month prior to my visit and asked that those documents be sent to me as they were available. The facility attempted to fax several hundred pages to me a few days before my visit but the large volume made that fax transmission unworkable. Those documents were available upon my arrival at the FCJDC on September 25. Further, although I have made repeated requests over the past months for the FCJDC administration to send copies of any new or revised policies and procedures to me in draft form, that has not occurred. The new Assistant Director was unaware of that

request and only emailed newly drafted policies and procedures and proposed job descriptions the day before my visit. The importance of my reviewing proposed policies was made clear when, during my June 2012 site visit, I was provided with two new policies and procedures that were inappropriate in a juvenile detention center and that failed to meet requirements of the Agreed Order. The failure of the FCJDC to provide requested documents, even though I have made such requests several weeks before each visit, limits my ability to fully prepare for my site visits and results in less efficient use of my time while there. Hopefully, the current administration will be able to address this recurring problem in the future and my future visits will not include the same frustration.

The FCJDC has provided an "Implementation Report" after each of my last two visits. That report was provided to the court as well. Unfortunately, each time I received that report on the final day of my site visit. Those reports have each contained information that has proven to be inaccurate, based on my review of documentation, interviews and direct observations. However, unless I receive the FCJDC "Implementation Report" prior to my visit, I am limited in my ability to use that information to verify or refute information contained therein. My time on site is, therefore, not used as efficiently as it could be and the time required to prepare my Quarterly Reports to the court is lengthened.

It is my impression that poor communication between and among the FCJDC staff and administration has been and continues to be problematic and results in persistent non-compliance with the terms of the Agreed Order. Much of that ineffective communication may have resulted from the repeated changes in administrations, the lack of a staff training program and the absence of an up-to-date, usable policy and procedure manual. Also, there has been a different Director and Assistant Director at each of my three visits and there does not appear to have been enough, if any, sharing of information between each of those teams of administrators regarding my comments, suggestions and recommendations. The FCJDC is one year into the Agreed Order and is significantly behind schedule in achieving implementation. I have been assured that the current administration will remain in place and is committed to achieving compliance with the Agreed Order and I can only hope that is the case. However, I have copied several representatives from both sides of the litigation in most of my electronic communication in order to ensure that my requests are addressed and that my technical assistance is made available to the pertinent individuals, regardless of who key staff members are at the FCJDC at the time. It seems that my correspondence is always not being shared and that has resulted in the FCJDC being further behind in achieving compliance than they should or could be. My April and July Monitoring Reports could have served as a guide to the FCJDC in achieving compliance with the Agreed Order. That said, those reports have not been shared with all parties responsible for implementation and the recommendations contained therein have not been attended to.

As has been the case in previous reports, my assessment of compliance will be based on a number of factors including interviews with youth and staff and through my direct observation. However, I will continue to emphasize the importance of documentation to better ensure that practices are institutionalized at the FCJDC and not merely occasional

occurrences. That documentation includes written expectations such as policies and procedures and job descriptions, verification of staff training, as well as documentation of actual practice such as examples of forms completed by staff to verify required practices. When that documentation does not yet exist, I will again offer recommendations or suggestions for developing that paper trail and I continue to be available to offer technical assistance in doing so as well. The FCJDC management has verbalized their good faith and commitment to compliance and has shown initiative and effort. However, the communication difficulties discussed above have resulted in work that will need to be redone or revised, including policies and forms that were not provided to me in draft, as requested. I again ask that the FCJDC share proposed policies and procedures and forms while they are in the process of being developed in order for me to offer guidance and technical assistance and to avoid the need to make continual revisions, other than those that would normally occur to ensure continued usefulness.

As indicated above, the FCJDC has replaced the facility's administration since my last visit. The new administrative staff members expressed their strong desire to work with me and to successfully achieve compliance with the terms of the Agreed Order. To achieve compliance with the Agreed Order, it will be important to have constancy in staffing, both administrative and line level, at the FCJDC. In addition to the Director and Assistant Director, there are a number of line staff members who are new and who lack training. It is critical to compliance to have all staff trained on the Agreed Order, on job expectations, on FCJDC policies and procedures, on life safety requirements and on juvenile justice best practice, at a minimum. Further, staff training is essential to ensuring the safety and security of youth and staff. Those staff members at the FCJDC who do have some training often were allowed to wait an unacceptably long time for that to occur. It is hoped that more stability in staffing will enable Forrest County to ensure that employees at the FCJDC are adequately trained in the future.

The FCJDC has made some limited progress on a number of the provisions in the Agreed Order. However, there are major areas of that Order, which were addressed in both my May and July 2012 Quarterly Monitoring Reports as well as in the April 2012 Monitoring Plan submitted to the Court, where little or no headway has occurred. In fact, there are three provisions of the Agreed Order where the FCJDC has regressed. Ratings have declined in provisions 2.1, 2.4 and 15.3. To have achieved so little movement at this point in the monitoring period is concerning.

I have repeatedly advised the FCJDC, both verbally during site visits and in writing in my reports and email correspondence, that compliance with the Agreed Order cannot be achieved until major tasks are accomplished, including a new or revised, policy and procedure manual, detailed, written job descriptions, and a comprehensive, juvenile justice focused staff training program. To date, little progress has been made in those areas. It is hoped that the FCJDC will place increased emphasis on those larger challenges. Failure to do so will preclude compliance with other, related provisions and will impede achieving compliance with the overall Agreed Order.

EVIDENTIARY BASIS OF FINDINGS:

On-site visit to Forrest County Juvenile Detention Center September 25-28, 2012

Interviews Conducted (staff):

- Chief Charles Bolton
- Administrative Assistant Sandi Carter
- Lakeisha Bryant, Director
- Neah Dismuke, Assistant Director
- James Varnado, Corrections Officer
- Maryon Roberts, Corrections Officer
- Sandra Baylor, Corrections Officer
- Ashley Guess, Corrections Officer
- Cherley Berry, Direct Care Worker
- Charles Hines, Direct Care Worker
- Joshua Edison, Direct Care Worker
- Joni Dixon, Direct Care Worker
- Brittany Davis, Direct Care Worker
- Montoyia Smith, Direct Care Worker
- Gregory Raynes, Corrections Officer
- Lajuanda Mosby, Corrections Officer
- Derek Jarvis, Shift Commander
- Tamara Baldwin, Corrections Officer
- Sky Johnson, R. N.
- Charles Griffiths, M. D.
- Sylvia Legradi, Pine Belt Mental Healthcare Resources
- Adrienne James, Pine Belt Mental Healthcare Resources
- Randall Weatherby, teacher
- David Miller, Board of Supervisors Attorney

Interviews Conducted (youth):

- G.B.
- M.H.
- S.S.
- D.W.
- D.J.
- D.L.
- X.B.
- I.F.
- T.L.

- K.L.
- D.B.
- L.H.

Documents provided:

Incident Reports:

- 6/3/12: Calvin Wilson
- 6/3/12: James Varnado
- 6/3/12: Greg Anderson
- 6/7/12: Jean Rester
- 6/9/12: Andre Cooley
- 6/9/12: Adrian Ratliff
- 6/9/12: Andre Cooley
- 6/13/12: Adrian Ratliff
- 6/15/12: Tamara Baldwin (incident occurred 6/13/12)
- 6/21/12: Charles Hines
- 6/21/12: Gregory Raynes
- 6/21/12: Andre Cooley
- 6/23/12: Andre Cooley
- 6/23/12: Maryon Roberts
- 6/24/12: Adrian Ratliff
- 6/24/12: Andre Cooley
- 6/24/12: Andre Cooley
- 6/25/12: James Varnado
- 6/25/12: Greg Anderson
- 6/25/12: Gregory Raynes
- 6/24/12: Andre Cooley
- 6/24/12: Adrian Ratliff
- 6/24/12: Andre Cooley
- 7/2/12: Andre Cooley (with accompanying FCJDC Suicide Watch Log)*
- 7/2/12: Andre Cooley
- 7/2/12: Adrian Ratliff
- 7/3/12: Andre Cooley
- 7/3/12: Andre Cooley (with accompanying FCJDC "Suicide Watch Log")
- 7/3/12: Adrian Ratliff
- 7/7/12: Kenny Harris
- 7/7/12: Charles Hines
- 7/9/12: Adrian Ratliff
- 7/10/12: Jean Rester (with accompanying FCJDC "One Hour/Fifteen Minute Visual Cell Check Log")
- 7/11/12: Adrian Ratliff

- 7/12/12: Adrian Ratliff
- 7/14/12: Gregory Raynes (#1)
- 7/14/12: Gregory Raynes (#2)
- 7/14/12: Sampson Long (#1)
- 7/14/12: Sampson Long (#2)
- 7/14/12: Greg Anderson
- 7/16/12: Andrea Estrada
- 7/18/12: Gregory Raynes
- 7/22/12: A. Eaton
- 7/22/12: Tamara Baldwin
- 7/23/12: Greg Anderson (Report states incident occurred on 7/24/12)
- 7/26/12: Ardesia Eaton (#1)
- 7/26/12: Ardesia Eaton (#2)
- 7/27/12: LaJuanda Mosby
- 7/29/12: Sampson Long
- 7/29/12: Sandra Baylor
- 8/11/12: James Varando (with accompanying FCJDC "One Hour/Fifteen Minute Visual Cell Check Log")
- 8/15/12: Randall Weatherby (teacher)
- 8/24/12: LaJuanda Mosby
- 8/28/12: Andre Cooley
- 8/29/12: LaKeisha Bryant
- 8/29/12: Charles Hines and Adrian Jarvis (with accompanying Strip Search Procedures form)
- 9/1/12: Ardesia Eaton
- 9/3/12: LaJuanda Mosby
- 9/7/12: Gregory Raynes (incident occurred 9/4/12)
- 9/15/12: James Varnardo
- 9/15/12: Andrew Mott
- 9/20/12: Tamara Baldwin
- 9/24/12: James Varnardo
- 9/25/12: James Varnardo
- 11/27/12 (?):Hargrove

Other Documents:

- Memorandum of Understanding of Hattiesburg Public School District and Forrest County Juvenile Detention Center Providing Continuous Education for Confined Juveniles (unsigned)
- FCJDC Daily Schedules (Saturday, Sunday, Monday/Wednesday, Tuesday/Thursday and Friday) (undated)
- Copies of completed Request for Medical Care forms
- Copies of Prescription Verification form (dated August 2012) (completed)

- Copies of Medication Log Sheets (completed)
- Copies of Inmate Medication Refusal forms (completed)
- Copies of Medication Release form (completed)
- Copies of Sample Prescription Labels
- Sample FCJDC Prisoner Medical Clearance Form
- Fact Sheet and Board Order: "Agreement for Medical Services—Southern Neurologic & Spinal Institute" for the Forrest County Jail and Evaluation Center (dated September 22, 2011)
- Fact Sheet and Board Order: "Nursing Services Agreement" for the Forrest County Corrections Facilities (dated August 18, 2011)
- Fact Sheet and Board Order: "Mobile X-Ray, Ultrasound and EKG Services" (dated December 8, 2011)
- Copies of Mental Health Treatment Plans
- Copies of Mental Health Assessments
- FCJDC Receiving Screening form (undated)
- FCJDC Receiving Screening form (dated August 2012)
- FCJDC Receiving Screening form (dated October 2012)
- Sample YASI
- Sample MAYSI-2 Questionnaire form
- Sample Strip Search Procedures form (undated)
- FCJDC Frisk/Strip Search Procedures form (dated July2012)
- FCJDC Frisk/Strip Search Form (Intake) (dated August 30, 2012)
- FCJDC Strip Search Form (Initial Intake) (dated September 21, 2012)
- Sample Yard Call Log (dated September 24, 2012)
- Sample Community Services letter from FCJDC Director
- FCJDC Care Packages form (undated)
- FCJDC General Regulations and Rules of Conduct for Detainees (undated)
- Forrest County Youth Court Division General Order Appointing Designees dated July 2009
- FCJDC General Regulations and Rules (for staff) (undated)
- Rules Violation Report form (dated September 17, 2012)
- FCJDC One Hour/Fifteen Minute Visual Cell Check Log (undated)
- FCJDC Juvenile Detainee Grievance Form (undated)
- Copies of Phone Logs
- FCJDC Organizational Chart (undated)
- FCJDC Staff List (effective September 14, 2012)
- Draft Policies and Procedures (dated September 10, 2012)
- FCJDC Juvenile Detainee Grievance Form (undated)
- FCJDC Suicide Watch Log form (undated)
- Forrest County Juvenile Detention Behavior Management System Disciplinary Guidelines (undated)
- Rights of Detainees in Custody form (Revised August 30, 2012)

- Sample Letter from FCJDC Director to "To Whom It May Concern" (?) regarding detainee's lack of progress while detained (revised September 2012)
- FCJDC Daily Headcount/Fax Transmission form (revised August 2012)
- Sample FCJDC Documentation of Voluntary Cell Confinement form with accompanying One Hour/Fifteen Minute Visual Cell Check Log
- Sample FCJDC Documentation of Voluntary Cell Confinement form without documentation of required fifteen-minute room checks
- FCJDC Detainee Handbook (dated September 18, 2012)
- FCJDC Parent Handbook (undated)
- FCJDC Announcement of CPR/First Aid Training for August 14 and 16, 2012)
- Copies of Sample FCJDC General Regulations and Rules of Conduct for Detainees (undated)
- Illustrations of two activities at the FCJDC
- FCJDC Staff Meeting Sign-in Sheet for Training on Agreed Order on April 10, 2012
- FCJDC Direct Care Worker's (DCW) Duties and Responsibilities (dated September 18, 2012)
- FCJDC Employee Absentee/Tardy Report form (revised August 30, 2012)
- Form Letter from FCJDC teacher to ? listing reasons a detainee did not receive educational services (revised September 2012)
- Instructions, with illustrations, of clothing that youth are to receive at FCJDC (dated September 2012)
- Seven sample FCJDC Weekly Menus (source unknown)
- Sample Rule Violation Reports (RVRs), two with accompanying Disposition Reports (September 15, 2012)
- Sample FCJDC Population Reports
- Random youth medical files (examined while on-site)
- Random youth legal files (examined while on-site)
- FCJDC "Brief Implementation Summary Report (September 25, 2012)

Monitoring Letters and other Correspondence:

- July 30, 2012 SPLC Monitoring Letter to Anne M. Nelsen
- August 10, 2012 email from Elissa Johnson to LaKeisha Bryant
- August 14, 2012 email from Lakeisha Bryant to Elissa Johnson
- August 17, 2012 letter from Elissa Johnson to Jim Dukes, Jr. and David Miller
- September 24, 2012 SPLC Monitoring Letter to Anne M. Nelsen

DVDs/Videos reviewed:

- July 7, 2012 Escape Incident

State Statutes:

- Mississippi Code of 1972 Annotated, § 37-13-91 (2011)
- Mississippi Code of 1972 Annotated, § 37-13-92 (2011)
- Mississippi Code of 1972 Annotated, § 43-21-321 (2011)
- Mississippi Code of 1972 Annotated, § 45-4-9
- Mississippi Board of Pharmacy, Pharmacy Practice Regulations and Pharmacy Practice Act, effective January 31, 2011

FINDINGS:

In measuring compliance, I have used the same system employed by the U. S. Department of Justice, which is similar to and consistent with the prior reports from the Southern Poverty Law Center. Because these definitions of compliance levels are somewhat narrowly crafted, in my first Monitoring Report, dated May 7, 2012, there are some provisions that I rated lower than in previous SPLC Monitoring Reports. Some ratings improved after my May 2012 Quartering Monitoring Report, illustrating effort on the part of the FCJDC administration since that time. In addition, there are several provisions of the Agreed Order that could be considered as at least as partial compliance or even as substantial compliance with the Agreed Order if there were written policies and procedures addressing those provisions. However, despite some progress in a few areas, there has been a relapse in compliance ratings on some provisions, which appears to be at least partly the result of break down in communication. Full compliance with the Agreed Order is a daunting task and cannot be achieved quickly or easily. However, the commitment expressed by the FCJDC administration gives me hope that that can be realized. Much work will still be necessary to accomplish the objectives of the Agreed Order but my impression at the time of my September 2012 site visit is that there is dedication to that goal.

The following levels of compliance are used to characterize Forrest County's progress in making needed reforms:

- Substantial Compliance (SC): The County is complying with all major components of the provision. The facility's practices address the requirements of the provision for most of the youth, most of the time. Policies are comprehensive and appropriately detailed and staff consistently implements them. The facility quickly rectifies episodic problems and minimizes program disruption. Isolated incidents of non-compliance do not preclude a finding of substantial compliance. At the same time, temporary compliance during a period of sustained non-compliance does not constitute substantial compliance.

- Partial Compliance (PC: The County has achieved compliance on significant components of the provision, but additional improvements are needed. Clarification of small elements of policy and greater consistency in practice are required.

- Non-Compliance (NC): The County either has not addressed the provision or has taken steps in furtherance of compliance but substantial improvements are needed. For example, policy may exist, but the policy needs significant revisions or modifications and rarely translates into practice.

The chart below summarizes present levels of compliance as well as prior ratings:

Provision		Compliance Ratings							
		*Feb 2012	May 2012	July 2012	Oct. 2012				
I. INTAKE									
1.1	Youth Assessment Screening Instrument	NC	NC	NC	NC				
1.2	MAYSI-2	PC	PC	PC	PC				
1.3	Provision of prescription medications	NC	NC	NC	PC				
1.4	Policies and practices to ensure youth medically fit for admission	PC	PC	PC	PC				
1.5	Meals upon admission	PC	PC	PC	PC				
1.6	Phone call and shower at admission	PC	PC	PC	PC				
1.7	Searches	NC	NC	NC	NC				
1.8	Alternative sanctions	CBD	CBD	NC	PC				
II. STAFFING AND OVERCROWDING									
2.1	Adequate number of trained staff, staff ratios	PC	PC	PC	NC				
2.2	Emergency release when exceeding ratios	SC	PC	PC	PC				
2.3	Maximum capacity and one- and two-person cells	SC	SC	SC	SC				
2.4	One- and two-person cells not exceeded	SC	SC	SC	PC				
III. CELL CONFINEMENT									
3.1	Structured, rehabilitative programming	NC	NC	NC	NC				
3.2	Youth in Holding, Detox, D-Unit allowed in living unit and involved in programming	PC	NC	NC	NC				
3.3	Cell confinement requirements	CBD	NC	NC	NC				
3.4	Mandatory and voluntary cell confinement	PC	PC	PC	PC				
3.5	Staff in living unit and actively engaged with youth; communications system	NC	NC	PC	PC				
IV. STRUCTURED PROGRAMMING									
4.1	Daily programming	NC	NC	NC	NC				
V. DISCILINARY PRACTICES AND PROCEDURES									
5.1	Disciplinary policy with positive interventions and graduated	NC	NC	NC	NC				

	sanctions								
5.2	Communication of rules to residents	NC	NC	PC	PC				
5.3	Maximum time of confinement, due process hearings	NC	NC	NC	NC				
VI. USE OF RESTRAINTS									
6.1	Mechanical restraints, when prohibited and allowed	NC	NC	PC	PC				
6.2	Mechanical restraints for transportation; not while in cell	NC	NC	PC	PC				
6.3	Restraints not used to secure youth to fixed object	SC	PC	PC	PC				
6.4	Evaluation by MH professional if mechanical restraints used longer than 15 minutes	NC	NC	PC	PC				
6.5	Prohibition of restraint chair or tasers	SC	PC	PC	PC				
6.6	Chemical restraints	PC	PC	PC	PC				
6.7	Prohibition of unlawful restraints	SC	PC	PC	PC				
6.8	Face-to-face supervision when mechanical restraints used	PC	PC	PC	PC				
6.9	Medical professional notification and involvement when mechanical restraints used	CBD	NC	PC	PC				
6.10	Prohibition of officers with chemical restraints in secure detention area	SC	SC	SC	SC				
6.11	Prohibition of officers with electronic restraints in secure detention area	SC	PC	SC	SC				
6.12	Prohibition of officers with firearms in secure detention area	SC	PC	SC	SC				
VII. USE OF FORCE									
7.1	Physical force, when prohibited and allowed; verbal de-escalation	PC	PC	NC	NC				
7.2	Medical professional involvement with use of force	CBD	NC	NC	NC				
VIII. MEALS AND NUTRITION									
8.1	Three meals and snack daily; provision of missed meals	SC	PC	PC	PC				
8.2	Compliance with USDA School Meals standards	NC	NC	NC	NC				
8.3	Access to drinking water	NC	NC	SC	SC				
IX. CLOTHING									
9.1	Provision of basic, clean clothing	NC	NC	NC	NC				
X. HYGIENE AND SANITATION									
10.1	Provision of hygiene items, showers, tooth-brushing, hand-washing	PC	NC	PC	PC				
10.2	Provision of sleeping mats and blankets	NC	NC	PC	PC				
10.3	Youth not deprived of sleeping mats and blankets	SC	PC	PC	PC				
10.4	Sufficient number of clean, sanitary mats and blankets	CBD	NC	NC	PC				

10.5	Clean, sanitary environment	NC	NC	PC	PC				
10.6	Policies and practices that comply with fire safety, weather emergencies, sanitation practices, food safety and environmental toxins	CBD	NC	PC	PC				
10.7	Clean drinking glasses and utensils	PC	PC	PC	PC				
XI. MEDICAL CARE									
11.1	Contracted medical services	NC	PC	PC	PC				
11.2	Availability of MD or nurse practitioner	NC	NC	NC	PC				
11.3	Sick call	NC	NC	PC	PC				
11.4	Preparation and distribution of prescription medications	SC	PC	PC	PC				
11.5	Confidentiality of medical and mental health services	PC	PC	PC	PC				
XII. MENTAL HEALTH									
12.1	Mental health services required	PC	PC	PC	PC				
12.2	Psychiatric evaluation for youth detained over 30 days	CBD	CBD	NC	NC				
12.3	Mental health treatment plans	CBD	NC	NC	PC				
XIII. SUICIDE PREVENTION									
13.1	Multi-tiered suicide prevention policy	PC	NC	NC	NC				
13.2	Mental health evaluation of youth on highest level of suicide watch	CBD	NC	NC	PC				
13.3	Participation in activities by youth on suicide watch; use of suicide gown; monitoring of suicide watch	CBD	NC	NC	NC				
13.4	Notification of youth court and guardian of youth on suicide watch	CBD	NC	NC	NC				
XIV. FAMILY SUPPORT AND INTERACTION									
14.1	Visitation privileges not restricted or withheld	SC	PC	PC	PC				
14.2	Availability of contact visits	NC	PC	PC	PC				
14.3	Scheduling of visitation; children of detainees' visits	PC	NC	NC	NC				
14.4	Phone calls to parents, primary caretakers or legal guardians	PC	PC	PC	PC				
14.5	Phone calls to attorneys, social workers and youth court staff	NC	NC	NC	NC				
14.6	Incoming phone calls from attorneys (and others)	CBD	NC	NC	NC				
XV. MISCELLANEOUS PROVISIONS									
15.1	Equal access to programs and services for male and female detainees	NC	NC	PC	PC				
15.2	At least one hour of large muscle exercise daily	PC	NC	NC	NC				
15.3	Policies and practices prohibiting the use of profanity by staff	NC	NC	PC	NC				
15.4	Grievance policy	NC	NC	NC	NC				
15.5	Policy that allows youth of all ages	NC	NC	NC	NC				

	and literacy levels to request to see attorney and/or youth court counselor								
15.6	Pre-service and in-service staff training program	NC	NC	NC	NC				

*Monitoring Report completed by SPLC
**CBD: Cannot be determined

In addition to the specific provisions of the Agreed Order discussed below, that Order also requires that "within 60 days of the effective date of this agreement, policies consistent with this agreement are drafted, in the process of being implemented, and that all detention staff will receive training on the requirements of this agreement." At the time of my first site visit, FCJDC staff members interviewed had very little information about the Agreed Order. When I visited the FCJDC in June, most staff members interviewed stated that they had received a copy of the Agreed Order and that meetings had been held explaining its requirements. However, with the recent addition of several replacement staff members, a number of FCJDC employees again reported only knowing about the lawsuit and Agreed Order from local media reports. The FCJDC must develop a system or training all employees on the Agreed Order, as required. In addition, it is vital all new employees receive at least a minimum level of orientation training that goes beyond the current practice of simply learning on the job. It is common practice in many juvenile detention and corrections facilities throughout the country to require training, generally at least forty hours, *before* being allowed to work directly with youth. The practice of placing employees to work at the FCJDC without training, and without requiring that they *at the very least,* be required to shadow a trained, experienced staff member before being allowing to work with children is unacceptable.

