UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION
HONORABLE DANIEL P. JORDAN III, U.S. DISTRICT JUDGE

J.H., ET AL, VS HINDS COUNTY MISSISSIPPI
3:11-CV00327 DPJ-FKB

Monitoring Compliance Report:

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Submitted by
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The
Ninth Monitor's Report
Henley-Young Juvenile Justice
Leonard B. Dixon

Background

On March, 28, 2012, Hinds County, Mississippi entered into a settlement agreement ordained and adjudged by Judge Daniel P. Jordan III, for the United States District Court Southern District of Mississippi, Jackson Division, regarding conditions of confinement at the Henley-Young Juvenile Justice Center, located in Jackson, Mississippi. According to the order the settlement agreement and its specifics requirements "shall apply to Henley-Young and any contractor that may provide services to Henley-Young in the future. The term "youth" herein often refers to individuals confined at Henley-Young. "The parties" understand that the requirements contained herein will be implemented without undue delay as soon as practicable. Unless otherwise indicated herein, the parties will collaborate to make all reasonable efforts to ensure that within 90 days of the effective date of the agreement, policies, and procedures consistent with the agreement are drafted, in the process of being implemented, and that all detention staff received training on the requirements. The parties agree and understand that the implementation will be an ongoing process that extends beyond the initial 90 days of the agreement. As part of the settlement agreement the defendant shall contract with Leonard Dixon, within 30 days of the court entry of this settlement agreement to serve as an expert who will be responsible for documenting the defendant's compliance with the terms of the agreement and for providing and/or arranging technical assistance and training regarding compliance with this settlement agreement. I will have full and complete access to detained youth, institutional files, medical files, mental health files, education files, video tapes, and youth, staff records and all other information and other reports by staff, grievances, incident reports, and other relevant documents and files maintained by Henley-Young.

All non-public information obtained by the expert shall be kept confidential, except that on a quarterly basis the expert shall file a report with the court documenting the progress of compliance. Neither party, nor any employee or agent of either party, shall have any supervisory authority over the expert's activities, reports, findings, or recommendations. The expert shall file with the Court and provide the parties with reports describing the Defendant's steps to implement this Settlement Agreement 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. These reports shall be written with due regard for the privacy interests of individual youth and staff and the interest of the Defendant in protecting against disclosure of non-public information. The expert shall have a budget sufficient to allow him to fulfill the responsibilities described in this Settlement Agreement. Mr. Dixon may consult other experts or consultants retained by either party. All parties shall receive copies of all draft reports from the other experts to Mr. Dixon prior to the issuance of Mr. Dixon's report, and shall have the option of being present at briefings from such experts to Mr. Dixon and Defendant. Mr. Dixon may initiate and receive ex parte

communications with the parties and their respective experts and consultants. It should be noted that on April 25, 2014 the settlement agreement was extended as set forth by the court.

Recommendations based on findings, observations and interviews
Result of visit on November 4 – 6, 2015

Documentation provided and reviewed
Memo regarding budget allocation dated September 25, 2015
Letter from Southern Poverty Law Center dated June 12, 2015 re: J.H. v. Hinds County, MS
Letter from Southern Poverty Law Center dated September 15, 2015 re: Strip searches of Resident M.C and Resident J. P
Letter from Southern Poverty Law Center dated September 25, 2015 re: Allegations of misconduct by Supervisor M. Collins
Letter from Southern Poverty Law Center dated October 6, 2015 re: Allegations of inappropriate use of force by officers on September 11, 2015
Letter from Southern Poverty Law Center dated October 6, 2015 re: Allegations of sexual assault on September 25 or 26, 2015
Letter from Southern Poverty Law Center dated October 15, 2015 re: Concerns regarding proper security measures and protection from harm
Letter from Southern Poverty Law Center dated October 22, 2015 re: Concerns regarding proper security measures and protection from harm on October 17, 2015 and October 18, 2015
Letter from Southern Poverty Law Center dated October 22, 2015 re: Concerns regarding confidentiality of legal visits
Letter from Disability Rights Mississippi dated July 6, 2015 re: Resident S. T
Letter from Disability Rights Mississippi dated July 23, 2015 re: Allegations of inappropriate sexual conduct
Email from Johnnie McDaniels to Alexandra Copper re: HY Request on Resident M. C
Email from Johnnie McDaniels to Alexandra Copper re: HY Request on Resident J. N
Letter from the Eichelberger Law Firm re: preservation of document's and things relevant to the detention and assault of Resident M. B dated via fax October 1, 2015
Email from Johnnie McDaniels to Attorney J. Matthew Eichelberger re: Resident M. B
Email from Johnnie McDaniels to Alexandra Copper re: resident visitation
Letter from Johnnie McDaniels to Jody Owens & Alexandra Copper re: failure of production of documentation by Henley-Young
Health Service Manuals (cover only):
NCCHC Correct Care Spring 2015 Volume 29 Issue 2
Journal of Correctional Health Care
Standards for Health Services in Juvenile Detention and Confinement Facility
Daily Summer Schedule for 4 Units
Daily In-School Schedule for 4 Units
Daily Rosters dated May 29, 2015 (missing all other sheets for month)
Daily Rosters for June 2015 (missing sheets for dates – 6, 7, 13, 14, 20, 21, 23, 27 and 28)
Daily Rosters for July 2015 (missing sheets for dates – 3, 4, 5, 11, 12, 18, 19, 25 and 26)
Daily Rosters for August 2015 (missing sheets for dates – 1, 2, 8, 9, 15, 16, 22, 23, 29 and 30)
Daily Rosters for September 2015 (missing sheets for dates – 5, 6, 7, 12, 13, 19, 20, 25, 28 and 29)

Daily Rosters for October 2015 (missing sheets for dates – 3, 4, 17, 18, 24 and 25)
Daily Rosters for November 2015 (missing sheets for dates – 1 and 4)
List of vacant positions, employees resigned and staff on leave of absence
Food service menus for 4 weeks approved October 19, 2015
Inspection Reports:
- Metro Fire Systems Invoice dated October 6, 2015
- Metro Fire Systems Pre-Engineered Restaurant Fire Suppression Systems Report Dated October 6, 2015
- Fire Inspection Report dated November 10, 2015

Grievance Report Graph from July 2015 to October 2015
HYJJJ Monthly Grievances submitted:
- July -24 grievances submitted by residents with only 2 resolution reports completed
- August -22 grievances submitted by residents with only 1 resolution report completed
- September -30 grievances submitted by residents with 3 resolution reports completed
- October -29 grievances submitted by residents with 3 resolution reports completed

Training Documentation:
- New employee orientation schedules and sign in sheets for various weeks
- Annual Refresher Training Schedule dated July 14, 2015 – July 15, 2015
- Training sign in sheets dated from July 3, 2015 to October 31, 2015
- Various memos dated from June 1, 2015 to October 26, 2015 listing staff to attend training

Policies:
- Special Health Needs Program (draft)
- DVD/RW with policies and procedures listed by chapters (none signed or approved) –
  1. General Administration
  2. Fiscal Management
  3. Personnel
  4. Training & Staff Development
  5. Citizen Involvement
  6. Emergency
  7. Security & Control
  8. Safety Procedures
  9. Rules & Discipline
  10. Juvenile Rights
  11. Food Services
  12. Sanitation & Hygiene
  13. Health Care
  14. Reception & Orientation
  15. Recreation & Activities
  16. Mail, Telephone & Visitation
  17. Mental Health

Henley Young Juvenile Justice Center Organization Chart
QA Reports:

October 2015 Analysis Data Report
Yearly Incident Count from November 2014 to October 2015
Graphs showing use of force incidents and incidents by shifts for months of February 2015 to July 2015
Graphs showing use of force incidents and incidents by shifts for months of August 2015 to September 2015
Monthly log detailing incidents for months of June 2015 to October 2015
Monthly log detailing use of force incidents for months of June 2015 to October 2015
Due Process Isolation Logs for months of June 2015 to October 2015

QA Audit Reports:
HYJJC Monthly QA report dated June 29, 2015
HYJJC Monthly QA report dated August 31, 2015
HYJJC Monthly QA report dated September 30, 2015
HYJJC Monthly QA report no date listed

Purchase Requisition for clothing/inventory dated May 6, 2015
Purchase Orders for clothing/inventory dated from August 13, 2015 to October 21, 2015
Purchase Orders for youth hygiene/sanitation dated from June 8, 2015 to October 5, 2015
Listing of residents placed on suicide precaution dated from June 2015 to October 2015
HYJJC Resident Incident Report/Use of Force/Unusual Incident Reports
June 2015 – 38 Residents (including some witness statements, medical reporting forms and a strip search forms)
July 2015 – 48 Residents (including some witness statements and medical reporting forms)
August 2015 – 46 Residents (including some witness statements and medical reporting forms)
September 2015 – 70 Residents (including some witness statements and medical reporting forms)
October 2015 – 115 Residents (including some witness statements and medical reporting forms)

File on Resident A. M.
File on Resident M. J.
File on Resident B. D.
Video on October 17, 2015 re: disturbance of youth
Video on October 20, 2015 re: lock manipulation

Staff Interviewed

Pieter Teeuwissen, County Attorney
Anthony Simon, County Attorney
Johnny McDaniels, Director
Eddie Burnside, Operations Manager
Brandon Dorsey, Public Defender
Tanecka Moore, Esq.
Janet McCoy, Training Coordinator 1 year
Emma Harris, 2nd Shift Detention Officer Intake 1 year 5 months
Jeanette Davis, Detention Officer/Laundry Worker

Marry Street, Detention Officer Intake Aide 16 years
Ferniece Galloway, Detention Officer Intake Aide 3 years
Fantoya Carter, RN
Thomas Cole Jr., Detention Officer 5 years
Thomas Petreit, LPN works with corporate office
Sandra Wilson, Family Nurse Practitioner
Tisha McClendon, Officer 2 years
Jacqueline Rhodes, Detention Officer 5 months
Carmen Davis, County Administrator
Peggy Hobson Calhoun, Hinds County Board of Supervisors

Youth Interviewed
Resident Q. T. 16 years old
Resident A. M. 13 years old
Resident D. J. 15 years old
Resident R. W. 16 years old
Resident B. D. 16 years old
Resident Q. P. 17 years old
Resident A. C. 15 years old

Introduction
This report is the result of my ninth official visit to the Henley-Young Juvenile Justice Center and the progress made since my previous visit. On November 4, through November 6, 2015, I conducted an official inspection/review of the facility. In this report I detail my findings from my visit which are based on the following criteria: 1) observations, 2) interviews, 3) SPLC reports 4) subject matter expertise in operating juvenile institutions, 5) best practices in juvenile justice, 6) document reviews, and 7) video and audio reviews. I would like to again thank the staff, facility administration, and the Hinds County attorneys for their continued cooperation in this process.

It should be noted that the facility has progressed since my last visit, specifically 2 provisions have moved to beginning compliance, 3 provisions moved to partial compliance, 4 provisions have moved to substantial compliance. However, 1 provision changed from substantial back to partial compliance.

The facility staff should be commended for their continued progress made by putting a new administration in place despite the political stress it has had to endure. This I will discuss later in the report. Since the last report, the County has put in place a new leadership team. This team appears to be the team that can move this facility forward. The new director, Johnnie McDaniels, appears to bring a sense of equilibrium in managing staff, engaging youth, and working with the county administration. It should be noted the new facility team had only been in place approximately six months, at the time of my review. This is a very short time as it relates to changing a culture. Although the county has been under this **consent decree** for a little over three years, this is the first time that an adequate and stable management team has been in place. It has been well known in our field that kids change their behaviors based on the demands of the environment and their perception and experiences in the juvenile justice system. That is

why facility culture is so important. A positive culture at Henley –Young is needed to create a community of people working under a set of policies and procedures that will bring the facility into compliance. A positive, stable culture gives the facility identity and meaning, which again, takes time to develop. The facilty is moving in the right direction. It should be noted that the new team in addition to Hind's County attorneys did visit detention facilities in Michigan and Illinois to get an enhanced understanding of juvenile detention operation.

As stated above, the facility has made progress in this review, in spite of the challenges inherent in operating a juvenile facility (i.e. increases in resident population, Juvenile Court personalities, inadequate staffing, inadequate funding, and lack of collaboration by other entities) and external road blocks. At some point, when one entity changes and others don't, one must examine the external barriers and their impact on the facility's success. Since my last report, several experts in the juvenile justice field have visited the facility and provided feedback for the various provisions (i.e. Mental Health, Medical, Education, and Training). These juvenile justice experts were contracted to give a subject matter review and the status of those aforementioned provisions. The experts were: Dr. Lisa Boesky (Mental Health) Ngozi Ezike, MD (Medical), Carol Cramer Brooks (Education), as well as Mr. Gerald Gay and Mr.Felton Satterfield (Training). Each consultant provided a report (see exhibits/attachments) on their reviews and recommendations, which I provided to the county and federal court. A 360 degree review of the facility will enable the new administration to identify the needs of the facility and will also provide the county with direction on the resources required to obtain full compliance with the settlement agreement.

As stated in my last report, there is still the political atmosphere at this facility that continues to create a toxic environment for staff and kids. Dr. Boesky's report and the report provided by Mrs. Brooks are quite revealing, as I indicated in my November email to all parties. This was also evident through my observation and review of documentation during my visit (see exhibit). For example, utilization of the video and camera system is controlled by the Juvenile Court, placed within the Juvenile Detention Center and owned by the County. The Juvenile Detention Center is not authorized to view video footage of its own cameras without prior approval of the Juvenile Court. This causes some concern and alarm because the delay and bureaucratic red tape involved in accessing the video system prevents the director from efficiently and effectively carrying out his responsibility to protect the well-being of the children housed within the facility. Additionally, the Juvenile Court can and does deny access to video and camera footage for review by the Juvenile Detention Center. I was denied access to review video footage for a specific incident (cell check, etc.) because the staff from the detention side had no access to the system to review incidents. This type of disruption will inhibit any director from carrying out his responsibilities in a thorough and professional manner. In addition the facility staff must be able to train in an environment conducive to learning. These are areas that should be remedied immediately by the county. These barriers and unbecoming actions are petty at best. I understand this is harsh language however I have discussed this in my previous reports, repeatedly. I would recommend that the County Board of Supervisors address this situation head on. How does the county expect the detention facility administration to do their job with the juvenile court controlling major tools needed for their jobs?

Another important issue I need to raise is the lack of legal documents that direct the detention facility on the courts directives regarding the resident. I reviewed 47 files seeking the court orders for the resident and only found these directives in four. There were no court orders or court dispositions indicating the expected path of the resident, which again points to the great need for a system to assure that the court's directives are being followed and that the facility is executing those mandates. An organized, data driven case management system is needed to assure that the resident is legally held in detention. The juvenile court is the only authorizer of the path of residents in the detention facility.

Facility and Operational Culture

Since the facility population has increased and is above the agreed upon 32 population cap, the county must provide the facility with the original staffing plan recommended to the court. In addition, case managers should be immediately put in place at the facility to begin to meet this agreement. Please see previous reports and Dr. Lisa Boesky's most recent attached report.

Based on my discussion with the new administration, to fully comply with the consent decree the need for consistency in all provisions is required. This means ensuring the following:

(1) Whether there are written policies covering this provision.
(2) Whether there are written procedures to implement the policies.
(3) Whether practices are consistent with the written policies and procedures.
(4) Whether the policies, procedures, and practices meet constitutional and other local requirements.

As it relates to conditions in a facility, the broader the permissible reason for detention, the more difficult it is to address institutional inadequacies. And the more difficult it becomes to meet the needs of the youth at any facility. For example the detention of mentally ill youth, requires special considerations in housing, staffing and mental health services. Likewise at Henley-Young detained dependent residents and status offenders; youth committed to the facility for disturbing the family peace, or residents held without court orders etc. present immediate classification and housing issues. They create a range of problems with educational services programming, and access to the outside world. Holding youth being transferred to the adult court may be good from a policy standpoint, but it too creates additional housing and programming issues for the detention facilty. Also, allowing the detention to be used for post disposition sanctions creates the need for additional counseling staff and rehabilitative programing. This is not just my professional opinion but the opinion of the collective wisdom of the professionals within the juvenile justice community, i.e. Youth Law Center, the Annie E. Casey Foundation, the National Council on Crime and Juvenile Delinquency, the Department of Justice, JJ law suits, etc.. Therefore, it is incumbent on all entities to work together to ensure that policy decisions are made with a practical understanding of how these policies affect the youth being placed in detention and the institution and staff.

Staffing

The facility has brought in a new administration and is in the process of continuous staff hiring. In addition, to attract more qualified employees the county has increased salaries and has begun to pay overtime and shift differentials. However, with the increase in population the facility must hire the agreed upon staffing recommended in the initial report. In addition, the need for case managers within the facility ,is still required to meet the Provisions 4, 5.1, 5.2, 5.3, 5.4, 5.5, 13.1, 13.2, 13.3, 13.4, 13.5, 13.6, and 16.5.

Building Cleanliness/Environmental Issues/Maintenance

The facility has hired an additional maintenance worker. However, the building is still in need of repair. Please see last report and most recent exhibits. The facility needs to enact a facility-wide maintenance schedule, as stated in my previous reports. **The shower stalls, electrical outlets, kitchen, painting and lighting are still in need of repair.**

Professional standards of care/Sustainability

One of the major goals of this process is to create a sustainable system that will last after the conclusion of the consent decree. The development of good policy and procedures that create professional standards is a major aspect of creating a sustainable system that protects constitutional rights of the residents housed within the facility. Therefore, a good management information and quality assurance program is essential to making evidence based decisions. These programs will ensure ongoing accurate and reliable indicators of the detention process and operations.

Good quality assurance (QA) processes allow staff, supervisors, facility administration and County administration to make evidence based decisions on the needs of the facility and the children housed within its walls. These systems once developed will give all parties data from routine 15 minute checks to capturing medical and mental health services that are being provided. These systems will also look at confinements, fights, incidents of youth- on -youth violence, staff on youth violence and the reductions in youth confinement periods. QA processes also allow in-depth auditing capabilities that ensure the facility is in compliances with State and Federal laws. These are some examples that relates to sustainability. I discuss this because in my experience once court intervention leaves everyone returns to the old way of doing business, which got the institution into trouble in the first place, which must be avoided. QA processes provide that data needed not only to sustain compliance but to meet a variety of grant and other funding reporting requirements.

Mental Health

Please see Dr. Boesky's Mental Health report and recommendations, in addition to my last report, which is still relevant as only the names have changed.

Suicide Prevention

Please see Dr. Boesky's report and recommendations, in addition to my last report.

Behavior Management/Isolation

During this review, I found that the facility has begun to implement a behavior management system; however, it is still in its infancy stage (see last report). The facility should continue to fully implement the behavior management program.

The facility must, however, continue to work on its inappropriate isolations of youth. During this visit, I found and observed girls are being left in their rooms for several hours after there was a shift change. Staff must follow the facility schedule as required. Also, I still found youth left on units alone without any supervision or staff engagement. This speaks to the October incident involving the fire sprinkler system being activated by youth. Because staff did not engage the residents, they were able to trigger the unit's sprinklers heads, break lights, break the television and flooded the unit. Because the officers failed to engage the residents the Jackson police (JPD) was called to restore order. Had the staff members engaged the youth properly the likelihood of the incident occurring would have been minor. Additionally, had the officers engaged the residents with proper use of force techniques the Jackson police would not have been needed (see provision 8.1). This is an area the new administration must address as it relates to continuous supervision, use of force, and de-escalation training becoming central to the operation of the facility.

Staff is still in the towers and not in the immediate proximity of youth. I also witnessed several youth in their room for no reason without supervision. Because there is no consistent behavioral management isolation rules in place, youth and staff are still in flux regarding what they're to do at this point. There is also a need to have the facilty rules permanently posted throughout the facility and on each unit.

During this visit no sanctions were posted. This should be addressed before my next official visit by posting and orientating youth entering the facility on the rules, creating an acknowledgement form that a youth has received, reviewed and understood them, as discussed in previous reports and discussions.

Activities/Recreation/Programming

Please see last report. During this visit, I found that the facility continues in the development of activities, recreation, and programming. In addition, I am recommending that the facility purchase frames that can be seamed to the wall that are clear and tamper proof so they cannot be torn down or discarded as the taped sheets that are currently being used (see exhibits). The frames I am recommending are used in other facilities including my own. They give a sense of order and they are very difficult to damage or deface. In addition, changes to schedules and activities can be updated easily by the facility (see exhibit).

Medical, Medication Review & Disposal

Please see Dr. Ezike's report and recommendations (Attachments). Also, please see my previous report. At the time of this review, the county has hired a new medical company, Quality Correctional Healthcare, to provide service for youth at Henley-Young.

Food Service

Based on my review and observations, the food was served in a timely manner. However, youth complained of not having enough food and that it was cold. Please see last report.

Based on this visit and my review of documents, the food service program is still in need of improvement, although some improvements have been made. However, residents still continue to complain about not having enough food and that the food is tasteless. In addition, there were still numerous complaints about the food being cold and not appealing (see exhibit). I again observed the food process during this visit and found that serving sizes were below the federal food standard requirements, and the temperature of the food was unacceptable.

However, during this visit, I found that food was being served in a timely manner and that the cooks were preparing food onsite.

I am still recommending that a major cleaning of the kitchen be done for sanitation purposes (see Exhibits 1 thru 6).

I am again reiterating that food service is an important part of institutional life (see previous report #7and #8).

89 day program/Juvenile Court

There has been no change since my last report, except it's not called the 89 day program. Now it's called the **secure intervention unit**, which does not change the program. While it has a new name, it still continues to be the same program as I have discussed in my previous reports. There are no case managers at the facility and no programming for these youth. Also please see Dr. Boesky's report. My statements from my previous report stand.

During this visit, I again interviewed staff and residents as it relates to this program. From a detention perspective, treatment perspective and correctional perspective "this program" serves very little purpose other than holding youths in detention for 89 days. Please see my facility update/technical assistance report submitted to the Court on November 24, 2014, where I explained the differences between juvenile detention and juvenile correctional facilities. Additionally, the resolution passed by the Hinds County Board, de facto eliminates the 89 day program in statement and this should be adhered to. With this in mind, please see previous reports.

Again as discussed in my previous reports, the 89 day concept is a very admirable idea. But, I reiterate, for this court program to function or to operate successfully, there are major changes needed as it relates to programming and staffing. At this point, the program is more a revocation

program than the therapeutic, treatment program that was intended. As I have stated in my previous reports, for this program to be effective and successful, the following areas must be incorporated in the program:

- Sufficient staff
- Target appropriate juveniles for the program (i.e. medium to high-risk)
- Target risk factors for delinquent behavior that are responsive to intervention
- ensure they are individualized and family based, and delivered in community settings when discharged
- Programming based on a particular treatment model
- well-trained staff and a program director who strongly supports the program outside of the facility's director
- Deliver a sufficient amount of treatment
- Adhere to a program design
- Monitor juveniles' progress on an ongoing basis and modify the program as needed
- Provide aftercare services
- Individual treatment plan (ITP) that reflects why the juvenile is in the program and what goals juvenile should accomplish during his stay. Also mentioned in the ITP is the juvenile's individual education plan (IEP), which specifies how to accomplish the juvenile's educational goals.
- Develop cognitive behavioral programs that confront juvenile's thinking errors and teach juveniles to overcome their thinking errors as a means of behavioral change.
- Develop positive peer culture (PPC) that teaches juveniles to assume responsibility for helping one another. It is based on the belief that the most powerful influence on a resident's behavior is peer pressure. PPC's goal is to teach basic values related to caring for others. PPC is centered on frequent meetings of small groups of juveniles (6-12) and one or two staff leaders. The juveniles are encouraged to help each other.
- Develop strength based practices that help juveniles to become accountable for their actions and responsible for their behaviors. Accountability is realized when a juvenile admits to the wrong and changes his/her behavior. When juveniles get into trouble, the care worker will initiate more behavior changes in juveniles by having them focus on how to solve their problems.

To ensure that there is an accountability case management in the 89 day program, I am recommending the following model be implemented:

- specifying troublesome behaviors
- identifying need(s)
- setting goal(s)
- evaluation

Need	physiological, social, psychological requirement(s) for the well-being of an individual
Goal	behavioral statement of how the individual will be at the end of a specified period of time
Service Action	behavioral statement of what the case manager plans and does to assist the individual(s) in achieving the goal
Evaluation	systematic collection of information on goal indicators and/or service action(s) for the purpose of decision making and planning

In addition, the court has to determine what therapeutic programs they will be using. An example of these programs would be psychoanalytic therapy, behavioral therapy, rationale emotive therapy, persons centered therapy, reality therapy, etc. It should be noted that I found in my review of documents, observations, and discussion with staff and residents no difference in the 89 day program than in the general detention program. One staff put it quite profoundly by stating, "When these youths get a long term sentence through the 89 day program they don't care and they are causing most of the problems. "**Detention is a short termed program and they are getting long term sentences."**

School

Please see Mrs. Brooks' report submitted 11/19/15, and please see my previous report. I am still concerned regarding the road blocks put up by the school. I must reiterate that the school is a major component of facility programming.

It is clear that the new facility administration is committed to making progress. However, they must be supported to continue in the direction they are moving by resources, political will, and support from all parties involved in this process to work cooperatively with Henley-Young and its staff and youth (See Brooks report).

Working in juvenile facilities is extremely stressful. These young people typically display hostility, defiance, and other resistances. They present considerable challenges. Therefore, it is important that facilities are not upset and damaged by nonproductive political trespassing, (the school not working with director, youth court dictation of who should attend school, etc.).

The school has a site leader. This is the fourth leader since this agreement started. However during this visit as stated in previous reports, youths continue to be placed out of school for behavioral issues, and they do not receive educational services during those times. Moreover, as stated in previous reports, youths who attend court hearings are not placed back in school after their return to the facility. They are taken to their units without any educational services being provided and an improper use of staff. It is very clear through research and basic common sense that these youths are behind in their educational progress for the most part and are in need of every educational opportunity available. In my previous reports it was recommended that the school be evaluated. This was a simple task which was not and has not been done to determine the needs in the areas laid out below.

For this report Carol Brooks a JJ educational expert reviewed the school program with some push back from the school administration. According to Mrs. Brooks there was hesitancy, foot

dragging and apprehension by the school as stated in her report and in her discussion with me in her goal to evaluate the school. I continue to recommend that the school follow the system developed by Rankin County where students being tested are tested away from the regular school programming and all other students are still in class receiving educational programming.

There are many conflicts between the mandates of the court, the school and the facility. Students who have court are not allowed to return to the classroom after their appearances, teachers suspend students from school based on their needs rather than the parameter of the detention facility and an already stretched staff becomes more stretched. These types of issues create problems that the line staff cannot surmount. There has to be one set of rules that are all encompassing for the facility that makes for a safe and secure environment and complies with the need for order within the facility.

The school should review their staffing to ensure that it is meeting the needs of the educational program (i.e. need physical educational, staff and an additional GED teacher).

I am still recommending that the school and the facility review the policy of not allowing residents to return to school after court. Further, the following areas should be addressed based on my interviews from my previous report with school staff:

A. "policy and procedure"
B. "everyone needs to know what to do"
C. "the expectations should be written even kids should know them"
D. "policy and procedure should be based on detention standards"
E. "everyone should have the tools to do their job"
F. "proper staffing is needed"
G. "staff should be well trained to deal with this population"

These are areas that should also be addressed as I have discussed in my previous reports. The school should use small portable classrooms (which can be placed on the grounds of the facility within the security fencing) to help alleviate the congestion for students and teachers who are now forced to teach class in a storage closet. This is below any standard, educationally or detention and is not conducive to learning. Again below are my recommendations from my previous reports.

Recommended School Plan:

A. The Henley-Young Facility will create and implement a plan to provide all of the following services and programs within their control related to the aspects of residents' education:
    a. maintain an adequate physical facility for education,
    b. provide adequate security and support in the classroom,
    c. establish an in-school points system based on rewards and consequences for behavior,
    d. establish and implement a schedule for transporting residents to and from school that assures that residents will have the opportunity to receive the required hours of educational services mandated by law.

B. Develop policies and procedures for all of the areas discussed above.

Solution/Plan

1. The Henley-Young Facility will make every effort to develop and formalize an interagency agreement between the Jackson Public School System and the HYC that:
    a. Provides adequate security within the school premises (including classrooms) for all residents including those residents requiring protective services or other special needs.
    b. Residents requiring protective services or other special needs shall have the same or equivalent educational services as other residents.
    c. Create an alternative educational plans for residents removed from the classroom for medical or behavioral issues.
    d. Provides a schedule for transporting residents to and from school that ensures that residents will have the opportunity to receive the hours of educational services mandated by law.
    e. Outline a cross training curriculum for HYC school employees and detention employees, which include an orientation and a safety curriculum and mandatory annual refreshment training for employees of the school.
    f. Ensure trainings will provide educational staff with appropriate facility policies that relate to or overlap with the school's operations to include the policies regarding rules, discipline and the behavior management program.
    g. Include development of a plan and appropriate materials for various educational levels, to be distributed and explained to residents in the health care unit, in room confinement or otherwise unable to participate in normal school classroom activities.
    h. Ensure the class schedules are driven by the security of the facility and that the school looks toward developing individual learning plans for each student in the school.
2. The Facility Director or designee shall review the circumstances surrounding the placement of all residents who are in isolation or seclusion, or residents who do not attend school for medical reasons and other behavioral maintenance processes to assess the feasibility of an early release to attend school each day.
    a. A list of the residents that are not allowed to attend school and the reasons for the administrative restriction shall be documented and distributed to the Principal of the HYC School.
    b. The Facility Director shall designate a liaison to interact with school daily and the JPS Administration should create a position for Compliance Administrator to review the progress of the school on a weekly basis.
    c. All instances in which school activities are suspended by the facility due to incidents or other extraordinary circumstances shall be reported to the Compliance Administrator within 24 hours.

When the School Principal or designee is having issues, whether of a safety nature or any other problems, they should be reported to the compliance administrator and the facility Director or designee immediately. **I am recommending again that the Jackson Public School system**

(JPS) hire a compliance officer to ensure that the school educational standards are being met (Is the new principal the compliance officer?).

Below are the compliance ratings and summary of ratings that will be used in this report. Please be reminded that though most are in Non-Compliance, policy development is most important and the start of this process. However, as stated above the facility has made progress on some provisions which moved them from Non-Compliance to beginning compliance.

Please note that many of the comments and recommendations in the provisions are restatements of previous reports because in those areas little movement has been made. The new Director should use these comments as a road map to developing a successful facility plan. He must also develop a comprehensive corrective action plan for guidance. That plan should have the following:

A. Clearly state the problem or weakness, including the root cause

B. List the individuals who will be accountable for the results of the corrective action plan

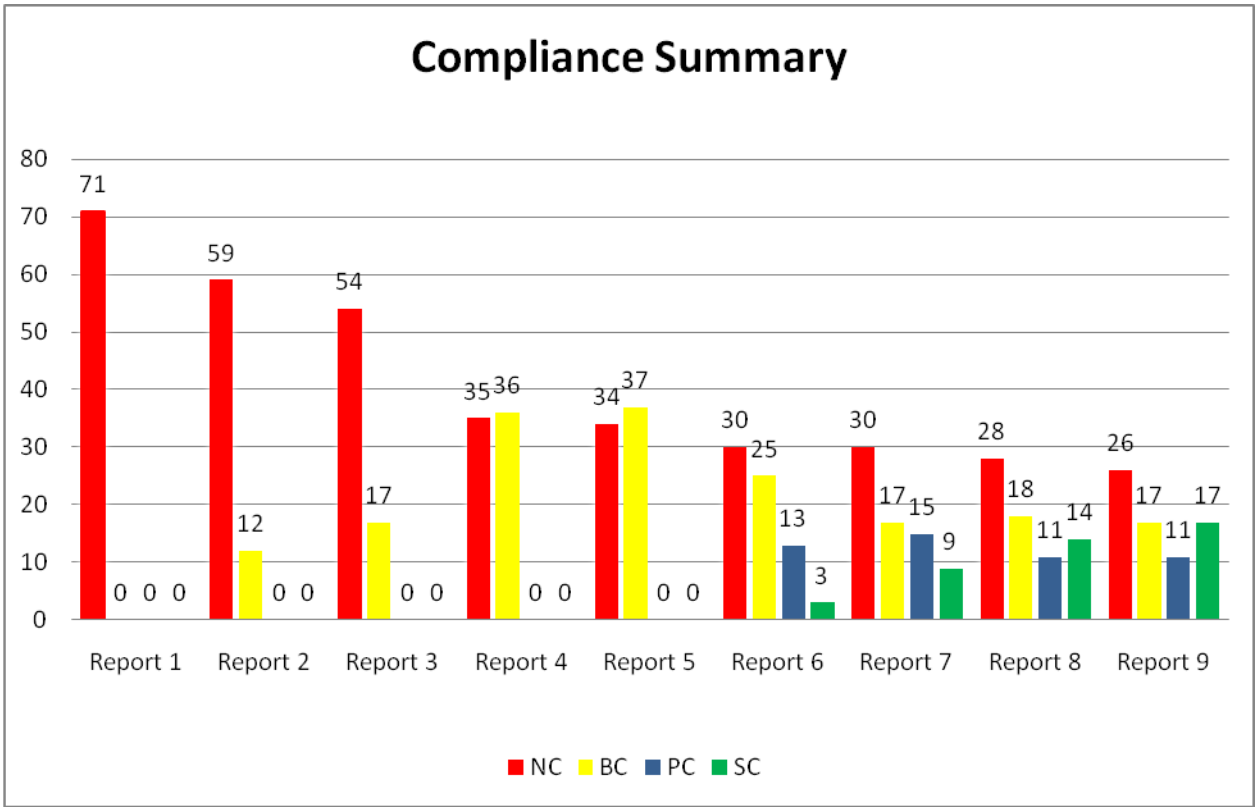
C. Create simple, measurable solutions that address the root cause

D. Each solution should have a person that is accountable for it

E. Set achievable deadlines

F. Monitor the progress of the plan

The graph has been included to show the progress made thus far on the 71 provisions:


Compliance Summary
80
70
60
50
40
30
20
10
0
71
0 0 0
59
12
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54
17
0 0
35
36
0 0
34
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3
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17
15
9
28
18
11
14
26
17
11
17
Report 1
Report 2
Report 3
Report 4
Report 5
Report 6
Report 7
Report 8
Report 9
NC
BC
PC
SC

Compliance Code Measurements

Substantial Compliance (SC): Practices follow the county-approved policies, training materials or other documents; practices follow policy with rare exception and exceptions lead to corrective action; trained staff fill all positions and vacancies are filled within 3 months; the County has completed work in an acceptable manner; policies, procedures and practice and training are fully operational and quality-assurance audited and audit exceptions lead to corrective action; outcomes meet or exceed agreement requirements.

Partial Compliance (PC): Policy and procedure is implemented in some but not all locations or times; staff are hired but not trained; the County is working on implementation but tasks are not completed; system implemented at some but not all locations or times, outcomes meet or exceed agreement requirements some of the time and in certain area.

Beginning Compliance (BC): Policy and procedure is written by the county but has not been implemented; funding and hiring authority are approved by the County but positions are not filled; training materials prepared and approved by the county but training has not started.

Non-Compliance (NC): No action taken and immediate steps needed to maintain schedule or prevent further delay. A policy may exist, but the policy may need significant revision or modifications and rarely translates into practice.

Provision	Intake	6th Report	7th Report	8th Report	9th Report
1.(1)	All Residents Admitted to Henley Young	NC	NC	NC	NC
1.(2)	MAYSI-2 Mental Health Screening	NC	NC	NC	NC
1.(3)	Prescription Medications	NC	NC	NC	NC
1.(4)	Meal Compliance	BC	PC	SC	SC
1.(5)	Telephone Usage	BC	PC	SC	SC
1.(6)	Strip Search Policy	BC	BC	BC	PC
Provision	**Staffing and Overcrowding**				
2.(1)	Direct Care Staff Ratio	NC	NC	NC	NC
2.(2)	Maximum Capacity Adjustment	PC	SC	SC	SC
2.(3)	One-Person Cell	PC	SC	SC	SC
Provision	**Cell Confinement**				
3.(1)	Structured, Rehabilitative & Educational Programming	NC	NC	BC	BC
3.(2)	Appropriate Access to Living Unit	NC	NC	NC	NC
3.(3)	Dangerous Residents	NC	NC	NC	NC
3.(4)	Isolation	NC	NC	NC	BC
3.(5)	Direct Care Staff on Units	BC	BC	BC	BC

Provision	Structured Programming	6th Report	7th Report	8th Report	9th Report
4	Educational, Rehabilitative, and/or Recreational Programs	NC	NC	BC	BC
Provision	**Individualized Treatment Plans/Treatment Program for Post-Disposition Residents**				
5.(1)	Residents Access to Adequate Rehabilitative Services	NC	NC	NC	NC
5.(2)	Health and/or Substance Abuse Treatment	NC	NC	NC	NC
5.(3)	Treatment Plans	NC	NC	NC	NC
5.(4)	Review of Individual Treatment Plans	NC	NC	NC	NC
5.(5)	Evening and Weekend Programs and Activities	NC	NC	NC	NC
5.(6)	Quality Assurance Program	BC	PC	PC	PC
Provision	**Disciplinary Practices and Procedures**				
6.(1)	Implement a Discipline Policy and Practice	NC	NC	NC	NC
6.(2)	Policy for Residents Violations	NC	NC	NC	NC
Provision	**Use of Restraints**				
7.(1)	Mechanical Restraints	BC	BC	BC	PC
7.(2)	Mechanical Restraints – Transportation	PC	BC	PC	SC
7.(3)	Misuse of Mechanical Restraints	BC	PC	PC	SC
7.(4)	Mental Health – Use of Mechanical Restraints	BC	BC	BC	BC
7.(5)	No Restraint Chairs, Chemical Restraints and/or Tasers	SC	SC	SC	SC
7.(6)	No Hogtying in Facility	SC	SC	SC	SC
7.(7)	Mechanical Restraints – One-On-One Supervision	PC	PC	PC	SC
7.(8)	Mechanical Restraints – Notice to Medical Professional	BC	BC	BC	PC
7.(9)	No Electronic Restraints	PC	SC	SC	SC
7.(10)	No Firearms in Facility	SC	SC	SC	SC
Provision	**Use of Force**				
8.(1)	No Misuse of Use of Force	NC	NC	NC	NC
8.(2)	Notice to Medical Professional After Use of Force	BC	PC	PC	PC
Provision	**Meals and Nutrition**				
9.(1)	All Meals and Snacks Must Be Nutritional	PC	PC	PC	PC
9.(2)	Comply with Nutrition Guidelines	BC	BC	BC	BC
9.(3)	Provide Drinking Water Throughout the Day	BC	PC	SC	PC
Provision	**Clothing**				
10	Provide Basic Clothing Items	BC	PC	PC	PC

Provision	Hygiene and Sanitation	6th Report	7th Report	8th Report	9th Report

11.(1)	Provide Appropriate Hygiene Products	BC	PC	PC	PC
11.(2)	Provide Sleeping Mats and Blankets	PC	PC	PC	SC
11.(3)	No Deprivation of Mats and Blankets	PC	PC	SC	SC
11.(4)	Sufficient Sanitary Mats and Blankets	PC	SC	SC	SC
11.(5)	Clean and Sanitary Environment	BC	BC	BC	BC
11.(6)	Fire Safety, Weather Emergencies, Sanitation Practices, Food Safety, and Provide Safe Environment	BC	BC	BC	BC
11.(7)	Clean Drinking Glasses and Eating Utensils	PC	PC	PC	PC
Provision	**Medical Care**				
12.(1)	Provide Residents With Adequate Medical Care	NC	NC	NC	NC
12.(2)	Provide Medical Professional When Needed	NC	NC	NC	NC
12.(3)	Implement a Sick Call Policy to Ensure 24 Hour Services	NC	NC	NC	NC
12.(4)	Prescription Medications Only Dispensed by Medical Staff	NC	NC	NC	NC
12.(5)	Provide Medical and Mental Health Services	NC	NC	NC	NC
12.(6)	Proper Monitoring Residents Who Require Individualized Attention	NC	NC	NC	BC
Provision	**Mental Health Care**				
13.(1)	Provide Adequate Mental Health Care	NC	NC	NC	NC
13.(2)	Residents and Psychotropic Medications	NC	NC	NC	NC
13.(3)	Within 72 Hours of Admittance Complete an Individual Mental Health Treatment Plan	NC	NC	NC	NC
13.(4)	Implement Policies and Procedures for Referrals	NC	NC	NC	NC
13.(5)	Sufficient Psychiatric Services	NC	NC	NC	NC
13.(6)	Psychiatrist and/or Counselors to Record Review to Ensure Proper Care	NC	NC	NC	NC
Provision	**Suicide Prevention**				
14.(1)	Multi-tiered Suicide Prevention Policy	BC	BC	BC	BC
14.(2)	Evaluate Highest Level of Suicide Watch Every 12 Hours by Medical Professional	BC	BC	BC	BC
14.(3)	Closely Monitor Suicide Watch Residents During All Activities	BC	BC	BC	BC
14.(4)	Court Shall be Notified Within 24 Hours of Any Residents on Suicide Watch	BC	BC	BC	BC
Provision	**Family Support and Interaction**				
15.(1)	Visitation Shall Not Be Restricted or Withheld	PC	PC	SC	SC
15.(2)	Provide Accommodations for Contact Visits	PC	SC	SC	SC

Provision	Family Support and Interaction (cont.)	6th Report	7th Report	8th Report	9th Report
15.(3)	Visitation Shall be Regularly Scheduled	PC	SC	SC	SC
15.(4)	Phone Calls Shall be Allowed Based on Policy	BC	PC	PC	PC
Provision	**Miscellaneous Provisions**				
16.(1)	Provide Equal Access To All Services	BC	BC	BC	BC
16.(2)	Provide the Opportunity To Participate In Large Muscle Exercise Every Day	NC	NC	NC	NC
16.(3)	Prohibit the Use of Profanity in the Presence of Residents	BC	BC	BC	BC
16.(4)	Provide Adequate Grievance Policy	BC	BC	BC	BC
16.(5)	Provide Residents of All Ages With the Opportunity to See Their Attorney and/or Residents Court Counselor	BC	BC	BC	BC

The following are my observations and recommendations specific to the provisions of this agreement.

1. Intake

Provision1.1 Intake	All residents admitted to Henley-Young shall receive a health screening, within 1 hour of admission or as soon as possible as reasonably thereafter, by appropriately trained staff as required by Mississippi Code Annotated § 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." Mississippi Code Ann. § 43-21-321(1). During this screening, Henley-Young shall obtain information regarding the resident's educational status by having the residents or intake officer complete an education screening form developed and provided by the Jackson Public School District.
Status	**Non-Compliance**
Discussion	During this visit and as with my previous visits, I find that the County still needs to comply with the above mentioned Intake provisions. The facility has developed policies and procedure regarding this provision. I advise that the recommendations provided by Dr Boesky be used to fully develop these policies. Further the staff should be trained and when needed retrained. The policies for this provision should be consistent for all youth entering the facility. Since this is a key provision, the facility, mental health and medical divisions should be involved in developing these policies, procedures and protocol. The school should also develop a separate intake process. For this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see attached XX). There are still youth who are entering the facility who are identified based on the MAYSI-2 screening who have identified suicidal and mental health risks that are not being addressed. Please see recommendations below:
Recommendations	1. Fully develop admitting policies and procedures to reflect provision 2. The court should provide staffing for intake purposes 3. The facility should provide enough staff to fully cover the care and custody issues in the facility 4. Ensure all staff who admit residents are properly trained 5. Develop training records 6. Provide documentation in an organized way on residents being screened/admitted (files) 7. Ensure all residents' records are available for my review with all areas of the provisions placed in the resident's file

	8. See Dr. Boesky's report/recommendations.
Evidentiary Basis	Document review, observation, interviews

Provision 1.2 Intake	All residents shall receive a MAYSI-2 mental health screening upon admission, as required by Mississippi Code Annotated § 43-21-321. The screening will be conducted in private by appropriately trained staff of Henley-Young. If the screening indicates that the residents is in need of emergency medical care or mental health intervention including, but not limited to, major depression, suicidal ideation, withdrawal from drugs or alcohol, or trauma, the detention staff shall refer those juveniles to the proper health care facility or community mental health service provider for further evaluation immediately or as soon as reasonably possible.
Status	**Non-Compliance**
Discussion	The status of this provision remains as non-compliance. As stated in my last report (8th), the facility needs first to answer the following questions below; then follow the recommendations. A. What are the program objectives for mental health screening? B. What are the characteristics or common traits the program wants to identify for emergency or follow-up clinical consultation? C. What MAYSI-2 scores will the facility use as the signal for the program staff to obtain clinical consultation or services? D. What mental health follow-up services are available when the resident's MAYSI-2 score indicates that they are needed? E. In what way will the facility develop a database that creates a profile of mental health needs in the population and program \decisions and adjustments needed to improve mental health services for the residents? In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit). Develop and follow mental health plan.
Recommendations	1. Develop comprehensive policy and procedures for this provision. 2. Develop resident files that are organized and arranged properly 3. Develop training and provide documentation of training 4. Identify person or person(s) whose responsibility is to score the instrument 5. Provide documentation on who reviews the instrument and note what services are provided for the residents in the facility and what services should continue when the residents leave the facility 6. Develop process whereby facility staff and court employees develop a system for the sharing of information and reviewing of residents'

	files which are centrally located and accessible to detention staff. 7. Develop plan 8. See Dr. Boesky's report/recommendations.
Evidentiary Basis	Document review, observation, interviews

Provision 1.3 Intake	Prescription medications will be secured for all residents who have a valid, current prescription within 8 hours of admission, if possible, but in no case, longer than 24 hours after admission, including weekends and holidays. If during a resident's detention, a medical professional either prescribes a new medication or renews a resident's previous prescription medication, Henley-Young 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. Henley-Young shall procure and/or purchase all prescription medications prescribed to confined residents.	
Status	**Non-Compliance**	
Discussion	The facility should continue to follow the recommendations below which are the same as in the previous report. The initial intake/admission process is a critical part of residents' transition when they are entering the facility. It should be noted, residents are not receiving physicals as required based on minimal juvenile detention standards and the Mississippi Youth Court code (43-21-321). In addition, there is no Pharm D to oversee medication administration and dosage. I saw no biomedical hazard receptacles, which implies that the facility has no contract with a waste removal company. Again, based on my review of documents and observation, over the past two and a half years no doctor, physician's assistant or practitioner has been hired. Also, there are no policies, procedures or protocols to guide these nurses. Therefore I am reiterating that the suggested actions and recommendations from my previous report be reviewed and put into action. I did meet with the current medical providers and they are in agreement that policies, procedures and protocols are needed. In addition, it should be noted that the company that is providing the medical services is a temporary staffing agency therefore there is a strong need for a licensed medical doctor, physician's assistant or a practitioner must be involved in developing the medical department. In addition to this report, Dr. Ngozi Ezike, an expert medical physician, with expertise in juvenile detention health services reviewed medical services within Henley-Young Juvenile Detention Facility. Dr. Ezike's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit). As stated in my introduction the county has hired a new medical management	

	company (QCHC) to provide medical services to the facility. It should be noted that youth are not receiving physicals as required based on minimum juvenile detention standards and the Mississippi Youth Court Code (43-21-321). There is also no Pharm D to oversee medication administration and dosage. Again, there are no policies, procedures, or protocols to guide nurses and staff. Therefore, I am reiterating again that my suggested actions and recommendations from my previous report be reviewed and put into action (see ending statement Dr. Ezike).
Recommendations	1. Hire a Medical Doctor, physician's assistant or a practitioner. This person must be involved in developing the medical department and to direct medical care. 2. Develop written policy and procedures or protocol for this provision 3. Document staff training on distribution and side effects of medication 4. Provide documentation on efforts to obtain prescription drugs 5. See Dr. Ezike report and recommendation.
Evidentiary Basis	Document review, observation, interviews
Provision 1.4 Intake	Upon admission to Henley-Young, all residents shall be offered a snack or meal in compliance with the United States Department of Agriculture's School Meals Program standards.
Status	**Substantial Compliance**
Discussion	The facility has maintained substantial compliance on this provision based on my observation, interviews and review. Therefore the facility must continue to follow the recommendations below.
Recommendations	1. Continue in the development of policies and procedures for this provision. 2. Procedures should be part of intake/admission procedure. 3. Ensure there are snacks or sandwiches available for residents being admitted between 6 pm and 5 am. 4. Ensure enough staff members are available to fully comply with the policies and procedures.
Evidentiary Basis	Document review, observation, interviews

Provision 1.5 Intake	Upon admission to Henley-Young, all residents shall be permitted to telephone a parent or legal guardian free of charge and to take a shower before being placed on the pod.	
Status	**Substantial Compliance**	
Discussion	The facility has remained at substantial compliance on this provision, based on my observation and review. Therefore the facility must continue to follow the recommendations below.	
Recommendations	1. If officers have been trained on this policy, they may need retraining. 2. Develop a consistent way to document the intake process that shows that a phone call and shower were completed. 3. Develop policy and procedure for this provision.(executed) 4. Train staff and document this training.	
Evidentiary Basis	Document review, observation, interviews	

Provision 1.6 Intake	Within 60 days of the date of this agreement, Henley-Young shall develop and implement policies that limit strip searches to instances where Henley-Young staff has an articulable suspicion that a resident may possess weapons or contraband. Anytime a strip search is conducted, Henley-Young 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 resident's privacy.
Status	**Partial Compliance**
Discussion	The status of this provision has moved to partial compliance. Based on my interviews with residents and review of documentation, there is contraband still being brought into the facility. However, as stated below, the facility needs to continue to ensure that safety and security is first to control the level of contraband entering the facility as stated in my previous report. I reiterate my statement below on ACA guidelines regarding contraband and my experience in institutional settings. (It is always better to be safe.) **It should be noted again that, there is contraband still entering the facility.** Although there is an agreement between the Board and SPLC regarding strip searches, I disagree with this as does the ACA as stated below. As it relates to proper intake and safety and security in a secured environment, the following must exist. Security (secured) is defined as "being free from danger or risk of loss: safe, fear from fear or doubt, anything that gives or assures safety". Security is an intricate and essential component of a juvenile detention facility. The process for admitting a resident to detention is extremely important. There is an art to getting residents fully and smoothly involved in the detention program. The admission process is what is called the "critical hour" because it is the first encounter with the resident. It is the first impression, sets the tone and it establishes the 'flavor' for the entire stay in detention. Detention is a complex situation, placing troubled residents together in a confined environment with high levels of uncertainty. The risk for problems is very high for both residents and staff. Good detention facilities supply staff with a substantial amount of information at admission. Since the first moments are critically important because it sets the tone it is important to have the best staff assigned to the admissions area. In addition, it is very important for staff to understand that youth are coming off the street based on being arrested and they are not aware of the circumstances surrounding the arrest or if the youth were properly searched by the arresting police officer. There are natural consequences when this process is not completed correctly. Therefore, to be clear the following should apply to residents being searched upon entering the facility. When staff are authorized to conduct a strip search, these guidelines should be observed for the staff's protection: • a strip search should occur only after staff have had training on how to conduct a strip search

	• strip searches should be conducted in a private area of the detention facility • staff must maintain a professional demeanor throughout the process • the resident should be asked to remove all of their clothing, and staff should refrain from inappropriate comments and staring • staff should not touch a resident during a normal strip search • staff are only permitted to conduct a strip search on a resident who is of the same sex Drug-related offenses, violent offenses, and serious felony offenses do constitute a reasonable suspicion to conduct a strip search. Additionally, the frisk search at admission and the inventory search of property may uncover contraband that creates a reasonable suspicion to conduct a strip search. Staff should be advised to conduct a strip search on all juveniles at admission.[1] ACA recommends completing a strip search as part of the admission process. In the absence of case law on the subject, conducting a strip search as a routine part of the admission process is advisable. Body-cavity searches are to be conducted by a licensed health care provider with the authorization from the responsible physician and facility administrator; staff should never conduct a body-cavity search. Specific reference is made to a visual, manual, or instrument search of a residents' anus and/or vagina. (Desktop Guide for Good Juvenile Detention) The facility has stabilized this area with permanent staffing on the day and afternoon shift. However, during my review of videos youth were left in this area unsupervised during the changing from evening to night shift, which must be addressed. A youth was able to obstruct the lock and leave the cell without staff being aware of what occurred. Again, based on my observations and review, as stated in my last report, the facility does have policy and procedures for this provision. During my interview with residents I found no residents who acknowledged there was inappropriate intrusion during the search process upon their admission to the facility. Although this is an area of concern, strip searching is necessary to ensure no contraband enters the facility. As long as searches are conducted in a humane manner by an officer of the same sex as the resident, no resident's rights are being violated. My greatest concern is still that in my interviews I learned that some of the residents reported that they were not searched before being placed on a unit. The process I observed was very loose and not well structured. It is important that the officers follow the policies and procedures as they direct this process. Failure to follow these procedures presents the possibility of having a very dangerous situation in the facility. The facility must follow its policies and procedures to provide a safe and secure environment. Continue to comply with this provision.

