

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF SOUTH CAROLINA

CHARLESTON DIVISION

Protection and Advocacy for People with ) Civil Action No.  
Disabilities, Inc., )

Plaintiff, )

vs. )

James Alton Cannon, Jr., in his official )  
capacity as Charleston County Sheriff, )  
Mitch Lucas, in his official capacity as )  
Assistant Charleston County Sheriff, Willis )  
Beatty, in his official capacity as Chief )  
Deputy of Charleston County Sheriff's )  
Office, and Charleston County School )  
District, )

Defendants. )

**MOTION FOR PRELIMINARY**  
**INJUNCTION AND MEMORANDUM**  
**OF LAW**

---

Plaintiff Protection and Advocacy for People with Disabilities, Inc. (“P&A” or “Plaintiff”), pursuant to Rule 65 of the Federal Rules of Civil Procedure, hereby moves this Court to issue a Preliminary Injunction directing Defendants and their agents at the Charleston County Juvenile Detention Center (“CCJDC”) to cease and desist immediately from engaging in practices that violate the constitutional and statutory rights of Plaintiff’s members (the “Children”). As set out below, the requested injunctive relief is narrowly tailored to prevent further ongoing, irreparable harm to the juvenile pretrial detainees—many of whom suffer from various mental illnesses and other disabilities, making them particularly fragile—during the pendency of this action, in which P&A is likely to prevail. Equity, the public interest, and common decency require implementation of the requested injunction.

## INTRODUCTION

This lawsuit seeks to rectify once and for all the ongoing unconstitutional, cruel, inhumane, and illegal practices and conditions which are pervasive at the CCJDC, a facility that is used to house minors who have not been convicted of any crime and who remain constitutionally protected from being punished for an alleged crime. The conditions and practices to which these Children are being subjected are abominable, posing a very real threat to their physical and mental health. The Defendants have been notified repeatedly and from multiple sources of these conditions and practices and yet have done nothing meaningful to resolve the situation. Meanwhile, a revolving group of our most vulnerable citizens is continually traumatized by the very system which should protect and, where necessary, rehabilitate them. These practices must be stopped.<sup>1</sup>

## FACTS

The CCJDC is located at 4350 Headquarters Road in North Charleston, South Carolina and houses children aged 11 to 16 years old charged with criminal or status offenses during the pre-adjudicatory phase of their juvenile case. (Exhibit B, John Rhoads Aff. ¶ 13b).<sup>2</sup> Many of these Children have mental health diagnoses. (*Id.* at ¶ 31). Approximately half of the Children arrive from Charleston County, while the remainder of the Children are brought in by law enforcement primarily from surrounding Berkeley County, Dorchester County, and Colleton County. (*Id.* at ¶ 13e). Other counties may also request detention of their Children. (*Id.*). The CCJDC is operated by the Charleston County Sheriff's Office headed by Sheriff James Alton

---

<sup>1</sup> Pursuant to Local Civil Rule (D.S.C.) 7.02, the undersigned conferred with Defendants' counsel in a good faith attempt to resolve the matter contained in this motion, but no agreement has been reached.

<sup>2</sup> John Rhoads is an expert in prison operations who has interviewed many of the Children and submitted an Affidavit in support of this motion.

Cannon, Jr. with Chief Deputy Willis Beatty and Assistant Sheriff Mitch Lucas having direct supervisory authority over the operation of the facility.

### **The Facility**

Constructed in 1967, the CCJDC has never been remodeled or renovated and is likely far past its useful life. (*Id.* at ¶ 13a and 13h). The facility has a total rated capacity of 26 juveniles, but it routinely houses more than double that number. (*Id.*). The cells are small, approximately eighty square feet, and are designed for single occupancy, but often house as many as four Children at a time. (*Id.* at ¶ 54). The walls are concrete block. (*Id.* at ¶ 23). Children are forced to sleep on a thin mattress placed on a metal or concrete bed. (*Id.* at ¶ 23). None of the Children are provided separate pillows and adequate bedding, and while blankets are provided, they are sometimes removed as punishment. (*Id.* at ¶ 28). The building is kept very cold at all times, and removal of a blanket causes sleep deprivation. (*Id.* at ¶ 25 and 28). Each cell has a toilet and a sink. (*Id.* at ¶ 13k). There is no other furniture of any kind in the cells. (*Id.* at ¶ 13k).

Furthermore, the facility has not been properly maintained and is in deplorable condition that makes it unfit for housing anyone, least of all Children. (*Id.* at ¶ 16). It has repeatedly failed inspections undertaken by the South Carolina Department of Corrections in numerous respects. (*Id.* at ¶ 13). The roof of the CCJDC leaks, and water enters the cells and common areas when it rains. (*Id.*). Mop buckets are used to collect rainwater that pours from the ceiling during storms, sometimes requiring evacuation of the building. (*Id.*). There is visible mold near the air vents, on and around windows, and in sections of the ceiling that often leak. (*Id.* at ¶¶ 16 and 17). The building has a foul, moldy smell. (*Id.* at ¶ 16). Bug bites are common, whether from bed bugs, spiders, or mosquitoes. (*Id.* at ¶ 19). Cockroaches are a common sight, and Children report hearing and seeing rats and mice in the facility. (*Id.* at ¶ 18). Toilets in the facility routinely

overflow under normal use causing urine, feces, and contaminated water to flood the cells as well as the hallway and adjacent cells. (*Id.* at ¶ 22). When Children are forced to sleep on the floor as a result of overcrowding, which occurs frequently, they are separated from the filthy floors by only a thin pad. (*Id.* at ¶ 23). Moreover, the availability of hot water from the sinks and the shower facilities is inconsistent, often resulting in Children choosing between a cold shower and no shower at all. (*Id.* at ¶ 55).

### **Time Spent in Cells**

The Children receive no respite from the medieval conditions of these cells as they typically are confined to them for 22 or more hours a day, even when they are not under disciplinary lockdown. (*Id.* at ¶ 13t and 45). The Children leave their cells only for a short amount of time to shower, make phone calls, and, occasionally, have indoor recreation. (*Id.* at ¶ 26). The indoor recreation is extremely basic, including books, a television, and one ping pong table. (*Id.*) The Children typically have to eat in their cells. (*Id.* at ¶ 13p). Although, as noted below, educational services are administered outside of the cell in a common area, most Children indicate they did not regularly receive this sort of instruction, and at most they met with a teacher only a few days out of the week. (*Id.* at ¶¶ 13n and 72). Showers are timed and brief, not providing adequate opportunity for proper hygiene. (*Id.* at ¶ 55). The Children are not allowed to go outside at all. (*Id.* at ¶¶ 13n and 58). These conditions are the equivalent of solitary confinement or disciplinary lockdown typically reserved for hardened criminals. (*Id.* at ¶ 16).

Reports vary as to how frequently guards check on the Children, although some indicate the guards inspect the cells only on shift changes, and many Children report guards are frequently not responsive to calls for help. (*Id.* at ¶ 63). In short, the average day in the life of a

Child in custody at CCJDC is a dark, lonely, unsanitary, and inhumane day of solitary confinement.

### **Lockdowns**

For discipline above and beyond the punishment of everyday existence at the facility, Children are regularly placed on lockdown in their cells, in solitary confinement in the “wet cell” (or “cool down room”), or strapped down in a restraint chair. These methods of punishment are inhumane, and their use in the twenty-first century, particularly to punish Children who have mental health issues or disabilities, shocks the conscience. Lockdown means the kids cannot leave their cells at all—no visitation with family, no phone calls, no education sessions, no showers, no recreation time, no books to read. (*Id.* at ¶ 28). Instead of being confined to their cells for 22-23 hours a day, they must stay in their cells 24 hours a day until the lockdown is lifted. (*Id.*). Some children have reported that, during lockdowns, they may also lose their blanket, which is necessary to stay warm in the very cold environment of the facility. (*Id.*). Lockdowns can last 24, 48, or 72 hours, and the length can reportedly be increased at the whim of the guards. (*Id.*). Sometimes individual Children are locked down, and sometimes all of the Children are placed on lockdown at the same time.

Lockdowns have been ordered for offenses such as knocking on a cell door to get a guard’s attention, laughing, cursing, spitting, or talking out of turn. (*Id.*) Many Children report that when a toilet overflows in a cell—which is a common occurrence because of the antiquated plumbing in the building—the affected Children are blamed and placed on lockdown. (*Id.* at ¶ 22). No Child has expressed an understanding of any consistent or rational application of lockdowns for particular offenses, but all understood that a lockdown is imposed as a

punishment, not merely as a cool down measure used to de-escalate or to protect the Children from themselves or others. (*Id.* at ¶ 30).

### **The Wet Cell**

Yet another and even more crude method of punishment is confinement to the wet cell. (*Id.* at ¶ 43). The wet cell is a small, locked, windowless room, with concrete walls and floor, about the size of a janitor’s closet. (*Id.* at ¶ 45). It has no sink, toilet, bed, or other fixtures aside from a concrete bench built into the back wall and a drain on the floor. The wet cell is a dark place, with some Children indicating it is illuminated by a single overhead, dim light bulb, and others saying there is no light in the room at all. (*Id.*). Because the wet cell has no toilet, a child confined to the room may be forced to “wet” himself or herself or urinate in the floor drain if toilet access is not provided timely. (*Id.*).

The reasons for confinement in the wet cell vary, but Children report being put there for minor infractions and are kept there for hours and sometimes for days. (*Id.*)<sup>3</sup> One Child refused to return to his normal cell after recreation time, so he was put in the wet cell for 6 hours. (*Id.* at ¶ 45). Another Child reported being confined in the wet cell on multiple occasions for failure to comply with instructions. (*Id.* at ¶45). He reported being confined in the cell alone for 2 days and being forced to sleep on the wet floor on a thin mat. (*Id.*). Another indicated he was placed in the wet cell in the restraint chair after the “green team” (SWAT team) came to the facility, presumably as a result of fighting. (*Id.* at ¶ 45). Yet another boy was confined for periods of 2 days and 5 days. The 5-day confinement took place in January 2020. During that confinement, the boy reported he was not given a mattress for the first night and he had to sleep on the hard floor. He further reported that he was required to wear only his underwear, socks, and a tee shirt

---

<sup>3</sup> More detail regarding the horrific treatment of Children in the wet cell is contained in the Rhoads Affidavit at ¶ 46.

while he was in the wet cell. During his 2-day confinement, which was in 2018, he was not given a mattress and was forced to sleep on the floor throughout. At that time he was about 13 years old. He was so upset that he repeatedly kicked the door until he was removed from the room by authorities pointing a taser at his chest and placed in the restraint chair for 10 hours (see below). (*Id.* at ¶45). The longest reported occupancy in the wet cell, thus far, comes from one Child who was confined for 10 days. (*Id.*). Most Children report receiving bathroom breaks while in the wet cell, and one child indicated his hands and feet were shackled while he was escorted to the toilet. (*Id.*).

### **The Restraint Chair**

A restraint chair is also used as a disciplinary measure. The chair resembles an “electric chair” with straps to completely immobilize a Child. (*Id.* at ¶ 47). It has straps that secure the Child’s feet and legs, waist, torso, arms, neck, and head. (*Id.*). At times the chair is used in the common area in plain view, and at other times it is used in conjunction with isolation of Children in the wet room. (*Id.*). The chair is often used for minor infractions, and Children are left in the chair for many hours with at least one Child reporting being confined to the restraint chair in the wet cell for two full days. (*Id.* at ¶¶ 45, 47). The restrained Children are routinely held longer than necessary to abate any threat of self-harm or harm to others. (*Id.* at ¶ 48). While in the wet cell and/or the restraint chair, Children report that they were not regularly monitored or checked on by CCJDC personnel, were not evaluated by medical or mental health professionals in connection with their confinement, were not afforded notice or an ability to contest the confinement, and were denied basic necessities such as food, water, and bathroom breaks. (*Id.* at ¶ 47). No witness has described the restraint chair as being used merely as a temporary measure

to prevent self-harm, but rather it is understood by the Children at the facility as a device used for disciplinary reasons.

### **Education Services**

Many of the Children report receiving little or no educational services while at the CCJDC. While some Children have reported leaving their cells for 1-3 hours 2-4 times per week for educational services, these Children generally do not receive grade-level or subject matter specific instruction, their educational services are not tailored to any individual Child's previous coursework, and their educational services do not result in academic credit required for the Children to be promoted to the next grade or to graduate high school. (*Id.* at ¶¶ 72, 75). Some Children report that the classroom instruction included coloring in a coloring book or watching a movie. (*Id.* at ¶ 72). Computers are in the building but are not used for instruction. (*Id.* at ¶ 72). Moreover, many of the Children at CCJDC have been diagnosed with various mental health issues and learning disabilities, but they are not provided with instruction and programs consistent with their Individual Education Plan (IEP) from their base school and are otherwise denied a Free Appropriate Public Education (FAPE) as required under federal law. (*Id.* at ¶ 73).

### **The Food**

Horrible, often inedible food in small portions is a universal complaint from Children at CCJDC. Children report being served spoiled food. (*Id.* at ¶ 80). The food is always cold, as the facility has no operational kitchen, and the meals are transported from elsewhere without a warmer. (*Id.*). The food is typically served very late, and the Children are hungry most of the time, with some losing weight during their stay in the facility. (*Id.* at ¶ 80). Children from families who can afford it pay for canteen privileges and survive on vending machine diets of chips and soda. (*Id.*).

### **Female Housing**

Female Children report persistent shortages of sanitary napkins and other toiletries. (*Id.* at ¶ 13i). Some report being confined in cells with used sanitary napkins littering the floor. (*Id.*) Female Children report male guards “flirting” with them. (*Id.* at ¶ 77). Although some female guards work at the facility, it is common for men to check on the female Children. (*Id.*) The cells are arranged such that these female Children do not have privacy from male guards, even when using the toilet. (*Id.*)

### **Health Screening**

The Children are not adequately screened and are not always assessed by medical, dental, or mental health personnel upon admission to CCJDC. (*Id.* at ¶¶ 13q, 70a). At the time many, if not most, of these Children are admitted to CCJDC, they have various medical and mental health issues for which they are undergoing treatment, including prescription medication, to manage their symptoms. (*Id.* at ¶¶ 13q, 65, 66, 69). However, the Children report that they are often denied or do not otherwise receive their prescribed medication on time or at all. (*Id.* at ¶¶ 66, 69). In at least one instance the Defendants’ neglect of a child’s need for regular medication for severe asthma resulted in worsening of the child’s condition and the need for her to be transported to the hospital in an ambulance. (*Id.* at ¶ 67). Nurses are rarely available, and Children report that physician visits are virtually nonexistent. (*Id.* at ¶ 68). Once admitted to CCJDC, the treatment that these kids were previously undergoing seems to stop, resulting in potentially dangerous interruption of treatment and negative side effects from medication withdrawal. (Exhibit A, Louis Kraus Aff. at ¶ 43).<sup>4</sup> While many, if not most, of the Children at CCJDC have diagnosed or diagnosable mental health issues and disabilities, they often are not

---

<sup>4</sup> Dr. Kraus is a child psychiatrist who has extensive experience with the juvenile criminal justice system and its effects on the mental health of those who pass through the system.

offered any mental health treatment at the facility—in some cases even if the treatment is requested by the Child or even ordered by the Family Court. (*Id.* at ¶ 17). By way of example, one Child attempted suicide and was placed in the wet cell in a suicide gown where he was seen only every other day by a mental health professional. (*Id.* at ¶ 41). If a suicidal Child is placed in the conditions of the wet cell and then is only seen every other day by a mental health professional, then almost certainly other Children with mental health issues but who have not attempted suicide are not getting any meaningful mental health treatment—and that is what the Children and their families report. (*Id.* at ¶¶ 8, 12, 17).

### **Defendants’ Knowledge of Harms**

The Defendants have been notified by multiple sources that these conditions and practices do not meet either industry or constitutional minimum standards. Most notably, on August 15, 2018, Charleston County Public Defender Ashley Pennington emailed a list of concerns and complaints by the then Child-residents of CCJDC to Defendant Beatty. Those complaints included:

- (a) confinement to cells for twenty-two (22) hours a day;
- (b) overcrowding;
- (c) no outside recreation;
- (d) not receiving prescribed medications;
- (e) not having access to EpiPen for possible severe allergic reactions;
- (f) not having prescription glasses;
- (g) placement of resident with history of PTSD, anxiety, asthma, and sexual/physical abuse in the wet cell for several hours with ankles shackled and hands handcuffed behind back because resident’s toilet overflowed followed by 24-hour lockdown for a week;
- (h) delayed medical treatment;
- (i) placement of Child on 24-hour lockdown because Child was asleep when guard came to collect food tray;
- (j) frequent profanity by personnel;
- (k) plumbing issues resulting in sewage backflow in toilets and showers;
- (l) milky white water from sinks as only drinking water;

- (m) placement in wet cell for eight (8) hours for verbal argument with another resident;
- (n) placement of Child on 48-hour lockdown for having a pencil in cell;
- (o) ceiling leaks;
- (p) failure to follow IEP; and
- (q) withholding school as discipline.

See E-mails from Pennington to Beatty, attached as Exhibit C. These and other similar conditions and practices have been the subject of many follow-up inquiries by the Public Defender’s Office, with the most recent email exchange occurring in March of 2020. *See id.* Despite these notices and complaints, Defendants have not undertaken sufficient measures to cure the constitutional violations. Consequently, Children entering this facility continue to be traumatized at the hands of the Defendants, who are public servants funded by the taxpayers of Charleston County and charged with protecting the Children.

### **ARGUMENT**

For preliminary injunctive relief to be granted, the movant must establish that “he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of the equities tips in his favor, and that an injunction is in the public interest.” *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008); *Metro. Reg’l Info. Sys., Inc. v. Am. Home Realty Network, Inc.*, 722 F.3d 591, 595 (4th Cir. 2013). Prohibitory injunctions seek to preserve the status quo while the lawsuit is pending, whereas mandatory injunctions seek to compel, rather than prohibit actions. *Wellin v. Wellin*, No. 2:13-cv-1831-DCN, 2013 U.S. Dist. LEXIS 166139, at \*9 (D.S.C. Nov. 22, 2013). “[M]andatory injunctions ‘should be granted only in those circumstances where the exigencies of the situation demand such relief.’” *Steves & Sons, Inc. v. Jeld-Wen, Inc.*, No. 3:20-cv-98, 2020 U.S. Dist. LEXIS 64450, at \*28 (E.D. Va. Apr. 10, 2020). Here, the exigencies are stark and compelling.

## **I. P&A Is Likely to Succeed on the Merits.**

### **A. Constitutional Claims**

The constitutional challenges to conditions and practices at the CCJDC are evaluated under the Due Process Clause of the Fourteenth Amendment. *Robles v. Prince George's Cty., Maryland*, 302 F.3d 262, 269 (4th Cir. 2002). Further, pretrial detainees, who have not been convicted of any crimes, retain at least those constitutional rights afforded to convicted prisoners, and consequently, the Eighth Amendment's prohibition on cruel and unusual punishment applies with equal if not greater force to pretrial detainees. *Bell v. Wolfish*, 441 U.S. 520, 545 (1979). Although the tests applicable to these conditions under the Fourteenth Amendment, on one hand, and the Eighth Amendment on the other, are overlapping and differing in some respects, all of these practices and conditions are plainly unconstitutional under both standards, and therefore, P&A is very likely to prevail on the merits as to each.

First, conditions of confinement that are imposed as “punishment” in the constitutional sense are unconstitutional. “[P]retrial detainees (unlike convicted prisoners) cannot be punished at all, much less ‘maliciously and sadistically.’” *Kingsley v. Hendrickson*, 576 U.S. 389, 400 (2015); *see also Slade v. Hampton Roads Reg'l Jail*, 407 F.3d 243, 250 (4th Cir. 2005) (“[W]hile the convicted prisoner is entitled to protection only against punishment that is ‘cruel and unusual,’ the pretrial detainee, who has yet to be adjudicated guilty of any crime, may not be subjected to *any* form of ‘punishment.’”) (emphasis in original). In determining whether a pretrial detainee has been subjected to a “punishment,” the detainee first must show a disability or harm “was (1) imposed [upon the detainee] with an expressed intent to punish or (2) not reasonably related to a legitimate nonpunitive governmental objective, in which case an intent to

punish may be inferred.” *Id.* Irrespective of whether an expressed intent to punish exists, P&A will show that the conditions and practices at issue here are not reasonably related to a legitimate, nonpunitive purpose, and they also appear excessive in relation to any conceivable alternative purpose assigned. *Id.*; see also *Kingsley v. Hendrickson*, 576 U.S. 389, 398 (2015) (“[A]s *Bell* itself shows (and as our later precedent affirms), a pretrial detainee can prevail by providing only objective evidence that the challenged governmental action is not rationally related to a legitimate governmental objective or that it is excessive in relation to that purpose.”).

Second, as noted, conditions of confinement are also subject to review under the Eighth Amendment.

The Eighth Amendment, which prohibits infliction of “cruel and unusual punishments,” U.S. Const. amend. VIII, applies to claims by prisoners against corrections officials challenging conditions of confinement. See *Scinto v. Stansberry*, 841 F.3d 219, 225 (4th Cir. 2016) (“[T]he Eighth Amendment imposes a duty on prison officials [\*\*8] to ‘provide humane conditions of confinement . . . [and] ensure that inmates receive adequate food, clothing, shelter, and medical care.’” (quoting *Farmer v. Brennan*, 511 U.S. 825, 832, 114 S. Ct. 1970, 128 L. Ed. 2d 811 (1994))); *Williams v. Benjamin*, 77 F.3d 756, 761 (4th Cir. 1996). Whether an inmate’s conditions of confinement amount to “cruel and unusual punishment” must be measured against “the evolving standards of decency that mark the progress of a maturing society.” *Estelle v. Gamble*, 429 U.S. 97, 102, 97 S. Ct. 285, 50 L. Ed. 2d 251 (1976) (quoting *Trop v. Dulles*, 356 U.S. 86, 101, 78 S. Ct. 590, 2 L. Ed. 2d 630 (1958)).

*Porter v. Clarke*, 923 F.3d 348, 355 (4th Cir. 2019).

An Eighth Amendment claim has two elements: (1) objectively, the deprivation suffered or injury inflicted was “sufficiently serious,” and (2) subjectively, the prison officials acted with a “sufficiently culpable state of mind.” *Farmer v. Brennan*, 511 U.S. 825, 834 (1994); see also *Williams v. Benjamin*, 77 F.3d 756, 761 (4th Cir. 1996). “What must be established with regard to each component ‘varies according to the nature of the alleged constitutional violation.’” *Williams*, 77 F.3d at 761. Objectively, the court must assess:

whether society considers the risk that the prisoner complains of to be so grave that it violates contemporary standards of decency to expose *anyone* unwillingly to such a risk. In other words, the prisoner must show that the risk of which he complains is not one that today's society chooses to tolerate.

*Helling v. McKinney*, 509 U.S. 25, 36 (1993). To satisfy the subjective prong, the plaintiff must establish the defendant acted with “deliberate indifference.” To prove deliberate indifference, plaintiffs must show that ‘the official kn[ew] of and disregar[ed] an excessive risk to inmate health or safety.’” *Porter v. Clarke*, 923 F.3d 348, 361 (4th Cir. 2019). “Deliberate indifference is ‘more than mere negligence,’ but ‘less than acts or omissions [done] for the very purpose of causing harm or with knowledge that harm will result.’” *Id.*<sup>5</sup>

Whether courts apply the unconstitutional punishment analysis or the deliberate indifference test is often a fact specific inquiry. In any event, P&A is likely to prevail on the merits of each.

## **1. Routine Use of Solitary Confinement<sup>6</sup> or Lockdown**

### **a. Solitary Confinement: 14<sup>th</sup> Amendment Punishment**

The routine practice at CCJDC of keeping Children locked in their cells for 22 or more hours every day is unconstitutional under the Fourteenth Amendment because these conditions are not reasonably related to a legitimate nonpunitive governmental objective. Thus, an intent to

---

<sup>5</sup> Plaintiff maintains that it is sensible after *Kingsley v. Hendrickson*, 576 U.S. 389, 398 (2015), to conclude that a different, less stringent standard should be applied to the claims of pretrial detainees than the traditional deliberate indifference test, but for purposes of this motion and to demonstrate a likelihood of success on the merits, Plaintiff will apply the traditional test. See *Gattuso v. C.C.S. Med. Dep.*, 2020 U.S. Dist. LEXIS 17078, \*11 (D. Md. January 29, 2020).

<sup>6</sup> Solitary confinement is defined as “the state of being confined to one’s cell for approximately 22 hours per day or more, alone or with other prisoners, . . . [with] limit[ed] contact with others.” United States Department of Justice, Letter to the Honorable Tom Corbett, Re: Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation, May 31, 2013, at 5, [http://justice.gov/crt/about/spl/documents/cresson\\_findings\\_5-31-13.pdf](http://justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf); see also *Peoples v. Annucci*, 180 F. Supp. 3d 294, 298 (S.D.N.Y. 2016) (“Solitary confinement, generally speaking, is the practice of socially isolating a prisoner from the general inmate population and depriving him or her of most environmental stimuli.”); (Exhibit A, Kraus Aff. ¶ 25).

punish may be inferred. *Slade*, 407 F.3d at 250. As noted by Dr. Kraus in his affidavit, the “degree of deprivation of meaningful social contact in the everyday confinement of children to their cells for 22-24 hours per day and no opportunity to go outside, even where there are 2-4 children confined together” meets the definition of solitary confinement. (Kraus Aff. ¶ 26). Solitary confinement is “a deterrent and a punitive force.” *Novak v. Beto*, 453 F.2d 661, 670 (5th Cir. 1971). By definition, as soon as a Child is placed into a cell under the conditions prevailing at CCJDC, that Child is being punished in violation of the Fourteenth Amendment.

Further, there can be no nonpunitive purpose for keeping pretrial detainee Children in such conditions. “An action may be reasonably related to a legitimate governmental purpose if ‘an alternative purpose to which [the act] may rationally be connected is assignable for it’ and the action does not appear ‘excessive in relation to the alternative purpose assigned.’” *Robles v. Prince George’s County*, 302 F.3d 262, 269-70 (4th Cir. 2002) (internal citations omitted). Here, the daily confinement of Children to their cells for 22 or more hours per day could serve no benefit because it does not achieve legitimate needs of the operators of the facility. According to Mr. Rhoads in his affidavit:

[A]cademic research continues to show that placing incarcerated youths in isolation has negative public safety consequences, does not reduce violence and likely increases recidivism. Further, there is no research showing the benefits of using isolation to manage youth behavior. By contrast, facilities that have reduced or eliminated the use of solitary confinement have seen a reduction in violence and infractions.

(*Id.* at ¶ 32). Thus, the only conceivable reason for the daily practice of confining Children to their cells for 22 or more hours is for the convenience of the operators of the facility and/or to save money. Neither is a sufficient justification. *See Petrick v. Maynard*, 11 F.3d 991, 995 (10th Cir. 1993) (“[T]he cost of protecting a constitutional right cannot justify its total denial.”).

The practice of imposing lockdowns, which is described in detail above as well as in the interviews summarized in the Rhoads Affidavit, is also punishment in violation of the Fourteenth Amendment. Presumably Defendants will maintain that using lockdowns of 24, 48, and 72 hours is to serve the nonpunitive purpose of maintaining order and discipline at the facility. But it is now well established that use of solitary confinement such as lockdowns as a means of enforcing discipline in juveniles is not effective. (*Id.* at ¶¶ 32, 33). Even if use of lockdowns were effective, using it for more than a mere cool down period and without close supervision by mental health professionals renders the confinement excessive in relation to the nonpunitive purpose. (*Id.* at ¶ 43; Kraus Aff. ¶ 39). The risk of harm posed to the Children placed on lockdown—particularly those who have pre-existing mental illness or a history of trauma or abuse—far outweighs the benefit. (Kraus Aff. ¶ 46); *see J.H. v. Williamson Cty., Tennessee*, 951 F.3d 709, 718 (6th Cir. 2020) (holding that juvenile pretrial detainee was particularly vulnerable to effects of solitary confinement due to his age and documented mental health issues and that his solitary confinement for twenty-one days for verbal threats was excessive in relation to the disciplinary purpose of the confinement).

**b. Solitary Confinement: 8<sup>th</sup> Amendment Deliberate Indifference**

**i. Objective Prong: Serious Risk of Harm**

Both the everyday solitary confinement and the use of lockdowns are also unconstitutional under the Eighth Amendment deliberate indifference analysis set forth above. First, as to the objective prong of the Eighth Amendment test, use of solitary confinement on Children on a daily basis and through lockdowns poses a sufficiently serious risk because it violates contemporary standards of decency to expose *anyone* unwillingly to such a risk. Further, these forms of confinement pose significant health risks to the Children detained at the CCJDC.

(Kraus Aff. ¶ 46). Not only do mental health experts agree on the harms, but courts have recognized that “solitary confinement of juveniles in government custody for punitive or disciplinary reasons, especially for extended periods of time and especially for youth who may suffer from mental illness, violates the Eighth Amendment’s prohibitions against the inhuman treatment of detainees.” *Doe by & through Frazier v. Hommrich*, No. 3-16-0799, 2017 WL 1091864, at \*2 (M.D. Tenn. Mar. 22, 2017). Indeed, the Fourth Circuit has found that, even with respect to adult prisoners on death row, “conditions of confinement . . . under which Plaintiffs spent, for years, between 23 and 24 hours a day ‘alone, in a small . . . cell’ with ‘no access to congregate religious, educational, or social programming’—pose a ‘substantial risk’ of serious psychological and emotional harm.” *Porter*, 923 F.3d at 357. The effects on Children are even more severe and alarming. “[T]here is a broad consensus among the scientific and professional community that juveniles are psychologically more vulnerable than adults.” *V.W. by & through Williams v. Conway*, 236 F. Supp. 3d 554, 583 (N.D.N.Y. 2017) (citing *Graham v. Florida*, 560 U.S. 48, 68 (2010) (“[D]evelopments in psychology and brain science continue to show fundamental differences between juvenile and adult minds.”); *Roper v. Simmons*, 543 U.S. 551, 569 (2005) (recognizing the “comparative immaturity and irresponsibility of juveniles)). And the Supreme Court has continued to stress that these fundamental differences are consequential in the Eighth Amendment context. *See, e.g., Miller v. Alabama*, 567 U.S. 460, (2012) (observing that youth “is a moment and condition of life when a person may be most susceptible to influence and to psychological damage”).

As a result, a “growing chorus of courts have recognized the unique harms that are inflicted on juveniles when they are placed in solitary confinement.” *J.H. v. Williamson Cty., Tennessee*, 951 F.3d 709, 718 (6th Cir. 2020); *see, e.g., Hommrich*, 2017 WL 1091864, at \*2

(granting a preliminary injunction preventing a detention facility from placing juveniles in solitary confinement as punishment or discipline and describing how “courts around the country have found increased protections for juveniles and persons with diminished capacities from inhumane treatment under the Eighth and Fourteenth Amendments”); *V.W. by and through Williams v. Conway*, 236 F. Supp. 3d 554, 583, 590 (N.D.N.Y. 2017) (issuing a preliminary injunction to enjoin a county and its officials “from imposing 23-hour disciplinary isolation on juveniles” and recognizing “there is a broad consensus among the scientific and professional community that juveniles are psychologically more vulnerable than adults”); *Turner v. Palmer*, 84 F. Supp. 3d 880, 884 (S.D. Iowa 2015) (denying qualified immunity to officials who placed a juvenile with psychiatric issues in solitary confinement and noting that, “[t]raditionally, juvenile detainees are afforded greater constitutional protection”).

Moreover, P&A’s constituent members—composing a significant portion of CCJDC residents—suffer from various disabilities including mental illnesses. “Placement of a mentally-ill detainee in solitary confinement ‘raises a genuine concern that the negative psychological effects of his segregation will drive him to self-harm.’” *J.H. v. Williamson Cty., Tennessee*, 951 F.3d 709, 719 (6th Cir. 2020) (quoting *Wallace v. Baldwin*, 895 F.3d 481, 485 (7th Cir. 2018)). As the Third Circuit has explained, confinement of a detainee should be assessed “in light of his mental illness,” recognizing the “growing consensus” that solitary confinement” can cause severe and traumatic psychological damage, including anxiety, panic, paranoia, depression, post-traumatic stress disorder, psychosis, and even a disintegration of the basic sense of self identity.” *Palakovic v. Wetzel*, 854 F.3d 209, 225 (3d Cir. 2017). The documented mental health issues of many of the Children at CCJDC make them particularly vulnerable to the effects of solitary confinement. (*See also* Kraus Aff. ¶¶ 26-46).

## ii. Subjective Prong: Deliberate Indifference

The second, subjective prong is also likely to be proved on the merits. Defendant officials responsible for the CCJDC are specifically aware of, and have consciously chosen to disregard, the serious risk of harm posed by the CCJDC's solitary confinement practices. First and foremost:

A plaintiff may satisfy this standard by “prov[ing] by circumstantial evidence that a risk was so obvious that it had to have been known.” *Makdessi v. Fields*, 789 F.3d 126, 136 (4th Cir. 2015). Put differently, “[a]n obvious risk of harm justifies an inference that a prison official subjectively disregarded a substantial risk of serious harm to the inmate.” *Schaub v. VonWald*, 638 F.3d 905, 915 (8th Cir. 2011).

*Porter*, 923 F.3d at 355. The harm posed to these Children is patently obvious, and hence it is appropriate to infer knowledge of the risk to Defendants. *See H.C. by Hewett v. Jarrard*, 786 F.2d 1080, 1089 (11th Cir. 1986) (“We further conclude that no reasonable person could believe that a juvenile [pretrial] detainee may be placed indefinitely in isolation and the key thrown away, i.e.—no notice of charges or hearing provided the detainee.”). Further, Defendants have been actually aware of the risks of serious harm to the Child residents of CCJDC and have ignored those risks. (*See Exhibit C, E-mails from Pennington to Beatty*). The conditions have not been addressed notwithstanding written notice from the Charleston County Public Defender. This is the very definition of deliberate indifference.

Further, Defendants are aware of the harms created by solitary confinement as a result of the growing body of law, much of which is set forth above, finding such conditions to be harmful not only to adults, but especially to Children and even more acutely for Children with disabilities. *See A.T. by & through Tillman v. Harder*, 298 F. Supp. 3d 391, 416 (N.D.N.Y. 2018) (granting preliminary injunction prohibiting jail's routine placement of juveniles in solitary

confinement under 8<sup>th</sup> Amendment deliberate indifference test, finding the defendant was subjectively aware of the risks of solitary confinement of juveniles partly because of complaints and partly because of imputed knowledge from pervasive research and cases so finding).

Thus, not only is the Defendants' routine placement of these Children in solitary confinement impermissible punishment under the Fourteenth Amendment, it is also the result of constitutionally prohibited deliberate indifference to the serious risk of mental and emotional harm to these Children. Thus, P&A is likely to succeed on the merits of its claims, and this Court should preliminarily enjoin Defendants' routine practice of housing these Children in solitary confinement lockdown.

## **2. Wet Cell**

The use of the wet cell is a disturbing indicator of a culture at the CCJDC that places order and discipline above all else, and which has no regard for the health and safety of the Children entrusted to this facility, much less their education, rehabilitation, and improvement. Isolation of Children for up to 10 days at a time in this cold, dark, vile-smelling, and ill-equipped room, restricting all human interaction, and sometimes depriving Children of other essentials such as a mattress or a blanket, are elements of torture that can only be viewed as punishment under the Fourteenth Amendment. In the case of an adult pretrial detainee facing similar conditions, the Tenth Circuit noted the conditions:

were partly retributive, partly precautionary, but, in any event, were unreasonably degrading and inhumane—a mere masquerade as essential custodial detention and therefore clearly excessive in relation to the alternative purpose [of essential custodial detention] assigned [to it] in manifest violation of plaintiff's rights of due process as a pretrial detainee.

*Littlefield v. Deland*, 641 F.2d 729, 731 (10th Cir. 1981) (internal citations omitted)  
(confinement of mentally-ill pretrial detainee to cell with no windows, no interior lights, no

bunk, no floor covering, and no toilet except for a hole in the concrete floor was unconstitutional); *see also Abila v. Funk*, 220 F. Supp. 3d 1121, 1184–85 (D.N.M. 2016) (holding similar conditions constituted unconstitutional punishment for pretrial detainee).

In addition, all of the same arguments which support the Eighth Amendment challenge to the other forms of solitary confinement apply even more persuasively when applied to the wet cell. With respect to the objective prong of the test, use of the wet cell poses a significant harm to the health and safety of the Children. (Exhibit B, Rhoads Aff. ¶ 43; Exhibit A, Kraus Aff. ¶ 27). For all the same reasons why solitary confinement alone could serve no legitimate governmental objective, solitary confinement in the wet cell poses an even greater risk of harm. As to the subjective component of the deliberate indifference test, on its face, this dungeon-type confinement is the very type of obvious risk of harm that “justifies an inference that a prison official subjectively disregarded a substantial risk of serious harm to the inmate.” *Porter*, 923 F.3d at 355. It is far worse in every respect than the adult death row conditions deemed unconstitutional in *Porter*, and it is plainly excessive in relation to any conceivable legitimate need to maintain discipline and order at this facility. In fact, use of this type of device is counterproductive to the goals of this facility. (Rhoads Aff. ¶ 32). Thus, P&A is likely to prevail on this claim, and the Court should immediately enjoin use of the wet cell.

### **3. Use of Restraint Chair**

Under the Fourteenth Amendment, any placement of juvenile pretrial detainees in a restraint chair for punishment or without penological purpose is constitutionally forbidden. *See Blackmon v. Sutton*, 734 F.3d 1237, 1242 (10th Cir. 2013). Indeed, courts have held that use of a restraint chair for long durations “against a pretrial detainee, without close monitoring and some provision for short periods during which the inmate is relieved of the restraints and given an

opportunity to move around, drink, and use the restroom facilities, amounts to unconstitutional punishment.” *Pardue v. Glass*, No. 05-5004, 2008 WL 249173, at \*21 (W.D. Ark. Jan. 29, 2008).<sup>7</sup> By contrast, cases which have upheld the use of restraint chairs have done so only when the facts indicated the detainee was confined for the limited penological purpose of safety and security, and when the detainee was carefully and frequently monitored, given frequent breaks, and allowed the opportunity to end the confinement by promising not to cause harm. *See e.g., Fuentes v. Wagner*, 206 F.3d 335 (3d Cir. 2000).

Here, the use of the restraint chair as described by multiple witnesses far exceeds any legitimate penological purpose of maintaining safety and security. Using the restraint chair as punishment is the very practice which has been declared violative of the Fourteenth Amendment by other courts. Thus, P&A is likely to succeed on this claim, and the Court should enjoin Defendants’ use of the restraint chair other than when necessary for the very narrow penological purpose of preventing self-harm.

#### **4. Failure to Provide Outdoor Recreation and Exercise**

P&A is also likely to succeed on the merits of its claim that the lack of outdoor exercise at the CCJDC violates the Eighth Amendment under the two-prong test. Under the first prong, it is well settled that a lack of outdoor exercise constitutes deprivation of a basic human need. *Collins v. McCall*, No. 2:13-CV-02700-RMG, 2014 WL 6809792, at \*9 (D.S.C. Dec. 3, 2014). Courts have found that outdoor exercise is required when inmates are confined in small cells almost twenty-four hours per day. *Spain v. Procunier*, 600 F.2d 189, 199-200 (9th Cir. 1979)

---

<sup>7</sup> *See also Undlin v. City of Minneapolis*, No. CIV. 08-1855JNEFLN, 2009 WL 3754208, at \*6 (D. Minn. Nov. 4, 2009) (manifest error of law for referee to dismiss plaintiff’s claims where plaintiff has alleged confinement to a restraint chair for four hours without any breaks or checks on his physical and mental condition for being “argumentative and irritating”).

(noting “substantial agreement” that “some form of regular outdoor exercise is extremely important to the psychological and physical well being” of inmates). This is particularly true for energetic teenagers. While the “totality of the circumstances,” including the length of deprivation, number of hours inmates are locked in their cells each day, and the practical opportunities available for exercise are to be considered, those factors here weigh heavily in favor of finding a constitutional violation. *See Collins*, at \*10. The average length of stay at the CCJDC is 15 days, according to the most recent information available. (Exhibit B, Rhoads Aff. ¶ 13c). It is not uncommon for Children to be detained for months at a time. (*Id.*) In addition, because the Children are housed in small, individual, and often overcrowded cells for 22 or more hours every day, the need for outdoor access is greater than it would be for juveniles housed in a better facility with more indoor recreation time and space. (*Id.* ¶ 59). Last, it is practical to provide outdoor access because the CCJDC has a recreation yard that is enclosed by a fence and even has two basketball goals (though they are missing their hoops). (*Id.* ¶ 58). Accordingly, Plaintiff is likely to succeed on the merits of this claim under a totality of the circumstances test, particularly in light of the *Porter* decision in which the Fourth Circuit found an Eighth Amendment violation where adult death row inmates were confined in circumstances similar to the CCJDC but with five days of outdoor exercise every week, as compared to no outdoor exercise at the CCJDC. *See Porter v. Clarke*, 923 F.3d 348 (4th Cir. 2019).

The second prong—deliberate indifference—is also met. Defendants must be aware that the Children are not permitted to go outside and therefore get no outdoor exercise, and in any event, the Public Defender pointed this problem out as far back as 2018. (*See Exhibit C, Pennington Emails*).

## 5. Failure to Provide Adequate Medical and Mental Health Care

“Among the traditionally recognized liberty interests of [juveniles] that survive confinement is the right to minimally adequate health care.” *Alexander S. v. Boyd*, 876 F. Supp. 773, 788 (D.S.C. 1995) (citing *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)). This right includes having “a sufficient number of trained medical staff to provide the basic components of a medical system.” *Id.* at 789. A juvenile detention center must “meet the health needs of the population.” *Id.* “Nursing staff should be available to adequately provide daily review of sick call requests, to administer reasonably prompt medical care and to train other staff members in identifying and monitoring the juveniles’ illnesses.” *Id.* A failure to provide such needed medical services is deliberate indifference under the Eighth Amendment. *Estelle*, 429 U.S. at 104-05. These rights are equally applicable to pretrial detainees. *Hill v. Nicodemus*, 979 F.2d 987, 991 (4th Cir. 1992) (“Pretrial detainees, like inmates under active sentence, are entitled to medical attention, and prison officials violate detainee’s rights to due process when they are deliberately indifferent to serious medical needs.”). Further, “[i]t is generally recognized that prompt medical screening is a medical necessity in pre-trial detention facilities.” *Dawson v. Kendrick*, 527 F. Supp. 1252, 1307 (S.D. W. Va. August 10, 1981). The failure to provide such screening, as well as classification, record keeping, sick call procedures, and timely access to care violate the Eighth Amendment rights of pretrial detainees. *Id.* at 1308.

Moreover, the requirement that detention facilities provide minimally adequate health care includes the requirement that they provide minimally adequate mental health care. In a recent decision, a federal court in Iowa determined that a residential school for juveniles adjudicated as delinquent violated substantive due process by failing to:

(1) formulate mental health treatment plans; (2) provide adequate crisis services by offering the therapy needed to assess the underlying causes of students' self-harming or suicidal ideations; (3) maintain confidential mental health records; (4) provide adequate discharge planning; and (5) properly oversee the mental health programming at the School, be that through a qualified mental health authority or other structure.

*C.P.X. v. Garcia*, 2020 U.S. Dist. LEXIS 61980, \*128 (S.D. Iowa March 30, 2020).

The interviews conducted by Mr. Rhoads with the Children detained at the facility show an absence of consistent medical and mental health screening, a failure to provide any meaningful mental health care, often slow (if any) response to acute medical needs, and a consistent failure to administer prescription medications. (Exhibit B, Rhoads Aff. ¶ 66). Further, as Dr. Kraus explains, data show that most Children placed in juvenile facilities have some form of mental illness. (Exhibit A, Kraus Aff. at ¶ 36). The failure to provide mental health care poses a serious and immediate risk to the Children at the facility. (*Id.* at ¶ 43). By delaying and denying CCJDC detainees much needed medical and mental health treatment, Defendants are acting with deliberate indifference to the Children's serious medical and psychological needs in violation of the Fourteenth Amendment. *See Alexander*, 876 F. Supp. at 778; *C.P.X.*, 2020 U.S. Dist. LEXIS 61980, \*128. Thus, P&A is likely to succeed on this claim, and the Court should order Defendants to comply with their obligations to provide appropriate medical and mental health care and treatment.

## **6. Failure to Provide Education**

Children at the CCJDC report that they do not always receive educational services and that, when instruction is provided, it is general, not challenging, and not individually tailored to each Child's mental or physical abilities in compliance with that particular student's IEP, or consistent with their pre-detention grade level and class assignments. (Exhibit B, Rhoads Aff. ¶

72). Moreover, none of the Children interviewed were allowed the state-mandated thirty hours per week of classroom instruction. *See* S.C. Code Ann. Regs. 43-232 & 234 (mandating thirty hours per week of classroom instruction). The undersigned represents that the CCSD, in consultations prior to filing this motion, indicated it is not able to provide the services to children brought into the CCJDC from other counties because CCSD has no authority over the other school districts. CCSD also raised concerns about its ability to provide services in the existing facility due to space limitations, given the number of children who are housed at the facility. Both of these concerns can be addressed on a preliminary basis by enjoining the CCJDC from accepting children from counties other than Charleston. Because approximately 50% of the children in the facility are from other counties, this injunction will serve both to alleviate the space needs, and it will alleviate the problem of teaching children from another county school district.

In short, the education provided to Children at CCJDC is far below the minimum standards required by state and federal law and regulations. Courts have held that juvenile pretrial detainees have a constitutional property interest in receiving the minimum level of education required under state regulations. *V.W. by & through Williams v. Conway*, 236 F. Supp. 3d 554, 586 (N.D.N.Y. 2017); *A.T. by & through Tillman v. Harder*, 298 F. Supp. 3d 391, 416 (N.D.N.Y. 2018). Thus, P&A is likely to succeed on this claim, and the Court should order Defendants to provide the Children at CCJDC with the education required by state and federal law and regulations and to cease accepting Children from other counties so that the CCSD can perform its duties.

## **B. Statutory Claims (ADA, Section 504, IDEA, S.C. Juvenile Justice Code)**

Under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504), Defendants are required to conduct an “individualized assessment” of a Child’s disability prior to imposing solitary confinement or other lockdown conditions. To establish a *prima facie* violation under either the ADA or Section 504, a plaintiff must show (1) he is a qualified individual with a disability; (2) defendant is an entity subject to the statutes; and (3) he was denied an opportunity to participate in or benefit from the defendant’s services, programs, or activities, or otherwise discriminated against by reason of his disability. *Wright v. N.Y. State Dep’t of Corr. & Cmty. Supervision*, 831 F.3d 64, 72 (2d Cir. 2016) (holding DOCCS’ “blanket ban” on use of motorized wheelchair fails to “make an individualized assessment of a disabled inmate’s particular needs”).

Here, many, if not most, of the Children housed at CCJDC have disabilities. (Exhibit B, Rhoads Aff. ¶ 50). Defendants routinely house these Children in conditions that constitute solitary confinement, and they also use additional restrictions, which include lockdowns, confinement to the wet room, and use of the restraint chair. Defendants impose these conditions and restrictions without consulting a mental health worker and without assessing whether the conditions and restrictions are appropriate. (*Id.* at ¶¶ 29, 38, 40, 47). These additional restrictions are often imposed on Children for behaviors that are simply the manifestations of their respective mental health issues and disabilities—manifestations that are only made more likely to occur because of the failure of the facility to administer medications or to provide mental health counseling. (Exhibit A, Kraus Aff. ¶ 43). While under lockdown, confined to the wet cell, or in the restraint chair, the disabled Children are unable to participate in any programs or activities otherwise available. Under the ADA and Section 504, a correctional facility cannot categorically

deny an inmate with a disability access to available programs, services, and benefits without first performing an individualized assessment. *A.T. by & through Tillman v. Harder*, 298 F. Supp. 3d 391, 417 (N.D.N.Y. 2018). Thus, P&A is likely to succeed on this claim.

The Individuals with Disabilities Education Act's (IDEA) purpose is to assure that "all children with disabilities" have a free appropriate public education which emphasizes special education. 20 U.S.C. § 1400(c).<sup>8</sup> The IDEA confers upon disabled students an enforceable right to public education in participating states. *Honig v. Doe*, 484 U.S. 305, 310 (1988). The IDEA applies to local juvenile detention facilities. 34 C.F.R. § 300.2(b)(iv); *Donnell C. v. Illinois State Bd. of Educ.*, 829 F. Supp. 1016, 1020 (N.D. Ill. 1993) (applying IDEA to pretrial detainees). With respect to the IDEA, the Defendants routinely fail to adhere to the substantive and procedural requirements mandated by federal law by: failing to create, implement, and follow an IEP for each student or follow procedural requirements such as a manifestation hearing before changing a qualifying juvenile's current placement. Thus, P&A is likely to succeed on this claim.

Moreover, as noted above, South Carolina state regulations mandate a minimum of thirty hours per week of classroom instruction. S.C. Code Ann. Regs. 43-232 & 234. The regulations also set forth a number of other minimum requirements including with respect to the subject matter of education, credit for high school, and class size. *Id.* Local detention facilities, such as the CCJDC, are required by statute to "provide educational programs and services to all preadjudicatory juveniles in its custody" which meet all regulatory requirements. S.C. Code Ann. § 63-19-360. Further, it is "the responsibility of the school district where a local detention center

---

<sup>8</sup> "Special education" has been defined to include instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings. 20 U.S.C. § 1401(a)(16).

. . . is located to provide adequate teaching staff and to ensure compliance with the educational requirements of this State.” *Id.*

Here, as demonstrated above, Defendants, including Defendant School District, have not ensured compliance with state minimum requirements such as the minimum thirty hours of weekly instruction time at CCJDC. Thus, P&A is likely to succeed on this claim, and the Court should enter an injunction requiring Defendants to comply with these statutes and regulations.

## **II. Without an Injunction, P&A’s Members Are Likely to Suffer Irreparable Harm.**

In a very similar case, a federal district court in New York succinctly addressed how plaintiffs showed irreparable harm, and the court’s reasoning applies equally here:

“First, as a general matter, there is a presumption of irreparable harm when there is an alleged deprivation of constitutional rights.” *Donohue*, 886 F. Supp. 2d at 150. In addition, plaintiffs have submitted substantial, convincing evidence that the Onondaga County defendants’ continued use of solitary confinement on juveniles puts them at serious risk of short- and long-term psychological damage, and that the related deprivation of education services by both defendants hinders important aspects of their adolescent development. *See, e.g., New York*, 872 F. Supp. 2d at 214 (“[I]nterruption of a child’s schooling causing a hiatus not only in the student’s education but also in other social and psychological developmental processes that take place during the child’s school, raises a strong possibility of irreparable injury.” (citation omitted)); *Cosgrove v. Bd. of Educ. of Niskayuna Cent. Sch. Dist.*, 175 F. Supp. 2d 375, 392 (N.D.N.Y. 2001) (McAvoy, J.) (“It is almost beyond dispute that wrongful discontinuation of a special education program to which a student is entitled subjects that student to actual irreparable harm.”). Accordingly, this element weighs in favor of granting a preliminary injunction.

*V.W. v. Conway*, 236 F. Supp. 3d 554, 588-589 (N.D.N.Y. February 22, 2017); *see also A.T. v. Harder*, 298 F. Supp. 3d 391, 417 (N.D.N.Y. April 4, 2018); *Doe v. Hommrich*, 2017 U.S. Dist. LEXIS 42290, \*5 (M.D. Tenn. March 22, 2017) (“The harm suffered in solitary confinement is not harm easily undone. Indeed, the loss of constitutional rights is presumed to constitute irreparable harm.”).

### **III. Balance of the Equities Favors Injunctive Relief.**

This factor requires balancing the constitutional rights of children at CCJDC with the Defendants' penological interests in maintaining safety and security for juvenile pretrial detainees at the facility. As indicated above, Defendants have confined Children at the CCJDC under conditions which are both impermissibly punitive under the Constitution and either have no penological purpose or exceed the permissible scope of that purpose. Indeed, the conditions and restrictions imposed at the CCJDC that violate the Children's constitutional rights *undermine* safety and security. (Exhibit B, Rhoads Aff. ¶ 32.). Thus, Defendants' penological interests in maintaining safety and security could not possibly justify these constitutional violations. Moreover, Defendants cannot use financial constraints to excuse their continued constitutional and statutory violations. *Petrick v. Maynard*, 11 F.3d 991, 995 (10th Cir. 1993) (“[T]he cost of protecting a constitutional right cannot justify its total denial.”) (quoting *Bounds v. Smith*, 430 U.S. 817, 825 (1977)). Here, the scope of the preliminary injunctive relief sought is narrowly tailored to protect the constitutional rights of the Children at CCJDC without unnecessarily invading the Defendants' orderly administration of the CCJDC facility. The balance of the equities favors this narrowly crafted injunctive relief. *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (“Furthermore, there was no abuse of discretion in the district court's determination that the equities favor issuance of a narrow, limited preliminary injunction.”).

### **IV. Preliminary Injunctive Relief Is in the Public Interest.**

Courts have held that “it is always in the public interest to prevent the violation of a party's constitutional rights.” *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012). Consequently, this factor favors entry of the requested injunctive relief.

## **V. Injunctive Relief Requested**

As the evidentiary submissions demonstrate, the CCJDC facility itself is unfit for housing Children, but Defendants' policies and practices exacerbate these conditions terribly by: routinely confining Children to their cells for twenty-two (22) or more hours per day without any disciplinary or safety rationale; denying Children any meaningful outlet for exercise, fresh air, or creative pursuits; denying Children medical and mental health treatment and prescription medication; denying Children even the minimum education mandated under the law; and then locking these same Children in a closet or strapping them to a chair for behaviors which were, in all likelihood, caused by the very lack of mental health treatment and programming perpetrated by the Defendants. These conditions and Defendants' policies and actions are trampling the constitutional and statutory rights of these Children—our most vulnerable of citizens—and are inhumane and unconscionable in a civilized society. Rather than educate and rehabilitate, they cruelly perpetuate and exacerbate the mental and behavioral problems which led these Children to CCJDC in the first place. P&A asks this Court to enter the requested injunctive relief to stop these Defendants from causing any further irreparable harm to these Children while P&A fights to protect and vindicate their rights under the law.

P&A requests a preliminary injunction providing the following relief from Defendants:

1. Immediately cease and desist from the routine and unconstitutional practice of placing the Children in solitary confinement and/or lockdown as punishment.
2. Immediately cease and desist from placing residents of CCJDC in the “wet cell” or locking residents either alone or with other residents in any room or cell which does not have natural light, an operable toilet, an operable sink, and a bed.
3. Immediately cease and desist from confining residents of CCJDC in their cell for more than ten (10) hours per day unless the resident has been temporarily assigned to separation for safety or disciplinary reasons.

4. Immediately cease and desist from placing residents of CCJDC in a restraint chair except by order of the CCJDC manager or designee for the sole purpose of preventing self-harm under the following circumstances:<sup>9</sup>

- (a) Such an order is issued by the CCJDC manager or designee who has had no involvement in the underlying incident that gave rise to the order.
- (b) The manager or designee conducts an examination of the resident and makes a determination that the resident poses a material threat of self-harm and immediately documents that finding.
- (c) After being placed in the restraint chair, the resident shall be monitored continuously and asked about his or her condition at frequent intervals.
- (d) The resident shall be released from the restraint chair as soon as the resident demonstrates he or she has regained a reasonable degree of control over his or her behavior.
- (e) Under no circumstances shall the resident be confined in the restraint chair for more than 60 minutes. If, after 60 minutes the resident continues to pose a material threat of self-harm, then an in-person examination by a psychiatrist or a LMHP under the direction of a psychiatrist will be provided and treatment will be provided pursuant to the direction of the psychiatrist or LMHP under his/her direction.
- (f) Upon release from the restraint chair, the resident shall be examined immediately by an LMHP or medical provider.
- (h) The restraint chair shall never be used to punish or discipline a resident.

5. Immediately cease and desist from placing residents of CCJDC in any other form of bodily restraint except as a security precaution during a transfer or temporary emergency. Restraints shall not be used on Children locked in a cell unless on a temporary emergency basis to prevent self-harm or harm to others. Restraints should never be used as punishment or discipline.

6. Allow each resident of CCJDC, except those temporarily placed in segregation for safety or disciplinary reasons, a minimum of one (1) hour per day of outdoor recreation and large-muscle exercise (weather permitting) in an area measuring the greater of: (a) at least fifty (50) by thirty (30) feet; (b) 750 square feet of unencumbered space with none of the dimensions less than fifteen (15) feet; (c) or fifteen (15) square feet per juvenile for the maximum number of juveniles who are expected to use the area at one time. If weather conditions do not allow for outdoor recreation or exercise, the residents shall be afforded the same amount of time for indoor recreation and exercise.

7. Perform medical, dental, and mental health screening of all juveniles, excluding intrasystem transfers, immediately upon admission to the facility with the findings recorded, including inquiry into the resident's current illnesses and health problems, mental health issues,

---

<sup>9</sup> P&A is mindful that both Dr. Kraus and Mr. Rhoads consider the use of a restraint chair to be dangerous and counterproductive. Both experts believe the restraint chair should not be used at all. P&A, however, is also aware that for purposes of this motion, relief must be narrowly construed, and accordingly Plaintiff requests relief that allows limited, careful use of the restraint chair if the Court concludes that enjoining all continued uses of the restraint chair is not warranted at this juncture. With regard to permanent prospective relief, P&A has asked the Court to enjoin CCJDC Defendants from any further use of the restraint chair.

disabilities, prescribed medications, and any ongoing medical or mental health treatment or counseling.

8. Confirm any previously prescribed medical or mental health treatments and prescribed medications for each juvenile within twenty-four (24) hours of admission to the facility.

9. Provide residents of CCJDC with their previously prescribed medical or mental health treatments and prescribed medications promptly and as prescribed commencing within twenty-four (24) hours of admission to the facility. Medications are to be administered by a qualified health care professional.

10. Have each resident of CCJDC requiring medical or mental health treatment and/or prescribed medications evaluated and assessed by an appropriate medical professional and/or licensed mental health professional within forty-eight (48) hours of admission to the facility and at least once per week thereafter to determine any needed modifications to such treatments or medications during the resident's stay at CCJDC.

11. Provide residents of CCJDC with a minimum of thirty (30) hours of grade-level and individually appropriate classroom or individualized instruction time per week in accordance with the minimum education program standards set out by the State Board of Education.

12. CCJDC must provide notice by email to CCSD within 12 hours after a child is placed in detention following his or her initial hearing in family court. CCSD is to commence instruction based on school coursework, assignments, books, and tests from their home school within seventy-two (72) hours of receiving such notice and daily thereafter so that each resident has the opportunity to stay up-to-date with his or her school work to prevent falling behind while at CCJDC. CCJDC must also provide CCSD notice of release of a child from detention.

13. Follow all requirements of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504), and the Individuals with Disabilities Education Act including the provision of a Free Appropriate Public Education (FAPE), conduct "appropriate evaluations" of Children suspected of having a disability, follow established individualized education plans (IEPs) for Children who receive special education, or in the case of a Child detained for months, establish an IEP if appropriate and needed, guarantee placement in the Least Restrictive Environment (LRE) where possible, encourage parental participation in placement decisions, and follow procedurally required safeguards.

14. Adhere to all minimum educational program requirements set forth by state statute and regulations, including S.C. Code Ann. Regs. 43-232 & 234.

15. Establish a clearly defined disciplinary system that ensures residents understand when, why, and how they have been disciplined and ensures that any punishment for a disciplinary violation is documented.

16. Enjoin CCJDC from accepting into the facility any children from counties other than Charleston.

## CONCLUSION

The Defendants' practices and the conditions at CCJDC violate the constitutional and statutory rights of P&A's constituent members. These practices must stop to prevent further

irreparable harm to these vulnerable members of society. Equity, the public interest, and common human decency demand the requested relief. Accordingly, P&A requests that this Court enter the requested preliminary injunctive relief.

**NELSON MULLINS RILEY & SCARBOROUGH LLP**

By: s/ROBERT H. BRUNSON

Robert H. Brunson  
Federal Bar No. 10399  
E-Mail: robert.brunson@nelsonmullins.com  
Patrick C. Wooten  
Federal Bar No. 10399  
E-Mail: patrick.wooten@nelsonmullins.com  
Andrew Connor  
Federal Bar No. 11191  
E-Mail: andrew.connor@nelsonmullins.com  
151 Meeting Street / Sixth Floor  
Post Office Box 1806 (29402-1806)  
Charleston, SC 29401-2239  
(843) 853-5200

Stuart Andrews  
Federal Bar No. 1099  
E-Mail: stuart.andrews@nelsonmullins.com  
1320 Main Street / 17th Floor  
Post Office Box 11070 (29211-1070)  
Columbia, SC 29201  
(803) 799-2000

-and-

Annie Elizabeth Andrews  
Federal Bar No. 13134  
E-Mail: andrewsanniee@gmail.com  
Post Office Box 957  
Mount Pleasant, SC 29465  
(843) 822-5329

*Attorneys for Plaintiff*

Charleston, South Carolina  
July 25, 2020

# **EXHIBIT A**

**Affidavit of Louis J. Kraus, M.D.**

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF SOUTH CAROLINA

CHARLESTON DIVISION

Protection and Advocacy for People with ) Civil Action No.  
Disabilities, Inc., )  
)  
Plaintiff, )

vs. )

James Alton Cannon, Jr., in his official )  
capacity as Charleston County Sheriff, )  
Mitch Lucas, in his official capacity as )  
Assistant Charleston County Sheriff, Willis )  
Beatty, in his official capacity as Chief )  
Deputy of the Charleston County Sheriff's )  
Office, and Charleston County School )  
District, )  
)  
Defendants. )

**AFFIDAVIT OF**  
**LOUIS J. KRAUS, M.D.**

- 
1. I, Louis J. Kraus, declare as follows:

**QUALIFICATIONS**

2. I am currently Professor and Chief of Child and Adolescent Psychiatry at Rush University Medical Center in Chicago, Illinois. In that capacity, I supervise and train child and adolescent psychiatry fellows in various placements, including in-patient, residential treatment, and outpatient programs for children, adolescents, and young adults. I am also currently the Psychiatric Director at the Sonia Shankman Orthogenic School, a residential treatment program for children and adolescents in need of support for profound emotional issues; the Founding Director of the Autism Assessment, Research, Treatment and Services Center at Rush University Medical Center; and the Medical Director of the Chicago Metropolitan Easter Seals Therapeutic School, a school providing

a continuum of services for children with autism. I also have a private practice where I assess and treat children and adolescents and provide therapy and psychopharmacological services.

3. I have worked with juveniles in correctional settings for the past 28 years, including for nine years from 1990 to 1999 as the treating psychiatrist at the Illinois Maximum Security Youth Center in Joliet, Illinois. From 2003 to 2004, I was a consultant to the Civil Rights Division of the United States Department of Justice on a Civil Rights of Institutionalized Person Act (“CRIPA”) investigation in Maryland. I also consulted with the American Civil Liberties Union of Illinois in a case challenging conditions in the Cook County Juvenile Temporary Detention Center, which resulted in system-wide restructuring of mental health services for juveniles held in pre-trial detention. I have served as a consultant on various other correctional and juvenile justice matters. I more recently worked as an expert in Palm Beach County and on several cases in Seattle, Washington.

4. I have been appointed to serve as monitor in consent decrees involving reform in juvenile justice systems in Arizona and Illinois, both of which included reform to the use of solitary confinement against juveniles in those systems. In my role in Illinois, which is currently ongoing, I am assessing and restructuring the mental health programming of the Illinois Department of Juvenile Justice. *See R.J. v. Bishop*, No. 1:12-cv-07289 (N.D. Ill.). In the Arizona case, I assisted the Department of Justice from 2005 to 2008 in restructuring the mental health, medical services, and dental services in two state facilities. *See United States v. Arizona*, No. 2:04-cv-01926-EHC (D. Ariz.).

5. I have also been involved in special education consulting and development of Individualized Education Programs (“IEPs”) for the past twenty-five years. I am currently a consultant on special education issues to over fifteen school districts in Illinois. I typically complete

one educational evaluation every one to two weeks, assist with developing IEPs, and attend IEP meetings. I have testified regarding special education issues in due process hearings under the Individuals with Disabilities Education Act as well as in other civil cases.

6. I have authored a number of publications on treatment of juveniles in correctional settings. I am the primary author of the American Academy of Child and Adolescent Psychiatry's ("AACAP") Policy Statement on Solitary Confinement. I assisted in the completion of the PA policy statement on Solitary Confinement of Juveniles, I co-edited two monographs on juvenile justice reform for the AACAP, co-edited a book through Cambridge University Press entitled *The Mental Health Needs of Young Offenders*, and, most recently, edited a book through the Child and Adolescent Psychiatric Clinics of North America entitled *Adjudicated Youth*, published in January of 2016. I wrote the Practice Parameter for Child and Adolescent Forensic Evaluations for child and adolescent psychiatry, which was published in the Journal of Child and Adolescent Psychiatry.

7. I have served in a number of professional appointments in my field. From June 2014 to 2015, I served as the chair-elect of the American Medical Association's Council on Science and Public Health, and from 2015 to 2016, I served as chair. From May 2012 to May 2015, I was the chair of the American Psychiatric Association's Council on Children, Adolescents and Their Families, which I had served in for 18 years. From October 2000 to October 2015, I was the chair of the AACAP's Juvenile Justice Reform Committee, and from 2011 to 2013, I was chair of the AACAP Assembly.

8. I was on the Board of Directors of the National Commission of Correctional Health Care ("NCCHC") from 1997 to 2003. I was appointed chairman of the NCCHC Committee on Juvenile Health Care from 1999 to 2003 and served as vice-chairman of the same committee in 1998.

9. I obtained my Doctor of Medicine degree, M.D., from the Chicago Medical School in 1987 and my Bachelor of Science degree, B.S., from Syracuse University in 1983.

10. I have included a copy of my Curriculum Vitae as Exhibit A, which includes all publications that I have authored in the past ten years and a list of all cases during the previous four years in which I testified as an expert at trial or by deposition.

### **INVOLVEMENT IN THIS CASE**

1. In this present case, I was initially contacted by Robert Brunson of Nelson Mullins to review interview records of youth who have been incarcerated within the Charleston County Juvenile Detention Center (“CCJDC”) as an expert in connection with concerns over conditions, policies and practices at the CCJDC. Specifically, I was asked to evaluate the use of punishment, solitary confinement and restraints, and offer an opinion on the impact on the youth’s mental health while in solitary confinement at the CCJDC. I was also asked to consider the adequacy of mental health, recreation, and educational services provided at the facility. I also understood I may be asked to offer additional opinions as this matter moves forward.

2. For the purpose of preparing this declaration, I reviewed several newspaper articles and notes from 31 interviews of youth who had been placed at CCJDC and their families.

3. It is my understanding that as the litigation progresses, I may be reviewing additional documents and information.

4. I am being compensated at the rate of \$400 per hour to prepare this declaration. In regard to travel, deposition, or trial testimony, I am compensated at the rate of \$3,000 per half day. My compensation is not dependent on my opinions or the outcome in this matter.

## OPINIONS AND BASES OF OPINIONS

### I. **FACTUAL BACKGROUND BASED UPON INTERVIEW SUMMARIES**

1. The CCJDC is more than 50 years old. (built in 1967).
2. I have viewed a picture of a typical cell. It's dangerous and antiquated. Its old beds and sinks are risks for hanging. It houses juveniles from ages 11 to 16. The facility is reportedly overcrowded. It is common practice when facilities are overcrowded that there is increased use of solitary confinement.

3. I was provided with summaries of phone interviews completed by another expert, John Rhoads, of youth previously or currently placed at CCJDC.

4. There was an interview by phone for 42 minutes with C.R. on June 18<sup>th</sup>, 2020. He had been in the juvenile facility in May of 2019 for 6 or 7 days. He had been there multiple times. He said he'd seen a nurse and took medications at night. He described his room as dirty, with mold on the walls and paint peeling off. He described bugs in the room, and he heard rats or mice in the attic space. He described the facility as being crowded. He said there were 3 people in his room, with only two beds. One person was sleeping directly on the floor on a mattress. There were problems with the toilets; sometimes they would overflow. Detainees are not allowed to have pencils in their room. He explained that the detainees were allowed to have books and that this was something new, only after a public defender in court complained about it and they donated the books. He got clean clothes each day and had appropriate bedding. They showered daily, but if you were on a 24- or 48-hour room confinement, you are not allowed to shower. They had no organized large muscle exercises although they had some free recreation time. He described discipline, including extended room time in the past. He said this occurred for petty behaviors. He also reported that custodial staff would use rubber bullets or chemical spray on the youth. He also talked about the wet room. This is a closet sized room with a light and a bench. He said that staff would

use leg irons and handcuffs on the detainees when placed in there and he once stayed in the wet room for 6 hours. If he had to go to the bathroom, staff would let you out, but you'd shuffle in shackles. He was also disciplined by being placed in a restraint chair with his neck, wrist, hips, legs, and feet buckled. He reported that he would attend school during his stay, but if he had any extended room confinement, he did not attend school.

5. There was a phone interview with B.P., the grandmother of O.L. and B.M. The interview occurred on June 19, 2020 for 43 minutes. Both youths have had periods of custody at CCJDC. O.L.'s last period of custody was March of 2020 and B.M.'s was in 2019. The grandmother reported that the facility was dirty and smelled. The room leaked and there was mold on the walls. The grandmother noticed water stains on the ceiling tiles. O.L. complained that the food was rotten. He also had bug bites. He described that there was overcrowding, and the detainees slept directly on the floor. O.L. described that the toilet overflowing was common and it was not because he had thrown anything down it. Nonetheless, he would be disciplined. While on extended discipline, detainees were not allowed out of their rooms. They had no canteen privileges and no school. B.P. reported that O.L. was having headaches. B.M. had bronchitis and asthma, but was not given any medication for this. O.L. has a history of Special Education interventions. He has an Individual Educational Plan (IEP). At no point, while staying at the facility, was there any discussion about his Special Education Needs.

6. There was a conference call with S.M. and her son, R.S. This occurred on June 22, 2020. R.S. was in custody in January 2020. He described the facility as being crowded and he had to sleep on the floor. When in lockdown, he reported you were not allowed to shower. He reported only having a few showers. Guards took away privileges for misbehavior, including canteen.

7. The CCJDC was described as rusty inside and out. The mother did not feel it was safe. R.S. was never allowed to go outside. R.S. described that he hated the food. For dinner, he described getting bologna, two pieces of white bread and mustard. He described that sometimes it was so bad, he wouldn't eat it. R.S. reported that often in the cell he was only allowed to wear his underclothes. He reported he was placed in the wet cell for 3 days. He described the floor as wet and had to sleep on a mat on the wet floor. He was placed there for not complying with directions. While in the wet room, he urinated on himself as the staff would not let him use the bathroom. R.S. reported that staff would threaten to put him in the restraint chair. R.S. was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). He was not given his medication while in custody. He reported submitting grievances, but it made no difference. He described the building as being old with many leaks and there were mop buckets to try to help with the leaks. Staff would serve a snack between dinner and bedtime. A school teacher came from Daniel Jenkins Academy once or twice per week. He is in Special Education and has an IEP. It does not appear that anybody reviewed this or that the IEP was being followed.

8. A conference call with T.L. and her son, C.J. occurred on June 23, 2020. He was in custody in May of 2020. He was diagnosed with ADHD and was on medication. There was no mental health help in the detention center. He had to sleep on the floor twice. The rooms were not clean. He stayed in the wet cell for two full days. There were no showers allowed in this time. He reported once during an evacuation to the adult detention center due to a hurricane, there were four kids placed in a single, small cell. He reported being once in the restraints in the chair for 4 to 6 hours. He said he saw staff firing rubber bullets during a fight. He said the food was terrible.

9. There was a conference call with B.P. and her grandsons, L.M. and B.M. on June 23, 2020. B.M. described being in the restraint chair while in the wet cell for two full days. When they

took him to the bathroom, he was in leg shackles with a belly chain and handcuffs. He also witnessed staff firing bean bags and rubber bullets. He remembered an attempted suicide at the institution. The child who attempted suicide rigged his shirt up to the air conditioning vent and tried to hang off the top bunk. The child's roommate started yelling. B.M. was placed at the facility on seven different occasions over two years total. He was 13 when he was first placed there. L.M. described attending school and said that it was easier than regular school. He recalls the staff gave his entire unit a 48-hour discipline time.

10. There was a conference call with S.M. regarding her son M.J. on June 23, 2020. M.J. was last at CCJDC for about a week in August in 2019. He had been there multiple times. He initially had a room by himself then later had a roommate. S.M. reported that M.J. had a seizure after being given a drink by other children one night, but it was not discovered until the following morning. He was sent to the hospital. His mother wasn't notified. He was put on medication for seizures and one for high blood pressure. M.J. said he witnessed staff beating an inmate. M.J. is in Special Education, secondary to his ADHD.

11. There was a conference call with M.G. regarding C.B., her son, on June 23, 2020. C.B. was in custody for four to five months total from between 2016 and 2018. He reported cleaning his room. He said the mold on the walls was too thick to come off. He said the food was not hot and there were no snacks. He was put on discipline for 72 hours. He was placed in the restraint chair for 12 hours. He also spent ten days in the wet cell.

12. There was a conference call with D.W., the aunt and legal guardian for her two nephews, D.W. and D.W. The call was on June 23, 2020. They were last in custody in May or June of 2020. They had no medical or mental health evaluation. One of them described having suicidal ideations. They discussed the unclean, moldy provisions in the facility. They were both on

medications for ADHD. Neither received their medications while in custody. One was in solitary confinement in the wet cell for two days. He did not get to shower one day. There was no outside exercise. They witnessed staff spraying detainees with pepper spray. One of them had to sleep on the floor.

13. There was a conference call with E.J. and her daughters, I.J. and G.J. The call occurred June 24, 2020. I.J. was in custody in March of 2020. Both were in custody in the last six months. They did not see a nurse for 3 days. Neither were on medications. They described the food as nasty and the facility as dirty. They never laundered their overclothes, but they did receive laundered underwear. One of them complained that the underwear was stained. Toilets would overflow and they would then receive a mandatory 48-hour detention, no matter what the issue was.

14. There was a conference call with L.C., regarding her sons, Z.C. and A.J. Z.C. was not present. A.J. was present for the interview, which occurred on June 25, 2020. A.J. was last in custody in May, 2019. It was for one week for two periods. A.J. recalled having a medical screening. He was diagnosed with having ADHD and was on medications, but no medications were given while in custody. He described mold on the ceiling. He reported having no bed, but rather slept on the floor. He was in a cell for 23 hours and received one-hour of recreation time. He witnessed a detainee getting shot with rubber bullets. On one occasion, he went to "the trailer" to watch television. He reported this was the only time he went outside. He reported that his roommate beat him up one night and pushed his head in the toilet. His brother Z.C. was in the cell next door and started banging on his door to get the staff's attention. Z.C. broke his wrist doing this and the staff never came. Z.C. never received any medical attention. Z.C. reported that as group punishment the guards would turn down the heat or turn on the air conditioning fully.

15. There was a conference call with C.G., regarding her grandson, J.P. on June 26, 2020. J.P. was currently at CCJDC and had been there for over a month. He did not have a medical evaluation to her knowledge since being there. She described that the shower was moldy, and he spent 23 hours per day in his cell and got one hour of recreation time.

16. There was a conference call with A.M. regarding C.A., her son. The call occurred on June 29<sup>th</sup>, 2020. C.A. has a history of ADHD and asthma and is in Special Education with an IEP. He was at the CCJDC several times. She reported her son was assaulted by his larger roommate. Following the assault, C.A. told the staff he was suicidal. They placed him in a suicide gown in the wet room for 3 days. She described the food was cold. The toilet overflowed and he was given 72 hours in disciplinary time with three people in the cell.

17. There was an interview with D.H. on July 1, 2020. He was 15 years of age. He was in an evaluation center and given time for a phone call by himself. He had previously been in the CCJDC from September 18, 2019 through February 27, 2020. He had no contact with the nurse or mental health staff while in custody. He has a history of Special Education. The staff would not allow his parents to bring his medication while in custody and he did not receive it. Two of the three people in his room had to sleep on the floor. He described that there were termites, bed bugs and even a lizard in the room. The room was cold. The staff would not give him a blanket. He had spider bites. He put in a sick call, but the nurse never came to see him. He reported he would not be able to consistently shower. The school was limited to 10 persons with two rotations. There was never any way to get credit for school. He was in the wet cell for five days. There was no light in the room. People would urinate on the floor. He reported there is no toilet in the wet cell. Staff would have to take you to go to the bathroom.

18. D.H. was placed in a restraint chair for 12 hours and not allowed to go to the bathroom. His head, chest, arms, legs and feet were strapped. He described there were 3 suicide attempts while he was there.

19. There was an interview with J.F. regarding her son, J.M., who was not present for the interview. This was on July 2, 2020. He was in the CCJDC three or four weeks prior. He had been there three times. He had medical problems with skin peeling around his mouth. His mother said she had to spend \$260 at the canteen for him to buy essential hygiene products that should have been provided. J.M. spent 23 hours a day in his cell. She reported that once he asked a guard what time it was and she responded by saying, "Your black ass should have never come to jail."

20. There was an interview with E.S. regarding her son, L.B. on July 2, 2020. He was in custody for two weeks several months prior. L.B. described the food as being nasty and the detention center as being filthy. He had a brain infection following his transfer from CCJDC to another facility. The doctors said it may have stemmed from a sinus infection. He was in CCJDC for about 45 days and then back there again before being sent to Georgetown Marine Institute placement. He was at the Georgetown placement for about 3 months and was then diagnosed with a brain infection sometime in March or April 2018. The infection is now gone. He has expressive language deficits, is deemed disabled and is now getting therapy. He reported being in his room 23 hours per day.

21. There was an interview with L.A. regarding her daughter, S.L. She was in custody in 2017 when she was 16 years old. Her daughter has severe asthma and requires daily medication. L.A. brought the medication to the CCJDC, but they did not provide it to S.L. S.L. was subsequently taken to the hospital by ambulance in handcuffs after suffering an asthma attack at CCJDC. Her mother arranged her release from the hospital through the family court.

## II. OPINIONS

### A. THE CCJDC FACILITY'S USE OF SOLITARY CONFINEMENT (WET CELL OR ISOLATION IN THEIR CELLS FOR 22-24 HOURS PER DAY) PUTS ADOLESCENTS AT A SUBSTANTIAL RISK OF SERIOUS HARM.

22. The interviews with these children and their families indicate that the CCJDC routinely keeps juveniles locked in small cells for 22-24 hours out of each day, with very limited opportunities for recreation or education, and with no mental health treatment. They may receive up to two hours of time outside their cells per day if they are not on lock down, but they are never allowed to go outside. They are allowed books, but not pencils or paper.

23. Sometimes children are kept in these cells alone and at other times with 1-3 other children. When more than two children are confined to a cell, some are forced to sleep on the floor.

24. The CCJDC has a policy or practice of using further isolation as discipline by placing the detainees on "lock down," which means they are not allowed to leave their cells at all for 24, 48 or 72 hours. As a further means of imposing discipline, the CCJDC sometimes confines children to the extreme isolation of the wet cell, with no bed or toilet, sometimes for days at a time and sometimes with additional restraints placed upon the child in the wet cell.

25. The United States Department of Justice defines solitary confinement as "the state of being confined to one's cell for approximately 22 hours per day or more, alone or with other prisoners, . . . [with] limit[ed] contact with others." *See* United States Department of Justice, Letter to the Honorable Tom Corbett, Re: Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation, May 31, 2013, at 5, [http://justice.gov/crt/about/spl/documents/cresson\\_findings\\_5-31-13.pdf](http://justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf). The American Academy of Child and Adolescent Psychiatry defines solitary confinement as a form of discipline or punishment that places an incarcerated individual "in a locked room or cell with minimal or no contact with

people, other than staff of the correctional facility.” (Exhibit C). The National Commission of Correctional Healthcare defines solitary confinement as “the housing of an adult or juvenile with minimal to rare meaningful contact with other individuals” ((Exhibit D).

26. The CCJDC Facility’s isolation of children in their cells for 22-24 hours per day—whether alone or with other children—and in the wet room constitutes solitary confinement as the term is commonly used in the field of Child and Adolescent Psychiatry. As policy statements in the above paragraph illustrate, what matters is not what constitutes solitary but rather the degree of meaningful social contact and the loss thereof and the degree of access to regular daily curriculum. There is a significant degree of deprivation of meaningful social contact in the everyday confinement of children to their cells for 22-24 hours per day and no opportunity to go outside, even where there are 2-4 children confined together. This is compounded by the absence of consistent educational services and other programming. The isolation is raised to a higher degree during lock downs, and it is most extreme in the wet cell.

27. It is my opinion, with a reasonable degree of medical certainty, that all adolescents in this case subjected to the CCJDC policies of solitary confinement as discussed above are at a substantial risk of serious harm to their social, psychological, and emotional development.

28. Even for juveniles who had been in solitary confinement and were not currently exhibiting obvious serious harm, solitary confinement can lead to underlying anxiety, hypervigilance and other signs of acute stress reactions.

**B. ADOLESCENTS IN DETENTION ARE AS A GROUP MORE VULNERABLE TO THE RISK OF SERIOUS HARM FROM SOLITARY CONFINEMENT.**

29. Solitary confinement can be dangerous for anyone, but adolescents as a group are particularly vulnerable to a substantial risk of serious harm from solitary confinement.

Because adolescents are still developing socially, psychologically, and neurologically, they are

especially susceptible to psychological harm when they are isolated from other people. Research, including research listed in Exhibit B, suggests that removing them from their regular routines, school, mental health treatment, and opportunities for interaction with peers can result in long-term lack of trust, hypervigilance, and paranoia.

30. Solitary confinement negatively impacts adolescents by perpetuating, worsening, or precipitating mental health concerns, including but not limited to post-traumatic stress disorders, psychosis, anxiety disorders, major depression, Bipolar Disorder, hypervigilance, agitation, general lack of trust, suicidal ideation, suicidal intent, self-mutilation, and suicidal behavior. As research cited in Exhibit C demonstrates, almost all suicides within juvenile correctional facilities occur when the adolescent is in some type of isolation.

31. Adolescents with underlying significant mental health issues are at even more extreme risk from the negative impact of isolation and solitary confinement. This can result in worsening depressive symptoms, worsening paranoia, and worsening acting out behaviors.

32. These mental health concerns can become long-term. Solitary confinement can lead to chronic conditions like depression, which in teenagers can manifest as anger or as self-harm. In addition, teenagers who experience depression and anxiety in their teenage years are at a higher risk of presenting with these diagnoses again. Damage associated with low self-esteem, vegetative features, and hopelessness associated with depression can similarly be long-standing. Depression has a 10-15% mortality rate associated with it, and solitary confinement increases the risk of suicide substantially compared to the general population.

33. Solitary confinement can lead to increased paranoia, which can result in hypervigilant thought processes agitated and violent behavior towards others.

34. Solitary confinement of juveniles can also lead to long-term trust issues with adults,

including paranoia, anger, and hatred directed at others. This makes it difficult to create a trusting, therapeutic relationship and can lead to noncompliance with treatment both now and in the future, making it hard for people to get the help that they need to address the mental health concerns resulting from solitary confinement.

35. Medical research on adolescent brains, including the research listed in Exhibit C, explains why juveniles are more vulnerable to the risk of long-term harm. In the adolescent brain, the connections between the frontal lobe and the mid-brain have not yet fully developed. The mid-brain, which is the part of the brain responsible for the flight-or-fight response, is firing away. If an adolescent is traumatized in certain ways, it can cause permanent changes in brain development and create a higher risk of developing permanent psychiatric sequelae (i.e., aftereffect of a disease) like paranoia and anxiety. Trauma based sequela, such as what is induced by solitary confinement, has a high likelihood of causing these permanent changes.

