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

Monitoring Compliance Report:

Draft Date: July 31, 2013

Report Date: August 28, 2013

Submitted by:

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INTRODUCTION:

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

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

The Agreed Order requires the monitor to "file with the Court and provide the parties with reports describing the Defendant's steps to implement this Agreed Order and evaluate the extent to which the Defendant has complied with each substantive provision of this agreement. Such reports shall be issued quarterly, unless the parties agree otherwise. The reports shall be provided to the parties in draft form for comment at least two (2) weeks prior to their submission to the Court." I have previously made quarterly, on-site, monitoring visits to the Forrest County Juvenile Detention Center (FCJDC) on March 27-30, 2012; June 26-29, 2012; September 25-28, 2012; January 4-9, 2013; March 24-29, 2013. Reports have been submitted to the Court and to the parties subsequent to each of those visits. My sixth monitoring visit was made to the FCJDC July 8-11, 2013. This report describes my assessment of compliance with the Agreed Order, to date, based on my site visit, interviews, and review of documents and videos.

The staff of the FCJDC, and the key management employees responsible for its operation, was again welcoming and open during my visit. I was given unlimited access to the facility and to staff and youth detained. I was able to be present at the facility during both day shifts (6:00 a.m. to 6:00 p.m.) and night shifts (6:00 p.m. to 6:00 a.m.).

I again submitted a written request for documents approximately four weeks before my visit and asked that those documents be sent to me no later than a week before my visit. I received most of those documents a few days before my site visit but the Southern Poverty Law Center (SPLC) also sent those documents to me on a disk so I was able to review them while traveling. That helped me to better prepare for my visit and to use my time on-site more efficiently.

At the time of my March 2013 visit, FCJDC still had not created a comprehensive policy and procedure manual for staff that would be consistent with the Agreed Order and that would ensure that FCJDC staff members have the written guidance needed to perform their jobs. At the time of that site visit, I had received five versions of the draft policy and procedure manual. Each time the *entire set* of proposed policies and procedures was provided, despite my repeated requests to receive *individual* draft policies as they are created. That created difficulty for me, as I did not have sufficient time to review those drafts prior to site visits. And, each time my recommendations for revisions to the draft policies and procedures were largely disregarded.

The FCJDC hired a new Assistant Director in September 2012 and she was delegated the task of writing policies and procedures. As is commonly done, she attempted to adapt policies and procedures from another state to the FCJDC. However, she failed to thoroughly review and proofread those borrowed policies before proposing them for the FCJDC. She submitted draft policies that could clearly not be implemented at the FCJDC, due to such things as physical plant differences, or that were not relevant to the needs of the FCJDC. She submitted draft policies that conflicted with the requirements of the Agreed Order. She failed to solicit my guidance regarding accepted juvenile detention practice. And, she repeatedly ignored my recommendations and feedback regarding draft policies that were problematic. Those actions resulted in the FCJDC being several months delayed in achieving compliance with the Agreed Order. And, the lack of written directions for the staff left them confused about expectations and resulted in a great deal of inconsistency in the practices at the FCJDC as well as in the treatment of juveniles detained there. And, the lack of written policies has led to my repeated finding of Non-Compliance or, barely, Partial Compliance with most of the provisions in the Agreed Order. Each time I review draft polices and procedures I do so with three goals in mind: 1) I look for them to be in compliance with the Agreed Order. 2) I look for them to be consistent with standard juvenile justice practice. 3) I look for them to be usable by the staff members who must rely on them for guidance. The policies and procedures that I reviewed five times, before and during my March 2013 visit, did not met those three criteria.

At the request of the Court and with the agreement of the two parties, I assumed the primary responsibility for developing an appropriate set of policies and procedures, consistent with the three objectives above. I drafted revised policies, based on the most recent version provided to me in March. I have held weekly phone calls with the FCJDC Director to collaborate on those proposed policies. It is essential that the facility administration participate in the process of developing policies and procedures. The FCJDC administration will be required to ensure that any policies and procedures adopted are thoroughly explained to staff and that they are fully implemented. The FCJDC must support and own their policies; no outside party can simply impose policies. That has resulted in the process of policy development being time-consuming and somewhat tedious. That is how it should be. Draft policies should reflect the position and philosophy of the administration and the jurisdiction while ensuring that accepted juvenile justice standards

of practice are met. Draft procedures should receive input from staff expected to implement them. In the case of the FCJDC, the attorney from the SPLC has also been involved in most of the weekly conversations and she has made valuable suggestions to ensure compliance with the Agreed Order. That process can be laborious but the end result should be worth the effort. Although there is still much work ahead on finalizing policies and procedures identified for inclusion in the manual, progress is finally transpiring. (Appendix A is a table that illustrates the progress on developing new policies and procedures for the FCJDC.)

Perhaps an even more arduous task than writing applicable policies and procedures, however, is the job of training of staff on policies and procedures that, in many cases, require significant changes in practices, and the ongoing monitoring of the staff's implementation of those new policies and associated practices. My review of documentation of new requirements at the FCJDC reveals that there is still a great deal that must be accomplished to ensure that practices at the FCJDC are consistent with new policies. It is clear that more thorough training needs to occur to not just introduce the new policies and procedures but to explain each policy's rationale and to discuss each element of the procedure. As I have stated in previous Monitoring Reports and many times to the FCJDC Director, training is not a one-time event but, rather, a continuous process. That ongoing guidance needs to occur ensure that the FCJDC staff is complying with written expectations.

The Agreed Order also states that the FCJDC "shall collaborate with the Plaintiffs to design and implement a comprehensive juvenile justice pre-service and in-service training program for detention center staff. Training shall include, but is not limited to, the mandatory reporting requirements for direct care workers, the requirements of the Prison Rape Elimination Act, verbal de-escalation techniques, adolescent brain development and developmental issues, effective communication with adolescents, effective documentation, appropriate use of force and restraint, and best practices for detention center administration." The former FCJDC Assistant Director was also assigned the task of developing a draft training plan when she was hired in September 2012. The SPLC attorney and I provided her with detailed instructions regarding the content of a juvenile detention training plan, along with written resources to use in accomplishing this task. However, she repeatedly disregarded our recommendations and simply provided lists of proposed training topics rather than the comprehensive training plan necessary to meet this requirement. At the time of my March 2013 site visit, The court and both parties to the lawsuit requested that I develop a draft training plan in order to create movement towards achieving this objective. I did that and submitted that draft to the two parties, in order to ensure the necessary collaboration, in April. The SPLC recommended some minor revisions that the FCJDC Director agreed to. However, at this point the training plan has not been finalized and adopted pending final approval by the Forrest County Sheriff's Department. It is hoped that will occur soon. Forrest County will need to analyze budgetary implications of the new plan and commit the necessary resources to ensure that it is implemented fully, both upon acceptance and in coming years.

As I have discussed in prior reports, Corrections Officers are required by state statute to attend Mississippi's state Corrections Academy and be certified within two years of employment. However, as I have also repeatedly stated, my review of the Corrections Academy Curriculum indicates that most of the training provided is designed for employees of adult jails and correctional facilities and is not appropriate for those working in juvenile settings. If the draft FCJDC training plan is adopted, the facility and Forrest County will need to invest in qualified trainers and juvenile justice curricula and provide the necessary training to staff. There will naturally be costs involved in ensuring that the staff of the FCJDC is properly trained. That makes the commitment to continuing to categorize employees as "corrections officers" and send them to the state corrections academy even less practical. Doing so results in FCJDC staff members receiving training that is, in many cases contradictory and counter-productive, and it entails the expenditure of funds that could be used for training that is juvenile justice focused. And, Direct Care Workers at the FCJDC do not attend that Academy and have not, therefore in the past, received any formal training in a similar planned, organized way.

Subsequent to my repeatedly making the recommendation that the FCJDC staff receive appropriate training, the facility administration requested information from me regarding a qualified trainer who could provide that opportunity for the current staff. I provided the name of a qualified trainer to provide at least some basic, initial training to staff. That trainer has trained on the National Juvenile Detention Association's *Detention Care Givers Basic Training Curriculum* throughout the country. That curriculum was developed by experienced practitioners with expertise in the juvenile detention field. The FCJDC contracted with that trainer and the current staff completed that training May 3, 2013. However, staff training cannot be viewed as a one-time event. The FCJDC must implement a training *program* that ensures that existing and future employees received training on both an initial and an ongoing basis. The FCJDC has a high rate of staff turnover and there have already been resignations since that juvenile detention training in April. Again, training must not be viewed as a single event but as something that will be continually offered to ensure employee competence.

The March 2012 Monitoring Plan presented to the Court also included the need for clear, written job descriptions for all staff at the FCJDC. The assignment to develop those job descriptions was also delegated to the former Assistant Director. She developed draft job descriptions that were incorporated into the draft policy and procedure, Organizational Chart and Job Descriptions. Those draft job descriptions were very general in nature and did not provide the specific guidance needed for them to be useful to employees. This monitor offered repeated guidance on writing job descriptions but my recommendations were disregarded. The FCJDC Director has assumed responsibility for the task of developing job descriptions, in collaboration with this monitor and the SPLC attorney. Hopefully those job descriptions, along with written policies and procedures and formalized training, will unambiguously explain expectations and assignments.

In my last monitoring report and at the status hearing held before the Court on March 27, 2013, the continuing problem of poor communications between this monitor and the FCJDC administration was discussed. That poor communication has lead to the FCJDC's making counter-productive decisions and has contributed to the significant delay in achieving compliance with the Agreed Order. The weekly phone conversations discussed above have helped to improved communication. Those calls have been used to jointly finalize new policies and procedures, to discuss the draft training plan and to address other issues, with the shared objective of moving forward towards compliance with the Agreed Order and, most importantly, in improving conditions of confinement at the FCJDC. It has been clear that the FCJDC administrators were appointed with little consideration of their qualifications in the juvenile justice field or as managers. They have had no training or experience in supervising or managing employees, including basic requirements based on statute and case law. Our weekly calls have also provided the opportunity to provide guidance, mentoring and coaching on the fundamentals of running a juvenile detention center as well as essential information about administration and management. The lack of training and guidance for the FCJDC administrators on dealing with issues of human resource management has resulted in well-intended but potentially detrimental and inconsistent discipline of staff members. Graduated discipline and discipline that is commensurate with the employees' actions has generally not occurred. And, although I have inquired about the existence of written personnel policies and procedures for the Forrest County Sheriff's Department, I have not received a reply to that question. And, even more concerning, the FCJDC Director has indicated to me that she does not know if the Sheriff's Department has personnel policies and procedures. The attorney for the Forrest County Board of Supervisors provided a great deal of information regarding personnel policies for Forrest County employees but he reported that, by statute, a sheriff can opt out of those policies and that the Forrest County Sheriff has chosen to do so. He did not know if the Forrest County Sheriff's Department has developed alternate human resource policies. As I have stated in previous reports, FCJDC administrators need knowledge on such fundamental matters as the Fair Labor Standards Act, the Family Medical Leave Act, the Americans with Disabilities Act, and Equal Employee Opportunity regulations on both a state and federal level. They need training on appropriate and effective supervisory and disciplinary practices. And they need written policies to ensure that they comply with case law and statute.

The internal communication at the FCJDC continues to be problematic. The FCJDC administration has been overly reliant on what they refer to as the "chain of command" to communicate information. However, the FCJDC is a small facility and the Director and Assistant Director can and should communicate directly with staff. The position of Staff Commander has been eliminated and the Shift Commanders have been shuffled and reassigned. Currently, two of the four Shift Commander positions are vacant. Relying on a chain of command that barely exists is an ineffective method of communication.

Until recently, there were no documented staff meetings, memoranda or other practices for communicating requirements. As I have stated in previous reports, such

methods are especially valuable when changes are frequent and ongoing, as is the case at the FCJDC. The FCJDC administration has begun scheduling staff meetings to work on improving communication and sharing of new information and requirements. That is progress but the quality of those meetings must improve in order for them to be effective. For example, the agenda of one staff meeting indicated that the staff was trained on six major, new policies and procedures in 30 minutes. It should surprise no one that those employees did not comprehend that voluminous information and, therefore, did not implement most components of those new policies. In general, the brief period of time allowed for shift changes is being used for meetings to train on policies and to communicate important issues. That time period should be devoted to transmitting information about the youth and the facility. In order to successfully convey such important information as new policies, procedure and practices, along with accompanying documentation requirements, time should be set-aside specifically for that purpose.

In accordance with my recommendations, the FCJDC has located several copies of the Policy and Procedure Manual throughout the facility for the staff to refer to as needed. Those manuals contain new policies and procedures as they are finalized. Several staff members indicated that they have reviewed those manuals during their shifts to improve their understanding of expectations. At this point, however, the manuals are simply binders containing new policies, are not well organized and lack a table of contents or index to facilitate locating information. That will need to occur soon as the number of policies in each binder increases.

Although a number of new policies and procedures have been developed at the FCJDC, most staff interviewed during my site visit still lack information on or understanding of those expectations. Not only are the policies and procedures not being implemented correctly or followed by staff members, the documentation required by those policies is consistently incomplete or inaccurate. Training on the new policies and procedures has clearly been cursory and inadequate. Again, as I discussed with the administrators, that type of training must not be viewed as a single *event* but, rather, as a continuous, ongoing *process.* FCJDC staff members cannot be expected to fully comprehend the many new expectations that have been established let alone fully implement them. However, both administrators and line staff report that when employees fail to comply with policies they are frequently "written up." This monitor has continued to try to teach more effective methods of ensuring that changes in philosophy, policy and practice occur. Punitive interventions can create resentment and can undermine efforts to effect change.

The current Director and Assistant Director express commitment to improvement at the FCJDC and to compliance with the Agreed Order. However, a number of employees interviewed during my visit revealed significant lack of understanding of new policies and accompanying expectations. Practices do not yet meet the expectations of either the Agreed Order or of the FCJDC's own written mandates. Further, some employees reported that they had been cautioned not to share information with the SPLC staff or with me that could be indicative of the facility's lack of compliance with the Agreed Order. A number of

employees made reference to the two-year deadline for achieving compliance in October 2013. Staff offered statements like: "We have been told that when the lawsuit is over, it's going to go back to how it was before," and "It is said all the time: 'If we can come out from under this in October, we don't have to keep doing all these things.'" A recent example of potentially suppressing important information was offered during interviews. Staff members interviewed reported to me that the incident reports from a serious incident on June 16 were only written after one of the youth involved told SPLC about that incident and the SPLC requested copies of the reports. That youth reportedly had been pressured to not tell SPLC about the incident. That could be true since the incident reports were dated nine days after the incident. Regarding the June 16 incident, the Director reported that she simply needed time to review the reports for grammar and format before they were approved. Incident reports need to be completed by all involved staff members before the end of the shift during which the incident occurs so that the administrators and others have current information available. The administrator should then approve reports or request that a staff member complete a separate amendment if additional information is needed. That system also eliminates any appearance concealing information.

I don't know where staff has acquired the impression that the time-limited Agreed Order means that the changes at the FCJDC are temporary or if that is the universal belief. However, not only did employees volunteer such statements, juveniles who I interviewed made similar assertions. I do not question the commitment of the FCJDC administration to improving the quality of care provided to youth detained at the facility. However, methodical monitoring on my part clearly reveals that there is still a significant amount of work to be completed before the FCJDC can be considered in compliance with the Agreed Order. If the looming October deadline is driving progress, then I am even more concerned about the lack of improvement.

Related to the deficient internal communication at the FCJDC, is the fact that youth files are maintained in the administrative area of the building and the staff members who are dealing with the juveniles on an ongoing, day-to-day basis do not have regular access to them or to the vital information that they contain. Some information that should be in those individual files, such as the Youth Assessment and Screening Instrument (YASI) required by the Agreed Order, are not even found in those files. All completed YASIs are filed together, not in individual juvenile's files, and rarely if ever viewed or utilized by staff working with those young people. That system also eliminates the ability of the staff or mental health professionals to compare YASI results over time. The FCJDC needs to develop a system for sharing important information being gathered on detained youth with the staff members who are working with those young people on a daily basis. This monitor has made specific recommendations to the FCJDC administration for addressing that issue. Hopefully, those suggestions will be implemented. Failing to do so exacerbates already inadequate internal communication at the FCJDC and contributes to poor quality of care of youth.

The fact that there are no written job announcements for positions at the FCJDC has resulted in some employees being assigned to jobs at the facility that they had no prior knowledge of or had not applied for. That has lead to some employees being assigned to work with youth when they had expected and hoped to be employed in an adult jail. The FCJDC Director reported that hiring decision responsibility varies and that she often does not have the final say on who is hired at the facility. The FCJDC and Forrest County must implement a systematic recruitment and hiring process in order to ensure that appropriate staff is employed at the facility.

Despite the apparently haphazard hiring process, there are individuals, at all levels, at the FCJDC who seem to be committed to the best interest of juveniles and who could prove to be valuable members of the staff. But, without necessary formal direction, as well as informal and ongoing support, staff will become increasingly discouraged and quality of care will continue to suffer. Staff turnover at the FCJDC is high. That is costly to the County and limits stability and uniformity in dealing with youth. There has been and continues to be a need for a culture change at the FCJDC and that will require consistent staffing as well as supervision, training and written directions. The FCJDC Director reported that she had had no orientation as a newly hired Forrest County employee and had not been trained on county personnel policies. The poor morale is a growing concern. Staff members express frustration with the poor communication within the FCJDC and dealing with them harshly rather than supportively seems to be aggravating those feelings. Change is challenging for all of us and that fact needs to be acknowledged and addressed by the FCJDC administration. Culture change is difficult, tedious and time-consuming but that is what needs to occur at the FCJDC in order to ensure that any modifications that are put in place to comply with the Agreed Order are not immediately reversed when that order expires.

As I have stated in previous reports, it appears that my Monitoring Reports and other communication with the FCJDC have been largely disregarded. Those reports have not been consistently shared with the FCJDC administration and the administration has attempted to move forward without any apparent consideration of the specific recommendations in my reports. It has been my impression that the summary table that offers compliance “grades” for each provision has been the focus of attention with little, if any awareness of the rationale for my ratings or the recommended steps for achieving compliance. I have strongly emphasized with the FCJDC Director the need to consider the discussion offered regarding each provision’s level of compliance and the tasks necessary to compliance. Instead, the FCJDC has chosen to offer its own appraisal of their level of success. Those reports have required time and effort that could have been better spent addressing the specific activities needed to comply with the Agreed Order and, in the process, improve the conditions of care of youth at the FCJDC.

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

occasional occurrences. That documentation includes written expectations such as policies and procedures and job descriptions, verification of staff training, as well as documentation of actual practice such as completed daily logs and examples of forms completed by staff to verify required practices. When that documentation does not yet exist, I again offer recommendations or suggestions for developing that paper trail and I continue to be available to offer technical assistance in doing so as well. In reviewing documents for this report, both prior to my visit and while on-site, I again found examples of contradictory information. In addition, some verbal reports provided by FCJDC administrators and staff members were contradicted by documentation of what actually occurred. Those conflicts seem more the result of ongoing confusion and lack of understanding by staff, and in some cases, administrators, of expectations and philosophy.

The FCJDC is over twenty-one months into the Agreed Order and is still significantly behind schedule in achieving implementation. The FCJDC should have achieved at least partial compliance with most provisions of the Agreed Order long ago. I should have been able to be monitoring ongoing compliance with the Agreed Order. Instead, I am providing a great deal of guidance and technical assistance. And, until the last several weeks, that assistance had been largely ignored.

The substantial delays at the FCJDC can be attributed to a number of factors.

First, although the Agreed Order was entered October 12, 2011, the parties could not agree on a monitor and I was not appointed until March 6, 2102, approximately six months later. I made my first site visit three weeks later and learned that virtually no effort had been made to achieve compliance with even the most basic provisions of the Agreed Order. Shortly after that visit, the Director and Assistant Director were replaced and when I returned for my second site visit a second set of administrators were in place. Unfortunately, neither of those individuals had any juvenile justice or relevant management knowledge or experience. And, again, no progress had been made in achieving compliance with the Agreed Order. At the time of those two initial visits, I was given assurances that the Sheriff's Department and the administration of the FCJDC were committed to compliance with the Agreed Order. I was hopeful but, subsequently, disappointed.

At the time of my next visit, in September 2012, there was a third Director/Assistant Director team. Again, neither had any administrative experience and little if any juvenile detention experience. That Director remains at the FCJDC and has attempted to achieve compliance. However, she delegated the writing of the FCJDC policies and procedures and the FCJDC training plan to the Assistant Director. As discussed above, the Assistant Director provided several drafts of poorly written policies that did not meet the needs of the facility. In doing so, she repeatedly ignored my specific feedback and recommendations. She also failed to provide a training plan and missed numerous deadlines that she herself had set. She offered only lists of proposed training topics and, although she was provided with a great deal of written information regarding the content

of a training plan, she again ignored those recommendations. She left the FCJDC in May 2013 and has been replaced, this time with an Assistant Director who was selected by the Director herself. The current team seems genuinely committed to accomplishing compliance with the Agreed Order. They are admittedly overwhelmed by the amount of work involved but are supportive of each other and seem open to suggestions and guidance. They seem to truly care about the youth population that the FCJDC serves and are willing to advocate on their behalf. They both need ongoing supervision, mentoring, guidance and instruction but they have been open to both formal and informal training and to information regarding accepted juvenile justice practice. Although it is my opinion that the FCJDC still has a great deal of work to do to comply with the Agreed Order, there is finally some momentum towards that end.

Although my Quarterly Monitoring Reports have provided specific recommendations for reaching substantial compliance, it appears that those reports have received little attention. But, with the weekly phone calls and accompanying email correspondence since April, communication has improved and there does seem to be some impetus moving forward. That said, the collaborative effort necessary to develop written policies and procedures is far from complete. In addition to the policy topics proposed by the FCJDC, there are numerous other areas where policies must be created. And, as discussed above, policy writing is just a part of the larger undertaking. Staff must be (continually) trained on new policies and procedures, including required documentation, and their understanding and compliance must be monitored for quality assurance. My assessment of practices at the FCJDC, based on review of documentation and videos, interviews with youth and staff, and direct observation is that much remains to be accomplished.

The FCJDC has again made very limited progress on most of the provisions in the Agreed Order. However, compliance ratings for the current monitoring have improved on several provisions. As has previously been the case, based on the rating system that I have used in each of my Monitoring Reports (see below), I feel there are a number of provisions that could have justified lower ratings simply due to the fact that the FCJDC has not had written policies and procedures nor have they adequately trained staff on new policies. Many provisions have received the rating of “Partial Compliance” based on the fact that the Forrest County originally verbalized commitment to improvement. However, anticipated progress did not ensue and, although I initially felt some optimism that the FCJDC and Forrest County were committed to success, I have been repeatedly disappointed. The lack of progress during my first year of monitoring the Agreed Order was due to the failure to focus on achieving the major objectives discussed in the April 2012 Monitoring Plan.

I have repeatedly advised the FCJDC, both verbally during site visits and on our regular phone conversations and in writing in my reports and email correspondence, that compliance with the Agreed Order cannot be achieved until major tasks are accomplished, including a new policy and procedure manual; detailed, written job descriptions; a formal resident orientation system; and, a comprehensive, juvenile justice focused staff training

program. As discussed above, during the past several weeks some progress has been made in those areas. The policy and procedure manual is still a work in progress and training the staff on new policies and full implementation must occur. There is a draft training plan but that plan has not received approval from Forrest County and no effort has been made to implement that plan. Job descriptions are in the draft policy and procedure and have still not been finalized or implemented and they omit important requirements for staff to ensure compliance with the Agreed Order. A formal resident orientation system has been implemented that will help to achieve compliance with a number of provisions. However, although I have recommended in every monitoring report that I have submitted that formal, written detainee orientation occur, it was necessary for me to create that program for the FCJDC in order to ensure implementation. The FCJDC administrations' lack of ability to generalize regarding concepts and issues has been concerning but, hopefully that is primarily due to inexperience. I can only hope that, through experience, training and mentoring they will begin to apply ideas across topics and incidents.

EVIDENTIARY BASIS OF FINDINGS:

On-site visit to Forrest County Juvenile Detention Center July 8-11, 2013

Interviews Conducted (staff):

- Lakeisha Bryant, Director
- Lajuanda Mosby, Assistant Director
- James Varnado, Corrections Officer
- Georgia Hunter, Corrections Officer
- Brittany Davis, Corrections Officer
- Dewayne Lindsey, Direct Care Worker
- Kenny Harris, Direct Care Worker
- Maryon Roberts, Corrections Officer
- Sandra Baylor, Corrections Officer
- Allen Ellis, Direct Care Worker
- Cherlie Berry, Direct Care Worker
- Charles Hines, Direct Care Worker
- Joshua Edison, Direct Care Worker
- Joni Dixon, Direct Care Worker (by phone)
- Gregory Raynes, Corrections Officer
- Michelle Ingram, Corrections Officer
- Tawana Philips, Direct Care Worker
- Derek Jarvis, Shift Commander
- Tamara Baldwin, Corrections Officer
- Bobby Crowell, Direct Care Worker
- Szilvia Legradi, Pine Belt Mental Healthcare Resources
- Katrina Johnson, R.N.

- Charles Griffiths, M.D.
- Randall Weathersby, teacher
- Captain Donnell Brannon
- Chief Charles Bolton

Interviews Conducted (youth):

- A.S.
- J.E.
- M.C.
- D.L.
- J.M.
- K.L.
- M.H.
- D.L.
- J.E.
- B.B.