A comprehensive staff training program details mandatory training topics for each category of employee, it spells out the minimum number of pre-service and annual training hours required, it discusses qualifications of trainers, it explains record-keeping expectations and other documentation requirements, and it discusses consequences for non-compliance. Apparently "Corrections Officers" employed by the FCJDC are required by state statute to attend the state's Corrections Academy and be certified within two years of employment. However, two years is an excessively long time for any staff member to be employed without training. The curriculum of that Academy has not been made available for my review but staff members interviewed reported that it includes about two weeks of adult-oriented training and about three days of juvenile focused training. That Academy may not be appropriate for a juvenile facility. And, Direct Care Workers do not attend that Academy nor do they receive any formal training in a planned, organized way. As I suggested in prior reports, it may be more cost-effective and more useful for Mississippi's juvenile facilities and agencies to collaborate to establish a training academy that better meets the needs of those programs. Requiring juvenile detention employees to be certified as Corrections Officers, depending the training provided, may be unnecessary and even counter-productive. It may be more effective to change job titles to a more accurate and

appropriate term like juvenile detention worker and provide appropriate training accordingly.

The FCJDC has had an out-of-date "Standard Operating Procedures" manual that was written in 2007. It has been my recommendation that the agency not only update that manual but that they do so in the form of both *policies* and *procedures,* not just the latter. A "policy" is a general statement of intent and it describes the purpose or "why and what" of the related procedure. A "procedure" offers detailed guidance to users and provides the "who, how, when and where" information. That format helps to ensure that actual practice adheres to the intent of the program. The policies and procedures provided to me did not follow that format, presumably because the Assistant Director, who was assigned to write policies and procedures, did not receive my correspondences and reports before she began her work.

Despite my repeated requests to review new or revised policies and forms in "draft" form, no new policies and procedures were provided for my review until the day before my site visit. The new Assistant Director had been on the job for only about six weeks and she had been tasked with writing policies and procedures. However, she had not been informed that I had asked to review those policies and procedures in draft nor had she been provided with copies of my May and July Monitoring Reports, both of which detailed what policies and procedures would be needed to meet the requirements of the Agreed Order. She wrote policies and anticipated training the staff on them while I was at the FCJDC but she revised her staff training agenda after she learned that she was to have obtained my feedback on policies before they were finalized. I gave her brief written comments on the policies, due to the limited time available, while on-site and made it clear that I am available for further consultation and technical assistance on those policies and other proposed documents. It is my hope that communication will improve at the FCJDC and that similar problems and accompanying delays in compliance will be avoided in the future.

In addition to policies and procedures, the Assistant Director did write staff job descriptions. Those were provided for my review with the policies and procedures and I offered suggestions for those as well. As I discussed with the FCJDC Director and Assistant Director, policies and procedures should always be reviewed regularly and revised as needed. Since the policies and procedures and job descriptions at the FCJDC will be either new or significant revisions, I recommend that they be reviewed, *with input from line staff members,* more frequently initially. Detailed, written job descriptions provide guidance to both new and existing employees and help to ensure accountability. Without written expectations, the FCJDC cannot expect that practices will be consistent between staff members or across different shifts. Those job descriptions should list major responsibilities and then enumerate the specific tasks required to carry out those responsibilities. Staff input in developing and revising job descriptions can help to ensure that they are realistic and that they do measure and evaluate what they are intended to.

I. INTAKE:

1.1 All youth shall receive a Youth Assessment and Screening Instrument (YASI) screening, within 1 hour of admission, by appropriately trained staff to obtain information required by Miss. Code Ann. § 43-21-321. "Information obtained during the screening shall include, but shall not be limited to, the juvenile's: (a) Mental health; (b) Suicide risk; (c) Alcohol and other drug use and abuse; (d) Physical health; (e) Aggressive behavior; (f) Family relations; (g) Peer relations; (h) Social skills; (i) Educational status; and (j) Vocational status." Miss. Code Ann. § 43-21-321(1).

Compliance Rating: **Non-Compliance**

Discussion:

At the time of my first site visit, the FCJDC was not using the YASI and, in fact, had not purchased the instrument nor had they trained any staff in its use. By the time of my June visit, the FCJDC had acquired the YASI and two staff members were trained in its administration. However, one of those staff members has been transferred to the jail and the other is a contract nurse who works only a limited number of hours at the FCJDC and who does not have time to administer the YASI and has not done so. The Director is making arrangements with the company that owns the YASI and the training rights to allow two FCJDC employees to pilot the company's new on-line training program. That training is planned for the first two weeks of October. However, the two employees who have been identified to be trained on the YASI both work during the day, on weekdays. Since youth may be admitted to the FCJDC at any time of the day or night, it would not be possible to administer the YASI within one hour of admission, as required by this provision with just those two staff members qualified. No youth detained at the FCJDC in the last three months have received the YASI and it is not known when youth will begin receiving that service.

No policy and procedure exists regarding the YASI. Without that written direction, staff lack ongoing information regarding expectations and the use of the YASI is less likely to become a customary piece of the admissions process.

The FCJDC seemed to be making some progress in achieving compliance with this provision at the time of my June visit when at least a few youth has received he YASI. However, with the staff changes that have occurred since June, the facility has digressed. No youth have received a YASI in the past few months. Until at least one staff member on all shifts is trained on the YASI and is administering that tool within one hour of admission, compliance cannot be achieved. It should also be noted that, as I indicated in my last report, the counselor from Pine Belt Mental Healthcare Resources again stated to me that she does not see the completed YASI but that information could be helpful to her and to other clinicians working with the youth in assisting those children while at the FCJDC and upon release. I would strongly recommend that the Pine Belt therapist review completed

YASI's and then, if appropriate and with proper releases, that she make that information available to other therapists working with FCJDC youth.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure regarding the use of the YASI that is consistent with this provision.
2. Provide documentation that all current and future staff members are trained on the new YASI policy and procedure. That training documentation should include, at least, date of training, time spent on that training, name of trainees, and name and qualification of trainer.
3. Provide documentation that at least one FCJDC staff member is present on shift at all times who is trained in administering and scoring the YASI, as recommended by the instrument's parent company, in order to ensure that the YASI is administered within the required timeline. That training documentation should include, at least, date of training, time spent on that training, name of trainees, and name and qualification of trainer.
4. Provide documentation of completed YASs on FCJDC youth.

1.2 All youth shall receive a MAYSI-2 mental health screening immediately upon admission, as required by Miss. Code Ann. § 43-21-321. The screening will be conducted in private by appropriately trained staff. If the screening indicates that the youth has urgent medical and/or mental health issues including, but not limited to, major depression, suicidal ideation, withdrawal from drugs or alcohol, or trauma, the youth shall be immediately evaluated by a mental health professional or taken to the local emergency room.

Compliance Rating: **Partial Compliance**

Discussion:

This provision includes multiple elements and substantial compliance will require meeting all of those. Currently, the MAYSI-2 is employed during the booking process on each youth detained. However, the manner in which that instrument is administered continues to be problematic. At the time of my initial visit in March 2012 youth were given the MAYSI-2 form and told to answer the questions. Many youth informed me that they did not read the questions and answered all "no." Those assertions were confirmed through my observations of the booking process and by reviewing completed copies of the MAYSI-2 in detainee files. By the time of my second visit, the MAYSI-2 was being administered with the booking officer reading the questions to youth and my review of files showed most forms had both "yes" and "no" answers. That is still the procedure but the questions are still not asked in private. The instrument is administered at the booking desk along with several other forms that are completed. That desk is centrally located in the FCJDC, with the medical exam room directly behind it, and various staff and other residents pass by or

mingle at that desk, potentially violating the confidentiality of youth being admitted. Interviews with the juvenile detained during my site visit confirmed that all had received a MAYSI-2 but that all were conducted at the booking desk, along with other admissions paperwork. The failure of the FCJDC to administer the MAYSI-2 in private results in the FCJDC being out of compliance with this provision.

It is noteworthy that the MAYSI-2 is scored by the booking officer, which allows the facility staff to refer youth to a mental health professional quickly if concerns are noted. The Memorandum of Understanding between the FCJDC and the Pine Belt Mental Healthcare Resources, dated October 8, 2010, requires that "all youth will be screened for symptoms of SED and Substance Misuse at entry by Detention Center staff utilizing the MAYSI-2;" and that "all youth who screen positive for symptoms will be assessed by MIMs Case Manager;" from Pine Belt. The FCJDC did not begin regularly administering the MAYSI-2 for over a year-and-a-half after that MOU was signed. The Pine Belt Mental Health care Resources clinician now receives all completed MAYSI-2 copies and uses them as part of her assessment. As recommended in my May and July 2012 reports, youth files at the FCJDC have been organized so that documents are chronological and multiple versions of the MAYSI-2 from repeated admissions can be reviewed to identify trends or historical concerns. Interviews with residents at the FCJDC confirmed that all had had a MAYSI-2 and that the questions were read to them rather than them being required to read and answer the questions.

No documentation of the training provided to staff was available for my review, including the substance of the training and the qualifications of the trainer.

Although all youth interviewed reported that the questions in the MAYSI-2 were read to them, my observation was that that was done in a fairly cursory fashion as one portion of the several intake requirements. Although the answer sheets in youth files that I reviewed had both "yes" and "no" answers, incorporating the administration of the MAYSI-2 with the legal paperwork rather than as a separate, private interview, seems to lead to less honesty on the part of youth. One youth interviewed acknowledged that he has tried to kill himself (as one of the questions asked) but that he lied in his answer because he "didn't want to go to Detox." (The practice of isolating potentially suicidal youth defies accepted clinical practice and contradicts accepted research in the area of suicide in juvenile detention. I will discuss that further under Section XIII below.) Two youth reported that they had answered "no" to all questions on the MAYSI-2 but both had several prior admissions and may have, therefore, chosen to take the instrument less seriously. Also, booking tasks at the FCJDC are now generally performed by two officers, who seem to take that responsibility seriously.

The existing *Standard Operating Procedure* manual, dated 2007, includes detailed instructions for staff to follow in booking youth into the facility. In the section entitled "Booking Procedures", the MAYSI-2 is addressed with just one general sentence that instructs staff to: "Complete the MAYSI Questions on the juvenile." No specific instruction

is provided on how that is to be done. The revised draft Policy and Procedure Manual, which was provided to me the day before my site visit, includes the following instruction: "Complete the MAYSI/YASI Questionnaire on the juvenile." No additional details are included regarding how that instrument is to be administered to facilitate compliance with this provision.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure regarding the use of the MAYSI-2 that is consistent with this provision. That policy and procedure should be in accordance with the *Users Manual* provided with the MAYSI-2.
2. Provide documentation that FCJDC staff are appropriately trained on the new policy and procedure and on the use of the MAYSI-2, including, at least, date of training, time spent on that training, name of trainees, and name and qualification of trainer. That training should be in accordance with the *Users Manual* provided with the MAYSI-2.
3. Administer the MAYSI-2 to youth upon admission in private and in a manner that maximizes its validity, including reading questions to youth, and, if necessary, providing clarification of meaning.
4. Provide documentation that completed MAYSI-2 screening instruments are reviewed by a mental health clinician and that that clinician uses the information in the instrument to determine needed services while juveniles are in the FCJDC and upon release, if appropriate.

1.3 Forrest County Juvenile Detention Center shall ensure that all youth who have a valid, current prescription for medications are provided their medication within 8 hours of admission, if possible, but in no case, longer than 24 hours after admission, including weekends and holidays. If during a youth's detention, a medical professional either prescribes a new medication or renews a youth's previous prescription medication, the Forrest County Juvenile Detention Center will secure the prescription medication within 8 hours of receiving the prescription, if possible, but in no case, longer than 24 hours after receiving the new prescription, including weekends and holidays. The Forrest County Juvenile Detention shall develop policies and procedures to ensure that medications are procured and distributed in accordance with professionally accepted standards.

Compliance Rating: **Partial Compliance**

Discussion:

The 2007 FCJDC *Standard Operating Procedure* manual does not address the issues in this provision and there is not yet a written policy and procedure as required. Interviews with facility management, line staff and medical staff still provided somewhat vague and

variable information regarding the requirements in this provision. Most staff members were aware that juveniles should have their medications when admitted although one new staff member indicated that she did not know if youth could be booked without medication, indicating a need for at least some basic new employee training. The Receiving Screening Form asks youth if they have any medication with them. However, it does not ask if they are currently taking prescribed medication, which would alert the staff of the need to obtain that medication. And, that form is not completed until the child is accepted for admission and the arresting/transport officer has left. One booking officer interviewed reported that youth are generally not admitted without prescribed medication. She stated that if the youth is from outside Forrest County, the arresting or transporting law enforcement officers are required to bring a child's medication with the child or otherwise obtain it before a youth is admitted and, if the youth is from Forrest County, the booking officer notifies the facility nurse who contacts the probation officer who then has twenty-four hours to bring the medication in. If the medication is not then delivered within twenty-four hours, the nurse reportedly gets a new prescription and gets it filled.

The nurse assigned to the FCJDC informed me that they are in the process of acquiring an Institutional Emergency Pharmaceutical Kit (IEPK), which has been recommend for the facility by Forrest General Hospital. The IEPK, must be approved by the Mississippi Board of Pharmacy and would allow "institutions, under the jurisdiction of the Board, that maintain prescription drugs on the premises for emergency use by patients" to "maintain a stock of prescription drugs for emergency use by patients who are confined to the institution." However, "Emergency kit medications shall be administered to patients only for emergencies and pursuant to a valid medication order or prescription. Institutional emergency medication kit drug supplies are not to be used when medications are readily available from a community or hospital pharmacy." (Mississippi Board of Pharmacy, Pharmacy Practice Regulations and Pharmacy Practice Act, effective January 31, 2011) The plan to acquire an IEPK is commendable but it will not address the typical need to obtain medications for acute or chronic care for individual youth at the FCJDC. Although interviews with staff and youth indicate that prescribed medications are generally obtained, it is not clear how quickly that occurs and it not known how that occurs. The FCJDC does not have a contract with a specific pharmacy and, if it is necessary to obtain a new prescription, it is not known how that occurs or what medical provider orders that prescription. In addition to the IEPK, the medical staff assigned to the FCJDC do have access to an on-line program that they use to verify that medication that is delivered by a parent, law enforcement officer, probation officer, youth court counselor or other individual matches the label on the container, which helps to avoid medical errors.

None of the incident reports from July 1, 2012 until my site visit illustrated examples of any juveniles being booked into the facility without his or her prescribed medication. It is highly likely that there will be youth who are booked into the FCJDC who have been on prescribed medication but do not inform the arresting/transporting law enforcement officer or the FCJDC booking officer. In those cases, the medical staff will need to obtain medications within required timelines. No documentation was provided of FCJDC staff or medical staff contacting parents or others to obtain required medication, including timelines. To comply with this provision, the FCJDC must obtain the youth's medication or

have a procedure in which the facility obtains that medication from a local pharmacy within the mandated timeframe. Doing so could require a new prescription be issued by a physician or nurse practitioner familiar enough with the child's case to be able to issue that prescription. At the time of my site visit the FCJDC had a new physician who had just been at the facility for one week. He expressed a great interest in helping to ensure quality medical services, including those required to comply with the provisions of the Agreed Order. He is the only medical professional working at the FCJDC who is qualified to diagnose or who is licensed to prescribe medication. It will be important to work with the physician, who is also the FCJDC Medical Director, to develop policy, procedure and practice that comply with this provision.

No written documentation or staff interviews substantiated that detainees' medication are being provided within the 8-hour and 24-hour requirements of this provision. My review of individual residents' medical records did verify that many youth are taking prescribed medications and that medications are obtained from various sources for those youth. However, those records still do not provide clear timelines for determining the need for medication and for obtaining it. The FCJDC nurse was very open to suggestions and to revising forms if necessary to improve required documentation.

Recommendations for achieving substantial compliance:

1. Develop written policies and procedures regarding the delivery of prescription medications that is consistent with this provision. Those policies and procedures should also address the need to verify that medications delivered by outside sources are actually what is prescribed.
2. Document staff training on the new policies and procedures.
3. Develop and implement forms or other paperwork to document that youth have prescriptions at the time of admission and/or that efforts are made to ensure that youth receive those medications within the timeframes established by this provision.
4. Provide examples of documentation of efforts made to obtain prescription medications.

1.4 The Forrest County Juvenile Detention Center shall develop and implement policies and practices that ensure all youth admitted to the facility are medically fit to be held in detention.

Compliance Rating: **Partial Compliance**

Discussion:

The 2007 FCJDC *Standard Operating Procedure* manual addresses this provision. Under the section, "Medical Clearance" that manual states: "If a juvenile displays signs of illness or injury, medical clearance will have to be given by a doctor or other medical

professional (i.e., EMT, RN) stating, in writing, that the juvenile is medically fit to be detained." Further, that procedure lists a number of symptoms that would preclude admission. The procedure describes the Medical Receiving Screening Report form that includes a list of questions that the booking officer is to ask the youth "in order to assess the physical and mental condition of the juvenile detainee." The draft Policy and Procedure Manual, Section Two: Receiving; Subject: Booking/Intake Procedures, does not address the requirements of this provision.

One Incident Report during the past three-month period documents an example of a youth stating that the arresting officer had abused him. The report is incomplete but an attached FCJDC Prisoner Medical Clearance Report appears to indicate that he was released by the Hattiesburg Police Department "instead of getting medical clearance."

The Medical Receiving Screening form, completed on each youth as part of the booking process, is not all-inclusive, nor can it be. It does not address the problem for which the youth in the one documented example was apparently denied admission. However, if that form is to be considered a tool for assessing medical fitness, it may need to be revised. Or, booking staff members need training on making decisions regarding the need for medical clearance. Staff interviewed did consistently report that youth are denied admission when they are in need of medical clearance but that appears to be a judgment call on the part of the booking officer who may or may not have the knowledge or expertise to make that decision. No training documentation was provided to indicate that staff members had received training on determining whether youth are medically fit to be held in detention. It is not known how staff members are qualified to make their assessment. There is a part-time registered nurse at the facility each weekday but that position was vacant at the time of my site visit and the jail nurse, who is also on-call for medical emergencies was filling in. During the hours that there is a nurse present, that individual might assist in assessing the need for medical clearance. However, that does not address the large majority of hours and days when no medical professional is on site.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure that is consistent with this provision.
2. Provide documentation of staff training on that policy and procedure.
3. Provide documentation of staff training on how to make a determination of whether a youth is medically fit to be held in detention.
5. Provide documentation verifying that youth delivered to the FCJDC are assessed to determine whether they are medically fit to be held in detention, including examples of youth who are refused admission based on the determination that they are not medically fit to be held and the outcome for youth who are not admitted due to medical concerns.

1.5 Upon admission to the Forrest County Juvenile Detention Center, all youth shall be offered a meal.

Compliance Rating: **Partial Compliance**

Discussion:

All youth and staff interviewed reported that juveniles are offered a meal at the time of admission to the FCJDC. Staff members reported that extra meals are ordered to ensure that they are available if new admissions arrive. There is still no written policy and procedure that ensures that this provision is established as part of the admission process both now and in the future. The FCJDC has a great deal of staff turnover and written policies can help ensure that expectations are communicated to all employees. The policy should require that admission paperwork be completed, including inquiry about allergies, before the child is offered a meal to ensure that the meal that is offered does not contain ingredients or food items that could cause an allergic reaction.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure consistent with this provision.
2. Provide documentation that all staff members are trained on that written policy and procedure.
3. Provide documentation that practice is consistent with this provision and the new policy and procedure.

1.6 Upon admission to the Forrest County Juvenile Detention Center, all youth shall be permitted to telephone their parent or legal guardian free of charge and take a shower as soon as possible.

Compliance Rating: **Partial Compliance**

Discussion:

The 2007 FCJDC *Standard Operating Procedure* manual does not address the requirements of this provision. In the Booking section, no mention is made of phone calls to parents or others by the juvenile. That section directs staff to strip search juveniles and have them change into detention clothing. Showers are not mentioned. The September 18, 2012 draft Policy and Procedure Manual, Section Two: Receiving; Subject: Booking/Intake Procedures, states: "Conduct a visual strip search of the juvenile. Youth will be required to disrobe and shower in the designated area."

The 2012, draft policy and procedure does not discussed youth phone calls at admission. Most youth reported that they were not offered a phone call at the time of admission. Some claimed that they were not allowed a phone call until the next regularly scheduled time (Monday, Wednesday or Friday.) Some reported that they were allowed to make a phone call later in that same evening. Those reports differ from my last visit when

most youth reported that they were allowed to make a phone call at admission, as required by this provision. Staff interviews regarding phone calls provided disconcerting answers. A number of staff are very new to the FCJDC and reported that they did not know what the phone procedures are. Some knew about the three weekly phone times but not the admission phone calls. One veteran staff member reported that juveniles are allowed to call their parents in the evening of the day they are admitted, *not* during the admissions process.

As was the case at the time of my last visit, staff and youth interviews consistently revealed that youth rarely shower at the time of admission. In fact, once again, none of the youth interviewed reported taking a shower at the time of admission. Most reported that a shower was not offered and others reported that they declined the admission shower. All reported that they took their first shower at the time of the next regularly scheduled showers in the evening, which could have been almost twenty-four hours after they were booked. One youth stated that she declined her admission shower because she would get a clean uniform at that time and not again when the evening showers occurred. She did not want to take her evening shower and have to put on the same, dirty uniform. Staff members confirmed that juveniles frequently decline the admission shower. That same girl also reported that she had not washed her hair in the two days that she had been at the facility because she cannot get the tangles out after shampooing without hair conditioner, which the FCJDC does not provide.

It is critical that youth admitted to detention all receive a shower at admission, prior to being placed in a living unit with other youth, to ensure the sanitation of the facility, the safety of the other youth and staff and to ensure the hygiene of the newly admitted child. Many facilities in the country also routinely require that the admission shower include shampooing with anti-lice shampoo. The FCJDC not only does not require lice prevention efforts, they do not require that a juvenile shampoo at all or even shower at admission. Although this provision merely requires that a shower be "offered", it is standard practice that youth admitted to a juvenile detention center shower at the time of admission. I strongly recommend that the FCJDC revise its policies and practices to require a complete shower and shampoo for all juveniles at the time of admission and before they are placed in a unit.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure consistent with this procedure.
2. Provide documentation of staff training on relevant policies and procedures.
3. Develop and implement a system for documenting the provision of a parent/guardian phone call at the time of admission and for documenting that all youth receive a shower at the time of admission.

1.7 Within 60 days of the date of this agreement, the Forrest County Juvenile Detention Center shall develop and implement policies that limit all searches,

except routine frisk searches to instances where Forrest County Juvenile Detention Center staff has a reasonable suspicion that a youth may possess contraband. Anytime a search other than a routine frisk search is conducted, the Forrest County Juvenile Detention Center staff must document, in writing, their suspicion, obtain permission from a supervisor, and conduct the search in a manner that minimizes the intrusion into the youth's privacy. Male detention center staff will search male youth and female detention center staff will search female youth.

Compliance Rating: **Non-Compliance**

Discussion:

The FCJDC *Standard Operating Procedure* manual provided to me at my last site two visits was written in 2007 and does not include a policy that meets the requirements of this provision. That manual addresses searches under the "Booking" section and again under the "Search Procedures" section. In both cases, staff members are directed to strip search all youth at the time of booking into the facility, a clear violation of this provision.

The 2012, draft FCJDC Policies and Procedures Manual addresses searches (Section Three: Control; Subject: Security and Control.) That policy addresses various types of searches and provides descriptions of each. However, that policy does not comply with the requirements of this provision. That policy states: "Strip search is conducted at juveniles' initial intake (booking) and also when a juvenile is outside of the facility and returns through booking." Such blanket strip searches exceed the reasonable suspicion criteria of this provision. The proposed policy does offer more guidance to staff than the 2007 Standard Operating Procedures Manual. It does address who may conduct a strip search and who may approve a strip search, although that authority is limited to the Director, Assistant Director or, in their absence, the Staff Commander. Those three individuals generally work weekdays, leaving evenings and weekends without a supervisor available to provide approval. The draft policy does not require that supervisory approval be obtained *prior* to conducting the search. In my July 2012 report I recommended that the FCJDC consider designating the Shift Commander position as supervisory for purposes of compliance with this provision. That has not occurred.

I requested copies of documentation of searches at my site visit. I received four versions of search forms, the Sample Strip Search Procedures form (undated), the Frisk/Search Search Procedures form (dated July 2012), the Frisk/Strip Search Form (Intake) (dated August 30, 2012), and, the Strip Search Form (Initial Intake), (dated September 21, 2012). None of those forms is consistent with the 2012 draft policy and none of them complies with the requirements of this provision.