36. Juveniles in jails are also vulnerable to a substantial risk of serious harm from solitary confinement for the additional reason that they are more likely than the general population to have diagnosed mental illnesses and learning disabilities, and a high incidence of trauma. Research shows that over 60 percent of the youth in correctional settings have an underlying major mental illness. (Exhibit C)

37. There is a clear medical consensus that for those adolescents with mental illness, the risk of serious harm is especially great. People with mental illnesses already have cognitive deficits in their brain structure or biochemistry. They already have weakened defensive mechanisms, are at a higher risk for mental health sequelae, and are more susceptible to the significant trauma of social isolation. The trauma of social isolation that can occur for those with mental illnesses will be more significant and long-lasting than for those without a mental illness.

38. Medical professionals, including organizations like the American Medical Association, agree that juveniles with mental illnesses should not be placed in solitary confinement for longer than one hour without a comprehensive evaluation from a physician. Solitary confinement should never be used to punish people with mental illnesses.

39. This professional consensus is best reflected in long-standing accreditation standards for isolation in psychiatric hospitals. The Joint Commission, the most commonly used accreditation agency for psychiatric hospital systems, limits the use of seclusion to the least amount of time possible for the immediate protection of an individual, in situations where less restrictive interventions have been ineffective. Those standards require that, if a person is placed in seclusion of any kind, after 1 hour alone a physician must assess their well-being.

40. It is my opinion that these youth are exposed to substantial risk of harm and exposed to a substantial risk of serious harm correlated to the use of solitary confinement.

41. These youth were placed in solitary confinement – at least with respect to lock downs and confinement to the wet room -- for punitive purposes. There is no behavioral or emotional benefit to placement in solitary confinement.

42. Treatment and interventions described by youth, their parents, guardians and grandparents by phone interviews included a lack of medical and mental health care. There was no additional mental health treatment. There was nothing in terms of therapy or updated psychopharmacological interventions. Children often are not given their medications while they are at the CCJDC, even those prescribed for mental illnesses.

43. The failure of the facility to administer medications is particularly troublesome and it creates a dangerous situation for all involved. First, interfering with the prescribed course of treatment for a mental illness can have immediate and negative effects on the patient. Depending

upon the condition, dosage and other conditions, a child could become more likely to act out inappropriately, more likely to fail or refuse to follow instructions, and/or less able to respond appropriately to the stresses of being in the facility. They are made more vulnerable to the effects of their illness if they are not treated. Second, in some circumstances, failing to give medications can cause withdrawal symptoms and may also result in adverse chemical imbalances, which could take weeks or months to correct later. Third, not only are the children suffering from mental illness themselves affected when they are denied treatments and medications prescribed for them, but other children housed in or near them may also be adversely affected by being exposed secondarily to the negative effects of the denial of medication. In other words, large numbers of children with mental illnesses placed together and denied their prescribed treatment is a problem that compounds itself as the children interact with one another in ways that are increasingly dysfunctional. For these reasons, the failure to administer medications appropriately places the Children at substantial risk of serious harm.

44. The restraint chair is dangerous. There is a risk for positional asphyxia. It is frightening. There is no place for this type of use of physical restraints. It is cruel punishment with no researched benefit for adolescents.

45. It is my opinion that the CCJDC facility exposed these adolescents to a substantial risk of serious harm.

46. It is my opinion that adolescents subjected to the policy and practice of using solitary confinement at the correctional facility are exposed to a substantial risk of serious harm. I base this opinion in part on the fact that juveniles as a group are vulnerable to the risk of serious harm from solitary confinement and the research showing that a high percentage of juveniles in a detention setting have mental illnesses that exacerbate those risks of harm.

**C. THE CCJDC FACILITY'S USE OF SOLITARY CONFINEMENT VIOLATES THE CONSENSUS OF PROFESSIONAL ORGANIZATIONS IN THE FIELD.**

47. The CCJDC Facilities use of solitary confinement violates the norms of professional organizations in the field. A number of organizations have condemned solitary confinement of children under the age of 18 as a categorical matter, recognizing that they are particularly vulnerable to the adverse psychiatric consequences of such confinement.

48. The American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association (APA) oppose the use of punitive solitary confinement for juveniles in correctional facilities, recognizing the heinous nature of solitary, relevant to an adolescent's developmental vulnerabilities and the majority of suicides in juvenile correctional facilities occur when the individual is isolated, or in solitary confinement. (Exhibit D)

49. The APA states solitary confinement should be avoided except in rare circumstances. The Policy statement described potential psychiatric consequences including depression, anxiety and self harm. The APA also states that solitary confinement should never be used for punitive purposes. (Exhibit E).

50. The National Commission on Correctional Healthcare, a major crediting agency takes a position that juveniles should be excluded from solitary confinement. (Exhibit F)

51. The American Medical Association has called for correctional facilities to halt isolation of juveniles in solitary confinement for disciplinary purposes. (Exhibit G). (The American Psychiatric Association has supported this physician statement.)

52. The United Nation's Rules for the Protection of Juveniles deprived of their liberty, which was approved by the General Assembly in December of 1990 and supported by the United States, specifically prohibits the solitary confinement of juvenile offenders. (Exhibit H.)

53. The World Health Organization has recognized that the U.N. and other international treaties called for a complete ban on solitary confinement for juveniles and young people, noting the particular vulnerabilities of children, who are developing, physically, mentally and socially and the high rates of mental illness and suicide among young people.

**D. THE CCJDC FACILITY USE OF SOLITARY CONFINEMENT IS COUNTER-PRODUCTIVE TO SAFETY.**

54. Based on my 26 years of academic and professional experience, experience serving as a federal monitor of correctional facilities in Illinois and Arizona, review of academic research and my review of the notes from interviews with teens from the CCJDC, my opinion is that the use of solitary confinement at the facility is counterproductive to safety.

55. Solitary Confinement inhibits juveniles' ability to cope with stressful situations and leaves them angered and more disturbed, and therefore leads to more misbehavior and rule infractions.

56. Handling misbehavior in juveniles should be through the engagement of appropriate de-escalation techniques, mental health interventions, and clear structures for imposing discipline.

**E. THE CCJDC IS NOT MEETING THE BASIC EDUCATIONAL NEEDS OF THEIR YOUTH.**

57. There are youth within the facility that are in Special Education with Individual Education Plans (IEPs). There is nothing to indicate that the IEPs are being met. Youth report being denied any form of education arbitrarily. Youth report not receiving credit for education received while at CCJDC. There is nothing to indicate that the Basic Education Needs of these youth are being met.

**F. THE PHYSICAL STATE OF CCJDC IS DEPLORABLE.**

58. Based on a newspaper article and the interview summaries of the children and their families, the conditions at CCJDC are deplorable. They are overcrowded. There is mold in the rooms. There are insects and possibly mice or rats and the toilets overflow. No child should be forced to live under these conditions. The older beds and other items offer possible spots that youth could hang themselves from.

**G. THERE IS LITTLE TO NO MEDICAL OR MENTAL HEALTH TREATMENT AT CCJDC.**

59. In terms of treatment and interventions, the juveniles report that they receive little to no therapy or psychopharmacological treatment. CCJDC appears extremely limited and does not adequately address the mental health concerns of the juveniles. As explained above, the denial of treatment to children suffering from mental illness is reckless, and creates problems not only for the children who go untreated, but for others in the facility, as well.

I certify under penalty of perjury that the foregoing is true and correct.

Dated: July 24, 2020

Northbrook, Illinois

A handwritten signature in black ink, appearing to read "Louis J. Kraus", written over a horizontal line.

Louis J. Kraus, MD

Chief, Child and Adolescent Psychiatry

Director of Forensic Psychiatry

Rush University Medical Center

# **EXHIBIT A**

**LOUIS JAMES KRAUS, M.D., DFAPA, FAACAP**

Woman's Board Professor of Child and Adolescent Psychiatry  
Chief, Section of Child and Adolescent Psychiatry  
Rush University Medical Center

910 Skokie Boulevard, Suite 230  
Northbrook, IL 60062  
Office Telephone: (847) 559-0560  
Cell: (847) 217-7755  
Email: rkraus9@mac.com

**PERSONAL DATA:**

Louis James Kraus, MD  
DOB: 12-3-1960 USA

**EDUCATION:**

1987 M.D., University of Health Sciences, The Chicago Medical School  
1983 B.S., Syracuse University

**POSTGRADUATE TRAINING:**

7/1/92-6/30/94 Child and Adolescent Psychiatry Fellow, The University of Chicago, Chicago, Illinois  
10/1/88-6/30/92 Psychiatry Resident, Northwestern University, Chicago, Illinois  
7/1/91-12/31/91 Chief Resident, Psychiatry, Northwestern University, Chicago, Illinois  
7/1/87-6/30/88 Surgical Intern, Boston University, Boston, Massachusetts

**ACADEMIC APPOINTMENTS:**

July 2016 – Present Professor of Clinical Psychiatry, Rush University Medical Center  
July 2003 – June 2016 Associate Professor of Clinical Psychiatry, Rush University Medical Center  
March 2001 – 2002 Visiting Associate Professor of Psychiatry, University of Illinois at Chicago  
July 2001 – 2002 Assistant Professor of Psychiatry, Northwestern University  
November 1997 – July 2001 Clinical Instructor, Dept. of Psychiatry, Northwestern University  
July 1994 – August 1997 Assistant Professor, Department of Psychiatry, University of Chicago

July 1994 – August 1997

Director of Child and Adolescent Forensic Psychiatry, University of Chicago

**BOARD CERTIFICATION:**

May, 2015

Maintenance of Certification in Child and Adolescent Psychiatry, by The American Board of Psychiatry and Neurology, Certification No. 3956

June, 1999

Board Certified in Forensic Psychiatry, by the American Board of Psychiatry and Neurology, Certification No. 1079

October, 1995

Board certified in Child and Adolescent Psychiatry, by The American Board of Psychiatry and Neurology, Certification No. 3956

December, 1993

Board certified in General Psychiatry, by The American Board of Psychiatry and Neurology, Certification No. 38252

**LICENSE:**

State of Illinois

No. 036-079584

Expires: 07/31/2020

State of Florida

No. ME 83084

Expires: 01/31/2021

State of Arizona

No. 33456

Expires: 04/03/2021

**HONORS AND AWARDS:**

- 2020 Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry from the American Psychiatric Association (APA) and APA Foundation.
- Child and Adolescent Psychiatry, Award: "Scholarship and Perseverance in the Creation of our Practice Parameter for Child and Adolescent Forensic Evaluations", 58<sup>th</sup> Annual Meeting, Toronto, Canada, October 2011.
- Fellow, American Academy of Child and Adolescent Psychiatry (2006)
- Distinguished Fellow, American Psychiatric Association (2004)
- Woman's Board Professor of Child and Adolescent Psychiatry, Rush University Medical Center (2004)
- AMA Glaxo Welcome Emerging Leaders Development Program (1998)
- Top Doctor – 1997 - 2001
- Resident Fellowship of The American Psychoanalytic Association (1992)
- Laughlin Fellow, Northwestern University (1991)
- Magna Cum Laude, Syracuse University
- Phi Beta Kappa Honor Society
- Honors Program in Biology, Syracuse University

**PROFESSIONAL SOCIETY MEMBERSHIPS**

American Medical Association

American Academy of Child and Adolescent Psychiatry

American Academy of Psychiatry and the Law

American Psychiatric Association

Illinois State Medical Society  
Illinois Council of Child and Adolescent Psychiatry  
Illinois Psychiatric Association  
Chicago Medical Society

**TEACHING EXPERIENCE:**

May 2008 – Present	American Psychiatric Association Mentor for psychiatric residents through the Council on Children, Adolescents and Their Families
July 2006 – Present	Supervise Rush child and adolescent psychiatry fellows at the Sonia Shankman Orthogenic School (a residential school)
July 2002 – Present	Supervise general residents and child and adolescent fellows at Rush University Medical Center
July 2002 – Present	Developed forensic rotation at Rush University Medical Center for child and adolescent fellows allowing them to observe forensic evaluations in court, and the Cook County Juvenile Pre-Detention Facility
July 2002 – Present	Develop school consult didactics as well as didactics dealing with Autism; Supervise Rush University Medical Center’s child and adolescent fellows in their school Autism rotation at the Chicago Metropolitan Easter Seals Therapeutic Day Schools
July 2002 - Present	Develop and teach the child and adolescent forensic psychiatry course for child and adolescent psychiatry fellows at University of Illinois at Chicago and Rush University Medical Center
July 2002 - Present	Teach and supervise medical students in clinical rotations through child and adolescent psychiatry at Rush University Medical Center
March 2001 – July 2002	Supervise and lecture residents at University of Illinois
August 1997 – March 2001	Teaching and lecturing to general psychiatry residents at Northwestern University
August 1997 – March 2001	Supervise child and adolescent psychiatry residents and general psychiatry residents at Northwestern University
August 1994 – 1997	Provide child and adolescent forensic psychiatry course offered to residents and fellows at the University of Chicago

August 1993 – 1997 Supervise child and adolescent psychiatry fellows, psychiatry residents and psychology trainees at the University of Chicago

July 1991- July 1992 Supervise psychiatry residents at Northwestern University

**ELECTED POSITIONS:**

June 2008 – Present	Chair, AACAP Delegation to AMA House of Delegates
July 2015 – June 2016	Chair, AMA Council on Science and Public Health
July 2014 – June 2015	Chair Elect, AMA Council on Science and Public Health
2011 – 2013	Chair, AACAP Assembly
2011 – 2013	AACAP Executive Committee
July 2008 – June 2016	AMA Council on Science and Public Health
2009 – 2011	Vice-Chair, AACAP Assembly
2007 – 2009	AACAP Assembly Treasurer
2007 – 2013	AACAP Council
2002 – 2004	AACAP Assembly Representative to the Executive Committee

**REVIEWER:**

Guest Reviewer – Journal of The American Academy of Child and Adolescent Psychiatry  
Panelists –AMA Organized Medical Staff on Science and Public Health June 6, 2018  
Guest

**TRAINEES AND MENTOREES:**

2005 – Present	Ongoing Mentoring for AACAP and APA Mentor Programs
2005 – 2007 (Jada Johnson, MD)	Vice Chair, Psychiatry, Illinois Masonic Hospital
2002 – 2004 (Shiraz Butt, MD)	Medical Director, Maryville Academy
1998 – 2000 (Lucyna Puskarska, MD)	Medical Director, River Edge Hospital
1997 – 1999 (Joseph McNally, MD)	Medical Director, Streamwood Hospital

**PROFESSIONAL SOCIETY APPOINTMENTS**

May 2015 – Present	American Psychiatric Foundation (APF BOD), Board of Directors
2014 – Present	CMS District 1, Delegate to 2014 Illinois House of Delegates
May 2012 – Present	Chair – Council on Children, Adolescents and Their Families, American Psychiatric Association
May 2012 – May 2014	Chicago Medical Society, District 1 Councilor
May 2012 – May 2013	Chicago Medical Society District 1, Alternate Delegate to Illinois 2013 House of Delegates
November 2010 – June 2011	APA Task Force on Prevention of Bullying.

2009 – Present	APA Political Action Committee (PAC) Board
October 2009 – Present	AACAP Committee on Juvenile Justice Reform
April 2008 – 2009	Member APA Council on Children, Adolescents and Their Families.
2008 – Present	AACAP Delegate to AMA House of Delegates
May 2007 – Present	Member – Council on Children, Adolescents and Their Families, American Psychiatric Association
September 2001 – Present	Co-chairman of the AACAP committee on Juvenile Justice Reform.
May 2001 – 2010	Chairman of the American Psychiatric Association Committee on Juvenile Justice Issues
December 2000 – 2007	AACAP Alternate Delegate to the AMA House of Delegates 2007
June 2000 – June 2002	President, Illinois Council of Child & Adolescent Psychiatry
December 1999 – December 2000	AACAP Delegate for Young Physicians to the AMA
November 1999 – 2001	Evanston Northwestern Healthcare Child Protection Committee
September 1999 – March 2001	Member, Evanston Mental Health Board, Substance Abuse Task Force
June 1999 – 2001	Member, AMA Advisory Board on Alcohol Intervention Project for Youth
January 1999 – January 2003	Chairman, National Commission on Correctional Health Care, Committee on Juvenile Health Care
1998- 2010	Member of the American Psychiatric Association Committee on Juvenile Justice Issues
October 1998 – Present	Delegate, for The Illinois Council of Child and Adolescent Psychiatry to American Academy of Child and Adolescent Psychiatry (AACAP)
September 1998 – 2000	Clinical Advisor, Chicago Metropolitan Child and Adolescent Comprehensive Community Services Systems Network Advisory Council
April 1998 – December 1998	Vice Chairman, National Commission on Correctional Health Care, Committee on Juvenile Health Care
April 1998 – December 1998	Vice Chairman, National Commission on Correctional Health Care, Task Force for Revision of the NCCHC Standards for Health Services in Juvenile Detention and Confinement Facilities

June 1997 – January 1999	Chairperson of AACAP Committee for New Physicians
June 1997 – January 2003	Board of Directors, National Commission on Correctional Health Care
January 1997 – July 2000	Program Chairman, Illinois Council for Child and Adolescent Psychiatry
July 1995 – July 1996	Program Chairman for Chicago Society for Adolescent Psychiatry
September 1994 – October 1999	AACAP Committee on Foster and Adoptive Families
March 1994 – December 1996	AACAP Alternate Delegate for Young Physicians to the AMA

**CONSULTING POSITIONS**

January 2013-Present	Federal Consent Decree appointment, Assessment and restructuring of the mental health programming for the Illinois Department of Juvenile Justice (IDJJ) under a Consent Decree filed with the Attorney General's Office by the American Civil Liberties Union (ACLU) of Illinois in December 2012 (RJ v. Bishop)
February 2006 – Present	Consultant to the ACLU
May 2003 – 2008	Consultant, United States Department of Juvenile Justice, Civil Rights Division
March 2001 – June 2002	Director, Child and Adolescent Forensic Psychiatry, University of Illinois at Chicago
1993 – Present	Forensic testimony in Juvenile Court (abuse/neglect & delinquency), Family Court focusing on custody and expert testimony in other state and federal cases. Previously worked as an Expert for the Cook County Public Guardian's Office and DCFS.
September 1992-1993	Psychiatrist Chairperson of the Physician Review Board for the City of Chicago, Department of Mental Health – 1992
1992 – Present	Expert testimony in juvenile and domestic relations courts in a variety of cases ranging from transfer hearings, abuse including Munchausen by Proxy, Child Advocacy Focusing on Custody and "Best Interest" of the Child
April 1990 – June 1990	Psychiatric Consultant to Illinois Youth Center, Joliet, Illinois; General Population and the Intensive Reintegration Unit
January 1990 – 1992	City of Chicago, South East Community Mental Health Center

**ADMINISTRATIVE SERVICES:**

2011 - Present	Development of the Autism Assessment, Research, Treatment and Services (AARTS) Center at Rush University Medical Center
2006 – Present	Director of the Sonia Shankman Orthogenic School and Rush University Medical Center’s clinical rotation for child and adolescent psychiatry fellows at Rush
2006 – Present	Director of Psychiatric Services, Sonia Shankman Orthogenic School
2002 – Present	Chief of Child and Adolescent Psychiatry, Rush University Medical Center
1999 – Present	Medical Director of the Chicago Metropolitan Easter Seals Therapeutic Schools

**CLINICAL SERVICE:**

2012 - Present	Director, Autism Assessment, Research, Treatment and Services Center at Rush University Medical Center
July 2005 – Present	Psychiatric Director Sonia Shankman Orthogenic School at Chicago
June 2005 – Present	Psychiatric Consultant to New Trier, Niles North and Niles West High Schools
February 2000 – June 2001	Director, Child and Adolescent and Forensic Psychiatry, University of Illinois at Chicago
January 1999 – present	Medical Director, Chicago Metropolitan Easter Seals Therapeutic School
September 1998 – Present	Psychiatric Consultant to Evanston Township High School
August 1997 – February 2000	Division Head of Child/Adolescent Psychiatry, Evanston Northwestern Healthcare
May 1997 – June 1999	Psychiatric Consultant to Youth Campus (A DCFS contracting agency)
September 1992 – May 1993	Psychiatrist Chairperson of the Physician Review Board for the City of Chicago, Department of Mental Health – 1992
July 1994 – August 1997	Assistant Director of Child and Adolescent Inpatient Services, University of Chicago

**MEDIA**

1. October 26, 1994, Chicago Sun Times, TV-Violence Line Elusive.
2. November 6, 1994, Chicago Tribune, “Mental health tests for kids spark debate;” Screening: Testing

would help parents, supporters say.

3. November 19, 1994, Chicago Tribune, Try Sandifer suspect as kid, experts say. Louis Kraus testified, "Derrick Hardaway suffers from a *conduct disorder* that developed in his early adolescence because of family tensions, physical abuse and other problems."
4. February 25, 1997, Chicago Tribune, Leniency sought for teen convicted of killing Sandifer.
5. March 13, 1997, Chicago Tribune, Return girl slowly to mom, psychiatrist say.
6. March 30, 1997, Chicago Tribune, Student-Teacher contact is becoming a danger zone. Kraus was quoted to say, "The students are drawn into the relationship because they idolize their teacher and often don't see anything wrong until much later. At that point they might feel depressed and used and have trouble forming relationships."
7. March 25, 1998, Chicago Tribune, 4 pupils, teacher die in schoolyard ambush.
8. March 25, 1998, Chicago Sun Times, Kids ambush kids; Shooting stuns school.
9. March 29, 1998, Violence is linked to genetics, early abuses that set patterns
10. April 6, 1998, Chicago Tribune, Teen smokers a pack short of a carton in wisdom department.
11. June 3, 1998, Toronto, Canada, American Psychiatric Association, The Daily Bulletin, Presidential Sessions on "A Time of Violence."
12. June 1998, Chicago Parenting, "Keeping rage from turning into tragedy."
13. August 14, 1998, Chicago Sun Times, Making Sense of kids' case.
14. August 14, 1998, Chicago Tribune, Young suspects sent home. Dr. Kraus testament was paramount in the 7-year-old being allowed to go home with his family.
15. Possley, M. and Puente, T., "Young Suspects Sent Home", Chicago Tribune, August 14, 1998
16. Kotlowitz, A., "The Unprotected", The New Yorker. February 8, 1999
17. March 7, 1999, Chicago Tribune, Aftermath an ordeal for parents, kids.
18. November 11, 1999, Northwest Herald, Boy who shot clerk sentenced.
19. February 23, 2000, Tribune Allied Health, Safety nets for teens.
20. April 9, 2000, Chicago Tribune, School provides unique antidote for depression.
21. January 30, 2001, Chicago Tribune, Files in Ryan Harris case shed new light. Disclosure of the results of the psychiatric interview changed interview process of minors.
22. December 7, 2001, Psychiatric News, AACAP Kraus was quoted "We certainly disagree with the Supreme Court ruling and believe the death penalty constitutes cruel and unusual punishment."
23. July 9, 2002, Psychiatric News, AMA Vows to Prevent Future Psychologist Prescribing Laws.
24. April 4, 2003, Study Questions Youths' Ability to Understand Trial Process, *Study Implications*.
25. July 18, 2003, Psychiatric News, Psychiatrist Wins AMA Leadership Post: *Psychiatry Scores in HOD*. Kraus argued successfully in favor of an amendment to a resolution asking that the AMA support comprehensive health education for female delinquent, including information on responsible sexual behavior and the prevention of sexually transmitted diseases and HIV/AIDS." Kraus also testified, "Medicaid reaches 44 million Americans, more than Medicare or any other form of health insurance and covers Americans who are among the poorest and most disadvantaged populations in the country."
26. February 13, 2004, Chicago, Metro North Shore, Abuse of cold medicine rising.
27. Tresniowski, A. Hewitt, B., "Escape from Hell", People Magazine. September 25, 2006
28. Reuters, "Experts say video games not an addiction in AMA Meeting", June 25, 2007
29. Neergaard, L. "Easy nondrug helps ADHD Kids", USA Today. September 3, 2007
30. Tanner, L. "Shock Treatment Sought for Autistic Man", USA Today. September 3, 2007
31. Reuters, "Antidepressant warnings scared parents, doctors", September 9, 2007
32. Fox News, "Study: Brains of ADHD Children Develop More Slowly than Brains of other Youngsters", November 13, 2007
33. Bynum, R., Stobbe, M., "Experts Dubious of Ga. 3<sup>rd</sup>- Grader Plot", Associated Press. April 2, 2008

34. October 31, 2008, The Wall Street Journal, Therapy, Antidepressants Ease Anxiety in Children.
35. Tanner, L., "Kids with ADHD on meds test better than peers", Associated Press. April 27, 2009
36. Tanner, L., "Jackson kids face hurdles coping with his death, universal trauma of losing a parent may be eased if stability can be offered", Associated Press. July 5, 2009
37. Fox News, "Psychiatrists say Blagojevich's choice to have daughters join him at court may be stressful", July 7, 2010
38. FOX – Judge Jeanine, "8-year Old Boy's Commitment to a Psychiatric Ward", February 19, 2011
39. CNN, Anderson Cooper 360, "KTH: Mass. School called 'house of horrors', May 24, 2012,
40. Fox News Chicago, "Beauty may no longer be in the eye of the beholder", May 10, 2012
41. CNN, Anderson Cooper 360, "Anderson Cooper Investigates Shocking RTC Treatment", June 4, 2012
42. Moran, M. "More research needed on SSRI's for treating Autism Disorders", Psychiatric News. Volume 47, Number 11. June 11, 2012
43. CNN, Anderson Cooper 360, "Crime and Punishment, The Sandusky Trial", June 12, 2012
44. NBC News Chicago, "How to Talk to Your Kids about Conn. Shooting", December 14, 2012
45. Niedowski, E., Tanner, L. "How to Talk to Your Kids about Conn. Shooting", Associated Press. December 15, 2012
46. CNN, Anderson Cooper 360, "Former Child Hostage Describes Captivity Underground", February 4, 2013
47. Fox News Chicago, "Violence has long term effects on children", August 12, 2013
48. England, C. "Helping young adults make the transition", Chicago Medicine Magazine, September 2013
49. Schmadeke, S., "State's youth prison system violates inmates' rights, experts say", Chicago Tribune. September 25, 2013
50. NBC News, "Black Box warning on antidepressants raised suicide attempt", July 18, 2014
51. FOX News, "How far should we go to discipline our kids", September 2014
52. FOX News, "Could a self-esteem booster turn your child into a narcissist?", March 2015
53. Al Jazeera America, "US Only Nation to Imprison Kids for Life," March 2015
54. US Today, "Doctor: Impact-separating-families tragic June 19, 2018
55. Fox News, "Medical experts warn that separating children from parents causes psychological damage June 20, 2018
56. March 20, 2019, Chicago Tribune, "Local autism community cheers Amy Schumer's loving disclosure that her husband has a form of autism". Kraus was quoted stating "To have someone like Amy Schumer come out and talk about this is really amazing. I think it will be wonderful for people (with autism) and perhaps generate interest in the dating population about autism"
57. AP News, "Linked by pain: 2 school massacre survivors, dad kill selves", March 25, 2019

## **SCIENTIFIC ACTIVITIES**

### ***a) Grants:***

2011-Present	Effects of memantine vs. placebo on motor planning and memory in children with autism spectrum disorders. \$74,176
2010	Rush Women's Board, Assessment of prevalence of Bipolar Disorder in adolescent population in a residential placement, \$30,000
April, 1999	Department of Human Service, State of Illinois Grant – Bridges Program for Development of School and Home-based Therapeutic Services for Adolescents, \$100,000 per year
March, 1998	Evanston Northwestern Healthcare Auxiliary Grant for Development of a Community-based Adolescent Mental Health and Substance Abuse

Program, \$1,000,000

**b) Research**

2011 – Present

1984 - 1986

Development of Research Program at the Rush AARTS Center Research under direction of Max Harry Weil, Ph.D., Chairman, Department of Medicine, University of Health Sciences, The Chicago Medical School, on the reversal of academia during cardiopulmonary resuscitation

1999 – 2001

Outcomes research focusing on adolescent dual diagnosis; early diagnosis and intervention in a community based treatment program.

**c) Poster Presentations**

Grunewald, S., Kraus, L., Youngkin, S., Wade, K. H., Forburger, N., Owley, T., Loftin, R., Fogg, L. & Soorya, L. (May 2014). *Access to care: Familial and racial variables associated with limited service access for individuals with ASD*. Poster presented at 2014 Annual International Meeting for Autism Research (IMFAR). Atlanta, GA.

Poster Presentation: APA Meeting, Washington, DC "Monitoring Resident Supervision in Times of Change," May 1992.

**SCHOLARSHIP**

**a) Books and Chapters**

1. Thomas, C.R., Kraus, L.J. "Public Policy Implications of Research on Aggression and Antisocial Behavior", *The Origins of Antisocial Behavior*. Oxford University Press, 2012.
2. Galatzer-Levy, R., Kraus, L., Galatzer-Levy, J., *The Scientific Basis of Child Custody Decisions*. Cambridge Press, 2009.
3. Kessler, C., Kraus, L, *The Mental Health Needs of Young Offenders*. Cambridge Press, 2007.
4. Geraghty, R., Kraus, L, Fink, P, "Assessing children's competence to stand trial and to waive Miranda rights: new directions for legal and medical decision-making in juvenile courts" in *The Mental Health Needs of Young Offenders*. Cambridge Press, 2007,
5. Kraus L, Sobel, H, "Post-adjudicatory assessment of youth" in *The Mental Health Needs of Young Offenders*. Cambridge Press, 2007.
6. Galatzer-Levy, R., Kraus, L.J., eds, *The Scientific Study of Child Custody Decisions*, Wiley Press, 1999.
7. Kraus, L, "Understanding the Relationship between Children and Caregivers" in *The Scientific Basis of Child Custody Decisions*, Wiley Press, Ed. Galatzer-Levy R. and Kraus, L 1999.
8. Leventhal, B. Kelman, J., Galatzer-Levy, R., Kraus, L., "Divorce, Custody, and Visitation in Mid-Childhood" in *The Scientific Basis of Child Custody Decisions*, Wiley Press, Ed. Galatzer-Levy R. and Kraus, L 1999.
9. Kraus, L.J., Trivedi, H.K. "Adjudicated Youth: Child and Adolescent Psychiatric Clinics of North America" in *Clinics Review Articles Volume 25*. Elsevier, 2016.

**b) Peer Reviewed Publications**

1. 1988 Practice Parameter for "Child and Adolescent Forensic Evaluations", Kraus, L, JAACAP, Vol 50,

No.12, Dec. 2011 pp1299-1312.

2. Geraghty, T.F., Kraus, L, "Treating the Mentally-Ill Offender: The Challenge of Creating an Effective, Safe and Just System," **The Journal of Criminal Law and Criminology**, Northwestern University School of Law 89 (1) Fall, 1998.
3. von Planta, M., Gluldipati, R., Weil, M.H., Kraus, L.J., Rackow, E., "Bicarbonate and Tromethamine (Tham) Buffers Fail to Improve Resuscitability During Porcine C.P.R.," **Federation Proceedings** 46 (4), 1145, 1987
4. von Planta, M, Gudipati, R., Weil, M.H., Kraus, L.J., Rackow, E., "Effects of Tromethamine and Sodium Bicarbonate Buffers During Cardiac Resuscitation," **Journal of Clinical Pharmacology** 28, 594-599, 1987

**c) Other Publications**

1. Kraus, L., Arroyo, W. "Recommendations for Juvenile Justice Reform, Second Edition", American Academy of Child and Adolescent Psychiatry Committee on Juvenile Justice Reform. October 2005.
2. Kraus, L, Arroyo, W. Editors, "Recommendations for Juvenile Justice Reform", **Monograph**, October 2001, American Academy Child and Adolescent Psychiatry.
3. Kraus, L. "Standards for Juvenile Detention and Confinement Facilities", Recommendations for Juvenile Justice Reform, **Monograph**, October 2001.
4. Kraus, L. "Females in the Juvenile Justice System", Recommendations for Juvenile Justice Reform, **Monograph**, October 2001.
5. Kraus, L, Morris R. "Seclusion and Restraint Standards in Juvenile Corrections", Recommendations for Juvenile Justice Reform, **Monograph**, October 2001.
6. Kraus, L, "Tackling Juvenile Justice," **AACAP News**, Volume 31, Issue 2, March/April 2000, pp. 75-76.

**PRESENTATIONS:**

American Psychiatric Association, "Children & Adolescents In Juvenile Detention", October 7, 2018  
Harvard University Conference, "Behind Bars: Health and Human Rights in U.S. Prisons" November 28, 2017  
AACAP 64<sup>th</sup> Annual Meeting, Washington, DC October 23-28, 2017  
Keynote Speaker, Eugene J-M.A. Thonar, PhD, Award Presentation, Rush University Medical Center, October 14, 2014

Grand Rounds, Rush University Medical Center, "Psychiatric Malpractice: Dos and Don'ts." May 21, 2014

**Chair**, AACAP Douglas B. Hansen, MD 39<sup>th</sup> Annual Review Course in Child and Adolescent Psychiatry, *Child and Adolescent Forensic Psychiatry*, Westin Chicago River North, Chicago, IL, March 22-23, 2014.

Autism, Behavioral Challenges and Complex Medical Needs (ABC) Conference, "Making Systems Work Across the Lifespan for Children with Special Needs," *Treatment and Advocacy for the Autistic Teen as they Transition into Adulthood*, Kraus, LJ, Palos Hills, IL November 22, 2013.

Illinois State Board of Education, Kraus, LJ, **Keynote Speaker**, "The Complexity of Diagnosis and Behavior of Students Placed Residentially." November 7, 2013.

Illinois State Board of Education, Kraus, LJ, "Juvenile Justice, Social Maladjustment and Associated Mental Health Disorder: How do we educate this difficult population and what do we do when they get out?" November 7, 2013.

7<sup>th</sup> Congress of Asian Society for Child and Adolescent Psychiatry & Allied Professions and 12<sup>th</sup> Biennial Conference of Indian Association for Child and Adolescent Mental Health; Kraus, LJ., **Chair**, "Cyberage and

Child Mental Health.” September 26, 2013, New Delhi, India.

12<sup>th</sup> Biennial Conference of Indian Association for Child and Adolescent Mental Health; Kraus, L.J., **Chair**, “Role in the Changing Landscape of Child and Adolescent Psychiatry and Mental Health,” September 25, 2013, New Delhi, India.

12<sup>th</sup> Biennial Conference of Indian Association for Child and Adolescent Mental Health, Kraus, L.J., “DSM-V: Implications for Child and Adolescent Psychiatry,” September 25, 2013, New Delhi, India.

Illinois Institute for Continuing Legal Education, IIT Chicago-Kent College of Law, “Cutting Edge Child Custody Symposium”, *Professional Training and Requirements*, June 21, 2013.

Illinois Institute for Continuing Legal Education, IIT Chicago-Kent College of Law, “Cutting Edge Child Custody Symposium,” *Point and Counterpoint: Adoption of Custody Evaluation Standards*, June 21, 2013.

American Psychiatric Association (APA) Annual Meeting Workshop; “A Career in Child and Adolescent Psychiatry: From a Developmental Perspective.” San Francisco, CA May 22, 2013.

Office of Juvenile Justice and Delinquency Prevention in Collaboration with the National Center for Youth in Custody “The Impact of Isolation Practices in Confinement Facilities,” National Webinar, April 3, 2013.

19<sup>th</sup> Judicial Circuit Child Representative/Guardian ad Litem Training, “Psychology of Child Development and Age Appropriate Visitation.” College of Lake County, Grayslake, Illinois, September 12, 2012.

Abraxas Education Forums; “The Role of Child and Adolescent Psychiatry in Public and Private Special Education.” Woodridge, IL March 30, 2012.

Learning Disabilities Association of America, 49<sup>th</sup> International Conference, “Dissecting a Bully: Interventions for the Bullied.” February 22-25, 2012, Chicago, IL.

APA Annual Meeting, “Wayward Youth Revisited”, May 17, 2011, Honolulu, Hawaii.

APA Annual Meeting, “Teen Bullying”, May 17, 2011, Honolulu, Hawaii.

ISBA Chicago Regional Meeting (Effective Advocacy for Juveniles with Mental Health Needs) “Diagnosis and Treatment of Mental Health in the Juvenile Justice System”, May 11, 2011.

American Academy of Child and Adolescent Psychiatry (AACAP) 57<sup>th</sup> Annual Meeting, “Variations in State Decisions on Custody” October 29, 2010, NY, NY.

AACAP 57<sup>th</sup> Annual Meeting, “Role of the Expert in Child & Adolescent Psychiatry Malpractice” October 29, 2010, NY, NY.

AACAP 57<sup>th</sup> Annual Meeting, “Advocacy for Children with Autism: How to Find the Right Services” October 29, 2010, NY, NY.

ISBA Family Law Section, Springfield, IL. “Custody Evaluations When Children Have Major Psychiatric Disorders”, October 15, 2010.

ISBA Family Law Section, Chicago, IL. "Custody Evaluations When Children Have Major Psychiatric Disorders", September 23, 2010.

DePaul University College of Law, "Juvenile Competency to Stand Trial and Understand Miranda", April 11, 2009.

Illinois State Bar Association (ISBA) and the Committee on Continuing Legal Education, Attorney Education in Child Custody and Visitation Matters, "Factoring a Child's Development into Custody and Visitation" November 21, 2008.

AACAP Members Forum, Practice Parameter for Child and Adolescent Forensic Evaluations, October 31, 2008.

55<sup>th</sup> Annual AACAP Meeting Chicago, "The Role of the Child Psychiatrist in Juvenile Competency" October 30, 2008.

Rush University Medical Center, Department of Pediatrics Grand Rounds, "Perspectives on Delinquency, Past and Present", August 12, 2008.

American Medical Association (AMA), "How has science impacted juvenile justice regarding competency, waiver hearings, adjudications, dispositions, and treatment (psychopharmacology)". Annual Meeting, Washington DC, July 2008.

Spring Midwest American Academy of Psychiatry and the Law (AAPL) Meeting, Chicago, IL, "Juvenile Competency to Stand Trial and Understand Miranda," Louis J. Kraus, MD, April 21, 2007.

National APA Meeting in San Diego, "Workshop on Juvenile Justice Presentation on Child Competency to Stand Trial and Understand Miranda. May 2007.

53<sup>rd</sup> Annual American Academy of Child & Adolescent Psychiatry, San Diego, CA, "The Psychiatrist's Role in Child Custody: A Mock Hearing," Louis J. Kraus, MD, October 28, 2006.

Rush University Medical Center, Department of Psychiatry Grand Rounds, "Capital Punishment for Teenagers – The Recent Supreme Court Decision Roper v Simmons: Discussion and Forensic Application of Current Neuroimaging Research on Teenagers ", April 20, 2005.

Cambridge Hospital, Department of Psychiatry Grand Rounds, "Juvenile Delinquency", September 2004

AACAP National Meeting, San Francisco – Symposium – "Addressing the Needs of Behavior Disordered Children Within the School System", San Francisco, CA, October 25, 2002.

University of Chicago – Workshop "Early Onset Bipolar Disorder", December 14, 2001.

Juvenile Justice Reform – Media Workshop, National AACAP meeting, Honolulu, Hawaii, October 2001.

Hephzibah Children's Association – Workshop "Child and Adolescent Psychiatric Diagnoses and Medications" September 28, 2001

A&E Television Broadcast on "Shattered Innocence - Fells Acres Abuse Case", August 8, 2001

15<sup>th</sup> Annual Statewide Forensic Conference, October 16-17, 2000 Loyola University Chicago, Illinois  
Department of Human Services

Speaking engagements at parent groups, managed care meetings, University of Chicago, the Department of Corrections and Probation

Media interviews on television, radio and in newspapers and various publications.

American Psychiatric Association – "Littleton – One Year Later, The Assessment of the Potentially Violent Child Within The School System," May 15, 2000.

Institute of Psychoanalysis, Conference on Youth and Violence, "Diagnosis and Treatment of Delinquents in a Maximum Security Youth Center," May 12, 2000

Evanston Northwestern Healthcare – Pediatric Grand Rounds, "Connections Program – Development of a Community-Based Adolescent Alcohol and Drug Treatment Program," May 2, 2000.

Evanston Northwestern Healthcare – Pediatric Grand Rounds, "ADHD, Differential Diagnosis and Treatment" April 4, 2000.

New Trier High School – Peer Helping, "Adolescent Youth Violence," March 2, 2000.

Response Center, Skokie, IL, "Adolescent School Violence," February 16, 2000.

Chicago Bar Association Matrimonial Law Committee, "Physical, Mental and Emotional Abuse in Custody Cases," February 14, 2000.

Cook County Public Guardian's Office, "Domestic Violence and How It Affects Children," January 31, 2000.

Illinois Psychological Association, "Assessment of Violence in Children and Adolescents, November 11, 1999.

New Trier Township, "School Violence - Treatment and Community Intervention," May 12, 1999.

Shand Morahan Worksite Lunch Program, "Signs of ADD/ADHD and Possible Treatment," April 21, 1999.

Evanston Northwestern Healthcare Health Watch Program, "Childhood Attention Deficit Disorder: Treatment Options," April 7, 1999.

Evanston Northwestern Healthcare, Department of Psychiatry, Professional Conferences, "School Violence," April 6, 1999.

The Warren Wright Adolescent Center, Stone Institute of Psychiatry, Northwestern Memorial Hospital, "Violence in Schools," November 6, 1998.

Institute for Women's Health, Evanston Northwestern Healthcare "Helping Kids Cope with Divorce," October 1998.

Illinois Society of Child and Adolescent Psychiatry, "Juvenile Transfer Hearings – The Psychiatric Evaluation," October 1998.

APA Meeting, Toronto, Ontario, Canada, "Treatment of Severe Delinquents in a Maximum Security Youth Center," June 1998.

Evanston Northwestern Healthcare Pediatric Lecture Series, "The Continuum of Behavior Disorders," April 1998.

Evanston Northwestern Healthcare Department of Psychiatry, Professional Conferences, "Transfer Hearings in Juvenile Court: Evaluation of Behavior Disordered Youth," January 1998.

Evanston Northwestern Healthcare Department of Psychiatry, Professional Conferences, "The Use of Attachment Theory in Custody Evaluations," January 1998.

Juvenile Justice Division of the Circuit Court of Cook County, "Psychiatric Assessments in Juvenile Justice Cases," June 1997.

Chicago Bar Association-Juvenile Law Committee, "Utilizing Psychiatric Evaluations In Juvenile Justice Cases: Transfer And Dispositional Hearings," February 1997.

Genesis Schools/Illinois Association of Counsel for Children, "Helping Incarcerated Youth Overcome Delinquency and Mental Illness," December 1996.

University of Chicago, Laboratory School Lower School Parents Association Lecture Series, "Is My Child's Behavior Normal?" November 1995.

CAUSES - Illinois Masonic Hospital, "Attachment Theory In The Use Of Bonding Evaluations," September 1995.

Illinois Probation and Court Services 1995 Annual Spring Conference, "Kids Killing Kids," March 1995.

Grand Rounds: Columbus Hospital Department of Pediatrics. "Delinquency, Etiology and Intervention," July 1994.

Cook County Juvenile Court, Office of the Public Guardian. "Munchausen By Proxy," July 1994.

Columbus Hospital, Department of Pediatrics Grand Rounds, "Delinquency, Risk Factors, and Interventions," July 1994.

International Correctional Education Association Conference, Chicago " Attention Deficit Hyperactivity Disorder," May 1993.

The American Psychoanalytic Association National Conference, New York, "Attachment Theory - Forensic Implications for Best Interest of the Child," December 1993.

Poster Presentation: APA Meeting, Washington, DC "Monitoring Resident Supervision in Times of Change," May 1992.

The University of Health Sciences, The Chicago Medical School, "Effects of Tham and NaHCO<sub>3</sub> on Acid Base Balance During CPR," 1984.

**Louis J. Kraus, MD**  
**910 Skokie Boulevard**  
**Suite 230**  
**Northbrook, IL 60062**

**Deposition and Testimony Cases**

*Telephone: 847-559-560*  
*Facsimile: 847-559-0612*

<b>2019 2016 L 011004 Consolidated with 2016 L 011007</b>	Kathleen Kunkle of Ancel, Glink, Diamond, Bush, DeCianni Krafthefer, P.C.	Jane Doe 1 v Cicero School District 99	Trial	Circuit Court of Cook County, Illinois, County Department, Law Division
---	---	---	-------	---

<b>2019 12 L 58</b>	Patrick Flaherty of Kinnally, Flaherty, Krentz, Loran, Hodge & Masur	Carolyn Overstreet, Special Adminstrator of the estate of Cynthia Overstreet, Deceased v Rhomas Rossi, MD et al	Deposition	Circuit Court of the Seventeenth Judicial Circuit Winnebago County, Illinois
-------------------------	---	---	------------	---

<b>2019 18 D 1071</b>	Jordan Rosenberg of Beermann, LLP	Dr. Jennifer Casey v Jason Sachman	Deposition	Circuit Court for the Nineteenth Judicial Circuit Lake County, Illinois
---------------------------	--------------------------------------	---------------------------------------	------------	---

<b>2019 16 D 6144</b>	Joan Comiskey of Law Office of Joan Comiskey and Leon Finkel of Berger & Schatz	Anthony Geroulis v Mirofora Geroulis	Deposition	Circuit Court of Cook County Illinois
---------------------------	---	---	------------	---

<b>2019 11 D 002 451</b>	Enrico Mirabelli of Beermann, Pritikin, Mirabelli, Swerdlove, LLP	Roiban Ryan v Suzanne Ryan	Trial	Circuit Court of Cook County Illinois
------------------------------	--	-------------------------------	-------	---

<b>2019</b> 9:19-CV-0061	Mario Williams, Dalls LePierre of Nexus Derechos Humanos Attorneys, Inc.	Natalya Paykina, on behalf of minor child, E.L. v Donna Lewin, Anthony Annucci, John Doe 1, John Doe 2, et al	Evidentiary Hearing	United States District Court for the Northern District of New York
-----------------------------	--	--	------------------------	--

<b>2019</b> 1:16-CV-08303	Steven Weil Weil and Chardon LLC	T.S., et at v Twentieth Centry Fox Television, et al.	Deposition	United States District Court for the Northern District of Illinois Eastern Division
------------------------------	--	--	------------	---

<b>2019</b> 2017 D 0301	Ruggio & Associates	Yasser Refaat Farid/ Hassan V Rehab Esmat Baldrerin	Deposition	Circuit Court of Cook County Illinois
----------------------------	------------------------	--	------------	---

<b>2019</b> 2017 D 1173	Richard Boonstra Boonstra, Hoogendoorn & Talbot LLP	Charles Pratt v Lisa Anne Settli	Trial	Circuit Court of Cook County Illinois
----------------------------	--	-------------------------------------	-------	---

<b>2019</b> 12 - L 132	Ann DeVries, Hinshaw & Culbertson Law, LLP	Chynna Brown v Rockford Memorial Hospital	Deposition	Circuit Court of the 17 <sup>th</sup> Judicial Circuit Winnebago County, IL
---------------------------	---	---	------------	--

<b>2018</b> 17 D 662	Miller, Shakman & Beem, LLP and Berger Schatz	Kemper Ryan v Kristen Ryan	Deposition	Circuit Court of the Nineteenth Judicial Circuit, Lake County, Il
-------------------------	---	-------------------------------	------------	--

<b>2018</b> 3:18-CV-05056	Law, Lyman, Daniel, Kamerrer & Bogdanovich, P.S.	Samuel Tarabochia v Thurson County; Peter Feliciano, Christopher Marx, Anjelita Fornara, Vic Herbert, John Cody White, Mike Fenton, Ted Bryan,	Deposition	U.S. District Court Seattle, Washington
------------------------------	--	---	------------	---

		Dana Hanson, in their individual capacities		
--	--	---	--	--

<b>2018</b> 12CV02595	Alan Mandel, Alan J Mandel Law Office	Nagrin Kormi v Antoinette Choate, and David L. Lee	Deposition	US District Court Northern District of Illinois Eastern Division
--------------------------	---------------------------------------	--	------------	--

<b>2018</b> 17 - D 662	Miller,Shakman and Beem LLC	Kemper Ryan v Kristen Ryan	Deposition	Circuit Court of the Nineteenth Judicial Circuit, Lake County, Il
---------------------------	-----------------------------	----------------------------	------------	---

<b>2018</b> 16-CV-01356-NJR-RLD	Roderick and Solange MacArthur Justice Center, Northwestern Pritzker School of Law	Delarren Mason v Superintendent Donald Schaefer, Cheryl Prost, et al.	Deposition	US District Court Southern District of Illinois
------------------------------------	--	---	------------	---

<b>2017</b> 16-CV-00039	Buckley Sandler	Latson V Clarke	Deposition	Western District of VA
----------------------------	-----------------	-----------------	------------	------------------------

<b>2017</b> 16-cv-02848-LHK	Daniel Berger of Grant & Eisenhofer	Charles Des Roche et el v California Physicians Service	Deposition	US District Court for the Northern District of California (San Jose Division)
--------------------------------	-------------------------------------	---	------------	---

<b>2017</b> 2012 F 000032	Michael Ochoa Law Office of Jeffery Leving, Ltd.	Whitlock/Kochevor	Deposition	1 <sup>st</sup> Municipal District - Cook County, Chicago
------------------------------	--	-------------------	------------	---

<b>2016</b> 2014 D 001488	Schiller DuCanto & Fleck	DePalo v. DePalo	Deposition Testimony	1 <sup>st</sup> Municipal District – Cook County, Chicago
------------------------------	--------------------------	------------------	-------------------------	---

<b>2016</b> 2014 D 009277	James Hagler, Esq. Law Office of Jeffery Leving, Ltd	Rea v. Rea	Deposition Testimony	1 <sup>st</sup> Municipal District – Cook County, Chicago
------------------------------	--	------------	-------------------------	---

<b>2016</b> 2014 D 009277	James Hagler, Esq. Law Office of Jeffery Leving, Ltd	Rea v. Rea	Deposition Testimony	1 <sup>st</sup> Municipal District – Cook County, Chicago
------------------------------	--	------------	-------------------------	---

<b>2015</b> 2010 L005691	B. Whalen	McKinley v Doe	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
-----------------------------	-----------	----------------	------------	---

<b>2015</b> 2013 D 000182	A Berman Grund & Leavitt	Radassnau 215(a)	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	-----------------------------	------------------	------------	---

<b>2014</b> 2008 D 10469	Michael Bender	Dowd v Strauss	Deposition Trial	1 <sup>st</sup> Municipal District-Cook County, Chicago
-----------------------------	----------------	----------------	---------------------	---

<b>2014</b> 008800	O'Connor v Hurst	Weinhouse	Trial	1 <sup>st</sup> Municipal District-Cook County, Chicago
-----------------------	------------------	-----------	-------	---

<b>2014</b> ON L143	Livingston/Berger	Miller v Morgan	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------	-------------------	-----------------	------------	---

<b>2014</b> 2013 D 005580	Schiller, DuCanto Fleck	Ring 215a	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	----------------------------	-----------	------------	---

<b>2014</b> 2009 L 003496	Stephen Veltman Pretzel, Strouger	Angel v Segal	Deposition Trial	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	--------------------------------------	---------------	---------------------	---

<b>2014</b> 2012-CV-000648	Minh C. Wai	LaCrosse v Veolia, et al	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
-------------------------------	-------------	-----------------------------	------------	---

<b>2013</b> 2010 D 007929	Brian Hurst	Burrows v Burrows 604.5	Trial	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	-------------	----------------------------	-------	---

<b>2013</b> 2010 D 009879	Levin & Conde	Blakeslee/Slade 604.5	Deposition Trial	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	---------------	--------------------------	---------------------	---

<b>2013</b> 2010 EV 11187C	Insley/Race	Dukes v Acadia et al	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
-------------------------------	-------------	-------------------------	------------	---

<b>2013</b> 2009 L 003496	Pretzel & Stouffer	Angel v Segal et al	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	--------------------	---------------------	------------	---

<b>2013</b> 2012 D 011835	Clancy Law	Sproston v Gallee DO	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	------------	-------------------------	------------	---

<b>2013</b> 2009 L 000083	Holfert Hickey, Melia & Assoc	Bjork v Beltran	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	-------------------------------------	-----------------	------------	---

<b>2013</b> 2007 L 009154	Richard Griffin	Molina v Morgan	Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	-----------------	-----------------	------------	---

<b>2013</b> 2012 D 011835	J. Dahlan	G. Rotter (215a)	Testimony	1 <sup>st</sup> Municipal District-Cook County, Chicago
------------------------------	-----------	------------------	-----------	---

<b>2012</b> 09 CV 7290	Wms. Montgomery & John	Green v Kabota	Opinion Deposition	1 <sup>st</sup> Municipal District-Cook County, Chicago
---------------------------	---------------------------	----------------	-----------------------	---

<b>2012</b>	Samuel Lockner Carlson, Caspers, Vandenburg	Elan v Teva	2 <sup>nd</sup> Opinion	
-------------	---	-------------	-------------------------	--

<b>2012</b>	Capital WRITS	How Brain Development Effect Both Intent & Culpability	Opinion	
-------------	---------------	---	---------	--

<b>2011</b>	Baizer Kolar & Lewis	Estate of K. Brock	Deposition	
-------------	-------------------------	--------------------	------------	--

<b>2011</b>	Cunningham Meyer & Vedrine	First Choice v Professional, Ltd. Et al	Deposition	
-------------	-------------------------------	---	------------	--

<b>2011</b>	Kevin Costello Zukowski, Flood, Rogers, McArdie	Jeremy March	Deposition Trial	1 <sup>st</sup> Municipal District
-------------	---	--------------	---------------------	---------------------------------------

<b>2010</b>  00 D 06326	Grund & Leavitt	Gleicher v Garland	Testimony	1 <sup>st</sup> Municipal District
-------------------------------	-----------------	--------------------	-----------	---------------------------------------

<b>2010</b>  4:09-CV-00033	York Legal Group	USA v Arkansas	Deposition	
----------------------------------	------------------	----------------	------------	--

--	--	--	--	--

# **EXHIBIT B**

**EXHIBIT B**  
**Documents Reviewed**

- Phone interview notes
- Newspaper article in the Charleston Post, dated March 5, 2020

# **EXHIBIT C**

## EXHIBIT C

### Publications relied on include:

- 1) Juvenile Justice Reform Committee of the American Academy of Child and Adolescent Psychiatry, *Solitary Confinement of Juvenile Offenders* (April 2012), [http://www.aacap.org/aacap/policy\\_statements/2012/solitary\\_confinement\\_of\\_juvenile\\_offenders.aspx](http://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx).
- 2) Press Release, American Medical Association, AMA Adopts New Policies to Improve Health of Nation at Interim Meeting (Nov. 11, 2014), <http://www.ama-assn.org/ama/pub/news/news/2014/2014-11-20-ama-policies-improve-health-of-nation.page>.
- 3) National Commission on Correctional Health Care, *Solitary Confinement (Isolation)* (adopted April 10, 2016), <http://www.ncchc.org/solitary-confinement>.
- 4) Louis J. Kraus, MD, CSAPH Report 8-A-16: Juvenile Justice System Reform (Resolution 2015-I-14) (2016) (unpublished Report of the AMA Council on Science and Public Health) (on file with author).
- 5) Kevin Whitley & John S. Rozel, *Mental Health Care of Detained Youth in Solitary Confinement and Restraint Within Juvenile Detention Facilities*, in CHILD AND ADOLESCENT CLINICS OF NORTH AMERICAN, ADJUDICATED YOUTH 71-80 (Louis J. Kraus, MD, ed., 2016).
- 6) Karen M. Abram, Linda A. Teplin, et al., *Posttraumatic Stress Disorder and Trauma in Youth in Juvenile Detention*, 61 ARCHIVES GEN. PSYCHIATRY 403, 403-10 (2004).
- 7) National Commission on Correctional Health Care, *Standards for Health Services in Juvenile Detention and Confinement Facilities* (2011).
- 8) Stuart Grassian, *Psychiatric Effects of Confinement*, 22 WASH. U. J.L. & POL'Y 325 (2006).
- 9) Linda A. Teplin, et al., *Psychiatric Disorders in Youth in Juvenile Detention*, 59 ARCHIVES GEN. PSYCHIATRY 1133, 1133-43 (2002).
- 10) Jay N. Giedd, et al., *Brain development during childhood and adolescence: a longitudinal MRI study*, 2 NATURE NEUROSCIENCE 861, 861-63 (1999).
- 11) Jay N. Giedd, et al., *Quantitative magnetic resonance imaging of human brain development: ages 4-18*, 6 CEREBRAL CORTEX 551, 551-59 (1996).
- 12) Andrew Clark, *Juvenile Solitary Confinement as a Form of Child Abuse*, The Journal of the American Academy of Psychiatry and the Law, 45 (3) 350-357 (2017).
- 13) *Juvenile Solitary Confinement as a form of Child Abuse*, The Journal of the American Academy of Psychiatry and the Law in 45 (3), 350-357, 2017.
- 14) American Psychiatric Association Position Statement on Solitary Confinement (restricted Housing) of Juveniles, July, 2018

# **EXHIBIT D**

EXHIBIT D  
Solitary Confinement of Juvenile Offenders  
AACAP

AMERICAN ACADEMY OF  
CHILD & ADOLESCENT  
PSYCHIATRY  
WWW.AACAP.ORG

Search

Families and Youth Medical Students and Residents Member Resources Resources for Primary Care  
CME & Meetings



Sign In My Profile Publications Donate My Cart About AACAP

## Solitary Confinement of Juvenile Offenders

### Quick Links

[Policy Statements by Topic](#)

[Policy Statements By Year](#)

### Approved by Council, April 2012

To be reviewed by June 2017

By the Juvenile Justice Reform Committee

Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis<sup>1</sup>. Due to their developmental vulnerability, juvenile offenders are at particular risk

of such adverse reactions<sup>2</sup>. Furthermore, the majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement.

Solitary confinement should be distinguished from brief interventions such as "time out," which may be used as a component of a behavioral treatment program in facilities serving children and/or adolescents, or seclusion, which is a short term emergency procedure, the use of which is governed by federal, state and local laws and subject to regulations developed by the Joint Commission, CARF and supported by the National Commission of Correctional Healthcare (NCHHC), the American Correctional Association (ACA) and other accrediting entities.

The Joint Commission states that seclusion should only be used for the least amount of time possible for the immediate physical protection of an individual, in situations where less restrictive interventions have proven ineffective. The Joint Commission specifically prohibits the use of seclusion "as a means of coercion, discipline, convenience or staff retaliation." A lack of resources should never be a



[http://www.aacap.org/aacap/policy\\_statements/2012/solitary\\_confinement\\_of\\_juvenile\\_offenders.aspx](http://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx)[8/27/2016 3:26:03 PM]

Solitary Confinement of Juvenile Offenders

rationale for solitary confinement.

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty establish minimum standards for the protection of juveniles in correctional facilities. The UN resolution was approved by the General Assembly in December, 1990, and supported by the US. They specifically prohibit the solitary confinement of juvenile offenders. Section 67 of the Rules states:

"All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the

juvenile concerned." In this situation, cruel and unusual punishment would be considered an 8th Amendment violation of our constitution<sup>3</sup>.

Measurements to avoid confinement, including appropriate behavioral plans and other interventions should be implemented<sup>4</sup>.

The American Academy of Child and Adolescent Psychiatry concurs with the UN position and opposes the use of solitary confinement in correctional facilities for juveniles. In addition, any youth that is confined for more than 24 hours must be evaluated by a mental health professional, such as a child and adolescent psychiatrist when one is available.

#### **References:**

1. Grassian, Stuart. "Psychiatric Effects of Solitary Confinement." *Journal of Law and Policy*. (2006): 325-383.
2. Mitchell, Jeff, M.D. & Varley, Christopher, M.D. "Isolation and Restraint in Juvenile Correctional Facilities." *J.Am. Acad. Child Adolesc. Psychiatry*, 29:2, March 1990.
3. Vasiliades, Elizabeth. "Solitary Confinement and International Human Rights: Why the U.S. Prison System Fails Global Standards." *American University International Law Review* 21, no. 1 (2005): 71-99.
4. Sedlak, Andrea, McPherson, Carla, *Conditions of Confinement*, OJJDP, May 2010.

Copyright ©2016 - American Academy of Child Adolescent Psychiatry. All Rights Reserved. [Contact Us](#) | [Disclaimer](#) | [Privacy Statement](#)

Developed by [Armstrong Enterprise Communicatio](#)

[http://www.aacap.org/aacap/policy\\_statements/2012/solitary\\_confinement\\_of\\_juvenile\\_offenders.aspx](http://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx)[8/27/2016 3:26:03 PM]

# **EXHIBIT E**

## EXHIBIT E

### APA Official Actions

# Position Statement on Solitary Confinement (Restricted Housing) of Juveniles

Approved by the Board of Trustees, July 2018 Approved by the Assembly, May 2018

“Policy documents are approved by the APA Assembly and Board of Trustees. . . . These are . . . position statements that define APA official policy on specific subjects. . .” – *APA Operations Manual*

#### Position:

**Solitary confinement of juveniles (also referred to as restrictive housing or segregation), with rare exceptions, should be avoided due to the potential for harm to the juveniles. Juveniles (persons under 18 years of age) are at particular risk of potential psychiatric consequences of prolonged solitary confinement, including depression, anxiety, and self-harm. In the rare case that a juvenile must be placed in solitary confinement, meaningful access to mental health care, medical care, education, and recreation should be provided in order to minimize the potential for psychological harm. Solitary confinement should never be used for punitive purposes.**

#### Authors:

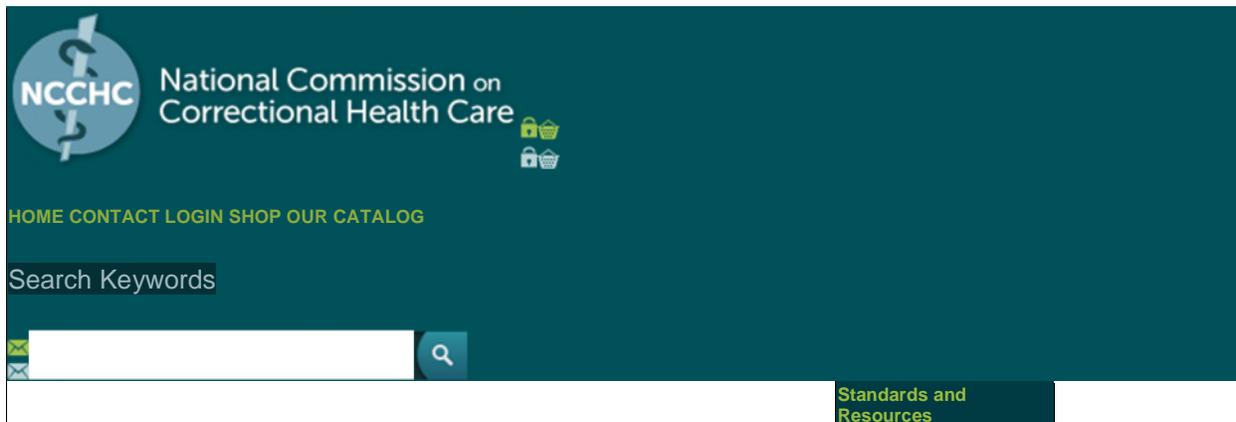
Peter Ash, M.D. (Chair); Aderonke Bamgbose-Pederson, M.D.; Jessica Bayner, M.D.; Elizabeth Ford, M.D.; Jai Gandhi, M.D.; Amy Gajaria, M.D.; Lisa Harding, M.D.; Helena Hansen, M.D., Ph.D.; Alexandra Junewicz, M.D.; Reena Kapoor, M.D.; Jungjin Kim, M.D.; Louis Kraus, M.D.; Michael Langley-DeGroot, M.D.; Richard Ly, M.D.; Jeffrey Metzner, M.D.; Bhinna Park, M.D.; Debra Pinals, M.D.; Joseph Penn, M.D.; Brooke Rosen, M.D.; Gabrielle Shapiro, M.D.; Robert Weinstock, M.D. for the Council on Psychiatry and Law; Council on Children, Adolescents, and Their Families; and Council on Minority Mental Health and Health Disparities

© Copyright, American Psychiatric Association, all rights reserved

# **EXHIBIT F**

## Exhibit F

Solitary Confinement (Isolation) | National Commission on Correctional Health Care



<http://www.nccchc.org/solitary-confinement>[8/27/2016 3:22:54 PM]

Solitary Confinement (Isolation) | National Commission on Correctional Health Care

9,10

physical health

and other international bodies have recognized that solitary confinement is harmful to health. The WHO notes that effects can include gastrointestinal and genitourinary problems, diaphoresis, insomnia, deterioration of eyesight, profound fatigue, heart

11

, this is not the view of most international organizations. The World Health Organization (WHO), United Nations,

Even those without a prior history of mental illness may experience a deterioration in mental health, experiencing anxiety, depression, anger,

palpitations, migraines, back and joint pains, weight loss, diarrhea, and aggravation of preexisting medical problems.

diminished impulse control, paranoia, visual and auditory hallucinations, cognitive disturbances, obsessive thoughts, paranoia, hypersensitivity to stimuli, posttraumatic stress disorder, self-harm, suicide, and/or psychosis. Some of these effects may persist after release from solitary confinement. Moreover, the very nature of prolonged social isolation is antithetical to the goals of rehabilitation and social integration.

These consequences are especially harmful to juveniles whose brains are still developing and those with mental health problems. In 2012, a task force appointed by the U.S. attorney general concluded:

Nowhere is the damaging impact of incarceration on vulnerable children more obvious than when it involves solitary confinement... Juveniles experience symptoms of paranoia, anxiety, and depression even after very short periods of isolation. Confined youth who spend extended periods isolated are among the most likely to attempt or actually commit suicide. One national study found that among the suicides in juvenile facilities, half of the victims were in isolation at the time

12

Psychologically, children are different from adults, making their time spent in isolation even more difficult and the developmental, psychological, and physical damage more comprehensive and lasting. They experience time differently—a day for a child feels

they took their own lives, and 62 percent of victims had a history of solitary confinement.

13,14,15,16

Adolescent Psychiatry has concluded that, due to their “developmental vulnerability,” adolescents are in particular danger of

17

In a report to the United Nations Human Rights Committee, Juan Méndez, U.N. special rapporteur on torture and cruel, inhuman, and degrading treatment, concludes that juveniles, given their physical and mental immaturity, should never be subjected to solitary confinement. He states that the imposition of solitary confinement of any duration on juveniles is cruel, inhuman, and degrading treatment and violates both the International Covenant on Civil and Political Rights and the Convention against Torture. He asserts, “given their diminished mental capacity and that solitary confinement often results in severe exacerbation of a previously existing mental condition,” the imposition of solitary confinement, of any duration, on persons with mental disabilities is

18

The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) state that solitary confinement should be prohibited in cases involving children and in the case of adults with mental or physical disabilities when their conditions

19

International standards established by the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders state that pregnant women should never be placed in solitary confinement as they are especially

20

longer than a day to an adult—and have a greater need for social stimulation.

The American Academy of Child and

adverse reactions to prolonged isolation and solitary confinement.

cruel, inhuman, or degrading treatment and also violates the Covenant and the Convention.

would be exacerbated by such measures.

susceptible to its harmful psychological effects.

In addition, placing these women in isolation impedes their access to necessary

and timely prenatal care.

21

The U.N. special rapporteur further asserts that solitary confinement is a harsh measure that may cause serious psychological and physiological adverse effects on individuals regardless of their specific conditions. He finds solitary confinement to be contrary to one of the essential aims of the penitentiary system, which is to rehabilitate offenders and facilitate their reintegration into society. He recommends a complete ban on prolonged or indefinite solitary confinement, citing 15 days as the starting point of prolonged

solitary confinement because, after that, “some of the harmful psychological effects of isolation can become irreversible.”<sup>22</sup> The Mandela Rules affirm that solitary confinement “shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review....” They specifically prohibit indefinite and/or prolonged (defined as a time period in excess of 15 consecutive days) solitary confinement, or placement in a dark or constantly lit cell, noting that these conditions

amount to “torture or other cruel, inhuman or degrading treatment or punishment.”<sup>23</sup>

By virtue of working in facilities where security and control, rather than the health and well-being of their patients, are the priorities, health professionals working in correctional facilities are often faced with ethical dilemmas. The participation of health care staff in actions that may be injurious to an individual's health is in conflict with their role as caregivers. This is especially true when they are called on to determine whether a patient is physically and psychologically well enough to be placed in solitary confinement. By doing so, health care providers become participants in the process of solitary confinement. Both the United Nations and the WHO are

opposed to such involvement on ethical grounds. The U.N. has stated that it is a contravention of medical ethics for health care staff, particularly physicians:

To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international

<http://www.ncchc.org/solitary-confinement>[8/27/2016 3:22:54 PM]

Solitary Confinement (Isolation) | National Commission on Correctional Health Care

instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with

24

The WHO states health care staff should never participate in enforcing any sanctions or in the underlying decision-making process, as this is not a medical act, and:

Doctors may frequently be approached when the sanction considered is solitary confinement. Solitary confinement has clearly been shown to be injurious to health. In cases where it is still enforced, its use should be limited to the shortest time possible. Thus, doctors should not collude in moves to segregate or restrict the movement of prisoners except on purely medical grounds, and they should not certify a prisoner as being fit for disciplinary isolation or any other form of punishment. Prisoners who are placed in isolation should be evaluated initially and periodically for acute mental illness, drug or alcohol withdrawal and injuries. If these are identified, prisoners should have access to prompt and effective treatment. Doctors should not certify

25

At the same time, health care staff must ensure that those in solitary confinement have access to and receive needed clinical care. As stated in the European Prison Rules (2006):

Medical practitioners or qualified nurses should not be obliged to pronounce prisoners fit for punishment but may advise prison authorities of the risks that certain measures may pose to the health of prisoners. They would have a particular duty to prisoners who are held in conditions of solitary confinement for whatever reason: for disciplinary purposes; as a result of their "dangerousness" or their "troublesome" behaviour; in the interests of a criminal investigation; at their own request. Following established practice, (see for example Rule 32.3 of the UN Standard Minimum Rules for the Treatment of Prisoners) such prisoners should be visited daily. Such visits can in no way be considered as condoning or legitimising a decision to put or to keep a prisoner in solitary confinement. Moreover, medical practitioners or qualified nurses should respond promptly to

26

Once a sanction is enforced, doctors must follow the prisoner being punished with extreme vigilance. It is well-established that solitary confinement constitutes an important stressor and risk, notably of suicide. Doctors must pay particular attention to such prisoners and visit them regularly of their own initiative, as soon as possible after an isolation order has taken effect and daily thereafter, to assess their physical and mental state and determine any deterioration in their well-being. Furthermore,

27

While correctional health care providers often encounter obstacles in the performance of their duties, there are specific challenges to the provision of health care to individuals in solitary confinement. Solitary confinement often makes it more difficult for patients to access care. Many facilities require that individuals in solitary confinement be shackled and accompanied by two officers when they are out of their cells. Many times, they must be body searched upon leaving and returning to their cells. As a result, health care staff may decide to perform their evaluations at cell-front, through bars or slots in the doors, either for their own or the patient's ease. Alternatively, clinical encounters may occur with the patient in a metal cage or behind a glass partition. Even when patients are taken to the medical clinic for evaluation, they often remain in restraints with custody officers in close proximity. Such arrangements are not respectful of an individual's dignity, interfere with privacy and confidentiality, and hamper or prevent the clinician from performing an adequate evaluation.

## POSITION STATEMENT

The following principles are to guide correctional health professionals in addressing issues about solitary confinement.

1. Prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual's health.

28

the relevant international instruments.

fitness for isolation.

request for treatment by prisoners held in such conditions or by prison staff.... The WHO also states:

doctors must immediately inform the prison management if a prisoner presents a health problem.

2. Juveniles

, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration.

3. Correctional health professionals should not condone or participate in cruel, inhumane, or degrading treatment of adults or juveniles in custody.

4. Prolonged solitary confinement should be eliminated as a means of punishment.

5. Solitary confinement as an administrative method of maintaining security should be used only as an exceptional measure when other, less restrictive options are not available, and then for the shortest time possible. Solitary confinement should never exceed 15 days. In those rare cases where longer isolation is required to protect the safety of staff and/or other inmates, more humane conditions of confinement need to be utilized.

6. Correctional health professionals' duty is the clinical care, physical safety, and psychological wellness of their patients.

<http://www.ncchc.org/solitary-confinement>[8/27/2016 3:22:54 PM]

**Solitary Confinement (Isolation) | National Commission on Correctional Health Care**

7. Isolation for clinical or therapeutic purposes should be allowed only upon the order of a health care professional and for the shortest duration and under the least restrictive conditions possible, and should take place in a clinically designated and supervised area.

8. Individuals who are separated from the general population for their own protection should be housed in the least restrictive conditions possible.

9. Health staff must not be involved in determining whether adults or juveniles are physically or psychologically able to be placed in isolation.

10. Individuals in solitary confinement, like other inmates, are entitled to health care that is consistent with the community standard of care.

11. Health care staff should evaluate individuals in solitary confinement upon placement and thereafter, on at least a daily basis. They should provide them with prompt medical assistance and treatment as required.

12. Health care staff must advocate so that individuals are removed from solitary confinement if their medical or mental health deteriorates or if necessary services cannot be provided.

13. Principles of respect and medical confidentiality must be observed for patients who are in solitary confinement. Medical examinations should occur in clinical areas where privacy can be ensured. Patients should be examined without restraints and without the presence of custody staff unless there is a high risk of violence. In situations where this cannot occur, the patient's privacy, dignity, and confidentiality should be maintained as much as possible. If custody staff must be present, they should maintain visual contact, but remain at a distance that provides auditory privacy.

14. Health care staff should ensure that the hygiene and cleanliness of individuals in solitary confinement and their housing areas are maintained; that they are receiving sufficient food, water, clothing, and exercise; and that the heating, lighting, and ventilation are adequate.

15. Adults and juveniles in solitary confinement should have as much human contact as possible with people from outside the facility and with custodial, educational, religious, and medical staff.

16. Appropriate programs need to be available to individuals in confinement to assist them with the transition to other housing units or the community, if released from isolation to the community.

17. In systems that do not conform to international standards, health care staff should advocate with correctional officials to establish policies prohibiting the use of solitary confinement for juveniles and mentally ill individuals, and limiting its use to less than 15 days for all others.

**Adopted by the National Commission on Correctional Health Care Board of Directors April 10, 2016**

## NOTES

1. Shames, A., Wilcox, J., & Subramanian, R. (May 2015). **Solitary confinement: Common misconceptions and emerging safe alternatives**. Vera Institute of Justice.

2. See, e.g., Madrid, 889 F. Supp. at 1265-66; Ruiz v. Johnson, 37 F.Supp.2d 855, 915 (S.D. Tex. 1999), 243 F.3d 941 (5th Cir. 2001), adhered to on remand, 154 F.Supp.2d 975 (S.D. Tex. 2001).

3. American Psychiatric Association. (December 2012). **Position statement on segregation of prisoners with mental illness**. 4. Scharff Smith, P. (2006). **The effects of solitary confinement on prison inmates: A brief history and review of the**

**literature**. *Crime and Justice*, 34(1), 441-528.

5. Haney, C. (January 2003). **Mental health issues in long-term solitary and "supermax" confinement**, *Crime & Delinquency*, (49)1, 124-156.

6. Grassian, S. (1983). **Psychopathological effects of solitary confinement**. *American Journal of Psychiatry*, 140, 1450-1454.

7. Grassian, S. (2006). **Psychiatric effects of solitary confinement**. *Washington University Journal of Law & Policy*, 22, 325-383.

8. Kaba, F., et al. (2014). **Solitary confinement and risk of self-harm among jail inmates**. *American Journal of Public Health*, 104(3), 442-447.

9. Clements, C. B., et al. (2007). **Systematic issues and correctional outcomes: Expanding the scope of correctional psychology**. *Criminal Justice and Behavior*, 34, 919-932.

10. Gendreau, P., & Goggin, C. (2014). Practicing psychology in correctional settings. In I. B. Weiner & R. K. Otto (Eds.), *The handbook of forensic psychology* (4th ed.). Hoboken, NJ: Wiley.

<http://www.ncchc.org/solitary-confinement>[8/27/2016 3:22:54 PM]

Solitary Confinement (Isolation) | National Commission on Correctional Health Care

11. World Health Organization. (2014). **Prisons and health** (p. 28).

12. Department of Justice. (December 2012). **Report of the Attorney General's National Task Force on Children Exposed to Violence**.

13. Steinberg, L., et al. (2009). **Age differences in future orientation and delay discounting**. *Child Development*, 80, 28-44.

14. Woolard, J., Odgers, C., Lanza-Kaduce, L., & Daglis, H. (2005). **Juveniles within adult correctional settings: Legal pathways and developmental considerations.** *International Journal of Forensic Mental Health*, 4(1), 1-18.

15. Laible, D., Carlo, G., & Raffaelli, M. (2000). **The differential relations of parent and peer attachment to adolescent adjustment,** *Journal of Youth and Adolescence*, 29(1), 45-59.

16. Arredondo, D. E. (2004). **Principles of child development and juvenile justice information for decision-makers.** *Journal of the Center for Families, Children & the Courts.*

17. American Academy of Child & Adolescent Psychiatry. (April 2012). **Solitary confinement of juvenile offenders** (Policy Statement).

18. Méndez, J. (2011). **Torture and other cruel, inhuman or degrading treatment or punishment.** Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment (p. 21).

19. United Nations. (May 2015). **United Nations standard minimum rules for the treatment of prisoners (the Mandela Rules)** (Rule 45).

20. United Nations. (2010). **United Nations rules for the treatment of women prisoners and non-custodial measures for women offenders (the Bangkok rules).**

21. ACLU Foundation. (2014). **Worse than second-class: Solitary confinement of women in the United States.**

22. United Nations. (May 2015). **United Nations standard minimum rules for the treatment of prisoners (the Mandela Rules)** (p. 13).

23. Op. cit. (Rules 43 & 44).

24. United Nations Office of the High Commissioner for Human Rights. (1982). **Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment.**

25. World Health Organization. (2007). **Health in prisons: A WHO guide to the essentials in prison health** (p. 36).

26. Council of Europe. (2006). **Commentary to recommendation rec(2006) 2 of the Committee of Ministers to Member States on the European Prison Rules.** 27. Op. cit., p. 13.

28. Stop Solitary for Kids. (2016). **Stop Solitary for Kids** (Position Statement). **ADDITIONAL RESOURCES**

1. National Commission on Correctional Health Care. (2012). **Correctional health professionals' response to inmate abuse** (Position Statement).

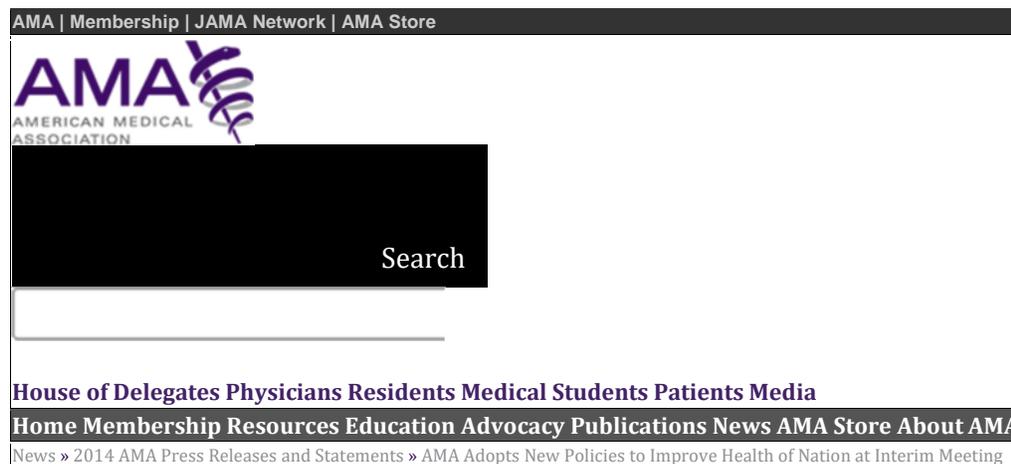
2. American Public Health Association. (November 2013). **Solitary confinement as a public health issue** (Policy Statement). 3. Shalev, S. (2008). **Sourcebook on solitary confinement,** London: Mannheim Centre for Criminology, London School of Economics.

4. Metzner, J. (2015). **Mental health considerations for segregated inmates.**

# **EXHIBIT G**

## EXHIBIT G

AMA Adopts New Policies to Improve Health of Nation at Interim Meeting



<http://www.ama-assn.org/ama/pub/news/news/2014/2014-11-20-ama-policies-improve-health-of-nation.page>[8/27/2016 3:28:19 PM]

AMA Adopts New Policies to Improve Health of Nation at Interim Meeting

Board Member William E. Kobler, M.D. "These facilities should restrict the use of isolation procedures to occasions when there is an acute risk to the health and safety of the juvenile or others."

The policy also stresses that the isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

### Medicaid Expansion Options and Alternatives

Believing that all patient should have access to the care they need, the AMA is concerned about the high number of low-income adults who remain uninsured in states that have opted not to expand their Medicaid programs. A new AMA policy passed today encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap, even if states choose not to adopt the Medicaid expansion outlined in the Affordable Care Act. The policy encourages states that are not participating in Medicaid expansion programs to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations. Further, the AMA encourages the Centers for Medicare and Medicaid Services to approve waivers that are consistent with the goals and spirit of expanding insurance coverage. The policy also urges that states use a transparent process for evaluating the success of their efforts to expand access to care and to report the results annually on their Medicaid websites.

"The AMA is sensitive to state concerns about expanding Medicaid in a traditional manner, but we believe they must find ways to expand health insurance coverage to their uninsured populations, especially as coverage disparities continue to grow between expansion and non-expansion states," said AMA Immediate Past Board Chair, David O. Barbe, M.D. "We encourage states that would otherwise reject the opportunity to expand their Medicaid programs to develop expansion waivers that help increase coverage options for their low income adult residents."

### Sobriety Checkpoints

Every two-hours, three people are killed in alcohol-related highway crashes, according to the Bureau of Transportation Statistics. Sobriety checkpoints have been proven to substantially reduce alcohol-related crashes, which is why the AMA adopted a new policy today to support the increased use of legal and constitutional sobriety checkpoints and advocate with state medical societies to overturn bans on the use of them to deter driving under the influence.

"Sobriety checkpoints are one of the National Highway Traffic Safety Administration's primary recommendations for reducing drunk driving, and this new policy will help increase the use of these checkpoints to save lives," said AMA Board Member Mary Anne McCaffree, M.D.

### FSMB State Licensing Compact

In an effort to make it easier for physicians to obtain licenses in multiple states while providing access to safe, quality care, the AMA adopted policy supporting an interstate compact developed by the Federation of State Medical Boards (FSMB).

Under the new policy, the AMA will work with medical associations, FSMB, and other interested stakeholders to ensure expeditious adoption of the compact and the creation of an Interstate Medical Licensure Commission. Through the licensure process, state medical boards assure that physicians are qualified - reviewing their education, training, character, and professional and disciplinary histories. In order to protect the interest of patients and their safety when medical services are provided either in-person or via telemedicine, we must maintain physician accountability, which requires state oversight.

"At least 10 state medical boards have adopted the compact, which streamlines the licensing process for physicians seeking licenses in multiple states and increases patient access to telemedicine services and we encourage more states to sign on to the compact so that we can ensure standards of care are maintained, whether treatment is provided in-person or via telemedicine," said AMA President-elect Steven J. Stack, M.D.

### **Coordination with Pharmacists to Improve Immunization Rates**

With data showing that less than half of adults over age 18 received an influenza vaccine last year, the AMA today adopted policy encouraging efforts to increase immunization rates in the U.S.

The new AMA policy recognizes the current role of pharmacists in vaccinating target populations that lack access to a medical home or that are otherwise unlikely to receive immunizations through physician practices. The policy affirms that health professionals who administer vaccines have shared responsibilities to ensure that vaccination administration is documented in the patient medical record and calls on physicians and pharmacists, as a part of the healthcare delivery team, to work together in the community to encourage patients to follow-up with a primary care physician to ensure continuity of care.

"It is important that we ensure patients have access to the care they need when they need it, especially access to preventive care like immunizations," said AMA Board Member William E. Kobler, M.D. "By complementing the efforts of physicians with the work of health professionals in other health settings to deliver vaccines, we have the ability to increase immunization rates, address vaccine-preventable illnesses and improve health outcomes."