Recommendations	1. Staff must be provided with the necessary training with information stating the trainer, name of the training class/course, time, date and location of training. 2. This documentation should be kept and logged in facility records 3. Continue to provide enough staff for adequate coverage 24/7.
Evidentiary Basis	Document review, observation, interviews

[1]Although, this provision will need modification, I understand that Hinds County has ceased its practice of strip searching residents during the admission process at Henley-Young unless there is an articulable suspicion that a resident possesses weapons, drugs, or contraband and is in the process of implementing a policy that complies with the consent decree.

2 Staffing and Overcrowding

Provision 2.1 Staffing and Overcrowding	Within 90 days of the date of this agreement, Henley-Young shall operate with a direct care staff to resident 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.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance. Based on document review, observation and interviews, the County has not complied with maintaining the resident population of 32. The population at times has moved to 50+ residents which means that the original 91 staff must be hired. The increase in population has created additional stress on the facility which has forced them to return to locking down residents because of staff deficiencies. I am concerned that without the stabilizing of the population the facility will revert back to its original 'environment'. The question we should ask, does the staffing plan agreed upon in 2014(32 youth) meet constitutional standards as it relates to adequate staffing? However, based on the increase in youth being detained at Henley-Young, the original staffing plan is now required. Because of the apparent need for more staffing, the facility must have time to hire and train new staff. As professionals in the field have concluded "Crowding is not just a housekeeping problem that simply requires a facility administrator to put extra mattresses in the day room when lights are out. Years of research and court cases have concluded that overcrowding produces unsafe, unhealthy conditions for both staff and residents." When staffing ratios fail to keep pace with the populations, the prevalence of violence and suicidal behavior rises. In addition, the staff habitually resorts to increase control measures as lockdowns and mechanical restraints. As it relates to mechanical restraints the facility is doing a very good job not using them except for transportation. Again, as stated above there are still many conflicts between the mandates of the court, the school and the facility. Students who have court still are not	

	allowed to return to the classroom after their appearances, teachers still suspend students from school based on their needs rather than the parameter of the detention facility and an already stretched staff becomes more stretched. These types of issues create problems that the line staff cannot surmount. This is another indication that when there is not sufficient and appropriate staff available, officers have a tendency to not engage residents on their inappropriate behavior, which in turn affects any structured programming. Again, the Henley-Young officers are compelled to inappropriately react to minor misbehaviors, out of fear that small situations will become big ones. As stated in my last report, the facility continues locking down residents that present potential conduct issues so other residents will be safe. Further, the officers are not equipped to handle residents with mental health problems due to their lack training and not having enough mental health professionals or mental health services available. This lack of service only exacerbates a resident's misbehavior when they are outside their rooms. They have nothing to lose because their misbehavior only gets them a return to their rooms. This approach of locking residents down for minor inappropriate behavior (i.e. talking out of turn, being somewhat verbally disruptive etc.) or displaying suicide ideation's is counter-productive for the residents because it is equivalent to awarding the residents for their misbehavior. This not in line with good juvenile detention practices. Because there are no qualified mental health professionals, at Henley-Young, residents are isolated and their needs are not being met. This situation places direct care staff in a quandary on how to handle these residents. Without regular access to mental health professionals, these children often deteriorate and staff members become apprehensive regarding their next step, so isolation becomes the norm. This should be addressed by the new director. Again, during this visit my observations and my record review revealed that because of the inadequate staffing levels there are no consistent security checks of residents who are placed on behavior management or isolation. There were residents placed on behavioral management and isolation without the appropriate documentation on the doors. This indicates that the residents are not being properly observed during this period, and that no records are being made of the residents' behavior while in behavior management or isolation. Therefore, there is again a need for major training as it relates to behavior management and isolation of residents at Henley-Young.

Recommendations

Units	Day Shift	Evening Shift	Night Shift	Total
A officer	3	3	2	8
B officer	3	3	2	8
C officer	3	3	2	8
D officer	3	3	2	8
Intake	1	1	1	3
Master Control	1	1	1	3
Staff for Court Transportation	2	2		4
Internal Transportation	2	2		4
Laundry	2	2		4
*Director	1			
*Deputy Director	1			
*Operation Manager	1			
Supervisors	3	3	2	8
	26	23	12	61

Duty Post Staffing/Administration

61 Direct care/supervisor/laundry staffing X 1.5 Relief Factor—Total staff needed to effectively operate the facility—91.5
1 to 8 Awake—1 to 10 Sleep

<u>Misc. post coverage</u>
Medical/MH Hospital Runs
One on One MH/Medical
Visitation
*Administration
*Maintenance

Evidentiary Basis: Document review, observation, interviews

Provision 2.2 Staffing and Overcrowding	If the staff-to-residents ratio falls below the requirements of section 2.1 for longer than two (2) days, the Director or his assignee shall immediately identify residents accused of nonviolent offenses who are eligible for less restrictive alternatives to secure detention and request an emergency release for eligible residents from the appropriate Residents Court. The maximum capacity of Henley-Young shall be calculated by determining how many direct care staff members can supervise residents in accordance with section 2.1. The current maximum capacity of Henley-Young is 84.
Status	**Substantial Compliance**
Discussion	The facility continues to be in substantial compliance on this provision based on my review of documents, interviews and observations. The facility does have policies and procedures in place signed by the Court Administrator; the youth court Judge, and the Executive Director. Although the facility has not reached its maximum capacity of 84 and there is a procedure in place to ensure steps are taken for releasing of residents who meet the criteria there is a concern regarding facility staffing and it capacity .Even though the provision is in substantial compliance the County agreed that the population would be capped at 32 beds .It has now far succeed the 32 bed population agreed upon with the federal court. .Therefore, this provision may need revision .This fluctuation creates a staffing and safety concern if there is not enough staff to maintain safety and security which may be a constitutional violation.
Recommendations	Continue to provide training to ensure that everyone is aware of the new policy and prepared for implementation should the need arise.
Evidentiary Basis	Document review, observation, interviews

Provision 2.3 Staffing and Overcrowding	No more than one resident shall be placed in a one-person cell.
Status	**Substantial Compliance**
Discussion	The facility continues to be in substantial compliance on this provision. I found no indication that the facility had more than one resident in a room. The facility has developed policies and procedures for this provision.
Recommendations	1. Develop and provide adequate training for this provision. 2. All training shall be documented.
Evidentiary Basis	Document review, observation

3 Cell Confinement

Provision 3.1 Cell Confinement	Residents shall be engaged in structured, rehabilitative, and educational programming outside of their cells during the hours of 7:00 a.m. to 9:00 p.m. each day, including weekends and holidays.	
Status	**Beginning Compliance**	
Discussion	The facility remains at beginning compliance. See comments below. During this visit, I found that although the facility had a daily program, it was not being followed. Again, as I discussed in my last report, youth placed out of school or on isolation must be provided with education and structured activities. During this visit, there were youth who were out of school and on their units with no educational staff and in their rooms. In addition, there was a youth placed in the intake area for safety issues not involved in school for several days (Youth A.M). The facility is also in the process of hiring a new recreation position to assist in developing this programming. As stated in my introduction, the facility needs to secure the frames I mentioned for security, structure, and to ensure schedules are not pulled down and discarded, which will provide a sense of order. See attached. It should be noted that the facility education program has been reviewed with **reluctance by** an outside juvenile education expert (see exhibit). It should also be noted that the facility is developing a behavior management program. The facility needs to maintain structure and consistency in daily schedules and routines. Again, staff must be removed from the towers. They should only be in towers as needed and not as a place for just gathering. There is also a need to fully develop a facility-wide reward and incentive program. Again, please review the introduction as it pertains to activities, recreation and programming. As to the school I direct you to read the introduction. My review of the files showed that there is still no case management within the facility. According to the residents, their basic recreation consists of playing cards and dominoes. They are allowed to go outside but there are no scheduled activities. Other than sitting on the bleachers and playing basketball for those who are engaged in that sport, there was nothing for residents to do. The facility continues to develop its positive behavioral management programs within the facility.	
Recommendations	1. Develop policies and procedures for this provision. 2. Review the schedules to be sure that they adequately reflect all daily activities. 3. Develop positive behavior management systems with rewards and consequences. 4. Remove the dark film from the Plexiglas in towers on unit which would allow staff to view the unit without there being visual obstruction (when lights on).**Executed**	

	5. Develop monthly recreation schedule. 6. See all of the recommendations for recreation activities and programming and for the school in the introduction. 7. Purchase frames for facility activities and schedule 8. Hire recreation staff 9. Fully develop award and incentive program
Evidentiary Basis	Document review, observation, interviews

Provision 3.2 Cell Confinement	Except when residents are in protective custody or confined subject to section 3.3 of this Settlement Agreement, residents placed in the Suicide or Booking cells shall be allowed to spend the hours of 7:00 a.m. to 9:00 p.m. on the appropriate living unit and to have the opportunity to engage in structured, rehabilitative, and educational programming, unless medically counter-indicated.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance Based on my review of documents and observation, there have been youth placed in the booking area who have not been involved in structured programming and were not supervised. This was apparent during the visit. Youth (AM) was placed in a booking cell for several days at the request of SPLC according to the facility administration. However, this youth was not involved in any structured programming. In addition, this youth was identified as having mental health issues because he was placed in a mental health smock during his time in the area. Also, my reviewing of videos revealed youth unsupervised in the area. As in my last report, there is a need for policy and procedures development, proper staffing, and supervision. My review of documents and observations showed that the facility still has not developed policy and procedures for this provision. During my review, I found residents on the unit living area still not being supervised. Again, as stated in my introduction, there were residents who were not allowed to attend school for the remainder of the day after returning from court. This is an issue that needs to be addressed immediately. Again during this visit, I observed residents who wanted to return to school but were not allowed. As stated previously, I recommend that students who are disruptive in the classroom and are removed from the classroom receive either behavioral management or are written up and receive due process. However, they should continue to be a part of the educational process. The school needs to revise any policies they may have regarding suspension of students from a school within a controlled environment. A student cannot be suspended from school in a detention facility therefore	

	the school needs to develop a better behavioral management system. If a resident is removed from school due to behavioral problems that resident should never be placed in the booking area. The facility still needs to develop data collection tools to use to determine and identify who is placed on units, time, length etc. when they are placed out of school. The facility remains non-compliant with this provision, therefore I am reiterating that the suggested actions and recommendations from my previous report be reviewed and put into action.
Recommendations	1. Follow recommendations as set forth in section 3.1. 2. Develop adequate policies and procedures for this provision. 3. Develop data collection for residents who are placed in protective custody or confinement. 4. Residents who are removed from school should be placed in a designated living area.
Evidentiary Basis	Document review, observation, interviews

Provision 3.3 Cell Confinement	Residents who pose an immediate, serious threat of bodily injury to others may be confined in their cells for no longer than 12 hours at a time without administrative approval. Residents 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 residents who are subject to cell confinement every 15 minutes. Staff must document all instances of cell confinement in writing and must document the justification for determining that a resident poses an immediate, serious threat of bodily injury.	
Status	**Non-Compliance**	
Discussion	During this review, I observed that youth were still being placed in their rooms without administrative or supervisory approval. These were also youth who were in their cells that were not in school or structured programming. During this visit I found the youth who were in their room had no review sheets on their doors. It should be noted that staff are still stationing themselves in the tower and are not in the proximity of youth they are to supervise. In my opinion with the increase in population, some kids not in school, youth not having proper mental health services, the staff is becoming overwhelmed again. Please see last report, the facility has developed a due process system however, staff need to follow it. In addition, there needs to be ongoing training and increased supervision by the administration or hire additional supervision. The QA Department is developing good data, which should continue. However,	

	the data must be used to provide a greater understanding of the facility operations. The status of this provision remains as non-compliance. Based on my review of documents, interviews with residents and staff and observation, residents are still being confined in their cells for long periods of time without appropriate documentation. During this visit, I again found residents, although they were not all locked in their rooms, they were on the units without being engaged in any meaningful programming or activities because they were placed out of school. Staff was still in the towers and not interacting with the residents on the unit. I have discussed this in my previous reports stressing that there must be enough staff in order for the staff and the residents to be engaged and for the safety and security while residents are on their units. Supervising residents from the tower fails in the face of good supervision and rehabilitation. Therefore the statements below from my previous report ($7^{th/8th}$) still stand. During this visit, I did find that the facility has developed a system for procedural due process for facility violations. However, there are no supervisory checks to the process which are critical to ensure that staff are following the policies and procedures and not just placing residents in their rooms discriminately. As stated in my previous reports the facility has developed policies and procedures and the QA department is still doing a good job. However, there is still a need for adequate training to ensure everyone is following the process. Again see my discussion of this matter in the introduction. Though processes on a few provisions have begun, it is vitally important that policy and procedures are developed to ensure a consistent, comprehensive, and standardized way of running the facility.
Recommendations	1. Develop adequate policies and procedures for this provision. 2. For residents placed in their rooms, develop forms that indicate the time residents will be in their rooms and post it on their doors. 3. Ensure that supervisors sign off on the form in 15 minute staggered visual checks when residents are placed in their rooms. 4. Develop a system of major and minor consequences for behavior. 5. Develop form for 15 minute checks and include in policy.
Evidentiary Basis	Document review, observation, interviews

Provision 3.4 Cell Confinement	Residents shall not be automatically subjected to cell confinement and/or isolation upon their admission to Henley-Young unless he or she would be subject to cell confinement under section 3.3.	
Status	**Beginning Compliance**	
Discussion	This status of this provision has moved to beginning compliance. This provision has moved to beginning compliance. The facility has assigned two intake officers during the day to this area. I found no indication that youth who were entering the facility during the first shift were locked down upon admittance. However, in my review of video for the afternoon shift it was revealed that youth were being placed in the admission cells and left alone with no supervision. This is an area that still needs to be addressed. Part of operating a facility is to ensure staff is consistently following policy and procedure. To follow on one shift and not the other is counterproductive. Policy and procedure must comport with practice.	
Recommendations	1. Develop adequate policies and procedures for this provision. 2. Ensure all staff is trained and document training. 3. See provision 3.3 4. Ensure practice is consistent with policy and procedure. 5. Ensure there is adequate staffing and supervision for this area	
Evidentiary Basis	Document review, observation	

Provision 3.5 Cell Confinement	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 residents are placed, and direct care staff shall be actively engaged with residents. From 10:00 p.m. to 7:00 a.m., staff shall conduct visual checks on residents every 15 minutes. Henley-Young shall ensure that every cell has an operating intercom that allows residents to communicate with staff at all times.	
Status	**Beginning Compliance**	
Discussion	This provision remains as beginning compliance. Again, I found youth alone on units and in their cell without any staff supervision. As stated in my Introduction, the staff continues to remain in towers. There must be additional supervision. See last report. The status of this provision remains as beginning compliance, therefore my discussion below still stands.	

	The facility has developed a policy and procedures regarding this provision. Again due to the lack of staff, or the deployment staff, it is very difficult for the facility to address this provision. During this visit I found residents were left unsupervised as stated in my previous reports and this continues to happen. Again, residents were on the unit without supervision although one staff was in the tower. There were doors opened on the unit which also allows for serious things to happen between residents. This is a major area of concern and must be addressed. It continues to make me uneasy as it has during my previous visits. Review of documentation and direct observation reveals that staffing continues to be a major problem at Henley-Young. The facility remains at beginning- compliance with this provision, therefore I am reiterating that the suggested actions and recommendations from my previous report be reviewed and put into action. Since a policy has been developed this provision remains in beginning compliance (**see Introduction).**
Recommendations	1. Develop adequate policies and procedures for this provision. 2. Provide adequate staffing. 3. Provide adequate staff supervision. 4. See my last report 5. Review the deployment of staffing
Evidentiary Basis	Document review, observation, interviews

4 Structured Programming

Provision 4 Structured Programming	Henley-Young shall administer a daily program, including weekends and holidays, to provide structured educational, rehabilitative, and/or recreational programs for residents during all hours those residents shall be permitted out of their cells, pursuant to section 3.1. Programming shall include: a. activities which are varied and appropriate to the ages of the residents; 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.
Status	**Beginning Compliance**
Discussion	The status of this provision remains at beginning compliance. Based on my review of documents, staff and youth discussion and observation, the facility continues to struggle to develop an adequate structure program. The facility is in the process of hiring another recreation staff to replace the previous one. The facility needs to fully develop the program to have clear and consistent programming. This should include proper programming for girls. The facility does not have a posted schedule throughout the facility for staff and youth to follow. Also during this visit I found that girls were still in their rooms although shifts had changed. This indicates that there was no consistent programming. The programming must have the following; A. Comprehensive policies and procedures B. Reasonable rules and expectations C. Order D. Organization and clarity F. Clear rewards and incentives G. Reasonable and consistently implemented sanctions H. Case management to ensure youth are there is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and progress youth are making during their stay. In addition for this report, Carol Cramer Brooks a detention education expert reviewed educational services within Henley-Young Juvenile Detention Facility. Ms Cramer Brooks report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Continue to develop adequate policies and procedures for this

	provision. 2. Provide adequate schedules for weekdays and weekend programming and act on it. 3. Develop an adequate monthly recreation schedule with age appropriate games and programs. 4. The facility need to hire an officer dedicated to developing and monitoring recreational programs. 5. Hire case management staff.
Evidentiary Basis	Document review, observation, interviews

6. Individualized Treatment Plans Treatment For Post-Disposition Residents

Provision 5.1 Individualized Treatment Plans Treatment Program for Post-Disposition Residents	Henley-Young shall ensure that residents have access to adequate rehabilitative services. Henley-Young shall ensure that children placed in the facility post-disposition will receive constitutionally compliant rehabilitative services.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance, therefore my statements below still stand. See the discussion of the 89 day program in the Introduction. Since there is no structured programming outside of individual counseling, the County needs to hire case managers to provide initial and ongoing case management services (i.e. treatment planning, family assessments, educational assessments, referrals for mental health or health services). Also the case manager will identify indicators of goals achieved, specify the person responsible for implementing the resident's and family's treatment goals; update treatment plans; and develop discharge plans with recommendations. In addition, the facility needs counselors who are responsible for a resident's safe adjustment to secure confinement. In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).	
Recommendations	1. Develop adequate policy and procedures to meet this provision. 2. Either fund properly or discontinue the 89 day program.	

	3. Review light weight residents in program (i.e. disturbing the family peace) and find alternative placement for them. 4. Fund appropriate staffing to develop individualized treatment plans for residents in 89 day program. 5. Develop and fund alternative community programming for residents in 89 day program that can be serviced in community. 6. Hire 3 case managers who are assigned and work for the facility director. 7. Hire case management staff.
Evidentiary Basis	Document review, observation, interviews

Provision 5.2 Individualized Treatment Plans Treatment Program for Post-Disposition Residents	Henley-Young shall ensure that residents in need of mental health and/or substance abuse treatment and/or who are in the facility post disposition shall have appropriate treatment plans developed and implemented in accordance with generally accepted professional standards of practice for mental health and rehabilitative services.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance. Again, see the technical assistance provided to the court dated November, 2014. Also see introduction on 89 day program. There has only been a name change to the program. However, there is still the need to hire case managers to create a possible treatment program if the county intends to meet this provision. In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).	
Recommendations	1. Develop adequate policies and procedures for this provision. 2. See recommendations under (5.1). 3. Hire case management staff. 4. Purchase case management system	
Evidentiary Basis	Document review, observation, interviews	

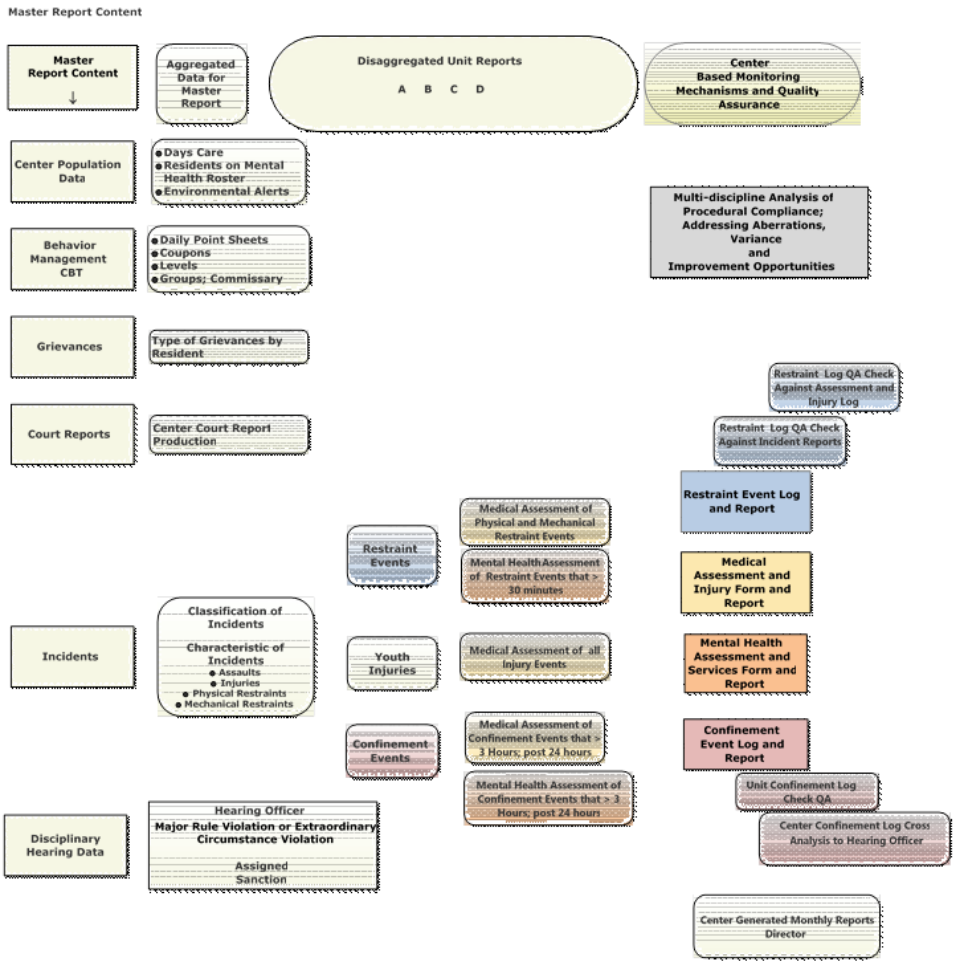
Provision 5.3 Individualized Treatment Plans Treatment Program for Post-Disposition Residents	Henley-Young shall implement policies and procedures for the required content of treatment plans, which shall include; a. That the treatment plan be individualized; b. An identification of the mental and/or behavioral health and/or rehabilitative issues to be addressed; c. A description of any mental health, medication or medical course of action to be pursued, including the initiation of psychotropic medication; d. A description of planned activities to monitor the efficacy of any medication of the possibility of side effects; e. A description of any behavioral management plan or strategies to be undertaken; f. A description of any counseling or psychotherapy to be provided; g. A determination of whether the type or level of treatment needed can be provided in the resident's current placement; and h. A plan for monitoring the course of treatment, and if necessary, for revising the treatment plan. i. A description of the precise terms the of the facility's long-term and short-term objectives for the residents, the full range of services to be provided, and procedures, and timetables and staff assignments for the implementation of such treatment plan; j. A plan for regularly engaging the family in the resident's treatment plan; k. A comprehensive re-entry plan that will assist the residents re-enroll in their home school and access medical, mental health, vocational and rehabilitative services based in the community.
Status	**Non-Compliance**
Discussion	In addition for this report, Dr. Ngozi Ezike, an expert medical physician, with expertise in juvenile detention health services reviewed medical services and Dr. Lisa Boesky, an expert mental health consultant, reviewed mental health services within Henley-Young Juvenile Detention Facility. Dr. Ezike's and Dr. Boesky's reports were submitted prior to this official report to give the facility an opportunity to begin implementation of their recommendations (see exhibit).
Recommendations	1. Develop comprehensive policies and procedures for this provision that includes the contents (A-K). 2. The County/Court shall define the criteria for the program a. It is important that post dispositional programs in other facilities be reviewed. b. Often seeing what is being done in other facilities provides insight into how to develop and operate these programs. 3. Provide dedicated staff to manage program. 4. Provide intensive training to these staff members.

	a. Train staff in various treatment modalities i.e. cognition, behavioral modification, modeling, psychotherapy, reality therapy, group therapy and group dynamics and other skills required to successfully facilitate the goals of the 89 day program. b. Create treatment teams c. Develop case planning and program development d. Assessment of the program to determine if it meets the needs of the court placed residents. e. Assessment tool to regularly monitor the success or lack of success of all residents in the program. 5. Provide auxiliary training to all other direct care staff. 6. Hire case management staff.
Evidentiary Basis	Document review, observation, interviews

Provision 5.4 Individualized Treatment Plans Treatment Program for Post-Disposition Residents	Henley-Young shall institute a program of periodic staff reviews every three weeks and evaluations of each resident's progress under his/her individualized treatment plan and of the appropriateness of the plan itself and Henley-Young's plan for such review.	
Status	**Non-Compliance**	
Discussion	In addition for this report, Dr. Ngozi Ezike, an expert medical physician, with expertise in juvenile detention health services reviewed medical services and Dr. Lisa Boesky, an expert mental health consultant, reviewed mental health services within Henley-Young Juvenile Detention Facility. Dr. Ezike's and Dr. Boesky's reports were submitted prior to this official report to give the facility an opportunity to begin implementation of their recommendations (see exhibit).	
Recommendations	1. Develop comprehensive policies and procedures for this provision. 2. Provide training to all staff. 3. Identify roles and responsibilities of direct care, treatment and educational staff as it relates to the staffing for 89 day program through policies and procedures and adequate funding and staffing. 4. Hire case management staff.	
Evidentiary Basis	Document review, observation, interviews	

Provision 5.5 Individualized Treatment Plans Treatment Program for Post-Disposition Residents	Henley-Young shall develop and implement a program that provides for evening and weekend programs and activities that allow residents to engage in meaningful activities.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance, therefore my statements below still stand. See the technical assistance provided to the court dated November, 2014. Based on my review of documents and observation, services are not in place and are still not being provided for this provision. I am reiterating the actions and recommendations from my previous report below. The programming of the facility is at a standstill as it relates to this provision. There are very few activities on weekends therefore there is no meaningful programmatic, structured activities except for card playing and dominoes. Take note of the discussion of these issues in the introduction.	
Recommendations	1. Develop comprehensive policies and procedures to meet the needs for this provision. 2. Provide adequate staffing for this program. 3. Develop a monthly recreational program with activities. 4. Keep records of activities provided and note those that were not provided and why. 5. Purchase board games etc. 6. Hire recreational staff. (executed) 7. Hire case management staff.	
Evidentiary Basis	Document review, observation, interviews	

Provision 5.6 Individualized Treatment Plans Treatment Program for Post-Disposition Residents	Henley-Young shall develop and implement an adequate quality assurance program.	
Status	**Partial Compliance**	
Discussion	The QA department at Henley-Young continues to develop their data fields. There is significant improvement from no data to what is being developed	

	now. The QA staff should be commended and encouraged to continue their effort. Based on my discussion with the administration, the county's IT department will be working with the facility to create and develop data sets that will produce reports that will provide the facility with the system to evaluate the current operations and provide the facility with information that will help them make better decisions as administrators and as facility operators. Now the following is needed: • I will provide the facility with templates for assistance in the full development of this process. • QA Data Collection Info • See introduction 
Recommendations	1. Develop comprehensive policies and procedures to meet the needs for this provision for the facility, school program and SICU program.

	2. Health Care: continuously assess the quality and adequacy of the health services provided, accurately evaluate the performance of staff providing health services and address identified deficiencies. 3. Recreation and Social programs: continuously assess the quality and adequacy of social and recreational programming provided; accurately evaluate the performance of staff in providing these programs. 4. Environmental Health and Safety: continuously assess the quality and adequacy of environmental health and safety, accurately evaluate the performance of staff in providing a safe and healthy environment and properly address identified deficiencies. 5. Discipline and order: continuously monitor use of discipline and promptly address misuse or over use of discipline and other identified deficiencies. 6. The facility must continue to develop monthly performance measures to indicate achievement in the desired area. 7. Review State of Florida Quality Assurance Model and for assistance in developing contact CJCA Performance Based Standard for Juvenile Detention Programs, also use ACA standards to establish policy guidelines. 8. Develop data collection system 9. See introduction
Evidentiary Basis	Document review, observation, interviews

6 Due Process/Isolation/Disciplinary Practices and Procedures

Provision 6.1 Disciplinary Practices and Procedures	Henley-Young shall implement a discipline policy and practice that incorporates positive behavior interventions and support. This policy shall include guidelines for imposing graduated sanctions for rule violations and positive incentives for good behavior.	
Status	**Non-Compliance**	
Discussion	Although the facility has a due process policy in place, the facility still needs to train staff in how to carry out sanctions for rule violations and positive incentives. In addition, youth are not aware of the sanctions and rules for the behavioral management system. There were also no rules or sanctions posted in the facility. Again in my discussion with youth and staff observation and document review, I found very little indication that positive behavior intervention or incentives for behavior modification were present (i.e. counseling, early bed, loss of privileges, mediation, etc.). Therefore, my statement below still stands._See last report. Again, this is a critical component of the disciplinary and behavioral management process to ensure residents are treated fair, humane and that	

	there is no misuse of the isolation and disciplinary process (review the introduction regarding this matter). The facility is implementing a due process behavior system which is partially complete. Based on my review of the documents the facility has initiated due process hearings, however staff officers are not adequately trained and the residents are not aware of the infractions and consequences because they have not received proper orientation to the program. The bottom line is there is inadequate orientation for entering the facility. There is still no positive incentive program for good behavior and sanctions for rule violation. Based on my review of documents and observation, positive behavioral intervention and supports are not in place and are still being worked on for this provision. I reiterate, the suggested actions and recommendations from my previous report. The facility should continue to follow the recommendations from the previous report. The facility is making improvement on the due process isolation and practice procedures. Although processes on a few provisions have begun, it is vitally important that policy and procedures are developed to ensure a consistent, comprehensive, and standardized method of running the facility. In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Develop adequate policies and procedures for this provision. 2. Develop new resident handbook. Residents are to receive these handbooks during orientation and sign for it. a) They shall include resident's rights, major and minor rule violations and the grievance policy. b) The handbook will explain to residents in their own language the rules and shall also be explained by staff that will have them sign and date a form indicating that both processes have occurred. c) These rules shall be posted on each unit. 3. Due process rules shall be posted on each unit. 4. Develop positive behavior intervention programs. 5. Assign and train an independent person(s) to handle due process isolation hearings. The person(s) must be independent of the unit staff. 6. Ensure residents who are in isolation are provided recreation and education services.
Evidentiary Basis	Document review, observation, interviews

Provision 6.2 Disciplinary Practices and Procedures	Residents who violate major rules may be subject to cell confinement for up to 24 hours for a single rule violation. An occasion in which a resident is alleged to have contemporaneously violated multiple major rule violations shall count as a single rule violation for the purposes of this section. No residents shall be confined to a cell for longer than 8 hours for a single rule violation without receiving written notification of the alleged rule violation and the occurrence of a disciplinary review/due process hearing before an impartial staff member, which includes participation by the accused residents. Under no circumstances shall residents be subjected to involuntary cell confinement for longer than 24 hours for disciplinary purposes. Residents 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.
Status	**Non-Compliance**
Discussion	The facility does have a due process system in place. However, during this visit I found youth that were placed in their rooms without any hearings. There were also youth left in their rooms after shift change and during the day without staff supervision. These youth were also not receiving any educational services during this time. Since this is new to the new director I am reiterating my statement from my previous report. (See Dr. Boesky's report) Again, when residents are accused of a major rule violation, they should be provided with a notice of the violation and an explanation of their right to have a hearing in which they are able to present their side of the event to an unbiased party, call witnesses on their behalf and ask for staff representation if it is requested. The hearing officer is required to interview the resident and any parties that observed the incident. Residents who require a due process hearing who are on the mental health caseload should have a qualified mental health professional determine whether being placed in isolation could cause a decline in functioning or any other relapse. The hearing officer may impose a variety of sanctions including the loss of privileges, restrictions, or isolation. The hearing officer may credit the resident for any time served in behavior management isolation pending the hearing. The residents have the right to appeal the decision of the hearing officer to the Director. My review of documents and interviews with staff and residents revealed the need for additional training to take place regarding this process. The staff and residents were unfamiliar on how the process works; therefore it is critical for the facility administration to review their policy and procedure on due process. It should also be noted that residents must see the process as fair.
Recommendations	1. Develop policies and procedures for this provision. 2. Develop sheets to place on door of any residents in confinement that identifies the reason for confinement and is review and signed by

	supervisor. 3. Ensure residents in confinement receive education and recreation services. 4. See 6.1 recommendations. 5. Provide training for all staff on these policies and procedures.
Evidentiary Basis	Document review, observation, interviews

7. Use of Restraints

Provision 7.1 Use of Restraints Mechanical	Mechanical restraints shall not be used to punish residents or for the convenience of staff. Mechanical restraints shall only be used to prevent self-harm and/or harm to others, subject to section 7.4, and for transportation to and from court, subject to section 7.2.	
Status	**Partial Compliance**	
Discussion	The status of this provision has moved to partial compliance. Based on my review of documents, interviews with youths and observations at this time I found no indication of overuse of mechanical restraints with the exception of transferring residents out of the facility. Again, I reiterate it should be noted that well run facilities only use mechanical restraints for transportation or exigent circumstances which may arise at any facility under supervisory approval.	
Recommendations	1. Officers shall receive training on policy and procedures. 2. Officers shall be trained on when it is appropriate to use mechanical restraints. 3. All training shall be documented. 4. The policy will require the documentation of any use of mechanical restraint and use of force incidents. 5. Restraint log should be implemented. 6. Continue to follow policy	
Evidentiary Basis	Document review, observation, interviews	

Provision 7.2 Use of Restraints Mechanical	Nothing in this section shall prohibit mechanical restraints from being placed on residents who are being transported to and from court or out of the facility, if staff have reason to believe that a residents presents a flight risk or is an imminent danger to the residents or others, or will engage in violent behavior. However, mechanical restraints should be removed immediately after the resident is placed in a cell and at no time shall a resident be placed in a cell wearing mechanical restraints.	
Status	**Substantial Compliance**	

Discussion	The facility has moved to substantial compliance on this provision. Based on my review of documents, interviews with youths and observations at this time I found no indication of overuse of mechanical restraints with the exception of transferring residents out of the facility. This should continue.
Recommendations	1. Develop and provide remedial training for this provision. 2. All training shall continue to be documented. 3. The policy will require the documentation of any use of mechanical restraint and use of force incidents. 4. Operationalize the edicts of this provision. 5. Additional supervision needed to ensure mechanical restraints are not misused. 6. Continue to follow the process to remain at SC.
Evidentiary Basis	Document review, observation, video recordings and discussion with residents

Provision 7.3 Use of Restraints	Restraints shall not be used to secure residents to a fixed object such as a restraint chair, bed, post, or chair.
Status	**Substantial Compliance**
Discussion	The facility has moved to substantial compliance on this provision. Based on my review of documents, interviews with youths and observations at this time I found no indication of overuse of mechanical restraints with the exception of transferring residents out of the facility. However, to remain at substantial compliance the facility continues to follow the recommendations (2, 3 and 4) below.
Recommendations	1. Complete the comprehensive policies and procedures for this provision. 2. Provide training for staff within the facility as described above on this provision and provide documentation of training. 3. Develop and use a mechanical restraint log. 4. Provide training on de-escalation techniques to try to use mechanical restraints only as a regular part of facility transport. 5. Additional supervision needed to ensure mechanical restraints are not misused.
Evidentiary Basis	Interviews, observation and document review

Provision 7.4 Use of Restraints	No residents shall be restrained for longer than 15 minutes, unless restraints are approved by a mental health professional or if determined to be necessary under section 7.2 or as reasonably necessary to prevent the residents from engaging in acts of self-harm or harm to others. If a residents must be restrained for longer than 15 minutes in order to prevent self-harm, that residents shall, as quickly as possible, be evaluated by a mental health professional or transported to a mental health facility.
Status	**Beginning Compliance**
Discussion	In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations
Recommendations	1. Continue to develop comprehensive policy and procedures for this provision with mental health professionals. 2. Provide training for staff on policy and procedures and document training. 3. Provide training on de-escalation techniques. 4. Develop Mental Health protocols for this provision. 5. Hire mental health professional or agency.
Evidentiary Basis	Document review

Provision 7.5 Use of Restraints	Henley-Young shall not use, or allow on the premises, restraint chairs, chemical restraints and/or tasers.
Status	**Substantial Compliance**
Discussion	I would like to continue to commend the facility on maintaining substantial compliance with this provision. Based on my most recent visit and my observations and review of documents, the facility continues to stay in substantial compliance as it relates to this provision. The facility should still ensure that below recommendations continues to be followed.
Recommendations	1. Ensure staff is following policies and procedures as it relates to this provision. 2. Document all training provided to all staff. 3. Ensure firearms and tasers are secured in a lockbox prior to entering secured area. 4. Retrain staff when deemed necessary.
Evidentiary Basis	Document review, observation, video

Provision 7.6 Use of Restraints	Henley-Young shall not subject residents to "hogtying," which is the practice of placing a resident's face down on a bed, floor, or other surface, and securing the resident's hands to his feet.	
Status	**Substantial Compliance**	
Discussion	I would like to continue to commend the facility on maintaining substantial compliance with this provision. Based on my most recent visit and my observations and review of documents, the facility continues to stay in substantial compliance as it relates to this provision. The facility should still ensure that below recommendations continues to be followed.	
Recommendations	1. Provide on-going training for staff on policies and procedures. 2. Continue to document all training provided to all staff.	
Evidentiary Basis	Observation, document review and interviews	

Provision 7.7 Use of Restraints	When a resident is placed in mechanical restraints, staff must provide one-on-one supervision for the duration of the restraint, except when mechanical restraints are deemed to be necessary for the reasons specified in section 7.2.	
Status	**Substantial Compliance**	
Discussion	The status of this provision has been moved to substantial compliance. The facility should continue with following the recommendations listed below.	
Recommendations	1. Provide on-going training for staff on policies and procedures. 2. Continue to document all training provided to all staff. 3. Ensure that residents who are placed in mechanical restraints are seen by a medical professional. 4. Restraint log should be implemented 5. Additional supervision needed to ensure mechanical restraints are not misused.	
Evidentiary Basis	Document review	

Provision 7.8 Use of Restraints	Henley-Young shall notify a medical professional whenever a resident is placed in mechanical restraints for reasons other than those specified in section 7.2. A medical professional shall examine the residents as soon as possible after restraints are removed, except when the residents was restrained for the reasons specified in section 7.2.	
Status	**Partial Compliance**	

Discussion	The status of this provision has moved to partial compliance. My review of documents again reveals that youths are being seen by medical professionals after the use of mechanical restraints. However, based on my observations and review of documents, I am reiterating that although policies and procedures are developed, there must still be adequate training and instruction to ensure that staff complies with policies and 8procedures. During this visit and my discussion with the new medical staff, there were indications that not all incidents youth were involved in were being reported. Therefore, the facility administration must ensure that supervisor are monitoring the facilty and very visible throughout the facility during their shifts. There is a strong need for accurate and consistent reporting of incidents. When incidents are not reported correctly, the integrity of the reporting system falls into question. This is also a training issue. As I have stated previously in my reports there must be a single matching reporting system used by all facility staff including the school. My review shows, the school still uses a different reporting system than the facility. This must be addressed to ensure consistency in the process.
Recommendations	1. Develop comprehensive policies and procedures for this provision.(Executed) 2. Provide training on policies and procedures. 3. Document all training provided to all staff. 4. Ensure that residents who are placed in mechanical restraints are seen by a medical professional. 5. Ensure that information being reported is accurate and consistent. 6. A single matching reporting system for the entire facility.
Evidentiary Basis	Document review

Provision 7.9 Use of Restraints	Hinds County does not currently and shall not in the future allow officers to enter the secure detention area of the facility with any electronic restraints, including, but not limited to tasers.	
Status	**Substantial Compliance**	
Discussion	The facility has remained at substantial compliance on this provision based on my most recent visit and my observations and review of documents. The facility should still ensure that below recommendations continues to be followed.	
Recommendations	1. Provide training for staff on policy. 2. Document all training provided to all staff.	
Evidentiary Basis	Document review	

Provision 7.10 Use of Restraints	Henley-Young is required to ensure that no officer enters the secure detention area of the facility with a firearm.
Status	**Substantial Compliance**
Discussion	I would like to continue to commend the facility on maintaining substantial compliance with this provision. Based on my most recent visit and my observations and review of documents, the facility continues to stay in substantial compliance as it relates to this provision. The facility should still ensure that the recommendations below should continue to be followed. Also see provision 7.9 as it relates to tasers. I would also reiterate under no circumstances should any staff, anyone connected to the facility, and law enforcement etc. have firearms on the premises especially in secure areas. All weapons must be secured in appropriate locked areas of the building.
Recommendations	1. Provide on-going training for staff on these policies and procedures. 2. Continue to document all training provided to all staff. 3. Have signs displayed at all entrances for securing firearms and tasers. 4. Staff needs to remain vigilant in ensuring this provision is followed and ensure that all **persons** entering the facility are screened and no firearms on their person entering a secured area of the building.
Evidentiary Basis	Document review, Observation

Use of Force

Provision 8.1 Use of Force	Physical force shall not be used to punish residents. Staff shall only use physical force to stop residents 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 residents. 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.
Status	**Non-Compliance**
Discussion	The status of this provision remains as non-compliance. Based on this review, I found that staff has been reluctant to engage youth and reduce the level of facility destruction (i.e. television, water sprinklers, locks etc.) This was made evident by watching several videos of incidents. Again, the facility still needs to develop policies and procedures for this provision. Based on my review of documents, I found very little de-

	escalation used and/or documented in incident reports. Due to the lack of structured programming, inadequate mental health services, behavioral modification (level or token economy systems) there is an increase in youth destruction at this time, which is a reversal from staff use of force as discussed in my previous report. In reviewing documents and video recordings, staff is still making decisions regarding use of force based on instinct and without proper or procedural training. During this visit I reviewed a video where a youth caused major destruction (breaking sprinkler heads which caused the unit doors to unlock, breaking lights and flooding) in the unit and several other youth helped. However, staff never engaged and the destruction did not end until law enforcement arrived. This could have ceased to happen if the staff would have deescalated the situation in the beginning. Therefore my statements below still stand. Based on my review of documents, the facility still needs to develop policies and procedures for this provision. In my review of incident reports, I found that there have been incidents of use of force. However I found no indication that any de-escalation techniques were used. Although officers are doing reports, they are not accurately recording information. When officers are captioning information, it should be truthful, accurate and detailed enough so they can testify on their observations two years from now if needed. It still appears from reviewing documents that report writing training is needed. Also there is a major need for de-escalation and proper restraint training and accurate documentation of incidents. In addition, reports must be legible, in plain English, and specific behavioral terms should be used. Regardless of how accurate and useful an observation may be, it has no value to others unless it is recorded legibly. Police and other juvenile detention facilities have addressed the legibility problem by typing their reports. Most agencies are completely computerized, and some are experimenting with laptop computers. Computerized records may eliminate legibility problems for this facility. Some reports are still written in flowing script (cursive) and on various forms. There should be one facility wide form used to capture information. This has been stated in my previous reports. In addition, there is a major need for data collection as it relates to use of force. This was also stated in my previous reports. There is a need for good data collection keeping regarding, medical and mental health, education, social services and all other operational services provided to the resident. Good data will assist the facility in determining answers to some of the following examples: A. The location of use of force B. The number of use of force incidents

	C. The number of use of force requiring mechanical restraints D. The type of restraint used E. Grievances F. The number of incidents requiring chemical agents G. The number of incidents involving non-lethal security devices (i.e. batons, tasers, etc.) H. The number of use of force incidents resulting in injury to residents or staff I. Plan of action to address each incident (i.e. disciplinary action, staff training or remedial training, resident's isolation, resident's behavior management, resident's mental health screening or evaluation etc.) It should be noted that the facility data has improved. Therefore, it is becoming easier to pin point areas for improvement.
Recommendations	1. Develop policy and procedures for this provision. 2. Provide training for on policies and procedures 3. Document all training provided to all staff. 4. Adapt an appropriate curriculum for training staff on the use of verbal de-escalation skill and safe use of physical restraints or mechanical restraints. 5. Revise form to distinguish between physical and mechanical restraints. 6. Contact the National Partnership for Juvenile Justice for recommendations on training program in this area. 7. Document and file report when there is use of force. 8. Ensure any time use of force is used residents are seen by a medical professional 9. Follow the facility's chain of command which will reduce staff confusion.
Evidentiary Basis	Document review, interviews

Provision 8.2 Use of Force	Henley-Young shall notify a medical professional, including but not limited to the licensed practical nurse on duty whenever physical force is used against a resident. A medical professional shall examine a resident immediately after the use of physical force.	
Status	**Partial Compliance**	
Discussion	The facility has hired a new medical company to handle medical service at Henley-Young. However, there is still a need for the development of medical protocol. The facility has remained at partial compliance on this provision based on my review of documents, interviews with residents and observations.	