Documents provided:

Incident Reports:

- 4/02/13: G. Raynes
- 4/02/13: Tawana Phillips
- 4/02/13: Dewayne Lindsey
- 4/05/13: Gregory Raynes
- 4/05/13: Dewayne Lindsey
- 4/12/13: Charles Hines
- 4/12/13: M. Smith
- 4/12/13: Derek Jarvis
- 4/12/13: LaJuanda Mosby
- 4/20/13: Michelle Ingram
- 4/20/13: Tamara Baldwin
- 4/20/13: Bobby Crowell
- 4/22/13: J. Varnado
- 4/22/13: Tawana Phillips
- 4/26/13: LaJuanda Mosby
- 5/05/13: J. Varnado
- 5/06/13: Allen Ellis
- 5/06/13: Montoyia Smith
- 5/06/13: Charles Hines
- 5/07/13: Charles Hines

- 5/07/13: D. Jarvis
- 5/07/13: J. Edison
- 5/07/13: Tamara Baldwin
- 5/07/13: Allen Ellis
- 5/12/13: Edison (no first name)
- 5/12/13: Cherlie Berry
- 5/12/13: J. Varnado
- 5/18/13: Dewayne Lindsey
- 5/18/13: Joni Dixon
- 5/18/13: G. Raynes
- 5/30/13: Georgia Hunter
- 6/06/13: Tawana Phillips
- 6/06/13: Tawana Phillips
- 6/16/13: Kenney Harris
- 6/16/13: Charles Hines
- 6/16/13: Joni Dixon
- 6/16/13: Bobby Crowell

Other Documents:

- Daily Head Count Reports: April 1 – 5 and April 9 – July 3, 2013
- Daily Shift Logs, June 2013
- FCJDC Organizational Chart
- Disciplinary Reports
- Room Check Logs (without the required documentation of reason for confinement)
- Youth's Written Statement forms (not attached to any specific incident)
- Training Sign-in Sheets, April 8 – 12, 2013 and April 29 – May 3, 2013
- Training Sign-in Sheets, May 16 and 17, 2013
- Staff Meeting sign-up sheet and minutes, June 13, 2013
- Staff Meeting Agenda (undated)
- Staff Meeting Agenda (June 24, 2013)
- Certificate of Completion, Directors' Training, Mississippi Office of Standards & Training, Juvenile Facilities Monitoring Unit
- Sample Employee Suicide Prevention and Behavior Management Policy Test
- Administrators' Saturday On-Call Schedule, June-July 2013
- Detainee Grievance Forms:
    - 4/5/13: K.J.
    - 5/5/13: J.E.
- Memorandum of Understanding of Hattiesburg Public School District and Forrest County Juvenile Detention Center Providing Continuous Education for Confined Juveniles, approved by Forrest County Board of Supervisors, June 4, 2012

- Agreement for Medical Services Forrest County and Southern Spinal and Neurologic Institute, effective October 1, 2011 through September 30, 2012 for services at the Forrest County Jail and the Forrest County Evaluation Center
- Approved Proposal (May 24, 2011) from Pine Belt Mental Healthcare Resources for mental health services at the FCJDC
- Nursing Services Agreement with Forrest General Hospital and Forrest County Correctional Facilities, approved August 18, 2011
- Service Agreement Forrest County Jail and Accurate Medical Diagnostics, LLC, undated
- Copies of Cell Check Logs
- Visitation Logs, March 26 – May 23, 2013
- Diagram of FCJDC showing location of cameras
- Sample Completed FCJDC Officer/DCW Activity Logs
- Completed Search forms:
  - Daily Cell Inspection Reports, April 3, 2013 – June 27, 2013
- Copies of Fire Drill and Evacuation Reports, April 1, 2013
- Hattiesburg Fire Department Inspection Report, April 29, 2013
- Copy of completed Inventory, March 12, May ?, and June 20, 2013
- Medical and Mental Health documents
  - Medication Log Sheets
  - Inmate Medication Refusal forms
  - Physician's Orders
  - Request for Medical Care forms
  - Sick Call Request forms
  - Receiving Screening forms
  - Mental Health Assessments and Treatment Plans
  - Medical and Mental Health Appraisal forms
- Draft Staff Job Descriptions
- FCJDC Daily Schedules (Saturday, Sunday, Monday/Wednesday, Tuesday/Thursday and Friday) (dated: January 8, 2013)
- FCJDC Minor and Major Rules Violations (for detainees)
- FCJDC Detainee Handbook (dated October 28, 2012)
- FCJDC Programming schedules for April, May, June and July 2013
- Completed YASI forms
- Completed MAYSI-2 Questionnaire forms
- Sample Employee Disciplinary Reports
- FCJDC Minor and Major Rules Violations (for detainees) (undated)
- FCJDC Detainee Handbook (dated October 28, 2012)
- Visitation Rules
- FCJDC Parent Handbook (undated)
- Inventory form (dated March 8, 2013)
- FCJDC Care Package forms and FCJDC computer-generated list of items provided to detainees

- Sample Completed FCJDC Documentation of Cell Confinement forms
- Sample Completed Voluntary Cell Confinement forms
- Sample Completed FCJDC Suicide Watch Log forms
- Sample Completed Suicide Supervision: Constant Watch forms
- Sample Completed FCJDC One Hour/Fifteen Minute Visual Cell Check Logs
- FCJDC Receipt of Returned Supplies (sample form dated January 10, 2013)
- Forrest County Correctional Facility Menus, 2013, Weeks 1-4
- Memo from Heather Crawford, Nutrition Systems, July 11, 2013
- Copies of Phone Logs, March 1, 2013 – May 22, 2013
- FCJDC Organizational Chart
- FCJDC Staff Schedules (dated March 8, 2013)
- "Participant Workbook: Nonviolent Crisis Intervention", from CPI
- Revised Draft Policies and Procedures, version #5 (provided March 28, 2013)
- Random youth legal files (examined while on-site)

Monitoring Letters, Other Correspondence and Phone Discussions:

- June 11, 2013 SPLC Monitoring Letter to Anne M. Nelsen
- July 2, 2013 Letter to Jim Dukes, Jr. and David from Elissa Johnson, SPLC
- July 2, 2013 Letter with enclosed documents from Elissa Johnson, SPLC
- Miscellaneous electronic correspondence and phone conversations with LaKeisha Bryant, FCJDC, and Elissa Johnson, SPLC

DVDs/Videos reviewed:

- April 2, 2013
- April 20, 2013
- May 3, 2013
- May 6, 2013
- May 18, 2013
- June 6, 2013
- June 16, 2013

Web Sites:

- http://www.orbispartners.com/assessment/yasi
- http://nysap.us/MAYSI2.html
- http://www.law.cornell.edu/wex/reasonable_suspicion
- http://www.nadcp.org/learn/what-are-drug-courts
- http://www.gpo.gov/fdsys/pkg/FR-2012-01-26/pdf/2012-1010.pdf
- http://www.ntrsys.com/docs/CORRECTIONAL-FACILITY_SAMPLE-MENU.pdf
- http://www.aap.org

- http://www.ncchc.org

State Statutes:

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

FINDINGS:

In measuring compliance, I use the same system employed by the U. S. Department of Justice, which is similar to and consistent with the earlier reports from the Southern Poverty Law Center. Because these definitions of compliance levels are somewhat narrowly crafted, in my first Monitoring Report, dated May 7, 2012, there were some provisions that I rated lower than in previous SPLC Monitoring Reports. Some ratings improved after my May 2012 Quartering Monitoring Report, illustrating some perceived effort on the part of the FCJDC administration. However, some ratings subsequently regressed. That relapse was in part a consequence of some decline in practices and part the result of stricter focus on the definitions of the three compliance levels. As I have stated in each of my Quarterly Monitoring Reports, there are several provisions of the Agreed Order that could be considered in at least partial compliance or even in substantial compliance with the Agreed Order if there were written policies and procedures addressing those provisions. In fact, several provisions did show improved ratings this time, due to the development and, at least partial implementation, of new policies and procedures. However, many policies and procedures are still pending. Much work will still be necessary to accomplish the objectives of the Agreed Order and I am committed helping the FCJDC achieving that goal. I have developed a draft training program and am working with the Director of the FCJDC to help to finalize policies and procedures but successful implementation of either of those can only occur with the full commitment of the FCJDC administration and the Forrest County Sheriff's Department.

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

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

time, temporary compliance during a period of sustained non-compliance does not constitute substantial compliance.

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

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

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

Provision		Compliance Ratings							
		*Feb 2012	May 2012	July 2012	Oct. 2012	Feb. 2013	May 2013	July 2013	
I. INTAKE									
1.1	Youth Assessment Screening Instrument	NC	NC	NC	NC	NC	NC	PC	
1.2	MAYSI-2	PC	PC	PC	PC	PC	PC	PC	
1.3	Provision of prescription medications	NC	NC	NC	PC	PC	PC	PC	
1.4	Policies and practices to ensure youth medically fit for admission	PC	PC	PC	PC	PC	PC	PC	
1.5	Meals upon admission	PC	PC	PC	PC	PC	PC	PC	
1.6	Phone call and shower at admission	PC	PC	PC	PC	PC	PC	PC	
1.7	Searches	NC	NC	NC	NC	NC	NC	NC	
1.8	Alternative sanctions	CBD	CBD	NC	PC	NC	NC	NC	
II. STAFFING AND OVERCROWDING									
2.1	Adequate number of trained staff, staff ratios	PC	PC	PC	NC	NC	NC	NC	
2.2	Emergency release when exceeding ratios	SC	PC	PC	PC	PC	PC	PC	
2.3	Maximum capacity and one- and two-person cells	SC	SC	SC	SC	SC	SC	SC	
2.4	One- and two-person cells not exceeded	SC	SC	SC	PC	PC	PC	PC	
III. CELL CONFINEMENT									
3.1	Structured, rehabilitative programming	NC	NC	NC	NC	NC	NC	NC	
3.2	Youth in Holding, Detox, D-Unit allowed in living unit and involved in programming	PC	NC	NC	NC	NC	NC	NC	
3.3	Cell confinement requirements	CBD	NC	NC	NC	NC	NC	NC	
3.4	Mandatory and voluntary cell confinement	PC	PC	PC	PC	PC	PC	PC	
3.5	Staff in living unit and actively engaged with youth; communications system	NC	NC	PC	PC	NC	NC	NC	

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

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

15.4	Grievance policy	NC	NC	NC	NC	PC	PC	PC	
15.5	Policy that allows youth of all ages and literacy levels to request to see attorney and/or youth court counselor	NC	NC	NC	NC	NC	NC	NC	
15.6	Pre-service and in-service staff training program	NC	NC	NC	NC	NC	NC	NC	

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

In addition to the specific provisions of the Agreed Order discussed below, that Order also requires that "within 60 days of the effective date of this agreement, policies consistent with this agreement are drafted, in the process of being implemented, and that all detention staff will receive training on the requirements of this agreement." At each of my site visits, including the most recent, FCJDC staff members interviewed had limited information about the Agreed Order. Staff members continue to report that they received information about the Agreed Order informally from their peers or from media reports. However, some staff reported that the Agreed Order has been discussed in staff meetings and the level of knowledge seems improved. Staff members were still unable to locate a copy of Agreed Order to use as reference. It is recommended that copies of the Agreed Order be available with each of the copies of the Policy and Procedure Manual in order to ensure ready availability. As I have stated in my previous reports, the FCJDC must develop a system for training all current and future employees on the Agreed Order, as required.

As I have also emphasized in all my prior reports, in addition to the development of a comprehensive training plan for the FCJDC, it is vital all new employees receive at least a minimum level of formal orientation training that goes beyond the current practice of simply learning on the job. It is common practice in juvenile detention and corrections facilities throughout the country to require training, generally at least forty hours, *before* being allowed to work directly with youth. The practice of placing employees to work at the FCJDC with no job-related training, and without requiring that they *at the very least,* be required to shadow a trained, experienced staff member with accompanying, systematic instruction before being allowing to work with children is unacceptable. Reportedly the FCJDC has begun scheduling newly hired employees with an experienced staff member. However, that process has not been formalized, is not documented and examples of that practice were clearly violated during my site visit. Despite my repeatedly recommending that the FCJDC develop a formal orientation and training system for new employees, including training on the Agreed Order as required, that has not yet occurred. The comprehensive staff training program that I have been asked to develop does include that requirement. In addition, it details mandatory training topics for each category of employee, it spells out the minimum number of pre-service and annual training hours required, it discusses qualifications of trainers, it explains record-keeping expectations and other documentation requirements, it discusses the need for a training committee, and it discusses consequences for non-compliance. However, the existence of a written training program is only the first step. The FCJDC must ensure that the requirements of that program are implemented. The plan is still in draft and implementation has not begun.

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

I. INTAKE:

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

Compliance Rating: **Partial Compliance**

Discussion:

My interviews and review of files indicates that youth admitted to the FCJDC are generally given a YASI. Current YASIs were available for all youth detained at the FCJDC during my latest site visit. Based on interviews with youth and with the FCJDC booking officer, it appears that youth do receive a YASI within the required timeframe when they are admitted during regular, weekday working hours. However, there are still only two FCJDC employees are trained to administer the YASI. When neither of those employees is working, it is necessary to summon one of them to give the YASI as required. If neither is available, the deadline for the administration of cannot be met. I have repeatedly recommended that the FCJDC have additional employees trained to administer the YASI in order to ensure that there are qualified staff who can do so around the clock since youth may be admitted at any time of the day or night. To date, that has not occurred.

In addition to the need to complete the YASI in a timely manner, the FCJDC needs to ensure that the completed instrument is utilized as it is intended. Reportedly, the completed YASIs are placed in a folder for the mental health professional from Pine Belt Mental Healthcare Resources (PBMHR) to review each weekday morning and to use as part of her mental health assessments. The mental health clinician reported that she has generally received those but still does not always receive them the day after admission. Also, the completed YASIs are then filed all together in a YASI file rather than in the files of individual youth. That system eliminates the ability to compare results for particular young people from one admission to the next, as intended by the instrument, therefore minimizing its value in serving youth. I advised the FCJDC executive secretary that a new YASI should be filed in that youth's file. However, if that change is made, those files still need to be more accessible to both the PBMHR clinician and to the FCJDC staff so that the information can be considered in meeting the current needs of detained youth. Currently, the information gleaned from the YASI has only limited utility.

I did have the opportunity to verify the existence of current YASIs for all youth. In the process, I discovered information that was a cause for concern. One youth who I had interviewed reported that he was scheduled to be placed in a mental health treatment facility that he had been in previously. He also listed three other programs where he had been placed in the past for mental health treatment. He is currently on multiple psychotropic medications and his version of his history seemed valid. However, his completed YASI indicated that he had no mental health issues. A second youth discussed a history of illegal drug offenses, including most recently use and sell of methamphetamine. His YASI indicated that he had no history of drug or alcohol problems. Those two examples raise red flags about the accuracy of the information that I was given by staff members regarding the administration of the YASI and cause me to further doubt their validity and usefulness.

The new FCJDC Admissions policy indicates that the "the booking officer shall complete the MAYSI/YASI Questionnaires, along with the Medical/Screening Forms on the juvenile in private." As discussed above, that seems to be occurring when the booking officer is on shift. However, when she is not available to book youth into the FCJDC, interviews confirm that the new policy is not being followed. Again, the FCJDC staff needs to be trained on this policy to ensure compliance.

<u>Recommendations for achieving substantial compliance:</u>

1. Provide documentation that all current and future staff members are trained on the new Admissions policy and procedure, including the requirements related to the administration of the YASI. That training documentation should include, at least, date of training, time spent on that training, name of trainees, and name and qualification of trainer.

2. Provide documentation that at least one FCJDC staff member is present who is trained in administering and scoring the YASI on shifts at all times, as recommended by the instrument's parent company, in order to ensure that the YASI is administered within the required timeline.
3. Provide documentation of completed YASIs on FCJDC youth.

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

Compliance Rating: **Partial Compliance**

Discussion:

Currently, the MAYSI-2 is administered during the booking process on each youth detained. Based on recommendations from this monitor, the FCJDC has revised its procedure for administering the MAYSI-2, along with other booking tasks of a confidential nature. The booking officer now uses a bifurcated process. She completes legal paperwork and computer entries, along with any needed tasks that must be handled before the transporting officer departs. She then moves with the newly admitted youth to a small room adjacent to the booking desk where she completes the Medical Screening Questionnaire and the MAYSI-2, along with other paperwork that require privacy and freedom from distraction. The *decision* to separate the paperwork and computer aspects of the booking process from the portions that are either confidential or are best completed with minimal distraction was made at the time of my January 2013 visit but that *actual change* did not occur for three months, until I was on-site in March. By the time I made my most recent visit the booking officer was consistently completing the booking process in that manner. That was verified by interviews with youth. Other youth interviewed, however, indicated that when a juvenile is booked in during hours when the regular booking officer is not present, the process reverts back to the former system. Clearly, the FCJDC booking officer has revised her practice but the other FCJDC staff members who may be required to book youth into the facility and administer the MAYSI-2 are not consistently ensuring that the process is done privately.

The FCJDC Policy and Procedure, "Admissions" has been completed and staff have reportedly trained on that policy. That new policy describes the divided booking process that the booking officer has adopted. However, since other FCJDC staff members are not following that practice, it appears that all staff members do not adequately understand the new policy and that additional training is necessary.

The completed MAYSI-2 is placed in a folder for the Pine Belt Mental Healthcare Resources clinician to review each weekday. She receives all completed MAYSI-2 copies and uses them as part of her assessment. Pine Belt Mental Healthcare Resources provides services to individual FCJDC youth based at least partially on the results of the MAYSI-2. Improving the manner in which that tool is administered should provide them with more honest information and enable them to serve youth more effectively. The FCJDC has a new Suicide Prevention Policy and Procedure (see #13.1 below) that requires that a youth who is assessed as needing Constant Suicide Watch be evaluated by a mental health professional or transported to a hospital emergency room within 24 hours. That policy complies with provision 13.1 but not with this provision, which requires that the youth be "*immediately* evaluated by a mental health professional or taken to the local emergency room." Despite that contradiction, the FCJDC did provide one example of a youth who was immediately transported to the emergency room, at the direction of the on-call nurse, when he was reportedly potentially suicidal. And, the new Suicide Prevention Policy and Procedure requires that a youth on the highest risk suicide level, (Constant Watch) "be directly observed on a constant, uninterrupted basis and staff shall interact with that youth while continuously observing him or her." That ensures that a child is not at immediate risk pending evaluation by a mental health professional.

It is not known what, if any, formal training on how to administer the MAYSI-2 has been provided to any FCJDC staff member. No documentation of any training provided to staff on administration of the MAYSI-2 was available for my review, including the substance of the training and the qualifications of the trainer. However, the MAYSI-2 is a very user-friendly tool that requires minimal training to administer and score.

Recommendations for achieving substantial compliance:

1. Provide documentation that FCJDC staff are appropriately trained on the new "Admissions" policy and procedure and on the use of the MAYSI-2, including, at least, date of training, time spent on that training, name of trainees, and name and qualification of trainer.
2. Administer the MAYSI-2 to youth upon admission in private and in a manner that maximizes its validity, including reading questions to youth, and, if necessary, providing clarification of meaning. Provide documentation of the administration of the MAYSI-2 as directed by this provision.
3. Provide documentation that completed MAYSI-2 screening instruments are reviewed by a mental health clinician and that that clinician uses the information in the instrument to determine needed services while juveniles are in the FCJDC and upon release, if appropriate.

1.3 Forrest County Juvenile Detention Center shall ensure that all youth who have a valid, current prescription for medications are provided their medication within 8 hours of admission, if possible, but in no case, longer than 24 hours after admission, including weekends and holidays. If during a youth's

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC draft policy and procedure, does not address the requirements of this provision. The FCJDC nurse and this monitor have worked on developing or revising draft medical policies and procedures but have not yet completed that project. The existing draft policy and procedure, "Medical Clearance," states: "2. Youth who exhibit any of the following behaviors or symptoms must receive medical clearance from a physician, hospital emergency room or emergency medical service (EMS)(911) prior to admission: . . . n. Youth who claim that they need certain types of medication but do not have such medications with him or her." That procedure does not provide specific instructions to staff to follow to ensure compliance with this provision. Generally, it has been reported to me that arresting or transporting officers are required to bring any current prescriptions with a youth to be detained. However, the current policy does not state that. And, shift logs for June 2013 revealed that there was at least one incident of a youth being admitted without prescribed medication at the direction of the FCJDC Director, who had been contacted by phone. No follow-up documentation was provided to document whether that youth's medication was provided within the subsequent 24 hours. The nurses have reported on my various visits that they obtain necessary prescribed medication, either from the parent or through a new prescription, within 24 hours. Nursing notes provided for my review verify that the nurses working at the FCJDC document their efforts to obtain prescribed medications, usually from parents. Some notes confirmed the delivery of medications within or just longer than 24 hours. A number of the nursing notes document the efforts to obtain the medication; it is unclear whether that medication is actually delivered.

As indicated in my previous monitoring reports, the Receiving Screening Form asks youth if they have any medication with them. That form also asks youth: "Are you presently taking medication for diabetes, heart disease, seizures, arthritis, asthma, ulcers, high blood pressure or a psychiatric disorder?" However, some forms reviewed had that box check "yes" but no medications listed. That also seems to contradict the FCJDC requirement that youth not be admitted without current prescribed medications. And, as I have discussed in the past, that form is not completed until the child is accepted for admission and the arresting/transport officer has left. At that point, the youth has

essentially been admitted before it is known if he is taking medication. The booking officer did verify that arresting or transporting officers usually call to notify the facility that they are bringing a child for admission and that the officer is informed at that time that any prescription medication will be required for admission. The booking officer provided one example of having recently denying admission when she received a call because the transporting officer did not have the child's medication. Other staff members also seemed aware of the requirement that youth on prescribed medication must have that with them in order to be admitted.

The facility nurse manager has described a procedure through which she contacts the child's family, physician, probation officer or counselor to obtain the prescribed medication if the child does not have it at admission. She reported that, if the medication is not promptly delivered to the facility, she may obtain a prescription from the FCJDC contract physician. However, the physician may not have enough information to be able to provide a prescription within 24 hours of the child's admission to the facility. And, it is still uncertain how effective that reported procedure would or does work after regular working hours on weekdays. Most of the youth interviewed during my site visit reported that they were not on prescribed medication at the time of admission and none reported not having it with them when booked. Although interviews with staff and youth indicate that prescribed medications are generally obtained, it is still not clear how quickly that occurs and it not known how that occurs other than the description provided by the FCJDC nurse. The FCJDC still does not have a contract with a specific pharmacy.

The nurse manager assigned to the FCJDC previously informed me that they have acquired an Institutional Emergency Pharmaceutical Kit (IEPK), which was recommend for the facility by Forrest General Hospital. An IEPK, must be approved by the Mississippi Board of Pharmacy and allows "institutions, under the jurisdiction of the Board, that maintain prescription drugs on the premises for emergency use by patients" to "maintain a stock of prescription drugs for emergency use by patients who are confined to the institution." However, "Emergency kit medications shall be administered to patients only for emergencies and pursuant to a valid medication order or prescription. Institutional emergency medication kit drug supplies are not to be used when medications are readily available from a community or hospital pharmacy." (Mississippi Board of Pharmacy, Pharmacy Practice Regulations and Pharmacy Practice Act, effective January 31, 2011) The availability of an IEPK may be helpful but, as I have stated in the past, it does not address the need to obtain specific medications for acute or chronic care for individual youth at the FCJDC.

In addition to the IEPK, the medical staff assigned to the FCJDC do have access to an on-line program that they use to verify that medication that is delivered by a parent, law enforcement officer, probation officer, youth court counselor or other individual matches the label on the container, which helps to avoid medical errors.

None of the incident reports reviewed illustrated examples of any juveniles being booked into the facility either with or without prescribed medication. However, it is highly likely that there will be youth who are booked into the FCJDC who have been on prescribed medication but do not inform the arresting/transporting law enforcement officer or the FCJDC booking officer, as has occurred in the past. In those cases, the medical staff needs to obtain medications within required timelines. However, based on medical documentation and interviews with staff and, especially, with nurses, it does appear that youth generally do received prescribed medication within the timeframes established by this provision, at least on weekdays, when a nurse is available. In addition, documentation and interviews verified that youth at the FCJDC do receive prescribed medication as needed. To comply with this provision, the FCJDC must obtain the youth's medication from the youth's family or have a written procedure in which the facility obtains that medication from a local pharmacy within the mandated timeframe. Doing so could require a new prescription be issued by a physician or nurse practitioner familiar enough with the child's case to be able to issue that prescription.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

I have work with the FCJDC administration to complete two policies and procedures that address the requirements of this provision. The "Admissions" and "Medical Clearance" policies and procedures were drafted concurrently to ensure consistency between the two. Both procedures delineate specific conditions for which a youth may be denied admission without prior medical clearance. The items in those lists are understandable for a non-medically-trained person, such as a booking officer and provide guidance to that person in

determining whether a juvenile may be safely admitted to the FCJDC. However, as discussed above, the FCJDC staff has not been adequately trained on the Admission policy and procedure and there is clearly a lack of information or understanding among many employees. And, the Medical Clearance policy and procedure is still waiting to be typed on the correct form and for the staff to be trained. Even with completed policies and procedures addressing the requirements of this provision, if the staff is not trained on those expectations, a compliance rating of Partial Compliance is still considered generous.

Staff interviewed did consistently report that youth are denied admission when they are in need of medical clearance but if staff are not familiar with the detailed policy, including the list of conditions that would preclude admission, it becomes a subjective judgment call on the part of the admitting officer who may or may not have the knowledge or expertise to make that decision and no written guidelines to use. There is generally good medical coverage for the facility during weekdays and the contract nurse manager is unofficially available on-call for medical questions that arise. During the hours that there is a nurse present, that individual might assist in assessing the need for medical clearance. However, that still does not address the large majority of hours and days when no medical professional is on site.

No Incident Reports during the past three-month period document examples of a youth being refused admission because they were deemed not to be "medically fit."

Recommendations for achieving substantial compliance:

1. Implement the written policies and procedures that have been written to address this provision.
2. Provide documentation of staff training on those policies and procedures.
3. Provide documentation of staff training on how to make a determination of whether a youth is medically fit to be held in detention.
4. Provide documentation verifying that youth delivered to the FCJDC are assessed to determine whether they are medically fit to be held in detention, including examples of youth who are refused admission based on the determination that they are not medically fit to be held and the outcome for youth who are not admitted due to medical concerns.