<http://www.ama-assn.org/ama/pub/news/news/2014/2014-11-20-ama-policies-improve-health-of-nation.page>[8/27/2016 3:28:19 PM]

AMA Adopts New Policies to Improve Health of Nation at Interim Meeting



<http://www.ama-assn.org/ama/pub/news/news/2014/2014-11-20-ama-policies-improve-health-of-nation.page>[8/27/2016 3:28:19 PM]

# **EXHIBIT H**

## EXHIBIT H

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...

<http://www.un.org/documents/ga/res/45/a45r113.htm>

United Nations

**A/RES/45/113**

Distr. GENERAL 14 December 1990

ORIGINAL: ENGLISH



## General Assembly

1 of 13

9/18/2016 11:28 AM

45/113. United Nations Rules for the Protection of Juveniles Deprived of their Liberty

The General Assembly,

Bearing in mind the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention on the Rights of the Child, as well as other international instruments relating to the protection of the rights and well-being of young persons,

Bearing in mind also the Standard Minimum Rules for the Treatment of Prisoners adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders,

Bearing in mind further the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, approved by the General Assembly by its resolution 43/173 of 9 December 1988 and contained in the annex thereto,

Recalling the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules),

Recalling also resolution 21 of the Seventh United Nations Congress on the Prevention of Crime and the Treatment of Offenders, in which the Congress called for the development of rules for the protection of juveniles deprived of their liberty,

Recalling further that the Economic and Social Council, in section II of its resolution 1986/10 of 21 May 1986, requested the Secretary-General to report on progress achieved in the development of the rules to the Committee on Crime Prevention and Control at its tenth session and requested the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders to consider the proposed rules with a view to their adoption,

Alarmed at the conditions and circumstances under which juveniles are being deprived of their liberty world wide,

Aware that juveniles deprived of their liberty are highly vulnerable to

A/RES/45/113

68th plenary meeting

14 December 1990

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...

<http://www.un.org/documents/ga/res/45/a45r113.htm>

2 of 13

9/18/2016 11:28 AM

abuse, victimization and the violation of their rights,

Concerned that many systems do not differentiate between adults and juveniles at various stages of the administration of justice and that juveniles are therefore being held in gaols and facilities with adults,

1. always be

2.

deprived of their liberty require special attention and protection and that their rights and well-being should be guaranteed during and after the period when they are deprived of their liberty;

3. Notes with appreciation the valuable work of the Secretariat and the collaboration which has been established between the Secretariat and experts, practitioners, intergovernmental organizations, the non-governmental community, particularly Amnesty International, Defence for Children International and Radda Barnen International (Swedish Save the Children Federation), and scientific institutions concerned with the rights of children and juvenile justice in the development of the United Nations draft Rules for the Protection of Juveniles Deprived of their Liberty;

4. Adopts the United Nations Rules for the Protection of Juveniles Deprived of their Liberty contained in the annex to the present resolution;

5. Calls upon the Committee on Crime Prevention and Control to formulate measures for the effective implementation of the Rules, with the assistance of the United Nations institutes on the prevention of crime and the treatment of offenders;

6. Invites Member States to adapt, wherever necessary, their national legislation, policies and practices, particularly in the training of all categories of juvenile justice personnel, to the spirit of the Rules, and to bring them to the attention of relevant authorities and the public in general;

7. Also invites Member States to inform the Secretary-General of their efforts to apply the Rules in law, policy and practice and to report regularly to the Committee on Crime Prevention and Control on the results achieved in their implementation;

8. Requests the Secretary-General and invites Member States to ensure the widest possible dissemination of the text of the Rules in all of the official languages of the United Nations;

9. Requests the Secretary-General to conduct comparative research, pursue the requisite collaboration and devise strategies to deal with the different categories of serious and persistent young offenders, and to prepare a policy-oriented report thereon for submission to the Ninth United Nations Congress on the Prevention of Crime and the Treatment of Offenders;

10. Also requests the Secretary-General and urges Member States to allocate the necessary resources to ensure the successful application and implementation of the Rules, in particular in the areas of recruitment, training and exchange of all categories of juvenile justice personnel;

11. Urges all relevant bodies of the United Nations system, in particular the United Nations Children's Fund, the regional commissions and specialized agencies, the United Nations institutes for the prevention of crime and the treatment of offenders and all concerned intergovernmental and non-governmental organizations, to collaborate with the Secretary-General and to take the necessary measures to ensure a concerted and sustained effort within their respective fields of technical competence to promote the application of the Rules;

Affirms that the placement of a juvenile in an institution should be a disposition of last resort and for the minimum necessary period;

Recognizes that, because of their high vulnerability, juveniles

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...  
<http://www.un.org/documents/ga/res/45/a45r113.htm>

3 of 13

9/18/2016 11:28 AM

12. Invites the Sub-Commission on Prevention of Discrimination and Protection of Minorities of the Commission on Human Rights to consider this new

international instrument, with a view to promoting the application of its provisions;

13. Requests the Ninth Congress to review the progress made on the promotion and application of the Rules and on the recommendations contained in the present resolution, under a separate agenda item on juvenile justice.

#### ANNEX

#### United Nations Rules for the Protection of Juveniles

##### Deprived of their Liberty I. FUNDAMENTAL PERSPECTIVES

1. The juvenile justice system should uphold the rights and safety and promote the physical and mental well-being of juveniles. Imprisonment should be used as a last resort.

2. Juveniles should only be deprived of their liberty in accordance with the principles and procedures set forth in these Rules and in the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules). Deprivation of the liberty of a juvenile should be a disposition of last resort and for the minimum necessary period and should be limited to exceptional cases. The length of the sanction should be determined by the judicial authority, without precluding the possibility of his or her early release.

3. The Rules are intended to establish minimum standards accepted by the United Nations for the protection of juveniles deprived of their liberty in all forms, consistent with human rights and fundamental freedoms, with a view to counteracting the detrimental effects of all types of detention and to fostering integration in society.

4. The Rules should be applied impartially, without discrimination of any kind as to race, colour, sex, age, language, religion, nationality, political or other opinion, cultural beliefs or practices, property, birth or family status, ethnic or social origin, and disability. The religious and cultural beliefs, practices and moral concepts of the juvenile should be respected.

5. The Rules are designed to serve as convenient standards of reference and to provide encouragement and guidance to professionals involved in the management of the juvenile justice system.

6. The Rules should be made readily available to juvenile justice personnel in their national languages. Juveniles who are not fluent in the language spoken by the personnel of the detention facility should have the right to the services of an interpreter free of charge whenever necessary, in particular during medical examinations and disciplinary proceedings.

7. Where appropriate, States should incorporate the Rules into their legislation or amend it accordingly and provide effective remedies for their breach, including compensation when injuries are inflicted on juveniles. States should also monitor the application of the Rules.

8. The competent authorities should constantly seek to increase the awareness of the public that the care of detained juveniles and preparation for their

return to society is a social service of great importance, and to this end active steps should be taken to foster open contacts between the juveniles and the local community.

9. Nothing in the Rules should be interpreted as precluding the application of the relevant United Nations and human rights instruments and standards, recognized by the international community, that are more conducive to ensuring

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...  
<http://www.un.org/documents/ga/res/45/a45r113.htm>

4 of 13

9/18/2016 11:28 AM

the rights, care and protection of juveniles, children and all young persons.

10. In the event that the practical application of particular Rules contained in sections II to V, inclusive, presents any conflict with the Rules contained in the present section, compliance with the latter shall be regarded as the predominant requirement.

## II. SCOPE AND APPLICATION OF THE RULES

11. For the purposes of the Rules, the following definitions should apply:

(a) A juvenile is every person under the age of 18. The age limit below which it should not be permitted to deprive a child of his or her liberty should be determined by law;

(b) The deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting, from which this person is not permitted to leave at will, by order of any judicial, administrative or other public authority.

12. The deprivation of liberty should be effected in conditions and circumstances which ensure respect for the human rights of juveniles. Juveniles detained in facilities should be guaranteed the benefit of meaningful activities and programmes which would serve to promote and sustain their health and self-respect, to foster their sense of responsibility and encourage those attitudes and skills that will assist them in developing their potential as members of society.

13. Juveniles deprived of their liberty shall not for any reason related to their status be denied the civil, economic, political, social or cultural rights to which they are entitled under national or international law, and which are compatible with the deprivation of liberty.

14. The protection of the individual rights of juveniles with special regard to the legality of the execution of the detention measures shall be ensured by the competent authority, while the objectives of social integration should be secured by regular inspections and other means of control carried out, according to international standards, national laws and regulations, by a

duly constituted body authorized to visit the juveniles and not belonging to the detention facility.

15. The Rules apply to all types and forms of detention facilities in which juveniles are deprived of their liberty. Sections I, II, IV and V of the Rules apply to all detention facilities and institutional settings in which juveniles are detained, and section III applies specifically to juveniles under arrest or awaiting trial.

16. The Rules shall be implemented in the context of the economic, social and cultural conditions prevailing in each Member State.

### III. JUVENILES UNDER ARREST OR AWAITING TRIAL

17. Juveniles who are detained under arrest or awaiting trial ("untried") are presumed innocent and shall be treated as such. Detention before trial shall be avoided to the extent possible and limited to exceptional circumstances. Therefore, all efforts shall be made to apply alternative measures. When preventive detention is nevertheless used, juvenile courts and investigative bodies shall give the highest priority to the most expeditious processing of such cases to ensure the shortest possible duration of detention. Untried detainees should be separated from convicted juveniles.

18. The conditions under which an untried juvenile is detained should be consistent with the rules set out below, with additional specific provisions as are necessary and appropriate, given the requirements of the presumption of innocence, the duration of the detention and the legal status and

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...  
<http://www.un.org/documents/ga/res/45/a45r113.htm>

5 of 13

9/18/2016 11:28 AM

circumstances of the juvenile. These provisions would include, but not necessarily be restricted to, the following:

(a) Juveniles should have the right of legal counsel and be enabled to apply for free legal aid, where such aid is available, and to communicate regularly with their legal advisers. Privacy and confidentiality shall be ensured for such communications;

(b) Juveniles should be provided, where possible, with opportunities to pursue work, with remuneration, and continue education or training, but should not be required to do so. Work, education or training should not cause the continuation of the detention;

(c) Juveniles should receive and retain materials for their leisure and recreation as are compatible with the interests of the administration of justice.

### IV. THE MANAGEMENT OF JUVENILE FACILITIES A. Records

19. All reports, including legal records, medical records and records of disciplinary proceedings, and all other documents relating to the form, content and details of treatment, should be placed in a confidential individual file, which should be kept up to date, accessible only to authorized persons and classified in such a way as to be easily understood. Where possible, every juvenile should have the right to contest any fact or opinion contained in his or her file so as to permit rectification of inaccurate, unfounded or unfair statements. In order to exercise this right, there should be procedures that allow an appropriate third party to have access to and to consult the file on request. Upon release, the records of juveniles shall be sealed, and, at an appropriate time, expunged.

20. No juvenile should be received in any detention facility without a valid commitment order of a judicial, administrative or other public authority. The details of this order should be immediately entered in the register. No juvenile should be detained in any facility where there is no such register.

#### B. Admission, registration, movement and transfer

21. In every place where juveniles are detained, a complete and secure record of the following information should be kept concerning each juvenile received:

- (a) Information on the identity of the juvenile;
- (b) The fact of and reasons for commitment and the authority therefor; (c) The day and hour of admission, transfer and release;
- (d) Details of the notifications to parents and guardians on every admission, transfer or release of the juvenile in their care at the time of commitment;
- (e) Details of known physical and mental health problems, including drug and alcohol abuse.

22. The information on admission, place, transfer and release should be provided without delay to the parents and guardians or closest relative of the juvenile concerned.

23. As soon as possible after reception, full reports and relevant information on the personal situation and circumstances of each juvenile should be drawn up and submitted to the administration.

24. On admission, all juveniles shall be given a copy of the rules governing the detention facility and a written description of their rights and obligations in a language they can understand, together with the address of

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...  
<http://www.un.org/documents/ga/res/45/a45r113.htm>

6 of 13

9/18/2016 11:28 AM

the authorities competent to receive complaints, as well as the address of public or private agencies and organizations which provide legal assistance.

For those juveniles who are illiterate or who cannot understand the language in the written form, the information should be conveyed in a manner enabling full comprehension.

25. All juveniles should be helped to understand the regulations governing the internal organization of the facility, the goals and methodology of the care provided, the disciplinary requirements and procedures, other authorized methods of seeking information and of making complaints, and all such other matters as are necessary to enable them to understand fully their rights and obligations during detention.

26. The transport of juveniles should be carried out at the expense of the administration in conveyances with adequate ventilation and light, in conditions that should in no way subject them to hardship or indignity. Juveniles should not be transferred from one facility to another arbitrarily.

### C. Classification and placement

27. As soon as possible after the moment of admission, each juvenile should be interviewed, and a psychological and social report identifying any factors relevant to the specific type and level of care and programme required by the juvenile should be prepared. This report, together with the report prepared by a medical officer who has examined the juvenile upon admission, should be forwarded to the director for purposes of determining the most appropriate placement for the juvenile within the facility and the specific type and level of care and programme required and to be pursued. When special rehabilitative treatment is required, and the length of stay in the facility permits, trained personnel of the facility should prepare a written, individualized treatment plan specifying treatment objectives and time-frame and the means, stages and delays with which the objectives should be approached.

28. The detention of juveniles should only take place under conditions that take full account of their particular needs, status and special requirements according to their age, personality, sex and type of offence, as well as mental and physical health, and which ensure their protection from harmful influences and risk situations. The principal criterion for the separation of different categories of juveniles deprived of their liberty should be the provision of the type of care best suited to the particular needs of the individuals concerned and the protection of their physical, mental and moral integrity and well-being.

29. In all detention facilities juveniles should be separated from adults, unless they are members of the same family. Under controlled conditions, juveniles may be brought together with carefully selected adults as part of a special programme that has been shown to be beneficial for the juveniles concerned.

30. Open detention facilities for juveniles should be established. Open detention facilities are those with no or minimal security measures. The population in such detention facilities should be as small as possible. The number of juveniles detained in closed facilities should be small enough to enable individualized treatment. Detention facilities for juveniles should be decentralized and of such size as to facilitate access and contact between the juveniles and their families. Small-scale detention facilities should be

established and integrated into the social, economic and cultural environment of the community.

#### D. Physical environment and accommodation

31. Juveniles deprived of their liberty have the right to facilities and services that meet all the requirements of health and human dignity.

32. The design of detention facilities for juveniles and the physical environment should be in keeping with the rehabilitative aim of residential

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...

<http://www.un.org/documents/ga/res/45/a45r113.htm>

7 of 13

9/18/2016 11:28 AM

treatment, with due regard to the need of the juvenile for privacy, sensory stimuli, opportunities for association with peers and participation in sports, physical exercise and leisure-time activities. The design and structure of juvenile detention facilities should be such as to minimize the risk of fire and to ensure safe evacuation from the premises. There should be an effective alarm system in case of fire, as well as formal and drilled procedures to ensure the safety of the juveniles. Detention facilities should not be located in areas where there are known health or other hazards or risks.

33. Sleeping accommodation should normally consist of small group dormitories or individual bedrooms, account being taken of local standards. During sleeping hours there should be regular, unobtrusive supervision of all sleeping areas, including individual rooms and group dormitories, in order to ensure the protection of each juvenile. Every juvenile should, in accordance with local or national standards, be provided with separate and sufficient bedding, which should be clean when issued, kept in good order and changed often enough to ensure cleanliness.

34. Sanitary installations should be so located and of a sufficient standard to enable every juvenile to comply, as required, with their physical needs in privacy and in a clean and decent manner.

35. The possession of personal effects is a basic element of the right to privacy and essential to the psychological well-being of the juvenile. The right of every juvenile to possess personal effects and to have adequate storage facilities for them should be fully recognized and respected. Personal effects that the juvenile does not choose to retain or that are confiscated should be placed in safe custody. An inventory thereof should be signed by the juvenile. Steps should be taken to keep them in good condition. All such articles and money should be returned to the juvenile on release, except in so far as he or she has been authorized to spend money or send such property out of the facility. If a juvenile receives or is found in possession of any medicine, the medical officer should decide what use should be made of it.

36. To the extent possible juveniles should have the right to use their own clothing. Detention facilities should ensure that each juvenile has personal clothing suitable for the climate and adequate to ensure good health, and which should in no manner be degrading or humiliating. Juveniles removed from or leaving a facility for any purpose should be allowed to wear their own clothing.

37. Every detention facility shall ensure that every juvenile receives food that is suitably prepared and presented at normal meal times and of a quality and quantity to satisfy the standards of dietetics, hygiene and health and, as far as possible, religious and cultural requirements. Clean drinking water should be available to every juvenile at any time.

#### E. Education, vocational training and work

38. Every juvenile of compulsory school age has the right to education suited to his or her needs and abilities and designed to prepare him or her for return to society. Such education should be provided outside the detention facility in community schools wherever possible and, in any case, by qualified teachers through programmes integrated with the education system of the country so that, after release, juveniles may continue their education without difficulty. Special attention should be given by the administration of the detention facilities to the education of juveniles of foreign origin or with particular cultural or ethnic needs. Juveniles who are illiterate or have cognitive or learning difficulties should have the right to special education.

39. Juveniles above compulsory school age who wish to continue their education should be permitted and encouraged to do so, and every effort should be made to provide them with access to appropriate educational programmes.

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...  
<http://www.un.org/documents/ga/res/45/a45r113.htm>

8 of 13

9/18/2016 11:28 AM

40. Diplomas or educational certificates awarded to juveniles while in detention should not indicate in any way that the juvenile has been institutionalized.

41. Every detention facility should provide access to a library that is adequately stocked with both instructional and recreational books and periodicals suitable for the juveniles, who should be encouraged and enabled to make full use of it.

42. Every juvenile should have the right to receive vocational training in occupations likely to prepare him or her for future employment.

43. With due regard to proper vocational selection and to the requirements of institutional administration, juveniles should be able to choose the type of work they wish to perform.

44. All protective national and international standards applicable to child labour and young workers should apply to juveniles deprived of their liberty.

45. Wherever possible, juveniles should be provided with the opportunity to perform remunerated labour, if possible within the local community, as a complement to the vocational training provided in order to enhance the possibility of finding suitable employment when they return to their communities. The type of work should be such as to provide appropriate training that will be of benefit to the juveniles following release. The organization and methods of work offered in detention facilities should resemble as closely as possible those of similar work in the community, so as to prepare juveniles for the conditions of normal occupational life.

46. Every juvenile who performs work should have the right to an equitable remuneration. The interests of the juveniles and of their vocational training should not be subordinated to the purpose of making a profit for the detention facility or a third party. Part of the earnings of a juvenile should normally be set aside to constitute a savings fund to be handed over to the juvenile on release. The juvenile should have the right to use the remainder of those earnings to purchase articles for his or her own use or to indemnify the victim injured by his or her offence or to send it to his or her family or other persons outside the detention facility.

#### F. Recreation

47. Every juvenile should have the right to a suitable amount of time for daily free exercise, in the open air whenever weather permits, during which time appropriate recreational and physical training should normally be provided. Adequate space, installations and equipment should be provided for these activities. Every juvenile should have additional time for daily leisure activities, part of which should be devoted, if the juvenile so wishes, to arts and crafts skill development. The detention facility should ensure that each juvenile is physically able to participate in the available programmes of physical education. Remedial physical education and therapy should be offered, under medical supervision, to juveniles needing it.

#### G. Religion

48. Every juvenile should be allowed to satisfy the needs of his or her religious and spiritual life, in particular by attending the services or meetings provided in the detention facility or by conducting his or her own services and having possession of the necessary books or items of religious observance and instruction of his or her denomination. If a detention facility contains a sufficient number of juveniles of a given religion, one or more qualified representatives of that religion should be appointed or approved and allowed to hold regular services and to pay pastoral visits in private to juveniles at their request. Every juvenile should have the right to receive visits from a qualified representative of any religion of his or her choice, as well as the right not to participate in religious services and

9/18/2016 11:28 AM

freely to decline religious education, counselling or indoctrination. H.  
Medical care

49. Every juvenile shall receive adequate medical care, both preventive and remedial, including dental, ophthalmological and mental health care, as well as pharmaceutical products and special diets as medically indicated. All such medical care should, where possible, be provided to detained juveniles through the appropriate health facilities and services of the community in which the detention facility is located, in order to prevent stigmatization of the juvenile and promote self-respect and integration into the community.

50. Every juvenile has a right to be examined by a physician immediately upon admission to a detention facility, for the purpose of recording any evidence of prior ill-treatment and identifying any physical or mental condition requiring medical attention.

51. The medical services provided to juveniles should seek to detect and should treat any physical or mental illness, substance abuse or other condition that may hinder the integration of the juvenile into society. Every detention facility for juveniles should have immediate access to adequate medical facilities and equipment appropriate to the number and requirements of its residents and staff trained in preventive health care and the handling of medical emergencies. Every juvenile who is ill, who complains of illness or who demonstrates symptoms of physical or mental difficulties, should be examined promptly by a medical officer.

52. Any medical officer who has reason to believe that the physical or mental health of a juvenile has been or will be injuriously affected by continued detention, a hunger strike or any condition of detention should report this fact immediately to the director of the detention facility in question and to the independent authority responsible for safeguarding the well-being of the juvenile.

53. A juvenile who is suffering from mental illness should be treated in a specialized institution under independent medical management. Steps should be taken, by arrangement with appropriate agencies, to ensure any necessary continuation of mental health care after release.

54. Juvenile detention facilities should adopt specialized drug abuse prevention and rehabilitation programmes administered by qualified personnel. These programmes should be adapted to the age, sex and other requirements of the juveniles concerned, and detoxification facilities and services staffed by trained personnel should be available to drug- or alcohol-dependent juveniles.

55. Medicines should be administered only for necessary treatment on medical grounds and, when possible, after having obtained the informed consent of the juvenile concerned. In particular, they must not be administered with a view to eliciting information or a confession, as a punishment or as a means of restraint. Juveniles shall never be testees in the experimental use of drugs and treatment. The administration of any drug should always be authorized and carried out by qualified medical personnel.

## I. Notification of illness, injury and death

56. The family or guardian of a juvenile and any other person designated by the juvenile have the right to be informed of the state of health of the juvenile on request and in the event of any important changes in the health of the juvenile. The director of the detention facility should notify immediately the family or guardian of the juvenile concerned, or other designated person, in case of death, illness requiring transfer of the juvenile to an outside medical facility, or a condition requiring clinical care within the detention facility for more than 48 hours. Notification should also be given to the consular authorities of the State of which a foreign juvenile is a citizen.

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...  
<http://www.un.org/documents/ga/res/45/a45r113.htm>

10 of 13

9/18/2016 11:28 AM

57. Upon the death of a juvenile during the period of deprivation of liberty, the nearest relative should have the right to inspect the death certificate, see the body and determine the method of disposal of the body. Upon the death of a juvenile in detention, there should be an independent inquiry into the causes of death, the report of which should be made accessible to the nearest relative. This inquiry should also be made when the death of a juvenile occurs within six months from the date of his or her release from the detention facility and there is reason to believe that the death is related to the period of detention.

58. A juvenile should be informed at the earliest possible time of the death, serious illness or injury of any immediate family member and should be provided with the opportunity to attend the funeral of the deceased or go to the bedside of a critically ill relative.

## J. Contacts with the wider community

59. Every means should be provided to ensure that juveniles have adequate communication with the outside world, which is an integral part of the right to fair and humane treatment and is essential to the preparation of juveniles for their return to society. Juveniles should be allowed to communicate with their families, friends and other persons or representatives of reputable outside organizations, to leave detention facilities for a visit to their home and family and to receive special permission to leave the detention facility for educational, vocational or other important reasons. Should the juvenile be serving a sentence, the time spent outside a detention facility should be counted as part of the period of sentence.

60. Every juvenile should have the right to receive regular and frequent visits, in principle once a week and not less than once a month, in circumstances that respect the need of the juvenile for privacy, contact and unrestricted communication with the family and the defence counsel.

61. Every juvenile should have the right to communicate in writing or by telephone at least twice a week with the person of his or her choice, unless legally restricted, and should be assisted as necessary in order effectively to enjoy this right. Every juvenile should have the right to receive correspondence.

62. Juveniles should have the opportunity to keep themselves informed regularly of the news by reading newspapers, periodicals and other publications, through access to radio and television programmes and motion pictures, and through the visits of the representatives of any lawful club or organization in which the juvenile is interested.

#### K. Limitations of physical restraint and the use of force

63. Recourse to instruments of restraint and to force for any purpose should be prohibited, except as set forth in rule 64 below.

64. Instruments of restraint and force can only be used in exceptional cases, where all other control methods have been exhausted and failed, and only as explicitly authorized and specified by law and regulation. They should not cause humiliation or degradation, and should be used restrictively and only for the shortest possible period of time. By order of the director of the administration, such instruments might be resorted to in order to prevent the juvenile from inflicting self-injury, injuries to others or serious destruction of property. In such instances, the director should at once consult medical and other relevant personnel and report to the higher administrative authority.

65. The carrying and use of weapons by personnel should be prohibited in any facility where juveniles are detained.

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...  
<http://www.un.org/documents/ga/res/45/a45r113.htm>

11 of 13

9/18/2016 11:28 AM

#### L. Disciplinary procedures

66. Any disciplinary measures and procedures should maintain the interest of safety and an ordered community life and should be consistent with the upholding of the inherent dignity of the juvenile and the fundamental objective of institutional care, namely, instilling a sense of justice, self-respect and respect for the basic rights of every person.

67. All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned. The reduction of diet and the restriction or denial of contact with family members should be prohibited for any purpose. Labour should always be viewed as an educational tool and a means of promoting the self-respect of the juvenile in preparing him or her for return to the community

and should not be imposed as a disciplinary sanction. No juvenile should be sanctioned more than once for the same disciplinary infraction. Collective sanctions should be prohibited.

68. Legislation or regulations adopted by the competent administrative authority should establish norms concerning the following, taking full account of the fundamental characteristics, needs and rights of juveniles:

- (a) Conduct constituting a disciplinary offence;
- (b) Type and duration of disciplinary sanctions that may be inflicted;
- (c) The authority competent to impose such sanctions;
- (d) The authority competent to consider appeals.

69. A report of misconduct should be presented promptly to the competent authority, which should decide on it without undue delay. The competent authority should conduct a thorough examination of the case.

70. No juvenile should be disciplinarily sanctioned except in strict accordance with the terms of the law and regulations in force. No juvenile should be sanctioned unless he or she has been informed of the alleged infraction in a manner appropriate to the full understanding of the juvenile, and given a proper opportunity of presenting his or her defence, including the right of appeal to a competent impartial authority. Complete records should be kept of all disciplinary proceedings.

71. No juveniles should be responsible for disciplinary functions except in the supervision of specified social, educational or sports activities or in self-government programmes.

#### M. Inspection and complaints

72. Qualified inspectors or an equivalent duly constituted authority not belonging to the administration of the facility should be empowered to conduct inspections on a regular basis and to undertake unannounced inspections on their own initiative, and should enjoy full guarantees of independence in the exercise of this function. Inspectors should have unrestricted access to all persons employed by or working in any facility where juveniles are or may be deprived of their liberty, to all juveniles and to all records of such facilities.

73. Qualified medical officers attached to the inspecting authority or the public health service should participate in the inspections, evaluating compliance with the rules concerning the physical environment, hygiene, accommodation, food, exercise and medical services, as well as any other aspect or conditions of institutional life that affect the physical and mental health of juveniles. Every juvenile should have the right to talk in

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...  
<http://www.un.org/documents/ga/res/45/a45r113.htm>

confidence to any inspecting officer.

74. After completing the inspection, the inspector should be required to submit a report on the findings. The report should include an evaluation of the compliance of the detention facilities with the present rules and relevant provisions of national law, and recommendations regarding any steps considered necessary to ensure compliance with them. Any facts discovered by an inspector that appear to indicate that a violation of legal provisions concerning the rights of juveniles or the operation of a juvenile detention facility has occurred should be communicated to the competent authorities for investigation and prosecution.

75. Every juvenile should have the opportunity of making requests or complaints to the director of the detention facility and to his or her authorized representative.

76. Every juvenile should have the right to make a request or complaint, without censorship as to substance, to the central administration, the judicial authority or other proper authorities through approved channels, and to be informed of the response without delay.

77. Efforts should be made to establish an independent office (ombudsman) to receive and investigate complaints made by juveniles deprived of their liberty and to assist in the achievement of equitable settlements.

78. Every juvenile should have the right to request assistance from family members, legal counsellors, humanitarian groups or others where possible, in order to make a complaint. Illiterate juveniles should be provided with assistance should they need to use the services of public or private agencies and organizations which provide legal counsel or which are competent to receive complaints.

#### N. Return to the community

79. All juveniles should benefit from arrangements designed to assist them in returning to society, family life, education or employment after release. Procedures, including early release, and special courses should be devised to this end.

80. Competent authorities should provide or ensure services to assist juveniles in re-establishing themselves in society and to lessen prejudice against such juveniles. These services should ensure, to the extent possible, that the juvenile is provided with suitable residence, employment, clothing, and sufficient means to maintain himself or herself upon release in order to facilitate successful reintegration. The representatives of agencies providing such services should be consulted and should have access to juveniles while detained, with a view to assisting them in their return to the community.

#### V. PERSONNEL

81. Personnel should be qualified and include a sufficient number of specialists such as educators, vocational instructors, counsellors, social workers, psychiatrists and psychologists. These and other specialist staff

should normally be employed on a permanent basis. This should not preclude part-time or volunteer workers when the level of support and training they can provide is appropriate and beneficial. Detention facilities should make use of all remedial, educational, moral, spiritual, and other resources and forms of assistance that are appropriate and available in the community, according to the individual needs and problems of detained juveniles.

82. The administration should provide for the careful selection and recruitment of every grade and type of personnel, since the proper management of detention facilities depends on their integrity, humanity, ability and professional capacity to deal with juveniles, as well as personal suitability for the work.

A/RES/45/113. United Nations Rules for the Protection of Juveniles Depr...  
<http://www.un.org/documents/ga/res/45/a45r113.htm>

13 of 13

9/18/2016 11:28 AM

83. To secure the foregoing ends, personnel should be appointed as professional officers with adequate remuneration to attract and retain suitable women and men. The personnel of juvenile detention facilities should be continually encouraged to fulfil their duties and obligations in a humane, committed, professional, fair and efficient manner, to conduct themselves at all times in such a way as to deserve and gain the respect of the juveniles, and to provide juveniles with a positive role model and perspective.

84. The administration should introduce forms of organization and management that facilitate communications between different categories of staff in each detention facility so as to enhance co-operation between the various services engaged in the care of juveniles, as well as between staff and the administration, with a view to ensuring that staff directly in contact with juveniles are able to function in conditions favourable to the efficient fulfilment of their duties.

85. The personnel should receive such training as will enable them to carry out their responsibilities effectively, in particular training in child psychology, child welfare and international standards and norms of human rights and the rights of the child, including the present rules. The personnel should maintain and improve their knowledge and professional capacity by attending courses of in-service training, to be organized at suitable intervals throughout their career.

86. The director of a facility should be adequately qualified for his or her task, with administrative ability and suitable training and experience, and should carry out his or her duties on a full-time basis.

87. In the performance of their duties, personnel of detention facilities should respect and protect the human dignity and fundamental human rights of all juveniles, in particular, as follows:

(a) No member of the detention facility or institutional personnel may

inflict, instigate or tolerate any act of torture or any form of harsh, cruel, inhuman or degrading treatment, punishment, correction or discipline under any pretext or circumstance whatsoever;

(b) All personnel should rigorously oppose and combat any act of corruption, reporting it without delay to the competent authorities;

(c) All personnel should respect the present Rules. Personnel who have reason to believe that a serious violation of the present Rules has occurred or is about to occur should report the matter to their superior authorities or organs vested with reviewing or remedial power;

(d) All personnel should ensure the full protection of the physical and mental health of juveniles, including protection from physical, sexual and emotional abuse and exploitation, and should take immediate action to secure medical attention whenever required;

(e) All personnel should respect the right of the juvenile to privacy, and in particular should safeguard all confidential matters concerning juveniles or their families learned as a result of their professional capacity;

(f) All personnel should seek to minimize any differences between life inside and outside the detention facility which tend to lessen due respect for the dignity of juveniles as human beings.

# **EXHIBIT B**

**Affidavit of John P. Rhoads**

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF SOUTH CAROLINA

CHARLESTON DIVISION

Protection and Advocacy for People with )  
Disabilities, Inc., )

Plaintiff, )

vs. )

James Alton Cannon, Jr., in his official )  
capacity as Charleston County Sheriff, )  
Mitch Lucas, in his official capacity as )  
Assistant Charleston County Sheriff, Willis )  
Beatty, in his official capacity as Chief )  
Deputy of Charleston County Sheriff's )  
Office, and Charleston County School )  
District, )

Defendants. )

Civil Action No.

**AFFIDAVIT OF**  
**JOHN P. RHOADS**

---

PERSONALLY appeared before me John P. Rhoads, who, being duly sworn,  
says:

1. My name is John P. Rhoads, and I am over the age of eighteen, suffer no legal disabilities, and am competent in all respects to testify regarding the matters set forth herein.

2. My educational background includes a B.A. in Sociology from Cal. State University at Sacramento and an M.A. in Correctional Counseling from Chapman College.

3. I have 34 years of direct experience working as a probation officer. I started in 1968 as an on-call counselor in the Sacramento County Juvenile Hall and retired as a Chief Deputy in charge of Juvenile Court Services in 1997. More than half of this time was working in institutions at every level.

4. In 1997 I accepted the job of Chief Probation Officer in Santa Cruz County California. I was in charge of Adult Probation, the Juvenile Division, and the Juvenile Detention Center. The detention center was a 42-bed facility. I retired from Santa Cruz County in 2002. I am attaching as **Exhibit A** an article published about the positive reforms we were able to achieve at the Santa Cruz facility.

5. In 2002 I began work with the Annie E. Casey Foundation as a team leader and consultant for the Juvenile Detention Alternative Initiative (JDAI). The Annie E. Casey Foundation is a private philanthropy based in Baltimore and working across the country to make grants that help federal agencies, states, counties, cities and neighborhoods create more innovative, cost-effective responses to the issues that negatively affect children, including poverty, unnecessary disconnection from family, and communities with limited access to opportunity. This Foundation has contributed immensely to improvements in conditions of juvenile detention centers around the country. I worked with assigned sites to help reform their juvenile justice systems. Importantly this included alleviating overcrowding, developing alternatives to incarceration, and improving conditions in their detention centers.

6. I worked on reform efforts in the following juvenile detention centers: Washoe Co. Nv. (Reno), Clark Co. Nv. (Las Vegas), Santa Clara Co. Ca. (San Jose), San Francisco City & County Ca., Ventura Co. Ca., (Ventura), Ada Co. Id. (Boise), Pima Co. Az. (Tucson), Dallas County Tx., Harris Co. Tx. (Houston).

7. I worked in this capacity until 2015. From 2015 forward I have worked as an expert in a number of cases involving conditions of confinement, injury and death of juveniles in custody. These cases are outlined in my resume which is attached as **Exhibit B**.

8. As a part of my background research to formulate opinions in this matter I have reviewed inspection reports conducted by the Jail and Prison Inspection Division of the South Carolina Department of Corrections (SCDC) for years 2014-2018. I have also viewed photographs of the facility.

9. I have also reviewed a Survey of Charleston County Juvenile Detention Center (CCJDC) conducted by the Protection & Advocacy for People with Disabilities, Inc. (P&A) dated June 6, 2018.

10. I have also reviewed information on the website for the South Carolina Department of Juvenile Justice (<https://djj.sc.gov/>), including the interactive reports containing information about the CCJDC and other similar facilities in South Carolina.

11. Also, since being retained on this matter, I have had conference calls with 17 witnesses pertaining to the experiences of 21 different children who have been formerly incarcerated in the CCJDC. Due to limitations on my ability to travel to Charleston and interview witnesses in person as a result of the COVID 19 pandemic, I have conducted all interviews by telephone. In some cases when a child was unavailable, I interviewed a parent or guardian. I have personally asked these folks to describe their experiences at the CCJDC and I made contemporaneous notes and drafted summaries of each witness interview. I have asked for others on the calls to review my notes for completeness and accuracy, and they have done so, in some cases adding information that was relayed but which I had failed to capture in my summary. I was the principal interviewer in each of these calls which were attended by an attorney and a paralegal of Nelson Mullins Riley & Scarborough. I have reviewed the final summaries of the interviews and affirm the summaries are complete and accurate. These summaries are attached as **Exhibit C**.

12. All of the information about conditions at the facility in this affidavit are based on my interviews, unless otherwise indicated. I have not relied exclusively on information provided by counsel unless specifically indicated.

13. Based upon my review of the SCDC inspection reports, the statistics on the DJJ web site, and the P&A survey from 2018, I am informed and believe the following facts pertaining to the operations of the facility, unless I note otherwise:

- a. The CCJDC was built in 1967 and has a capacity to house 26 children.
- b. It houses children between the ages of 11 and 16.
- c. As of FY 2017/18, the average stay of a detainee at the facility was 15 days, although based on my interviews it is not uncommon for children to be detained for months.
- d. As of the March 16, 2018 SCDC inspection, the average daily population at the facility was 30 males and 5 females in the preceding three months, and “had significantly larger high counts.” The report noted that this population size violated applicable minimum standards.
- e. The CCJDC serves Charleston County and all its municipal governments, as well as Berkeley and Dorchester County agencies. I am further informed by counsel and believe that the facility also serves Colleton County. Approximately half of the children housed at the CCJDC are from Charleston County.
- f. As of March 16, 2018, the CCJDC was scheduled to be staffed by 5 corrections officers over 4 shifts per day. There were five vacancies on the

guard staff as of this date, so only 4 guards were available for each shift. There were also 5 vacancies in 2007.

- g. The CCJDC violated the SCDC Standard each and every year by neglecting to provide a desk, hooks or closet space, and a chair or stool in children's sleeping rooms.
- h. The CCJDC violated the SCDC Standard each and every year by failing to accommodate ADA accessibility requirements without extensive housing and plumbing renovations.
- i. Upon check in, each male juvenile is provided with a striped jumpsuit and a "hygiene pack," including a toothbrush, toothpaste, deodorant and a drinking cup. Shampoo and soap bars are also provided. Feminine products are provided to females. Female detainees, however, reported that sufficient supplies of sanitary napkins are not provided. Males are also provided with a white T-shirt, boxer shorts, gym socks and plastic sandals. I am unclear on what personal items are provided to females generally, but some indicate in interviews that they are not provided jumpsuits. Interviews with children and their families indicate that at least on some occasions when the toiletries are used up, children are required to buy additional supplies from the canteen.
- j. Until June 5, 2018, the CCJDC required that all jumpsuits be worn only outside of the juveniles' rooms and therefore children wore only underclothes in their cells at that time. This is confirmed by some children who were detained at the facility before June 5, 2018.

- k. The cells are equipped only with a bunk bed, mattress inside a heavy plastic cover with a raised end as a pillow, toilet and wash basin. No separate pillow is provided. The juveniles are issued a mattress bag cover and a grey cloth blanket. Nothing else is provided.
- l. The CCJDC has a “cool room” where juveniles may be assigned to cool down or if on restriction. Although the P&A report describes this as a “cool room,” I understand this is most likely a reference to the “wet cell,” discussed below.
- m. Females are apparently sometimes housed in a separate communal, mobile unit, which has been in place for at least 12 years. The unit is accessed through a side door of the general activity room and contains a toilet room and two shower stalls. This information is not consistent with at least some females who report being housed in the main building on a separate hall from the boys and where they could be seen by male guards.
- n. The P&A report states that, based upon information provided by officer Brown to the P&A inspector, CCJDC provides education services. The report indicates education is provided at CCJDC by the Charleston County School District (CCSD), with detainees attending either morning or afternoon sessions during the school year, and special sessions during the summer. The report states those children attending the morning session are allowed to go outdoors and engage in outdoor activity with a “coach.” It further states that children are allowed outside during the afternoon school sessions. This information is contradicted by many of the children I interviewed and who indicated educational services were often not provided and the children were

not allowed to go outside at all. The P&A report states that Lt. Platts stated “administration is looking at revising the schedule for going to the outdoor recreation area,” but based upon my interviews, this apparently has not happened.

- o. CCJDC has a central activity room, furnished with installed square tables, a flat screen tv with basic cable and classroom chairs for school work. The room includes a bank of pay phones for children to make collect calls and a kiosk where commissary items may be ordered. Calls and use of the kiosk are privileges, which may be withheld for 1 to 3 days as determined by staff.
- p. CCJDC detainees are served breakfast, lunch, dinner and a snack. Some meals are served to females in the central activity room, while males generally eat in their cells.
- q. All CCJDC medical treatment is administered by the adult jail. The P&A report states detainees are screened within one hour of arrival, but this is not consistent with my interviews in which many children denied receiving medical screening. The P&A report states that medications are administered three times a day, but nearly every child and parent/guardian interviewed denied that children receive their medications at all.
- r. CCJDC contracts the Department of Mental Health clinic for mental health requests, while the children must request general “sick calls” through a paper request or the same kiosk at which they may order commissary items. In my interviews, children generally denied receiving any meaningful mental health care and medical visits were generally described as hard to get.

- s. CCJDC allows parents, grandparents or legal guardians to visit 4 days per week from 6:30pm-9pm, while ministers or attorneys are permitted to visit at any time.
- t. CCJDC confines children to their rooms for 23 hours per day during the week, and 22 hours per day on the weekends, when not out for school sessions.

14. The CCJDC violated multiple SCDCC Standards regarding overcrowding each and every year, housing almost double the maximum occupancy rate at times. For example, according to DJJ data available online, in FY 2016/17, the average daily population was 42. In FY 17/18, the number increased to 57. Although DJJ has not published the average daily numbers for subsequent years, I am informed and believe that the total number of Children housed for some period of time in the facility has increased each year with 343 in 2017/18 (which translated to an average daily population of 57), 358 in 2018/19, and 397 in 2019/20. Interviews relating to the conditions of the facility prior to the COVID 19 pandemic indicate that overcrowding conditions have continued to exist at the facility.

15. Based upon my interviews, I have grave concerns about the conditions to which children are exposed on a daily basis at the CCJDC and find that the conditions are grossly outside the norm of how other juvenile detention centers are typically operated. In fact, the CCJDC provides the overall worst conditions for children of any similar facility I have ever seen in my entire career of over 34 years. This facility seems more like a concentration camp than a detention center for children, and I urge the Court to act promptly to alleviate these abominable and inhumane conditions before more harm is done to these young lives.

## **Unsanitary and Unsafe Conditions**

16. Every witness I have interviewed indicated the physical condition of the detention center is deplorable. The conditions at the CCJDC are the equivalent of solitary confinement or disciplinary lockdown typically reserved for hardened criminals. The facility was generally described as dirty, smelly, and moldy. The roof leaks and old mop buckets are routinely placed around to capture the rain water as it falls. I am informed by counsel that, during storms, the building is sometimes evacuated and this was confirmed by C.J., who described being confined in a small room at the adult facility with three other boys for 2 days as a result of an evacuation. The mold is believed to come from the roof and window leaks throughout the building.

17. Because of visible mold and chronic moisture in the building, it is probable that the air quality is not healthy, particularly for children with asthma, chronic bronchitis, compromised immune systems, and other physical vulnerabilities.

18. Children reported seeing bugs, including ants, lizards, spiders, termites and roaches in their cells. A.C. stated that he had a rat in the cell with him and complained, but was not moved to another cell until the next day. Others describe hearing the sounds of apparent rats in the ceiling. I am unaware at this point of what pest control efforts are undertaken, but obviously whatever work has been done is not adequate to maintain a clean and sanitary environment for these children.

19. Several children report experiencing bug bites, which could be attributable to bed bugs, ants, or spiders.

20. Regularly the children are required to have their meals in these unsanitary cells.

21. The toilets and showers at the CCJDC have drainage problems that cause flooding in the cells. Overflowing toilets is a regular occurrence reported by many of the children,

including C.R., L.M., I.J., G.J., J.M. and C.J. This flooding sometimes causes water contaminated with urine and feces to flow onto the same floors where children are sometimes required to sleep in overcrowded conditions. Worse still, these children are frequently blamed for overflowing toilets which are likely caused by poor plumbing systems and, as is explained further below, lockdowns are often used to punish children for these events. While I cannot be certain that all of the overflowing toilets are due to plumbing issues and there is reason to believe that some overflows are caused by intentional acts of children held at the facility, in my experience, it would be highly unusual for toilets to overflow as commonly as is described by the children I interviewed primarily as a result of intentional behavior.

22. Children report that they are required to sleep in small, locked, and bare cells, with a metal or concrete bed covered with a mat. When the CCJDC becomes overcrowded, Children are forced to sleep on the floor on mats, sometimes in wet conditions caused by roof leaks and overflowing toilets. For example, C.R., L.M. R.S., C.J., D.W., C.A., I.J., G.J. and A.C. all described various circumstances in which they or other Children slept on the floor.

23. Staffing at the CCJDC is apparently inadequate to allow a timely response to emergencies such as behavioral disturbances, fires, or other situations requiring evacuation. Fights and/or attacks take place in cells without guards making any effort to halt the violence and to restore order, as described by A.M. regarding her son C.A., as well as by A.C. and R.S.

24. Children, including A.C. and C.B., report that the CCJDC is maintained in a very cold condition, and I am informed by counsel that in the past the HVAC systems have malfunctioned in the midst of summer, requiring days for repairs to take place. These observations cause me to be concerned that the heating and cooling units are not functioning properly.

## **Arbitrary and Excessive Use of Solitary Confinement**

25. There is prolonged solitary confinement—which is also known as room confinement, isolation, separation, or seclusion—as a matter of practice at the CCJDC. Detainees, including G.J., I.J., A.C., J.P., J.M. L.R and C.A., say they are let out of their rooms for 1-2 hours of recreation a day. The indoor recreation is extremely basic, including books, a television, and one ping pong table. The only other time they would be let out would be to attend school and for brief family visits on certain days. C.R. said he attended some bible study if he was not on lockdown.

26. The United States Department of Justice defines solitary confinement as “the state of being confined to one’s cell for approximately 22 hours per day or more, alone or with other prisoners, . . . [with] limit[ed] contact with others.” See United States Department of Justice, Letter to the Honorable Tom Corbett, Re: Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation, May 31, 2013, at 5, [http://justice.gov/crt/about/spl/documents/cresson\\_findings\\_5-31-13.pdf](http://justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf). As a practical matter, children are placed in solitary confinement for virtually their entire stay at the CCJDC—whether this is for days, weeks, or months—because of the very limited recreation time and opportunities for interactions outside of their cells. As a consequence of the lack of stimulation and sensory deprivation, many Children at the CCJDC sleep or simply lie on their beds for long periods during the day.

27. In addition, to mete out punishment for various offenses, the CCJDC frequently places children on “lockdown” in their cells. On lockdown, conditions are worse yet. Lockdown means the kids cannot leave their cells at all – no visitation with family, no education sessions, no showers, no recreation time, no books to read, as described by R.S., J.H., C.B., C.R., and C.J..

Instead of being confined to their cells for 22-23 hours a day, they must stay in their cells until the lockdown is lifted. A.C. reported that during lockdowns, they may also lose their blanket, which is necessary to stay warm in the very cold environment of the facility. They have to eat in their cells. Lockdowns can last 24, 48 or 72 hours, and the length can reportedly be increased at the whim of the guards. Sometimes individuals are locked down, and sometimes all of the children are placed on lockdown at the same time. Lockdowns have been ordered for offenses such as knocking on a cell door to get a guard's attention, laughing, cursing, spitting, or talking out of turn.

28. I am unaware of any procedure in place at the CCJDC by which qualified professionals determine whether and to what extent solitary confinement in the form of a lockdown is appropriate.

29. Children report having no understanding of any consistent or rational application of lockdowns for particular offenses, but they understand that a lockdown is imposed as a punishment, not merely as a cool down measure used to de-escalate or to protect the children from themselves or others.

30. Based upon my knowledge, skill, training and experience in the field of juvenile detention center operations, I am aware that a number of national organizations have concluded that solitary confinement should never be used for minors. For example, standards published by the National Commission on Correctional Health Care ("NCCHC") require that youth "should be excluded from solitary confinement of any duration." The American Medical Association and the American Academy of Child & Adolescent Psychiatry ("AACAP") similarly oppose the use of solitary confinement for children and adolescents. The JDAI has published comprehensive standards that prohibit the use of solitary confinement as a disciplinary measure or for any reason

other than as a temporary response to behavior that threatens immediate harm to a youth or to others. These standards state that facilities should not use room confinement as a substitute for special individualized programming, including educational services and treatment plans developed with mental health staff and the youth's family members. If a young person is placed in isolation, JDAI standards require that the isolation last no longer than four hours and that staff develop individualized programming for the youth or consult with a qualified mental health professional about whether a youth's behavior requires that he or she be transported to a mental health facility. The NCCHC has recognized that children are different from adults, making their time spent in isolation even more difficult and the developmental, psychological, and physical damage more comprehensive and lasting. Children experience time differently—a day for a child feels longer than a day to an adult—and have a greater need for social stimulation. AACAP has similarly concluded that, due to their developmental vulnerability, adolescents are at a particular danger of adverse reactions, including depression, anxiety, and psychosis, when exposed to prolonged isolation and solitary confinement. Unfortunately, many of the children detained at the CCJDC *already* suffer from depression, anxiety, and other mental health disorders. Placing these children in solitary confinement, especially for extended periods of time, exacerbates these children's problems and causes irreparable harm.

31. Solitary confinement is antithetical to the goal of maintaining safety and security in juvenile detention facilities. When a child is experiencing anger as a symptom of mental illness, use of solitary confinement often results in additional anger, and additional time in solitary confinement. According to the CJCA, academic research continues to show that placing incarcerated youths in isolation has negative public safety consequences, does not reduce violence and likely increases recidivism. Further, I am aware of no research showing the benefits

of using isolation to manage youth behavior. By contrast, facilities that have reduced or eliminated the use of solitary confinement have seen a reduction in violence and infractions. These facilities have ensured that separation only occurs after multiple attempts to defuse tensions, and not as an alternative for controlling the manifestations of mental illness.

32. These harms of improper and excessive use of solitary confinement are increasingly recognized around the nation. Federal courts in four states have ordered facilities to cease improper solitary confinement. Seven states have enacted laws in the past three years limiting the use of isolation in juvenile facilities, and several other states are considering similar legislation. In December 2018, Congress passed bipartisan legislation to limit isolation of youth in federal facilities in the First Step Act. The First Step Act only allows brief isolation when there is an immediate risk of physical harm and never as a punishment. (Source: *Not in Isolation: How to Reduce Room Confinement While Increasing Safety in Youth Facilities*, Published by the Center for Children’s Law and Policy, Council of Juvenile Correctional Administrators, Center for Juvenile Justice Reform, Georgetown University and Justice Policy Institute (June 2019) (Attached as **Exhibit D.**)

33. At the CCJDC, children are frequently placed in lockdown or other forms of solitary confinement in situations other than those where the child’s behavior threatens immediate harm to the child or to others, and children are not released from solitary confinement when they have demonstrated that they are in control of themselves.

34. Children report being placed in lockdown or other forms of solitary confinement as punishment at the discretion of the guards – which appears to vary significantly from one guard to the next – without any due process, such as a hearing before any type of judicial authority. R.S. and C.B. said they filed grievances, but never heard anything about them, while

L.M., I.J. and G.J. said they never filed grievances because nothing would be done about them. C.J. didn't even think there was a grievance process at CCJDC.

35. As with any juvenile detention center, many children at the CCJDC with mental illness have a difficult time complying with the CCJDC's disciplinary rules because of their illness. As a result, children are often placed in lockdown or other forms of solitary confinement essentially as a result of their illnesses. Placing children with mental illness in solitary confinement—especially when doing so for extended periods of time—exacerbates the suffering and difficulties associated with the mental illness.

36. The CCJDC's failure to provide sufficient mental health services to the children also results in symptomatic behavior giving rise to punishment, instead of the treatment that is needed. Extensive literature in the field indicates these punishments may result in long-lasting and substantial harm to all children and are particularly harmful to children already suffering from significant mental illness.

37. To the extent solitary confinement is used, the child in solitary confinement should receive constant supervision from qualified mental health clinicians. At the CCJDC, however, children placed in solitary confinement are not under constant supervision and often do not have any form of regular contact with mental health clinicians. This practice creates a dangerous situation for the children.

38. Defendants also fail to provide children placed in solitary confinement with adequate education, counseling, recreation, or other rehabilitative treatment. These services at the CCJDC are inadequate, as set forth in more detail below, during normal operations when children are not in lockdown. When in lockdown, however, children are denied any semblance of

an effort to rehabilitate, educate, counsel or treat, much less such an effort that could be described as respectful and dignified.

39. Based upon information provided from these children and their families, it appears highly likely that guards administering lockdowns lack proper training and qualifications to administer this punishment within appropriate limits to ensure the health and safety of the children.

40. Children held in solitary confinement at the CCJDC report from their own experience, as well as observations of other children, that they experience extreme loneliness, anxiety, rage, suicidal thoughts, and depression, among other potentially debilitating emotional and psychological problems. D.W. said he thought about suicide. D.H. reported that three people tried to commit suicide during his stay. They were placed in the wet cell in a suicide gown and naked underneath. One girl tried to cut herself. The others tried to hang themselves. He said mental health staff came in every other day to talk to the kids who attempted suicide.

41. In my opinion, the uses of solitary confinement, both as an everyday event based upon how the facility is designed and operated, and also by the excessive, discretionary haphazard and poorly conceived use of lockdowns, are far out of step with minimally acceptable standards and practices at other, similar facilities, and these practices pose a very substantial threat of physical and mental harm to the children housed at CCJDC.

**Use of excessive force, the “restraint chair,” and the “Wet Cell”**

42. Children, including C.R., B.M., L.M. C.J., A.C. and D.H., described to me the common use of excessive force. Guards and apparently outside police forces called to the facility for fights apparently brandish weapons, including guns that shoot rubber bullets, assault type rifles that shoot bean bags, cannisters of pepper spray, and tasers. In addition to these weapons,

excessive force and restraints are carried out by confining children to a “restraint chair,” and extreme solitary confinement in the “wet cell” or “cool down room.” The CCJDC’s practices of using mechanical restraints and other uses of force on children as forms of punishment and behavior management are grossly inconsistent with accepted practices in juvenile detention facilities. Further, these practices cause significant harm to the children and do not appear to be justified by some purpose other than to terrorize and punish the children for misconduct in the facility.

43. It is widely recognized in the field of juvenile detention that physical and mechanical restraint of children, as with improper seclusion, can cause physical, psychological, and emotional damage. Accordingly, physical force or mechanical restraints should be used on children only if less restrictive alternatives would be ineffective and, even then, only to the degree and duration necessary to bring the situation under control. In addition, as a matter of standard procedure, any application of physical force or mechanical restraints should be fully documented.

44. At the CCJDC, as a form of punishment more severe than the everyday confinements to cells for 22-23 hours and also more severe than lockdowns of 24-72 hours, guards place children in what is commonly referred to as the wet cell, which is a small room about the size of a mop closet, lit by a dim single light bulb in the ceiling and containing only an air vent, a bench, and a drain on the floor.<sup>1</sup> Because the wet cell has no toilet, a child confined to the room may be forced to “wet” himself or herself or to use the drain in the floor as a toilet when he or she needs to urinate if toilet access is not provided timely. Children placed in the wet

---

<sup>1</sup> I have received conflicting reports about whether the wet cell has one dim light bulb or no light, but in either event it is described as a very dark room. Not all children report that there is a drain hole in the floor, as well. Most kids report, however, that the room does have one dim light bulb and a drain in the middle of the floor which smells strongly of urine.

cell sometimes have their ankles shackled and their wrists handcuffed while they are in the cell and/or when they are being escorted to the toilet. B.M. reported being confined for two days in the wet cell while also confined to the restraint chair (see below). C.R. was put in the wet cell for six hours. C.B. described being confined to the wet cell for 10 days. C.J. was confined for periods of 2 days and 5 days. D.H. experienced a 5-day confinement in January 2020. During that confinement, D.H. reported he was not given a mattress for the first night and he had to sleep on the hard floor. He did receive a mattress after the first night. He further reported that he was required to wear only his underwear, socks and a tee shirt while he was in the wet cell. During his 2-day confinement, which was in 2018, he was not given a mattress and was forced to sleep on the floor throughout. At that time he was about 13 years old. He was so upset that he repeatedly kicked the door until he was removed from the room by authorities pointing a taser at his chest and placed in the restraint chair for 12 hours (see below).

45. Children report being put in the wet cell for various offenses including being blamed for overflowing toilets. D.H. also reported that when detainees attempt suicide, they are put into the wet cell in a suicide gown and no other clothing. Reportedly those put in the wet cell after attempting suicide are allowed to see a mental health representative every other day during their isolation.

46. As another form of punishment, children report being placed in a restraint chair, which is sometimes used in conjunction with the wet cell, as noted above, and is sometimes used in the common area in plain view. The restraint chair looks like an electric chair with straps used to fully immobilize the children by strapping down their feet, legs, torso, arms, neck and head. Children report being placed in the restraint chair for arbitrary and minor offenses and being restrained for excessive lengths of time and without any monitoring by qualified mental health

professionals. Again, as with the use of lockdowns, no due process is reported as being offered prior to strapping children into the chair as punishment. B.M. was strapped into the chair in the wet cell for two days. D.H., who was put into the restraint chair after being upset that he was denied a mattress in the wet cell, indicates that he was restrained in the chair for 12 hours. He was allowed to exercise his arms for a brief period every 2 hours. He was not fed, taken to the bathroom or allowed to drink anything while he was in the restraints. He received no mental health care or counseling and he was never informed what behavior would be required for him to be released from the chair.

47. Restraint chairs are not recommended for use in children's detention. If it is used, it should be used only where the child is determined to be a threat to himself, and it must be monitored by medical staff and mental health staff. As soon as the person in the chair has control of themselves, they should be taken out of the chair. Prolonged periods of time in the restraint chair are extremely harmful and unacceptable by any standard. Keeping children in the restraint chair for hours at a time is far longer than necessary to abate any threat of self-harm or harm to others.

48. It is apparent that CCJDC relies on the wet cell and the restraint chair as disciplinary measures for arbitrary and inconsistent reasons which vary based upon what guards are on duty. Again, children report that the severity and extent of punishment is highly dependent upon what guards are on duty, which reflects a culture of wide discretion rather than carefully administered policies and procedures. Children are not given any form of a hearing or opportunity to tell their side of a story (due process) before being put in the wet cell or restraint chair. They are not told for how long they will be confined or what they must do to earn their release.

49. These arbitrary practices plainly lead to excessive punishment for the children, which is very concerning for all, but especially for those who are vulnerable due to mental health problems, such as PTSD, anxiety, or depression. The majority of children I interviewed had some form of disability. Placing a child suffering from mental illness in the wet cell or a restraint chair would almost certainly exacerbate the child's mental illness, and placing a child who did not previously suffer from mental illness in the wet cell or restraint chair could cause the child to begin suffering from mental trauma.

50. In response to fights and disorder, the CCJDC or an outside SWAT team known as the "Green Team", according to D.H. and C.J., also uses guns loaded with rubber bullets and/or assault type rifles with bean bags to restore order and discipline. Children are shot with projectiles from these weapons for failing to follow orders such as failing to get on the ground when instructed. Being shot with rubber bullets and bean bags causes extreme pain, bruising, humiliation and emotional harm. I have never heard of any other facility that has police officers fire any form of guns, whether with rubber bullets or bean bags, at unarmed children housed in a detention facility. This is an abhorrent practice that could be justified by no conceivable scenario, and it raises not only serious concerns about training and best practices, but it evidences that the CCJDC is operated in a culture of violence, cruelty, fear and retribution, rather than one of safety and rehabilitation.

51. The extent to which children are being terrorized at the CCJDC is exemplified by a story one mother, E.F., shared. After her son J.M. was released from the facility, he and his Godfather went to Wal Mart. While there, they saw two guards from the facility shopping. When J.M. saw the guards, he immediately turned and ran away from the store in terror.

## **Overcrowding and Failure to Provide Beds to Children**

52. The CCJDC facility is frequently overcrowded, resulting in children being forced to sleep on the floor of the facility. This issue is widely reported and substantiated by published statistics of SCDJJ, which indicate that the population of the facility has grown significantly in recent years from 30 per day in FY 2015/16 to 42 per day in FY 2016/17 to 57 per day in FY 2017/18. SCDJJ statistics are not available on the web site for FY 2018/19 or 2019/20, but as noted above, the total number of children housed at the facility on an annual basis has increased each year.

53. Even in cells with only two children, the rooms are too small and fail to provide sufficient total floor space per occupant. Most of the cells at the CCJDC facility are designed for single occupancy. The square footage of the cells is, upon information and belief, 80 feet. Nonetheless, these cells frequently house more than one child, and sometimes as many as four children. D.H. described how three boys were placed into a single cell which had only one functioning bed because the top bunk was broken and would collapse. The boys were forced to put two mattresses side by side on the floor and sleep there, while one boy slept in the bottom bunk. He further reports that other cells were not fully occupied and beds were available, but these children were nonetheless forced to sleep in this condition. He said he received no explanation for why they had to share a cell when others were available.

54. A.C., I.J. and D.W. report not having sufficient time to take an adequate shower, often not having hot water in the showers, and having to purchase soap from the canteen at times. D.H. reported having to take cold showers in a cold building, so sometimes they decline to take a shower altogether.

55. Some report having to wear dirty uniforms, although the practice of being forced to wear only underwear and an undershirt at all times in cells was apparently ended in 2018.

56. Children have been able to call their families only if they had money to pay for the calls. Parents have been required to deposit money in a prepaid account in order for calls to be allowed.

### **Failure to provide outdoor access and programming**

57. The children reported almost unanimously that they were never allowed to go outside, even though information provided to P&A in its June 2018 inspection indicated children are allowed outside during school and that they are even are provided a coach for activities. I do not know why they are not permitted out of doors, if that is indeed the practice. The facility has a recreation yard with two basketball goals (with the hoops missing). Further, minimum standards call for children in custody to have one hour of large muscle exercise every day, weather permitting. Generally accepted professional standards require that juvenile justice facilities provide recreation and meaningful activities such as group and individual therapy, social skills training, and other programming.

58. Forcing children to remain indoors and in small cells for weeks or months at a time without access to sufficient recreation and/or outside activities—particularly in conditions such as those that exist at the CCJDC—places the children at significant risk of suffering physical, psychological, mental, and emotional injuries.

59. The problems created by the inadequate programming and outdoor access at the CCJDC are exacerbated by the lack of a behavior management program at the CCJDC. The failure to provide outdoor access, adequate programming or behavior management is not only violative of the Children's rights, but predictably results in behavior problems.

### **Failure to provide separation of individuals with violent propensities**

60. To ensure Children housed at CCJDC are safe, the facility should have a system for screening and separating aggressive juveniles from more passive ones and determining appropriate levels of institutional classification. This is a minimally adequate standard of care.

61. The CCJDC appears not to provide such a system for screening and separating aggressive from passive Children, or if such a system exists, it is not being implemented and/or is ineffective.

62. Younger, smaller and more vulnerable children, such as C.A., have been beaten up by larger and more aggressive children. Guards reportedly are very commonly not responsive to such attacks, even when other children make loud noise by shouting for help and banging on walls and doors. In one instance, a vulnerable youth, A.C., was attacked by his roommate who kicked and punched the smaller child and pushed his head into the toilet. Z.C., a child in the adjoining cell screamed for help and banged on the wall as loudly as he could. No guards responded to protect the child being attacked. Z.C. suffered a hand injury from his efforts, but received no treatment for it. After he was released from the CCDJC, he was diagnosed with a broken wrist, but it could not be set because too much time had passed since the injury.

63. The apparent lack of a system of separation poses a serious risk of injury to children and falls far below the most fundamental practices required to ensure the safety of children housed in a juvenile detention center.

### **Failure to Provide Adequate Health Care**

64. Certain children incarcerated at the facility have specific medical needs, including physical ailments such as asthma, chronic bronchitis, sleep disorders, and diabetes. Nonetheless, the CCJDC does not provide regular and appropriate medical assessments to the Children upon

admittance, and the CCJDC fails to provide timely access to qualified health professionals when the children are in need of health services. Further, when children do receive healthcare services, the services are reported to be inadequate.

65. The facility frequently fails to provide the children with their prescribed medications at the proper dosages at proper intervals or, in many if not most cases, fails to provide the children with their prescribed medications at all. Often the intake personnel refuse to accept medicines provided by parents of the children, or they will accept the medicines and return them unused at the end of the incarceration period. This was a very familiar refrain among those interviewed. D.H., reported being in the facility for six months off of his medication for ADHD and Oppositional Defiant Disorder (ODD).

66. In at least one instance as described by L.A., the Defendants' neglect of a child's need for regular medication for severe asthma resulted in worsening of the child's condition and the need for her to be transported to the hospital in an ambulance.

67. The CCJDC does not maintain health care workers at the site on a full time basis, but apparently nurses visit twice daily. Reports as to the responsiveness of guards to requests for medical care varied somewhat, with some children claiming they did not receive care and others indicating they did eventually receive a treatment when a nurse came to the facility.

### **Failure to Provide Adequate Mental Health Care**

68. Many, if not most, children detained at the CCJDC suffer from various forms of mental illness, and many are prescribed psychotropic medications. The majority of children interviewed indicated having some form of disability with ADHD appearing most commonly. The CCJDC, however, very often fails to provide children with their prescribed medication, including psychotropic medications, and fails to provide any regular individualized mental health

assessment, treatment, counseling, or psychotherapy to the children in need of such services. Children and their families report that even when a family court judge has ordered mental health treatment, the facility does not provide it.

69. The CCJDC also fails to do the following:

a. Properly screen the Children for medical conditions, including mental health conditions, upon their arrival at the CCJDC.

b. Employ a sufficient number of qualified mental health professionals to counsel and treat the children with mental health treatment needs.

c. Adequately train and supervise staff to respond in appropriate ways to the children with mental health issues.

d. Provide a continuum of mental health services to meet the needs of the children.

e. Provide adequate or effective group counseling by trained staff.

f. Provide a confidential setting for counseling.

70. As a result of these failures, the children do not receive counseling or other necessary mental health treatment.

#### **Failure to Provide Access to Adequate Education Services**

71. Defendants fail to ensure that all children at the CCJDC have access to educational services, including special education services. School at the detention facility is very spotty. Some children say they never go, whereas some say they go 1 or 2 hours a week. A.C. told me that he attended 5 days a week for 1-2 hours. D.H. reported that education is provided in two shifts with 10 children in each shift. If more than 20 children are in the facility, then the excess children get no instruction that day. This is consistent with C.J. who said only some children would be allowed to have education. Education is commonly refused for students on

lockdown or facing other forms of isolation. Some reported having teachers come from Daniel Jenkins School to teach some of the kids. Other children, including L.M., complained that the school was not hard enough or was not related to the subjects they had in regular school. J.M.'s mother and C.J. both said the school work consisted of coloring and watching movies. C.J. said the work was below grade level and he never received credit and did not attend much school while there. C.R. reports that Children are also not allowed to have pencils in their cells. Although the facility apparently has computers, no child reported using them in conjunction with their school work.

72. A substantial number of children interviewed, including R.S., M.H. M.J. and C.A., have been identified as Special Education students with an IEP (individual education plan). They are supposed to have certified special ed teachers who follow the IEP. All the children I talked with who were special ed said they have a diagnosis of ADHD and were supposed to be taking medication. The CCJDC in conjunction with the local school system should:

- a. Adequately identify, assess, or evaluate Children to determine whether they have special needs and how such special needs can be met.
- b. Follow IEPs for children who need special education.
- c. Provide related services, such as speech therapy and psychological therapy, to children with disabilities who need such services to benefit from their education.
- d. Obtain and/or provide adequate information from schools that children attend prior to their detention at the CCJDC to properly ascertain the children's special needs.
- e. Provide adequately trained, certified special education teachers to provide special education services to children who need these services.

73. As a result of Defendants' failures, the children are denied their right to education and do not make progress in school.

74. Almost universally, the children reported not receiving any credit when they returned to school for the education provided, if any, at the CCJDC.

### **Cross gender privacy issues**

75. CCJDC houses both male and female children.

76. Although females are generally housed in a different wing of the building, the facility fails to ensure the privacy and safety of female children at all times. Specifically, male guards have ready access to the female wing, and the windows in cell doors allow guards to view females in their cells, including when they are dressing, performing personal hygiene and using the toilet. I.J. and G.J. report being confined in cells with used sanitary napkins littering the floor. I.J. reported male guards flirted with her and she said that, although some female guards work at the facility, it is common for men to check on the female children.

77. The lack of privacy afforded female children renders them susceptible to trauma and contributes to anxiety and loss of self-esteem, which are counterproductive to the goals of juvenile justice.

### **Lack of Due Process for Alleged Disciplinary Violations**

78. There is no due process offered on major discipline, such as lockdowns, the wet cell or the restraint chair. Staff decide the punishment and that is the end of it. Minimum standards recommend an official process where there is an independent investigation and interviews with witnesses before giving the punishment. That does not happen in this facility.

### **Lack of Nutritious and Appetizing Food**

79. Every single detainee said the food at CCJDC was awful. They described it as being cold, having no taste and soggy, and B.M. reported being served milk that was spoiled. A typical example of a meal was a piece of bologna with two slices of soggy white bread. Some refused to eat the food and others claimed to get sick after consuming it. Because the facility does not have an operational kitchen, the food comes from the main jail, without a warmer, and is always delivered late and cold. Children who could afford to do so and who were aware of the system could order junk food, such as chips and soda, from the canteen on Sundays, and it would be delivered on Thursdays. The families were required to pay in advance for this food, and if the child was released before consuming the pre-ordered snacks, they forfeit the money. Children reported being hungry most of the time.

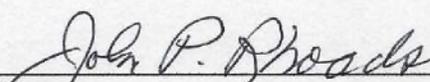
80. There also does not seem to be any special diets for either religious reasons or medical reason or simply because of a vegetarian request. Children have a need for a higher quality diet that addresses their needs. Further investigation into the nutritional value, quantity, and cleanliness of the food served is warranted, but significant evidence indicates that the CCJDC does not meet the most minimal requirements for providing adequate food to the children housed at the facility.

### **Evaluation**

81. In my opinion, this center is not meeting the minimum acceptable standards for Juvenile Detention Centers in South Carolina, nor would it meet the standards of any civilized society. It is more like a concentration camp than a place to house children who are accused of a

crime or status offenses. There are issues of excessive force and isolation that are harmful to children. It is a cruel and punitive rather than a rehabilitative system.

82. In my opinion the CCJDC has been incredibly lucky that they have not experienced a disaster such as a death of a child in custody. Excessive isolation and restraint can cause children to decompensate and act in ways that harm themselves. This does not seem to be a caring environment and needs to reform and change immediately before more harm can be done to these children and their families.

  
Signature \_\_\_\_\_  
Print Name: John P. Rhoads

Dated: 7-24-2020

# **EXHIBIT A**

[Home](#) / [Special Report](#) /

# Detention Redemption

BY PEGGY TOWNSEND   AUGUST 14, 2005



Santa Cruz County's juvenile hall sits on a pine- and oak-studded hillside across from a state park. It is a low-slung building made of concrete block with doors painted a bilious shade of green.

From outside, it hardly looks like a national model for juvenile-justice reform. But inside, empty cells stand as testament to what has happened over the last eight years. Instead of locking young criminals behind bars, this mostly liberal seaside community has bucked the national trend and is sending all but the worst offenders into alternative corrections programs. Led by a band of reformers and embraced by a community that was one of the few in California to vote against a get-tough-on-crime initiative in 2000, the county is keeping kids at home,

supervising them closely, and enrolling them in community-based programs that provide drug counseling and job training. Data is assembled to see who is coming into the system and why they are there, and the time it takes to get a youngster into a group facility has been more than halved. Notably, this progress has occurred in a state known in justice circles as the “Great Detainer,” because some 25 percent of all detained youth nationally are held here.

The result is that juvenile hall is half empty most days, youth felony arrests are down 48 percent, and officials say that instead of spending money on building new cells, they are putting it into programs that work. “The fact is,” says Scott MacDonald, one of the reform effort's architects, “our outcomes have been excellent.”

---

Santa Cruz County sits 70 miles south of San Francisco. Its northern half is home to the University of California, Santa Cruz and tourist-filled beaches; its south is mostly Latino and agricultural, with long rows of strawberries pushing up against housing developments. And although the county is known for its liberal bent -- Santa Cruz city-council members once held a medical-marijuana giveaway on the steps of City Hall -- it faced many of the youth crime problems other California counties did in the mid-1990s.

Santa Cruz's 42-bed juvenile hall routinely held 50 to 60 teenagers, and failed even minimum health and safety standards. Kids were doubled up in the tiny cells, remembers Judy Cox, an easygoing woman who was an early engineer of the reform movement

and is now the county's chief probation officer. "We had them sleeping on the floors," she says. "Their heads were right next to the toilets." It was a struggle just to get the young inmates showered and fed. Tensions were high, fights were common, and injuries to both staff and kids were rising. "We were just dealing with day-to-day survival," Cox says.

County officials and probation staff sought change, but it was like trying to turn an ocean liner. Entrenched ways and lack of money made it hard to do. Then John Rhoads came to head the department in 1997. A former deputy probation chief in Sacramento, Rhoads had been part of the Annie E. Casey Foundation juvenile-justice reform initiative there. "John brought these tools to help our jurisdiction reduce reliance on detention," Cox says. "The first thing we did was to develop an objective screening process at the front door."

That meant that when police brought a young offender in, probation officers would use a set of objective criteria to determine if he or she was a threat to public safety or would skip out on his or her court date. Those at high risk, such as violent offenders and teens with prior arrest records, were locked up. Those deemed "medium risk" were sent home with electronic monitoring, receiving daily visits from probation officers. Those who were picked up for misdemeanors and would likely make court appearances were simply cited and sent home.

But street cops complained that young crooks were beating them back to the neighborhood. They said the county had gone soft on crime. So Rhoads sat down with the county's law-enforcement chiefs and

hammered out a list of crimes -- like high-speed chases and robbery -- and criminal history that should result in bookings and those for which a young offender should simply be cited. The chief-approved lists were handed out to every street officer. The county also streamlined its placement process so that children spent less time waiting to enter treatment centers or group homes; the average dropped from 27 days to nine. The number of kids in juvenile hall fell, too.

Soon, probation officials realized that just emptying the hall would do nothing to improve public safety -- or to help at-risk kids. "As we loosened detentions," says MacDonald, assistant chief probation officer, "we tightened our relations with the community." Probation officials began to link with local organizations that provided services kids needed: drug treatment, counseling, job training, and work programs. One of them, the Youth Community Restoration Project, sent weekend detainees out to restore sensitive environmental areas and build retaining walls instead of idling in juvenile hall. With additional training, some eventually landed jobs in the community. "If 328 youth a year meet on weekend work projects, and if 46 of them are referred to job training and mentorship, and 28 of those are placed in entry-level jobs, success seems small," says David True, who heads the program. "But that's 28 youth who aren't stealing your TV or hitting each other. It's a very hard road, but still more effective than incarceration."

In his cluttered office, MacDonald thumbs through statistics to show what the broader reforms have meant for the county. In 1996, juvenile hall had an

average daily population of 50 children, he says. Last year, the average was 22. He jumps up and phones the hall: Today's population is just 16. More importantly, MacDonald says, since the county reformed its detention practices, its juvenile crime rate has fallen -- even as the youth population has risen. Juvenile felony and misdemeanor arrests are down 48 percent and 43 percent, respectively. While it's true that juvenile crime is down throughout California, Santa Cruz's concurrent drop shows that reform doesn't, contrary to popular belief, cause more crime. "The reality is that *not* locking these kids up does not result in an increase in crime," MacDonald says.

It also doesn't result in increased costs. Much of the reform happened by simply changing how things are done in the department, Cox says. While keeping a teen locked up costs \$184 a day, letting one stay home with electronic monitoring, supervision and counseling, or work programs costs \$64. The county also avoided spending millions of dollars to staff and build bigger detention facilities.

Change could not have happened without political will, however. Voters, political leaders, and even judges supported reform. Superior Court Judge John Salazar, who presided over Santa Cruz County Juvenile Court for four years, says that when he began, "My approach was ... to draw a line in the sand and give options and tell the kids what would happen if they didn't follow through. We kept drawing lines in the sand and kids kept walking over them." It took seeing youngsters repeatedly recycle through the system to change his mind. He now talks about the benefits of keeping young offenders home

and addressing their needs -- whether it's drug treatment or just buying them a new set of clothes because they were too embarrassed to go to school in hand-me-downs -- instead of throwing them in jail. "The government," Salazar says, "does a lousy job of raising other people's kids."

Also key to reform was the mundane task of data collection. Santa Cruz monitors everything from the race of young arrestees to case resolution. Such attention to data not only keeps people working more efficiently but also helps to defend reform practices and to develop new programs, local officials say. For instance, when data showed that young Latino heroin addicts had more success getting clean if programs kept them connected to their families, the county helped design a drug program to do just that. "We scrutinized everything and looked at what does work, and we implemented the things that did work," Cox says.

Maria Griselda Hernandez knows that firsthand. A 20-year-old with almond-shaped eyes and long brown hair, Hernandez spent so many days in juvenile hall as a teen she lost count. She used heroin, sold drugs, got into fights. Then, when she was 17, instead of locking her up again, officials sent her through a drug-rehabilitation program and to the Youth Community Restoration Project, where a young Latino counselor helped her get a job interview. Today, Hernandez works full time at a local nonprofit and is attending college. "My counselor told me something I will never forget," says Hernandez quietly. "She said, 'Your life is a testimony.' She told me that everything I had been through I could use in a positive way." Hernandez

doesn't even hesitate when asked where she would have been without those programs. "I would probably be in jail."

*Peggy Townsend is a journalist who lives in Santa Cruz, California.*

**ISSUE: SHUT UP, ALREADY!    SPECIAL REPORT**

by Peggy Townsend



**THE AMERICAN PROSPECT**

About the  
Prospect /  
Contact Info  
Browse Archive /  
Back Issues  
Subscription  
Services  
Privacy Policy

**DONATE TO THE PROSPECT**



Copyright 2020 | The American Prospect, Inc. | All Rights Reserved

Built with Metro Publisher™



# **EXHIBIT B**

## R E S U M E

2020

John P. Rhoads  
10095 Aniane Street  
Reno, NV 89521  
E-Mail: johnprhoads@hotmail.com

### **Education:**

- California State University, Sacramento - Sociology, B.A. June 1969
- Chapman College - Correctional Counseling, M.A. August 1972

### **Work Experience:**

#### JPR Consulting, September 2002 to present

Private consultant working in Juvenile Justice issues throughout the United States. Most of my time is contracted to the Annie E. Casey Foundation working in their Juvenile Detention Alternative Initiative. I have served as a technical assistance provider in the following sites, Dallas (Dallas) and Harris Counties (Houston) in Texas, Pima County (Tucson) Arizona, and Washoe (Reno) and Clark (Las Vegas) Counties in Nevada, and Ada (Boise) County in Idaho, and Ventura, Santa Clara, San Francisco Counties in California.

I also serve as a member of the National Associates Program on Youth Justice for The Vera Institute of Justice doing work on Children In Need of Service in New York State.

Served as a member of the Juvenile Justice Reform Commission in Nevada. The Commission was formed by the Nevada State Supreme Court.

I have served as an expert in the following cases:

Moyle v. Contra Costa County, et al, Case No. Co05-02324 in the United States District Court, Northern District of California

Morris v. CDCR, et al, Case No. CV07-05954 in the United States District Court, Central District of California

Served as an expert for Sacramento County in the Stipulated Consent Decree of the David Porter v. Verne Speirs and David Gordon, Case No: 06AS03654 in the Superior Court for the State of California, County of Sacramento

S.C. Finley. Case No. CV09-3956-GHK (EX)

Townsend et al v. Imperial County et al, California Southern District Court

Summers v. County of San Diego Case No. 37-2014-00037484-CU-PO-CTL

2016 to present serving as a consultant to the Attorney General of California helping on conditions issues in juvenile facilities.

## **John Rhoads**

### **Qualifications**

- In June, 1968 in Sacramento County, California I began my career as an on-call probation assistant working in the juvenile hall. From 1988-1991, I served as the Assistant Chief Deputy of the Sacramento County Juvenile Hall, and from 1991-1997, I served as the Chief Deputy (Superintendent). The Sacramento County Juvenile Hall was a large residential institution with a capacity of 254 beds. I retired as a Chief Deputy Probation Officer in April 1997 from Sacramento County
- I became the Chief Probation Officer in Santa Cruz County in April 1997 and retired from that position in September 2002. As the Chief Probation Officer of Santa Cruz County, I had under my direction the Adult and Juvenile Probation department and the responsibility for a 42 bed juvenile hall.
- In September 2002 I moved to Reno, Nevada and began private consulting. I have been the sole proprietor and have worked in consulting since that time. Most of my consulting work has been with the Annie E. Casey Foundation in their Juvenile Detention Alternatives Initiative. This initiative has been active since 1992.
- I currently am in emeritus status with the foundation providing technical assistance as needed. Previously I have served as Team Leader in the following sites: Ada County, Boise, Idaho; Ventura County, California; Orange County, California; Pima County, Tucson, Arizona; Washoe County, Reno, Nevada; Clark County, Las Vegas, Nevada; Dallas County, Texas; Harris County, Houston, Texas.
- I also have worked as a consultant to the Youth Justice Program of the Vera Institute of Justice, mainly on detention reform and children in need of service (CHINS) programs in New York
- I have also served as part time trainer and consultant for the National Partnership for Juvenile Service formerly known as the National Juvenile Detention Association. This was through a training grant at various sites around the country.
- My education is a B.A. degree in Sociology from California State University (1969) at Sacramento and a M. A. in Correctional Counseling from Chapman College (1972). I have a lifetime Community College and Counseling credentials and hold a Marriage, Family and Child Counseling license #6667 from the State of California. That license is currently in an inactive status.

## List of Positions Held

### Chief of Probation, March 1997 to September 2002

Santa Cruz County, California. Department head in charge of combined adult and juvenile probation department. This also included a 42-bed detention center.

### Chief Deputy, January 1996 to 1997

Sacramento, California. I managed the Juvenile Court Division. This Division prepared all pre-sentence investigations and also handled intake functions at the Juvenile Hall.

### Chief Deputy, April 1991 to January 1997

Sacramento, California. I was the Superintendent of the Sacramento County Juvenile Hall. I administrated overall operations of the Juvenile Hall (bed capacity of 254), Home Supervision, Electronic Monitoring and the Juvenile Work Project. Total Budget responsibilities were in excess of 9.2 million dollars.

### Assistant Chief Deputy, July 1988 - April 1991

Sacramento, California. I worked as the Assistant Chief Deputy of the Sacramento County Juvenile Hall, administrating general day to day operations of a large-scale institution.

### Supervising Probation Officer, February 1984 - July 1988

Sacramento, California. Worked in Adult Court unit.

### Supervising Probation Officer, October 1980 - February 1984

#### Neighborhood Alternative Center, Sacramento, California

Working as a shift supervisor for Sacramento County Probation Department in the 601-shelter facility. Organizing and supervising work schedules of counselors and childcare workers in a residential treatment facility. Ongoing supervision of casework on an outpatient/inpatient basis for families and children.

### Acting Division Director, February 1982 - September 1982

#### Neighborhood Alternative Center, Sacramento, California

Because of illness to our regular director, I was appointed to this position on a temporary basis. This involved preparing a budget for the division and administering an employee force of approximately 25. In September, I returned to my former position of Supervising Probation Officer.

### Supervising Probation Officer, June 1978 - October 1980

#### Sacramento County Boys Ranch, Sacramento, California

Supervisor in charge of shift at Boys Ranch with on going responsibility to supervise a residential treatment program for 80 boys.

Supervising Counselor, October 1976 - June 1978

Sacramento County Juvenile Hall, Sacramento, California

Supervisor in charge of the treatment program in the Juvenile Hall, which is a Pre-placement unit with emphasis on family therapy as an intervention.

Assistant Marriage Counselor, September 1975 - October 1976

Family Court Services, Sacramento County, Sacramento, California

Marriage Counselor for the Conciliation Court. We offered marriage and divorce counseling as well as counseling for divorced couples experiencing problems over the visitation of children.