	Based on my interviews with nursing staff, I found that some youth were not being seen by medical personnel in a timely manner or when they were involved in physical altercations. Please see the report of Dr. Ngozi Ezike, an expert medical physician, with expertise in juvenile detention health services reviewed medical services within Henley-Young Juvenile Detention Facility. Dr. Ezike's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Complete procurement of services as quickly as possible. 2. Continue to develop comprehensive policies and procedures for this provision. 3. Provide on-going training to staff on policies and procedures. 4. Continue to document all training provided to all staff. 5. Review nursing schedule and provide more hours at facility. 6. Provide written documentation of examination of residents by medical professional in every instance. 7. Provide additional medical services after hours and on weekends. (executed) 8. Document and file in resident's records when there is use of force.
Evidentiary Basis	Document review, interviews, observation

9. Meals and Nutrition

Provision 9.1 Meals and Nutrition	Residents shall be provided three meals and a snack daily. If a residents 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 detention.	
Status	**Partial Compliance**	
Discussion	The status of this provision remains as partial compliance. It should be noted that during this visit food is being prepared at the facility and served in a timelier manner. However, residents still complain about the portions they are receiving and the presentation. As stated in my last report, the food service area is in need of maintenance, repair and cleanliness. Again, as stated in my previous reports, food service is an important part of institutional life. A comprehensive food service program must be developed if the facility is to meet the unique needs of its juvenile population. Juvenile health, nutrition, and morale in this environment are all directly related to	

	the effectiveness of the food service program. Meals served to incarcerated juveniles must be nutritionally balanced and calorically adequate. They must be tasty, appealing, and served in an aesthetically acceptable manner to avoid conduct and behavior problems. If juveniles believe the facility's staff and management have maximized their efforts to provide a healthy and appealing food program, conduct can and will improve.
Recommendations	1. Continue to review portions to ensure residents receive enough food during meals. 2. Develop policy and procedures for this provision.(executed) 3. Continue to provide training for kitchen staff and all other staff members involved with handling food and preparing meals. 4. Continue to document compliance with this provision. 5. Food should be served in a timely manner and consistent with facility schedule once developed. 6. Review the National Food Service Management Institute from the University of Mississippi that details "Food Safety Facts". 7. Food service area is in need for maintenance, repair and cleanliness.
Evidentiary Basis	Document review, observation, interviews

Provision 9.2 Meals and Nutrition	All meals and snacks served to residents at Henley-Young shall, at a minimum, comply with the nutrition guidelines set forth in the United States Department of Agriculture's School Meals Program standards.
Status	**Beginning Compliance**
Discussion	The status of this provision remains as beginning compliance. As stated provision 9.1 and in my introduction, residents continue to complain that they are not receiving enough to eat and that the food is still cold when it arrives on the units. Therefore my statements below still stand. It should be noted that I have not seen any training records or had the opportunity to meet with the nutritionist. The nutritionist should be made available upon my next visit.
Recommendations	1. Develop policy and procedures for this provision(executed) 2. Provide training for kitchen staff and all other staff members involved with handling food and preparing meals.
Evidentiary Basis	Document review, observation, interviews

Provision 9.3 Meals and Nutrition	Residents shall be provided access to drinking water throughout the day.
Status	**Partial Compliance**
Discussion	The facility has been downgraded to partial compliance on this provision. Due to the removal of water coolers on the units specifically the girls units. Because of the fear of staff to engage youths and the lack of supervision along with the increase in youths, this has created a level of reluctance on staff to perform their duties. Therefore, staff has removed the coolers from the units. If the coolers are to be removed, the water fountains on the units must be operable. Based on my discussion with residents, documentation review, observations, and interviews the facility has been providing water during the day. Although the facility had moved to substantial compliance in this provision the recommendations below that the County should repair the water fountains should continue. This would allow the facility to discard the use of water coolers. Therefore my below statements from my previous report (8th) should still be addressed.
Recommendations	1. Contact County or State Environmental office to conduct test on water system. (executed) 2. Ensure residents receive water during school and recreational periods and at night. 3. Develop a policy for incidents regarding water quality and procedures to address them. 4. Repair inoperable drinking fountains.
Evidentiary Basis	Document review, observation, interviews

10. Clothing

Provision 10 Clothing	Henley-Young shall provide basic clothing items for residents at all times. These items must include, at a minimum, socks, underwear, uniform, shoes, and undershirts. For girls, these items must also include a brassiere. When appropriate, Henley-Young shall also provide residents with a coat, hat, and gloves. Residents must be provided with a clean uniform, socks, undershirt, underwear, and brassiere, if applicable, upon intake and at least once per day. No residents shall be deprived of these basic clothing items for any reason, including, but not limited to, as a punishment, because these items are being washed, or due to overcrowding.
Status	**Partial Compliance**

Discussion	The facility has remained in partial compliance on this provision. Based on my recent review and observation, I did find socks and underwear that should be discarded. I did meet with the laundry staff and the operational manager to work on a protocol for discarding tattered and ragged clothing. See attached. Based on my most recent review and observation, the area I reviewed continues to be more organized and functional than before. The laundry staff I interviewed only required minimum technical assistance and were amenable to the recommendations I made regarding organizing certain items by size and are still complying. The facility still needs to develop a system for replacing tattered or damaged clothing on a regular and consistent basis. I will review this area for substantial compliance. I am still recommending the facility to order non colored underwear and undergarments. This would allow the facility to sanitize the under clothing and sheets by using a more potent cleaner.
Recommendation	1. Check washer and dryer to ensure they are working properly. 2. Ensure that girls and boys are equally involved in cleaning and folding clothes. 3. Hire 2 laundry staff to ensure clothing is handled properly. (executed) 4. Ensure that all staff and residents wear protective material (smocks and gloves) when handling chemicals and clothing. 5. Discard clothing that is torn, dingy and in poor condition. 6. Develop a system for replacing clothing on a regular and consistent basis. 7. Develop schedule for distribution. 8. Develop a system for prewashing clothing (i.e. undergarments etc.)
Evidentiary Basis	Document review, observation, interviews, photographs

11. Hygiene and Sanitation

Provision 11.1 Hygiene and Sanitation	Residents 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 residents uses 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 residents. Girls must be provided with panty liners on a daily basis and other feminine products as needed. Residents will be issued a comb and brush upon entering the facility; however, if residents are issued a recycled comb or brush or a comb or brush that has been used by another residents, Henley-Young shall ensure that the comb and brush is sterilized and in good condition.
Status	**Partial Compliance**
Discussion	The facility has remained at partial compliance on this provision. I will again review this area for substantial compliance at my next visit. I would also recommend that a licensed barber and/or beautician be retained. Based on my most recent review and observation, residents were receiving toothbrush, toothpaste and other hygiene products which were provided in individual hygiene kits. Residents still complained about not having combs to groom their hair.
Recommendations	1. Ensure that hygiene kits are properly labeled and **residents are not** sharing each other's hygiene products or items. 2. Ensure items such as hair brushes, if shared, are sterilized and in good condition. 3. Provide training for staff on these policies and procedures. 4. Ensure that clean face towels are available for residents. 5. Develop a schedule for distribution of hygiene kits. 6. Retain a licensed barber and/or beautician.
Evidentiary Basis	Document review, observation, interviews

Provision 11.2 Hygiene and Sanitation	Residents shall be provided with sleeping mats and blankets that are clean and odorless sleeping mats shall be sanitized between uses by residents, and residents shall receive clean blankets weekly.
Status	**Substantial Compliance**
Discussion	The status of this provision has moved to substantial compliance. Based on my review of documents and observation, the facility needs to continue to ensure that mattresses and blankets are discarded properly

	Policies and procedures have been developed. The facility has provided training to ensure that the process outlined in the policies and procedures is followed. The facility needs to continue to monitor the condition of the blankets and mattresses for signs of holes and tattering The facility needs now to follow the recommendations below.
Recommendations	1. Continue to discard all blankets and mattresses that are tattered and have holes in them. 2. Clean and maintain laundry area in orderly fashion. 3. Develop forms or system of documentation for distribution and inventory 4. Label and designate an area for towels, sheets, clothing etc.
Evidentiary Basis	Document review, observation

Provision 11.3 Hygiene and Sanitation	Under no circumstances shall residents be deprived of mats and blankets.
Status	**Substantial Compliance**
Discussion	The facility remains at substantial compliance. I found no indication that residents have been deprived of mats and blankets. The facility administration needs to continue to be vigilant regarding staff adhering to the process outlined in the policy and procedures regarding the issuing and maintenance of mats and blankets.
Recommendations	1. Provide training to staff on policy and procedures. 2. Develop system for inventory and distribution
Evidence	Observation, and document review

Provision 11.4 Hygiene and Sanitation	Henley-Young shall maintain a sufficient number of clean, sanitary mats and blankets that correspond with the facility's maximum capacity.
Status	**Substantial Compliance**
Discussion	The facility remains at substantial compliance, as I found no indication based on my observation and documents review that residents were being denied mattresses and blankets. There were enough blankets and mattresses. As stated in provision 11.3, the facility administration needs to continue to be vigilant regarding staff adhering to the process outlined in the policy and procedures regarding the issuing and maintenance of mats and blankets.

Recommendations	1. Develop policies and procedures for this provision. (executed) 2. Provide training to staff on policy and procedure. 3. Provide an inventory of mats and blankets.
Evidentiary Basis	Observation and document review

Provision 11.5 Hygiene and Sanitation	Residents shall be provided with a clean, sanitary environment.
Status	**Beginning Compliance**
Discussion	The status of this provision remains as beginning compliance. During this visit, I found that the facility continues to need of major physical plant maintenance; showers needed repair, toilets were filthy, mold and mildew in the showers, several showers did not have hot water, soap scum was in all of the showers, the shower heads were leaking, the units smelled of urine and shower stalls were rusting along with adequate lighting being an issue. In addition, there were holes in several of the shower stall walls. See exhibits. Therefore my statements below still stand. Building maintenance is an ongoing and continuous process. **Please review the introduction.**
Recommendations	1. Develop policies and procedures for this provision. (executed) 2. See areas in discussion that should be addressed. 3. Develop housekeeping and cleaning schedule. 4. Develop checklist or inspection report for each unit and area of building. 5. Develop work order system to ensure that when problem arise they are addressed. 6. Develop corrective action plans as needed. 7. Provide training for staff on policy and procedures. 8. Ensure delivered food items are dated and rotated from old to new.
Evidentiary Basis	Document review, observation, interviews

Provision 11.6 Hygiene and Sanitation	Hinds County shall ensure that Henley-Young complies with relevant law regarding fire safety, weather emergencies, sanitation practices, food safety, and the elimination and management of environmental toxins.
Status	**Beginning Compliance**
Discussion	The status of this provision remains as beginning compliance. In my review of documents, I have not seen any updates from my

	previous visits therefore my statement below stands. I am reiterating there be internal monthly checks and maintenance annually and in the event when the fire extinguisher is used it must be replaced or recharged by a certified company. Again, the facility needs to have another full review of the fire and sprinkler system to ensure that all violations were corrected. Again, with the above being said there are no indications that the sprinkler or fire systems are working adequately. However during the facility disturbance were youth flooded the unit, there were no records of the fire marshal reviewing the system to determine its operation and or functionality. As stated before the sprinkler system must comply with national fire protection standards. Again, although the facility has policies or procedures regarding fire safety it begs the question, "Has the facility been evaluated by a Fire Marshall that is licensed and certified by the State of Mississippi?" In addition, the kitchen is in need of a major cleaning and sanitizing.
Recommendations	1. Develop policies and procedures and plans for fire safety, evacuation etc. (executed) 2. Develop adequate staff training regarding fire safety. 3. Properly maintain and repair fire equipment. 4. Ensure intercom systems are operating properly. 5. Ensure all mattresses used by residents are fire resistant. 6. Routinely test all fire equipment and system. 7. Ensure that all electrical outlets, wires and equipment (lights) are properly working. 8. Develop work order system to ensure items are repaired. 9. Ensure that all areas in this provision are addressed by a certified professional. 10. Review entire fire safety program/system 11. Facility needs to develop corrective action plan. 12. Clean and Sanitize kitchen 13. Develop cleaning procedures
Evidentiary Basis	Document review, observation

Provision 11.7 Hygiene and Sanitation	Residents shall be provided with clean drinking glasses and eating utensils.	
Status	**Partial Compliance**	
Discussion	The status of this provision remains as partial compliance. Based on review of documents and interviews with residents, I found no indication that	

	drinking glasses and eating utensils were not cleaned. However, in my review of the kitchen, the kitchen equipment is in need of a major cleaning. Therefore, my statement above stands. The kitchen is in need of major cleaning.
Recommendations	1. Develop policies and procedures for this provision. (executed) 2. Provide a thorough cleaning of the kitchen and all equipment and Utensils
Evidentiary Basis	Document review, observation and interviews

12.Medical Care

Provision 12.1 Medical Care	The parties agree, however, that henceforth, Henley-Young shall provide residents 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. Hinds County is responsible for procuring and/or paying for all medications provided to residents.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance. Based on interviews and observations and document reviews, the County has hired a new medical company at Henley-Young. However, there is still a need for policies, procedures, or protocols in place for the facility. The County has the responsibility to maintain medical care and provide medication and all other needs for residents. On this provision, I am still reiterating that the actions and recommendations from my previous report should be reviewed and followed. The County must look at the medical filing system in place at this point and change it to meet contemporary medical standards. See additional discussion in the sections 1.2 and 1.3. Please see medical report from Dr. Ngozi Ezike, an expert medical physician, with expertise in juvenile detention health services reviewed medical services within Henley-Young Juvenile Detention Facility. Dr. Ezike's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit)	
Recommendations	1. Develop policies, procedures and protocols for this provision. 2. Develop policies and procedures and protocols based on standards for Health Services in Juvenile Detention and Confinement facilities. 3. Provide training for staff members who administer medication to residents on proper usage and possible side effects. Also, train the	

	staff on emergency protocols if side effects occur. 4. Have a licensed medical professional review and sign off on policy, procedures and protocols. 5. Have a licensed health professional periodically review and provide supervision to the nurse at facility. 6. Develop forms to coincide with provision. 7. Remove medication from bags and place them in secure, organized areas and develop forms to determine what medications are present in the facility at all times. 8. Hire or have on contract a physician to review medical area. 9. Ensure that residents receive vision exams, dental screenings, mental health screenings, hearing tests, etc. 10. Order folders with 2 dividers, end tab, classification folders in letter size with 2 prongs for medical charts.
Evidentiary Basis	Document review, observation, interviews

Provision 12.2 Medical Care	Henley-Young shall ensure that a medical professional is available to examine residents confined at the facility to identify and treat medical needs, when necessary.
Status	**Non-Compliance**
Discussion	The status of this provision remains as non-compliance. Based on my review of documents and observation. The facility still needs to develop policies, procedures, and protocols. The facility has hired a new medical company to provide services to Henley-Young. (S**ee the Introduction**.) In addition for this report, Dr. Ngozi Ezike, an expert medical physician, with expertise in juvenile detention health services reviewed medical services within Henley-Young Juvenile Detention Facility. Dr. Ezike's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit)
Recommendations	1. Hire qualified medical professional for nights and weekend care. 2. Develop policies, procedures and protocols for this provision. 3. Provide training for staff on this provision.
Evidentiary Basis	Document review, observation, interviews

Provision 12.3 Medical Care	Henley-Young shall implement its sick call policy and practice which ensures that confined residents who request non-emergency medical attention are examined by a medical professional within 24 hours of a residents placing him or herself on sick call, excepting weekends and holidays.
Status	**Non-Compliance**
Discussion	The status of this provision remains as non-compliance based on my interviews, documents review and observation. Therefore my below statements still stand. Although the facility has 14 hour nursing service daily during the week and four hours on Saturday and Sunday there is still no policy, procedures and protocols as to how sick-calls should be administered to residents. The facility must develop the processes, and practices for this provision. The facility still has the responsibility of maintaining medical care and medication for all of the health needs of the residents. On this provision, I am reiterating that the actions and recommendations from my previous report should be reviewed and followed (**see the Introduction**). In addition for this report, Dr. Ngozi Ezike, an expert medical physician, with expertise in juvenile detention health services reviewed medical services within Henley-Young Juvenile Detention Facility. Dr. Ezike's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Develop policies, procedures and protocols for this provision. 2. Place a kite box on each unit. 3. Provide training for staff on this provision. 4. Nurse or designated person, making daily rounds to retrieve kites (Request for Medical Service Forms).
Evidentiary Basis	Document review, observation, interviews

Provision 12.4 Medical Care	Prescription medications shall only be distributed by licensed medical staff or Henley-Young staff who has been trained by licensed medical personnel.
Status	**Non-Compliance**
Discussion	The status of this provision remains as non-compliance based on my interviews, document review and observation. Therefore my statements below still stand. The facility has two registered nurses who are licensed to distribute

	medications to the residents. The problem is that the facility has no policies, procedures or protocols in place to direct this distribution. The facility still has the responsibility of maintaining medical care and medication for all of the health needs of the residents. On this provision, I am reiterating that the actions and recommendations from my previous report should be reviewed and followed (**see the Introduction**).
Recommendations	1. Develop policies, procedures and protocols to address this provision. 2. These policies, procedures and protocols must include the appointment of a medication administration protocol. 3. There must be a medication record of all medicines administered. a. One record to reflect all medicines leaving the pharmacy; b. An additional record kept in each resident's case file. 4. Ensure that the training is comprehensive make certain that all medical contingencies are considered. 5. The staff should be trained on what side effects to look for drugs commonly prescribed to residents with mental health needs. 6. Provide training to staff on the policy, procedures and protocols for this provision. 7. All training should be documented and conducted annually.
Evidentiary Basis	Document review, observation, interviews

Provision 12.5 Medical Care	Medical and mental health services shall be provided in a manner that ensures the confidentiality of resident's health information.
Status	**Non-Compliance**
Discussion	The status of this provision remains as non-compliance based on my interviews, document review and observation. Therefore my statements below still stand. The facility still has the responsibility of maintaining medical care and medication for all of the health needs of the residents. On this provision, I am reiterating that the actions and recommendations from my previous report should be reviewed and followed (**see the Introduction**). In addition for this report, Dr. Ngozi Ezike an expert medical physician, with expertise in juvenile detention health services reviewed medical services within Henley-Young Juvenile Detention Facility. Dr. Ezike's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Develop policies, procedures and protocols to address this provision. 2. Get HIPAA requirements and institute them the facility. 3. Designate the persons who have access to the resident's medical

	records within the facility and outside of the facility, but within the juvenile justice system. 4. Provide training to staff on policies, procedures and protocols. 5. Provide training to staff on HIPAA requirements, and document training. 6. Designate a HIPPA Privacy Officer.
Evidentiary Basis	Document review, observation, interviews

Provision 12.6 Medical Care	Henley-Young shall develop procedures for monitoring residents who require individualized attention because of medical issues that do not involve requiring the residents to sleep on a mat in the visitation room.
Status	**Beginning Compliance**
Discussion	Based on my review of documents and observations, this provision is being moved to beginning compliance. There has been no consistent youth sleeping in the intake area with the exception of Resident A.M. who was requested by SPLC to be moved because youth was not feeling safe. It should be noted that this youth had serious mental health issues, and because of the increase in the facility's population, this was the only space available to house this youth. The facility still has the responsibility of maintaining medical care and medication for all of the health needs of the residents. On this provision, I am reiterating that the actions and recommendations from my previous report should be reviewed and followed (**see the Introduction**).
Recommendations	1. Develop policies, procedures and protocols to address this provision. 2. Develop processes of continuous monitoring residents with stable medical issues, i.e. the care for diabetic residents who are on an insulin regiment. a. What are the medical requirements of the residents who need monitoring? b. Who is responsible for the monitoring? c. How are the records kept of the monitoring? 3. Provide training to staff on the policies, procedures and protocols for this provision. 4. Annual competency training.
Evidentiary Basis	Document review, observation and interviews

13. Mental Health Care

Provision 13.1 Mental Health Care	Henley-Young's contractor, Hinds Behavioral Health Services, shall provide adequate mental health services to all confined residents 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 residents or the resident'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.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance. Based on my review of documents and observation, services are still not in place and are still not being provided. The only changes to this provision, is the residents' names have changed. I am reiterating that the actions and recommendations from my previous report should be reviewed and followed. It is without question that there are residents entering this facility that need access to structured mental health services (i.e. resident J.N.–several suicide attempts, resident L.M. (suicidal behavior), resident M.C. (attempted suicide), Resident S.T. (attempted suicide), Resident L.G. (attempted suicide), Resident A.M. (attempted suicide), Resident K.M. (self-injury), and Resident Q.H. (attempting to self-harm). See provision 1.2. There are still inadequate mental health services at this facility. Generally accepted professional standards require that mental health counseling be provided frequently and consistently enough to provide meaningful intervention for residents. Although residents may be seen by Hinds Behavioral Health Services, there is no documentation that indicates the needs of the residents or any planned strategies for the residents once they return to the facility. The Henley-Young mental health counseling is inadequate to the needs of mentally ill residents in both frequency and content. My review of records reveals no evidence of any counseling or use of any treatment plans or strategies. It should be noted that treatment planning, including identifying symptoms and behaviors is a critical part of effective treatment for residents with mental health illness or problems. An effective program should communicate treatment plans for mentally ill residents to all staff involved in the management of the residents in this detention facility and services should be coordinated prior to their implementation. Although some residents who are in need of mental health services are in the 89-day program and are assigned case managers, these individuals have no mental health training and they serve primarily as liaisons between the facility and the courts rather than focusing on coordinating care at the facility for mentally ill residents. In addition for this report, Dr. Lisa Boesky, an expert mental health	

	consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Ensure that the facility has a Standardized Assessment Tool i.e. the MAYSI-2 to use during the intake process. 2. Develop policies and procedures to address this provision. 3. Provide training to staff on policies and procedures and provide documentation of training. 4. Develop documentation that will track resident's progress during their stay at facility. 5. Ensure there is communication between Hines Behavioral Health Services, Juvenile Court Case Managers and Facility Staff on residents receiving mental health services. 6. Hire case management staff.
Evidentiary Basis	Document review, observation, interviews

Provision 13.2 Mental Health Care	Residents 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. Such evaluations may be performed by and through employees of Hinds Behavioral Health.
Status	**Non-Compliance**
Discussion	The status of this provision remains as non-compliance. Based on my review of documents and observation, services are still not in place and are still not being provided for this provision. I am reiterating that the actions and recommendations from my previous report should be reviewed and followed. **Please review the Introduction.** In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Develop policies and procedures to address this provision. 2. Provide training to staff on policies and procedures. 3. Hire case management staff.
Evidentiary Basis	Document review, observation, interviews

Provision 13.3 Mental Health Care	Within 72 hours of a resident's admission to the facility, staff shall develop individual mental health treatment plans for residents who are under the care of a mental health provider. Treatment plans shall emphasize continuity of care and shall ensure that whenever possible, residents are transported to appointments with their regular mental health provider, whether the appointments are standing or made after the resident's initial detention.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance. Based on my review of documents and observation, services are still not in place and are still not being provided for this provision. I am reiterating that the actions and recommendations from my previous report should be reviewed and followed. **Please review the Introduction**. In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).	
Recommendations	1. Develop policies and procedures to address this provision. 2. Provide training to staff on policies and procedures. 3. Policies and procedures shall be reviewed and signed by a licensed mental health professional (psychiatrist, etc.). 4. Hire case management staff.	
Evidentiary Basis	Document review, observation, interviews	

Provision 13.4 Mental Health Care	Henley-Young shall develop and implement policies and procedures for referring residents in need of psychiatric services to a licensed psychiatrist for a timely mental health evaluation. Such services may be provided by and through employees of Hinds Behavioral Health.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance. Based on my review of documents and observation, services are still not in place and are still not being provided for this provision. I am reiterating that the actions and recommendations from my previous report should be reviewed and followed. **Please review the Introduction**. In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this	

	official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Develop policies and procedures to address this provision. 2. Provide and document training to staff on policies and procedures. 3. Hire case management staff. 4. Policies and procedures shall be reviewed and signed by a licensed mental health professional (psychiatrist, etc.).
Evidentiary Basis	Document review, observation, interviews

Provision 13.5 Mental Health Care	Hinds County shall employ or contract for sufficient psychiatric services to permit a psychiatrist to fulfill the following functions: a. conduct needed psychiatric evaluations prior to placing residents on psychotropic medications; b. Monitor, as appropriate, the efficacy and side effects of psychotropic medications; c. Participate in treatment team meetings for residents under the psychiatrist's care; d. Provide individual counseling and psychotherapy when needed; e. Evaluate and treat in a timely manner all residents referred as possibly being in need of psychiatric services; and f. Provide adequate documentation of treatment. g. All evaluations and services outlined above may be performed and/or provided by and through employees of Hinds Behavioral Health or any other duly qualified Mental Health agency.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance. Based on my review of documents and observation, services are still not in place and are still not being provided for this provision. I am reiterating that the actions and recommendations from my previous report should be reviewed and followed. **Please review the Introduction**. In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).	
Recommendations	1. Develop policies and procedures to address this provision. 2. Provide training to staff on policy and procedures and document training. 3. Hire case management staff. 4. Policies and procedures shall be reviewed and signed by a licensed	

	mental health professional (psychiatrist, etc.).
Evidentiary Basis	Document review, observation

Provision 13.6 Mental Health Care	The psychiatrist and/or counselors shall review, if necessary, incident reports, disciplinary reports, suicide watch logs, and lockdown logs of residents under their care to determine whether their treatment is working and, if not, how it should be modified.	
Status	**Non-Compliance**	
Discussion	The status of this provision remains as non-compliance. Based on my review of documents and observation, services are still not in place and are still not being provided for this provision. I am reiterating that the actions and recommendations from my previous report should be reviewed and followed. **Please review the Introduction**.	
Recommendations	1. The mental health of the residents in the custody of the facility needs to be closely monitored at all times. 2. The facility needs to develop policies and procedures to address this provision. 3. Provide and document training to staff on policies and procedures and document training. 4. Facility needs documentation from a mental health organization on plan of action for residents receiving a mental health services. 5. Hire case management staff. 6. Policies and procedures shall be reviewed and signed by a licensed mental health professional (psychiatrist, etc.).	
Evidentiary Basis	Document review, observation	

14. Suicide Prevention

Provision 14.1 Suicide Prevention	Henley-Young 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 residents for whom the "suicide cell" is deemed necessary in conjunction with this suicide prevention policy.	
Status	**Beginning Compliance**	
Discussion	The status of this provision remains as beginning compliance. The facility has developed policy and procedures for this provision. Now the facility must develop training programs to ensure that staff learn and adhere to the policy and procedures. Further, staff must become familiar with the process. Once the facility hires a new mental health provider, they must ensure that	

	the suicide prevention policy is included in the overall mental health program. **Please review the Introduction**. In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Develop policies and procedures to address this provision. (executed) 2. Provide and document training for staff on policy and procedure. 3. Facility needs to ensure that the suicide prevention policy is included in the overall mental health program. 4. Policies and procedures shall be reviewed and signed by a licensed mental health professional (psychiatrist, etc.).
Evidentiary Basis	Document review, observation

Provision 14.2 Suicide Prevention	Any residents 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 resident on the highest level of suicide watch is not evaluated by a mental health professional within 24 hours, the residents shall immediately be transported to a local mental health facility or emergency room for evaluation and/or treatment.	
Status	**Beginning Compliance**	
Discussion	The status of this provision remains as beginning compliance. The facility has developed policy and procedures for this provision. Now, there must be training programs developed to ensure that staff members adhere to the policy and procedures and that they are familiar with the process. Once the facility hires a new mental health provider, they must ensure that the suicide prevention policy is included in the overall mental health program. **Please review the Introduction.** In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibits)	
Recommendations	1. Develop policies and procedures to address this provision. (Executed) 2. The facility needs mental health professionals to help and enhance the development of these policies and procedures as they are the	

	authorities in this area. 3. Provide training for staff on policies and procedures and document training. 4. Identify a mental health agency to help develop policies, procedures and protocols. 5. Facility needs to ensure that the suicide prevention policy is included in the overall mental health program. 6. Policies and procedures shall be reviewed and signed by a licensed mental health professional (psychiatrist, etc.).
Evidentiary Basis	Document review, observation

Provision 14.3 Suicide Prevention	Residents on suicide watch shall participate in recreation, school, and any other structured programming. Residents shall not be required to wear a "suicide gown" unless locked in a cell. Staff shall closely monitor residents on suicide watch, which includes logging activities every 15 minutes.	
Status	**Beginning Compliance**	
Discussion	The status of this provision remains as beginning compliance. A training program still needs to be developed to ensure that staff members adhere to the policy and procedures and that they are familiar with the process. Once the facility hires a new mental health provider, they must ensure that the suicide prevention policy is included in the overall mental health program. **Please review the Introduction.** In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibits)	
Recommendations	1. Develop policies and procedures to address this provision with the assistance of a mental professional. (executed) 2. Provide and document training for staff on policies and procedures. 3. Facility needs to ensure that the suicide prevention policy is included in the overall mental health program. 4. The facility needs mental health professionals to help and enhance the development of these policies and procedures as they are the authorities in this area. 5. Policies and procedures shall be reviewed and signed by a licensed mental health professional (psychiatrist, etc.).	
Evidentiary Basis	Document review, observation	

Provision 14.4 Suicide Prevention	When a resident is placed on any level of suicide watch, a report shall be made within 24 hours to the resident's court, as well as to the resident's guardian, and his or her defense attorney.	
Status	**Beginning Compliance**	
Discussion	The status of this provision remains as beginning compliance. A training program still needs to be developed to ensure that staff members adhere to the policy and procedures and that they are familiar with the process. Once the facility hires a new mental health provider, they must ensure that the suicide prevention policy is included in the overall mental health program. P**lease review the Introduction.** In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibits)	
Recommendations	1. Develop policies and procedures for making and distributing the reports in this provision. (executed) 2. Provide training for staff on policies and procedures and document training. 3. Facility needs to ensure that the suicide prevention policy is included in the overall mental health program 4. The facility needs mental health professionals to help and enhance the development of these policies and procedures as they are the authorities in this area. 5. Policies and procedures shall be reviewed and signed by a licensed mental health professional (psychiatrist, etc.).	
Evidentiary Basis	Document review, observation	

15. Family Support and Interaction

Provision 15.1 Family Support and Interaction	Visitation shall not be restricted or withheld from residents unless the detention center director determines that a visit will violate the security of Henley-Young or will endanger the safety of residents, visitors, or staff. Visitation should not be restricted as a form of punishment.	
Status	**Substantial Compliance**	
Discussion	The status of this provision remains at substantial compliance. During this visit I found that visitation was still being conducted in the multi-purpose room. As stated in my previous report, the facility must ensure that there is proper staffing available to provide for the visitation process to maintain reliability in it**. Please review the staffing section of the Introduction.**	

Recommendations	1. Provide and document training for staff on policies and procedures. (executed) 2. Provide and document training for staff on policies and procedures. 3. Ensure that there is proper staffing availability to maintain reliability.
Evidentiary Basis	Document review, observation and interviews

Provision 15.2 Family Support and Interaction	Within 90 days of the effective date of this Settlement Agreement, Henley-Young shall provide accommodations that allow residents to have contact visits with their families.	
Status	**Substantial Compliance**	
Discussion	The facility remains at substantial compliance. Based on my most recent visit. I found that the facility continues to allow contact visits. The facility should continue to ensure that proper staffing is available to make certain that this continues. The visitation program should be incorporated into the overall facility program that will help with providing a better structure. **Please review the Introduction**.	
Recommendations	1. Develop policies and procedures to address this provision. (executed) 2. Identify area where contact visitation will take place. 3. Provide and document training for staff on policies and procedures. 4. Ensure that there is proper staffing availability to maintain reliability. 5. Ensure that visitation program is included in the overall facility program.	
Evidentiary Basis	Document review, observation and interviews	

Provision 15.3 Family Support and Interaction	Visitation shall be regularly scheduled at least three times per week, which shall include evening and/or weekend visitation times in order to encourage family visitation. Henley-Young shall permit the minor siblings of confined residents to participate in visitation, as long as the minors' parent or guardian is present during the visit and the siblings are not harmful to the residents who are detained at Henley-Young. Henley-Young shall also permit a confined resident's own child (ren) to participate in visitation	
Status	**Substantial Compliance**	
Discussion	The facility remains at substantial compliance on this provision. The facility must continue to follow the recommendations below.	
Recommendations	1. Develop policies and procedures and practices to address this provision. (executed)	

	2. Provide and document training for staff on policies and procedures. 3. Ensure that there is proper staffing availability to maintain reliability. 4. Ensure that visitation program is included in the overall facility program.
Evidentiary Basis	Document review, observation and interviews

Provision 15.4 Family Support and Interaction	Residents may receive phone calls from their attorneys. At the discretion of the Director or assignee, in emergency situations, residents may receive phone calls from parents, primary caretakers, or legal guardians. Emergency phone calls and phone calls from attorneys should not be restricted as a form of punishment.	
Status	**Partial Compliance**	
Discussion	The facility remains at partial compliance on this provision based on my most recent visit and document review. However, there is still no indication that residents are allowed to mail letters as part of access to supportive relationships that residents have with families and others in the community. This (mail) is a major part of the rehabilitative process. Staff now needs to be trained on policies and procedures and the facility should ensure that policy and procedures are being followed. During this visit and review of documents, I found no indication that youth receive any contact from their attorneys until they enter court. Because there is no case management, youth are left to wonder about their case or its status. This provision has not been moved to substantial compliance because the residents still do not have full access to their legal team. I found no evidence that the residents have visits from their lawyers within the facility as established by best practices and professional standards within juvenile detention facilities: 1) Privileged mail from court, attorney, 2) Visits from lawyers, paralegals or any legal support staff, 3) Provide a private place for confidential discussions, and 4) Have policies, procedures and protocols incorporated in resident's right to counsel.	
Recommendations	1. Develop policies and procedures and practices to address this provision. (Executed) 2. Provide and document training for staff on policies and procedures. 3. Ensure that there is proper staffing availability to maintain reliability. 4. Ensure that residents are allowed to mail letters.(County will pay for postage) 5. Hire case managers 6. Develop form for attorney to signed indicating their visits, for placement into youth files	

Evidentiary Basis	Document review, observation and interviews

16. Miscellaneous Provisions

Provision 16.1 Miscellaneous Provisions	Male and female residents shall be provided with equal access to educational and rehabilitative services, medical care, and indoor and outdoor recreation.	
Status	**Beginning Compliance**	
Discussion	The status of this provision remains as beginning compliance. During my most recent visit, the basketball courts have been resurfaced and repaired. In addition, according to the female residents I interviewed, they rarely participate in outside activities and, when they do, it consists mostly of sitting on the bleachers because the male residents were using the basketball court and they are not allowed on the court while the males were outside using it. However, there were still no schedules posted or documents showing equal programming for male and female residents. In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).	
Recommendations	1. Develop policies and procedures and practices for this provision. (Executed) 2. Cease in the designation of female residents as being solely responsible for laundry; this is a duty male residents can perform as well as females. (executed) 3. Develop monthly recreational schedules. 4. Develop comprehensive facility schedules. 5. Provide training for staff on policies and procedures and document training. 6. Ensure that there is proper staffing availability to maintain reliability. 7. Repair court and goal area. 8. Posting of schedule on units.	
Evidentiary Basis	Document review, observation, interviews	

Provision 16.2 Miscellaneous Provisions	The parties agree, however, that henceforth: All residents shall have the opportunity to engage in at least one hour of large muscle exercise a day.	
Status	**Non-Compliance**	

Discussion	The status of this provision remains as non-compliance. Based on my most recent review of documents, interviews with the residents and observation, residents are still not consistently engaging in 1 hour of large muscle exercise daily. As stated previously, residents are placed in their rooms when there is not enough staff available. In addition, on the weekends, residents are still only allowed out when there is enough staff available. There still is no schedule of recreational or program activities, and when residents were allowed out, it was random with no schedule being followed. This should be rectified once the new staff are hired and trained. There must be a schedule in place and adhered to which will ensure that residents are receiving the required time out of their units and rooms and that structured activities are available, unless a resident has been placed on behavior management or isolation. However, even residents who are placed in a behavior management program must be allowed the required time out of the unit and room for recreational and large muscle exercise. (See resident A.M) In addition, because there was an attempted escape, all youth were held inside for several days. In a situation like this, the youth who were the offenders are the ones who should be monitored closely.
Recommendations	1. Develop policies and procedures and implement practices to address the needs of this provision. 2. Develop and implement programming and recreational schedules. 3. Provide and document training for staff on policies and procedures. 4. Ensure that there is proper staffing availability so that residents are not unnecessarily "locked" in their cells.
Evidentiary Basis	Document review, observation, interviews

Provision 16.3 Miscellaneous Provisions	Henley-Young shall implement a policy which prohibits staff from insulting residents or calling them names, and using profanity in the presence of residents	
Status	**Beginning Compliance**	
Discussion	The status of this provision remains as beginning compliance. Based on my review of the videos, staff needs to refrain from threatening and intimating behavior. Training should be implemented based on the training facilitated by Gerald Gay and Felton Satterfield, consultants from the National Partnership of Juvenile Services Detention and Corrections. The training was a" train the trainer" to be implemented throughout the facility. Their report was submitted prior to this report that would give the facility an understanding of the various training techniques as it relates to juvenile detention care. (see exhibits)	
Recommendations	1. Develop policies and procedures and practices to address the needs of this provision. (Executed) 2. Provide training to staff in the proper de-escalation techniques of	

	residents. 3. Administration must provide enough supervision to reduce or eliminate insulting behavior by staff. 4. Discipline and retrain staff as needed. 5. Provide training for staff on policies and procedures and document training. 6. Hire an independent person to investigate allegations of abuse or complaints regarding staff by residents. (Executed)
Evidentiary Basis	Document review, observation and interviews

Provision 16.4 Miscellaneous Provisions	Henley-Young shall implement an adequate grievance policy that is accessible to all residents regardless of literacy levels, and that provides residents with the opportunity to appeal facility level determinations. Residents shall obtain the grievance forms from the school liaison.	
Status	**Partial Compliance**	
*Discussion	This provision has moved to partial compliance. I reviewed grievance from June-October 2015. I also reviewed data collection from this period. The facility does have a grievance process in place and working at times. Some youth still are not aware of the system and some lack confidence in it. However, some feel it is okay. At this point, the QA department has done a good job in collecting data and responding to youth grievances. However, there is still a need for grievance boxes on each unit. In addition, there needs to be ongoing training for staff since there are new employees being hired. Also, new youth entering the facility should be oriented on the grievance system. The facility should ensure that all youth are adequately familiar with the grievance process. The data collection system should also track grievances to determine who, what, and where the administration will place its efforts for corrective action purposes. The facility should now continue to evolve this process so it becomes consistent throughout the facility. Please see previous report (#8). The facility must now make certain that staff is trained properly and that residents are made fully aware of the grievance process. There must now also be consistency in the system to move to substantial compliance.	
Recommendations	1. Place grievance boxes on each unit and school, residents should not be required to request a grievance form. 2. Provide training for staff on policies and procedures and document training. 3. Provide training for residents on policies and procedures and document training.	

	4. Ensure that residents are adequately familiarized with the grievance process during their orientation into the facility 5. Add a place on the Resident's Grievance Resolution Report for a resident to request an appeal and place for the Director's resolution. 6. Ensure Resident's Grievance Resolution Reports are provided to the resident for their signature and their response to the outcome. If the resident disagrees with the resolution the resident has the right to appeal the decision to the director. 7. Any retractions of grievances should be done by residents and not by staff.
Evidentiary Basis	Document review, observation, interviews

Provision 16.5 Miscellaneous Provisions	Hinds County denies that Henley-Young does not currently have an adequate policy whereby residents can request to see their attorney and/or Residents Court counselor. The parties agree, however, that henceforth: Henley-Young shall develop and implement an adequate policy that allows residents of all ages and literacy levels with the opportunity to request to see their attorney and/or Residents Court counselor. Residents shall obtain the form requesting a visit from his/her counselor from the school liaison. Henley-Young agrees to 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.	
Status	**Beginning Compliance**	
Discussion	The status of this provision remains as beginning compliance. Based on my interviews with residents, there is still no indication they had the opportunity to meet with their public defender prior to or after their court hearings. I did meet with the public defender along with the County counsel and the director of the facility to discuss options to implement a procedure for contacts. In addition because the facility has no case management, it has become very difficult for residents to be updated on their case or the ability to discuss their case. As recommending in other provisions and in my introduction, I am reiterating again that case managers are needed to ensure that residents are not falling through the cracks. Again, based on my most recent visit and review of documents, residents	

	are still complaining that they have not had the opportunity to speak with their attorneys. Also, in my review of the records, there was no indication that attorneys had been visiting. However, court counselors were seen during visit, present in the facility and seeing the residents. However, the counselor's presence does not represent my discussion with youth that they don't see their counselors and don't know what is happening with them or their case. Additionally, I found no forms for requesting visits from counselors, attorneys or school liaisons. And I found no training on 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. Even though the facility has developed a policy and procedures for this provision, it has to ensure there is consistency and follow through not just a document developed. In addition for this report, Dr. Lisa Boesky, an expert mental health consultant, reviewed the mental health services within Henley-Young Juvenile Detention Facility. Dr. Boesky's report was submitted prior to this official report to give the facility an opportunity to begin implementation of her recommendations (see exhibit).
Recommendations	1. Develop policies and procedures and practices for this provision. 2. Provide and document training for staff on policies and procedures. 3. Develop single form and system for incident reporting. 4. Develop system for receiving and mailing privileged and non-privileged mail for residents. 5. Hire case management staff. 6. Policies and procedures shall be reviewed and signed by a licensed mental health professional (psychiatrist, etc.).
Evidentiary Basis	Observation, interviews and Document reviews

Conclusion

This is my ninth official visit to the Henley-Young Juvenile Justice Facility. The facility continues to make gradual improvements and should continue moving in a positive direction. Since my last report I have had several technical assistance visits. However, there are still other provisions that have made no movement such as the physical plant and which is again deteriorating and must be addressed by the county. The new administration has been in place for six months and appears to be developing an understanding of the facility and its needs. Also, having staff in the kitchen and laundry room area has shown improvement .With the increase in population the facility needs to reevaluate the youth to staff ratio and hire the additional staff needed to address this issue. Because education, mental health and medical care continue to be of major concern due to the lack of policies, procedures and protocols, it is incumbent upon the county to assist the facilty with the resources needed.

During September and October, four experts in juvenile justice produced evaluations and recommendations to the Hinds County Juvenile Justice Facility. These experts reviewed the education, medical, mental health, training and culture of the facility. Their reports have been attached. These reports have been submitted as expert opinions of the needs of the facility.

The County should continue to support the new administration and provide them with the staff and equipment needed to meet the provisions of this consent decree. As I have stated above, for the facility to be successful all entities must work together and support this facility.

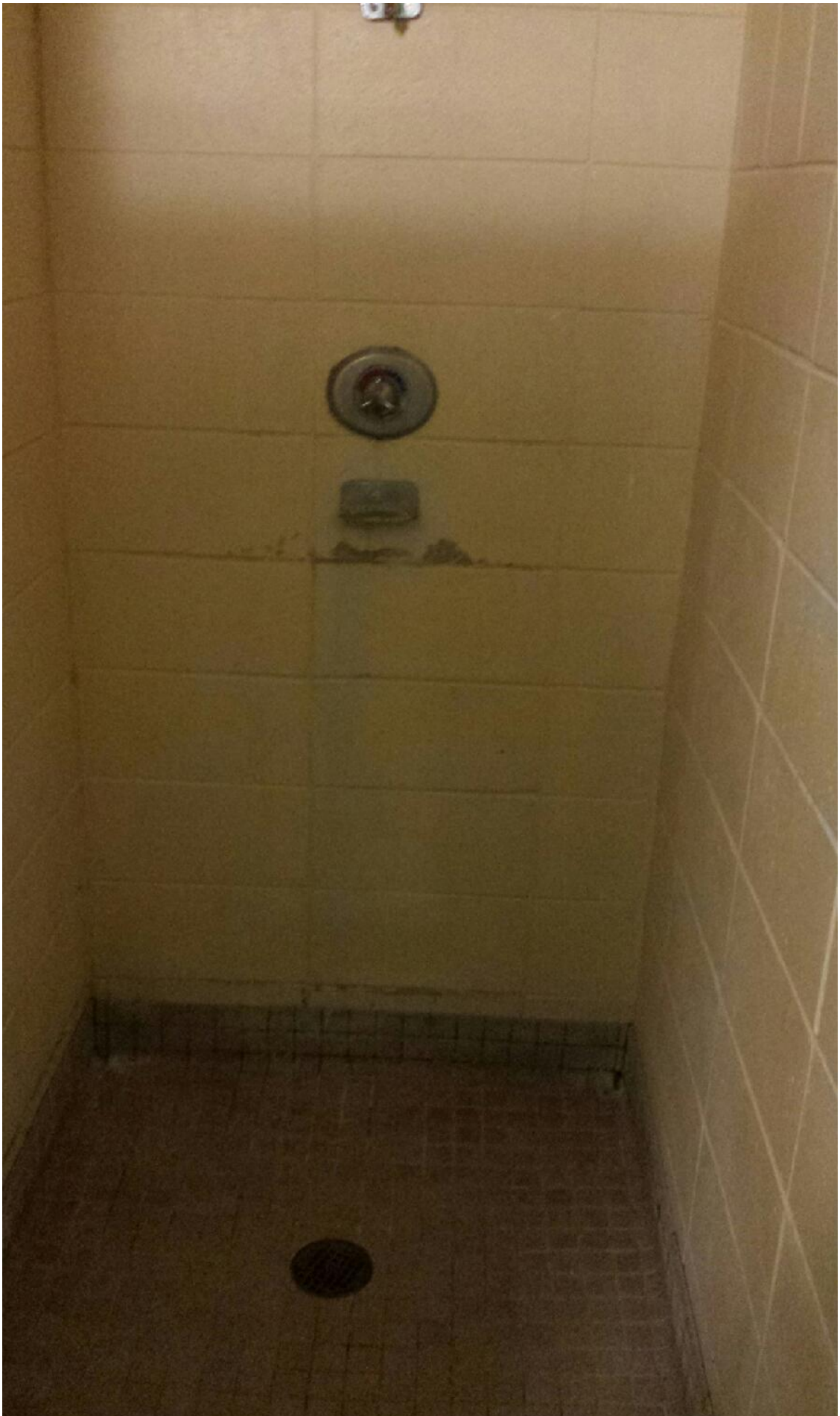
I appreciate the work of Dr. Linda Boesky, Dr. Ngozi Ezike Carol Cramer Brooks and Gerald Gray and Felton Satterfield for their assistance through the insightful observations and reports. I would also like to thank the Hinds County Board, the County's Attorneys Anthony Simon and Pieter Teeuwissen, County Administrator Carmen Davis, facility staff and the facility Director Johnnie McDaniels for their assistance and cooperation.