The July 2012 version states: "Only male officers can frisk male youths and female officers can only frisk female youth. There will be no cross gender searches unless it is

related to *exigent circumstances*." The August 30, 2012 version states the same thing. The September 21, 2012 version states: "Only male officers can search male youths and female officers can only search female youth." Although the blanket strip searches mandated by that last version violate this provision, deleting the "exigent circumstances" phrase is important. Because the FCJDC must always have at least one staff member on duty, at all times, of each gender, there should never be a circumstance that would justify cross-gender searches. In addition, the FCJDC has excellent response from the Forrest County Sheriff's Department or the Hattiesburg Police Department in emergency situations, which would also prevent any need for cross-gender searches.

Of greater concern is the fact that the most current version of the form *and* the draft policy both mandate that "All new detainees entering Forrest County Juvenile Detention Center will be strip searched for the safety of its officers and the safety of the residing detainees to reduce potential carriers of contraband into the facility." No mention of "reasonable suspicion that a youth may possess contraband", as required by this provision, is included in either document. The 2012, draft policy does require that a "Frisk search is conducted when staff has a reasonable suspicion that juvenile may possess contraband." This provision does not require the reasonable suspicion standard for a frisk search and, in fact, a thorough frisk search at designated times, such at admission and when returning from outside the facility, is customary in juvenile detention. The FCJDC has recently had incidents of contraband entering the facility that could likely have been prevented if staff were conducting thorough frisk searches. When it came to my attention that the most recent search form and the proposed policy require blanket strip searches I expressed my concerns to the Director. She assured me that they were not in fact doing that and that the form and the policy would be revised.

Interviews with youth and staff again verified the apparent confusion and lack of clear policy or guidelines regarding searches at the FCJDC. Most youth interviewed reported that they had been required to remove their clothing, other than their underwear, in order to be searched at the time of admission. That practice exceeds the definition of a frisk search and exceeds the Basic Frisk Search description in the draft policy. Staff interviews offered varying responses. New staff members were generally unfamiliar with the facility's policy. More seasoned staff indicated that youth are required to undress to their underwear for "a strip/pat search".

An example of inconsistency regarding the conducting of searches, at the least, and potential violation of juveniles' rights is documented by an August 30, 2012 Incident Report. In that case, when four juveniles were implicated in an incident involving contraband (cigarettes and a lighter), only one youth was striped searched. No explanation was provided of why that youth was searched and why the other three youth were not searched. The Strip Search Procedures form requests "Reason for Search." The staff member completing the form only stated "Smoking" in response to that question, without any addition explanation of reasonable suspicion. The incident report indicates that a

different youth voluntarily turned in the lighter. That documentation is inadequate to explain or justify a strip search.

Staff interviews also addressed other types of searches. At the time of my June 2012 visit, some staff members interviewed said they are not allowed to do cell searches due to the Agreed Order. (The Agreed Order does not address cell searches.) That was very concerning at the time because, during my site visit, I consistently observed the juveniles' rooms as very untidy and dirty, containing many prohibited items, and, because of the clutter, it was not possible to determine whether those rooms contained potential weapons, tools or other contraband. At that time, it was also possible for juveniles to "pop" open the locks on their room doors from either the inside or the outside using such items as playing cards and eating utensils. The locks have since be repaired and can no longer be opened by youth. At my recent visit, residents' rooms were less messy and they are now reportedly being required to make their beds. However, they were often still cluttered and contained items that are prohibited. The 2012, draft policy states that there are four kinds of searches: "Basic Strip Search, Strip Search, Shakedown Search and Body Cavity Search." It also refers to "Cell Block Inspection" but does not define a "cell block" or describe how it is to be inspected. It is normal and expected practice in a juvenile detention center that individual rooms should be routinely inspected and, if indicated, searched. Such searches must not be arbitrary and must be conducted in a manner that respects the youth's space. Since the FCJDC has had problems with contraband entering the secure area and since residents still manage to accumulate items beyond what is allowed in their individual rooms, the FCJDC should develop an appropriate room search policy and procedure to more effectively ensure the safety and security of the facility, the staff and of the youth. That recommendation was included in my July 2012 report as well.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure that is consistent with the requirements of this provision. That policy and procedure needs to define "supervisor", at least as it is applied in this provision. That could include written delegation of authority to a "shift supervisor" or "shift leader" who would be adequately trained to perform that function.
2. Provide written documentation that all staff members have been trained on that new policy and procedure.
3. Provide documentation of implementation of the requirements of this provision, including a written description of reasonable suspicion and *prior* supervisory permission.

1.8 The Forrest County Juvenile Detention Center will support applications for alternative sanctions to secure detention that are reasonably calculated to reduce the demand for secure detention beds.

Compliance Rating: **Partial Compliance**

Discussion:

Many of the young people detained at the FCJDC are ordered there by a Youth Court judge for failure to comply with a court order, often for such non-violent behaviors as failing a drug screen. Those sentences may be for an extended period of time. Research indicates that use of secure detention in that way can be, not only counter-productive, it can result in negative impacts. Youth in detention are removed from their school while in detention which often results in them falling farther behind. They are unable to participate in positive activities in their community with family, church, sports and other institutions. And, most frequently, they develop resentment, feel unfairly treated, are not contrite, do not develop insight or make a logical connection between their behavior and the consequence of being in detention. Interviews with both youth and staff again confirmed that is the case.

During my site visit, the FCJDC Director described their efforts to offer an alternative to secure detention as a disposition for the Youth Court. She has offered the opportunity for youth to perform community service on Saturdays, performing cleaning work and being supervised by the detention center staff. Her efforts are to be commended. The program had only served one or two youth at the time of my site visit and it is unknown how supportive the judge and the Youth Court staff will be of that alternative. I am also concerned that the FCJDC also has a number of youth committed by the Youth Court, also as a disposition, from Friday afternoons until Sunday afternoons. That increases the FCJDC population on weekends, with no concomitant increase in staffing. That could result in staff being unable to ensure that the youth in detention receive the services that they need to be getting if they are required to supervise community service youth. That is even more worrisome given the fact that the FCJDC is still not in compliance with the requirement that they provide daily structured programming.

The development and availability of alternatives to secure detention continues to be strongly encouraged. Such non-secure programs do offer a number of benefits. Those programs help to avoid the negative effects of institutionalization. Those programs allow a youth to remain involved in positive activities in the community, including school, church, sports and other activities. Those programs reduce overcrowding in detention. And, those programs are cost-effective. But, those programs need to occur without depriving youth in secure detention of the services that they should be receiving.

Development of alternative programs to secure detention should be a collaborative effort by a variety of stakeholders such as the Forrest County Sheriff's Department, the FCJDC administration, the youth court, the school district and others. Often, those programs are developed initially to address issues of overcrowding. However, it is visionary and positive when a jurisdiction recognizes the value of alternative programs for the youth and community. The FCJDC has taken the initiative in creating alternative

sanctions; they should seek and include the involvement of other stakeholders with responsibility for what is in the best interest of the youth of Forrest County.

Recommendations for achieving substantial compliance:

1. Collaborate with community stakeholders to address this provision.
2. Develop written policies and procedures regarding the current alternative sanction program and any future programs that may be developed.
3. Incorporate expectations in FCJDC job descriptions that address alternative sanctions and FCJDC roles.

II. STAFFING AND OVERCROWDING

2.1 The Forrest County Juvenile Detention Center shall ensure that there are sufficient numbers of adequately trained direct care and supervisory staff to supervise youth safely, protect youth from harm, allow youth reasonable access to medical and mental health services, and allow youth adequate time spent in out-of-cell activities. Within 60 days of the date of this agreement, the Forrest County Juvenile Detention Center shall operate with a direct care staff to youth ratio of 1:8 from the hours of 6:00 a.m. until 10:00 p.m. and a ratio of 1:10 from the hours of 10:00 p.m. to 6:00 a.m. Nothing in this provision shall prohibit the use of adequately trained volunteers to provide services to detained youth.

Compliance Rating: **Non-Compliance**

Discussion:

This provision has multiple elements and all of those elements must be complied with to achieve Substantial Compliance. The FCJDC hired additional Direct Care Workers (DCW) (formerly: "Dorm Monitors") after the Agreed Oder was entered. Reportedly, those Direct Care Workers (are required to remain in the living units with youth to supervise them. The other direct care staff members at the FCJDC are the Corrections Officers.

A review of staff schedules and population reports show that the required ratio appears to be generally met. However, during my site visit I was present on one evening shift where there were only three staff members working in the facility. One Corrections Officer/Shift Commander was assigned to the control room where she was responsible for all communications within the facility and between the facility and the community, for opening and locking doors electronically, and all other safety and security requirements. The control room must be staffed continuously. Generally juvenile justice practice would not consider administrative, support or security staff as part of the youth-to-staff ratio and, given the requirements of the control room officer at the FCJDC, that should also be the case there. On the night in question there were sixteen (16) youth in residence, two

females in the A Unit and fourteen (14) males in B and C Units. There was one male Corrections Officer who reported that he had worked at the FCJDC for about three months and one female DCW who reported that she had worked at the FCJDC for one week. Neither reported having had any training since their employment. The male officer was responsible for working with the male youth in both B and C Units, resulting in at least half the time where each unit was without a staff member present. And, the male officer was also required to leave and *both* units at times while taking clothes to and from the laundry room. When I inquired of the control room officer what would happen if there was an altercation in one of the male units she stated: "Mike would just have to jump in." Mike has no training. That is a gross violation of this provision and contradicts even the most basic safety and security requirements of any juvenile facility. The control officer did report that there is normally one more DCW on that shift but that he was serving a suspension. When I expressed my concerns about the situation that I had observed to the Director the following day, she acknowledged that she had forgotten to fill the shift of the DCW who was off. The FCJDC Director has much on her plate. The facility has created the position of Staff Commander to oversee Shift Commanders. His specific job description is somewhat unclear and probably still being defined. It may be appropriate to delegate the responsibility for ensuring shift coverage to that person. More important, the FCJDC should develop and enforce a policy and procedure that requires a staff person to remain on shift until relieved. That expectation is standard in juvenile corrections to ensure safety and security.

During most of my observations on three separate visits, it has appeared that there is a sufficient number of direct staff at the FCJDC and that the incident described above is the exception. However, those staff members do not consistently supervise youth, as required by this provision. During my latest site visit, I again frequently observed residents in their units with no staff members present. During my recent visit, I observed some staff sitting outside the dayrooms of Units B and C observing the youth rather that being present within the dayrooms. The dayrooms in Units A, B and C are monitored by control room staff using cameras, although the camera lens in Unit A is still very unclear and it is extremely difficult to clearly observe youth and staff in that dayroom. That problem was pointed out in my last two reports but no change has occurred. Camera monitoring is not adequate and does not comply with this provision. When youth are in the dayroom without staff present, they are free to roam that room and to go into and out of individual cells unsupervised. Several of the Incident Reports from the three-month review period documented incidents where youth were unsupervised by staff. Most incident reports documented youth "creating a disturbance" or "fighting." It is my assessment that most, if not all, of those incidents could have been prevented or at least minimized if staff had been present in the units and actively engaged with youth. The frequent altercations between juveniles documented in incident reports illustrate the problems that can arise when youth are not directly supervised. And, when youth are in their individual cells, they are not visible and they are subject to self-harm or harm from other youth.

The newly created Staff Commander and the Shift Commanders' job descriptions should include the expectation that they ensure the physical presence of the line staff in the units with the youth. In addition, policy should prohibit staff members from leaving the building without prior supervisory approval, without punching out and in on a time clock and without ensuring that someone is available to replace the staff member who is temporarily absent from the facility or late in arriving for work. I have recommended that the FCJDC implement a time clock system to ensure greater accountability but they have chosen not to do that. The FCJDC should, at least, implement a policy that prohibits line staff from leaving the building without prior supervisory approval.

No staff training documentation was available for my review so it is not known how much, if any, training direct care staff members receive and what the nature of that training is. In some examples, based on my interviews, DCWs have had no facility-specific training. Reportedly, the State of Mississippi requires Corrections Officers to complete the state's Corrections Academy within two years of hire. That is an extremely long time for an employee to be working without formal training and could lead to dangerous practices by inadequately trained staff. In addition, staff members who have attended that Academy reported that the Academy provides approximately two weeks of adult corrections training and less than one week of juvenile training. There may be some areas where the adult training is applicable to a juvenile setting; without reviewing the curriculum I cannot know that. But, adult training could also be counter-productive and inappropriate for employees in a juvenile setting. The Mississippi state statue reportedly requires that corrections officers be certified by attending the state's corrections academy. Mississippi Code of 1972 Annotated, § 45-4-9 refers to certification of "jail officers", which may indicate that that certification is intended for officers employed an adult jail, not a juvenile detention center. It is not known whether statute requires juvenile detention centers be staffed by corrections or jail officers. If not, it may be more appropriate for the FCJDC to create a specific position to replace the corrections officer position. That new position would be designed to meet the unique needs of a juvenile facility and a juvenile population. Individuals in that role would be required to receive training appropriate for a juvenile facility in a more timely basis. The FCJDC has no formal, facility-based training program to supplement or supplant the state corrections academy and to ensure that employees receive vital training in a timely manner. They have begun discussing the development of such a training program. The training plan required by the Agreed Order may successfully address staff training needs and may replace the correction academy requirement. The FCJDC has high staff turnover, making staff training a challenge. However, allowing untrained or inadequately trained staff to work with youth in an environment where those youth are deprived of all control can and, in fact, has, lead to dangerous treatment of children.

Direct care staff members do not have written job descriptions. The lack of written job descriptions leads to a lack of clarity regarding job expectations and a lack of accountability on the part of both direct care staff members and administration. Job descriptions are being developed and are expected to be implemented soon. But, it is not clear which staff members at the FCJDC are considered "direct care staff" for purposes of

ensuring that required ratios are met. It is assumed that includes corrections officers and direct care workers. However, there are employees holding the title of "corrections officer" who have primary assignments that would preclude them from being counted as part of the staff to youth ratio such as the Control Room Officer, the Booking Officer and the Staff Commander. Those staff members' assignments require that they spend part or all of their shifts outside the living units, making them unavailable to directly supervise youth.

The involvement of volunteers can be a valuable addition to a comprehensive detention program. Although trained, adult volunteers may be used to supplement staff, they should not be used to replace staff and should not be responsible to ensure the safety of the youth.

The issues of the lack of direct staff supervision, inadequate number of staff members on some shifts and the lack of training for staff at the FCJDC have worsened at the FCJDC and have lead to their compliance rating regressing on this provision.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure consistent with this provision. That policy and procedure should prohibit staff from leaving youth without direct supervision unless they are replaced and without prior supervisory authorization.
2. Clarify for all FCJDC who has supervisory authority and the extent of that authority.
3. Develop and implement a staff-training program for all new and existing staff that includes training on expectations for supervising and interacting with youth.
4. Provide documentation that all new staff members are trained on job expectations in a timely manner.
5. Develop detailed, written job descriptions for all staff members at the FCJDC that include, at a minimum, expectations for supervising and working with youth.
6. Develop written policy and procedure that addresses requirements for staff who need to leave their work location, including at a minimum, arrangement for coverage and prior supervisory approval.
7. Consider establishing a time clock system to adequately monitor FCJDC staff time.
8. Investigate the possibility of replacing the "corrections officer" position with a title, accompanying job description and training, more appropriate for a juvenile facility.

2.2 If the staff-to-youth ratio falls below the requirements of § 2.1 for longer than two (2) days, the Director or his assignee shall immediately identify youth accused of nonviolent offenses who are eligible for less restrictive alternatives to secure detention and request an emergency release for eligible youth from the appropriate Youth Court. This provision shall not apply in the event that the Governor of Mississippi declares a state of emergency.

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC has not exceeded capacity since the Agreed Order dated October 12, 2011 so it has not been necessary to implement release procedures as described in this provision. However, there is still no written policy and procedure or other objective, written guidelines that would provide assurance that such procedures would be followed should the population increase beyond design capacity and be sustained at that level for two days or longer.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedures consistent with this provision.

2.3 The maximum capacity of the Forrest County Juvenile Detention Center shall be calculated by determining how many youth can be held in the facility when no more than two youth are assigned to a two-person cell, and no more than one youth is assigned to a one person cell. A two-person cell is a cell that contains two built-in permanent bunks. A one-person cell is a cell that contains one built-in, permanent bunk. The capacity calculation shall not include cells that are regularly used for intake or observation, nor shall it include any cells that are not attached to a dayroom. The current maximum capacity of the Forrest County Juvenile Detention Center is 32.

Compliance Rating: **Substantial Compliance**

Discussion:

The FCJDC appears to be in compliance with this provision.

Recommendations for achieving substantial compliance:

None

2.4 No more than two youth shall share a two-person cell, and no more than one youth shall be placed in a one-person cell.

Compliance Rating: **Partial compliance**

Discussion:

The population of the FCJDC continued to be well below capacity, generally ranging between eight and eighteen youth, since my last site visit, based on my review of population reports. No more than two youth were housed in any two-person cells during my visit although a number of cells housed two youth despite the availability of one-person

cells. No reports were received from either youth or staff of this provision being violated through housing assignments.

Although the FCJDC does not *house* more than two youth in a two-person cell or more than one youth in a one person cell, based on youth and staff interviews, review of incident reports and my own observations, it is clear that it is common to allow several youth to spend time, unsupervised, in one cell. That practice could be dangerous, could lead to bullying or violence, and must not be allowed to occur. Incident reports document examples of youth entering other residents' rooms and defacing those rooms with feces and other substances. Those incidents then led to fights between juveniles.

Although this provision was in substantial compliance in previous reports, I simply cannot again award that rating as long as residents are allowed to freely enter rooms of other youth, unsupervised by staff. That practice is not only unsafe, it can and has lead to incidents within the facility.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedures consistent with this provision.
2. Document staff training on the policy and procedure.
3. Create a specific facility rule for youth prohibiting youth from entering rooms of other detainees.
4. Document that all youth have been made aware of that rule through an initial orientation that includes, among other things, an explanation of FCJDC minor and major rules, through providing all youth with a copy of the FCJDC rules and through posting the FCJDC rules

III. CELL CONFINEMENT

3.1 Youth shall be engaged in structured, rehabilitative programming outside of their cells during the hours of 7:00 a.m. to 10:00 p.m. each day, including weekends and holidays.

Compliance Rating: **Non-compliance**

Discussion:

Among the documents requested and provided to me by the FCJDC was the daily facility schedule. There are actually five different schedules, Saturday, Sunday, Monday/Wednesday, Tuesday/Thursday and Friday. Those new schedules had not yet been implemented and were not posted in the facility. Those schedules do suggest that the waking hours, between 7:00 a.m. and 10:00 p.m. are generally scheduled with a variety of programming activities. However, my interviews with staff and youth, review of documents, and observations throughout the four days that I was on site make it clear that

there is still little or no structured, rehabilitative programming for youth at the FCJDC. The daily routine and activities at the FCJDC appear to be disorganized and, at times, chaotic. Even the daily school schedule, so very important to this population is often disregarded or changed.

The new schedule requires that juveniles wake-up at 7:00 a.m. are locked down for the night at 10:00 p.m. The 2007 FCJDC *Standard Operating Procedure,* in the "Lock-down Procedures" section, states that youth are locked down at 20:00 Friday through Sunday and at 22:00 on Saturday. That manual further states: "Unless otherwise noted, all units will stay locked down until 0600 hours the next morning." The written procedures and the actual practice at the FCJDC have not been consistent with each other and their compliance with the requirements of this provision appears to vary. Most staff did seem to be aware of the expectations of the new schedule, which is consistent with the schedule that was posted but, again, not followed at the time of my last visit, at least regarding times for wake-up and lights-out. There are no clocks in the units and I was told that the FCJDC was not allowed to hang clocks where youth may access them. However, it is important for youth to know what they should expect during their day (a posted schedule) and to know what time it is in order to anticipate activities and to be responsible. In addition, a posted schedule and visible clocks would help to provide more structure to the staff and would also help hold them accountable for ensuring that youth do receive the programming required by this provision. There are clocks specifically designed for environments that may be subject to abuse. I recommend that the FCJDC investigate that option.

There is one teacher employed by the Hattiesburg School District who serves the FCJDC. At the time of my June 2012 visit school was not in session. At the time of my March 2012 visit, the teacher was serving only four youth at a time for one hour each. At that time he had no written schedule for his school day, which would list the subjects being taught and the students being served. The Mississippi Code of 1972 Annotated, § 37-13-91(d) defines a School day as "not less than five (5) and not more than eight (8) hours of actual teaching in which both teachers and pupils are in regular attendance for scheduled schoolwork." The Mississippi Code of 1972 Annotated, § 37-13-91(f) defines a "compulsory school-age child" as "a child who has attained or will attain the age of six (6) years on or before September 1 of the calendar and who has not attained the age of seventeen (17) years on or before September 1 of the calendar year." Clearly the limited school program at the FCJDC of one hour per day per child did not meet the requirement of the state statute. There is ample research that verifies that lack of formal education leads to potentially lifelong problems. Young people who are not adequately educated will be un- or underemployed, will be more likely to become involved with the adult criminal justice system and will be more likely to be incarcerated as adults.

The Mississippi compulsory education statute was discussed in my June report and at the beginning of the 2012-2013 school year, all youth at the FCJDC began attending school for up to five hours. However, there continue to be a number of areas where the school program continues to be sub-standard, therefore, not contributing adequately to the

required structured, rehabilitative programming. The teacher's daily attendance role is simply taken from the FCJDC population reports and does not delineate attendance by period, subject or even morning or afternoon. If a child is in class at any time, that child is counted as present. In viewing the roll it was noted that no class was held on at least two days during the week before and during my visit. The teacher informed me that school had been cancelled because a FCJDC staff meeting was held. School cannot be cancelled for the convenience of the facility. I was told by the FCJDC administration that half the staff attended that staff meeting one day and the other half attended on a different day. Those arrangements were made to ensure staff coverage at the facility. Therefore, since staff members were on shift, school should not have been cancelled. During my visit I observed youth in their units in the morning an hour-and-a-half after the scheduled start of the school day. That same day, I observed youth in their units an hour after they were scheduled to return to school following lunch. Staff and youth interviewed gave a variety of answers when I asked how many hours school is held each day and what the schedule is. No attendance or participation records are kept by subject and no effort is made to individualize the academic program to address learning or credit deficits other than on a computer-based program available on four computers in the classroom. Lesson plans are not written. Any credits that a youth may earn for time spent in school while at the FCJDC are not transferred upon release. Federal mandates are not being met, including Individual Educational Plans and special education services. Not only does the very limited school program at the FCJDC not contribute to structured, rehabilitative programming outside of their cells, as required by this provision, it does not meet legal requirements or help ensure that youth detained at the FCJDC will have the same opportunities for productive lives as juveniles living at home or elsewhere in the community. That said, at least the FCJDC and the Hattiesburg School District has attempted to schedule the school day to approximate the state law and it is a vast improvement over the extremely inadequate school program that was in existence in March 2012.

There is still no planned recreation program at the FCJDC but most youth and staff report that the residents usually go outside daily for an hour unless inclement weather prevents that. Both staff and youth reported that the sole outside recreational activity is still basketball although the staff usually lead the boys' units in warm-up stretches and calisthenics before beginning play. However, as has been the case in past site visits, when I observed the boys outside for their daily outside recreation, approximately half or fewer of the boys were shooting baskets with staff while the other half of the male detainees were sitting idly on the sidelines with no staff interaction. Youth and staff interviewed confirmed that what I observed is typical and that youth are allowed to choose not to participate. No alternative activity is provided for youth who do so. That does not ensure that youth received "structured, rehabilitative programming."

There still appears to be little or no organized, planned, structured, rehabilitative programming provided for the youth at the FCJDC. Staff members and juveniles that I interviewed reported that daily activities include watching television, playing cards or Dominos, watching movies, "hanging out", "laying around" and "sometimes go outside". No

other activities that might be considered structured or rehabilitative were mentioned. Although a certain amount of free time may be incorporated into a schedule it is important that youth be kept busy and involved in facility programming. That not only benefits the young people who are detained, it helps maintain order and security at the facility and reduces the number of incidents that may occur. The physical plant at the FCJDC has significant limitations and creates substantial challenges in achieving compliance with this provision. The FCJDC administration has attempted to be creative in developing programming and has invited religious volunteers to visit and provide group activities. Although those are reportedly scheduled on most weekdays, none occurred during my visit. To date, little programming has occurred at the FCJDC.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedures consistent with this provision.
2. Document staff training on the policy and procedure.
3. Develop written staff job descriptions that address the requirements of this provision.
4. Develop a structured schedule of daily activities, including a variety of rehabilitative programs such as recreation, arts and crafts, and education.
5. Establish a system to hold staff members accountable for adhering to the daily schedule.
6. Work with local school officials to develop an appropriate, full-day educational program that is available to all youth at the FDJDC that ensures that youth receive education appropriate to their academic level and in accordance with their academic needs, including special education needs.