Yuba College Part-time Instructor, School year 1975-1976

Administration of Justice Department, Sacramento, California

I taught Introduction to Corrections and Juvenile Delinquency.

Senior Deputy Probation Officer, March 1975 - September 1975

Sacramento City Police Department, Sacramento, California

I was on loan to the Sacramento City Police Department, Youth Services Division. I acted in the capacity of a juvenile intake officer on-site.

Deputy and Senior Deputy Probation Officer April 1972 - March 1973

Sacramento County Probation Diversion Project, Sacramento, California

Assigned to the Diversion Project where I received Special Training in family counseling. In this unit we applied Crisis Intervention and Brief Therapy in hopes of handling pre-delinquent behavior.

Deputy Probation Officer, September 1970 - 1971

Sacramento County Probation, Juvenile Field Unit, Sacramento, California

Juvenile Field Supervisor of a regular delinquent caseload.

Counselor I & II, June 1968 - September 1970

Sacramento County Juvenile Hall & Sacramento County Boys Ranch

Institutional duties as assigned.

**Military:**

Radarman 3rd Class, USNR

June 1966 - June 1968

U.S.S. Floyd B. Parks, DD884

Active duty two years on a destroyer serving in the Western Pacific.

**Professional Licenses and Memberships:**

- ◆ Marriage, Family and Child Counseling License (Inactive)
- ◆ Community College Teaching Credential
- ◆ Community College Counseling Credential
- ◆ California Association of Probation Institution Administrators (State Legislative Chair 1994-1995).

**Additional Experience:**

- ◆ April 1988 to December 1993: Part-time Instructor at the Public Safety Center in Sacramento, California teaching in the CORE Probation Assistance and Probation Officer and Supervising Probation Officer courses.
  
- ◆ Juvenile Justice Initiative Steering Committee. I participated in the planning and implementation of the Juvenile Justice Initiative. This core group has worked for four years to achieve the goals outlined in a grant received by Sacramento County from the Annie E. Casey Foundation. It produced major beneficial changes in the Sacramento County Juvenile Justice System.
  
- ◆ Consultant to the State of New Mexico, Children and Youth Services Division, working with Judicial Districts on population management issues and alternatives to incarceration.
  
- ◆ Chairperson of the Bay Region of the Chief Probation Officers of California
  
- ◆ Served on the California Judicial Council Probation Task Force reviewing all of the functions of Probation in California.
  
- ◆ Served on California Judicial Council Family and Juvenile Advisory Committee.
  
- ◆ California State Board of Corrections Standard Review Executive Committee
  
- ◆ California Coalition against Sexual Assault (CALCASA) Strategic Forum.
  
- ◆ Chairperson of the Santa Cruz County Criminal Justice Council.

**Awards:**

1994 "Julia Lathrop Award for Outstanding Contribution to the Field of Juvenile Justice." This is one of five National Awards granted annually by the American Criminal Justice Association.

1999 Youth Law Center "Unsung Hero for 1999". Presented for the work done in Santa Cruz, California on disproportionate minority confinement and institutional crowding

2002 "Jerry Darling" Award for recognition of a career of dedicated service in the field of probation and continual leadership and vision regarding the care of institutionalized youth in the State of California given by the California Association of Probation Institution Administrators.

# **EXHIBIT C**

Draft

Notes from Conference call with families

**Interview by phone with C.R. and mother D.S. on June 18, 2020 at 4pm est. The interview lasted for 42 minutes and Lauren Lynch, Robert Brunson, John Rhoads were on the call.**

C.R. stated that he had been in the Juvenile Facility in May of 2019. He was there for 6 or 7 days. He has been in CCJDC multiple times.

I asked if he had a medical evaluation by a Dr. or nurse. He said he had seen a nurse on the next day. I asked if he was taking medication while he was there and was it given to him every day. He stated it was administered at night. He did not comment on whether he was supposed to take the medication more often. I presume the medication is administered by custody staff.

I inquired about his having someone to talk to regarding his mental health. He said that he did and that it helped him, but they always came late. He had to wait 24 hours to talk to someone. He was never placed on any kind of special watch for suicidal ideation while in custody during this stay.

He says his room was dirty with mold on the walls and paint peeling off. He said there were bugs in the room, and he heard rats or mice in the attic space. The facility was crowded and there were three people in the room with only two beds. One person was sleeping directly on the floor on a mattress. He also stated that there were problems with the toilet. It sometimes overflowed.

Detainees are not allowed to have pencils in their rooms. They are allowed books. C.R. said his room had appropriate lighting for him to read. Having books is a new addition only after a public defender

inquired about it and donated the books.

There were clean clothes given out each day and he had appropriate bedding. He did say that staff would not allow any extra blankets if you asked for them.

He was able to attend some bible study.

He said they showered daily but that if you were on a 24- or 48-hour room confinement you were not allowed to shower.

He said that he never went outside, and he did know why. It appears that free recreation time was spent in the open areas inside the facility. He did not indicate they had any organized large muscle exercise at all.

He had been disciplined and given extended room time before. He said it was usually for petty behaviors. He said that the custodial staff used rubber bullets and chemical sprays on the detainees if there were any problems. He talked about the "wet room". It is a closet sized room with a light and a bench. He said that staff would put on leg irons and handcuffs on the detainees when placed in there. He stayed in the wet room for 6 hours once. If you had to go to the bathroom staff would let you out and have you shuffle to the bathroom in shackles with your hands cuffed in front.

He was also disciplined by being placed in the restraint chair, with his neck, wrists, hips, legs and feet shackled.

He said that he attended school during his stay. People who were on extended room confinement did not attend school.

**Interview by phone with B.P. She is the grandmother of O.M. , L.M. and B.M. The call was on June 19, 2020 and lasted 43 minutes. Neither L.M. and B.M. were available, so the call was with B.P., John Rhoads, Lauren Lynch, and Robert Brunson.**

Both young men have had multiple periods of custody in CCJDC. L.M.'s last period of custody was in March 2020 and B.M.'s was in 2019.

When asked about the cleanliness of the facility she replied that it was dirty and smelled. L.M. had told her that the roof leaked and that there was mold on the walls. In the visiting area she noticed the water stains on the ceiling tiles. She stated she never had any communication with any of the facility staff during her visits.

She stated that L.M. complained the food was rotten. He stated he had bug bites. there was overcrowding in the facility with some detainees sleeping directly on the floor. He told her that he could hear rats or mice in the ceiling at night. L.M. stated that they never were allowed to go outside. There was no organized hour of large muscle exercise.

L.M. complained of being blamed for having his room toilet overflowing. He stated that it's common for this to occur in the facility. L.M. told staff that he did not stuff anything down the toilet and it was not his fault. Staff would place detainees on discipline for this regardless of what the detainees said. When on extended discipline detainees are not allowed out of their rooms, no canteen privileges, and no school. B.P. said that L.M. was having headaches and that B.M. has bronchitis and asthma but was not given any of his medication during his stay.

BM. Said that the food was not cooked properly and he was served spoiled milk.

B.P. says the facility has a canteen for snacks that can be purchased through an inmate account. She said she had placed money in there several times and when L.M. was released she asked about returning the unused money. She was told by staff that they could return her money, but she could place in another detainee's account if she wanted.

One of her grandsons, L.M. , is a special education student with an Individual Education Plan. No one discussed her grandson's special education status with her.

**Conference call with S.M. and her son R.S. 11am 6/22/2020. Lauren Lynch, Robert Brunson and John Rhoads were on the call**

R.S. was in custody in January 2020. He was unsure about seeing medical and mental health when he was first placed into custody. The facility was crowded and he did have to sleep on the floor.

S.M. gave money to R.S.'s canteen. She never got any money back when he left and didn't ask about it.

When on lockdown, you aren't allowed to get showers. R.S. didn't get many showers.

Guards took away privileges for misbehavior; they took away R.S.'s canteen.

CCJDC is rusted inside and out; not safe inside or out. R.S. was never allowed to go outside.

R.S. hated the food; he got bologna, 2 pieces of white bread and mustard for dinner.

Sometimes, he wouldn't eat at all because it was so bad.

R.S. was in CCJDC when the children were only allowed to wear their underclothes in the cell.

Once a guard grabbed R.S. by the neck to stop him from fighting.

He was also placed in the wet cell for three days. He said the floor was wet and he had to sleep on a mat on the wet floor. He said he was placed in the wet room for not complying with directions. he also stated that while in the wet room he urinated on himself as the staff would not let him out to use the bathroom.

R.S. said that staff threatened to put him in the restraint chair. He did not say they ever placed him in the chair.

R.S. has been diagnosed as having ADHD according to both him and his

mother. He did not receive any of his medication while in custody

He said he once submitted a grievance but it did not seem to make any difference. It sounds as if the grievance system is in name only and staff don't investigate or get back to grievant.

He said staff have a nasty attitude.

The building is old and dilapidated with many leaks. There are mop buckets placed around where the leaks occur. The ceiling tiles are waterstained.

He did say that staff served a snack between dinner and bedtime.

School teacher came from the Daniel Jenkins Academy once or twice a week. School was not like attending regular school. He is a special education student and does have an IEP.

He felt staff let the boys fight each other before eventually breaking it up.

His first time in the Detention Center he was 11 years old and that was for running away from home. He later was in when he went downtown to sell palmetto roses and was accused of stealing a car

R.S.'s mom feels as though they discriminate against the kids. She says you can tell the more fortunate children, you can tell when someone has money, by where they sit at visitation

S.M. said R.S. got colds and puffy eyes, you could tell he was getting sick when he was in there. His public defender told the judge R.S. was deteriorating in there

There was no follow-up care when he came out

**Conference Call with T.L. and her son C.J. on 6/23/2020 (Robert Brunson, Lauren Lynch and John Rhoads)**

He was last in custody May of 2020 and he has been in detention 6 or 7 times

He has been diagnosed with ADHD and has medication for that. Said that the Court had ordered him to take the medication. He spoke to someone at the facility about not getting his medication, but was told they did not have it. He said they knew he had ADHD and other conditions, but did not give him his medicine.

He said there was no Mental Health help in the detention center. He had a mental health counselor at home, but did not see the counselor while he was in the facility.

He had to sleep on the floor twice. The rooms were not clean. There was mold on the windows. He mentioned they did not have toilet seats on the toilets.

He said they never went outside. They got to get out of their room one hour each day. When out they could watch TV and make phone calls.

A PE teacher would come one or two times a week, but only some people were allowed to go outside. Only some people were allowed to "go to school."

While on lockdown, the children are not allowed to go to school, have canteen privileges or make phone calls or visitation with family. Lockdowns last 24, 48 or 72 hours and you have to stay in your cell. Most of the time they do not allow showers during lockdown.

He stayed in the wet cell for two full days twice. He said one time there were four kids placed in the wet cell while they were evacuated to the adult facility due to a hurricane and it was real cold. He stated staff would not give them blankets when they asked for them. On that

occasion, he stayed in the cell for 2 days, while the other stayed there for 5 days. C.J. was there when he could only wear boxers, t-shirts and socks in his cell. He had to leave his jumpsuit outside the cell. They didn't have grievances at CCJDC; they wouldn't do anything about it.

Sometimes children are shackled while in the wet cell, particularly if you beat on the door.

One time he was in the restraint chair for 4-6 hours.

He says he saw the Green Team respond to a group fight and fire rubber bullets. They told a boy to get on the ground and he didn't get on the ground so they shot him down. The boy who was shot was severely bruised and required medical attention. He was placed in the "cool down room" after being shot and brought to the ground.

Toilets overflow frequently. When a toilet overflows in one room, it flows into others. He blamed other children for causing the toilets to overflow.

Food was always late arriving from the jail and terrible. He used his canteen money to buy salt and pepper. He threw up from eating bad food. He described being hungry all the time because the food was so "nasty." Sometimes dinner would not arrive until 10pm.

He said in other facilities the children help each other, but at the CCJDC, "boys are fighting for survival."

School work was easy. They did the same thing every day. Provided 6<sup>th</sup> grade work for a 10<sup>th</sup> grader. He never got credit for school work done at the facility. They did "coloring and dumb stuff."

**Conference call with B.P. and her grandsons L.M. and B.M. This was a follow up call as the boys were not present when B.P. was interviewed. 6/23/2020 0800**

B.M. said he had breathing problem and was not given his medication while in custody.

He said he never saw a nurse.

B.M. was placed in the restraint chair before. He said one time he was in the chair for two full days. They wheeled the chair into the wet cell; when they took him to the bathroom, he was in leg shackles with a belly chain and handcuffed in the front.

He also said he witnessed staff firing bean bags and rubber bullets at detainees. The bean bag gun is orange and the rubber bullet gun is green; He got hit by rubber bullets and it was no joke. Feels like a baseball hit you and you fly off your feet; when one person gets hit, everybody falls because nobody wants to get hit

He says the staff carries pepper spray

He remembers an attempted suicide that occurred in the institution. The child rigged his shirt up to the AC vent and tried to hang off the top bunk. His roommate started yelling for help; he was taken to the hospital in shackles

He complained about the food. He said it was not cooked. His grandmother put money in the canteen fund and that helped because he was hungry from not eating the regular food.

He stated he had been in custody for over two years all told in the seven different time he was in the institution; he was 13 the first time he was in

L.M. his brother complained of his toilet overflowing and getting 72 hours of mandatory confinement. L.M. said there were no grievances.

The building smelled terrible.

L.M. said the staff provided a snack but the food was awful.

He said he had had not been in the restraint chair but saw others in the restraint chair for 24 hours placed in the wet cell. He saw the restraint chair in June or July of 2019

He further stated that he remembered staff using rubber bullets twice last year.

He would attend school but it was easier than regular school.

He was the only one to indicate that staff utilized group discipline once by giving the entire unit 48 hours discipline time.

**Conference call with S.M. and M.J. 6/23/2020 (Stuart Andrews, Lauren Lynch and John Rhoads)**

M.J. was last in CCJDC for about a week in August of 2019. He has been there multiple times.

When M.J. was initially detained there was an issue with whether he would be charged as an adult or a minor because of recent changes in the law, so he was isolated and not offered a determination hearing within the prescribed time.

He initially had a room by himself, but later got a roommate.

Placed in a room by himself. Recreation was one hour out of his room

He said kids told him to drink something and he did. He had a seizure during the night. It was not noticed until morning. He was sent to the hospital at MUSC. Mother was not notified. She asked an officer from Berkeley County who arrested M.J., to look into it for her. She resides in Columbia. The officer found out about the hospitalization and worked a release for M.J. to go home. A bond hearing was set for 6:30pm that evening. His mother arrived from Columbia at the court at 6:15pm and the hearing had already occurred. He was discharged from CCJDC that evening. His mother was very angry about how this matter was handled. She thought that had she not asked the officer to intervene, she can't imagine what might have happened to her child. I think she feels they were trying whitewash the issue.

The toxicology report didn't show anything and they initially blamed the seizure on stress. Exactly two weeks after M.J. was discharged from CCJDC, he had another seizure in front of his mother. She says it was the worst day of her life.

He is now on two medications- one anti-convulsion and one for high blood pressure. He was always healthy and never had seizures prior to going into CCJDC. They are still trying to determine if he is epileptic. The dr. says the drink may have triggered something.

M.J. felt disrespected. His mother feels staff are not professional. She was there once when a guard locked himself out of the building while going to the restroom. There was a woman named "Ms. Polite" who was very rude. She reported her but nothing was done about her.

M.J. was once in solitary confinement for 3 days because he slammed the phone down. Even though the phone was already broken, they charged him with that and she had to pay \$165 for the phone. Another boy called her to tell her that M.J. was in lockdown and couldn't call her. The staff didn't call her.

M.J. witnessed staff beat an inmate. He told her the guard was very aggressive towards the boy but M.J. didn't understand why. She will ask him for more details about this. This incident sticks with M.J. and he brought it up to her again not long ago.

M.J. is in Special Education and is diagnosed ADHD

**Conference call with M.G. and son C.B. 6/23/2020 2:30pm EST (Stuart Andrews, Lauren Lynch and John Rhoads)**

C.B. was in custody for 4-5 months all told between 2016-2018.

Says his room was cleaned because he cleaned it himself. Though he says the mold was too thick on the walls to come off. Never had any breathing problems but his room smelled badly.

He never spoke with anyone about his mental health.

Food was not hot. No snacks.

He had canteen privileges and experienced having it taken away from him as discipline

He was placed on discipline for 72 hours. He said he was able to shower while on discipline. He couldn't have canteen or make phone calls.

They never went outside. Allowed only one hour out of their rooms

He filed a grievance once but they didn't do anything about it.

Stated he was in the restraint chair for 12 hours. He was accused of starting a riot. When in the chair staff refused to let him go to the bathroom. He said the staff told him to wet himself. He held until he was released from the chair.

States he spent ten days in the wet cell which was very cold. He reminded them of how long he had been in there and they finally let him out. Thinks they forgot about him. He did absolutely nothing for 10 days- no reading or anything.

He attended school 2-3 hours 2 days a week

**Conference call with J.H. re her son M.H., daughter J.H. was not present for the interview on 6/23/2020 at 0900**

M.H. was last in the facility in June 2020. He was there for 3 weeks. He did not see a nurse for a physical evaluation or screening.

M.H. did not receive any mental health services.

He is a special education student with an IEP.

He was in his cell all the time. Sometimes he did get let of his room for his one hour until 9pm.

Food was nasty. He spent one hour in the restraint chair.

J.H. said her daughter J.H. was only in one night. She also thought the food was bad and the facility was filthy.

There was another detainee who was in custody during M.J.'s stay for assaulting J.H. (rape). J.H. said the judge had ordered staff to not allow that person to be within 100 feet of her son. They were both let out at the same time for a free hour. The other boy walked right by M.H. while he was in the shower; anything could have happened. She was upset that they did not follow the Judge's order.

M.H. had headaches while in custody could have been an allergic reaction to the mold.

**Conference Call with D.W., aunt and legal guardian of her twin nephews D.W. and D.W. (6/23 at 1:30pm; Patrick Wooten, Lauren Lynch and John Rhoads)**

Last in custody in May or June 2020.

They do not think they had medical or mental health evaluation

One nephew said he thought about suicide. Does not remember talking to staff about that.

They discussed the unclean, moldy conditions of the facility. The aunt said when she visited she could tell it was dirty and had a bad smell. She said it was very dark and spooky inside.

Both boys are on medication for ADHD. They did not receive their medication while in custody. D.W. explained that the boys are inclined to act out when they miss their medication.

Boys were let out of their rooms for one hour a day. Sometimes, the boys couldn't make calls because they only had one hour to get a shower and do other things.

The boys received one pair of boxers each and had to wash them while they were in the shower.

The twins told her not to put money in the canteen because they wouldn't get it.

The oldest twin, D.W., is behind in school because of CCJDC.

D.W. was placed in solitary for 2 days in the wet cell. She thinks it would have been about 2 ½ years ago, when he was 14 years old.

D.W. stated he did not get to shower one day because they ran out of time. His PO tried to get him out of there because it was so bad for his mental health.

There was no outside exercise.

They witnessed staff spraying detainees with Pepper Spray.  
D.W. had to sleep on the floor.

**Conference call with E.J. and daughters I.J. and G.J., 6/24/2020**  
**(Robert Brunson, Lauren Lynch and John Rhoads)**

I.J. was last in custody in March 2020, stayed one week.

Both were in custody in the last six months together length of stay unknown.

Did not see the nurse for three days.

Neither are on medications. No mental health contact.

They both complained about the food describing it as nasty, cold and wet

Floors in the facility were dirty. They described their mattress as being dirty. They said the mattresses did not have a plastic covering and that it was soft therefor stained and dirty. They also stated that they were never ever given pillows. The bedding never gets cleaned.

While in custody they never laundered their overclothes but they did receive laundered underwear. One of the girls complained the underwear was stained.

They were in their cells for 23 hours a day, with one hour of rec time. Sometimes, they got a morning and afternoon break, but mostly they just got one break.

Never filed a grievance because they wouldn't do anything about it. They barely paid attention to us.

They went outside once for 30 minutes.

Toilets would overflow and they would receive mandatory 48 hours of detention, no matter whose fault it was

Once you are booked into a room, the staff gives you a mop and a bucket to clean your cell; they don't provide any disinfectant or cleaning solutions.

They said staff allowed detainees to fight before they made a move to break it up.

I.J. experienced coughing and wheezing. She never saw a nurse about it.

The boys' side was always packed and some had to sleep on the floor.

Sometimes, they missed showers because the guards ran out of time. They would only allow small groups of girls to go at a time. The boys got more time in the showers than the girls did. They never had enough time to take a good shower.

One day of school while in custody. They would just show a movie or something, not real school.

I.J. said a staff member flirted with her. He called her into the library and told her she was too pretty to be in there.

There were female guards, but sometimes male guards would check on them.

Whenever a shift changed, a guard would come around and check on them, but that was about it. They probably came every 5 hours or so.

They had used sanitary napkins in their room and staff told them they were allowed only one pad in the morning and at night. They were on backorder at times.

**Conference call with L.C. re sons Z.C. and A.C. (Z.C. not present for interview; A.C. was present)(Robert Brunson, Lauren Lynch and John Rhoads) 6/25/2020**

A.C. was last in custody May 2019. In custody for one week on two periods.

A.C. saw medical the first day and was given a shot, plus a medical screening.

A.C. has been diagnosed with ADHD and has medication. No medication given while in custody.

A.C. said he had rats and roaches in his cell. Told staff about it and was moved the next day.

Complained of mold on the ceiling. He had a cough in custody. He also has bronchitis.

He also complained of being put on 24 hour restriction for something his roommate did.

He had a bed but other people were sleeping on the floor.

He witnessed a detainee getting shot with rubber bullets for not getting on the ground; he witnessed it as he was coming out of his cell to rec; everyone was then sent back to their cells. He attended school every day for 1-2 hours. He does not think he received any school credit for attending.

He was in his cell for 23 hours and got 1 hour of recreation time. This was scary for L.C. because A.C. had ADHD and couldn't call her.

He changed his underwear every day and his jumpsuit on Wednesdays.

He says staff does not allow enough time for showers.

He described the food as bad. It was soggy with no taste. Sometimes he ate, and sometimes he didn't, depending on what it was.

He got to go to the trailer one time with 6 other detainees and watch TV. In order to access the trailer one must go outside. This is the only detainee who ever talked about getting outside. The trailer had a bunk bed and tv with Netflix in it. A female guard took them over to it.

He said staff came by his cell about every 45 minutes to check on him. They wouldn't talk to him.

He had a problem with his roommate one night. He said his roommate beat him up and pushed his head into the toilet. His brother Z.C. was in the cell next to his and heard the commotion and started banging on his door to get staff's attention. Z.C. broke his wrist doing this and no staff ever came. This occurred at 2am in the morning. Neither boy received any medical treatment following this incident. L.C. took Z.C. to the dr. after he was discharged and learned his wrist was broken. Since it had already started healing, they were unable to put it in a cast, and Z.C. now has problems with that wrist.

He said guards would turn down the air conditioning to make the institution cold. This would occur when detainees were banging on the door. It was a group punishment. Staff would also refuse to give detainees an extra blanket. Water from the vents would drip down on A.C.'s head and made him even more cold.

**Conference call with C.G. re: her grandson J.P. (6/26 with Robert Brunson, Lauren Lynch and John Rhoads)**

J.P. is currently at CCJDC and has been there over a month.

She does not believe J.P. had a medical evaluation inside there.

She's already explained everything and we're taking it too far by asking if he's on medication

J.P. got a bump on his head and it went away on its own. He received no medical treatment for it

He got a stomach ache from eating the food; nurse came after a couple of days; gave him some pills and he felt better

Another kid hit a guard and the guard hit him back

Termites flying in his cell

Shower is moldy

He buys soap from the canteen because the soap they give him makes him break out

He spends 23 hours in his cell and gets 1 hour of recreation

**Conference call with A.M. re her son C.A. on June 29, 2020. C.A. was not present as he is incarcerated at another institution (Robert Brunson, Lauren Lynch and John Rhoads)**

C.A. has ADHD, asthma and has been identified as a Special Education student with an IEP.

He has been in the Charleston County Detention Center several times. Mother was not sure whether he was medically screened on each admittance. C.A. has medication for his asthma. She said when she delivered his medication to the facility, he would get it but if she did not the facility would not provide it.

She said her son was assaulted by a roommate much larger than her son. Her son said his roommate hit him and kicked him for about 15 minutes. He had bruises and cuts from the assault. Staff in the facility did not respond until after the beating. They were apparently unaware of it. This occurred in the late afternoon. It is hard to understand why staff did not hear the noise from this cell. C.A. told staff he was suicidal after they came in order to have them take him out of the cell. They placed him in the wet room in a suicide gown. He stayed in the wet cell for three days. There were charges filed against the roommate for this.

The gown looks like a long life jacket that extends below his hips. C.A. was previously attacked by 3 boys on a school bus when he was younger.

When asked about conditions in the facility he told his mother that the ceiling leaks, there was mold on the vents and wall. He also told her there were spiders and ants in the room.

Food was cold and nasty.

A roommate stuffed the toilet causing it to overflow. Staff gave everyone in the cell 72 hours on disciplinary time for the event. There were 3 persons in the cell.

Some boys had to sleep on the floor.

He had some school but he didn't get any credit for it- just "seat time."

He told his mother they never went outside and that they spent 22 hours a day in the cell.

He saw guard shoot a boy in the shower with a bean bag gun; the boy was doing something silly, not violent.

He knew about the restraint chair but never personally experienced it.

**Interview with D.H., age 15 7/1/2020 (John Rhoads, Robert Brunson and Lauren Lynch)**

D.H. was in custody in an evaluation center and was given time for a phone call by himself about his stay in the Charleston Detention Center. He was last in the center for 6 months getting out on Feb 27, 2020. He went in on 9/18/19.

No contact with nurse or mental health while in custody.

He is a special ed student and supposed to take a medication. He says the staff would not allow his parents to bring in his medication while in the detention center. He never received his medication during his stay at CCJDC.

One cell he shared with 2 other people had two bed bunk arrangement however the top was broken. One person got a bed and the other two slept on the floor. This was not a larger cell and the two mattresses had to be squeezed together right in front of the toilet. According to D.H. there were other rooms with only one person where they could have placed his cell mates to have more room but staff refused. He said there were termites, roaches, bedbugs and once a lizard in his room. The room was cold and he asked for a blanket and staff refused. His mother also asked the staff to move him. They told her they would move him but they never did.

He had spider bites; put in a sick call to the nurse but she never came to see him

Sometimes he did not shower because the water was cold. They didn't always get a shower every day; the shower had mildew in it

School was limited to 10 persons at a time with 2 rotations. Obviously not all detainees were getting regular school. The curriculum was 6-8th grade level. He never got any credit for his school;

He was in the wet cell for five days. He said there was no light in the

room. The room has one wooden bench and it's dirty; people piss on the floor. There is a window in the door and staff checked on him every two hours. He did not get a mattress to sleep until the second day. He only had a sheet and was wearing his drawers, socks and shirt, no jumpsuit. This was the most recent time he was in the wet cell, probably around January 2020. He was placed in the wet cell because a guard said he flooded his room when he flushed the toilet, so she called the Green Team. When the Green Team came, there was no water on the floor of his cell and he didn't flood it, but they still put him in the coolout room anyway.

One time he saw the Green Team come in the unit and shoot a kid with a bean bag because he would not come out of the shower. The gun they used looked like an AR. They put the kid in a restraint chair for a whole day. When the kid came out of the restraint chair, D.H. noticed he had a big bruise on his shoulder from being shot

There is no toilet in the wet cell; some staff would take you to the bathroom and others wouldn't; he saved a cup from lunch and used that to pee in; he also stole a book when they took him to the bathroom once so he'd have something to do in the wet cell

Another time he was in the wet cell for two days without a mattress.

The Green Team once pointed a taser at him; he had a beam on his chest, but they didn't tase him.

Sometimes the guards would not allow him out of his cell on Sunday before midnight so that he could order his canteen and get it on Thursday; they would wait til after midnight on purpose so that he wouldn't get his canteen that week

Never went outside and said the food was nasty. The drink they call Jamboree makes your head hurt; when he ordered the same drink from canteen, he didn't get a headache but when he got it with his meal, he did.

He was once placed in the restraint chair for 12 hours and not allowed to go to the bathroom. They strapped in his head, chest, arms, legs and feet. They let him move his arms every 2 hours, but he never got any exercise while he was in it. They also put a spit mask on him. They the chair in the kitchen so they could keep an eye on him. Any of the kids let out for their one hour could see him. They placed him in the restraint chair after he was kicking his door in the wet cell because they were not going to give him a mattress.

No staff ever told him what he could do to get out of the cool out room or restraint chair.

There is a scanning mechanism on the doors that the guards scan every time they come by your cell. They don't look in your cell every time they come by; maybe only every other time

Three people tried to commit suicide during his stay. They were placed in the wet cell in a suicide gown and naked underneath. One girl tried to cut herself. The other two tried to hang themselves. He said mental health staff came in every other day to talk to the kids who attempted suicide.

**Interview with J.F. re her son J.M. not present. July 2, 2020 (John Rhoads, Robert Brunson, and Lauren Lynch)**

Last in custody at CCJDC 3 or 4 weeks ago; is currently at evaluation center, scheduled to return to CCJDC next week while he awaits placement

He has been in 3 times.

He had a medical problem with skin peeling around his mouth. Mother says he should have been given medication. She says he never got to see a nurse and she thinks it was because he was not any medication on a regular basis.

He complained of mold in the showers. He also said the water doesn't come out of the shower right- it's a different color. He also said there are worms in the showers; mother thinks there are parasites in the water

Rooms were nasty.

Mother states they do not allow detainees to wear their uniforms(jump suits) in their rooms. She knows this because they were piled outside each occupied cell. She also noticed that when parents would come to visit, the kids would be buttoning up their clothes as they came down the hallway, as if they were just getting dressed.

Mother says they have a system for identifying how many times you have been there by the color of the jumpsuit. Never heard this from anyone else.

She complained about them pushing the food cart outside causing a lot of insects to gather on it. She felt it was unhealthy.

Mother says she spent \$260 on the canteen in a month. Son had to buy toothbrushes, tooth paste, soap, personal needs that should be provided by the center.

Says her son went to school to paint pictures. They also colored and

watched movies for school.

Says one time the toilets overflowed and the children were evacuated to the trailer. Her son was accused of causing the overflow. They placed him in the wet cell.

J.M. was in his cell for 23 hours per day, with one hour of recreation time.

After he was released J.M. was shopping with his Godfather in Walmart when he saw three custody officers from the Charleston County Detention Center. Mother says her son immediately ran out of the store and away.

Once when J.M. asked a guard what time it was, she responded by saying, "your black ass should have never come to jail."

**Interview with E.S. regarding her son L.R., 7/2/2020 (John Rhoads, Robert Brunson and Lauren Lynch)**

Was in custody for two weeks a couple of months ago.

Food was nasty

He stated detention center was filthy

She said her son came down with a brain infection after he went to placement. Doctors don't know what caused it. They asked her if he had been in water or anything or if anything had bitten him. She didn't know because he wasn't in her care when this happened. Dr's thought it might have stemmed from a sinus infection. They did not say anything about an airborne pathogen.

L.B. was in CCJDC, then in evaluation in Columbia for about 45 days, then sent back to CCJDC, then sent to Georgetown marine institute for placement; his Mom thinks he was there for less than 3 months when he was diagnosed with the brain infection; this was probably in March or April of 2018

Infection gone now. evaluation about infection says he has expressive language deficit. He was deemed disabled and is getting therapy now. Therapy is helping

He did not get speech therapy in the Charleston County Detention Center when he was in this year

Said he was in his room 23 hours a day.

**Interview with L.A. re: her daughter S.L. (John Rhoads, Robert Brunson, and Lauren Lynch)**

Last time S.L. was in custody at the detention center was 2017 when she was 16. She was placed in custody on a pick up order from the Family Court based on a complaint from her mother that causing problems at her home as well as school. She was not on probation and was a status offender.

L.A. stated her daughter has severe asthma. When S.L. was placed in custody her mother brought her medication to the center. She needs this medication every day. The center told her they could not accept and that she had to call the jail and arrange to bring in there so the nurse when she came to the detention center to give out medication. According to the mother they did not come over that evening to give her daughter her medication. The next morning she tried to reach out again, but didn't hear back, so she went on to work. After work that evening she so worried about her daughter having an asthma attack she went to the detention center. When she arrived she saw an ambulance there and found out her daughter had suffered an asthma attack and was going to the hospital.

Even though her daughter was a status offender they brought her out of the facility in handcuffs and leg irons. They even kept her handcuffed to the hospital bed.

Mother arranged her release from the hospital to her custody thru the Family Court.

S.L. later told her mother that she had to bang on her cell door while she was having the asthma attack to get the guards to come to her.

Mother stated that her daughter said the food was cold, place was moldy, it stank and there was water dripping from rusty faucets. She saw a big spider and cockroaches.

The children never get to go outside.



# **EXHIBIT D**

JUNE 2019

# NOT IN ISOLATION

---

HOW TO REDUCE ROOM CONFINEMENT  
**WHILE INCREASING SAFETY**  
IN YOUTH FACILITIES



**Stop**  
**Solitary**  
**for Kids**

## **ACKNOWLEDGEMENTS**

### **ABOUT STOP SOLITARY FOR KIDS**

Stop Solitary for Kids is a national campaign to end solitary confinement of youth in juvenile and adult facilities in the United States. The campaign is a joint effort by the Center for Children’s Law and Policy, the Center for Juvenile Justice Reform, the Council of Juvenile Correctional Administrators, and the Justice Policy Institute. Stop Solitary for Kids aims to end solitary confinement by working with key decision makers in all three branches of government at the federal, state, and local levels through research, public education, policy reform, improved facility practices, legislative changes, training, and technical assistance. To learn more, please visit our website: [www.StopSolitaryforKids.org](http://www.StopSolitaryforKids.org).

### **CAMPAIGN PARTNERS**

Center for Children’s Law and Policy  
Council of Juvenile Correctional Administrators  
Center for Juvenile Justice Reform at Georgetown University  
Justice Policy Institute

---

### **AGENCIES**

This publication would not be possible without the resources and time provided by the following agencies. Administrators and staff in these agencies participated in multiple in-person and phone interviews, responded to requests for information, and provided policies and data.

Colorado Division of Youth Services  
Massachusetts Department of Youth Services  
Oregon Youth Authority  
Shelby County Sheriff’s Office, Memphis, Tennessee  
Juvenile Court of Memphis and Shelby County

## FACILITIES

We thank the administrators and staff of the following facilities for accommodating site visits from our staff and providing access to administrators, staff, and youth:

Gilliam Youth Services Center, Denver, Colorado  
Lookout Mountain Youth Services Center, Golden, Colorado  
MacLaren Youth Correctional Facility, Woodburn, Oregon  
Metro Youth Services Center, Dorchester, Massachusetts  
Paul T. Leahy Center, Worcester, Massachusetts  
Shelby County Juvenile Detention Center, Memphis, Tennessee

---

## INDIVIDUALS

We thank the following individuals in each jurisdiction for providing direct assistance in this project or allowing us to use their experiences and quotes to enhance this publication.

### **COLORADO DIVISION OF YOUTH SERVICES**

Anders Jacobson, Director  
Heidi Bauer, Director of Communications and Legislative Affairs  
Erik Julius, Director, Lookout Mountain Youth Services Center  
Jamie Nuss, Director, Gilliam Youth Services Center

### **MASSACHUSETTS DEPARTMENT OF YOUTH SERVICES**

Peter Forbes, Commissioner  
Ruth Rovezzi, Deputy Commissioner of Operations and Support Services  
Margaret Chow-Menzer, the Deputy Commissioner of Administration and Finance  
Cecely A. Reardon, General Counsel  
Nancy Carter, Director of Regional Operations  
Yvonne Sparling, Director of Clinical Services\*  
Robert Turillo, Assistant Commissioner of Program Services  
Louise DiMarzio, Executive Assistant

Daniel O'Sullivan, Metropolitan Regional Director  
David Chandler, Director of Research and Internal Review Board Chair  
Barbara Morton, Central Regional Director  
Lynn Allen, Facility Administrator  
Lenny Beatty, Facility Administrator  
Fred Hurley, Facility Administrator  
Meghan McDermott, Clinician  
Elisa Samuels, Program Administrator  
Demetrius Solomon, Shift Administrator  
Mark Auguste, Shift Administrator  
Jerry Cambero, Shift Administrator  
Rudy Kolaco, Shift Administrator  
Brian Daley, DYS Research Analyst III

\*Special thanks for the substantial contribution of Dr. Yvonne Sparling, the DYS Director of Clinical Services. The Massachusetts portion of the report relies heavily on the information, content, and internal documents created and generously shared by Dr. Sparling.

In 2006, the DYS Clinical Advisory Council endorsed the use of Dialectical Behavior Therapy (DBT), developed by Marsha Linehan (1993), as the therapeutic framework for clinical services in DYS residential programs and developed a DBT Manual for all DYS residential programs.

As part of the DYS DBT Manual, Dr. Sparling wrote "[Dialectical Behavior Therapy as a Behavior Management Approach](#)," which established the fundamentals of DBT practice within the agency and has been used in efforts to decrease the use of room confinement.

### **PRETRIAL JUSTICE INSTITUTE**

We thank the Pretrial Justice Institute for allowing us to use interviews with members of Massachusetts Department of Youth Services staff with as source material for this report.

## **OREGON YOUTH AUTHORITY**

Joe O'Leary, Director  
Fariborz Pakseresht, Former Director  
Clint McClellan, Assistant Director  
Heber Bray, Operations Policy Analyst  
Erin Fuimaono Assistant Director of Development Services  
Kristen Kolb, Project Manager  
Jamie McKay, Program Director, McLaren  
Ken Jerin, Superintendent, Rouge Valley Youth Correctional Facility  
Alicia Cozad, Superintendent, Oak Creek Youth Correctional Facility  
Dan Berger, Superintendent, McLaren Youth Correctional Facility  
Jennifer Thurlow, Executive Assistant to the Director  
Sanya Kite, Executive Assistant  
Ann Butte, Executive Assistant

## **SHELBY COUNTY SHERIFF'S OFFICE**

Deidra Bridgeforth, Assistant Chief  
Debra Fessenden, Legal Advisor

## **JUVENILE COURT OF MEMPHIS AND SHELBY COUNTY**

Pam Skelton, Chief Administrative Officer

### **WE WOULD LIKE TO THANK THE FOLLOWING INDIVIDUALS FOR EFFORTS IN PREPARING THIS REPORT:**

Shay Bilchik  
Michael Dempsey  
Wendi Faulkner  
Jeremy Kittredge  
Lisa Macaluso  
Valerie McDowell  
Jennifer Lutz  
Beth Oprisch

Daniel Pollitt  
Sadie Rose-Stern  
Marc Schindler  
Sherika Shnider  
Mark Soler  
Jason Szanyi  
Madeline Titus  
Michael Umpierre  
Annie Veyakhone

## **ACLU OF COLORADO**

Rebecca Wallace, Staff Attorney

### **FUNDERS**

This report would not have been possible without generous support from:

Andrus Family Fund

Anonymous

The Annie E. Casey Foundation

The Jacob and Valeria Langeloth Foundation

The Tow Foundation

### **RECOMMENDED CITATION**

Jennifer Lutz, Mark Soler, and Jeremy Kittredge, *Not In Isolation: How to Reduce Room Confinement While Increasing Safety in Youth Facilities* (Washington, DC: Center for Children's Law and Policy and the Justice Policy Institute, May 2019).

# **Table of Contents**

<b>8</b>	<b>Executive Summary</b>
<b>13</b>	<b>Introduction</b>
<b>17</b>	<b>Bound and Unbound: Colorado’s Efforts to Reduce Isolation</b>
<b>34</b>	<b>The Massachusetts Department of Youth Services</b>
<b>56</b>	<b>Shelby County, TN: Major Reforms by Sheriff’s Office</b>
<b>71</b>	<b>Oregon Youth Authority</b>
	<b>Appendix:</b>
<b>103</b>	<b>Guidelines for Contact with Jurisdictions in This Report</b>
<b>104</b>	<b>Jurisdiction-Based Resources</b>
<b>109</b>	<b>Summary of Quotations</b>
<b>118</b>	<b>Index</b>

## Executive Summary

In 2016, the Center for Children’s Law and Policy, Council of Juvenile Correctional Administrators, Center for Juvenile Justice Reform at Georgetown University, and Justice Policy Institute launched the Stop Solitary for Kids campaign. The Campaign’s goal is to safely reduce and ultimately end the dangerous practice of solitary confinement for young people in juvenile and adult facilities. Collaboration between stakeholders both inside and outside youth facilities is a key Campaign philosophy. The Campaign works with advocates, lawmakers, state and local government official, state juvenile justice agency directors, superintendents of state and local juvenile facilities, parents, youth, and community leaders to highlight effective strategies to reduce and eliminate solitary confinement.

There is widespread and growing awareness of the harms and ineffectiveness of solitary confinement within the youth justice field and among the public at large. The practice – alternatively described as “room confinement,” “isolation,” “separation,” or “seclusion” – is the involuntary placement of a youth alone in a room or other area for any reason other than as a temporary response to behavior that risks immediate physical harm. As demonstrated throughout this publication, the harms of solitary confinement are experienced most acutely by youth with mental illness, youth with trauma histories, youth of color, and LGBTQ and gender non-conforming youth.

Not in Isolation is a practical guide to help leaders and agencies develop roadmaps to reducing room confinement in their facilities. Because there are multiple existing resources documenting the negative effects of room confinement on youth and staff, Not in Isolation instead focuses on ways to avoid and prevent the practice of room confinement altogether.

### **ANSWERING THE QUESTION: “IF NOT ROOM CONFINEMENT, THEN WHAT?”**

As national developments and standards call for limits on the use of room confinement, the challenge of implementation falls largely on state and local facilities. In 2015, the Council of Juvenile Correctional Administrators published the [Toolkit on Reducing Isolation](#), which outlined several core strategies for reducing room confinement. However, throughout the Campaign’s work, agency directors and facility superintendents ask additional questions such as, “How can I reduce room confinement while keeping youth and staff safe?” and “How have other facilities like mine started this process?” Many administrators want information on effective strategies to reduce room confinement *and* real-world examples of how to implement strategies in practice.

This first-of-its-kind publication tells the stories of how three state agencies and one county sheriff’s department operating a juvenile detention facility undertook efforts to safely reduce the use of room confinement: Colorado Division of Youth Services; Massachusetts Department of Youth Services; Oregon Youth Authority; and Shelby County Sheriff’s Department in Memphis.

## NOT IN ISOLATION IS A PRACTICAL RESOURCE. EACH CHAPTER INCLUDES:

- Perspectives, quotes, and examples from facility and agency staff;
- Sample policies, forms, tools, and other materials; and
- Details from each site about challenges, lessons learned, and results (qualitative and quantitative).

While none of the jurisdictions featured in this publication are perfect models, they achieved measurable reductions in the frequency and duration of room **CONFINEMENT**. *Not in Isolation* includes data from each jurisdiction to show that it is possible to reduce room confinement without increasing violence in a facility. Moreover, shifting youth justice facility practices away from punitive isolation and toward models that focus on emotional regulation and behavioral skills helps youth successfully transition back into their communities.

The title of this publication reflects that understanding that reforms related to room confinement do not occur in isolation from other aspects of facility operation. Reducing room confinement is inseparably related to changes in staffing, training, mental health services, programming, behavior management, and other factors.

## WHY NOW IS THE TIME TO REDUCE ROOM CONFINEMENT

Room confinement has recently been catapulted into the national spotlight due to a convergence of mainstream media attention, litigation, legislation, policy developments, and investigative reports. As awareness about room confinement grows, so does public scrutiny and legal jeopardy for jurisdictions that continue the practice unchecked. It is more critical than ever that youth justice facility and agency administrators develop alternatives to room confinement consistent with evolving best practices, professional standards, and an understanding of adolescent development. Several recent developments highlight the urgency to reduce room confinement for facilities that house young people:

- Federal courts in four states have entered orders against facilities for putting **YOUTH IN ISOLATION, RESULTING IN HUNDREDS** of thousands of dollars in litigation costs.
- Legislation in seven states in the past three years has limited the use of isolation in youth facilities. Several other states are currently considering similar legislation.
- In December 2018, Congress passed bipartisan legislation to limit isolation called the [First Step Act](#), which permits isolation only when there is an immediate physical harm – never as a sanction or punishment – for youth in federal custody.
- In 2018, Congress also reauthorized the [Juvenile Justice and Delinquency Prevention Act](#) (JJDP), which requires states to provide data on the use of isolation and describe their strategies to reduce its use.

## HOW TO USE THIS PUBLICATION

This report can be used by youth justice system administrators, supervisors, staff, practitioners, and advocates, as well as policymakers and other key stakeholders, to:

1. Provide concrete examples of how several jurisdictions have reduced room confinement;
2. Give practical guidance on how to translate strategies to reduce room confinement into practice;
3. Generate new ideas about how youth facilities and agencies can successfully reduce room confinement;
4. Encourage comprehensive efforts to reduce room confinement that focus on multiple areas of operation (behavior management, training, staffing, mental health) to improve overall outcomes for youth and staff;
5. Provide credible perspectives from staff and administrators on why and how to reduce room confinement;
6. Highlight the need for state and local youth facilities to reexamine and change their use of room confinement;
7. Demonstrate that it is possible to reduce room confinement in a diverse range of youth facilities without sacrificing staff safety. This includes facilities and agencies with large youth populations, detained and committed youth, older youth, youth charged as adults, and youth with violent charges; and
8. Develop a better understanding of the resources, time, and supports necessary for facilities to create lasting reductions in room confinement.

## TAKEAWAYS ON REDUCING ROOM CONFINEMENT

*Not in Isolation* demonstrates that there are multiple paths to reducing room confinement. Each jurisdiction was driven to reduce room confinement by different external and internal circumstances, and each used a slightly different approach to achieve success. However, there are several common strategies and lessons learned:

- Structure efforts to reduce room confinement around a central principle or approach that connects policies, practice, and culture.
- Include staff in planning, developing, and implementing changes.
- Provide strong leadership committed to reducing room confinement despite setbacks and challenges.
- Create a communication plan to message changes in room confinement to staff.
- Prepare administrators, supervisors, and senior staff to explain why reducing room confinement is the right thing to do.
- Understand the use of room confinement in relation to other aspects of facility operation, (e.g.

level of staffing, programming for youth, adequacy of staff training, utilization of mental health professionals, and effectiveness of the behavioral management systems).

- Use data to identify problem areas and create targeted solutions.
- Prioritize positive relationships between staff and youth as a tool to maintain safety.
- Redefine alternatives to room confinement as proactive interventions (versus reactive approaches of waiting until behavior has escalated to the point of requiring room confinement).
- Develop tools and practices to help youth exit room confinement as quickly as possible.
- Be prepared to make a case for additional resources by documenting your current practice, progress, results, and needs.
- Leverage external relationships with unlikely allies.

## HIGHLIGHTS FROM EACH JURISDICTION

### COLORADO DIVISION OF YOUTH SERVICES

1. Developed an organizational model to change agency culture and improve practices;
2. Used the legislative process to request additional staffing resources;
3. Implemented an incentive-based behavior management system;
4. Remodeled physical environments to align with principles of adolescent development and rehabilitation; and
5. Relied on regular data analysis to steer reforms.

### MASSACHUSETTS DEPARTMENT OF YOUTH SERVICES

1. Integrated Dialectical Behavior Therapy (DBT) into the behavior management system and living unit management;
2. Redefined accountability based on skill-building – rather than punishment – to change behavior;
3. Identified positive youth-staff relationships as a critical tool for facility safety;
4. Developed “exit strategy” guidelines to help youth transition out of room confinement quickly;
5. Created individual support plans for youth who continuously acted out or could not respond to programming.

### SHELBY COUNTY JUVENILE DETENTION CENTER

1. Implemented daily circle-up groups;
2. Enhanced staff training on how to work with youth and Safe Crisis Management;
3. Established a standardized review of videos and documentation of room confinement incidents;

4. Hired an additional staff to enhance programming and volunteer activities; and
5. Relied on assistance and examples from consultants (including other facilities).

### **OREGON YOUTH AUTHORITY**

1. Changed culture before changing policy;
2. Developed a culture based on Positive Human Development (PHD);
3. Used data strategically to create Skill Development Counselors and specialized units;
4. Leveraged the political process to secure funding; and
5. Created a 10-Year Plan that included redesigning physical plants to support alternatives to room confinement.

## **SECTIONS OF THE REPORT**

### **CHAPTERS ON FOUR JURISDICTIONS**

Each chapter describes how a jurisdiction reduced room confinement over time.

### **HIGHLIGHTS AND KEY EXAMPLES**

*Not in Isolation* also includes section headings, bullet-pointed guidelines, images, and graphics to direct practitioners to specific areas of interest. Each heading contains links to useful policies, forms, and examples.

### **APPENDIX OF RESOURCES AND TOOLS FROM EACH JURISDICTION**

This publication includes a section listing resources (policies, forms, training materials, and videos) from each jurisdiction.

### **APPENDIX OF QUOTES FROM ADMINISTRATORS AND STAFF**

*Not in Isolation* tells the story of each jurisdiction through the insights and experience of administrators and staff. The publication contains an appendix of quotes from these individuals.

## Introduction

In 2016, the Center for Children’s Law and Policy, Council of Juvenile Correctional Administrators, Center for Juvenile Justice Reform at Georgetown University, and Justice Policy Institute launched the [Stop Solitary for Kids campaign](#). The Campaign’s focus has been to safely reduce and ultimately end the dangerous practice of solitary confinement for young people in juvenile and adult facilities. The Campaign currently has the [support of over 50 national professional associations](#), including associations representing youth justice agencies and facility directors, medical and mental health professionals, advocates, and others.

There is widespread and growing awareness of the many harms of solitary confinement within the youth justice field and among the public at large. This includes a recognition that the different terms that are used to describe solitary confinement—“room confinement,” “isolation,” “separation,” “segregation”—all describe the same thing. This publication refers to the practice either as room confinement, isolation, or by the term used in the jurisdiction described. What matters, and what is harmful, is the practice of involuntarily placing a youth alone in a room for any reason other than as a temporary response to out-of-control behavior that threatens immediate harm to the youth or others. Once the youth calms down, the youth should be released from his or her room and returned to regular programming.

In the years since the Campaign’s launch, many [state and local jurisdictions](#) have [taken significant steps](#) to reduce or end the use of room confinement through legislation, litigation, or policy changes. In December 2018, Congress took an important step toward ending youth isolation by passing the bipartisan [First Step Act](#), which prohibits facilities that house youth in federal custody from using isolation as punishment and permits isolation only when youth behavior poses a risk of immediate physical harm that cannot otherwise be de-escalated. In 2018, Congress also reauthorized the [Juvenile Justice and Delinquency Prevention Act](#) (JJDP), which now requires states to provide data on the use of isolation and describe their strategies to reduce its use.

When we work with agency directors and facility superintendents to reduce solitary, the first question we are asked is, “How can I reduce room confinement while keeping youth and staff safe?” In this first-of-its-kind report, we provide detailed case studies of how four jurisdictions undertook efforts to safely reduce the use of isolation. As readers will see, reforms related to room confinement did not occur in isolation. They required a comprehensive look at staffing, training, mental health services,

**I** f the clinicians are just writing up an ISP and telling people what to do, it will fail. If you get everyone’s input, there is more follow-through and buy in. All of this stuff leads to less room confinement. *Daniel O’Sullivan, Metropolitan Regional Director, Massachusetts DYS*

programming, behavior management, and other factors. While none of the jurisdictions featured in this publication are perfect models, they achieved measureable reductions in the frequency and duration of room confinement through promising practices. And while the impetus for undertaking this work and the particular strategies varied across each jurisdiction, the results were the same: sharp reductions in the use of room confinement along with improved safety for youth and staff.

Unlike previous publications, this report does not detail the harms of room confinement. Those have been widely documented and accepted by youth justice professionals, and we provide references to that literature. This report provides practitioners with concrete, practical, and effective tools and strategies in the context of real-world reforms. It also provides public officials, parents, and other advocates for youth with examples of success and models that they can work to adopt in their own communities. Ending room confinement for young people is no longer a distant dream; it has been achieved in a variety of settings and facilities in different parts of the country, and the lessons learned here can be applied to any juvenile facility seeking more humane treatment of youth in custody.



Photo credit: Richard Ross

# NOT IN ISOLATION

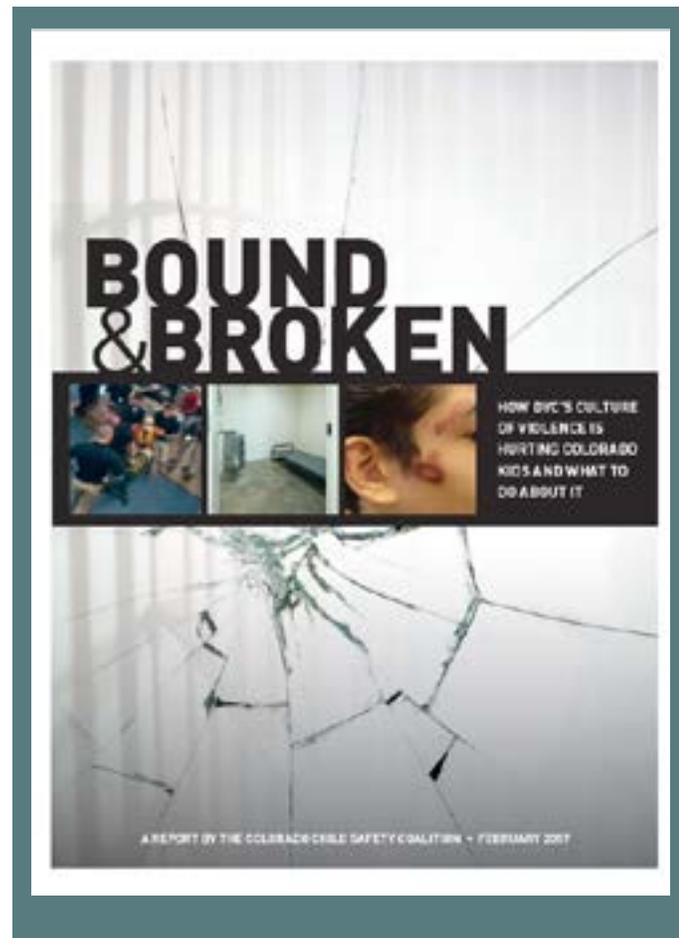
HOW TO REDUCE ROOM CONFINEMENT  
**WHILE INCREASING SAFETY**  
IN YOUTH FACILITIES

**COLORADO DIVISION  
OF YOUTH SERVICES**

## Bound and Unbound: Colorado's Efforts to Reduce Isolation

### IMPETUS FOR CHANGE

On March 2, 2017, the Colorado Child Safety Coalition released a report, [Bound and Broken: How DYC's Culture of Violence is Hurting Colorado's Kids and What to Do About It](#), which painted a picture of regular and violent abuse of young people in facilities operated by the Colorado Division of Youth Corrections (DYC). The report was based on interviews with youth who were or had been in 11 of the state's 13 juvenile justice facilities (10 operated by DYC), a review of over 1,000 pages of internal DYC documents, and videos and medical reports of incidents between 2013 and 2016. It found that fights and assaults in DYC facilities increased 42% between 2013 and 2016, that DYC staff physically restrained youth at least 3,611 times from January 2016 through January 2017, and that staff placed youth in solitary confinement 2,240 times during the same period. This happened while the number of young people held in DYC facilities *decreased* and staffing and funding for the facilities *increased*.



The report also found that DYC staff commonly used “pain compliance” techniques including knee strikes and pressure points. Perhaps most concerning, the report included photos that documented a full body physical restraint device known as the WRAP, which was similar to a straitjacket. DYC staff put young people in the WRAP at least 253 times from January 2016 through January 2017. The report included photos and quotations from youth who had been subjected to the painful practices.

The report recommended prohibiting the use of the WRAP, the pain compliance techniques, and the use of solitary confinement. It also recommended adopting the “Missouri model” of small facilities with homelike environments and strong positive relationships between youth and their peers and between youth and staff.

At the time of the report, Anders Jacobson was newly appointed as the Director of DYC (and continues in that position today). Concerns about mistreatment of youth in DYC facilities were not new to him. In fact, he had been appointed temporary director of DYC in September 2016, when the former director left his position following reports of violence in the Spring Creek Youth Services Center, a DYC facility in Colorado Springs. Three months later, in December 2016, Jacobson was formally appointed to the director position.

The concerns also were not new to members of the Colorado Child Safety Coalition: the ACLU of Colorado, Disability Law Colorado, the Colorado State Public Defender, and the Colorado Juvenile Defender Center (CJDC). In June 2014, the ACLU, Disability Law, and CJDC notified the Executive Director of the Department of Human Services, who oversaw DYC, that youth in DYC facilities had been placed in seclusion for days, weeks, and longer, as a form of “treatment.”<sup>2</sup> By July 1, 2014, DYC agreed to stop using seclusion in a punitive way. However, on October 4, 2015, the Colorado Springs Gazette reported that, based on a review of DYC records, 299 youth had been placed in isolation since DYC changed its policy.<sup>3</sup> The Gazette article highlighted the story of a 14-year-old boy who spent 22 days in seclusion, often for 23 hours a day, at Spring Creek. That month, DYC [updated its policy](#)<sup>4</sup> to limit the use of seclusion to emergency situations, which were defined by statute as situations involving “a serious, probable, imminent threat of bodily harm.”<sup>5</sup> Generally, seclusion was limited to four hours, but could be extended if the emergency continued.<sup>6</sup>

## STATE LEGISLATION

In May 2016, with strong support from the Child Safety Coalition, the Colorado legislature approved [HB16-1328](#),<sup>7</sup> a bill to strengthen protections for youth in state-run facilities with respect to restraint and seclusion. The new law codified into statute the Division’s policy that seclusion could never be used as punishment, sanction, retaliation, or as part of a treatment plan. The bill limited seclusion to emergency situations when “a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm.”<sup>8</sup> The bill prohibited the use of isolation for more than four hours unless a prescribed protocol was followed, including examination by a mental health professional, and prohibited isolation for more than eight hours in two consecutive days without a court order. HB16-1328 also established the Youth Seclusion Working Group to advise DYS on policies, procedures, and best practices related to seclusion and alternatives to seclusion.<sup>9</sup>

### Requirements Established by HB16-1328

- Seclusion could never be used as punishment, sanction, retaliation, or as part of a treatment plan;
- Limited seclusion to emergencies when “a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm;
- Required increasing approval at four and eight hours;
- Created a statewide Youth Seclusion Working Group to review data and make recommendations on reducing seclusion and restraints.

## LIMITED STAFF

In late 2016 and early 2017, Jacobson hoped that increasing the number of staff—and thereby decreasing staff-to-youth ratios and improving supervision—would improve the situation. The ratio at that time was 1:11, while the national standard and accepted practice in the field was 1:8.<sup>10</sup> Governor

John Hickenlooper requested \$5 million to add 80 full-time employees to DYC, and another \$3 million for enhanced mental health and physical health care.<sup>11</sup> At the time, the agency only received funding for a portion of the requested staff positions. However, with continued legislative advocacy, the agency eventually received funding necessary to maintain a 1:8 ratio.<sup>12</sup>

The Bound and Broken report was a wake-up call. DYC had previously begun reforms, including limiting the use of seclusion by policy and training staff in a trauma-responsive approach. However, the Bound and Broken report made it clear that more effort was needed. In May 2017, again with strong support from advocates, the legislature passed a new bill, [HB17-1329](#), designed to bring about major culture change in DYC facilities.<sup>13</sup>

The Missouri Youth Services Institute,<sup>14</sup> led by former Missouri DYS Director Mark Steward, was brought in as a consultant on the pilot project.

## ENCOURAGING RESULTS

Within a year there were important developments. In November 2017, DYS issued [a formal policy](#)<sup>15</sup> (which it amended in 2018), defining the criteria and limits for use of involuntary seclusion in a locked room or area; voluntary youth-initiated time outs (not to exceed 60 minutes, usually in an open area); and staff-initiated time outs (not to exceed 60 minutes, usually in an open area). The WRAP devices were removed from DYS facilities. The staff-to-youth ratios were 1:8 in seven of the 10 DYS facilities.

Staff members were consistently assigned to the same group of youth, allowing the development of stronger relationships between youth and

## Changes Made by HB17-1329

Changed the name of the Division of Youth Corrections to the Division of Youth Services (DYS) (at the request of the Division);

Clarified as its primary mission to focus on rehabilitation;

Established a 20-bed pilot program with a low staff-to-youth ratio to test the effectiveness of a therapeutic group treatment approach and the ability of the Division to keep youth and staff safe without the use of seclusion and restraints other than handcuffs;

Provided additional training to staff of the pilot program as needed;

Called for the integration of trauma-responsive principles and practices into all elements of programming;

Codified the phase-out of physical strikes on youth, pain-compliance and pressure-point techniques, the WRAP, and the use of isolation that the Division had already prohibited via policy;

Expanded the role of the statewide Youth Seclusion and Restraint Working Group;

Required an independent assessment of the Division;

Created community boards in each region of the Division; and

Required extensive documentation of each instance of the use of restraint or seclusion in DYS facilities.

staff. The job title of correctional officers was changed to “youth services specialists.”<sup>16</sup> The job description for the position sought candidates who want to “engage with youth and build positive relationships.”<sup>17</sup> Routine strip searches after family visits were discontinued because they can be traumatic for youth. Strip searches were only conducted if there was probable cause and with approval from facility administration. Youth dressed in school uniform-type polo shirts and khaki pants rather than prison-like hospital scrubs. A number of the units were remodeled, with more homelike furniture, softer colors on the walls, and plants. Metal beds and 3” mattresses were replaced with more homelike beds and 7” mattresses. Simple blankets were replaced with comforters. Jacobson described the reforms as part of the culture change: “It really feeds into our vision of where we are going.”<sup>18</sup>

### Encouraging Progress in Colorado

- Developed new policy on seclusion
- Banned the WRAP
- Stopped routine strip searches after family visits
- Youth clothing switched to polo shirts and pants
- Remodeled units to be more homelike
- Increased staffing
- Changed job title to “youth service specialist” to prioritize positive relationships with youth
- Remodeled units to create less institutional environments and more comfortable beds

### Key Elements of New Seclusion Policy

Seclusion only permitted during an emergency as defined by Colorado Revised Statute 26-20-102(3), or when there is a serious imminent threat of bodily harm and the present ability to cause such bodily harm;

Staff must attempt less restrictive alternatives or determine that such alternatives would be ineffective or inappropriate;

Seclusion may be used only for the period of time necessary to prevent the continuation or renewal of an emergency;

Staff must conduct visual checks at least every 5 minutes;

Staff must conduct a verbal check and try to engage the youth back into programming every 5-15 minutes;

The shift supervisor, direct care staff, and behavioral health staff must meet to discuss a plan to process the youth out of seclusion as soon as possible;

Seclusion may not exceed 4 hours except in rare circumstances involving input from a mental health professional and approval from the Director of DYS;

Seclusion exceeding 72 hours requires a court order; and

Facility directors review a monthly report on seclusions, including the incident leading up to seclusion and the staff members involved.

Equally importantly, seclusion incidents were down from a high of 302 in October 2016 to 97 in July 2018, a reduction of 68%. The median length of time in seclusion also decreased to 37 minutes for the period of March to August 2018. Average isolation time has been under one hour since September 2016.<sup>19</sup>

FIGURE 1

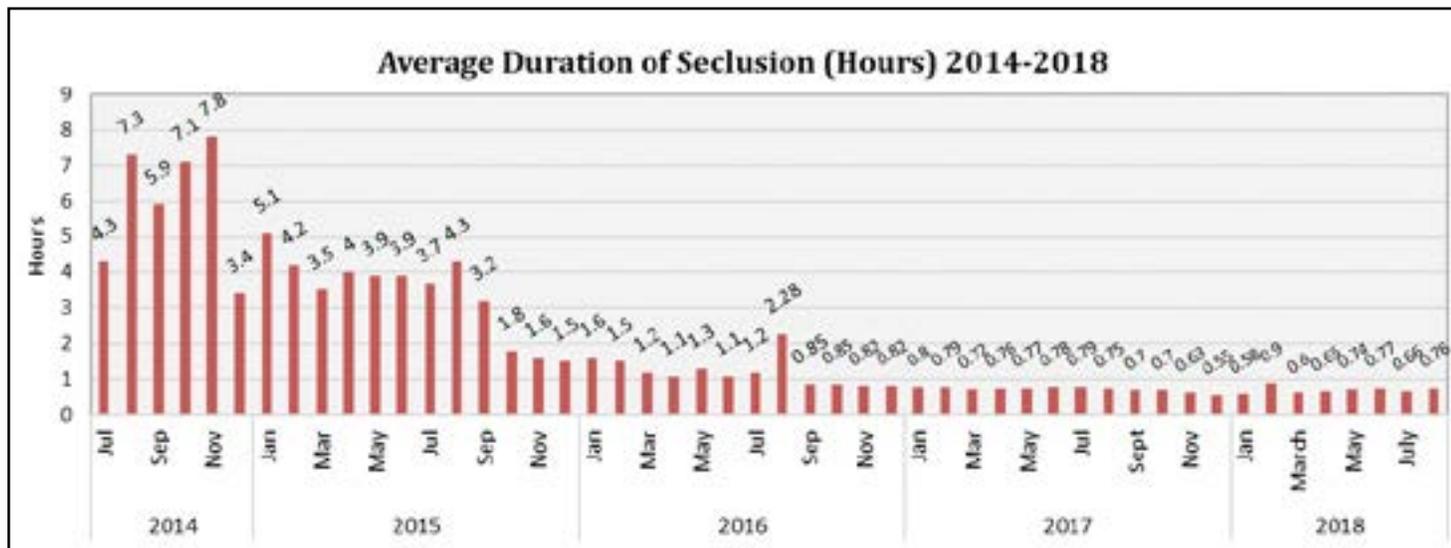
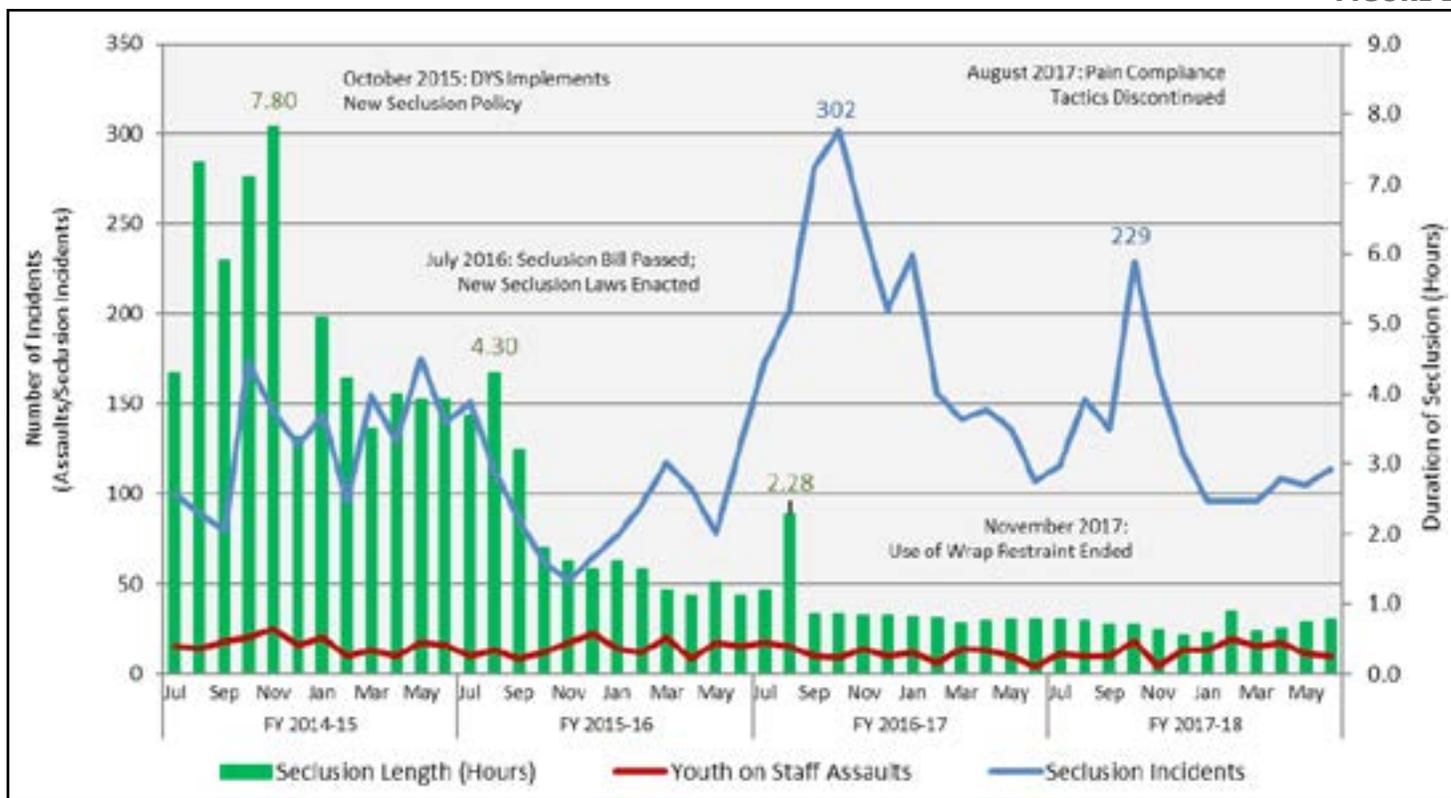


FIGURE 2



## CHALLENGES FOR DYS

### DEEPLY ENTRENCHED CORRECTIONAL PRACTICES

DYS faced a number of major challenges. First, the correctional practices—reliance on restraints and seclusion—were deeply entrenched in the facilities and in the agency. Staff had been trained on the practices for many years. Agency policies either authorized the practices or were broad enough to allow their use. As a result, some veteran staff felt helpless during the transition to the new culture. They found it difficult to give up the old ways of doing business when they were not yet confident of the effectiveness of the new policies and practices. These staff may have been in a minority among all DYS staff, but they demonstrated the stresses of making the changes.

### CULTURE CHANGE

DYS staff also had to learn alternative ways to relate to youth and to address conflict and confrontation situations. For example, the effort to change the culture meant that the Division would be an agency that first and foremost provided services and care, rather than control and discipline. The legislature signaled this clearly in HB17-1329 by adding, as the first purpose of the agency, to “increase public safety by providing rehabilitative treatment....”

The culture change also meant staff needed to develop a relationship-based approach to youth, rather than relying on their authority to set rules and impose discipline. Staff also needed to think in terms of identifying and building on youth’s strengths, rather than applying consequences for misbehavior.

Some staff have continued to be skeptical, complaining that youth could assault staff and only get a writing assignment as a consequence. Staff have been concerned about gang members in DYS facilities who they say have initiated fights and group confrontations. Staff have also been concerned about the older youth (18 to 21-year-olds) who have also been confined in DYS facilities. Some staff have felt that, although DYS has given them a lot of tools, those tools don’t work for the older age group. Some staff have complained

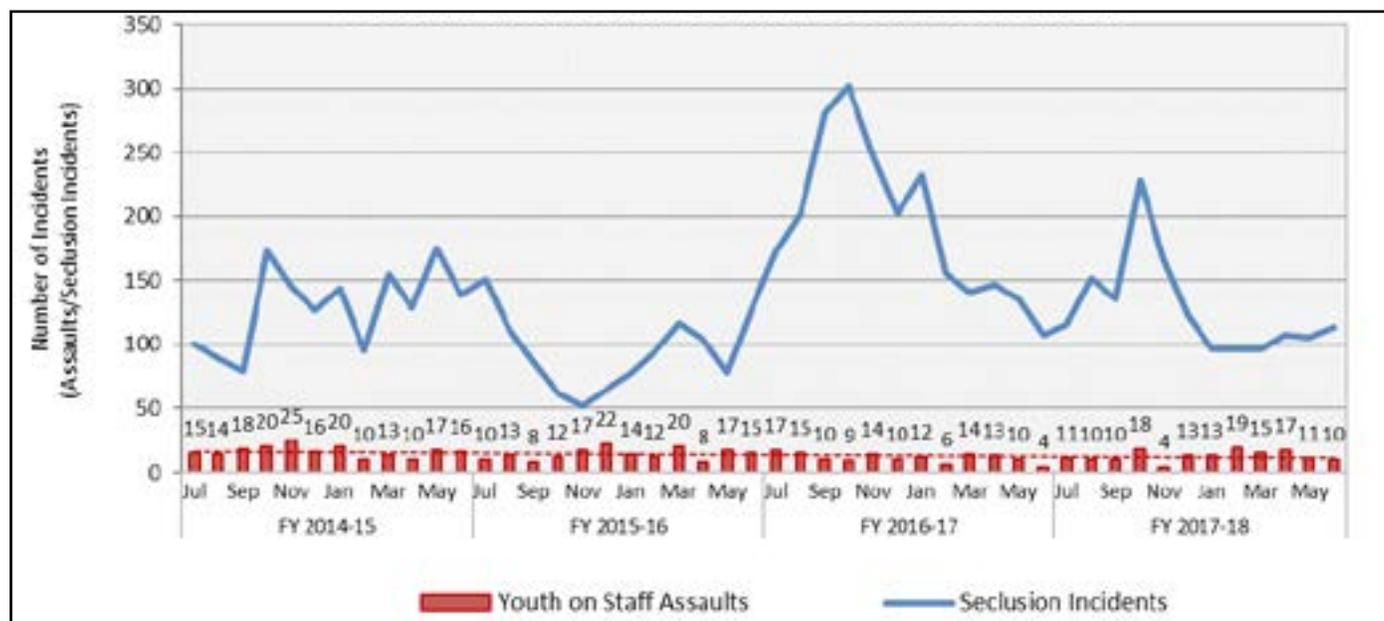
## ASSAULTS ON STAFF TRENDING DOWN

**A**ny youth-on-staff assault is a matter of great concern. However, the most recent DYS data show that youth assaults on staff have remained flat and at a relatively low level for the past four years, notwithstanding the number of older youth being held by DYS. In February 2019 there were 18 youth assaults on staff across all 10 facilities operated by DYS.

Anders Jacobson

that, with the new policies, they have been afraid to put their hands on youth—to use physical control techniques on which they had been trained—even when such actions were necessary to break up fights.

FIGURE 3



### NEED FOR NEW STAFF TRAINING

DYS had been training staff on trauma-responsive care for some time. HB17-1329 codified the focus on creating trauma-responsive environments. In HB17-1329, the legislature explicitly acknowledged that many youth committed to the Division have experienced trauma, including physical and sexual abuse, abandonment, violence in their homes or communities, or loss of a family member. For these youth, a safe, humane, and nurturing environment was necessary for youth to develop coping skills and trusting, healthy relationships. The legislature defined trauma-responsive care to mean care in which staff were trained to expect trauma in the youth they saw, to recognize how staff behavior and agency practices could trigger painful memories and retraumatize youth, and to resist taking actions or using words that might retraumatize youth in their care.<sup>20</sup> Thus, staff had to be trained on trauma-responsive care, the reasons for it, and the implications for how they would act toward youth in the facilities.

Staff also needed to learn other skills, including how to de-escalate conflict situations before they became major confrontations. HB17-1329 also required staff assigned to the pilot program to have training on rehabilitative treatment, adolescent behavior modification, trauma, safety, and physical management techniques that do not harm youth.

Finally, staff had to be confident that the new skills they would learn would actually work. As in many other facilities, some DYS staff had a genuine fear of some youth in the facilities who had shown violent tendencies. Without being able to use restraints and seclusion as in the past, staff needed to be confident of their own safety, so that they could safely implement the new training and policies that they received.

## **STAFF SHORTAGES**

Adequate staffing is a critical component of efforts to reduce the use of isolation. The national standard of 1:8 staff-to-youth ratio<sup>21</sup> is based on decades of correctional experience. Supervising troubled adolescents in a locked environment is a difficult task under any circumstances. When the ratio goes above 1:8, staff can't provide the attention, supervision, support, and accountability that each youth needs. Additionally, without adequate supervision, youth are free to misbehave or get involved in more serious misconduct.

In addition, in many facilities across the country, as a result of staff vacancies and sick days, staff must work involuntary double shifts. Staff may report to work at 8 a.m., expecting to leave at 4 p.m., only to be told that they must continue to work until midnight. As difficult as it is to properly supervise youth for eight hours, it is much more difficult to do so for 16 hours straight. Moreover, inadequate numbers of staff cause burnout by staff who do work, and some of those staff ultimately decide to leave. Staff shortages also lead to staff retention problems, which further exacerbate staffing shortages.

As facilities under pressure seek to hire new staff, they keep the job requirements at a minimum, often requiring only a GED.<sup>22</sup> Pay scales in juvenile justice facilities are often low. The applicants for those jobs are often young, just past high school age, meaning that they are only a few years older than the youth they supervise.

DYS facilities had all of these problems. The staff-to-youth ratio in most facilities was usually 1:11, but sometimes went even higher. At times, staff were required to work involuntary double shifts. Staff retention was a problem. State personnel policies required only a high school diploma, and new staff often had few qualifications for the demanding jobs.<sup>23</sup> Pay was low. And many new staff were in their early 20s.

## **WHAT WORKED**

### **EXPOSURE OF THE PROBLEMS**

The members of the Colorado Child Safety Coalition performed an important public service by investigating reports of abusive conditions in DYS facilities, putting their findings into a

widely-publicized report, and continuing to prod DYS to do better. The Bound and Broken report did not initiate reforms in the Division, but it strongly accelerated the pace of reforms that were in process. The report is a well-researched and careful analysis of the Division's own data and reports as well as a powerful collection of the voices of young people who were subjected to seclusion and restraint. For example, one youth described isolation as "like being treated like an animal. You're doing bad, go to your cage."<sup>24</sup> Sometimes a single statement is as powerful as a raft of data. Figure 4 shows a typical DYS isolation cell prior to the reform process.

### **MULTIPLE LEGISLATIVE RESPONSES**

HB16-1328 and HB17-1329 were important for codifying reforms that DYS had already undertaken and for prompting more change. The Missouri-like pilot project authorized by HB17-1329 was a thoughtful effort to try a different approach on a limited scale before expanding it to the entire agency. The legislature provided an opportunity to demonstrate the effectiveness of small groupings with low staff-to-youth ratios, without using seclusion or restraints, in actual practice.

### **DIRECT CONFRONTATION OF THE PROBLEMS BY AGENCY LEADERSHIP**

Jacobson began working on the problems with seclusion and restraints when he took over as temporary director of DYS and continued those efforts when he became permanent director. As noted above, his first approach, particularly at Spring Creek, was primarily to increase the number of staff at facilities, in order to bring down the staff-to-youth ratios and make supervision more effective. When that proved inadequate to the scope of the problems, he developed a more comprehensive approach. When the Bound and Broken report came out, he expressed concern about some of the allegations, but largely agreed with many of the policy recommendations.<sup>25</sup> Even before the Bound and Broken report was released, he traveled to Missouri with Representative Pete Lee, who represented Colorado Springs and was a legislative leader in reform efforts; Rebecca Wallace, staff attorney at the ACLU of Colorado; and other agency leaders, to see that system firsthand.<sup>26</sup> He continued to push the legislature for more staff for DYS facilities. He was committed

**FIGURE 4**



**COLORADO DYS SECLUSION CELL**

to changing the culture of the agency. He developed a model with a sound, evidence-based foundation. DYS had been training staff on the Sanctuary Model since 2014, but Jacobson increased the agency's efforts once he became the director.

### **TALKING WITH STAFF ABOUT THEIR CONCERNS**

A critical element of reform at DYS was the commitment of leaders to talk with unit staff to hear their concerns about the reforms. Reforms such as those needed at DYS cannot be imposed solely from the top down. Staff have genuine, sincere concerns about their own safety when the traditional disciplinary methods are removed. Staff must develop new skills to provide alternatives to seclusion and restraints, and must feel confident that their new skills will protect them as well as the youth. A central part of the process for administrators is listening to staff concerns, and addressing those concerns in new trainings, policies, and practices.

### **SETTING SPECIFIC LIMITS ON THE USE OF SECLUSION**

HB16-1328 set specific limits for the use of seclusion and conditions for extending those limits. After the Bound and Broken report demonstrated that the practices continued, the legislature passed the much more comprehensive HB17-1329. The two pieces of legislation were important for codifying limits that DYS had previously put into policy.

### **LIMITATIONS OF LEGISLATION**

Legislation and policies do not guarantee compliance. Legislation is not self-executing and agency policies are not always implemented properly. However, there is a considerable benefit in having the desired policy—very limited use of seclusion—on the record in state law for agency leaders and staff, and for the public. At a minimum, a formal statutory statement of desired policy provides a goal for agency personnel and a standard by which to hold them accountable.

### **DEVELOPMENT OF STRATEGIC GOALS AND OBJECTIVES**

To provide a foundation for its operations and reform efforts, DYS developed a model with several components. Its "vision" lists youth first: "Achieving youth success and safer Colorado communities."<sup>27</sup> In addition, its "strategic goal" reflects the transition it has undergone: "The Division will operate healthy trauma-responsive organizational environments as demonstrated through prosocial, safe, and nonviolent interactions."

To accomplish this goal, DYS has adopted the Sanctuary Model, a theory-based, trauma-informed, evidence-supported whole culture approach to changing organizational culture which is used in many states throughout the country.<sup>28</sup> A critical part of the Sanctuary

Model is the Seven Commitments: non-violence, emotional intelligence, open communication, social responsibility, democracy and shared governance, inquiry and social learning, and growth and change. All DYS staff are trained on the Sanctuary Model and the Seven Commitments.

Further, DYS utilizes five “key strategies”: the right services at the right time, safe environments, proven practices, quality staff, and restorative justice principles and practices.

Operationally, DYS has nine objectives for achieving its strategic goal:

1. Increase DYS senior leadership presence and engagement across the organization;
2. Create DYS small group processes to address day-to-day behavioral issues;
3. Shift the atmosphere of secure facilities to a more “homelike” atmosphere;
4. Create DYS “teams” of youth and staff in all facilities;
5. Optimize the use of residential state-operated and contract capacity;
6. Use the Behavioral Health Framework to develop the DYS treatment approach;
7. Condense and simplify DYS staff training;
8. Integrate trauma-responsive principles and practices into all elements of the DYS organization; and
9. Recruit, hire, and retain quality staff.

All of these come together in the Colorado Model, shown on the next page. The Colorado Model provides an overview of DYS’s approach to care and custody of young people.

### **ADDITIONAL STAFF**

Jacobson’s first response to the problems at Spring Creek was to request additional staff. He continued to press the legislature for additional staff for DYS facilities. Between 2014 and 2017, DYS requested 280 new positions, but only received funding for 143.<sup>29</sup> However, by 2018, DYS received funding for all the needed positions, so that all DYS facilities maintained a 1:8 ratio (some with lower ratios, such as Lookout Mountain with 1:6).

## **COLORADO’S STEPS TO SECURE ADDITIONAL STAFF POSITIONS**

- Established internal working group
- Interviewed facility directors and staff
- Internal staffing analysis
- Compared current ratios to ratios needed to meet PREA standards
- Created a legislative decision item and made specific request for resources from the Joint Budget Committee
- Provided testimony regarding staffing needs.

**FIGURE 5**

**The Colorado Model**



June 2017

In order to receive additional funding, DYS established an internal working group, conducted interviews with all facility directors, and put together an internal staffing analysis. This allowed DYS to compare staffing ratios to ratios needed to meet PREA ratios in all juvenile justice facilities. DYS officials created a legislative decision item based on information from the working group along with a specific request for staffing resources the agency needed. Once the decision item was introduced and discussed in the Joint Budget Committee, DYS administrators testified about their staffing needs.<sup>30</sup>

## **NEW TRAINING**

After the Spring Creek issues were addressed, DYS adopted Verbal Judo<sup>31</sup> as a strategy for de-escalation. Staff also were trained on Motivational Interviewing,<sup>32</sup> which can be useful in helping youth get through emotional barriers to change.