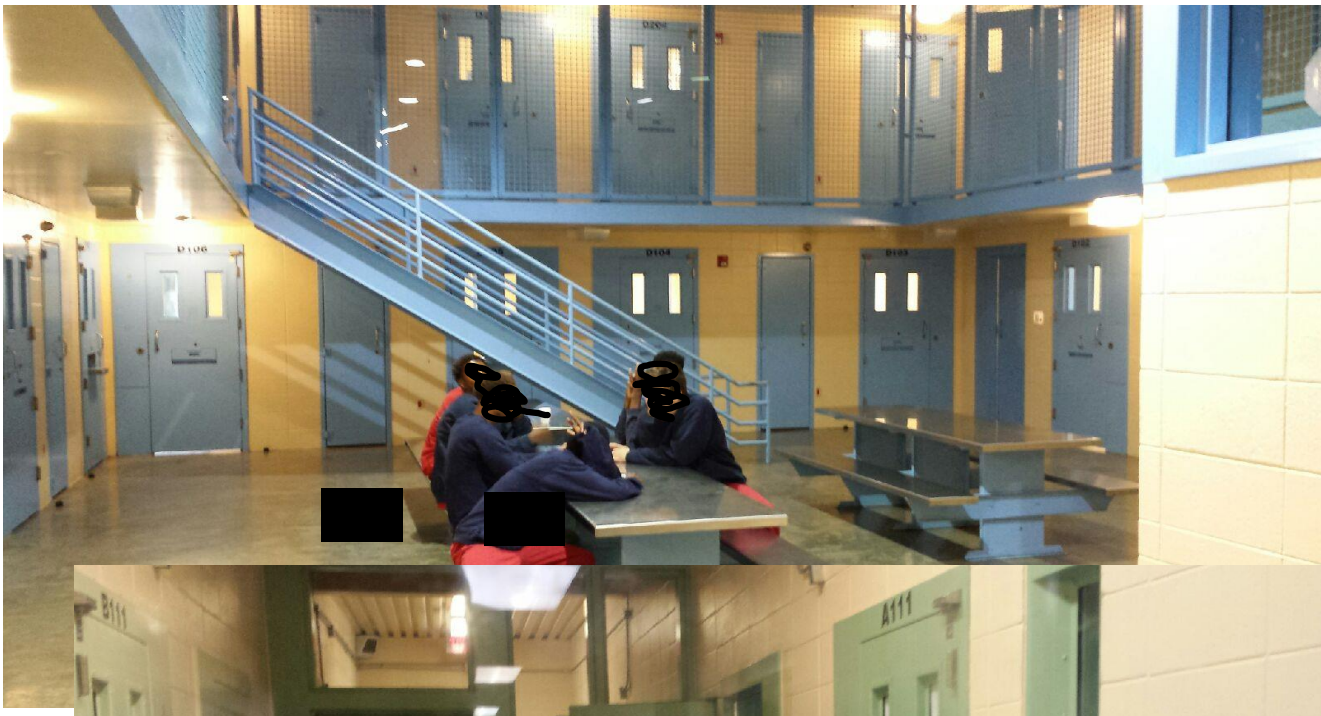
LEONARD DIXON

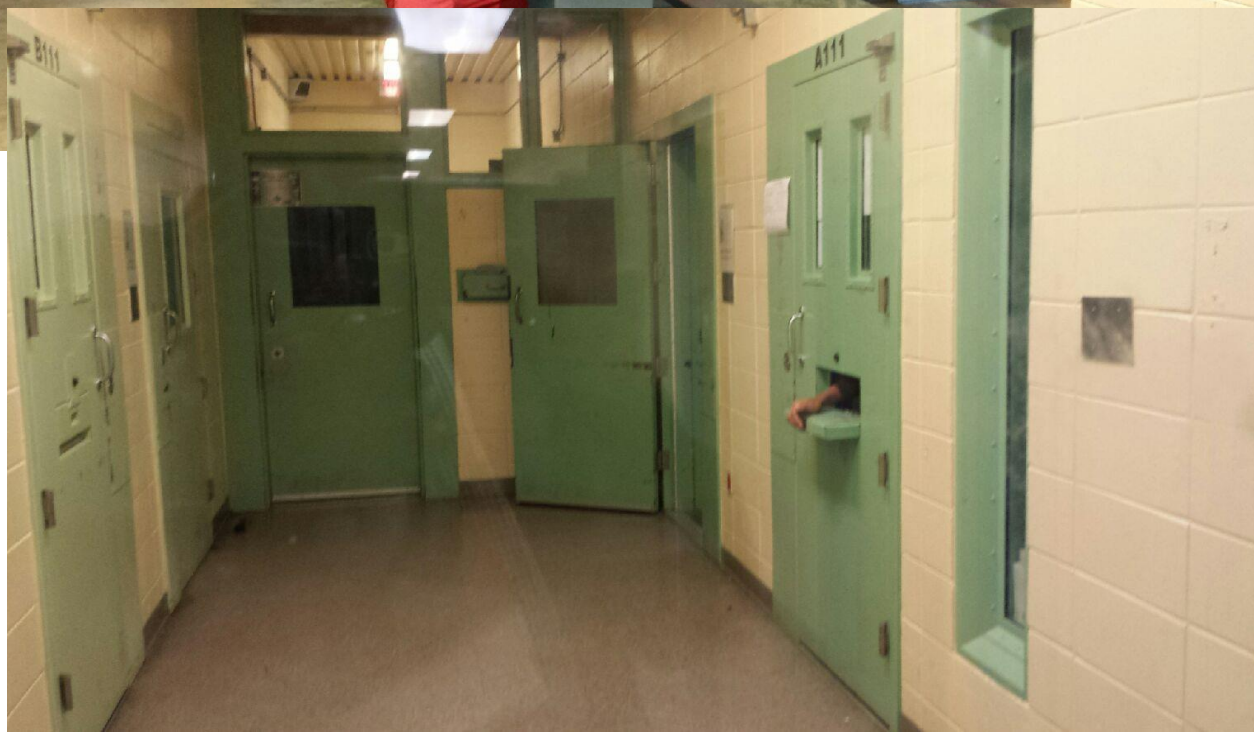
Attachments;

Dr.Boesky, mental health report
Brooks, education report
Dr. Ezike's, medical report
Gray and Satterfield, training and programming report

Exhibits 1-6



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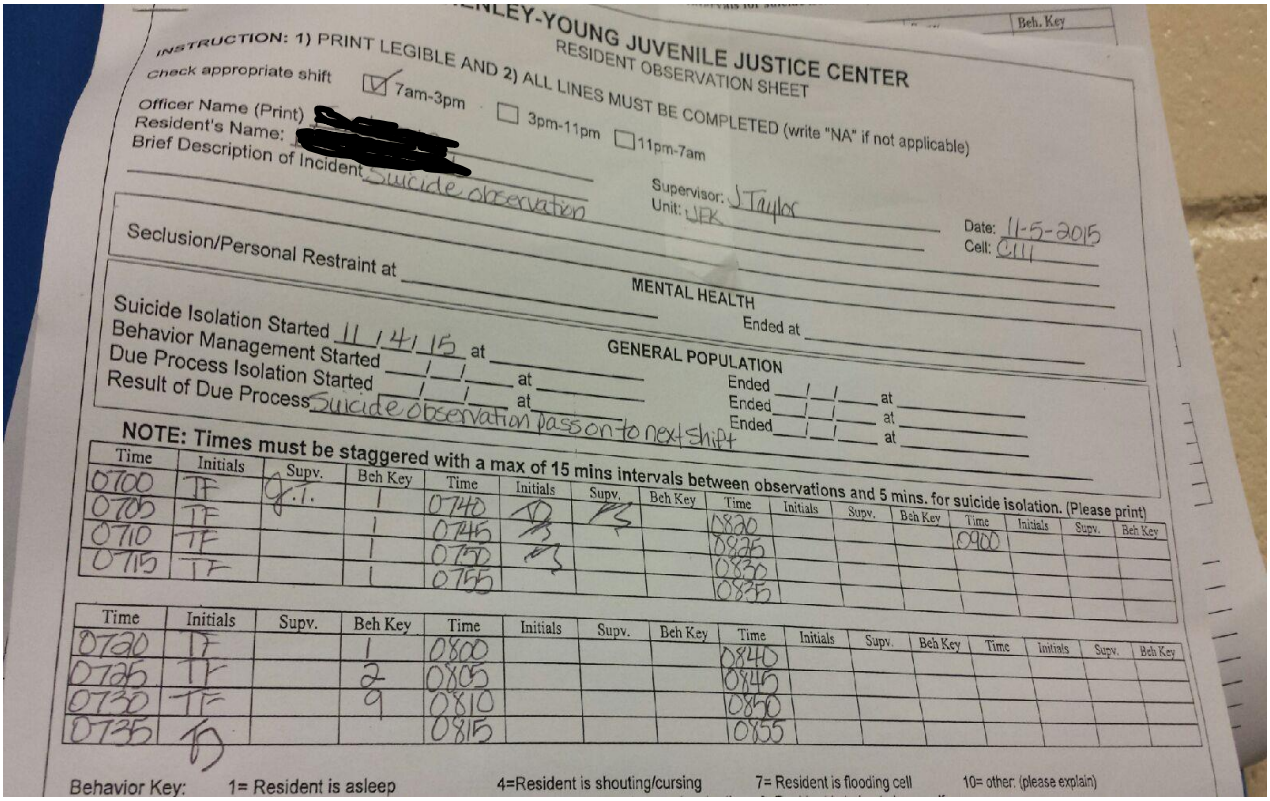


HENLEY-YOUNG JUVENILE JUSTICE CENTER
RESIDENT OBSERVATION SHEET

INSTRUCTION: 1) PRINT LEGIBLE AND 2) ALL LINES MUST BE COMPLETED (write "NA" if not applicable)

Check appropriate shift: ☑ 7am-3pm ☐ 3pm-11pm ☐ 11pm-7am

Officer Name (Print): [redacted] Supervisor: J Taylor Date: 11-5-2015

Resident's Name: [redacted] Unit: JFK Cell: C11

Brief Description of Incident: Suicide observation

Seclusion/Personal Restraint at _____ MENTAL HEALTH Ended at _____

Suicide Isolation Started 11/4/15 at _____ GENERAL POPULATION Ended __/__/__ at _____

Behavior Management Started __/__/__ at _____ Ended __/__/__ at _____

Due Process Isolation Started __/__/__ at _____ Ended __/__/__ at _____

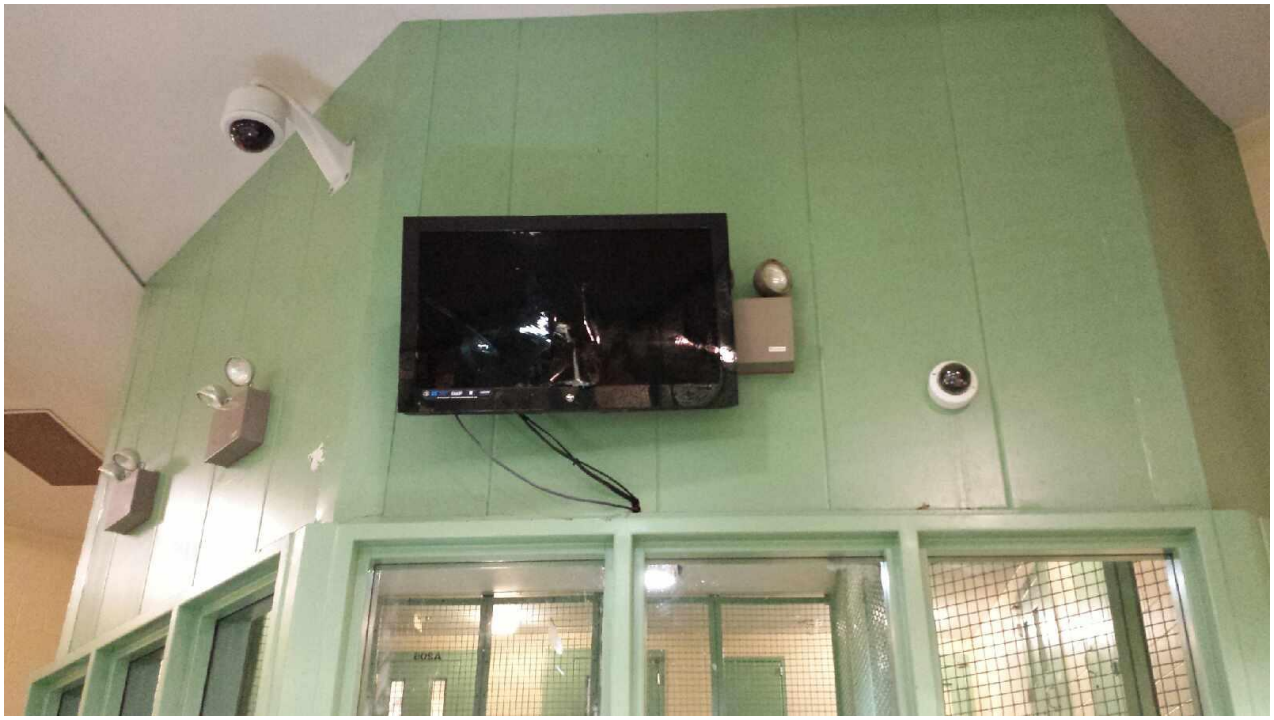
Result of Due Process: Suicide observation pass on to next shift Ended __/__/__ at _____

NOTE: Times must be staggered with a max of 15 mins intervals between observations and 5 mins. for suicide isolation. (Please print)

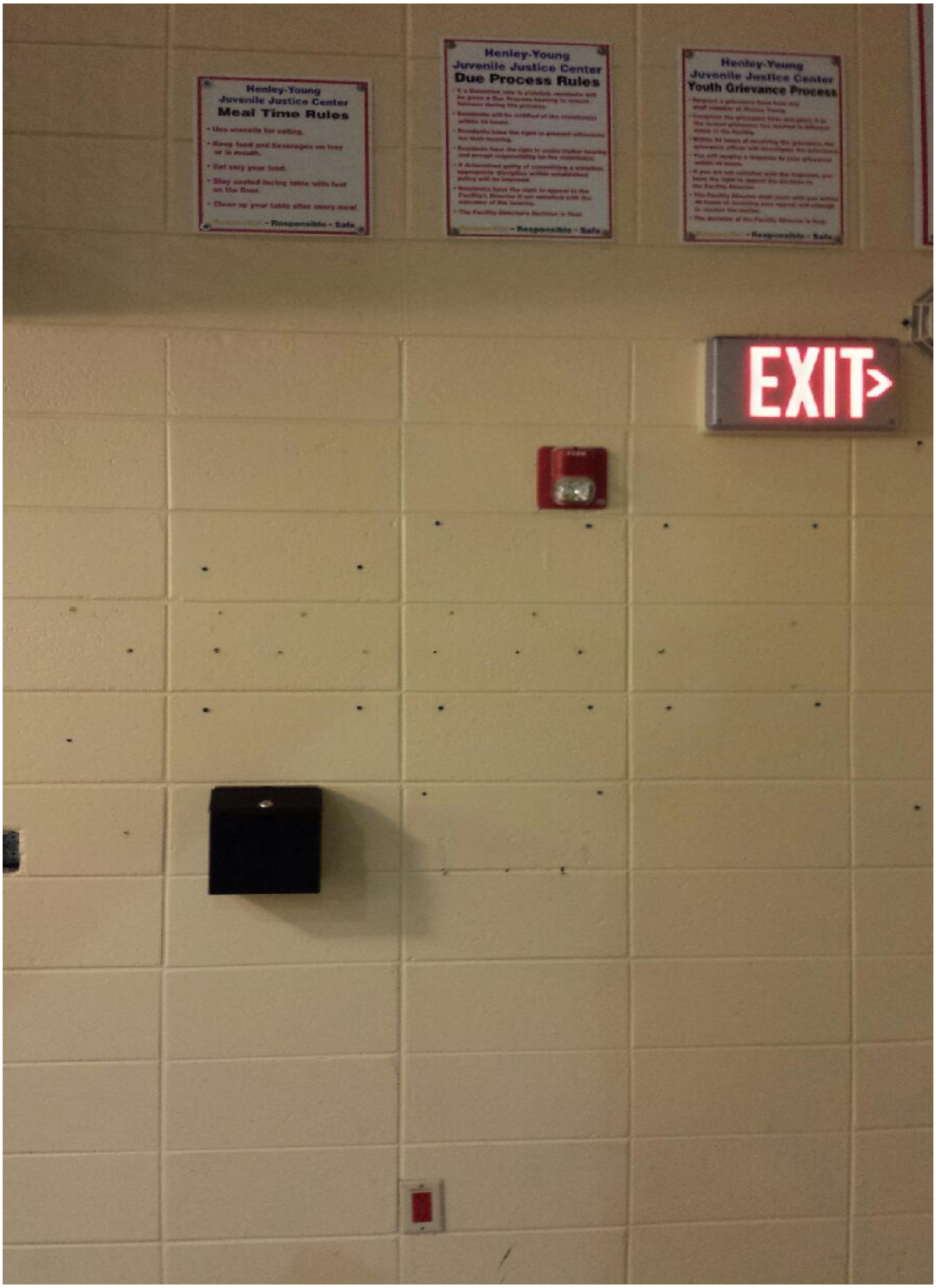
Time	Initials	Supv.	Beh Key	Time	Initials	Supv.	Beh Key	Time	Initials	Supv.	Beh Key	Time	Initials	Supv.	Beh Key
0700	TF	J.T.	1	0740	TF	[illegible]		0820				0900			
0705	TF		1	0745	TF	[illegible]		0825							
0710	TF		1	0750	TF	[illegible]		0830							
0715	TF		1	0755				0835							

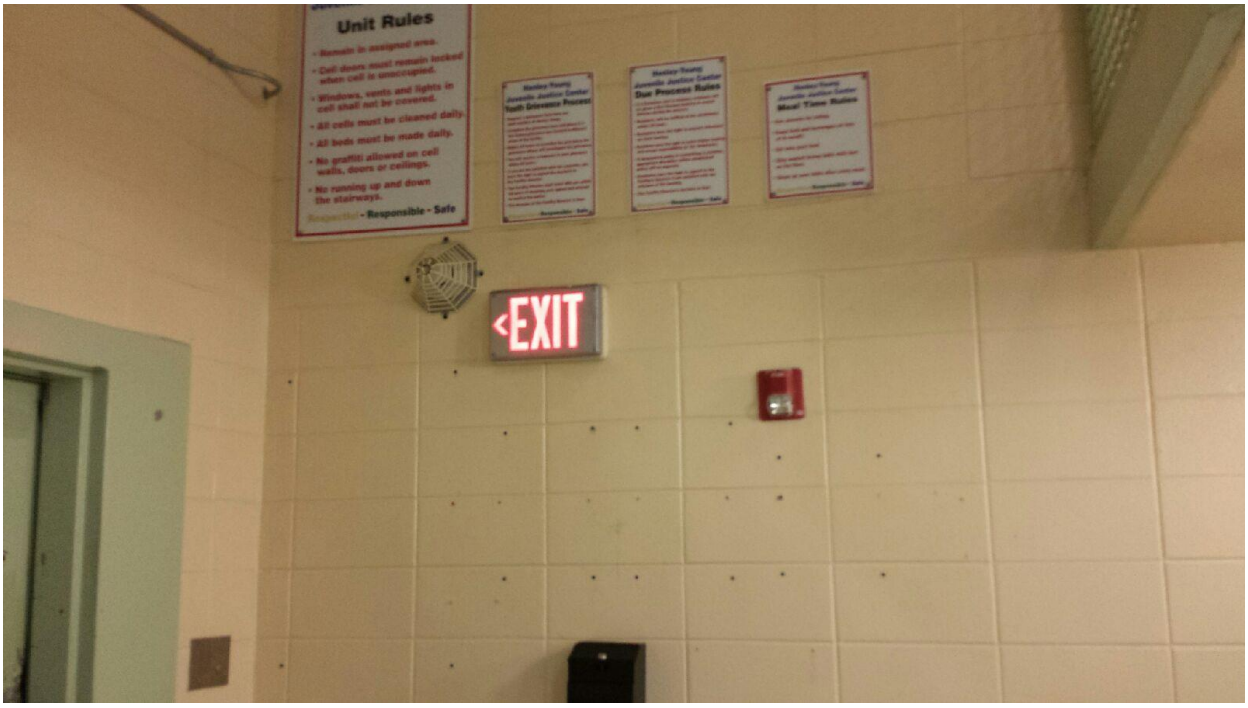
Time	Initials	Supv.	Beh Key	Time	Initials	Supv.	Beh Key	Time	Initials	Supv.	Beh Key	Time	Initials	Supv.	Beh Key
0720	TF		1	0800				0840							
0725	TF		2	0805				0845							
0730	TF		9	0810				0850							
0735	TF			0815				0855							

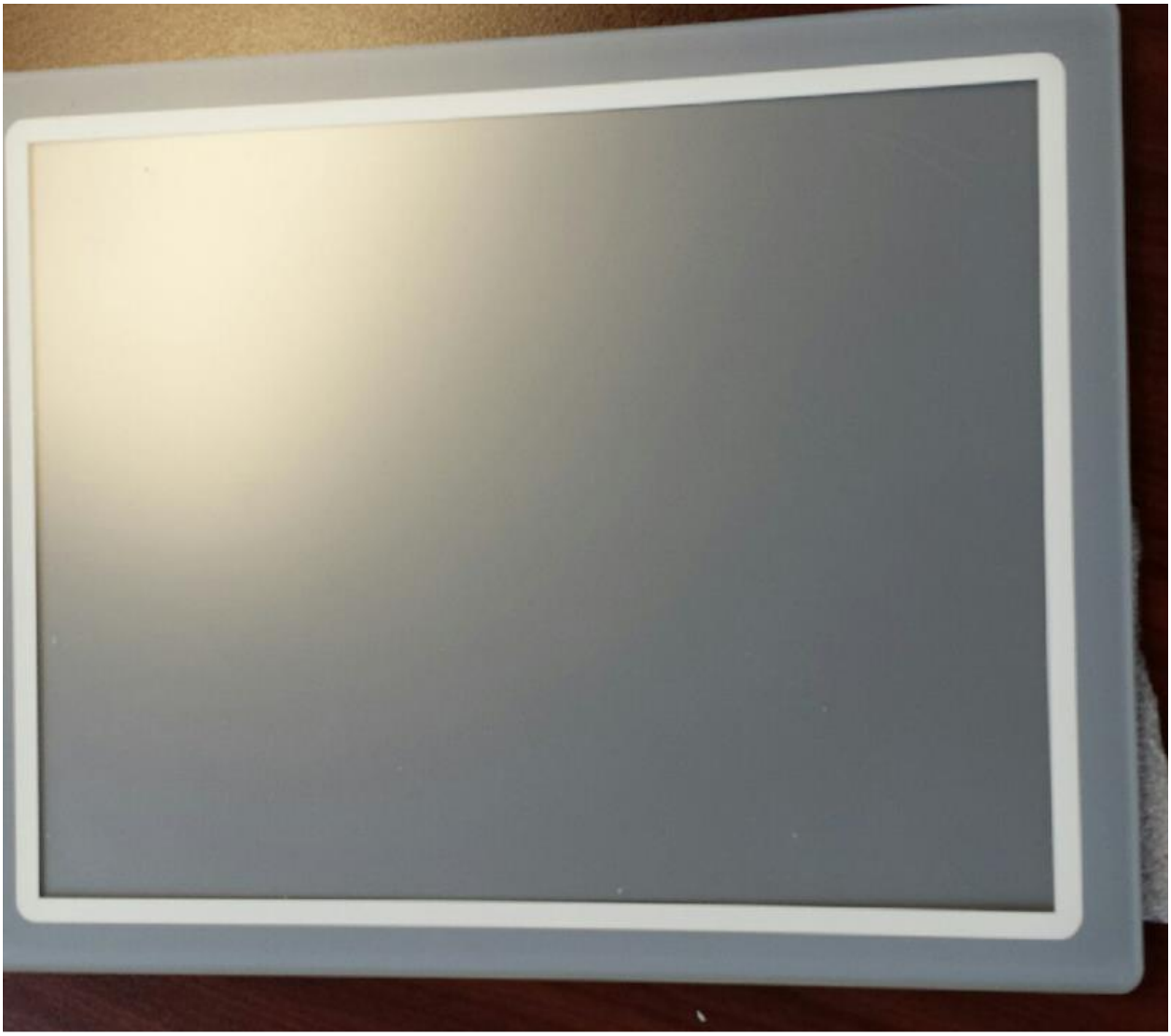
Behavior Key: 1= Resident is asleep 4=Resident is shouting/cursing 7= Resident is flooding cell 10= other: (please explain)




A104


Henley-Young
Juvenile Justice Center
Meal Time Rules
Henley-Young
Juvenile Justice Center
Due Process Rules
Henley-Young
Juvenile Justice Center
Youth Grievance Process
EXIT


Unit Rules
EXIT



4Attachments

NPJS Detention and Corrections Careworker Training Curricula

Learning Leadership and Performance

Facilitated by
Gerald Gay and Felton Satterfield

Consultant's Report for the Henley-Young Juvenile Facility Staff Training September 13-17, 2015

To
Federal Monitor Leonard Dixon

Date of Report

October 18, 2015

Gerald Gay and Felton Satterfield

Learning Leadership and Performance Consultants

Date of Report October 18, 2015

Dear Mr. Dixon

The report that follows describes the training we delivered for sixteen Henley-Young Juvenile Facility staff the week of September 13-17, 2015, and provides our impressions and recommendations to ensure that the Center is able to best apply the training content in continuing to improve the quality of care for staff and the youth in their custody.

In order to give staff the most updated information, we chose the NPJS Detention and Corrections Careworker Training Curricula. These curricula were built on current national standards and best practices in our industry. In order to give the curricula credibility, experts in their fields, including adolescent brain research, suicide prevention, and mental health, incorporated content through a series of videos fashioned in the style of TED-Talks, known as NPJSpeaks. The idea was to bring the experts right into the training sessions.

We selected the modules based on specific requests from the Center and an effort to bring Henley-Young and its staff in compliance with the requirements of the Federal Monitor's request. At the end of this report, we have listed the learning objectives for each module and show the correlation between the provisions set forth by the Monitor and the information taught. Anywhere there was a connection between the two, that particular provision was added underneath that module.

BASED ON INTERACTIONS WITH STAFF, TOUR OF THE FACILITY AND DISCUSSIONS WITH VARIOUS ADMINISTRATORS WE RECOMMEND THE FOLLOWING KEY AREAS OF FOCUS TO THE ADMINISTRATION AT THE HENLEY- YOUNG JUVENILE FACILITY

Communication – As the administration moves forward with building a detention facility that rises to national best practice level, it is imperative to have open communication between staff and the new administration. The administration is under pressure from the federal monitor to come into compliance in many areas. As the administration moves forward with their plans to it is important to communicate their vision to staff, give them an opportunity to provide feedback and provide the staff clarity regarding their role in moving the detention facility forward.
Staff support and buy-in are of the upmost importance to creating a healthy professional environment.

Accountability It has been statistically demonstrated that youth thrive best in structured caring and consistent environments. In environments where individual employee agendas are allowed to take precedence over

agency need, consistency wanes and chaos ensues. The period of transition for the Henley Jackson facility is ripe for strengthening a new core group of committed and trained supervisors dedicated to moving the new agency mission forward.

Consistency – A natural by-product of more effective supervision is greater consistency throughout the facility. Adherence to facility expectations, programming, procedures and practices is essential from staff to staff and shift to shift. All staff should have the same message and be on the same page more often than not. The idea is to prevent youth from taking advantage of inconsistency and lack of teamwork.

Age Appropriate Units – To whatever degree is physically possible youth must be placed in groups of similar ages and maturity. This enables age appropriate programming while decreasing possibilities of negative influence from older, more experienced, youth

Recommendations for Programming – Possible sources are facility staff, volunteers or interns.

- Remedial education (e.g. math, English, preparation for GED). Tutor might come from local universities and colleges where student receive credit for teaching hours
- Use of local celebrities (sports, musicians, artists, public officials)
- Job interviewing skills
- Life skills programs (e.g., banking, cooking, etc. for all age groups)
- Age appropriate movies
- Small libraries on each of the units with age appropriate reading materials

Qualified Mental Health Professional (QMHP) - Ensure there is a qualified professional available to support staff. According to the National Commission on Correctional Health Care (NCCHC) Qualified Mental Health Professionals (QMHP) are psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who, by virtue of their education, credentials, and experience, are permitted by law to evaluate and care for the mental health needs of patients.

Create a viable training function: Training is not an event designed to solve a problem. It is a process designed to provide learning opportunities and skills enhancement which, with proper supervision, should transfer to on the job performance. This type of learning and performance model will not occur naturally. It must be intentionally created. The National Partnership for Juvenile Services can assist with this goal.

Creation and Use of an Appropriate Point and Level System

- Using staff, youth and a Behavior Management System expert to create a system specific to the Henley Young Detention facility is essential to effectively managing the youth population. Inclusion is the key. Youth won't adhere to a program if they are not motivated by the incentives and staff will resist a program that is too complicated.
- Staff should be taught to recognize and appropriately respond to negative as well as positive behavior of the youth. Negative behaviors can unintentionally be reinforced, just as positive behaviors will be extinguished if not properly reinforced.
- Privileges should be earned by youth. Nothing beyond their basic needs is free. Lengthy and ongoing discussion is required to create an appropriate list of privileges and rewards.
- Research has shown this client population to lack efficient connection between their thinking and emotional brain. Impulsivity is the norm. Staff should be taught to provide limited opportunities to warn youth before levying fines or punishment. The system should afford youth the ability to earn points back if lost due to negative behavior (exceptions being critical incidents involving assaults, escapes, etc.). *Y*outh should feel that they can earn their way back from a mistake and still make their level.

Physical Building – While there isn't much that can be done to change the actual structure of the building, every effort should be made to create an atmosphere that encourages positive interaction and creative thought.

Some examples include: Using soft colors throughout the building (not just yellow). Designate a wall for each unit to paint - painted by the youth under the supervision of staff or volunteers from an arts institute. Staff should reach out to local paint stores and ask them to donate the paint – use your tax exempt status as a write off for those businesses willing to participate (if possible).

Mr. Dixon, hopefully the connection between the modules delivered in this session and the requirement set forth in the Henley-Young Juvenile Facility report has been successfully fulfilled. It is our hope that the staff at Henley-Young is successful in meeting the needs of a very difficult population of youth. If we can be of any assistance going forward please don't hesitate to contact the National Partnership for Juvenile Services.

TRAINING MODULES DELIVERED WITH CORRELATIONS TO PROVISIONS

1. Understanding Adolescent Development Through Current Brain Research

Learning Objectives:

Based on knowledge gained about adolescent development and recent research in adolescent brain development, learners will

- Apply information about adolescent brain development to typical behaviors exhibited by youth in restricted settings.
- Demonstrate knowledge of physical, social, sexual and cognitive domains of adolescent development through participation in small group activities/exercises.
- Identify appropriate staff behavior responses that provide positive developmental guidance in a restricted setting.
- Analyze case studies to determine developmental issues, facility issues and staff interaction issues that impact decision-making.
- Develop staff interaction strategies that mitigate the effects of trauma in the facility environment.
- Create an individual action plan, grounded in the developmental assets, that includes five behaviors staff can use to help youth become more developmentally competent.

2. Behavior Management: Shaping Youth Success Through Coaching, Modeling And Teaching

Learning Objectives:
In this session you will:

- Use the A-B-C model to explain the process of manipulating the antecedents and consequences to influence youth behavior.
- Use criteria provided in class to evaluate a daily schedule of activities for values/behaviors – both learned and unlearned.
- Based on information presented in class, list programmatic strategies for increasing appropriate behavior, decreasing inappropriate behavior and teaching pro-social skills.
- Use guidelines for effective rule writing to write a sample rule(s) for an assigned topic.
- Based on a role-play situation of a potential explosive behavior, create

the appropriate staff response to diffuse the situation.

Provisions Addressed:

3.2 Cell Confinement, 6.1 Disciplinary Practices and Procedures, 6.2 Disciplinary Practices and Procedures, 16.1, 16.2, 16.3

3. Building Healthy Relationships With Youth

Learning Objectives

In this workshop, you will be able to:

- Identify the purpose and importance of each of the multiple roles youth care workers need to have with youth
- Practice active listening and other appropriate communication skills staff need in order to be an effective role model for youth
- Identify the skills youth need to develop to engage in healthy peer-to-peer relationships
- Identify the challenges staff face in promoting and encouraging supportive relationships with and among youth
- Develop a personal plan for building healthy relationships with youth

Provisions Addressed:

3.2 Cell Confinement, 4.1 Structured Programming, 5.5 Individualized Treatment Plans Treatment Program for Post-Disposition Youth, 6.1 Disciplinary Practices and Procedures, 6.2 Disciplinary Practices and Procedures, 8.1 Use of Force, 10.1 Clothing, 11.1 Hygiene and Sanitation, 15.1 Visitation, 15.2, 15.3, 15.4, 16.1, 16.2, 16.3

4. Youth With Mental Health Disorders: What You Need To Know

Learning Objectives

In this workshop, you will:

- Better understand youth in custody with mental health disorders and identify effective strategies to use when working with them
- Describe the essential elements of a Juvenile Corrections Approach, a Treatment Oriented Approach and a Trauma-Responsive Approach as they relate to the effective care of youth in custody.
- Identify potential ways staffs' mental health can be impacted by working in a juvenile justice facility and some potential ways to minimize the effect of this on their personal and professional lives.

Provisions Addressed:

3.3 Cell Confinement, 4.1 Structured Programming, *5.2* Individualized Treatment Plans Treatment Program for Post-Disposition Youth, 5.3 Individualized Treatment Plans Treatment Program for Post-Disposition Youth, 5.5 Individualized Treatment Plans Treatment Program for Post-Disposition Youth, 6.1 Disciplinary Practices and Procedures, 6.2 Disciplinary Practices and Procedures, 7.1 Use of Restraints, 7.7 Use of Restraints, 8.1 Use of Force, 10.1 Clothing, 11.1 Hygiene and Sanitation, 12.2 Medical Care, 12.4 Medical Care, 12.5 Medical Care, 12.6 Medical Care, 13.1 Mental Health Care, 13.2, Mental Health Care, 13.3 Mental Health Care, 13.4 Mental Health Care, 13.5 Mental Health Care, 13.6 Mental Health Care, 16.1, 16.2, 16.3

5. Conflict Resolution

Learning Objectives

In this workshop, you will,

- Understand that conflict is an opportunity for positive change, increased communication, and improved interpersonal relationships.
- Using the knowledge of the P-I-N Triangle and through class discussion and activities, distinguish between positions, interests, and underlying needs in a conflict.
- Using the information in the training manual and class discussion, apply the information of conflict modes to determine advantages and disadvantages of each mode and present the findings to the class.
- In a role play, resolve a conflict using the guidelines covered in class on dealing with emotions and using effective communication skills.

6. Juvenile Rights

Learning Objectives

After completing this workshop, participants will:

- Using class materials and group discussion, review the laws and policies that affect a juvenile's rights.
- Using class materials and group discussion, apply the Balancing Test from Turner v. Safely to a scenario created by your participant group.
- Using class materials and group discussion, identify the key elements of a grievance procedure and compare different grievance procedures to each other.
- Through class materials and group discussion, analyze the different ways juveniles can access the community.

Provisions Addressed:

2.1 Staffing and Overcrowding**,** 3.2 Cell Confinement, 3.3 Cell Confinement, 7.7 Use of Restraints, 10.1 Clothing

7. Using Positive Youth Development Strategies With Youth

Learning Objectives

In this workshop, you will:

- Identify benefits to youth care workers of taking a Positive Youth Development approach
- Practice shifting your focus from youth deficits to their strengths to encourage growth and change
- Identify ways to use Positive Youth Development strategies on the job
- Develop program/activities for youth on your shift/unit with your team
- Identify ways to give youth positive opportunities for challenge and growth without risking safety and security

Provisions Addressed:

2.1 Staffing and Overcrowding, 3.1 Cell Confinement, 4.1 Structured Programming, 5.5 Individualized Treatment Plans Treatment Program for Post-Disposition Youth, 6.2 Disciplinary Practices and Procedures, 11.1 Hygiene and Sanitation, 15.1 Visitation, 15.2, 15.3, 15.4, 16.1, 16.2, 16.3

8. Suicide Prevention Among Youth In Custody: What You Need To Know

Learning Objectives

After completing this training, participants will be able to:

- Describe why youth in custody are at risk for suicide and better identify those who may be at the “highest” risk. Identify ways to more effectively implement their facility’s current suicide prevention program (i.e., prevention, intervention, post intervention) based on national standards and best practices.
- Describe suicide screening and assessment, why both are important, and the essential role direct care staff play in both.
- List suicide hazards specific to their facility and potential ways to mitigate them.
- Describe the role of the Quality Mental Health Professional (QMHP)

with regard to suicide prevention and how direct care staff can effectively assist him/her/them.
- List specific ways the behavior of the direct care staff and their relationships with youth can positively or negatively impact suicidal youth.

Provisions Addressed:

1.2 Intake, 3.1 Cell Confinement, 3.3 Cell Confinement, Cell Confinement, 3.5 Cell Confinement, 5.5 Individualized Treatment Plans Treatment Program for Post-Disposition Youth, 6.2 Disciplinary Practices and Procedures, 7.4 Use of Restraints, 8.1 Use of Force, 10.1 Clothing, 11.1 Hygiene and Sanitation, 12.2 Medical Care, 12.4 Medical Care, 12.5 Medical Care, 12.6 Medical Care, 1 Mental Health Care, 13.2, Mental Health Care, 13.3 Mental Health Care, 13.4 Mental Health Care, 13.5 Mental Health Care, 13.6 Mental Health Care, 14.1 Suicide Prevention, 14.2 Suicide Prevention, 14.3 Suicide Prevention, 14.4 Suicide Prevention, 16.1, 16.2, 16.3

9. Safety, Security And Supervision

Learning Objectives

During this workshop, participants will:

- Discuss your facility's application of the three goals of security.
- Using a class generated list and discussion in your groups, decide which admission steps affect safety and security.
- Review the guidelines of a good emergency plan and become aware of its impact on safety & security.
- *Using class discussion, analyze the different types of searches and the S.T.O.P.S guideline for effective searches.*
- Using discussion and the policy, trainees will learn proper resident transportation procedures

Provisions Addressed:

1.6 Intake, 3.1 Cell Confinement, 3.2 Cell Confinement, 3.3 Cell Confinement, 3.5 Cell Confinement. 4.1 Structured Programming
5.5 Individualized Treatment Plans Treatment Program for Post-Disposition Youth, 6.2 Disciplinary Practices and Procedures, 7.1 Use of Restraints, 7.4 Use of Restraints, 7.7 Use of Restraints, 8.1 Use of Force, 10.1 Clothing, 11.1 Hygiene and Sanitation, 12.2 Medical Care, 12.5 Medical Care, 12.6 Medical Care, 16.1, 16.2, 16.3

Henley-Young Juvenile Detention Center
Education Program Review

Conducted by
Carol Cramer Brooks
on September 15-17, 2015

Report submitted
November 16, 2015

Introduction

This report is submitted following an on-site review of the education program at the Henley-Young Juvenile Justice Center (HYJJC). The education program is operated by the Jackson Public Schools (JPS) under the leadership of Dr. Calvin Lockett.

I conducted this review at the request of Mr. Leonard Dixon, federal compliance monitor, Case 3:11-cv-00327-DPJ-FKB on September 15-17, 2015. Since this is my first communication with this court, I am including my credentials in the form of a resume in Attachment A. To summarize, I have more than thirty years experience working in juvenile detention education and juvenile justice at the local, state and national government levels. These unique experiences of education and juvenile justice have allowed me to provide consultation, feedback and evaluative comments regarding education programs in confinement settings across the country.

Attachment B reflects a series of e-mails between JPS legal counsel Joanne Nelson Shepard and myself that took place on September 14; the notes from the phone call from Dr. C. Lockett on September 14; and agenda for the September 15-17 site visit.

In addition to my years of experience and work with practitioners and experts in the juvenile detention education field, my review was guided by three sources:
Farmer, Randy and Carol Cramer Brooks. 2014. *"Education."* In *Desktop Guide to Quality Practice for Working with Youth in Confinement.* National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. http://www.desktopguide.info/?q=node/19.

Domenici, David (2012). Designing and Implementing Quality Education Programs in Confinement Settings. Bulletin for the National Center for Youth in Custody webinar series on Improving Conditions of Confinement in Facilities.

Practitioner-Policy Rubric Secure Care Youth Detention/Correctional Setting. (2015 WORKING DRAFT). Center for Educational Excellence in Alternative Settings.

School Review

It should be noted that time and again throughout the review it became clear that what is written as policy is not implemented as practice and what is written as policy is good practice for a public school, but not considered best practice in detention education programs. For each topic area I reviewed, I considered a continuum that reflected practice and policy as it was Unlikely to Support Student Achievement/Engagement on one end of the continuum to Indicative of a High Performing School, likely to Support Student Achievement/Engagement on the other. This reflects the measurement tool used by David Domenici Director of the Center for Educational Excellence in Alternative Settings (CEEAS). In each review area, I identify the ends of the continuum first.

I. Leadership

1. Continuum: Site based Leadership of education program is not in place or is largely ineffective to A high performing school has a full-time administrator and/or lead teacher with full authority over all aspects of the school program components.

Observation:

A. Principal

Dr. Calvin Lockett is the current principal (Executive Director) of the school program at the HYJJC. Based on my review of past compliance reports, Dr. Lockett is the fourth principal for the school program in the last three years. His responsibilities as leader of the detention education program appear to be only a portion of his responsibilities for the JPS. He does not have a designated office space in the school area and spends limited amount of time at the program.

B. Lead Teacher

Ms. Brandie Finley was recently (August 2015) named Lead Teacher in addition to her responsibilities as the only Exceptional Education teacher. As Lead Teacher her responsibilities are limited to providing assistance and consultation to her co-teachers regarding classroom instruction and student learning.

Findings:

1. The constant change in leadership in the school program has had a negative impact on the ability of the school program to make progress on the recommendations in the compliance reports or toward best practice in general. As a result, each compliance report, dating back to the 2nd report, simply repeats the same list of requirements with no progress being made. Constantly changing leadership means that administration and staff is always having to adjust to a new leadership style and philosophy and never getting to address the issues at hand, i.e. the compliance requirements or the issues that are keeping the school program from excelling.
2. The Lead Teacher's limited scope along with her responsibilities as the only Exceptional Education teacher will not allow her to assist in addressing the issues outlined in the compliance reports.

Recommendations:

JPS should assign a full-time administrator to the facility or rewrite the responsibilities of the Lead Teacher to include more administrative functions. If the second option were chosen, a second EES teacher would need to be added to the staff so as not to compromise the level of EES services provided to eligible youth. An on-site administrator could immediately address teaching and learning strategies, behavior management concerns, build team with the juvenile justice staff and continue to move the program toward continuous improvement and best practice.

II. Staffing

Continuum:
1. Agency has little to no capacity to influence quality of teachers/staff in its educational programs to Agency has articulated strategy to recruit, support and retrain high quality teachers/staff who believe fully that all students can succeed and deserve the highest quality of education; agency/education provider has strong teacher performance/evaluation tools.

2. Agency is not aware of funding sources, and has little to no control over the amount of funding it receives/allocates to education to clear, delineated per-pupil based source of education funding that is appropriate for student population, is in line with state-wide funding formula

Comments:
Determining appropriate staffing levels for an education program in a detention program is complex. It cannot be based on a daily count, as is often the case in the public school system, because the daily count fluctuates every day sometimes every hour. Nationwide some facilities base the staffing level on the average daily population (ADP), while others base staffing levels on the rated capacity of the building. Basing staffing on the rated capacity of the building provides the most accurate number of general education staff needed to also implement best practice strategies. EES and other support staff are typically not included in this formula. Best practice indicates general education classroom sizes of a 1:10 teacher/student ratio (Farmer, Randy and Carol Cramer Brooks. 2014. *"Education."* In *Desktop Guide to Quality Practice for Working with Youth in Confinement.* National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. http://www.desktopguide.info/?q=node/19.

Observation:
The difficulty in determining appropriate staffing levels for the education program at the HYJJC is that the rated capacity of eighty-four is not reflective of the current reform efforts to reduce the population. Using the above formula would require 8.5 general education teachers at the HYJJC to meet industry standards. However, through the efforts of the courts and the compliance monitor, the population at the facility has been reduced to thirty-two via a court agreement, indicating a need for 3.5 general education teachers using the same formula. Both days that I was on-site, the population was thirty-three and thirty-four with an indication that there is not total will and capacity to maintaining the reduced population.

The other staffing issue I reviewed is the current credentialing of staff, relating this to the needs of youth in a detention education program. The JPS education staff at the HYJJC has the following teaching credentials:
Dr. Lela S. Bolls: Ele Edu (K-3), English (7-12), Nursery – Grade 1, Reading (K-12) – all valid through 6/30/16

Gale Stapleton: Social Studies (7-12), valid through 6/30/22

Swasti Safaya: General Sciences (7-12), valid through 6/20/20

Lee Bennett: Business Education (7-12), Mathematics (7-12), Economics (7-12), all valid through 6/30/17

Brandie Finley: English (7-12), Music Education vocal (K-12), Reading (K-12), Mild/Mod Disabilities (K-12), all valid through 6/30/18

It is quite an achievement on the part of the JPS that they are able to staff the education program with teachers who are all teaching in their credentialed areas. This is difficult to accomplish in small detention education programs. Having valid credentials is part of the equation for successful detention educators. The other part is having teachers with the temperament, attitude, and characteristics required to develop relationships with "relationship resistant" students. Based on classroom observations documented later in the report, this is the part of the success equation some of the teachers struggle with.
‘

Additionally the staff consists of Ms. Jones who completes assessments, Ms. Scott, the school secretary and Mr. Coleman and Mr. Sutter, both coordinators focusing on transition services. Mr. Coleman was the former principal until it was determined that he didn't have the proper administrative credentials to continue in that role. Credentials were not provided for Mr. Sutter or Mr. Coleman. Other than providing transition services, it is unclear what role each plays in the school program.

Findings:
Per interview with facility administration, they have no participation in recruiting, hiring or training teachers for the education program at the detention facility. They also are not aware of the funding structure or of the per pupil revenue that JPS receives for youth in the detention education program.

Recommendations:

1. In the absence of an on-site school administrator, redefine the role of the Lead Teacher to include administrative functions and a focus on program development to address the issues raised by the compliance monitor.
2. Hire a second Exceptional Education Services (EES) teacher to be able to better address the needs of the EES students in the program, i.e. provide a broader continuum of EES services including inclusion in the general education classrooms with consultation services and/or team teaching.
3. Once the population of the HYJJC is stabilized and a possible new "rated capacity" is determined, conduct a staffing analysis to determine the number and appropriate role of education staff needed to provide general education services and support services.
4. Given the needs of the population of youth at the HYJJC and the skill-set of the teachers – currently have two teachers certified in reading, consider focusing a major part of the curriculum on reading/literacy, determine need for two transition coordinators or reassign duties.

5. Include representative from the HYJJC administration on the interview team when making hiring decision for the school program.

III. School Program

A. Policy Review

Continuum:

1. Policy does not exist or reflects the policy of a public school program to policy recognizes the nature of short term detention education program including adaptations to programming, curriculum, transition, inclusion in the juvenile justice program, etc.

Findings:

A policy exists on education in the Henley-Young Juvenile Detention Center Policy Manual/Operational Guide. It is not signed or dated by the Executive Director, Dr. Calvin Lockett, Jackson Public Schools. Specifically it outlines a school program in alignment with the Jackson Public Schools and not one based on best practices in detention education.

As part of policy/program review I came across practices that seemed to be in contradiction to the stated policy. Policy indicates that HYYJJC will provide residents with guaranteed rights to educational services and that all residents will be required to attend school daily, Monday – Friday. However,

1. There exists a form entitled the "Academics Refusal" form allowing minors to basically sign out of school, stating that they recognize that there is an attendance policy, but they choose to decline the work that was offered.
2. Students are not allowed to return to school after court until the following day.
3. Students are being "suspended" from the juvenile detention school, spending multiple days out of classroom time. This is based on review of incident reports, dates allowed back in school and logs of work sent to the units which are kept by each teacher.

Recommendations:

1. Policy developers (should include representatives from JPS and HYJJC) should read the education chapter in the *Desktop Guide to Quality Practice for Working With Youth in Confinement (Desktop Guide to Quality Practice for Working with Youth in Confinement.* National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. http://www.desktopguide.info/?q=node/19) and rewrite the policy to reflect standard and best practice for a detention education program recognizing that a detention education program is significantly different in scope and purpose from public school education programs.
2. Eliminate all "programmatic" obstacles to youth attending school. We know that many of the youth in the juvenile justice system are significantly behind in academic standing and skills. They do not need adult assistance to stay out of school. Compulsory education laws and facility rules can be used to

support prohibiting youth from "signing" out of school. Decisions regarding youth returning to school after court or any community appointment should be made on a case-by-case basis and determined by the demeanor of the youth. Youth cannot be suspended from "detention education" programs where a primary purpose is to re-engage youth into education.

B. Daily schedule, student groupings, class sizes

Continuum:

1. Daily instructional time does not meet state minimum standard to daily instructional time meets minimum standard.

2. Little or no evidence of assessment strategy in place to measure student skills at intake, exit, or throughout stay in program, little or no evidence of processes designed to review performance data to assess instruction, curriculum, student needs to robust system for assessing student performance at intake, exit and at regular intervals in core subjects, evidence that assessment drives instruction.

Findings:

Based on the daily schedule provided, students attend school 290 minutes per day. This is 10 minutes short per day of the 300-minute standard required in most state standards. Ten minutes does not sound like a lot, unless you think of it in terms of larger units of time: 50 minutes/week (one class period), 52 classes/year, all for a population of youth so in need of every bit of education they can get. There is a 60 minute recreation time at the end of each day, however that is not taught by a JPS certified physical education staff and does not follow a certified curriculum, therefore cannot be counted as instructional time.

Students are grouped into middle and high school classes that are separated by gender. Student records are requested/received from previous schools in a timely manner. Additionally students are assessed using the Test of Adult Basic Education (TABE), Wide Range Achievement Test (WRAT), San Diego Quick Reading Assessment, math assessments, and needs assessments. These are all common assessments used in detention education programs. Assessment results are recorded on the Youth Court School Individual Academic Plan 2015-2016. The teachers do not use these forms to plan lessons, i.e make accommodations or modifications to the standard lesson. Instead, they rely on the Lead Teacher to provide them with student assessment results that significantly deviate from the norm.

Students receive instruction in the core curriculum (math, science, English and social studies) based on high school or middle school curriculum. Core classes are fifty minutes in length. The afternoon classes, Character Education instruction, are forty-five minutes in length. EES students receive services in a self-contained

classroom based on their IEP. Depending on the population of the facility, class sizes range from five to seventeen.

A sample memorandum provided for review indicates that upon release from the facility, grades that the student earned for the core classes are transferred to the receiving school. It did not appear from the review that students earn credit for the Character Education classes.

Recommendations:

1. Increase the two classes after lunchtime that are forty-five minutes to fifty minutes each in order to meet the three hundred minute of instructional time/day standard.
2. Award credit for the Character Education class. The students are spending two class periods each day in Character Education. With the right content and taught in the right manner, this is a very valuable part of every detention education program. Given that youth are typically behind in credits in school, they need to be able to earn credits for this work.
3. Further review is warranted into the purpose of the Individual Academic Plan, i.e. how do the teachers use the information in planning lessons? How was it intended that the teachers would use the information?

C. Curriculum

Continuum:

Curriculum is not modified to meet needs of transient student body (i.e., not chunked, modular, project based); little or not evidence of systematic design-based approach to promote engagement, relevance, little or not evidence of standards based alignment to curriculum is tailored to meet needs of transient student population; curriculum is centered around themes of engagement, relevance and problem-solving, curriculum is culturally relevant, is appropriate and individualized for students based on likely length of stay, academic level and placement, curriculum is standards-based

Findings:

As noted earlier, all teachers teach in their certified area. The school curriculum consists of core classes (math, English, science and social studies) at the middle and high school levels and EES self-contained; Character Education; and individualized Pre-GED studies. Each school day ends with a recreation hour.

Core curriculum instruction seeks to align with the JPS standards. Teachers provided sample lesson plans for review, however they were not the lesson plans for the lessons that I observed during the site visit. Based on my review, it appears as though the teachers start with the standard lesson in the JPS database and then prepare Performance Task Guides for classroom instruction.

Recommendations:

1. Revise curriculum units based on average length of stay data and relevant themes for youth in detention setting and not the traditional units of study.
2. Explore GED testing options for those students advanced in age, lacking in credits, and sufficient academic skills.

D. Classroom Observation

Continuum:

Little or no evidence of clear school-wide instructional practices to clear, observable, school-wide instructional strategies in place including direct instruction, mini-lessons, group work, differentiation, individualization, explicit literacy approaches, instructional model prioritizes engagement principles, classroom environment is instruction rich.

Findings:

Over the course of the two-day site visit I observed in each teacher's classroom during two class periods. Critical in detention education programs is the teacher's ability to engage student's in the learning process, so when I do classroom observations, that is the outcome I am looking for, does the teacher use all of their skills, tools and resources available to them to engage all students in the learning process throughout the course of the instructional hour. Classroom sizes varied from three students to seven students.

Teachers participated in a variety of instructional strategies and learning activities to engage students including:

English: vocabulary development, sentence structure, literature; student tag reading, teacher oral reading

Math: values in equations; student board work, direct instruction, demonstration

Science: particles of atoms; student tag reading, teacher lead reading, workbook questions on the Smart Board; Character Education – Honesty, read-a-long and worksheet

Social Studies: Students reading in different textbooks, answering questions; map work, research on the Smart Board

EES: individualized instruction in math, science and social studies

During my observations teachers appeared engaged with students both whole class and individual, trying to keep them on task with the lesson. Students varied in their levels of engagement with the teacher and the learning depending on factors including if the teacher was working directly with them, if the teacher was addressing their subject area (teacher addressing U.S. History and they are working in Government), relevancy and interest in the lesson, ability to do the work, etc.

Occasionally I observed students engage in inappropriate behavior in the classroom. In response, teachers either requested that the juvenile justice staff remove the students from the classroom or the juvenile justice staff removed the student(s) without consulting the teacher (see Behavior Management section).

NOTE: One student who had engaged in a power struggle with a teacher requested to speak with me. In honoring that request the student informed me that the things that I was observing in the school program that day did not happen every day. This was the only day they had ever been asked to do the activities that they were doing. That everything was a show for me.

Whether or not this student was accurate or just angry with the teacher, it is always the predicament for an external reviewer to determine if the "snapshot" seen in a very short period is an accurate picture of daily practice. I was getting a lot of messages from juvenile justice staff and now from this youth that it was not. Therefore, I made the decision to take advantage of opportunity to review videotape from classrooms in the previous month.

E. Videotape Observations

On September 17, 2015 I reviewed randomly chosen (I chose dates, class hours and teachers) videotape of previous class periods (2 per teacher) from August 15-September 15, 2015. Although these videotapes still do not give the complete picture of what happens in each classroom (they do not have audio), they did continue to fill in the picture. In these videotapes I observed significantly less teacher engagement. Teachers spent much of the classroom time sitting at their desks, students spent much more time sleeping and not involved in classroom activities. I did not observe a beginning to class periods or an ending. Students wandered in and out and finally got started with assignments. Teachers wandered in and out as did the juvenile justice staff. All-in-all the environment was very chaotic for learning.

Recommendations for Classroom instruction:

1. Teachers should receive training in strategies for teaching in a mixed ability classroom specifically developed for a detention education program by the National Partnership for Juvenile Justice. This builds on training that they have already received this year on differentiated instruction and applies it specifically to a confinement setting.
2. Instructional strategies should be more focused on student-centered strategies, i.e. kinesthetic strategies, projects, application of concept strategies, as opposed to reading textbooks.
3. Specifically with small numbers in the classroom, teachers should be much more engaged with students to promote their learning.

IV. Behavior Management

Continuum:

Limited or no school-wide behavior management system observed or articulated; school curriculum does not include social emotional skill development to School and facility implement the same behavior management system; consistent implementation from class to class; well-defined strategies

for implementation and ongoing improvement; plan includes incentives and appropriate consequences; school curriculum includes social-emotional skill development based on student need.

Findings:
The policy states that: 1.) students are subject to all classroom expectations as stated in the Positive Behavior Intervention Plan, 2.) JPS has adopted the Positive Behavior Intervention and Support (PBIS) approach for behavior management and implemented it in the Court School, 3.) unit officers are responsible for safety and control in the classrooms and shall make decisions in conjunction with the School Director, regarding residents' removal from the classroom, and 4.) regarding discipline during school, the Youth Court School follows the JPS District's Code of Conduct with regard to the policy and procedures of the HYJJC. If a student is removed from class for behavior purposes, they are to complete academic packets delivered each morning.

These are all statements from the policy included in the Operations Manual that support my concern with the randomness of the approach toward behavior management that should instead be used as a very systematic tool to work with youth on managing inappropriate behaviors and teaching new behaviors. Is their behavior management system PBIS? JPS Code of Conduct? HYJJC staff?

I found no evidence of PBIS in action. I reviewed "Infraction Documentation" (documents completed when students are removed from class for behavior infractions); "Student Behavior Instruction/Reflection Packs" Log (document logging academic packs delivered to the units); and "Behavior Improvement Form" (reflection document required of the student when they return to school). This review revealed that the same nine (9) students were suspended frequently and from every class ranging in time from three (3) hours to five (5) days. It also revealed two classrooms presenting with seventy (70) percent of the suspensions. There was not a consistent use of the "Behavior Improvement Form", as I found them being used with approximately one quarter of the youth returning to classes.