3.2 Except when youth are in protective custody or confined subject to § 3.3 of this Agreed Order, youth placed in the Holding, Detox, or D-Unit cells shall be allowed to spend the hours of 7:00 a.m. to 10:00 p.m. on the appropriate living unit to have the opportunity to engage in structured, rehabilitative programming.

Compliance Rating: **Non-Compliance**

Discussion:

There is still virtually no structured, rehabilitative programming at the FCJDC. During my site visit I did observe a youth housed in the D-Unit for disciplinary purposes. Although fifteen-minunte room checks were documented, I did not observe those checks occurring during some of the time that I was able to observe that unit. That is obviously a potentially serious, egregious and potentially fraudulent falsifying of records. The FCJDC has a history of confining youth to their rooms in A, B or C units, isolating them in D unit or isolating them in the Detox or Holding cells without documenting minimum fifteen-minute checks. I would recommend that the FCJDC consider installing a monitoring system that

uses a hand-held wand that swipes a unit on each room door to verify that the staff member at least went to the individual doors. Those systems do not guarantee that the staff member visually checks the child but they do confirm that the room was visited. Many juvenile facilities around the country are using those systems as a safety measure and to help hold staff accountable. The fifteen-minute room-check documentation for the youth confined to D Unit during my visit also indicated that he was behaving calmly and compliantly most of the 24 hours that he was confined. He could have been returned to the group at almost any time; continuing his confinement served only to punish him, not for him to regain control and to gain his compliance. That is not an appropriate use of confinement. And, he was, in the process, denied any opportunity to participate in programming, had there been any. He was even denied the opportunity to interact with staff or with other youth who were watching television, playing cards or socializing and he was unable to join in regular recreational activities as required. With little or no structured, rehabilitative programming, the FCJDC cannot be considered in compliance with this provision. I did not observe juveniles being held in either Detox or Holding during my site visit. My review of incident reports for the period of June 2012 through September 2012 did reveal that juveniles may be placed in Detox or Holding, as well as D Unit, as a disciplinary measure but those reports still did not indicate the time of placement or the time of release, whether required fifteen-minute room checks were conducted or whether youth placed in D Unit, Detox or Holding were offered the opportunity to engage in any kind of programming, even the one hour of school and the one hour of outdoor activity that is provided.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure consistent with this provision.
2. Provide documentation of staff training on the policy and procedure.
3. Develop and implement a structured schedule of daily activities, including a variety of rehabilitative programs such as recreation, arts and crafts, and education.
4. Provide documentation of the use of the Holding, Detox and D Unit cells, including the youth placed in those cells being allowed to spend the hours of 7:00 a.m. to 10:00 p.m. on the appropriate living unit to have the opportunity to engage in structured, rehabilitative programming.
5. Install an electronic system to verify that rooms are checked at required intervals when juveniles are confined.

3.3 Youth who pose an immediate, serious threat of bodily injury to others may be confined in their cells for no longer than 8 hours at a time without administrative approval. Youth who are placed on cell confinement for this reason shall be released from their cells daily to attend school, maintain appropriate personal hygiene and to engage in one hour of large muscle exercise. Staff must perform visual checks on youth who are subject to cell confinement every fifteen minutes. Staff must document all instances of cell

confinement in writing and must document the justification for determining that a youth poses an immediate, serious threat of bodily injury.

Compliance Rating: **Non-compliance**

Discussion:

Written incident reports for the period of June 3, 2012 through September 25, 2012 illustrated numerous examples of cell confinement. However, most reports did not specify the time that the period of confinement began or the time that that period ended. Therefore, it is not possible to determine if those confinement periods exceeded the eight-hour period, requiring administrative approval. No documentation was provided of confined juveniles being "released from their cells daily to attend school, maintain appropriate personal hygiene and to engage in one hour of large muscle exercise", as required by this provision. In fact, in one case, the FCJDC schoolteacher initiated the confinement. That report does not indicate whether any effort was made to reintegrate that youth into school or otherwise address the issues that may have led to that discipline. It also does not indicate the time of confinement or the time of release. Of the 54 copies of incident reports provided by the FCJDC for my review, only four included documentation of fifteen-minute visual checks. That documentation includes the time of the visual as well as a statement of the youth's behavior at that time (i.e. "laying down".) When a youth is calm and appears to be compliant, the staff should attempt to reintegrate him into the group rather than dictate these apparent determinate periods of confinement, which seem to be the norm at the FCJDC. Some incident reports specifically state that a youth was to be locked-down for eight hours. That determinate period of confinement contradicts effective disciplinary practice in which a juvenile may be confined until he calms down or becomes compliant. One incident report even states that the juvenile "will remain in D-4 for (8) hours" and that his "cool-down isolation will expire @ 23:00 hours (11:00) p.m." That practice also fails to comply with the requirement of this provision of documenting "the justification for determining that a youth poses an immediate, serious threat of bodily injury." It may also exemplify staff attempting to circumvent the requirement of this provision that administrative approval be obtained for periods of confinement exceeding eight hours. There are also still examples of the entire group being placed on lock-down when only one or two youth are have offended.

The FCJDC Incident Report form includes a line that states "Reviewed by:____Date:____". At the time of my first visit in March 2012, none of the incident reports that I reviewed had an approval signature. At the time of my June 2012 visit, most of the fifty-two reports reviewed did have an approval signature. That approval was by the Assistant Director at that time. That Assistant Director also completed incident reports but her own reports were either not approved or she signed her own approval. When I discussed several problematic reports with the administrative staff, and asked the Assistant Director why she approved them, she acknowledged that she merely signed them and had not considered that she should read them for content or appropriateness before

signing with her approval. I advised both the Assistant Director and the Director that an administrator should review all incident reports and that those reports should not be approved until they were complete and appropriately written. I also advised them that such a practice could serve as a training tool for staff as well as an opportunity for administration to oversee incidents in the facility. Most of the incident reports provided for my review this time did have approval signatures but there were still many of the incident reports that had incomplete information. The incident report form does not include space to document visual checks on confined youth. Reports did not include the exact time of confinement and the time of release from confinement. Some incident reports state that a youth has violated a "major rule." There is no list of either major or minor rules at the FCJDC. A youth should only be confined based on his violation of a specific, written rule that youth have been notified of. A youth should only be confined until he becomes calm and is ready to rejoin the group. My June 2012 report discussed these same issues but little has changed.

The 2007 FCJDC *Standard Operating Procedure* does not address incident report requirements. That manual does have a section on "Rule Violation Reports" that states that the juvenile "is given written notice of the [rule] violation, a hearing in front of an impartial Officer to determine guilt and determine sanctions, and a means of appeal. Sanctions include suspension/loss of visitation, suspension/loss of store call privileges, suspension/loss of T. V. privileges, etc. Corporal punishment is not a sanction and is never to be used nor should nay [sp] punishment that violates the civil rights of the juvenile." Rule Violation Reports have recently begun to be used again at the FCJDC. However, the 2007 policy discusses possible sanctions that cannot occur at the FCJDC (there is no store, for example) or which would be a violation of a juvenile's rights and have no relationship to the offence committed (lost of visitation or phone, or loss of T. V. which would only be possible through cell confinement.) That 2007 policy is in the process of being revised but the initial draft of the revised version lacks sufficient specificity to be administered fairly and consistently and requires additional work. There is also a draft policy and procedure entitled "Documentation" but that policy does not address either Incident Reports or Rule Violation Reports. The 2007 *Standard Operating Procedure* manual does not address room confinement and it does not address visual checks on youth confined to their cells. The draft Policy and Procedure discusses "Cell Confinement" when it is used as a last resort effort and there is no mention of the required fifteen-minute rooms checks, as required by this provision.

Recommendations for achieving substantial compliance:

1. Develop policy and procedure consistent with this provision and which ensures that disciplinary confinement at the FCJDC occurs only for violating specific, written rules and that the duration of any disciplinary confinement occurs only until the youth becomes calm and is no longer a potential threat. The existing section of the *Standard Operating Procedure* on "Rule Violation Reports" should be revised

consistent with this agreement or replaced with an appropriate policy and procedure.

2. Develop or revise forms used to document cell confinement, consistent with this provision, including at least the date and time of the incident, type of incident, detailed description of the incident, youth involved/youth witnesses, staff involved/staff witnesses, date and time of report, administrative review with date and time, date and time of placement in confinement and release from confinement, and medical information. Consideration may be given to the development of two forms, an incident report form that would be used for all unusual incidents and a room confinement form that would be used for all room confinement, generally for disciplinary purposes, and that would include space to document required room checks.
3. Provide documentation of staff training on the policy and procedure and required documentation.
4. Provide examples of documentation of the revised practice required by this provision.

3.4 Youth shall not be automatically subjected to mandatory cell confinement and/or isolation upon their admission to the Forrest County Juvenile Detention Center unless he or she would be subject to cell confinement under § 3.3. Nothing in this paragraph shall prohibit Detention Center staff from allowing youth to choose to spend time in their cells. No youth shall be subject to mandatory cell confinement unless he or she would be subject to cell confinement under § 3.3. In the event that a youth opts to spend time in his or her cell, Detention Center staff shall develop policies and procedures for documenting voluntary cell confinement

Compliance Rating: **Partial Compliance**

Discussion:

During my site visit I did not observe any juveniles in either the Detox cell or in the Holding cell. Staff and youth interviews indicated that youth admitted to the FCJDC are generally dealt with by staff immediately and are placed in one of the living units after completing intake requirements.

Youth are still allowed to be voluntarily placed in a room in D Unit which essentially isolates them, does not allow them to be oriented by staff, does not facilitate their integration into the group and is a potentially dangerous practice. When a youth chooses voluntary room confinement, the FCJDC documents that youth's decision by having him sign a "Documentation of Voluntary Cell Confinement" form. That form states: "I am choosing to stay in my cell. I understand that every day from 7:00 a.m. to 10:00 p.m. I have the right to be out of my cell. During those times, I understand that I can ask an officer to let me out of my cell to spend time on the unit." However, that form does not document

regular visual checks by staff, efforts by staff to persuade the child to join the larger group attempts to determine why the youth has chosen to isolate himself. Staff informed me that youth often do choose placement in D Unit in order to be separated from the boys in either Units B or C because they are afraid of or intimidated by those boys. However, Unit D consists of nothing but cells with no dayroom, no structured activities and little or no staff interaction. If a child is frightened of the other youth in either Unit B or C the staff members should address those feelings and act in such a way that the youth is reassured and feels safe. The practice of allowing youth to voluntarily isolate themselves should be discouraged and staff members should be trained in relationship-building and verbal skills to encourage the youth to join the larger group. Because there is still very little structured programming in the living units and limited staff presence and because the building construction and sound from the television elevate the noise level, there is a chaotic atmosphere in the three living units, which could understandably cause a youth to feel intimidated. Meeting the expectation that staff be present in the units and interact positively with youth can mitigate such feelings.

The most recent research on juvenile suicide in confinement (see, "Juvenile Suicide in Confinement: A National Survey"; Hayes, Lindsay M.; U. S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention; 2009), reports that approximately half of the completed suicides in juvenile facilities occurred when youth were confined to their rooms. Facility staff have less information on youth who have recently been admitted to detention and allowing those young people to voluntarily isolate themselves does not allow staff members to learn of the child's fears and needs. Simply put, isolation should be avoided to enhance youth safety. My March and June 2012 Monitoring Reports also included this advice but there appears to have been no change in the practice of overusing the D Unit rooms at the FCJDC. And, when I was on site at the FCJDC, I observed D Unit rooms being used but I again did not observe the required, fifteen-minute visual room checks being conducted of youth in those rooms.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure that is consistent with this procedure. That policy and procedure should discourage voluntary room confinement at anytime, including immediately upon admission. That policy and procedure should require a written justification for any cell confinement, should require that staff members document their efforts to facilitate the child's joining the larger group and require documentation of visual room checks a minimum of fifteen minutes apart. That policy and procedure should require that a mental health professional assess a child who chooses to be voluntarily isolated after efforts are made unsuccessfully to have that child rejoin the group.
2. Provide documentation of staff training on the policy and procedure.
3. Provide written examples of youth who are confined to their cells, either voluntarily or involuntarily, including justification for that confinement, efforts to have the child

join the larger group and random visual room checks at a minimum of fifteen-minute intervals.

3.5 At all times between the hours of 7:00 a.m. to 10:00 p.m., at least one direct care staff shall be stationed on any living unit where two or more youth are placed, and direct care staff shall be actively engaged with youth. From 10:00 p.m. to 7:00 a.m., staff shall conduct visual checks on youth every 15 minutes. Within 60 days of the execution of this agreement, the Defendant shall ensure that every cell has an adequate communication system that allows youth to communicate with staff at all times.

Compliance Rating: **Partial Compliance**

Discussion:

This provision has multiple elements and substantial compliance requires that all of those elements be addressed.

Although, several months ago, the FCJDC hired a number of Direct Care Workers (formerly Dorm Monitors) to provide direct supervision of youth in the living units, I again observed numerous times during my recent site visit when no staff member was present in various units. At the time of my first site visit there were times when I observed up to six direct care staff members in the control room. During my last visit it was rare to see anyone in the control room other than the officers assigned there and during this visit staff informed me that they were prohibited from "hanging out" in the control. However, Direct Care Workers in the units were often not engaged with residents but appeared to be simply observing until they were required to react to a problem or altercation. My review of incident reports for the three-month monitoring period revealed several examples of disturbances or fights where staff members had not been present in the dayrooms at all and were required to respond from some other location in the facility. As was discussed in 2.1 above, I even observed some staff sitting outside the dayrooms observing residents through a window rather than being stationed on the living unit and "actively engaged with youth," as required by this provision. And, as stated in Provision 2.1, it is my assessment that most, if not all, of those incidents could have been prevented or at least minimized if staff had been present in the units and actively engaged with youth. The frequent altercations between juveniles documented in incident reports illustrate the problems that can arise when youth are not directly supervised.

During my visit I observed few youth confined to their cells during either day or evening shifts. At the time of my last site visit, forms had been developed to document visual rooms checks but, as discussed in 3.3 above, documentation of visual, fifteen-minute checks of confined youth was not provided with incident reports describing confinement. As was discussed in my July 2012 report, forms used to document room checks had pre-printed times at fifteen minute or one hour intervals. FCJDC administration was advised by

this monitor that room checks should be random and that the time of the checks should not be pre-printed on the form in order to ensure randomness. The form has been revised to eliminate the pre-printed times. However, in the few cases where documentation of fifteen-minute room checks was provided, those checks were still at exactly fifteen-minute intervals rather than random.

The FCJDC has an intercom system in residents' cells but I again observed officers in the Control Room being non-responsive to residents' requests and, since there were often no staff members in the unit day rooms, no staff were readily available to respond to youth needs. The officers working in the Control Room have numerous duties to perform, possibly leading to delays in responding to youth. However, neither youth nor staff (nor court-appointed monitors) can see outside the dayrooms and can only yell for assistance or continue to knock on the door and hope that assistance will be forthcoming. That system is simply not responsive, adequate or safe.

The finding of Partial Compliance with this provision is given with hesitance and only because the FCJDC usually has a sufficient number of staff on duty to comply with this provision. However, any future monitoring reports would require significantly progress to not be found in Non-Compliance.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure consistent with this provision.
2. Provide documentation of staff training on the relevant policy and procedure.
3. Develop written direct care staff job descriptions that include the expectations of this provision.
4. Provide written documentation of random, visual checks on confined youth at least every fifteen minutes. Those visual checks must be done directly, not via a monitoring camera.

IV. STRUCTURED PROGRAMMING

4.1 The Forrest County Juvenile Detention Center shall establish and administer a daily program, including weekends and holidays, to provide structured educational, rehabilitative, and/or recreational programs for youth during all hours that youth shall be permitted out of their cells, pursuant to § 3.1. Programming shall include:

- **a. activities which are varied and appropriate to the ages of the youth**
- **b. structured and supervised activities which are intended to alleviate idleness and develop concepts of cooperation and sportsmanship; and**
- **c. supervised small group leisure activities, such as a wide variety of card and table games, arts and crafts, or book club discussions.**

Compliance Rating: **Non-Compliance**

Discussion:

There is still no daily program to provide structured educational, rehabilitative, and/or recreational programs for youth at the FCJDC. There has been some effort to provide activities to the juveniles but only to a very limited extent. I was provided with five new written schedules (Saturday, Sunday, Monday/Wednesday, Tuesday/Thursday and Friday) that reflected scheduled activities for most of the residents' waking hours. However, those schedules were not posted and had not yet been implemented. And, those schedules lack the specificity necessary to ensure that staff members are meeting the requirements of this provision. And, as was discussed in 2.1 above, what schedule does exist at the FCJDC is not consistently adhered to, including the hours that the youth are slated to be in school. In addition to an explicit, written, posted schedule of planned activities, I would again recommend that the FCJDC hang clocks in the living units that will help both staff and youth ensure that scheduled activities actually do occur as planned. In addition to the school hours being varied during my site visit, the outdoor recreation period appears to be flexible and the written schedules do not allow sufficient time for both boys and girls to spend at least one hour each day in recreation, even if the two boys' units are combined. Again, during my most recent visit, the only recreational activity that occurred was a maximum of one hour of basketball in the outside play area, with over half of the boys being allowed to not participate. No activities were observed in the dayrooms other than some playing of cards. The television sets were on continuously, regardless of whether anyone was watching them and the volume added to the commotion and limited the possibility of providing programming as required by this provision. There were again frequent times when juveniles were observed in dayrooms with no staff present. Games were observed stored in the Control Room but were never seen in the units during my visit. Books were also stored in the Control Room but none of the youth interviewed reported knowing how to borrow books from the Control Room or from the school classroom.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure that requires a daily program to provide structured educational, rehabilitative, and/or recreational programs for youth at the FCJDC and that details expectations for staff in carrying out the program.
2. Implement a written daily schedule of activities at the FCJDC and establish the expectation among staff that it be adhered to.
3. Develop written job descriptions for staff at the FCJDC that address the requirement that they implement a daily program to provide structured educational, rehabilitative, and/or recreational programs for youth at the FCJDC.
4. Provide written documentation of daily programming provided to youth at the FCJDC.

V. DISCIPLINARY PRACTICES AND PROCEDURES

5.1 The Forrest County Juvenile Detention Center shall develop a discipline policy and practice that incorporates positive behavior interventions and supports. This policy shall include guidelines for imposing graduated sanctions for rule violations and positive incentives for good behavior.

Compliance Rating: **Non-Compliance**

Discussion:

The FCJDC still has no discipline policy and procedure that incorporates positive behavior intervention and supports and, therefore, there are no guidelines for rule violations and positive incentives for good behavior. The existing *Standard Operating Procedures* manual does not include a discipline policy and procedure. The only discussion in that manual related to this provision is under the section entitled "Rule Violation Reports." That section states: "All cellblocks at the Forrest County Juvenile Detention Center have posted rules and regulations for the detainees to follow. These rules and regulations are necessary to keep control over the detainee population and to provide safety to staff and detainees. Each Officer will enforce the rules and regulations." Nothing in that policy and procedure addresses the elements of this provision. And, staff members reported that Rule Violation Reports (RVRs) had just recently been reintroduced at the FCJDC but staff members interviewed were unclear about when RVRs are to be used. With the exception of two RVRs, the only documentation of discipline still appears to be the completion of Incident Reports. However, there is no documentation, through RVRs or Incident Reports of minor or major rule violations and any resulting disciplinary action or graduated sanctions. It appears that most disciplinary action consists of room confinement and I did review documentation, in come cases, of regular, fifteen-minute room checks, as required by Provision 3.3 of the Agreed Order. However, I also directly observed rooms with residents confined for disciplinary purposes without fifteen-minute room checks being conducted. It is not clear exactly what room confinement is used for at the FCJDC. Since there is no list of major and minor rules and no discipline policy and procedure that incorporates positive behavior intervention and supports, a youth at the FCJDC could be confined for up to eight (8) hours without administrative approval simply based on an untrained staff member deciding that he may "pose an immediate, serious threat of bodily injury to others", under Provision 3.3. In fact, incident reports from the three-month monitoring period document occasions when youth are required to spend a determinate period of eight hours of room confinement. No mention is made of "up to" eight hours or of early release from confinement, based on appropriate behavior.

Facility rules were posted in all units but those rules are still very general and do not provide clear expectations to youth and staff in order to ensure that incentives and sanctions are consistent and fair. I discussed the need to delineate lists of minor and major rules of conduct for youth at my March and June visits but that has not yet occurred.

Incident reports that I reviewed illustrated a number of examples of disciplinary actions based on alleged violation of rules that were not written down anywhere. I witnessed the intake process for two detainees while on site and noted that residents were offered a copy of a "Handbook", which contained *no* discussion of rules, to look at during the admission process. That booking process includes several steps and numerous tasks that must be completed and the juveniles that I observed did not read the "Handbook" nor were they provided with their own copy to refer to while at the FCJDC, even if it had included a list of facility rules. There is still no formal orientation that occurs at the time of admission explaining the facility rules and the facility discipline policy, among other things.

During my site visit a number of youth and staff described a recent disciplinary practice that is not only inappropriate, it is not documented and is not based on any written policy and procedure. That practice involves requiring youth to perform twenty push-ups for swearing, an additional twenty push-ups if a female is present and an additional twenty push-ups for taking the Lord's name in vain. Use of mandatory physical exercise as a punishment is unacceptable legally, is divergent from prevailing juvenile justice practice and is a slippery slope towards potentially more dangerous and punitive measures. That practice should cease immediately. (Since my September site visit, subsequent to an October 9, 2012 letter from the Southern Poverty Law Center expressing concern about the use of mandatory push-ups as discipline, the FCJDC Director has informed all parties that that practice is no longer allowed.)

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure consistent with this provision. That policy and procedure should include a list of minor and major rules and the accompanying sanctions for violating those rules. That policy and procedure should include graduated sanctions for rule violations as well as positive incentives for good behavior.
2. Provide written documentation that all staff members have been trained on the new policy and procedure.
3. Develop a comprehensive, written list of minor and major rules for the facility. Provide a copy of those rules to each youth at the time of admission as part of a facility orientation procedure. Post the list of rules prominently in each unit.
4. Develop forms to document disciplinary interventions and sanctions.
5. Provide documentation that the newly developed forms are being used and that the new policy and procedure is being followed.

5.2 The Forrest County Juvenile Detention Center shall clearly communicate facility rules to all residents and post rules prominently throughout the facility.

Compliance Rating: **Partial Compliance**

Discussion:

As stated in provision 5.1 above, at the time of my site visit, facility rules were posted in all units. The written rules are still very general and do not provide clear expectations to youth and staff in order to ensure that incentives and sanctions are consistent and fair. The posted FCJDC General Regulations and Rules of Conduct for Detainees does not list specific, minor and major rules to inform residents of what facility expectations are and what consequences are for violating rules. In addition to that list, I was provided with a Page 2 that does offer more specificity but still does not define rules as minor or major. Page 2 was not provided to me at the time of previous visits and is not posted in the units or elsewhere in the facility. The Detainee Handbook, dated September 18, 2012, does not include mention of rules of conduct. I was able to observe the intake process for detainees on two different days. During that process, new residents were given a copy of the Handbook to look at but there was insufficient time to read it, it was not explained to them and they were not provided with a copy to keep. The youth at the FCJDC still do not receive their own written copy of the rules upon admission and there is still no formal orientation at the time of admission explaining the facility rules and the facility discipline policy, among other things.

Recommendations for achieving substantial compliance:

1. Develop a comprehensive, written list of minor and major rules for the facility that accompanies a discipline policy and procedure.
2. Post that list of facility rules prominently at least in each of the units.
3. Provide a copy of those rules to each youth at the time of admission as part of a facility orientation procedure.

5.3 Youth who violate major rules may be subject to room or cell confinement for up to 24 hours for a single rule violation. An occasion in which a youth is alleged to have contemporaneously violated multiple major rule violations shall count as a single rule violation for the purposes of this section. No youth shall be confined to a room for longer than 8 hours for a single rule violation without written notification of the alleged rule violation to the accused youth and the occurrence of a disciplinary review/due process hearing before an impartial staff member of the Forrest County Sherriff's Department (including but not limited to Detention Center Staff) who was not involved in the rule violation. The hearing shall include the participation of the accused youth. Under no circumstances shall youth be subject to involuntary cell confinement for longer than 24 hours for disciplinary purposes. Youth who are placed on cell confinement shall be released daily from their cells to attend school, maintain appropriate personal hygiene and to engage in one hour of large muscle exercise.