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

Compliance Rating: **Partial Compliance**

Discussion:

All youth and staff interviewed reported during my site visit that juveniles are offered a meal at the time of admission to the FCJDC. Staff members reported that extra

meals are provided by the jail for staff and those meals are given to youth who are admitted. The new policy and procedure, "Admissions," states: "Lastly, the juvenile shall be offered a meal and escorted to his/her assigned unit." I again recommend that the policy and procedure make clear that any meal provided to a youth does not contain ingredients that could cause an allergic reaction after completing the Medical Receiving Screening form, which asks that question. For example, the menus provided for my review, of the meals delivered to the FCJDC indicate that peanut butter sandwiches are a staple several times each week even though peanuts are a common allergy. The only possible alternative meals are reportedly the meals that are sent for staff consumption but it is not known if they offer an alternative to peanut butter.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC draft policy and procedure, "Admissions," does address both elements of this provision. That document states: "It is the responsibility of the booking officer to ensure that the youth is given a phone call with efforts of contacting his/her parent or legal guardian before being assigned to a housing unit in detention." In conjunction with the development of the new Admissions policy, we have also created an Orientation Checklist that is to be completed by the booking officer. That checklist itemizes several issues that are addressed with youth at admissions and documents the completion of several booking tasks, including the admissions phone call.

All youth in the FCJDC during my March site visit reported that they were offered a phone call at the time of admission. Some youth even reported that they were afforded the opportunity to call again later when they were unsuccessful in reaching a family member. Staff interviews regarding phone calls generally verified that youth are now receiving a phone call at the time of admission.

The new FDJDC Admission policy and procedure also states: "After searching the juvenile, he/she should sign for and receive the detainee uniform (i.e. shirt/pants, underwear, footwear etc.). Youth should then be required to shower in the Holding Cell.

The officer shall collect all of the juvenile's clothes and place the items with the juvenile's property." The FCJDC physical plant has numerous limitations and the building was not designed to provide for a "designated area" for showers to occur in the intake area, which would normally be the case. However, in order to achieve compliance with this provision, the FCJDC installed a shower in a cell, formerly called the "holding cell," located in the booking area. The availability of that cell allows all newly admitted youth to shower prior to entering the secure housing area, as is normal procedure in a juvenile detention center. Youth interviewed during my site visit gave differing responses when asked if they were offered a shower at admission. Five youth reported that they did shower at admission in the holding cell. Four youth reported that they showered in a D Unit cell after they were admitted. One youth reported that he showered in his assigned cell in B Unit when he was admitted late at night. As is the case with other aspects of the new Admissions policy and procedure, it appears that not all FCJDC staff members are familiar with the expectations of that policy for admissions showers. And, a number of youth at the FCJDC during my visit had been detained for several weeks and, in one case, nearly three months. It could be that those youth were admitted prior to the new policy being fully implemented. That said, the expectations that are officially delineated in that policy were in place for some months prior to the finalization of the new policy. Staff members should have known of the admission shower requirement. Requiring that all youth shower at the time of admission, prior to placement on the living unit, is standard practice in juvenile detention. And, the time of the day or night should not justify exceptions. All staff at the FCJDC must be thoroughly trained on admissions procedures to ensure compliance with this provision and adherence with accepted juvenile justice practice.

As has been repeatedly stated, it is critical that youth admitted to detention all receive a shower at admission, including shampooing their hair, prior to being placed in a living unit with other youth, to ensure the sanitation of the facility, the safety of the other youth and staff and to ensure the hygiene of the newly admitted child. Many facilities in the country also routinely require that the admission shower include shampooing with anti-lice shampoo. Although this provision merely requires that a shower be "offered", it is standard practice that all youth admitted to a juvenile detention center shower at the time of admission.

Recommendations for achieving substantial compliance:

1. Provide documentation of staff training on the new Admissions policy and procedure.

1.7 Within 60 days of the date of this agreement, the Forrest County Juvenile Detention Center shall develop and implement policies that limit all searches, except routine frisk searches to instances where Forrest County Juvenile Detention Center staff has a reasonable suspicion that a youth may possess contraband. Anytime a search other than a routine frisk search is conducted, the Forrest County Juvenile Detention Center staff must document, in writing,

their suspicion, obtain permission from a supervisor, and conduct the search in a manner that minimizes the intrusion into the youth's privacy. Male detention center staff will search male youth and female detention center staff will search female youth.

Compliance Rating: **Non-Compliance**

Discussion:

The most recent version of the draft FCJDC policy and procedure, "Searches of Youth and Center," discusses searches. That policy addresses various types of searches and provides descriptions of each. That policy now incorporates most of the requirements in this provision. However, that policy has not been finalized and has not been implemented.

I again requested copies of documentation of searches conducted during the quarter under review. The only search documentation that I was provided were copies of the Daily Cell Inspection Report form. That daily inspection is a helpful safety and security addition to the FCJDC. I was provided with a sample "Frisk/Strip Search" form that is reportedly used to document the frisk search that is conducted at booking. The only searches that must be documented at the FCJDC are strip searches and body cavity searches. Staff members interviewed during my site visit reported that they are not allowed to conduct strip searches and that only medical personnel may conduct body cavity searches. There is clearly a great deal of misunderstanding regarding what searches are allowed and how they must be documented.

The former FCJDC Assistant Director informed me at my last site visit that they are not doing strip searches at all as they are waiting for guidance on the meaning of "reasonable suspicion." Following that site visit, I performed a simple Google search and found several definitions of "reasonable suspicion" in language that was easily understood by a layperson. One of those definitions, from a Cornell Law School web site, was forwarded to the FCJDC administration for reference. The FCJDC Director and I used that definition in the latest draft search policy and procedure.

Although frisk searches are apparently being conducted during the admissions process, staff interviewed generally reported that those searches occurred after the booking paperwork is complete. Some staff did report that the admissions frisk search occurs at the booking desk, immediately when the youth enters the facility. That is standard practice and will be required in the new Search policy and procedure, currently in draft. Most youth interviewed reported that they received a frisk search when they were admitted but, as with staff interviews, those reports varied. Some youth reported being frisked as soon as they entered the facility and some youth reported being frisked after the booking paperwork was completed. And, two youth described an admissions search that more accurately corresponds with the definition of a strip search, not a frisk search. The apparent lack of consistency regarding the admissions searches at the FCJDC makes it clear

that a comprehensive policy and procedure are needed that will comply with this provision and will ensure the safety and security of the facility. And, based on the inconsistent search practices described by both staff and youth, it is also obvious that FCJDC employees will need meticulous training on the new Search policy as soon as that is finalized.

As I indicated in my last monitoring report, the FCJDC has obtained a hand-held wand for detecting metal objects but most staff reported that is only used to search visitors and it is not used to search youth. My observation of youth being booked into the FCJDC again confirmed that practice.

The FCJDC staff has become more systematic in conducting cell searches. I observed that juveniles' rooms are not as cluttered, untidy or dirty as was formerly the case, which helps in identifying contraband. The apparently improved quality of cell searches, documented in incident reports and Cell Inspection Reports, may be the result of better informal guidelines for staff. However, the new Search policy and procedure will also address that issue before it is finalized and implemented.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Non-Compliance**

Discussion:

Many of the young people detained at the FCJDC are ordered there by a Youth Court judge for failure to comply with a drug court order, often for such non-violent behaviors as failing a drug screen. Those sentences are often for an extended period of time. Research indicates that use of secure detention in that way can be, not only counter-productive in modifying a child's behavior, it can have other negative results. Youth in detention are removed from their regular school while in detention, which often results in them falling

farther behind. They are unable to participate in positive activities in their community with family, church, sports and other institutions. And, most frequently, they develop resentment, feel unfairly treated, are not contrite, do not develop insight or make a logical connection between their behavior and the consequence of being in detention. Interviews with both youth and staff again confirmed that is the case. Committing youth for extremely long periods of time (90+ days), as is done at the FCJDC, with limited interaction with the Court, the assigned probation officer or Youth Court counselor and no treatment is contrary to the national drug court model (http://www.nadcp.org/learn/what-are-drug-courts). Drug courts are designed to place a great deal of emphasis on providing youth with "intensive treatment and other services they require to get and stay clean and sober." Regardless of what services youth ordered to drug court in Forrest County receive, and no youth could describe any services other than random drug screens, they receive virtually no treatment or other services during their extremely lengthy stays at the FCJDC.

The FCJDC still does not have an established system of alternate sanctions to secure detention for youth ordered to secure care by the Youth Court, either as a disposition or pending adjudication. The current use of juvenile detention as a consequence of violating a drug court order is clearly not working. Most of those youth could benefit from services consistent with the national drug court model or from some other non-secure alternative to secure detention. Clearly there is a need to more effectively serve youth who are simply "doing time." In interviews, many youth serving lengthy commitments indicate that they simply want to "get off youth court" and will do their time in detention but that they do not intend to change harmful or anti-social behaviors. I continue to be concerned that the FCJDC also has a number of youth committed by the Youth Court, also as a disposition, from Friday afternoons until Sunday afternoons. That increases the FCJDC population on weekends, with no concomitant increase in staffing. That is even more worrisome given the fact that the FCJDC is still not in compliance with the requirement that they provide daily structured programming.

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

They FCJDC staff and administration expressed concern for youth who are serving long sentences in detention and they recognize the damage that is caused. They have advocated for some youth, to the limited extent possible, but they have no authority to decrease sentences or divert youth to non-secure alternatives. It is commendable that the FCJDC administration has attempted to develop some alternative services for the Youth Court in the past. However, it is a concern that those services may widen the net to young people who may otherwise not be served by the FCJDC. Development of alternative

programs to secure detention should be a collaborative effort by a variety of stakeholders such as the Forrest County Sheriff's Department, the FCJDC administration, the youth court, the school district and others. Often, those programs are developed initially to address issues of overcrowding. However, it is visionary and positive when a jurisdiction recognizes the value of alternative programs for the youth and community. The FCJDC should seek and include the involvement of other stakeholders with responsibility for what is in the best interest of the youth of Forrest County to achieve compliance with this provision. And, they must develop and implement a clear, written policy and procedure that ensures that the FCJDC offers alternative sanctions only to youth who would otherwise be detained.

Recommendations for achieving substantial compliance:

1. Collaborate with community stakeholders to address this provision.
2. Develop written policies and procedures regarding any alternative sanction program that may be developed.

II. STAFFING AND OVERCROWDING

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

Compliance Rating: **Non-Compliance**

Discussion:

This provision has multiple elements and all of those elements must be complied with to achieve Substantial Compliance. Although the FCJDC hired additional staff last year and should have a sufficient number of employees to ensure that required ratios are met, those staff members are still not consistently scheduled in a manner that meets the requirements of this provision. Although there are generally an ample number of employees at the facility during normal daytime working hours on weekdays, there are shifts, either nights or weekends when staffing coverage is inadequate. That problem is made worse when the facility has vacant positions or when regularly scheduled employees are absent for some reason. The current staff-scheduling scheme does not use employees efficiently or effectively. There are numerous times during the evening and weekend hours

when the number of staff members in the facility is not adequate to make sure that structured programming occurs and that safety and security can be ensured. I reviewed incident reports and accompanying documents detailing several episodes where altercations occurred that appeared to have been preventable if FCJDC staff had been available or if they had intervened in a timely and appropriate manner.

Although my review of staff schedules and population reports show that the required ratio appears to be generally met where there are not vacant positions or absent employees, the physical design of the facility and the activities occurring at key times of the day or evening should require that employees' schedules be adjusted to meet the needs of the program and of detainees. During regular weekday hours (approximately 8:00 a.m. to 5:00 p.m.,) in addition to the schedule of officers and direct care workers (DCWs) that occurs on "day" shifts (6:00 a.m. to 6:00 p.m.,) there are a number of other staff present, including the Director, the Assistant Director, the Executive Secretary (who is also a certified officer), the booking officer and a "roaming" officer. Day shifts also include one additional DCW. However, the critical time period between 6:00 p.m. and bedtime (10:00 p.m.) has the same four employees, including the Shift Commander who may not leave the control room, who work through the night while the youth are sleeping. The FCJDC has been allowed to work employees overtime when necessary to ensure coverage. That is important and an acceptable approach. That does not always occur, however, and there are occasions when there are an insufficient number of staff members present. And, as I have stated in previous reports, adequate coverage of the facility and compliance with ratio mandates could more cost-effectively be accomplished through better and more efficient scheduling. In addition, there are still shifts that are scheduled with multiple new, inexperienced and untrained staff working without an adequate number of veteran, trained employees to ensure safe practices. That clearly does not ensure compliance with this provisions requirement that the FCJDC be staffed with a sufficient number of "*adequately trained* direct care and supervisory to supervise youth safely." That problem is caused, in part, by the frequent and apparent arbitrary movement of employees from shift to shift and from position to position. When an officer position opens up, administrators unilaterally select a direct care worker to move into that position. There is no fair and open recruitment, application and selection process through which candidates would be compared and chosen. The existence of shifts filled with inexperienced employees is also the result of the lack of a staff-training program that includes any pre-service training.

The FCJDC administrators are aware of the problem of staff members too frequently leaving youth alone in their units without supervision and with no structured programming. Those occurrences have been repeatedly documented through reports and videos. When youth are in the dayroom without staff present, they are free to roam that area and to go into and out of individual cells unsupervised. And, as I have discussed in prior reports, I again viewed a number of videos where staff responding to altercations used restraint techniques that are not acceptable and are not a part of the crisis prevention training (CPI) that the staff attended in December 2012. As I have previously pointed out, the line staff at the FCJDC have been advised that they are required to be present on the

units and that “at least one direct care staff shall be stationed on any living unit where two or more youth are placed, and direct care staff shall be actively engaged with youth,” as required by provision 3.5. However, that is still not a consistent practice at the FCJDC.

The FCJDC staff received training in May by a national expert in the juvenile justice field on a curriculum designed for juvenile detention. That curriculum emphasizes the importance of direct interaction with youth and will hopefully help establish a culture that ensures compliance with this provision. However, as I stated in my last report and as I have repeatedly pointed out to the FCJDC administration, that training was a one-time event. Administrators must reinforce formal training with oversight, monitoring, coaching, encouragement and support. The FCJDC will also need to ensure that future employees are trained in the expectations of this provision. The training plan required by the Agreed Order addresses staff training on this issue. The FCJDC has high staff turnover, causing staff training to be a challenge. However, allowing untrained or inadequately trained staff to work with youth in an environment where those youth are deprived of all control can lead and, in fact, has lead, to dangerous treatment of children. The expectation that line staff provide direct supervision, including the programming required in provision 4.1 below, is a significant change to long-term practices at the FCJDC. That change is based on a philosophical shift and the administration needs to clearly explain the rationale for that philosophy. The FCJDC staff needs to understand the evidence-based arguments for that change and not simply receive mandates based on the Agreed Order. To date, based on my interviews with staff over time, I perceive the practice of punishing employees violating requirements to be a common, albeit ineffective, approach that has lead to resentment and distrust.

The FCJDC draft policies and procedures address the requirements of this provision in “Staff-to-Youth Ratio” and “Programs and Activities.” However, the process of revising, finalizing and implementing those policies, including training staff, is ongoing. But, both of those draft policies basically elaborate on provisions in the Agreed Order. The FCJDC must not wait for written policies to be completed to implement those provisions. In addition, the written employee job descriptions are still in draft form and those documents are written in a very general manner and, until requested by this monitor, those job descriptions did not include any reference to the requirement that staff provide programming activities. Job descriptions need to be finalized and provided to employees. This monitor continues to be available to provide technical assistance with scheduling of staff, policy development and comprehensive job descriptions.

The draft policy, Staff-to-Youth Ratio, answers the question of which staff members at the FCJDC are considered “direct care staff” and which are considered “supervisory” for purposes of ensuring that required ratios are met. That definition includes “corrections officers” and “direct care workers” and excludes the shift commander, who is required to remain in the Control Room and, therefore, may not respond to emergencies and does not have direct interaction with youth. For purposes of this provision, the shift commander is considered supervisory.

As I have stated in previous reports, the involvement of volunteers can be a valuable addition to a comprehensive detention program. Although trained, adult volunteers may be used to supplement staff, they should not be used to replace staff and should not be responsible to ensure the safety of the youth.

The issues of the lack of direct staff supervision, inadequate number of staff members on some shifts, the lack of training for staff at the FCJDC and incomplete job descriptions continue to be problematic at the FCJDC with no evident improvement during the recent monitoring period.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC has not exceeded capacity since the Agreed Order, dated October 12, 2011 so it has not been necessary to implement release procedures as described in this provision. My review of daily population reports for the current monitoring period again confirmed that the population continues below capacity. However, there is still no written policy and procedure or other objective, written guidelines that would provide assurance that such procedures would be followed should the population increase beyond design capacity and be sustained at that level for two days or longer. There is a draft policy and procedure and as soon as that is finalized and implemented this provision should be found in substantial compliance.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Substantial Compliance**

Discussion:

The FCJDC appears to be in compliance with this provision.

Recommendations for achieving substantial compliance:

None

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

Compliance Rating: **Partial compliance**

Discussion:

The population of the FCJDC has continued to be below capacity since my last site visit, based on my review of population reports. The facility has had one of the three units closed for renovation for several months and that work had just been completed before my recent site visit. Therefore, all three units are now available for youth. The facility is able to control admissions to the extent that they do not exceed the number of available beds. No more than two youth were housed in any two-person cells during my visit although a number of cells housed two youth despite the availability of one-person cells. No reports were received from either youth or staff of this provision being violated through housing assignments.

Although the FCJDC does not *house* more than two youth in a two-person cell or more than one youth in a one person cell, based on youth and staff interviews, review of incident reports, video recordings and my own observations, it is clear that multiple youth are still allowed to go into and out of cells freely without supervision throughout the day. That practice can be dangerous, can lead to bullying or violence, and must not be allowed to occur. It should be noted, however, that the newly established Rules for youth at the FCJDC includes a prohibition against "Entering the room of another youth without staff permission." That is progress but, during my visit, I frequently observed youth entering the rooms of other youth with no staff intervention. Staff members seem aware of the rule but must be more consistent in enforcement. Incidents have continued to occur in individual detainee rooms where the staff cannot observe.

This monitor has revised the Classification policy and procedure, which incorporates the requirements of this provision. As soon as that policy is finalized and all staff members are thoroughly trained on the relevant procedures, this provision should be in substantial compliance.

Recommendations for achieving substantial compliance:

1. Finalize and implement written policy and procedure consistent with this provision.
2. Document staff training on the policy and procedure.

III. CELL CONFINEMENT

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

Compliance Rating: **Non-compliance**

Discussion:

The FCJDC has five different schedules, Saturday, Sunday, Monday/Wednesday, Tuesday/Thursday and Friday. The current schedules are dated January 3, 2013. Those schedules include several hours each day that are described as "leisure activities" but there is no written program that lists planned events for each day. Without more detailed plans, staff members are left with the discretion to provide limited or no programming. The daily routine and activities at the FCJDC still appear to be disorganized and, at times, chaotic. My interviews with staff and youth, review of documents, and observations throughout the four days and evenings that I was on site again make it clear that there is still little or no structured, rehabilitative programming for youth at the FCJDC.

As discussed in provision 2.1 above, the latest "Organization Chart and Job Descriptions" draft policy does include job descriptions for staff members at the FCJDC, including those that were omitted from the last draft. And, at the recommendation of this monitor, those job descriptions now include instructions to staff members to provide "programming to youth" at the FCJDC. The Shift Commander job description also instructs that individual to "coordinate a program of constructive activities." However, the Shift Commander position has been eliminated. And, that vague directive does not sufficiently ensure that programming occurs at the FCJDC or that the staff members on duty provide programming. Previous Monitoring Reports have recommended that written job descriptions for line staff members include the expectation that staff members provide planned, structured programming activities. As I have also previously recommended, the next step is actually putting that expectation into practice.

There are still no clocks in the units and I was told that the FCJDC was not allowed to hang clocks where youth may access them. However, the FCJDC did hang a clock outside B and C Units that is visible through the unit windows. There is no clock for A Unit. It is important for youth to know what they should expect during their day (a posted schedule) and to know what time it is in order to anticipate activities and to be responsible for participation. In addition, as I have stated in the past, a posted schedule and visible clocks would help to provide more structure to the staff and would also help hold them accountable for ensuring that youth do receive the programming required by this provision. There are clocks specifically designed for environments that may be subject to abuse. I again recommend that the FCJDC investigate that option.

There is one teacher employed by the Hattiesburg School District who serves the FCJDC. During the regular academic year, school is scheduled for five hours, although the actual time that youth are in school is frequently shortened as the result of late starts in the morning or afternoon and early return to the units at for lunch or at end of the school day. At the time of my March 2013 site visit, the FCJDC and the schoolteacher had begun a practice of allowing youth to sign a "School Refusal Form" that a youth signed if he or she chose not to attend school. That practice is not acceptable. A child should not be allowed to decide whether he or she attends school on a given day. It is the responsibility of

parents, or guardians, as in the case of a child in a juvenile detention center, to ensure that the child attends school. Use of that form was a slippery slope in which youth were opting to sleep-in rather that arise on time to attend school. Adolescents lack the wisdom or maturity to make that decision. Staff reported that allowing youth to miss school decreased behavior problems that they may create in the classroom. However, FCJDC staff members are in the classroom to assist with discipline and the youth-to-staff ratio is more than adequate. The teacher should have a classroom discipline program and the FCJDC staff should assist in implementing that program. Simply allowing youth to sleep in and not attend school cannot be considered a disciplinary measure. To make that situation worse, a youth who missed school in the morning was not allowed to attend school later in the day. The juvenile justice population is generally two to three years deficit in academic progress and credits towards graduation. While they are in detention they should not be free to aggravate that problem by voluntarily missing school. Fortunately, it appears that the use of the School Refusal form has ceased.

The contractual agreement with the Hattiesburg Public School District requires the district to provide six weeks of half-day school at the FCJDC. Youth at the facility were completing their last, four-day week of summer school during my visit. Although my classroom observation revealed little academic activity in the FCJDC school, that opportunity did at least ensure that youth had structured programming for four hours, four days each week for part of the summer. That opportunity was negatively impacted when the group of boys in the facility during my site visit were split, due to behavioral problems, and each group was only allowed to attend school two hours each day.

Although most youth at the FCJDC are now attending school for up to five hours a day during the academic year, there are still a number of areas where the school program continues to be sub-standard. The teacher's daily attendance role is simply taken from the FCJDC population reports and does not delineate attendance by period, subject or even morning or afternoon. If a child is in class at any time during the school day, that child is apparently counted as present for the day. No attendance or participation records are maintained by subject and little effort is made to individualize the academic program to address learning or credit deficits other than on a computer-based program in the classroom. Lesson plans are not written. Any credits that a youth may earn for time spent in school while at the FCJDC are not transferred upon release. Federal mandates are not being met, including Individual Educational Plans (IEPs) or the Individuals with Disabilities Education Act (IDEA) addressing special education services. Although the very limited school program at the FCJDC may contribute to structured, rehabilitative programming outside of their cells, as required by this provision, it does not meet legal requirements or help ensure that youth detained at the FCJDC will have the same opportunities for productive lives as juveniles living at home or elsewhere in the community.

There is still no planned recreation program at the FCJDC but most youth and staff report that the residents usually go outside daily for an hour unless inclement weather prevents that. Unfortunately, both youth and staff members interviewed indicated that

rain and cold or, recently, extreme heat, have again prevented outdoor recreation from occurring. Both staff and youth reported that the sole outside recreational activity is still generally basketball. However, some staff reported that other activities have been attempted, such as volleyball, but that the small recreation yard limits options and the copious amount of razor wire above the perimeter fence has caused their balls to be punctured. Youth who choose not to participate in the recreation activity are still allowed to sit idly nearby. There were no females at the FCJDC during my site visit and there had only been one female detainee in the last several weeks. However, staff claims that female and male youth receive equivalent recreation. That has not been the case when interviewing youth and staff at prior visits when girls were housed at the FCJDC.

Staff must be expected to plan and organize recreational activities for all youth daily. Participation should not be considered optional and youth should be encouraged to participate through the availability of a variety of opportunities, not just basketball. The overall lack of sufficient recreational activities is clearly at least partly due to the fact that the daily schedule only allows one-and-one-half hours for recreation for all FCJDC. Although the FCJDC staff may allow both boys' units (B and C) to go outside together and they generally allow boys housed in D Unit cells to participate in recreation with C or B Unit, they do not allow males and females outside together. That means that there is simply not enough time for both boys and girls to get their required minimum of one hour of large muscle activity each non-school day when females are housed at the FCJDC. The FCJDC physical facility has many limitations, including the lack of space for indoor large muscle activities. However, that requirement must be met and the FCJDC staff and administration will need to be creative in doing so.

The FCJDC administration still does not know what the average length of stay is for a child at the facility. That is important, basic data that facilities normally document for planning purposes. Interviews with both youth and staff verify that many youth are at the FCJDC for as long as several weeks and even months at a time. That situation makes it even more critical for them to receive structured, rehabilitative programming, including physical recreation.

Each time I have visited the FCJDC I have requested documentation of programming activities that *actually occurred* on specific dates. Prior to my March 2013 visit, I received calendars for January and February 2013 that purportedly listed programming that had occurred. However, when I compared those monthly calendars with the Daily Shift Logs, detailing *actual* minute-to-minute activities and movement of all staff and others in the facility, most of the programming listed on the calendars was not accounted for. Prior to my most recent visits, I received calendars of activities but, again, those were just *planned* activities and not those that actually *occurred*. My review of shift logs again revealed that little or no programming on most shifts. The FCJDC administrators are admittedly frustrated with the line staff members' failure to provide planned, structured programming to detained youth. Again, that requirement is part of an overall change in philosophy and culture. Culture change takes time and a great deal of tenacious effort. That effort only

began when the current Director was hired less than a year ago. And, the emphasis during most of that time has been on changing practices without recognizing the need to change culture. The former will not effectively occur until the latter is accomplished.