In the classroom observations, juvenile justice staff handled behavior management by removing students from the classroom. In on instance the teacher simply looked at the juvenile justice staff and said "he needs to go, I'm not putting up with this behavior." I had not observed any interaction between the teacher and that student, nor any misbehavior on the part of the student. In another instance where the teacher attempted to address behavior, the teacher and the student entered into a power struggle, arguing to the point that voices were raised. Finally the teacher gave up and instructed the student to leave the classroom. That also became a verbal struggle. At that point other students became engaged in the misbehavior and it took several minutes to be able to sort out, move students to different desks and begin instruction again.

Recommendations:

1. Teachers should be responsible for the basic behavior management of the classroom with the assistance of the juvenile justice staff. The juvenile justice staff should be in the classroom, but responsible for only the most severe behavior interventions. In order to do this effectively, teachers need to complete behavior management training.
2. The school program and the juvenile justice program at the HYJJC have to have the SAME behavior management program. PBIS is a proven approach in the public school systems and has also had success in some juvenile detention facilities. However, it cannot be an approach simply used in the school program without adopting it in the juvenile justice side also. Levels and point systems are used successfully in juvenile justice facilities and frequently used in the school program also. Whichever choice is made (PBIS or a point/level/reward system), cross training in the behavior management program must also occur and the same program must be consistently implemented.
3. There needs to exist a continuum of behavior responses that are available for the teachers to use thus making removal from the detention education program an absolute last resort for the least amount of time necessary for the youth to regain control of his/her behavior and suspension from the program a NON OPTION.

V. Exceptional Education Process
Continuum:
School has no procedure for referral, identification, evaluation of suspected youth with disabilities, offers one service delivery model, no related services; Parents not included in IEP process; Teachers are unaware of educational and behavioral goals of students per IEPs/504 plans; School does not assist students in qualification for services post release TO School has established procedures for referral, identification, evaluation of suspected youth with disabilities, offers a continuum of special education services and provides related services per IEPs; Parents/guardians are included in the IEP process along with all required participants per IDEA; Teachers and staff are aware of and consistently support attainment of educational and behavioral goals and the provision of services and modifications to the learning environment per IEPs/504 plans; School employs a specific person assisting with student qualifications for students post release.

Findings:
Many detention education programs find it difficult to implement an exceptional education process. This is not the case at the HYJJC. Much of this is due to the work of the EES teacher Ms. Brandie Finley, who executes the process outlined in the document "Youth Court School: Exceptional Education Process". Students who are eligible for special education services receive services in a "pull-out" setting for specific hours based on their IEP. In addition, there is a process in place for these students to receive ancillary services, i.e. speech and language, through the JPS. A more comprehensive review of services would determine specifically the

correlation between instruction and individual goals and objectives as they appear on the youth's IEP.

Ms. Finley is the only EES teacher. She has recently been named the Lead Teacher. A primary responsibility in this capacity is to work with the general education teachers in a quasi teacher consultant role. Currently there is only the "pull-out" service delivery model. The general education teachers are not expected to make accommodations or modifications to their curricula to address the needs of exceptional education students while they are in the general education classrooms.

Recommendations:

1. Add an additional EES teacher to the staff at HYJJC. This would allow the further development of the EES continuum of services. They would be able to develop the referral, identification and evaluation component as well as adding additional service delivery options as dictated by the IEPs. One EES teacher would continue to provide "pull-out" services for those youth that are IEP'd for self-contained classrooms and the other would work specifically in the general education classrooms, allowing those students who are IEP'd for support services only to remain in general education.
2. General education teachers need to become more involved in the education of EES students in their classrooms, making accommodations and modifications to their lessons so this student(s) can experience success with their non- EES peers. These accommodations/modifications should be documented on lesson plans.

VI. Physical Space and Safety
Continuum:
Little or no evidence that the education space is maintained as a safe and secure setting as well as and engaging environment that promotes learning TO School environment that respects safety and security concerns (controls for equipment and supplies; physical layout of classroom, etc.) WHILE promoting learning.

Findings:
The school program occupies designated space in the detention center. Realistically there are three classrooms. The EES and social studies classrooms are make-shift classrooms that are safety and security concerns because of the size and shape of the classrooms. EES students typically need space to separate from each other, often to stop annoying each other. That is impossible to accomplish in the current classroom, which can only allow for two students at a time. The long narrow social studies classroom (room for two rows of desks with a very narrow walk space between) would make it very easy for youths to plan to block off the front of the room while a fight occurs in the back of the room and staff could not get to the fight. The office that is occupied by Ms. Jones, formerly a closet, is just unacceptable.

All of the classrooms in the school area are safety concerns because of the amount of "stuff" (books piled outside of shelving units, papers, boxes, materials, unused equipment, etc.) that is just piled and stored everywhere in the classrooms. There is an issue made about turning in pencils etc., but no concern for the number of spaces in the classrooms that pencils could be hidden. Because everything in the classrooms is in random piles, it is very easy to hide things and very hard to find things that have been hidden because everything is random.

Recommendations:

1. For safety reasons, address the inappropriate classroom and office space as soon as possible. Several past compliance reports recommended exploring the use of placing portable classrooms within the secure fence of the HYJJC. Although I am not completely in favor of this option as it physically separates the school program, it is one option to addressing the inappropriate classroom space. And this concern is minimized by the decision of where to place the portables. There may be other options if for some reason JPS is reluctant to look at this option, as it appears that they are. Regardless, this should be one of the first recommendations acted on as it is a safety concern for youth and staff.
2. Make the classrooms a safe environment. Organize and put things away that are not being used each day. School classrooms are not storage closets. Find a different place in the building to store equipment that is not being used. Better yet, if the Smart Boards have made the need for an overhead projector unnecessary, get rid of it. Not only does this eliminate places to hide things, it eliminates things that can be thrown in a fight. Most importantly, it sends the message that you care about the environment that the students learn in.
3. Teachers should attend cross-training in safety and security, and specifically receive training in setting up a safe and secure classroom.

VII. Relationship with HYJJC program

Continuum:

Limited or no evidence of systematic, collaboration between school and secure staff re: behavior management, scheduling, etc; TO Consistent, systematic communication between school and secure staff, at both the line and leadership level; alignment and collaboration around behavior management, scheduling, etc; Joint training to ensure cohesive and consistent messaging and clarity of roles during the school day; Articulated agreement between county and school agency

Findings

Across the country juvenile detention centers rely on education providers to deliver the education program in the facilities. The typical model is similar to the one at HYJJC where the local district or the regional education service agency contracts with the facility. In ALL well run facilities something powerful happens with this relationship. Even though the staff are hired by the local district, they understand that they work in a program operated within another jurisdiction where education

is not always the kingpin. They also understand that although the local district pays their paycheck, it really benefits them to become an integral part of this other staff. In ALL well run facilities, the director of the facility understands that education is the youth's primary avenue to a successful life and the most important part of their day shift programming. And, like medical and mental health, not typically in their area of expertise. In other words it takes a team, with mutual respect.

JPS considers the school program a separate entity from the detention center. It calls the school the Youth Court School, connecting more with the court than the detention center. Other than relying on the juvenile justice staff to provide behavior management, I saw very little evidence of working together or respect toward each other. The disrespect was evident at the initial meeting when the school principal refused to come meet with myself and the facility director in the directors office despite being requested to do so a couple of times.

Recommendations:

1. I am making the assumption that all parties want to have the best detention education program possible. I know that that only works when the facility and the school provider are working together to make that happen. JPS and the facility administration should work on all school related issues together.

Attachments

Attachment A: Resume

CAROL CRAMER BROOKS

2227 S. ROSE ST., KALAMAZOO, MI 49001 ~ carol.brooks1959@att.net ~ 269.377.1605

Career Goal
To promote the well-being of youth, families, and communities through education and advocacy

Personal Goal
To HOPE always.

Employment

Director, *OJJDP National Center for Youth in Custody,* Office of Juvenile Justice and Delinquency Prevention, National Institute of Corrections, National Partnership for Juvenile Services
2013-present

Direct a national center to advance the field of juvenile justice by providing training and technical assistance and serve as a national clearinghouse for information, materials and resources for effective practices.

Center Coordinator*, OJJDP National Center for Youth in Custody,* Office of Juvenile Justice and Delinquency Prevention, National Institute of Corrections, National Partnership for Juvenile Services and Council for Juvenile Correctional Administrators, 2010-2013

Co-Direct a national center to advance the field of juvenile justice by providing training and technical assistance and serve as a national clearinghouse for information, materials and resources for effective practices.

Lead Consultant*, Juvenile Justice Associates, LLC and the National Partnership for Juvenile Services,* 2008-present

Provide training and technical assistance for juvenile justice facilities/organizations/jurisdictions/foundations primarily in program and staff development, training curriculum development and educational programming.

Division Director*, Program Development and Support Services,* Bureau of Juvenile Justice, State of Michigan, 2005-2007

Responsibilities included oversight of the Education, Training, Quality Assurance, Policy and Juvenile Justice Assignment Units for the state-run confinement facilities and community-based programs.

Principal, Kalamazoo Regional Educational Service Agency, Juvenile Home Schools, 2003-2005

Responsibilities included oversight of the educational programs for adjudicated youth in the Kalamazoo County Juvenile Home Schools – the Youth Center School (detention) and the Intensive Learning Center (day school).

Director of Training and Confinement Education Programs, National Juvenile Detention Association, Center for Research and Professional Development, 1997-2003

Responsibilities included training curriculum development and revision and the organization and delivery of detention line staff and confinement educator training.

Teacher**,** Kalamazoo Valley Intermediate School District, Youth Center School/Intensive Learning Center, 1990-1997

Responsibilities included the implementation of behavior management program and academic instruction in social studies (anger and stress management, conflict resolution).

Teacher**,** Allegan County Intermediate School District, Allegan County Youth Center, 1987-1990

Responsibilities included the development and implementation of the behavior management and academic programs for the detention unit. Delivered academic instruction in social studies, science and math.

Teacher**,** Romulus Community Schools, Beacon Day Treatment Program, 1986-1987

Responsibilities included providing instruction in secondary and remedial language arts.

Teacher**,** Kalamazoo Valley Intermediate School District, Intensive Learning Center. 1984-1986

Responsibilities included providing instruction in secondary and remedial English and prevocational workshop at the Kalamazoo County Juvenile Home. While employed I was a member of the ILC Program Design and Development Team.

Education

December, 1992 **Western Michigan University,** Kalamazoo, Michigan
Master of Public Administration
Concentration: Social Agencies (Program Planning and Design)

August, 1982 **Western Michigan University,** Kalamazoo, Michigan
Bachelor of Science, cum laude
Major: Special Education (EI)
Minor: Math for the Elementary Teacher

Certification

June, 1988 **Michigan Continuing Certificate**
K-8: All subjects
K-12: Special Education (emotionally impaired)
K-9: Mathematics

May, 1997 **Special Education Teacher Consultant**
June, 2004 **Life Space Crisis Intervention trainer**

Training and Technical Assistance

I have provided training for direct care staff, supervisors, administrators and educators in detention and corrections facilities in thirty-six U.S. states and territories. (A complete listing is available upon request.)

I am a frequent presenter at state and national juvenile justice conferences. Some examples include:

- National Symposium for Juvenile Services, 1996-present
- National Juvenile Services Training Institute, 1997-2006
- Heartland Juvenile Services Training Institute
- Michigan Juvenile Detention Association
- Illinois Juvenile Detention Symposium
- Indiana Juvenile Detention Association Summit
- Indiana Department of Corrections Pre-service Academy
- Louisiana Governor's Conference
- Missouri Juvenile Justice Association

I have provided technical assistance to jurisdictions in efforts to develop and implement corrective action plans to address issues identified in federal litigations (actual or pending). Some examples include:

- Wayne County Juvenile Detention Center, Detroit MI – develop and implement plan to deliver special education services as part of the

Memorandum of Understanding with the Department of Justice, Washington DC

- Maxey Training School, Bureau of Juvenile Justice, State of Michigan – develop, plan and implement plan to deliver special education services at the Maxey Boys Training School as part of the Memorandum of Understanding with the Department of Justice, Washington DC
- Mississippi Department of Human Services, Division of Youth Services, Jackson, MS – develop plan for education program, train staff and write educational policy as part of the Memorandum of Understanding with the Department of Justice, Washington DC
- Cook County Juvenile Temporary Detention Center, Chicago, IL - provide program and staff development, administrative team coaching and mentoring, participate on hiring teams and operate as liaison with Chicago Public Schools as part of the federal Transitional Administrator's reform efforts at the CCJTDC.
- Orleans Parish School Board, New Orleans Youth Study Center, New Orleans, LA – develop a program design plan for the education program at the New Orleans Youth Study Center and monitor the School Board's implementation of and compliance with the plan as part of the Consent Decree between the defendants and the Orleans Parish School Board in a class action lawsuit.

Professional Affiliations

Member, National Juvenile Detention Association, 1997-2006

Member, Michigan Juvenile Detention Association, 1997-2006

Founding Member, Council for Educators of At-Risk and Delinquent Youth (CEARDY), 1999-present

Member, Education Administrators of Adjudicated Youth (EAAY), 2003-2008

Member, National Partnership for Juvenile Services (NPJS), 2004-present

CEO, National Partnership for Juvenile Services (NPJS), 2011 - present

Publications

Cramer Brooks, C., & Roush D., (2014, Spring). Transformation in the Justice System. ***Reclaiming Children and Youth,*** 23, Issue 1, 42-46.

Roush,D., Cramer Brooks, C., & Kielas, C. (1998, Fall). Accountability-Based Training for Line Staff in Juvenile Confinement and Custody Facilities. ***Journal for Juvenile Justice and Detention Services, 13,*** 85-93.

Wolford, B., & Cramer Brooks, C. (1999, Spring). Juvenile Justice Education Administrator: An Occupational Analysis. ***Journal for Juvenile Justice and Detention Services, 14,*** 87-98.

Cramer Brooks, C., & White, Carter, Ph.D. (1999, Spring). National Training Curriculum for Educators of Youth in Confinement. Washington D.C.: U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention.

Roush, D., Cramer Brooks, C., Hondros, D., & Philson, B. (2002, Summer). Juvenile Detention Careworker Training (3rd edition). Washington D.C.: U.S. Department Of Justice Office of Juvenile Justice and Delinquency Prevention.

References

Available upon request.

Attachment B: Timeline of Events

September 14, 2015
E-MAIL CORRESPONDENCE

Sept. 14, 2015 at 11:09 (initial e-mail from the JPS – JoAnne Nelson Shephard, District Counsel)

Good morning. Please accept this correspondence on behalf of Dr. Calvin Lockett with the Jackson Public Schools. He is in receipt of your email this past Friday afternoon. Please be informed that he will be unable to compile the documentation in the amount of time given—Tuesday afternoon. Normally, the external auditors schedule a meeting with the principal to review the process prior to a request for documents. The District is desirous of complying with your request, but needs sufficient advance notice. Please contact Dr. Lockett to schedule a time to discuss the process and a time to gather and review documents.

Thanks.
JoAnne
JoAnne Nelson Shepherd
District Counsel
Jackson Public School District
662 S. President Street
Jackson, MS 39201
601-960-8916
jnelson@jackson.k12.ms.us

September 14, 2015 at 12:09 (my response)
Ms. Nelson,

Thank you for reaching out to me on behalf of Dr. Lockett. I am happy to hear that the District is willing to comply with the request. Every district I work with has different procedures so I typically work within the procedures that are acceptable from the perspective of the federal courts, especially given the nature of the documents requested - i.e. they are programmatic documents typically readily available in school programs and not youth specific documents. The nature of the request is simply to give me some background regarding the program and what I will observe. If the documents aren't available to me until during my site visit, that is o.k. also, it just doesn't allow for the perspective ahead of time.

I am happy to meet with Dr. Lockett tomorrow afternoon (my flight arrives at 12:15), Wednesday or Thursday morning to discuss this request. I will proceed with my observations and interviews as planned and hope to be able to meet with Dr. Lockett at the facility. Please let me know what works.

I am using this e-mail as a way of corresponding to all parties at one time - including Mr. Leonard Dixon - the federal monitor who requested my visit.

Thank you, I am looking forward to seeing the school program and the good things you are doing with the youth in the facility.
Carol

September 14, 2015 at 1:07 (response from JPS)
Thank you, Ms. Brooks, for understanding. However, the District wishes that no observations or interviews take place until you have met with Dr. Lockett and agreed on the structure and process. Thank you again.

September 14, 2015 at 1:20 (my final e-mail response to JPS)

Dr. Lockett,
Given this position, I am hoping that you have time or can make yourself available to meet with me tomorrow afternoon as soon as I arrive in Jackson.

As I said in previous e-mail I arrive at 12:15. How does 1:30 at the facility work?

I am happy to work with you on this one and appreciate your willingness to do the same.

Sincerely
Carol

LOG OF PHONE CALL

Received phone call from Dr. Calvin Lockett at 7:57 p.m. on September 14, 2015. He indicated that he would be unable to provide the materials requested in the time period requested, that he didn't think that it was fair for me to come to observe the teachers and he wished that I would come at a different time. However, he also indicated that I would find him very workable. We agreed to meet at 1:30 CST the following day when I arrived in Jackson.

September 15, 2015

Note: Flight to Jackson, MS was delayed. Meeting with Dr. Lockett was delayed until 3:00 p.m. CST.

Met with Dr. Lockett to discuss the parameters of the review, specifically the difference between the role of the consultant providing a review of the education program as part of the programming structure of the juvenile detention center and the Executive Director of the school program conducting teacher evaluations. Although it is impossible for the consultant to not observe events and teacher behaviors in the classroom, the analysis of those events and behaviors differ greatly when viewing them from the overall programmatic structure as opposed to the individualized teacher evaluation process implemented by most districts.

Met Ms. Finely (Lead teacher/EES teacher), Mr. Coleman and Mr. Sutter (transition coordinators). Ms. Finely was assigned to have all the documents that I had requested available for me at 8:00 a.m. the following morning and to have me sit in an office to review the documents. Mr. Sutter was to take me out on a transition run.

September 16, 2015

Observed classrooms

Talked with teachers/staff

Ms. Finely (Lead teacher/EES teacher

Dr. Bolls (English)

Ms. Jones (Assessment)

Interviewed students

September 17, 2015

Talked with teachers

Mr. Bennett (Math)

Ms. Safaya (Science)

Ms. Stapleton (Social Studies)

Observed classrooms

Talked with juvenile justice administration/staff

Mr. Burnside

Mr. Dorsey

Mr. McDaniels

3 direct care staff that requested anonymity

Reviewed randomly chosen video-tape of previous class periods (2 per teacher) from August 15-September 15, 2015.

Henley-Young Juvenile Justice Center
Detention Division
Mental Health Services Review
Report Date November 4, 2015

Submitted by Lisa Boesky, Ph.D.
3952 Clairemont Mesa Blvd. #205
San Diego, CA 92117
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troubledteenexpert.com

Background

On March, 28, 2012, Hinds County, Mississippi entered into a settlement agreement ordained and adjudged by Judge Daniel P. Jordan III, for the United States District Court Southern District of Mississippi, Jackson Division, regarding conditions of confinement at the Henley-Young Juvenile Justice Center, located in Jackson, Mississippi. As part of the settlement agreement the defendant contracted with National Juvenile Justice Expert Leonard Dixon to serve as a monitor of the agreement. He responsible for documenting the defendant's compliance with the terms of the agreement and for providing and/or arranging technical assistance and training regarding compliance with the settlement agreement. Mr. Dixon asked me to review the mental health services provided to the youth at the Henley-Young juvenile detention center.

With regard to the "juvenile detention center," I had full and complete access to all staff members, detained youth, and relevant documents. I was not permitted to speak with the Youth Court Counselors (or their supervisor), who are located in the Henley-Young Juvenile Justice Center outside of the detention facility near the juvenile court. I made multiple attempts and repeatedly explained the importance of their involvement. This was unfortunate as the Youth Court Counselors appear to play a significant role in key decisions related to some youths' mental health treatment, it was reported their role commonly impacts the mental health symptoms of detained youth, they have the most contact with youths' parents/caregivers, and they likely play a key role in transition planning/reintegrating youth with mental health disorders back into the community after release from the detention center.

Recommendations based on findings, observations and interviews

Site-Visit on September 28-29, 2015

Draft Policies:
Mental Health-- Suicide Precaution and Prevention (3)
Mental Health--Staff and On-Call Mental Health Services
Mental Health—Scope of Mental Health Services
Mental Health—Treatment Planning
Mental Health—Requests for Services
Mental Health—Youth Screening and Instruments
Rules and Discipline—Behavior Management Isolation
Rules and Discipline—Due Process Isolation

Mail, Telephone, Visiting—Visiting Regulations
Security and Control—Use of Force
Quality Assurance Department—Monthly Incidents (September 2015)
Due Process Isolation Log (September 2015)
Daily Activity Schedules For All Four Units
Daily Roster (September 28, 2015)
Docket Summaries
Resident A.H.
Resident D.A.
Resident D. C.
Resident Q.P.
Resident D.M.
Resident T.W.
Complaint for Injunctive and Declaratory Relief (6/1/11)
Agreed Order Granting Approval of Settlement Agreement and Certifying a Settlement Class
Plaintiffs' Memorandum in Support of Motion for Contempt
Monitoring Compliance Report (1/28/15)

Adults Interviewed

Johnnie McDaniels, Executive Director
Eddie Burnside, Operations Manager
Brenda Felix, Mental Health Program Administrator
Eric Dorsey, Quality Assurance Coordinator
Ja'Net McCoy, Training Coordinator
Jessica Johnson, Recreation Coordinator
Marcus Collins, Detention Supervisor
Tom Cole, Detention Officer, Certified Crisis Prevention Institute (CPI) Trainer
Angela Harvey, Hinds Behavioral Health
Jacquelyn Boddy, Marion Counseling Services
Fantoya Carter, Detention Nurse
Ferniece Galloway, Intake Counselor
Kalvin Harris, Detention Officer
Kiara Neal, Detention Officer
Jacqueline Rhodes, Detention Officer
Cassandra Thomas, Detention Officer
X, Mental Health Facility Personnel
Y, Child Protective Services Personnel, Department of Human Service
A, Parent of Youth Currently Detained at Henley-Young
B, Parent of Youth Detained at Henley-Young in the past three months
Arthur Sutton, Behavior Specialists in the Detention School
Jon Coleman, Behavior Specialists in the Detention School

Youth Interviewed

Resident X.C., 17 years old
Resident D.H., 17 years old
Resident C.W., 17 years old

Resident D.T., 15 years old
Resident D.J. 17 years old
Resident C.S. 16 years old
Resident J.E., 15 years old

Introduction

This report is the result of my site visit to the Henley-Young Juvenile Justice Center—Detention Division on September 28-29, 2015. My impressions, comments and recommendations are based on my observations during the site visit; interviews with a variety of staff, detained youth and additional relevant professionals working with youth in the detention facility; relevant documents; my mental health education, training and knowledge; my experience working in/with juvenile justice facilities; and my understanding of the standards and current best practices with regard to mental health services in juvenile justice facilities. I sincerely appreciate Henley-Young's juvenile detention center's leadership team, mental health professional, facility staff, and youth for their flexibility, openness, and cooperation during the site visit. From the moment of initial contact, the leadership team at the detention facility has been accommodating and supportive, and all seem genuinely committed to improving mental health services for the youth in their care.

High Rates of Mental Health and Substance Use Disorders Among Incarcerated Youth

Studies of youth in custody have found 63% to 92% met formal criteria for a mental health or substance use disorder. When one of the studies removed conduct disorder and substance use disorders, almost half of youth still met criteria for a mental health disorder.

Suicide thoughts and attempts are more frequent among youth in custody; extreme levels of irritability and aggression are common, and self-injury is not unusual. One study found 93% of youth in custody had at least one traumatic incident; over half of the youth had experienced trauma six or more times.

Most incarcerated youth with mental health disorders suffer from two or more impairing conditions simultaneously, with some also having a co-occurring substance use disorder as well. The assessment, treatment, and management needs of these youth is different and more complex than for those who suffer from only one condition. These youth are at increased risk of recidivism during young adulthood, and of dying by suicide.

Community-Based Treatment for Youth with Mental Health, Substance Use and Trauma-Related Needs and Their Families

Youth charged with running away, disturbing the family peace, domestic violence/simple assault, and similar offenses may be dealing with issues related to abuse, neglect, chaotic family environments, and/or parents/caregivers with untreated mental health, substance use or trauma related disorders. Intensive community-based treatment in their own home, with their family/caregivers, is likely to be more effective than removing them from their home and placing them in a detention facility; it is also likely to be more cost-effective.

Invest in intensive, home-based, wraparound models of outpatient treatment for youth charged with minor, non-violent and/or family-related charges (including youth typically detained/incarcerated for non-violent or family-related probation violations) as many of them may have mental health, substance use and trauma-related disorders

Findings

- During my site visit to the Henley-Young detention facility there were youth charged with: disturbing the family peace, disorderly conduct/disturbing the family peace, domestic violence/disturbing the family peace, domestic violence/simple assault (5), possession of a synthetic drug, disorderly conduct, disorderly conduct/resisting arrest, "simple domestic", running away (4), shoplifting, and domestic violence (2).
    - While locked in the facility, these youth were physically and emotionally separated from their parents/caregivers and their community.
    - The youth listed above were housed with residents who were charged with: strong arm burglary, possession of a weapon (2), auto theft (2), and robbery.
    - Placing low-risk offenders with high-risk offenders may have a detrimental impact on the low-risk offenders, including raising their risk of recidivism.
    - I tried to speak with the Youth Court Counselors to better understand decisions to detain/incarcerate youth with the above charges, but I was not permitted to speak with them or their supervisor
- Some youth had been detained/incarcerated at the Henley-Young detention facility from a very young age (11-14 years old) on charges such as disturbing the family peace and assault: simple domestic violence or assault: simple
    - According to documents, those youth were incarcerated in the Henley-Young detention facility 6-14 times.
    - One youth returned to the Henley-Young detention facility five additional times for "disturbing the family peace," "malicious mischief," "assault: simple," and "running away." As he got older he returned to the facility on charges of burglary, robbery and larceny: petit and motor vehicle theft: grand.

Recommendations

- Community-based treatment should be provided to youth with mental health, substance use and trauma-related disorders *prior* to incarceration at the Henley-Young detention facility and *continued once released.*
- Youth should continue to receive treatment while detained, but should never be detained at the Henley-Young detention facility *in order* to receive treatment.
- Assess the frequency and lengths of confinement for youth detained/incarcerated on minor, non-violent or family-related charges (including those detained/incarcerated for non-violent or family-related probation violations) as many of them may have mental health, substance use and trauma-related disorders
    - Assess the appropriateness, effectiveness and cost of detaining/incarcerating these youth compared to connecting them and their families with intensive, home-based, evidence-based treatment programs in the community.
- Invest in intensive, home-based, wraparound models of outpatient treatment for youth with mental health, substance use , and trauma-related disorders and their families (especially for those who are younger), as they are more likely to be cost-effective and clinically effective than housing youth charged with minor, non-violent or family-related charges in a detention facility
    - See section on *Mississippi Youth Programs Around the Clock (MYPAC)* in this report
    - Examine the juvenile justice reforms in Clayton County (Georgia) & Daviess County (Kentucky)
- Consider supervised release with programs such as home detention, electronic/GPS monitoring, intensive supervision, day and evening reporting centers in combination with evidence-based treatment in the community for youth who are detained/incarcerated on minor, non-violent or family-related charges (including those detained/incarcerated for non-violent or family-related probation violations).
- A report released by *Youth Advocate Programs* found that more than eight out of 10 youth in an alternative-to-incarceration programs remained arrest free, and nine out of 10 were at home after completing their community-based program, at a significant cost substance use vings.

Mental Health, Substance Use, and Trauma-Related Services in the Henley-Young Detention Facility

When youth with mental health, substance use and trauma-related disorders must be detained at the Henley-Young detention facility, screening, assessment, meaningful programming, and evidence-based treatment should be provided while they are in custody.

Mental Health and Substance Use "Screening"

To effectively manage and treat juveniles with mental health, substance use and trauma-related disorders, detention facilities must be able to identify these youth, their challenges, and their strengths. Doing so increases the likelihood that these youth will be housed appropriately, referred to qualified mental health and substance use treatment professionals, and receive necessary clinical treatment, including psychotropic medication when needed. Mental health and substance use screening and assessment results can also help inform which management strategies may be most effective with youth, which can help reduce youth agitation, anger, depression, hopelessness, assaults, and suicide.

All youth admitted to Henley-Young detention facility, regardless of their estimated length of stay, should receive a mental health substance use, and trauma-related screening within 1 hour of admission, or as soon as reasonably possible thereafter, by appropriately trained staff.

Findings

- Every youth who enters the Henley-Young detention facility is given the Massachusetts Youth Screening Instrument—Version 2 (MAYSI-2), regardless of his or her estimated length of stay. This screening tool is normed on youth in juvenile justice settings and asks questions about mental health, substance abuse, suicide, and trauma.
- Youth at the Henley-Young detention facility are supposed to take the electronic version of the MAYSI-2 at one of two computers, which have partitions around them for youth privacy.
- The electronic version of the MAYSI-2 prints out a data sheet that lists each of the MAYSI-2 scales with a youth's score and if that score falls into the "Warning" or "Caution" range, it then lists the exact items on each scale that a youth endorsed (e.g., Have you felt angry a lot, Have you been drunk or high at school).
- The electronic version of the MAYSI-2 program was not working correctly. When I took the screening tool myself, it skipped one-third to one-half of the questions, which was reportedly consistent with comments from youth.
    - In addition, I saw several data reports that only listed the MAYSI-2 scales and whether they met the cut off for "warning" or "caution," but did not list any of the youths' endorsed items as it was designed to do.
    - I was told that because of concerns about the electronic version, some youth were given the MAYSI-2 verbally and their answers scored by hand.
- It was reported that once completed, a copy of the MAYSI-2 results went into a youth's master file, a copy was given to Ms. Frelix, the sole mental health professional in the detention facility, and a copy was sent to the youth's Youth Court Counselor (YCC).
- When multiple youth are admitted to the facility simultaneously, I was told they are placed in holding cells and let out one at a time to allow for privacy.
- I did not see any forms for transporting officers to complete regarding youth behavior (e.g., exhibiting signs of mental illness, signs of alcohol or drug intoxication/withdrawal, or warning signs of suicide/suicidal behavior). However, I was told that intake staff ask general questions of transporting officers to get an idea of the youths' behavior prior to arrival at the facility.

- Other than the MAYSI-2, no other mental health, substance use, or trauma-specific screening tools were administered to youth at intake.

Recommendations

- Develop formal policies and procedures regarding mental health, substance use and trauma-related screening at intake for all youth admitted to the Henley-Young detention facility, and ensure associated screening practices are provided consistently and effectively.
- Fix the electronic version of the MAYSI-2 immediately. Administer the MAYSI-2 by hand until all questions are asked of youth electronically and the data print out lists youth's score on each scale, whether the score is designated as "warning" or "caution", and all endorsed items are listed.
- If youth cannot read or the computer program is not working, consider using the "audio computer" where the MAYSI-2 items are read to youth versus a staff member reading the questions
- Integrate at least four questions inquiring about youths' strengths, resiliencies and/or protective factors into the intake screening process.
- Integrate at least one question asking youth if they would like to speak to a mental health or substance use professional about concerns they have in relation to their thinking, mood, or behavior, including thoughts or behavior related to hurting themselves.
- So as not to solely rely on youths' self-report:
    - Implement a brief and standardized "behavioral observations" form for intake professionals to complete regarding their observation of youth during the intake process
    - Implement a brief and standardized form inquiring transporting officers, and other relevant adults, about youths' mood, behavior, statements, etc. prior to arriving at the facility.
- If a youth is overtly intoxicated or extremely agitated, staff should delay mental health/substance use/trauma-related screening until they can elicit compliance and obtain reliable results. Youth should not be placed in general population until the screening is completed.

Intake Professionals

Screening for mental health, substance use and trauma-related disorders should be performed at intake by qualified and trained personnel.

Findings

- The staff member working in intake seemed genuinely invested in youth. She was comfortable and confident in her role. She showed me a screening tool that she thought may be more effective than I current one they were using and I supported that view.
- I was not able to observe an actual intake (few youth were admitted during the site visit) so I am unable to comment on the style/tone of the intake process.

Recommendations

- Ensure all professionals conducting mental health, substance use and trauma-related screening are knowledgeable about mental health symptoms, normal adolescent development, the stress of incarceration, and signs of intoxication and withdrawal. Provide more training where needed. They should be sensitive and discreet when asking questions related to traumatic experiences.

  - Juvenile justice professionals who administer brief mental health, substance use and trauma-related screening tools at intake do not need to have the same mental health knowledge as psychologists, but their knowledge and training must be appropriate to the task at hand.
- Because their interaction with youth sets the tone for the youth's stay in the detention facility, ensure intake professionals are warm, caring, and genuinely interested in the information youth are providing versus appearing as if completing a checklist.
- Intake professionals should describe the purpose of screening to youth, briefly introduce each screening tool, and explain how the results will/will not be used.

Referrals to Mental Health and Substance Use Professionals

When screening indicates that youth may possibly have symptoms of a mental health, substance use or trauma-related disorder, youth should receive a more extensive assessment to explore the nature and severity of the symptoms/issues, as well as determine the necessity of specialized treatment services.

Youth identified as potentially having a mental health or trauma-related disorder, at potential risk of harm to themselves or others, or who request to speak to a qualified mental health professional (QMHP) or their parent/caregiver requests it (at intake or anytime during their detention stay) shall be immediately referred to a QMHP for further assessment. QMHPs Referrals should be reviewed by a QMHP within 12 hours; in situations when that is not possible, within 24 hours. The QMHP should then meet with youth as soon as possible, based on the severity of youths' risk and need.

Youth identified as potentially having a substance use disorder or who request to speak to a qualified substance use professional or their parents/caregiver requests it (at intake or anytime during their detention stay), shall be immediately referred to a QSUP for further assessment. Referrals should be reviewed by a QSUP within 24 hours. The QMHP should then meet with youth as soon as possible, based on the severity of youths' risk and need.

Findings

- It was reported that youth who score in the "caution" or "warning" range on the Suicide Ideation scale of the MAYSI-2 are referred to the mental health professional. The policy states that the shift supervisor should be notified about these types of scores and they are to contact Ms. Frelix, the mental health professional.
  - The current policy states that the shift supervisor may place a youth scoring in the "caution" or "warning" range on the Suicidal Ideation scale on Suicide Alert until further notice by Ms. Frelix.
- I was told intake staff are conservative with regard to suicide risk. If they have any concerns about youths' risk of suicide, they make a referral to the mental health professional and/or nurse and place the youth on Suicide Alert.
- I watched the Ms. Frelix review some of the MAYSI-2 reports given to her and sat in while she met with one young woman who had endorsed several concerning statements during intake screening. Ms. Frelix asked the young woman about these issues in a genuinely caring fashion to better understand her frame of mind and the reason(s) she was currently distressed. She asked a variety of good follow-up questions, including inquiries about suicide and self-injury. She also asked questions from a standardized tool that addressed depressive symptoms and suicide risk.
- There is no qualified substance use professional (QSUP) in the detention facility to follow up with youth identified as potentially having a substance use disorder during screening.
  - This is problematic given the high number of substance use issues among incarcerated youth.
- I was shown a "mental health help request form" that youth could fill out to request time with Ms. Frelix. It was unclear if this form has currently been implemented throughout the facility and whether staff and youth are aware of it and/or utilizing it.

- I observed staff informally refer youth to Ms. Frelix throughout the day. She did her best to see the youth immediately when possible.
- Ms. Frelix is the only mental health professional for the entire detention facility. She is responsible for all mental health and suicide assessments. She is also responsible for a variety of other mental health-related tasks (e.g., mental health treatment, safety plans for suicidal youth, re-assessing youth on Suicide Alert status, mental health and suicide prevention training).
    - There are not enough qualified mental health professionals (QMHPs) in the detention center to meet the needs of youth with mental health and trauma-related disorders.
    - There are not enough qualified substance use professionals(QSUPs) in the detention center to meet the needs of youth with substance use disorders.

Recommendations

- Develop formal policies, procedures and practices regarding the referral of youth with mental health and substance use disorders to QMHPs and QSUPs. Clear decision rules should be in place regarding what indicators should trigger these referrals.
- All facility staff should have access to the mental health referral process, as they are valuable observers of youth behavior. Requiring shift supervisors to sign-off on formal mental health referral slips submitted by staff helps them remain informed regarding a youth's struggles.
- Modify some of the wording on the "mental health help request form" to reduce redundancy and increase clarity; include youth concerns regarding alcohol/drug use, and an inquiry about some positive steps they have taken regarding their issue of concern.
    - Then implement the "mental health request form" throughout the facility. Educate youth about the form during orientation. Educate staff about the form, when to encourage youth to fill one out, and the importance of being sensitive and discreet about the information youth write on the forms.
- QMHPS should review mental health referrals within 12 hours from when the referral was written; in situations when that is not possible, within 24 hours.
- QSUPs should review substance use referrals within 24 hours from when the referral was written; in situations when that is not possible, within 48 hours.
- Hire QMHPs to assist Ms. Frelix in reviewing and responding to mental health referrals from intake screening, staff on the units, youth, and youths' parents/caregivers.

Rescreening for Mental Health, Trauma and Substance Use Symptoms

The thoughts, moods, and circumstances of incarcerated youth can shift quickly. Therefore, in addition to mental health, substance use and trauma-related screening at intake, youth should be re-screened for mental health symptoms any time youth display dramatic changes in behavior and/or if staff suspect mental health symptoms not already identified. Re-screening for mental health, substance use and trauma-related disorders should occur any time staff suspect (or residents admit) youth were not truthful when asked initial screening questions.

Findings

- There appears to be an informal process in place for Ms. Frelix, to re-screen youth for mental health disorders. However, because she is the sole provider of mental health services for the entire facility, which houses a multitude of clinically complex youth, some youth with mental health disorders who need re-screening are likely not getting it.
- There is no substance use re-screening in the detention facility

Recommendations

- When formal policies, procedures and practices regarding the screening process for mental health, substance use and trauma-related disorders are being developed, include a section on mental health, substance use, and trauma "re-screening" to ensure youth who are in need of this service receive it consistently and effectively.
- QMHPs should administer mental health-specific, substance use-specific, trauma-specific and suicide-specific screening tools when indicated.
- To avoid solely relying on youths' self-report, QMHPs should actively seek information from direct-care staff about youth moods/behavior and pay special attention to youth's behavioral observations during a re-screening.
- Always ask about youths' strengths, resiliencies, and protective factors during a re-screening.
- Hire QMHPs to help provide re-screenings, as there are not enough mental health professionals currently to complete this task, as well as effectively perform other required mental health-related responsibilities.
- Hire qualified substance use professionals to provide re-screenings, as there is currently no one in the facility to do this this

Mental Health, Substance Use and Trauma-Related Assessment

More comprehensive than screening, assessments often take hours to complete, and results provide the foundation for treatment planning within the facility and as youth prepare for transition back to the community. Mental health, substance use and trauma-related assessments should be completed by QMHPs and QSUPs, respectively, for youth who have "red flagged" or "screened in"(based on agreed upon decision points) during the intake screening process, as well as youth displaying significant mental health, substance use or trauma-related symptoms during their detention stay

Findings

- Informal mental health assessments are performed by Ms. Frelix
- No formal mental health assessments are being administered to youth in the facility
- No informal or formal substance use assessments are being administered to youth in the facility
- No informal or formal trauma-related assessments are being administered to youth in the facility

Recommendations

- Develop formal policies, procedures and practices regarding evidence-based assessment of mental health, substance use and trauma-related disorders among youth in the detention facility and ensure associated assessment practices are provided consistently and effectively.
- Youth referred for an assessment based on scores in the "caution" or "warning" range on the MAYSI-2 should receive the associated MAYSI-2 "second screening forms" to help clarify youths' issues
- Any and all youth detained/incarcerated for 30 days or more at the Henley-Young detention facility should receive a mental health, substance use and/or trauma-related assessment if indicated by intake screening or the display of moods or behaviors of concern anytime throughout their stay. Thirty days (or more) provides a key opportunity to conduct a quality assessment, as youth are not using alcohol/drugs, are likely to show up to the appointment, are being supervised by adults 24/7, and the assessment process does not need to be done in one large block of time (which can be difficult for youth in distress or who have attention/impulsivity issues) and instead broken up over several days.
- Youth should never be detained for the purpose of accessing a mental health assessment. It is unethical and likely illegal. The recommendations in this section of the report are for youth who are already being detained/incarcerated due to criminal behavior.

- Mental health assessments should go into more depth on issues covered in the mental health screening and explore youths' thoughts, feelings and behavior in a variety of key areas of a youth's life.
- Clinicians should assess a youth's level of functioning—psychologically, intellectually, emotionally, and socially—to better understand where youth has challenges and areas of success/resilience.
- Mental health assessments at the Henley Young detention facility should include: a clinical interview with youth; tests of cognitive and intellectual functioning; personality test; rating scales and checklists regarding youth moods and behavior; information from individuals familiar with a youth's functioning (e.g., parents/caregivers and other family members, Youth Court Counselor, detention staff, caseworkers, previous treatment providers); and behavioral observations.
    - Administer mental health-specific, substance use-specific, trauma-specific and suicide-specific screening tools when indicated.
    - Assessment tools should be standardized, valid, reliable and normed on populations as close to the youth at Henley-Young detention facility as possible.
    - Some mental health tools have components to detect youth who are hiding, minimizing, exaggerating, or faking mental health symptoms. These tools should be used when assessing incarcerated youth and/or specialized tools that detect "malingering."
    - If assessment tools are used that lack adequate levels of validity and/or reliability, those issues should be taken into account and noted in any interpretations and recommendations based on findings.
- Criteria from the Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition (DSM-V) should be used to establish whether a youth has a mental health, substance use or trauma-related disorder(s); if so, QMHPs should determine the scope and severity. Carrying a formal diagnosis has major ramifications for youth; therefore, clinicians who assign them to youth should have formal training in screening and assessment of mental health, substance use and/or trauma and the provision of mental health diagnoses among young people.
- Mental health, substance use and trauma-related diagnoses should only be assigned after a comprehensive and thorough mental health or substance use assessment.
- Mental health, substance use, and trauma should not be assessed in isolation because the three are highly interrelated, with overlapping symptoms. When youth have co-occurring mental health and substance use disorders and/or trauma and substance use disorders, QMHPs and QSUPs should examine how the conditions interact.
- Because of the significant trauma histories among incarcerated youth, QMHPs and QSUPs should evaluate the effect trauma plays in a youth's moods and behavior before assigning a mental health or substance use diagnosis.
- Situational factors should also be taken into account before diagnoses are made; youth who react to a temporary stressor must be distinguished from those with true mental health disorders.
- Mental health diagnoses are of little value without detailed and individualized recommendations. Therefore, assessment results and detailed individualized recommendations should be summarized by QMHPs in written form with terms understandable to a youth's parents/caregivers, Youth Court Counselor, and child-serving professionals from various disciplines.
    - Key findings relevant to the management of a youth while in the facility should be communicated to relevant staff on a brief written summary sheet (and verbally if possible); efforts should be made to protect a youth's privacy as much as possible by providing only information necessary for staff to be strategic and individualized in supporting the youth and managing his/her behavior while detained/incarcerated.
- QMHPs and QSUPs should provide face-to-face feedback to youth regarding key findings from the assessment.
- Short stays at the Henley-Young detention facility typically do not provide enough time for comprehensive mental health, substance use and/or trauma-related assessments and the provision of a formal diagnosis. In these situations, QMHPs and QSUPs should spend as much time as is feasible assessing a youth's symptoms, developing plans that address immediate issues that may impede his/her success in the temporary setting, and communicating key information to individuals supervising, interacting with and making decisions about these youth.

  - Administer mental health-specific, substance use-specific, trauma-specific and suicide-specific screening tools when indicated.
- Hire licensed doctoral (Ph.D.) level clinical psychologists who have the education, training and experience in administering mental health assessments to adolescents. For time and cost-efficiency, consider hiring a psychometrist who can help administer and score the mental health assessment tools.
- Hire at least one licensed substance use professional who has education (master's level minimum), training and experience in alcohol and drug use assessments with adolescents. .

The Transfer of Detained/Incarcerated Youth to Acute Inpatient Psychiatric Facilities for Mental Health Assessments

Findings

- After being detained and spending time at the Henley-Young detention facility, it appears that a number of youth are being transferred to several different acute psychiatric care programs. I was told the average length of stay is 7-10 days and then youth are returned to the detention center.
  - It was not clear if that 7-10 days counted as time served. Several staff did not think so, but I was unable to confirm/refute this with Youth Court Counselors since I not permitted to speak with them.
- I was reviewed four youths' "Discharge & Continuing Care Plans" from two different acute care facilities and was very concerned about the diagnoses given to them
  - Youth D.H. 7/31/17 (10-day stay at Diamond Grove Center) Discharge Diagnosis: Disruptive Mood Dysregulation Disorder/Conduct Disorder
  - Youth K.T. 8/20/15 (10-day stay at Diamond Grove Center) Discharge Diagnosis: Disruptive Mood Dysregulation Disorder/Conduct Disorder
  - Youth R.M. 9/17/15 (7-day stay at Diamond Grove Center) Discharge Diagnosis: Disruptive Mood Dysregulation Disorder/Conduct Disorder
  - Youth J.N. 9/22/17 (7-day stay at Alliance Health Center) Discharge Diagnosis: Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Intermittent Explosive Disorder r/o Psychosis NOS and on another sheet Discharge Diagnosis: Disruptive Mood Dysregulation Disorder, Conduct Disorder, PTSD, Physical Abuse-victim
- Given the prevalence rate of Disruptive Mood Dysregulation Disorder (DMDD) is around 1%-3% for adolescents, it seems unlikely that one particular psychiatric facility would receive three youth from one specific detention facility within a two month period that all had the exact same diagnosis.
  - I spoke with one of these youth during my site visit and he reported significant and chronic substance use issues. I am confused and concerned as to why this was not included in his diagnosis (i.e., Disruptive Mood Dysregulation Disorder/Conduct Disorder).
- Many incarcerated youth who have been diagnosed with Conduct Disorder or Oppositional Defiant Disorder have significant histories of trauma. I do not know whether these youth were assessed for trauma-related experiences/symptoms prior to being diagnosed with Conduct Disorder or Oppositional Defiant Disorder.
- There is little research on Intermittent Explosive Disorder (IED), particularly in adolescents, including how best to treat it. Many incarcerated youth who suffer from trauma-related issues are misdiagnosed with IED. I do not know whether the impact of trauma was assessed and ruled out.
- Psychosis NOS is no longer listed as a diagnosis in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).
- The report from a "Psychological Evaluation" was included in one of the discharge packets. From the report, it appears the youth was only administered two tools.
  - The intellectual assessment tool that was given is known to be reliable and valid, but is a briefer and less comprehensive than the more commonly used tools to measure youths' intellectual functioning. The youth

seemed to exhibit a significant discrepancy between his verbal and nonverbal intellectual functioning, which can have diagnostic significance. However, this was not discussed.
    - The personality test that was administered is not standard for a primary assessment of personality functioning; it does not appear to be scored or interpreted with a current reliable/valid scoring system and results are primarily provided in jargon.
    - The youth was diagnosed with four mental health/substance use disorders that had little relation to the results from the "Psychological Evaluation." This would be concerning for any individual, but particularly for this youth who is only 13 years old.
- I do not know if the documents I reviewed are representative of the services provided at each of the inpatient mental health facilities the Youth Court Counselors (YCCs) most commonly refer youth to; I repeatedly asked to speak with the YCCs or their supervisor to obtain additional information and clarify these issues, but was not permitted to speak with them.
- It is a reasonable expectation that an inpatient psychiatric facility that specializes in adolescents (and often costs a significant amount of money) would provide mental health assessments and diagnostic practices that meet professional standards. From the information I reviewed, I am concerned this is not the case.
- Some of the acute inpatient programs are one to one and a half hours from the Henley-Young detention facility, making it more difficult for some parents to visit and be involved with their child
- It was reported that most youth transferred to these inpatient treatment facilities for "acute" mental health issues are not agitated (and are typically fairly calm) and have already assimilated into the Henley-Young detention program when moved to the new residential placement.
- It was also reported that these inpatient mental health facilities designed to provide acute inpatient mental health services have declined to take youth at the detention facility who were experiencing "acute" mental health issues.
    - They have also reportedly removed youth from their programs and sent them back to the detention facility when youths' behavior became aggressive or difficult-to-manage, even when potentially stemming from their mental health issues.
    - I repeatedly tried to talk with the Youth Court Counselors, who refer youth at the detention center to these programs and set up the admission interviews, to clarify these issues and find out more about the mental health/substance abuse/trauma-related services these programs provide, but I was not permitted to speak with them.

Recommendations

Note: An accurate diagnosis is one of the most important first steps to accurate treatment. If youth receive inaccurate or inappropriate mental health, substance use or trauma-related diagnoses, the likelihood of effective treatment is not high. Being labeled with a mental health disorder (or multiple disorders) can be stigmatizing, can impact youths' eligibility for various programs (e.g., outpatient treatment programs, residential placements, the military), and can influence other peoples' view of the youth and the youths' view of themselves.

- Inpatient psychiatric programs should engage in evidence-based assessment that meets professional standards prior to giving youth mental health diagnoses.
    - Each inpatient mental health facility that youth are sent to from the Henley-Young detention center should be assessed and evaluated for quality and effectiveness of mental health, substance use and trauma-related assessments of youth.
    - Psychometric tools, scoring and interpretation protocols, and diagnoses resulting from any and all assessments should be reviewed.
    - There are a multitude of mental health and trauma-related tools that have good psychometric properties and are the standard for mental health assessments of adolescents. If these tools are not provided for most mental health assessments of youth being sent from the Henley-Young detention center, explore the reasons as to why that is.