Compliance Rating: **Non-Compliance**

Discussion:

Based on my review of Incident Reports for the period of June 3, 2012 through September 24, 2012 I found numerous examples of residents being placed on room confinement. However, as discusses in 3.3 above, most reports did not specify the time that the period of confinement began or the time that that period ended. No documentation was provided of confined juveniles being "released from their cells daily to attend school, maintain appropriate personal hygiene and to engage in one hour of large muscle exercise", as required by this provision and provision 3.3. Therefore, it is not possible to determine if those confinement periods exceeded the eight-hour period, requiring "written notification of the alleged rule violation to the accused youth and the occurrence of a disciplinary review/due process hearing before an impartial staff member of the Forrest County Sherriff's Department," as required by this provision. In fact, as discussed in 3.3 above, there were a number of incident reports that documented confinement of a juvenile by a line staff member for exactly eight hours, which appears to be a way to circumvent the required "written notification of the alleged rule violation to the accused youth and the occurrence of a disciplinary review/due process hearing." Further, there were a number of incident reports that documented confinement of a juvenile by a line staff member for twenty-four hours with no documentation of administrative review or due process. I was provided with two completed Rule Violation Reports (RVRs), each with an accompanying form, entitled "Disposition" that appears to be some kind of hearing documentation. That "Disposition" form appears out-of-date and it does not adequately address the elements of this provision. Other than the two samples of that "Disposition" form, there was no documentation that youth received "written notification of the alleged rule violation or of any disciplinary review/due process hearing before an impartial staff member of the Forrest County Sheriff's Department, who was not involved in the incident", before the youth was disciplined with room confinement of as much as twenty-four hours. Only a handful of records were available to document regular, fifteen-minute checks on youth confined to their rooms.

There is no written list or definition of "major" or "minor" rules. Based on incident reports, I have to conclude that staff members are still able to make arbitrary determination regarding whether a major rule has been violated. Incident reports describe behaviors but, without a clearly stated list of rules, it is difficult to determine whether a youth is contemporaneously violating more than one major rule. There is no documentation that juveniles at the FCJDC receive notification of alleged rule violations and whether their rights to disciplinary review/due process hearings honored.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision and which ensures that disciplinary confinement at the FCJDC occurs only for violating specific, written rules and that the duration of any disciplinary confinement is only

until the youth becomes calm and is no longer a potential threat. The existing section of the *Standard Operating Procedure* on "Rule Violation Reports" should be revised consistent with this agreement or replaced with an appropriate policy and procedure.

2. Provide written documentation that all staff members have been trained on the new policy and procedure.
3. Provide documentation of room confinement, including, at a minimum, date and time of confinement and date and time of release, reason for the confinement, staff member initiating the confinement and notification of the youth of alleged rule violation, his right to disciplinary review/due process hearing and minimum fifteen-minute room checks.
4. Develop a list of major and minor facility rules that is made available to all youth at the time of admission and posted in all units.
5. Develop a written orientation process that explains such things as facility rules and juveniles' rights and include information consistent with this provision in that process.

VI. USE OF RESTRAINTS

6.1 Mechanical restraints shall not be used to punish youth or for the convenience of staff. Mechanical restraints shall only be used to prevent self-harm, subject to § 6.4, and for transportation to and from court or outside the facility, subject to § 6.2.

Compliance Rating: **Partial Compliance**

Discussion:

School was in session during my visit and interviews with both staff and youth, along with my observation, verified that shackles are no longer being used on youth attending school at the FCJDC. Staff and resident interviews also verified that shackles are no longer being used to transport youth to the Forrest County Youth Court, located in the same building as the FCJDC. Youth at the FCJDC are required to wear shackles when being transported outside the building for such things as medical appointments. That use would generally be considered an appropriate use of mechanical restraints to ensure security and not for the convenience of staff. However, no written documentation justifying that practice was provided for my review, including such things as policies from law enforcement agencies responsible for transportation. Reportedly, juveniles at the FCJDC may be placed in mechanical restraints if they are trying to hurt themselves but interviews and documents reviewed would indicate that that practice is unusual. Further, if a youth is actively trying to hurt himself, the use of mechanical restraints would generally be considered inappropriate and, if staff cannot persuade that youth to cease self-harm, mental health intervention or transportation to a mental health facility or hospital should be arranged as quickly as possible.

There is still no written policy and procedure to ensure that practices at the FCJDC are consistent with the requirement of this provision. The draft Policy and Procedure provided for my review lacks sufficient specificity and includes directives to staff that are contrary to the requirements of this provision.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the requirements of this provision and of the new policy and procedure.
3. Provide written documentation of examples of the use of mechanical restraints, illustrating compliance with this provision.

6.2 Nothing in this section shall prohibit mechanical restraints from being placed on youth who are being transported to and from court or outside the facility, if staff have reason to believe that a youth presents a flight risk or will engage in violent behavior. Youth shall not be placed in a cell while wearing mechanical restraints.

Compliance Rating: **Partial Compliance**

Discussion:

As stated in 6.1, shackles are no longer being used on youth attending school at the FCJDC or to go to the Forrest County Youth Court in the same building as the FCJDC. Interviews with both staff and youth and direct observation verified that practice.

The use of mechanical restraints for transportation purposes may be considered appropriate and may be required by policies established by agencies doing the transporting such as law enforcement agencies. However, there should be written justification for that use that explains why a youth is considered a flight risk or will engage in violent behavior or indicating that it is the policy of the law enforcement agency responsible for transportation.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the new policy and procedure.
3. Provide written documentation of incidents where mechanical restraints are placed on youth who are being transported to and from court or outside the facility, because staff have reason to believe that a youth presents a flight risk or will engage in violent behavior.

4. Provide written documentation from law enforcement agencies responsible to transport youth outside the FCJDC that mechanical restraints are required by those agencies' policies.

6.3 The Forrest County Juvenile Detention Center will continue to prohibit the use of restraints to secure youth to a fixed object such as a restraint chair, bed, post, or chair.

Compliance Rating: **Partial Compliance**

Discussion:

Although there are no examples available of the use of restraints to secure youth to a fixed object such as a restraint chair, bed, post, or chair and staff and youth interviews again verified that practice does not occur, no written policy and procedure exists prohibiting that practice. The FCJDC has significant staff turnover and it is important to have written policies and procedures to ensure compliance, both currently and in the future.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the new policy and procedure.

6.4 No youth shall be restrained for longer than 15 minutes, unless restraints are approved by a mental health professional or if determined to be necessary under § 6.2. If a youth must be restrained for longer than 15 minutes in order to prevent self-harm, that youth shall, as quickly as possible, be evaluated by a mental health professional or transported to a mental health facility.

Compliance Rating: **Partial Compliance**

Discussion:

As stated in 6.1 and 6.2 above, it was consistently reported by both staff and juveniles that youth are no longer placed in mechanical restraints to attend school. Most staff interviewed reported that juveniles are only placed in mechanical restraints for transportation outside the facility. A few staff reported that youth may be placed in mechanical restraints to keep them from harming themselves or others. Even that latter use appears to be rare, based on interviews and my review of incident reports. Since there are no documented incidents of use of restraints during the three-month review period, there is no documentation that the use of mechanical restraints for longer than fifteen minutes was approved by a mental health professional. All three *Implementation Reports* from the FCJDC state that they "will have the youth evaluated by a mental health

professional or transported to a medical facility" but there is no policy and procedure requiring that.

The 2007 FCJCC *Standard Operating Procedure* manual addresses this issue in the section entitled "Psychiatric Emergencies". That section states: "In cases where juveniles are engaged in self-destructive behavior, physical restraints may be used. Physical restraints are to be used as a last resort and only while a juvenile is engaged in self-destructive behavior." That procedure does not address mental health evaluation or transportation to a mental health facility. That procedure lacks specificity; therefore, adherence could lead to inappropriate use of mechanical restraints. Use of restraints for a self-harming child should be only subsequent to a mental health assessment and approval by a mental health professional or medical professional with relevant expertise. Restrained youth should be directly and continuously monitored by staff.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation that all staff members at the FCJDC have been trained on the new policy and procedure.
3. Provide written documentation that the contracted mental health provider is aware of the requirements of this provision and is willing to comply.
4. Provide written documentation of compliance through Incident Reports or other documents.

6.5 Forrest County Juvenile Detention Center shall not use or allow on the premises, restraint chair and tasers.

Compliance Rating: **Partial Compliance**

Discussion:

There were no reports of a restraint chair or tasers present at the FCJDC and none were observed during my site visit. There is a posted prohibition against tasers at the facility. A previous Director of the FCJDC issued a memorandum to law enforcement agencies informing them of that prohibition. It is important that written policies and procedures exist to ensure future compliance with this provision.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation that all FCJDC staff members have been trained on the new policy and procedure.

6.6 Forrest County Juvenile Detention Center Staff or any other officer shall not regularly carry chemical restraints in the secure part of the facility. Within 60 days of the effective date of this Agreed Order, the Forrest County Juvenile Detention Center shall keep chemical restraints in a locked and secured location, outside of the living areas. The Forrest County Juvenile Detention Center shall develop a policy and procedure that requires staff to log the date, time, and justification for 1) each time a chemical restraint is removed from the locked, secured location, and 2) each time a chemical restraint is applied to a youth.

Compliance Rating: **Partial Compliance**

Discussion:

During my site visit, it was consistently reported in staff interviews that no chemical restraints are available or carried by staff at the FCJDC. Two youth interviewed by plaintiffs' attorneys claimed to have seen staff carrying chemical restraints although that has not been verified. It is commendable that the FCJDC appear to be operating successfully without the use of chemical restraints and they should continue to do so. However, there are several new, untrained staff members and all staff should be oriented and trained in a written policy and procedure that is consistent with this provision. The facility is located near to local law enforcement and law enforcement responds quickly when summoned. If chemical restraints are deemed necessary in a particular emergency, that would best be done by responding law enforcement officers who are trained to do so. The existing *Standard Operations Procedure* manual has a "Use of Chemical Agents Policy" that states: "No Chemical Agents are to be carried or used at the Forrest County Juvenile Detention Center."

Recommendations for achieving substantial compliance:

1. Review and revise, as necessary, the current written policy and procedure to ensure that it is consistent with this provision. Preferably, that policy and procedure should be consistent with current practice at the FCJDC and should prohibit the presence and use of chemical restraints at the facility by anyone other than law enforcement summoned to deal with emergency situations.
2. Provide written documentation that all FCJDC staff members have been trained on the new policy and procedure.

6.7 Forrest County Juvenile Detention Center will continue to prohibit unlawful restraints, including but not limited to, the practice of placing a youth face down on a bed, floor, or other surface, and securing the youth's hands to his feet.

Compliance Rating: **Partial Compliance**

Discussion:

Staff interviews and incident reports again attest that staff members are aware that they are expected to use "the least amount of restraint necessary" in dealing with out-of-control youth. However, there is still no written policy and procedure that addresses this provision, including the definition of unlawful restraints. At the time of my last two site visits I was told that they are looking at adopting an appropriate curriculum for training all staff members on the use of verbal de-escalation skills and safe physical restraint. Nurse Sky Johnson has had the assignment to select a training program. Because the half-time nurse position at the FCJDC is currently vacant, Nurse Johnson has been filling in and reportedly has not had time to research appropriate programs. No program has yet been selected although this monitor did make a recommendation of two programs that are effectively used in a number of juvenile facilities throughout the country. Corrections Officers reportedly receive restraint training when they attend the statewide corrections training academy. However, as discussed in provision 2.1 above, they may work at the facility for as long as two years before they are required to attend the academy. And, it is not known what curriculum is used for restraint training at the academy and whether that curriculum is considered appropriate for use with juveniles. Further, Direct Care Workers, whose primary responsibility is reportedly the supervision of residents, are not required to attend the academy.

Although FCJDC staff members are able to articulate the "least amount of force necessary" expectation, there is no clarity on what that phrase actually means. And, an incident that occurred shortly before my June 2012 visit that culminated in the termination of a veteran staff member who was a Shift Leader and who had attended the state Corrections Academy, revealed that is not necessarily the practice. Not only are FCJDC employees not getting needed training in a timely fashion, the substance of that training should be reviewed to determine if it is appropriate for employees in a juvenile facility. Clearly, the FCJDC needs to proceed with its plans to adopt a training curriculum for all employees that is appropriate for use in juvenile facility and that emphasizes verbal de-escalation.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure consistent with this provision.
2. Provide written documentation of staff training on the new policy and procedure.
3. Ensure that all staff members at the FCJDC have training on the use of restraint, with a curriculum that is accepted and appropriate for use in a juvenile facility and that emphasizes verbal de-escalation skills.
4. Provide written documentation of staff training on the use of restraints.

6.8 When a youth is placed in mechanical restraints, staff must provide face-to-face supervision for the duration of the restraint, except when mechanical restraints are deemed to be necessary for the reasons specified in 6.2.

Compliance Rating: **Partial Compliance**

Discussion:

Mechanical restraints are routinely used in transporting youth from the FCJDC to court and other locations outside the facility as discussed in 6.2 above. They are no longer being used in order for juveniles to attend school at the facility. Staff and youth interviews confirm that mechanical restraints are seldom used within the facility.

Both the second and the third FCJDC *Implementation Reports* indicate that they are waiting dates from the training officer for staff training. It is not known what that training will consist of and whether it would be consistent with the requirements of the Agreed Order or this provision. There is no comprehensive policy and procedure addressing the use of mechanical restraints and any staff training must be consistent with an acceptable policy and procedure and with the provisions of the Agreed Order, which would not necessarily be comparable to use with an adult criminal population. That said, the fact that the FCJDC administration continues to claim that they are not in compliance with this provision due to the lack of availability of a training officer is problematic. The draft Policy and Procedure provided for my review lacks sufficient specificity and includes directives to staff that are contrary to the requirements of this provision.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the new policy and procedure.
3. Develop written direct care staff job descriptions that include expectations for constant face-to-face monitoring youth any time mechanical restraints are used and for supervising and monitoring youth, without the use of mechanical restraints, in order to minimize the need for restraints.
4. Provide written documentation of constant, face-to-face supervision of youth placed in mechanical restraints.

6.9 Forrest County Juvenile Detention Center shall notify a medical professional whenever a youth is placed in mechanical restraints for reasons other than those specified in § 6.2. A medical professional shall examine a youth as soon as possible after restraints are removed, except when a youth was restrained for the reasons specified in § 6.2.

Compliance Rating: **Partial Compliance**

Discussion:

Incident reports reviewed for the period June 3, 2012 through September 25, 2012 revealed no examples of the use of mechanical restraints. In an incident prior to my June 2012 visit, restraints were used by responding law enforcement officers to control a youth and he was subsequently provided with medical care when he complained of pain. It is not known whether a medical professional would have been notified in that case had the child not complained of pain. No comprehensive, written policy and procedure still exists to provided staff at the FCJDC direction consistent with this provision.

Recommendations for achieving substantial compliance:

1. Develop written policy and procedure that is consistent with this provision.
2. Provide written documentation that all FCJDC staff members have been trained on the new policy and procedure.
3. Ensure that all medical staff members serving the FCJDC are trained on the requirements of this provision.
4. Provide written documentation of examination by a medical professional as soon as possible after mechanical restraints are removed, except when a youth was restrained for the reasons specified in provision 6.2.

6.10 Immediately, upon the Court's approval of this Agreed Order, the Forrest County Juvenile Detention Center shall take measures to ensure that no officer enters the secure detention area of the facility with any chemical restraints, except in accordance with § 6.6.

Compliance Rating: **Substantial Compliance**

Discussion:

The FCJDC has posted a sign at the side entrance to the facility notifying staff members of the requirements of this provision. A former Director of the FCJDC issued a memorandum to law enforcement agencies informing them of that prohibition. Staff interviewed reported that chemical restraints are not allowed within the facility. There is no written policy and procedure addressing this provision.

Recommendations for achieving substantial compliance:

1. Although the existing *Standard Operating Procedure* manual prohibits chemical restraints, I would again reiterate my #1 recommendation in 6.6 above.

6.11 Immediately, upon the Court's approval of this Agreed Order, the Forrest County Juvenile Detention Center shall take measures to ensure that no officer

enters the secure detention area of the facility with any electronic restraints, including, but not limited to tasers.

Compliance Rating: **Substantial Compliance**

Discussion:

The FCJDC has posted a sign at the side entrance to the facility notifying staff members of the requirements of this provision. A former Director of the FCJDC issued a memorandum to law enforcement agencies informing them of that prohibition. Staff interviewed reported that electronic restraints, including tasers, are not allowed within the facility. There is no written policy and procedure addressing this provision.

Recommendations for achieving substantial compliance:

1. Although the FCJDC is in Substantial Compliance with the stated requirements of this provision, I would still recommend that they develop a written policy and procedure consistent with this provision and ensure that all staff members are trained on that policy and procedure.

6.12 Immediately, upon the Court's approval of this Agreed Order, the Forrest County Juvenile Detention Center will continue to take measures to ensure that no officer enters the secure detention area of the facility with a firearm.

Compliance Rating: **Substantial Compliance**

Discussion:

The FCJDC has posted signs at all entrances to the facility notifying anyone entering the facility of the requirements of this provision and prohibiting firearms. A former Director of the FCJDC issued a memorandum to law enforcement agencies informing them of that prohibition. Staff interviewed reported that law enforcement officers leave their firearms in their vehicles. There is no written policy and procedure addressing this provision.

Recommendations for achieving substantial compliance:

1. Although the FCJDC is in Substantial Compliance with the stated requirements of this provision, I would still recommend that they develop a written policy and procedure consistent with this provision and ensure that all staff members are trained on that policy and procedure.

VII. USE OF FORCE

7.1 Physical force shall not be used to punish youth. Staff shall only use physical force to stop youth from causing serious physical injury to self or others or to prevent an escape. If physical force is necessary, staff must use the minimum amount required to safely contain the youth. Whenever possible, staff shall avoid the use of force by first attempting verbal de-escalation techniques. Staff shall be required to fully document in writing every instance of use of force.

Compliance Rating: **Non-Compliance**

Discussion:

Incident reports provided for my review described a number of examples where force was used by staff to intervene in altercations or to compel compliance with a staff directive. Use of force by untrained or inappropriately trained staff can be dangerous and can result in injury to a youth or staff member. The training of staff at the FCJDC is insufficient at best and is, with some staff, virtually non-existent. Staff interviewed provided a variety of responses when asked when force may be used. One employee said "When they don't want to cooperate." One staff responded: "Probably when kids are fighting. . .we are not allowed to hit kids." One staff responded: "When two kids are fighting." Another staff stated that force "should never be used. . .that's what I've heard." All staff members having direct contact with youth should be thoroughly trained on the facility's policy on use of force and should be trained on an appropriate curriculum that emphasizes verbal de-escalation. That is not occurring at the FCJDC.

As discussed in provision 6.7 above, FCJDC staff are not trained on a curriculum that is designed specifically for juveniles and that emphasizes de-escalation skills. It is not known what curriculum is used at the state corrections academy that Corrections Officers attend some time within two years of their hire date. Direct Care Workers do not attend that academy. Registered Nurse Sky Johnson informed me that she has been asked to select a training program for the staff at the FCJDC that teaches safe physical restraint techniques and that emphasizes verbal de-escalation. That need was identified and curricula were recommended in my last two reports but no training has yet been selected. De-escalation and restraint training should be provided to staff before they work directly with juveniles or as soon as possible after hire with periodic updates (generally annually) by a trained trainer.

As discussed in provision 6.1 above, the draft Policy and Procedure on Use of Force provided for my review lacks sufficient specificity and includes directives to staff that are contrary to the requirements of this provision.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation that all FCJDC have been trained on the new policy and procedure.
3. Ensure that all staff members at the FCJDC have training on the use of force, with a curriculum that is accepted and appropriate for use in a juvenile facility and that emphasizes verbal de-escalation skills.
4. Provide written documentation of staff training on use of force.

7.2 Forrest County Juvenile Detention Center shall notify a medical professional whenever physical force is used against a resident. A medical professional shall examine a youth as soon as possible after the use of physical force.

Compliance Rating: **Non-Compliance**

Discussion:

Incident reports reviewed for the period June 3, 2012 through September 25, 2012 revealed a number of occurrences where force was used. In most reports it was unclear specifically the type or extent of force used. Descriptions included such things as "Officer Jarvis grabbed G.B.," "minimum force was used to get him to his cell," "Officers Hines and Harris separated the two," "the two were separated," "we kept pushing against them," "DCW C. Hines was in between them trying to stop them," "grab a hold of youth J.B. to take him away," "pulled A.T. away. . .and Officer Jarvis pulled J.E. away," "myself and Wilson separated the youth," and "the fight was broken up and both youth were separated." In no case was there documentation that a medical professional was notified or that a medical professional examined the youth. The Incident Report form asks whether medical treatment was required and the "Yes" box is check on several reports. Several incident reports left that question blank. Most reports checked "No" when asked if medical treatment required. This provision does not provide staff with authority to *not* notify a medical professional but, rather, requires that such notification and subsequent examination occur in *all* cases of use of force.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation that all FCJDC staff members are trained on the new policy and procedure.
3. Provide documentation that the medical professionals assigned to serve the youth at the FCJDC are aware of the requirements of this provision.
4. Provide training to all FCJDC staff on report-writing.
5. Provide written documentation of compliance with this provision.

VIII. MEALS AND NUTRITION

8.1 Youth shall be provided three meals and a snack daily. If a youth misses a meal because he or she is attending court, or some other appointment, he or she shall receive the missed meal upon his or her return to the Forrest County Juvenile Detention Center.

Compliance Rating: **Partial Compliance**

Discussion:

Staff and residents at the FCJDC consistently reported to me that they receive three meals and a snack daily and that youth who miss a meal due to an appointment or court appearance are offered one upon their return. Staff reported that they order extra meals for that purpose. Most residents even asserted that the quality of the food had improved. The existing 2007 *Standard Operating Procedure* manual addresses "Feeding Procedures" but does not specifically require that youth receive a meal if they are away from the facility during regular meal times. A revision should be made to policy and procedure to ensure that current practice will persist.

Recommendations for achieving substantial compliance:

1. Revise the existing policy and procedure to address this provision.
2. Ensure that all FCJDC staff members are trained on the revised policy and procedure.

8.2 Within 30 days of the effective date of this agreement, all meals and snacks served to youth at the Juvenile Detention Center shall, at a minimum, comply with the nutrition guidelines set forth in the United States Department of Agriculture's School Meals Program standards.

Compliance Rating: **Non-Compliance**

Discussion:

Meals for the residents at the FCJDC are reportedly delivered three times daily from the Forrest County Jail. Some residents volunteered in interviews with this monitor that the quality of the meals has improved recently. Sample weekly menus were provided for my review. However, no documentation was offered verifying that the meals served at the FCJDC meet U.S.D.A. School Meal requirements, including review by a registered dietician with expertise in those requirements and in the minimum dietary requirements for adolescents.

As I have indicated in my previous reports, a juvenile facility is eligible for monetary reimbursement through the U.S.D.A for compliance with those School Meal requirements and that the FCJDC is forgoing that additional funding by their non-compliance with this provision.

Recommendations for achieving substantial compliance:

1. Establish a meal service contract with a government entity or private contractor that ensures compliance with this provision.
2. Provide written documentation that menus are approved by a registered dietician and that they meet U.S.D.A. School Meal requirements.

8.3 Youth shall be provided with ready access to drinking water throughout the day.

Compliance Rating: **Substantial Compliance**

Discussion:

The FCJDC practice is to provide a clean Styrofoam drinking glass to each youth with every meal. The facility also has coolers in each unit day room with drinking water that is cleaned and refilled three times each day. Residents now have ready access to drinking water throughout the day and are provided with clean cups with each meal.

Recommendations for achieving substantial compliance:

None.

IX. CLOTHING

9.1 The Forrest County Juvenile Detention Center shall ensure youth are provided basic clothing items at all times. These items must include, at a minimum socks, underwear, uniform, shoes, and undershirts. For girls, these items must also include a bra. When appropriate, the Forrest County Juvenile Detention Center shall also provide youth with a coat, hat, and gloves. Youth may choose to use their own socks, underwear, and undershirts, and bras instead of those provided by the Detention Center. Youth must be provided with a clean uniform, socks, undershirt, underwear, and bra, if applicable, upon intake and at least once per day. No youth shall be deprived of these basic clothing items for any reason, including, but not limited to, as a punishment or because these items are being washed.