There still appears to be little or no organized, planned, structured, rehabilitative programming provided for the youth at the FCJDC. Staff members and juveniles that I interviewed again reported that daily activities include watching movies, playing cards, playing Dominos, watching TV, writing letters, and "yard call". When programming does occur, it often appears to be poorly planned, if it is planned at all, and lacks structure or rehabilitative intent. Some staff interviewed during my site visit again reported that they do not plan programming activities during the evening hours because the youth need that time for leisure and to relax. In fact, programming absolutely must be planned during those evening hours in order to provide rehabilitative opportunities and, by keeping youth positively engaged, to minimize misbehavior and acting-out. Although a certain amount of free time may be incorporated into a schedule it is important that youth be kept busy and involved in facility programming. That not only benefits the young people who are detained, it helps maintain order and security at the facility and reduces the number of incidents that may occur. Numerous incident reports and videos reviewed for this report revealed that problems frequently occur during evening hours when staff members on duty are not actively engaged with youth and no programming is occurring.

The physical plant at the FCJDC has significant limitations and creates substantial challenges in achieving compliance with this provision. The FCJDC administration has attempted to be creative in developing programming and has invited volunteers to visit and provide group activities. However, the provision of periodic activities does not meet the requirements of this provision.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Non-Compliance**

Discussion:

As discussed in 3.1 above, there is still very little structured, rehabilitative programming at the FCJDC. Incident reports document numerous examples of residents being placed in D Unit cells, which is essentially isolation, for disciplinary purposes. In addition, youth are still frequently allowed to place themselves on "voluntary room confinement" during waking hours, which allows them to isolate without the opportunity to engage in structured, rehabilitative programming or to otherwise interact with either staff or peers. In fact, the use of voluntary room confinement is excessive, seems to increased in frequency and may be used for staff convenience. This monitor worked with the FCJDC and the SPLC to create a form for use when a youth requests voluntary cell confinement. That form replaces one that had been in place and that failed to ensure safeguards for youth. The new form requires that a mental health professional be involved when a youth chooses to isolate him or herself to ensure that that isolation is not an indication of suicide risk or other mental health needs. In addition, the new Behavior Management Program policy and procedure, on which all employees have been trained, addresses the use of voluntary room confinement, including the completion of the new form. The new policy and accompanying form have been implemented but in no case has a mental health professional been contacted, as required. Voluntary isolation can be a dangerous practice and should be discouraged. However, that practice appears to be common at the FCJDC and the staff appears to not be well trained on the new expectation and they seem to consider contacting mental health to be optional. As is the case with most other new policies and procedures at the FCJDC, neither line staff nor administration appears to understand expectations, the updated documentation and safety practices required with voluntary room confinement. Staff members are not being held accountable for compliance.

An updated Suicide Prevention policy and procedure, based on the most current research in the field, has been implemented at the FCJDC and all employees received thorough training on that policy. However, it is clear from my interviews with staff members that there is still a great deal of misunderstanding about suicide prevention requirements. That misunderstanding may be due, in part, to the fortunate fact that there have been very few youth during the past three months since that policy was written who have been on suicide watch. But, not one staff member interviewed could articulate the levels of supervision required for youth who may be suicidal. And, documentation revealed that the frequency of monitoring checks provided to youth who were on suicide watch,

since implementation of the new policy, was done at the same, unsafe rate that was the practice before the *new* policy. Youth on "Constant" suicide watch have still been placed in a D Unit cell and checked at 15-minute intervals rather than "directly observed on a constant, uninterrupted basis and staff shall interact with that youth while continuously observing him or her," as required by policy.

When youth are confined to their rooms or to a room in D Unit, it appears that fifteen-minute room checks were documented. However, that room-check documentation is still maintained separately from the documentation of the *reason* for room confinement (e.g. Voluntary Room Confinement, Disciplinary Room Confinement.) That practice has makes it difficult to verify that required safety checks have occurred for individual youth during specific periods of isolation. For this recent site visit, the SPLC organized documentation by occurrence to assist me in reviewing that information. That was very helpful and is what the FCJDC should be doing routinely in order for them to ensure that confinement is justified and when specific confinement occurs, that it is monitored. And, most incident reports provided for my review were on an older, obsolete version of the incident report form, they contained inaccurate information or they were incomplete. Even those reports that were on the new form, implemented during the recent review period, were not completed correctly or thoroughly. That makes it difficult to determine the reason for or the duration of a youth's isolation. And, there is little or no documentation of any efforts to either allow or encourage confined youth to join their peers in order to participate in any type of activity as required by this provision.

The FCJDC has a history of confining youth to their rooms in A, B or C units, segregating them in D unit or isolating them in the Detox or Holding cells without documenting minimum fifteen-minute checks. I have recommended that the FCJDC consider installing a monitoring system that uses a hand-held wand that swipes a unit on each room door to verify that the staff member at least went to the individual doors. Those systems do not guarantee that the staff member visually checks the child but they do confirm that the room was visited. Many juvenile facilities around the country are using those systems as a safety measure and to help hold staff accountable. Fifteen-minute room-check documentation that I was provided to review again often indicates that confined youth were behaving calmly and compliantly. However, those youth are allowed or required to remain in seclusion. That practice not only violates this provision, it is potentially dangerous.

The FCJDC has converted the Holding Cell to a shower room and that room is reportedly only used for that purpose now. The Detox Cell is usually just used to interview youth privately during the booking process. I received no documentation of placement in Detox during the most recent monitoring period.

Recommendations for achieving substantial compliance:

1. Provide documentation that the FCJDC Behavior Management policy and procedure is being complied with, including Voluntary Room Confinement.
2. Provide documentation of ongoing staff training on the policy and procedure.
3. Develop and implement a structured schedule of daily activities, including a variety of rehabilitative programs such as recreation, arts and crafts, and education.
4. Provide documentation that when youth at the FCJDC are placed in the Holding cell, Detox cell or D Unit cells, other than as allowed in 3.3, those youth are being allowed to spend the hours of 7:00 a.m. to 10:00 p.m. on the appropriate living unit to have the opportunity to engage in structured, rehabilitative programming.
5. Install an electronic system to verify that rooms are checked at required intervals when juveniles are confined.

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

Compliance Rating: **Non-compliance**

Discussion:

Written incident reports for the current review period again illustrated numerous examples of cell confinement. However, most reports still do not specify the time that the period of confinement began or the time that that period ended. In most cases, the room check forms necessary to determine the duration of the confinement and the frequency of room checks, often do not accompany the incident reports. Finally, through approximately half of the review period, the incident report form used by staff was an obsolete version that had been replaced in January 2013, which did not include some critical information to determine whether this provision had been complied with. Therefore, it is again not possible to determine when confinement periods exceeded the eight-hour period, requiring administrative approval. No documentation was provided of confined juveniles being “released from their cells daily to attend school, maintain appropriate personal hygiene and to engage in one hour of large muscle exercise”, as required by this provision. Most reports indicated that administration had been “notified” but few confirmed whether administration had approved periods of confinement exceeding eight hours.

FCJDC again provided sample documentation of fifteen-minute visual room checks on the FCJDC "One Hour/Fifteen Minute Visual Cell Check Log," and its replacement, the FCJDC Room Check Log form. Fifteen-minute checks are not always documented for youth as required with some incidents having checks occur as long as three hours apart. Efforts to release youth "from their cells daily to attend school, maintain appropriate personal hygiene and to engage in one hour of large muscle exercise" are not documented on those logs, even when the logs document that the youth is awake and calm. In some cases, Room Check Log forms are provided with no accompanying documentation, as required, that explains and justifies the confinement. And, Room Check Logs were not provided for all incidents of confinement. Two youth were placed on "Constant Suicide Watch" during the reporting period. The new Suicide Prevention policy requires that youth on Constant Watch be "directly observed on a constant, uninterrupted basis and staff shall interact with that youth while continuously observing him or her." Despite that requirement, on which all FCJDC staff have been well trained, documentation indicates that youth were still checked at fifteen-minute intervals, as was the former practice.

The FCJDC Incident Reports are now being reviewed by either the Director or the Assistant Director. I was told that those reviewers require that the incident reports be revised before final approved to ensure quality. Despite that supposed requirement, reports are still often poorly written, lack sufficient specificity, have missing information or are inaccurate. There were examples of very lengthy delays between incidents occurring and the report being finalized, in order to obtain administrative approval. Some staff complained in interviews that administrators had changed the substance of their reports and they were expected to sign reports that had been revised. The FCJDC Director assured me that that is not the case and that she simply makes grammatical corrections. I have advised her to accept the reports as they are written in the future in order to eliminate that perception and if revisions are needed, she should have the employee complete an addendum to the original report. Clearly, the FCJDC staff needs training on report writing. They did receive some training on report writing in the weeklong training provided in May but, like most training, that training event must be followed with feedback from actual experience on an ongoing basis. The incident report form has been revised in order to try to improve the quality of the information but employees are still not completing all sections of the form. It is clear that the staff needs additional training on the new form, the required information and the rationale for the changes.

A new Behavior Management Program policy and procedure that addresses the elements of this provision has been finalized and all FCJDC staff members have been trained on that policy. That new policy is comprehensive and it introduces new practices that include positive interventions and graduated sanctions. To the staff's credit, they seem to have fairly effectively implemented the positive sanctions in the new Behavior Management Program but there is still a great deal of misunderstanding regarding the graduated sanctions and disciplinary options. During my site visit I was able to spend time with both administrators and line staff reviewing that issue and making specific recommendations. Training on the new policy occurred when it was introduced in May

and again at staff meetings but the complexity of that new strategy means that employees will need continuous, ongoing training and guidance. The new policy and procedure also replaces forms with new documentation requirements. My review of completed forms indicates that staff members do not understand them fully either. Again, that will require continuing oversight and feedback from administration. At this point, documentation is inconsistent and incomplete and does not substantiate compliance with this provision.

Recommendations for achieving substantial compliance:

1. Provide documentation of compliance through such documentation as Incident Reports, Disciplinary Reports, Disciplinary Review forms, Room Check Logs and Voluntary Room Confinement forms that are current, accurate and complete. Provide documentation *by incident* so that any and all documentation of a particular incident is maintained together for my review and in each youth's file.

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

Compliance Rating: **Partial Compliance**

Discussion:

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

Youth are still allowed to be voluntarily placed in a room in D Unit, which essentially isolates them, does not facilitate their integration into the group and is a potentially dangerous practice. When a youth chooses voluntary room confinement, the FCJDC documents that youth's decision by having him sign a "Documentation of Voluntary Cell Confinement" (now revised to as a "Voluntary Room Confinement") form. The revised form includes additional requirements, including the requirement that a new form be completed each shift, every day; the youth's stated reason for requesting room confinement; the name and signature of the administrator approving the placement; staff efforts to persuade the youth to join his/her peers; and information about referral to mental health. Unfortunately, FCJDC staff members do not understand the importance of completing all of

that information. Although there were a significant number of Voluntary Room Confinement forms submitted, none of those forms were completed thoroughly. And, several of those forms lacked the required documentation of room checks, as required. The large number of Voluntary Cell or Room Confinement forms completed during the current monitoring period is of concern and causes me to fear that youth are being persuaded or pressured to chose confinement as a convenience for staff. And, in most cases when room checks are documented, they do not indicate that you are released from confinement to participate in school, recreation or other programming. The draft FCJDC policy and procedure, "Classification," addresses that required documentation of voluntary room confinement and is pending finalization and implementation.

The FCJDC has been undergoing renovation work for several months and there have been only two units available for the placement of youth. The FCJDC has had almost no female admissions; they have successfully diverted most girls to other facilities in the state. However, during June, while the A Unit was still closed, one female was admitted. She was required to be isolated in a D Unit cell during that time and, although she had daily yard call, no other programming, including school is documented during that period. That situation only occurred once and is unlikely to reoccur since all three units are now open and available. However, that situation is unacceptable and should not have occurred.

During my visit staff informed me that some male youth choose placement in D Unit in order to be in a more quiet location. One youth reportedly suffers from headaches and both that youth and the staff verified that he prefers a D Unit room for quiet. That is an unfortunate reality of the FCJDC physical plant which is of metal construction and extremely noisy and chaotic. That practice may be acceptable on rare occasions if there is medical verification of the youth's need for quiet. But, teenagers are imitators. If one youth is allowed to request a quieter room, others will as well. The FCJDC has six D Unit cells and could not accommodate all the youth who might make that request. And, as has been discussed in this and all previous reports, D Unit does not offer the same opportunities for interaction with either peers or staff. I have observed several examples of youth "voluntarily" placed in D Unit who were not released during the day for programming and who were segregated for long periods from other youth and from staff.

The most recent research on juvenile suicide in confinement (see, "Juvenile Suicide in Confinement: A National Survey"; Hayes, Lindsay M.; U. S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention; 2009), reports that approximately half of the completed suicides in juvenile facilities occurred when youth were confined to their rooms. The new Suicide Prevention policy and procedure is based on that research and precludes isolation for any period for youth on constant suicide watch. However, as discussed in 3.3 above, the FCJDC staff still does not fully understand that new policy and in at least one incident, a youth on constant suicide watch was checked at fifteen-minute intervals. Again, although the staff has been trained on that new policy, it is a significant change in practice for the facility and they will require continuous oversight and reminders. As I have

repeatedly stated, isolation should be avoided to enhance youth safety and particularly if a youth may be suicidal.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Non-Compliance**

Discussion:

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

During my recent site visit, I again observed numerous times when no staff member was present in various units. Both incident reports and video recordings for the three-month monitoring period again illustrated examples of disturbances or fights where staff members had not been present in the dayrooms at all and were required to respond from some other location in the facility. Direct Care Workers (DCWs) no longer appear to be stationed in the hall outside the B and C Unit cells to monitor youth; they are now stationed inside the units. But, they are frequently out of the units for various reasons and I often observed, both in person and on video recordings, the DCWs observing and documenting

their observations on Activity Logs rather than being actively engaged with youth, as required by this provision. In fact, I observed occasions when the DCW on duty was so focused on writing in his or her Activity Log that that DCW failed to see problems that were otherwise clearly materializing. I recommended to the FCJDC administration during my recent site visit that the Activity Log be eliminated as it appears to take precedence over the much more important work of supervising and interacting with youth. I was informed that the Activity Log has been required in order to document the DCW's actual presence at the facility for his or her scheduled shift. I again advised them to implement a time clock system for that purpose, which is a more efficient, effective and commonplace method of keeping track of staff hours worked. The frequent altercations between juveniles and other disruptive behavior documented in incident reports illustrate the problems that can arise when youth are not directly supervised. Because this problem is serious in nature, despite the fact that it has been discussed repeatedly in monitoring reports and with the administration while on site but continues to occur, I must consider the FCJDC in non-compliance with this provision until they address the expectation that staff are "*stationed on any living unit* where two or more youth are placed, and direct care staff shall be *actively engaged with youth*."

Forms used to document visual rooms checks include documentation of visual, fifteen-minute checks of confined youth. However, as discuss in provision 3.2 above, those room check forms still do not accompany incident reports, voluntary room confinement forms, disciplinary forms, and other forms used to justify confinement, making it difficult to ensure that required monitoring of confined youth occurs and that youth are released from confinement when planned.

The FCJDC has an intercom system in residents' cells and in the day rooms with which youth can contact the officer stationed in the control room. However, that officer has many tasks and at times is slow to respond or non-responsive to residents' requests and, when there were no staff members in the unit day rooms, no staff were readily available to respond to youth needs. The FCJDC has hand-held radios for all staff to carry. Use of those radios adds an additional level of safety and security and helps to limit the noise level, aggravated by the need to shout for assistance when intercoms are not functioning or are not responded to. But when there are no staff members in the unit, there are no radios there either. Since there are numerous occasions when there are no staff members in the unit, if the staff members in the Control Room do not respond, youth are completely isolated while confined.

The draft Staff-to-Youth Ratio policy and procedure is still pending finalization and implementation. That draft policy will addresses the requirements of this provision.

Recommendations for achieving substantial compliance:

1. Finalize and implement a written policy and procedure consistent with this provision.

2. Provide documentation of staff training on the relevant policy and procedure.
3. Develop written direct care staff job descriptions that include the expectations of this provision.
4. Provide written documentation of random, visual checks on confined youth at least every fifteen minutes. Those visual checks must be done directly, not via a monitoring camera.
5. Replace the DCW Activity Logs with a more effective system such as a time clock system.

IV. STRUCTURED PROGRAMMING

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

a. activities which are varied and appropriate to the ages of the youth

b. structured and supervised activities which are intended to alleviate idleness and develop concepts of cooperation and sportsmanship; and

c. supervised small group leisure activities, such as a wide variety of card and table games, arts and crafts, or book club discussions.

Compliance Rating: **Non-Compliance**

Discussion:

There is still no daily program to provide structured educational, rehabilitative, and/or recreational programs for youth at the FCJDC. There has been some effort to provide activities to the juveniles but only to a very limited extent. The five written schedules (Saturday, Sunday, Monday/Wednesday, Tuesday/Thursday and Friday,) reflect some structure but delineate no specific scheduled activities for most of the residents' waking hours. I was provided with schedules of planned activities for April, May and June but the daily shift logs indicate that little if any structure programming actually occurred. Written schedules still lack the specificity necessary to ensure that staff members are meeting the requirements of this provision. I have recommended in the past that the FCJDC produce daily schedules that list hour-by-hour plans and that subsequently confirm what *actually did occur*. That procedure would help hold staff accountable for providing structured activities and would help the administration plan more effectively. I again made that recommendation to the FCJDC administration during my latest site visit.

During my last two site visits and in both subsequent monitoring reports, I recommended that the FCJDC hang clocks in the units to help both staff and youth ensure that scheduled activities actually do occur as planned. One clock was hung in the hall outside B and C Units that can be seen through the windows. No clock was provided for A

Unit and youth in D Unit have no clock visible. The availability of a specific, written schedule of planned activities for each day, along with clocks to help youth and staff adhere to that schedule could help facilitate programming. However, staff members interviewed do not seem to have any sense that they are obligated or responsible to ensure that youth are involved in structured programming.

The written schedules still do not allow sufficient time for all three units to spend at least one hour each day in outdoor recreation, even if two units are combined. Again, during my most recent visit, the only recreational activity that occurred was a maximum of one hour of basketball in the outside play area, with half of the boys being allowed to not participate. No activities were observed in the dayrooms other than some playing of cards and occasional video games. The television sets are no longer allowed on during the daytime. That change helps to minimize the noise and chaos in the dayrooms. There were again frequent times when juveniles were observed in dayrooms with no staff present and no activities available for them to participate in. That situation was repeatedly documented in incident reports and videos recordings. I was provided with written reports and accompanying videos of serious incidents that occurred during hours of the day when no activities were planned or provided. In fact, those incidents often occurred when no staff members were present supervising youth or keeping them busy with positive pursuits.

Some staff interviewed again reported that there is no structured programming during the evening hours between 6:00 and 10:00 p.m. because youth need time to relax. That four-hour block would be an ideal period to provide planned, structured rehabilitative programming for youth at the FCJDC. Clearly, there is a misunderstanding, either among line staff or administration regarding the need for programming at the FCJDC and when it is to be provided. Despite the fact that I have advised the administration and staff, both while on site and in my monitoring reports, that youth will have fewer and less serious behavior problems if they are kept busy and involved in positive, structured programming, organized use of free time has not improved.

The FCJDC Director and Assistant Director are aware of the need for the staff to offer a range of beneficial programming activities. They are frustrated with the failure of their employees to follow-through with that expectation. They acknowledge that historically staff members at the FCJDC have had few job expectations and have been required to do little more than observe and monitor youth behavior, intervening only in incidents of physical acting-out. The requirement that they plan, organize and provide structured, rehabilitative programming is a new requirement and part of an overall culture change at the FCJDC. However, as I have informed both administrators and line staff members, the expectations in this provision are typical in juvenile detention centers. It is past time for the culture of the past to change at the FCJDC and for staff to work as a team to improve the environment for youth and the safety of the facility.

The FCJDC draft policy and procedure, Programs and Activities, addresses the requirements in this provision. That policy and procedure will be reviewed with the FCJDC Director, revised as necessary and finalized soon.

Recommendations for achieving substantial compliance:

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

V. DISCIPLINARY PRACTICES AND PROCEDURES

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

Compliance Rating: **Partial Compliance**

Discussion:

I drafted a Behavior Management policy and procedure for the FCJDC shortly after my March 2013 site visit. That draft was reviewed and revised collaboratively with the FCJDC Director and the SPLC attorney. The draft was ready for incorporation into the staff training in April, which helped the staff not only gain information on the new policy but to learn about concepts, theories and philosophy behind effective behavior management in juvenile justice facilities. The new policy "incorporates positive behavior interventions and supports" as well as "guidelines for imposing graduated sanctions for rule violations and positive incentives for good behavior." The policy was adapted from a policy used successfully in all juvenile detention centers, of all sizes, in the State of Georgia for many years and it complies with the various provisions of the Agreed Order.

The new policy was finalized shortly after the formal training and has been implemented to some extent. There are significant changes in practice for the staff of the FCJDC and even for some youth who have been frequently held at the FCJDC have been somewhat taken aback by the new procedures. That said, youth interviewed during my site visit spoke positively about the new Behavior Management Program and asserted that it has a positive impact on their behavior. Staff members interviewed also report that they feel that the new program motivates the juveniles in a positive way. However, further inquiries revealed that many employees are somewhat frustrated with the program as they view it as rewarding youth positively without mandating consequences for negative acting-out. The new behavior management program introduces positive supports and disciplinary sanctions that are significantly different from past practices at the FCJDC. And, the new policy provides clear, specific instructions for staff to follow in addressing youth behavior, something that was previously absent at the FCJDC. Conversations with youth, line staff and administration reveal that, while the positive reinforcers, consisting of points earned by youth to be used to "purchase" rewards are being utilized but that other elements of the program are only somewhat implemented. Youth may also be "fined" for misbehavior but fines have been rarely assessed. Other "penalties" available for staff use in response to misbehavior have also not yet been utilized. The program is based on levels that a youth may attain where increasing numbers of privileges are available. However, to date, those levels still seem to lack much meaning to either youth or staff.

The new program is complex and full implementation would not be expected quickly. However, it is important for the FCJDC administration to monitor that program closely and provide ongoing guidance to the staff to assist them understanding the various elements of the system. After the new Behavior Management policy and procedure was finalized, FCJDC staff members received additional training. Unfortunately, that training was cursory at best. The sign-up sheet for the training meeting indicated that staff was trained on five policies and procedures, including Behavior Management, as well as unspecified other items in 30 minutes. That is obviously not sufficient for any new policy and especially for a policy as different and complex as the Behavior Management Program. The behavior management program must be carried out fully in order to be successful. And, it must be understood in order to be carried out. The staff at the FCJDC has lacked clear guidelines for managing youth discipline and, in the past, interventions have focused on disciplining the negative behavior, not rewarding the positive. Discipline has consisted almost exclusively of room confinement that has not necessarily resulted from youth violating specific, written rules but, rather, based on an individual staff member's opinion regarding expected behavior. In the past, rules have usually been posted but then largely ignored. Neither youth nor staff members were knowledgeable of those rules. The new program requires that discipline be based on the violation of a specific minor or major rule, not be arbitrary and subjective.

New forms have also been created to accompany the behavior management program and to ensure that both positive supports and disciplinary sanctions are thoroughly documented. Staff members are using most of those forms but, again, they are

not yet fully utilizing the forms designed to address misbehavior in a graduated manner. Again, the FCJDC administration will need to monitor closely and provide assistance, mentoring and coaching as the line staff members continue to learn the new system.

I am encouraged that the new behavior management program is being implemented at the FCJDC and I hope that future reviews would reveal more comfort with the entire program.

Recommendations for achieving substantial compliance:

1. Continue implementation of the Behavior Management Program.
2. Provide written documentation that all staff members have been thoroughly trained on the new policy and procedure.
3. Provide documentation that the newly developed forms are being used and that the new policy and procedure is being followed.

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

Compliance Rating: **Substantial Compliance**

Discussion:

The FCJDC has implemented a new policy and procedure, Rules of Behavior and staff have reportedly all been trained on that policy. Lists of both major and minor rules are now posted in all of the units. There is also a new Behavior Management policy and procedure, to be discussed in 5.1 above, which is based, in part, on those rules. Both youth and staff members interviewed were able to identify the rules and, unlike previous visits, seemed to actually base disciplinary decisions on those rules. In the past, discipline was arbitrary and neither youth nor staff members could describe any of the rules. As the behavior management program at the FCJDC is more fully implemented, youth and staff should become increasingly familiar with major and minor rules.

In addition to the posting of the FCJDC rules in each living unit and more closely adhering to those rules in administering discipline, the new Detainee Orientation Checklist includes an explanation of the rules. The FCJDC booking officer uses that Checklist to ensure that she addresses required topics, including an explanation of the facility rules. It is not known how consistently other FCJDC staff members follow the required booking process, as described in the Admissions Policy and Procedure. However, since it has been shown that other requirements of the admissions process are not regularly followed when the booking officer is not present, including showers and searches, it is not certain that the rules are explained by staff who book youth in other than regular weekdays when the booking officer is absent.

Recommendations for achieving substantial compliance:

1. Provide documentation that all FCJDC staff members are trained on the Admissions policy and procedure, including an explanation of the rules.

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

Compliance Rating: **Partial Compliance**

Discussion:

The requirements in this policy are addressed in the new Behavior Management policy and procedure. All FCJDC staff have been trained on that policy and procedure but there are still a number of problems with its implementation. That policy introduces significant changes in practice at the FCJDC and includes several elements. In order to achieve substantial compliance with this provision, the new policy and accompanying documentation will need to be more fully understood and followed.