  - Assessment tools that are not evidence-based, or their scoring/interpretation has not been shown to have high reliability and/or validity, should be used as supplementary information, not as the primary components of a formal mental health evaluation.
  - Only those inpatient mental health facilities whose assessment practices are effective and in line with professional standards and best practices should be considered as potential placement options.
- Incarcerated youth frequently have significant trauma-related symptoms, so when not properly assessed, they can be mis-diagnosed as having Oppositional Defiant Disorder, Conduct Disorder, Attention Deficit/Hyperactivity Disorder, Bipolar Disorder, Disruptive Mood Dysregulation Disorder and Substance Use Disorders as a primary disorders; therefore the inpatient mental health facilities that assess youth from the Henley-Young detention center should be evaluated for their use of trauma-related assessments and if/how often traumatized youth are mis-diagnosed with the above disorders.
  - Due to the high rate of trauma among youth from the Henley-Young detention center, only those facilities who assess trauma in line with professional standards and best practices should be considered as potential placement options.
- Transferring youth with mental health, substance use and trauma-related needs back and forth to different placements should only be done when the services provided are necessary, appropriate, and effective.
  - It typically takes time for youth with mental health/substance use disorders and trauma-related needs to adjust to a juvenile detention facility: the correctional environment, rules, expectations, routine, staff, peers, etc. Because these youth thrive with security, consistency and predictability, moving youth out of the detention facility to a new placement for 7-10 days with new rules, expectations, routine, staff, peers, etc. can be stressful and disruptive.
  - This is particularly true in the case of the Henley-Young detention center because it appears the majority of youth return to the detention facility after a week or so and once again have to adjust to the correctional environment, rules, expectations, routine, staff, peers, etc.
  - Parent contact, support and involvement is a key protective factor for youth with mental health, substance use, and trauma-related needs, particularly during stressful situations such as out of home placements.
- The current process of transferring youth who have mental health, substance use or trauma-related needs that are “not acute” (and are oftentimes “chronic”) to inpatient psychiatric programs specializing in “acute” care should be assessed and evaluated for appropriateness and effectiveness, including the consideration of such factors as emotional/behavioral cost to youth, as well as the financial cost of this process.
  - Alternative models of accessing similar types of care should also be considered.
- In cases where it is shown to be beneficial and effective for youth at the Henley-Young detention facility to be transferred to acute inpatient psychiatric facilities for 7-10 days, their stay should count toward “time served.”

Mental Health Reassessment

Youth with mental health, substance use and trauma-related disorders may need periodic reassessments to determine whether their diagnosis (or lack thereof) and current treatment plan (or lack thereof) remain accurate. Serious mental health disorders may increase in severity as youth move into late adolescence; in contrast, a youth’s depressed mood, anxiety, or suicidal thoughts may disappear after a major stressor is removed.

Youth with mental health, substance use or trauma-related disorders should be re-assessed when they exhibit a dramatic change in mood or behavior, experience significant stress, or when there is reason to believe a previous mental health evaluation was unreliable or invalid.

Findings

- Ms. Frelix conducts brief informal mental health re-assessments when staff are concerned about youth. She meets with youth and says she gathers information from staff about the youths' mood and behavior.
- It does not appear that any formal re-assessments are done with standardized, valid and reliable tools.
- It does not appear there is a formal process for communicating to staff key results from a re-assessment.
- There are no reassessments of youth with substance use disorders because there are currently no initial assessments.

Recommendations

- A formal process for re-assessing youth with mental health, substance use and trauma-related disorders should be integrated into the mental health, substance use and trauma-related assessment policy(s) and procedures.
- A standardized summary sheet should be completed after re-assessments of youth to inform staff of key issues (while considering youths' privacy) they need to know to effectively support and manage youth in the facility.

Strength-Based Mental Health, Substance Use and Trauma-Related Screening and Assessment

Many confined youth have experienced tragedy, trauma, and crisis. Their strength and resiliency is often one of the primary reasons they survived—physically and emotionally—and these assets should be identified and explored. When incarcerated youth with mental health and substance use disorders (many of whom have been screened/assesses repeatedly throughout their formative years) experience adults as interested in knowing about them as a whole person and not just their problematic symptoms and behaviors, the likelihood of getting accurate information is higher. Strength-based assessments also provide key information that staff can incorporate into the support and management of youth within the facility, and helpful information to include/integrate into treatment plans.

Strength-based and resilience-related questions and measures should be integrated into the screening and assessment process for mental health, substance use and trauma-related disorders.

Findings

- As is common in many juvenile justice facilities, the mental health screening done at Henley-Young detention facility is deficit-based and primarily focuses on youths' difficulties, challenges and problems
- Informal mental health assessments appear to be fairly deficit-based
- There are no formal mental health or substance use assessments

Recommendations

- Incorporate strength-based and resilience-related questions and measures into both the screening and assessment process for mental health, substance use and trauma-related disorders.
    - Rather than asking only about problems, difficulties, and areas in which youth struggle, mental health, substance use and trauma-related screening and assessment should also ask about areas in which juveniles have achieved or excelled.
    - Questions about behaviors youth may be embarrassed or ashamed about should be balanced with questions about their strengths, interests, and past choices of which they are proud.

- A strength-based approach should not overlook criminal behavior or ways youth have harmed others; however, it should strive for a more balanced approach.

Trauma-Responsive Care

Trauma (e.g., abuse, neglect, witnessing domestic violence, repeated moves, forced removal from parent/caregiver, raised by parents with untreated mental health and/or substance use disorders, violent neighborhoods, death of a loved one) among incarcerated juveniles is the rule, not the exception.

One study found 93% of youth in custody had at least one traumatic incident; over half had experienced trauma six or more times. Many youth in custody have experienced "poly-victimization"—multiple forms of victimization experienced by a single child. The greater the number of traumatic experiences, the more damage to a child or adolescent**.**

Compared to other traumatized youth, those who have experienced multiple types of traumas are at double the risk of developing Major Depression, three times more likely to develop Posttraumatic Stress Disorder, and three to five times more likely to abuse alcohol or other drugs. They are also at higher risk of engaging in delinquent behavior, struggling in school, running away and becoming suicidal. Experiencing multiple types of trauma is associated with "reactive aggression" (e.g., impulsive, angry aggression in response to *perceived* provocation versus aggression to obtain status, power, or material goods).

Youth who experience early and severe trauma (particularly physical and sexual abuse; neglect; domestic violence) are often revved up, tense, and hypervigilant; they can be easily triggered into a defensive or aggressive response toward staff or peers. Youth with multiple traumas in their history may exhibit: unpredictable moods, difficulty calming down once upset, angry outbursts that are often out-of-proportion to what initially provoked them, apparent lack of concern for others, minimal impact of sanctions and negative consequences, and minimal response to psychotropic medication.

Some features of incarceration (e.g., not knowing what is going to happen to them/how long they will remain in the facility, not being told important information, being housed in a small locked room/cell, intimidating and/or aggressive peers, confrontational or harsh staff, being physically searched) can exacerbate traumatized youths' feelings of vulnerability and loss of control, which often triggers an automatic, biologically programmed "fight or flight" survival response/trauma-related reaction such as verbal or physical aggression, emotional or physical withdrawal, destructive behavior, and/or out-of-control behavior.

The role of trauma should be addressed and integrated into screenings, assessments, and treatment interventions with youth who are detained/incarcerated.

Findings

- Every staff that I spoke with (direct-care to administration) acknowledged the significant amount of trauma in the histories of the youth residing at the Henley-Young detention facility.
- The staff I spoke with did not appear to be familiar with the ways that trauma can manifest in youths' mood, thoughts, and behavior (particularly in negative and sometimes aggressive ways), including within the detention environment.
- Both staff and youth reported the two most common triggers for residents' suicidal thoughts/behavior, aggression, destructive, or out of control behavior was 1) lengthy waiting times to find out what was going to happen to/with youth, how long they would have to remain at the facility, and when the youth could return home and 2) when youth received distressing answers to these questions, particularly when delivered quickly and with little compassion or support.

- Trauma is often misdiagnosed as another mental health disorder (Intermittent Explosive Disorder, Depression, Bipolar, Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Conduct disorder) by mental health professionals in the community.
- Consistent with research findings, many detention staff reported that alcohol and drug use by some, if not many, of the residents was likely related to coping with previous or current trauma.
- From what I was told, it did not appear that the Juvenile Drug Court required any of the participating youth to attend trauma-related treatment, despite the high number of traumatized youth who use alcohol and other drugs. I tried to talk with the Youth Court Counselors to clarify, but was not permitted.
- It was not clear if the detention professionals I spoke with recognized the various ways current juvenile detention practices may be re-traumatizing for some youth.

Recommendations

- Develop and implement policies, procedures, and practices to ensure that youth with trauma-related needs receive trauma-responsive screenings, assessments and treatment
- Add a brief standardized, reliable and valid trauma-specific screening tool once the intake screening protocol is working consistently and effectively (e.g., fix MAYSI-2) and a formal process is developed to keep youths' responses to the trauma-specific tool confidential
- Provide a full-day of training on trauma-informed/responsive care (e.g., understanding the impact of trauma on youths' moods, thoughts, behavior, and brains; trauma-responsive management strategies to use in detention) to *all* detention facility staff (direct-care to administration).
    - Clinical training on trauma-informed/responsive treatment should be provided to/obtained for all mental health and substance use treatment professionals working in the detention facility
- Continue focusing on safety, structure, and accountability within the facility, with an emphasis on clear, specific behavioral expectations and a strength-based behavior management programs—while also teaching youth skills to better manage their thoughts and behavior.
- Continue to emphasize key relationships between youth and supportive adults, especially direct-care staff.
- Create a space (e.g., comfort room) on each unit for youth to practice calming themselves down when agitated, upset or feeling out-of-control.
- Create a culture within the facility where negative youth behavior is not automatically viewed as intentional; staff are willing to consider that negative behavior could be the result of traumatized youth being triggered and overreacting to what they *perceive* to be a threat.
    - From a trauma-responsive approach, youth are not to blame for their victimization and traumatic experiences, but are responsible for learning how to effectively cope and manage their emotions and behavior when their trauma response is triggered.
    - Staff should listen and provide support to traumatized youth, help them de-escalate when upset, and assist them in developing more adaptive thoughts and behaviors when triggered by people or situations.
- Staff should exhibit patience, creativity, and flexibility in their management and programming of trauma-affected youth.
- Whenever situations in which youth will likely feel particularly vulnerable must occur (e.g., room confinement, physical restraint, safety smock), staff at all levels should be aware of the potential for re-traumatization and do all they can to prevent that from happening.
- Provide opportunities for youth to learn practical coping skills to help them manage feelings of anger, shame, guilt, embarrassment, or fear stemming from witnessing or experiencing traumatic experiences.
- Youth should be referred to a QMHP if they are distressed by trauma-related symptoms and/or their trauma-related symptoms impair their ability to function appropriately in the detention school, on the living unit, or in relationships with staff or peers.

- QMHPs should help youth in the facility recognize how they have been impacted by trauma, identify what specifically triggers their trauma-related reactions (e.g., angry outbursts, shutting down, aggression, overreacting, self-injury), and teach them more appropriate ways to respond.
    - Evidence-based, gender-specific treatment for trauma, including sexual abuse, should be available for girls and boys who are detained/incarcerated for 30 days or more.
- QMHPs should attend "due process" hearings for youth who have significant trauma-related symptoms.
    - During the hearing, the role trauma may have played in an incident (e.g., reactive aggression) should be considered and the process should allow for mitigation of sanctions when indicated
- Encourage any/all mental health professionals to evaluate the role of trauma on youths' ability to pay attention, mood, and behavior before diagnosing them with mental health or substance use disorders or prescribing psychotropic medication.
- Interdisciplinary treatment teams should integrate the impact of trauma into case conceptualizations of youth, individualized treatment plans, interventions, and daily programming.
- All staff should be diligent about their role as mandated reporters of child abuse and neglect and clearly explain to youth what information remains confidential (if any), what information can be released and under which specific circumstances, and who will likely receive information if a report must be made.
- Hire case managers within the detention facility to serve as a liaison between the Youth Court Counselor, facility staff, parents/caregivers, and youth.
    - Youth Court Counselors seem to have a *substantial* amount of different and time-intensive responsibilities and reportedly cannot always provide the necessary information, predictability for youth, and emotional support typically needed by traumatized youth who can become extremely anxious, agitated, and distressed when they do not know what is going to happen with them/to them.
- Due to the high numbers of youth who use alcohol and other drugs to cope with witnessing or experiencing traumatic events, youth who displayed a pattern of alcohol or other drug use prior to incarceration and/or who are involved with the Juvenile Drug Court should be screened for trauma.
    - If a youth "red flags" on the trauma screening tool, a more in-depth trauma-related assessment and trauma-related treatment services should be provided.

Suicide Prevention

Suicide is the leading cause of death among youth in juvenile justice facilities and is more common among incarcerated youth than those in the community. Death can seem like the only option to detained/incarcerated youth who feel hopeless, alone, anxious, or depressed and who want to escape unbearable psychological pain, distressing circumstances, or dire futures.

A study of youth in detention found *one in ten* had thought about killing themselves in the previous six months, and a little over *one in ten* had made an actual suicide attempt at some point in their lives, with many trying to kill themselves more than once. Fewer than half of the youth with recent suicidal thoughts had told anyone about them.

The best way to prevent suicide in detention facilities is to prevent youth from becoming suicidal in the first place. Addressing youth's mental health symptoms; providing youth with as much certainty, predictability and control as safely possible; building positive staff/youth relationships; quality education and vocational programs; a home-like environment; evidence-based psychotherapy; a trauma-responsive approach; parent/caregiver engagement; emphasizing skill-building over punishment; strength-based behavior management; meaningful programming; a variety of recreation and leisure activities; and consistent collaboration between juvenile justice, mental health, medical and education staff are some key ways to reduce the chances that youth in detention will want to or will try to take their own life. Despite having all of these factors in place, some youth may still become suicidal while detained/incarcerated.

Juvenile justice facilities should have a comprehensive suicide prevention program with policies, procedures and practices that address prevention strategies, the identification of potentially suicidal youth, responses that keep suicidal youth safe and help reduce their suicidal thoughts and behavior, and how to intervene appropriately and effectively if there is a suicide attempt. The comprehensive suicide prevention program should be consistently implemented and conform to national standards and best practices in juvenile corrections.

Policies and Procedures

Suicide prevention policies and procedures should be written clearly, concisely, and in language easily understood by staff at all levels.

Findings

- There was some confusion as to which suicide prevention policy the staff are currently working off of. Policy A.S.5 is the current suicide prevention policy staff have been trained on and are supposed to be following. However, there is also an updated version of the suicide prevention policy that is two pages longer and contains additional components, but it is also listed as A.S.5.
    - The suicide prevention policy in place is outdated and does not accurately reflect current practices occurring in the facility (e.g., the facility now has a mental health professional).
    - The current suicide prevention policy has not been officially signed and dated.
- Ms. Frelix is currently working on updating the detention facility's Suicide Prevention policy. The most recent "draft" is significantly longer, more comprehensive and provides more detail regarding what detention staff, shift supervisors and QMHPs should do and when regarding youth who are a potential risk for suicide.
    - It has a multitude of components congruent with national standards and best practices, however there are a few components included in policy that the facility does not physically have in place at this time or are not currently possible due to the limited number of mental health professionals (i.e., one) at the facility.
- Despite the confusion over the suicide prevention policy, the fact it is outdated, and the number of youth with mental health disorders housed in juvenile detention facilities, I was told there has never been a completed suicide at the Henley-Young detention center since the current building opened over a decade ago.

Recommendations

- Ensure any and all suicide prevention policies are accurate and are formally signed and dated.
- Continue developing the new and updated suicide prevention policy and procedures, ensuring they are consistent with national standards and best practices in juvenile corrections.
- Implement the new suicide prevention policy and procedures as soon as possible, ensuring the facility has all the staffing and physical components in place needed for staff to perform the required practices/duties.
- Ensure the new suicide prevention policies, procedures and practices are implemented consistently and effectively.
- Evaluate the number of QMHPs needed to carry out the requirements of the new suicide prevention policy and hire additional QMHPS as soon as possible to cover those critical responsibilities.

Suicide Prevention Training

Upon hire, every detention facility staff member who comes into contact with youth, or makes key decisions about youth, should receive mandatory, practical, up-to-date and interactive training on suicide prevention among youth in custody (8 house minimum); mandatory refresher training (2-4 hours minimum) should occur annually.

Findings

- Suicide Prevention training is not mentioned in the current suicide prevention policy.
    - The updated draft policy requires Suicide Prevention training as part of the Orientation process, but does not specify the length of the training. It also requires two (2) hours of refresher Suicide Prevention training each year.
- It was reported that all staff but 4 (3 of the 4 are newly hired staff) have attended a four (4) hour training in Suicide Prevention, which included the current suicide prevention policy.
    - I was told the last class occurred August 2014 and was taught by Ms. Frelix.
    - I was told that suicide refresher courses at the detention facility are two (2) hours in length.
- In mid-September, some staff (including the only staff trainer and only mental health professional) attended a new Suicide Prevention training program developed by the National Center for Youth in Custody (NCYC)/National Partnership for Juvenile Services (NPJS) and delivered by two professional trainers with significant experience in juvenile justice.
    - It is my understanding that the Suicide Prevention training was designed to be an eight (8)-hour training, but it was reported that it was delivered as a five (5) to six (6)-hour training. Staff were unable to identify what material from the curriculum was not covered, so it is possible the full training was delivered.
- It was reported that Ja'Net McCoy, the training coordinator (i.e., sole staff trainer) and/or Ms. Frelix would deliver the full-day NCYC/NPJS training to the remainder of the facility staff.
- Despite the majority of staff having completed the Suicide Prevention training, one youth on Suicide Alert status was voluntarily isolating himself in his room and sleeping while other peers were interacting in the dayroom. It did not appear that direct-care staff recognized these behaviors as potential symptoms of/or worsening depression or suicidality. Staff also did not remove several potentially dangerous items from his room.

Recommendations

- Update the suicide prevention policy, procedures and practices to ensure that all staff who interact with youth, and make key decisions about youth, in the detention facility receive a minimum of eight (8) hours of Suicide Prevention training before interacting with youth and at least two (2) hours of Suicide Prevention refresher training each year. Consider using the NCYC/NPJS Suicide Prevention training module, delivered as a full-day training (8 hours).
- The training coordinator and mental health professional should carefully review and study the material for the NCYC/NPJS Suicide Prevention training (e.g., detailed curriculum with instructions on how to deliver the training, PowerPoint slides and video clips, participant manual/handouts) to familiarize themselves with the material before delivering it.
- Begin providing the new Suicide Prevention training for all Henley-Young staff that interact with youth, and make decisions about youth, as soon as possible.
- All newly hired staff should attend the new Suicide Prevention training prior to working independently with youth.
- Ensure that all detention facility staff are trained on signs/symptoms of depression among adolescents, warning signs of suicide among youth, and issues related to the intensive monitoring and safe housing of suicidal youth.

Suicide Screening & Identification of Suicidal Youth

All youth in the detention facility should be screened for suicide risk upon intake, in a private setting, by appropriately trained staff using a standardized form with interview questions, behavioral observations, and information from the transporting officer. All staff should continuously be on the lookout for youth who display warning signs of suicide, and youth should be re-screened for suicide risk whenever indicated by their statements, behavior, or information coming from other sources.

Findings

- Youth receive the MAYSI-2 upon intake, which has a "suicide scale." They are also asked a question about suicide on an "admission screening form" and the nurse's "medical" screening form also contains two questions about suicide.
- Most youth take the MAYSI-2 at the computer, which has partitions so youth sitting next to each other have some privacy.
    - During my site visit, the computerized/electronic MAYSI-2 was not working correctly.
- When I was in the intake area, there was enough privacy for a youth to be interviewed by staff confidentially; the same was true for the nurses medical office.
    - If there were multiple youth being admitted to the intake area at the same time, I was told youth are placed in holding cells and let out one at a time to allow for privacy.
- I was told that intake staff ask general questions of transporting officers to get an idea of the youths' behavior prior to arrival at the facility.
    - The suicide prevention policy requires intake staff to ask transporting officers or probation officers about "special precautions or circumstances.

Recommendations

- Ensure the updated suicide prevention policy, procedures and practices require that all youth admitted to Henley-Young juvenile detention facility are screened for suicide risk upon intake and whenever indicated by a youth's statements, behavior, or information coming from other sources.
- Fix computerized MAYSI-2 program immediately; conduct and score all MAYSI-2s by hand until electronic/computerized version is consistently working effectively.
    - If youth cannot read or the electronic/computerized program is not working, consider using the "audio computer" where the MAYSI-2 items are read to youth versus a staff member reading the questions
- Implement a standardized process for staff to observe and document behavioral observations (e.g., mood, posture, tone of voice, energy level, scar/marks on body) during suicide intake screening.
- Implement a standardized process to gather information from transporting officers, and any other relevant adults, regarding potential warning signs of suicide so staff do not solely rely on youth's self-report
- Suicidal thinking and behavior can ebb and flow; emphasize the importance of all staff continuously being on alert for youth displaying warning signs of suicide and clarify staffs' role when faced with youth they are concerned about
- Ensure that all staff who interact with youth in detention are skilled enough to spend 5-10 minutes talking with youth regarding suicidal thoughts and behavior in order to determine whether or not they are potentially suicidal and in need of referral to a QMHP.
- Ensure all staff who interact with youth in detention know what steps to take when a youth denies suicidal ideation, but staff remains concerned about his/her suicide risk.

Referral to a QMHP for a Suicide Assessment

Youth identified as potentially suicidal should be immediately referred to a QMHP for a face-to-face suicide assessment; if a QMHP is not immediately available youth should be continuously observed and monitored while awaiting the assessment—which should occur as soon as possible, but not longer than 24 hours.

Youth who elicit staff concern in relation to suicidal thoughts or behaviors at any point during their stay should be immediately referred to a QMHP for a suicide assessment.

Findings

- The current policy explains to staff the actions they should take if they are concerned youth may be suicidal. However, the current policy is outdated regarding who staff should refer youth to for a suicide assessment; details about when the suicide assessment should occur are also missing.
- In current practice, staff refer potentially suicidal youth to Ms. Frelix for further assessment. She is the only mental health professional in the detention facility and the primary person who places youth on/removes youth from Suicide Alert status.
    - Ms. Frelix makes herself available to staff 24/7 and has received calls late at night or on weekends.
- Assessing potentially suicidal youth is one of the most important responsibilities within the detention facility and Ms. Frelix seems to realize that. However, because of the time required to assess youth for suicide risk, it does not allow her much time to do other essential responsibilities required of a mental health professional.
    - Ms. Frelix reported that ten youth were admitted over a weekend in October, with several of them requiring follow-up assessments Monday morning due to potential suicide risk.
- When Ms. Frelix is not in the building, it was reported that a shift supervisor or one of the medical staff (usually the nurse) place youth on 5 minute intensive monitoring until evaluated by Ms. Frelix within 24 hours (this does not include weekends and holidays). However, this is not listed in the current policy.

Recommendations

- Update and implement Suicide Prevention policy, procedures and practice ensuring a formalized process of referring youth at potential risk for suicide to QMHPs for suicide assessment as soon as possible, but no longer than 24 hours—including weekends and holidays.
- Ensure suicide prevention policy and practices are consistent with one another.
- Youth should be placed on the highest level of Suicide Alert (constant supervision) until seen by a QMHP for a face-to-face suicide assessment, which should occur as soon as possible, but no longer than 24 hours after the QMHP has been contacted.
- Ensure the facility has numerous QMHPs to whom staff can refer potentially suicidal youth; on-call coverage in the evenings and on weekends should be shared by multiple QMHPs.

Suicide Assessment

Suicide assessments conducted by QMHPs should determine a youth's degree of suicide risk, the level of monitoring needed, specific components for a safety plan, and if transfer to a psychiatric hospital is necessary. QMHPs should have the license, education, training, and experience to make these decisions.

Findings

- There is very little information about suicide assessment in the current policy.
- I observed Ms. Frelix meet with a female resident who had multiple concerning endorsements on the intake screening tools. Ms. Frelix asked the young woman about them in genuinely caring fashion to better understand her distress and concerns. She asked appropriate follow-up questions, including directly asking about suicide and self-injury. She also read questions aloud from a standardized tool assessing depressive symptoms and potential suicide risk to the young woman to gather additional information.
- Ms. Frelix showed me several forms inquiring about suicidal thoughts/behavior and important associated issues that she utilizes during her suicide assessments (e.g., "initial suicide screening form," subsequent suicide risk assessment form) to gather information from youth.

- The suicide assessment process gathers important information regarding suicide risk, but appears to be fairly informal with no formal scoring/interpretation of standardized suicide screening/assessment tools.
- It was reported that Ms. Frelix meets with youth on Suicide Alert status daily (except weekends and holidays) to re-assess their suicide risk.
    - She states that in addition to talking with the youth, she talks with staff and inquires about youth behavior on the unit, particularly unusual behavior.
    - She says she periodically speaks with medical staff (i.e., nurses) regarding youth on Suicide Alert status.
    - I was told that a new contract with medical staff will require nurses to also meet with youth on Suicide Alert status daily.
- It was reported that incident reports regarding suicidal behavior need to be written by direct-care staff by the end of their shift, therefore key information about suicidal youth is often not available to Ms. Frelix when she is doing her suicide assessments.
- It did not appear that parents are typically contacted as part of the suicide risk assessment process.
- During suicide assessments, Ms. Frelix said that she has worked with medical staff to transfer acutely suicidal youth to the University of Mississippi Medical Center (UMC), who then placed youth in a psychiatric facility for adolescents. She had no complaints or concerns about this process.
- I observed Ms. Frelix making individualized decisions about what youth on Suicide Alert status could/could not have with regard to safety. However there does not appear to be a formalized process for “safety plans.”

Recommendations

- Update and implement Suicide Prevention policy, procedures and practice ensuring youth deemed a potential risk of suicide receive a formal suicide assessment by a QMHP as soon as possible, but no longer than 24 hours after being identified as a potential risk for suicide and placed on Suicide Alert status.
- Utilize standardized suicide assessment tools that are reliable and valid with adolescents, score them and incorporate results into suicide assessment decisions.
- Ensure any and all mental health professionals within the facility responsible for providing suicide risk assessments are trained in assessing adolescents for suicide, including evidence-based suicide risk predictors.
    - They should also be trained in developing individualized “safety” plans.
- A determination of suicide risk should take into account a youth’s current behavior, history, and issues specific to the Henley-Young detention facility, in addition to a youth’s statements.
    - Because parents/caregivers may be able to provide information regarding youth’s history of suicide, current stressors, what has been helpful/unhelpful for reducing suicidal thoughts/behaviors in the past, and the types of support they can potentially provide for their child, they should be contacted during the assessment process whenever possible.
- QMHPs should develop individualized “safety” plans that inform all staff regarding youth’s risk of suicide; briefly lists their mood/behavior, strengths and protective factors, current stressors, warning signs or high risk behaviors to be alert to; and any other information needed by direct-care staff to effectively supervise, monitor and manage a youth at high risk of suicide.
    - Safety plans should address any modifications or restrictions to standard programming that are required for a youth’s safety based on his/her level of suicide risk.
    - Safety plans should be as least restrictive as safely possible and should be attached to the form used to document the intensive monitoring of suicidal youth.
- Youth placed on Suicide Alert status should be re-assessed in person (not through a door) by a QMHP at least once per day to determine if their suicide status has changed and, if it has, the QMHP takes action to address it (e.g., increase or decrease the required level of monitoring, transfer youth to psychiatric hospital, removal from Suicide Alert status).

- The period following removal from Suicide Alert status is a high-risk time for some youth; therefore, QMHPs should remain in close contact with youth after precautions end, assessing for suicide risk over the next several days.
    - Contact should then be slowly spaced out, with QMHPs periodically assessing suicide risk.
- Require documentation of suicide-related incident reports be done as soon as possible so key information is communicated to the mental health professional making decisions about a youths' level of suicide risk.
- Ensure QMHPs providing suicide assessments and making decisions about suicidal youth have the license, education, training, and experience to do so.
- Evaluate the number of QMHPs needed to carry out necessary suicide assessment requirements and hire additional QMHPs as soon as possible to cover these critical responsibilities.

Treatment for Suicidal Thoughts and Behaviors

QMHPs should develop individualized "treatment" plans for youth on Suicide Alert status specifically targeting suicidal thoughts or behavior, and secondarily other related key issues and needs. Treatment plans should emphasize the development and strengthening of protective factors as much as reducing suicide risk factors. QMHPs should use evidence-based or best practice psychotherapy to reduce suicidal thoughts and behavior, as well as address underlying issues.

Direct-care staff are essential to the treatment of suicidal youth; they should be encouraged to build positive and supportive relationships with all youth during day-to day interactions and provide extra support to youth who are suicidal.

Findings

- The current policy does not discuss treatment or treatment plans for suicidal thoughts and behaviors.
    - The updated draft policy that has not been implemented discusses treatment plans, but does not address evidence-based treatment.
- Treatment plans are not developed for youth on Suicide Alert status at this time.
- There is no evidence-based treatment for youth experiencing suicidal thoughts and/or behaviors.
    - There is only one mental health professional in the facility and she is typically carrying out other required tasks, including other suicide-related responsibilities.
- Although direct-care staff seem to view themselves as essential to the "safety" of suicidal youth, particularly when observing them on intensive-monitoring, they not appear to view themselves as essential to the "treatment" of suicidal youth.
- There was a young man who swallowed a tack at the facility; he was sent to the hospital, was apparently cleared to be released, and then returned to the detention center. Ms. Frelix continued his intensive monitoring at the facility. However no treatment plan or mental health treatment was provided.

Recommendations

- Update and implement Suicide Prevention policy, procedures and practice ensuring youth placed on Suicide Alert status receive an individualized treatment plan and evidence-based treatment specifically targeting suicide-related thoughts and behaviors, as well as developing and strengthening protective factors.
- Ensure all mental health professionals working in the facility are trained in the development of treatment plans and the provision of treatment of suicidal adolescents, including evidence-based treatment and best practice psychotherapy strategies to reduce suicidal thoughts and behavior, as well as address underlying issues.
- QMHPs should provide treatment to suicidal youth while on Suicidal Alert status and continue to provide follow-up treatment and monitoring to reduce the risk of relapse after a suicidal crisis is over.

- Verbalize frequently the importance of staff building positive and supportive relationships with all youth, but particularly those who are suicidal—and how this is a key part of "prevention" and "treatment" for suicidal thoughts/behavior.
    - Encourage staff to build positive and supportive relationships with all youth during day-to day interactions and to provide extra support to those who are suicidal; reinforce staff for doing so.
- Evaluate the number of qualified mental health professionals (QMHPs) needed to develop treatment plans for suicidal youth and provide suicidal youth with evidence-based treatment focused on reducing suicidal thoughts and behaviors; hire additional professionals as soon as possible to cover these critical responsibilities.

Intensive Monitoring

Staff should monitor youth at high risk for suicide in person and on an irregular schedule not to exceed 5 or 10 minutes, depending on a youth's level of risk. Staff should "continuously" observe (1:1 youth-to-staff ratio) actively suicidal youth (threatening or engaging in suicide-related behavior) or transfer them to the hospital. Staff should clearly document all monitoring. Any staff member should be able to place a youth on intensive monitoring, but only QMHPs should be able to lower or take youth off intensive monitoring.

Findings

- The current Suicide Prevention policy requires staff to monitor youth every five (5) minutes, but there is no detail about how staff should document this monitoring.
    - The updated draft policy that has not been implemented has 3 different levels of staggered watch and a precautionary status, including staggered watches every 5 or 10 minutes and 1:1 observation.
- Staff complete a "Resident Observation Sheet" when providing intensive monitoring. The sheet has several strengths, but some of the wording is outdated. When I saw this form in action, staff only wrote the word "Suicide" in the section "Briefly Describe Incident".
- According to the current Suicide Prevention policy, the Resident Observation Sheet is supposed to be posted to the door of the rooms/cells of youth on Suicide Alert and staff carry it with them when youth are out of their rooms.
    - I observed this form being carried by a staff member monitoring a suicidal youth; however it was also within view of other youth.
- A young woman who was put on Suicide Alert status earlier in the day was not being monitored more closely during second shift, which is a potentially dangerous situation. Staff were interacting with her, but they had not been informed that she had been placed on Suicide Alert status.
- It was reported that Mrs. Frelix, a shift supervisor, or medical staff (i.e., nurse, psychiatrist) can place a youth "on" Suicide Alert, but only Ms. Frelix or the psychiatrist can take a youth "off" Suicide Alert. This is not stated in the current policy.
    - The updated draft policy that has not been implemented allows for "any designated staff" to place a youth on Precautionary Status, but only a QMHP can initiate, continue, upgrade, downgrade or discontinue Suicide Alert or Precautionary Status.

Recommendations

- Update and implement Suicide Prevention policy, procedures and practices with three (3) levels of intensive monitoring for suicidal youth that includes irregular schedules not to exceed 5 minutes or 10 minutes based on a youth's level of risk, and continuous observation (1:1 youth to staff ratio) for actively suicidal youth.
- If a youth placed on Due Process Isolation becomes suicidal, they should be monitored continuously (1:1 youth to staff ratio)

- Ensure the "Resident Observation Form" describes the incident prompting Suicide Alert status with enough detail to help staff supervise the youth effectively.
    - Staff should be as sensitive and discreet as possible when carrying and completing the Resident Observation Form
- A youth's "safety plan" should be attached to the documentation sheet for intensive monitoring (e.g., Resident Observation Form)
- Juvenile justice, mental health, and medical professionals should be adequately trained to place potentially suicidal youth on Suicide Alert status (this would refer to "Precautionary Status" if the updated draft policy is implemented). Only QMHPs should be able to reduce or remove youth from intensive monitoring.
- Closed-circuit television can supplement, but never replace, in-person staff monitoring.
- To reduce stigma, intensive monitoring should be referred to as "Safety Watch," "Safety Precautions" or something similar versus "Suicide Alert."
    - The updated draft policy that has not been implemented yet refers to it as "Safety Alert" which is comparable.

Safe Housing of Suicidal Youth

All rooms or cells that house suicidal juveniles should be "suicide-resistant" (e.g., large viewing windows, no secure objects youth can tie something to and asphyxiate themselves, nothing youth can use to suffocate themselves) and juvenile justice facilities should have enough suicide resistant rooms to meet the needs of their population.
Suicidal youth should not be isolated; if this must be done for safety reasons, the decision should be made in collaboration with a QMHP and suicidal youth must be continuously monitored. Suicidal youth who can safely participate in standard facility programming should do so with more intensive levels of supervision, monitoring, and documentation. Suicidal youth should have access to the same academic, recreation, and leisure opportunities as their peers, unless these are modified for safety purposes; only QMHPs should implement or remove these modifications, and they must be documented and communicated to all relevant staff.

Youth on Suicide Alert should be housed near staff stations, with staff regularly interacting with them. Suicidal youth should remain in regular clothing (except if wearing shoelaces or belts), unless they use their clothing to harm themselves. In those instances, only that piece of clothing should be removed. Safety smocks should not be used, except in rare circumstances where it is indisputably necessary for youth safety and is done in collaboration with a QMHP. Youth should never be made to wear special clothing that signifies their risk of suicide.

Findings

- There are no "suicide-resistant" rooms on any of the units. Most, if not all rooms have desks, collapsible hooks, and metal beds.
    - The beds are bolted to the floor, and although very close to the wall, it seems possible to thread something thin between the wall and the bed. The updated draft Suicide Prevention policy refers to housing youth in suicide-resistant rooms.
- In line with least-restrictive housing, I observed a youth on Suicide Alert status outside during "recreation" talking with other youth and later in the dayroom interacting with peers and staff. He was wearing his regular clothes and not stigmatized in any way. This is consistent with current policy and the updated draft policy.
- The units have two tiers with safety fencing that youth would reportedly sometimes climb onto from the upper tier. The facility recently installed Plexiglass over key portions of the fencing to prevent this from happening and it seems to be effective
- It was reported that "safety smocks" are only used for youth on SP when they are in their room during a 20 minute shift change and when residing in their room for the evening. While visiting a unit I saw a young woman on

Suicide Alert status who was in her room without a suicide smock because staff were not aware she had been put on Suicide Alert status.

- I observed a young man on Suicide Alert who was housed in a cell a few feet outside the main unit and isolated from rest of the group, which made it harder for staff to observe and monitor him, and more difficult for the young man to alert staff if he needed help/support.
    - This same youth put a book and papers over his window so it was partially obstructed; he had several items in his room that could be used for a suicide attempt (e.g., extra clothing, including a ripped t-shirt; cup of grease for his hair; brush; deodorant; two blankets). These items were removed when I requested it.
    - Once out of his room, this young man was integrated into the dayroom activity and not stigmatized in any way.
- Ms. Frelix reported putting several important changes into place to help keep suicidal youth safe: removing white sheets youth could easily tear and replacing them with thicker blankets, removing paper suits and replacing them with safety smocks, and removing coats for youth that contained strings they could pull out and replacing them with sweatshirts.
    - She has also requested that laundry workers discard any blankets that have tears or are frayed so potentially suicidal youth cannot tear them further.

Recommendations

- Update and implement Suicide Prevention policies, procedures, and practices to ensure that all youth on Safety Alert status are housed in “suicide-resistant” rooms” near staff
- Create suicide-resistant rooms on each unit immediately. Given the design of current rooms/cells at the Henley-Young detention center, attention should be directed at ensuring there are large enough windows for an unobstructed view of the entire inside of youths’ room/cell, concrete slab beds versus metal beds, no collapsible hooks, food pass doors can be closed and locked, no desks/chairs or other items that youth can tie something to or around, intercoms for suicidal youth to communicate with staff if needed, and tamper-proof light fixtures.
    - An assessment of other potential suicide risks in youths’ rooms/cells should be completed to ensure they are removed when creating “suicide-resistant” rooms.
- Suicide-resistant rooms should be close to the staff tower; ideally using the rooms/cells where staff can most easily view youth inside their room while located inside the staff tower.
- House all youth on Suicide Alert status in suicide-resistant rooms.
- Because many detained/incarcerated youth have a multitude of suicide risk factors, incarceration can be stressful, and many of youths’ typical coping skills are restricted in detention, efforts should be made to remove any obvious and non-necessary items/components that could be dangerous for a suicidal youth from all regular rooms/cells.
- Staff should encourage youth on Suicide Alert status to participate in some type of activity when they want to isolate and/or sleep in their room during times of resident activities.
    - If youth show a pattern of isolation, refer youth to QMHP for evaluation.
- No youth should ever be allowed to cover any part of their window.

Communication About Suicidal Youth

Juvenile justice, mental health, medical, and educational staff should meet daily to discuss which youth in the facility are on Suicide Alert status and the most effective strategies to observe and manage them. Juvenile justice staff should communicate from one shift to another about 1) which youth are on Suicide Alert, 2) the level of intensive monitoring required, and 3) any specific information needed to help keep these youth safe. Communication about suicidal youth should occur between facility staff and community agencies (e.g., arresting or transporting officer, local court, psychiatric or medical hospitals) when necessary. QMHPs should communicate with juvenile justice and medical staff before removing youth from Suicide Alert status.

Juvenile justice, mental health, and medical staff should document essential information related to which juveniles require more intensive monitoring and why. Documented information from a variety of sources helps juvenile justice staff strategically manage suicidal youth and helps QMHPs evaluate and develop intervention strategies for them.

Findings

- There were no daily interdisciplinary meetings to discuss which youth in the facility are on Suicide Alert status and the most effective strategies to observe and manage them.
    - Neither the current Suicide Prevention policy or updated draft policy discuss daily interdisciplinary meetings.
- Information about youth on Suicide Alert status appears to primarily be communicated verbally and passed on from one individual to another.
- Each unit reportedly has a log book for documenting youth behavior, including youth who have been placed on Suicide Alert status. I was told the shift supervisors are supposed to read the log book and pass on this information, as well as other essential information, to shift supervisors starting the next shift.
    - Central control is also supposed to have a list of youth on Suicide Alert.
- There was a breakdown in communication with a young woman who was placed on Suicide Alert status by Ms. Frelix. The staff on evening shift were unaware of her suicide risk status and the need for intensive monitoring. Had I not walked on the unit that evening, it is possible (even likely) that young woman would have gone the entire night alone in her room which had several items with which she could asphyxiate herself.
- It is unclear how much communication occurs regarding suicidal youth between detention staff and the Youth Court Counselor, as well as Ms. Frelix and the Youth Court Counselors.
    - Based on two suicidal youth at the facility I observed/spoke with, it did not appear to be very much.
- Mrs. Frelix reported talking with direct-care staff prior to removing youth from Suicide Alert status.

Recommendations

- Update and implement Suicide Prevention policies, procedures, and practices to ensure that brief interdisciplinary meetings occur daily to discuss which youth in the facility are on Suicide Alert status, the reasons why, and the most effective strategies to observe and manage them.
    - This meeting should be part of a daily general interdisciplinary meeting that also focuses on youth who are struggling in the facility, behaving aggressively or who have other needs that need to be addressed.
- A formal system should be implemented to ensure juvenile justice staff communicate from one shift to another regarding 1) which youth are on Suicide Alert status or had their Suicide Alert status change 2) the level of intensive monitoring required for youth on Suicide Alert status 3) any specific information needed to help keep these youth safe at the facility.
    - Consider “shift change” meetings where staff from first and second shift are both present.
- Communication about suicidal youth should occur between QMHPs and community agencies (e.g., arresting or transporting officer, local court, psychiatric or medical hospitals) when necessary.
- QMHPs should communicate with medical staff, in addition to juvenile justice staff, before removing youth from Suicide Alert status.
- A formal referral system should be implemented with standardized forms for direct-care staff to complete when referring youth who have already been placed on a unit and appear to be at potential risk of suicide; this helps provide/document important information the QMHP needs to assess youths’ risk.
    - Supervisors should sign off on these referral forms.
- A formal referral system should be implemented with standardized forms for youth to refer themselves once already placed on a unit if they are experiencing suicidal thoughts or behaviors.

  - These forms should be delivered to a QMHP as soon as possible after a youth fills it out. Staff should be sensitive and discreet about these youth self-referrals.
- Mental health and medical staff should document essential information related to which juveniles require more intensive monitoring and why in the medical and mental health files
- All staff working within the facility should document factual information (e.g., what they observed, heard, read) and avoid statements about motivation (e.g., trying to get attention).
  - Behavioral observations related to depressed mood, irritability, or aggression should also be recorded.

Responding to an Active Suicide Attempt

Staff must know how to respond to suicide attempts in progress, especially hangings and other forms of asphyxiation, and should be trained in providing first-aid, CPR, and other life-saving measures. Realistic suicide-intervention drills should be conducted randomly and regularly to help staff practice life-saving strategies in situations where a youth's life is not at risk. A suicide cut down tool, CPR mouth shield or pocket mask, Ambu bag, and first aid kit should be located on every unit, easily accessible to staff, and inventoried at least once per day. Staff who discover a youth attempting suicide should immediately respond, assess the severity of the emergency, alert other staff to call for medical personnel if needed, and begin life-saving measures. Staff should never assume youth are dead and should do all they can to keep youth alive until medical professionals take over.

Findings

- The current Suicide Prevention policy does not address how staff should respond to an active suicide attempt.
  - The updated draft policy that has not been implemented has a detailed section on this topic that walks staff through the steps of how best to respond. Much of the information is consistent with the paragraph above, however there is at least one important grammatical error (i.e., "direct care shall presume that the victim is dead" should be "direct care staff shall never presume the victim is dead")
- It was reported that the CPR training is done by a contracted trainer and is four (4) hours in length.
  - I was told the use of a "cut down" tool is covered in the Suicide Prevention training.
- It was reported that every unit has a first aid kit, the facility will be ordering mouth shields and there are no Ambu bags in the facility.
- No mock suicide intervention drills have been conducted.
- A suicide "cut down" tool was located on the wall of the staff tower, out of reach of the youth, on the units visited.
  - Cut down tools were kept in plastic holders to keep them protected, as wells as act as an added barrier to keep them from being accessed by youth. Unfortunately, the plastic holders were difficult for adults to open, which could be problematic during an emergency life/death situation.

Recommendations

- Update and implement Suicide Prevention policies, procedures, and practices to ensure that all staff know how to respond to suicide attempts in progress, especially hangings and other forms of asphyxiation, and are trained in providing first-aid, CPR, and other life-saving measures.
  - Suicide Prevention policies and procedures should also address suicide-intervention "drills" and safety equipment for each unit.
- Ensure 100% of staff receive training on CPR, first aid, and other life saving measures
- Conduct four (4) realistic mock suicide prevention drills randomly each year so staff can practice life-saving strategies in situations where a youth's life is not at risk.
- Obtain different holders for cut down tools that are easier to open quickly

  - Ensure all staff know where the cut down tool is located on each unit
- Ensure every unit has a mouth shield and Ambu Bag in addition to the first aid kit that is easily accessible to staff.
- Implement a formal process for inventorying the cut down tool, mouth shield, Ambu Bag, and first aid kid at least once daily with documentation when completed.

Notification of Suicidal Behavior

Parents/caregivers should be notified as soon as possible when their son or daughter is placed on Suicide Alert status, and asked about strategies that have previously decreased their child's distress. It should be clear to staff who they should contact (within the facility and outside authorities) and at what point regarding potential, attempted, and completed suicides. If youth are a high risk for suicide close to the time they are released from the facility, QMHPs should enlist the support of parents/caregivers and community mental health providers with regard to continued assessment, monitoring, and treatment.

Findings

- The wording in the current Suicide Prevention policy is not exactly clear, but it seems to say that parents should be notified when youth make a suicide attempt.
  - The updated draft Suicide Prevention policy that has not been implemented states that parents should be contacted if a youth is determined to be at risk for suicide.
- It was reported that current practice at the detention facility is to contact parents only after a suicide attempt requiring medical attention/hospitalization.
  - It is possible that the Youth Court Counselor alerts parents when their child is placed on Suicide Alert status since they have more contact with parents in general; I cannot say for sure as I was not permitted to speak with them.
- The current Suicide Prevention policy describes who staff should contact in the event of a suicide attempt, or a completed suicide.
  - The updated draft policy that has not been implemented gives more details about who to notify in the event of a suicide attempt, but does not appear to cover a completed suicide.
- Ms. Frelix said she often is not told when a youth is being released from the detention facility, including youth on Suicide Alert status; she said it would be helpful to have this information.

Recommendations

- Update and implement Suicide Prevention policies, procedures, and practices regarding the notification of appropriate individuals (e.g., parents, administrators, juvenile court, youth attorneys, outside authorities) regarding potential, attempted, and completed suicides and how and when the notification should take place.
- Parents/caregivers should be notified as soon as possible (but no more than 2 hours) anytime their son or daughter is placed on Suicide Alert status, and asked about strategies that have previously decreased their child's distress.
- The juvenile court and a youth's attorney should be notified anytime a youth is placed on Suicide Alert status; this should occur within 24 hours of placement on Suicide Alert status.
- If youth are a high risk for suicide close to the time they are released to the community, QMHPs should enlist the support of parents/caregivers and community mental health providers with regard to continued assessment, monitoring, and treatment.
  - QMHPs should be alerted when a youth on Suicide Alert status is going to be released from the detention facility. They should be given as much advanced notice as possible.

- When youth on Suicide Alert status are released from the facility, QMHPs should educate parents/caregivers about the danger of guns and other potentially lethal means in the home and encourage them to remove these items immediately.

Reviews of Suicide Attempts and Completed Suicides

All suicide attempts (regardless of the severity) should be reviewed in some manner. Administrative, mental health and medical reviews should occur any time there is a suicide attempt requiring medical care or a completed suicide to better understand exactly what happened, why, and what necessary improvement measures are required, if any. A psychological autopsy should be conducted within 30 days of a completed suicide by a psychologist or psychiatrist to better understand the specific factors that may have contributed to a youth taking his or her own life. A quality-assurance process should be in place to monitor the components of a facility's suicide prevention program, with immediate modifications made when indicated.

Findings

- It was reported that no formal reviews have taken place after any previous suicide attempts.
- The current suicide prevention policy does not address any type of review after a serious suicide attempt or completed suicide.
    - The updated draft policy that has not been implemented has a section on the review process that contains details that are in line with national standards.
- The Quality Assurance Coordinator has recently begun collecting data on suicidal thoughts, suicide attempts and self-injurious behavior based on incident reports
- The Suicide Prevention Program at the Henley-Young detention facility seems to be in transition to a new Suicide Prevention policy and associated practices; the new policy is longer and more comprehensive and contains a multitude of improvements. However, because there are several versions of Suicide Prevention Policies and none of them are signed and dated, it is easy to confuse what staff should currently be doing and what Quality Assurance should be monitoring.
- The training coordinator would like to put together a binder for each staff that contains all relevant policies, including the Suicide Prevention policy.
    - Once policies are signed and dated they can be added to these policy manuals.

Recommendations

- Update and implement Suicide Prevention policies, procedures, and practices ensuring all suicide attempts (regardless of the severity) are reviewed in some manner; administrative, mental health and medical reviews occur any time there is a suicide attempt requiring medical care or a completed suicide; and a psychological autopsy is conducted within 30 days of a completed suicide.
    - The goal of the reviews should not be figuring out who to blame, but to better understand exactly what happened, why, and what necessary improvement measures are required, if any.
    - The psychological autopsy should be conducted by a psychologist or psychiatrist to better understand the specific factors that may have contributed to a particular youth taking his/her own life.
- The Suicide Prevention policy should be updated and implemented as soon as possible, making sure the policy and practices within the facility correspond with one another.
    - There should only be one policy that staff work off of and everyone in the facility should be clear which policy that is.
- A formal Quality Assurance process should be put into place to monitor all the components of the facility's suicide prevention program, with immediate modifications made when indicated.

  - The Quality Assurance process should continue to collect data on suicidal thoughts, suicide attempts and incidents of self-injury.
    - In addition to gathering information from incident reports, the Quality Assurance Coordinator should communicate, coordinate and collaborate with the QMHPs regarding suicidal youth
- Ensure all Suicide Prevention policies in use are signed and dated
  - Implement the idea of having a binder of all current and relevant policies so everyone in the facility is clear what policies they need to follow.
    - Explore what distribution model would be most effective given the needs of the detention center (e.g., binder on each unit, binder for each staff)

Debriefing After a Suicide Attempt or Completed Suicide

A debriefing (e.g., structured group process to help individuals effectively cope in response to a traumatic loss) should be made available as soon as possible (preferably 24 hours, no longer than 72 hours) after an incident to all staff and youth who may have been impacted by a serious suicide attempt or completed suicide. Staff involved in the incident should not be mandated to immediately return to job duties. Youth should be encouraged to talk with a QMHP about any thoughts and feelings they have in relation to a peer's suicide or suicide attempt. Staff should be encouraged to seek additional support through the Employee Assistance Program if available, or other sources, if needed.