## **INCENTIVE-BASED BEHAVIOR MANAGEMENT PROGRAM**

All DYS facilities have incentive-based behavior management programs. All facilities use the same framework, but some have variations. For example, one facility uses a behavior management program called SOAR, which stands for Show Safety, Own Behaviors, Achieve Results Through Problem Solving, and Respect and Help Others. There is a [Phase Behavior Matrix](#) which functions as a behavioral expectations chart. The chart lists negative behaviors to be avoided (“refrains from destruction of property”) and positive behaviors to emulate (“uses appropriate voice level”). Youth are graded on whether they meet the standards (1) sometimes, (2) consistently, or (3) almost always, and earn points on SOAR Cards that can be cashed at the SOAR Store for snacks and other rewards. DYS facilities also apply incentives by naming a Student of the Month and, for staff, an Employee of the Month.

## **MORE HOMELIKE PHYSICAL ENVIRONMENT**

DYS closed its seclusion rooms and created “relaxation rooms” for youth to calm down or spend brief periods alone. The rooms, such as the ones in Figure 6, feature soft furniture like beanbag chairs, carpeting, pillows, books, stuffed animals, and pictures on the walls. In addition to changing youth clothing to school uniform-like polo shirts and khakis, DYS changed staff uniforms to more casual shirts and pants.

## **EXTENSIVE PROGRAMMING**

Providing engaging programming is an important part of efforts to reduce isolation. When youth are idle or bored, they get restless. Weekends can be particularly challenging because there is no school and often little programming. On the other hand, when youth are occupied in interesting activities, they are much less likely to get into trouble. The most effective juvenile justice facilities provide extensive programming all day and into the evening. DYS

provides a minimum of 14 hours of programming during weekdays, and a minimum of 12 hours of programming each day on the weekends.

## BEHAVIORAL HEALTH STAFF

Research shows that between 40% and 80% of incarcerated youth have at least one diagnosable mental health disorder.<sup>33</sup> Every youth admitted to a DYS facility gets assigned to a behavioral health staff member. Those staff have small caseloads, usually 7–9 youth. This allows behavioral health staff to follow up with individual youth and intervene quickly when appropriate.

## REGULAR DATA COLLECTION

Regular data collection and analysis provide a concrete foundation for monitoring and accountability. One DYS staff said, “We collect data on everything. We use data every day.”<sup>34</sup> The Youth Seclusion & Restraint Working Group collects and reports detailed data on seclusion and restraint semi-annually.<sup>35</sup> DYS collects data monthly. For example, data from the Gilliam Youth Services Center, a pre-adjudication juvenile justice facility operated by DYS, indicated that 61% of the fights in the facility occurred on Saturdays. That made it possible to identify the underlying problem and develop a solution.

**Ideas for Analyzing**  
Data: Youth Seclusion &  
Restraint Working Group  
Reports.

In semi-annual reports, the Colorado Working Group summarizes key data on seclusion and restraints. The format of the report is a helpful example for facilities and agencies considering how to analyze and display data in useful ways. [A sample report from March to April 2018](#) is available as an example.

## CONCLUSION

DYS has made enormous progress over the past two years in reducing the use of seclusion. Many people, inside and outside of DYS, made the changes possible. DYS needs to continue monitoring its own progress to ensure the sustainability of the reforms.

Some problems remain. Advocates are concerned that the reductions in the use of room confinement have not been accompanied by overall change in the agency culture. Some staff are unable or unwilling to become part of the reforms. In addition, although use of the WRAP ended in November 2017, DYS instituted a different restraint procedure, called the Side Hold, in January 2018. Although advocates have expressed concerns about the restraint, records show that the restraint is used infrequently—an average of one time a month in each facility, which may demonstrate the effectiveness of the reforms that DYS has implemented. The Division will continue to monitor its use to ensure that it remains rare.<sup>36</sup>

Overall, DYS has done a remarkable job of reducing the use of isolation in a relatively short period of time. The strategies it found effective should be useful to other jurisdictions making similar efforts.

DIVISION OF YOUTH SERVICES NUMBER AND AVERAGE DURATION OF SECLUSION INCIDENTS September 2017 - August 2018												
FACILITY	AOP	NUMBER OF SECLUSION INCIDENTS		PERCENT CHANGE [Period1 vs. Period2]	NUMBER OF SECLUSION CLIENTS [Unique] <sup>1</sup>		PERCENT CHANGE [Period1 vs. Period2]	AVERAGE SECLUSION LENGTH IN HOURS		PERCENT CHANGE [Period1 vs. Period2]	MEDIAN SECLUSION LENGTH IN HOURS	
		Mar18-Aug18 (AVG)	Sep17-Feb18		Mar18-Aug18	Sep17-Feb18		Mar18-Aug18	Sep17-Feb18		Mar18-Aug18	
Adams	22.6	78	67	-14%	36	45	25%	0.50	0.32	-36%	0.44	0.23
Betty K. Marler	29.6	16	0	-100%	11	0	-100%	0.50	N/A	N/A	0.38	N/A
Gillum	42.6	30	13	-57%	16	10	-38%	0.30	0.13	-58%	0.65	0.10
Grand Mesa	59.8	65	55	-15%	29	31	7%	0.50	0.58	18%	0.21	0.55
Lookout Mountain	147.4	176	90	-49%	68	49	-28%	0.60	0.75	26%	0.45	0.70
Marvin W. Foote	61.1	108	91	-16%	46	43	-7%	0.80	0.74	-8%	0.47	0.58
Mount View	97.9	197	45	-77%	93	33	-65%	0.60	0.50	-16%	0.60	0.47
Platte Valley	93.7	55	132	240%	36	59	64%	0.70	0.92	31%	0.62	0.87
Pueblo	13.9	10	0	-100%	4	0	-100%	0.70	N/A	N/A	0.58	N/A
Robert E. Denier	13.3	9	0	-100%	4	0	-100%	0.70	N/A	N/A	0.91	N/A
Spring Creek	47.9	91	73	-20%	55	38	-31%	0.80	0.80	0%	0.75	0.73
Debuson Pike	58.8	37	53	43%	11	19	73%	0.80	0.75	-7%	0.85	0.68
<b>TOTAL</b>	<b>648.7</b>	<b>872</b>	<b>619</b>	<b>-29%</b>	<b>373</b>	<b>313</b>	<b>-16%</b>	<b>0.68</b>	<b>0.70</b>	<b>3%</b>	<b>0.57</b>	<b>0.62</b>

<sup>1</sup>Total is not a sum of unique clients by facility (112 Sep-Feb; 127 Mar-Aug), as a client may have been included at multiple facilities within the reporting period.

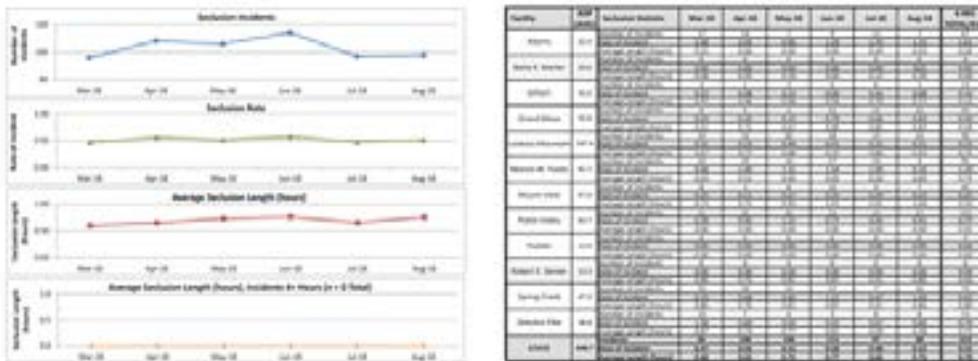


FIGURE 7 SAMPLE DATA FROM COLORADO SECLUSION & RESTRAINT WORKING GROUP<sup>264</sup>

<p><b>Six-Month Period Totals (per facility and agency total)</b></p> <ul style="list-style-type: none"> <li>• Number of seclusion incidents</li> <li>• Number of unique seclusion clients</li> <li>• Average duration of seclusion (hours)</li> <li>• Median duration of seclusion (hours)</li> <li>• % change from previous six-month period</li> </ul>	<p><b>Monthly Data (per facility)</b></p> <ul style="list-style-type: none"> <li>• Number of seclusion incidents</li> <li>• Rate of seclusion incidents (per 100-bed days)</li> <li>• Average duration of seclusion</li> </ul>
<p><b>Aggregate Summary on Demographics of Secluded Youth</b> (by seclusion incidents and unique secluded clients)</p> <ul style="list-style-type: none"> <li>• Age</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Gender</li> </ul>	<p><b>Aggregate Trends Over Six-Month Period (agency total)</b></p> <ul style="list-style-type: none"> <li>• Number of seclusion incidents</li> <li>• Rate of seclusion incidents</li> <li>• Average duration of seclusion (hours)</li> </ul>



Photo credit: Richard Ross

# NOT IN ISOLATION

HOW TO REDUCE ROOM CONFINEMENT  
**WHILE INCREASING SAFETY**  
IN YOUTH FACILITIES

**MASSACHUSETTS  
DEPARTMENT OF  
YOUTH SERVICES**

# The Massachusetts Department of Youth Services

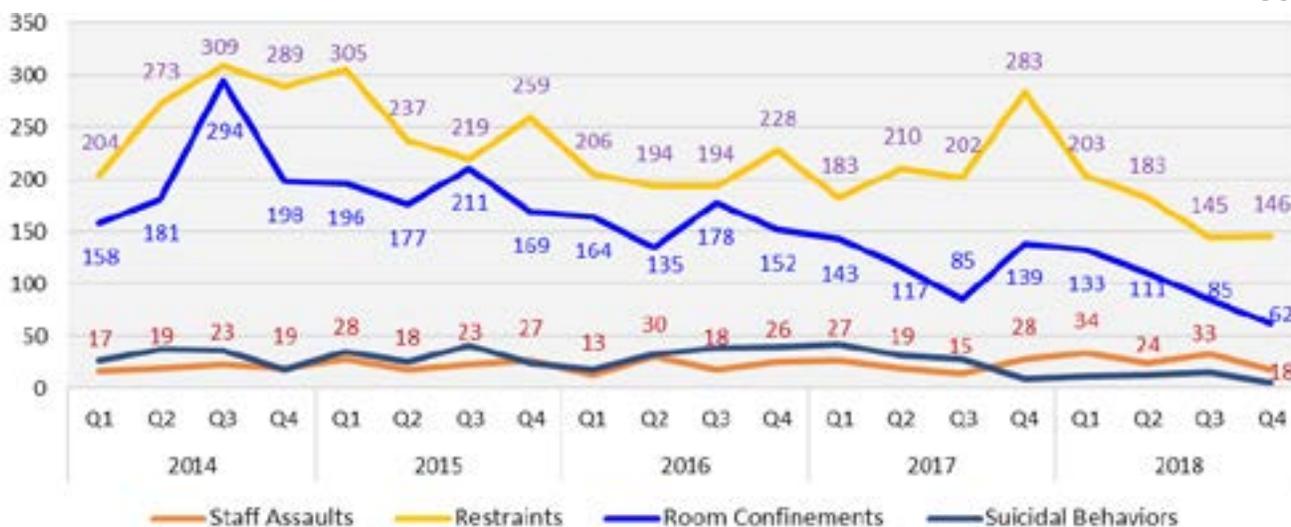
## TRAGEDY SPARKS ACTION

In 2003, a 15-year-old boy hanged himself with a sheet while alone in his room at the Metro Youth Services Center in Dorchester, MA.<sup>37</sup> Shortly thereafter, another child completed suicide. Both took their own lives while alone in their cells in facilities operated by the Massachusetts Department of Youth Services (DYS). As DHS struggled to find a path forward, administrators wanted to understand what factors were contributing to high rates of self-harming behavior.

During the investigation, DHS found that most incidents of self-harm occurred when youth were in room confinement.<sup>38</sup> This connection is now well-documented in juvenile justice facilities across the country. According to a study commissioned by the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP), more than 50% of suicides in juvenile justice facilities occur when youth are in room confinement.<sup>39</sup> In Massachusetts, there were 39 suicide attempts by children in DHS custody in 2003.<sup>40</sup> Agency leaders agreed that something had to change.

Over the next decade, DHS pushed forward with a series of reforms to drastically reduce room confinement as a way to increase safety. "It's not just about room confinement," current DHS Commissioner Peter J. Forbes explains. "It's about staff being assaulted, fights among the kids, any kind of property damage that you track, room confinement, and restraints."<sup>41</sup> These related problems shared common solutions: clear policies, positive behavior management, integrated clinical services, and well-resourced staff. Between 2008 and 2016, DHS cut the number of room confinements by over 65% while also reducing restraints and assaults.

FIGURE 8<sup>22</sup>



Source: Massachusetts DHS. Data excludes unit wide confinements, threat to self, population management (see definition), or confinement during investigation of an incident.

### DYS Room Confinements, Average Duration & Assaults on Staff

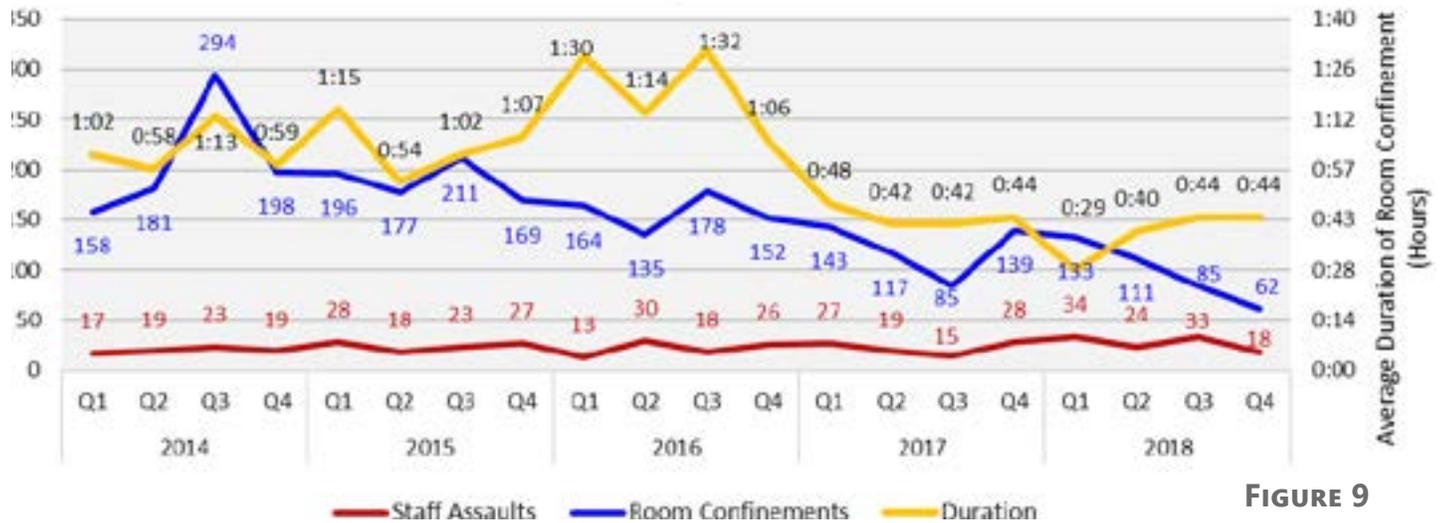


FIGURE 9

### AGENCY HISTORY

DYS operates Massachusetts’ juvenile justice services. In addition to a continuum of residential programs, reception centers, foster care, and community-based services, DHS has 15 secure residential programs for young people up to the age of 21. The agency also contracts with providers to operate 9 additional secure programs in DHS buildings. Seven programs are for secure detention, while the remaining programs house committed youth.

Each DHS program serves 12–15 youth.<sup>43</sup> Each program is staffed with a program director, clinical director, clinicians, and 21–24 full-time direct care staff, or “group workers.” DHS is organized into five geographic regions, each with a regional director who oversees individual programs. Forbes leads the agency along with an executive team housed in the Central Office in Boston. Other executives include Ruth Rovezzi, the Deputy Commissioner for Operations and Support Services, and Margaret

“Putting kids in their rooms makes them less safe,” says Forbes.

“There is an impulsivity that makes kids act in ways that they wouldn’t outside of room confinement.”

Chow-Menzer, the Deputy Commissioner of Administration and Finance. The agency's mission is to make communities safer by improving the life outcomes of youth through effective treatment and skill development.<sup>44</sup>

In 2004, DYS faced challenges that impacted the safety and security of its youth population. Over 3,200 youth cycled through the agency's 19 secure facilities each year. In order to compensate for overcrowding and high youth-to-staff ratios, DYS relied primarily on room confinement to manage residents. Many youth spent a large percentage of their time isolated in their rooms every day. Under these conditions, it was only a matter of time until another youth died or was seriously injured.

Over the next few years, DYS made several changes to limit the use of room confinement. When reforms began, the agency had no policy, data, or practice expectations around room confinement. Administrators needed baseline data on how programs were using room confinement to determine whether changes were working. As a first step, DYS began collecting and reviewing data on room confinement with a simple telephone reporting system. Each evening, a second shift supervisor called Central Office to report which youth had been in room confinement that day, the reason, and for how long. This initial approach helped set an expectation of transparency and accountability around the use of room confinement.

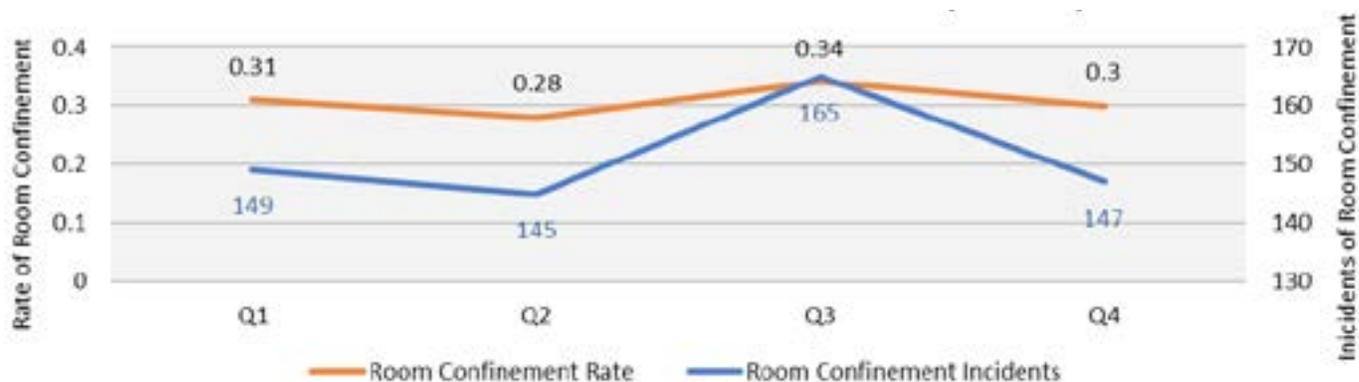
## USING DATA TO ADVANCE REFORM

Not every facility or agency has an advanced data collection system. Fortunately, this is not necessary to begin the process of reducing room confinement. The most important step for DYS was making a start, however modest. Recognizing the value of data from the outset increases the chance that efforts to reduce room confinement will succeed. Data also is an important tool to maintain focus on safety during the improvement process. DYS uses data in several key ways.

DYS measures the duration and frequency of room confinement. Frequency can be displayed as actual number of room confinements or by the number of room confinements per 100 client-days. The per client-days ratio allows DYS to compare the rate of room confinement relative to the number of youth. A client-day equals one youth for one day. Ten youth over 30 days is 300 client-days. A per 100 client-day rate of 0.5 in a program with 10 youth means one-half a room confinement over 10 days (10 youth x 10 days = 100 client-days or 1 ½ room confinements over 30 days (10 youth x 30 days = 300 client days).<sup>45</sup> Figure 10 on the next page illustrates the difference in the two measurements using DYS data from 2016.

- DYS views room confinement within the broader context of agency safety. Administrators and program leaders use data to determine how room confinement trends compare to other important safety indicators: assaults on youth, assaults on staff, restraints, property damage, industrial accidents, and staff time out of work.
- DYS administrators use data to help anchor conversations with union officials and other stakeholders around a shared set of facts.

**FIGURE 10 NUMBER OF INCIDENTS VS. RATE OF ROOM CONFINEMENTS (DYS 2016)**



Source: Massachusetts DYS, excludes unit wide confinement and confinement for population management.

## A MAJOR POLICY SHIFT

In 2008, DYS took a significant step toward reducing room confinement by introducing a new policy that dramatically limited its use. Although room confinement had decreased since 2003, the agency needed a clear written policy to advance and sustain improvements. The biggest change in the new policy was that staff could no longer use room confinement as punishment, retaliation, or as a response to non-compliant behavior.<sup>46</sup> Staff could only use room confinement as a last resort to ensure the safety of youth or staff, to calm a youth exhibiting seriously disruptive dangerous behavior, or for population management in limited circumstances. Although Massachusetts does not impose a fixed time limit on room confinement, the policy does require increasing levels of approval and clinical involvement over time.

## SUICIDE PREVENTION

DYS is acutely aware of the connection between room confinement and the elevated risk of self-harm. Shortly before introducing the new room confinement policy, DYS also revised its [Suicide Assessment Policy](#). The agency consulted with nationally renowned expert Lindsay Hayes to create the updated suicide policy. Dr. Hayes is a nationally recognized expert in the field of suicide prevention within jails, prisons, and juvenile justice facilities,<sup>47</sup> and conducted seminal research showing that over half of youth suicides in juvenile justice facilities occur in room confinement.<sup>48</sup>

Taken together, the policies clarify two critical points:

1. *Youth at risk of suicide require intensive supervision:* Staff provide constant 1:1 “eyes-on” supervision to youth on full or elevated suicide watch, even during sleeping hours.<sup>49</sup>

2. *Room confinement is not appropriate for youth on any level of suicide watch:* The room confinement policy establishes a clear prohibition on room confinement of youth who are at risk of self-harm or suicide.

## TALKING TO STAFF ABOUT REDUCING ROOM CONFINEMENT

Administrators at the state level were responsible for drafting the revised room confinement policy. To secure buy-in from all levels of staff across the state, the agency focused on a communication strategy. Regional directors and program directors spoke to staff at all secure residential programs during in-person meetings. This showed that agency leaders were invested in the change. It also created an opportunity for staff to hear why ending room confinement was important. DYS framed the conversation about reducing room confinement around the issue of safety, which was a shared goal for almost all staff. In Massachusetts, the policy roll out involved meaningful and direct participation from agency leaders. Forbes describes that "It require[d] people getting in their cars and driving out to the secure programs and meeting with people at shift change in the facility to talk about the purpose and the why and the implementation plan."<sup>50</sup>

Despite careful planning about communication, the new policy was met with considerable push back from staff who felt that administrators were taking away an essential tool. The American Federation of State, County and Municipal Employees (AFSCME), Local 1368, represents almost 80% of DYS secure care staff. AFSCME voiced concerns about how the policy change would impact staff safety.

In retrospect, administrators offer two insights about reassuring staff when making changes around the use of room confinement. First, administrators should involve all levels of direct care staff in the process of creating the policy. "Policy development is a great place to get people on board," says Forbes. "Getting a policy written is really important, but the process is as important as the substance."<sup>51</sup> Second, administrators can anticipate concerns for staff safety when communicating about the policy change. Before DYS introduced the new policy to staff, the buzz was that it banned room confinement in all circumstances, which was not true. "The biggest mistake we made was we said, 'no room confinement'

### Insights from Staff - How to Talk About Room Confinement

"Staff think, 'if I cannot lock this kid in his room for 12 hours or the weekend, then I am unsafe.' We are trying to say 'you are safer if the kid has a relationship with you.'"<sup>265</sup>

"Change is difficult for everyone, but all everyone wants to know about change is 'how is it going to affect me and how to do my job, and how to keep me safe.' The benefit has to be personalized. We should have said 'here's the benefit to reducing room confinement because you are building positive relationships with the kids.' If we can get kids out [of room confinement] faster into the population, it increases the safety in the moment and long term."<sup>266</sup>

rather than a 'reduction' [in room confinement]," recalls a regional administrator.<sup>52</sup> "When we said 'no,' staff felt like there was never a circumstance that it could be useful, even if the youth was extremely violent. In reality it is still a tool, but it needs to be used under specific circumstances. Messaging is so important."

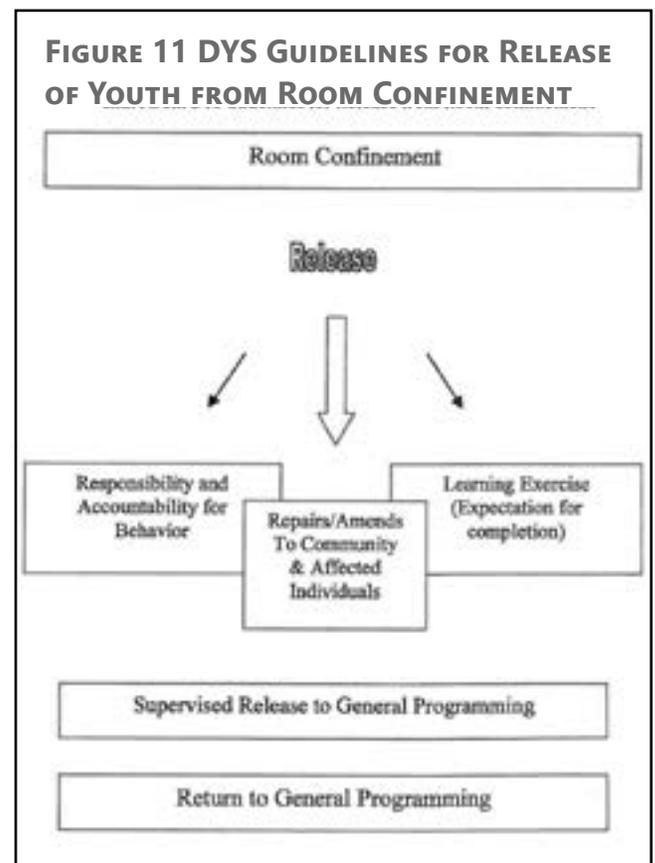
## EXIT STRATEGIES

In addition to limiting the permissible use of room confinement, DYS also focused on shortening the amount of time that youth spent in room confinement. The new room confinement policy outlined a release process for staff to follow when a young person is in room confinement.<sup>53</sup> According to policy, this process typically takes anywhere from 5 to 30 minutes. "How they get out [of room confinement] is just as important as how they get in," says Forbes.<sup>54</sup> Group workers and clinical staff immediately begin talking to youth in room confinement to help them process emotions. "We don't just close the door and leave them in there to calm down on their own. That's not helpful if we want them to regain control," notes a DYS clinician.<sup>55</sup>

As soon as youth are calm, staff begin a process of small steps to get youth out of the room confinement space. These steps may include:

- Opening the door while youth are still inside;
- Allowing youth to move slightly outside the doorway of the cell/room;
- Taking youth outside the room to an area away from other residents;
- Discussing the incident with youth using the Dialectical Behavioral Therapy (DBT) Coaching Protocol for Conflict Resolution;
- Using DBT tools to help youth process the incident (e.g., Behavior Chain Analysis, repair assignments);
- Using relationships with youth to determine whether they are calm enough to exit room confinement; and
- Assessing whether a youth needs to complete conflict resolution work with other residents before rejoining the program.

Release from room confinement does not necessarily mean that a resident immediately returns to regular group programming. A facility administrator explains that "[i]nitially staff thought that there was no room



confinement and we were going to put the kids in the population no matter what—and that’s not what we do.”<sup>56</sup> In 2016, DYS and AFSCME developed the [DYS Guidelines for Release from Room Confinement](#),<sup>57</sup> which give staff additional guidance on getting youth out of room confinement.<sup>58</sup> The Guidelines instruct staff to create an individualized set of activities or steps to help youth successfully transition back into general programming.

After introducing the room confinement policy in 2008, DYS leaders balanced concerns for staff safety with a firm resolve to stay the course. The agency invested heavily in a new behavior system framework over the next few years to equip staff with skills and alternatives to avoid room confinement. By April 2011, almost all cases of room confinement lasted less than four hours.<sup>59</sup>

## **TRANSFORMING RESPONSES TO YOUTH BEHAVIOR: DIALECTICAL BEHAVIOR THERAPY**

While DYS was developing the room confinement policy, it was also testing a new clinical approach that would eventually become a touchstone for all agency programs—DBT, originally developed by Marsha Linehan at the University of Washington to treat chronically suicidal clients. Dialectical Behavior Therapy (DBT) has since been adapted for people who are impulsive and have difficulty controlling their emotions.<sup>60</sup> Research shows that DBT is associated with reductions in recidivism for justice-involved youth and has positive effects on reducing aggression.<sup>61</sup>

DYS adapted Linehan’s original model as a behavioral management framework to decrease the use of room confinement. The DYS Director of Clinical Services, Dr. Yvonne Sparling, first piloted DBT at the Grafton short-term residential program for girls in 1999.<sup>62</sup> The results were impressive. Girls who received DBT had fewer restraints and moved through the behavioral level system more quickly. The following year, a second pilot program for boys yielded similar results. In 2006, the DYS Clinical Advisory Council endorsed the use of DBT as the therapeutic framework in all secure care facilities and developed a DBT Manual for all DYS secure facilities.

As part of the DYS DBT Manual, Sparling wrote “[Dialectical Behavior Therapy as a Behavior Management Approach](#),” which established the fundamentals of DBT practice within the agency. In addition to the DBT program practices (described below), all clinical staff within the first six months of hire complete an online training course developed by Dr. Linehan through Behavior Tech, a Linehan Institute Training Company. DYS also hired DBT coaches for each region of the state to provide training and consultation to facility leaders and staff.<sup>63</sup>

The core premise of DBT is that problem behavior is caused by a deficit in skills, not a moral failing or disregard for consequences.<sup>64</sup> In other words, youth engage in dysfunctional behaviors because they do not know how or when to use more effective strategies. They may not even understand how their current behaviors contribute to undesirable outcomes. DBT focuses on four main areas of skill development: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness.

The goal of DBT is to help youth learn skills to understand and change their behavior, especially in difficult situations.<sup>65</sup> Under this theory, room confinement will not deter negative behavior because it doesn't teach youth the skills they need to behave differently.

As practiced in DYS facilities, DBT is rooted in key values about young people:

- Youth are doing the best they can;
- Youth want to improve and must learn and practice new behaviors;
- Staff can help youth change to meet their goals;
- Relationships with youth are a core strategy in helping youth change their behavior;
- Behavioral principles apply to both youth and staff;
- Youth learn by seeing staff model positive skills and behaviors; and
- Staff need support when using DBT.

### Dialectical Behavior Therapy

DBT helps young people understand their behaviors and replace them with more effective coping skills. DBT doesn't just replace room confinement—it replaces the underlying behavior that triggers room confinement.

Eventually, DYS incorporated elements of DBT in many aspects of facility programming. DBT became a common language for youth, clinical staff, direct care staff, and administrators across all DYS programs. Perhaps most importantly, it created alternatives to room confinement.

DYS used four primary practices to integrate DBT into the daily lives of youth and staff.

#### 1. Weekly DBT Skills Groups

Building positive relationships between staff and youth is a core strategy to manage youth behavior. Each unit is assigned a clinician who is physically located in the living area. Assigned clinicians conduct two DBT group sessions each week. They designate a DBT "Skill of the Week" and assign DBT homework to youth. Clinicians also conduct weekly individual sessions and daily groups on substance abuse, high-risk situations, health relationships, and communication techniques.<sup>66</sup> Thanks to physical proximity and regular interaction, group workers learn de-escalation and coaching skills modeled by trained clinicians.

For Massachusetts, the most effective aspect of DBT is the high level of participation from line staff. Group workers co-teach DBT groups alongside clinical staff and reinforce DBT skills in the living unit. One advantage of co-facilitated groups is that line staff are much more likely to observe youth using skills within the program. Group workers can teach certain DBT skills more effectively than clinical staff because they are more likely to be similar to youth in gender, race, and ethnicity. As Sparling points out, "It's really important to have youth see that a skill is something that adults use and it's not just a clinical tool."<sup>67</sup>

## 2. Distress Tolerance Plans

Every youth works with an assigned advocate (staff member) to create a [Distress Tolerance Plan](#), which is updated weekly. Each direct care staff, including educators, must be familiar with all Plans. Youth's Distress Tolerance Plans covers five areas:

1. Behaviors youth will try to achieve;
2. Behaviors youth will try to avoid;
3. Triggering events that might cause youth to lose control;
4. Skills youth can use in the program; and
5. Ways that adults can help youth.

## 3. DBT Coaching Protocol for Conflict Resolution (FAVOR)

Most young people in juvenile justice facilities across the country have mental illnesses, histories of trauma, or difficulty regulating their emotions. When young people become upset or frustrated, many facilities respond by threatening physical force to control the situation. DYS realized that these traditional responses didn't work for most adolescents. In fact, those responses escalated conflicts. To teach staff another way to respond to youth in crisis, Sparling developed the DBT Coaching Protocol for Conflict Resolution.<sup>68</sup> Using this five-step approach, staff respond to youth experiencing behavioral or emotional difficulties by engaging, validating youth's feelings, and helping them use DBT skills to process emotions. All group workers and clinical staff are trained to use the protocol, which is represented by the acronym "FAVOR."<sup>69</sup>

- F Focus on Yourself  
When approaching a tense situation, staff first focus on regulating their own emotional state, body language, and voice.
- A Assess the Situation for Safety  
Staff may separate a youth from the group while continuing to engage the youth in a positive way. Separation does not mean room confinement.
- V Validate Youth Feelings and Perception  
Validation techniques are based on research that people calm down faster when they feel understood. Validation doesn't necessarily mean agreement with a youth's point of view. Staff ask questions and listen rather than debating the accuracy of the youth's perceptions.
- O Offer Skill Alternatives  
Once a youth has regained control, staff offer suggestions about what DBT skills the youth could use in similar situations. To do this effectively, staff must be familiar with youth's Distress Tolerance Plans and DBT skills.

R Reinforce Youth's Attempt to Try New Skills

Staff reinforce youth's attempts to use positive skills, even if the youth was not fully successful. Learning new behavior takes practice, and youth are more likely to try again if their attempts are recognized.

#### 4. Behavior Chain Analysis

When a youth exhibits negative behavior that results in a repair or major rule violation, he or she completes a Behavior Chain Analysis.<sup>70</sup> Behavior Chain Analysis is a DBT tool to help youth process what happened and understand why they acted the way they did. Youth review all behavior chains with their clinicians, although they may complete an analysis worksheet with line staff immediately after the negative behavior. Behavior Chain Analyses require youth to identify five things about their behavior(s).

1. Their thoughts and feelings before the event;
2. The triggering event;
3. Their own actions;
4. The consequences of their actions; and
5. Possible alternative actions or tools they could use.

## USING BEHAVIOR MANAGEMENT TO REDUCE ROOM CONFINEMENT

In 2014, DYS issued a [Positive Based Residential Programming Advisory](#),<sup>71</sup> that replaced the previous behavior modification policy. Under the old model, staff were spending most of their time policing negative behavior rather than interacting with youth and encouraging positive behavior. Existing sanctions did nothing to address the underlying issues behind youth behavior.

Text Box: Focusing on Efforts to Improve Skills, Not Compliance

An excellent example of staff focusing on individual improvements rather than compliance and capitalizing on an opportunity to treat all behavior as a learning experience can be seen in this video clip. In [this video example](#), a DYS Facility Administrator describes a particular incident. Insert video link.

The advisory combined positive-based behavior management, positive youth development,<sup>72</sup> and DBT principles. DYS outlined certain mandatory requirements, but allowed each program to decide certain details of its behavior management system with input from residents and staff. In addition to preventing negative behavior inside DYS facilities, the policy was designed to give youth skills to successfully transition back into the community. The new DYS behavior management system relies on five important tools:

## 1. PROGRAM ADVANCEMENT BASED ON SKILLS, NOT COMPLIANCE

The new behavior management system used a “stage” system based on competency in social and emotional DBT skills. It replaced a hierarchical “level” system based on compliance. Staff address misbehavior through repairs and other internal processes, not by taking away youth’s phase status. Under the old point-based level system, some youth spent weeks climbing to the next level only to lose multiple levels in one day due to misbehavior. Other youth with preexisting mental illness or trauma were not able to meet the behavior requirements to reach higher levels or earn incentives.

## 2. DIARY CARDS

DYS replaced the daily point system with [diary cards](#) to track behavior based on each individual youth’s progress. One side of the diary card lists youth’s short-term behavioral goals and the other side lists DBT skills they are learning. Youth can earn incentive points for demonstrating DBT skills and improved behavior. Youth cannot lose points—they can only fail to earn incentive points. Each program developed its own diary card based on DBT skills taught in the program. Each day, youth spend 5–10 minutes with staff to individually review their diary cards, explaining what they did well and what DBT skills they could use to do better next time. Staff guide the conversations and sign the diary card. Many programs do this in the evening, shortly before lights out.

## 3. REPAIRS

Staff use repairs to hold youth accountable for negative behavior instead of room confinement. Repair is a DBT term for actions to compensate or rectify a harm that someone has caused. When youth misbehave or break rules, they must complete repairs. Repairs are meant to show youth that consequences exist for their actions. However, as the Director of Clinical Services clarifies, the “[g]oals for repairs are totally the opposite from [goals for] isolation.” Room confinement teaches young people what it’s like to be isolated, while repairs teach them the value of healthy connections with other residents and staff. The two main goals of repairs are (1) to help youth understand the impact of their actions on themselves and others and (2) to give youth the skills necessary to process and change their behavior.

Repairs include an acknowledgment of the negative behavior, an apology to the affected person or group, and actions to compensate for the harm done. Programs created their own repair systems with menus of activities for each category of behavioral infraction. Some activities involve staff or other residents.

**Figure 12. Sample Guidance for Repair Assignments**

	Repair 1	Repair 2	Repair 3
Triggering Event	Class 1 Infraction	Class 2 Infraction	Class 3 Infraction
Duration	Up to one active shift	1–3 active shifts	3–7 active shifts
Activities	Two items from List 1 One item from List 2	Two items from List 1 Four items from List 2 One item from List 3	Three items from List 1 Four items from List 2 Three items from List 3

Sample	Repair			Activities
	<u>Repair List 1</u>	<u>Repair List 2</u>	<u>Repair List 3</u>	
	Behavior Chain Analysis	Clean bathroom	Whole unit apology	
	Written apology	Fold laundry	DBT posters and role plays	
	Mindfulness worksheet	Sweep room	Co-facilitate DBT group/activity	
	Infraction essay	Clean windows	Write speech for community meeting	
	Journaling assignment	DBT poster	Extra/personalized DBT skill packets	

During a repair, youth are separated from other residents for a period of time (usually measured in shifts) or until they complete the assigned repair activities. Separation during a repair is not a substitute for room confinement. Youth on repair status remain in the same physical space with other youth. They participate in regular school, DBT groups, and other programming, usually sitting at a separate table or in a chair several feet away from other youth. During recreational activities, youth work on repair assignments, which often involve assistance from staff. The length of the repair and the assigned actions are based on the level of infraction.

The introduction of repairs helped DYS chip away at opposition from staff who believed that room confinement was necessary to hold youth accountable. The concept of repairs highlighted an important distinction between accountability and punishment. While both concepts may require youth to do things they don't enjoy, accountability means that youth take responsibility for their actions. The difference between accountability and punishment is that repairs (accountability) require the youth to make amends with those negatively affected by the youth's behavior, while punishment is just a sanction. All repairs involve a written task the youth must present to a group of staff. As the Director of Clinical Services explains, youth must demonstrate that they "understand how their actions affected other people and how they will act differently in the future, so there's a lot of work."<sup>73</sup> Meanwhile, youth miss out on recreational programming and incentives. Repairs also require that youth acknowledge their misbehavior to another resident(s) or staff, which is a difficult task for most people—especially teenagers.

## 4. INCENTIVES

The positive-based behavior management system is based on recognizing behavioral progress. Evidence from many criminal justice and youth-serving contexts shows that incentives are more effective at changing youth behavior than sanctions.<sup>74</sup> As an agency, DYS has worked to create an environment where staff are searching for opportunities to “catch youth doing something right.” Programs recognize and reward youth who practice positive skills and behaviors with a range of incentives that include verbal praise and group recognition. “We don’t look to punish our kids while they are here. The fact that they are here losing their freedom, we feel is hard enough,” explains a program director. “In order to have our kids buy into our system and follow our rules we offer them incentives.”<sup>75</sup>

## 5. INDIVIDUAL SUPPORT PLANS

Another tool used by DYS to prevent room confinement is the Individual Support Plan (ISP). An ISP is a short-term intervention plan for youth who continuously act out or cannot respond to programming. The DYS Assistant Commissioner of Program Services describes the [Individual Support Plan Policy](#)<sup>76</sup> as an “all-hands-on-deck approach.”<sup>77</sup> When DYS implemented the new room confinement policy, “we recognized . . . this challenge in either assisting youth preventing or minimizing the recurrence of another isolation incident.”<sup>78</sup>

The ISP process can be initiated by a request from any staff member, a family member, or a young person. Within 48 hours, the program director organizes an interdisciplinary team that includes the youth and his or her parent or guardian. The team holds a meeting and produces a written plan that identifies the youth’s needs and lists specific interventions that the youth or staff may use. The collaborative structure of ISP meetings is critical. As one regional director explains, “If the clinicians are just writing up an ISP and telling people what to do, it will fail. If you get everyone’s input, there is more follow-through and buy in. All of this stuff leads to less room confinement.”<sup>79</sup>

ISPs list the youth’s strengths, behavioral triggers, warning signs, interventions, and incentives. Room confinement cannot be part of an ISP, although an ISP can state that staff may use room confinement if the youth engages in specific violent behavior that causes an immediate risk of physical harm. All direct care, clinical, and educational staff are expected to be familiar with the ISP.

### Examples of ISP Interventions

- Youth “will receive multiple staff check-ins during a shift to receive attention; these check-ins will be conducted at minimum three times per shift and documented in the log.”
- “I can ask to speak to my clinician when I am feeling stressed out.”
- Youth “will be permitted to take a time out when frustrated and may read, complete word searches, crossword puzzles, utilize music and stress-balls, or draw.”
- “I will receive ramen on Sundays if I have not received any repairs for the week.”
- “Staff will approach me when I look heated (am showing warning signs) and review coping skills with me.”

## STEPS TO SUPPORT STAFF SAFETY

Staff and labor unions voiced concerns about how changes to the room confinement and behavior management policies affected staff safety. They pointed out other problems including mandatory overtime, burnout, and high staff turnover. DYS took several steps to affirm the importance of staff safety and provide resources and support to staff.

### AGENCY SAFETY COMMITTEE

To create a regular and structured process for addressing concerns from staff, DYS established a state Safety Committee. Members include management and frontline staff from DYS Regional and Central Offices, human resources staff, labor relations and workers' compensation staff from the Executive Office of Health and Human Services, and representatives from all major labor unions. The committee structure allows union leaders to discuss concerns in an open problem-solving forum. The Safety Committee meets every two months to review data in safety index areas, evaluate potential reforms, and make recommendations to DYS. Safety Committee reports begin with data on room confinement, assaults on youth, assaults on staff, restraints, property damage, industrial accidents, and staff time out of work.

DYS also founded a Workforce Planning and Development work group to address issues and make recommendations regarding recruitment, on-boarding, training, coaching, retention, and evaluations.

### INCIDENT RESPONSE TEAM PROCEDURE

DYS created an [Incident Response Team Procedure](#)® to provide a consistent response to serious incidents in DYS facilities involving youth violence against other youth, youth violence against staff, escape attempts, and significant property damage. If an IRT is requested, administrators convene a team within two business days to review all reports, statements, and video footage. The IRT includes the DYS caseworker, program or facility director, director of residential services, regional director,

## DYS BEHAVIOR MANAGEMENT IN A NUTSHELL

Youth earn incentive points/opportunities for positive participation in programming and using DBT skills.

Youth must make repairs for negative behavior. Youth lose the opportunity to participate in recreational programming or redeem previously earned incentives during the repair period.

Repairs are categorized by the severity of the rule violation. Violence against other youth or staff are the most serious. Youth have a menu of incentives and repairs and can make choices based on the situation.

Youth who continuously act out or cannot respond to programming may receive an ISP.

Serious behaviors may result in an agency-level Incident Response Team (IRT) hearing.

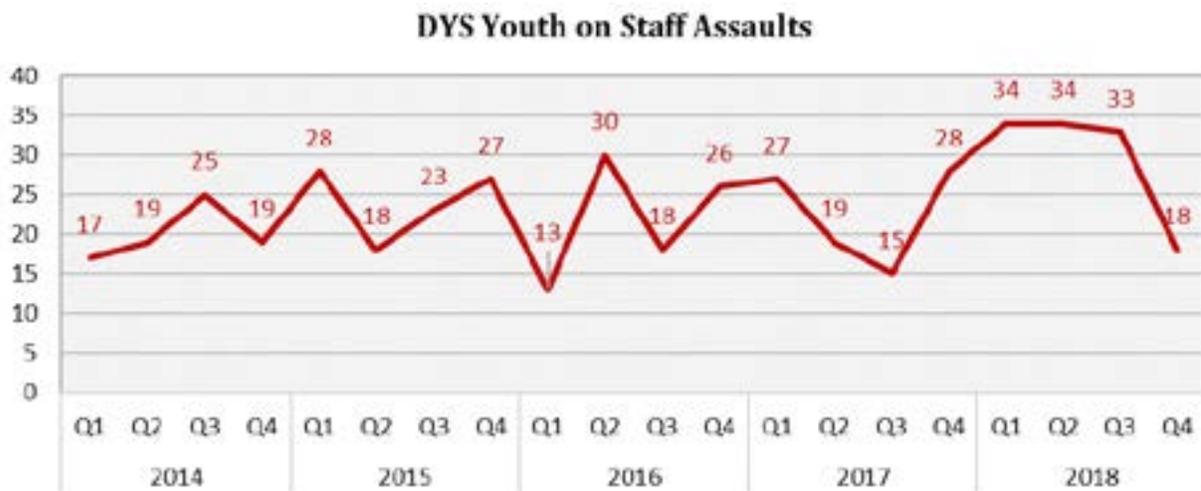
regional clinical coordinator, the resident, any staff who were involved, and the youth’s parent or guardian. The team discusses the treatment plan and all parties have a chance to speak and give input. The IRT can support the program’s response, change the consequences imposed by the program, transfer the youth to another program, or take other actions.

In some situations when a young person seriously injured staff, the IRT could recommend that the youth go to a program called the Stabilization Unit, a small (10–12 bed) program for youth who were violent or struggled in other DYS programs. Youth could stay anywhere from 30 days to 6 months. DYS administrators stress that the Stabilization Unit was not designed to be or operated as an isolation or punishment unit. It operated like other DYS secure facilities, except all programming and clinical sessions were individual and the staff to youth ratio was very high. DYS ultimately closed the Stabilization Unit in 2018 because they no longer had a need for such a program.<sup>81</sup>

“The really difficult kid is one who punches a staff person. Staff are going to confront you with that, and you have to have a response. We have a detailed protocol in the event that it happens.”

### **MOU TO SUPPORT STAFF**

In response to a recommendation from the Safety Committee, DYS and AFSCME Local 1368 created a protocol if a staff member chooses



to pursue a criminal complaint against a youth. DYS does not require staff to press charges, but it supports staff who elect to do so. The protocol was reflected in a Memorandum of Understanding (MOU) designed to help staff navigate the court process. The MOU established communication duties between staff, agency administrators, union representatives, law enforcement, and the local prosecutor. Assaults on staff have remained similar with a slight decrease per quarter between Calendar Year (CY) 2015 to CY 2016 and CY 2016 to CY 2017.<sup>82</sup>

**FIGURE 13**<sup>83</sup>

## WHAT HAPPENS WHEN YOUTH ASSAULT STAFF?

Youth who commit an assault do not necessarily receive room confinement. If a youth is de-escalated and has regained control, room confinement is not necessary.

Staff use the behavior management system to respond to youth's behavior (repairs, "freezing" incentives, Behavior Chain Analysis, updating a Distress Tolerance Plan).

If a young person is physically violent and less restrictive interventions have failed, staff may use room confinement to ensure safety.

If a youth is in room confinement, staff follow the DYS room confinement policy and Guidelines for Release from Room Confinement to help youth exit as quickly as possible.

Staff or youth may request an ISP.

The program follows the IRT procedure.

Staff initiate the MOU process if they choose to pursue criminal charges.

## DYS BASIC TRAINING TOPICS

- Adolescent development
- Trauma-informed care
- Positive youth development
- Suicide awareness and prevention
- Safety, security, and searches
- De-escalation and DBT
- Practical application of physical restraints and defensive disengagement techniques
- Educational services
- Working with girls
- Working with gang-involved youth

## **ANNUAL RECERTIFICATION TRAINING TOPICS**

Positive youth development  
Adolescent brain development  
Suicide prevention  
De-escalation  
Use of force  
Situational awareness  
Defensive and disengagement techniques

### **DYS STAFFING**

DYS programs have an average of 21 FTE direct care staff for each 12–15 bed program. Staff in the pilot staffing program work overlapping 10-hour shifts.

### **DIRECT CARE STAFF**

First shift: 1:5  
Second shift: 1:4  
Third shift: 1:7 (minimum of three direct care staff)

### **CLINICAL STAFF**

Clinical staff are on site during evening and weekend hours.  
Clinical director (psychologist or licensed independent social worker).  
Two master's level clinicians who are licensed or license-eligible.  
Each of the five regions of the state has a licensed clinical psychologist, a Regional Clinical Coordinator, and a Regional Clinician who is licensed clinical psychologist or licensed independent social worker, in addition to the Clinical Directors and clinicians who are program based.

## TRAINING

DYS invested heavily in ongoing training to give staff skills to prevent room confinement and the use of force. New hires attend three weeks of Basic Training at the DYS Training Academy.<sup>84</sup> During Basic Training, staff receive a full day of training on de-escalation techniques, and another eight hours on suicide prevention. Direct care staff also attend an annual recertification training at the Academy. Both Basic Training and recertification require staff to participate in scenarios and demonstrate proficiency in DYS-approved physical restraint techniques.<sup>85</sup> When staff are confident in their ability to physically intervene if necessary, they are less likely to preemptively use room confinement.

"We've also done a lot of training with our staff on adolescent brain development," says Rovezzi. "That has helped our staff step back a little bit and think 'this isn't necessarily personal, this is the way this young person reacts.'"<sup>86</sup>

## SUICIDE PREVENTION TRAINING

Suicide prevention is a priority topic in Basic Training and annual recertification. Staff learn how to distinguish between situations which require suicide assessment and situations that may require room confinement.<sup>87</sup> The DYS Director of Clinical Services Sparling explains that trainers spend a lot of time with both new and experienced staff "on how placing the youth in room confinement really increases the likelihood that they may make a serious suicide attempt. [They] really stress the importance of doing everything you can to keep a kid out of room confinement."<sup>88</sup>

**"IF YOU HAVE A RELATIONSHIP WITH A YOUNG PERSON, YOU CAN ENGAGE THEM IN MAKING DIFFERENT CHOICES BEFORE IT COMES TO THE NEED TO PUT SOMEONE IN THEIR ROOM."**

## RELATIONSHIPS EQUAL SAFETY

Training also highlights the role of positive relationships with youth as a tool to keep staff safe. One shift supervisor observes: "It's safer now from when I started 17 years ago. There is much more training for us. Less restraints are happening because staff are communicating between themselves and talking to the kids, building the relationships with the kids to make them understand that we are not here just to put hands on them. We are here to talk to them, to help them make a better change in their life."<sup>89</sup> Another facility administrator agrees that "[t]hose conversations build trust... those conversations that we have with them equal safety and security."<sup>90</sup>

## PILOT STAFFING PROGRAM

Although DYS has high staffing ratios compared to many other systems,<sup>91</sup> facility staff have challenging and complex jobs. In 2018, DYS began piloting a new schedule to reallocate staffing resources without increasing full time employee (FTE) positions. The pilot program also reduces stress by giving staff an additional day off and reducing the likelihood of forced overtime. Staff in the pilot program work four consecutive 10-hour days with three days off rather than five consecutive eight-hour days. This schedule provides more staff positions during times when assaults are most likely to occur, which data

show are between dinner and bedtime.<sup>92</sup> Staff in the pilot reported feeling more rested and, because shifts overlap, they have more time to communicate information from one shift to another.<sup>93</sup>

### **LOST TIME AND STAFF TURNOVER**

Many of the strategies discussed in this report cannot be implemented without enough qualified staff. Two data indicators to support the need for additional staff positions are lost time and turnover or attrition rates. DYS measures lost time by dividing lost time workers' compensation claims by the agency's FTEs. Massachusetts disaggregates this data by category of staff. Between FY 2015 and FY 2018, the rates of lost staff time for all levels of group workers decreased from 27 to 17.4.

DYS also tracks group worker attrition by calculating the turnover rate within one year of hire and the turnover rate during the initial six-month probationary period. As outlined in the DYS Safety Task Force, this information is straightforward if administrators know what information to track. Based on the example below, which does not disaggregate turnover by staff position, DYS reduced its turnover rate for new hires by more than 50%.<sup>94</sup>

**FIGURE 14 DYS GROUP WORKER 1 ATTRITION**

Calendar Year	Total Group Worker 1 Hires	Turnover Rate Within Year of Hire	Turnover Rate During Probationary Period
2014	88	31.8%	4.5%
2015	87	42.5%	4.6%
2016	114	39.5%	12.3%
2017	103	14.6%	1.0%

## **STATE LEGISLATIVE ACTION**

### **THE STATE TASK FORCE**

Although assaults on staff have gone down, several staff were seriously injured by youth in 2015 and 2016. In response, DYS and AFSCME created the DYS Safety Task Force.<sup>95</sup> Task Force members included representatives from DYS, AFSCME, the state legislature, and other child-serving and oversight agencies. The Task Force's purpose was to make recommendations to the secretary of the Executive Office of Health and Human Services on how to increase safety for DYS staff and youth. Over the course of a year, the Task Force held six meetings and conducted a comprehensive review of relevant policies and best practices. Members reviewed data on risk indicators including assaults, use of restraints, room confinement, suicidal behaviors, and staff injuries resulting from being assaulted or using restraints. The Task Force also heard from national experts and DYS staff.

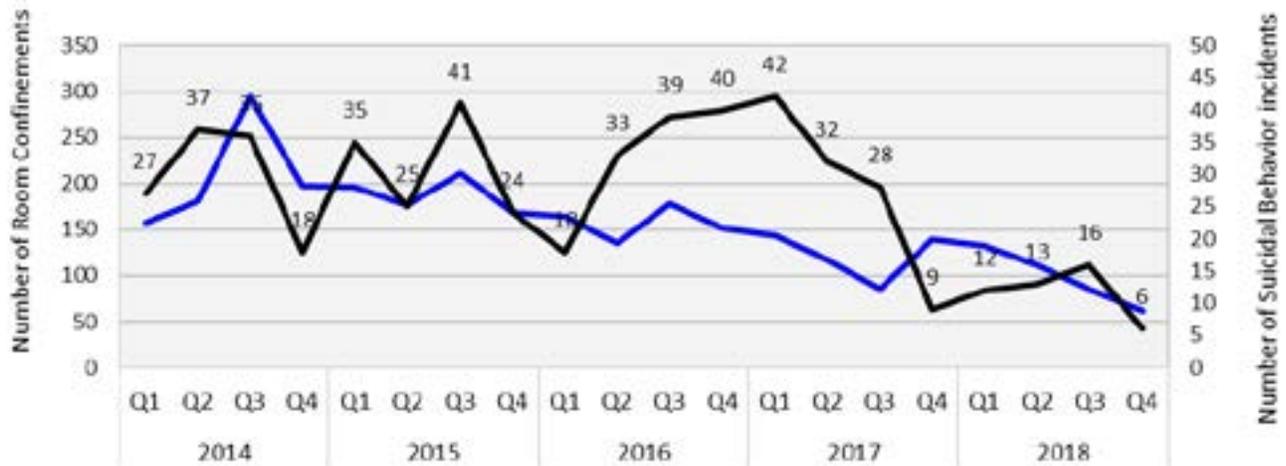
In February 2018, the Task Force released its [DYS Safety Task Force Final Report](#).<sup>96</sup> The report

included several recommendations to enhance resources and support for staff. The Task Force also recommended that DYS review the internal communication structure—especially with respect to room confinement—so that “practice expectations articulated at the DYS executive level are understood and embraced throughout agency operations.”<sup>97</sup> Specifically, the Task Force addressed situations when youth become suddenly violent without warning. While infrequent, situations where verbal de-escalation is not practical and staff need to use room confinement immediately to prevent physical harm are possible. Although this is consistent with the room confinement policy, DYS administrators agreed to work more closely with unions and regional directors to ensure clear communication with direct care staff.

### STATE LAW FOLLOWS AGENCY POLICY

In 2018, Massachusetts passed legislation that codifies DYS policy limits on room confinement. The change was part of a broad criminal justice reform bill.<sup>98</sup> Section 10B of Bill S. 2371 prohibits DYS from putting youth in room confinement “as a punishment, harassment or consequence for noncompliance or in retaliation for any conduct.”<sup>99</sup> The law took effect on December 31, 2018.

FIGURE 15 DYS SUICIDAL BEHAVIOR IN SECURE FACILITIES



### CONCLUSION

The average duration of room confinement in DYS programs was 44 minutes during the last quarter of 2018 and 39 minutes for the 2018 calendar year.<sup>100</sup> Some staff quoted in this report couldn’t remember the last time they saw a youth in room confinement. Although the Massachusetts story of reducing room confinement was rooted in policy change to protect youth from self-harm. To be sure, the rate of suicide and self-harm has gone down, but the agency’s story of reducing room confinement evolved into part of a broader transformation of how the agency works with young people. As a deputy commissioner said, the agency’s “work as a juvenile justice agency is preparing young people to return to their communities as citizens, as contributing members of their community. For that, they need skills. They need to be able to manage the demands of life. They need to have an education that prepares them for employment. They need to have positive relationships with others. They are not going to get any of that locked in a room somewhere.”<sup>101</sup>



Photo credit: Richard Ross

# NOT IN ISOLATION

HOW TO REDUCE ROOM CONFINEMENT  
**WHILE INCREASING SAFETY**  
IN YOUTH FACILITIES

**SHELBY COUNTY, TN**

# Shelby County, TN: Major Reforms by a Sheriff's Office

## IMPETUS FOR CHANGE

On April 26, 2012, the U.S. Department of Justice (DOJ) issued a [Findings Report](#)<sup>102</sup> notifying the Juvenile Court of Memphis and Shelby County that the court was violating the civil rights of youth detained at the Shelby County Juvenile Detention Center by failing to provide them with reasonably safe conditions of confinement and freedom from undue bodily restraint. The report also found that the court violated the due process rights of children appearing for delinquency hearings, and that the court's administration of justice violated the equal protection rights of the children by discriminating against black children.

The report was the culmination of an extensive investigation by the DOJ. In January 2007, the DOJ's Civil Rights Division had received a complaint about a variety of issues from the Juvenile Court Ad Hoc Committee, a committee of the Shelby County Board of Commissioners.<sup>103</sup> Later that year, the National Center for State Courts<sup>104</sup> and the Memphis Bar Association<sup>105</sup> issued reports on the ongoing problems.<sup>106</sup> The DOJ investigation began in August 2009. It included consultation with experts in the field; interviews with court personnel, children appearing before the court on delinquency matters, and administrators; and review of policies and procedures, court documents, recordings of hearings, case files, materials, and statistical data. The Juvenile Court fully cooperated with the assessment.

After the Findings Report was issued, the Juvenile Court quickly decided to cooperate with the DOJ to remedy the deficiencies. It retained national suicide prevention expert Lindsey Hayes to assess the facility and make recommendations, which were subsequently adopted. In addition, the Health Department agreed to assist in providing round-the-clock medical and mental health care.

## MEMORANDUM OF AGREEMENT

On December 17, 2012, the DOJ, the Juvenile Court, and the county announced a [Memorandum of Agreement](#)<sup>107</sup> (MOA) with detailed reforms and timelines for their implementation. With respect to the use of physical restraints and seclusion, the MOA provided that staff would use the least amount of force necessary to stabilize the situation and protect the safety of the child and others; prohibited unapproved forms of physical restraint and seclusion; limited restraint and seclusion to those circumstances where a child posed an immediate danger to self or others, and when less restrictive means had been attempted but were unsuccessful; required prompt and thorough documentation of all incidents; required that staff be held accountable for excessive and unpermitted force; required immediate evaluation of all children involved in incidents by medical staff; and called for formal reviews of all uses of force and allegations of abuse.<sup>108</sup>

The MOA also prohibited routine use of isolation for children on suicide precautions unless specifically authorized by a qualified mental health professional, and such situations had to be documented in incident reports.<sup>109</sup>

The MOA included other provisions. It prohibited the use of a restraint chair and pressure point controls. It required improvements in suicide prevention. It also included extensive provisions regarding due process in delinquency hearings and protection from racial discrimination. To assess the implementation process and compliance with the MOA, the agreement appointed two monitors, one each for due process and equal protection violations, and a facility consultant, also known as the protection from harm consultant, who would receive documentation and visit the county every six months.

The facility consultant was David Roush, Ph.D., who ran secure juvenile programs and served as a consultant to many jurisdictions across the country.

The Findings Report noted several times that the Annie E. Casey Foundation's [Juvenile Detention Alternatives Initiative](#) (JDAI) had begun work in Shelby County earlier in 2012.<sup>110</sup> JDAI is a national initiative to reduce unnecessary incarceration of young people without jeopardizing public safety.<sup>111</sup> It operates in almost 300 jurisdictions throughout the country. Core strategies for JDAI include using objective instruments to determine admissions of young people to juvenile justice facilities, developing alternatives to secure facilities, reducing racial and ethnic disparities in the juvenile justice system, and ensuring safe and humane conditions of confinement for young people who are incarcerated. Thus, there was considerable overlap between JDAI's mission and core strategies and the provisions of the MOA. The MOA recommended continued engagement by the county and Juvenile Court in JDAI.<sup>112</sup>

### **TRANSFERRING OPERATION OF THE DETENTION CENTER TO THE COUNTY SHERIFF**

In August 2014, Dan Michael was elected judge of the Juvenile Court of Memphis and Shelby County (the county also has multiple magistrates or referees to handle juvenile cases). In July 2015, after extensive discussions, assessments, planning, reorganizing, and budgeting, Judge Michael and the Juvenile Court transferred operation of the Juvenile Detention Center to the Shelby County sheriff. There was significant concern about having a law enforcement agency run a juvenile justice facility,<sup>113</sup> but the effort had several potential benefits. The sheriff was able to hire juvenile justice facility staff into his office at higher salary levels and was able to provide more extensive training for correctional staff than had been available. The DOJ already operated a facility, Jail East, for young people transferred to prosecution in adult criminal court. The Sheriff's Office was a large agency, with more than 2,000 employees, and therefore had more staff who could be assigned to the juvenile facility. It already had contracts in place for food and medical services, which could quickly be utilized for youth in juvenile justice facilities. In addition, as a law enforcement organization, the Sheriff's Office had a clear chain of command structure that could help in implementing changes in policies and practices.

At the time of the transfer, the juvenile justice facility had multiple problems, including and beyond the ones identified in the DOJ Findings Report. The physical plant was old and outmoded. There were only three classrooms, so many youth were not able to go to school or went only for a few hours per day, which was itself a violation of the law. Other than school, two hours of recreation, and two

hours of “leisure” time, young people generally spent the rest of their time confined to their rooms. There was no other programming. With little to do most of the day, many youth got bored, noisy, and disruptive. Youth were regularly put into room confinement for three days for discipline. There were chronic staff shortages, so single staff on duty were often responsible for 16–24 youth at a time, when professional standards limit staff-to-youth ratios to 1:8.<sup>114</sup> In addition, youth wore prison-type jumpsuits.

## CHALLENGES

After the transfer of responsibility and development of a new system of reporting remedial actions, the key indicators of safety and well-being of youth went the wrong way. According to the Consultant’s Sixth Report,<sup>115</sup> between July and October 2015 there was a 12% increase in the reported use of disciplinary room confinement. There also was a 30% increase in the reported average duration of room confinement. In addition, during that period, there was a 58% increase in suicidal behaviors, a 31% increase in the rate of assaults of youth on youth, a 36% increase in the use of physical restraints, and a 303% increase in the use of mechanical restraints. Frequent staff turnover exacerbated these problems.<sup>116</sup>

Parts of the increases were a result of documentation practices. Staff were documenting the use of restraints during routine transportation for medical and dental visits as uses of force within the facility. Likewise, staff were documenting routine time in rooms for sleeping as isolation, room confinement, and suicide watch precautions.



**FIGURE 16 YOUTH RECREATION AT SHELBY COUNTY JUVENILE DETENTION CENTER**

Some changes requested by Roush were implemented prior to his visit in September 2015, including improved food service, larger meals and healthy snacks, improved room lighting and painting, and allowance of books in youths’ rooms. In addition, all staff had received 40 hours of training and were certified by the State of Tennessee for the first time.

By April 2016, there had been more improvements that affected the use of isolation.<sup>117</sup> Programming and group activities were added, a full-time counselor was hired to expand programs for young people, visits were extended, and additional phone calls were allowed. The Positive Behavior Management System (PBMS) was implemented and all staff were trained on

it. Youth received information about PBMS in the Detainee Handbook which they could keep in their rooms.<sup>118</sup>

At the same time, youth complained of a “22/2” program on weekends which kept them confined in their rooms for all but two hours a day. Youth also identified issues with “Red Card” disciplinary status, which carried 23/1 room confinement for three days and the use of handcuffs and shackles during the one hour out of their rooms.<sup>119</sup> In addition, documentation of room confinement incidents was unreliable; too much information was collected by hand, data forms were not completed consistently, and there were problems with storage and retrieval of data.<sup>120</sup> Roush labeled the situation “...unacceptable. It is the ‘canary in the coal mine,’ a reliable indicator of more serious problems.”<sup>121</sup>

Six months later, there were additional improvements. Staff were conducting daily [circle-up groups](#), or ad hoc counseling sessions, in the units, sometimes multiple times a day. The groups provided youth with information about the daily schedule, including upcoming activities during the shift. They also provided a “safety valve” for youth who needed to vent or express emotions. The groups also provided youth with staff models of respectful, caring adults.<sup>122</sup>

PBMS had begun to take root, with colorful posters about the system being displayed throughout the building. Youth and staff described positive outcomes as a result of the new token economy system. A youth advisory committee provided information to the director of PBMS about any youth concerns.<sup>123</sup>

Staff also began receiving a variety of new trainings. Chief Inspector of Juvenile Detention Deidra Bridgeforth implemented a 16-hour

## Initial Improvements in Shelby County

- State certification of all staff
- Positive Behavior Management System
- Training on how to work with youth
- Improved data metrics tracking key behaviors
- Standardized review of videos and documentation of room confinement incidents
- A full-time staff position to expand programs for young people
- Additional programming
  - Daily circle-up groups
- Youth advisory committee
- Improved conditions in youth rooms
- Increased visitation and phone calls

## Definition of Room Confinement in Shelby County Juvenile Detention Center

Room confinement is defined as the placement of the youth in any secured room away from general population, with authorization. The youth’s behavior and/or the safety and security of the youth and the Assessment for Release determine when the youth leaves the room.

Shelby County measures room confinement as involuntary confinement for longer than 59 minutes. The data does not include periods of involuntary confinement of less than 59 minutes, which they consider “time-outs.”

training on differences between youth and adults, and how to work with youth who are incarcerated. With funding from OJJDP, two outside consultants delivered a 40-hour training for trainers on youth-specific issues. The training clarified adult learning styles and helped the trainers understand how to teach in ways that were effective for staff. The Sheriff's Office also sent a staff member to a training on safe crisis management with special emphasis on de-escalation skills.<sup>124</sup>

The data system, used for tracking room confinements and uses of force, showed significant improvement, due to a focused effort by the lead data researcher from the Juvenile Court and her counterpart in the Sheriff's Office. They developed an improved data metrics plan that identified key behaviors to track. Monitoring of the use of restraints also improved with a standardized review of videos and documentation of all incidents.<sup>125</sup>

At the same time, however, Roush reported that room confinement remained an ongoing concern, as did the use of physical restraints.<sup>126</sup> Youth complained of widespread inconsistencies among staff in awarding points under the PBMS. Youth also complained of favoritism and group punishment, and a level of disrespect and profanity toward them by a majority of the male staff.<sup>127</sup>

By April 2017, the number of room confinements had dropped significantly, but the average duration of room confinements increased substantially. The facility consultant<sup>128</sup> reported that "youth are remaining in their rooms after incidents for a far longer time than is necessary for them to 'cool down' or reduce their agitation to near normal levels."<sup>129</sup>

## **THE TURNING POINT**

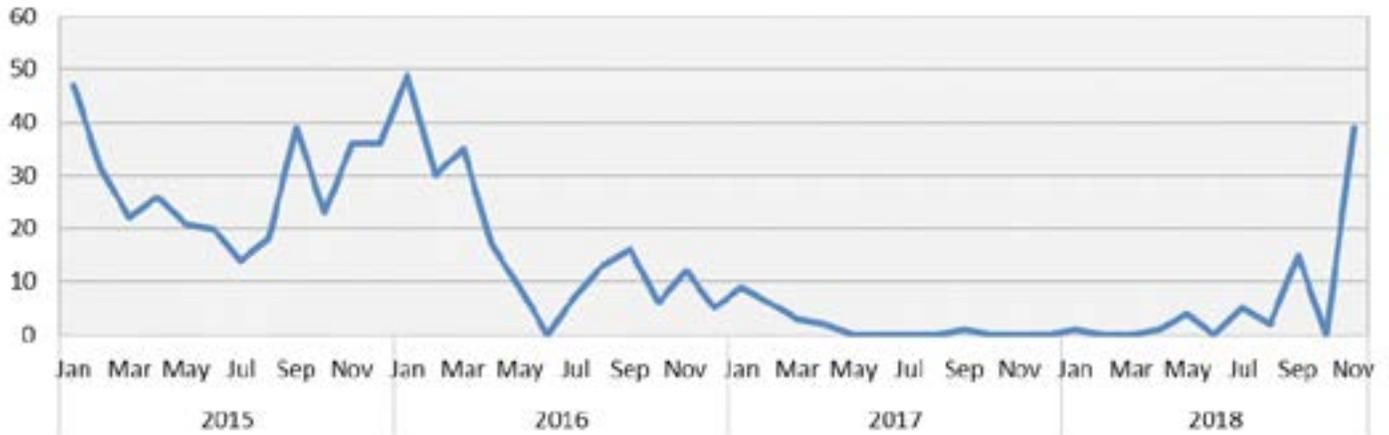
But by October 2017, just six months later, things had changed significantly. Staff more fully incorporated their training, new facility policies, and the developmental approach to adolescents into their relationships with youth and responses to misbehavior. Programming increased to fill up time when youth had been idle. The facility consultant noted that use of room confinement longer than one hour "has dropped to zero," and he pronounced the facility in compliance with the room confinement provision of the MOA.<sup>130</sup>

For 2018, juvenile justice facility records show a very low level of room confinement—none at all in February, March, June, and October; only one instance in January and April; and five each in July and September. November was an outlier: there were 19 uses of room confinement on 39 youth.

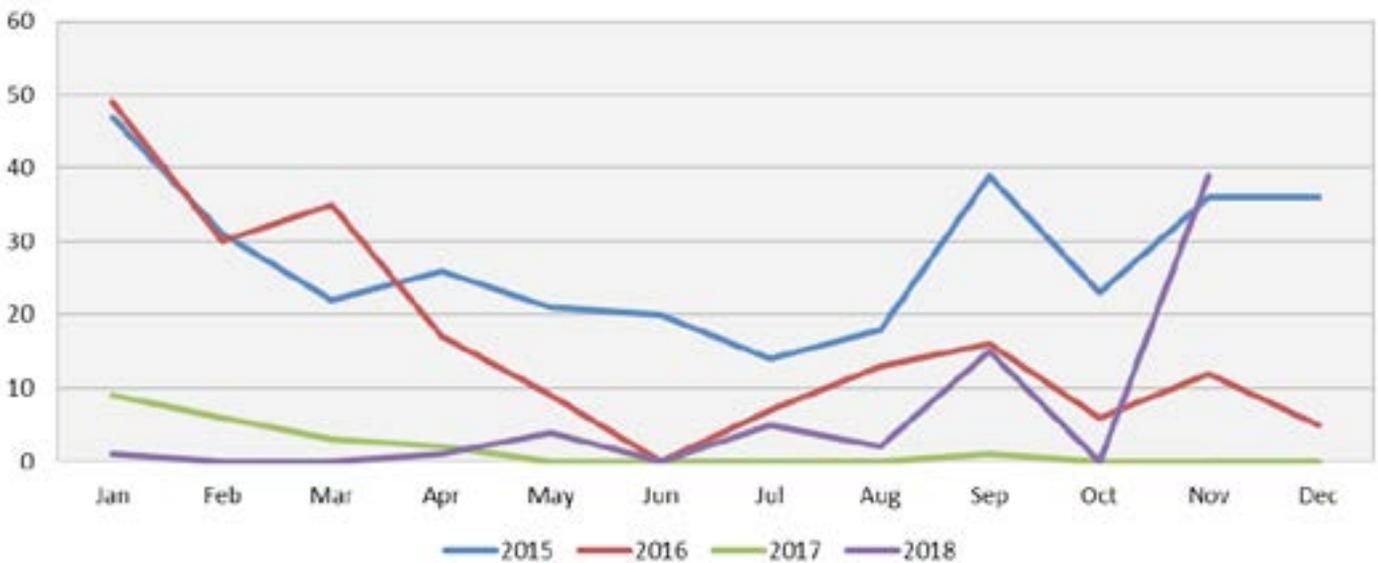
Facility administration attributes that primarily to a group of 10 youth who were arrested together and detained in early November, who proceeded to cause considerable disruption on November 3 and for days afterward. All in all, however, the data show a very strong reduction in room confinement, completely or virtually eliminating it for most months of the year. The figure below shows two useful ways that administrators viewed data to determine the overall chronological trend in room confinement incidents, but also to determine during which months more incidents occurred.

FIGURE 17 COMPARISON OF DISPLAYING TRENDS IN ROOM CONFINEMENT

**Shelby County Room Confinements 2015-2018**



**Shelby County Room Confinements by Month**



Reducing room confinement in a sustainable, meaningful way was a challenge that, in Fessenden’s words, “required all hands, and brains, on deck.”<sup>131</sup> It began with staff engaging the youth in their rooms every 15 minutes to see if they were calm, safe to be around others, and had insight into what triggered the bad behavior and how to control it moving forward. This process could go on for long periods of time as staff tried different approaches to reach the youth. Sometimes the discussions resulted in behavior “contracts” written by the staff and youth. Now youth occasionally ask staff to allow them be alone in their rooms when they are struggling with emotions or issues that they feel will cause them to be disruptive. This process underscores the importance of relationships between youth and staff.

Staff must now obtain permission for room confinement at every level up the command chain, including medical and a Chief Inspector. Not surprisingly, staff realized it was more efficient to utilize de-escalation and adolescent behavior techniques to resolve the problem.

Room confinement reduction and PBMS went hand in hand. As staff became more creative in offering meaningful rewards, such as increased visitation and phone calls, they realized that removing some of those rewards could be a significant deterrent. Staff complained in the beginning that youth were not being sufficiently “punished” for assaultive behavior, so staff were asked to participate in developing a disciplinary matrix that would ensure consistency on each shift. Youth were also allowed input, since they were very vocal about inconsistencies.

Recently, Roush suggested rewarding staff for positive outcomes, particularly de-escalation. An officer appreciation program is now in place. Peers nominate each other for monthly honors which include gift cards and meals with the Chiefs.

## WHAT WORKED

There were many factors that made it possible for the Sheriff’s Office to achieve significant reductions in the use of room confinement.

### LEADERSHIP

The chief architects of reform at the Sheriff’s Office were Sheriff Bill Oldham, who supported reforms and made the financial commitment to train current staff, add new staff, improve food services, add programming, and make improvements to the physical plant; Assistant Chief Kirk Fields, who became the director of the juvenile justice facility when responsibility was transferred from the Juvenile Court; and Bridgeforth, who was promoted to assistant chief and director of the facility in September 2018, when Fields was promoted to chief jailer.

Fields and Bridgeforth were committed from the beginning to making changes and going beyond the mandates of the MOA. Early on, they wanted to be proactive. They were particularly concerned about the extensive use of room confinement. When Bridgeforth asked why there was so much use of solitary, staff told her that it was because of staff shortages. “It hurt me so much to see children in rooms like that,” she said. She also felt that isolation was the wrong approach. “Room confinement causes mental illness,” she says. “You’re teaching violence when you use force.”<sup>132</sup>

## DEPARTMENT OF JUSTICE INVESTIGATION AND THE MOA

Although agreements between the DOJ and state or local governments are often sources of friction, the overall experience was positive for the Sheriff’s Office. The close involvement by Roush and the many suggestions he made for new policies, practices, and training were particularly valuable. Debra Fessenden, the sheriff’s legal advisor, helped connect the Sheriff’s Office to the National Partnership

for Juvenile Services as a way to bring in more training, as well as to other resources recommended by Roush. Bridgeforth says that “DOJ was a great learning experience.”<sup>133</sup>

Roush was particularly helpful in explaining what makes “behavior management” work: not the type or severity of the sanctions, but rather the importance of developing rewarding relationships between youth and staff,<sup>134</sup> and having extensive programming to keep youth occupied throughout the day. Bridgeforth also says that Fessenden, who was positioned between the DOJ attorneys and the Sheriff’s Office, “kept us accountable.”

## NEW POLICIES AT THE JUVENILE JUSTICE FACILITY

The Sheriff’s Office revised a number of policies that had been in effect at the juvenile justice facility and wrote new ones. The policy on [Involuntary Room Confinement](#),<sup>135</sup> put into effect a year after the transfer of responsibility, states that staff may only put a youth in room confinement if the youth poses an immediate danger to self or others, and less restrictive crisis intervention techniques have failed. Room confinement requires approval and documentation by a lieutenant, a captain, the chief inspector, and medical personnel. When the youth is put in his or her room, staff must advise the youth on the reason for the confinement and the expectations for release. Cited examples of expectations for release are the youth appearing calm for 2–5 minutes and verbally stating that they are ready to return to regular activities. Each incident is reviewed by a Multidisciplinary Review Team that includes correctional senior staff, the director of mental health, and a health department senior representative. The members of the team also view all videos of confrontation incidents.

A new policy on [juvenile justice services](#),<sup>136</sup> put into effect in February 2017, sets forth four levels in the use of force continuum and clear parameters as to when and what kind of physical force can be used. The policy is keyed to training for staff by [Safe Crisis Management](#)<sup>137</sup> and [Crisis Prevention Institute](#),<sup>138</sup> two programs of verbal and non-physical intervention that have been very successful in other jurisdictions. Importantly, the policy states that “The use of physical force *or seclusion* as a disciplinary sanction, punishment, or as a training or behavior modification technique is strictly prohibited” (emphasis added).



FIGURE 18 SHELBY COUNTY PROGRAMMING

At the same time, in February 2017, the facility put into effect a [new policy on the Positive Behavior Management System](#).<sup>139</sup> The PBMS outlines positive behavioral expectations in five areas such as

cooperation, participation, and positive reinforcement by youth of good behavior by other youth. It also lists basic skills—following instructions, accepting consequences, showing respect, showing concern—for which youth can be rewarded with coupons redeemable for snacks. The facility created a [list of items](#) available to youth in the Adams’s Street Corner Store, which is named after the street on which the juvenile justice facility is located. It is called a “store” instead of a “commissary” to avoid an association with jails and prisons. In addition to the snacks and treats on the list, youth also can sleep late, get extra time on phone calls, or get extra visitors. Prior to the transfer of responsibility to the sheriff, there had been a positive behavior management point system, but the rewards were more limited.

## NEW TRAINING FOR JUVENILE DETENTION FACILITY STAFF

Correctional administrators were well aware that, as Bridgeforth says, “To change something, you need to replace it with something better.”<sup>140</sup> With recommendations from Roush, the Sheriff’s Office brought in a variety of new training for correctional staff.

First, staff working in juvenile justice facilities at the time of the transfer of responsibility had to be trained and certified as corrections deputies. Bridgeforth conducted much of the training, which provided an opportunity for her to develop relationships with the staff who were now working under her command.

The staff benefitted from new training on Safe Crisis Management, a program that is recommended by the DOJ and has been effective in reducing the use of force and isolation in many juvenile facilities across the country. Before the transfer of responsibility, staff said that “room confinement was the only punishment we had.”<sup>141</sup>

Some correctional staff could not or would not go along with the new program and had to leave. Most, however, did cooperate and appreciated the new training.

**Equally important, the new training was evidence-based and developmentally appropriate; Bridgeforth says the staff was trained “on the science of rewards.” This required a real adjustment from their previous orientation, but staff eventually saw the improvements firsthand in their new roles as teachers, coaches, and mentors. “It worked” she says.**

## NEW PROGRAMMING

One of the first moves after the transfer of responsibility was to hire a new program manager. This provided a point of focus for new programming opportunities. The number of volunteers coming into the facility was increased from 15 to the current 45. The sheriff built a new classroom so that all youth can go to school every day. There is enrichment programming after school, and group circle-ups several times a day, with an emphasis on positive developments in the units. In the evening, table games, television, and other programs are available, including mentoring programs, baptisms, and “Wild Wednesdays” with speakers such as a former television news reporter, judges, police officers, ministers, and fraternity brothers. Community partners who help to broaden youths’ cultural horizons

also are involved. These include a famous artist who helped youth create a mural of historical figures in the dining room, a Shakespeare company that puts on plays and teaches dramatics, and musicians providing gospel, blues, and classical music. "I want all kids out all day," Bridgeforth says.<sup>142</sup>

### **VISIT TO ANOTHER JUVENILE JUSTICE FACILITY**

It was also helpful for juvenile correctional administrators and staff to visit another facility that already had several of the components they wanted to bring to Shelby County. In June 2017, two administrators and three juvenile officers visited the [Youth Center of High Plains](#) in Amarillo, TX. They had discussions and round tables with administrators, staff, and youth on the individual responsibility value system and [Rational Behavior Therapy](#)<sup>143</sup> in use in the facility, disciplinary management, and the token economy. The Shelby County group found that the site visit helped them to better understand the behavior management training materials provided to them by Roush and the training presented by the National Partnership for Juvenile Services consultants.

### **ADDITIONAL STAFFING**

There was a staffing analysis<sup>144</sup> done in 2016 that showed the need for more staff and more programming. The Sheriff's Office brought in new people for intake and added three sergeants and two captains from its adult corrections facility, in addition to new staff in the units. All new staff had to complete 40 hours of youth-specific training.

There was general agreement on the need to keep an appropriate ratio of youth to staff. This was challenging because the daily population at the facility fluctuates, ranging from over 100 to as low as 40 during 2018. Youth can be situated in nine areas of the facility: the boys north unit, the boys south unit, the girls unit, four classrooms, and two gyms. The incidents of room confinement decreased substantially in 2017 and 2018 at the same time as additional staff were added and training was enhanced.<sup>145</sup>

### **MENTAL HEALTH RESOURCES**

There also was an increase in availability of mental health clinicians. A qualified mental health professional is onsite during the day Monday through Friday, and part-time on the weekends. A clinician is available on call during other times. Clinicians now facilitate programs with youth, conduct one-on-one counseling, and are more involved in the workings of the facility.

### **SUPPORT AND APPRECIATION FOR STAFF**

The emphasis on positive youth behavior was accompanied by increased support for correctional staff. The additional training showed staff that administrators wanted them to have the tools to do their job better. Administrators added specific positive reinforcers for staff. There is now an employee of the month and an employee of the quarter, and staff can receive breakfast or lunch with the chief. One staff reported, "I feel more appreciated than ever before."

## ENVIRONMENT IN JUVENILE JUSTICE FACILITIES

The physical plant for the juvenile justice facility is older and has design flaws. Nevertheless, correctional administrators made some important positive changes in the experience of living in the facility. The youth no longer wear prison-like jumpsuits, and instead have t-shirts and khakis. They are referred to as “youth” or “children” instead of “juveniles.” The time for lights out increased two hours—from 6 p.m. to 8 p.m. After a visit from members of the county commission and a supplemental appropriation, the facility stopped charging parents for calls from their children. Now all calls are free, which has made a substantial difference to youth and their families.<sup>146</sup>

For a time, there were no regular hair cutting services available to youth in the facility. After the transition, facility administrators brought in hair cutting services monthly to attend to youths’ needs.