Based on my review of Incident Reports for the current period, I found numerous examples of residents being placed on room confinement. However, the older version of the Incident Report form, which was used for about half of the incidents, does not specify the time that the period of confinement began or the time that that period ended. And, along with that form, the FCJDC used Rule Violation Report (RVR) forms to notify youth of alleged rule violations. That form also includes no information about the time of confinement or the time of release. A new Incident Report form has been created for the FCJDC that incorporates a number of important pieces of information that were not included previously. And, the RVR has been replaced with a Disciplinary Report form and a Disciplinary Confinement Review form in order to more accurately and thoroughly

document the reasons for discipline along with the mandatory review of disciplinary confinement extending beyond eight hours.

Documentation of room checks of youth on confinement is maintained separately from the paperwork justifying the confinement so it is difficult to determine how long a youth was confined. Instructions accompanying the new forms require that they be maintained together. However, that still does not occur routinely. The SPLC organized the various documents for me so that the documents justifying confinement (Incident Reports, Disciplinary Reports) were matched with related paperwork (Disciplinary Confinement Review forms, Room Check forms.) That effort helped in reviewing compliance. My review of that documentation reveals that forms are still not being completed as required by the new Behavior Management policy and procedure. It is clear that the staff still does not understand requirements and the reasoning behind them.

Again this review period, documentation of confined juveniles being "released from their cells daily to attend school, maintain appropriate personal hygiene and to engage in one hour of large muscle exercise", as required by this provision and provision 3.3 was lacking. Several Room Check Logs included fifteen-minute checks throughout the period of confinement without the youth leaving his or her cell for school, recreation or programming.

Despite the need for additional staff training on the Behavior Management policy and procedure, my review of documentation and interviews with staff indicate that disciplinary confinement is being discouraged at the FCJDC and that efforts are being made to utilize less severe sanctions. Unfortunately, staff interviewed also indicated that at times they feel that a youth should be confined for the safety of other youth and staff but that the staff was dissuaded from doing so "because of the Agreed Order." Disciplinary confinement is one component of a range of options that should be available to the staff of a juvenile detention center and used as appropriate. Disciplinary confinement should not occur without ensuring due process protections occur and the new Behavior Management policy and procedure builds those safeguards in. And, disciplinary confinement should be a last resort, not the only option utilized. In the past, documentation of confinement listed the "major rule violated" but rarely, if ever, could the "rules" recorded on reports be found on the list of rules posted in the units. Both youth and staff generally disregarded those posted rules. The staff now generally seems to know that only major rules on the official list may be used to justify disciplinary confinement.

Recommendations for achieving substantial compliance:

1. Fully implement the Behavior Management policy and procedure.
2. Provide written documentation that all staff members have been thoroughly trained on the new policy and procedure, including follow-up monitoring and training.
3. Provide documentation of room confinement, including, at a minimum, date and time of confinement and date and time of release, reason for the confinement, staff

member initiating the confinement and notification of the youth of alleged rule violation, his right to disciplinary review/due process hearing and minimum fifteen-minute room checks.

4. Provide written documentation that youth confined for more than eight hours are assured the "occurrence of a disciplinary review/due process hearing before an impartial staff member of the Forrest County Sherriff's Department (including but not limited to Detention Center Staff) who was not involved in the rule violation."
5. Ensure that all forms related to a particular youth's confinement at a particular time (e.g., Incident Report, Disciplinary Report, Disciplinary Confinement Review, Room Check Logs) are maintained together.

VI. USE OF RESTRAINTS

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

Compliance Rating: **Partial Compliance**

Discussion:

Staff and resident interviews verified that shackles are being used to transport youth to the Forrest County Youth Court, located in the same building as the FCJDC. Youth at the FCJDC are required to wear shackles when being transported outside the building for such things as medical appointments. That use would generally be considered an appropriate use of mechanical restraints to ensure security and not for the convenience of staff and would be in compliance with this provision. However, no written documentation justifying that practice was provided for my review, including such things as policies from law enforcement agencies responsible for transportation.

There is a draft policy and procedure addressing the requirements in this provision. This monitor made significant changes to the initial draft but the revisions have not yet been finalized or implemented.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

As stated in 6.1, shackles are reportedly still used for youth to attend the Forrest County Youth Court in the same building as the FCJDC and for appointments and hearings away from the facility.

The use of mechanical restraints for transportation purposes may be considered appropriate and may be required by policies established by agencies doing the transporting such as law enforcement agencies. However, there should be written justification for that use that explains why a youth is considered a flight risk or will engage in violent behavior or indicating that it is the policy of the law enforcement agency responsible for transportation. Without clear, written policy or other official directives from transporting law enforcement agencies, the FCJDC staff must provide documentation of each individual instance of the use of mechanical restraints, documenting "that a youth presents a flight risk or will engage in violent behavior" in order to comply with this provision. That time-consuming requirement could be avoided if the FCJDC obtains verification from transporting law enforcement agencies that *they* require mechanical restraints for transport.

As discussed in 6.1 above, the draft policy and procedure addressing the use of mechanical restraints has been rewritten but had not been finalized or implemented.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

Although there are no examples available of the use of restraints to secure youth to a fixed object such as a restraint chair, bed, post, or chair and staff and youth interviews again verified that practice does not occur, no written policy and procedure exists prohibiting that practice. The draft policy and procedure discussed in 6.1 and 6.2 above has not yet been finalized. As I have discussed in prior reports, the FCJDC has significant staff turnover and it is important to have written policies and procedures to ensure compliance, both currently and in the future.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

Staff and youth interviewed during my site visit reported that juveniles are only placed in mechanical restraints for transportation outside the facility. Some interviewees reported that mechanical restraints are used to transport youth to the Forrest County Youth Court, located in the same building as the FCJDC. Since there are no documented incidents of use of restraints during the three-month review period, there is no documentation that the use of mechanical restraints for longer than fifteen minutes was approved by a mental health professional.

As discussed in 6.1, 6.2 and 6.3 above, the draft policy and procedure addressing the use of mechanical restraints has been rewritten but has not been finalized.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

There were again no reports of a restraint chair or Tasers present at the FCJDC and none were observed during my site visit. There is a posted prohibition against Tasers at the facility. A previous Director of the FCJDC issued a memorandum to law enforcement agencies informing them of that prohibition. It is important that written policies and procedures exist to ensure that all staff members are aware of the requirements of this provision and to ensure future compliance. The policy and procedure "Firearms and Contraband," has been rewritten but must still be finalized to incorporate the requirements of this provision.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

During my site visit, it was consistently reported in staff interviews that no chemical restraints are available or carried by staff at the FCJDC. Further, it was reported that law enforcement officers entering the FCJDC are not allowed to bring chemical restraints into the facility. It is positive that the FCJDC appears to be operating successfully without the use of chemical restraints and they should continue to do so. However, there is frequent staff turnover at the FCJDC and there are several new, untrained staff members and all staff need to be oriented and trained in a written policy and procedure that is consistent with this provision. The facility is located near to local law enforcement and law enforcement responds quickly when summoned. It is important that the FCJDC staff members are aware that responding law enforcement officers are also prohibited from carrying chemical restraints inside the facility.

The policy and procedure that addresses this provision, "Firearms and Contraband," has been rewritten but must still be finalized.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

Staff interviews and incident reports again attest that staff members are aware that they are expected to use "the least amount of restraint necessary" in dealing with out-of-control youth. However, videos of incidents that occurred during this reporting period indicate that staff members still appear to resort to physical restraint prematurely or unnecessarily. Those videos again illustrate physical restraint techniques that are not included in the Crisis Prevention Institute (CPI) training that the FCJDC staff attended in December 2012. CPI is recognized as an accepted curriculum for juvenile detention and correction facilities but the techniques must be used properly. In addition, incident reports

and videos still reveal that staff resort to physical restraints because they are either not present in the units with the youth, as required, or they are not interacting with youth and able to anticipate and prevent fights and altercations. And, I was provided with employee discipline paperwork verifying completed when employees used excessive force with youth. The draft FCJDC Crisis Intervention policy and procedure does *prohibit* unlawful restraints, but such techniques still appear to be commonplace. I believe that is because the FCJDC staff has not been thoroughly trained on safe physical management practices and, in critical situations, they instinctively resort to holds and restraints that are not sanctioned and that could be harmful. Although I again find the FCJDC to be in partial compliance with this provision, that is only because the there is a prohibition against unlawful restraints despite the fact that the practice often does not comply with that prohibition.

The draft policy and procedure, “Crisis Intervention,” does not address the requirements of this provision. This monitor is in the process of rewriting that policy and procedure.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

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

The FCJDC draft policy and procedure, “Crisis Intervention,” addresses the use of mechanical restraints. However, that draft policy and procedure does not include the requirements of this provision, including the provision of “face-to-face supervision for the duration of the restraint.” In addition, it should be noted that the draft policy and procedure permits the use of mechanical restraints in some situations that would not be

considered appropriate such as the "Prevention of property damage." This monitor is in the process of rewriting that policy and procedure.

Recommendations for achieving substantial compliance:

1. Finalize and implement a written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the new policy and procedure.
3. Provide written documentation of constant, face-to-face supervision of youth placed in mechanical restraints.

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

Compliance Rating: **Partial Compliance**

Discussion:

Incident reports reviewed for the recent monitoring period through revealed no examples of the use of mechanical restraints. The FCJDC draft policy and procedure, "Crisis Intervention," does not address the requirements of this provision. This monitor is in the process of rewriting that policy and procedure.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC has posted a sign at the side entrance to the facility notifying staff members and others entering the facility of the requirements of this provision. A former Director of the FCJDC issued a memorandum to law enforcement agencies informing them of that prohibition. Staff interviewed reported that chemical restraints are not allowed within the facility. FCJDC staff members have only informal, verbal instructions that chemical restraints are prohibited in the facility. There is no written policy and procedure addressing this provision. This monitor is in the process of rewriting that policy and procedure.

Recommendations for achieving substantial compliance:

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

6.11 Immediately, upon the Court's approval of this Agreed Order, the Forrest County Juvenile Detention Center shall take measures to ensure that no officer enters the secure detention area of the facility with any electronic restraints, including, but not limited to tasers.

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC has posted a sign at the side entrance to the facility notifying staff members and others entering the facility of the requirements of this provision. A former Director of the FCJDC issued a memorandum to law enforcement agencies informing them of that prohibition. Staff interviewed reported that electronic restraints, including Tasers, are not allowed within the facility. FCJDC staff members have only informal, verbal instructions that electronic restraints are prohibited in the facility. There is no written policy and procedure addressing this provision. This monitor is in the process of rewriting that policy and procedure. The FCJDC has significant staff turnover and it is important to have written policies and procedures to ensure compliance, both currently and in the future.

Recommendations for achieving substantial compliance:

1. Finalize and implement a written policy and procedure consistent with this provision.

2. Provide written documentation that all FCJDC staff members have been trained on the new policy and procedure.

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC has posted signs at all entrances to the facility notifying anyone entering the facility of the requirements of this provision and prohibiting firearms. A former Director of the FCJDC issued a memorandum to law enforcement agencies informing them of that prohibition. Staff interviewed reported that law enforcement officers leave their firearms in their vehicles. The FCJDC has significant staff turnover and it is important to have written policies and procedures to ensure compliance, both currently and in the future. This provision is addressed in the draft version of the policy and procedure, "Firearms and Contraband," but that policy is still pending numerous corrections by this monitor.

Recommendations for achieving substantial compliance:

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

VII. USE OF FORCE

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

Compliance Rating: **Non-Compliance**

Discussion:

Incident reports and video recordings provided for my review again illustrated a number of examples where force was used by staff to intervene in altercations or to compel compliance with staff directives. Video recordings illustrated examples of inappropriate

use of force including pushing, hitting, throwing and slamming of youth by staff. I again observed examples of FCJDC staff using improper and unsafe holds for purpose of restraint or transport subsequent to altercations. There were numerous incidents documented where staff were either not present in the unit or where they were simply observing youth but not interacting with them. Programming was not occurring in any of the several incidents that I observed. Had staff been present and interacting with youth, they may have been able to prevent incidents that resulted in the use of force or may have been able to de-escalate verbally.

The FCJDC does not yet have an official policy or requirement that staff members be present with youth but the facility administration has unambiguously directed Officers and DCWs to be present in the units with youth at all time when two or more youth are present, as required by this Agreed Order. However, my observations, confirmed by incident reports and video recordings, revealed that it is still common for staff to leave youth unsupervised, other than by a Control Room camera, in living units for periods of time. That practice is unacceptable and appears to have resulted in unnecessary incidents requiring the use of force. Staff interviews again indicated that force is generally only used to "break-up fights" or "when there is an altercation." However, one egregious example, viewed on video, revealed an example of an officer entering a unit after a group of youth had been acting-out, charging at one of the youth, grabbing him, pushing him and restraining him using an unauthorized hold in a manner that appeared to be purely retaliatory. Although that incident did result in staff discipline, other staff interviewed regarding the event told me that they did not feel the officer had been in the wrong. That attitude is a concern to both me and to the FCJDC administrators. The fact that some staff members interviewed during my site visit made reference to the October 2013 deadline for the Agreed Order, leads me to be concerned that the belief exists that standards of care that existed prior to that Order will reemerge if monitoring ceases. Inappropriate and dangerous use of force was reportedly typical prior to the Agreed Order and could become the norm again.

As I have stated in previous reports, use of force by untrained or inappropriately trained staff can be dangerous and can result in injury to a youth or staff member. The staff at the FCJDC received training use of force and verbal de-escalation skills in December 2012 on the Crisis Prevention Institute (CPI) curriculum, which is used in many juvenile facilities. Staff members reported to me that that training was helpful, particularly in providing some useful ideas for avoiding the need to use physical force. However, due to the high rate of staff turnover at the FCJDC, there are a number of staff working at the facility who have not received that training. And, that training curriculum indicates that the basic training module is 16 hours in length. But, the trainer condensed the program to nine hours for the FCJDC staff. It is clear that all staff at the FCJDC need more comprehensive training on CPI or an equivalent curriculum, including competency in appropriate use of force. At this point, no plans exist to schedule that training. Staff who received the training several months ago need skills development and new staff need the entire course. As I stated in my last two reports, that training must be incorporated into a

comprehensive training plan at the FCJDC. De-escalation and restraint training should be provided to staff before they work directly with juveniles or as soon as possible after hire with periodic updates (generally annually) by a trained trainer. FCJDC Corrections Officers also attend corrections officer certification training. That training is primarily designed for adult settings and the Direct Care Workers do not attend. That training agenda lists several elements of the "Use of Force and Basic Defensive Tactics" module. None of those elements discuss the need to prevent the need for physical intervention and the use of verbal de-escalation techniques. I continue to be concerned that the FCJDC staff members are receiving adult-focused training that may be counter-productive and contradictory to the youth-focused CPI training.

The latest version of the draft Policy and Procedure, "Crisis Intervention," is not consistent with the requirements of this provision. This monitor is in the process of rewriting that policy and procedure.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Non-Compliance**

Discussion:

Incident reports reviewed for the current review period revealed numerous occurrences where force was used with youth. It was again unclear from the description in those reports specifically what was the type or extent of force used. The new form specifically asks which CPI hold is used but that section is usually left blank. Descriptions included such things as "using minimal force, picked up youth J and carried/escorted him to his cell," "I tried to pull the youth apart," "helped to break up the fight," "Officer M and I separated the two youth." Those descriptions are vague but they still illustrate the use of force. Only a few reports indicate that a medical professional was called and almost no reports indicate if the medical professional was actually reached or whether a message was left, if any medical advice was offered if a youth was examined. One incident report

documents contact with the nurse and verified that she recommended that the youth be transported to the Forrest General Hospital Emergency Room. However, in most cases where a medical professional was reportedly contacted, there is either no information about whether the youth was actually seen by a medical professional, whether the medical professional responded to a message left or what advice the medical professional offered. As has been the case in the past, staff interviews indicated that there were again incidents where FCJDC staff members on duty were unable to reach the nurse for guidance. There should be a written medical on-call schedule to ensure that a medical professional can be contacted at all times to advise staff at the FCJDC. I have made that recommendation in the past but it has not been followed.

In the past, it has not been the practice at the FCJDC to have all youth examined by a medical professional "as soon as possible after the use of physical force." Based on documentation in incident reports, it is still not clear when medical staff members are notified, when a medical professional examines a juvenile and what the outcome of that examination is. However, interviews with staff and youth now indicate that a medical professional, generally one of the nurses, usually sees youth on the next business day. On an emergency basis, it appears that youth are still only seen if a determination is made, usually by lay and untrained staff, that the youth needs care or if the youth requests medical care. In that case, the youth is transported to the hospital. The Incident Report form asks whether medical treatment was required and the "No" box was check on several reports. However, a number of those reports then indicated in the narrative section that the nurse was contacted. Incident reports that are completed inaccurately and/or incompletely make it impossible to determine if a medical professional is notified when force is used.

The latest version of the draft Policy and Procedure, "Crisis Intervention," is not consistent with the requirements of this provision. This monitor is in the process of rewriting that policy and procedure.

Recommendations for achieving substantial compliance:

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

VIII. MEALS AND NUTRITION

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

Compliance Rating: **Partial Compliance**

Discussion:

Staff and residents at the FCJDC consistently reported to me that they receive three meals and a snack daily and that youth who miss a meal due to an appointment or court appearance are offered one upon their return. Staff reported that extra meals are provided for the staff and those meals are available for youth at admission. Some residents asserted that the quality of the food had diminished after somewhat improving last year. Staff members all agreed with that complaint. The FCJDC draft policy and procedure, "Meal Schedule" mandates three meals and a snack daily and includes the requirement that if "a youth misses a meal because he or she is attending court, or some other appointment, he or she shall receive the missed meal upon his or her return to the Forrest County Juvenile Detention Center." That policy and procedures has been revised and is pending finalization.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Non-Compliance**

Discussion:

Meals for the residents at the FCJDC are delivered three times daily from the Forrest County Jail. Both residents and staff volunteered in interviews with this monitor that the quality of the meals has again worsened in the past several months. The draft FCJDC policy and procedure, "Food Services Vendors" requires vendors, on contract with the Forrest County Jail, "to prepare these meals in a manner that is consistent with all federal, state,

county, and local laws and regulations." This monitor will work with the FCJDC Director to revise that policy and procedure to more clearly comply with this provision, including the United States Department of Agriculture's School Meals Program standards. (http://www.gpo.gov/fdsys/pkg/FR-2012-01-26/pdf/2012-1010.pdf) All staff members interviewed report that they believe that youth at the FCJDC are provided with the same meals as adult inmates at the jail.

The FCJDC did provide me with two memorandums from a dietician with the County's food vendor. The first, dated July 11, 2013 stated that the "menus prepared for Forrest County Corrections have been prepared by a Registered Dietician and meet all state and federal guidelines for correctional facilities in Mississippi." After I explained to the FCJDC Director that those guidelines do not meet the requirements of this provision, I received a second memo. The second memo, dated July 12, 2013 stated that the "menus for the Forrest County Juvenile Detention Center have been prepared by a Dietician licensed in Mississippi and are in compliance with the United States Department of Agriculture's School Menu Program Standards." Written menus provided for my review contain a footnote that states: "2. For Juvenile's [sic] Menus: EVERYday, add 1 juice at breakfast and 1 2% Milk at Lunch." None of the FCJDC staff members interviewed were aware of that requirement. And, even if that directive is complied with, the menus still do not meet those standards in at least some areas. The Standards require low-fat milk be provided at *both* breakfast and lunch, Monday through Friday. The menus at the FCJDC include milk only at breakfast and not every weekday, as required. Adding milk at lunch would still not ensure that milk is provided *twice* daily. And, it is noteworthy that the sample correctional menu on the vendor's web site states: "Decreasing milk to once a day will decrease the daily cost by $0.22." (http://www.ntrsys.com/docs/CORRECTIONAL-FACILITY_SAMPLE-MENU.pdf) The Standards require fruit be provided at breakfast everyday, Monday through Friday. Assuming that juice is considered a fruit, adding it daily would meet that standard. Unfortunately, however, my interviews with both staff and youth, along with my observations consistently have indicated that the additional milk and juice are not provided as indicated in the written menus. It is not known where the apparent breakdown in communication is occurring. I cannot find the FCJDC in compliance with this provision until I can confirm that the actual practice at the FCJDC and the meals provided are consistent with the written menus as well as with the requirements of this provision.

As I have indicated in my previous reports, a juvenile facility is eligible for monetary reimbursement through the U.S.D.A for compliance with those School Meal requirements and that the FCJDC is forgoing that additional funding by their non-compliance with this provision. When a jurisdiction opts to contract for meals with a private vendor, it is typical for the contract to include the requirement that the vendor maintain necessary records and submit necessary paperwork for that reimbursement. I would recommend that the Forrest County Sheriff's Department consider amending its meal contract to do so.

Recommendations for achieving substantial compliance:

1. Ensure that the meal service contract achieves compliance with this provision.
2. Provide verification that the meals being served at the FCJDC are at least consistent with the written menus provided by the chosen vendor and that they include all items necessary to meet U.S.D.A. School Meal requirements.

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC practice is to provide a clean Styrofoam drinking glass to each youth with every meal. The facility also has coolers in each unit day room with drinking water that is reportedly cleaned and refilled two times each day. However, during my site visit and in videos of prior incidents I observed times when units did not have a water cooler present. That reportedly occurred because one or more juvenile had acted-out and the cooler was removed temporarily. However, removing the cooler denies all youth access to water and I observed units with the coolers removed after the incident had ended and the youth were all calm.

The draft policy and procedure, Serving Meals, has been modified to include the requirements of this provision. That policy and procedure has not yet bee finalized.

Recommendations for achieving substantial compliance:

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

IX. CLOTHING

9.1 The Forrest County Juvenile Detention Center shall ensure youth are provided basic clothing items at all times. These items must include, at a minimum socks, underwear, uniform, shoes, and undershirts. For girls, these items must also include a bra. When appropriate, the Forrest County Juvenile Detention Center shall also provide youth with a coat, hat, and gloves. Youth may choose to use their own socks, underwear, and undershirts, and bras instead of those provided by the Detention Center. Youth must be provided with a clean uniform, socks, undershirt, underwear, and bra, if applicable, upon intake and at least once per day. No youth shall be deprived of these basic clothing items

for any reason, including, but not limited to, as a punishment or because these items are being washed.

Compliance Rating: **Partial Compliance**

Discussion:

The new FCJDC policy and procedure, "Admissions" indicates that youth are provided with a full set of detention clothing items upon admission. The new FCJDC policy and procedure, "Dress Code/Bedding/Hygiene" states: "Juveniles detained at the FCJDC shall wear only FCJDC clothing unless medically approved to wear personal clothing." Interviews with both youth and staff indicate that youth are usually being provided with all necessary clothing items. Some youth did again acknowledge that they are allowed to wear their own socks or underwear and, again, none indicated that there were medical reasons for that. It is standard practice in juvenile detention that all items of clothing be provided to all youth. That is important to ensure safe hygiene practices, to avoid any appearance of favoritism or unfairness and to eliminate trading or bartering.

I observed the distribution of clothing during the beginning of the evening shift and reviewed the current inventory of clothing. I did observe that some items of clothing in some common sizes appeared to be in low supply. It is important for staff to notify the FCJDC Executive Secretary if they are in need of additional items of clothing and for her to maintain an ongoing inventory in order to ensure that supplies are always sufficient to meet the population need. The FCJDC population has been consistently below capacity but should the facility near capacity, it appears that they would not have a sufficient number of items in some sizes.

In my last monitoring report I recommended that the FCJDC implement a schedule for inventory and purchasing in order to maintain an adequate supply of clothing and other stores. I would reiterate that recommendation here. Inadequate supply has been a problem in the past and some youth have not received some items of clothing.

Youth are issued clean clothing each day during regularly scheduled showers. Youth clothing is laundered during the overnight shift by staff on duty.

Recommendations for achieving substantial compliance:

1. Fully implement a written policy and procedure that is consistent with this provision.
2. Provide written documentation that FCJDC staff members and medical staff members are trained on the revised policy and procedure.
3. Develop an effective system for monitoring inventories of clothing to ensure that there is always an adequate supply for any number, gender and size of residents who may be admitted to the FCJDC.

4. Provide written documentation of compliance with this provision.

X. HYGEINE AND SANITATION

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC provides prepackaged hygiene packets for all juveniles. Those packets contain soap, shampoo, deodorant, toothbrush, toothpaste and comb. Interviews with both juveniles and staff confirmed that those packets are routinely distributed at the time of admission. Juveniles generally reported that those hygiene products are replenished as needed. In addition, the FCJDC has obtained hair conditioner for youth who need to comb tangles out after shampooing. In earlier visits, some girls told me that they did not shampoo their hair when showering because they could not comb through the tangles. Not shampooing is not healthy or hygienic and shampooing should be a part of the regular hygiene routine. The FCJDC still does not provide brushes for youth. In addition, the new Behavior Management Program offers name-brand hygiene products for youth to "purchase" with the points that they earn through positive behavior. Those items are popular with youth and staff members report that they have been motivating.

When asked, again none of the youth interviewed said they wash their hands before meals. That is a routine that staff should require as part of each mealtime schedule in order to encourage that habit.

The new FCJDC policies and procedures, "Dress Code/Bedding/Hygiene" and "Admissions" address the requirements of this provision. Those policies and procedures have been finalized and reportedly staff members have been trained although no documentation of that training has been provided. There are other procedures that are required during the admission process that do not consistently occur with the regular booking officer is not on shift. Unless all staff are thoroughly trained on this related policy, full compliance can not be found.

Recommendations for achieving substantial compliance:

1. Provide written documentation of staff training on the new policies and procedures.

2. Provide documentation that all aspects of this provision are followed, including the provision of brushes and the brushing of teeth at least twice daily.