Findings

- The current Suicide Prevention policy mentions critical incident debriefings; the updated draft policy discusses it in a little more detail
- It was reported that suicide attempts were discussed in staff meetings with those who were present, but no formal debriefings have taken place for the majority of youth or staff.
  - No completed suicides have occurred at the Henley-Young detention facility since the building opened over 10 years ago, so it is possible that type of incident would have prompted a formal debriefing

Recommendations

- Update and implement Suicide Prevention policies, procedures, and practices to ensure debriefing opportunities are available to all staff who may have been impacted by a serious suicide attempt or completed suicide as soon as possible (preferably 24 hours, no longer than 72 hours) after the incident
- Facility staff involved in a serious suicide attempt or completed suicide should not be mandated to immediately return to job duties.
- Facility staff should be encouraged to seek additional support through the Employee Assistance Program if available, or other sources, if needed.
- Ensure debriefing opportunities are available to all youth who may have been impacted by a serious suicide attempt or completed suicide as soon as possible (preferably 24 hours, no longer than 72 hours) after the incident
- Youth should be encouraged to talk with a QMHP about any thoughts and feelings they have in relation to another resident's suicide or suicide attempt.

Self-Injury

Self-injury (e.g., cutting, carving, scratching, or punching oneself; head banging; pulling out stitches) refers to intentional self-inflicted injury to the body without the intent to die. It is often used to cope with negative feelings, such as anger, depression, or anxiety.

Self-injury should be distinguished from suicide in the screening, assessment and treatment of youth in juvenile justice facilities, yet still be regarded as a significant risk factor for suicide.

Findings

- Self-injury is reportedly not very common at this particular detention facility; it was stated that it is much less common than suicidal thoughts and behaviors.
- It was reported that some direct-care staff refer to "self-injury" as "suicidal" behavior and may document it as such.
    - Because of this, it was reported that Ms. Frelix and Ms. McCoy, the training coordinator, will be meeting with some staff in October to help them better distinguish self-injury from suicidal behavior.
- It does not appear that questions about self-injury are included at the intake screening
- One young woman was engaging in minor self-injury on her arms during my site visit and openly told Ms. Frelix about it. Ms. Frelix placed her on Suicide Alert status so she could be more closely observed by staff.
    - Ms. Frelix individualized this young woman's safety plan and verbally communicated it to staff.

Recommendations

- Develop policies, procedures and practices to ensure self-injury is distinguished from suicide in screening, assessment and treatment of youth in the facility, yet still regarded as a significant risk factor for suicide.
- Ensure all staff who interact with, and make key decisions about youth, at the detention facility understand how self-injury differs from suicide, yet realize it is a significant risk factor for suicide.
- Ensure all staff take self-injurious behavior seriously and refer youth who engage in this behavior to a QMHP for an evaluation.
- Youth who engage in a pattern of self-injury should receive a comprehensive mental health assessment to identify any psychological issues or disorders, and to determine what function the behavior serves in the context of the facility.
- Housing and monitoring decisions should be based on findings from the mental health assessment.
    - Unless their self-injury is severe, most youth can participate in standard facility programming with minor modifications. Modifications should be presented to youth as safety measures and not punishment for their self-injurious behavior.
    - Isolating youth who self-injure should be avoided; if it must be done for safety reasons, decisions should be made in collaboration with a QMHP.
    - If the Henley-Young detention facility is unable to safely manage a youth with severe self-injury, the youth should be transferred to an inpatient/residential mental health facility.
- QMHPs should develop individual treatment plans, use evidence-based skill-building psychotherapy, and help staff reinforce youth for not engaging in self-injury and for using appropriate coping skills.
- Staff from all disciplines should provide emotional support and attention to youth before they self-injure, especially during periods of transition or change.
    - Encourage staff to maintain a matter-of-fact attitude and tone when dealing with self-injury; these youth are often ashamed of their behavior and know that it is unusual and strange..

Treatment for Mental Health, Substance Use and Trauma-Related Disorders

The treatment needs of youth with mental health, substance use and trauma-related disorders do not decrease or disappear when they enter juvenile detention; in fact, their needs may intensify due to the stress of incarceration. The responsibility to address these needs is detailed in national standards and class action lawsuits (e.g., incarcerated youth with serious mental health disorders have a constitutional right to mental health treatment).

Some primary goals of treatment during incarceration include:

- Stabilize youth's emotions and behavior.
- Reduce youth suffering and impairment in key areas.
- Decrease self-destructive behavior.
- Maintain a safe and orderly living environment
- Facilitate opportunities for youth to succeed
- Educate youth about their mental health and/or substance use disorder
- Help youth develop skills to reduce mental health symptoms and/or substance use
- Help youth develop necessary skills to better control their emotions and behavior.
- Help youth develop necessary skills to function more successfully in the community

Youth with significant mental health, substance use and/or trauma-related needs who are detained/incarcerated 30 days or more should receive an individualized treatment plan, as well as individual and/or group treatment. Individualized treatment plans, as well as individual and/or group treatment should be provided to any youth, regardless of length of stay, if their mental health, substance use or trauma-related symptoms impair their ability to function appropriately within the facility.

Findings

- Many of the youth detained at the Henley-Young detention facility appear to have longstanding (vs. acute) mental health disorders (including a significant number of youth with trauma-related symptoms and co-occurring mental health and substance use disorders) impacting their thoughts, moods and behavior.
- All staff and youth interviewed stated that youth are not learning any skills to help them positively change their behavior (e.g., control their anger, make better choices, think before acting) once released from the detention facility.
    - When asked what they would do differently when released to prevent themselves from coming back, most youth said "I don't know", "Do better," "Stay out of trouble" or something similar.
    - These same staff and youth agreed that it would be beneficial to have skill-based individual and group treatments focusing on key issues youth struggle with (e.g., "anger management", paying attention, better controlling their emotions, using alcohol and other drugs, "deal with family issues", "communication").
- Hinds Behavioral Health, a community mental health center, has an exclusive contract with the Jackson Public School District to provide mental health services to middle and high school students. The detention school is run by the Jackson Public School District, therefore the therapist(s) from Hinds Behavioral Health (located at the Henley-Young Juvenile Justice Center outside of the detention facility) is reportedly responsible for providing therapy to youth in the detention facility. Marion Counseling also has a therapist in the same location who is reportedly responsible for providing therapy to youth who were on the Marion Counseling caseload while in the community.
    - Although therapists from Hinds County Behavioral Health and Marion Counseling said they are willing to provide individual and/or group treatment with the youth in detention, they described a significant number of tasks required of them in relation to the juvenile court, leaving them little to no time to provide therapy services to detained/incarcerated youth.
    - In addition, detained/incarcerated youth are in school during the majority of the hours these therapists work at the juvenile court/juvenile justice center.
    - If they did have more time to meet with youth, it was reported that lack of physical space to do so is an issue.
    - There appears to be little communication, collaboration and coordination between the Henley-Young detention facility and the Hinds Behavioral Health and Marion Counseling therapists located on the

juvenile court side of the juvenile justice center. It was reported that one of the therapist no longer has a phone in her office.
    - The youth I spoke with said they had not met with a therapist from Hinds County Behavioral Health or Marion Counseling during their stay.
        - I believe these youth were all attending the detention school run by Jackson Public School District (Hinds County Behavioral Health is the exclusive provider for the Jackson Public School District) and at least two of them reported having a therapist at Hinds Behavioral Health in the community.
- There do not appear to be any psycho-educational groups (e.g., alcohol/drug use, anger management, social skills) being provided to youth in the facility
- There is no individual or group treatment for mental health, substance use or trauma-related disorders being provided by employees of the detention facility.
    - There is only one mental health professional, Ms. Frelix, working within the detention facility and she is typically engaged in other mental health and suicide-related requirements; there is no substance use professional to provide treatment.
- Consider developing a specialized unit (or two) for youth who will be detained/incarcerated for 30 days or more.
    - This unit(s) would be better able to provide effective assessments and treatment, as well as develop individualized treatment plans and hold productive Interdisciplinary Team meetings.
    - The token economy system (e.g., incentives) can be tailored for youth residing in the facility for longer periods.
    - Youth who complete their treatment program successfully in the detention facility should be able to be released sooner.
        - This can serve as a powerful motivator to attend and participate in mental health, substance use and trauma-related treatment.
- Some youth are being sent from the Henley-Young detention facility to “acute” psychiatric/mental health facilities for treatment; this is seemingly for treatment. The length of stay at these facilities appears to be around 7-10 days.
    - It typically takes time for youth with mental health/substance use disorders and trauma-related needs to adjust to a juvenile detention facility: the correctional environment, rules, expectations, routine, staff, peers, etc. Because these youth thrive with security, consistency and predictability, moving youth out of the detention facility to a new placement for 7-10 days with new rules, expectations, routine, staff, peers, etc. can be stressful and disruptive.
        - This is particularly true because it appears the majority of youth *return* to the Henley-Young detention center following their 7-10 day stay and again have to adjust to the correctional environment, rules, expectations, routine, staff, peers, etc.
- Diagnosis typically drives treatment: knowing a youth’s mental health, substance use or trauma-related diagnosis should drive the treatment plan and they type of treatment services they receive. Given the potential mis-diagnosis that may be occurring at some of the acute inpatient psychiatric programs the detention center transfers youth to (see section “The Transfer of Detained/Incarcerated Youth to Acute Inpatient Psychiatric Facilities for Mental Health Assessments” earlier in this report), youth may be receiving associated treatments that are inappropriate and/or potentially harmful
- It can be challenging for parents to navigate the working of one residential placement (juvenile detention); they then must navigate the workings of another residential placement (acute mental health facility), and then re-navigate the initial placement (juvenile detention).
    - Parent contact, support and involvement is a key protective factor for youth with mental health, substance use, and trauma-related needs, particularly during stressful situations such as out of home placements.
    - Some of these inpatient programs are one to one and a half hours from the Henley-Young detention facility, making it more difficult for some parents to visit and be involved with their child.
- It was reported that many youth from the Henley-Young detention facility who are sent to “acute” psychiatric/mental health facilities are not typically “acutely” mentally ill.

  - Many were reported to carry diagnoses of Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, and Intermittent Explosive Disorder, and at the time of referral, evaluation for eligibility, and transfer, these were described as calm and integrated into the detention program.
  - It was also reported that when detention staff have tried to get youth who demonstrate "acute" issues (e.g., extreme anger, dangerous aggression, uncontrollable behavior) admitted to these facilities, the acute psychiatric/mental health facilities do not admit them.
  - I tried to talk with the Youth Court Counselors (and/or their supervisor) about these issues since they play a primary role in setting up interviews related to youth eligibility for the inpatient psychiatric programs, but I was not permitted to speak with them.
- Several staff members mentioned that some youth sent to residential psychiatric facilities have been "kicked out" and returned to the detention facility. I tried to confirm/refute this with the Youth Court Counselors since they are reportedly involved in the return of youth from inpatient psychiatric programs, but I was not permitted to speak with them or their supervisor.
- It was unclear whether or not youth who are transferred to acute inpatient psychiatric facilities can count the 7-10 day stay as part of their time served. Several staff did not think so, but I was unable to confirm/refute this issue with Youth Court Counselors (and/or their supervisor) as I not permitted to speak with them.
- It was reported that some youth were potentially being held in detention in order for them to be assessed for eligibility in a residential psychiatric facility, with uncertain time frames as to how long that process would take. I tried to talk with the Youth Court Counselors (and/or their supervisor) about this issue, but was not permitted to speak with them.

Recommendations

- Develop and implement policies, procedures, and practices to ensure that youth with significant mental health, substance use and trauma-related needs who are detained 30 days or more receive an individualized treatment plan, as well as individual and/or group treatment. Individualized treatment plans, as well as individual and/or group treatment should be provided to any youth, regardless of length of stay, if mental health, substance use or trauma-related symptoms impair their ability to function appropriately within the facility.
- While detained/incarcerated, *all* youth in the facility should have access to psycho-educational groups and practical, skill-based treatment groups focused on: managing one's anger, controlling one's emotions/emotion regulation, constructively dealing with difficult situations, effective social skills, and other key issues youth in the detention facility struggle with.
  - *All* detained/incarcerated youth should have access to psycho-educational groups focused on alcohol and other drug use/abuse.
- Individual and group treatment for mental health (including trauma-related issues) and substance use should primarily be provided by QMHPs and QSUPs, respectively, who work in the detention facility rather than therapists who have primary responsibility to the juvenile court.
  - This does not seem to be a service that Hinds Behavioral Health and Marion Counseling can provide consistently and effectively due to the limited number of therapists and the significant amount of court-related responsibilities they described.
- A QMHP should be assigned to each unit so there is continual communication with detention staff and increased opportunities to get to know/understand the youth, develop relationships with them, provide supportive counseling as needed, and participate in crisis intervention efforts.
  - Treatment groups can be run on each of the different units.
- QMHPs should attend "due process" hearings for youth who have mental health disorders.
  - During the hearing, the role a youths' mental health symptoms may have played in an incident should be considered and the process should allow for mitigation of sanctions when indicated
- In addition to a focus on reducing mental health symptoms, QMHPs should also help youth develop and strengthen protective factors.

- Allocate more space for the provision of mental health, substance use and trauma-related treatment. Consider ways to utilize space that is already available (e.g., multipurpose room, units, the non-operational "no contact" visiting area, outside spaces, medical rooms when available) to provide a confidential setting for treatment groups and individual sessions with QMHPs, QSUPs, and other treatment providers.
- Treatment for co-occurring mental health and substance use disorders should be integrated and provided by the same treatment provider (if proficient in treatment for both mental health *and* substance use disorders) or by two or more providers who closely communicate and all take responsibility for intervention goals.
- Because youth in juvenile justice facilities often have multiple mental health, substance use and trauma-related issues (many of which may be longstanding and challenging to treat) plus a variety of environmental stressors—"relapse" should be expected and planned for and not just punished (e.g., within the detention facility, Juvenile Drug Court, etc.).
- Transferring youth with mental health, substance use and trauma-related needs back and forth to different placements should only be done when the treatment services provided are necessary, appropriate, and effective.
    - Assess and evaluate the necessity, appropriateness and effectiveness of the "process" of transferring youth with mental health, substance use or trauma-related needs that are "not acute" (and are oftentimes "chronic") from the detention facility to a 7-10 day inpatient psychiatric program specializing in "acute" care, including the consideration of such factors as clinical effectiveness, cost-effectiveness, and unintended negative consequences to youth.
    - Alternative models of accessing similar types of treatment should be considered.
- It is commendable for a juvenile justice agency to want to seek out inpatient mental health services for the youth in its care, however it must be ensured that those treatment services are appropriate for the youth receiving them, and be of sufficient quality and effectiveness.
    - Therefore, the "7-10 day acute inpatient treatment programs" and the "treatment services they provide" for youth transferred from the Henley-Young detention facility, many of whom have chronic mental health, substance use or trauma-related disorders should be evaluated for appropriateness and effectiveness.
- Confirm/refute the report that some youth sent to the residential psychiatric facilities have been "kicked out" and returned to the detention facility.
    - If confirmed, assess whether youth are removed from the program for the exact mental health, substance use or trauma-related behaviors they are sent there for and/or for issues listed in their treatment plan (e.g., difficulty controlling their anger, poor problem solving, inappropriate social skills, trauma triggers, mood disorders)
- When youth at the Henley-Young detention facility are transferred to acute inpatient psychiatric facilities for 7-10 days, their stay should count toward their time served.
- Community-based treatment should be provided to youth with mental health, substance use and trauma-related disorders *prior* to incarceration at the Henley-Young detention facility and *continued* once released.
    - Youth should continue to receive treatment while detained/incarcerated, but should <u>never</u> be detained/incarcerated at the Henley-Young detention facility *in order* to receive treatment.
- Invest in intensive, home-based, wraparound models of outpatient treatment for youth with mental health, substance use, and trauma-related disorders and their families, as they are more likely to more be cost-effective and clinically effective for eligible youth than sending them to detention
    - See section in this report titled "Intensive Home-Based, Wraparound, Community Mental Health Treatment in Mississippi"
- Assess the level of funding and resources needed for the provision of effective treatment services to youth with significant mental health, substance use, and trauma–related issues who are detained/incarcerated at the Henley-Young detention facility including, but not limited to, QMHPs and QSUPs.
    - Acquire the needed level of funding and resources as soon as possible in order to implement essential treatment services as soon as possible.

Intensive Home-Based, Wraparound, Community Mental Health Treatment in Mississippi

Youth who run away from home are often dealing with issues related to abuse, neglect, chaotic family environments, and/or parents/caregivers with untreated mental health, substance use or trauma related disorders. Receiving treatment in their home with their family will likely be more effective than removing them from their home and placing them in a detention facility; it is also likely to be more cost-effective.

There appears to be a home-based, family-driven, strength-based community treatment program in Mississippi titled "MYPAC: Mississippi Youth Programs Around the Clock."

The Mississippi Children's Home Services website states the following information about MYPAC.

In Mississippi, it appears Youth Villages offers home-based services through MYPAC: Mississippi Youth Programs Around the Clock. The Mississippi Division of Medicaid developed MYPAC to provide intensive services to children and their families where they need it most – at home. Under MYPAC, families select an organization that will provide children's mental health services and coordinate all other services needed by the child and family.

Their website states that: Youth Villages MYPAC uses the family-driven, strengths-based wraparound approach. Our Primary Service Coordinators visit with the child and family in their home at least weekly to provide intensive case management. The coordinators also facilitate child and family teams that brainstorm and decide which services and supports a child and family will need in order to be successful. Family members and natural supports for the child and family are an integral part of each child and family team. If a family lacks natural supports, our coordinators will help build a family's support system.

MYPAC therapists are available to provide in-home therapy, family therapy, individual therapy, and specific therapies to address trauma and substance abuse, if needed. Youth Villages MYPAC also offers psychiatric evaluation and medication management services through a board-certified psychiatrist and psychiatric nurse practitioner. In addition, our coordinators and therapists are on call 24/7 to provide support and crisis intervention services.

A variety of additional services, based on the specific needs of each child and family, can be provided or arranged if determined by a child and family team. These services may include in-school support, day treatment, group therapy, tutoring, YVLifeSet services, pre-vocational/vocational services, respite, recreational services and activities, transportation, and other non-traditional services that would achieve improvement in child and family functioning. Family support partners may also assist families through family-to-family support and advocacy.

The goal of the MYPAC program is to provide intensive support and assistance to families until a strong formal and informal support network can be developed and built around the child and family that will enable the child to be successful long-term in his or her own home.

Our outcome data shows that more than 90 percent of the children who leave the Youth Villages programs continue to live successfully at home two years later, meaning they are doing well in school and staying out of trouble with the law.[emphasis added]

Findings

- Of the youth I interviewed, only one felt previous treatment services were helpful; she was a young woman who was (and may still be currently) enrolled in MYPAC. She said she felt supported and that it taught her and her family new skills

Recommendations

- Representatives from the Juvenile Court/District 3 should assess the quality and effectiveness of the MYPAC program for adolescents who have mental health, substance use and trauma-related disorders, if they have not done so already.
    - If the MYPAC program is found (or has been found) to be of good quality and effectiveness for young people with mental health, substance use, and trauma-related disorders and their families, representatives from the Juvenile Court/District 3 should assess how often this program is used for youth with mental health, substance use, and trauma-related disorders prior to youth being detained/incarcerated at the Henley-Young detention facility and upon release back to the community.
    - If MYPAC is not used very frequently, Representatives from the Juvenile Court/District 3 should explore the reasons why
- If there are no significant reasons contraindicating the MYPAC program for youth with mental health, substance use and trauma-related disorders, the Juvenile Court/District 3 should utilize this program and others like it for low-risk, non-violent youth who are currently being detained/incarcerated in the detention facility. This is especially relevant for youth with mental health, substance use and trauma-related issues who are often detained/incarcerated on charges related to running away, disturbing the family peace, destroying property, domestic violence, and probation violations for drug use or not taking a drug test.

A Supportive Environment

Detained/incarcerated youth with mental health, substance use and trauma-related disorders are more likely to actively participate in treatment if they feel that the staff genuinely cares about them. Staff should actively engage youth and develop trusting and empathic relationships with them.

Findings

- All but one youth I spoke with said the majority of direct-care staff (“officers”) at the facility truly cared about them and the other residents and that only a small percentage were there to “collect a paycheck”.
    - The one exception was a youth who said “half” of the staff cared about the youth versus the “majority” of staff.
    - Each of those youth could identify at least two staff members they could talk to about their problems.
- None of the youth I spoke with expressed concern regarding being harmed by staff.
- None of the youth I spoke with expressed concern regarding physical harm by other youth.
    - However, one youth reported that a peer urinated and defecated in his room, as well as put his glasses in the toilet. A staff member I spoke with believed the perpetrator was set up by older more sophisticated youth on the unit.
    - The victim did not believe there was enough accountability for the resident who committed these acts
- The majority of peer-to-peer interactions I witnessed were youth hanging out, playing cards, playing basketball, and joking around with one another.
- I repeatedly witnessed staff engaging in conversations with residents and playing cards with them. This seems like a particularly positive finding given what I have read about the history of the Henley-Young detention facility.
- Once youth are placed in their individual locked rooms/cells at end of the night, staff are required to clean up the unit. There were brief periods when no staff was present on the unit.

  - At night, alone in their room can be a high-risk time for some youth with mental health, substance use or trauma-related issues, including some who may be suicidal or self-injurious.
- When speaking directly to youth or requesting an action from youth, I heard several staff refer to youth solely by their last name.
- Although referred to as "Officers" and addressed by youth as "Officer X," direct-care staff wear professional uniforms that are more casual and approachable than uniforms resembling police/security officers.

Recommendations

- Develop and implement policies, procedures, and practices to train, support and reward staff in relation to developing trusting, empathic and supportive relationships with the youth in their care.
- Continue to encourage staff/youth interaction, and the building of relationships between them.
  - Reinforce staff who build positive and supportive relationships with youth.
- Administrators and supervisors should ensure that all direct-care staff understand that some youth with mental health, substance use and trauma-related disorders require accommodations or adjustments in programming to be successful in the facility, as well as help direct-care staff members be strategic about providing the accommodations/adjustments.
- Take seriously and investigate incidents of youth-on-youth harassment and enforce strong accountability to send the message to the perpetrator, victim, as well as other residents that type of behavior is unacceptable and will not be tolerated
- At least one staff member should remain on the unit at all times if youth are present, including in the evening when youth are in their rooms.
  - Youth can seek out staff support if/when emotionally struggling, youth tend to feel safer when a staff member is present, and it can ensure the safety of the youth if threats are being yelled from room to room.
  - Plus, staff are more likely to be able to provide valuable information when allegations arise in relation to something happening between two residents on the unit.
- Consider having staff call youth by their first name. If last names must be used, consider requiring staff to use a Mr. or Ms. In front of them.
- Change the job title name for direct-care staff from "Officer" to "Youth Care Worker" or something similar.
  - A name change may positively impact direct-care staff's perception of themselves and their job responsibility, as well as youths' perception of staff.
  - If a name change occurs, require youth to refer to staff members by Mr. or Ms. in front of their last name

Facility Atmosphere

Findings

- Morale seemed high among staff of all levels and positions. I witnessed numerous interactions where various staff members were seen smiling and engaging in upbeat conversations as they passed one another in the in the hallways, and when staff interacted with youth outside during recreation time and on the units.
  - Several direct-care staff described feeling a sense of comradery with their co-workers, felt they worked well as a team, and had confidence their co-workers "had their back" if faced with a challenging or dangerous situation.
- The acoustics on the units is detrimental to rehabilitation and treatment, and can make a noisy/disruptive situation worse.
  - It was loud, with a significant echo. It was difficult to hear what others were saying, as well as hear myself think.

  - This situation is amplified with a large group of teenagers, a television that is on, and the frequent comings and goings that occur in a detention facility.
  - Loud, echoing acoustics can be stressful and/or challenging for a variety of youth (and staff), but particularly so for youth with mental health, substance use and trauma-related disorders.
  - Poor acoustics are not as big of an issue if a youth resides in the detention center for a day or two. However, many youth have been detained/incarcerated at the Henley-Young Detention Facility for close to three months or longer.
- The units appear cold, sterile and "institutional," which is detrimental to rehabilitation and mental health, substance use and trauma-related treatment.
  - The walls were completely bare.
  - A cold, sterile, institutional living situation is not as big of an issue if a youth resides in the detention center for a day or two. However, many youth have been detained/incarcerated at the Henley-Young Detention Facility for close to three months or longer.
  - On a positive note, it was reported that the walls used to be a dingy, depressing color and that Mr. Burnside, the Operations Manager, put much thought into choosing the current colors and personally helped with the actual painting.

Recommendations

- Decrease the "institutional" look and feel and sound of the units and make it more "homelike" in look, feel and sound.
  - Consider putting youth art, painted murals and positive/empowering quotes on the walls
  - Purchase comfortable furniture
  - Add carpet or area rugs
  - Have youth create and then display holiday decorations
  - Investigate ways that other juvenile justice facilities have improved their unit acoustics, while also ensuring safety and security

Token Economy System

A well-designed, easy-to-understand, easy-to-implement, and effective strength-based token-economy system can help provide structure and accountability to a detention facility, as well as motivate youth to comply with behavioral expectations and motivate them to engage in prosocial activities.

Findings

- The detention center has recently implemented a token economy system involving points and associated privileges.
  - Staff and youth both reported that it has been helpful.
  - One youth complained that some giving out of points seems subjective.
  - Most incentives/rewards for good behavior/high earning of points are delayed until the weekend.
  - There did not appear to be a large variety of incentives/rewards for positive behavior
  - Due to limited resources, it was reported that staff invested in the token economy program were purchasing some incentives for the youth with their own personal money

Recommendations

- Continue using the new token economy program and make revisions as necessary to make it as effective as possible.
    - It is common for a juvenile justice facility that implements a new token economy system to go through several revisions/tweaks within the first year it is put into use
    - Make all behavioral goals as specific, objective and measurable as possible
    - Add additional incentives to the token economy system, including a larger variety of incentives and more meaningful incentives.
        - This is particularly important for youth detained/incarcerated for 30 days or more.
    - Ensure some type of immediate reinforcers/rewards are built-in on each weekday if possible (1-2 weekdays minimum).
    - Most incentives do not cost money. However, funding/resources should be provided to cover the incentives that do, so staff are not using their own personal money.
    - Review how many points youth currently receive each day/week with the token economy system. Assess whether current goals are too easy to achieve, to difficult to achieve, or at the right level.
    - For youth committed 30 days or more, add one or two individualized objective behavior(s) for them to work on daily in addition to the mandatory behaviors all youth are expected to do

Psychotherapy ("Talk Therapy") While In Custody

Brief, practical, evidence-based psychotherapy should be provided to youth with mental health, substance use and trauma-related disorders in juvenile detention facilities. Intensive, individualized, family-based psychotherapy in the community should be provided prior to detention and immediately upon release.

Findings

- There is no group psychotherapy provided to youth while they are detained/incarcerated at the Henley-Young detention facility.
- There is no individual psychotherapy provided to youth while they are detained/incarcerated at the Henley-Young detention facility.
- There is only one mental health professional for the entire facility.
    - She is responsible for doing all the follow-up assessments in relation to suicide and mental health screening, mental-health and suicide prevention training, as well as other responsibilities (e.g., crisis intervention, policy writing) related to youth with mental health and trauma related symptoms.

Recommendations

- Develop and implement policies, procedures, and practices to ensure that youth with mental health, substance use and trauma-related disorders receive brief, practical, evidence-based individual and/or group psychotherapy (depending on their needs) while detained/incarcerated at the Henley-Young detention facility.
- Develop and implement policies, procedures, and practices to ensure that youth receive intensive, individualized, family-based psychotherapy in the community prior to detention and immediately upon release when needed.
- Create a "mental health caseload" (inclusive of youth with trauma-related disorders and disruptive, impulse-control, and conduct disorders) and a "substance use caseload" for youth who have significant mental health, substance use or trauma-related disorders; or for youth whose mental health, substance use or trauma-related

symptoms are impairing their ability to function appropriately in the facility; and/or for youth at deemed to be at increased risk for self-injury or suicide while detained/incarcerated.

- Brief, practical, evidence-based psychotherapy (individual and/or group, depending on a youth's need) that has been used effectively with incarcerated youth should be provided to youth on the "mental health caseload"
    - Ensure all treatments with a cognitive-behavioral component are appropriate for a youth's intellectual and developmental level
    - Make rooms/areas where psychotherapy occurs (e.g., multipurpose room, units) more homelike and less sterile (e.g., carpet or area rugs, pictures on the wall, comfortable seating)
    - Individual and group psychotherapy should be conducted by QMHPs and QSUPs who have knowledge and experience providing brief, practical, evidence-based psychotherapy to adolescents
    - Encourage direct-care staff and/or shift supervisors to co-lead psychotherapy groups
- Intensive, home-based, individualized, family-oriented psychotherapy in the community should be provided to youth with mental health, substance use and trauma-related disorders who are assessed to be "low risk" and/or have been charged with non-violent offenses (e.g., non-violent probation violations, family-related charges such as "disturbing the family peace") rather than detaining/incarcerating them.
- Following *release* from the Henley-Young detention facility, intensive, home-based, individualized, family-oriented psychotherapy in the community should be provided to youth with mental health, substance use and trauma-related disorders to reduce symptoms and family conflict, as well as to help reduce the likelihood of youth going to a restrictive, more costly inpatient psychiatric facility or returning to juvenile detention.
- Individual and group psychotherapy provided to girls with mental health, substance use and trauma-related disorders in the detention facility should be "gender-specific," taking into account their unique issues and needs.
- Regardless of a youth's length of stay in the detention facility, parent/caregiver involvement in psychotherapy should be encouraged and actively sought

Individualized Treatment Plans

Individualized treatment plans should be developed for youth with significant mental health, substance use and trauma-related disorders, for any youth whose mental health, substance use and trauma-related symptoms are impairing their ability to function appropriately in the detention facility, and/or for youth deemed to be at increased risk for self-injury or suicide while detained/incarcerated. These treatment plans, including an individualized behavior management plan, shall be strength-based, driven by a youth's needs, and consistent with current professional standards of care.

Findings

- There are currently no individualized treatment plans developed to address mental health, substance use, trauma, self-injury or suicide at the Henley-Young detention facility.
- Ms. Frelix reports that it is challenging to develop individualized treatment plans when she does not know how long a youth will remain in the facility (e.g., 2 days, 21 days, 89 days) and/or does not have a youth's mental health records so must solely rely on a youth's self-report
- There is no QSUP to develop individualized substance use treatment plans for youth

Recommendations

- Develop and implement policies, procedures, and practices to ensure that individualized treatment plans are developed for youth on the "mental health caseload" and "substance use caseload" (i.e., youth with significant mental health, substance use and/or trauma-related disorders, any youth whose mental health, substance use and trauma-related symptoms are impairing their ability to function appropriately in the detention facility, and/or for

youth at deemed to be at increased risk for self-injury or suicide while detained/incarcerated). See section above on Psychotherapy ("Talk Therapy") While In Custody
    - Individualized treatment plans should be strength-based, driven by a youth's needs, include an individualized behavior management plan, and be consistent with current professional standards of care.
    - Whenever possible, the development of the individualized treatment plan should include the youth and parents/caregivers.
    - Treatment plans should be written clearly, without jargon, so all adults interacting, managing and treating the youth understand the treatment goals and what services should be provided to help youth achieve them.
    - Treatment plans should consider whether or not a youth's current diagnosis is reliable and valid before using it as a primary piece of information in the development of the plan.
    - Treatment objectives must be specific, objective, measurable, and achievable.
    - Review treatment plans as often as needed to confirm the value and relevance of existing goals; however, no longer than every 30 days.
- Develop and implement policies, procedures, and practices to ensure that QMHPs at the Henley-Young detention facility are informed and/or can look up key information regarding a youth's expected length of stay (e.g., 2 days, 82 days), as well as previous/current mental health treatment as soon as possible to help determine the most effective type of information to include in a youth's treatment plan.

Involvement of Direct Care Staff in Mental Health, Substance Use and Trauma-Related Treatment

Direct-care staff are key members of the mental health, substance abuse and trauma "treatment team." Because of their close interaction with youth, they are often the first to notice unusual youth behaviors, moods, or statements of concern. They are typically the main professionals in the detention facility referring youth for mental health or substance use assessment or treatment.

Direct-care staff should perceive themselves as central to the treatment process, as should the youth and other professionals throughout the facility.

Findings

- Although the direct-care staff I spoke with acknowledged the importance of their interactions, reactions, and management strategies on youths' mental health, they did not perceive themselves as important to the "treatment" of the residents.
    - They also did not believe they were viewed as important to the mental health "treatment" process by administration, their co-workers, or the youth.
- Each of the direct-care staff I spoke with expressed a desire to be more formally involved in treatment, including providing information/feedback about youth to the professionals who assess them, participating in treatment team meetings, and were open to leading psycho-educational groups or co-leading mental health or substance use "treatment" groups with a QMHP or QSUP.

Recommendations

- Formal practices should be developed and put into place to engage and involve direct-care staff in mental health, substance use and trauma-related treatment of the youth at the Henley-Young detention facility.
- Administration should convey the important role that direct-care staff members play in the mental health of the youth they work/interact with.

  - Efforts should be made to communicate this message to all staff /professionals throughout the facility, youth and parents/caregivers.
- Feedback regarding a youth's mood and behavior on the unit should be formally collected in writing from direct-care staff who regularly interact with him/her prior to a mental health or substance use assessment.
- Interdisciplinary treatment team meetings should include at least 1-2 direct care staff members who are familiar with the specific young man or woman being discussed.
  - Direct-care staff may need to rotate in/out of the meeting depending on which youth are being discussed
- Psycho-educational groups should be manualized so that direct-care staff members who are interested, trained and have the ability to effectively deliver the curriculum to youth can do so.
  - Psycho-educational groups should be run by two direct-care staff members or co-led by a direct-care staff member and QMHP or QSUP.
- Mental health and substance use "treatment" groups should be led by a licensed and trained QMHP or QSUP, respectively. Direct-care staff who are interested and trained should be encouraged to serve as co-leaders (not as security) if they can do so effectively.

Involving Parents or Caregivers in Mental Health, Substance Use and Trauma-Related Treatment

Involving parents/caregivers in their child's mental health, substance use and trauma-related treatment is essential and this remains true while their son or daughter is detained/incarcerated. Most parents do not know how to become involved, and many do not have the resources and supports to do so.

Parent/caregiver involvement in mental health, substance use and trauma-related treatment should be encouraged and actively sought

Findings

- I spoke with two mothers whose children had both been detained/incarcerated at the Henley-Young detention facility on two separate occasions; one of the youth was residing at the detention center while we spoke. Both mothers wanted group treatment for their children that taught them skills and changed their thinking.
  - One of the mothers believed those types of treatment groups were already occurring at the detention facility
  - Both mothers thought the detention facility was not "strict" enough and wanted more negative experiences for their youth while residing there in hopes it would make their sons not want to go back
  - One of the mothers thought her son's Youth Court Counselor was "superb" and that the YCC was responsive whenever she called for information.
- There is no formal mental health, substance or trauma-related treatment currently provided in the detention facility with which parents could become involved.

Recommendations

- Develop and implement policies, procedures, and practices to ensure that parents/caregivers are involved in their child's mental health, substance use and trauma-related treatment while their son or daughter is incarcerated at the Henley-Young detention facility.
- Devote time and energy to actively engaging parents/caregivers in the treatment process to increase their motivation to get/remain involved, and to foster positive treatment outcomes.
- Allow parents/caregivers to ask questions, provide input, and participate in decision-making; this is empowering and makes it more likely they will support and commit to the treatment process.

- Educate parents about repeated research findings that show practical, skill-based treatments aimed at youth's thoughts, moods and behaviors have been shown to be more effective in modifying negative behavior versus making a youth's stay at juvenile detention unpleasant, difficult or punitive.
- When parents/caregivers of youth at the detention facility appear reluctant to participate in treatment, explore whether it is due to negative experiences with previous treatment providers, feeling hopeless about their child's situation or their child's future or another reason; do not assume they are oppositional, uncaring, or resistant to the treatment process.
- All interactions with parents/caregivers should be strength-based.
- If parents/caregivers cannot attend in-person meetings, look into participation by conference call, webcams, Skype, Facetime, or another communication option.
- Efforts should be made to include fathers, even if they are only distantly involved in a youth's life.
- Parents/caregivers should be encouraged to call the the Henley-Young detention facility with questions or concerns about the mental health, substance use and trauma-related treatment of their children.

Physical Activity & Mental Health

Vigorous exercise can enhance self-esteem, decrease depression, reduce anxiety and tension, and help youth sleep better; exercise can change chemicals in the brain, including those associated with mood-related disorders. Providing detained/incarcerated youth with a variety of opportunities to be active and participate in outdoor recreational activities gives them a chance to demonstrate success in pro-social activities and burn off energy. Team sports help youth resolve conflict without intimidation and aggression and engage in healthy competition. Individual recreation activities should also be available, as some youth are self-conscious about their coordination or skill level.

Juvenile justice facilities should have a formalized program focusing on a variety of different exercises and physical activities for all youth, including those with mental health, substance use and trauma-related needs. These activities should take place outside, except under extreme weather conditions.

Findings

- Youth appeared more energetic and upbeat when outside in the fresh air
    - Staff also appeared more energetic and upbeat when outside in the fresh air
- When observing youth at recreation time, the majority of the boys seemed to enjoy playing basketball, which was quite competitive at times with many skilled players.
    - Not all youth exhibited interest in or skills for playing basketball.
    - It did not appear there were other physical activities for them to engage in so they just sat or stood around.
- I spoke with the current recreation coordinator who says she works Tuesday-Saturday, sometimes until 7pm.
    - She stated the detention facility is planning on hiring another recreation specialist.
    - She reported needing more equipment to work with.
- Easily-accessible storage space was requested with which to store recreation-related equipment.
    - It appeared efforts were already being made to clear out unused space in the multi-purpose room.
- Basketball seems to be the primary form of recreation and I was told there have been basketball tournaments in the past.
    - The girls I spoke to were not interested in basketball and expressed frustration that basketball seemed like the main recreation activity at the facility
- I was told there was not enough physical space for the recreation coordinator to run indoor activities.
    - She primarily used the multipurpose room, but it not always available.

  - It was reported that recreation activities have been cancelled if the weather is poor and the multipurpose room is occupied
- The recreation coordinator seemed open to a variety of additional ideas for recreation activities and had several creative ideas of her own
  - It was reported that in the past, the facility brought in a fitness trainer/personal trainer who did exercises with the youth using large resistance bands
- The recreation coordinator said that she takes youth who are on Due Process Isolation out for one hour of large muscle exercise.
- Concern about the weather was reported, especially rainy days when the outside courtyard can get quite muddy
- With regard to inside recreation activities, it was reported that card tournaments have occurred in the past. The recreation coordinator wants to do art/drawing with the youth, but needs art supplies.

Recommendations

- Develop and implement policies, procedures, and practices to ensure that every youth in the facility receive a minimum of one hour of "physical" activity outside (unless extreme weather conditions) each and every day.
- Hire at least one more recreation specialist for the detention facility.
  - Spread the recreation specialists' schedules out so a recreation specialist is at the facility for a full-day, seven days a week.
  - Recreation is particularly important on the weekends when there is no school, and typically less structured activities and more sitting around.
- Continue current schedule of having a recreation specialist work with the youth into the evening, as many youth are attending school at the detention center for much of the day.
  - Daytime is ideal to work with youth who on Due Process Isolation status.
- Recreation should be held every day no matter what.
  - If extreme weather conditions and the multipurpose room is not available, provide recreation activities (with as much movement as possible) on the unit. This should be a rare circumstance.
- Because vigorous exercise can burn off energy, decrease depression, reduce anxiety and tension, enhance self-esteem, and help youth sleep better, opportunities for high intensity aerobic activities should be regularly available.
- Provide opportunities for youth to participate in a variety of outdoor recreational activities to give them a chance to demonstrate success in pro-social activities and burn off energy.
- Every effort should be made to hold recreation activities outside daily for all youth, especially those on Due Process Isolation status and those detained for 30 days or more.
  - Proper clothing should be provided for very hot and cold weather.
- When possible, the staff who accompanies youth outside for recreation activities should be rotated because being outside the detention center and in fresh air can positively impact staff morale and mood
- Offer team sports in addition to basketball to help youth engage in healthy competition and resolve conflict without intimidation
- Bring in a fitness trainer/personal trainer again to do exercises with the youth using large resistance bands
- Implement yoga into the recreational program.
  - Yoga can help reduce stress, decreases depression and anxiety, reduce fatigue and aid sleep. It appears to impact the fight or flight mechanism, which is commonly affected among youth with trauma histories.
  - Look into bringing in a yoga teacher who is willing to volunteer his/her time.
- When forced to hold recreation activities inside, consider interesting and educational board games, cornhole/bean bag toss, Wii, and other interactive activities.
  - However, every effort should be made to have youth engage in "physical" activities (outside if at all possible)

- Implement physical activities that are appealing to the girls in the detention facility; several of them were obese and reported doing little to no activity when residing at the Henley-Young detention center.
    - Consider Zumba (seek out a Zumba teacher to volunteer), volleyball (look into a portable net), soccer, etc.
- When youth on Due Process Isolation are given their one hour of large muscle exercise, ensure they spend the majority of their time physically moving
- Regularly offer "individual" recreation activities, as some youth are self-conscious about their coordination or skill level, and/or may be intimidated or uncomfortable in the group.

Psychotropic Medication

Many youth in custody have been prescribed psychotropic medication to help control their moods or behavior. It can be vital to a youth's success, and for some, it is life-saving. However, due to the side effects and safety profiles of some of these medications, the inconsistent manner in which many justice-involved youth take their medication, and the risk of youth using alcohol/drugs in combination with psychotropic medication, professionals who prescribe these powerful medicines to detained/incarcerated youth should have the license, education, training and experience to do so with justice-involved youth; and even then, must exercise caution.

Policies and formal guidelines should be in place that clearly address: which medical professional(s) is responsible for continuing a youth's prescription of psychotropic medication when they enter the detention facility; the writing of new prescriptions of psychotropic medication for youth in the facility; informed consent by parents/caregivers; medical monitoring of youth taking psychotropic medication; communication, continuity of care, and prescribing practices when youth are about to be released; and forced medication during emergency situations.

Findings

- It was reported that the Henley-Young detention facility contracts with a medical agency for their psychiatric care.
    - However, that contract was ending and a contract with a new medical agency was going to begin. It is my understanding the new contract is now in place.
- It was reported that a psychiatrist was coming to the facility two (2) hours week with the old contract. It is my understanding that under the new contract a psychiatrist is required to come to the facility two (2) hours a week.
- It was reported by medical staff that significantly more psychiatrist time was necessary.
- The nursing staff distribute all medication to youth
- Almost 1 in 4 youth (9 out of 38) were on psychotropic medication during my site visit; this included stimulants, antidepressants and some very strong/powerful medicines such as antipsychotics and anticonvulsants.
- Although all youth I spoke with admitted to having mental health symptoms, only one youth said the psychotropic medication prescribed was helpful
- The nurse reported good communication with the mental health professional in the detention facility and little contact with the therapists from Hinds Behavioral Health and Marion Counseling.
- Most of the youth I spoke with said they had been prescribed psychotropic medication prior to their current stay at the detention center, although most were not currently taking it while detained.
    - Since these youth reported diagnoses of Anxiety, Depression, Intermittent Explosive Disorder, "attention problems," it is possible that without their medication, symptoms of these disorders may be exhibited in the facility with peers and staff.

- Although some youth on medication reside in the Henley-Young detention facility for a brief period, some remain for 21, 45 or 90 days or more.
    - Some of these youth may take psychotropic medications that require medical monitoring, including blood draws to ensure youth do not have toxic levels
- I question some of the mental health diagnoses given to the youth residing in the detention center (see the section "The Transfer of Detained/Incarcerated Youth to Acute Inpatient Psychiatric Facilities for Mental Health Assessments" in this report)
    - When young people are misdiagnosed, the likelihood that they are prescribed the wrong treatment, including the need for psychotropic medication or the type of psychotropic medicine, if needed, is fairly high.
- The nurse stated that she contacted the parents of youth on psychotropic medication and requested that they bring the medication into the facility.
- Given the high numbers of youth with mental health disorders entering and remaining in the Henley-Young detention facility, and the high percentage of youth who have been prescribed psychotropic medication, two (2) hours of psychiatric care seems incredibly low.
    - When one considers the time needed for the psychiatrist to review a youth's records, transport time of bringing a youth to the psychiatrist, and time needed for documentation and other administrative functions, there is only a brief amount of time leftover to interact with and assess youth.
    - This brief amount of time to conduct an assessment is particularly problematic given the clinical complexity of many of the youth at the detention facility: high rates of trauma, potential stressful living situation prior to incarceration or while incarcerated, and co-occurring mental health and substance use disorders.
    - Given only two (2) hours a week, it seems the psychiatrist would only be able to see a very limited number of youth and/or conduct inappropriately brief psychiatric assessments, with little to no time to educate youth about their medication and allow time for youth to ask questions or request clarification.
- There appears to be good communication, collaboration and communication between the mental health professional at the facility and the nurses, but not between the mental health professional at the facility and the psychiatrist.
    - This is likely due to the very limited hours the psychiatrist is at the detention facility.

Recommendations

- Due to the complex clinical picture (e.g., co-morbid mental health disorders, co-occurring mental health and substance use disorders, stressful living situations prior to incarceration or while incarcerated, high rates of trauma, and suicidal thoughts/behavior) of the youth at the Henley-Young detention facility, psychiatric services should be provided by a board certified child/adolescent psychiatrist (or another type of medical professional who is trained in the psychiatric and mental health care of adolescents and can prescribe medication independently).
- Any and all professionals prescribing psychotropic medication to youth at the Henley Young detention facility should be licensed and have the required education, training, and experience to prescribe this type of medicine to adolescents, including adolescents who commonly use alcohol and other drugs.
- A psychiatrist (or another type of medical professional who is trained in the psychiatric and mental health care of adolescents and can prescribe medication independently) should provide services to the youth within the Henley-Young detention facility a minimum of two (2) days a week, for a minimum of four (4) hours each day.
- Youth should be monitored medically, psychologically, and behaviorally according to professional standards and best practices to ensure they are not experiencing any negative effects from the prescribed medication
- Policies and formal guidelines should be in place that clearly address: which medical professional(s) is responsible for continuing a youth's prescription of psychotropic medication when they enter the detention facility; the writing of new prescriptions of psychotropic medication for youth in the facility; informed consent by

parents/caregivers; medical monitoring of youth taking psychotropic medication; communication, continuity of care, and prescribing practices when youth are about to be released; and forced medication during emergency situations

- "Due Process" hearings should take into account if youth are supposed to be taking prescribed psychotropic medication, but do not have access to it at the facility. If so, sanctions may need to be mitigated and the youth should be seen by the psychiatrist
- When youth display a pattern of negative or concerning behavior (e.g., significant irritability, out-of-control behavior, aggression, lethargy/apathy, sadness, destructive behavior), medical staff should be contacted to see if youth are supposed to be taking prescribed psychotropic medication, but do not have access to it at the facility.
    - If so, the nurse should attempt to have parents/caregivers bring it to the facility
    - If that does not happen, the youth should be seen by the psychiatrist (or another type of medical professional who is trained in the psychiatric and mental health care of adolescents and can prescribe medication independently)
- When youth in the facility struggle with suicidal thoughts/behavior or self-injury and do not have access to psychotropic medication that has been prescribed to them, they should be seen by the psychiatrist (or another type of medical professional who is trained in the psychiatric and mental health care of adolescents and can prescribe medication independently)
- When a youth's mood or behavior is significantly impairing their ability to behave appropriately in the detention facility, the youth should be assessed by a QMHP and an individualized treatment plan developed and implemented. If indicated, the QMHP should refer the youth to the psychiatrist (or another type of medical professional who is trained in the psychiatric and mental health care of adolescents and can prescribe medication independently) for a medication evaluation
- Because psychotropic medication can have unpleasant and sometimes serious side effects, juvenile justice and mental health staff should receive basic training at least annually on side effects associated with medications commonly prescribed to youth in the detention facility.
    - Serious medication side effects (e.g., suicidal ideation, seizures), as well as side effects that can lead to negative responses from staff and sanctions for youth (e.g., increased irritability, lethargy, restlessness) should be highlighted during the training.
- Whenever a youth is prescribed a new medication, the prescribing professional should educate youth about it in a brief, understandable way, including: why a particular medication has been prescribed for them, what positive behavior changes are expected to occur from taking the medication, how the medication works within their body, and potential side effects of the medication (how common or rare) in case they experience unusual bodily changes.
- Communication and collaboration between the QMHP(s) and psychiatrist is essential, particularly with regard to clinically complex and difficult-to-manage youth, including those who are self-injurious or suicidal.
    - On the days the psychiatrist is at the facility, he/she should participate in a brief interdisciplinary "mental health" meeting to discuss youth on Suicide Alert status, as well as those exhibiting significant irritability, sadness, hopelessness, aggression, self-injury, and/or difficulty functioning in the detention program.
    - If this is not possible due to scheduling, at a minimum, the psychiatrist and QMHP(s) should meet briefly to discuss these youth.
    - A formal process should be developed for the psychiatrist (or another type of medical professional who is trained in the psychiatric and mental health care of adolescents and can prescribe medication independently) to inform the QMHP(s) of relevant information resulting from psychiatric assessments of youth
- Psychiatrists (or another type of medical professional who is trained in the psychiatric and mental health care of adolescents and can prescribe medication independently) should make every effort to collect information about a youth's previous medications (e.g., which ones were helpful), review previous medical records, and consult with past treatment providers.
    - Nursing staff can often help gather this information.

- Policies and procedures related to identifying and correcting medication errors must be in place
    - All medication errors should be immediately reported.
- Implement group and individual "skill-based" therapy to help youth learn to regulate their emotions, modify their thinking, behave pro-socially, and cope with current stressors because youth may discontinue their medication once released

Qualified Mental Health Professionals (QMHPs)

Juvenile justice facilities must have enough Qualified Mental Health Professionals (QMHPs) and Qualified Substance Use Professionals (QSUPs) to meet the needs of youth with mental health, substance use and trauma-related disorders in their care. QMHPs and QSUPs should be licensed and have the education, knowledge, training and experience to provide effective assessment and treatment services to detained/incarcerated youth, one of the most clinically complex and challenging groups of young people.