Compliance Rating: **Non-Compliance**

Discussion:

The existing *Standard Operating Procedures* manual addresses the provision of clothing under the "Booking Procedures" section. That section states: "8. After searching the juvenile, dress him/her out in an [sp] detainee uniform. Collect all juvenile's clothes, except for underwear and socks. Place these items with the juvenile's property." No mention is made in that manual of providing clean underwear and socks to the juvenile, even upon request. Parents are allowed and requested to bring in clean, white underwear and socks for their child at the FCJDC.

Youth admitted to the FCJDC are required to change from their personal clothing into a uniform provided by the facility. However, as discussed in provision 1.6, youth frequently do not shower at the time of booking and often do not shower until the next regularly scheduled shower time in the evening. According to both staff and residents, youth are often provided with clean underwear and socks only if they request those items. Some youth interviewed reported that the facility was out of underwear and socks for males. An administrator confirmed that problem of insufficient inventory, reporting that Forrest County has had a spending freeze during the month of September to close out the fiscal year. The FCJDC should have planned for that annual spending freeze and ensured that all inventories were adequate. That poor planning results in youth being required to wear their personal underwear and socks. Those personal items may be worn unwashed until a parent delivers clean items. Several pairs of the rubber clog shoes that the juveniles are provided with had holes in the bottoms.

Staff interviews also verified that juveniles may wear their own underwear and socks and that they may have parents bring extra. Staff members reported that juveniles may also wear facility provided underwear and socks. One staff member reported that youth whose parents do not bring personal underwear to the facility for them may wear underwear "leftover" from prior residents or they may wash the underwear that they were wearing when admitted in the sink in their room. Youth often reported that they do not like the color or style of the FCJDC underwear and, therefore, choose to wear their own, even if it has not been laundered. Making the wearing of FCJDC underwear and socks optional seems to discourage youth from requesting those items and contributes to the problem of not having sufficient number of clean, hygienic clothing items.

As stated in my last Monitoring Report, juvenile detention centers typically require that residents exclusively wear facility-provided clothing, including underwear and socks, to ensure cleanliness and to avoid damage to or loss of personal clothing. Because youth do not all have more than one set of underwear and socks and in order to ensure that they wear only clean clothing items, the FCJDC should adopt a practice of providing *all* items of clothing to youth while they are at the facility.

Recommendations for achieving substantial compliance:

1. Revise the existing policy and procedure regarding the provision of clothing to admitted youth to ensure that all youth are provided, by the FCJDC, with a complete set of clean clothing, including underwear and socks at all times.
2. Provide written documentation that FCJDC staff members are trained on the revised policy and procedure.
3. Develop an effective system for monitoring inventories of clothing to ensure that there is always an adequate supply for any number, gender and size of residents who may be admitted to the FCJDC.
4. Provide written documentation of compliance with this provision.

X. HYGEINE AND SANITATION

10.1 Youth shall be provided with the means to maintain appropriate hygiene, including soap and shampoo for showers, which will occur at least once daily, soap for washing hands after each time the youth use the toilet, and toothpaste and a toothbrush for tooth brushing, which will occur at least twice daily, a comb and brush, that if shared, shall be sterilized between uses by youth.

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC provides prepackaged hygiene packets for all juveniles. Those packets contain soap, shampoo, deodorant, toothbrush, toothpaste and comb. Interviews with both juveniles and staff confirmed that those packets are routinely distributed at the time of admission. Juveniles generally reported that those hygiene products are replenished as needed. Two youth reported that they had to request their initial "CARE" packages. Two youth reported that the receive only liquid soap on a washrag at shower time. A number of residents' individual rooms had multiples of some of their hygiene products, a situation that would be considered contraband in many facilities. When asked about that, juvenile reported that they are allowed to accumulated extras. Two new staff reported that they were "not sure" what youth receive. No brush is provided nor is there a system for providing any additional items that may be needed by juveniles such as hair conditioner to be able to remove tangles after shampooing and lotion for particularly dry skin. Those more unique items would not be needed by all youth but should be available on a case-by-case basis as requested by a youth and approved by the nurse or staff. As reported in provision 1.6, one girl interviewed reported that she had not washed her hair since her admission two days earlier because she cannot get the tangles out of her hair after she shampoos without cream rinse or conditioner and a brush. Not only is that unhygienic, it is insensitive to a common need of female detainees. When asked, none of the youth interviewed said they wash their hands before meals.

There is no written policy and procedure addressing the requirements of this provision.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the new policy and procedure.
3. Provide written documentation of practice that is consistent with this provision.

10.2 Youth shall be provided with sleeping mats and blankets that are clean and odorless and sleeping mats shall be sanitized between uses by youth and youth shall receive clean blankets weekly.

Compliance Rating: **Partial Compliance**

Discussion:

During my recent site visit I did not have the opportunity to count all sleeping mats in the FCJDC as I have done on previous visits. However, I did inspect most occupied rooms and found that they all had mats with some having extra mats and there were additional mats in the storage area in D Unit. Some of the mats beig used are torn, have holes in them and, therefore, cannot be sanitized. At the time of my last visit, there were twenty-eight mats in the facility, including four that were still in shipping boxes. That is four fewer than the capacity of the FCJDC. During my first site visit there were twenty-nine mats but some were damaged and torn and could not, therefore, be sanitized and needed to be discarded. Staff informed me that the mats are sanitized by spraying them with Lysol between resident each usage. However, as was the case at my June 2012 visit, during my recent visit there were some residents who had two mats because they had kept a mat belonging to a fellow juvenile when that juvenile was released. The second mat had not been sanitized and the youth taking possession of the released juvenile's mat simply moved it to his or her room. At least two residents showed me that they each had several blankets that had been used by released residents and those had not been cleaned. One female resident informed that she had been give an extra mat by staff because she is pregnant.

The FCJDC has blankets and linens laundered by the Forrest General Hospital. That system appears to generally work but one staff member reported that she washed used blankets before they go to Forrest General Hospital because they get smelly in large plastic garbage bags while waiting to be picked up. The facility now has new blankets and has replaced the blankets that I observed to be tattered, frayed and holey at my first visit. Both staff and residents reported that clean blankets are provided weekly.

The 2007 *Standard Operating Procedures* manual at the FCJDC does not address the provision of mattresses and blankets, including sanitizing and laundering them and replacing them as they become damaged.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure consistent with this provision. That policy and procedure should address the frequency of blankets being provided and it should establish a laundry schedule that ensures that clean blankets are distributed in accordance with this provision. That policy should describe a system for sanitizing mats between uses. That policy should also establish a procedure for inspecting mats and blankets for damage and the need for replacement. That policy should discuss the number of blankets and mats that youth are allowed to have, when and by whom exceptions may be made and how that is monitored.
2. Provide written documentation that all FCJDC staff members have been trained on the new policy and procedure.
3. Provide written documentation that practice is consistent with this provision.

10.3 Under no circumstances shall youth be deprived of mats and blankets.

Compliance Rating: **Partial Compliance**

Discussion:

No youth reported being deprived of mats or blankets and no individual rooms that were occupied by youth during my site visit were without mats or blankets. As discussed above, some youth had unauthorized extra blankets that had been used by previous residents. Since my last visit, most youth and staff reported that youth are provided with three blankets, rather than the previous two each, so that one may used as a pillow since no pillows are provided. Although it is not mandated by this provision, it is standard practice to provide pillows, pillowcases and sheets as well as blankets to youth in juvenile detention and it is suggested that the FCJDC consider doing so as well.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision. That policy and provision should address such issues as when clean mats and blankets are provided, how many mats and blankets are minimally required and under what circumstances a youth may receive more than one mat and more than two blankets.
2. Provide written documentation that all FCJDC staff members have been trained on the new policy and procedure.

10.4 Forrest County Juvenile Detention Center shall be required to maintain a sufficient number of clean, sanitary mats and blankets that correspond with the facility's maximum capacity.

Compliance Rating: **Partial Compliance**

Discussion:

As discussed in 10.2 above, I observed a sufficient number of mats and blankets for the current population during my site visit. I did not count all the mats in the building this visit but I did note that there were still some damaged mats being used by juveniles. Those cut or torn mats cannot be sanitized and, therefore, should be discarded. There were not sufficient numbers of mats to correspond with the facility's maximum capacity at either of my last two visits. The population has been much below its rated capacity of thirty-two but the FCJDC needs to have at least that many, undamaged, clean mats at all times. There was an ample number of blankets and they were generally in good condition. However, as discussed in 10.2 above, some youth were using mats and blankets that had been assigned to previous residents, which had not been clean and sanitized. The arrangement with Forrest General Hospital to wash blankets and linens seems to better ensure that those items are clean when distributed but the failure to ensure that blankets and mats are turned in for cleaning when juveniles are released undermines those efforts.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision and that establishes a system of examining mats and blankets to determine when replacement is needed and that ensures that mats and blankets are turned in and cleaned when youth are released.
2. Provide written documentation of staff training on the new policy and procedure.
3. Procure additional mats to meet the requirements of this provision.
4. Develop an inventory of mats and blankets in order to monitor the required availability and determine when new mats and blankets need to be ordered.
5. Provide written notification to youth, possibly through an orientation process, of the procedure for obtaining clean mats and blankets as required by this provision.

10.5 The Forrest County Juvenile Detention Center shall ensure that youth are provided with a clean, sanitary environment, which shall include, but is not limited to, regularly cleaning the facility and facilitating regular pest control measures.

Compliance Rating: **Partial Compliance**

Discussion:

During my site visit I again observed youth in the process of mopping floors in dayrooms. Staff members did appear to be supervising them. No youth were observed to be wearing gloves while they cleaned. I was informed by both youth and staff members that the facility is cleaned daily and several youth reported to me that they had been performing extra cleaning in anticipation of my visit. The individual sleeping rooms are still more cluttered than should be allowed in a juvenile detention but there was improvement since my last visit and youth informed me that they are now being required to make their beds each morning. The day rooms and individual sleeping rooms appeared more tidy than during my prior visits but there was still a great deal of accumulated grime, particularly in corners, and youth showed me mold in a variety of locations in each unit and "spit corners" in the corners of the B and C Unit dayrooms.

The FCJDC does have a contract for quarterly pest control services, which was verified with written documentation.

The 2007 *Standard Operating Procedures* manual at the FCJDC addresses cleanliness under the section "Daily Sanitation Policy." That policy reads as follows:

> "The Forrest County Juvenile Detention Center will be kept clean, orderly manner. Juvenile detainees will cleanup their cell and their cellblock after every meal. However, juveniles will not be used to clean up outside their assigned cellblocks.
>
> Detention Officers:
>
> 1. Make cleaning equipment available to each cellblock daily.
> 2. Floor, toilets, showers, washbasins, sinks, tables and the dayroom area will be cleaned daily.
> 3. Garbage will be removed from the cellblock and the detention center daily.
> 4. If the juveniles refuse to clean, file an incident report and the Chief of Corrections will decide how to punish the juveniles.
> 5. Juveniles in the cellblock will be responsible for daily cleaning of their cellblock.
> 6. The Officers will inventory and inspect all mops and brooms before he/she takes them out of the cellblock."

This policy appears to be adapted from an adult facility, based on terminology used (i.e. cellblock, Chief of Corrections). This policy also specifically requires that juveniles who refuse to clean be punished. Doing so would be inappropriate in a juvenile facility. Youth may not have the knowledge or skills to clean and staff members should be expected to work with them in completing their assignments. This policy needs to be revised.

The FCJDC reports that they have a cleaning service for the office area of the building. However, the living areas are not professionally cleaned and the FCJDC does not have janitorial staff members who are trained and knowledgeable regarding appropriate cleaning products and techniques. All living areas of the facility need to be thoroughly and professionally deep cleaned. The walls in the individual rooms have ubiquitous graffiti,

much of which is vulgar and obscene in nature. The rooms all need to be painted after which the staff at the FCJDC needs to monitor the rooms for future damage. If a room is damaged, the responsible resident should be held accountable.

Recommendations for achieving substantial compliance:

1. Thoroughly and professionally deep clean the living areas of the FCJDC and repaint the individual sleeping rooms.
2. Revised the policy and procedure to ensure that it is consistent with this provision and to ensure that it is appropriate for a juvenile facility. Include expectations for both staff and youth as discussed above.
3. Provide written documentation of staff training on the revised policy and procedure.
4. Establish rules and expectations for residents to maintain their living areas, including dayrooms and individual rooms.
5. Provide training to staff members who supervise residents regarding proper cleaning techniques, schedules and products to ensure that the facility is kept clean.
6. Provide written documentation of staff training on cleaning practices and methods.

10.6 Within 90 days of the date of this agreement, Forrest County shall develop policies and practices to ensure that the Juvenile Detention Center complies with relevant law regarding fire safety, weather emergencies, sanitation practices, food safety and the elimination and management of environmental toxins.

Compliance Rating: **Partial Compliance**

Discussion:

The 2007 *Standard Operating Procedures* manual at the FCJDC includes sections entitled "Fire Plan", "Escape Plan", "Natural Disaster", and "Power Outages and Chemical Releases". None of those sections address relevant law regarding fire safety, weather emergencies, sanitation practices, food safety and the elimination and management of environmental toxins, as required by this provision. The FCJDC conducted two fire drills under the guidance of the Forrest County Fire Department prior to my June 2012 visit but has not conducted any drills since that time. The FCJDC administrators informed me that they are making arrangements with the Forrest County Fire Department to assist them in developing an appropriate fire prevention policy and procedure and they anticipate conducting fire drills on a monthly basis in the future. It is not known what the relevant laws for the State of Mississippi, Forrest County or the City of Hattiesburg are in this area and the FCJDC administration will need to ascertain what those applicable laws are to ensure compliance with those laws and with this provision.

Recommendations for achieving substantial compliance:

1. Develop policy and procedure consistent with this provision.
2. Provide written documentation of staff training on the new policy and procedure.
3. Provide documentation of practice that demonstrates compliance with this procedure such as monthly fire drills, weather emergencies and food safety inspection reports.

10.7 Youth shall be provided with clean drinking glasses and eating utensils.

Compliance Rating: **Partial Compliance**

Discussion:

Interviews with both youth and staff at the FCJDC, as well as observations during my site visit, verified that youth do receive clean utensils with each meal. The FCJDC also generally provides clean Styrofoam cups with each meal. Two youth interviewed claimed that the provision of clean cups is dependent upon which staff member is working. I did not observe the large number of used, dirty, damaged cups in the dayrooms and sleeping rooms that I observed on my last visit and it does appear that there is more effort made to discard used cups after meals, along with other disposable utensils and serving items. The 2007 FCJDC *Standard Operating Procedure* manual contains a "Feeding Procedure" section but that section does not address the requirements in this provision and no updated policy and procedure has been written.

Recommendations for achieving substantial compliance:

1. Revise the policy and procedure to incorporate the requirements of this provision.
2. Provide written documentation of staff training on the new or revised policy and procedure.

XI. MEDICAL CARE

11.1 The Forrest County Juvenile Detention Center shall execute contracts to ensure youth are provided with adequate medical care, including: prompt screenings; a full physical exam within 72 hours after their detention hearing or disposition order, as applicable; access to medical professionals and/or prescription medications when needed; and prompt transportation to a local hospital in the case of a medical emergency.

Compliance Rating: **Partial Compliance**

Discussion:

This provision includes multiple elements, all of which must be complied with to achieve Substantial Compliance.

The medical services at the FCJDC are provided through the Forrest General Hospital which contracts for medical professionals. There is a contract for one full-time registered nurse. There has been a registered nurse who has been only scheduled to be on-site at the facility four hours a day, Monday through Friday and a second registered nurse who serves the facility on an irregular basis in the afternoons and who is also on-call and a licensed professional nurse who assists on occasion, primarily with paperwork. The primary, half-time nurse position was vacant at the time of my recent visit so the on-call nurse had increased her hours to fill in until the position is filled. In June I was provided with a copy of an Agreement for Medical Services—Southern Neurological and Spinal Institute for a physician "to provide basic medical care as needed to see and treat sick inmates at the *Forrest County Jail and Forrest County Evaluation Center* at least twice per week as the result of sick call." Not only does that contract not address physician services at the FCJDC or address the requirements of this provision, it expired on September 30, 2012. I was also provided a copy in June of a contract between Forrest County and Accurate Medical Diagnostics, LLC for X-ray services at the *Forrest County Jail*. Again, no mention is made of the FCJDC.

At the time of my previous visit, the facility had been without a physician for about a month but was in the process of filling that position. Apparently, the physician selected at that time did not work out and he has recently been replaced with a new contract physician/medical director who will be at the facility for part of one day each week and on-call as needed. Because nurses are not qualified to complete physical examinations, the nurse completes a physical assessment on youth, generally on the next weekday following admission. However, when the facility has been without a physician, they have been unable to complete physical examinations, particularly within the required timeline. I was provided with copies of "Request for Medical Care" forms for 76 youth. Eleven of those forms had not been completed because the youth were released before they could be seen by the physician. The same form is used by the FCJDC for multiple purposes, including when a youth makes a sick call requests. Therefore, of the 65 completed forms, in the area of the form asking for the "Complaint," eleven forms listed "Physical" and something else and six forms just listed something else as the purpose of the visit. The remaining 48 completed forms gave "Physical" as the sole reason for being seen by the medical doctor. The "Request for Medical Care" form does not include a place to indicate the date of admission or date of hearing so it is impossible to determine from those forms whether the juveniles were seen within the 72-hour timeframe required by this provision. I do not have data on the number of youth admitted to the FCJDC during the past quarter so it is not possible to determine how many did receive physical exams as required.

While the FCJDC contract physician was present in the facility seeing the six youth who had been admitted the previous day, I was at the booking desk, observing the admission process. The medical exam room is located directly behind the booking desk so I observed youth being escorted into and out of that room for their physical exams. After two youth were observed being escorted to see the doctor, I noted the very brief length of time that they remained in the medical exam room. I then timed the remaining youth and they each spent approximately three minutes with the physician. This provision requires that youth receive a full physical exam and I simply cannot accept that they are receiving a full physical exam in three minutes. I discussed those concerns with the nurse and previously provided web site information to her for the American Academy of Pediatrics and the National Commission on Correctional Health Care to use as guidelines in developing an appropriate format and minimum standards for such services as physical examinations. The juvenile justice population is often medically underserved and is highly medically at-risk. A comprehensive physical examination, designed to address particular issues common to that population is critical. The new physician/medical director at the FCJDC brings excellent qualifications to his position and he verbalized an interest in providing quality service to the FCJDC and to the youth it serves. At the time of my visit he was evolving in his new role. This seems to be an ideal time to establish improved levels of medical care for the youth at the FCJDC.

The medical assessment completed by the nurse includes blood pressure checks, blood tests and urine tests and a list of health-related screening questions. Residents interviewed reported that they had been to the nurse for their assessment soon after they are admitted.

The nurse prepares prescription medications for youth and places them in a secure cabinet for staff to access when they are to be administered. She completes a comprehensive record of what medications have been prescribed and when they are to be administered. The FCJDC does not have a contract or other arrangement with a local pharmacy and is largely dependent upon parents to deliver prescribed medications.

There are no standing orders for routine or common medical complaints that could be used by the nurse or a direct care staff member when the physician is not available. There is still no clear procedure for handling daily sick call. Staff members interviewed regarding sick call generally indicated that youth request to see the nurse or complete a form requesting to see the nurse. Youth interviews again also provided a variety of responses to questions about sick call. Several youth reported that they would tell a staff member and most knew that there is a sick call form to fill out. Staff interviewed did confirm that there is a nurse is on-call but several staff again complained that they often had to wait for a long time for her to respond to her calls. In order to ensure substantial compliance with this provision, the FCJDC will need to develop an on-call system or schedule that ensures that calls are responded to within a reasonable and set time period. To expect the one registered nurse, who has full-time duties with the Forrest County

Sheriff's Department, to assume that entire responsibility does not appear to be effective, is probably not realistic and does not seem fair.

My review of Incident Reports again revealed examples of emergency medical teams being called with quick response and there were examples of youth being transported to a hospital, usually due to a medical complaint at the time of booking. The FCJDC uses AAA Ambulance Services for most transporting. Documents indicate that the Forrest County Sheriff's Department is also very quick to respond and helpful in emergencies.

The 2007 FCJDC *Standard Operating Procedures* manual addresses a number of medical and health-related topics. Some of those policies appear to be based on jail policies (based on such terminology as Chief of Corrections.) However, those policies could serve as a basis for more comprehensive and juvenile-focused policy and procedures to meet the elements of this provision and more effectively meet the medical and health-related youth at the FCJDC.

Recommendations for achieving substantial compliance:

1. Provide copies of current contracts for medical services at the FCJDC.
2. Although there is a registered nurse at the FCJDC at least twenty-hours each week who generally sees admitted youth within the required timeframe, she completes a physical assessment, not a physical examination. The FCJDC must also ensure that youth receive a physical exam, which can be completed by a physician or a mid-level practitioner such as a nurse practitioner, within the timeframe established by this provision. The current physical examination format and form should be revised to ensure the comprehensiveness of that service and to effectively meet the medical needs of the FCJDC population.
3. Provide documentation that required physical examinations are provided within the required timeframe.
4. Develop written policy and procedure regarding provision of medical screenings and physical examinations, as required, and prescription medications as needed.
5. Develop and implement forms or other paperwork to document youth prescriptions at the time of admission and the efforts made to ensure that youth receive those medications as needed.
6. Provide examples of documentation of efforts made to obtain prescription medications.
7. Revise the 2007 FCJDC *Standard Operating Procedures* manual to address sick call, physician care and other medical and health-related issues.
8. Provide written documentation of FCJDC and contracted medical staff training on new/revised policy and procedure.
9. Develop an on-call schedule for medical staff that ensures that a medical professional is available at all times to receive phone calls and to respond as necessary.

11.2 The Forrest County Juvenile Detention Center shall ensure that a medical doctor and/or nurse practitioner is available to examine youth confined at the facility to identify and treat medical needs.

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC had contracted with a new medical doctor, who began his work at the facility about one week prior to my visit. At this point, he is scheduled to be in the facility for part of one day each week but indicated to me that he is available on other days as well, as needed. His ultimate availability is yet to be determined and no contract for his services was provided for me to review. It will be important that the physician and/or a nurse practitioner is available as required to meet the requirements of this provision as well as 11.1 above. There were six youth admitted on the first day of my visit and the physician did come in the following day to see those young people. There is no nurse practitioner or other mid-level medical professional available to examine youth at the facility

Recommendations for achieving substantial compliance:

1. Ensure that a medical doctor, nurse practitioner or other mid-level medical professional is available to examine youth at the facility to respond to, identify and treat medical needs. In order to ensure that availability, the medical doctor or mid-level practitioner would need to be scheduled at the facility more than the current once per week or would need to be available to address the need for timely physical exams and sick call.
2. Provide written documentation that a medical doctor or nurse practitioner or other mid-level medical professional is available for a sufficient amount of time to examine youth at the facility to identify and treat medical needs.
3. Provide written documentation that youth at the FCJDC are being examined and that their medical needs are identified and treated.

11.3 The Forrest County Juvenile Detention Center shall develop a sick call policy and practice which ensures that confined youth who request non-emergency medical attention are examined by a medical professional within 24 hours of a youth placing himself on sick call, excepting weekends and holidays.

Compliance Rating: **Partial Compliance**

Discussion:

As discussed in 11.1 above, there is still no clear procedure that is followed for sick call at the FCJDC. The 2007 FCJDC *Standard Operating Procedure* manual addresses "Requests for Medical Care". That procedure states:

"Medical Request Forms (MRF) will be available to juvenile detainees on a daily basis.

The Booking Officer is responsible for the daily delivery and pickup of Medical Request Forms. Request forms should be turned in daily to the nurse by 11:00 a.m.

Medical Request Forms will be review by the nurse to evaluate and prioritize medical complaints.

If a juvenile detainee cannot properly fill out a MRF, an Officer shall assist the juvenile in completing the form and have the juvenile sign the form."

This procedure is not consistent with the information provided in any staff or youth interviews that I conducted. The nurse is still only regularly scheduled to be at the facility until 12:00 noon so 11:00 a.m. on weekdays would be too late for her to address residents' medical requests until at least the following day. However, there were numerous copies of "Request for Medical Care" forms documenting sick call requests and subsequent medical care. It appears that sick call requests are responded to by the nurses, and by the physician when available, but it is not clear whether that occurs within the expected 24 hours. Most forms included dates and times of requests but some still did not. Some forms included dates and times that the child was seen; some still did not.