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

Compliance Rating: **Partial Compliance**

Discussion:

During my recent site visit I counted all sleeping mats in the FCJDC. The mats appeared clean and most were new. I did not observe any mats that had tears or other damage that would require that they be discarded, as has been the case on earlier visits. The FCJDC administrative secretary assisted me in counting the mats but we had difficulty finding them all; they were located in various places throughout the facility, stored haphazardly with no apparent system. There is no policy and procedure for maintaining and sanitizing the mats. That lack of organization or maintenance of mats leads me to conclude that mats are not sanitized between uses as required. In fact, I observed a newly admitted youth who was escorted to a room that had a mat left from the former resident. There were 25 mats for the 32-bed facility when I counted them and the inventory dated June 20, 2013 indicated that there were 26 mats on that date. The Deputy Chief Forrest County Sheriff has stated that they could obtain additional mats from the jail if necessary. However, that should not be necessary and the FCJDC should have the needed 32 sanitized mats on hand.

The FCJDC has blankets and linens laundered by the Forrest General Hospital. That system appears to be effective. There were an ample number of blankets in storage, in addition to those provided to current residents. And, the FCJDC is no longer using the shabby, torn blankets that had been commonplace in the past. The June 20, 2013 inventory indicated there were 103 blankets. That is a sufficient number of blankets but I would again recommend that the FCJDC establish a more systematic inventory schedule to help monitor the stock. Both staff and residents reported that clean blankets are provided weekly. Youth consistently reported that they are given three blankets to use, one to lie on, one as a cover and one to use as pillow.

As discussed in 10.1 above, the new FCJDC policy and procedure, "Dress Code/Bedding/Hygiene" addresses the requirements of this provision. That policy and procedure has been finalized and reportedly staff members have been trained although no documentation of that training has been provided. There are other procedures that are required during the admission process that do not consistently occur with the regular booking officer is not on shift. Unless all staff are thoroughly trained on this related policy, full compliance can not be found.

Recommendations for achieving substantial compliance:

1. Provide written documentation of staff training on the new policy and procedure.
2. Provide documentation that all aspects of this provision are followed, including the sanitizing of mats between uses.
3. Develop an ongoing inventory system to ensure an adequate supply of mats and blankets are available at the facility at all times.

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

Compliance Rating: **Partial Compliance**

Discussion:

No youth interviewed during my site visit reported being deprived of mats or blankets and no individual rooms that were occupied by youth during my site visit were without mats or blankets. The new FCJDC policy and procedure, "Dress Code/Bedding/Hygiene" addresses the requirements of this provision. However, staff has not been trained on that policy and procedure. As discussed in 10.2 above, all youth and staff reported that youth are provided with three blankets, rather than the previous two each, in order for one to be used as a pillow, since no pillows are provided. Although it is not mandated by this provision, it is standard practice to provide pillows, pillowcases and sheets as well as blankets to youth in juvenile detention and it is again suggested that the FCJDC consider doing so as well.

The FCJDC has provided a list of all items maintained for use at the FCJDC in the form of an inventory. However, there still does not exist a system for completing that inventory on a regular schedule and for using that inventory to order needed supplies in a timely basis.

Recommendations for achieving substantial compliance:

1. Provide written documentation that all FCJDC staff members have been trained on the new Dress Code/Bedding/Hygiene policy and procedure.
2. Develop an ongoing inventory system to ensure an adequate supply of mats and blankets is maintained at the facility at all times.

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

Compliance Rating: **Partial Compliance**

Discussion:

As discussed in 10.2 above, I observed a sufficient number of mats and blankets for the current population during my site visit. I did again count all the mats in the building this visit and there were twenty-five mats in the facility. Those mats all appeared to be fairly new and did not appear to be damaged, as has been the case at earlier visits. There have not been sufficient numbers of mats to correspond with the facility's maximum capacity at any of my site visits. The population has been much below its rated capacity of 32 but the FCJDC needs to have at least that many, undamaged, clean mats at all times. The Deputy Chief Forrest County Sheriff stated that they could obtain additional mats from the jail if necessary. However, the facility needs to have 32 mats to comply with this provision. If the mats are readily available at the jail, they can be stored at the FCJDC to comply with this provision.

I observed an ample number of blankets in the storeroom and they were in good condition. The March 8, 2013 inventory listed 103 blankets. Youth and staff interviewed reported that each youth receives three clean blankets at admission and each time linens are laundered. No youth indicated that they had extra blankets, left by detainees who had been released, as has been the case in the past. The arrangement with Forrest General Hospital to wash blankets and linens seems to ensure that those items are clean when distributed.

Although the FCJDC has developed a written inventory of supplies, that inventory does not appear to be completed on any regularly scheduled basis. Without a consistent schedule for conducting the inventory, it is not possible to use that as a tool for planning and purchasing needed supplies.

The new policy and procedure, "Dress Code/Bedding/Hygiene" addresses the requirements of this provision. However, since some FCJDC staff members are not in compliance with some components of that policy and procedure, additional training appears to still be needed.

Recommendations for achieving substantial compliance:

1. Fully implement the Dress Code/Bedding/Hygiene policy and procedure.
2. Provide written documentation of staff training on the new policy and procedure.
3. Procure additional mats to meet the requirements of this provision.
4. Develop an inventory system to use in monitoring the number of mats and blankets in order to ensure the required availability and determine when new mats and blankets need to be ordered.

10.5 The Forrest County Juvenile Detention Center shall ensure that youth are provided with a clean, sanitary environment, which shall include, but is not

limited to, regularly cleaning the facility and facilitating regular pest control measures.

Compliance Rating: **Partial Compliance**

Discussion:

During my site visit I again observed youth in the process of mopping floors in dayrooms. Staff members did appear to be supervising them. No youth were observed to be wearing gloves while they cleaned. I was informed by both youth and staff members that the facility is cleaned daily and several youth again reported to me that they had been performing extra cleaning in anticipation of my visit. The individual sleeping rooms are now tidier than they were on earlier visits and it appears that staff members are now enforcing the expectation that youth maintain clean, uncluttered rooms. Youth informed me that they are now required to make their beds each morning. Youth have the opportunity to earn points, through the Behavior Management Program, each day for maintaining their rooms in a clean, tidy manner. The day rooms also appeared tidier than during my prior visits. All three units have been renovated and the final unit was reopened shortly before my site visit. The work included painting over graffiti with a substance that is not easily marked.

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

The FCJDC draft policy and procedure, "Sanitation," addresses the requirements of the provision. That policy and procedure is pending revisions and has not yet been implemented.

The FCJDC has a cleaning service for the public area of the building. However, the living areas are not professionally cleaned and the FCJDC does not have janitorial staff members who are trained and knowledgeable regarding appropriate cleaning products and techniques. Staff and youth should have clear guidelines and training on expectations and methods of cleaning to ensure that the facility is cared for on a regular basis. That is particularly the case with the renovations that have occurred or are planned. Prior to those upgrades, the dayrooms and sleeping rooms had filth that had been allowed to accumulate over a long period of time. It would be unfortunate if the renovated areas were allowed to again deteriorate in such a way.

Recommendations for achieving substantial compliance:

1. Finalize and implement a policy and procedure that it is consistent with this provision.
2. Provide written documentation of staff training on the policy and procedure.

3. Provide training to staff members who supervise residents regarding proper cleaning techniques, schedules and products to ensure that the facility is kept clean.
4. Provide written documentation of staff training on cleaning practices and methods.

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC still does not have completed policies and procedures that address all the elements of this provision. Subsequent to agreement by the parties on March 27, 2013 and in compliance with the court's order, this monitor is drafting policies and procedures for the FCJDC that comply with the Agreed Order. That process involves the FCJDC Director and others as necessary in order to ensure maximum buy-in. Currently, there are policies in draft form addressing the elements of this provision. Following collaboration with the FCJDC, those policies and procedures will be finalized and readied for implementation. The FCJDC provided documentation of just one *monthly* fire drill, conducted on April 1, 2013 and an inspection report completed by the Hattiesburg Fire Department on April 29, 2013. It is not known if there were other fire drills. The draft policy and procedure, "Emergency Preparedness and Evacuation," requires fire drills to be conducted monthly. It is concerning if the FCJDC has reverted to conducting fire drills less frequently than their own draft policy requires. No other documentation applicable to this provision, such as food safety inspection reports and health department reports, has been provided by the FCJDC. Documentation provided for review still does not indicate what relevant laws, if any, apply. It is still not known what the relevant laws for the State of Mississippi, Forrest County or the City of Hattiesburg are in this area and the FCJDC administration will need to ascertain what those applicable laws are to ensure compliance with those laws and with this provision.

Recommendations for achieving substantial compliance:

1. Finalize and implement policy and procedure consistent with this provision.
2. Provide documentation of relevant state and local laws addressing the elements of this provision.
3. Provide written documentation of staff training on the new policy and procedure.
4. Provide documentation of practice that demonstrates compliance with this procedure such as monthly fire drills, weather emergency responses, health department inspections reports and food safety inspection reports.

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

Compliance Rating: **Partial Compliance**

Discussion:

Interviews with both youth and staff at the FCJDC, as well as observations during my site visit, verified that youth do receive clean utensils with each meal. The FCJDC also generally provides clean Styrofoam cups with each meal. The FCJDC draft policy and procedure, "Serving Meals," does not address the requirements of this provision. This monitor has revised that draft policy and procedure to ensure compliance. Upon review by the parties, that revised policy and procedure will be finalized.

Recommendations for achieving substantial compliance:

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

XI. MEDICAL CARE

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

Compliance Rating: **Partial Compliance**

Discussion:

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

The nursing services at the FCJDC have been provided through contract with the Forrest General Hospital. No current contract was provided for my review this monitoring period but I did interviews one of the nurses while on-site and she reported no changes to the former level of services. The contract provided for my review at my last visit in March 2013, : "Nursing Services Agreement" for the Forrest County Corrections Facilities (dated August 18, 2011,) indicates that it is intended to serve "inmates" of the "infirmary and other Forrest County Correctional Facilities." It does not make reference to the Forrest County Juvenile Detention Center. That contract requires the Hospital to "provide one full-

time equivalent, registered nurse to the Facilities." There is no detail about how many hours of nursing service is to be provided at the FCJDC, if any. That lack of specific contract language could allow Forrest County to limit the level of nursing care to the point that medical provisions of the Agreed Order cannot be met. There has been nursing coverage the FCJDC during most weekday hours, using a group of registered nurses and a licensed practical nurse. A registered nurse who has numerous other diverse responsibilities at the Forrest County Jail and other Forrest County facilities, as well as the FCJDC has overseen those services. And, she is the only medical professional unofficially designated to be on-call for acute medical needs. At the time of my January and March 2013 visits, she reported that there were plans to created an on-call schedule for sharing those responsibilities. However, no medical on-call schedule has yet been developed.

Physician services are provided through contract with the Southern Neurologic and Spine Institute. The copy of that contract provided for my review indicated that the contract ended on September 30, 2012 although the Forrest County Board of Supervisors' attorney previously assured me verbally that it is still in effect. And, that contract commits the Southern Neurological and Spine Institute "to provide basic medical care as needed to see and treat sick inmates at the *Forrest County Jail and Forrest County Evaluation Center* at least twice per week as the result of sick call." As has been discussed in prior reports, that contract does not address physician services required by the Agreed Order at the FCJDC. As is the case with the Nursing Services Agreement discussed above, the failure to include the Forrest County Juvenile Detention Center in the contractual requirements could result in the contractor ceasing services to the FCJDC. The county needs to provide greater assurance that they plan to continue to meet the medical needs of juveniles at the FCJDC, both now an in the future.

The supervising nurse and the physician have assured me that the physician is generally at the FCJDC twice each week to ensure that all youth admitted do receive a physical examination within 72 hours. The physician informed me that he is scheduled to be at the facility on Tuesdays and "often on Friday." It may be assumed that the Friday visits occur only when youth are admitted after his routine Tuesday visit.

Because nurses are not qualified to complete physical examinations, the nurse completes a physical assessment on youth, generally on the next weekday following admission. In the past, during periods of time when the facility has been without a physician, they have been unable to complete physical examinations, particularly within the required timeline. The contract physician has been at the FCJDC during my last three site visits and it appears that timely physical examinations are now occurring. The contract nurse supervisor created a system to record the date of admission on the form that is used for the physical examination to help ensure that that occurs. That is an improvement over the confusing documentation that existed at previous visits. The same form is still used for both physical examinations and for all sick call services. It is difficult to determine from the review of the many copies of that "Request for Medical Care" form when the care provided

is an intake physical and when it is some other medical service. The nurses do maintain comprehensive documentation of medical services for youth.

The FCJDC contract physician informed me that the physical examination that he performs is comparable to a sports physical. It is not known at this point whether time required for that examination differs from the approximately three to five minutes that I observed youth receiving at the time of my September visit. As was discussed in previous monitoring reports, this provision requires that youth receive a full physical exam and I simply cannot accept that they are receiving a full physical exam in three minutes. I discussed those concerns with the nurse in September and previously provided web site information to her for the American Academy of Pediatrics and the National Commission on Correctional Health Care to use as guidelines in developing an appropriate format and minimum standards for such services as physical examinations. The juvenile justice population is often medically underserved and is at high medical risk. A comprehensive physical examination, designed to address particular issues common to that population is critical. Youth interviewed during my recent site visit confirmed that the physician usually just "talked to" them and that they were only with him for a very brief time. The physician/medical director at the FCJDC brings excellent qualifications and he has verbalized a commitment to providing quality service to the FCJDC and to the youth it serves. It is hoped that he will ensure that the physical examinations of youth at the FCJDC meet at least minimal standards for the population. Many youth admitted to the FCJDC have been detained at the facility previously and, in those cases, if that prior detention was fairly recent, the physical exam would not necessarily be as comprehensive. But, the passage of time and intervening events would indicate a more thorough examination than is currently being provided.

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

The nurse prepares prescription medications for youth and places them in a secure cabinet for staff to access when they are to be administered. She completes a comprehensive record of what medications have been prescribed and when they are to be administered. The FCJDC does not have a contract or other arrangement with a local pharmacy and is largely dependent upon parents to deliver prescribed medications. However, documents do indicate that the FCJDC has obtained medications for youth from the Forrest General Hospital Pharmacy.

The procedure for handling daily sick call requires that a youth notify an Officer or a Direct Care Worker that he needs medical attention. The staff member completes the "Sick Call Request Form" and forwards it to the nurse. The nurse reviews that information and generally sees the child that same day or on the next weekday. Staff members and youth interviewed regarding sick call generally confirmed that practice. Staff interviewed did

confirm that the nurse manager is on-call but several staff again reported that they often had to wait for a long time for her to respond to her calls and, she has been on medical leave for approximately a month and unavailable. As has been discussed in previous monitoring reports, in order to ensure substantial compliance with this provision, the FCJDC will need to develop an on-call system or schedule that ensures that calls are responded to within a reasonable and set time period. To expect the nurse manager, who has full-time duties with the Forrest County Sheriff's Department, to assume that entire responsibility does not appear to be effective, is probably not realistic and does not seem fair. There have been documented incidents where medical care or medical transportation was delayed due to the lack of availability of adequately trained staff. There is now an administrative on-call schedule, for issues that arise after hours, wherein staff members on duty may call the Director or the Assistant Director. However, neither the Director nor the Assistant Director is medically trained and can only advise the staff to arrange transportation to a hospital for care. A medically trained professional might be able to assess a situation and offer guidance that would be less time-consuming and less costly.

Incident Reports have documented examples of emergency medical teams being called with quick response and there were examples of youth being transported to a hospital as a result of injuries occurring from within the facility. FCJDC administrators or staff members have also transported injured youth in some cases. The FCJDC reportedly uses AAA Ambulance Services for most transporting. Documents indicate that the Forrest County Sheriff's Department is also very quick to respond and helpful in emergencies.

The FCJDC contract nurse manager was tasked with the responsibility of writing medical and mental health policies and procedures for the facility. That is an enormous assignment and she acknowledged having had no experience or training in that type of work. It is essential that the FCJDC have comprehensive policies and procedures, including those that address medical and mental health issues. Like the rest FCJDC policy and procedure manual, that effort is extremely delayed. This monitor has assumed responsibility for writing the medical and mental health policies and procedures and will continue to work closely with the nurse manager and others as appropriate in finalizing those.

Recommendations for achieving substantial compliance:

1. Provide copies of current contracts for medical services at the FCJDC.
2. Finalize and implement policy and procedure consistent with this provision.
3. Provide documentation that FCJDC staff and contracted medical staff members have been trained on that policy and procedure.
4. Although there is usually a registered nurse at the FCJDC at least twenty-hours each week who generally sees admitted youth within the required timeframe, she completes a physical assessment, not a physical examination. The FCJDC must also ensure that youth receive a physical exam, which can be completed by a physician or a mid-level practitioner such as a nurse practitioner, within the timeframe

established by this provision. The current physical examination format and form should be revised to ensure the comprehensiveness of that service and to effectively meet the medical needs of the FCJDC population.

5. Provide documentation that required physical examinations are provided within the required timeframe.
6. Develop and implement forms or other paperwork to document youth prescriptions at the time of admission and the efforts made to ensure that youth receive those medications as needed.

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

<u>Compliance Rating:</u> **Partial Compliance**

<u>Discussion:</u>

The FCJDC has a contract with the Southern Neurologic and Spine Institute for physician services. The current physician has been in his role at the facility for approximately nine months. At this point, he is scheduled to be in the facility for part of one day each week (Tuesdays) but he indicated to me that he is available on other days as needed (usually Fridays.) That schedule ensures that youth admitted to the FCJDC receive a timely physical examination. As discussed in 10.1 above, the contract commits the Southern Neurological and Spine Institute "to provide basic medical care as needed to see and treat sick inmates at the *Forrest County Jail and Forrest County Evaluation Center* at least twice per week as the result of sick call." That contract does not address physician services at the FCJDC as required by the Agreed Order. There is no nurse practitioner or other mid-level medical professional available to examine youth at the facility. However, at the time of my site visit, the physician was meeting that need.

<u>Recommendations for achieving substantial compliance:</u>

1. Develop and implement written policy and procedure consistent with this provision.
2. Continue to ensure that a medical doctor, nurse practitioner or other mid-level medical professional is available to examine youth at the facility to respond to, identify and treat medical needs.
3. Provide written documentation that a medical doctor or nurse practitioner or other mid-level medical professional is available for a sufficient amount of time to examine youth at the facility to identify and treat medical needs.
4. Provide written documentation that youth at the FCJDC are being examined and that their medical needs are identified and treated.
5. Provide copies of current contracts for medical services at the FCJDC.

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

Compliance Rating: **Substantial Compliance**

Discussion:

The FCJDC Sick Call Policy and Procedure has been finalized but the staff has not yet been trained on that new policy. That new policy and procedure is in compliance with this provision. And, as discussed in 11.2 above, the facility has had a sick call practice that appears to meet the requirements of this provision and the new policy. As long as there is a registered nurse at the facility each weekday, as is currently the case, this provision can be complied with. Interviews with both youth and staff also verified that sick call requests are addressed. I reviewed numerous copies of "Request for Medical Care" forms documenting sick call requests and subsequent medical care. It appears that sick call requests are responded to by the nurse, and by the physician when available. The practice of adding additional information, including admission date, to the "Request for Medical Care" form, which documents treatment, helps to ensure that sick call requests are met in a timely manner. The new FCJDC Detainee Orientation Checklist includes an explanation of the facility's sick call procedure.

In order to ensure confidentiality of juveniles' medical information, as required in provision #11.5 below, it is again recommended that the Sick Call Request form be revised in such a way that it does not require the child to provide extensive details about the child's medical need.

Recommendations for achieving substantial compliance:

1. Provide written documentation that all FCJDC staff members and medical contractors are trained on the new policy and procedure.

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

Compliance Rating: **Partial Compliance**

Discussion:

The FDJDC draft policy and procedure, "Medication Administration Policy," addresses the elements of this provision. That policy and procedure still needs to be

revised before it is ready to be implemented. This monitor has worked on a revised version of that policy and procedure that meets the requirements of this provision and work with the FCJDC to ensure implementation.

The registered nurse manager assigned to the FCJDC has described the procedure that the nurses follow for ensuring that prescription medications are administered properly. They prepare the medications and distribute them when there is a nurse present. They place prepared, individually labeled medications in a locked cabinet for direct care staff to distribute at other times. Staff interviews confirm that description.

At the time of my June 2012 visit to the FCJDC, I was provided with documentation of FCJDC staff training on medication administration, conducted on June 21, 2012. However, that training would not be consistent with the requirements of this provision as the 2007 *Standard Operating Procedure* manual was still being used at that time. The instructions in that manual were not in compliance with this provision. No documentation of current staff training on draft policy and procedure, on required practice or on the requirements of this provision has been provided for my review.

Recommendations for achieving substantial compliance:

1. Finalize and implement written policy and procedure ensure consistent with this provision.
2. Provide written documentation that all FCJDC staff members are trained on the new/revised policy and procedure.

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

Compliance Rating: **Partial Compliance**

Discussion:

The physical plant at the FCJDC presents challenges to providing medical and mental health services in a manner that ensures confidentiality. In the past, youth were sometimes seen by the nurse in the medical office behind the booking desk with the door partially open. The mental health counselor conducted groups in the staff lounge where a great deal of traffic occurred, particularly since that room was located between the booking area and the facility kitchen. However, during my last three site visits, when the physician and nurse were in the medical exam room seeing youth, the door was closed and the mental health counselor now conducts groups in a Youth Court conference room or in the classroom, depending on availability. The mental health counselor also has a very small room located on the D Unit hallway where it is possible to see one or two youth at a time privately.

The "Request for Medical Care Form" is used to document a number of medical services at the FCJDC, including sick call requests. The procedure is reportedly for youth to notify a line staff member of his medical need. The youth or staff member completes the request portion of the form and the staff member forwards it to the nurse. That practice requires youth to provide information about medical complaints that can then be read by staff. Those complaints could be of a confidential and sensitive nature. It is again recommended that those completed forms be provided to the facility nurse directly, if possible. Or, as discussed in 11.1 above, it is also recommended that the form be revised to not require the child to provide extensive details about the medical need, if the form may be read by line staff, in order to ensure confidentiality.

When the regular booking officer is on duty at the FCJDC, she now completes the Medical Screening Questionnaire in the Detox cell, which is located in the booking area but which is private from the booking desk. That practice ensures that a youth's responses to those medical screening questions cannot be overheard. However, when the booking officer is not on duty, interviews with youth and staff indicate that the new Admission Policy and Procedure is not being followed. Apparently FCJDC staff members have not been trained on the new policy and procedure and the Medical Screening Questionnaire is still being completed at the booking desk, where other staff or youth can overhear a child's responses. It was a recurrent concern that a number intake questionnaires and documents were completed at the booking desk, which precluded privacy and confidentiality. That concern was discussed with the FCJDC administration at the time of my January 2013 site visit and an agreement was reached to develop a two-phase booking system. Under that plan, the legal paperwork, computer entries and other requirements that are primarily routine in nature would occur at the booking desk. Then the booking officer would move with the child to a more private location in the admissions area where the MAYSI-2 risk assessment, along with the Medical Receiving Screening Questionnaire, detainee rights, facility rules and other tasks requiring time and attention from both the officer and the child can be accomplished. That would assure that the Medical Receiving Screening Questionnaire and the MAYSI-2 are administered privately, where the child is more likely to answer honestly, improving the validity of those documents and their worth to staff and mental health clinicians. However, that change was not implemented until some time after my March 2013 visit and is still only the practice when the FCJDC booking officer is on duty, despite the fact that there is now a written policy and procedure in place mandating that practice

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

Recommendations for achieving substantial compliance:

1. Fully implement the new Admissions policy and procedure.

2. Provide documentation that all FCJDC staff and contracted staff at the FCJDC are trained on the policy and procedure.
3. Ensure that, when FCJDC staff or medical professionals are addressing confidential issues with youth they do so privately.
4. Ensure that sick call inquiries made to direct care staff are done in a private, confidential manner.
5. Ensure that the Medical Screening Questionnaire is completed in private.

XII. MENTAL HEALTH CARE

12.1 The Forrest County Juvenile Detention Center shall contract for or otherwise secure adequate mental health services to all confined youth with a mental health diagnosis or serious mental health need, as indicated by the MAYSI-2. This shall include, but is not limited to, the provision of individual and group counseling sessions upon the request of a youth or the youth's parent/guardian, access to a mental health professional at the detention center, and the distribution and medical monitoring of psychotropic medications by a medical professional.

Compliance Rating: **Partial Compliance**

Discussion:

This FCJDC receives mental health services through Pine Belt Mental Healthcare Resources (PBMHR.) However, it should be noted that I have not been provided with a copy of the finalized contract between the FCJDC and PBMHR but, rather, a copy of a *proposal f*or mental health services approved May 24, 2012. As I indicated with the contracts for nursing and physician services above, the lack of a specific contract for services to youth at the FCJDC could mean that necessary services will not be provided. The Proposal from Pine Belt Mental Healthcare Resources For Delivery of Mental Health Services to FCJDC that I was provided included the elements of this provision. The Forrest County Board attorney previously reported that he believed that the Board had approved that proposal. If that Proposal is implemented, this provision should be able to achieve compliance. At the time of this report, I have not received confirmation that that Proposal has been approved or implemented.

There is a counselor who is at the facility for a few hours two days each week. She reports that she sees youth in either a group or individually but she reports that she sees them individually before she determines that they can be seen in a group. She tries to see every youth detained unless the youth chooses not to see her. Most youth reported seeing the Pine Belt counselor and spoke positively about her. She reported that she refers "high-risk" youth for follow-up care through Pine Belt Mental Healthcare Resources if they are from Forrest County or through the youth's own county or through their youth court counselor. When the room that the therapist had previously used for group counseling

sessions was changed to use as a staff lounge, she was not provided with a location to conduct group counseling until my September monitoring report stressed the importance of that service. Since that time, arrangements have been made for the counselor to conduct groups in a Youth Court conference room or in a classroom. She also was provided with a small room in the D Unit hallway where she can meet with youth individually.