Findings

- There is only one mental health professional, Ms. Frelix, in the Henley-Young juvenile detention facility and she has primary responsibility for all mental health and trauma-related issues in the building, including those related to self-injury and suicide.
- Although a significant improvement over not having any full-time mental health professionals in the detention center (and Henley-Young is commended for the hiring a full-time mental health professional), having only one mental health professional is woefully inadequate to provide the necessary mental health and trauma-related services required, especially given the clinically complex and challenging groups of young people detained/incarcerated at the detention center.
    - Studies of youth in custody have found 63% to 92% met formal criteria for a mental health or substance use disorder.
        - When one of the studies removed conduct disorder and substance use disorders, almost half of youth still met criteria for a mental health disorder.
    - Suicide thoughts and attempts are more frequent among youth in custody.
        - One study found close to one in 10 youth in custody thought about suicide in the past 6 months; more than one in 10 youth had made a suicide attempt at some point in their lives. Fewer than half of the youth who reported recent thoughts of suicide had told anyone about them.
    - Extreme levels of irritability and aggression are common among youth in custody.
    - One study found 93% of youth in custody had at least one traumatic incident
        - Over half of the youth had experienced trauma six or more times.
    - Almost all of the youth I spoke with at the detention center (or of whose records I reviewed) had been diagnosed with more than one mental health disorder and/or reported significant drug use, and/or reported a history of trauma.
    - Many youth at the Henley-Young juvenile detention facility have spent time at inpatient/residential psychiatric facilities.
- Because there is only one mental health professional, Ms. Frelix is on call during evenings and weekends, seven days a week without any back-up.
    - She reported (without complaint) having received calls from the detention facility on the weekend.
    - There is no mental health professional to cover the mental health and trauma-related services at the facility, including those related to suicide if she is ill, on vacation, etc.
- Ms. Frelix reported having a master's degree in Criminology and Justice Services, a master's degree in Criminal Justice, a master's degree in Marriage and Family Counseling, an educational specialist degree in Counseling and working on doctorate in Marriage and Family Counseling.

  - She reports being licensed as a social worker, marriage and family therapist and professional counselor.
  - She stated she is an adjunct professor of Psychology and Counseling at Mississippi College, a Christian University.
- Ms. Frelix has been at the Henley-Young detention facility for the past 2 years and has served as the Director and the Operations Manager prior to her current position as Mental Health Administrator which she has held since May 2015.
  - She says she previously worked at the Oakley Youth Development Center, the only state juvenile correctional facility in Mississippi.
  - She reported experience with some gender-responsive treatment with incarcerated girls at Oakley.
  - See section "Safe Housing of Suicidal Youth" in this report for several important changes Ms. Frelix reported putting into place at the facility to help keep suicidal youth safe.
- During my site visit, Ms. Frelix knew a multitude of youth by name, despite the how many there were and the constant comings and goings of a detention facility.
  - She also knew quite a bit about their histories (sometimes quite detailed), particularly youth with significant mental health or suicide-related issues.
- The thinking process and actions Ms. Frelix described indicated that she takes suicide prevention and the high-risk nature of the detention facility's population of youth very seriously and that makes every attempt to prioritize meeting with youth at risk of suicide.
  - Ms. Frelix stated that she goes onto the units, educates staff on potential suicide risks she becomes aware of and how to remedy them quickly, and emphasizes the importance of staff having a heightened awareness about suicidal thoughts and behavior among youth.
    - This can sometimes be perceived by select staff as her telling them how to do their job.
    - She appears appropriately cautious and concerned about potential suicides among this high–risk population and seems committed to keeping youth in the detention facility safe.
- Ms. Frelix exhibited interest and positive rapport when interacting with youth.
  - When most youth saw her, they wanted to talk/interact with her.
  - Ms. Frelix intentionally called over several different youth when she saw they were about to be released to release to ensure they received a Walmart gift card they were promised for their participation in a course on sexually transmitted diseases.
- Ms. Freslix discussed the importance of confidentiality and tries to provide youth as much privacy as possible given safety issues.
- Ms. Frelix also demonstrated positive rapport with a variety of staff members in different positions.
- She was knowledgeable about various staff members and their roles, who was in/out of the facility each day, which staff members were covering which parts of the facility, and their style of supervising youth.
- Ms. Frelix was knowledgeable about the culture of juvenile corrections and the backgrounds of many of the youth in the facility.
- Ms. Frelix consistently made herself accessible to youth and staff.
- It did not seem that most staff acknowledged or appreciated the significant amount of responsibility that Ms. Frelix carries each day in her role as the sole mental health professional in the detention facility.

Recommendations

- QMHPs should be available on-site at the Henley-Young detention facility or by telephone, 24-hours a day, seven days a week.
- QMHPs at the Henley-Young detention facility should provide the following services when necessary, as well as other related services when indicated:
  - Suicide assessments
  - Placement of youth on or removing youth from Suicide Alert status
  - Safety plans for suicidal youth

  - Mental health assessments
  - Crisis intervention assistance
  - Individual psychotherapy
  - Group psychotherapy
  - Individualized treatment plans
  - Attend due process hearings of youth with mental health disorders or significant trauma-related histories
  - Assess the effects of potentially traumatizing experiences (e.g., isolation, witnessing peers' self-injury or suicide attempt) when necessary
  - Staff education, training, coaching
- QMHPs should have the education, training, experience and license to carry out the tasks listed above with youth who have a broad range of emotional and behavioral disorders. This includes education, training and experience in the following areas:
  - Normal adolescent development
  - Interactive effects of mental illness and substance use
  - Impact of trauma, include multiple interpersonal traumas
  - Cognitive, emotional, behavioral, and lifestyle issues common among incarcerated youth
  - Best practices for screening and assessing detained/incarcerated youth
  - Evidence-based interventions and best practices for justice-involved youth who have mental health, substance use, and trauma-related symptoms.
- All efforts should be made to hire licensed doctoral (Ph.D.) level psychologists trained in the assessment and treatment of adolescents to serve as QMHPs in the Henley-Young detention center.
- Although Ms. Frelix, the current mental health professional, does not have a doctorate in psychology, her knowledge of juvenile justice, the specific population of youth at Henley-Young, and the culture and inner workings of a juvenile correctional facility is very valuable to the facility in addition to her mental health knowledge and experience.
  - It is recommended that she obtain additional education and training in evidence-based mental health and trauma-informed treatment for adolescents.
  - It is also recommended that she obtain additional education, training and experience in mental health assessment or closely communicate, coordinate and collaborate with QMHPs in the detention facility who have additional education, training, and experience in mental health assessment.
- Given the high-need and clinically complex population of youth in the Henley-Young detention facility (e.g., more than one mental health disorder, co-occurring mental health and substance use disorders, significant trauma histories, multiple suicide risk factors, aggression, impulsivity, volatile moods) a QMHP should be assigned to each unit so the required responsibilities (see list above of services provided by a QMHP) can be provided/performed.
  - Having a QMHP assigned to each unit also assists in getting to know more about the individual youth he/she is assessing or treating, the building of trust and of relationships with both youth and staff, as well as understanding the current culture/dynamics on the unit and the role that plays in youths' mental health and trauma-related symptoms.
    - Have a QMHP on each unit increases the likelihood that direct-care staff will regularly seek input from the QMHP about managing youth with mental health (including trauma-related symptoms) and/or difficult-to-manage youth and that QMHPs will regularly seek input from direct-care staff about the youth in their care and strategies that have or have not been effective.
    - Managing detained/incarcerated juveniles with mental health disorders is typically made easier with information from mental health staff; mental health assessments and treatment are more individualized and effective with input from direct-care staff.
  - When working with a specific dedicated group of youth and staff, QMHPs are likely to be more effective when assisting with crisis situations , supporting distressed youth and coaching staff in the

moment with regard to effective strategies when managing or supporting youth with mental health or trauma-related symptoms, self-injury or suicidal thoughts/behaviors.

- Assess the need for one or more psychometrists to assist in the administration and scoring of tests measuring youths' intellectual, emotional, psychological and social functioning.
  - This can often be cost-effective.
- Ensure any and all new QMHPs hired have the skills and willingness to communicate and collaborate with Youth Court Counselors and parents/caregivers, as well as juvenile justice, substance use, educational, and medical professionals in the detention facility.

Qualified Substance Use Professionals (QSUPs)

Qualified substance use professionals (QSUPs) at the Henley-Young detention facility should provide substance use assessment and treatment services to youth with substance use disorders, as well as other substance use-related services when indicated:

Findings

- There are no substance use professionals at the Henley-Young detention facility.

Recommendations

- Assess how many youth at the Henley-Young detention facility meet criteria for a substance use disorder to determine how many QSUPs are required to meet their assessment and treatment needs.
- Hire enough QSUPs to meet the assessment and treatment needs of youth at the facility who have substance use disorders.
- Any and all QSUPs hired should have the license, education, training and experience to provide evidence-based assessment and treatment services to adolescents who have alcohol and other drug use disorders.
- All QSUPs should be trained and proficient in "motivational interviewing" with adolescents.
- Ensure any and all QSUPs hired have the skills and willingness to communicate and collaborate with Youth Court Counselors and parents/caregivers, as well as juvenile justice, mental health, educational, and medical professionals in the detention facility.

Interdisciplinary Team (IDT) Meetings

Formal, structured Interdisciplinary Treatment Team meetings should be held at least once a week on each unit. At least one staff member from each discipline should be in attendance; the goal is to use the unique skills and knowledge of every individual at the meeting. When team members have different backgrounds, training, philosophies, work experience, and current roles, treatment plans tend to be more informed, comprehensive, and strategic.

Findings

- There are currently no Interdisciplinary Team (IDT) meetings held at the Henley-Young detention center.
- Several staff members (including direct-care staff) expressed support regarding the implementation of IDTs, as well as interest in participating in these meetings.

Recommendations

- Develop and implement policies, procedures, and practices to ensure that Interdisciplinary Team meetings occur weekly to discuss youths' treatment plans and modify them as needed.
- To increase efficiency and effectiveness, once there is a QMHP on each unit, Interdisciplinary Team Meetings should focus solely on youth residing on a particular unit
- Representatives from mental health, juvenile justice, education, medical, substance use (if applicable), recreation (if applicable) and juvenile court should attend each meeting.
- IDT meetings should be welcoming and supportive, with input solicited from everyone in attendance
- Parents/caregivers should be encouraged to attend IDT meetings (e.g., in person, by phone, or by webcam), as should key individuals from the community such as probation staff, community treatment providers, residential placement personnel, etc.
- Youth should be present for a significant part of the IDT meeting, be involved in the development and review of the treatment plan, and have the opportunity to ask questions, seek clarification, and make requests.

Coordinated Case Management

Findings

- The Henley-Young Youth Court Counselors, located outside the detention facility, appear to be required to perform several tasks/responsibilities typically carried out by a case manager. I repeatedly tried to talk with the Youth Court Counselors and/or their supervisor about any/all case management duties, but was not permitted to speak with them.
- Youth and staff at the Henley-Young detention facility consistently reported that a key trigger for agitated, aggressive, destructive or suicidal behavior (or thoughts) in the detention center is youth not knowing what is going to happen to them, not knowing when they will be able to go home, and when receiving upsetting answers to these questions, it is sometimes delivered quickly and not always in a compassionate and/or supportive manner.
    - This is not surprising given detained/incarcerated youth often have mental health and substance use disorders, significant trauma histories, and poor coping skills.
    - Despite some youth reportedly being triggered by information from their YCC, two of the youth I spoke with said they felt their YCC was "on my side" or "trying to help me."
- Detention staff consistently reported they could support youth significantly more effectively if they had additional information regarding youth and their current situation from the Youth Court Counselors.
    - Staff did not feel this was a purposeful withholding of information, but was more likely due to the substantial number of tasks and responsibilities Youth Court Counselors are required to do.

Recommendations

- Hire a case manager for each unit to serve as a liaison between detention staff, Youth Court Counselors, parents/caregivers, and youth--particularly those with mental health/substance use disorders and trauma-related needs.
    - This could potentially shorten the time (potentially a number of days or longer) youth spend anxiously awaiting information regarding what will happen to them, including how long they will likely remain in the facility.

  - Having detention case managers also increases the likelihood youth would receive more time/support during the actual delivery of distressing news and detention staff would receive key information about youths' situation, that can inform them how to most effectively support youth should they become agitated, aggressive, destructive or suicidal.
  - It can also increase communication between the detention facility and parents/caregivers of youth with mental health, substance use and trauma-related disorders, as well as youth who are suicidal.
  - It can also assist the Youth Court Counselor with transition planning prior to a youth's release.
  - Detention case managers can monitor youths' treatment progress while in the detention facility, communicate with parents/caregivers regarding their son/daughter's behavior while incarcerated and inform them of their child's progress (or lack thereof) in treatment, plus engage and motivate youth and their parents/caregivers to participate in treatment.
- Any and all case managers should possess the skills and willingness to effectively communicate and collaborate with mental health, substance use, medical, educational and juvenile court professionals.
- Any and all case managers should possess the skills and willingness to effectively engage and communicate with a wide variety of parents/caregivers.

Community Reintegration

When not adequately prepared for the transition from confinement back to the community, youth with mental health, substance use and trauma-related disorders can become overwhelmed, frustrated, and discouraged. Treatment gains may disappear if appropriate resources and support services are not in place. Because these youth often have multiple needs upon release, they typically require resources, support and services from multiple systems, including housing, family, mental health, substance use, school/work, child welfare, medical, and possibly probation or parole

Reintegrating detained/incarcerated youth back into the community should be a key focus of attention and efforts for all youth, but particularly those with mental health, substance use, and trauma-related disorders. Transition planning should begin the day a youth is detained/incarcerated.

Findings

- I was told transition planning is the responsibility of the Youth Court Counselors YCC), as they interact with parents, schools, and child welfare, as well as make referrals to a variety of services (including mental health and substance use) in the community.
  - Although I made multiple attempts, I was not permitted to speak to the Youth Court Counselors (YCC) or their supervisor so am unable to comment on what transition services are provided for youth prior to release from the Henley-Young detention facility nor the effectiveness of these services.
- It is not common practice for professionals in the detention facility to talk with parents or mental health providers in the community prior to a youth's release.
- Seventeen-year-old incarcerated youth who are released from a juvenile correctional facility without resources, services and support can end up in adult jails and may eventually go to prison.
  - Two of the youth I spoke with reported being "held until they were 18"—for one youth that was close to three months.
    - It was not clear what type of transition services were being set up for either of them, as I was not permitted to speak with the YCCs or their supervisor.
  - Releasing youth from a 60-90 day stay in a juvenile correctional facility can be a "set up" for recidivism if resources, services and support are not put into place before youth return to the community.
  - For these two youth, recidivism would likely mean the adult criminal justice system

Recommendations

- Check to see if policies, procedures and practice are in place with the Juvenile Court and the Youth Court Counselors (YCC) ensuring incarcerated youth with mental health, substance use and trauma-related disorders are connected to key resources, supports and services *prior* to being released from the detention facility.
    - If these are not in place, develop and implement them immediately
- Transition planning/reintegrating youth back into the community should begin as soon as a youth is detained/incarcerated and should be a key focus of attention and efforts while a youth is in custody. The following areas should be addressed when indicated for a youth: housing, family, mental health, substance use, school/work, child welfare, medical, and probation.
    - Seventeen-year old youth should not be released from the detention facility on/close to their 18th birthday without a transition/reintegration plan that addresses needed resources, services and supports.
- Although all youth removed from the community and placed in the detention facility need some type of transition planning, special attention should be given to youth with mental health, substance use and trauma-related disorders who are detained for 30 days or more.
- A variety of individuals involved with a youth's supervision and treatment (e.g., YCC, QMHP, QSUP, education professional(s), detention professional(s), parents/caregivers, youth) should provide input into community transition plans; they should be written in objective language that can be understood by youth, their parents/caregivers, and professionals from diverse systems.

Oakley Youth Development Center (OYDC)

Oakley Youth Development Center (OYDC), about 30 minutes outside Jackson, is the sole juvenile correctional facility for children adjudicated into the state juvenile correctional system in Mississippi. The OYDC website stated the only youth who can be committed there have been 1) adjudicated delinquent for a felony or 2) have been adjudicated delinquent three (3) or more times for a misdemeanor offense. It was reported that after the settlement of a large class-action lawsuit, OYDC now provides a variety of educational and treatment services.

Findings

- The OYDC website states the facility offers a variety of assessments, individual and group therapy (including anger management, social skills development, drug and alcohol awareness), recreation, and education.
- It also states that each student receives a complete physical and a full-scale psychological assessment which includes: IQ testing, personality profile, drug and alcohol abuse risk questionnaire, suicide risk assessment, achievement testing and a trauma risk assessment.
- It was reported that Oakley currently has numerous mental health professionals and case managers.
- While I was at the Henley-Young detention facility, there were youth charged with strong arm burglary, possession of a weapon (2), auto theft (2), and robbery.
    - Many youth at the detention facility had been detained/incarcerated multiple (and some many) times.
    - Yet, there was not a single mention from youth regarding the possibility of being sent to Oakley, ever spending time at Oakley or knowing another juvenile from Hinds County that spent time at Oakley.
    - When I asked detention staff about his, I was told that they did not know of any youth who served their sentence at Oakley (one staff thought he "heard" about one youth).
    - I found this odd, as it is the only the state juvenile correctional facility in Mississippi.

Recommendations

- Investigate whether the reported services on the OYDC website are currently being provided at that facility.

- Assess the number of youth who have been sent to ODYC from Hinds County.
    - If the number of youth sent to ODYC from Hinds County is significantly less than other counties similar to Hinds, evaluate how these decisions are made, and if eligible youth in Hinds County are not being referred to ODYC, evaluate the primary reasons why
- Ensure low risk, non-violent youth are not sentenced to ODYC
- Evaluate the potential harm and benefits for serious juvenile offenders with mental health, substance use or trauma-related disorders to be sentenced to one longer-term placement in OYDC that reportedly offers a range of assessment and treatment services versus shorter, repeated stays at Henley-Young detention facility that currently offers minimal assessments and no psycho-education, skills groups or treatment.

Staff Training

When the adults working in juvenile justice facilities do not receive adequate training on mental health (including trauma) and effective behavior management, they can become frustrated and discouraged, leading to burnout and ineffective—and sometimes harmful—management strategies. Without an understanding of youth with mental health and trauma–related disorders, as well as how to effectively manage this population (many of the biggest behavior management challenges in juvenile detention involve youth with histories of trauma and/or mental health disorders), staff can unintentionally escalate a crisis situation, exacerbate youth distress, or trigger a deterioration of youths' symptoms. This can be dangerous for both youth and staff.

All staff should receive a minimum of eight (8) hours of training on each of the following topics 1) identifying and managing incarcerated youth with mental health, substance use, and trauma-related disorders and 2) effective behavior management with clinically complex and difficult-to-manage youth in juvenile correctional settings, including effective alternatives to isolation and restraint

Findings

- It was reported that Henley-Young detention facility staff receive two (2) hours of "mental health" training and that all but one permanent staff and three newly hired staff have attended the training.
    - I was told that this training is currently taught by Ms. Frelix, the only mental health professional in the detention center.
- It was reported that Henley-Young detention facility staff receive a four (4) hour "behavior management" training taught by Ms. McCoy, the training coordinator, that can be delivered in two and one half (2.5) hours, and that all but one permanent staff and three newly hired staff have attended the training.
- It was reported that Henley-Young detention facility staff receive an eight (8) hour "nonviolent crisis intervention" training developed by the Crisis Prevention Institute (CPI) that is taught by Mr. Cole, a staff member who has been certified by CPI.
- Some Henley-Young detention facility staff received the NCYC/NPJS "Mental Health" training module in mid-September.
    - It is designed as an eight (8)-hour training, but it was reported to have been given in 5-6 hours.
- There is one Training Coordinator who is responsible for providing the majority of orientation training for all new employees, staff training on new topics/policies/procedures, and annual refresher trainings.
    - I was told she is responsible for teaching all of the courses herself except Crisis Prevention Institute/CPI training (which is taught by staff member who is a certified CPI instructor) and Mental Health, Suicide Prevention, and Adolescent Development (which are taught by Ms. Frelix, the facility's mental health professional; however being the only mental health provider in the detention facility, Ms. Frelix is then removed from other essential mental health responsibilities).
- Scheduled trainings taught by the Training Coordinator cannot occur if she is out sick, on vacation or not at work for other reasons.

- Staff I spoke with said they felt positively about the Nonviolent Crisis Intervention (with an emphasis on verbal de-escalation) training developed by the Crisis Prevention Institute (CPI) and believed it is helpful. They said it helped staff be more proactive versus reactive
    - Several staff said strategies from this training were most commonly needed 1) when youth would become agitated or worried over knowing what is going to happen to them and/or how long they will remain in the detention facility and 2) after youth receive distressing news from a Youth Court Counselor and the counselor leaves and it is not clear when they will see her/him again
        - I was told this "could be a day or a week"
- Trainings at the Henley-Young detention facility appear to be reserved solely for Henley-Young detention staff

Recommendations

- Ensure all staff (direct-care to administration) receive a minimum of eight (8) hours of training on identifying and managing incarcerated youth with mental health disorders.
    - Consider using the NCYC/NPJS "Mental Health" training curriculum released in 2014.
- Ensure all staff (direct-care to administration) receive a minimum of eight (8) hours of training on effective behavior management with clinically complex and difficult-to-manage youth in residential settings, including effective alternatives to isolation and restraint.
- Ensure all staff (direct-care to administration) receive a minimum of eight (8) hours of training on providing trauma-responsive care with incarcerated juveniles.
    - Consider using the National Child Traumatic Stress Network training "Think Trauma: A Training for Staff in Juvenile Justice Residential Settings"
- Conduct a training assessment and evaluate the required training needs of staff and hire an additional trainer(s) to ensure all staff are trained in key areas as soon as possible, as well as attend annual refresher trainings.
    - Trainers should be knowledgeable, engaging and down-to-earth professionals who recognize the expertise of juvenile detention staff and the challenges of working in a juvenile detention facility
- Integrate a brief section on "self-injury" into the Suicide Prevention (see separate section devoted to Suicide Prevention) or Mental Health training, describing what it is, how it differs from suicide, how it is a significant risk factor for suicide, and some effective strategies for managing this dangerous behavior in detention.
    - If time does not permit this method of delivery, consider doing small trainings on each unit covering the same material regarding "self-injury."
- Continue the CPI's Nonviolent Crisis Intervention training and have Mr. Cole provide real-world "coaching" with staff/youth interactions on each of the units
- Have QMHPs provide brief informal trainings to staff on key mental health and trauma-related issues
- Mental health and substance use professionals (when hired) must continue to update their skills yearly with continuing education courses, workshops and/or trainings.
- Consider inviting detention school staff (e.g., educators, behavior specialists) and the Youth Court Counselors to mental health, trauma-responsive, behavior management, and Nonviolent Crisis Intervention trainings, as this material is very relevant to their roles and responsibilities with youth
    - Training a diverse group of participants is a good way to bring together the various disciplines that must communicate, collaborate and coordinate the care of youth in the detention facility.
    - The training itself can help professionals carrying out different roles learn more about one another and serves as a starting point for exchanging ideas.
- At a minimum, administrators, supervisors and treatment professionals (mental health and substance use) should attend national conferences relevant to their position and job responsibilities.
    - Research, professional standards and best practices in the area of mental health, substance use, trauma, suicide prevention, and juvenile justice are continuously evolving.
    - Ideally, a group of direct-care staff should attend national juvenile justice conferences.

Medical Services Review
Henley-Young Juvenile Justice Center - Detention Division
Report Date: November 11, 2015

Prepared by Ngozi Ezike, MD, CCHP

Henley-Young Juvenile Justice Center
Detention Division
Medical Services Review
Report Date November 11, 2015

Submitted by Ngozi Ezike, MD, CCHP
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Background

On March 28, 2012, Hinds County, Mississippi entered into a settlement agreement ordained and adjudged by Judge Daniel P. Jordan III, for the United States District Court Southern District of Mississippi, Jackson Division, regarding conditions of confinement at the Henley-Young Juvenile Justice Center. As part of the settlement agreement, the defendant contracted with National Juvenile Justice Expert Leonard Dixon to serve as a monitor of the agreement. He is responsible for documenting the defendant's compliance with the terms of the agreement and for providing and/or arranging technical assistance and training regarding compliance with the settlement agreement. I was asked to review the medical services provided to the youth at the Henley-Young Juvenile Justice Center. I performed a site visit to the Henley-Young Juvenile Center on September 16 and 17, 2015.

Adults Interviewed

Johnnie McDaniels, Executive Director
Eddie Burnside, Operations Manager
Brenda Felix, Mental Health Program Administrator
Nurse Carter (Registered Nurse)
Nurse Gathings (Licensed Practice Nurse)
Nurse Burch (Registered Nurse)
Nurse Wilson (Nurse Practitioner)
Mr. Brown, Health Services Administrator

Youth Interviewed

Resident KB, 17yo male
Resident DJ, 17yo female

Introduction

This report is the result of my site visit to the Henley-Young Juvenile Justice Center—Detention Division on September 16-17, 2015. My impressions, comments and recommendations are based on my observations during the site visit; interviews with staff, management, and youth; review of the health records of the detained youth; my medical education, training and knowledge; my experience working in/with juvenile justice facilities; and my understanding of the standards and current best practices with regard to medical services in juvenile justice facilities.

Before my visit, on September 9, an email was sent to the administrative leadership requesting documents needed for review upon my arrival. Upon arrival to the facility, the documents requested had been prepared. By the end of my visit, many requested items were still not available. See Appendix A.

Healthcare Vendor

Quality Choice Correctional HealthCare's contract with Henley-Young abruptly ended on September 15, 2015. A new vendor, Quality Choice Healthcare Company was identified to take over the medical operations. At the time of the visit, these changes had just been announced and town halls were taking place to discuss the impact and significance of the vendor changes with the medical staff.

Medical Staffing

Administrator
There is a Health Services Administrator who has been in the position since April 2014. He reports to the corporate office. He has a primary office location at an alternate site. He stated that he is on site once weekly and calls the facility daily.

Nursing
During the weekdays, there is a registered nurse that works the day shift, approximately 8a-4p. There is a 2nd nurse that works from 4p-12a. Currently, the 2nd nurse position is filled by a licensed practice nurse (LPN). There is no nursing coverage overnight, from 12a-8a. On Saturday and Sundays, an RN works a 12 hour shift each day from 7a – 7p.

Midlevel Clinical Provider
A Nurse Practitioner is on site at the facility for approximately 4 hours per week, usually on Thursdays.

Physician Provider
Dr. Raymond Sutton is designated as the medical director for 4 locations – Henley Young, Raymond Detention Center, Hinds County Penal Work Center, and Jackson Sheriff's Jail. He is also the supervisory physician for the Midlevel Clinical Provider. No direct clinical care is provided by this physician to the youth of the facility. The Nurse

Practitioner reports that she can access the supervisory physician by phone if needed. I did not have contact with this individual during my site visit.

Findings

- The Health administrator was not well versed in the standard practices of the medical department that he was overseeing. For example, he was aware of the need for universal tuberculosis screening but was unaware that this screening was not being performed in the facility. He did not know that pregnancy tests were not being offered to all females upon admission. He was also unaware that oral screenings were not being performed.
- There is no overlap of shift times from day to evening nurse.
- The licensed practice nurse (LPN) works independently during her shift from 4p-12a
- According to Mississippi Nursing Practice Law and stated in 30 Miss. Admin Code Pt. 2380, Chapter I, nursing assessment is outside of the scope of practice of the licensed practice nurse.
- Among the items that I received from the administrator was a Manual of Health Policies that is consistent with both NCCHC and ACA standards.
- Unfortunately, there is no congruence between actual practice at the facility and most of the policies listed in the manual.

Recommendations

- The Health Services Administrator needs additional support to learn and understand the basics of creating and sustaining an effective healthcare operation for detained youths in a correctional setting. That support could be granted by working with a medical consultant specializing in juvenile corrections and/or by attending conferences and/or trainings focused on juvenile correctional healthcare
- The transition to a new vendor that has experience delivering healthcare in correctional settings may provide the necessary additional support.
- I would recommend that the policies in the Manual of Health Policies be used as a guide to implement actual facility practices.
- The staffing should allow for additional Clinical Provider hours to meet the needs of the facility. **Provision 12.2 Medical Care**
- There should be an opportunity for the day nurse to give report to the oncoming evening nurse to create a proper handover.
- The LPN is not permitted to independently perform the assessments needed for sick call and the History and Physical/Mental Health assessment. The LPN has to work with an RN to perform these tasks. **Provision 12.1 Medical Care**

Reproductive Health

Findings

- Female youth are not routinely screened for pregnancy.
- Detained youth's' Urine Nucleic Acid Amplification Testing (NAAT) samples are picked up on Tuesday and Fridays and taken to the State Lab to test for Gonorrhea and Chlamydia.
- After the results are received, if there is a positive result and the youth is still in the facility, transportation is arranged for treatment at Crossroads Clinic. Transportation orders are usually fulfilled within 1 or 2 business days
- If the youth with a positive test has been released, the staff at Crossroads or from the Health Department is to follow up with the youth by phone.
- HIV testing can be performed at the Crossroads Clinic if the youth requests the testing.

Recommendations

- All female youth should have a urine pregnancy test administered during the intake process.
- Given the increasing prevalence of STI's in adolescents nationwide and the fact that Mississippi Chlamydia rates were 30% higher than the overall US average (www.msdh.ms.gov "Chlamydia Rates by year, United States and Mississippi, 2003-2013"), STI testing and treatment should be a priority for the detained youths.
- Protocols should be developed and enacted to ensure more timely delivery of the urine samples to the State Lab for testing. The sooner the samples are taken to the lab, the sooner a positive result can be detected and the sooner treatment can be started.
- Single dose treatments for gonorrhea and chlamydia should be considered to be kept on site to be administered to youths with positive STI results to avoid treatment delays.
- Given the CDC's recommendation for routine HIV testing for all adolescents, a protocol should be developed and enacted to ensure all admitted youth have access to testing and counseling. This could be achieved through partnerships with local community organizations whose focus is HIV testing and education.

Intake Screening/History and Physical

Findings

- Nursing staff consistently perform an assessment within 24 hours of admission. Nurses complete the History and Physical/Mental Health Assessment. The Nurse Practitioner (midlevel provider) only sees patients referred by the nurses rather than performing a physical on all admitted youth.
- Youth admitted when no nurse is on duty are brought to the clinic the following day to be assessed.

- Youth deemed by detention center staff to need medical attention are sent to the Emergency room for evaluation.
- Routine infection control measures such as tuberculosis screening are not performed.
- Pregnancy tests are not performed routinely on female youth.

Recommendations (Provision 1.3 Intake, Provision 12.1 Medical Care)

- Without advanced training, registered nurses are not permitted to perform the history and physical (H and P) for admitted youth. One option to correct this would be to have a physician provide a structured training to the registered nurses on performing the H and P. However, the better option is to have the Nurse Practitioner complete the H and P for all admitted youth. A separate, screening intake is to be performed by the nurse within hours of admission. (The Agreement says that the physical will be performed within 72 hours. Standards outlined by the National Commission on Correctional Health Care (NCCHC) allow for the physical to be performed within 7 days of admission.)
- Ideally, there should be medical staff on duty at the facility or within close physical proximity to the facility around the clock. If that is not achievable, there should be formalized training for detention staff on the intake screening procedure in the absence of medical staff. The training should be explicit in establishing criteria for youth that will require medical evaluation overnight (through the emergency department) before the health staff is on site in the morning.
- There should be a physician available after hours to consult by phone on the youth admitted if/when there is no medical staff on site.

STI Prevention

Findings

- Detained youth's Urine Nucleic Acid Amplification Testing (NAAT) samples are picked up on Tuesday and Fridays and taken to the State Lab to test for Gonorrhea and Chlamydia.
- Depending on the day of the youth's sample collection, test results can take from 6 -10 days to be returned. It can take up to 14 days from testing to treatment.
- After the results are received, if a positive result is detected and the youth is still in the facility, transportation is arranged for youth to be treated at Crossroads Clinic. Transportation orders are usually fulfilled within 1 or 2 business days
- If the youth with a positive test for Gonorrhea and/or Chlamydia has been released, the staff at Crossroads or from the Health Department will follow up with the youth by phone.
- There is no documentation that the sample has been collected until the results are received.

Recommendations

- If the youth is released before Urine STI test results return, the staff from Henley-Young should follow up with the youth by phone to ensure notification occurs and document the notification. This should be done for both positive and negative results.
- Henley- Young staff should be able to provide options for where the released youth can go for treatment during the notification call.
- Before the lab result is sent back, there should be chart documentation that the urine sample has been collected from the youth.

Off Site Care - Emergency Department, Hospitalizations

Findings

- Detained youths are appropriately sent to the ER for services that cannot be provided at the facility.
- There are usually no accompanying hospital documents from the treating hospital/ Emergency Department when the youth return.
- When the health staff call for results, Emergency department representatives do not release the medical information.
- Per the Administrator, Merrit Hospital has an official contract with Hinds County.
- From discussion with the nurses, youth are sent to both the University Mississippi Medical Center Hospital (UMMC) and Merritt Hospital of Central Mississippi Medical Center (CMMC).

Recommendations

- A formalized agreement, e.g. a Memorandum of Agreement, if not currently in place, is needed between the Detention Center and the University Mississippi Medical Center Hospital and Central Mississippi Medical Center.
- The agreement should delineate a standard protocol for sending physician notes, x-ray reports, and lab test results back to the facility with the patient after discharge.

Licensing, Certification, and Background Checks of Medical Staff

Findings

- Health Administrator did not maintain any licensing, certification or background check documents for the medical staff.
- When staff independently provided some of the documents, some staff AED/CPR certifications were expired.

Recommendations

- There should be a formal process for ensuring medical staff's licenses and certification are maintained and up to date.
- Proof of these licenses and certifications should be readily available
- Proof of background checks are also necessary.

- Proof of Continuing Education (CE) hours should be collected by administration.

Medication Cart

Findings

- There was an assortment of over the counter medications on the medication cart. The following list is of items on the cart that were expired:
- Biofreeze expiration date: 08/15
- 1st Aid Antiseptic Spray expiration date: 07/2015
- Hydrocortisone Cream 1% expiration date: 12/2014
- Petroleum Jelly expiration date: 04/2014
- Mupirocin Ointment expiration date: 04/2015
- Aspirin packets expiration date: 05/2015
- Muscle JEL expiration date: 02/2015

Recommendations

- There should be a protocol to identify all medications with pending expiration dates to remove these medications before the month of expiration.
- Audits by the healthcare administrator will be necessary to ensure that this practice is consistently upheld.

Organization of the Medical Chart

Findings

- There was a chart for every youth for whom I requested to review the medical chart.
- The paperwork was not in chronological order.
- There were no problem lists in the charts.

Recommendations

- There should be a problem list in every chart.
- Papers should be filed in the various sections of the chart in chronologic order with most recent documents on top.

Psychiatric Services (covered in full detail by Mental Health expert)

Findings

- There was no Qualified Mental Health Professional on staff at the facility.
- There had been 6 weeks without a psychiatric provider despite having youth in the facility on psychotropic medications.
- Per the administrator, a psychiatrist, Dr. Nagle, had quit in July of 2015 and a replacement physician, Dr. Gupta, only came to the facility one day before resigning.

- There were 2 suicide attempts in the preceding 6 weeks prior to my site visit.

Recommendations

- Securing a mental health team (Psychiatrist and mental health specialists) for the facility is an acute priority.
- Training has to be given to the staff that will be performing the mental health assessments.

Internal Review/ Quality Review of Services

Findings

- There is no review or auditing of the work of the LPN, RN's or Nurse Practitioner (NP) at the facility.
- There is no essentially no contact between the nurse practitioner and the medical director. The medical director does not review any of the clinical work performed by the Nurse practitioner.
- At the time of the audit, there were no quality improvement strategies or processes in place.
- Before the conclusion of my site visit, the administrator presented a new audit tool document and was instructing the nurses on how to use it.
- There are no evaluations by the administrator or medical director for any of the medical staff members.

Recommendations

- The administrator, or a designee, should perform audits of the work performed by the nursing staff.
- There should be, at a minimum, annual evaluations for each of the medical staff members.
- There should be chart audits by the medical director to review the work of the midlevel provider.

Sick Call (Provision 12.3 – Medical Care, Provision 12.5 – Medical Care)

Findings

- The nursing staff effectively deals with sick calls within 24 hours.
- LPN's address sick calls independently.
- Youth have to request a sick call form from security staff and return the filled form to the security staff.

Recommendations

- Sick call boxes should be installed on each living unit so that youth can confidentially submit their requests to the medical department.

- Sick calls need to be addressed by RN level nurses. LPN's are practicing out of their scope by performing sick calls independently.

Access to Daily Large Muscle activity

Findings

- The youth interviewed reported that outdoor recreation had ceased due to a recent escape attempt.

Recommendations

- One hour of large muscle activity should be offered to youth daily. If the youth cannot go outdoors, alternative indoor accommodations must be made.

Meals and Nutrition (Provision 9.1—Meals and Nutrition)

Findings

- The youth interviewed reported that they received three meals daily and a snack.
- The youth reported drinking fountains with water that was not potable.
- Allergies are identified and documented on the H and P.
- One youth reported that his meals were not free of the food for which he reportedly had a life-threatening allergy.

Recommendations

- Meals must be specially planned and prepared for youth with life-threatening allergies.
- The drinking fountains with non-potable water should be turned off to prevent accidental ingestion.

Notes from Interviews with Youth

KB, 17 yo male

Multiple previous admissions to the detention facility
There is an orientation for newly admitted residents
MAYSI screening performed during every admission
Physical exam upon admission, genital exam was not performed, listened to heart and lungs, eyes checked, no Snellen test,
Has never had dental services at the facility
Receives three meals and snacks every day
Food “tastes bad”, “Didn’t receive enough food”. “Not enough salt or pepper”
No outside recreation in 1 week. No substitute recreation indoors. Previously went outside every 2-3 days but there was a recent escape attempt.
Reported recent personal suicide attempt; he was transferred to ER, given suicide gown but no counseling when returned to the facility.
Two sets of clothes are changed weekly
Receives deodorant and soap
Youth are involved in washing clothes. In some instances, clothes are washed only with water, no soap.
No sick call forms on the living section. After requesting Sick calls from the guards, they have to go to another room to retrieve it. Forms are given back to the guards who are able to read it.
Sick calls are responded to promptly but no privacy in the process.
Nurses perform checks after restraint
Youth receive health education – condom use demonstrations, STI education
Flu Shots are not administered at the facility
Unsafe to drink from the water fountain. → Vomiting ensues from drinking from water fountain. However, there is a cooler with cold water
Despite reported food allergy, youth reports being served the offending food item almost daily. His reported reaction to the food is “throat swelling and difficulty breathing”
Asthma inhalers for the youth are not kept by the youth but kept in the tower. Youth have to request for the guards to retrieve the albuterol inhaler when needed
Casts and crutches are used by youth on the pod

DJ, 17 yo female

Reports undergoing complete physical at the time of admission
Would like to see more variety in the food that is served
Receives 1 cup of juice per day and 2 cups of milk per day, cooler of water on the pod
Snack is given at 8p
No recent outside recreation since a youth tried to flee and there are no indoor gyms
No dental services offered
No contraception services offered to her

Comments from Interviews with Medical Staff

Additional hours are needed for the midlevel provider – at least 8 hours weekly
Common ailments – Scabies, dermatitis from cosmetic products, UTI's (diagnosed by urine dipstick)
No access to labs from UMMC
No available dental services
No insulin on hand for sliding scale correction
No pharmacy or pharmacy verification when medications brought from home
Limited oversight on overall practices and procedures by management

Findings from Review of Medical Charts

Ten youths were selected from the September 16, 2015 roster which listed all of the 39 detained youths, 33 males and 6 females. I reviewed the entire chart in each instance, including documents from the current admission and those from previous admissions. The selected charts represented 26% of the youth at the facility.

Chart #1: CM 16yo admitted 9/1/15

- History and Physical/Mental Health Assessment
  - Performed on 09/01/15. Day 1 of admission
  - The assessment did not include the patient's height and weight.
- Urine STI screen (for gonorrhea and chlamydia):
  - Sample collected on 9/01/15.
  - Order for transport to Crossroads for Positive Result on 09/15/15
- History and Physical/Mental Health Assessment (previous admission) performed on 03/04/15
- Urine STI screen (for gonorrhea and chlamydia):
  - Results reported 03/15/15
  - Positive result →Youth referred to Crossroads Clinic on 3/15/15
  - Seen at Crossroads for treatment on 3/17/15
- Sick Calls/Provider Visits
  - Two Sick calls were completed by resident on 9/1/14 and 9/3/14 with chief complaint of "headache and diarrhea."
  - Both nursing assessments took place within 1 business day.
  - Vitals were taken during both nursing visits but temperature was not taken during the first visit.
  - Ibuprofen was administered during the first nursing visit.
  - During both nursing visits, the patient was referred to the nurse practitioner.
  - The nursing visit for the second sick call with the same complaint in 2 days did not acknowledge the persistent symptomatology.
  - Nurse Practitioner saw patient on 9/4/14 and addressed headache complaint. Diarrheal complaint was not addressed.
  - In chart, total of four sick calls. Three out of four sick calls had documentation of a visit/assessment by the facility nurse.
- Urine STI screen (for gonorrhea and chlamydia)
  - Collected on 9/01/14,
  - Received in the lab on 9/09/14
  - Results reported on 9/11/14.
- Emergency Room Activity:
  9/2/15 Sick call for leg and thumb injuries

9/2/15 Nurse evaluation of complaint
9/2/15 Transport to ER for thumb/leg
9/2/15 ER paperwork from University Hospital present

Chart #2: MW 17yo admitted 7/27/15

- History and Physical/Mental Health evaluation:
  - Done on 7/27/15 Day 1 of admission
- Urine STI screen:
  - Collected on 7/27/15,
  - Received in lab on 7/30/15,
  - Positive result on 08/03/15
  - No documentation of referral for treatment
- Emergency Room Activity: N/A
- Sick Calls:
  - 3 out of 3 sick calls were appropriately addressed by the nursing staff within 24 hours.

Chart #3: DG 17yo admitted 9/15/15

- History and Physical/Mental Health evaluation:
  - Done on 9/15/15 Day 1 of admission
- History and Physical/Mental Health evaluation: (previous admission)
  - Done on 11/6/14
- Urine STI screen (previous admission)
  - Collected on 11/6/14,
  - Received in lab 11/10/14,
  - Negative result on 11/12/14
- Emergency Room Visits :N/A
- Sick Calls:
  - 1 sick call in the chart
  - 11/7/14 “chest pain” (sick call written by nurse).
  - Addressed by nurse within 24 hours.
  - Given laxative for constipation.
  - No follow up visit established.

Chart #4 DL 16yo admitted 9/2/15 (previous admissions: 4/5/15, 1/21/15, 9/10/14)

- History and Physical/Mental Health evaluation:
  - Completed on 9/2/15, Day 1 of admission

- Urine STI screen
  - Collected on 9/2/15,
  - Received in lab 9/9/15,
  - Positive Result on 9/11/15
- Chronic Care:
  - Asthma identified. No Peak Flows recorded
- Emergency Room visits:
  - Patient was transported to ER on 2/5/15 after persistent complaints of "stomach pain and vomiting" that did not respond to laxatives.
  - Patient received CT scan for "rule out appendicitis".
  - On 2/5/15, Patient was seen by Nurse Practitioner for post ER follow up.
- Sick Calls
  - 2 total sick calls found in chart
  - Both were addressed by nursing staff.
  - One was appropriately addressed within 24 hours.
  - One sick call was not signed or dated by assessing nurse so timeliness could not be determined.

Chart #5 JC 15yo admitted 7/1/15

- History and Physical/Mental Health:
  - Completed on 7/1/15. (Previous admission: completed on 10/22/14)
- Urine STI screen
  - Collected on 7/1/15,
  - Received in lab 7/6/15,
  - Negative result reported on 7/9/15
- Four Medical Reporting Forms filled
- ER Visits/Hospitalization:
  - Medical reporting form indicated return from State hospital with medications.
  - No hospital records or documents found in chart.
- Sick Calls
  - 1 Sick call that was appropriately addressed within 24 hours.
- Chronic Care:
  - Medication Administration Record (MAR) contains documentation of psychotropic medications (Clonidine, Zyprexa, Vyvance)
  - No documentation of an associated diagnosis in the chart.

Chart #6 DA 15yo admitted 9/10/15

- History and Physical/Mental health Assessment
  - Completed on 9/10/15 Day 1 of Admission (previous assessment: 8/9/15)

- Allergies
  - Food allergy to onions documented in chart
- Urine STI screen
  - Collected on 8/9/15,
  - Received in lab 8/12/15,
  - Negative result reported on 8/18/15
- ER visits: NA
- Sick Calls
  - 2 sick calls that were appropriately addressed within 24 hours
- Chronic Care
  - Patient on multiple psychotropic medications as listed on MAR but no psychiatric diagnoses listed in chart
  - Chart lists patient as "borderline diabetic" and Hepatitis C +
  - No labs in chart
  - No order for finger stick glucose checks found in chart
  - No plan of care to address the chronic care diagnoses

Chart #7 JM 17yo admitted 8/27/15

- History and Physical/Mental Health Assessment:
  - Completed on 8/12/15. No assessment found to correspond with current admission (Previous admission: completed on 10/1/14)
- Urine STI screen
  - Collected on 8/12/15,
  - Received in lab 8/17/15,
  - Negative result reported on 8/19/15
- Chronic Care:
  - Medication Administration Record (MAR) has documentation of Depakote
  - No additional chart documentation of any diagnosis to support the use of this medication
- ER visit/Hospitalization:
  - Documentation that patient was "released" from facility to Hospital
  - Additional chart documentation indicating discharge from Diamond Grove Hospital.
  - No hospital records or documents found in chart from the Diamond Grove admission.
- Sick Calls
  - Two Sick calls that were addressed within 24 hours.
  - The two sick calls were within 1 week of each other and were for the same chief complaint of "head pounding".

- Patient was appropriately referred to the Nurse Practitioner following the second sick call.
- A third sick call was present but patient was transferred to Diamond Grove before the nurse could perform an assessment.

Chart #8 PG 15yo admitted 9/10/15

- History and Physical/Mental Health:
  - completed on 9/11/15 Day 2 of admission
- Urine STI screen: information not in chart
- Chronic Care: not applicable
- ER visit/Hospitalization: not applicable
- Sick Calls: none in chart

Chart #9 JT 15yo admitted 9/8/15

- History and Physical/Mental Health Assessment:
  - Completed on 9/8/15. Day 1 of admission
  - (Previous admission: assessment completed on 05/18/15
- Urine STI screen:
  - Collected on 05/18/15,
  - Received in lab 05/20/15,
  - Negative result reported on 05/26/15
- Two Medical Report Forms filled
- Chronic Care: not applicable
- ER visit/Hospitalization: not applicable.
- Sick Calls: none in chart.

Chart #10 TS 17yo admitted 09/4/15

- History and Physical/Mental Health:
  - completed on 09/04/15 Day 1 of admission
- Urine STI screen:
  - collected on 9/4/15,
  - received in lab 09/09/15,
  - Negative result reported on 9/11/15.
- Contraception
  - Note identified need for Quarterly Birth Control Injection on 9/9/15
  - No documentation that it was actually given
- One Medical Reporting Form filled
- Chronic Care:
  - Patient identified as having: Rheumatoid Arthritis, Diabetes, and Eczema.
  - Diabetes

- Care Plan in chart
- Orders
    - Blood sugars to be checked three times daily and as needed,
    - oral hypoglycemics and sliding scale insulin,
    - urine ketones for sugars over 450,
    - diabetic diet.
- Eczema – Treatment with triamcinolone cream
- Rheumatoid Arthritis – No care plan or other documentation concerning this diagnosis

- ER visit/Hospitalization:
    - ER visit for evaluation of elevated sugar and to obtain labs.
    - Hospital records document order for Glipizide and Metformin.
    - No lab results present in chart
- Sick Calls - 1 Sick call that was appropriately addressed within 24 hours.

General Summary of Chart Review Findings

All charts that were requested were made available for review. However, Nurses were assembling the charts, hole punching loose documents and filing them in the charts as I requested them. Chart documents were not arranged in chronological order. Multiple nursing assessments were not dated and timed.

Medical Reporting Form and Medical Encounter Form appear to be different versions of same document type.

STI screening was performed consistently on all youth reviewed.

Sick calls are triaged and managed by the nurses in a timely manner.

The asthma patient did not have peak flow spirometry performed or documented in the chart.

No chart evidence that drug levels were being followed to ensure medications remained in the therapeutic range, when applicable.

Recommendations

History and Physical/Mental Health evaluation form and all of the medical department's forms/paperwork need to include the date of birth or another identifier to distinguish youths with identical or similar names.

The history and physical should be performed by a physician or midlevel provider.

Memo for Documentation – this form has no name or date line. A space to write the youth's name and to write the date is needed.

Chronic Care

Asthma patients requiring Albuterol inhaler administration should be allowed to Keep the inhaler On Person (KOP) to encourage and promote immediate, unobstructed use when medically indicated. (**Provision 5.3 –Individualized Treatment Plans Treatment Program for Post-Disposition**)

All asthma patients should have peak flows performed and documented. (**Provision 5.3 –Individualized Treatment Plans Treatment Program for Post-Disposition**)

Diabetic patients should have documentation of HbA1c and it should be repeated every 3-6 months based on previous level. (**Provision 5.3 –Individualized Treatment Plans Treatment Program for Post-Disposition**)

Sick call boxes should be installed on each living unit so that youth can confidentially submit their requests to the medical department. (**Provision 12.5 – Medical Care**)

Providers (MD's, PA's (Physician Assistants) and NP's) should perform the History and Physicals on youth after an initial intake by nurses. To do this, more hours will need to be allotted to the midlevel provider.

Obtain AED's for the facility and train detention staff on its use

Create and implement programs around obesity

X Ngozi Ezike, MD

Ngozi Ezike, MD

APPENDIX A

Items Requested for Inspection before Arrival to Facility

Current medical manual and updates, written policy and procedures, including nursing protocols (along with revisions)*
Review of intake/screening process (if not in medical manual)*
Review of process for obtaining emergency or specialty care (if not in medical manual)*
Review of medication pass process (if not in medical manual)*
Current listing of all residents in the facility on the days of my visit*
Medical staffing plan with total numbers of filled and vacant positions
Audits, inspections, complaints or accreditation reports conducted by professional or advocacy groups
Access to the medical records of all the current residents of the facility *
Daily List of all residents with chronic medical conditions, including pregnancy and their medications
Nursing shift reports
Infirmary reports
Confinement check logs
Injury reports
Incident reports related to medical operations
Grievances related to medical operations
Mortality reviews (last 3 years)
Food service records, including menus and dietary guidelines
List of all licensed medical professionals working at the facility
List of all detention staff working in medical department
Records of detention staff training on CPR/BLS/First Aid
Records for Medical staff personnel – Licenses, CPR/BLS certification, continuing Education hours*
Quality Improvement studies or reports
Two (2) blank copies each of the following documents:

- Receiving Screening
- Initial Health Assessment
- Health Service Request Form
- Referral to ER (emergency room)
- Special Diet form
- Chronic Care forms or templates
- Grievance form

*Documents that were obtained and/or processes that were verbally explained by the conclusion of the site visit.