**“When we cut their hair, their whole demeanor changed,” says Bridgeforth. “Children saw we cared about how they looked, so they cared about how they looked.”<sup>267</sup>**

## ACCOUNTABILITY

Correctional administrators also acted to provide greater accountability of staff. At the time of the transfer of responsibility, review of incidents was inconsistent. Now the [Major Incident Review Form<sup>147</sup>](#) provides three levels of review and specifically asks whether there was any wrongful conduct by staff or any violations of policies and procedures, and if so, what steps were taken to address and correct any violations. Staff who violate the rules or use force in a way contrary to Safe Crisis Management are subject to progressive discipline, from verbal warnings to written reprimands to suspensions from work for one, three, or five days.

The teams that review videos of incidents focus on what happened just before the confrontation occurred. Where was the officer located on the unit? What was he or she doing? Were they aware that a confrontation was brewing? What action could they have taken to resolve the conflict before a confrontation occurred? This focus on antecedents enables administrators to counsel individual staff, modify training, and clarify policies as needed.

## CONCLUSION

Detention administrators and staff in Shelby County have not resolved all issues involving room confinement. A sudden uptick in the use of isolation in November 2018 shows that a group of very disruptive youth can test the patience and commitment of even the best administrators and staff. After ten months of an average of 1.8 room confinements per month, a group of youth flooded their rooms the day before a facility audit by the American Correctional Association.

**FIGURE 19 SHELBY COUNTY ROOM CONFINEMENTS, RESTRAINS, ASSAULTS & AVERAGE DURATION OF CONFINEMENT**



DATA ON YOUTH AND STAFF ASSAULTS NOT AVAILABLE FOR 2015.

In addition, the [new written policy on Detainee Discipline](#)<sup>148</sup> provides for room restriction for up to five days as a sanction for misbehavior, which is inconsistent with the Involuntary Room Confinement and Juvenile Detention Services policies, and which seems unnecessary in light of the very rare use of room confinement during 2018.

Furthermore, the population of the facility varies considerably during the year, usually decreasing early in the year until reaching a low point during the summer, then growing from October to the end of the year, when the population can be almost double that of the summer months. This creates challenges for the plan to have no more than eight youth in each area of the facility other than classrooms and special programs during daytime activities.

Moreover, reform in the use of room confinement is time-consuming and staff-intensive, and requires patience. Correctional administrators and staff in Shelby County stayed committed to their duties during the transfer of responsibility, and have brought together the necessary components for significant reductions in the use of isolation. However, they are aware that continued success

will depend on constant attention to detail and regular review of behavior by both youth and staff. Their efforts toward that end include posting of monthly statistics on assaults, de-escalations, and use of force; daily observation of staff performance by supervisors to ensure compliance with policies and procedures; and facilitation of Youth Advisory Council meetings twice a month, which provide detained youth with opportunities to discuss and have input on ways to improve the Positive Behavior Management System.

Nevertheless, the reductions in the use of room confinement at the Shelby County Juvenile Detention Center are impressive. The many changes in policies, practices, training, programming, staffing, environment, and available resources put correctional administrators and staff in a strong position to continue the reforms.

The sheriff's continuing commitment to reform is shown through the ongoing partnership with the judge and the court. The DOJ had terminated many provisions of the MOA in the intervening years, as the county came into compliance. On October 19, 2018, the DOJ terminated the final provisions, removing DOJ oversight of the juvenile detention facility.<sup>149</sup> However, on December 11, less than two months later, Sheriff Floyd Bonner reached out to Roush to serve as a consultant to ensure the forward trajectory. Roush continues to provide technical advice and support.



Photo credit: Richard Ross

# NOT IN ISOLATION

HOW TO REDUCE ROOM CONFINEMENT  
**WHILE INCREASING SAFETY**  
IN YOUTH FACILITIES

**OREGON YOUTH  
AUTHORITY**

# Oregon Youth Authority

## INTRODUCTION

When current Oregon Youth Authority (OYA) Director Joe O’Leary joined the agency as the deputy director in 2012, the agency was experiencing significant challenges managing youth with disruptive behaviors. OYA’s average length of stay in isolation was twice the national average.<sup>150</sup> “A lot of bad outcomes were happening for the kids. Kids were ending up in the Behavior Management Unit for a long time. Luckily, we had no suicides during that time. A lot of bad outcomes were happening for the staff. The staff burnout was super high. The staff morale was super low. We were putting staff in an untenable situation. We realized that we had a big issue. And it was cyclical and deeply engrained in the culture.”<sup>151</sup>

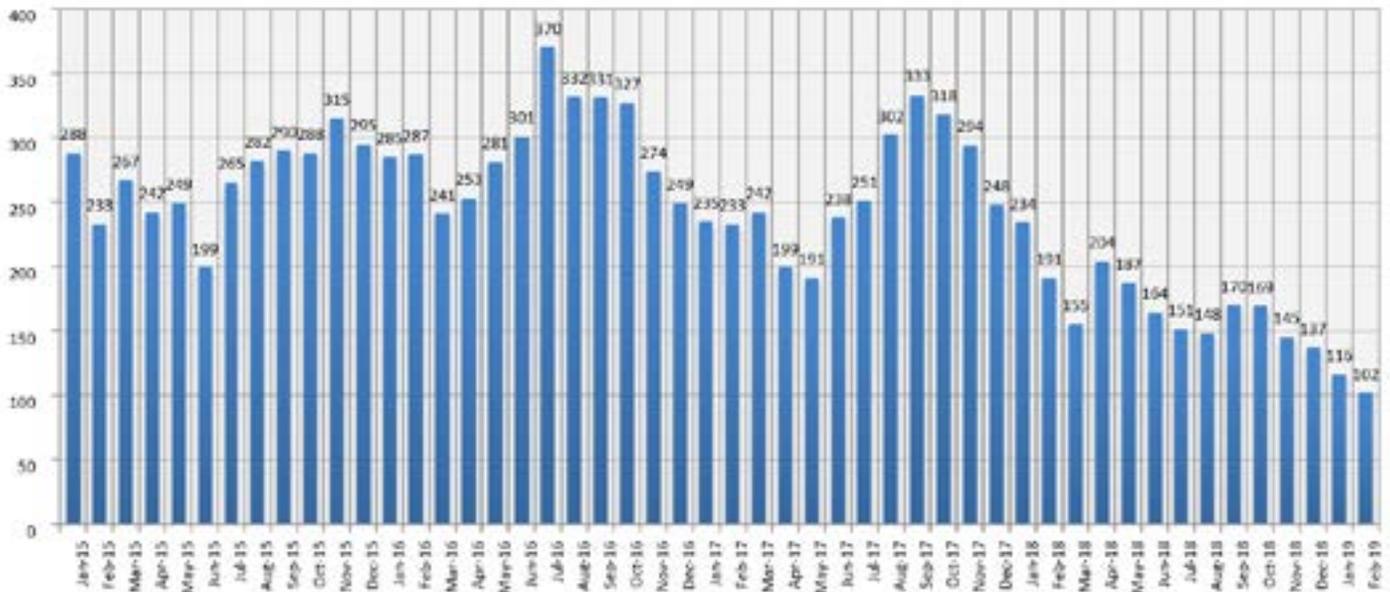
Oregon’s story of reducing room confinement is unconventional. While many of the ingredients of reform are similar to those used by other agencies, OYA followed a very different recipe. In order to create an environment that would support and sustain policy changes, OYA began by changing the institutional culture around the use of room confinement. Implementing a new policy was one of the final steps in the process. Agency leaders saw that nationally accepted practices were shifting away from the use of isolation and decided to change the practice on their own terms rather than wait for a tragedy, lawsuit, or external litigation. “The research about the impact of isolation on kids is there. If we didn’t take it head-on and start to change our own practices, then other people were going to do it for us,” Erin Fuimaono, OYA’s assistant director of development services said.<sup>152</sup>

Despite an older population charged with serious offenses, OYA was able to make significant reductions in isolation and implement a policy that bans isolation as punishment. Under Oregon state law, youth sentenced as adults may remain in OYA custody until age 25. Almost 60% of youth in OYA facilities are 18 years or older. Oregon’s story sets an important example for other jurisdictions as the recently reauthorized federal Juvenile Justice and Delinquency Prevention Act (JJCPA) prevents states from housing youth charged as adults in adult facilities and jails, which means that facilities across the country will soon accommodate more youth charged with serious offenses.<sup>153</sup>

The number of incidents of isolation in OYA facilities dropped from 370 in July 2016 to 140 in December 2018.<sup>154</sup> Violence has decreased and staff report feeling safer. Rather than isolation, staff rely on proactive approaches and intervene at the earliest point, versus reactive approaches of waiting until behavior has escalated to the point of requiring isolation.<sup>155</sup> Despite these improvements, OYA administrators acknowledge that they still have a long way to go. While the frequency of isolation has gone down, the average duration of isolation incidents is still longer than average. The average duration of isolation in February 2019 was just under 24 hours, while national data from Performance-based Standards<sup>156</sup> shows that more than 80% of isolation incidents in other juvenile justice correctional facilities end in less than eight hours. Administrators explain that the duration of isolation remains high because the threshold for isolation has increased to include only serious

behavior. The current OYA policy threshold for isolation requires actual violence or an imminent threat of violence. OYA is working to reduce duration by creating specialized positions and developing reintegration requirements, as discussed below. "This is not easy," said O'Leary. "We are mid-stream in our transition, and it takes a long time and a lot of intentionality."<sup>157</sup>

**FIGURE 20 TOTAL ISOLATION INCIDENTS (2015-FEBRUARY 2019)**



**FIGURE 21 ISOLATION DURATION IN HOURS (JAN 2017-FEB 2019) (HH:MM)**

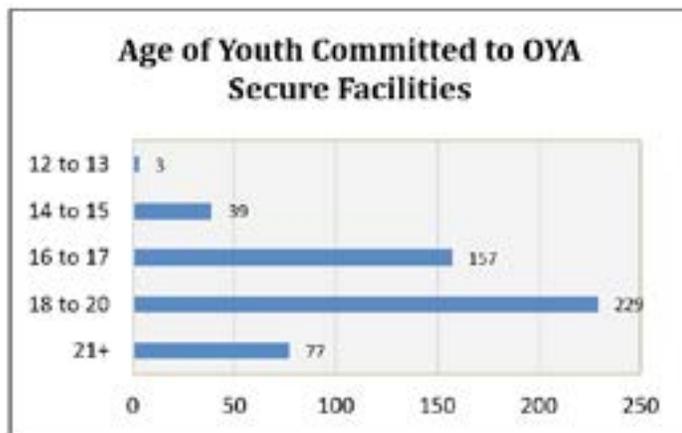


**I. AGENCY BACKGROUND**

The OYA was created by Senate Bill 1 in 1995. OYA is responsible for the supervision, management, and administration of juvenile justice commitment facilities; state parole and probation services; and community out-of-home placements for youth. The agency has nine secure facilities, which are also called close custody facilities. Five are secure commitment facilities and four are camp facilities with transitional and vocational programs. Approximately 505 young people are committed to OYA close custody facilities. In 2017, OYA closed two facilities, including one of its largest correctional facilities, Hillcrest Youth Correctional Facility.

OYA works with many older youth with serious charges. In 1994, Oregon passed Ballot Measure 11, which required youth as young as 15 years old to be charged and sentenced to mandatory sentences as adults for certain offenses.<sup>158</sup> To minimize the impact of youth charged as adults on the Department of Corrections, state legislation also permits youth who are sentenced as adults to stay in OYA custody up to age 25.<sup>159</sup> Almost 45% of the youth in OYA secure facilities are serving adult sentences. As of January 2019, 280 youth were committed to OYA through the juvenile justice system, while 225 were committed by the Department of Corrections. In 2019, 45% of youth in OYA close custody facilities were ages 18–21. Youth ages 21 years and older made up 15% of the population.<sup>160</sup>

**FIGURE 22 AGE OF OYA YOUTH**



**FIGURE 23 MOST SERIOUS OFFENSES OF OYA YOUTH**

Most Serious Charge	Youth Number of Youth	Percentage of Youth
Sexual Offense	128	25%
Property	111	22%
Person-to Person	110	22%
Robbery	72	14%
Homicide Related	41	8

Although the population of youth in OYA secure programs has decreased by 55% since 2000,<sup>161</sup> a large part of the population is made up of older youth, youth charged with serious offenses, and youth with significant mental health and trauma histories. More than 75% of youth committed to OYA facilities have diagnosed mental health disorders.<sup>162</sup> Almost 43% of girls and 16% of boys are victims of sexual abuse,<sup>163</sup> while 29% of girls and 12% of boys have exhibited past suicidal behavior.<sup>164</sup>

Notably, Oregon just enacted legislation that would reverse many aspects of Measure 11. In May 2019, the Oregon House of Representatives passed [Senate Bill 1008](#), which would require all cases to

begin in juvenile court and establish a “second look” process for youth sentenced as adults halfway through their sentence.<sup>165</sup> The bill, which would apply to matters pending after January 1, 2020, passed by two-thirds of both chambers of the state legislature and is on the way to the governor, who has indicated she will sign it into law.

## THE CHALLENGES

### LACK OF CLEAR POLICY GUIDANCE ON ISOLATION

Like many juvenile justice facilities and agencies, OYA historically relied on isolation to control youth behavior. Although OYA prohibited room confinement as punishment in 2005, there was little policy guidance, and staff continued to use the practice as a punishment or sanction. Prior to 2010, youth with serious and chronic behavioral issues frequently spent periods of 60 to 90 days in the agency’s Behavior Management Unit, which was housed in an isolation unit. Staff also could impose consecutive periods of isolation, and there was no limit on the maximum length of time youth could spend in isolation.

In 2010, OYA introduced a behavior matrix to create consistency in behavior management responses across the agency. The matrix system created categories of behavioral offenses and corresponding “refocus options” that staff could use. A refocus option was defined as an “appropriate response to, or sanction for, behavior.” Because a refocus option could be either a sanction or a response to youth behavior, the behavior matrix listed isolation as a refocus option without technically violating OYA’s existing policy against isolation as punishment. However, the behavior matrix did cap the amount of isolation that staff could use at five days.

In practice, facility staff continued to use isolation as a punishment even after the behavior matrix was introduced. Although the matrix banned consecutive periods of isolation and established an upper time limit on isolation, it did not provide any other guidance for staff. Staff continued to use isolation as punishment, generally for the maximum allowable time.<sup>166</sup> As one facility administrator explains, “Where people got stuck is [the behavior matrix] still had isolation listed as ‘up to five days.’ Just because the matrix said up to five days doesn’t mean it needed to be five days, or it’s the right thing to do.”<sup>167</sup>

## II. HOW OYA MADE REDUCTIONS IN ISOLATION

### LETTING STAFF LEAD THE REFORM PROCESS

In 2013, OYA administrators put the task of reducing isolation on the top of their agenda. Securing buy-in from all levels of staff was critical. Former OYA Director Fariborz Pakseresht explained why OYA could not successfully implement changes in isolation practices without the front-line staff: “The culture we have in the organization predates us by many years. In attempting to shift the culture some staff may see us as just another flavor of the day, week, month.... Those who are resistant to

change may be fairly confident that they can outlast us and the new initiative. In most cases they are correct.”<sup>168</sup> OYA administrators structured staff participation in the isolation reduction process so that staff could feel ownership and pride in the results.

## INTERNAL ISOLATION AND REINTEGRATION OVERSIGHT COMMITTEE

OYA did not eliminate isolation, but the agency asked staff to reshape the way it was used. In October 2014, OYA established an Internal Isolation and Reintegration Oversight Committee (Internal Isolation Committee) made up of management staff from facilities, direct care staff (called Group Life Coordinators or GLCs), union representatives, and treatment staff. OYA instructed the committee to use research and national best practices to do two things: (1) create a new definition of isolation, and (2) redefine when and how staff could use isolation. The Internal Isolation Committee recommended the following revisions to the definition and threshold for the use of isolation:<sup>169</sup>

### THE ISOLATION DEFINITION IMPLEMENTATION WORKGROUP

Once the Internal Isolation Committee developed recommendations for the new isolation definition and threshold, OYA faced the larger task of mapping out a successful implementation process. To do this, administrators again formed a diverse committee of staff in early 2015 to develop alternative interventions to isolation and to identify the necessary resources to make those alternatives work.

As with the Internal Isolation Committee, the Isolation Definition Implementation Workgroup (Implementation Workgroup) included a broad range of approximately 30–40 staff throughout the agency with multiple layers of direct care workers from every facility. This included supervisors, mental health professionals, training staff, and GLCs. Diverse representation on the workgroups was critical, said Fuimaono, “because it allowed for the cross section of folks to become much more educated on the issue of why reducing isolation was the right choice for everyone and the different factors at play. We chose that group of folks carefully because we wanted them to be message carriers when they went back to their facilities and to speak about their own experiences on the workgroup when [other staff] had questions about the process.”<sup>170</sup>

“YOU CAN’T GO AWAY IN THE LAB AND COME UP WITH A GREAT POLICY. YOU HAVE TO GO OUT THERE AND GET THE FOLKS THAT ARE DOING THE WORK, KNOW THE KIDS, KNOW THE OPERATIONS, KNOW THE CLINICAL PIECE, KNOW YOUTH DEVELOPMENT, AND GET THEM AROUND THE TABLE TO BE PART OF THIS EFFORT. YOU CAN’T GO FROM THE TOP DOWN.”

—ASSISTANT DIRECTOR CLINT MCCLELLAN<sup>268</sup>

## COMMUNICATING CHANGE TO THE WORKFORCE

Acting on recommendations of the Implementation Workgroup, Fuimaono and OYA Assistant Director Clint McClellan went to all 38 housing units in OYA secure facilities to meet with staff. Their goals were to explain that a major change was coming in the isolation policy and to ask staff what resources they needed to make this change happen. The plan was for Fuimaono, McClellan, and members of the Implementation Workgroup to continue these conversations with staff over a period of months.

They began conversations by asking staff members why they decided to work for OYA. “Almost everyone said they wanted to make a positive difference with kids, or to help communities by helping kids,” said Fuimaono.<sup>171</sup> If some staff disagreed with this, Fuimaono and McClellan pushed. The goal was to get everyone to agree on some shared positive values. “We acknowledged that there was a time when [isolation] was thought of as the appropriate thing to do, but we are shifting mindsets and have new research and an understanding of skill development in behavior change,” Fuimaono said. “None of us would be using computers from 2000. The same is true in how we interact with young people.”<sup>172</sup> Administrators focused on linking the impetus for reducing isolation directly to OYA’s mission and values.<sup>173</sup>

Fuimaono elaborated, “We clarified that OYA was not eliminating the use of isolation, but we were talking about how to use it differently. We had to balance our message about what is effective for kids with the acknowledgement that our staff are in harm’s way sometimes. [Isolation] would still be an option as a safety intervention, but not as a punishment. Because that doesn’t work.”<sup>174</sup>

The message to staff from the beginning was that the agency was moving toward a model where staff used isolation only if violence was imminent.<sup>175</sup> However, they explained that the agency would create alternatives and ensure that the culture was ready to support the change.<sup>176</sup> “Messaging it this way was great because it didn’t freak everyone out,” said McClellan, “but there was still a lot of inconsistency in how staff and facilities were using isolation.”<sup>177</sup>

## ONGOING COMMUNICATION WITH STAFF

Implementation Workgroup members traveled to individual units two to three times over the next year, continuing discussions at the team level, reinforcing that the leadership at the highest level was listening to their concerns and fears about what could happen.<sup>178</sup> With time and support from other agency initiatives to change culture and provide more resources like Skill Development Coordinators, most staff began to accept the idea that reducing isolation was possible. However, despite careful messaging, some staff still interpreted the information to mean that the agency would eliminate isolation without workable alternatives. As McClellan emphasized, “The key about culture change is that key messages have to go out over and over again. You will still have people say that what they heard was that we’re taking away their tools. You just have to get the message out as many times and ways as possible.”<sup>179</sup>

## STAFF AS CREDIBLE MESSENGERS

One of the ways that administrators reinforced reasons to reduce isolation was by relying on local staff members as credible messengers. Leaders worked to support and energize those credible messengers so they could reach others. Alicia Cozad, then the deputy superintendent at Oak Creek Youth Correctional Facility (Oak Creek) said, “What we found were some champions. Those who understood the facility’s vision and goals to reduce isolation. They were able to carry those words forward because other staff respected them.”<sup>180</sup>

## MAKING A COMPELLING CASE AGAINST ISOLATION

Clear and frequent communication with staff about the impending policy change was only half the battle. The agency also needed staff to understand *why* the change was necessary. “It’s not enough to just to tell our employees that they will have to do things differently. We must take the time to put a compelling case together that makes sense to staff. Is the change going to improve safety? Is it going to create a more pleasant working environment? Is it going to create better futures for youth?” Pakseresht explained.<sup>181</sup> OYA made a compelling case against isolation with some of the following messages:

- Administrators and Implementation Workgroup members showed staff data that high rates of isolation were correlated with high rates of youth-on-staff violence. “Youth-on-youth violence was steady, but youth-on-staff violence went up. That got a lot of people’s attention,” said McClellan.<sup>182</sup>
- “What is the human cost of continuing to do business as usual? For example, the trauma that could be inflicted on youth, potentially increasing the numbers of future victims and compromising the safety of the community. At the same time there is the fiscal impact and a monetary cost of continuing the current practice. For example, longer stays in youth correctional facilities, potential transfer to adult prison, and the unquantifiable cost of future crime and victims,” said Pakseresht.<sup>183</sup>
- “When I was out working in community programs and we would get youth who experienced isolation, they would struggle when they were in the community. In the community, our main tool is to work with them, talk to them—we don’t use isolation. But their go-to was to run away from the community programs. It took a lot of time to figure out how we could work with them in the community. Shifting the approach in a facility away from punitive isolation and teaching how to regulate and problem-solve before they ever leave gives them a better chance at successful reentry,” said Program Director Jamie McKay.<sup>184</sup>
- “When you rely on a door between you and a kid as your primary source of safety, you create an ‘us vs. them’ environment. Then, when you have to open that door for something, now it’s ‘you vs. them.’ That dynamic doesn’t go away automatically, and bad things can happen,” said Operations Policy Analyst Heber Bray.<sup>185</sup>

## CHANGING CULTURE BEFORE POLICY

In 2015, the Implementation Workgroup made a critical recommendation: OYA should change the culture around isolation *before* implementing a new policy on isolation. As OYA shifted from a punitive model to a developmental model, administrators faced the challenging process of countering an existing culture.

### WHY FOCUS ON CULTURE FIRST?

OYA administrators and staff expressed the importance of changing culture in order to achieve sustainable reductions in the practice of isolation. Pakseresht noted, “We can rewrite policies and procedures, develop the best manuals and practice models, issues directive and decrees, but if [we] are not able to shift those shared values and beliefs and understandings that define the present culture, very little will change.”<sup>186</sup>

In addition, Fuimaono recalled, “[We] started out thinking that we needed more staff, we needed in-between spaces where kids can go when they need a break, but not isolation. We thought about creating rooms with calming furniture and paint and music. Then we thought, ‘Well wait a minute—we can throw staff at this issue, we can create these spaces, but if staff aren’t thinking differently about how to intervene with these behaviors and address them, we are just going to use those things in the same way.’”<sup>187</sup> Without a culture change, staff would continue to use new resources as punishments. Likewise, youth would interpret them as punishments. “You can’t just throw out a policy and hope that it sticks,” McClellan reiterated.<sup>188</sup>

### ROLE OF LEADERSHIP IN CULTURE CHANGE

Leaders at different levels of the agency played a critical role in changing the culture. OYA leaders describe their approach:

- “Leadership plays a critical role in organizational change. We must understand the impetus for the change and explain it to others. Why are [we] moving in this direction and what is the price that [we] might pay for inaction? We always want to be ahead of the wave of change rather than being overtaken by it,” said Pakseresht.<sup>269</sup>
- “We have a saying: ‘Executive team leaders are here to support and develop our managers, who support and develop our staff, who support and develop our youth.’ You can’t have one of those out of place. They all have to be in alignment,” said McClellan.<sup>270</sup>
- “We have to be the message—not the messengers. There’s a huge difference. People look for weakness in the armor. They think if you are not really bought in [to a practice or policy change], they don’t have to do it,” said Superintendent Dan Berger.<sup>271</sup>
- “We must model the change that we want to implement. To change behavior and culture consistently, as an organization, we as top leaders as well as our executive team, our managers at every level of the organization, must walk the talk. How we treat staff as leaders and how effectively we listen will translate directly and indirectly to how staff exhibit the same behavior with youth,” said Pakseresht.<sup>272</sup>
- “Don’t say, ‘Central Office says we have to do this thing.’ If you are a leader here, you should be out there saying, ‘Here’s what we are doing. Here’s why we are doing it. And here’s how you are a part of this,’” said Berger.<sup>273</sup>

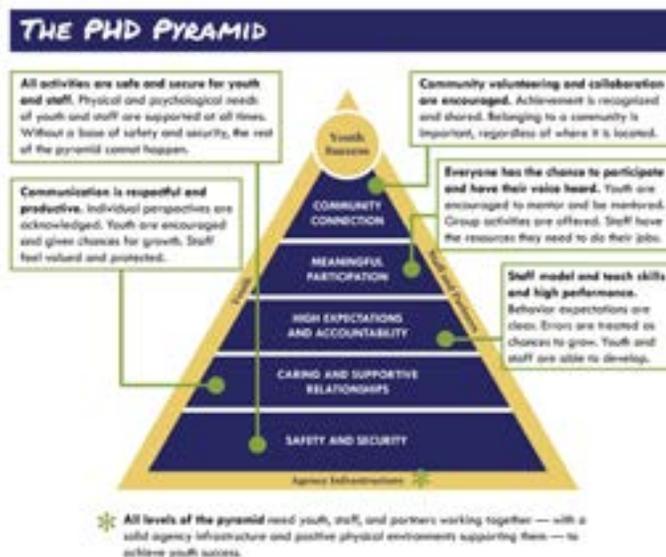
## A CULTURE OF POSITIVE HUMAN DEVELOPMENT

As OYA was working to reduce isolation, the agency was simultaneously making a shift to a developmental approach. OYA anchored its new approach around Positive Human Development (PHD). The core principles of PHD effectively reinforced the agency's efforts to prevent isolation.

### Defining Positive Human Development

Positive Human Development, which is based on the underlying model of Positive Youth Development (PYD), relies on research on adolescent brain development and developmental psychology to help youth become healthy, productive, and crime-free adults.<sup>109</sup> To represent the five elements of PHD, OYA uses the PHD Pyramid, which is included in training materials, brochures, and on posters throughout facilities. A summary of PHD is available in the agency's online publication, [Positive Human Development at a Glance](#).<sup>100</sup>

FIGURE 24 POSITIVE HUMAN DEVELOPMENT PYRAMID



PHD prioritizes safe and normative environments that support healthy adolescent brain development and maximize positive changes in youth and staff. Isolation does the exact opposite.

### **POSITIVE HUMAN DEVELOPMENT (PHD) vs. POSITIVE YOUTH DEVELOPMENT (PYD)**

In 2017, the Council of Juvenile Correctional Administrators (CJCA) released the [CJCA Toolkit: Positive Youth Development](#) which defined PYD as “a way of seeing young people in terms of who they are becoming, rather than their past behaviors or current situations.”<sup>101</sup> The CJCA Toolkit highlights several core components of PYD:

- Youth are resources to be developed, not problems to be fixed;
- Young people have strengths and the ability to develop new competencies and pro-social skills;
- People behave negatively as a normal response to unmet needs (for adolescents these are often status, belonging, autonomy, and excitement);
- Change occurs when youth build skills and receive support to meet their needs; and
- Primary strategies to work with youth are skill development, attachment, and engagement.<sup>192</sup>

PHD differs from PYD primarily in the recognition that staff also benefit from PYD approaches.<sup>193</sup> O’Leary described an experience that led OYA to adopt PHD: “Initially we thought OYA would adopt the PYD model. We sent some of our staff to PYD trainings. They came back and told us that they could buy into the PYD approach of treating youth as resources, but *they* wanted to be viewed as resources as well. Staff said, ‘If OYA can get to a place where I feel as though I’m being viewed as a resource, then I can do that with the kids [who] we work with every day.’”<sup>194</sup>

FIGURE 25 WHY POSITIVE HUMAN DEVELOPMENT

The [Why Positive Human Development Guide](#) includes a visual break down of how the PHD culture is integrated into OYA living units.<sup>195</sup>

## SAFETY

The foundation of PHD (as can be seen in the PHD pyramid) is safety—both emotional and physical. OYA’s experience shows that isolation undermines safety. Administrators knew that staff were most likely to be injured when attempting to use isolation.<sup>196</sup> As the agency reduced isolation, several safety indicators in facilities improved. Although success was not linear and the agency faced setbacks, data trends showed that, over time, fewer staff were injured and more staff felt safe.



FIGURE 26

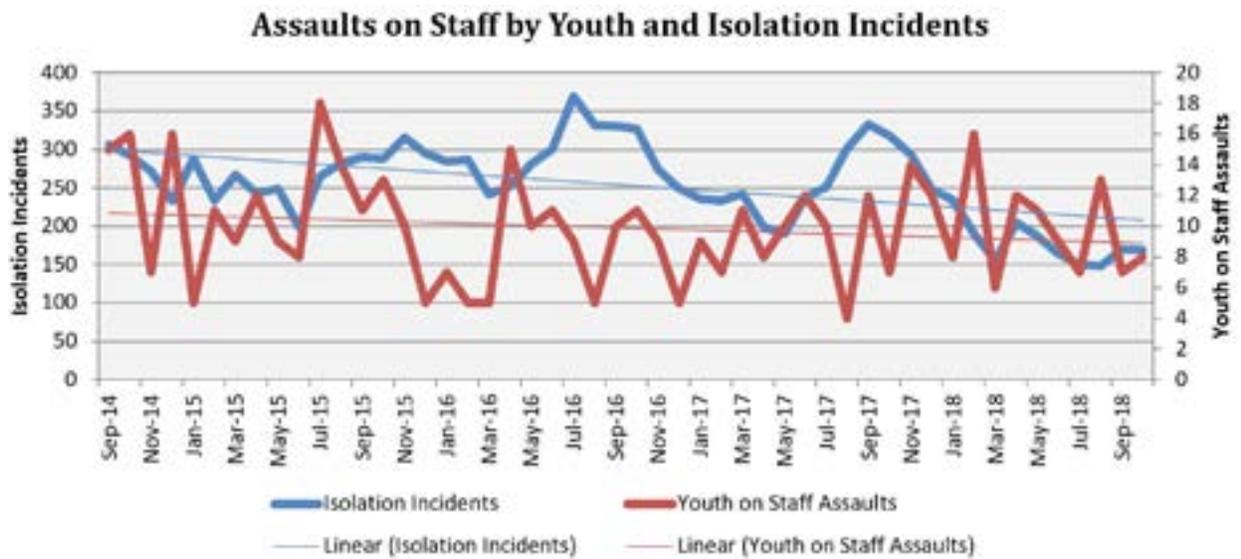
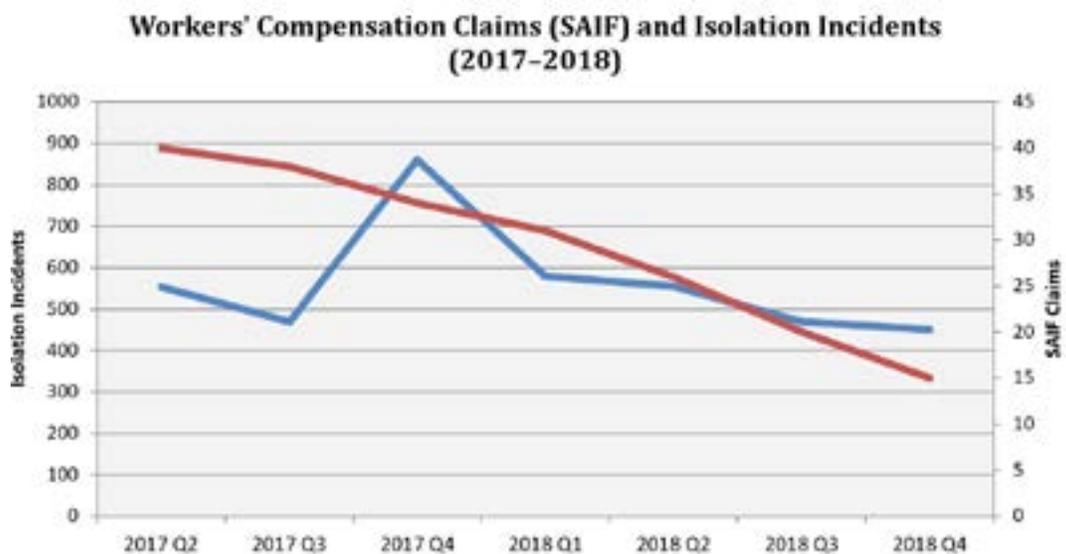


FIGURE 27



## FUNDAMENTAL PRACTICES GUIDE

In 2018, OYA Facility Services designed, developed, and disseminated [Fundamental Practices for Living Units—Moving PHD Into Practice](#)<sup>197</sup> to support the application of PHD in OYA facilities. The practice guide gives OYA staff practical and specific examples of how to use PHD.<sup>198</sup> Berger describes Fundamental Practices as a “playbook for the living units” on using five important practices to help operationalize PHD. “We had to find something tangible for people,” he said.<sup>199</sup> Each fundamental practice links back to a core element of PHD.

## FUNDAMENTAL PRACTICES

1. Clean, Safe, and Organized Living Units
2. Youth and Staff Engagement
3. Developmentally Appropriate Milieu Services
4. Building Community
5. Community Skill Building

FIGURE 28 SAMPLE FROM FUNDAMENTAL PRACTICES FOR LIVING UNITS GUIDE<sup>200</sup>

Fundamental Practices for Living Units

3

Developmentally Appropriate Milieu and Services

PHD Alignment	Actions
<p><b>Level:</b> High Expectations and Accountability</p> <p><b>Developmental Principle:</b> People as resources</p>  <p><b>Why?</b> This practice is where the rubber meets the road. It is skill-building. Everyone is different and we all come with a variety of skills. In order for us to develop, we need to have high expectations that are reasonable and rising for our skill level. Expectations and goals are tailored to allow successes and challenge growth. Consequences are effective if they relate to the issue, are immediate, and include a learning component.</p>	<p>Youth expectations are individualized, reasonable, and rising.</p> <p>Services, consequences and incentives are developmentally appropriate, individualized and focused on skill building and shaping behavior.</p> <p>Safe opportunities are provided for youth to practice making reasonable choices and decisions when appropriate.</p> <p>Youth have input on the level system, consequences, and incentives.</p> <p>Emphasis is on positive reinforcement, including verbal, nonverbal, written, and environmental.</p> <p>Behavior is addressed appropriately and timely.</p> <p>Staff role modeling skills:</p> <ul style="list-style-type: none"> <li>• Behavior</li> <li>• Communication</li> <li>• Interpersonal skills</li> </ul> <p>Recognition and celebration of achievements and accomplishments.</p> <p>Youth individually assigned services and progress are visually available for youth and staff (White/magnetic board).</p> <p>Positive signage is posted neatly and prominently to visually reinforce program principles.</p>

Oregon Youth Authority  
Page 17

Moving PHD into Practice

Developmentally Appropriate Milieu and Services

What it looks like:

	Youth move toward identified goals or achievement
	Youth are developing and practicing new skills
	Youth support each other
	Youth and staff feel they are viewed as a resource
	Youth progress through level system based upon their individual skill set and capabilities

Oregon Youth Authority  
Page 18

When staff raised concerns that they could not hold youth accountable without isolation, administrators focused on redefining accountability. For McClellan, that meant giving youth “the skills to be able to learn from their mistakes and hold themselves accountable. Because that’s really the only way they’re going to create safety in the community . . . Isolation is not a place where you can develop skills at all. There are plenty of things we have to develop to hold kids accountable in terms of consequences. Isolation just isn’t one of them.”<sup>201</sup>

Cozad described shifting the narrative away from behavioral control to behavioral support at Oak

Creek: "It has taken time to pivot. Just because one kid is taking advantage or doing something doesn't mean they all will. What we need to put into perspective for staff is that we have not gone through what most of these kids have experienced. So when [staff] think that punishing a little bit harder is the key to success, our culture has pushed back. What we need is empathy and to have high expectations. In essence, treating these kids as your own children goes a long, long way."<sup>202</sup>

## EXTERNAL PARTNERSHIPS

### COMMUNITY ADVISORY GROUP

To the surprise of many staff, OYA administrators reached out to a group of advocates and organizations as part of the external Isolation Community Advisory Group (Advisory Group). The Advisory Group's role was to give feedback on Internal Isolation Committee recommendations. Members included Youth Rights and Justice, Disability Rights Oregon, Partnership for Safety and Justice, a child psychiatrist, a juvenile court judge, a juvenile detention manager, a juvenile prosecutor, a public defender, the American Civil Liberties Union, and the Oregon Commission on Black Affairs.

O'Leary saw the benefit of involving a group that he describes as "essentially, everyone who would sue us" early in the process.<sup>203</sup> McClellan says, "Initially, we were a bit skeptical about doing workgroups and then inviting [the external Advisory Group members] in and them tearing it apart, but that didn't happen."<sup>204</sup> [W]e wanted these people close to us during the process, but the beauty of the execution was how they embraced the partnership and the insights we got from them," said O'Leary.<sup>205</sup> While the Advisory Group was not involved in drafting policy, they were invited to give advice and perspective. When outside stakeholders who might otherwise challenge agency practices with lawsuits or legislation were allowed insight into the process of reducing isolation through a transparent process, they were more likely to support the agency's plan.

## LEVERAGING POLITICAL AND LEGISLATIVE RELATIONSHIPS

The state legislature controls OYA's budget and resources. Strategic involvement and communication with state political leadership was an essential component of OYA's process of reducing isolation. O'Leary pointed out that "changes around isolation would not have worked if we had not been given budget flexibility, if we were not given additional funding through creative means to modify some of our physical environments. So having engagement with political leadership was critical."<sup>206</sup>

In 2015, the legislature considered legislation that would have banned isolation but would have been challenging for OYA to implement. The bill was drafted without input from OYA or other juvenile justice practitioners. The bill ultimately did not pass. OYA then asked the Joint Committee on Ways and Means to create a 2015 budget note requiring OYA to study the issue of isolation and create a set of recommendations to reduce the practice by February 2016.<sup>207</sup> The Ways and Means Committee is the legislative appropriations committee that determines state budget policy and sets the biennial

state budget. “The request for a budget note and our subsequent recommendations were literally a nail banged into the wall on which we could hang some funding requests. And some policy requests too,” stated O’Leary.<sup>208</sup> As a result of the [response that OYA submitted](#),<sup>209</sup> the 2017–2019 biennial budget allocated OYA funding for additional staff and physical structures to reduce isolation.

### OYA Supports Legislation to Reduce Isolation

Even though it had failed to pass, the 2015 bill to ban isolation allowed OYA leaders to highlight the urgent need for the agency to invest in steps to reduce isolation on its own terms. “It gave us the opportunity to go to our staff and say, ‘[L]ook, this is coming. We can choose to get ahead of this, or we can let something happen to us that may or may not be administrable. What do you want to do?’ That helped to create a mandate to drive planning and action to reduce isolation. In the next legislative session, we offered our own bill,” said O’Leary.<sup>210</sup>

OYA sponsored [Senate Bill 82](#),<sup>211</sup> which was passed in 2017. The bill adopted OYA’s policy that youth cannot be placed alone in a locked room as “sanctions and punishment for violation of rules regulating the conduct of youth offenders and any other persons in the custody of the youth authority.”

The law doesn’t apply to local juvenile detention facilities.<sup>212</sup> Part of OYA’s stated purpose in sponsoring the law was that the agency policy banning isolation as punishment could be reversed if not codified in state law.<sup>213</sup>

## III. WHAT WORKED

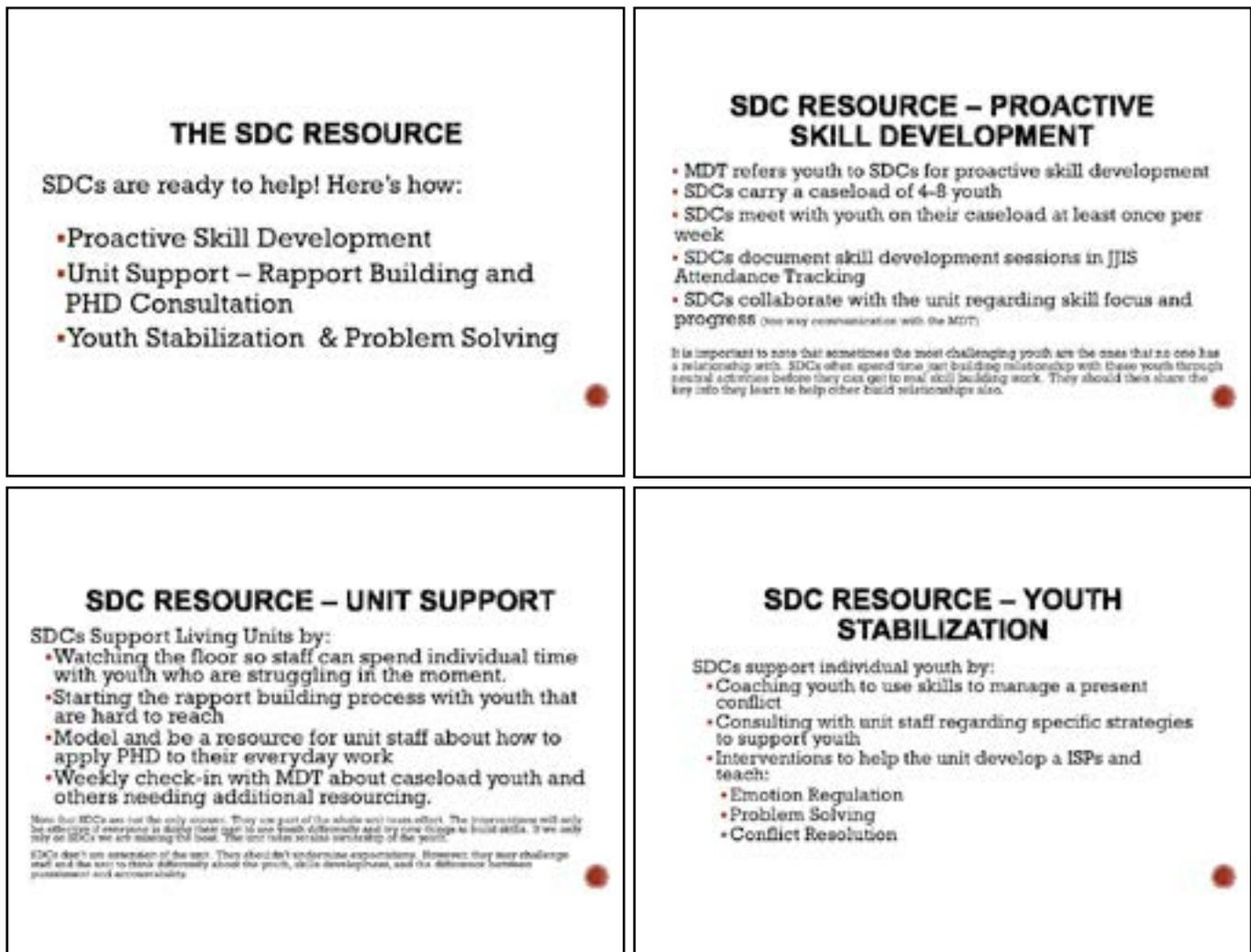
### **SKILL DEVELOPMENT COORDINATORS**

In 2013, OYA closed its Behavior Management Unit, which relied primarily on isolation, and repurposed staff positions to create 11 Skill Development Coordinators (SDCs). SDCs are specially trained staff who work with youth with the long-term goal of reducing isolation and helping youth reintegrate out of isolation as quickly as possible.

Rather than moving challenging youth to another unit, SDCs are designed to help youth be successful in regular housing. “When staff asked us what to do about difficult youth,” recounted Bray, “we said, ‘You’re going to keep them on your unit. And we’re going to give you these extra staff to help that kid ‘skill up.’”<sup>214</sup>

In February 2015, OYA used existing vacancies to create and deploy an additional nine SDCs at four facilities. Several of the agency’s strategies to reduce isolation required additional funding. “We had to commit to being proactive instead of reactive,” said Bray. “Making that shift is really hard. It costs money up front to save money on the back end, and that’s not the way our society is wired.”<sup>215</sup>

FIGURE 29 OYA SDC RESOURCE



### SKILL DEVELOPMENT COORDINATOR FUNCTIONS

SDCs serve three main functions:

#### 1. *Work Regularly with Youth to Prevent Isolation*

SDCs work multiple times a week with youth who are prone to behavior that could result in isolation to develop and practice self-regulation and appropriate interaction with peers and staff.<sup>216</sup> “We teach them how to problem-solve, stabilize themselves, take ‘no’ for an answer without getting into conflict. We reduce isolation by teaching kids how to act in the system and how to ask for resources,” one SDC explained.<sup>217</sup> MaClaren Youth Correctional Facility (MaClaren) has six campus SDCs who staff the facility, including weekends.<sup>218</sup>

## 2. *Assist with Unit Management to Allow Unit Staff to Work with Youth*

When a youth escalates or acts out, unit staff help the youth use skills to process their emotions and calm down. In order to do this, an SDC can “sub in” and help manage other youth while the assigned GLC works with the individual youth. SDCs are not meant to replace unit staff in dealing with crisis situations.

## 3. *Help Youth in Isolation Transition Back to Living Units Quickly*

In some OYA facilities, youth who meet the new threshold for isolation are transferred to a separate physical unit until staff determine they are ready to reintegrate back to their living unit. MacLaren, for instance, has an Intervention Unit (IU). Four SDCs staff the IU for sixteen hours a day. According to Berger, youth on the IU “spend most of their time in what’s called Core, which is like a dayroom. They go out, work with SDCs, and have meals together out in the Core. As long as there isn’t a serious conflict between kids, they are out in Core together.”<sup>219</sup> Once a youth on the IU is emotionally regulated and ready to engage in reintegration planning, OYA policy requires that the youth spend as much time as possible out of the isolation room.<sup>220</sup> Superintendent of the Rogue Valley Youth Correctional Facility Ken Jerin noted, “Once [youth] are regulated—they are no longer hitting the walls, threatening other people, when they are talking reasonably—which may take an hour or two, they may not be able to be safely reintegrate back into the living unit immediately. SDCs work with the kids at this moment to move them along.”<sup>221</sup> During that period, SDCs also communicate with the living unit leadership team to create a plan to bring the youth back to the unit as quickly as possible.

In order to enhance the staffing pattern for the IU at MacLaren, Berger selected additional staff when the Hillcrest and MacLaren facilities were combined in 2017. Before the new staffing pattern became operational, the IU staff took a two-week team retreat. “We completely rebuilt the program in the light of PHD,” he said. “We didn’t want kids to just go down there and sit. If kids had to go to isolation and had to go to IU, they were engaged in skill development when they were there. That was the basis of rebuilding this program.”<sup>222</sup>

## **ENVIRONMENTS MATTER: CHANGING PHYSICAL SPACES**

The traditional design of OYA facilities and living units contributed to overuse of isolation. OYA structures and staffing plans were built around the concept of group milieu management, so staff had two choices for managing youth behavior: one large group living space or isolation. If a youth couldn’t handle the group environment, it was impossible to separate him or her to allow for re-regulation without isolation.

Physical environments play a critical role in healthy adolescent development. If facilities put youth in institutional environments, youth are more likely to become institutionalized, which prevents successful transitions back to the community. In order to prevent institutionalized thinking and behavior, the agency also needed to create secure environments that were as normal as possible.<sup>223</sup>

In 2013 the Oregon Legislature directed OYA to produce a 10-year plan for secure facilities to address the decreasing youth population and develop long-term goals to align physical spaces with best practices, including reducing the use of isolation.<sup>224</sup> In 2014, OYA worked with consultants to develop a [10-Year Strategic Plan for Facilities](#) (10-Year Plan)<sup>225</sup> for creating physical environments that support PHD. In 2015, the state legislative budget fully funded the 10-Year Plan.<sup>226</sup> The consultants who conducted assessments as part of the 10-Year Plan found that “The current mix of facilities within the OYA system does not support the vision, mission, and culture of OYA. Housing and living areas reflect the most serious gap between vision and reality. The majority of youth are housed (with long lengths of stay) in densely populated dormitory living units. Program and treatment space is not adequate to support relief and break-out space.”<sup>227</sup>

## 10-YEAR PLAN RECOMMENDATIONS

The 10-Year Plan recommended several major environmental changes:

- Environments that support relationships by creating open, comfortable spaces to connect;
- Living spaces with natural lighting and views of nature and the horizon;
- Environments with non-institutional furniture, fixtures, and decor;
- Display boards that show youth accomplishments; and
- Increased access to recreational and treatment spaces to develop skills with staff and better prepare youth to transition back to the community.<sup>228</sup>

## NEW UNITS

Another key feature of the 10-Year Plan is reducing the size of living units from 25 beds to 16 beds. In 2017, OYA consolidated two large correctional facilities. As part of the 10-Year Plan for smaller living units and to help absorb the additional population from consolidating MacLaren with now-closed Hillcrest facility, OYA built six 16-bed living units at MacLaren. The new living buildings house the intake units, two mental health units, and a pilot trauma unit called the University of Life. The new units include individual rooms, two living rooms, an outside porch, and several multipurpose detention-secure rooms

with natural light. The individual rooms have visual display boards that youth may decorate, large windows, and light switches that youth control.<sup>229</sup> OYA created the [Letting in the Light video](#) to showcase the design process and benefits of the new buildings.<sup>230</sup>

**FIGURE 30 OYA LETTING IN THE LIGHT VIDE**



**FIGURES 31-35 BEFORE AND AFTER**





**“If it’s more institutionalized, it looks more like prison, like a dungeon, then obviously we’re not going to change. We’re just going to be what we’re looked at upon as, like criminals, or animals.” — Youth at MaLaren<sup>274</sup>**



Moreover, OYA secured meaningful youth participation during the process of designing the new buildings. A youth intern participated in all design meetings and a team of youth worked with a local artist to create artwork throughout the buildings.<sup>231</sup> OYA also organized a visioning

charrette—“a technique for consulting with some of the most interested stakeholders”<sup>232</sup>—with 15 youth to structure input to designers. It involved meetings where participants discussed challenges and opportunities to develop a shared vision and goal for the project.<sup>233</sup>

### In-Between Spaces

As discussed, the design of older OYA structures prevented youth from stepping away from the group milieu to calm down and process emotions. This was especially problematic for adolescents, who are more impulsive, emotional, and susceptible to peer influence than adults. Because OYA houses a population of especially reactive adolescents more likely to have experienced trauma or mental illness, the traditional correctional design model wasn't helpful for their situation. As part of the 10-Year Plan, OYA focused on creating spaces and rooms that allowed youth to be somewhere between the large group and an individual cell, or “in-between” spaces. Staff also identified and used pre-existing in-between spaces such as repurposed buildings or rooms and outdoor areas. For example, Oak Creek removed the door from a room, painted it, and added rocking chairs and comfortable furniture. “Now it's a playing space, so girls can come and go freely. It's not a place where they get placed,” says Denessa Martin, chief of operations for Facility Services.<sup>234</sup>

## **STAFFING AND HIRING**

### **STAFFING**

In order to transition away from using isolation, OYA needed to hire additional staff and repurpose existing staff. Each living unit is made up of a Unit Leadership Team, which consists of the Living Unit Manager (LUM), a Case Coordinator (CC), and a dedicated Qualified Mental Health Professional (QMPH or Q). OYA's staffing numbers vary based on the needs of youth, but all units have a 1:8 staff-to-youth ratio. On specialty mental health or trauma units, the agency adds an additional GLC and keeps the youth population at 16 or less. Specialty units also share an additional QMPH to provide coverage seven days a week, or 1.5 FTE per unit.

### **CURRENT HIRING PRACTICES**

All OYA direct care positions require a high school diploma or a GED. Almost 90% of direct care staff are Level II GLCs, which also requires six months experience working with young people. If applicants do not have that experience, they can start as Level I GLCs and move their way up.<sup>235</sup> OYA's hiring goals are to select applicants with a “youth-first” mindset who are interested in working with youth in close custody settings. “We don't want corrections officers. We want folks who can work with kids and can learn security protocols as well,” explained Berger.

To attract qualified candidates, OYA’s human resources recruitment team attends jobs fairs and conducts outreach at local colleges and universities. They also created an [Oregon Youth Authority Recruitment Video](#).<sup>236</sup> Application materials are also designed to convey the agency’s PHD philosophy. Cozad described Oak Creek’s tailored application package: “We send out a hiring letter to potential applicants about the work we do. In essence—working with girls is challenging and rewarding at the same time. There will be accountability when youth make mistakes, which is inevitable with teenagers. What we want to tell [applicants] is that we expect kids to be kids.”<sup>237</sup>

**FIGURE 36 OYA RECRUITMENT VIDEO**



## **USING DATA TO TARGET ISOLATION**

### **OREGON’S STATEWIDE JUVENILE JUSTICE CASE MANAGEMENT AND REPORTING SYSTEM**

OYA has a well-developed data collection system. When the agency was established in 1995, one of its initial activities was to create a statewide, collaborative, integrated information management system that became known as the Juvenile Justice Information System (JJIS).<sup>238</sup> OYA provides training and technical support on JJIS to juvenile justice facilities in all Oregon counties and more than 100 external partner agencies.<sup>239</sup> Counties can access data on juvenile recidivism and programs as well as track individual youth information from initial contact with the juvenile justice system throughout all stages of their involvement.<sup>240</sup> According to OYA, Oregon is one of only three states with a statewide data system for youth in the justice system.<sup>241</sup> As discussed below, OYA requires staff to complete a series of online forms when placing a youth in isolation. Because the forms capture information through drop down menus, the agency can track why youth are placed in isolation and, at every 15-minute interval, why the youth is not ready to exit isolation.

## USING DATA STRATEGICALLY

OYA uses data to identify underlying factors (or as seen through a PHD lens, unmet needs) associated with isolation and responds by developing staffing resources, specialized units, and behavior management interventions to address those factors. For instance, OYA executive staff knew that a large percentage of the youth population had mental health issues and past trauma histories. However, by backing up this knowledge with quantifiable data, they were able to justify requests for additional resources and allocate those resources in effective ways.

### **EXAMPLE OF SMART DATA USE**

Bray asked staff to track serious behavior incidents in a unit over a three-month period by day and time. While he suspected that most incidents would occur at bedtime, he was wrong. Most incidents occurred around 4 p.m., the time that youth returned to the unit from recreation. "Kids were still amped up. There was no cooling-down time," said Bray. "They had to shift from outside rules to inside rules with the snap of a finger. You'd think that 15, 16, 17-year-olds could shift, but shifting from one set of rules to another is actually an advanced cognitive skill. We would have fights in the line and fights right when we got inside. We'd have kids blowing up because they wanted to get a drink of water and it wasn't their turn yet." As a team, staff decided to end recreation five minutes early and take steps to ease the transition for youth. "We'd have kids walk one slower deep-breathing lap before they came inside. While they walked the lap, staff reminded them of the inside rules in a nice calm voice by saying, 'Hey, remember guys, we're going inside. We're going to take our shoes off, we're going to line up, and table by table, we're going to go to the drinking fountain.'" <sup>242</sup> After making these small changes, isolation incidents during the 4–5 p.m. period dropped dramatically.

## FACILITY SAFETY INDEX

The Facility Safety Index is one method that OYA uses at both an agency and facility level to evaluate the progress or problems in facilities.

### Facility Safety Index Measures

- Number of isolation placements
- Frequency of isolation placements (adjusted to account for unit and facility population)
- Average duration of isolation placements
- Restraints
- Youth-on-youth assaults
- Youth-on-staff assaults
- Youth fights
- Contraband

While managers can check the safety index factors at any time, the agency performs quarterly target reviews. Administrators meet to discuss the safety index data and discuss what factors are “behind the numbers.” Berger said that leaders ask questions such as: What do these numbers mean? Why have they gone up? Why have they gone down? Are the data points connected with programs, resources, or management? “Then we come up with actual plans to see what we need to move,” he said. “Is this a one-off? Is this a rough month? Or do we have a trend here we that need to do a major shift?”<sup>243</sup> Another important aspect of the safety index as a tool is the ability to see the trends in data. “One point about following numbers is that we have to focus on the trendlines and not react extremely to any one point in time,” explained O’Leary.<sup>244</sup>

When interpreting data to guide reforms, OYA leaders also stress the importance of disaggregating data. “In Oregon we have big facilities. We have 13 living units in one facility,” said McClellan, “so getting one big conglomerate of data doesn’t tell us a lot. We have to break those [data] down to the individual living units, shifts, or other factors.”<sup>245</sup>

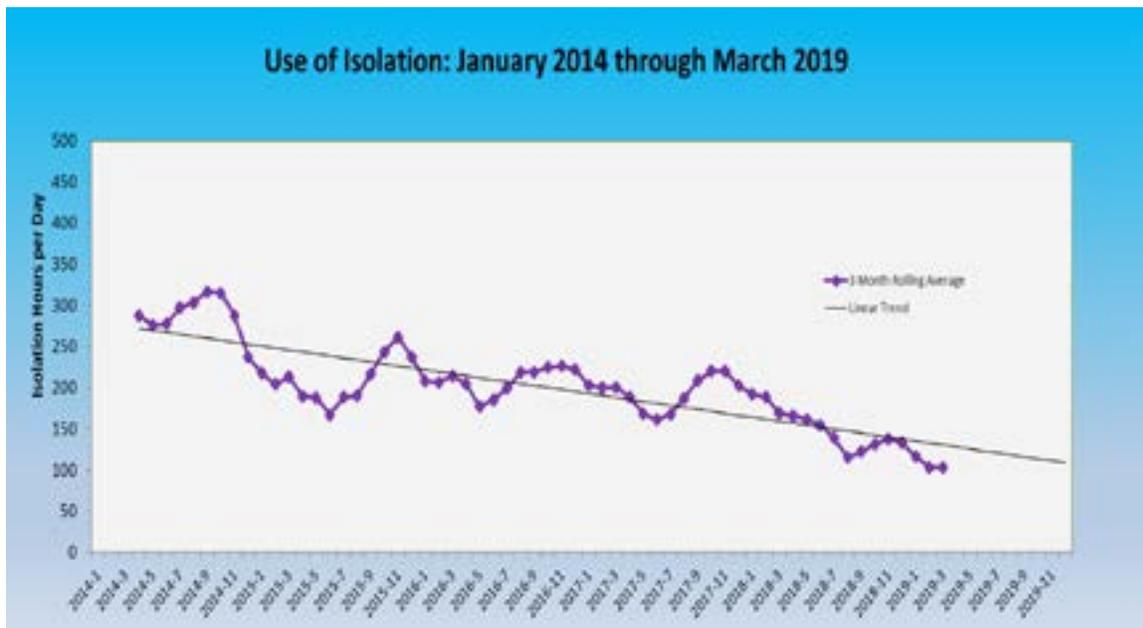
## ROLLING AVERAGE

OYA also uses a “rolling average” as a measure of the agency’s overall use of isolation. The rolling average uses a measure of isolation hours per day by combining the number of incidents and duration. “One youth in for 10 hours and 10 youth in for 1 hour will still tell us that we relied on 10 hours of isolation to maintain a safe environment,” explained Bray. Also, because the number of isolation incidents varies considerably from month to month—especially when data includes all facilities or units within a facility—the monthly rolling average is the average of the past three months. This allows the agency to better see trends over time. Finally, the rolling average corrects for the youth population. In other words, the use of isolation may decrease simply because there are fewer youth in a facility or agency. The rolling average allows administrators to see true isolation use and change over time. Based on the rolling average, OYA has reduced the use of isolation by 71% in five years.<sup>246</sup>

### Tips When Using Data

- Ask what is “behind the numbers.”
- Meaningful data is disaggregated.
- Change takes time—focus on trends.
- Expect trend lines to go up and down.

FIGURE 37 ROLLING AVERAGE—OYA USE OF ISOLATION



## SPECIALIZED UNITS AND OPPORTUNITIES

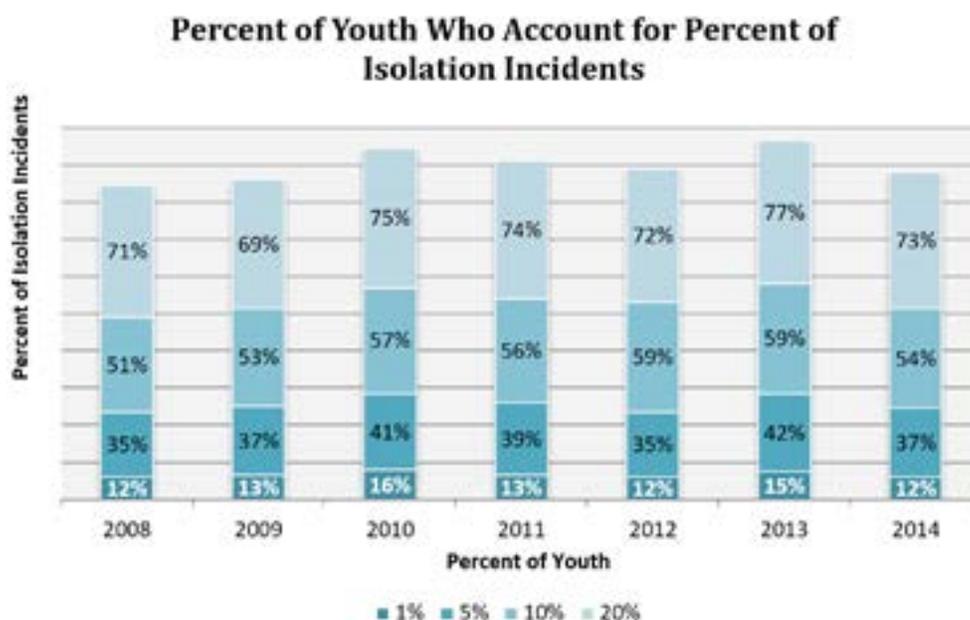
### MENTAL HEALTH UNITS

As mentioned above, many youth in OYA facilities have significant mental health needs. Bray explained that “we can look at the data and say that 83% of our kids have a mental health diagnosis.”<sup>247</sup> According to OYA budget documents, “[a]s of 2018, 45% of OYA youth were previously served by the child welfare system and 41% were served by the I/DD system.”<sup>248</sup> Based on this information, OYA created specialized mental health units to address the staffing and behavioral support needs of youth with mental health issues.

### THE UNIVERSITY OF LIFE

Another part of the Internal Isolation Committee’s work was to make recommendations on how to prevent isolation. “One way we’ve done this,” said Bray, “is by looking at the youth who account for isolation incidents.”<sup>249</sup> In 2014, OYA identified that approximately 20% of youth account for 73% of isolation episodes.<sup>250</sup>

FIGURE 38



This information allowed OYA to do two things: (1) focus SDCs' efforts on those youth to reduce isolation, and (2) develop a specific unit-based community and programming to better address this group's needs. When the agency took a closer look at the population involved in most isolation incidents, they found that most were emotionally reactive youth with a history of trauma or mental health issues. The agency created a trauma-informed pilot unit at MaClaren called the University of Life. The unit is housed in one of the facility's new buildings. OYA designed a staff-intensive environment and curriculum focused on skill development and emotional regulation rather than behavioral compliance. For this particular subset of youth, OYA leaders realized that using isolation and force to control behavior wasn't working. "As soon as you meet resistance with resistance, you're going to get escalation—every time," stated Bray. "You just can't do it with these kids."<sup>251</sup>

Asking staff to make the switch to focusing on emotional regulation was not easy. Bray summarized the challenges that OYA staff faced when making the change: "Now we are asking [staff] to think of [themselves] not as corrections officers but as brain developers. This kid's brain wasn't developed normally because of trauma, and his 'How do I calm down?' mental pathway isn't fully formed. We have to develop it. Staff on the [University of Life] will tell you that it's the hardest work they've ever done and also the most rewarding."<sup>252</sup>

For youth entering the University of Life, there was a 77% decrease in incidents and an 84% decrease in isolation.<sup>253</sup>

## **PROGRAMMING AND VOCATIONAL OPPORTUNITIES FOR OTHER YOUTH**

Although many isolation incidents involved emotionally reactive youth, data showed that the second largest group who ended up in isolation were more aggressive or gang-involved youth. For these young people, the prospect of valuable vocational and education programs was a powerful incentive. “We had all these older kids here,” said Berger. “Some of them were very entrenched gang members and there was violence because frankly, they didn’t have anything else to do here. We weren’t making the program about them. We were making it about control.”<sup>254</sup> OYA has since focused on enhancing college and vocational programming. The agency now has more than 50 work and training programs and more than 30 professional certifications or achievements available to youth, including computer science, construction/woodshop, culinary arts, horticulture, HVAC Assistant Worker, welding, barbering license, LBME Electrician’s License, and Automotive Service Excellence Certificates. At MacLaren, 40 youth are working on their bachelor’s degree.<sup>255</sup> “As we build programs to really have them engage in developing their own futures,” Berger continued, “these guys kind of pulled out of that mindset. We saw huge reductions in incidents in all of our units, especially kids that had longer-term Department of Corrections sentences.”<sup>256</sup> Current data shows that less than 20% of isolation incidents are caused by youth committed as adults.

## **SAFETY PROGRAMS**

When less restrictive interventions are not effective, OYA may create a safety program for youth. A safety program is defined as an “intensive, youth-specific, time-limited intervention that modifies a youth’s activities to focus on developing the youth’s emotion regulation and problem-solving skills.” The two types of safety programs include Individual Safety Plans (ISPs) and Community Safety Protocols (CSPs). ISPs are used to create on-unit programming for youth who need more structure and skill-building. Youth who demonstrate a pattern of unsafe behavior that may lead to violence may receive an ISP.<sup>257</sup>

Some youth may also receive a CSP, which may require youth to spend time on the IU or another space outside their housing unit. Staff may use a CSP if a youth demonstrates “continuously violent or aggressive behavior that creates significant safety concerns for the living community milieu or if they have a significant incident that results in serious bodily harm or extreme property damage that jeopardizes youth or staff safety and has significant living community negative impact.”<sup>258</sup> A CSP may result in youth spending a longer period of time in isolation, which presents concerns. However, youth on CSP must spend at least 8 hours of awake time each day out of their room (out of isolation) working with staff and other youth. These hours are tracked electronically and

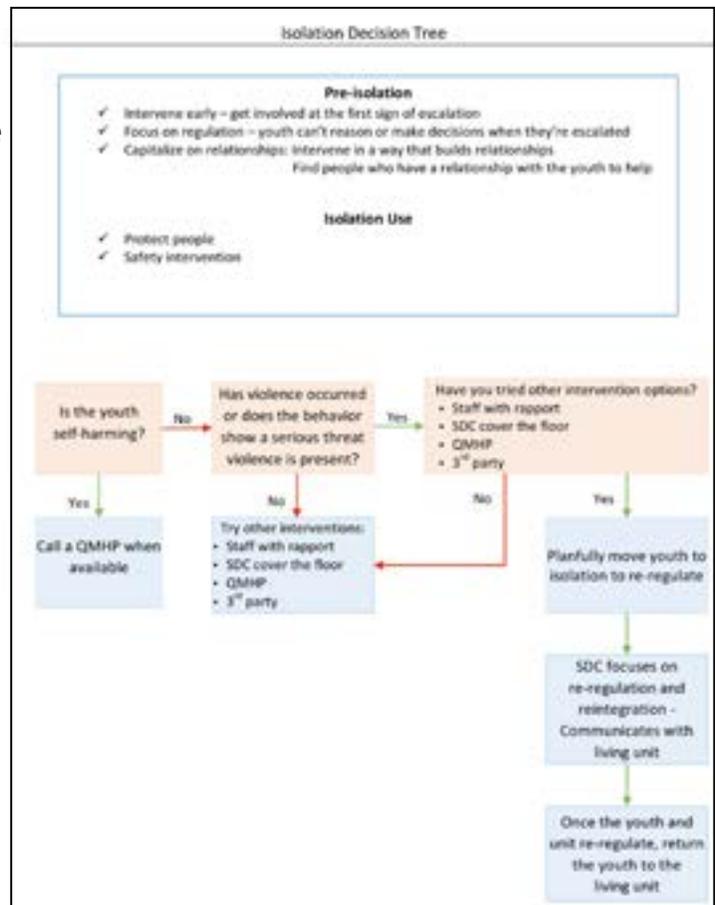
monitored. CSPs are meant to slowly reintegrate youth back into normal programming. CSPs are heavily regulated, and the agency uses them as a last resort. A multi-disciplinary committee must agree to place a youth on a CSP and administrators in the OYA Central Office in Salem, OR, review the CSP weekly. As of June 12, 2019, OYA has three youth on CSPs agency-wide.

## THE NEW POLICY AND BEHAVIOR MATRIX

Although the Internal Isolation Committee’s recommendations in 2015 determined where the agency’s isolation threshold would be, the new policy based on those recommendations did not go into effect until July 2018.<sup>259</sup> The previous threshold permitted isolation if there was danger to institutional order, which allowed staff to use almost unlimited discretion. “You could drive a truck through that,” said O’Leary. “When we changed our policy, we took away that catchall and adopted a much more unambiguous threshold.”<sup>260</sup> [Policy II-B-1.2, Use of Time-out, Room-lock Other, Isolation, and Safety Programs in OYA Facilities](#) permits isolation only: (1) if a youth is in danger of physically harming others; (2) where a serious threat of violence is present; or (3) violence has occurred.

FIGURE 39 ISOLATION DECISION TREE

The policy also contains a prescriptive process and timeline for moving a youth out of isolation. To help clarify the isolation threshold for staff, the agency created an [isolation decision tree](#). If staff use isolation, they must complete an electronic isolation checklist to be reviewed by the superintendent. As seen in Figure 40, the form reminds staff that isolation must be used only to manage a youth’s crisis behavior when the youth is in danger of physically harming others, where a serious threat of violence is present, or violence has occurred. Staff must indicate yes or no to questions about each one of the three threshold questions as well as whether or not the youth was in crisis.



The [updated version of the behavior matrix](#) no longer includes isolation as a refocus option for any type of youth behavior. When the agency implemented the revised policy on isolation in 2018, it also implemented two related policies on behavior management:

- [Incentives and Reinforcing Behavior](#)<sup>261</sup>
- [Youth Refocus Options](#)<sup>262</sup>

## REINTEGRATION FROM ISOLATION

A subgroup of the Internal Isolation Committee was charged with making recommendations for a reintegration protocol to ensure that youth exit isolation as quickly as possible. The subgroup's recommendations were adopted as part of OYA's new policy:

- A reintegration plan for each youth with specific interventions to help youth re-regulate and transition back to the living unit. The [Youth Reintegration Form](#) prompts staff to describe the underlying or triggering event, what intervention or conflict resolution has been done, and what skills youth will use to reintegrate back into a group setting. This must also be completed and submitted electronically via the form shown in Figure 42.
- Interventions provided by living unit staff, QMHPs, and SDCs. Interventions could include peer or staff mediation, emotion management/re-regulation skills and strategies, behavior analyses, and goal setting. Staff must also complete an electronic form detailing
- Evaluation every 15 minutes for behavioral changes, and continuous updates in a "youth engagement readiness" assessment. As shown in Figure 41, staff must indicate whether the youth is re-regulated and ready to exit his or her room and begin reintegration planning. If the staff marks that the youth is not re-regulated, the electronic system requires staff to select one of three reasons why: verbally aggressive, physically agitated, or non-communicative.

FIGURE 40 ELECTRONIC INITIAL ISOLATION PLACEMENT REVIEW CHECKLIST

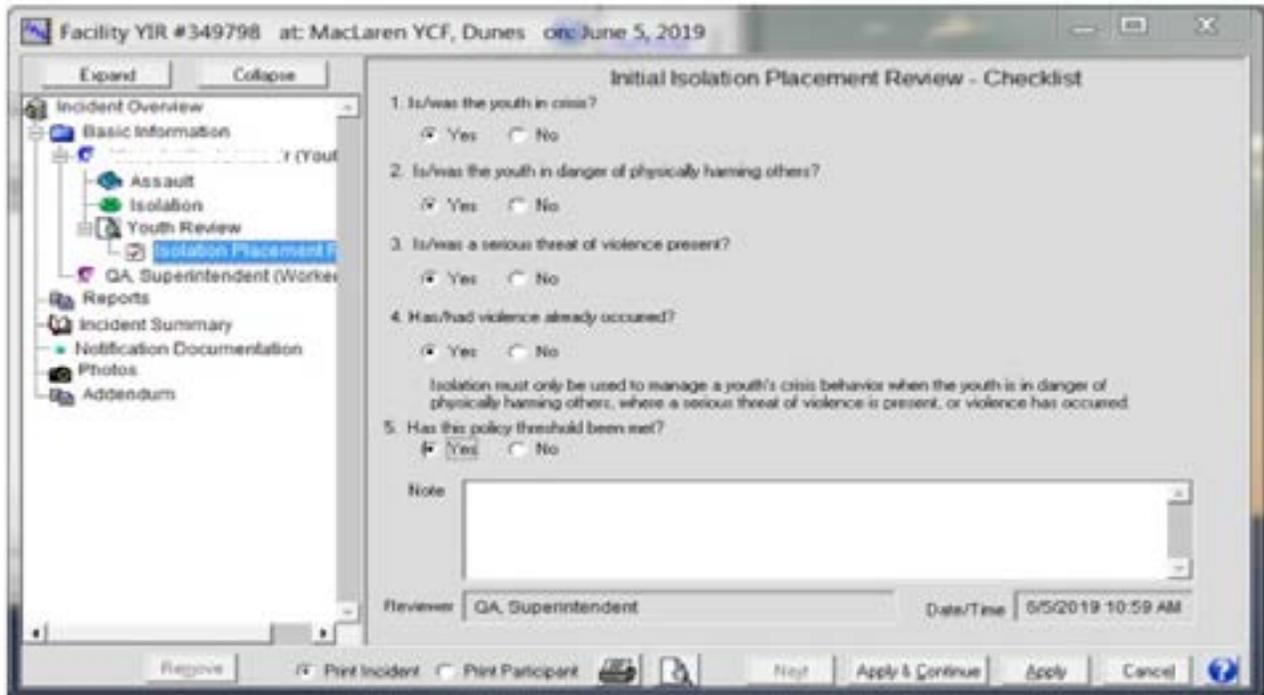
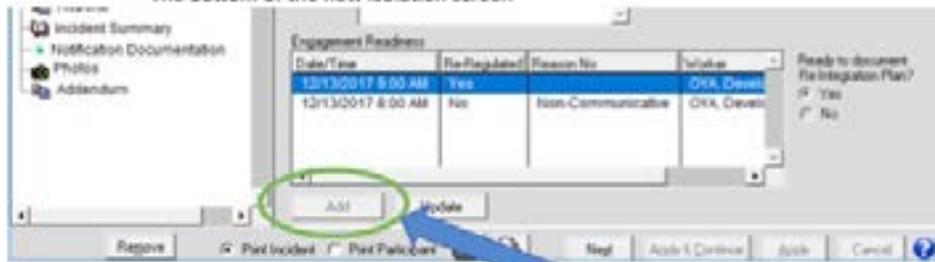


FIGURE 41 ELECTRONIC 15-MINUTE READINESS CHECK FOR YOUTH IN ISOLATION

## Engagement Readiness Checks

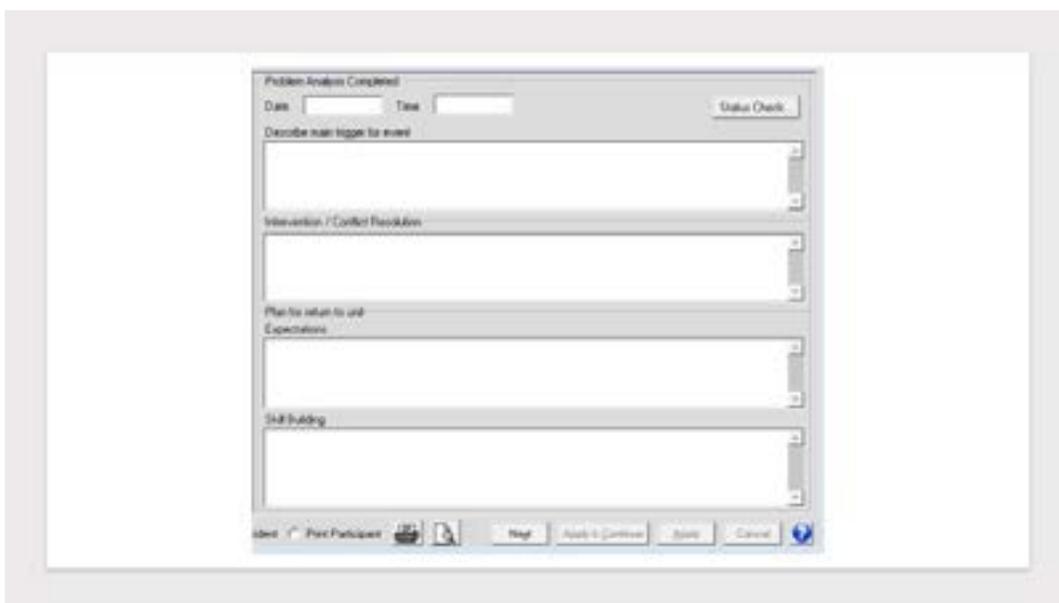
The bottom of the new isolation screen



By clicking Add, the engagement readiness check screen pops up requiring a yes or no. If no, there are 3 choices in the drop down

- Verbally aggressive
- Physically agitated
- Non-communicative

FIGURE 42 ELECTRONIC REINTEGRATION PLAN

The image shows a screenshot of a software interface for creating an electronic reintegration plan. The window title is "Problem Analysis Completed". It features several input fields: "Date" and "Time" at the top left, and a "Status Check" button at the top right. Below these are four large text areas with scrollbars, labeled "Describe main trigger for event", "Intervention / Conflict Resolution", "Plan for return to unit Expectations", and "Skill Building". At the bottom, there is a toolbar with icons for "Print", "Save", "Cancel", and "Help", along with a "Print Participant" checkbox.

## ISOLATION POLICY (2018) KEY COMPONENTS:

- Staff must carefully deliberate and consider the risk and needs of a youth and situation prior to using isolation as an intervention.
- Isolation cannot be used for administrative convenience, as a substitute for staff supervision, or as a substitute for individualized treatment.
- Staff must use other less restrictive interventions when appropriate.
- A staff member not involved in the incident must try to help the youth with regulation and problem solving prior to using an isolation intervention.
- The manager on duty must immediately be notified and approve the isolation.
- A QMHP must conduct a mental health status assessment within one hour of isolation.
- Self-harming behaviors may not result in isolation unless deemed appropriate by a QMHP.<sup>263</sup>
- Staff must monitor the youth in isolation every 15 minutes for well-being and possible return to the general population.
- A documented assessment must be completed every two hours of youth's

engagement and readiness to begin the reintegration process.

- Once a reintegration plan is created, the manager on duty must document and review the plan twice daily to ensure the youth's quick return to unit programming.
- The facility superintendent and facility services assistant director must approve placement in isolation at 72 hours and five days, respectively.

OYA chose not to implement a new isolation policy until alternatives were in place and the institutional culture was ready to support the change. Since implementing the revised isolation policy in July 2018, isolation incidents have continued to go down. The total number of isolation incidents initially increased in September and October of 2018, and data for the following months shows a steady decline, reaching an all-time low in January 2019.



## Guidelines for Contact with Jurisdictions in This Report

This report highlights examples of how state agencies and local juvenile justice facilities have implemented developmentally appropriate and youth-centered responses to successfully reduce room confinement.

The state and local examples in this paper should be understood largely as promising approaches, not perfect examples. We greatly appreciate the time and resources that these jurisdictions dedicated to making this publication possible and ask that readers credit the four jurisdictions when adopting their materials. Also, we ask that readers respect administrators' time and contact the jurisdictions only with serious and clear requests for information. Please follow the jurisdictions' preferred method of contact:

### **COLORADO DIVISION OF YOUTH SERVICES**

Please contact:

Heidi Bauer

Director of Communications and Legislative Affairs

Division of Youth Services, Office of

[Heidi.Bauer@state.co.us](mailto:Heidi.Bauer@state.co.us)

[www.colorado.gov/cdhs/dys](http://www.colorado.gov/cdhs/dys)

### **MASSACHUSETTS DEPARTMENT OF YOUTH SERVICES**

DYS prefers that requests are forwarded the Center for Children's Law and Policy. Please contact:

Jenny Lutz

Attorney, Center for Children's Law and Policy

Campaign Manager, Stop Solitary for Kids

[jlutz@cclp.org](mailto:jlutz@cclp.org)

### **OREGON YOUTH AUTHORITY**

Please contact:

Benjamin Chambers

Communications Director

Oregon Youth Authority

[Benjamin.chambers@oya.state.or.us](mailto:Benjamin.chambers@oya.state.or.us)

### **SHELBY COUNTY JUVENILE DETENTION CENTER**

Please contact:

Debra Fessenden

Legal Advisor

Shelby County Sheriff's Office

[debra.fessenden@shelby-sheriff.org](mailto:debra.fessenden@shelby-sheriff.org)

## Jurisdiction-Based Resources

### COLORADO DEPARTMENT OF YOUTH SERVICES: POLICIES AND RESOURCES

- Colorado Division of Youth Services policies and associated links: <https://www.colorado.gov/pacific/cdhs/policies-3>.
- Colorado Division of Youth Services, *Phase Behavior Matrix*, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Colorado-Phase-Matrix.pdf>.
- *Policy S 14.3 B, Time-out; Seclusion and Program Refusal*, Colorado Division of Youth Services, (effective 11-1-2017, amended 04-01-2018), <https://drive.google.com/file/d/0B32vshZrERKsUTBqZjFMcnNUS28/view>.
- *Youth Services Specialist I Job Description – Mount View Youth Services Center*, Colorado Division of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Job-Description.pdf>.
- Colorado HB16-1328, Use of Restraint and Seclusion on Individuals, 2016 Regular Session, <https://leg.colorado.gov/bills/hb16-1328>.
- Colorado HB17-1329, 2017 Regular Session, Reform Division of Youth Corrections, <https://leg.colorado.gov/bills/hb17-1329>.
- Youth Seclusion & Restraint Working Group, *Semi-Annual Report: March 1, 2018 – August 31, 2018* (Colorado Office of Children, Youth & Families, Division of Youth Services, January 1, 2019). [http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Seclusion-Restraint\\_COMMITTEE\\_Mar18-Aug18\\_Jan2019\\_Report\\_FINAL\\_1-1-19-2.pdf](http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Seclusion-Restraint_COMMITTEE_Mar18-Aug18_Jan2019_Report_FINAL_1-1-19-2.pdf).

### MASSACHUSETTS DEPARTMENT OF YOUTH SERVICES: POLICIES AND RESOURCES

- Massachusetts Department of Youth Services policies: <https://www.mass.gov/lists/dys-policies-regulations>.

- *Policy on Involuntary Room Confinement 03.03.01(a)* (effective 03-13-2013), Massachusetts Department of Youth Services, <https://www.mass.gov/lists/dys-policies-regulations>.
- *Policy on Suicide Assessment in Secure Facilities 02.02.05(c)* (effective 11-01-2005), Massachusetts Department of Youth Services, <https://www.mass.gov/lists/dys-policies-regulations>.
- *Incident response team procedure in support of the management guidelines for responding to traumatic workplace incidents*, Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/IRT-Procedure.pdf>.
- *Policy on Individual Support Plan 02.02.02(c)* (effective 03-15-2013), Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/02.02.02c-Individual-Support-Plan.doc>.
- *DYS Guidelines for Release from Room Confinement*, 11-21-2016, Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Guidelines-for-Release.pdf>.
- Dr. Yvonne Sparling, *DBT as a Behavior Management Approach*, Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/DBT-as-BMA.pdf>.
- *Sample Distress Tolerance Coping Plan*, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Sample-DTP.pdf>.
- *Sample DBT Diary Card*, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Sample-Diary-Card.pdf>.
- *Based Residential Programming Advisory*, 06-11-2014, Massachusetts Department of Youth Services, *Positive* <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Advisory.pdf>.
- *Job Description for Group Worker I*, Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Youth-Services-Group-Worker-I-Central-Region.pdf>.