Completed MAYSI-2 forms are placed in a folder for a PBMHR licensed clinician to review each weekday. She is able to use that information as part of psycho-social assessments on youth. She then develops treatment plans based on those assessments. She also reports that she is called for consultation regarding such concerns as a child's potential for suicide and does suicide risk assessments on those youth. The FCJDC completes YASIs on each youth, although records indicate that the YASI is not always completed within one hour, as required by the Agreed Order. The therapist reported that she has begun using that information as well in developing treatment plans.

Both the counselor and the licensed clinician are master's level professionals and are, therefore, not qualified to provide medical monitoring of psychotropic medications. Neither the nurse manager nor the physician at the FCJDC has psychiatric credentials. A psychiatrist at PBMHR reportedly provides monitoring of psychotropic medications. However, a number of youth who have been committed for lengthy determinant periods for violating court orders reported to me that they had previously been or were currently on psychotropic medications and had not seen a psychiatrist recently. However, records and interviews did verify that at least one youth at the facility during my recent site visit was transported to PBMHR to see the psychiatrist for medication monitoring.

The FCJDC draft medical policy and procedure, "Mental Health Treatment," does not address the requirement of this provision. This monitor will work with the FCJDC administration and their contracted medical and mental health providers to develop and implement mental health policies and procedures that comply with this provision.

Recommendations for achieving substantial compliance:

1. Finalize and implement a written policy and procedure that is consistent with this provision.
2. Provide written documentation that all FCJDC staff and contracted medical and mental health personnel are trained on the policy and procedure.
3. Provide written documentation of compliance with this provision with examples of completed forms and other paperwork.

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

Compliance Rating: **Non-Compliance**

Discussion:

Interviews with youth, FCJDC staff and with the FCJDC nurses and the Pine Belt Mental Healthcare Resources clinician confirmed that referrals to a psychiatrist still occur rarely. I was provided with 41 copies of mental health assessment forms completed by the PBMHR clinician during the monitoring period. All of those assessments forms included an "Initial Treatment Plan" that included "individual/group therapy and CBT" (cognitive behavioral therapy.) No other treatment recommendations were made and in no case was it recommended that a youth be referred for psychiatric evaluation or for psychiatric review of current psychotropic medications. Staff and youth interviews confirmed that youth were currently taking psychotropic medications and, in at least one case, those interviews confirmed that a youth had recently been transported to see the PBMHR psychiatrist. The PBMHR clinician has reported that many of the youth from Forrest County are current Pine Belt clients and may receive psychiatric services before their admission to the FCJDC or upon release. It is common for youth to be committed for lengthy, determinant sentences to the FCJDC for violating a Youth Court order. A number of youth serving those sentences, usually 90 days, again reported having been on psychotropic medications in the past but they have not seen a psychiatrist during their current commitment.

The staff members who work with the youth at the FCJDC on a daily basis are not queried by a psychiatrist for information regarding those juveniles' behavior, to assist in making informed decisions regarding the efficacy of prescribed psychotropic medications.

The FCJDC draft medical/mental health policies and procedures do not address the requirements of this provision. This monitor will develop mental health policies and procedures that comply with this provision and work with the FCJDC and contracted medical and mental health providers to implement them.

The copy of a Proposal from Pine Belt Mental Healthcare Resources For Delivery of Mental Health Services to FCJDC that I was provided for my September 2012 visit included the elements of this provision. The Forrest County Board attorney reported that he believed that the Board had approved that proposal. If that Proposal implemented, this provision should be able to achieve compliance. At the time of this report, I have not received confirmation that that Proposal has been approved or implemented.

Recommendations for achieving substantial compliance:

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

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

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

Compliance Rating: **Partial Compliance**

Discussion:

The licensed clinician from PBMHR assigned to the FCJDC completes assessments on FCJDC youth, based on completed MAYSI-2, YASI and other information. She uses that assessment data to development treatment plans. She reported that if a youth is a current PBMHR client, she does notify the child's assigned therapist of his detention. The form used for the assessments and treatment plans includes spaces for the date of admission and the date of service. All of the assessments and treatment plans reviewed were completed within the 72 hours required by this provision. The form used by the clinician to document assessments and treatment plans indicates that the treatment plan is based on the assessment, the MAYSI-2 and the YASI. Although treatment plans are developed by the mental health clinician, there is no indication that those plans are implemented during the youths' detention and it is not known how, those plans are implemented, if at all, upon release. As discussed in provision 12.2 above, all Initial Treatment Plans developed for the youth at the FCJDC during the most recent monitoring period are identical with no individualization, as should be the case. It is not known if subsequent, individualized treatment plans are developed for youth.

As discussed in provision 12.2 above, all of the Initial Treatment Plans in the 41 files that I reviewed were identical with no individualization.

The FCJDC draft medical/mental health policies and procedures do not address the requirements of this provision. This monitor will develop mental health policies and procedures that comply with this provision and work with the FCJDC and contracted medical and mental health providers to implement them.

The copy of a Proposal from Pine Belt Mental Healthcare Resources For Delivery of Mental Health Services to FCJDC that I was provided for my September 2012 visit included the elements of this provision. The Forrest County Board attorney reported that he believed that the Board had approved that proposal. If that Proposal implemented, this

provision should be able to achieve compliance. At the time of this report, I have not received confirmation that that Proposal has been approved or implemented.

Recommendations for achieving substantial compliance:

1. Develop and implement a written policy and procedure consistent with this provision.
2. Provide documentation of implementation of that policy and procedure, including individualized treatment plans that emphasize continuity of care and shall ensure that whenever possible, youth are transported to appointments with their regular mental health provider, whether the appointments are standing or made after the youth's initial detention.

SUICIDE PREVENTION

13.1 The Forrest County Juvenile Detention Center shall develop a multi-tiered suicide prevention policy that has at least three stages of suicide watch. Suicide watch shall not be used as punishment. The "suicide cell" shall be reserved for youth for whom the "suicide cell" is deemed necessary in conjunction with this suicide prevention policy.

Compliance Rating: **Partial Compliance**

Discussion:

A Suicide Prevention policy and procedure was developed for the FCJDC in April. That policy was provided to the trainer that came to train the FCJDC staff on juvenile detention practice, using the *Detention Care Givers Basic Training* curriculum, and she was able to incorporate that policy as she provided information on suicide among youth in juvenile facilities, current research and best practice. That policy and procedure has three levels of suicide watch, Close, Intermediate and Constant. That policy addresses the seven elements in the research report on suicide in juvenile facilities provided to the FCJDC and to Forrest County. New forms were created, to be used with the new policy and procedure and those forms are available. That policy and best practice does not include the use of a "suicide cell."

This provision does not address implementation but it is important to note, as has been discussed in other provisions above, there is still considerable misunderstanding about the new policy and additional, ongoing training will be required as employees of the FCJDC deal with the issue of suicide prevention. Documentation of the examples of two youth on suicide watch did not comply with the new policy and procedure.

Recommendations for achieving substantial compliance:

1. Provide documentation of ongoing training on the new policy and procedure to ensure that FCJDC staff and contractors are in compliance.
2. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

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

Compliance Rating: **Partial Compliance**

Discussion:

Pine Belt Mental Healthcare Resources (PBMHR) has assigned a clinician to the FCJDC to conduct assessments, subsequent to the completion of the MAYSI-2 and, on an as needed basis, when there is a potential risk of suicide. That clinician previously informed me that if the child is a current PBMHR client she does not do the assessment but she does contact the child's current Pine Belt therapist. It is still not known whether those youth are seen by their therapist or by another mental health professional as required by this provision. There were two examples of youth who were potentially suicidal during the current monitoring period. In one case the mental health clinician from PBMHR was notified as required in the new policy. She assessed the youth and provided her clinical recommendations to the staff. In the second example, staff on duty *did not* notify the mental health clinician, as required by the new policy. The former practice was to notify the contract nurse and that is what the staff did in that second case. At the nurse's advice, the juvenile was immediately transported to Forrest General Hospital for evaluation. Incident reports were not clear regarding subsequent placement or follow-up. Although the FCJDC staff clearly needs follow-up training on the new Suicide Prevention policy and procedure, it appears that they are generally in compliance with this provision, based on the two examples that I was able to review.

Because no staff member interviewed during my site visit was able to clearly explain the three levels of suicide watch and since there are other aspects of the new Suicide Prevention policy and procedure that are not being adhered to, I cannot find the FCJDC in Substantial Compliance with this provision. Suicide is one of the most critical issues in juvenile detention facilities and it is essential that the FCJDC fully understand expectations in order to ensure safety.

Recommendations for achieving substantial compliance:

1. Provide documentation of ongoing training on the new policy and procedure to ensure that FCJDC staff and contractors are in compliance.
2. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

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

Compliance Rating: **Partial Compliance**

Discussion:

As indicated in 13.1 and 13.2 above, there have been only two youth who have been evaluated as potentially suicidal during the current monitoring period. Documentation indicates that one youth was confined to a room under "constant" supervision and checked at fifteen-minute intervals for a period of time. That limited monitoring was formerly the norm but it does not comply with the new policy and procedure. It is not known what occurred with the other youth after he was evaluated at Forrest General Hospital Emergency Room. Although staff members interviewed were all unclear about some aspects of the Suicide Prevention policy and procedure, including the three levels of suicide watch, they did seem to recognize, from the training that the received in April, that former practices at the FCJDC are no longer considered appropriate. Although the FCJDC has suicide gowns at the facility, no interviewee reported any use of a suicide gown in memory. The new Suicide Prevention policy and procedure addresses the use of suicide gowns. That policy states: "Removal of clothing or use of 'suicide gowns' or restraints can be degrading and can increase a suicidal youth's self-destructive behavior. Therefore, those actions should be avoided other than for short periods of time, solely based on instructions from a qualified mental health professional, while a youth is actively engaging in self-destructive behavior and awaiting transfer to a mental health facility or hospital." It will be necessary to provide additional, follow-up training to all staff members on that and other aspects of the new policy to ensure compliance.

Research and the new policy both make clear that "incarceration and isolation" are considered risk factors for suicide. Therefore, all youth in any juvenile detention center are considered at risk and must be under "Close Supervision" when confined to their rooms. That level requires "observation at staggered intervals not exceeding 15 minutes." As discussed above, room checks are generally conducted at fifteen-minute intervals but documentation indicates that that timeframe is exceeded at times. Youth at the FCJDC are still allowed to voluntarily isolate themselves in rooms in Unit D, which is not staffed full-

time, which has no day room and which offers no staff or peer interaction or activities. It is essential that those youth are monitored as required by policy. And, those juveniles are still not assessed for potential suicidal tendencies when they opt to self-isolate, as the new policy requires.

There is still little or no structured programming and limited recreation at the FCJDC, as discussed previously in this report. However, it is imperative that youth who are confined to their room for any reason, but especially for suicide watch, be allowed to participate in "recreation, school and other structured activities." Documentation provided for my review indicates that does not always occur.

Recommendations for achieving substantial compliance:

1. Provide documentation of ongoing training on the new policy and procedure to ensure that FCJDC staff and contractors are in compliance.
2. Provide written examples of the implementation of all aspects of the new Suicide Prevention policy and procedure and the use of the relevant forms or other means of documentation that this provision is complied with.

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

Compliance Rating: **Non-Compliance**

Discussion:

The new Suicide Prevention policy and procedure includes this requirement. One example of a youth who was placed on suicide watch during the monitoring period included a completed Suicide Supervision: Constant Watch form with an unsigned note indicating that the youth's counselor had been notified. No documentation of a youth's guardian being notified was provided. Based on the lack of understanding of the new policy by FCJDC staff members, I cannot assume that the youth court and the guardian are or will be notified.

Recommendations for achieving substantial compliance:

1. Provide documentation of ongoing training on the new policy and procedure to ensure that FCJDC staff and contractors are in compliance.
2. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation that this provision is complied with.

XIV. FAMILY SUPPORT AND INTERACTIONS

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC has generous visiting hours during weekdays. Current posted times are 8:00 a.m. to 12:00 noon and 1:00 p.m. to 4:00 p.m. on weekdays and weekends as approved. The "Detainee Handbook" and the "Parent Handbook," available in the FCJDC lobby, both provide information about visitation, including information about days of the week, times of visitation, who can visit, visitor dress expectations, storing of personal items during visits and special visits. The FCJDC has added pre-approved weekend visitation to the posted visitation times in the lobby of the FCJDC and at the booking desk to address the requirements of this provision. However, none of the completed visitation sign-up sheets for April, May and June 2013 documented any weekend visits. It is not known how parents or guardians are notified of the availability of that option. Most staff members interviewed regarding visitation were somewhat unclear about the times of visitation but that is likely due to the fact that youth are simply summoned to the visitation area by an administrator when a visitor arrives. Most staff did indicate that weekend visits may now be arranged in advance with the Director. The fact that staff interviews differ from actual visits documented, may indicate that the weekend visitation is a very new practice. However, it is important that all staff, youth and potential visitors are informed of that option.

The new FCJDC Visitation policy and procedure has been finalized but at the time of my site visit, the staff had not yet been trained on that new requirement. The new policy addresses the expectations in this provision. Without comprehensive training, including follow-up oversight to ensure that revised practices in particular are followed, there is no assurance that this provision will be complied with.

Youth and staff interviewees all indicated that visits are generally contact visits. The FCJDC Director recognizes the importance of family involvement and encourages contact visits, limiting them only in rare cases.

My observations and interviews with staff and youth again verified that visits are allowed, with the required youth court worker authorization, throughout weekday hours. The FCJDC Director stated that she approves visits during other times when requested. No documentation of the authorization of visits outside weekday hours was provided. The visitation log is maintained by the facility to verify when visits take place and with whom the visit occurs.

Recommendations for achieving substantial compliance:

1. Implement the new Visitation policy and procedure.
2. Provide written documentation that all FCJDC staff members have been trained on the revised policy and procedure.
3. Provide documentation of notification of detainees and their families of this provision.
4. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC allows youth to have contact visits with family members by using just one side of the divided visiting room. Staff and youth interviewed verified that contact visits are the norm for youth at the FCJDC. However, as discussed in 14.1 above, the new Visitation policy and procedure has not yet been implemented and FCJDC have not been trained on that policy. Contact visits for all youth at the FCJDC were denied for a period of time last year based on just a few incidents involving just a limited number of youth. That denial of rights is less likely to reoccur if there is a clear, written policy and procedure that all staff are familiar with.

Recommendations for achieving substantial compliance:

1. Implement the new Visitation policy and procedure.
2. Provide written documentation that all FCJDC staff members have been trained on the revised policy and procedure.
3. Provide documentation of notification of detainees and their families of this provision.
4. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

14.3 Visitation shall be regularly scheduled at least three times per week or approved by appointment, and shall include evening and/or weekend visitation times in order to encourage family visitation. The Forrest County Juvenile Detention Center shall permit the confined youth's own children to participate in visitation.

Compliance Rating: **Partial Compliance**

Discussion:

As discussed above, visitation hours are generous on weekdays. However, the visitation rules allowing weekend visits in order to accommodate families' work schedules, travel times and other limitations during the evening or on weekends had just been changed and posted within a day of my site visit. The FCJDC Director stated that she does approve visitation outside regular visitation hours but, again, no examples of having done so were available. And, it is not known how or if that option is made known to detainees or their family members. There is now a detainee Orientation Checklist that includes visitation as one of the rights that is explained at admission. Both the "Detainee Handbook" and the "Parent Handbook" indicate that regular visiting hours are on weekdays but that "Special weekend visitation privileges must be approved in advance by the administration." Interviews with FCJDC administrators and line staff indicate that evening and/or weekend visits are allowed with administrative approval. It does appear that evening and/or weekend visits are now allowed although that appears to be a very new practice and no documentation of weekend visits was provided in the Visitation Sign-up sheets.

Interviews with youth and staff confirmed that a youth's own children may be allowed to visit "as long as the minors' parent or guardian is present during the visit and authorized by the respective Youth Court."

As discussed in 14.1 above, the new FCJDC Visitation policy and procedure has been finalized but at the time of my site visit, the staff had not yet been trained on that new requirement. The new policy addresses the expectations in this provision. Without comprehensive training, including follow-up oversight to ensure that revised practices in particular are followed, there is no assurance that this provision will be complied with.

Recommendations for achieving substantial compliance:

1. Implement the new written policy and procedure addressing the requirements of this provision.
2. Ensure consistency between that manual and posted Visitation Rules, the "Detainee Handbook" and the "Parent Handbook."
3. Provide written documentation that all FCJDC staff members have been trained on the new policy and procedure.
4. Provide notification of visitation rules consistent with this provision to parents and to juveniles at admission.
5. Provide written examples of the implementation of the new policy and procedure and the use of the relevant forms or other means of documentation.

14.4 Within 30 days of the effective date of this agreement, youth shall be afforded an opportunity to call parents, primary caretakers or legal guardians free of

charge three times per week. The hours youth may make calls shall encourage family contact.

Compliance Rating: **Partial Compliance**

Discussion:

Youth at the FCJDC are allowed to make phone calls free of charge three times each week at the booking desk during the evening shift that begins at 6:00 p.m. Staff and youth interviews confirmed that practice and I observed youth making phone calls. In addition, youth at the FCJDC may earn points through the new Behavior Management Program and use those points to purchase longer or additional phone calls. Copies of phone logs were provided for April, May and June 2013 that documented phone calls at least three times each week. Some of those logs were still incomplete, omitting dates and times of calls but it appears that most, if not all, residents received phone calls at least three times per week. There are also phones in each dayroom in Units A, B and C that were formerly used for making collect phone calls but during my previous visits those phones in Units A and C were reported to be nonfunctional and on my recent visit I was informed that those phones are no longer being used.

The “Detainee Handbook” and the “Parent Handbook” both state: “Juveniles are given phone calls three times a week: Monday, Wednesday and Friday.”

Officers interviewed consistently reported that youth are allowed to make phone calls during the evening shift, three days each week. Time of phones calls documented on Phone Logs varied and that information was often left off the logs but the calls generally appear to occur during the evening. Staff members again gave differing responses regarding how permission is granted for additional calls. Phone calls are made at the booking desk, the youth dials the number and the conversation is held in the staff member’s presence. Staff members interviewed again offered conflicting responses regarding whether the identity of the individual being called is verified. Some staff members reported that they verify that person’s identity and some stated that they do not. Because Phone Logs are often incomplete or incorrectly filled-out, it is impossible to determine who was called in many cases.

Youth interviewed generally verified that they are now allowed phone calls in the evenings on Mondays, Wednesdays and Fridays. Youth again reported that they look forward to phone calls and that it is a motivator and that they often use the points earned through positive behavior to purchase additional phone calls. It is important for youth to maintain contact with their parents, primary caretakers or legal guardians in order to encourage successful reintegration to their home and community. The FCJDC is to be commended for offering additional or longer phone calls as a reward for positive behavior.

The new Detainee Orientation Checklist includes an explanation of the FCJDC telephone usage procedures.

The FCJDC "Telephone Usage" policy and procedure has been revised and finalized. That policy requires the staff member to "dial the phone number, ask for person being called, and place call in call log." Interviews with youth and staff indicate that compliance with that requirement is not consistent. Further, the new policy requires that "regularly scheduled telephone calls are ten (10) minutes in duration." However, interviews with both youth and staff and Telephone Logs indicate that phone calls are often only being allowed for five minutes unless the youth "purchases" additional time. The FCJDC staff has not yet been trained on the new Telephone Usage policy and procedure.

Recommendations for achieving substantial compliance:

1. Fully implement the new Telephone Usage policy and procedure.
2. Provide written documentation of staff training on the policy and procedure.
3. Provide sample documentation of phone calls made by youth at the FCJDC including, at least, name of youth, name and relationship of person called, and date, time and duration of phone call.

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

Compliance Rating: **Non-Compliance**

Discussion:

The new FCJDC Telephone Usage policy and procedure, addresses the requirements of this provision. However, as discussed in 14.4 above, the FCJDC staff has not yet been trained on that new policy and procedure. Most staff members interviewed were still not aware of an established procedure for contacting attorneys, social workers or counselors. When asked how a youth could call his or her attorney, social worker or Court counselor, staff responses included such things as: "I guess they can call pretty much any time," "They are notified at booking," "I don't know," "We use the chain of command," "They tell staff and the staff tells the counselor to come see them," "They ask and they are allowed" and, "Kids can't call; administration has to call." Most youth interviewed stated that they did not know how to contact their attorneys, social workers or counselors. The new Detainee Orientation Checklist includes the discussion of telephone usage at the FCJDC. However, it is clear that that discussion is omitting an explanation of the youth's right to call his or her attorney, social worker or Court counselor or the process for doing so. The "Detainee Handbook" (dated September 18, 2012) includes a section entitled "Rights of Detainees in Custody" that quotes Section 43-21-311 of the Mississippi Code of 1972. That includes information about the right of the juvenile to be visited by "counsel and authorized

personnel from the youth court." It also states that "when a child is taken into custody, the child may immediately telephone his parent, guardian or custodian; his counsel; and personnel of the youth court." However, during my observation of youth being booked into FCJDC, the "Detainee Handbook" was still just briefly provided to the youth to look at, without enough time to read it. There is still no verbal explanation of the content of the "Handbook" provided and a youth is still not allowed to have his own copy to refer to. Even, if that were the case, that document does not explain how a youth is to contact his attorney, social worker or Youth Court counselor after he is admitted. This monitor received daily logs of phone calls made in April, May and June 2013. Most of those logs were not completed correctly or completely. Those logs frequently omitted the identity of the person being called. However, no log documented any phone calls to attorneys, social workers or Youth Court counselors.

Recommendations for achieving substantial compliance:

1. Fully implement the new FCJDC Telephone Usage policy and procedure, including those elements consistent with the requirements of this procedure.
2. Provide written documentation of staff training on the policy and procedure.
3. Provide sample documentation of phone calls made to or received from attorneys, social workers or Youth Court workers.
4. Ensure that the youth orientation procedure includes an explanation of the process for a youth to use in calling his or her attorney, social worker or counselor.

14.6 Youth may make and receive prescheduled, confidential phone calls with their attorneys. At the discretion of the Director or assignee, in emergency situations, youth may receive phone calls from parents, primary caretakers, or legal guardians.

Compliance Rating: **Non-Compliance**

Discussion:

As discussed in 14.5 above, youth are not adequately informed of their right to make or receive phone calls to or from their attorneys. In addition, staff members interviewed were clearly still unaware of that option. Phone Logs for April, May and June 2013 do not document any phone calls either to or from attorneys. Although regularly scheduled *outgoing* phone calls are well documented, there is no documentation of phone calls *received* from parents, primary caretakers or legal guardians, even in emergency situations.

The new Phone Usage policy and procedure addresses the requirements of this provision. That policy states: "Youth are allowed telephone access to contact legal representatives, Youth Court Counselor or Department of Human Services caseworker at any appropriate time, working hours 8:00 a.m. to 5:00 p.m. These calls shall also be

logged." At the time of my most recent site visit, that new policy was not being adhered to and staff had not been trained on that policy.

Recommendations for achieving substantial compliance:

1. Fully implement a written policy and procedure that is consistent with this provision.
2. Provide written documentation of staff training on the policy and procedure.
3. Provide sample documentation of phone calls made and received by youth, to or from attorneys and others in emergencies (with required authorization), including, at least, name of youth; name and relationship of person called or calling; and date, time and duration of phone call.
4. Ensure that the FCJDC detainee orientation process includes an explanation of the process for youth to use to comply with this provision.

XV. MISCELLANEOUS PROVISIONS

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

Compliance Rating: **Partial Compliance**

Discussion:

The FCJDC draft policy and procedure, "Male/Female Interaction," states: "Both male and female youth shall receive the same amount of time of recreational activities, school, and other offered services." That policy and procedure has not yet been finalized.

The 2012-2013 school schedule was revised at the FCJDC to adhere with Mississippi state statute requiring five hours of academics each day for all youth. In order to meet that requirement for all detained youth with just one teacher at the FCJDC, both male and female youth now attend school together. At the time of previous site visits, female detainees reported not attending school on some days. The FCJDC has had almost no female detainees during the past several months as they have had one unit closed for renovation and were often using both the other two units for male residents. There were no female youth at the facility during my recent site visit or the previous visit in March 2013.

The continuous closure of one of the three units for remodeling for the last several months has resulted in occasionally housing female detainees in D Unit cells in order to use the two available units for male detainees. D Unit consists of only six cells along the hallway outside the control room. There is no day room and it is not possible to provide any interaction with staff or other youth or any programming for youth in D Unit. Using

those D Unit cells for females has deprived them of equivalent opportunities to those provided to male detainees. Daily Population Reports indicate that there have been very few females housed at the facility during the period of remodeling. However, reports indicate that a female detainee was require to be housed in a D Unit cell from the time of her admission on June 26, 2013 until A Unit renovation was completed on June 28, 2013. Shift Logs indicate that she remained in her room during most of her time in D Unit, therefore depriving her of equal access to programming, including school and recreation, and severely limiting her interaction with staff or peers. The FCJDC administration reported that they had persuaded the court to postpone her commitment, anticipating the completion of the A Unit renovation, but the renovation work was delayed and, by June 26 they could no longer do so. That situation, though rare, is unacceptable and should not have occurred.

During past site visits, there were some planned activities provided by outside volunteers. Both male and female youth participated in those activities equally.

The therapist from Pine Belt Mental Healthcare Resources again reported that she sees all juveniles who are willing to meet with her and the clinician again reported that she also sees all youth regardless of gender. The FCJDC nurse manager reports meeting with both male and female youth as necessary. My observations and review of documentation confirm that.