It is important that there be a written policy and procedure regarding sick call and that all staff and youth are familiar with the established sick call procedure.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation that all FCJDC staff members are trained on the new/revised policy and procedure.
3. Provide written documentation that juveniles are informed of the sick call procedure at the time of admission.
4. Provide written documentation that regular sick call occurs as required by this provision.

11.4 Prescription medications shall only be prepared by licensed staff, and preferably distributed by licensed medical staff. In the absence of medical staff, prescription medications may be distributed by staff who have received proper and adequate training.

Compliance Rating: **Partial Compliance**

Discussion:

The 2007 FCJDC *Standard Operating Procedure* manual addresses "Dispensing Medication". That procedure gives instructions on "dispensing" prescriptions by direct care staff but does not address the role of medical staff. That procedure states: "The Booking Officer shall be responsible for the daily delivery of prescribed medication of both pills and liquids." That procedure does not comply with current FCJDC practice or with the requirements of this provision.

The registered nurse assigned to the FCJDC described the procedure that she follows for ensuring that prescription medications are administered properly. She prepares the medications and distributes them when she is present. She places prepared, individually labeled medications in a locked cabinet for direct care staff to distribute at other times. Staff interviews and at least one incident report document that the on-call nurse has responded to the facility's questions about prescription instructions and has gone to the facility to ensure proper arrangements for medications are made.

At the time of my June 2012 visit to the FCJDC, I was provided with documentation of FCJDC staff training on medication administration, conducted on June 21, 2012, for seven FCJDC staff members. Of those seven, only one is still employed at the FCJDC and no current training documentation was provided.

Recommendations for achieving substantial compliance:

1. Revise the FCJDC policy and procedure on "Dispensing Medications" to ensure consistency with this provision. As dispensing medication is beyond the scope of practice for a registered nurse, the terminology should be changed to "administering."
2. Provide written documentation that all FCJDC staff members are trained on the new/revised policy and procedure.

11.5 The Forrest County Juvenile Detention Center shall continue to provide medical and mental health services shall be provided in a manner that ensures the confidentiality of youth's health information.

Compliance Rating: **Partial Compliance**

Discussion:

Medical and mental health services at the FCJDC are still not always provided in a manner that ensures confidentiality. Youth are still sometimes seen by the nurse in the medical office behind the booking desk with the door partially open. However, during my site visit, when the physician and nurse were in the medical exam seeing youth, the door was closed.

The room that was formerly used by the mental health provider to meet with youth in either a group or individually has been converted to a staff lounge. The mental health provider has been provided with a small room on the D Unit hall that is not large enough to see more than one or two youth at a time. When she tries to meet with groups, she must meet in the living units, which are not conducive to discussing sensitive issues and are do not offer adequate privacy. The physical plant at the FCJDC does present challenges to achieving the requirements of this provision but efforts must be made to ensure confidentiality while still ensuring that appropriate mental health services, such has psycho-educational groups, can occur.

The Request for Medical Care form, is used to document a number of medical services at the FCJDC, including sick call requests. The procedure is reportedly for youth to obtain that form from a line staff member and return it to a line staff member, to be passed on to the nurse. That practice requires youth to provide information about medical complaints that can then be read by staff. Those complaints could be of a confidential and sensitive nature. It is recommended that those completed forms be provided to the facility nurse directly.

The admissions screening questionnaire, is completed at the booking desk by the Booking Officer, where a child's responses could be overheard by other staff or youth. That screening questionnaire previously included some medical questions that were extremely intrusive in nature ("Do you have HIV or AIDS?") and that could have violated medical confidentiality. After discussing that situation with the nurse at the FCJDC, she revised that form and that type of questions were deleted from the Receiving Screening Questionnaire and are now dealt with only by medical professionals.

The nurse maintains separate medical files on each youth that are not accessible to FCJDC staff, are kept locked and that are confidential. Information in those files is reportedly only shared with permission or with approved medical providers.

Recommendations for achieving substantial compliance:

1. Ensure that a private location is provided for mental health providers to meet with youth in a group setting at the FCJDC.
2. Ensure that, when a medical professional in the medical office/exam room is seeing youth, the door is kept closed and non-medical staff members are not present.
3. Ensure that sick call inquiries made to direct care staff are done in a private, confidential manner.

XII. MENTAL HEALTH CARE

12.1 The Forrest County Juvenile Detention Center shall contract for or otherwise secure adequate mental health services to all confined youth with a mental

health diagnosis or serious mental health need, as indicated by the MAYSI-2. This shall include, but is not limited to, the provision of individual and group counseling sessions upon the request of a youth or the youth's parent/guardian, access to a mental health professional at the detention center, and the distribution and medical monitoring of psychotropic medications by a medical professional.

Compliance Rating: **Partial Compliance**

Discussion:

This FCJDC receives mental health services through Pine Belt Mental Healthcare Resources (PBMHR.) There is a therapist who is at the facility for a few hours two to three days each week. She reports that she sees youth in either a group or individually but she reports that she sees them individually before she determines that they can be seen in a group. She tries to see every youth detained unless the youth chooses not to see her. Most youth reported seeing the Pine Belt counselor and spoke positively about her. She reported that she refers "high-risk" youth for follow-up care through Pine Belt Mental Healthcare Resources if they are from Forrest County or through the youth's own county or through their youth court counselor. The room that the therapist had previously used for group counseling sessions was recently change to use as a staff lounge. The therapist was provided with a small room in the D Unit hallway but that room is too small for her to meet with more than one or two youth at once. She reports that she is presently has no place at the FCJDC to do group sessions other than in the units where the noise level is too high and there is no privacy to ensure client confidentiality. Psycho-educational groups are generally the most appropriate way to serve a juvenile detention population efficiently and the therapist should be provided with adequate space to do that. The therapist reports that she does not review the completed MAYSI-2 forms but, since my last visit, PBMHR has also begun providing the services of a licensed clinician who reviews completed copies of the MAYSI-2 and does psycho-social assessments. She then develops treatment plans based on those assessments. She also reports that she is called for consultation regarding such concerns as a child's potential for suicide and does suicide risk assessments on those youth. Both the therapist and the licensed clinician are master's level professionals and are, therefore, not qualified to provide medical monitoring of psychotropic medications. Since there is a new physician at the FCJDC, it is not yet known what his role will be in providing medical monitoring of psychotropic drugs. One youth's mental health treatment plan indicated that he had been taking a particular psychotropic drug but that he had been "non-compliant." No information was available about his receipt of that drug while at the FCJDC or whether a qualified provider had seen him for medication management.

The 2007 FCJDC *Standard Operating Procedure* manual has a section entitled "Psychiatric Emergencies." Like much of that manual, it appears to be adopted from an adult facility needs to be revised to address this provision and meet the needs of the FCJDC.

I was provided with a copy of a Proposal from Pine Belt Mental Healthcare Resources For Delivery of Mental Health Services to FCJDC that includes the elements of this provision. The Forrest County Board attorney reported that he believed that the Board had approved that proposal. If that Proposal is accepted and implemented, this provision should be able to achieve compliance.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision. That procedure should incorporate the information derived from the MAYSI-2 as well as other information available from medical staff members, youth court workers, and others.
2. Provide written documentation that all FCJDC staff and contracted medical and mental health personnel are trained on the policy and procedure.
3. Make an appropriate space available to the PBMHR therapist to conduct groups with youth at the FCJDC.
4. Provide written documentation of compliance with this provision with examples of completed forms and other paperwork.

12.2 Youth who are confined for longer than thirty (30) continuous days and who are prescribed psychotropic medications, shall be evaluated by a psychiatrist every thirty (30) days.

Compliance Rating: **Non-Compliance**

Discussion:

Interviews with the FCJDC nurses and the Pine Belt Mental Healthcare Resources clinician confirmed that referrals to a psychiatrist do not occur. The PBMHR clinician did report that many of the youth from Forrest County are current Pine Belt clients and may receive psychiatric services that she is not aware of.

At the time of my June 2012 visit, I was provided with a Proposal from Pine Belt Mental Healthcare Resources For Delivery of Mental Health Services to FCJDC that includes the elements of this provision. The Forrest County Board attorney reported that he believed that the Board had approved that proposal. If that Proposal is accepted and implemented, this provision should be able to achieve compliance.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure consistent with this provision.
2. Provide written documentation that all staff members have been trained on the policy and procedure.

3. Develop a system for documenting and monitoring youth at the FCJDC to ensure compliance with this provision.
4. Provide written documentation of compliance with examples of completed forms or other paperwork.

12.3 Within 72 hours of a youth's admission to the facility, the contractor shall develop individual mental health treatment plans for youth who are under the care of a mental health provider. Treatment plans shall emphasize continuity of care and shall ensure that whenever possible, youth are transported to appointments with their regular mental health provider, whether the appointments are standing or made after the youth's initial detention.

Compliance Rating: **Partial Compliance**

Discussion:

For about one month prior to my September site visit the licensed clinician from PBMHR assigned to the FCJDC had been completing assessments on FCJDC youth, based on completed MAYSI-2 and other information. She uses that assessment data to development treatment plans. She reported that if a youth is a current PBMHR client, she does not complete an assessment or treatment plan but that she does notify the child's assigned therapist of his detention. The form used for the assessments and treatment plans includes spaces for the date of admission and the date of service. Most assessments and treatment plans were completed within the 72 hours required although two had lag times of approximately two weeks and on one form the dates were missing. The form used by the clinician to document assessments and treatment plans indicates that the treatment plan is based on the assessment and the YASI. Since no YASI's are being completed at the FCJDC as required by provision 1.1, the clinician has limited information with which to develop a treatment plan.

I was provided with a Proposal from Pine Belt Mental Healthcare Resources For Delivery of Mental Health Services to FCJDC that includes the elements of this provision. The Forrest County Board attorney reported that he believed that the Board had approved that proposal. If that Proposal is accepted and implemented, this provision should be able to achieve compliance.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure consistent with this provision.

SUICIDE PREVENTION

13.1 The Forrest County Juvenile Detention Center shall develop a multi-tiered suicide prevention policy that has at least three stages of suicide watch.

Suicide watch shall not be used as punishment. The "suicide cell" shall be reserved for youth for whom the "suicide cell" is deemed necessary in conjunction with this suicide prevention policy.

Compliance Rating: **Non-Compliance**

Discussion:

The 2007 *Standard Operating Procedure* manual at the FCJDC addresses the subject of suicide in two sections, "Suicide Prevention for At-Risk Detainees" and "Attempted and Successful Suicides." However, neither of those sections is comprehensive or consistent with current research in the area of juvenile suicide in confinement. (See, *Juvenile Suicide in Confinement, A National Survey*, Lindsay M. Hayes, National Center on Institutions and Alternatives, for the U. S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention, February 2009.) The release of Hayes' research lead many juvenile facilities around the country to alter practices that were shown to be counter-productive or even dangerous. The FCJDC should make similar changes to their procedures. Information about that research was provided to the Forrest County Chief Deputy Sheriff, the former FCJDC Director, the current FCJDC Director and the Forrest County Sheriff's Office nurse prior to and subsequent to previous visits for use in updating their policy and procedure. By the time of my September 2012 visit, no effort had been made to develop an appropriate suicide prevention policy and procedure in accordance with that current research. That report recommends that comprehensive suicide prevention programming include the following components:

- Training of all staff
- Identification/Screening
- Communication
- Housing
- Levels of Supervision
- Intervention
- Reporting, and
- Follow-up/mortality review

Current research advises against the use of confinement or isolation for suicidal youth, except for brief periods when a child is engaging in self-destructive behavior. That report further advises that "whenever possible, suicidal youth should be housed in the general population, mental health unit, or infirmary, in close proximity to staff." (p. 30) The current practice of placing potentially suicidal youth in the Holding Room or Detox Room at the FCJDC would not comply with this recommendation.

The current policy at the FCJDC includes two levels of observation and those levels do not conform to the research and recommendations cited above. Generally, youth deemed potentially suicidal are placed in Detox or Holding where they are monitored on camera. That is

contrary to best practice and current research. Further, the instructions for the FCJDC Suicide Watch Log give contradictory instructions to staff.

There has been no staff training on suicide prevention since my last site visit and in my July 2012 report I described one training session provided through the Forrest County Sheriff's Department titled "Special Topics in Mental Health: Recognition, De-escalation & Suicide Prevention". However, as I stated in that report, only a handful of attendees were FCJDC employees and the other attendees worked elsewhere for the Sheriff's Department. Training in *adult* suicide prevention may be inappropriate for *juvenile* practitioners. And, as I stated in that July report, since the FCJDC has no up-to-date policy and procedure for Suicide Prevention and Intervention, I have concerns that this training is inconsistent with the current research addressing suicide in juvenile facilities. Basically, it appears that no FCJDC employee has been trained in evidence-based suicide prevention for juveniles.

Recommendations for achieving substantial compliance:

1. Revise the existing FCJDC policy and procedure for consistency with this provision and consistency with the recommendations in the research report cited above.
2. Develop forms or other means of documenting compliance with the new policy and procedure.
3. Provide written documentation that all FCJDC staff and contractors have been trained on the new policy and procedure.
4. Include information on seeking help if a child feels potentially suicidal or knows of a peer who may be suicidal in a formal orientation procedure for juveniles.
5. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

13.2 Any youth placed on the highest level of suicide watch shall be evaluated by a mental health professional, ideally within 12 hours, but in no case, longer than 24 hours of his or her placement on suicide watch. If a youth on the highest level of suicide watch is not evaluated by a mental health professional within 24 hours, the youth shall immediately be transported to a local mental health facility or emergency room for evaluation and/or treatment.

Compliance Rating: **Partial Compliance**

Discussion:

The suicide prevention section of the 2007 FCJDC *Standard Operating Procedure* manual discussed in 13.1 above does require that the:

"JDC Director:

- Notify Pine Belt Mental Healthcare Resources for an evaluation to be done, as quickly as possible. They will perform a risk assessment on the juvenile.

If the juvenile is actively trying to commit suicide or threatening to commit suicide, and you cannot contact PBMH, call the Sheriff's Office Dispatcher (or jail) and arrange transportation for the juvenile to Forrest General Hospital Emergency Room.

- Notify the jail nurse.
- Notify the Chief of Corrections.
- Verify that proper documentation is done in the Suicide Watch Log."

That policy appears to be based on a jail policy and is not entirely applicable to the FCJDC. The organizational chart provided to me has no "Chief of Corrections" and the regular nurse assigned to the FCJDC is not the "jail nurse" while the nurse on-call to the FCJDC is not the nurse who works regularly at the FCJDC.

Since my last visit, Pine Belt Mental Healthcare Resources (PBMHR) has assigned a clinician to the FCJDC to conduct assessments, subsequent to the completion of the MAYSI-2 and, on an as needed basis, when there is a potential risk of suicide. That clinician informed me that if the child is a current PBMHR client she does not do the assessment but she does contact the child's current Pine Belt therapist. It is not known whether those youth are seen by their therapist or by another mental health professional as required by this provision. The clinician reported that she is contacted by the FCJDC nurse or by a staff member to complete a suicide assessment and she generally sees those youth within twenty-four hours of being contacted. The nurse described the same procedure and I was provided with copies of PBMHR Suicide Risk Assessment forms verifying that practice. The form does not indicate when the referral is made so it is impossible to determine the time lapse between referral and assessment. The FCJDC does not have a current, research-based suicide prevention policy that addresses the elements of this provision. There is no policy that includes levels of suicide watch but the clinician indicated that she sees all youth who may be suicidal.

Staff interviewed during my visit again gave somewhat conflicting responses when asked about the FCJDC suicide procedures. Two staff members interviewed indicated that they do not know what the suicide prevention procedure is. Most again indicated that a potentially suicidal youth would be placed in a Holding Room or in Detox and that the nurse would be called. Staff reported that supervision of the youth would ensue at fifteen-minute intervals. No mention was made of levels of supervision or that constant supervision, which is recommended, would be implemented. Staff members again differed in their reports of how that would occur. Some staff members reported that they would observe the youth on the camera in Detox or Holding. Sadly, research has shown that successful suicides have occurred in correctional facilities while an individual is supposedly being watched constantly on a camera. Most staff members reported that youth are checked every fifteen minutes. One officer stated that suicidal juveniles are placed in a suicide gown.

I was able to review completed Suicide Watch forms. That form refers to "Constant" and "Close" supervision the explanations of those two terms is confusing and contradictory. Both types of watch require fifteen-minute room checks at "staggered intervals." However, the completed form documents fifteen-minute checks at exactly fifteen minutes intervals. And, there is no place on that form to describe the reason for the suicide watch, including the youth's presenting behavior or statements.

Recommendations for achieving substantial compliance:

1. Revise the existing FCJDC policy and procedure consistent with this provision and consistent with current research provided to the FCJDC administrators.
2. Provide written documentation that all FCJDC staff and contractors have been trained on the new policy and procedure.
3. Develop forms or other means of documenting compliance with the new policy and procedure.
4. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

13.3 Youth on suicide watch shall participate in recreation, school, and any other structured programming. Youth shall not be required to wear a "suicide gown" unless locked in a cell or unless a "suicide gown" is ordered by a mental health professional. Staff shall closely monitor youth on suicide watch, which includes logging activities every 15 minutes.

Compliance Rating: **Non-Compliance**

Discussion:

As discussed in 13.1 and 13.2 above, the existing 2007 FCJDC *Standard Operating Procedure* is out of date and in need of revision in order to comply with current research and to adhere to the provisions of the Agreed Order. Interviews with staff offered varied comments regarding suicide prevention procedures at the FCJDC. One staff member informed me that suicidal residents are placed in a suicide gown or blanket.

Youth at the FCJDC are allowed to voluntarily isolate themselves in either their own individual rooms or in a room in Unit D that is not staffed full-time. Those juveniles are still not assessed for potential suicidal tendencies when they opt to self-isolate. Although that appears to be a common occurrence, no examples of documentation of monitoring of those youth was provided. Isolation can be considered a risk for suicidal behavior and should be minimized. Staff again informed me that sometimes juveniles prefer to be placed in Unit D because they are frightened or intimidated by other residents. All juveniles should feel safe while at the FCJDC and staffing levels and staff interaction with youth should be adequate to ensure that.

As discussed in 13.2, sample completed Suicide Watch Log forms were provided. Those forms documented room checks of juveniles on suicide watch but did not document that youth's participation in recreation, school or any other structured programming. Those forms documented room checks at exactly fifteen-minute intervals without being staggered or random. It seems clear that the staff members at the FCJDC are not certain about the expected suicide-monitoring requirement. Mental health consultation reports of potentially suicidal youth did not indicate whether a mental health professional orders a suicide gown. However, if wearing a suicide gown is required for youth who convey suicidal feelings, it is less likely that those youth would express themselves as being placed in that gown is degrading and humiliating.

There is little or no structured programming and limited school and recreation at the FCJDC, as discussed previously in this report. Based on youth and staff interviews, however, it would appear that residents are generally isolated in a Holding Room, in the Detox Room on in their individual room if they are considered potentially suicidal. It is not known whether potentially suicidal youth are allowed to participate in recreation, school, and any other structured programming. No documentation was provided that would indicate if that occurs.

Recommendations for achieving substantial compliance:

1. Revise the existing FCJDC policy and procedure for consistency with this provision.
2. Provide written documentation that all FCJDC staff and contractors have been trained on the new policy and procedure.
3. Develop forms or other means of documenting compliance with the new policy and procedure.
4. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

13.4 When a youth is placed on any level of suicide watch, a report shall be made within 24 hours to the appropriate youth court and to the youth's guardian.

Compliance Rating: **Non-Compliance**

Discussion:

Existing FCJDC 2007 *Standard Operating Procedure* does not address the requirements of this provision and no documentation of reports having been made to the appropriate youth court and to any youth's guardian, as required were provided. No staff member interviewed addressed this requirement.

Recommendations for achieving substantial compliance:

1. Revise the existing FCJDC policy and procedure for consistency with this provision.
2. Provide written documentation that all FCJDC staff and contractors have been trained on the new policy and procedure.
3. Develop forms or other means of documenting compliance with the new policy and procedure.
4. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

XIV. FAMILY SUPPORT AND INTERACTIONS

14.1 Visitation privileges shall not be restricted or withheld from youth unless the detention center director determines that a visit will violate the security of the Forrest County Juvenile Detention Center or will endanger the safety of residents, visitors, or staff.

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC has generous visiting hours during weekdays. Current posted times are 8:00 a.m. to 12:00 noon and 1:00 p.m. to 4:00 p.m. on weekdays. The "Detainee Handbook" provides information about visitation, including information about days of the week, times of visitation, who can visit, visitor dress expectations, storing of personal items during visits and special visits. The copy of the "Parent Handbook" appended to the September 25, 2012 FCJDC "Brief Implementation Summary Report" has that same information. However, as has been discussed in the report, the "Detainee Handbook" is only briefly provided to juveniles during the intake process, without sufficient time to read it and no personal copies are provided to youth for reference. And, I have not been informed if the "Parent Handbook" is yet being used or when it will be implemented. There is a clear, visible sign in the reception area of the FCJDC that explains visitation rules and which parents and other potential visitors can refer to. The 2007 FCJDC *Standard Operating Procedure* Manual, under the "Visitation" section, indicates that visitation "will be held daily between the hours of 0900 and 1800." That manual is silent on the days of the week that visits are allowed. No policy exists that discusses circumstances under which the Director may restrict or withhold visits, such as requiring visits to occur in the divided visiting room, and no documentation of that having occurred and why was provided. A youth did report being required to visit his mother in the divided visiting room to the SPLC attorney but no documentation of that was available. Updated policy and procedure is needed to accurately reflect current visitation rules and to ensure compliance with this provision. My observations and interviews with staff and youth indicated that visits are allowed, with the required youth court worker authorization, throughout weekday hours. The FCJDC Director stated that she approves visits during other times when requested. No

documentation of the authorization visits outside regular hours was provided. A visitation log is now being maintained by the facility to verify when visits take place and with whom the visit occurs.

Recommendations for achieving substantial compliance:

1. Revise the FCJDC *Standard Operating Procedure* manual or develop new policies and procedures to be consistent with this provision and ensure consistency between that manual and posted Visitation Rules.
2. Provide written documentation that all FCJDC staff members have been trained on the revised policy and procedure.
3. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

14.2 Within 60 days of the effective date of this Agreed Order, the Forrest County Juvenile Detention Center shall provide accommodations that allow youth to have contact visits with their families.

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC allows youth to have contact visits with family members by using just one side of the divided visiting room. The physical plant has limitations but the FCJDC has been open to making accommodation. Because there is only one visitation room, visits must be held one at a time but the FCJDC staff informed me that that has not been a problem. Interviews with staff and, most importantly, with juveniles confirmed that family visits are generally contact visits. There is no written policy available to staff, youth and family members explaining when contact visits may not be allowed.

Recommendations for achieving substantial compliance:

1. Revise the 2007 FCJDC *Standard Operating Procedure* manual or draft policy and procedure to be consistent with this provision and ensure consistency between that manual and posted Visitation Rules.
2. Provide written documentation that all FCJDC staff members have been trained on the revised policy and procedure.

14.3 Visitation shall be regularly scheduled at least three times per week or approved by appointment, and shall include evening and/or weekend visitation times in order to encourage family visitation. The Forrest County Juvenile Detention Center shall permit the confined youth's own children to participate in visitation, as long as the minors' parent or guardian is present during the visit and authorized by the respective Youth Court.

Compliance Rating: **Non-Compliance**

Discussion:

As discussed above, visitation hours are generous on weekdays. However, there is still no regularly scheduled visitation to accommodate families' work schedules, travel times and other limitations during the evening or on weekends. The FCJDC Director stated that she does approve visitation outside regular visitation hours but had no examples of having done so. And, it is not known how or if that option is made known to family members. The "Parent Handbook" indicates that visitation is only available on weekdays; no mention is made of evening of weekend visitation. The 2007 FCJDC *Standard Operating Procedure* manual does not address the availability of visitation during evening or weekend hours. The "Detainee Handbook" and the "Parent Handbook" both state: "Youth are allowed visits from parents, legal guardians and grandparents." The 2007 FCJDC *Standard Operating Procedure* manual says: "Only the visitors authorized by Youth Court will be allowed to visit." Neither document discusses visits from the confined youth's own children.

Recommendations for achieving substantial compliance:

1. Revise the FCJDC *Standard Operating Procedure* manual or develop policy and procedure to be consistent with this provision and ensure consistency between that manual and posted Visitation Rules, the "Detainee Handbook" and the "Parent Handbook."
2. Provide written documentation that all FCJDC staff members have been trained on the revised policy and procedure.
3. Provide notification of visitation rules consistent with this provision to parents and to juveniles at admission.
4. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

14.4 Within 30 days of the effective date of this agreement, youth shall be afforded an opportunity to call parents, primary caretakers or legal guardians free of charge three times per week. The hours youth may make calls shall encourage family contact.