- Lenny Beatty, Facility Administrator, Video Clip on Positive-Behavior Management, <https://youtu.be/bTj5XLJhgfs>.

## **SHELBY COUNTY JUVENILE DETENTION SERVICES: POLICIES AND RESOURCES**

- Policy Procedure Manual (June 2015), Shelby County Juvenile Detention Services Bureau, <https://www.shelbycountyttn.gov/DocumentCenter/View/11670/Detention-Policy-Procedure-Manual?bidId=>.
- *Policy on Juvenile Detention Services, Standard Operating Procedure 356* (effective 02-08-2017), Shelby County Sheriff's Office, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/MEMPHIS-JDS-SOP-356.pdf>.
- *JDS Positive Behavior Management System, Standard Operating Procedure 357* (effective 02-08-2017), Shelby County Sheriff's Office, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Positive-Behavior-Management-System-SOP.pdf>.
- *JDS Detainee Involuntary Room Confinement, Standard Operating Procedure 713*, (effective 07-06-2016), Shelby County Sheriff's Office, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/JDS-SOP-713-Detainee-Involuntary-Room-Confinement.pdf>.
- *Detention Services, Major Incident Review Form*, Shelby County Sheriff's Office, *Juvenile* <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Major-Incident-Review-Form.pdf>.
- *Detention Policy and Procedure Manual, Policy #VII-2, Detainee Disciplinary Procedures* (reviewed 07-14-2015), Shelby County Juvenile Court, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Shelby-County-Detainee-Disciplinary-Procedures-Policy-VII-2.pdf>.

## **OREGON YOUTH AUTHORITY: POLICIES AND RESOURCES**

- Policies, Rules, and Statutes (webpage), Oregon Youth Authority, [https://www.oregon.gov/oya/Pages/policy\\_rule.aspx](https://www.oregon.gov/oya/Pages/policy_rule.aspx).
- Reports and Publications (webpage), Oregon Youth Authority, [https://www.oregon.gov/oya/Pages/rpts\\_pubs.aspx](https://www.oregon.gov/oya/Pages/rpts_pubs.aspx).

- *OYA Quick Facts*, January 2019, <https://www.oregon.gov/oia/docs/QuickFacts/QuickFacts.pdf>.
- *Positive Human Development at a Glance*, Oregon Youth Authority, January 2019, <https://www.oregon.gov/oia/docs/glance/AtAGlance-PHD.pdf>.
- Juvenile Justice Information System (webpage), Oregon Youth Authority, <https://www.oregon.gov/oia/pages/jjis.aspx>.
- Senate Bill 82, An Act relating to rules regulating conduct of persons in the custody of the Oregon Youth Authority, 2017 Regular Session, <https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB82/Enrolled>.
- Letter from OYA Director Fariborz Pakseresht to Interim Joint Committee on Ways and Means (12-07-2015), [http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/OYA\\_Isolation-Budget-Note-Response.pdf](http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/OYA_Isolation-Budget-Note-Response.pdf).
- *10-Year Strategic Plan for Close Custody Facilities*, 08-26-2014, Oregon Youth Authority, <http://bit.ly/oia10yrplan-doc>.
- *Youth Reintegration Plan* template, Oregon Youth Authority, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/06/OYA-Youth-Re-Integration-Plan.docx>.
- *Letting in the Light Video*, 02-16-2017, Oregon Youth Authority <https://www.youtube.com/watch?v=SdXbzB8YpT8&feature=youtu.be>.
- *Fundamental Practices for Living Units – Moving PHD Into Practice* (2018), Oregon Youth Authority, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/06/FundamentalPractices-2018.pdf>.
- *OYA Recruitment Video*, 11-02-2016, Oregon Youth Authority, <https://www.youtube.com/watch?v=qq7VQ7jgki8&feature=youtu.be>.
- *Isolation Decision Tree* (2018), Oregon Youth Authority, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/06/Isolation-Tree-JPEG.jpg>.
- *Policy II-B-1.2, Use of Time-out, Room-lock Other, Isolation, and Safety Programs in OYA Facilities* (effective 07-16-2018) Oregon Youth Authority, <https://www.oregon.gov/oia/policies/II-B-1.2.pdf>.

- *Policy II-B-2.0, Behavior Management – Behavior Incentives and Reinforcing Behavior* (effective 12-21-2018), Oregon Youth Authority, <https://www.oregon.gov/oya/policies/II-B-2.0.pdf>.
- *Policy II-B-2.1 – Behavior Management – Youth Refocus Options* (effective 07-16-2018), Oregon Youth Authority, <https://www.oregon.gov/oya/policies/II-B-2.1.pdf>.
- *Policy II-B-2.1 – Behavior Management – Youth Refocus Options Chart* (effective 07-16-2018), Oregon Youth Authority, <https://www.oregon.gov/oya/policies/II-B-2.1.pdf>.

## QUOTATIONS

- *"We collect data on everything. We use data every day." Jamie Nuss, Director, Gilliam Youth Services Center*
- *"It's not just about room confinement. It's about staff being assaulted, fights among the kids, any kind of property damage that you track, and room confinement and restraints." Peter Forbes, Commissioner, Massachusetts DYS*
- *"[P]utting kids in their rooms makes them less safe." There is an impulsivity that makes kids act in ways that they wouldn't outside of room confinement." Peter Forbes, Commissioner, Massachusetts DYS*
- *"It require[d] people getting in their cars and driving out to the secure programs and meeting with people at shift change in the facility to talk about the purpose and the why and the implementation plan." Peter Forbes, Commissioner, Massachusetts DYS*
- *"Policy development is a great place to get people on board. Getting a policy written is really important, but the process is as important as the substance." Peter Forbes, Commissioner, Massachusetts DYS*
- *"The biggest mistake we made was we said 'no room confinement' rather than a 'reduction' [in room confinement]. When we said 'no' staff felt like there was never a circumstance that it could be useful, even if the youth was extremely violent. In reality, it's still a tool, but it needs to be used under specific circumstances. Messaging is so important." Daniel O'Sullivan, Metropolitan Regional Director, Massachusetts DYS*
- *"Staff think, if I cannot lock this kid in his room for 12 hours, or the weekend – I am unsafe. We are trying to say, you are safer if the kid has a relationship with you." Ruth Rovezzi, Deputy Commissioner, Massachusetts DYS*
- *Change is difficult for everyone, but all everyone ever wants to know about change is 'how is it going to affect me and how to do my job, and how to keep me safe'. The benefit has to be personalized. It should have said 'here's the benefit to reducing room confinement because you are building positive relationships with the kids.' If we can get kids out [of room confinement] faster into the population, it increases the safety in the moment and long term. Lynn Allen, Facility Administrator, Massachusetts DYS*
- *"How they get out [of room confinement] is just as important as how they get in." Peter Forbes, Commissioner, Massachusetts DYS*

- *"We don't just close the door and leave them in there to calm down on their own. That's not helpful if we want them to regain control." Lynn Allen, Facility Administrator, Massachusetts DYS*
- *"Initially staff thought that there was no room confinement and we were going to put the kids in the population no matter what – and that's not what we do." Lenny Beatty, Facility Administrator, Massachusetts DYS*
- *"It's really important to have youth see that a skill is something that adults use and it's not just a clinical tool." Yvonne Sparling, Director of Clinical Services, Massachusetts DYS*
- *"How do you address staff concerns but not concede that we are going back to model with room confinement. "We need to acknowledge it. We need to have a response to it. Then locally, we have to look at the underlying causes." Ruth Rovezzi, Deputy Commissioner, Massachusetts DYS*
- *"Goals for repairs are totally the opposite from [goals for] isolation." Yvonne Sparling, Director of Clinical Services, Massachusetts DYS*
- *"They need to understand how their actions affected other people and how they will act differently in the future, so there's a lot of work [in repairs]." Yvonne Sparling, Director of Clinical Services, Massachusetts DYS*
- *"We don't look to punish our kids while they are here. The fact that they are here losing their freedom, we feel is hard enough. In order to have our kids buy into our system and follow our rules we offer them incentives." Elisa Samuels, Program Director, Massachusetts DYS*
- *"We recognized when we revamped our room confinement practices in 2007 this challenge in either assisting youth preventing or minimizing the recurrence of another isolation incident." Robert Turillo, Assistant Commissioner of Program Services, Massachusetts DYS*
- *"If the clinicians are just writing up an ISP and telling people what to do, it will fail. If you get everyone's input, there is more follow-through and buy in. All of this stuff leads to less room confinement." Daniel O'Sullivan, Metropolitan Regional Director, Massachusetts DYS*
- *"The really difficult kid is one who punches a staff person. Staff are going to confront you with that and you have to have a response. We have detailed protocol in the event that it happens." Peter Forbes, Commissioner, Massachusetts DYS*
- *"We've also done a lot of training with our staff on adolescent brain development. . . That has helped our staff step back a little bit and think - this isn't necessarily personal, this is the way*

*this young person reacts.” Ruth Rovezzi, Deputy Commissioner, Massachusetts DYS*

- *“We spend a lot of time [in training] on how placing the youth in room confinement really increases the likelihood that they may make a serious suicide attempt. We really stress the importance of doing everything you can to keep a kid out of room confinement.” Yvonne Sparling, Director of Clinical Services, Massachusetts DYS*
- *“If you have a relationship with a young person, you can engage them in making different choices before it comes to the need to put someone in their room.” Ruth Rovezzi, Deputy Commissioner of Massachusetts DYS*
- *“It’s safer now from when I started seventeen years ago. There is much more training for us. Less restraints are happening because staff are communicating between themselves and talking to the kids, building the relationships with the kids to make them understand that we are not here just to put hands on them. We are here to talk to them, to help them make a better change in their life.” Rudy Kolaco, Shift Administrator, Massachusetts DYS*
- *“I believe that those conversations build trust... those conversations that we have with them equal safety and security.” Lenny Beatty, Facility Administrator, Massachusetts DYS*
- *“Our work as a juvenile justice agency is preparing young people to return to their communities as citizens, as contributing members of their community. For that they need skills. They need to be able to manage the demands of life. They need to have an education that prepares them for employment. They need to have positive relationships with others. They are not going to get any of that locked in a room somewhere.” Ruth Rovezzi, Deputy Commissioner, Massachusetts DYS*
- *“It hurt me so much to see children in rooms like that. Room confinement causes mental illness. You’re teaching violence when you use force.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*
- *“DOJ was a great learning experience.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*
- *“I want all kids out all day.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*
- *“To change something, you need to replace it with something better.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*
- *“When we cut their hair, their whole demeanor changed. Children saw we cared about how they looked, so they cared about how they looked.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*

- *"This required a real adjustment from their previous orientation, but staff eventually saw the improvements firsthand in their new roles as teachers, coaches, and mentors: "It worked." Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff's Office*
- *"A lot of bad outcomes were happening for the kids. Kids were ending up in the Behavior Management Unit for a long time. Luckily, we had no suicides during that time. A lot of bad outcomes were happening for the staff. The staff burn out was super high. The staff morale was super low. We were putting staff in an untenable situation. We realized that we had a big issue. And it was cyclical and deeply engrained in the culture." Joe O'Leary, Director, OYA*
- *"The research about the impact of isolation on kids is there. If we didn't take it head on and start to change our own practices, then other people were going to do it for us." Erin Fuimaono, Assistant Director of Development Services, OYA*
- *"Where people got stuck is [the Behavior Matrix] still had isolation listed as 'up to 5 days.' Just because the Matrix said up to 5 days doesn't mean it needed to be 5 days, or it's the right thing to do." Alicia Buettner, Superintendent, OYA*
- *"The culture we have in the organization predates us by many years. In attempting to shift the culture some staff may see us as just another flavor of the day, week, month.... Those who are resistant to change may be fairly confident that they can outlast us and the new initiative. In most cases they are correct." Fariborz Pakseresht, Former Director, OYA*
- *"You can't go away in the lab and come up with a great policy. You have to go out there and get the folks that are doing the work, know the kids, know the operations, know the clinical piece, know youth development, and get them around the table to be part of this effort. You can't go from the top down." Clint McClellan, Assistant Director, OYA*
- *"We acknowledged that there was a time when [isolation] was thought of as the appropriate thing to do, but we are shifting mindsets and have new research and an understanding of skill development in behavior change. None of us would be using computers from 2000. The same is true in how we interact with young people." Erin Fuimaono, Assistant Director of Development Services, OYA*
- *"We clarified that OYA was not eliminating the use of isolation, but we were talking about how to use it differently. We had to balance our message about what is effective for kids with the acknowledgement that our staff are in harm's ways sometimes. [Isolation] would still be an option as a safety intervention, but not as a punishment. Because that doesn't work." Erin Fuimaono, Assistant Director of Development Services, OYA*
- *"Messaging it this way was great because it didn't freak everyone out, but there was still a lot of inconsistency in how staff and facilities were using isolation." Clint McClellan, Assistant Director, OYA*

- *“The key about culture change is that key messages have to go out over and over again. You will still have people say that what they heard was that we’re taking away their tools. You just have to get the message out as many times and ways as possible.” Clint McClellan, Assistant Director, OYA*
- *“What we found were some champions. Those who understood the facility’s vision and goals to reduce isolation. They were able to carry those words forward because other staff respected them.” Alicia Buettner, Superintendent, OYA*
- *“It’s not enough to just to tell our employees that they will have to do things differently. We must take the time to put a compelling case together that makes sense to staff. Is the change going to improve safety? Is it going to create a more pleasant working environment? Is it going to create better futures for youth?” Fariborz Pakseresht, Former Director, OYA*
- *“Youth on youth violence was steady but youth on staff violence went up. That got a lot of people’s attention.” Clint McClellan, Assistant Director, OYA*
- *“What is the human cost of continuing to do business as usual? For example, the trauma that could be inflicted on youth, potentially increasing the numbers of future victims and compromising the safety of the community. At the same time there is the fiscal impact and a monetary cost of continuing the current practice. For example, longer stays in youth correctional facilities, potential transfer to adult prison, and the unquantifiable cost of future crime and victims.” Fariborz Pakseresht, Former Director, OYA*
- *“When I was out working in community programs and we would get youth who experienced isolation, they would struggle when they were in the community. In the community, our main tool is to work with them, talk to them – we don’t use isolation. But their go-to was to run away from the community programs. It took a lot of time to figure out how we could work with them in the community. Shifting the approach in a facility away from punitive isolation and teaching how to regulate and problem solve before they ever leave gives them a better chance at successful reentry.” Jamie McKay, Program Director, OYA*
- *“When you rely on a door between you and a kid as your primary source of safety, you create an us vs. them environment. Then when you have to open that door for something, now it’s you vs. them. That dynamic doesn’t go away automatically, and bad things can happen.” Heber Bray, Operations Policy Analyst, OYA*
- *“We can rewrite policies and procedures, develop the best manuals and practice models, issues directive and decrees, but if [we] are not able to shift those shared values and beliefs and understandings that define the present culture, very little will change.” Fariborz Pakseresht, Former Director, OYA*
- *“[We] started out thinking that we needed more staff, we needed in-between spaces where kids can*

*go when they need a break but not isolation. We thought about creating rooms with calming furniture and paint and music. Then we thought, 'well wait a minute - we can throw staff at this issue, we can create these spaces, but if staff aren't thinking differently about how to intervene with these behaviors and address them, we are just going to use those things in the same way.' Erin Fuimaono, Assistant Director of Development Services, OYA*

- *"You can't just throw out a policy and hope that it sticks." Clint McClellan, Assistant Director, OYA*
- *"Leadership plays a critical role in organizational change. We must understand the impetus for the change and explain it to others. Why are [we] moving in this direction and what is the price that [we] might pay for inaction? We always want to be ahead of the wave of change rather than being overtaken by it." Fariborz Pakseresht, Former Director, OYA*
- *"We have a saying: 'Executive team leaders are here to support and develop our managers, who support and develop our staff, who support and develop our youth.' You can't have one of those out of place. They all have to be in alignment." Clint McClellan, Assistant Director, OYA*
- *"We have to be the message – not the messengers. There's a huge difference. People look for weakness in the armor. They think if you are not really bought in [to a practice or policy change], they don't have to do it." Daniel Berger, Superintendent, OYA*
- *"We must model the change that we want to implement. To change behavior and culture consistently, an organization, we as top leaders as well as our executive team, our managers at every level of the organization, must walk the talk. How we treat staff as leaders and how effectively we listen will translate directly and indirectly to how staff exhibit the same behavior with youth." Fariborz Pakseresht, Former Director, OYA*
- *"We tell staff, 'don't say, 'central office says we have to do this thing.' If you are a leader here, you should be out there saying, 'Here's what we are doing. Here's why we are doing it. And here's how you are a part of this.'" Daniel Berger, Superintendent, OYA*
- *"Initially we thought OYA would adopt the PYD model. We sent some of our staff to PYD trainings. They came back and told us that they could buy into the PYD approach of treating youth as resources, but they wanted to be viewed as resources as well. Staff said, 'If OYA can get to a place where I feel as though I'm being viewed as a resource, then I can do that with the kids [who] we work with every day.'" Joe O'Leary, Director, OYA*
- *Accountability is "[giving] them the skills to be able to learn from their mistakes and hold themselves accountable. Because that's really the only way they're going to create safety in the community . . . Isolation is not a place where you can develop skills at all. There are plenty of things we have to develop to hold kids accountable in terms of consequences. Isolation just isn't one of them." Clint McClellan, Assistant Director, OYA*

- *"It has taken time to pivot. Just because one kid is taking advantage or doing something doesn't mean they all will. What we need to put into perspective for staff is that we have not gone through what most of these kids have experienced. So when [staff] think that punishing a little bit harder is the key to success, our culture has pushed back. What we need is empathy and have high expectations. In essence, treating these kids as your own children goes a long, long way." Alicia Buettner, Superintendent, OYA*
- *"Initially, we were a bit skeptical about doing workgroups and them inviting [the external Advisory Group members] in and them tearing it apart, but that didn't happen." Clint McClellan, Assistant Director, OYA*
- *"[W]e wanted these people close to us during the process, but the beauty of the execution was how they embraced the partnership and the insights we got from them." Joe O'Leary, Director, OYA*
- *"Changes around isolation would not have worked if we had not been given budget flexibility, if we were not given additional funding through creative means to modify some of our physical environments. So having engagement with political leadership was critical." Joe O'Leary, Director, OYA*
- *"It gave us the opportunity to go to our staff and say, '[L]ook, this is coming. We can choose to get ahead of this, or we can let something happen to us that may or may not be administrable. What do you want to do?' That helped to create a mandate to drive planning and action to reduce isolation. In the next legislative session, we offered our own bill." Joe O'Leary, Director, OYA*
- *"The request for a budget note and our subsequent recommendations were literally a nail banged into the wall on which we could hang some funding requests." Joe O'Leary, Director, OYA*
- *"When staff asked us what to do about difficult youth, we said 'you're going to keep them on your unit. And we're going to give you these extra staff to help that kid 'skill up.'" Heber Bray, Operations Policy Analyst, OYA*
- *We had to commit to being proactive instead of reactive. Making that shift is really hard. It costs money up front to save money on the back end, and that's not the way our society is wired." Heber Bray, Operations Policy Analyst, OYA*
- *"We teach them how to problem-solve, stabilize themselves, take 'no' for an answer without getting into conflict. We reduce isolation by teaching kids how to act in the system and how to ask for resources." Corey Ramsay, Skill Development Coordinator, OYA*
- *Youth on the IU "spend most of their time in what's called Core, which is like a dayroom. They go out, work with SDCs, and have meals together out in the Core. As long as there isn't a serious conflict between kids, they are out in Core together." Daniel Berger, Superintendent, OYA*

- *"Once [youth] are regulated – they are no longer hitting the walls, threatening other people, when they are talking reasonably – which may take an hour or two, they may not be able to be safely reintegrated back into the living unit immediately. SDCs work with the kids at this moment to move them along." Ken Jerin, Superintendent, OYA*
- *We completely rebuilt the program in the light of PHD," he says. "We didn't want kids to just go down there and sit. If kids had to go to isolation and had to go to IU, they were engaged in skill development when they were there. That was the basis of rebuilding this program." Daniel Berger, Superintendent, OYA*
- *"If it's more institutionalized, it looks more like prison, like a dungeon, then obviously we're not going to change. We're just going to be what we're looked at upon as, like criminals, or animals." Youth at MacLaren Youth Correctional Facility*
- *"We don't want corrections officers. We want folks who can work with kids and can learn security protocols as well." Daniel Berger, Superintendent, OYA*
- *"We send out a hiring letter to potential applicants about the work we do. In essence – working with girls is challenging and rewarding at the same time. There will be accountability when youth make mistakes, which is inevitable with teenagers. What we want to tell [applicants] is that we expect kids to be kids." Alicia Buettner, Superintendent, OYA*
- *"Kids were still amped up. There was no cooling down time. They had to shift from outside rules to inside rules with the snap of a finger. You'd think that 15, 16, 17-year-olds could shift, but shifting from one set of rules to another is actually an advanced cognitive skill. We would have fights in the line and fights right when we got inside. We'd have kids blowing up because they wanted to get a drink of water and it wasn't their turn yet. We'd have kids walk one slower deep-breathing lap before they came inside. While they walked the lap, staff reminded them of the inside rules in a nice calm voice by saying, 'Hey, remember guys, we're going inside. We're going to take our shoes off, we're going to line up, and table by table, we're going to go to the drinking fountain.'" Heber Bray, Operations Policy Analyst, OYA*
- *"One point about following numbers is that we have to focus on the trendlines and not react extremely to any one point in time." Joe O'Leary, Director, OYA*
- *"In Oregon we have big facilities. We have 13 living units in one facility. So getting one big conglomerate of data doesn't tell us a lot. We have to break those [data] down to the individual living units, shifts, or other factors." Clint McClellan, Assistant Director, OYA*
- *"As soon as you meet resistance with resistance, you're going to get escalation - every time. You just can't do it with these kids." Heber Bray, Operations Policy Analyst, OYA*

- *“Now we are asking [staff] to think of [themselves] not as corrections officers but as brain developers. This kid’s brain wasn’t developed normally because of trauma, and his ‘how do I calm down’ mental pathway isn’t fully formed. We have to develop it. Staff on the [University of Life] will tell you that it’s the hardest work they’ve ever done and also the most rewarding.” Heber Bray, Operations Policy Analyst, OYA*
- *“We had all these older kids here. Some of them were very entrenched gang members and there was violence because frankly, they didn’t have anything else to do here. We weren’t making the program about them. We were making it about control.” Daniel Berger, Superintendent, OYA*
- *“As we build programs to really have them engage in developing their own futures, these guys kind of pulled out of that mindset. We saw huge reductions in incidents in all of our units, especially kids that had longer term Department of Corrections sentences.” Daniel Berger, Superintendent, OYA*
- *“When we changed our policy, we took away that catchall and adopted a much more unambiguous threshold.” Joe O’Leary, Director, OYA*
- *“After implementing the University of Life, there was a 77% decrease in incidents and an 84% decrease in isolation.” Fariborz Pakseresht, Former Director, OYA*

- 1 Colorado Child Safety Coalition, *Bound and Broken: How DYC's Culture of Violence is Hurting Colorado's Kids and What to Do About it* (Colorado: Colorado Child Safety Coalition, 2017), <http://static.aclu-co.org/wp-content/uploads/2017/03/Bound-and-Broken-report-Feb17-complete.pdf>.
- 2 Chester R. Chapman, Mark Silverstein, and Kim Dvorchak, *Letter to CDHS Director Reggie Bicha*, June 18, 2014, <http://static.aclu-co.org/wp-content/uploads/2017/02/2014-06-18-Letter-to-DHS-Executive-Director-Bicha.pdf>, cited in *Bound and Broken*, 8.
- 3 Megan Schrader, Debbie Kelley, and Maria St. Louis-Sanchez, "Youth Lockups: Trouble behind bars, Solitary confinement, History lesson, Fixing the problem," *The Gazette* (Colorado Springs, CO), October 4, 2015, [https://gazette.com/news/youth-lockups-trouble-behind-bars-solitary-confinement-history-lesson-fixing/article\\_faf8bfd8-d24b-5590-84d6-582f4a84884f.html](https://gazette.com/news/youth-lockups-trouble-behind-bars-solitary-confinement-history-lesson-fixing/article_faf8bfd8-d24b-5590-84d6-582f4a84884f.html).
- 4 Colorado Department of Human Services, Division of Youth Services, Policy S 14.3 B, *Time-out; Seclusion and Program Refusal* (Denver, CO: Effective October 15, 2015, amended November 1, 2017), <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Colorado-2015-Policy-S-14.3B-.pdf>.
- 5 Colorado Revised Statutes, Section 26-20-102(3) (2016).
- 6 Colorado Office of the State Auditor, Department of Human Services, Division of Youth Corrections, *Performance Audit* (September 2016), 13. [https://leg.colorado.gov/sites/default/files/documents/audits/1557p\\_division\\_of\\_youth\\_corrections\\_performance\\_audit\\_september\\_2016.pdf](https://leg.colorado.gov/sites/default/files/documents/audits/1557p_division_of_youth_corrections_performance_audit_september_2016.pdf).
- 7 Colorado HB16-1328, *Use of Restraint and Seclusion on Individuals*, 2016 Regular Session, <https://leg.colorado.gov/bills/>
- 8 *Ibid.*
- 9 "Youth Seclusion Working Group," Colorado Department of Human Services, accessed May 9, 2019, <https://www.colorado.gov/pacific/cdhs-boards-committees-collaboration/youth-seclusion-working-group>.
- 10 "Juvenile Detention Facility Assessment: Guidelines for Conducting a Facility Assessment (2014 Update)," *Juvenile Detention Alternatives Initiative: A Project of the Annie E. Casey Foundation* (2014), at 68. <http://www.cclp.org/wp-content/uploads/2016/06/JDAI-Detention-Facility-Assessment-Standards.pdf>; U.S. Department of Justice, *National Standards to Prevent, Detect, and Respond to Prison Rape*, 28 CFR § 115.313(c), (May 16, 2012), [http://www.ojp.usdoj.gov/programs/pdfs/prea\\_final\\_rule.pdf](http://www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf).
- 11 Debbie Kelley, "'Culture of violence' in Colorado Youth Corrections includes physical restraints, solitary," *Colorado Springs Gazette* (Denver, CO), March 2, 2017, <https://kdvr.com/2017/03/02/new-report-puts-colorado-division-of-youth-corrections-under-fire/>.
- 12 See note 31.
- 13 Reform Division Of Youth Corrections, Colorado HB17-1329, 2017 Regular Session, <https://leg.colorado.gov/bills/hb17-1329>.
- 14 Missouri Youth Services Institute, accessed May 9, 2019, <http://www.mysiconsulting.org/>.
- 15 Colorado Department of Human Services, Division of Youth Services, Policy S 14.3 B, *Time-out; Seclusion and Program Refusal* (Denver, CO: Effective November 1, 2017, amended April 1, 2018), <https://drive.google.com/file/d/0B32vshZrERksUTBqZjFMcnNUS28/view>.
- 16 Jennifer Brown, "Assaults Down by Nearly Half as Reforms Take Hold in Colorado Youth Lock-up Centers," *Denver Post*, February 26, 2018, <https://www.denverpost.com/2018/02/26/colorado-youth-lock-up-centers/>.
- 17 "Youth Services Specialist I – Mount View Youth Services Center," State of Colorado, accessed May 6, 2019. <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Job-Description.pdf>.
- 18 *Ibid.*
- 19 Mark Soler and Anders Jacobson, "More States Need to Limit Solitary Confinement, Which Doesn't Work," *Juvenile Justice Information Exchange*, September 12, 2018, <https://jjie.org/2018/09/12/more-states-need-to-limit-solitary-confinement-which-doesnt-work/>.
- 20 Reform Division of Youth Corrections, Colorado HB17-1329.
- 21 *Juvenile Detention Facility Assessment: Guidelines for Conducting a Facility Assessment*.
- 22 Passage of the General Education Development (GED) test is considered by some, but not all, as equivalent to a high school diploma.
- 23 Nevertheless, DYS seeks applicants with a bachelor's degree for direct care staff.
- 24 Colorado Child Safety Coalition, *Bound and Broken*, note 1.
- 25 Drew Engelbart, "Report puts Colorado Division of Youth Corrections under fire," *Fox 31 News* (Denver, CO), March 2, 2017, <https://kdvr.com/2017/03/02/new-report-puts-colorado-Division-of-youth-corrections-under-fire/>.
- 26 Debbie Kelley, "'Culture of violence.'"
- 27 DYS's Mission statement is more traditional: To protect, restore, and improve public safety utilizing a continuum of care that provides effective supervision, promotes accountability to victims and communities, and helps youth lead constructive lives through positive youth development. See, *Ibid.*, <https://www.colorado.gov/pacific/cdhs/about-youth-services>.
- 28 Sandra L. Bloom, M.D., "The Sanctuary Model," *The Sanctuary Model*, accessed May 2, 2019, <http://sanctuaryweb.com/>.

- 29 Jennifer Brown, "Fewer youths, more staff mean less violence at once-embattled youth detention center in Colorado Springs," Denver Post, April 1, 2017, <https://www.denverpost.com/2017/04/17/spring-creek-detention-center-less-violence/>.
- 30 Heidi Bauer, email message to Mark Soler, May 13, 2019.
- 31 Verbal Judo is a widely-used method of verbal de-escalation, with more than one million graduates of Verbal Judo courses worldwide; See, "Verbal Judo" Verbal Judo Institute, Inc., accessed May 2, 2019, <http://verbaljudo.com/>.
- 32 Motivational Interviewing is a counseling method that helps people resolve ambivalent feelings and insecurities in order to find the motivation they need to change behavior. It is also useful as a non-confrontational, empathetic strategy to help hostile individuals move through the emotional stages of change; See, "Motivational Interviewing," Psychology Today, accessed May 2, 2019, <https://www.psychologytoday.com/us/therapy-types/motivational-interviewing>.
- 33 Lee Underwood and Aryssa Washington, "Mental Illness and Juvenile Offenders," International Journal of Environmental Research in Public Health 13, no. 2 (2016): 228, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772248/>.
- 34 Jamie Nuss, interview with Mark Soler, December 19, 2018.
- 35 Youth Seclusion & Restraint Working Group, Semi-Annual Report: March 1, 2018 – August 31, 2018 (Colorado Office of Children, Youth & Families, Division of Youth Services, January 1, 2019). [http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Seclusion-Restraint\\_COMMITTEE\\_Mar18-Aug18\\_Jan2019\\_Report\\_FINAL\\_1-1-19-2.pdf](http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Seclusion-Restraint_COMMITTEE_Mar18-Aug18_Jan2019_Report_FINAL_1-1-19-2.pdf).
- 36 Ibid.
- 37 Corey Dade, "Youth dies in DYS custody," The Boston Globe, December 14, 2003, [http://archive.boston.com/news/local/massachusetts/articles/2003/12/14/youth\\_dies\\_in\\_dys\\_custody/](http://archive.boston.com/news/local/massachusetts/articles/2003/12/14/youth_dies_in_dys_custody/).
- 38 Peter Forbes, "Stop Solitary for Kids Launch Event," presentation, National Press Club, Washington, DC, April 19, 2017, <https://www.youtube.com/watch?v=173CfXLeMQs&feature=youtu.be>.
- 39 "The circumstances that lead to room confinement at the time of death included failure to follow program rules/inappropriate behavior (47.3%), threat/actual physical abuse of staff or peers (42.1%), and other (10.6%)." Lindsay M. Hayes, Juvenile Suicides in Confinement: A National Survey (United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention, February 2004), x-xi, <https://www.ncjrs.gov/pdffiles1/ojjdp/grants/206354.pdf>.
- 40 Dade, note 40. This figure includes youth in non-secure and community-based DYS programs.
- 41 Peter Forbes, Reducing isolation in youth facilities: strategies and lessons learned from the field webinar, Council of Juvenile Correctional Administrators, February 13, 2018, <https://www.youtube.com/watch?v=SpMTYRtXE4A&feature=youtu.be>.
- 42 Ruth Rovezzi, email, May 16, 2019.
- 43 Massachusetts Department of Youth Services, The DYS Safety Task Force Report: Recommendations for Promoting Youth and Staff Safety in DYS Residential Programs, February 2018, 2, [https://www.mass.gov/files/documents/2019/02/26/SafetyTask%20Force%20Report\\_FINAL\\_2.9.18.pdf](https://www.mass.gov/files/documents/2019/02/26/SafetyTask%20Force%20Report_FINAL_2.9.18.pdf).
- 44 Massachusetts Department of Youth Services, 2017-2018 Internal Control Plan, 6, May 11, 2018, <https://www.mass.gov/files/documents/2018/05/14/DYS%202017-2018%20ICP%20FINAL-CTR-5.11.18.pdf>.
- 45 DYS Safety Task Force Recommendations, note 46, at 8.
- 46 DYS revised the policy in 2013. Massachusetts Department of Youth Services, Involuntary Room Confinement 03.03.01(a) (effective 03-13-13), <https://www.mass.gov/lists/dys-policies-regulations>.
- 47 "Staff," National Center on Institutions and Alternatives, accessed May 14, 2019, <http://dev.ncianet.org/criminal-justice-services/suicide-prevention-in-custody/staff/>.
- 48 See Hayes, note 42.
- 49 Massachusetts Department of Youth Services, Suicide Assessment in Secure Facilities 02.02.05(c) (effective 11-01-05), <https://www.mass.gov/lists/dys-policies-regulations>.
- 50 Peter Forbes, February 13, 2018.
- 51 Ibid.
- 52 Daniel O'Sullivan, interview with Jennifer Lutz, July 9, 2018.
- 53 Massachusetts Department of Youth Services, Involuntary Room Confinement 03.03.01(a), Section G (effective 03-13-13), <https://www.mass.gov/lists/dys-policies-regulations>.

- 54 Peter Forbes, February 13, 2018.
- 55 Lynn Allen, interview with Jennifer Lutz, July 9, 2018.
- 56 Lenny Beatty, interview with Pretrial Justice Institute, October 31, 2017.
- 57 Massachusetts Department of Youth Services, DYS Guidelines for Release from Room Confinement, November 21, 2016, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Guidelines-for-Release.pdf>.
- 58 Peter Forbes, February 13, 2018.
- 59 Council of Juvenile Correctional Administrators, Toolkit: Reducing the Use of Isolation, March 2015, 20, <http://cjca.net/wp-content/uploads/2018/02/CJCA-Toolkit-Reducing-the-Use-of-Isolation-1.pdf>.
- 60 Marsha Linehan, *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (New York, NY: The Guilford Press, 1993); Marsha Linehan, *Skills Training Manual for Treating Borderline Personality Disorder* (New York, NY: The Guilford Press, 1993).
- 61 California Department of Corrections and Rehabilitation, *Dialectical Behavior Therapy: Evidence for Implementation in Correctional Settings*, March 2011, 1-2, [https://www.cdcr.ca.gov/Juvenile\\_Justice/docs/DBT\\_Evidence\\_Draft\\_04\\_06\\_2011.pdf](https://www.cdcr.ca.gov/Juvenile_Justice/docs/DBT_Evidence_Draft_04_06_2011.pdf).
- 62 Massachusetts Department of Youth Services, *DBT as a Behavior Management Approach*, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/DBT-as-BMA.pdf>.
- 63 Ibid.
- 64 "How DBT Helps," The Linehan Institute, Accessed May 1, 2019, <https://behavioraltech.org/research/how-dbt-helps/>.
- 65 Ibid.
- 66 Meghan McDermott, interview with Jennifer Lutz, July 9, 2018.
- 67 Yvonne Sparling, telephone conversation, April 16, 2019.
- 68 Massachusetts Department of Youth Services, *DBT as a Behavior Management Approach*, 4, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/DBT-as-BMA.pdf>.
- 69 This acronym was developed by Dr. Yvonne Sparling, Director of Clinical Services, as an approach to help staff remember key steps to approaching youth in developmentally appropriate ways.
- 70 Massachusetts Department of Youth Services, *DBT as a Behavior Management Approach*, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/DBT-as-BMA.pdf>.
- 71 Massachusetts Department of Youth Services, *Positive Based Residential Programming Advisory*, June 11, 2014, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Advisory.pdf>.
- 72 "Historically, the field of juvenile justice has primarily viewed youths as either a victim or villain. Positive youth development uses a primary lens of seeing youths as resources to be developed." Council of Juvenile Correctional Administrators, *Toolkit: Positive Youth Development*, April 2017, 10, <http://cjca.net/wp-content/uploads/2018/11/CJCA-Toolkit-final-doc-Aug.-9-2017.pdf>.
- 73 Yvonne Sparling, interview with Jennifer Lutz, April 25, 2019.
- 74 *Effective Responses to Offender Behavior: Lessons Learned for Probation and Parole Supervision* (American Probation and Parole Association, National Center for State Courts, and The Pew Charitable Trusts, 2012), <https://www.appa-net.org/eWeb/docs/APPA/pubs/EROBLLPPS-Report.pdf>; H.S. Muscott, E.L. Mann, and M.R. LeBrun, "Positive Behavioral Interventions and Supports in New Hampshire: Effects of Large-Scale Implementation of Schoolwide Positive Behavior Support on Student Discipline and Academic Achievement," *Journal of Positive Behavior Interventions* 10 (July 2008): 190-205, <https://doi.org/10.1177/1098300708316258>.
- 75 Elisa Samuels, interview with Pretrial Justice Institute, October 31, 2017.
- 76 Massachusetts Department of Youth Services, *Individual Support Plan 02.02.02(c) (effective 03-15-13)*, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/02.02.02c-Individual-Support-Plan.doc>.
- 77 Robert Turillo, *Reducing isolation in youth facilities: strategies for working with your most challenging youth* webinar, Council of Juvenile Correctional Administrators, September 25, 2018, <https://www.youtube.com/watch?v=rAWDQ5xdci4&t=395s>.
- 78 Ibid.
- 79 Daniel O'Sullivan, interview with Jennifer Lutz, July 9, 2018.
- 80 Massachusetts Department of Youth Services, *Incident response team procedure in support of the management guidelines for responding to traumatic workplace*

incidents, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/IRT-Procedure.pdf>.

81 Ruth Rovezzi, telephone conversation, April 25, 2019.

82 DYS Safety Task Force Recommendations, note 46, at 23.

83 *Ibid.*

84 New hires may begin working in a secure facility after one week at the DYS Training Academy as long as they complete the remaining two weeks of Basic Training within 90 days. This training structure gives staff important context for the second and third week of Basic Training. Massachusetts Department of Youth Services, Training Announcement: 2017 Annual Review Training, December 2016.

85 Massachusetts Department of Youth Services, Training Announcement: 2017 Annual Review Training, December 2016; Massachusetts Department of Youth Services, Training Protocol for Basic Training, Annual Review, and DYS Statewide Restraint, December 2014.

86 Ruth Rovezzi, interview with Pretrial Justice Institute, April 17, 2017.

87 Ruth Rovezzi, interview with Jennifer Lutz, July 9, 2018.

88 Yvonne Sparling, telephone conversation, April 16, 2019.

89 Rudy Kolaco, shift administrator, interview with Pretrial Justice Institute, October 30, 2017.

90 Lenny Beatty, interview with Pretrial Justice Institute, October 31, 2017.

91 DYS Safety Task Force Recommendations, note 46, at 15.

92 DYS Safety Task Force Recommendations, note 46, at 18–19.

93 Ruth Rovezzi, interview with Jennifer Lutz, April 25, 2019.

94 DYS Safety Task Force Recommendations, note 46, at 26.

95 DYS Safety Task Force Recommendations, note 46, at 4–6.

96 DYS Safety Task Force Recommendations, note 46, at 15.

97 DYS Safety Task Force Recommendations, note 46, at 18.

98 Bill S. 2371: An Act Relative to Criminal Justice Reform, 190th, <https://malegislature.gov/Bills/190/S2371>.

99 *Ibid.*

100 Ruth Rovezzi, email, May 14, 2019; Ruth Rovezzi, email, May 16, 2019.

101 Ruth Rovezzi, interview with Pretrial Justice Institute, April 17, 2017.

102 United State Department of Justice, Civil Rights Division. Investigation of the Shelby County Juvenile Court (Findings Report), April 26, 2012, [https://www.justice.gov/sites/default/files/crt/legacy/2012/04/26/shelbycountyjuv\\_findingsrpt\\_4-26-12.pdf](https://www.justice.gov/sites/default/files/crt/legacy/2012/04/26/shelbycountyjuv_findingsrpt_4-26-12.pdf).

103 *Id.* at 5.

104 David C. Steelman et al., A Brief Assessment of the Juvenile Court System in Shelby County, Tennessee: Report to Shelby County Government (National Center for State Courts: June 2007), <https://cdm16501.contentdm.oclc.org/digital/collection/famct/id/176>.

105 Findings Report, note 114.

106 *Id.* at 6.

107 United States Department of Justice, Civil Rights Division, Memorandum of Agreement Regarding the Juvenile Court of Memphis and Shelby County (MOA), December 17, 2012, [https://dashboard.shelbycountyttn.gov/sites/default/files/file/pdfs/doj\\_moa%2012-12.PDF](https://dashboard.shelbycountyttn.gov/sites/default/files/file/pdfs/doj_moa%2012-12.PDF).

108 *Id.* at 28.

109 *Id.* at 29. The Report of Findings found that there was a high rate of suicidal behavior among youth at the Shelby County Juvenile Detention Facility, a lack of involvement of Clinical Services, and a failure to engage in necessary suicide prevention in the physical plan. Investigation, note 1, at 58–59. The MOA contained remedial provisions to address these problems. MOA, note 119, at 29–31.

110 Findings Report, note 114, at 7.

111 “Juvenile Detention Alternatives Initiative” The Annie E. Casey Foundation, accessed May 2, 2019, <https://www.aecf.org/work/juvenile-justice/jdai/>.

112 Findings Report, note 114, at 66.

113 The facility consultant noted several of those concerns in his Sixth Report: that accepted best practice in the juvenile justice field is to have a juvenile justice facility operated by a juvenile court, local or state child and family services agency, or designated youth services or youth corrections division of a local or state social services agency,

but not local law enforcement; the adult-oriented (vs. developmental) approach to incarceration in law enforcement agencies; routine use of isolation for discipline; focus on compliance with rules rather than developing staff relationships with youth; and seeing the family as tangential or even as an obstruction. David Roush, Letter to Winsome G. Gayle and Richard Goemann, U.S. Department of Justice, December 17, 2015, 1–2, <https://www.justice.gov/crt/file/802811/download>.

114 See United States Department of Justice. Prison Rape Elimination Act, Juvenile Facility Standards, Final Rule, 28 C.F.R. 115.313(c), May 17, 2012, <https://www.preadvocate.com/sites/default/files/content/preafinalstandardstype-juveniles.pdf>; Juvenile Detention Alternatives Initiative, Juvenile Detention Facility Assessment: Standard Instrument, 2014 Update (Baltimore: Annie E. Casey Foundation, 2014): 68, <https://www.aecf.org/resources/juvenile-detention-facility-assessment/>.

115 Letter to Winsome G. Gayle, note 125, at 1–2.

116 *Id.* at 2.

117 David Roush, Juvenile Court of Memphis and Shelby County (Juvenile Court), MOA Protection from Harm Stipulations: 7th Report of Findings and Recommendations, June 2016, 5, 12–13, <https://www.justice.gov/crt/file/871626/download>.

118 *Id.* at 3–4.

119 *Id.* at 12–13.

120 *Id.* at 5.

121 *Id.* at 19.

122 David Roush, Juvenile Court of Memphis and Shelby County (Sheriff's Department), MOA Protection for Harm Stipulations: 8th Report of Findings and Recommendations, December 8, 2016, <https://www.justice.gov/crt/case-document/file/936586/download>, 4.

123 *Id.* at 4.

124 *Id.* at 15.

125 *Id.* at 16.

126 *Id.* at 5.

127 *Id.* at 7.

128 Bernard Glos, Ph.D., had replaced David Roush.

129 Bernard Glos, Juvenile Court of Memphis and Shelby County (Sheriff's Department), MOA Protection for Harm Stipulations: 9th Report of Findings and Recommendations, May 17, 2017, <https://www.justice.gov/crt/case-document/file/974641/download>, at 4, 8.

130 Bernard Glos, Juvenile Court of Memphis and Shelby County (Sheriff's Department), MOA Protection for Harm Stipulations: 10th Report of Findings and Recommendations, November 28, 2017, <https://www.justice.gov/crt/page/file/1022256/download>.

131 Debra Fessenden, email to Mark Soler, May 1, 2019.

132 Deidra Bridgeforth, interview with Mark Soler, December 12, 2018.

133 *Ibid.*

134 National Research Council, *Reforming Juvenile Justice: A Developmental Approach* (Washington, DC: The National Academies Press) 179–181, “...interventions with the most success at altering the level of subsequent offending provide opportunities for an adolescent to develop successfully in a supportive social world.”

135 Shelby County Sheriff's Office, JDS Detainee Involuntary Room Confinement, Standard Operating Procedure 713, (effective 07-06-16), <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/JDS-SOP-713-Detainee-Involuntary-Room-Confinement.pdf>.

136 Shelby County Sheriff's Office, Juvenile Detention Services, Standard Operating Procedure 356 (effective 02-08-17), <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/MEMPHIS-JDS-SOP-356.pdf>.

137 “The Safe Crisis Management Training Company,” JKM Training, Inc. accessed May 2, 2019, <https://safecrisismanagement.com/>. Safe Crisis Management is a comprehensive training program focused on preventing and managing confrontation events and improving safety. It incorporates a trauma-sensitive approach with an emphasis on building positive relationships with individuals,

138 “Crisis Prevention Institute,” Crisis Prevention Institute, last modified 2019. <https://www.crisisprevention.com/>. Crisis Prevention Institute is an international organization that specializes in the safe management of disruptive and assaultive behavior.

139 Shelby County Sheriff's Office, JDS Positive Behavior Management System, Standard Operating Procedure 357 (effective 02-08-17), <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Positive-Behavior-Management-System-SOP.pdf>.

140 Deidra Bridgeforth, interview with Mark Soler, December 12, 2018.

- 141 Ibid.
- 142 Ibid.
- 143 "Rational Emotive Behavior Therapy," Psychology Today, last modified 2019. <https://www.psychologytoday.com/us/therapy-types/rational-emotive-behavior-therapy>. The therapy is also known as Rational Emotive Behavior Therapy.
- 144 See, e.g., National PREA Resource Center, Developing and Implementing a PREA-Compliant Staffing Plan, [https://www.prearesourcecenter.org/sites/default/files/content/staffing\\_plan\\_final\\_w\\_bja\\_logo\\_submt.pdf](https://www.prearesourcecenter.org/sites/default/files/content/staffing_plan_final_w_bja_logo_submt.pdf).
- 145 See Figure 19.
- 146 Sarah Macaraeg, "Free calls for juveniles: Shelby County announces jail phone reform," Memphis Commercial Appeal, November 18, 2018. <https://www.commercialappeal.com/story/news/2018/11/18/juvenile-detention-free-calls-shelby-county-gtl-justice-reform/1941618002/>.
- 147 Shelby County Sheriff's Office, Juvenile Detention Services, Major Incident Review Form, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Major-Incident-Review-Form.pdf>.
- 148 Shelby County Juvenile Court, Detention Policy and Procedure Manual, Policy #VII-2, Detainee Disciplinary Procedures (reviewed 07-14-15), <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Shelby-County-Detainee-Disciplinary-Procedures-Policy-VII-2.pdf>.
- 149 Omer Yusuf, "Justice Department ends federal oversight of Juvenile Court," Daily Memphian, October 20, 2018, <https://dailyemphian.com/article/799/Justice-Department-ends-federal-oversight-of-Juvenile-Court>.
- 150 Joe O'Leary, "Thinking Outside the Box: Ways to Safely Reduce Room Confinement," American Correctional Association Winter Conference presentation, January 12, 2019.
- 151 O'Leary, Thinking Outside the Box.
- 152 Erin Fuimaono, interview, June 28, 2018.
- 153 Juvenile Justice Reform Act of 2018, 34 U.S.C. 11117, December 21, 2018, <https://www.congress.gov/bill/115th-congress/house-bill/6964/text?q=%7B%22search%22%3A%5B%22Juvenile+Justice+and+Delinquency+Prevention+Reauthorization+Act+of+2018%22%5D%7D&r=1&s=1>.
- 154 Audrey Wieber, "MacLaren takes STEPS to cool young offenders," Portland Tribune, January 8, 2019, [https://pamplinmedia.com/pt/9-news/416398-318881-maclaren-takes-steps-to-cool-down-young-offenders?wallit\\_nosession=1](https://pamplinmedia.com/pt/9-news/416398-318881-maclaren-takes-steps-to-cool-down-young-offenders?wallit_nosession=1).
- 155 OYA Director Fariborz Pakseresht, letter, December 7, 2015, [http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/OYA\\_Isolation-Budget-Note-Response.pdf](http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/OYA_Isolation-Budget-Note-Response.pdf).
- 156 Performance-based Standards (PbS) is a data-driven improvement model grounded in research that holds juvenile justice agencies, facilities, and residential care providers to the highest standards for operations, programs and services. June 13, 2019, <https://pbstandards.org/about-us>.
- 157 O'Leary, Thinking Outside the Box.
- 158 Oregon Revised Statutes 137.700 and 137.707.
- 159 Oregon Youth Authority, "OYA Facilities Services," [https://www.oregon.gov/oya/pages/facility\\_services.aspx](https://www.oregon.gov/oya/pages/facility_services.aspx).
- 160 Oregon Youth Authority "January 2019 OYA Quick Facts," <https://www.oregon.gov/oya/docs/QuickFacts/QuickFacts-Jan2019.pdf>.
- 161 "Ways and Means Public Safety Committee Presentation," Oregon Youth Authority, March 4–6, 2019, <https://apps.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/166265>.
- 162 Oregon Youth Authority, "Oregon Youth Authority at a Glance," January 2019, <https://www.oregon.gov/oya/docs/OYAAtAGlance.pdf>.
- 163 "OYA at a Glance," 2019.
- 164 "OYA at a Glance," 2019.
- 165 Oregon Senate Bill 1008, 80th Oregon Legislative Assembly, 2019, Regular Session, <https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB1008/Enrolled>.
- 166 Pakseresht, letter, December 7, 2015.
- 167 Alicia Cozad, phone interview, May 1, 2018.
- 168 Fariborz Pakseresht, "Reducing isolation in youth facilities: strategies and lessons learned from the field" webinar; Council of Juvenile Correctional Administrators, May 15, 2015, <https://www.youtube.com/watch?v=4kF0CNXSafM>.
- 169 Pakseresht, letter, December 7, 2015.
- 170 Erin Fuimaono, interview, June 28, 2018.

- 171 Clint McClellan, interview, June 28, 2018.
- 172 Fuimaono, interview, June 28, 2018.
- 173 McClellan, "Reducing isolation in youth facilities."
- 174 Fuimaono, interview, June 28, 2018.
- 175 McClellan, interview, June 28, 2018.
- 176 McClellan, interview, June 28, 2018.
- 177 McClellan, interview, June 28, 2018.
- 178 Fuimaono, interview, June 28, 2018.
- 179 McClellan, interview, June 28, 2018.
- 180 Cozad, phone interview, May 1, 2018.
- 181 Pakseresht, "Reducing isolation in youth facilities."
- 182 McClellan, interview, June 28, 2018.
- 183 Pakseresht, "Reducing isolation in youth facilities."
- 184 Jamie McKay, phone interview, May 4, 2018.
- 185 Heber Bray, "Reducing isolation in youth facilities: strategies for dealing with your most challenging youth" webinar, Council of Juvenile Correctional Administrators, September 25, 2018, <https://www.youtube.com/watch?v=rAWDQ5xdcI4&t=395s>.
- 186 Pakseresht, "Reducing isolation in youth facilities."
- 187 Fuimaono, interview, June 28, 2018.
- 188 McClellan, "Reducing isolation in youth facilities."
- 189 Oregon Youth Authority, "OYA Budget Narrative," 2019–2021 Biennium, 6, <https://www.oregon.gov/oya/docs/2019-21/2019-21-GBB-OYA.pdf>.
- 190 Oregon Youth Authority, "Positive Human Development at a Glance," January 2019, <https://www.oregon.gov/oya/docs/glance/AtAGlance-PHD.pdf>.
- 191 Council of Juvenile Correctional Administrators, "Toolkit: Positive Youth Development," April 2017, 9, <http://cjca.net/wp-content/uploads/2018/02/CJCA-Toolkit-final-doc-Aug.-9-2017.pdf>.
- 192 Council of Juvenile Correctional Administrators, "Toolkit: Positive Youth Development," April 2017, 9-11, <http://cjca.net/wp-content/uploads/2018/02/CJCA-Toolkit-final-doc-Aug.-9-2017.pdf>.
- 193 Oregon Youth Authority, "OYA Budget Narrative," 2019-2021 Biennium, 24, <https://www.oregon.gov/oya/docs/2019-21/2019-21-GBB-OYA.pdf>.
- 194 O'Leary, Thinking Outside the Box.
- 195 Oregon Youth Authority Facility Services, "Why Positive Human Development," <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/06/PHD-in-Practice-Graphic.jpg>.
- 196 O'Leary, Thinking Outside the Box.
- 197 Oregon Youth Authority, "Fundamental Practices for Living Units–Moving PHD Into Practice," January 2018, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/06/FundamentalPractices-2018.pdf>.
- 198 Oregon Youth Authority, "OYA Budget Narrative," 2019-2021 Biennium, 23, <https://www.oregon.gov/oya/docs/2019-21/2019-21-GBB-OYA.pdf>.
- 199 Berger, phone interview, May 2, 2018.
- 200 Oregon Youth Authority, "OYA Budget Narrative," 2019-2021 Biennium, 25, <https://www.oregon.gov/oya/docs/2019-21/2019-21-GBB-OYA.pdf>.
- 201 McClellan, "Reducing isolation in youth facilities."
- 202 Cozad, phone interview, May 1, 2018.
- 203 O'Leary, Thinking Outside the Box.
- 204 McClellan, interview, June 28, 2018.
- 205 O'Leary, Thinking Outside the Box.
- 206 O'Leary, Thinking Outside the Box.
- 207 Oregon Youth Authority, Budget Report and Measure Summary SB 5542 A, Joint Committee on Ways and Means, 2017–2019 Biennium, <https://olis.leg.state.or.us/>

- Liz/2017r1/Downloads/Committeemeetingdocument/99485.
- 208 O'Leary, Thinking Outside the Box.
- 209 Oregon Legislative Information System, "Oregon Youth Authority Use of Isolation Agency Report," January 2016, <https://olis.leg.state.or.us/liz/201511/Downloads/CommitteeMeetingDocument/82242>.
- 210 O'Leary, Thinking Outside the Box.
- 211 Senate Bill 82, An Act relating to rules regulating conduct of persons in the custody of the Oregon Youth Authority, 2017 Regular Session, <https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB82/Enrolled>.
- 212 Sarah Radcliffe. "Don't Look Around: A Window into Inhumane Conditions for Youth at NORCOR." Disability Rights Oregon, 2017, 12, <https://droregon.org/wp-content/uploads/REPORT-Dont-Look-Around-A-Window-into-Inhumane-Conditions-for-Youth-at-NORCOR-December-5-2017.pdf>.
- 213 Chris Lehman. "Bill would ban the use of solitary confinement to discipline youth offenders in Oregon," NW News Network, February 8, 2017, <https://www.nwnewsnetwork.org/post/bill-would-ban-use-solitary-confinement-discipline-youth-offenders-oregon>.
- 214 Heber Bray, phone interview, May 1, 2018.
- 215 Bray, phone interview, May 1, 2018.
- 216 Ken Jerin, phone interview, April 27, 2018.
- 217 Korey Ramsay, quote from Fariborz Pakseresht and Joe O'Leary, Ways and Means Public Safety Subcommittee presentation, February 2017, <https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/98868>.
- 218 Berger, phone interview, May 2, 2018.
- 219 Berger, phone interview, May 2, 2018.
- 220 Oregon Youth Authority Policy II-B-1.2, Use of Time-out, Room-lock Other, Isolation, and Safety Programs in OYA Facilities, 2018, <https://www.oregon.gov/oya/policies/II-B-1.2.pdf>.
- 221 Jerin, phone interview, April 27, 2018
- 222 Berger, phone interview, May 2, 2018.
- 223 Oregon Youth Authority, "OYA Budget Narrative," 2019-2021 Biennium, 12, <https://www.oregon.gov/oya/docs/2019-21/2019-21-GBB-OYA.pdf>.
- 224 Oregon Youth Authority, 2013-15 Biennial Report, July 1, 2015 at 4, <https://www.oregon.gov/oya/reports/2013-15%20Biennial%20Report.pdf>.
- 225 Oregon Youth Authority, "10-Year Strategic Plan for Close Custody Facilities, Section 4, Oregon Youth Authority Existing Facilities Assessment" (Aug. 26, 2014), p. 4-4, <http://bit.ly/oya10yrplan-doc>.
- 226 Oregon Youth Authority, 2013-15 Biennial Report, July 1, 2015 at 4, <https://www.oregon.gov/oya/reports/2013-15%20Biennial%20Report.pdf>.
- 227 Oregon Youth Authority, "10-Year Strategic Plan for Close Custody Facilities, Executive Summary" (Aug. 26, 2014), p. 1-3, <http://bit.ly/oya10yrplan-doc>.
- 228 "OYA Budget Narrative," 12.
- 229 O'Leary, Thinking Outside the Box.
- 230 Oregon Youth Authority, "Letting in the Light," February 16, 2017, <https://www.youtube.com/watch?v=SdXbzB8YpT8&feature=youtu.be>.
- 231 "The New Model for Remanded Youth: Spaces for Hope, Healing & Transformation," Correctional News, June 27, 2018, <http://correctionalnews.com/2018/06/27/new-model-remanded-youth-spaces-hope-healing-transformation/>.
- 232 "Planning a Vision Charette," D.I.Y. Creative Placemaking, <http://www.artscapediy.org/Creative-Placemaking-Toolbox/Who-Are-My-Stakeholders-and-How-Do-I-Engage-Them/Planning-a-Visioning-Charrette.aspx>.
- 233 "Planning a Vision Charette."
- 234 Denessa Martin, phone interview, April 23, 2018.
- 235 Heber Bray, "Reducing isolation in youth facilities: strategies for dealing with your most challenging youth" webinar, Council of Juvenile Correctional Administrators, September 25, 2018, <https://www.youtube.com/watch?v=rAWDQ5xdci4&t=395s>.
- 236 Oregon Youth Authority Recruitment video, November 2, 2016, <https://www.youtube.com/watch?v=qq7VQ7jgki8&feature=youtu.be>.
- 237 Cozad, phone interview, May 1, 2018.
- 238 Elizabeth Seigle, Nastassia Walsh, Josh Weber, "Core Principles for Reducing Recidivism and Improving Other Outcomes for Youth in the Juvenile Justice System Council of State Governments Justice Center," 2014, <http://csgjusticecenter.org/wp-content/uploads/2014/07/Core-Principles-for-Reducing-Recidivism-and-Improving-Other-Outcomes->

for-Youth-in-the-Juvenile-Justice-System.pdf.

- 239 Seigle, Walsh, Weber, "Core Principles."
- 240 Seigle, Walsh, Weber, "Core Principles."
- 241 Oregon Youth Authority, "Juvenile Justice Information System," <https://www.oregon.gov/oya/pages/jjis.aspx>.
- 242 Bray, phone interview, May 1, 2018.
- 243 Berger, phone interview, May 2, 2018.
- 244 O'Leary, Thinking Outside the Box.
- 245 McClellan, interview, June 28, 2018.
- 246 Heber Bray, email, June 14, 2019.
- 247 Bray, phone interview, May 1, 2018.
- 248 OYA 2019-2021 Agency Budget Request, 16.
- 249 Bray, phone interview, May 1, 2018.
- 250 Erin Fuimaono and Joe O'Leary, "Reducing and preventing the use of isolation," Oregon Youth Authority, presentation, slide 12, September 30, 2015, <https://apps.leg.state.or.us/liz/201511/Downloads/CommitteeMeetingDocument/80489>.
- 251 Bray, phone interview, May 1, 2018.
- 252 Bray, phone interview, May 1, 2018.
- 253 Fariborz Pakseresht and Joe O'Leary, Ways and Means Public Safety Subcommittee presentation, slide 56, February 2017, <https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/98868>.
- 254 Berger, phone interview, May 2, 2018.
- 255 Audrey Wieber, "MacLaren takes STEPS to cool young offenders," Portland Tribune, January 8, 2019, [https://pamplinmedia.com/pt/9-news/416398-318881-maclaren-takes-steps-to-cool-down-young-offenders?wallit\\_nosession=1](https://pamplinmedia.com/pt/9-news/416398-318881-maclaren-takes-steps-to-cool-down-young-offenders?wallit_nosession=1).
- 256 Berger, phone interview, May 2, 2018.
- 257 Oregon Youth Authority Policy II-B-1.2(1) Individual Safety Plan.
- 258 Oregon Youth Authority Policy II-B-1.2(b) Community Safety Protocol.
- 259 Oregon Youth Authority Policy II-B-1.2, 2018.
- 260 O'Leary, Thinking Outside the Box.
- 261 Oregon Youth Authority Policy II-B-2.0, Behavior Management–Behavior Incentives and Reinforcing Behavior, 2018, <https://www.oregon.gov/oya/policies/II-B-2.0.pdf>.
- 262 Oregon Youth Authority Policy II-B-2.1, Behavior Management–Youth Refocus Options, 2018, <https://www.oregon.gov/oya/policies/II-B-2.1.pdf>.
- 263 Pakseresht, letter, December 7, 2015.
- 264 Ibid.
- 265 Ruth Rovezzi, interview with Jennifer Lutz, July 9, 2018.
- 266 Lynn Allen, interview with Jennifer Lutz, July 9, 2018.
- 267 Deidra Bridgeforth, interview with Mark Soler, December 12, 2018.
- 268 Clint McClellan, "Reducing isolation in youth facilities: strategies and lessons learned from the field" webinar, Council of Juvenile Correctional Administrators, February 13, 2018, <https://www.youtube.com/watch?v=SpMTYRtXE4A&feature=youtu.be>.
- 269 Pakseresht, "Reducing isolation in youth facilities."
- 270 McClellan, "Reducing isolation in youth facilities."
- 271 Dan Berger, phone interview, May 2, 2018.
- 272 Pakseresht, "Reducing isolation in youth facilities."
- 273 Berger, phone interview, May 2, 2018.
- 274 Fariborz Pakseresht and Joe O'Leary, Ways and Means Public Safety Subcommittee presentation, slide 93, February 2017, <https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/98868>.

# **EXHIBIT C**

**Emails from Pennington to Beatty**

**Archived:** Friday, July 24, 2020 8:55:58 AM  
**From:** [Annie E. Andrews](#)  
**Sent:** Fri, 19 Jun 2020 17:03:07 +0000ARC  
**To:** [Patrick Wooten](#)  
**Subject:** FW: Continuing Problems at Juvenile Detention  
**Sensitivity:** Normal

---

[REDACTED]

---

**From:** Ashley Pennington <[APennington@charlestoncounty.org](mailto:APennington@charlestoncounty.org)>  
**Sent:** Thursday, September 06, 2018 5:02 PM  
**To:** Annie E. Andrews <[AAndrews@charlestoncounty.org](mailto:AAndrews@charlestoncounty.org)>  
**Subject:** RE: Continuing Problems at Juvenile Detention

[REDACTED]

[REDACTED]

---

**From:** Annie E. Andrews  
**Sent:** Thursday, September 06, 2018 3:42 PM  
**To:** Ashley Pennington <[APennington@charlestoncounty.org](mailto:APennington@charlestoncounty.org)>  
**Subject:** Re: Continuing Problems at Juvenile Detention

[REDACTED]

[REDACTED]

On Sep 3, 2018, at 1:42 PM, Ashley Pennington <[APennington@charlestoncounty.org](mailto:APennington@charlestoncounty.org)> wrote:

[REDACTED]

**From:** Ashley Pennington  
**Sent:** Monday, September 3, 2018 1:41 PM  
**To:** Willis Beatty  
**Subject:** RE: Continuing Problems at Juvenile Detention

Dear Chief Beatty,  
I understand that the juveniles have been moved back to Headquarters Road. My juvenile defender lawyers report that the A/C is working and the interior has been painted, which is good.

However, our child clients are back to being confined every day as if they were in the disciplinary detention section of the main adult

jail. These children are still being confined in their cells (with their roommate(s)) for up to 22 hours per day when school is not in session on weekends and holidays. Sometimes there are three boys assigned to the same cell. Most have not committed a significant infraction of the detention center rules. They are simply being detained like that pretrial. And, school only reduces their "lock-down" time to 17-18 hours per day.

It seems to us that lengthy, daily confinement causes significant unwarranted harm. The children are being held under the most restrictive conditions, like they were unmanageable adult detainees who pose a danger to staff or others. This isolation and minimal interaction with others does NOT fit juvenile detention standards for juvenile detainees under SC Code Section 63-19-360(5). The standards require the detention center to "minimize idleness" and to provide at least 70 square feet of total floor space per occupant. Sometimes there are three boys assigned to the same cell. This all seems to be driven by a structure with too little space. The males and females cannot have direct supervision at the same time in the more interactive common area. And, we are taking children from other counties and adding to our space shortage.

I have been told recently that SC Protection and Advocacy has toured the facility and came away concerned. The Civil Rights Division of the Justice Department has also inquired about the detention center.

The pods in the main jail are far more appropriate for these children. Please look further into these conditions at Headquarters Road. I ask that you reconsider all these facts and put the juveniles back in the pods until we have time to design and to build a more appropriate juvenile detention facility.

All the best,

*Ashley*

D. Ashley Pennington  
Ninth Circuit Public Defender  
101 Meeting Street, 5th Floor  
Charleston, SC 29401-2214

(843) 958-1850  
(843) 958-1870(direct)  
(843) 478-1230(mobile)

(843) 958-5149(facsimile)

[apennington@charlestoncounty.org](mailto:apennington@charlestoncounty.org)

[www.lowcountrydefenders.org](http://www.lowcountrydefenders.org)

Confidential Notice: This electronic mail transmission and any and all accompanying documents and information contain data and matters belonging to the sender which may be confidential and legally privileged. This information is intended ONLY for the use of the individual entity to whom it is addressed. If you are not the intended recipient, any disclosure, copying, distribution or action of any sort taken in reliance on the contents of the information contained in this transmission or any attachments is strictly prohibited and objected to. If you have received this transmission in error, please immediately notify us by telephone at (843) 958-1870 and also delete the message. Thank you.

---

**From:**

Ashley Pennington

**Sent:** Wednesday, August 15, 2018 4:53 PM

**To:** Willis Beatty <[wbeatty@charlestoncounty.org](mailto:wbeatty@charlestoncounty.org)>

**Subject:** Juvenile Detention

**Importance:** High

Dear Chief,

Thanks for moving the juveniles on Sunday. Some of the public defender attorneys have met with their clients recently and then passed on some complaints about the setting and problems that they are encountering at the Headquarters Road facility. See below:

Girl,  
DC

- Did not go outside one time.
- Not receiving 3 medications she normally receives for the treatment daily. Does not have access to an EpiPen for severe allergic reactions. Does not have her glasses so has trouble seeing.
- Was placed in the "wet cell" by Officer XX for several hours with her ankles shackled and her hands handcuffed behind her back after an incident in which her toilet overflowed, allegedly on purpose. "I could not find a comfortable position to sit/lay while I was shackled/handcuffed like this and I asked for water on one occasion, but was not given any." Following her time in the "wet cell" for this incident Girl was put on 24hr a day lockdown for nearly a week. For one of the days Girl asked to take a shower and was told she could not.
  - o According to DSS/medical records, Girl has a diagnosis of PTSD, anxiety, asthma, and a history of sexual and physical abuse.
- On Friday August 10th, Girl put in a request to be seen by medical because she had itchy bumps all over her lower back and behind her ears as though she was having an allergic reaction. She showed her

attorney the bumps, which look like patches of tiny pimples. She was not seen until 5 days later, after she had put in two subsequent medical requests. When she was seen she did not receive a diagnosis or any sort of medication.

- “I was put on 24hr lockdown once because I was sleeping when XX came by my room to collect the food tray.” She was told that it was disrespectful to leave the tray by the door for XX to pick up instead of handing it to her.

- Officer XX regularly cusses at the kids saying things like “sit your ass down.” Staff are sometimes on a “power trip.”

- Conditions generally:

- o A/C vent leaks onto the floor,

- o “All of the toilets are connected” so if one is flushed in an adjacent cell, the toilet in her cell may begin to rise and could overflow

- o Feces came up through the drains in the showers on one occasion because of a flooding issue

- o Guards say to drink the water from the sinks in their rooms, but it is milky white

Jail

- The current conditions are “significantly better,” “no comparison”

- “The staff seems resentful of us kids because they don’t have the power to just lock us in our rooms all day long.”

Girl

DC:

- Did not go outside one time.

- Receives medication to help her sleep, but sometimes doesn’t receive them until 12am.

- Was placed in the “wet cell” one day from 6am to 2pm after having a verbal argument with another girl. You cannot go to the bathroom in there and it smells like urine because kids often cannot hold it and have to go on the floor. You can bang on the doors to attempt to get the staff’s attention, but they usually can’t hear you because all of the banging coming from the nearby boys’ rooms.

- Was placed on 48hr lockdown because she had a pencil within her cell (that she was using to write a list of goals to share with her attorney and the judge).

- Conditions generally:

- o A/C vent leaks water on the floor

- o Toilets are all connected so when some people flush their toilets too

many times it causes other toilets to flood. One day girls started flushing a lot and there was feces/urine everywhere. The girls were all taken to the common area while the mess was cleaned, but it wasn't cleaned well and when they returned the smell was so bad it gave her a headache.

- o "I had bruises on my legs from sleeping in the bed. I showed them to my mom and she thought that maybe there was metal poking out that was rubbing me the wrong way at night. I looked under my mattress and it is just metal wires. I'm not sure what is wrong with the beds."

- "Being at the detention center is like throwing a new puppy into a small room all day long while you go to work." For a time I didn't have a roommate and I could only have human contact by yelling through the vents.

Jail:

- o "This place is 100% better. I go to rec outside at night and enjoy the fresh air. It's really a blessing. I'm not alone in my cell anymore."

Boy

DC:

- Only went outside a handful of times.

- Guards will punish you by taking you out of school

- Has been on 48hr-72hr lockdown for just talking to other kids in adjacent cells who were beating on their doors.

- "Being in detention is just really stressful and lonely. I don't know how to explain it. My family says that I've changed since I've been here."

- Conditions generally:

- o There are rats in the vents. You can hear them really late at night when people stop banging on the doors.

- o Only the hot water works in my room and I'm told to just drink the water when I'm thirsty, but it's hot.

- o The ceiling in my room was leaking for a long time and not just when it rained, but they finally fixed it.

- "Some people have been in the wet cell just for beating on the door, and I know that some people in there are shackled and handcuffed and they put a chain in between the two so that you can't really move."

Jail:

- "Being here makes me happy, excited even. When I left DC my eyes hurt when they moved us. It's so dark in there and they don't let us outside. It's been months since I've been outside. Please tell them not to send me back there."

- People are happier here and probably less likely to fight because they don't have all this energy from being kept in a box all day.
- You have more privacy here because the shower curtains cover you in these showers. Also you can pee without people watching you. In your cell your roommate just watches you pee from a few feet away and it's embarrassing. The clothes are cleaner here as if the detergent is better or they use bleach because our whites are whiter.
- You have rec all day instead of for just 2hrs a day. I've been outside several times already.

## Boy

### DC:

- Never been outside
- I have an IEP, but Detention doesn't follow it. They probably don't know what grade most kids are in. They just lump us in groups and teach us the same stuff.
- I've never been in the "wet cell," but I know lots of kids go there for banging on their doors and kids bang on the doors all the time.
- Conditions generally:
  - o The ceiling leaks brown stuff
  - o Toilets always leak and break
  - o A/C breaks
  - o Nothing seems to work well
- You can't cover yourself in the showers at the DC which makes me uncomfortable

### Jail:

- I like that I can talk to my mom every day and you can see your brothers on the video. At Detention you can't see your siblings.
- You eat at tables here, which I really like instead of eating in our rooms. I feel like we have longer to eat.
- I've been outside several times.

## Girl

### DC:

- Never went outside one time.
- You are not allowed to go to school if you get into trouble, and people get put on lockdown for things like trying to get a guard's attention by banging on the door, but that is the only way to get their attention.

- Conditions generally:
  - o A/C leaks
  - o The sink water is a milky color and guards say to drink that. That is all you have to brush your teeth with.
  - o There were rats in the ceiling in the nurse's bathroom
  - o Guards cut the water off in my cell once because they said the toilets didn't work, but I couldn't use the bathroom for hours.
- What is DC like? "It is miserable. No one should be there. These kids are going through a lot of stuff anyway, we're sad and lonely anyway, and it just makes our problems worse."

Jail:

- This place is way better.
- I can watch TV and play cards or games, which you can't do at the DC because the games are too worn and cards are missing.
- You can watch what you want on the TV because the TV faces the kids. At DC the guards tell you that you can only watch what they want and they just watch TV from the back of the room.
- The ceilings are higher and the lighting is better. The sunlight comes in. I feel "chilled out" and just more comfortable.
- I can sit at a table and eat like you would for a real meal. At the DC you only get 5min or so to eat. As soon as the guards finish giving meals to the last kid, they start collecting the trays from the first kids. You barely have time to look at your food.
- The mood with the girls is better at the jail.
- Clothes are cleaner here. The washer must work better or they use different detergent because you can smell it on your clothes like they're clean.
- I think the staff is nicer here because there are more cameras and different crews of people are watching how they treat us.
- I like that you can call your parents more here.
- I go to rec all day long here.

Could you consider leaving the juveniles where they are?

Apparently conditions are much better.

Best,  
Ashley

D. Ashley Pennington

Ninth Circuit Public Defender  
101 Meeting Street, 5th Floor  
Charleston, SC 29401-2214

(843) 958-1850  
(843) 958-1870(direct)  
(843) 478-1230(mobile)  
(843) 958-5149(facsimile)

[apennington@charlestoncounty.org](mailto:apennington@charlestoncounty.org)

[www.lowcountrydefenders.org](http://www.lowcountrydefenders.org)

Confidential Notice: This electronic mail transmission and any and all accompanying documents and information contain data and matters belonging to the sender which may be confidential and legally privileged. This information is intended ONLY for the use of the individual entity to whom it is addressed. If you are not the intended recipient, any disclosure, copying, distribution or action of any sort taken in reliance on the contents of the information contained in this transmission or any attachments is strictly prohibited and objected to. If you have received this transmission in error, please immediately notify us by telephone at (843) 958-1870 and also delete the message. Thank you.

@font-face  
{font-family:Calibri;  
panose-1:2 15 5 2 2 2 4 3 2 4;}  
@font-face  
{font-family:Tahoma;  
panose-1:2 11 6 4 3 5 4 4 2 4;}  
@font-face  
{font-family:"Comic Sans MS";  
panose-1:3 15 7 2 3 3 2 2 2 4;}  
  
p.MsoNormal, li.MsoNormal, div.MsoNormal  
{margin:0in;  
margin-bottom:.0001pt;  
font-size:12.0pt;  
font-family:"Times New Roman","serif";}  
a:link, span.MsoHyperlink  
{mso-style-priority:99;  
color:blue;  
text-decoration:underline;}  
a:visited, span.MsoHyperlinkFollowed  
{mso-style-priority:99;  
color:purple;  
text-decoration:underline;}  
p  
{mso-style-priority:99;  
mso-margin-top-alt:auto;  
margin-right:0in;  
mso-margin-bottom-alt:auto;

```
margin-left:0in;
font-size:12.0pt;
font-family:"Times New Roman","serif";}
p.MsoAcetate, li.MsoAcetate, div.MsoAcetate
{mso-style-priority:99;
mso-style-link:"Balloon Text Char";
margin:0in;
margin-bottom:.0001pt;
font-size:8.0pt;
font-family:"Tahoma","sans-serif";}
span.EmailStyle18
{mso-style-type:personal-reply;
font-family:"Calibri","sans-serif";
color:#1F497D;}
span.BalloonTextChar
{mso-style-name:"Balloon Text Char";
mso-style-priority:99;
mso-style-link:"Balloon Text";
font-family:"Tahoma","sans-serif";}
.MsoChpDefault
{mso-style-type:export-only;
font-size:10.0pt;}
@page WordSection1
{size:8.5in 11.0in;
margin:1.0in 1.0in 1.0in 1.0in;}
div.WordSection1
{page:WordSection1;}
-->
```

**Archived:** Friday, July 24, 2020 8:56:02 AM  
**From:** [Annie E. Andrews](#)  
**Sent:** Fri, 19 Jun 2020 17:02:10 +0000ARC  
**To:** [Patrick Wooten](#)  
**Subject:** FW: Juvenile Detention  
**Sensitivity:** Normal

---

[REDACTED]

---

**From:** Ashley Pennington <[APennington@charlestoncounty.org](mailto:APennington@charlestoncounty.org)>  
**Sent:** Friday, August 17, 2018 11:53 AM  
**To:** Annie E. Andrews <[AAndrews@charlestoncounty.org](mailto:AAndrews@charlestoncounty.org)>  
**Subject:** FW: Juvenile Detention

[REDACTED]

---

**From:** Ashley Pennington  
**Sent:** Thursday, August 16, 2018 2:55 PM  
**To:** Willis Beatty <[wbeatty@charlestoncounty.org](mailto:wbeatty@charlestoncounty.org)>  
**Subject:** Re: Juvenile Detention

Sounds good. Just thought it might easier and cheaper to manage. The kids are much happier. They don't have to be in lockdown like the detention center.

Ashley Pennington  
(843) 478-1230

On Aug 16, 2018, at 2:52 PM, Willis Beatty <[wbeatty@charlestoncounty.org](mailto:wbeatty@charlestoncounty.org)> wrote:

Ashely, I am in Columbia today will look into tomorrow when I return. Appreciate the heads up.

Willis

Chief Deputy W. Beatty, CJM, CCE  
Sent from my iPhone

On Aug 15, 2018, at 16:52, Ashley Pennington <[APennington@charlestoncounty.org](mailto:APennington@charlestoncounty.org)> wrote:

Dear Chief,

Thanks for moving the juveniles on Sunday. Some of the public defender attorneys have met with their clients recently and then passed on some complaints about the setting and problems that they are encountering at the Headquarters Road facility. See below:

Girl,

## DC

- Did not go outside one time.
- Not receiving 3 medications she normally receives for the treatment daily. Does not have access to an EpiPen for severe allergic reactions. Does not have her glasses so has trouble seeing.
- Was placed in the “wet cell” by Officer XX for several hours with her ankles shackled and her hands handcuffed behind her back after an incident in which her toilet overflowed, allegedly on purpose. “I could not find a comfortable position to sit/lay while I was shackled/handcuffed like this and I asked for water on one occasion, but was not given any.” Following her time in the “wet cell” for this incident Girl was put on 24hr a day lockdown for nearly a week. For one of the days Girl asked to take a shower and was told she could not.
  - o According to DSS/medical records, Girl has a diagnosis of PTSD, anxiety, asthma, and a history of sexual and physical abuse.
- On Friday August 10th, Girl put in a request to be seen by medical because she had itchy bumps all over her lower back and behind her ears as though she was having an allergic reaction. She showed her attorney the bumps, which look like patches of tiny pimples. She was not seen until 5 days later, after she had put in two subsequent medical requests. When she was seen she did not receive a diagnosis or any sort of medication.
- “I was put on 24hr lockdown once because I was sleeping when XX came by my room to collect the food tray.” She was told that it was disrespectful to leave the tray by the door for XX to pick up instead of handing it to her.
- Officer XX regularly cusses at the kids saying things like “sit your ass down.” Staff are sometimes on a “power trip.”
- Conditions generally:
  - o A/C vent leaks onto the floor,
  - o “All of the toilets are connected” so if one is flushed in an adjacent cell, the toilet in her cell may begin to rise and could overflow
  - o Feces came up through the drains in the showers on one occasion because of a flooding issue
  - o Guards say to drink the water from the sinks in their rooms, but it is milky white

## Jail

- The current conditions are “significantly better,” “no comparison”
- “The staff seems resentful of us kids because they don’t have the power to just lock us in our rooms all day long.”

## Girl

### DC:

- Did not go outside one time.
- Receives medication to help her sleep, but sometimes doesn’t receive them

until 12am.

- Was placed in the “wet cell” one day from 6am to 2pm after having a verbal argument with another girl. You cannot go to the bathroom in there and it smells like urine because kids often cannot hold it and have to go on the floor. You can bang on the doors to attempt to get the staff’s attention, but they usually can’t hear you because all of the banging coming from the nearby boys’ rooms.

- Was placed on 48hr lockdown because she had a pencil within her cell (that she was using to write a list of goals to share with her attorney and the judge).

- Conditions generally:

- o A/C vent leaks water on the floor

- o Toilets are all connected so when some people flush their toilets too many times it causes other toilets to flood. One day girls started flushing a lot and there was feces/urine everywhere. The girls were all taken to the common area while the mess was cleaned, but it wasn’t cleaned well and when they returned the smell was so bad it gave her a headache.

- o “I had bruises on my legs from sleeping in the bed. I showed them to my mom and she thought that maybe there was metal poking out that was rubbing me the wrong way at night. I looked under my mattress and it is just metal wires. I’m not sure what is wrong with the beds.”

- “Being at the detention center is like throwing a new puppy into a small room all day long while you go to work.” For a time I didn’t have a roommate and I could only have human contact by yelling through the vents.

Jail:

- o “This place is 100% better. I go to rec outside at night and enjoy the fresh air. It’s really a blessing. I’m not alone in my cell anymore.”

Boy

DC:

- Only went outside a handful of times.

- Guards will punish you by taking you out of school

- Has been on 48hr-72hr lockdown for just talking to other kids in adjacent cells who were beating on their doors.

- “Being in detention is just really stressful and lonely. I don’t know how to explain it. My family says that I’ve changed since I’ve been here.”

- Conditions generally:

- o There are rats in the vents. You can hear them really late at night when people stop banging on the doors.

- o Only the hot water works in my room and I’m told to just drink the water when I’m thirsty, but it’s hot.

- o The ceiling in my room was leaking for a long time and not just when it rained, but they finally fixed it.

- “Some people have been in the wet cell just for beating on the door, and I

know that some people in there are shackled and handcuffed and they put a chain in between the two so that you can't really move."

Jail:

- "Being here makes me happy, excited even. When I left DC my eyes hurt when they moved us. It's so dark in there and they don't let us outside. It's been months since I've been outside. Please tell them not to send me back there."
- People are happier here and probably less likely to fight because they don't have all this energy from being kept in a box all day.
- You have more privacy here because the shower curtains cover you in these showers. Also you can pee without people watching you. In your cell your roommate just watches you pee from a few feet away and it's embarrassing. The clothes are cleaner here as if the detergent is better or they use bleach because our whites are whiter.
- You have rec all day instead of for just 2hrs a day. I've been outside several times already.

Boy

DC:

- Never been outside
- I have an IEP, but Detention doesn't follow it. They probably don't know what grade most kids are in. They just lump us in groups and teach us the same stuff.
- I've never been in the "wet cell," but I know lots of kids go there for banging on their doors and kids bang on the doors all the time.
- Conditions generally:
  - o The ceiling leaks brown stuff
  - o Toilets always leak and break
  - o A/C breaks
  - o Nothing seems to work well
- You can't cover yourself in the showers at the DC which makes me uncomfortable

Jail:

- I like that I can talk to my mom every day and you can see your brothers on the video. At Detention you can't see your siblings.
- You eat at tables here, which I really like instead of eating in our rooms. I feel like we have longer to eat.
- I've been outside several times.

Girl

DC:

- Never went outside one time.
- You are not allowed to go to school if you get into trouble, and people get

put on lockdown for things like trying to get a guard's attention by banging on the door, but that is the only way to get their attention.

- Conditions generally:
  - o A/C leaks
  - o The sink water is a milky color and guards say to drink that. That is all you have to brush your teeth with.
  - o There were rats in the ceiling in the nurse's bathroom
  - o Guards cut the water off in my cell once because they said the toilets didn't work, but I couldn't use the bathroom for hours.
- What is DC like? "It is miserable. No one should be there. These kids are going through a lot of stuff anyway, we're sad and lonely anyway, and it just makes our problems worse."