There is still very little structured programming at the FCJDC and youth in all units, were again observed playing cards sitting idly each time I have been on-site. The five daily schedules do not allow a sufficient amount of time for all youth to receive the required one-hour of large muscle exercise daily. Female detainees in the past have reported that they have not gone outside daily. And staff members have acknowledged at prior visits that they allow female detainees to go outside and sit in the sun, rather than participate in the same level of exercise as male detainees. Because the FCJDC usually has a much greater proportion of male detainees, there is concern that females' needs and rights may be disregarded to serve the larger group of males. Now that renovations are complete on all three units at the FCJDC and females will presumably again be regularly housed at the facility, it will be important to ensure that female detainees, although much fewer in number, received equivalent quantity and quality of recreational and structured programming.

Recommendations for achieving substantial compliance:

1. Finalize and implement the policy and procedure, Male/Female Interaction, to ensure compliance with this provision.
2. Provide written documentation that all FCJDC staff members have been trained on that policy and procedure.
3. Develop written job descriptions for all staff at the FCJDC describing staff responsibilities to ensure compliance with this provision.

4. Provide examples of documentation of daily schedules, including actual activities that did occur, to demonstrate compliance with this provision.

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

Compliance Rating: **Non-compliance**

Discussion:

In each of my previous quarterly Monitoring Reports I described observing youth outside with staff and approximately half of those youth were sitting idly and not participating in the recreational activity (basketball). During my recent visit I again observed the same thing occurring. Interviews with both youth and staff members again confirmed that is typical and that youth are not required to participate in large muscle activity. Basketball is still almost the only activity offered, regardless of individuals' interests and skills. As discussed in 4.1 and 5.3 above, there is not a sufficient amount of time in the daily schedule for all youth to receive the one required hour of large muscle exercise daily. Further, staff and youth have reported that female residents at the FCJDC may not receive recreation if "there are not that many of them." And, staff reported that the girls "usually just want to go out and sit in the sun." Staff reported that youth in D Unit are allowed to participate with the other youth during recreation and I did observe youth housed in D Unit joining their peers for recreation. It has been noted that the recreation area at the FCJDC is very small and recreational options are limited. There is no area indoors where physical activity can easily occur. When weather is inclement, FCJDC youth may get no large muscle exercise. Staff at the FCJDC needs to be creative in ensuring that, when youth cannot go outside, they still receive at least one hour of large muscle exercise daily. Youth have received six weeks of half-day summer school and are now out of school until fall, which would allow more time for recreation. However, my observations and interviews indicated that the regular school year schedule is still usually followed. It was suggested that, now that school is out until fall, that youth have recreation during the cooler, morning hours and the, hopefully, again in the afternoon.

Until the FCJDC schedule incorporates a adequate amount of time for all youth to get daily large muscle exercise for at least one hour, the schedules are consistently adhered to and staff members are held accountable for ensuring that juveniles do receive at least one hour of large muscle exercise daily, compliance with this provision cannot be assured. Further, until there is a clear and written expectation that staff members ensure that all youth receive that exercise, regardless of the weather conditions and the preferences of individual youth, this provision cannot be fully complied with.

This monitor has rewritten the FCJDC draft policy and procedure, "Programming and Activities," to ensure compliance with this provision, as well as with provision 4.1, but that policy has not yet been finalized. That said, interviews with staff clearly confirm that employees of the FCJDC are well aware that youth are required to receive one hour of large muscle daily and they are not meeting that expectation.

Recommendations for achieving substantial compliance:

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

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

Compliance Rating: **Non-Compliance**

Discussion:

This provision specifically requires policies as well as practices that establish a clear expectation that staff shall not use profanity in the presence of youth nor shall staff insult youth or call them names. The FCJDC policy and procedure, "Code of Ethics," has been revised to address the requirements of this provision. That policy stresses the important of professional communication including "not using profanity in the presence of youth, insulting youth or calling them names." That policy and procedure has been finalized but the FCJDC staff has not yet been trained on those expectations. The FCJDC draft policy, "Disciplinary Policy" lists behaviors that could result in disciplinary action. That policy specifically prohibits "Using profanity in the presence of youth, insulting youth or calling them names." However, that policy has not yet been finalized. Most youth interviewed this time again stated that staff members do not swear at or in front of residents.

Recommendations for achieving substantial compliance:

1. Implement the Code of Ethics policy and procedure.
2. Provide written documentation that all FCJDC staff members have been trained on the Code of Ethics policy and procedure.
3. Finalize and implement the Disciplinary policy and procedure.

4. Provide written documentation that all FCJDC staff members have been trained on the Disciplinary policy and procedure.

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

Compliance Rating: **Partial Compliance**

Discussion:

A comprehensive grievance policy and procedure was finalized for youth at the FCJDC over two months ago. However, during this monitoring period, only two grievances were submitted. No grievances have been submitted since the implementation of the new grievance procedure. Interviews with both employees and youth revealed that the new procedure is not understood and not one employee could explain the new written policy.

There is a new Grievance form for youth to use in submitted grievances. That form was designed to be understood by youth at low reading levels or to be explained by staff. But, since that form has not yet been used, it is not yet known if that form will meet the needs of the youth and the requirements of this provision.

Youth interviewed about the FCJDC grievance procedure generally indicated that they did not know what the procedure was or, like staff interviewed, they described the procedure incorrectly. A number of youth did not know what a “grievance” is and none could describe what is grievable at the FCJDC.

During the last monitoring period I there were 17 grievances for me to review. The fact that there have been just two in the recent three-month period, and none since the new policy and procedure was adopted, causes considerable concern. Clearly neither staff members nor youth understand the new procedure, which may be why it is not being used or encouraged. Although the grievance procedure is included in the Detainee Orientation Checklist, it appears that the explanation provided at the time of admission is not sufficient. The September 18, 2012 FCJDC “Detainee Handbook” addresses Detainee Grievance Policy & Detainee Concerns in general terms. However, detainees who I have observed being admitted have not been offered enough time to read the “Handbook” and youth are still not provided with a copy to keep and refer to. And, it is obvious to me that the FCJDC staff has not received adequate training on the new policy and procedure.

The FCJDC does have one grievance box located in the hallway outside the units. Most youth and staff indicated that a grieving youth would be escorted to the box and allowed to place his grievance form in the box himself. However, two staff reported that they might put the form in the box. Most youth again indicated that they would likely not

file a grievance because "it would not do any good." Based on interviews, although there is a new written grievance policy and procedure, I do believe that there is an established practice for a youth to follow if he has a grievance.

I have repeatedly recommended that the FCJDC administration maintain a file and develop a log of all detainee grievances in order to track complaints, to ensure that juveniles' rights are honored, to monitored the rate of decisions in favor of the grieving youth, and to make and identified changes to policy or practices as a result of that aggregated information. That has not yet occurred.

The new FCJDC grievance policy and procedure introduces some alterations. Although the FCJDC staff has reportedly been trained on that policy, that training was unsuccessful in ensuring that staff actually understand and, therefore, correctly implement the revised expectations.

Recommendations for achieving substantial compliance:

1. Fully implement the new FCJDC grievance policy and procedure.
2. Provide written documentation that all staff members at the FCJDC are trained on the new grievance policy and procedure and the new detainee orientation procedure and related forms.
3. Develop a grievance log to track youth grievances by such factors as date, time and type of grievance.
4. Ensure that the youth orientation procedure fully informs newly admitted youth of how to make use of the facility's grievance policy and procedure.
5. Provide sample copies of completed youth grievances.
6. Provide copies of completed grievance logs.

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

Compliance Rating: **Non-Compliance**

Discussion:

This monitor has worked with the FCJDC Director and the SPLC to develop a written policy consistent with this provision. However, at the time of my site visit, that policy had not yet been implemented nor had the staff been trained.

Staff members interviewed regarding this provision were again not aware of an established procedure for contacting attorneys or counselors. None of the youth interviewed stated that they know how to contact their attorneys or counselors. When

asked about that issue, staff replies included such responses as: "They are notified at booking," (That specific topic is not included on the Orientation Checklist.) "I think they can Monday through Friday during business hours. I don't know who they talk to," "They can just use the phone pretty much any time," "I don't know," "I don't know; I guess they go through the chain of command," "They tell a staff who tells the counselor to come see them. Sometimes they call and sometimes they write," "They are told what to do at booking," and, "Kids can't call. We have to notify administration." The "Detainee Handbook" (dated September 18, 2012) includes a section entitled "Rights of Detainees in Custody" that quotes Section 43-21-311 of the Mississippi Code of 1972. That includes information about the right of the juvenile to be visited by "counsel and authorized personnel from the youth court." It also states that "when a child is taken into custody, the child may immediately telephone his parent, guardian or custodian; his counsel; and personnel of the youth court." Nothing is stated about contacting an attorney and/or Youth Court counselor after admission. And, the "Detainee Handbook" was still just briefly provided to the youth to look at, without enough time to read it. There is still no verbal explanation of the content of the "Handbook" provided and a youth is still not allowed to have his own copy to refer to.

<u>Recommendations for achieving substantial compliance:</u>

1. Implement the new written policy and procedure that has been developed to address this provision.
2. Provide written documentation that all FCJDC staff members have been trained on the new policy and procedure.
3. Ensure that the written youth orientation procedure informs newly admitted youth at the FCJDC of the procedure for them to follow to request to see their attorney and/or Youth Court counselor.
4. Provide sample copies of facility orientation of youth documenting that process.
5. Provide examples of documentation (i.e. completed forms) of youth at the FCJDC requesting to see their attorney and/or Youth Court Counselor.

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

<u>Compliance Rating:</u> **Non-Compliance**

Discussion:

At the request of the Court and the parties to the Agreed Order, this monitor developed a training plan/program for the FCJDC and the SPLC in April 2013. That plan was based on a number of sources, including the American Correctional Association (ACA) standards (See, *Standards for Juvenile Detention Facilities, 3rd Edition*, May 1991), the Council of Juvenile Correctional Administrators, *Performance-based Standards (PbS),* the Federal Prison Rape Elimination Act and related implementation tools, and sample training documents from other jurisdictions in New York, Georgia, Pennsylvania, Texas, Utah and Idaho. That plan was presented to the FCJDC Director and the SPLC attorney. The SPLC attorney requested some very minor changes, which were incorporated. The FCJDC Director reported that she supported the plan. However, to date, the training plan has not received final approval from the Forrest County Sheriff's Department and, therefore, has not been implemented. Approval of the plan must assume that the necessary resources will be made available for implementation. That commitment from Forrest County is essential before this provision can be found in compliance. The staff at the FCJDC has historically received almost no training appropriate to a juvenile facility. The current staff had the opportunity to receive training on the National Juvenile Detention Association's *Detention Care Givers Basic Training Curriculum.* However, that training was a one-time event. A "comprehensive juvenile justice pre-service and in-service training program" is an ongoing plan that ensures that current and future employees are adequately trained and prepared to perform their jobs.

The FCJDC has begun documenting training for staff. However, that documentation is still inconsistent and haphazard and does not comply wit the draft training plan. The recommended filing system for documenting training is still in need of revision and the database is not yet developed.

Recommendations for achieving substantial compliance:

1. Collaborate with the Plaintiffs and the Monitor to finalize 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.
2. Provide written documentation of staff members' training as required by this provision.

SUMMARY AND CONCLUSION:

Although the Forrest County Juvenile Detention Center administration has begun to show some momentum towards achieving compliance with the Agreed Order, that progress has been slow and the FCJDC is significantly behind what would be considered a reasonable schedule at this point. There have been a number of events and breakdowns that have resulted in multiple delays. The parties to the Agreed Order could not agree on a monitor so I was not appointed until the agreement was six months old. At that point, virtually no effort had been made by the FCJDC administration to meet the expectations of the agreement. Shortly after my first site visit in March 2012, the Director and Assistant Director were summarily replaced. Unfortunately, their replacements lacked expertise or experience in the juvenile justice field or in administration and they both admitted that they had not chosen that assignment. They were subsequently replaced, shortly after my second site visit, with a Director who lacked juvenile justice or management experience but who at least expressed an interest in serving that youthful population and in achieving compliance with the Agreed Order. An Assistant Director was also selected approximately one month later but she also lacked significant juvenile justice or management experience.

The administrators received very little assistance with such general administrative issues as hiring, supervising and disciplining employees; planning for and purchasing of supplies; and coordinating and collaborating with stakeholder agencies in the community. As I have stated in each of my Quarterly Monitoring Reports, the FCJDC administrators need clear guidance on a regular and systemic basis. They need training on basic personnel issues and regulations, including written human resource policies and procedures. They need to know what budgetary limitations are and what expenditures are allowed in their efforts to comply with the Agreed Order. Not only do the FCJDC line staff members not have written job descriptions, the administrators also have not been provided with definitive job expectations, both regarding day-to-day operation of a juvenile detention facility and concerning compliance with the Agreed Order. It does not appear to have been made clear what decision-making authority has been delegated to them and what decisions require a higher level of approval.

There were clear philosophical and stylistic differences between the Director and Assistant Director, hired a year ago, which created roadblocks for the FCJDC in accomplishing necessary objectives. Major tasks delineated in my March 2012 Monitoring Plan were delegated to the Assistant Director, including writing policies and procedures, developing the training plan and drafting job descriptions, all of which she failed to complete, after eight months of effort. That failure occurred in spite of my regular and recurrent guidance and technical assistance around best practices. She typically ignored my feedback and repeatedly offered only slightly revised versions of those documents with few, if any, on the needed changes to make them appropriate and useful. That Assistant Director left her employment at the FCJDC in May and has been replaced by an Assistant Director who the Director was able to select herself. The current administrative team is still very inexperienced but they seem to compliment each other and are mutually

supportive. They both express the desire to work cooperatively to achieve compliance with the Agreed Order and they both convey a desire to advocate for the youth detained at the FCJDC.

As I have discussed in previous reports, much of the delay during the first six months of my monitoring effort (second six months of the two-year monitoring period) was in part due to changes in administrative and line staff and in communication breakdown that occurred between the various administrative teams and between administrator and me. In addition to the four Director/Assistant Director teams, there has been significant line staff turnover. That has resulted in many staff members being untrained and having little knowledge of the Agreed Order and its requirements or of expectations of officers or direct care workers at the FCJDC.

There are a number of reasons for the staffing changes that have occurred at the FCJDC and staffing changes will always occur to some extent. However, that situation at the FCJDC has contributed to the facility's struggles in adhering to most provisions of the Agreed Order. It is not clear how hiring decisions are made at the FCJDC. There is no formal job announcement of vacant positions that would offer a general description of the job and expectations of prospective hires. Selection may be made by the Director or by an official with the Forrest County Sheriff's Department. Some employees that I interviewed acknowledged that they had no idea that they would be working at the FCJDC and assumed they were applying to work at the jail. None of the employees that I interviewed reported that they knew what to expect prior to being hired. As has been discussed in prior monitoring reports, compliance with the Agreed Order will not be possible without the involvement of and commitment by the entire staff at the FCJDC, not just the administrators. However, staff members interviewed during my recent site visit again reported having limited information about the Agreed Order. During this most recent visit, the level of awareness of the Agreed Order seems somewhat heightened. Unfortunately, that awareness seems to be largely the result of the impending October deadline for the two-year period of the order, not necessary a function of an increased focus on revising practices in order to comply with the various provisions.

Subsequent to the Court's request and the parties' agreement at the time of my March 2013 site visit, I assumed responsibility for writing policies and procedures for the FCJDC and for drafting the FCJDC training plan. That draft training plan was completed in April and presented to the two parties for them to "collaborate," as required by the Agreed Order. The SPLC offered some minor modifications to that draft, which the FCJDC Director agreed to. However, the Forrest County Sheriff's Department has not yet approved the draft plan. That approval is essential to ensure implementation as the county will need to commit resources to that effort. In the meantime, the FCJDC has selected a training committee, as required by the draft plan, but, other than the weeklong training event in April on the *Detention Care Givers Basic Training* curriculum, no effort has been made to plan or provide appropriate, juvenile justice-focused staff training.

In addition to the training plan, I have written draft policies and procedures for the FCJDC. The process for finalizing those policies and procedures has been tedious and time-consuming, as it should be. Weekly phone calls have occurred with the Director and the SPLC attorney to review and, as necessary, revise draft procedures. It is essential to enlist active input from the FCJDC in that process to ensure support and buy-in from the facility and to confirm that new procedures are feasible and realistic. The SPLC has offered valuable input in the discussions, especially in reference to past abuses that we want to avoid. Numerous new policies and procedures have been finalized and others are pending. Staff training has occurred on most of the new policies but, based on insufficient levels of compliance and ongoing lack of understanding by staff, additional training is still needed. A number of new policies and procedures have given rise to significant changes in practice that are consistent with standard juvenile detention practice and that are consistent with the Agreed Order. Modifying long-standing practices does not occur easily and without persistent oversight, monitoring, reminders and encouragement. The FCJDC administration will need to ensure that that occurs. Doing so will also entail their own in-depth understanding of the changes and the rationale for making them. (See Appendix A, Policies and Procedures table.)

New job descriptions for FCJDC staff members, also in accordance with previous recommendations and the April 2012 Monitoring Plan submitted to the Court, are being revised in collaboration with the new policies and procedures. There are now job descriptions for all positions at the FCJDC in the draft policy and procedure manual but those still require revision and finalization. As has been discussed elsewhere in this and prior monitoring reports, those job descriptions still lack information relevant to the provisions in the Agreed Order and they have not been implemented. New job descriptions will still need to be provided to the FCJDC staff.

My monitoring has encompassed my review of documentation, including video recordings; my observations; and, my interviews with staff, youth and other stakeholders. The FCJDC administrators have expressed support for my efforts and recognition that their employees continue to be in non-compliance with the Agreed Order as well as policies, procedures and other expectations of the FCJDC. They have become more open and welcoming of suggestions and guidance and that has resulted in some, albeit limited, progress during the current monitoring period.

I have continued to emphasize the importance of generating and maintaining comprehensive documentation in order to help ensure that practices are institutionalized, that staff are held accountable for following expectations and that youth are served appropriately and safely. I review documentation in order to determine whether a practice is typical, routine and part of expectations for staff, not simply an event concurrent with my site visit. New policies and procedures require documentation to ensure accountability and the FCJDC administration will need to monitor that documentation, now and in the future, to corroborate what is reported to them. The quality of documentation

continues to suffer and it appears that the FCJDC staff needs additional training on report-writing and monitoring of the thoroughness of their report completion.

Both the FCJDC Director and the new Assistant Director have some experience working with a juvenile population. However, their juvenile detention facility and general management experience is limited. I have provided and will continue to offer suggestions to the Sheriff's Department regarding resources for them to learn about accepted juvenile justice practice from peer groups throughout the country. Juvenile justice practice is very different from adult corrections and, although the Forrest County Sheriff's Department could offer useful resources in operating the FCJDC, such as human resources management advice and purchasing expertise, they have not done so. And, juvenile detention guidance will need to be sought elsewhere. It is has been my hope that the FCJDC, the Forrest County Sheriff and I would be able to work together to succeed in meeting the requirements of the Agreed Order within the Court's timeframe. However, other than the improved communication resulting from the weekly phone conversations since March, little else has changed to demonstrate commitment by the Sheriff. The FCJDC Director meets with her peers from other Mississippi counties to take advantage of their experience and advice. She reports that their guidance has been helpful to her as she gains knowledge about operating a juvenile detention center. I have provided training recommendations and resources to the Forrest County Sheriff and the FCJDC administration. Those suggestions have included training for all juvenile detention staff and specifically for juvenile detention administrators. Some training is available on-line or electronically at little or no cost. Some training does require monetary investment. However, the historic dearth of training appropriate for staff and administrators at the FCJDC makes that investment critical to ensure the facility is operated in accordance with basic accepted standards. Forrest County is to be commended for recognizing the need for appropriate, juvenile justice training for the staff of the FCJDC and for investing in training with an expert trainer on a nationally recognized curriculum in April. However, that training *event* does not meet the need for a training *program*.

Staff turnover at the FCJDC continues to be a challenge. As stated, staffing changes will always occur and are expected. And, it may be that some FCJDC employees have opted to leave rather than comply with the changes that have been implemented at the facility. If that is the case, those resignations may allow the FCJDC to hire employees who share the commitment to improvement necessary to serve the young people detained. In order to do so, it is important that the applicants are informed of general job expectations and that the FCJDC administration make hiring decisions systematically, based on a thorough review process. In addition to the new job descriptions that are being developed, that process will require such basic components a written job announcement and a fair screening process. The FCJDC administrators have expressed a desire to recruit and hire in accordance with standard human resource and legal practices but they need training on those requirements procedures. And once suitable staff members are selected, they must be trained extensively. Until there is a training program in place at the FCJDC, that cannot occur.

In addition changes to daily practices with youth at the FCJDC, there has been a need for a culture change at the facility and that also takes time and effort. Training provided in April and the Director's compassion and concern for the youth at the facility have helped to move towards a philosophy that is more empathic and positive. I can only hope that will continue. That mindset on the part of the FCJDC leadership must be implanted throughout the staff and be supported by the Sheriff's Department. That effort is still in ongoing.

I have discussed with the FCJDC Director the importance of using the recommendations in my Quarterly Monitoring Reports to guide efforts to move forward. She has indicated that she has not typically received those reports; I have provided copies to her. I again emphasize that my reports, including the narrative information and the specific recommendations that are included, be used as tools for achieving compliance with the Agreed Order and establishing acceptable juvenile detention practices. The ratings tables in those reports are included as a cursory summary but they represent a great deal of detail that should be attended to.

Although progress towards compliance with the Agreed Order has been exceedingly slow, there seems to have been some headway over the last three months. The Director has been open to suggestions, has been receptive to recommendations and has expressed her commitment to making the enduring changes necessary to achieve successful compliance with the Agreed Order and to meet the needs of youth. I have tentatively scheduled my next site visit but the time elapses quickly and, at the current rate of progress, I cannot anticipate being even somewhat near to full compliance by then. I continue to be available to offer technical assistance to the FCJDC. I am encouraged when I see progress and I share the administration's frustration at the slow pace.

I have closed each of my Monitoring Reports by stating: Youth in the juvenile justice system, at all levels and in all settings, can become productive, law-abiding citizens and, eventually, effective parents, if they receive help, guidance, compassion and commitment from the adults that they interact with in their lives. The Forrest County Juvenile Detention Center has the opportunity to offer that future to the young people it serves. However, I must add, that the FCJDC has not yet achieved that objective.

JULY 2013 QUARTERLY MONITORING REPORT

APPENDIX A

Forrest County Juvenile Detention Center

Policies and Procedures

Chapter	Policy	Status
A. Personnel	Code of Ethics	Finalized; pending typing on correct form, staff training and implementation
	Organizational Chart & Job Descriptions	Pending, under review
	Dress Code	Finalized; pending typing on correct form, staff training and implementation
	Evaluations	Pending additional information from Forrest County HR and additional review
	Release of Information	Finalized; pending typing on correct form, staff training and implementation
	Reporting to Duty	Finalized; pending typing on correct form, staff training and implementation
	Requesting Time Off	Pending review
	Shift Change	Pending review
	Staff Meetings	Pending review
	Staff-to-Youth Ratio	Pending review
	Training	Pending review
	Electronics Usage	Pending review
	Vehicle Operation	Pending review
	Disciplinary Policy	Pending review
	Personnel Files	Pending review
B. Juveniles	Admissions	Finalized; pending staff training
	Behavior Management/Incentives	Finalized; staff trained; being implemented
	Classification	Pending review
	Dress Code/Bedding/Hygiene	Finalized; pending staff training
	Celebratory Food/Gifts	Pending review
	Juvenile Legal Rights	Finalized; pending typing on correct form, staff training and implementation
	Grievances	Finalized; being implemented
	Mail	Finalized; pending training of staff and implementation
	Male/Female Interaction	Pending review
	Personal Property	Pending review
	Programs and Activities	Pending review
	Records	Pending review
	Rules of Behavior	Finalized; implemented
	Telephone Usage	Finalized; pending training of staff and implementation
	Television Usage	Pending review
	Transportation	Pending review

	Visitation	Finalized; pending training of staff and implementation
	Release of Juveniles	Pending review
C. Security & Control	Abuse and Neglect Reporting	Reviewed and finalized; pending typing on correct form, staff training and implementation
	Alleged Delinquent Offenses	Being reviewed, temporarily on hold for additional information
	Control Room	Pending review
	Security	Pending review
	Crisis Intervention	Pending review
	Escape/Attempted Escape	Pending review
	Hostages	Pending review
	Key Control	Pending review
	Firearms and Security Equipment	Pending review
	Limited Access Areas	Pending review
	Monitoring of Video and Audio Equipment	Pending review
	Riot and Disturbance Control	Pending review
	Sanitation	Pending review
	Searches	Review in process; pending finalization
	Walking Policy	Pending review
D. Emergency Procedures	Bomb Threat	Pending review
	Emergency Codes & Planning	Pending review
	Emergency Evacuation Drill	Pending review
	Hurricanes and Tornados	Pending review
	Power Failure	Pending review
	Train Derailment & Chemical Spill	Pending review
E. Food Services	Food Services Vendors	Pending review
	Meal Schedule	Pending review
	Religious Diets	Pending review
	Serving Meals	Pending review
	Snacks	Pending review
	Special Diets	Pending review
Medical & Mental Health	Sick Call	Finalized; pending staff training and implementation
	Medical Clearance	Finalized; pending typing on correct form, staff training and implementation
	Suicide Prevention	Finalized; being implemented
Other Policies and Procedures Still Needed **(list not inclusive)**	Access to Medical Care	
	Medical Confidentiality	
	Medication Administration	
	Physical Assessment and Examination	
	Mental Health Services	
	Special Needs Youth	
	Incident Report Writing	
	PREA	

	Internal and External Communication	
	Citizen Involvement and Volunteers	
	Inventory Control	
	Purchasing, Petty Cash, Budget Control	
	Personnel Manual	
	Drug-free Workplace	
	Juvenile Records	
	Information System	
	ADA Compliance	
	Control of Contraband	
	Tools and Equipment	
	Library Services	
	Alternative Sanctions to Secure Detention	
	Access to Drinking Water	

Updated: August 28, 2013