Compliance Rating: **Partial Compliance**

Discussion:

Youth at the FCJDC are allowed to make phone calls free of charge three times each week at the booking desk during the evening shift that ends begins 6:00 p.m. That is a change from previous practice that allowed phone calls during the day shift, when parents

and others were often at work and unavailable. Staff and youth interviews confirmed the changed practice and I observed youth making phone calls. Sample phone logs were provided from dates in July and August that documented phone calls that were all during the afternoon, day shift hours, not during the evening shift. It is unknown when the new schedule was implemented. Some of those logs were incomplete, omitting dates, time of calls. There are also phones in each dayroom in Units A, B and C that were formerly used for making collect phone calls but during my previous visits those phones in Units A and C were reported to be nonfunctional and on my recent visit I was informed that those phones are no longer being used.

The "Detainee Handbook" and the "Parent Handbook" both state: "Juveniles are given phone calls three times a week: Monday, Wednesday and Friday or additional days at the approval of the facility administrators."

Officers interviewed reported that youth are allowed to make phone calls during the evening shift, three days each week. The schedule time for phone calls varied from "sometime after showers" to "around 6:30 p.m." to "about 7:30 p.m." Those calls are made at the booking desk, the youth dials the number and the conversation is held in the staff member's presence. The staff member does not ensure the identity of the individual being called.

Youth interviewed generally verified that they are now allowed phone calls in the evenings on Mondays, Wednesdays and Fridays. One youth reported that they are sometimes allowed to make phone calls on Sundays as well, "depending on who is working." Youth reported that they look forward to phone calls and that it is a motivator. That point was made in my July 2012 report. Many facilities offer extra or longer phone calls as a reward for positive behavior. One youth reported that he has asked his family to not visit him in person because it upsets them to see him locked up. He especially values talking to them by phone. It is important for youth to maintain contact with their parents, primary caretakers or legal guardians in order to encourage successful reintegration to their home and community. And, offering additional or longer phone calls as a reward for positive behavior could be a component of a comprehensive behavior management program at the FCJDC.

The 2007 FCJDC *Standard Operating Procedures* manual states that the "detention center telephone system will be turned on at 0800 hours and turned off at 2000 each day." It goes on to discuss obscene, harassing or threatening calls and consequences if a juvenile damages a phone. The policy is silent on which phones are to be used, how phone calls are to be made and documented, and whether calls are collect or free of charge. There is no formal facility orientation process for youth, informing them of their rights, including their rights to phone calls, as addressed in this provision.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the policy and procedure.
3. Provide sample documentation of phone calls made by youth at the FCJDC including, at least, name of youth, name and relationship of person called, and date, time and duration of phone call.
4. Develop a written youth orientation procedure that ensures that all newly admitted youth at the FCJDC are informed of their rights to phone calls, consistent with this provision, while detained at the facility.
5. Provide sample copies of facility orientation of youth documenting that process.

14.5 Youth shall be afforded reasonable opportunities to call attorneys, Department of Human Services social workers, and Youth Court staff free of charge.

Compliance Rating: **Non-Compliance**

Discussion:

Youth are still not informed of their right to call their attorneys. There is no formal facility orientation process for youth, informing them of their rights, including their rights to phone calls, as addressed in this provision. Staff members interviewed were unfamiliar with what procedure should be followed. Two staff members said they did not know how they would contact attorneys or professional workers. One staff member said that youth are "informed at booking." Another staff said he is "still learning the rules." Another staff member reported that the staff "tell them that they have that right" but did not elaborate about when and how that is done. The 2007 FCJDC *Standard Operation Procedure* manual section, "Telephones" does not address this right. None of the youth interviewed were aware that they are allowed to call their attorneys, social workers or Youth Court Workers.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the policy and procedure.
3. Provide sample documentation of phone calls made to or received from attorneys, social workers or Youth Court workers.
4. Develop a written youth orientation procedure that ensures that all newly admitted youth at the FCJDC are informed of their rights to phone calls, consistent with this provision, while detained at the facility.
5. Provide sample copies of facility orientation of youth documenting that process.

14.6 Youth may make and receive prescheduled, confidential phone calls with their attorneys. At the discretion of the Director or assignee, in emergency

situations, youth may receive phone calls from parents, primary caretakers, or legal guardians.

Compliance Rating: **Non-Compliance**

Discussion:

As discussed above, youth are not informed of their rights to make or receive phone calls to or from their attorneys. Staff members interviewed were vague about or unaware of that option. Youth interviewed did not know how they would contact their attorneys. The 2007 FCJDC *Standard Operation Procedure* manual section, "Telephones" does not address attorney phone calls. That manual also does not discuss phone calls from parents, primary caretakers or legal guardians in emergency situations. There is still no formal facility orientation process for youth, informing them of their rights, including their rights to phone calls, as addressed in this provision.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the policy and procedure.
3. Provide sample documentation of phone calls made and received by youth, to or from attorneys and others in emergencies (with required authorization), including, at least, name of youth, name and relationship of person called or calling, and date, time and duration of phone call.
4. Develop a written youth orientation procedure that ensures that all newly admitted youth at the FCJDC are informed of their rights to phone calls, consistent with this provision.
5. Provide examples of facility orientation of youth documenting that process.

XV. MISCELLANEOUS PROVISIONS

15.1 Forrest County Juvenile Detention Center will continue to provide male and female youth shall be provided with equal access to educational and rehabilitative services, medical care, and indoor and outdoor recreation.

Compliance Rating: **Partial Compliance**

Discussion:

The 2012-2013 school schedule has been revised at the FCJDC to adhere with Mississippi state statute requiring five hours of academics each day. In order to meet that requirement with all detained youth with just one teacher, the FCJDC male and female

youth have all begun attending school together. I did observe class with all youth. Both youth and staff interviewed gave varying answers when asked what hours school is held. That uncertainty may be the result of the inconsistency regarding school that I described in provision 3.1 above. The two girls at the FCJDC both reported that "there is no school in the afternoon" although I did observe them in school one afternoon during my visit. Since the schoolteacher bases his daily attendance role on the FCJDC population report, if school is held on a particular day, he apparently counts a youth as present for the entire day. That information may often be inaccurate or incomplete and does not provide documentation of whether males and females have equal access to school.

The therapist from Pine Belt Mental Healthcare Resources again reported that she sees all juveniles who are willing to meet with her and the clinician reported that she also sees all youth regardless of gender.

There is still virtually no structured programming at the FCJDC and youth in all units, both male and female, were observed watching television, playing cards or visiting while I was on-site. The five new schedules that I was provided only include one hour of recreation on weekdays and one-and-a-half hours on weekends. I was informed that male and female detainees do not have recreation together. Therefore, the new schedules do not offer enough time for all three units to get the minimum daily hour of large muscle exercise required, even if the two male units are joined. Because the FCJDC usually has an approximately 80 to 100 percent male population, there is concern that females' needs and rights may be disregarded to serve the larger group of males. The unit dayrooms have televisions on constantly that add to the noise, increase the stress level and precludes alternative activities. The physical plant does not provide adequate indoor space for activities and the furniture in the dayrooms is permanently attached, limiting options for leisure, rehabilitative or recreational activities. However, those limitations are the same in both the male units and the female unit.

Information provided regarding medical care indicated that equal access is provided to both male and female detainees.

Of greatest concern is the fact that there is still no organized, planned, structured, rehabilitative programming provided to the youth at the FCJDC, as discussed in 3.1, 3.2, 3.4 and 4.1 above. The FCJDC must develop a structured schedule of daily activities, including a variety of rehabilitative programs such as recreation, arts and crafts education and make those activities equally available to both male and female detainees.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure consistent with this provision.
2. Provide written documentation that all FCJDC staff members have been trained on that policy and procedure.

3. Develop written job descriptions for all staff at the FCJDC describing staff responsibilities to ensure compliance with this provision.
4. Provide examples of documentation of daily schedules, including actual activities that did occur, to demonstrate compliance with this provision.

15.2 All youth shall have the opportunity to engage in at least one hour of large muscle exercise a day outside, except in the case of inclement weather or a facility wide-emergency. If youth are unable to engage in at least one hour of large muscle exercise outside, Detention Center staff shall provide an opportunity for the youth to exercise indoors.

Compliance Rating: **Non-compliance**

Discussion:

In my last two quarterly Monitoring Reports I described observing youth outside with staff and approximately half of those youth were sitting idly and not participating in the recreational activity (basketball). During my recent visit I again observed the same thing occurring. Interviews with both youth and staff members confirmed that is typical and that youth are not required to participate in large muscle activity. Basketball is still almost the only activity offered regardless of individuals' interests and skills. I did observe the two boys' units outside for recreation and observed that they now participate in stretching, calisthenics and jogging, lead by one of the youth, to warm-up before playing basketball. It should be noted that the recreation area at the FCJDC is very small and recreational options are limited. There is no area indoors where physical activity can practically occur.

As discussed above, I was provided with five new daily schedules for the FCJDC but they had not yet been implemented at the time of my visit. The schedules do include time for "Recreation/Yard" daily but they do not break the time down by unit and the schedules allow only a total of one hour on weekdays and an hour-and-a-half on weekends. Those times are insufficient to provide one hour of daily large muscle exercise for units A, B and C unless all three units are together. I have never observed the male and female units in the yard together and I am informed that does not occur. It is not known if or how juveniles held in Unit D receive recreation. Until the FCJDC schedule incorporates a adequate amount of time for all youth to get daily large muscle exercise for at least one hour, the schedules are consistently adhered to and staff members are held accountable for ensuring that juveniles do receive at least one hour of large muscle exercise daily, compliance with this provision cannot be assured. Further, until there is a clear and written expectation that staff members ensure that all youth receive that exercise, regardless of the weather conditions, this provision cannot be fully complied with.

The 2007 *Standard Operating Procedures* manual at the FCJDC in the section "Exercise Opportunities" states: "The opportunity to exercise will be made to juvenile

detainees Monday through Friday of each week." That procedure does not address the amount of time that youth are to exercise and does not require that youth exercise on weekends.

Recommendations for achieving substantial compliance:

1. Revise the FCJDC exercise policy and procedure to be consistent with this provision.
2. Provide written documentation that all FCJDC staff members have been trained on the revised policy and procedure.
3. Develop written job descriptions for all staff at the FCJDC describing staff responsibilities to ensure compliance with this provision.
4. Provide examples of documentation of daily schedules, including actual activities that did occur, to demonstrate compliance with this provision.

15.3 The Forrest County Juvenile Detention Center shall develop policies and practices to ensure staff shall not use profanity in the presence of youth, nor shall staff insult youth or call them names.

Compliance Rating: **Non-Compliance**

Discussion:

This provision specifically requires policies as well as practices that establish a clear expectation that staff shall not use profanity in the presence of youth nor shall staff insult youth or call them names. The 2007 FCJDC *Standard Operating Procedures* manual includes a "Code of Conduct" that delineates "a list of rules and regulations governing employee behavior." That procedure does not address the requirements in this provision. The draft Policy and Procedure, "Employee Policies," discusses a number of issues that could result in employee discipline but it does not address the requirement of this provision. Most youth interviewed this time again stated that staff members do not swear at or in front of residents but a few youth again reported that staff members do swear in the presence of youth.

Despite my previous recommendation that the FCJDC develop a policy and procedure and an Employee Code of Conduct that addresses this provision, the draft policy and procedure provided for my review was silent on the issues. The failure of the FCJDC to ignore this requirement while youth continue to report incidents of staff swearing leads me to decrease my rating of compliance on this provision.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure and/or written Employee Code of Conduct that addresses this provision.

2. Provide written documentation that all FCJDC staff has been trained on the policy and procedure and/or Employee Code of Conduct.

15.4 Within 30 days of the date of this agreement, the Forrest County Juvenile Detention Center shall develop and implement an adequate grievance policy that is accessible to all youth regardless of literacy levels, and that provides youth with the opportunity to appeal facility level determinations.

Compliance Rating: **Non-Compliance**

Discussion:

There is still no written grievance policy at the Forrest County Juvenile Detention Center. The FCJDC did create a Grievance form that juveniles can submit after my first visit. That form lacks some important elements, particularly the name of the staff member hearing the grievance, the date and time of that hearing, and any potential appeal option. Most staff members interviewed were aware of the existence of the grievance form and reported that they would provide that form to a juvenile wanting to make a formal complaint. Three staff members, however, were very new and lacked training or even basic new employee orientation. They were not aware of the grievance process. Most of the youth interviewed did know what a grievance is and were at least somewhat aware of the process, generally after I explained that "a grievance is like a complaint." However, four youth did not know about the grievance procedure even with my guidance and most youth stated that they had no confidence in the grievance process. One youth reported that he had filed a grievance and was pleased with the result. He indicated that he had complained about a staff member swearing at him, that another staff member overheard the swearing by the staff member and that the offending staff member was suspended. I requested copies of all grievances since my last site visit in June 2012 and was informed by administration that none had been filed.

The September 18, 2012 FCJDC "Detainee Handbook" addresses Detainee Grievance Policy & Detainee Concerns in general terms. However, as discussed above, detainees who I observed being admitted were not offered enough time to read the "Handbook" and youth are not provided with a copy to keep and refer to. Since there is no formal orientation process that would discuss such things as detainee rights and facility rules, the grievance policy is not clearly explained to youth.

A grievance procedure is a critical component of any juvenile detention center and youth must feel it is fair, accessible and confidential. The fact that there have reportedly been no grievances, according the to the FCJDC administration, in the three-month period before my visit is not to the facility's credit and seems to illustrate the fact that youth at the FCJDC lack confidence in the current, inadequate grievance procedure.

Recommendations for achieving substantial compliance:

1. Develop and implement an adequate written grievance policy and procedure that is accessible to all youth regardless of literacy levels, and that provides youth with the opportunity to appeal. That grievance policy should be perceived as fair and effective by the youth at the FCJDC.
2. Develop a grievance log to track youth grievances by such factors as date, time and type of grievance.
3. Develop a written youth orientation procedure that ensures that all newly admitted youth at the FCJDC are informed of how to make use of the facility's grievance policy and procedure, among other things.
4. Provide sample copies of facility orientation of youth documenting that process.
5. Provide written documentation that all staff members at the FCJDC are trained on the new grievance policy and procedure and orientation procedure.
6. Provide sample copies of completed youth grievances.
7. Provide copies of completed grievance logs.

15.5 Within 30 days of the date of this agreement, the Forrest County Juvenile Detention Center shall develop and implement an adequate policy that allows youth of all ages and literacy levels with the opportunity to request to see their attorney and/or Youth Court counselor.

Compliance Rating: **Non-Compliance**

Discussion:

This FCJDC has still not developed a policy and procedure that allows youth of all ages and literacy levels with the opportunity to request to see their attorney and/or Youth Court counselor. The existing FCJDC 2007 *Standard Operating Procedures* manual does not address the requirements of this provision. Most youth interviewed stated that they did not know how to contact their attorneys or counselors. There still is no formal orientation process at the FCJDC that documents such things as an explanation of rules and rights, including contacting attorneys or counselors. All three *Implementation Reports* from the FCJDC state: "As part of their rights, youth are always made conscious that they can contact their attorney or counselor at any time." There is no explanation of how youth are "made conscious" of that right. The "Detainee Handbook" (dated September 18, 2012) includes a section entitled "Rights of Detainees in Custody" that quotes Section 43-21-311 of the Mississippi Code of 1972. That includes information about the right of the juvenile to be visited by "counsel and authorized personnel from the youth court." It also states that "when a child is taken into custody, the child may immediately telephone his parent, guardian or custodian; his counsel; and personnel of the youth court." However, during my observation of youth being booked into FCJDC, the "Detainee Handbook" was briefly provided to the youth to look at, without enough time to read it. No verbal explanation of the content of the "Handbook" was provided and a youth is not allowed to have his own

copy to refer to. Even, if that were the case, that document does not explain how a youth is to contact his attorney or youth court counselor after he is admitted.

Recommendations for achieving substantial compliance:

1. Develop a written policy and procedure that is consistent with the requirements of this provision.
2. Provide written documentation that all FCJDC staff members have been trained on the new policy and procedure.
3. Develop a written youth orientation procedure that ensures that all newly admitted youth at the FCJDC are informed of the procedure for them to follow to request to see their attorney and/or Youth Court counselor. Require that the orientation topics are also explained verbally by staff.
4. Provide sample copies of facility orientation of youth documenting that process.
5. Provide examples of documentation (i.e. completed forms) of youth at the FCJDC requesting to see their attorney and/or Youth Court Counselor.

15.6 The Forrest County Juvenile Detention Center shall collaborate with the Plaintiffs to design and implement a comprehensive juvenile justice pre-service and in-service training program for detention center staff. Training shall include, but is not limited to, the mandatory reporting requirements for direct care workers, the requirements of the Prison Rape Elimination Act, verbal de-escalation techniques, adolescent brain development and developmental issues, effective communication with adolescents, effective documentation, appropriate use of force and restraint, and best practices for detention center administration.

Compliance Rating: **Non-Compliance**

Discussion:

There is still no comprehensive juvenile justice pre-service and in-service training program for detention center staff at the FCJDC and no effort had been made to develop one prior to my visit. In addition to the topics required by this provision, a comprehensive training program should delineate training requirements by job title and the number of required hours of pre-service and annual training. Such a training program should be designed specifically for a juvenile facility. Although there may be some training topics that are appropriate for either a juvenile or an adult setting, such as First Aid and CPR, most topics should be selected or modified for a juvenile setting and a juvenile population. In developing a comprehensive training program, most facilities model the American Correctional Association (ACA) standards (See, *Standards for Juvenile Detention Facilities, 3rd Edition*, May 1991). ACA standards discuss a array of training-related topics including the timing and frequency of training, amount of time required for training and minimum topics to be covered for both administrative and direct care staff. Training attendance

should always be documented. Careful record keeping is essential to ensure that staff members maintain their required levels of training and to confirm that the facility and the employee are accountable for meeting training expectations. Staff training is an ongoing necessity, not a one-time occurrence and the FCJDC training program should address individual employees' needs for training updates and reviews as well as training on current and emerging issues.

To coincide with my September 2012 site visit, the Southern Poverty Law Center (SPLC) arranged a meeting with the FCJDC administration, the Forrest County Chief Deputy Sheriff, the Forrest County Board Attorney and myself to discuss the development of a training program. The SPLC provided copies of the ACA training standards discussed above and a list of recommended training topics to use as a guideline. The FCJDC administrators committed to develop a training plan in draft by October 17, 2012, which they agreed to send to the SPLC, Chief Bolton and me. It was hoped that meeting would help to generate progress towards compliance with this provision. Unfortunately, at this time of filing this report, no training plan has been provided and no additional progress has occurred in achieving compliance with this provision.

The FCJDC did hold staff meetings during the week that I was visiting to train on the new Policy and Procedure Manual. The agenda for those meetings was changed, however, when the Assistant Director learned that I had requested the opportunity to review policies in *draft* form. Most of the draft policies and procedure will need modification to ensure compliance with the Agreed Order. Additional training of staff is anticipated as new policies are finalized. However, as of the filing of this report, policies and procedures have not yet been written with significant revisions to the draft versions are still pending. And, as I stated in my last report, sporadic training *events* do not comprise a training *program* and do not ensure that training needs are met.

This monitor continues to be available to assist and provide technical assistance to the FCJDC in developing a comprehensive training program and the required collaboration with the Plaintiffs can also provide assistance with that effort.

Recommendations for achieving substantial compliance:

1. Design and implement a comprehensive juvenile justice pre-service and in-service training program for detention center staff. Training shall include, but is not limited to, the mandatory reporting requirements for direct care workers, the requirements of the Prison Rape Elimination Act, verbal de-escalation techniques, adolescent brain development and developmental issues, effective communication with adolescents, effective documentation, appropriate use of force and restraint, and best practices for detention center administration. That training program should include a system of recording training attended by individual staff members. In developing their training program, it is recommended that the FCJDC refer to the ACA *Standards for Juvenile Detention Facilities, 3rd Edition* for guidance. The FCJDC

should collaborate with the Plaintiffs in the design and implementation of a training program.

2. Provide written documentation of staff members' training as required by this provision.

SUMMARY AND CONCLUSION:

Although the Forrest County Juvenile Detention Center administration continues to work towards achieving compliance with the Agreed Order, that progress has been slow and the FCJDC is considerably behind what would be considered a reasonable schedule at this point. Delays have been due largely to changes in administrative and line staff and in communication breakdown that has occurred between the various administrative teams. In addition to a new Director and Assistant Director, there has been significant line staff turnover. That has resulted in many staff members being untrained and having little knowledge of the Agreed Order and its requirements. There are a number of reasons for the staffing changes that have occurred at the FCJDC and staffing changes will always occur to some extent. However, that situation at the FCJDC has contributed to the facility's struggles in adhering to most provisions of the Agreed Order. Compliance with that Order will not be possible without the involvement of and commitment by the entire staff at the FCJDC, not just the administrators. It is hoped that the FCJDC will have more employee consistency in the foreseeable future. I have been advised that the current administrative team will be in place to carry-out the terms of the Agreed Order and that they have the support of the Sheriff's Department. The Director and Assistant Director both verbalize commitment to accomplishing a positive outcome. I continue to assure them that I support their efforts and am available to offer technical assistance.

Both the FCJDC Director and Assistant Director have some experience working with a juvenile justice population. However, their juvenile detention facility and general management experience is limited. I have and will continue to offer suggestions to them and to the Sheriff's Department regarding resources for them to learn about accepted juvenile justice practice from peer groups throughout the country. Juvenile justice practice is very different from adult corrections and, although the Forrest County Sheriff's Department may offer many useful resources in operating the FCJDC, such has human resources management advice and purchasing expertise, juvenile detention guidance will need to be sought elsewhere. It is my hope that the FCJDC, the Forrest County Sheriff and I will be able to work together to succeed in meeting the requirements of the Agreed Order within the Court's timeframe.

As has been the case during previous visits, I again met a number of staff members and contractors who expressed commitment and professionalism and the FCJDC administration continues to convey diligence and resolve in working with this monitor and with the Plaintiffs in complying with the requirements of the Agreed Order. The FCJDC administration has begun writing policy and procedures, which is one of the major objectives that I have repeatedly recommended. As discussed in this report, the Assistant

Director was given the task of writing those policies and procedures but she was not informed that I requested the opportunity to review them and make recommendations for revisions if necessary. The existing *Standard Operation Procedures* manual is very out-of-date, in many cases inappropriate for a juvenile facility and not in compliance with the Agreed Order. And, I was provided with two proposed new policies at the time of my June 2012 visit that were very problematic. In my meetings and in correspondence I have provided the FCJDC with a recommended format for policies and procedures but the new draft policies did not follow that format. Therefore, I have made it clear that I feel it is important for me to offer input to new or revised policies. As discussed in my previous Quarterly Reports, a number of the provisions in the Agreed Order can achieve Substantial Compliance with the addition of written policies and procedures that are consistent with those provisions, along with accompanying documentation that all staff members at the FCJDC have been trained on those policies and procedures. Those policies and procedures must be written in such a way that they clearly communicate to the users the "why, what, who, when, where and how" of each subject.

The FCJDC has begun writing job descriptions for staff members, also in accordance with previous recommendations and the April 2012 Monitoring Report submitted to the Court. They also have begun planning a comprehensive staff training program. Those two tasks are also critical. Had detailed job descriptions that reflected the expectations in the Agreed Order been available when the several new employees began at the FCJDC, they would have been at least somewhat more prepared for their new roles. And, if the FCJDC had a staff training program, as required, those new staff members, as well as the veteran employees, would be further ahead in ensuring that practices at the FCJDC comply with the Agreed Order.

To date, we are at the halfway point in the time period established by the Court for achieving compliance with the Agreed Order. Unfortunately, although the FCJDC has made some, incremental progress, they are far from halfway towards reaching that objective. And, they have actually regressed in some provisions of the Agreed Order. I would recommend that the FCJDC administration more closely focus on the specific recommendations in my Quarterly Monitoring Reports in their efforts. And, it is important to have staff support and buy-in to ensure that practices are consistent and in accordance with the Order and subsequent policy. To the extent possible, I would recommend that the FCJDC delegate tasks to experienced and qualified employees. Further, I would advise them to seek assistance from the Sheriff's Department where appropriate.

I will reiterate: Youth in the juvenile justice system, at all levels and in all settings, can become productive, law-abiding citizens and, eventually, effective parents, if they receive help, guidance, compassion and commitment from the adults that they interact with in their lives. The Forrest County Juvenile Detention Center has the opportunity to offer that future to the young people it serves.