Jail:

- This place is way better.
- I can watch TV and play cards or games, which you can't do at the DC because the games are too worn and cards are missing.
- You can watch what you want on the TV because the TV faces the kids. At DC the guards tell you that you can only watch what they want and they just watch TV from the back of the room.
- The ceilings are higher and the lighting is better. The sunlight comes in. I feel "chilled out" and just more comfortable.
- I can sit at a table and eat like you would for a real meal. At the DC you only get 5min or so to eat. As soon as the guards finish giving meals to the last kid, they start collecting the trays from the first kids. You barely have time to look at your food.
- The mood with the girls is better at the jail.
- Clothes are cleaner here. The washer must work better or they use different detergent because you can smell it on your clothes like they're clean.
- I think the staff is nicer here because there are more cameras and different crews of people are watching how they treat us.
- I like that you can call your parents more here.
- I go to rec all day long here.

**Could you consider leaving the juveniles where they are?** Apparently conditions are much better.

Best,

**Ashley**

D. Ashley Pennington  
Ninth Circuit Public Defender  
101 Meeting Street, 5th Floor

Charleston, SC 29401-2214

(843) 958-1850

(843) 958-1870(direct)

(843) 478-1230(mobile)

(843) 958-5149(facsimile)

[apennington@charlestoncounty.org](mailto:apennington@charlestoncounty.org)

[www.lowcountrydefenders.org](http://www.lowcountrydefenders.org)

Confidential Notice: This electronic mail transmission and any and all accompanying documents and information contain data and matters belonging to the sender which may be confidential and legally privileged. This information is intended ONLY for the use of the individual entity to whom it is addressed. If you are not the intended recipient, any disclosure, copying, distribution or action of any sort taken in reliance on the contents of the information contained in this transmission or any attachments is strictly prohibited and objected to. If you have received this transmission in error, please immediately notify us by telephone at (843) 958-1870 and also delete the message. Thank you.

**Archived:** Friday, July 24, 2020 8:56:06 AM  
**From:** [Annie E. Andrews](#)  
**Sent:** Fri, 19 Jun 2020 16:55:57 +0000ARC  
**To:** [Patrick Wooten](#)  
**Subject:** FW: Juvenile Detention Center  
**Sensitivity:** Normal

---

**lu9668 ?External Email**lu9658 ? - From: AAndrews@charlestoncounty.org

---

**From:** Ashley Pennington <APennington@charlestoncounty.org>  
**Sent:** Thursday, June 14, 2018 2:37 PM  
**To:** Megan S. Ehrlich <MEhrlich@charlestoncounty.org>; Holly J. Bendure <HBendure@charlestoncounty.org>; Annie E. Andrews <AAndrews@charlestoncounty.org>; Maryellen Rankin <MRankin@charlestoncounty.org>; J Tim. Taylor <JTTaylor@charlestoncounty.org>; Tammie J. Coppinger <TCoppinger@charlestoncounty.org>  
**Subject:** FW: Juvenile Detention Center

[Redacted]

[Redacted]

[Redacted]

[Redacted]

---

**From:** Willis Beatty  
**Sent:** Thursday, June 14, 2018 1:58 PM  
**To:** Ashley Pennington <[APennington@charlestoncounty.org](mailto:APennington@charlestoncounty.org)>; Mitch Lucas <[mlucas@charlestoncounty.org](mailto:mlucas@charlestoncounty.org)>  
**Subject:** RE: Juvenile Detention Center

Ashley I am sorry I have looked into all this and was going to send out the info and got side tracked. Please see my answers to your questions and let me know if you have any other ones

Willis

*Willis Beatty, CJM, CCE  
Chief Deputy  
Charleston County Sheriff's Office*

*Sheriff Al Cannon Detention Center*  
*3841 Leeds Ave*  
*North Charleston, SC 29405*  
*843-529-7314 Office*  
*843-529-7406 Fax*  
[wbeatty@chalestoncounty.org](mailto:wbeatty@chalestoncounty.org)

---

**From:** Ashley Pennington  
**Sent:** Thursday, June 14, 2018 11:58 AM  
**To:** Mitch Lucas <[mlucas@charlestoncounty.org](mailto:mlucas@charlestoncounty.org)>  
**Cc:** Willis Beatty <[wbeatty@charlestoncounty.org](mailto:wbeatty@charlestoncounty.org)>  
**Subject:** RE: Juvenile Detention Center

Dear Mitch,

We emailed on this on June 4. I am following up on the juvenile detainees having to strip and be in their underwear in their cells at the Juvenile Detention Center, the SMU 18 + hour lockdown conditions regardless of their behavior and the lack of fresh air or exercise for all the kids in detention.

What can be done about to address these harsh conditions for these juvenile detainees?

Best,

**Ashley**

(843) 478-1230 (mobile)

---

**From:** Ashley Pennington  
**Sent:** Monday, June 04, 2018 3:33 PM  
**To:** Mitch Lucas <[mlucas@charlestoncounty.org](mailto:mlucas@charlestoncounty.org)>  
**Cc:** Willis Beatty <[wbeatty@charlestoncounty.org](mailto:wbeatty@charlestoncounty.org)>  
**Subject:** Re: Juvenile Detention Center

Many thanks!

Ashley Pennington  
(843) 478-1230

On Jun 4, 2018, at 2:53 PM, Mitch Lucas <[mlucas@charlestoncounty.org](mailto:mlucas@charlestoncounty.org)> wrote:

I will get with Willis and try to get answers to your questions,

.

Mitch

Mitch Lucas  
Assistant Sheriff  
Charleston County Sheriff's Office  
3691 Leeds Avenue  
North Charleston, S.C. 29405

843-554-2443 Office

---

**From:** Ashley Pennington  
**Sent:** Monday, June 4, 2018 10:26 AM  
**To:** Mitch Lucas <[mlucas@charlestoncounty.org](mailto:mlucas@charlestoncounty.org)>  
**Subject:** Juvenile Detention Center

Dear Mitch,

We spoke briefly on Thursday that my juvenile defenders are concerned that their clients are forced to strip to their underwear and leave their jail uniforms in the hall outside their door. The kids complain to us that they are sometimes very cold. I recently visited a juvenile detainee and saw all the kid's uniforms piled outside their cell doors myself. **This was nothing new found it had been done for years and has never been addressed till now. The Juvenile are no longer having there clothed left outside this was done in the days before the security fence new window covers and cameras were added.**

Our clients also say that the detention center has increased the lock down/cell time of the kids to 18+ hours per weekday for all the kids and more lockdown on weekends when there is no school. For some reason, they cannot have pen and paper in their cells; only two books. They say that their cell windows facing outside are mostly covered and that they almost never are allowed in the outside rec area. **Ashely, this had nothing to do with the population or holding for other counties. This was caused by the amount of 17 year old's that were help for family court. I have been working on this for about a year and your complaint help me get resolution that I can hold all 17 year old's in one area separated from 16 years and younger and 18 years and older. This caused difficulties at Juvenile since they could not be out with the Juveniles and everything had to be done separately. So wreck time should have been resolved also found small issue with the way the classroom things were setup as well which gave us limited space.**

These clients are not on disciplinary punishment, although their custody seems comparable to the SMU or 1A at the jail. My fear is that these punitive conditions are being caused by overcrowding or staff shortages rather than a response to specific kid conduct. It could be being worsened as we take kids from surrounding counties.

As you know, this is not a punishment center. I am concerned that these conditions will embitter these kids and/or desensitize them to imprisonment. I doubt that these policies meet current juvenile detention standards. It will not help them to behave as responsible young men and women since they are all caged like career criminals. I was surprised to hear and see all this and I thought you would be interested too. Is there something that we can do to address these questions?

Best,  
**Ashley**

D. Ashley Pennington  
Ninth Circuit Public Defender  
101 Meeting Street, 5th Floor  
Charleston, SC 29401-2214

(843) 958-1850  
(843) 958-1870(direct)  
(843) 478-1230(mobile)  
(843) 958-5149(facsimile)

[apennington@charlestoncounty.org](mailto:apennington@charlestoncounty.org)

[www.lowcountrydefenders.org](http://www.lowcountrydefenders.org)

Confidential Notice: This electronic mail transmission and any and all accompanying documents and information contain data and matters belonging to the sender which may be confidential and legally privileged. This information is intended ONLY for the use of the individual entity to whom it is addressed. If you are not the intended recipient, any disclosure, copying, distribution or action of any sort taken in reliance on the contents of the information contained in this transmission or any attachments is strictly prohibited and objected to. If you have received this transmission in error, please immediately notify us by telephone at (843) 958-1870 and also delete the message. Thank you.

**Archived:** Friday, July 24, 2020 8:56:09 AM  
**From:** [Annie E. Andrews](#)  
**Sent:** Fri, 19 Jun 2020 16:54:06 +0000ARC  
**To:** [Patrick Wooten](#)  
**Subject:** FW: Juvenile Detention Center  
**Sensitivity:** Normal

---

[REDACTED]

---

**From:** Ashley Pennington <APennington@charlestoncounty.org>  
**Sent:** Monday, June 04, 2018 10:52 AM  
**To:** Annie E. Andrews <AAndrews@charlestoncounty.org>; J Tim. Taylor <JTTaylor@charlestoncounty.org>; Maryellen Rankin <MRankin@charlestoncounty.org>; Holly J. Bendure <HBendure@charlestoncounty.org>  
**Subject:** FW: Juvenile Detention Center

[REDACTED]

---

**From:** Ashley Pennington  
**Sent:** Monday, June 04, 2018 10:26 AM  
**To:** Mitch Lucas <[mlucas@charlestoncounty.org](mailto:mlucas@charlestoncounty.org)>  
**Subject:** Juvenile Detention Center

Dear Mitch,

We spoke briefly on Thursday that my juvenile defenders are concerned that their clients are forced to strip to their underwear and leave their jail uniforms in the hall outside their door. The kids complain to us that they are sometimes very cold. I recently visited a juvenile detainee and saw all the kid's uniforms piled outside their cell doors myself.

Our clients also say that the detention center has increased the lock down/cell time of the kids to 18+ hours per weekday for all the kids and more lockdown on weekends when there is no school. For some reason, they cannot have pen and paper in their cells; only two books. They say that their cell windows facing outside are mostly covered and that they almost never are allowed in the outside rec area.

These clients are not on disciplinary punishment, although their custody seems comparable to the SMU or 1A at the jail. My fear is that these punitive conditions are being caused by overcrowding or staff shortages rather than a response to specific kid conduct. It could be being worsened as we take kids from surrounding counties.

As you know, this is not a punishment center. I am concerned that these conditions will embitter these kids and/or desensitize them to imprisonment. I doubt that these policies meet current juvenile detention standards. It will not help them to behave as responsible young men and women since

they are all caged like career criminals. I was surprised to hear and see all this and I thought you would be interested too. Is there something that we can do to address these questions?

Best,  
**Ashley**

D. Ashley Pennington  
Ninth Circuit Public Defender  
101 Meeting Street, 5th Floor  
Charleston, SC 29401-2214

(843) 958-1850  
(843) 958-1870(direct)  
(843) 478-1230(mobile)  
(843) 958-5149(facsimile)

[apennington@charlestoncounty.org](mailto:apennington@charlestoncounty.org)

[www.lowcountrydefenders.org](http://www.lowcountrydefenders.org)

Confidential Notice: This electronic mail transmission and any and all accompanying documents and information contain data and matters belonging to the sender which may be confidential and legally privileged. This information is intended ONLY for the use of the individual entity to whom it is addressed. If you are not the intended recipient, any disclosure, copying, distribution or action of any sort taken in reliance on the contents of the information contained in this transmission or any attachments is strictly prohibited and objected to. If you have received this transmission in error, please immediately notify us by telephone at (843) 958-1870 and also delete the message. Thank you.

**Archived:** Friday, July 24, 2020 8:56:12 AM

**From:** [Annie E. Andrews](#)

**Sent:** Fri, 19 Jun 2020 17:07:39 +0000ARC

**To:** [Patrick Wooten](#)

**Subject:** FW: plans for new juvenile detention center

**Sensitivity:** High

**Attachments:**

[Minimum Standards for Local Juvenile Detention SC 2018.pdf](#) 

---

**From:** Ashley Pennington <APennington@charlestoncounty.org>

**Sent:** Monday, December 03, 2018 3:49 PM

**To:** Maryellen Rankin <MRankin@charlestoncounty.org>; J Tim. Taylor <JTTaylor@charlestoncounty.org>; Annie E. Andrews <AAndrews@charlestoncounty.org>; Holly J. Bendure <HBendure@charlestoncounty.org>; Caroline M. Bickley (cbickley@homesc.com) <cbickley@homesc.com>

**Subject:** FW: plans for new juvenile detention center

**Importance:** High



---

**From:** Ashley Pennington

**Sent:** Monday, December 03, 2018 3:45 PM

**To:** Willis Beatty <[wbeatty@charlestoncounty.org](mailto:wbeatty@charlestoncounty.org)>

**Subject:** RE: plans for new juvenile detention center

**Importance:** High

Dear Chief,

I am disappointed to report to you that all three public defender lawyers who represent juveniles still report to me that their kid clients are only out of their cells two hours a day, except for when they are in school. This means 22 hours of lockdown on weekends with nothing to do. This is like the kind of lockdown that occurs in adult disciplinary units. Kids are on the floor in "boats". And, the roof is still leaking in the library.

Here are examples:

Boy (incarcerated for over 30 days):

I have had 2 roommates since October. The child who entered my cell last sleeps on the floor in a boat. There is not much room to walk around inside of the cell because there are 3 people and the room is so small. When asked "What do you do with your time?," he said "I twist my hair, watch the walls, and we all try to sleep as much as we can. I started reading a book called Dear Martin, but you can only read so much." "White stuff" comes out of the sink when you cut it on and our room has flooded more than once after the toilet in someone else's cell overflowed and water entered my room. You only get 2hrs of rec, one hour in the morning and one hour at night. "I don't think this place has been good for my mind." I have not been receiving the school assignments from my school even after you complained to the detention center and my mom complained to the detention center and my school. I'm worried being here will hurt my grades since I am not getting my

assignments.

Boy (incarcerated for 1 week):

On 11/14 I had to wait until nighttime to take a shower because the hot water wasn't working. When you take a shower you have to cut the water on all 4 showers at once (there are 5 shower heads, but only 4 work) because that is the only way to get the hot water out. It gets so cold in detention in November. Last night the toilet in my room overflowed after my roommate went to the bathroom. He didn't use that much toilet paper. He used a normal amount, it's just that the toilets are so bad they overflow all the time. The water had pee and poop in it and it overflowed to the hall and they made us clean it all up. As far as rec—you only receive 2hrs of rec if you go to school. If you do not wake up for school, you only get 1hr of rec at night and you lose the 1hr of rec during the day. Other kids here have had 2 roommates in their room for a good while.

I am increasingly concerned that your senior staff there are not following your directives that we discussed. You know my view that the kids are better off at the main jail. Headquarters Road is seems to be unworkable since the staff continue to leave them locked down. What can we do to alleviate this unacceptable situation as we plan and build the new detention center?

I have attached the SC Standards for Juvenile Detention. I do not think we can wait on this. Please advise.

Thanks!

**Ashley**

(843) 478-1230 (mobile)

---

**From:** Ashley Pennington  
**Sent:** Tuesday, October 09, 2018 1:50 PM  
**To:** Willis Beatty <[wbeatty@charlestoncounty.org](mailto:wbeatty@charlestoncounty.org)>  
**Subject:** FW: plans for new juvenile detention center

Dear Chief,

I am checking again about your schedule to look at the plans for the new juvenile detention center. I have time tomorrow afternoon. Just let me know what works for you.

Best,

**Ashley**

(843) 478-1230 (mobile)

---

**From:** Ashley Pennington  
**Sent:** Monday, October 01, 2018 4:56 PM  
**To:** Willis Beatty <[wbeatty@charlestoncounty.org](mailto:wbeatty@charlestoncounty.org)>  
**Cc:** Annie E. Andrews <[AAndrews@charlestoncounty.org](mailto:AAndrews@charlestoncounty.org)>; Maryellen Rankin <[MRankin@charlestoncounty.org](mailto:MRankin@charlestoncounty.org)>; J Tim. Taylor <[JTTaylor@charlestoncounty.org](mailto:JTTaylor@charlestoncounty.org)>; Holly J. Bendure <[HBendure@charlestoncounty.org](mailto:HBendure@charlestoncounty.org)>  
**Subject:** RE: plans for new juvenile detention center

Dear Chief,

I have polled my people and we are available on Wednesday, Oct 10 if you can fit us into your schedule that day.

**Ashley**

(843) 478-1230 (mobile)

---

**From:** Ashley Pennington

**Sent:** Friday, September 28, 2018 10:55 AM

**To:** Willis Beatty <[wbeatty@charlestoncounty.org](mailto:wbeatty@charlestoncounty.org)>

**Subject:** plans for new juvenile detention center

Dear Chief,

I would like to set a time to look at the plans for the new detention center. I have three juvenile defense lawyers who are just as curious. When is a convenient time for you for us to come by?

Best,

**Ashley**

D. Ashley Pennington

Ninth Circuit Public Defender

101 Meeting Street, 5th Floor

Charleston, SC 29401-2214

(843) 958-1850

(843) 958-1870(direct)

(843) 478-1230(mobile)

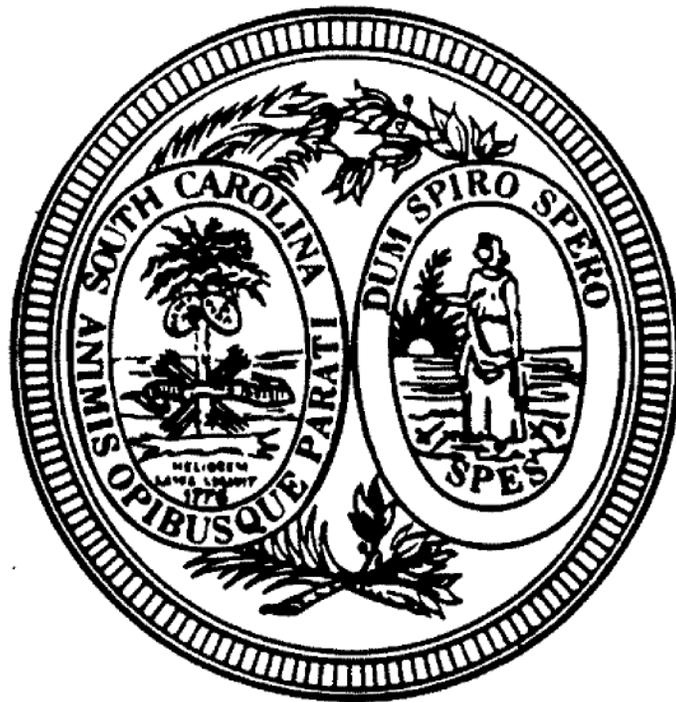
(843) 958-5149(facsimile)

[apennington@charlestoncounty.org](mailto:apennington@charlestoncounty.org)

[www.lowcountrydefenders.org](http://www.lowcountrydefenders.org)

Confidential Notice: This electronic mail transmission and any and all accompanying documents and information contain data and matters belonging to the sender which may be confidential and legally privileged. This information is intended ONLY for the use of the individual entity to whom it is addressed. If you are not the intended recipient, any disclosure, copying, distribution or action of any sort taken in reliance on the contents of the information contained in this transmission or any attachments is strictly prohibited and objected to. If you have received this transmission in error, please immediately notify us by telephone at (843) 958-1870 and also delete the message. Thank you.

# **Minimum Standards for Local Juvenile Detention Facilities in South Carolina**



## **Type VII Facility Juvenile Detention**

## TABLE OF CONTENTS

<b><u>Standard Number</u></b>	<b><u>Subject Title</u></b>	<b><u>Page Number</u></b>
5000	<b>GENERAL INSTRUCTIONS</b>	<b>1</b>
5001	Statutory Authority	1
5002	Introduction	5
5003	Integrity of Independent Sections	5
5004	Other Standards and Requirements	5
5005	Definitions	5
5006	Acronyms	11
5010	<b>APPLICATION OF STANDARDS</b>	<b>11</b>
5011	Types of Facilities	11
5012	Variances and Waivers	12
5013	Emergency Suspension of Standards	12
5014	Inspections	12
5100	<b>ADMINISTRATION/MANAGEMENT</b>	<b>13</b>
5130	Manual of Policies and Procedures	13
5140	Emergency Pre-Planning	14
5150	Juvenile Population Report	14
5160	Personnel	14
5170	Number of Personnel	14
5180	Jail Management Training	14
5190	Pre-Service Training	15
5200	Operations Training	16
5210	In-service Training	16
5220	Training Records	16
5230	Employee Regulations	16
5240	Organizational Chart	16
5260	<b>ADMISSIONS</b>	<b>16</b>
5270	Admission Procedures	17
5271	Guidelines for Detention Documents	18
5280	Booking and Record Information	18
5290	Retention of Juvenile Property	19
5300	Admission of Injured, Ill, or Intoxicated Juveniles	19
5310	Death of a Juvenile	20
5320	Recording and Reporting of Attempted Suicides	20
5330	Log Reports	20
5340	Orientation	20
5350	Discharge, Transfer, or Release of a Juvenile	21
5355	<b>SECURITY</b>	<b>21</b>
5360	Weapons Control	21
5370	Less Lethal Weapons	21
5374	Use of Physical Force	22
5375	Use of Restraints	22

5380	Key Control	22
5390	Tool Control	23
5400	Facility Security	23
5410	Juvenile Movement	23
5430	Juvenile Governance	23
5440	<b>CLASSIFICATION PLAN</b>	<b>24</b>
5450	Classification Categories	24
5460	Classification Review	24
5470	<b>SEPARATION</b>	<b>24</b>
5480	Communicable Diseases	24
5490	Mentally Disordered Juveniles	25
5495	Administrative Separation	25
5500	Females	25
5520	<b>DISCIPLINE</b>	<b>25</b>
5530	Rules and Disciplinary Penalties	25
5535	Plan for Juvenile Discipline	25
5540	Forms of and Limits on Disciplinary Action	26
5545	<b>PHYSICAL PLANT</b>	<b>27</b>
5550	Initial Planning	27
5560	Rated Capacity	28
5570	Facilities Prior to July 1980	28
5590	Facilities From July 1980 Through June 2007	29
5595	Facilities Constructed From July 2007, to the Present	31
5596	Staff/Juvenile Interaction	31
5597	Facility Location	32
5598	Juvenile Housing	32
5610	<b>JUVENILE PROGRAMS AND ACTIVITIES</b>	<b>34</b>
5620	Visitation	34
5630	Correspondence	35
5640	Telephone	36
5650	Access to Legal Counsel and Courts	36
5660	Grievance Procedure	36
5700	<b>MEDICAL SERVICES</b>	<b>37</b>
5710	Responsible Physician	37
5720	Medical Procedures	37
5730	Screening	37
5731	Health Appraisal	38
5732	Pharmacy Standards	38
5740	Emergencies	38
5750	Sick Call	39
5760	<b>JUVENILE CLOTHING AND PERSONAL HYGIENE</b>	<b>39</b>
5765	Clothing Issue	39
5770	Personal Care Items	39

5775	Showering	39
5780	Hair Care Services	40
5785	Bedding and Linen Issue	40
5787	Laundering of Bedding and Linens	40
5790	<b>FOOD</b>	<b>40</b>
5800	Frequency of Service	40
5830	Dietary Allowances	40
5840	Menus and Food Preparation	41
5850	Sanitation and Food Storage	41
5860	Kitchen Staff	41
5870	<b>GENERAL SANITATION AND MAINTENANCE REQUIREMENTS</b>	<b>41</b>
5875	Housekeeping Requirements	41
5890	Vermin, Insects, and Pests	42
5900	Drinking Fountains	42

## 5000 GENERAL INSTRUCTIONS

### 5001 STATUTORY AUTHORITY

The authority to establish and enforce the standards and requirements herein, unless otherwise noted, is based upon the South Carolina Code of Laws, 1976, as amended, Sections 24-9-10 through 24-9-50, and Section 20-7-6845, which read as follows:

24-9-10. Jail and Prison Inspection Division established in Department of Corrections; personnel.

There is hereby established a Jail and Prison Inspection Division under the jurisdiction of the Department of Corrections. The inspectors and such other personnel as may be provided for the Division shall be selected by the Director of the Department.

24-9-20. Inspection of State and local penal facilities housing prisoners or pretrial detainees ; reports.

The Division shall be responsible for inspecting, in conjunction with a representative of the State Fire Marshal, at least annually every facility in this State housing prisoners or pretrial detainees operated by or for a state agency, county, municipality, or any other political subdivision, and such inspections shall include all phases of operation, fire safety, and health and sanitation conditions at the respective facilities. Food service operations of the facilities must be inspected at least annually by an employee of the Department of Health and Environmental Control. The inspections of local confinement facilities shall be based on standards established by the South Carolina Association of Counties and adopted by the Department of Corrections, and appropriate fire and health codes and regulations. The division, the inspecting fire marshal, and the food service inspector of the Department of Health and Environmental Control shall each prepare a written report on the conditions of the inspected facility. Copies of the reports shall be filed with the chairman of the governing body of the political subdivision having jurisdiction of the facility inspected, the chairman of the governing body of each political subdivision involved in a multi-jurisdictional facility, the administrator, manager, or supervisor for the political subdivision, the responsible sheriff or police chief if he has operational custody of the inspected facility, and the administrator or director of the inspected facility. All reports shall be filed through the Director of the Department of Corrections.

(NOTE: In addition to representatives from those state agencies mentioned in the above referenced statute, officials from the Department of Public Safety are also authorized to inspect jails and prisons for compliance with the federal Juvenile Justice and Delinquency Prevention Act.)

24-9-30. Enforcement of minimum standards.

(a) If an inspection under this chapter discloses that a local confinement facility does not meet the minimum standards established by the South Carolina Association of Counties and adopted by the Department of Corrections, and the appropriate fire and health codes and regulations, the Director of the South Carolina Department of Corrections shall

notify the governing body of the political subdivision responsible for the local confinement facility. A copy of the written reports of the inspections required by this chapter shall also be sent to the resident or presiding judge of the judicial circuit in which the facility is located. The governing body shall promptly meet to consider the inspection reports, and the inspection personnel shall appear, if requested, to advise and consult concerning appropriate corrective action. The governing body shall initiate appropriate corrective action within ninety days or may voluntarily close the local confinement facility or objectionable portion thereof.

(b) If the governing body fails to initiate corrective action within ninety days after receipt of the reports of inspections, or fails to correct the disclosed conditions, the Director of the South Carolina Department of Corrections may order that the local confinement facility, or objectionable portion thereof, be closed at such time as the order may designate. However, if the Director determines that the public interest is served by permitting the facility to remain open, he may stipulate actions to avoid or delay closing the facility. The governing body and the resident or presiding judge of the judicial circuit shall be notified by registered mail of the Director's order closing a local confinement facility.

(c) The governing body shall have the right to appeal the Director's order to the resident or presiding judge of the circuit in which the facility is located. Notice of the intention to appeal shall be given by registered mail to the Director of the South Carolina Department of Corrections and to the resident or presiding judge within fifteen days after receipt of the Director's order. The right of appeal shall be deemed waived if notice is not given as herein provided.

(d) The appeal shall be heard before the resident or presiding judge of the circuit who shall give reasonable notice of the date, time, and place of the hearing to the Director of the South Carolina Department of Corrections and the governing body concerned. The hearing shall be conducted without a jury in accordance with the rules and procedures of the Circuit Court. The Department of Corrections, the governing body concerned, other responsible local officials, and fire and health inspection personnel shall have a right to be present at the hearing and present evidence which the court deems appropriate to determine whether the local confinement facility met the required minimum standards on the date of the last inspection. The court may affirm, reverse, or modify the Director's order.

#### 24-9-35. Reports of deaths of incarcerated persons; penalty.

If any person dies while being incarcerated in any municipal or county overnight-lockup, or jail, county prison, or state correctional facility, the jailer or any other person physically in charge of the facility at the time death occurs shall immediately notify the coroner of the county in which the institution is located. The jailer or other person in charge shall also report the death and circumstances surrounding it within seventy-two hours to the Jail and Prison Inspection Division of the Department of Corrections. The division shall retain a permanent record of such reports. Reports shall be made on forms prescribed by the division.

Any person knowingly and willfully violating the provisions of this section shall be deemed guilty of a misdemeanor and upon conviction shall be fined not more than one

hundred dollars.

24-9-40. Certification of compliance with design standards; notification of opening or closing of state or local prison facility.

In order to certify compliance with minimum design standards, the Jail and Prison Inspection Division of the Department of Corrections shall be provided with architectural plans before construction of any state or local confinement facility. Further, the Jail and Prison Inspection Division shall be notified not less than fifteen days prior to the opening of any state or local prison facility so that inspections and reports may be made. Ninety days prior to the closing of any state or local prison facility, the Division shall be notified by the officials concerned.

24-9-50. Reports on detention facilities to the Department of Corrections; electronic reporting preferred.

(A) Each local governmental entity responsible for a municipal, county, regional, or multi-jurisdictional detention facility shall report to the Department of Corrections, at the times and in the form required by the department, data and information prescribed by the department:

(1) for the classification and management of prisoners who receive sentences greater than three months; and

(2) on the classification and management of prisoners who are in pretrial status and prisoners who receive sentences to be served locally.

(B) Data and information authorized in the Minimum Standards for Local Detention Facilities in South Carolina for the operation and management of a statewide jail information system shall be reported to the department by each local governmental entity.

(C) To the greatest extent possible, reports should be submitted through a means of electronic data transfer approved by the department. If it is not possible for a local governmental entity to submit reports through the approved means of electronic data transfer, it shall certify such to the department. The department and the respective local governmental entity shall determine a suitable alternative means for submission of reports until such time as the local governmental entity is able to electronically transfer data in the manner approved by the department.

20-7-6845. Institutional services. The Department of Juvenile Justice shall provide institutional services which include, but are not limited to:

(4) providing juvenile detention services for juveniles charged with having committed a criminal offense who are found, after a detention screening or detention hearing, to require detention or placement outside the home pending an adjudication of delinquency or dispositional hearing. Detention services provided by the department for the benefit of the counties and municipalities of this State must include secure juvenile detention centers. The size and capacity of the juvenile detention facilities needed must be determined by the department after its consideration and review of minimum standards for local detention facilities in South Carolina for the design, construction, and operation of juvenile detention centers. These recognized state standards must be met or exceeded by the department in determining the size and capacity of the juvenile detention centers and in planning for the construction and operation of the facilities. The department shall determine and announce the anticipated maximum operational capacity of each facility

and shall contact each county and municipal governmental body in this State for the purpose of determining which counties or municipalities anticipate utilizing these facilities upon each facility becoming operational. The department shall inform each county and municipal governmental body of the existing state and federal laws regarding the confinement of juveniles charged with committing criminal offenses, of each county's and municipality's ability to develop its own facility or to contract with other counties or municipalities for the development of a regional facility, and of the availability of the department's facilities. This notice must be provided to each county and municipality for the purpose of determining which county governmental bodies desire to enter into an intergovernmental agreement with the department for the detention of juveniles from their particular community who are charged with committing a criminal offense for which pretrial detention is both authorized and appropriate. No later than September 1, 1993, the department shall report to the Budget and Control Board on the strategy of each county to comply with requirements of counties under this article. The department must include with its report a plan for the construction and the operation of those facilities which are projected to be necessary for the preadjudicatory detention of juveniles in this State. No later than September first of each subsequent year, the department shall report to the board on the status of all preadjudicatory juvenile detention facilities known to be operational or planned, regardless of ownership or management. Beginning with the report to the board which is due no later than September 1, 1996, the department must include an annual status report on the numbers of juveniles in pretrial detention who are awaiting disposition in general sessions court, whether they have been waived by the family court or whether they qualify due to the offense with which they are charged. The board then will coordinate with all responsible and affected agencies and entities to ensure that adequate funding is identified to prevent the detention or incarceration of juveniles who are awaiting disposition by, or who are under the jurisdiction of, the family court in adult jails anywhere within the State of South Carolina and to prevent the detention of juveniles who are awaiting disposition by general sessions court in facilities which do not provide actual sight and sound separation from adults who are in detention or custody. Upon completion of each facility and upon the determination by the Jail and Prison Inspection Division of the Department of Corrections that each facility is staffed in accordance with relevant standards and can be operated in accordance with these standards, the division shall determine and announce the rated capacity of each facility. A facility operated by the Department of Juvenile Justice for the preadjudicatory detention of juveniles must be maintained and continued in operation for that purpose until approved for conversion or closure by the Budget and Control Board. However, a county or municipality which decides to maintain its own approved facilities or which has entered into a regional intergovernmental agreement, which has provided secure facilities for preadjudicatory juveniles, and which meets the standards set forth above, may continue to operate these facilities. County and regionally operated facilities are subject to inspection by the Jail and Prison Inspection Division of the Department of Corrections for compliance with the standards set forth above and those created pursuant to Section 24-9-20. The division has the same enforcement authority over county, municipal, and regionally operated secure juvenile detention facilities as that which is provided in Section 24-9-30. In Department of Juvenile Justice operated facilities, the department shall determine an amount of per diem for each child detained in a center, which must be paid by the governing body of the law enforcement agency having original jurisdiction where the offense occurred. The per diem paid by the governing body of the law enforcement agency having original jurisdiction where the offense occurred must be based on the average operating cost among all preadjudicatory state facilities. The

Department of Juvenile Justice must assume one-third of the per diem cost and the governing body of the law enforcement agency having original jurisdiction where the offense occurred must assume two-thirds of the cost. Per diem funds received by the department must be placed in a separate account by the department for operation of all preadjudicatory state facilities. Transportation of the juvenile to and from a facility is the responsibility of the law enforcement agency having jurisdiction where the offense was committed. Transportation of juveniles between department facilities, if necessary, is the responsibility of the department.

#### 5002 INTRODUCTION

These regulations have been prepared and adopted for the purpose of establishing minimum standards for the operation, administration, and design of local juvenile detention facilities. These regulations shall be known as "Minimum Standards." The development of these Standards has not been an arbitrary or discretionary procedure. Various agencies and organizations involved in local corrections in South Carolina were solicited and asked for comments on these Standards. Various national standards developed by professional organizations such as the American Correctional Association, the Council of Juvenile Correctional Administrators, the American Bar Association, and the American Medical Association, as well as sound management principles, were the fundamental guides for the development of the Standards.

The recommendations that are also contained herein are policies and/or procedures which may be implemented with a view toward improving local juvenile detention operations, and every effort should be made to follow them.

#### 5003 INTEGRITY OF INDEPENDENT SECTIONS

If any section, subsection, sentence, clause, or phrase of these standards is, for any reason, subsequently held to be unconstitutional; contrary to federal or state law; or otherwise inoperative, such decisions shall not affect the validity of the remaining portion of the standards.

#### 5004 OTHER STANDARDS AND REQUIREMENTS

These are considered minimum standards and nothing that is contained in these standards shall be construed to prohibit a city, county, or multi-jurisdictional agency operating a local juvenile detention facility from adopting other standards and requirements governing its own employees and facilities, provided such standards exceed and do not conflict with these standards. Nor shall these standards be construed as an authority to violate any national or state fire, building, health, or safety code, regulation, or standard.

#### 5005 DEFINITIONS

The following definitions shall apply:

- (a) "Agency Director" means the governing authority for the South Carolina Department of Corrections, who and which act by and through the Director of the Jail and Prison Inspection Division and his/her designated employees.

- (b) "Facility Administrator" herein means the County Administrator/Manager/Supervisor, Sheriff, Mayor, City Administrator/Manager, or other official charged by law with the administration of a local juvenile detention facility.
- (c) "Facility Manager" means the detention director, chief jailer, warden, superintendent, jail administrator, or other comparable employee who has been delegated the responsibility for operating a local juvenile detention facility by a Facility Administrator.
- (d) "Shall" and "will" are mandatory; "should" is expected practice; and "may" is permissive.
- (e) "Security personnel" means those officers with the rank of deputy, correctional officer, detention officer, or other equivalent sworn or civilian rank whose primary duties include the supervision of juveniles.
- (f) "Emergency" means any significant disruption of normal policies, procedures, or activities caused by riot, fire, attack, or other similar disturbance.
- (g) "Facility" is, for the purposes of these standards, any holding cell (if not part of another facility as defined in this paragraph); overnight lockup; juvenile holdover facility; city, county, or multi-jurisdictional jail; county prison camp or work camp; work/punishment center; juvenile detention center; or juvenile community residential facility.
- (h) "Holding Cell" is a facility (City/County/Multi-Jurisdictional Lockup) for the temporary holding of persons for detoxification or who are awaiting bond, other judicial action, or transportation. If a person is to be detained longer than six (6) hours, he/she shall be transferred to a Type I or Type II facility.
- (i) "Type I Facility" is a facility (overnight lockup) for the temporary detention of persons who are being held while awaiting a judicial hearing. If a person is going to be detained longer than forty-eight (48) hours, he/she shall be transferred to a Type II facility unless there is some documented compelling reason for not doing so.
- (j) "Type II Facility" is a facility (City, County, or Multi-Jurisdictional Jail) which houses persons awaiting court action, inmates sentenced to three (3) months or less, and civil contemptors.
- (k) "Type III Facility" is a separate facility (County or Multi-Jurisdictional Prison Camp) which houses only sentenced adult inmates.
- (l) "Type IV Facility" is a facility (combined County or Multi-Jurisdictional Jail/Prison Camp) which houses persons awaiting court action, civil contemptors, and inmates sentenced to three (3) months or less, and which may also house inmates with longer sentences under a designated facilities agreement with the Department of Corrections.

- (m) "Type V Facility" is a work/punishment center, stand alone or otherwise, which houses sentenced inmates and civil contemptors who are participating in community programs such as work release or education release.
- (n) "Type VI Facility" is a Juvenile Holdover Facility for the temporary custody of juveniles who are awaiting an initial detention hearing. If a juvenile is not released after the hearing, he/she must be transferred to a Type VII or VIII facility. An approved secure Local Juvenile Holdover Facility may detain juveniles who are alleged to have perpetrated acts that would constitute a violation of criminal law if done by an adult and juveniles who have been committed for violation of a valid court order. An approved non-secure Juvenile Holdover Facility may detain all other categories of status offenders who are legally eligible for detention.
- (o) "Type VII Facility" is an approved Local Juvenile Detention Center for the lawful custody and treatment of juveniles who are alleged to have perpetrated acts that would constitute a violation of criminal law if done by an adult and juveniles who have been committed for violation of a valid court order.
- (p) "Type VIII Facility" is a Juvenile Community Residential Facility which is a structure, or is within a structure, that lacks security hardware and other more traditional confinement accessories and which serves as an alternative for the provision of non-secure housing and/or programming for pre- and/or post-adjudicatory juveniles.
- (q) "Type IX Facility" is Home Detention, which means confinement of a person to his/her place of residence and/or other location(s) as an alternative to incarceration when there are both legal authority and administrative provisions to do so.
- (r) "Standards" are the paragraphs, sections, or lines preceded by a four (4) digit number, which are considered minimum standards for the operation of a local juvenile detention facility. "Discussion" following a standard is for guidance and clarity, but it is not part of the official standard nor is it mandatory. "Recommendations" should not be considered standards. They are principally suggestions for the efficient operation of a facility, but they are not requirements.
- \*(s) "Juvenile" is an individual who is under the age of seventeen years.
- \*(t) "Delinquency" means the perpetration of an act by a juvenile which, if done by an adult, would constitute a violation of the law.
- \*(u) "Status Offenders" are juveniles who are charged with, or who have perpetrated, offenses that would not be criminal if done by an adult.
- \*(v) "Juvenile Detention" means the temporary care of juveniles in physically restrictive facilities. This does not constitute "arrest" but "custody." Custody is not punitive. When juveniles are charged as adults, the taking into "custody" may actually be considered to be "arrest"; however, juveniles in preadjudicatory and/or

pretrial detention status are managed under the least restrictive circumstances appropriate based upon classification and other available information.

- (w) "Direct Supervision" means management of juveniles in which security personnel are not separated by a barrier that prohibits visual and audio interactions with the juveniles. Officers work directly in housing units and provide frequent, non-scheduled observation of and personal interaction with juveniles. Each housing unit has at least one (1) Security Officer posted to supervise the unit twenty-four (24) hours a day, seven (7) days a week. Security Personnel/Supervisors are assigned at a ratio of no less than one (1) per every twelve (12) juveniles during the day (1:12), and when the entire juvenile population in a living unit is in a secured mode (e.g., cells/rooms are locked for sleeping, etc.), the ratio may be altered to a ratio of one staff member to no more than twenty-four (24) juveniles during the night (1:24), provided that adequate supervision is maintained in each living unit.
- (x) "Housing Unit" means a group or cluster of single and/or multiple occupancy cells or detention rooms that houses juveniles and is immediately adjacent and directly accessible to a day room or activity room.
- (y) "Local Detention Committee" refers to the permanent, formal group established by the South Carolina Association of Counties for the purpose of considering requests for waivers, proposed classification plans, and other appropriate matters as determined by the Association's Board of Directors.
- (z) "Variance" is a temporary deviation from a standard(s) in extenuating circumstances which can be overcome in a reasonable period of time; "waiver" is a long term deviation from a standard(s) in extenuating circumstances which are not likely to be overcome in a reasonable period of time.
- (aa) "Essential Support Functions" are the duties and activities identified by the Facility Manager and the Jail and Prison Inspection Division for the safe, secure, and efficient operation of the facility.
- \*(ab) "Juvenile Charged as Adult" is a person under the age of criminal majority, who may be housed in an approved adult facility which meets sight/sound separation requirements because his/her case is being handled in General Sessions Court.
- (ac) "Average Daily Population (ADP)" is the official count taken at midnight for an aggregate time period and divided by the number of days in the specified time period.
- (ad) "Average Length of Stay (ALOS)" is the period of time spent in a facility by pre-adjudicatory/pre-trial juveniles as calculated using the following formula:  $ALOS = (365 \times \text{Pre-adjudicatory/Pre-trial ADP} \div \text{Total Pre-adjudicatory/Pre-trial Bookings for One Year})$ .
- (ae) "Operational Capacity" is the optimum number of juveniles that a facility can efficiently and effectively manage and classify. Operational capacity is usually expressed as a percentage of design or rated capacity (e.g., 80% of rated

capacity). This percentage will vary from one facility to another, based on factors such as the types of juveniles held, housing unit design, and proximity of staff. *Note: Authoritative Reference: "Resource Guide for Jail Administrators", Mark D. Martin & Thomas A. Rozazza, NIC, December 2004, Page 52.*

- (af) "Design Capacity" is the total number of beds in a facility as envisioned by the architect and initially built.
- (ag) "Rated Capacity" is the total number of recognized beds in a facility as approved by the Jail and Inspection Division based upon criteria in the Minimum Standards.
- (ah) "Intercom" refers to equipment or a system that enables initiating and receiving sound at each station within a facility without dependence upon staff assistance.
- \*(ai) "Youthful Offender" refers here to an inmate who is:

(1) under seventeen years of age and has been bound over for proper criminal proceedings to the court of general sessions pursuant to Section 20-7-7605 for allegedly committing an offense that is not a violent crime, as defined in Section 16-1-60, and that is a misdemeanor, a Class D, Class E, or Class F felony, as defined in Section 16-1-20, or a felony which provides for a maximum term of imprisonment of fifteen years or less; or

(2) seventeen but less than twenty-five years of age at the time of conviction for an offense that is not a violent crime, as defined in Section 16-1-60, and that is a misdemeanor, a Class D, Class E, or Class F felony, or a felony which provides for a maximum term of imprisonment of fifteen years or less.

- (aj) "Juvenile Specifics Training Course" is a forty (40) hour training course that shall include but not be limited to:
  - (a) Juvenile rights;
  - (b) Officer leadership;
  - (c) Interpersonal sensitivity;
  - (d) Safety and security;
  - (e) Adolescent development;
  - (f) Behavioral management;
  - (g) Behavioral observation and recording;
  - (h) Basic health care and communicable disease issues;
  - (i) Dynamics of managing mentally disordered youth;
  - (j) Suicide prevention issues;
  - (k) Conflict resolution; and
  - (l) Effective communication.

- (ak) "Class 2 LCO" means a local facility detention officer who shall successfully complete a training program as approved by the Criminal Justice Academy. Officers possessing a current Class 2-LCO Certification shall be required to complete the number of hours of in-service instruction per year as specified by the Jail Standards Committee and approved by the Criminal Justice Academy.

- (al) "Class 2 JCO" means a juvenile correctional officer with the Department of Juvenile Justice who shall successfully complete a training program as approved by the Criminal Justice Academy. Officers possessing a current Class 2-JCO certification shall be required to complete an agency in-service program approved by the Criminal Justice Academy of at least forty hours every three years. At least one course each year shall be a legal update course.
- (am) "Nutraloaf" is a loaf style form of nourishment prepared using ingredients and processes that meet mandated dietary and nutritional requirements. It is designed to be consumed without the need for utensils and is served as an alternative to regular juvenile meals because of behavior problems such as misuse of food or throwing of bodily waste.
- (an) "Juvenile Justice and Delinquency Prevention Act" refers to federal legislation that was passed by the United States Congress in 1974. It has changed the way states and communities deal with troubled youth. The original goals of the Act and of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) were simple: to help state and local governments prevent and control juvenile delinquency and to improve the juvenile justice system. These goals were reaffirmed in the reauthorization of the Act several times, most recently in 2002. A second important element in the 1974 Act was to protect juveniles in the juvenile justice system from inappropriate placements and from the harm, both physical and psychological, that can occur as a result of exposure to adult inmates. Yet another important element of the JJDP Act emphasized the need for community-based treatment for juvenile offenders. In passing the JJDP Act, Congress recognized that keeping children in the community is critical to their successful treatment.

The JJDP Act, in its current form through the 2002 reauthorization, establishes four core protections with which participating states and territories must comply to receive grants under the JJDP Act:

Deinstitutionalization of status offenders (DSO);  
Separation of juveniles from adults in institutions (separation);  
Removal of juveniles from adult jails and lockups (jail removal); and  
Reduction of disproportionate minority contact (DMC), where it exists.

Meeting the core protections is essential to creating a fair, consistent, and effective juvenile justice system that advances the important goals of the JJDP Act.

Each participating state must develop and implement a strategy for achieving and maintaining compliance with the four core protections as part of its annual Formula Grants State Plan. A state's level of compliance with each of the four core protections determines eligibility for its continued participation in the Formula Grants programs. For example, failure to achieve or maintain compliance, despite good faith efforts, reduces the Formula Grant to the state by 20 percent for each core requirement not met. In addition, the noncompliant state must agree to expend 50 percent of the state's allocation for that year to achieve compliance with the core requirement(s) with which it is not in compliance.

\*These definitions are not intended to denote language of the current state law, but are given to assist in possible categories of classification.

## 5006 ACRONYMS

ACA - American Correctional Association  
ADA - Americans with Disabilities Act  
AJA - American Jail Association  
ANSI - American National Standards Institute  
CJCA - Council of Juvenile Correctional Administrators  
DHEC - South Carolina Department of Health and Environmental Control  
IBC - International Building Code  
IEBC - International Existing Building Code  
IFC - International Fire Code  
IMC - International Mechanical Code  
IPC - International Plumbing Code  
JJDP Act - Juvenile Justice and Delinquency Prevention Act  
MASC - Municipal Association of South Carolina  
NCCHC – National Commission for Correctional Health Care  
NFPA - National Fire Protection Association  
NJDA - National Juvenile Detention Association  
NSA - National Sheriffs' Association  
OJJDP - Office of Juvenile Justice and Delinquency Prevention  
OSHA - Occupational Safety and Health Administration  
PbS - Performance Based Standards  
SBC - Standard Building Code  
SC - South Carolina - used to denote existing edition of the Minimum Standards for  
Local Detention Facilities in South Carolina  
SCAC - South Carolina Association of Counties  
SCCJA - South Carolina Criminal Justice Academy  
SCDC - South Carolina Department of Corrections  
SCDJJ - South Carolina Department of Juvenile Justice  
SCDPS - South Carolina Department of Public Safety  
SCJAA - South Carolina Jail Administrators' Association  
SCSA - South Carolina Sheriffs' Association  
SEBC - Standard Existing Building Code  
SFMRR - State Fire Marshal Rules and Regulations  
SFPC - Standard Fire Prevention Code  
SL - State Law  
SMC - Standard Mechanical Code  
SMSA - Standard Metropolitan Statistical Area

## **5010 APPLICATION OF STANDARDS**

### **5011 TYPES OF FACILITIES**

All standards and requirements herein shall apply to every local juvenile detention facility in South Carolina except where exceptions have been documented. These standards and requirements do not necessarily apply to adult detention facilities unless they have been incorporated into the respective edition(s) of Minimum Standards when appropriate.

### **5012 VARIANCES AND WAIVERS**

- a. The Director, Jail and Prison Inspection Division, may grant specific variance from these Standards for sufficient reasons and in the public interest. Any variance granted shall be reviewed at least annually by the Director and continued only if substantial progress is being made to comply with the Standard(s).
- b. All requests for waivers shall be submitted in writing to the Director, Jail and Prison Inspection Division, with explanation of extenuating circumstances and justification included. He/she shall review all documentation available to him/her, may consult with local officials where the facility is located, and may request additional information. A written recommendation from the Director, Jail and Prison Inspection Division, shall be submitted within thirty (30) days to the Local Detention Committee of the South Carolina Association of Counties. The Committee may request additional information from any of the parties involved, and may ask them to appear in person to clarify issues and answer questions from members of the Committee. A written response shall be rendered by the Committee within sixty (60) days after receiving the referral and recommendation from the Director, Jail and Prison Inspection Division. Decisions of the Committee shall be final.

### **5013 EMERGENCY SUSPENSION OF STANDARDS**

The Facility Administrator may temporarily suspend, for a period not to exceed three (3) days, any standard herein in the event of an emergency which threatens the safety of the local detention facility, any of its juveniles or staff, or the public.

Such suspension shall be reported to the Jail and Prison Inspection Division immediately, or no later than the next business day, by telephone, and then in writing via fax; through e-mail; or by letter as soon as practical, outlining the nature of the emergency; expected end of the emergency; and steps taken to reduce or eliminate it. In no event shall such a suspension continue more than three (3) days without the approval of the Director, Jail and Prison Inspection Division, for a time specified by him/her.

### **5014 INSPECTIONS**

Inspecting authorities employed by the Department of Corrections and Department of Public Safety are charged with the duty of inspecting all local detention facilities within the State of South Carolina where juveniles are or may be held. Inspecting authorities may enter any local detention facility in this State at any time without prior notice; shall

be admitted without unnecessary delay; and may confer privately with any employee or juvenile after coordination with the Facility Manager or the senior official on duty. Visits will deal with inspections and related matters but will not involve investigations of criminal activities. As a professional courtesy, inspecting authorities will attempt to meet with the Facility Manager or senior official on duty at the time of the visit. Inspecting authorities may make additional visits to provide technical assistance when requested.

In accordance with South Carolina Code of Laws, Section 24-9-20, staff from the Jail and Prison Inspection Division of the Department of Corrections will conduct an annual inspection of each local detention facility. The inspecting authorities will conduct an exit interview with the Facility Manager or designee. A written report will be provided within sixty (60) days of the inspection.

## **5100 ADMINISTRATION/MANAGEMENT**

Once a year, the Facility Administrator should arrange for a visit of the facility by the governing body, circuit court judges, magistrates, and other interested parties, to examine the facility's condition, the treatment of juveniles, and the programs available for juveniles.

## **5130 MANUAL OF POLICIES AND PROCEDURES**

Each facility shall have a written manual of all policies and procedures for the operation of the facility that will be reviewed annually and updated as needed.

These policies and procedures will be made readily available to all personnel. The following standards require written policies and procedures:

5140	Emergency Pre-Planning	5430	Juvenile Governance
5220	Training Records	5440	Classification Plan
5230	Employee Regulations	5450	Classification Categories
5260	Admissions	5480	Communicable Diseases
5270	Admission Procedures	5490	Mentally Disordered Juveniles
5280	Booking and Record Information	5495	Administrative Separation
5290	Retention of Juvenile Property	5530	Rules and Disciplinary Penalties
5310	Death of a Juvenile	5535	Plan for Juvenile Discipline
5320	Recording and Reporting of Attempted Suicide	5610	Juvenile Programs and Activities
5330	Log Reports	5620	Visitation
5350	Discharge, Transfer, or Release of a Juvenile	5630	Correspondence
5360	Weapons Control	5640	Telephone
5370	Less Lethal Weapons	5650	Access to Legal Counsel and Courts
5374	Use of Physical Force	5660	Grievance Procedure
5375	Use of Restraints	5732	Pharmacy Standards
5380	Key Control	5740	Emergencies
5390	Tool Control	5750	Sick Call
5410	Juvenile Movement	5870	General Sanitation and Maintenance Requirements

5140 EMERGENCY PRE-PLANNING

Each facility shall have current written procedures to be followed in emergency situations. These plans shall include procedures for the following emergency situations:

fire	disturbances
escape	suicides and attempted suicides
taking of hostages	power failures
group arrests	natural disasters
bomb threats	homeland security issues

Discussion: The facility should detail in writing specific procedures which can be implemented quickly when an emergency occurs. The procedures should contain provisions for sounding an appropriate alarm, alerting officials, mobilizing needed resources, and ending the alert. For example, a fire suppression plan would be coordinated with, and recognized by, the local fire department and would include a fire prevention plan in the policies and procedures manual; regular facility inspection by staff; fire prevention inspections by the fire department having jurisdiction; an evacuation plan; and a plan for the emergency housing of juveniles in case of a fire or other incident.

5150 JUVENILE POPULATION REPORT

Each facility shall have a system for physically counting juveniles. Each facility shall conduct a head-count at least once per shift. Additionally, an official headcount shall be taken at midnight everyday.

5160 PERSONNEL

5170 NUMBER OF PERSONNEL

- (a) The Facility Administrator shall designate a Facility Manager who is qualified by training and experience to supervise staff and juveniles.
- (b) Each facility shall have sufficient personnel to provide twenty-four (24) hour supervision and processing of juveniles, to arrange full coverage of all identified security posts, and to accomplish essential support functions.
- (c) If one (1) or more female juvenile(s) is/are in custody, there shall be at least one (1) female security officer on duty, who shall be immediately available and accessible to female juveniles.
- (d) A staffing analysis (using NIC Staffing Analysis Workbook or other industry recognized plan) shall be conducted to determine facility staffing needs. The staffing analysis shall be reviewed annually and updated as needed.
- (e) Each facility shall have a designated training coordinator.

5180 JAIL MANAGEMENT TRAINING

All managerial personnel, including the facility manager and supervisory personnel of a

local juvenile detention facility, shall successfully complete at least forty (40) hours of relevant training to include the jail management training program, in addition to orientation training as prescribed and/or approved by the South Carolina Criminal Justice Academy. Additionally, at least forty (40) hours of relevant training will be completed each year thereafter. Such management training shall include but not be limited to:

- (a) Fiscal, general, and personnel management;
- (b) Administrative and logistical support management;
- (c) Correctional program development;
- (d) Jail planning;
- (e) Labor law and legal problems in jail administration;
- (f) Staff/management and community relations;
- (g) Community resources for juvenile detention alternatives;
- (h) Suicide prevention; and
- (i) Juvenile justice system

Such management training shall be satisfactorily completed by all managerial personnel as soon as practical but, in any event, within not more than one (1) year after the date of assignment to supervisory duties. Anyone who has completed jail management training prior to current assignment within the last three (3) years and/or has three (3) years of corrections management or supervisory experience may be exempted from this requirement upon a review of credentials by the Criminal Justice Academy.

#### 5190 PRE-SERVICE TRAINING

All non-security personnel (to include: administrative, support, and contract) and volunteers will be required to complete an orientation program which has been approved by the Facility Manager.

All security staff assigned to a local juvenile detention facility must complete the forty (40) hour juvenile specifics training course prior to assignment.

Such training shall include but not be limited to:

- (a) Juvenile rights;
- (b) Officer leadership
- (c) Interpersonal sensitivity;
- (d) Safety and security;
- (e) Adolescent development;
- (f) Behavioral management;
- (g) Behavioral observation and recording;
- (h) Basic health care and communicable disease issues;
- (i) Dynamics of managing mentally disordered youth;
- (j) Suicide prevention issues;
- (k) Conflict resolutions; and
- (l) Effective communication.

An accredited CPR and first aid training course shall be successfully completed.

## 5200 OPERATIONS TRAINING

Jail operations training shall be satisfactorily completed by all security personnel and supervisory personnel as soon as practical but, in any event, within not more than one (1) year after the date of assignment to security duties.

The Facility Manager or designee shall coordinate with the Criminal Justice Academy within the first six (6) months of each employee's hire date to schedule jail operations training.

## 5210 IN-SERVICE TRAINING

All non-security personnel shall be required to complete in-service training which has been approved by the Facility Manager.

Class 2-LCO officers shall meet the adult Minimum Standards training requirements. In addition, officers must successfully complete the Juvenile Specifics training course every three (3) years.

Officers shall be recertified in CPR and first aid training as required.

### Discussion:

The purpose of the in-service training is to keep the employees up to date on procedures and incidents and methods of handling them. This requirement may be met by sessions scheduled on a weekly or monthly basis.

## 5220 TRAINING RECORDS

Each facility shall maintain records on types and hours of training completed by each security officer. This training shall be reported to the South Carolina Criminal Justice Academy in a form acceptable to the Academy.

Each facility shall maintain records on types and hours of training completed by non-security personnel and volunteers. These records shall be reviewed at least quarterly by the training coordinator, and they shall be available for examination by inspectors on-site.

## 5230 EMPLOYEE REGULATIONS

A written code of ethics prohibits staff, contractors, and volunteers from using their official positions to secure privileges for themselves or others and from engaging in activities that constitute a conflict of interest. This code is available to all employees.

## 5240 ORGANIZATIONAL CHART

Each facility shall have an organizational chart which reflects the line of authority and responsibility within the facility.

## 5260 ADMISSIONS

Each facility shall have written procedures for admitting juveniles. No neglected, dependent, abused, or alien child shall be detained or confined in any local detention facility if he/she is taken into custody based solely on matters related to his/her alleged condition as a neglected, dependent, abused, or alien minor. No juvenile who is alleged to be a status offender shall be detained or confined in any local detention facility unless he/she is committed for violation of a valid court order.

- (a) Every attempt shall be made to contact the parent or legal guardian of each juvenile as soon as possible upon his/her admission to the facility provided that this has not already been done by another agency. These attempts may be by telephone call and/or personal visit.
- (b) When a juvenile is not released to a parent, guardian, or custodian, the Family Court shall be notified upon admission; or, if admission occurs after business hours, the Family Court shall be notified at the beginning of the next business day.
- (c) If a juvenile is not released to the custody of his or her parents, or to another responsible adult, upon arrival at the facility, the Department of Juvenile Justice shall be contacted immediately.
- (d) Unless otherwise ordered by the court, a juvenile shall be released to the custody of his/her parents, guardian, custodian, DJJ, or others as designated by the court.
- (e) A juvenile who has been taken into custody shall not be detained or placed in secure confinement for more than six (6) hours in any facility which has not been approved as a juvenile holdover facility or a juvenile detention center.
- (f) A juvenile who is to be detained or placed in secure confinement for more than six (6) hours must be given a detention hearing within forty-eight (48) hours from the time of being taken into custody, excluding weekends and holidays.
- (g) After the initial forty-eight (48) hour detention, a juvenile shall not be held longer than seven (7) days without a court-ordered extension. Additional extensions, not to exceed seven (7) days each, may be made only by subsequent orders of the court. Such orders shall be in writing.

## 5270 ADMISSION PROCEDURES

Each facility shall have written procedures for admitting new juveniles which include:

- (a) Verification of arrest or commitment papers;
- (b) Proper search of each juvenile and his/her possessions;
- (c) Inventorying, packing, and storing of clothing and personal possessions;
- (d) Medical, dental, and mental health screenings; (See 5730)
- (e) At least two completed telephone calls by each juvenile;
- (f) Shower and hair care, if necessary;
- (g) Issue of clean clothing;

- (h) Photographing and, if applicable, fingerprinting\*;
- (i) Interview for obtaining identifying data and recording personal data and information to be used for mail and visiting lists;
- (j) Screening interview;
- (k) Providing orientation and issuing written orientation materials to the juvenile and procedures for mail and visiting;
- (l) Issue of personal hygiene items and bedding;
- (m) Classification;
- (n) Assignment of a registered number;
- (o) Assignment to a housing unit; and
- (p) Obtaining victim information as required by South Carolina Code of Laws, Section 16-3-1530.

\*Juveniles shall be photographed or fingerprinted only in accordance with South Carolina Code of Laws, Section 20-7-8515 (F), (G), and (H).

#### 5271 GUIDELINES FOR DETENTION DOCUMENTS

- (a) Juvenile arrestees and juveniles who have been taken into custody should never be accepted without a charging document. Verbal holds shall not substitute for commitment documentation.
- (b) An arrest or booking report shall contain a charge and include the name and agency of the arresting officer.
- (c) Juveniles detained at the facility shall be legally held on the authority of a court order.

#### 5280 BOOKING AND RECORD INFORMATION

- (a) A record for each juvenile detainee shall be established at admission, or as soon as possible after admission, and shall be maintained throughout the period of confinement. Such record(s) shall include:
  - \* (1) Picture;
  - (2) Booking number;
  - (3) Date and time of arrest;
  - (4) Name and aliases of person;
  - (5) Last known address;
  - (6) Date and time of commitment and authority thereof;
  - (7) Name and title of officers presenting and receiving detainee;
  - (8) Specific charges;
  - (9) Court and sentence (if adjudicated juvenile);
  - (10) Sex;
  - (11) Age and date of birth;
  - (12) Race;
  - (13) Marital status;
  - (14) Name and address of next of kin;
  - (15) Health status;
  - (16) Record of cash and property;

- (17) Record of misconduct and discipline administered;
- (18) Name, address, relationship, and phone number of parent(s), legal guardian(s), and person(s) with whom a juvenile resides at time of admission and/or other methods of contact;
- \* (19) Medical records;
- (20) Bond information; and
- (21) Social security number if available.

\*Medical records shall be secured and shall be available to staff members only when such access is required in the performance of duties. Juveniles shall be photographed and fingerprinted only in accordance with South Carolina Code of Laws, Section 20-7-8515 (F), (G), and (H).

- (b) Each facility shall have written policies and procedures for safeguarding juvenile records from improper and unauthorized disclosure. A separate jail book or police blotter shall comply with the following:
  - (1) Juvenile records shall be clearly marked "Confidential";
  - (2) Juvenile records shall be kept secured and separate from adult records; and
  - (3) Records of juveniles shall not be opened to the public for inspection, and shall be opened to inspections only by such government agencies as are legally authorized.

#### 5290 RETENTION OF JUVENILE PROPERTY

Facility policy shall require that, whenever cash or personal property is taken from a juvenile, the following actions shall be taken:

- (a) A listing, including description, of each item shall be made and signed by both the officer and the juvenile. A copy of this list shall be made available to the juvenile as a receipt. If a juvenile refuses to sign, the reasons for his/her refusal should be noted on the list and witnessed by a second employee.
- (b) The property taken shall be kept under lock and key.
- (c) When the property is returned to a juvenile, he/she shall be directed to sign a statement saying that the property has been returned to him/her. If he/she refuses to sign, a second witness is needed.
- (d) A facility should not release a juvenile's property to any third party without the permission of the juvenile's legal guardian or by court order.
- (e) Facility policy shall govern the possession of items of clothing or jewelry.

#### 5300 ADMISSION OF INJURED, ILL, OR INTOXICATED JUVENILES

Any juvenile who appears to be either severely injured or acutely ill, or who is in a stupor or a coma, even through the apparent cause may be intoxication, shall be examined by a physician prior to acceptance or admission to rule out the possibility of brain injury or organic disease as a cause of the apparent disability. If a juvenile is referred to a

community hospital or other medical facility and is returned, his/her admission to the facility shall be predicated upon written medical clearance.

Further, if after an examination and treatment as appropriate, and upon advice and concurrence of the examining physician, the juvenile is kept at the facility, he/she shall be maintained by security staff under the level of observation determined necessary by the physician until such time that he/she shall have completely recovered from the stupor or coma. If, after a reasonable period of time, he/she has not completely recovered, the juvenile shall be transferred to a medical facility for further examination and treatment.

#### 5310 DEATH OF A JUVENILE

The death of a juvenile must be reported in writing to the Jail and Prison Inspection Division within seventy-two (72) hours of the occurrence, and must be reported by telephone on the day that it occurs. The facility administrator shall request an autopsy by the County Coroner or his/her designee to ascertain the cause of death.

#### 5320 RECORDING AND REPORTING OF ATTEMPTED SUICIDE

A report of each attempted suicide shall be included in the records of the attempting juvenile and of the facility. Each attempted suicide shall be reported immediately to the responsible medical authority or a health or mental health authority. Each attempted suicide shall be reported in writing to the Jail and Prison Inspection Division within five (5) days.

#### 5330 LOG REPORTS

Each incident which impairs or endangers the life or physical welfare of an employee, a juvenile, and/or a visitor shall be recorded and retained. Each incident involving death, fire, escape or other extraordinary outcome shall be reported by telephone to the Jail and Prison Inspection Division on the day that it occurs; or, when it occurs after business hours, it shall be reported on the next business day. Each such incident shall also be reported to the Jail and Inspection Division in writing within seventy-two (72) hours of the occurrence.

In addition, each incident which impairs or endangers the life or physical welfare of a juvenile shall be reported to the local office of the Department of Juvenile Justice by the next business day after the event occurred. The "local office" is defined as the DJJ office in either the juvenile's county of residence or the county where the juvenile was charged. The Department of Juvenile Justice may also obtain written information from the facility regarding such incidents.

#### 5340 ORIENTATION

An orientation program by the facility's staff shall be conducted for new juveniles. The orientation shall include but not be limited to:

- (a) Information pertaining to facility procedures such as those concerning wake-up time, meals, mail, visiting, telephone, work, and medical care;
- (b) Rules of conduct;

- (c) Disciplinary procedures;
- (d) Contraband; and
- (e) Information regarding available programs.

Reasonable accommodations shall be made for non-English speaking juveniles, illiterate juveniles, and juveniles with disabilities.

#### 5350 DISCHARGE, TRANSFER, OR RELEASE OF A JUVENILE

Positive identification of each juvenile shall always be made by the releasing officer before discharge, transfer, or release is effected. An NCIC check shall be conducted prior to the release of a juvenile. Upon determination and verification that a release has been properly authorized, clearance procedures should be carried out expeditiously in order to avoid unnecessary delay. Whenever a discharge, transfer, or release is effected, a record shall be made of the date, time, and authority.

The discharge process should also address the following issues:

- (a) A signed property form verifying the return of all property, including valuables and money; (If the juvenile refuses to sign the property form, another employee should sign as witness that the juvenile refused.)
- (b) A signed form verifying that all approved medication has been given to the juvenile;
- (c) A signed form verifying that all facility owned property has been turned in by the juvenile;
- (d) Verification of identity and completion of a NCIC check, fingerprint card, and current photo on file, if applicable;
- (e) Verification that there are no existing holds, detainers, and/or notifies; and
- (f) Confirmation of victim notification as outlined in South Carolina Code of Laws, Section §16-3-1530.

#### 5355 SECURITY

##### 5360 WEAPONS CONTROL

- (a) Except in emergency situations, no employee, law enforcement personnel, or other official shall be permitted to carry lethal weapons within the security portion of a facility.
- (b) Each facility shall have written policies and procedures governing the use of lethal weapons. A written report must be filed each time that lethal force is used.

##### 5370 LESS LETHAL WEAPONS

- (a) Facility personnel authorized to use less lethal weapons, including but not limited to: tear gas; mace (chemical agents); tasers; stun belts; and stun shields, shall be trained and certified in their use.
- (b) Less lethal weapons shall be inventoried, inspected, and, if applicable, weighed every month to determine their condition and expiration dates.

- (c) Each facility shall have written policies and procedures governing the use of less lethal weapons. A written report must be filed each time that less lethal force is used.
- (d) Appropriate medical care shall be provided and documented following each use of force incident.

Discussion:

Special attention should be given to the potential danger of the spreading of chemical agents through the air ventilation system. Juveniles must be removed if the area becomes contaminated.

5374 USE OF PHYSICAL FORCE

Facilities shall have written policies, procedures, and practices restricting the use of physical force to instances of justifiable self defense, protection of others, protection of property, disruption of operations, and prevention of escapes, and then only as a last resort and in accordance with appropriate statutory authority. In no event is physical force justifiable as punishment. A written report shall be prepared following each use of force and shall be submitted to administrative staff for review.

5375 USE OF RESTRAINTS

Each facility shall have written policies and procedures which provide that instruments of restraint shall not be used except:

- (a) As a security precaution during a transfer or temporary emergency;
- (b) On medical grounds at the direction of the physician or responsible medical authority; and
- (c) By order of the facility manager or designee to prevent a juvenile from self injury, injury to others, or property damage. However, restraints shall never be used as punishment.

5380 KEY CONTROL

The facility shall have a written policy and procedure governing the following:

- (a) Facility and vehicle keys shall be inventoried and stored in a secure area when not in use.
- (b) There shall be one (1) full set of well-identified facility keys, other than those in use, secured in a place accessible only to authorized personnel for use in the event of an emergency.
- (c) No juveniles shall be permitted access to, nor allowed to handle, facility or vehicle keys.
- (d) An inventory and log of all keys shall be made at the beginning of each shift.
- (e) Keys necessary for unlocking doors installed in a means of egress shall be

individually identifiable by both touch and sight, as mandated by Standard 408.7.4. of the International Fire Code.

#### 5390 TOOL CONTROL

There shall be a written tool control plan including the standard use of inventory shadow boards, etchings, or color coding of facility tools to ensure that such tools are not used to breach the security of the facility. This plan shall include tools used in the kitchen and medical units. Tools brought into the facility for maintenance or repairs shall be accounted for at all times.

#### 5400 FACILITY SECURITY

- (a) All juveniles leaving the confines of the facility for any reason should be searched prior to leaving and shall be searched prior to re-entering the facility.
- (b) All security locks and doors shall be regularly inspected to ensure proper working order.
- (c) All cellblock doors and all corridor doors shall be kept locked except when necessary to permit entry or exit.
- (d) Unoccupied cells, detention rooms, and storage rooms shall be searched and kept locked.
- (e) All facilities shall have two-way intercom systems for emergency communications. This shall not substitute for custodial personnel, as required in Standard 5170.
- (f) All incidents that result in serious physical harm to or threaten the life of any juvenile in the facility shall be reported promptly to the facility manager.
- (g) Vehicles in the facility's parking lot should be kept locked at all times.

#### 5410 JUVENILE MOVEMENT

- (a) Each facility shall have written policies and procedures for handling juvenile movement which include classification by custody level, consideration of medical and mental health, and employee escort protocol.
- (b) Juveniles shall not be transported in the same vehicle with adult inmates.
- (c) Female juveniles shall not be transported in the same vehicle with male juveniles unless there is secure separation between the females and males and there is clear visual observation and supervision by a security officer.

#### 5430 JUVENILE GOVERNANCE

Written policy and procedure shall provide that no juvenile or adult inmate nor group of juveniles or adult inmates is given control or authority over any juveniles nor given

access to records, legal documents, or confidential information pertinent to any juveniles.

#### **5440 CLASSIFICATION PLAN**

Each facility shall develop and implement a written classification plan to properly assign juveniles to classification categories for placement in housing and other detention specific functional situations based upon consideration of sex; age; criminal sophistication; seriousness of alleged crime; assaultive/non-assaultive behavior; medical rules; and other applicable criteria.

#### **5450 CLASSIFICATION CATEGORIES**

- (a) The facility provides for the separate management of the following categories of juveniles:
- (1) female and male juveniles;
  - (2) juveniles with special problems (alcoholics, narcotics addicts, mentally disturbed persons, physically handicapped persons, persons with communicable diseases);
  - (3) juveniles requiring disciplinary detention;
  - (4) juveniles requiring administrative separation; and
  - (5) other categories that may pose a security problem which include but are not limited to: high profile cases; sexual deviants; sex offenders; and predators.
- (b) The admission of all juveniles to separation units shall be documented in a permanent log, specifying the name; number; location; date admitted; reason for admission; tentative release date; and special circumstances and needs of each juvenile.

#### **5460 CLASSIFICATION REVIEW**

The juvenile classification plan specifies criteria and procedures for determining and changing the status of a juvenile. The plan includes an appeals process for classification decisions.

#### **5470 SEPARATION**

#### **5480 COMMUNICABLE DISEASES**

Each facility shall have written policies and procedures providing for the separation of all juveniles with communicable diseases.

##### **Discussion:**

To determine if such separation shall be made, in absence of medically trained personnel at the time of admission, an inquiry shall be made of the juvenile to establish whether he/she has or has had tuberculosis or whether he/she presently has hepatitis, a sexually transmitted disease, or other special medical problems. (See Medical Services 5700 through 5750.)

**5490 MENTALLY DISORDERED JUVENILES**

Each facility shall have written policies and procedures providing for the appropriate housing of all mentally disordered juveniles as determined by the classification plan.

**5495 ADMINISTRATIVE SEPARATION**

Each facility shall develop and implement written policies and procedures for the administrative separation of juveniles who are determined to be prone to escape or to assault staff and other juveniles, or whose presence in the general population poses a serious threat to the orderly operation or security of the facility. Such policies and procedures shall include:

- (a) Documentation of reasons for placement and retention in administrative separation;
- (b) Self placement (protective custody): juvenile signs agreement requesting to be placed in, or removed from, protective custody, (should be afforded the same privileges as general population); and
- (c) Periodic review and documentation, at least every seven (7) days, of each juvenile in administrative separation.

**5500 FEMALES**

- (a) Female juveniles shall be confined in an area separated from normal auditory and visual contact with male juveniles.
- (b) Female juveniles shall be afforded the same rights and privileges as male juveniles.

**5520 DISCIPLINE**

**5530 RULES AND DISCIPLINARY PENALTIES**

Each facility shall have established written rules and specific penalties for major and minor violations to guide juvenile conduct. Such rules shall be stated simply and posted conspicuously in housing units and the booking area, or issued to each juvenile upon admission. Reasonable accommodations shall be made for non-English speaking juveniles, illiterate juveniles, and juveniles with disabilities.

**5535 PLAN FOR JUVENILE DISCIPLINE**

Each facility shall develop and implement a formal written procedure for imposing punishment for violation of rules, which includes:

- (a) Summary punishment for minor violations;
- (b) Procedures for major violations, which include:
  - (1) Written notice (at least twenty-four (24) hours prior to hearing) to the juvenile(s) of the charge(s) against him/her;

- (2) An opportunity for the juvenile(s) to prepare a defense to the charge(s) against him/her;
  - (3) A hearing before an impartial panel or officer;
  - (4) An opportunity for the juvenile to present information and to request witnesses in his/her own behalf;
  - (5) A decision based upon the charge(s) and information produced at the hearing;
  - (6) Preparation and retention of a summary of the proceedings; and
  - (7) A review of the decision of the hearing officer or panel by the Facility Manager;
- (c) Assurance that no juvenile shall sit in judgment of, or have supervisory authority over, other juveniles.

Discussion:

The determination of whether a violation of facility rules and regulations is major or minor is determined not in the substantive violation but in the potential punishment. Any violation that results in a forfeiture of good time or in punitive segregation is major and requires the attendant due process protection. Those violations resulting in suspension of privileges, extra duties, etc., may be classed as minor, requiring only notice of charges, opportunity to respond, and disposition reduced to writing.

5540 FORMS OF AND LIMITS ON DISCIPLINARY ACTION

- (a) Summary punishment shall not exceed a reprimand, extra work detail, or the loss of privileges, including disciplinary separation of no more than two (2) consecutive days.
- (b) Room restriction for minor misbehavior serves only a "cooling off" purpose and is short in time duration, with the time period (15 to 60 minutes) specified at the time of assignment. During room restriction, staff contact is made with the juvenile at least every 15 minutes, or more frequently depending on his/her emotional state. The juvenile assists in determining the end of the restriction period.
- (c) Juveniles placed in disciplinary separation shall maintain their basic rights.
- (d) No juvenile shall be deprived of the implements necessary to maintain an acceptable level of personal hygiene.
- (e) The use of restrictive diets as a form of punishment is prohibited. (The use of Nutriload is not considered to be a restrictive diet.)
- (f) Strip cells shall not be used as a form of punishment.
- (g) Medication or the withholding of medication and/or treatment shall not be used for the purpose of discipline.
- (h) No juvenile shall be subjected to discipline or treatments which are dehumanizing, including but not limited to disrespect, profanity, or taunting.

- (i) Juveniles shall not be deprived of sleep as a form of disciplinary action.
- (j) Serious violations of rules, e.g., assaults, sexual assaults, malicious damage to property, and escapes, shall be referred to the solicitor for prosecution. Reported offenses must be investigated and documented.
- (k) Juveniles shall be entitled to correspondence, visitation, and telephone privileges in accordance with the rules and regulations established by each facility. Restrictions on these privileges should not be imposed unless such privileges have been suspended and/or restricted based on legitimate government interests related to the safe and secure operation of the facility; to prevent continued criminal activities; or other similar concerns.
- (l) No juvenile shall inflict punishment of any type on another juvenile.

**5545 PHYSICAL PLANT**

5550 INITIAL PLANNING

- (a) When the construction of a new facility, or the extensive remodeling of, or addition to, an existing facility is considered, the governing body shall file a letter of intent with the Jail and Prison Inspection Division within ten (10) working days of the resolution or formal action to proceed.

The Jail and Prison Inspection Division will respond within ten (10) working days upon receipt of the letter and offer to assist agencies with the technical expertise necessary for the effective and economical construction of detention facilities.

- (b) Prior to the design phase, a program statement shall be filed with the Jail and Prison Inspection Division which includes the following:
  - (1) Projected capacity of facility;
  - (2) Types of juveniles to be housed;
  - (3) Juvenile movement;
  - (4) Food preparation and serving;
  - (5) Staffing;
  - (6) Bookings/releases;
  - (7) Visiting and attorneys' interviews;
  - (8) Laundry operations;
  - (9) Juvenile separation;
  - (10) Future needs and possible expansion; and
  - (11) Activities such as recreation and rehabilitation programs
- (c) A copy of the preliminary design documents and working drawings shall be submitted to the Jail and Prison Inspection Division for pre-construction review to evaluate compliance with these standards prior to releasing for bid. The Division shall respond in writing within thirty (30) working days to advise whether materials reviewed were in compliance with relevant standards, and to remind all

parties concerned of their responsibility to adhere to applicable laws, standards, codes, and regulations in the design and construction of the project.

- (d) The Jail and Prison Inspection Division shall provide consultation service to the city or county, as may be requested.

#### 5560 RATED CAPACITY

The Director of the Jail and Prison Inspection Division shall ascertain the maximum number of juveniles, of whatever classifications, based upon square footage and other relevant requirements, which can properly be housed in each facility and in the various living areas within each facility. After determining the rated capacity, the Director shall notify, in writing, the Facility Manager, the Facility Administrator, and the governing body which has responsibility for the facility. These numbers shall be reviewed during each annual inspection.

#### 5570 FACILITIES PRIOR TO JULY 1980

Unless otherwise noted, this standard applies to all facilities which were operational or for which plans were submitted and approved prior to July 1980. Each such facility shall comply with the following requirements for living units:

- (a) The number of juveniles occupying a cell, room, or dorm shall not exceed the rated capacity of the cell, room, or dorm when based upon the "average daily population" for the previous three (3) months.
- (b) All cells or rooms with a minimum of seventy (70) square feet and less than one hundred (100) square feet shall have a rated capacity of one (1) juvenile.
- (c) All cells or rooms of one hundred square feet or greater may be considered multiple occupancy cells or room, with rated capacity based upon a minimum of fifty (50) square feet per juvenile.
- (d) Any cell, room, or area designated for separation shall be single occupancy, with a rated capacity of one (1) juvenile.
- (e) Any existing facility with less than seventy (70) square feet per cell or room shall not confine a juvenile to his/her cell or room more than twelve (12) hours per day excluding counts. (An exception to this requirement is that juveniles temporarily assigned to separation may be confined more than twelve (12) hours.)
- (f) Any cell, room, or area to which juveniles are confined (locked in) shall have one (1) operable water closet for every ten (10) juveniles in male facilities and one (1) for every eight (8) juveniles in female facilities, and shall have a minimum ratio of one (1) operable lavatory with running water for every twelve (12) juveniles, that are accessible twenty-four (24) hours a day. (Urinals may be substituted one-for-one for water closets in male areas; however, two thirds of fixtures shall be water closets.)
- (g) Each facility shall provide, in addition to the bed, a desk or approved writing

surface; hooks or storage space; and a chair or stool for each juvenile.

- (h) Artificial lighting shall be provided of at least twenty (20) foot-candles at desk level and in the personal grooming area; and natural light shall be available from an opening or window that has a view to the outside, or from a source within twenty (20) feet of the room. Other lighting requirements for the facility should be determined by tasks to be performed. Night light should provide good visibility for supervision, but should not hinder restful sleep.
- (i) Forced air circulation of at least ten (10) cubic feet per minute turnover of fresh or purified air shall be provided for each juvenile. Heating, ventilation, and acoustical systems will be provided to ensure healthful and comfortable living and working conditions for juveniles and staff. Ventilation will be available in the event of a power failure.
- (j) Juveniles have access to operable showers with temperature-controlled hot and cold running water at a minimum ratio of one (1) shower for every eight (8) juveniles. Water for showers is thermostatically controlled to temperatures ranging from 100 to 120 degrees Fahrenheit to ensure the safety of juveniles and to promote hygienic practices.
- (k) Where programs are offered, sufficient area for them shall meet the need and provide space for the following:
  - (1) Religious services;
  - (2) Counseling;
  - (3) Interviews;
  - (4) Classroom;
  - (5) Library; and
  - (6) Recreation.
- (l) Each facility shall have adequate space for the secure storage of juvenile personal clothing, personal property, and institutional clothing and bedding.
- (m) Each facility shall have an emergency lighting system in case of power failure.
- (n) Each facility shall have adequate storage area(s) for cleaning utensils and supplies.
- (o) Each facility shall have an automatic fire alarm system in accordance with Fire Codes (Reference NFPA 72-e-1974).

Discussion: Where the climate warrants, individual rooms that cannot be adequately ventilated by other means should be air conditioned. When ventilation systems fail, there should be backup power sources or alternative means of ventilation.

#### 5590 FACILITIES FROM JULY 1980 THROUGH JUNE 2007

Unless otherwise noted, this standard applies to all facilities which became operational or for which plans were submitted and approved after June 1980, and prior to July 2007.

- (a) All cells, rooms, or dormitories shall have access to natural light and have, at a minimum, fifty (50) square feet of unencumbered floor space per juvenile if single occupancy. For multiple occupancy cells, rooms, or dormitories there shall a minimum of thirty five (35) square feet of unencumbered floor space per juvenile.
- (b) All housing units and activities areas shall have, at a minimum:
  - (1) Artificial lighting shall be provided of at least twenty (20) foot-candles at desk level and in the personal grooming area; and natural light shall be available from an opening or window that has a view to the outside, or from a source within twenty (20) feet of the room. Other lighting requirements for the facility should be determined by tasks to be performed. (Night light should provide good visibility for supervision, but should not hinder restful sleep.);
  - (2) Natural light;
  - (3) Forced air circulation of at least ten (10) cubic feet per minute of fresh or purified air per juvenile;
  - (4) Any cell, room, or area to which juveniles are confined (locked in) shall have one (1) operable water closet for every ten (10) juveniles in male facilities and one (1) for every eight (8) juveniles in female facilities, and shall have a minimum ratio of one (1) operable lavatory with running water for every (12) juveniles that are accessible twenty-four (24) hours a day. (Urinals may be substituted one-for-one for water closets in male areas; however, two thirds of fixtures shall be water closets.);
  - (5) Bed; desk, table, or shelf; storage space or hooks; and adequate accessible seating; and
  - (6) Juveniles have access to operable showers with temperature-controlled hot and cold running water at a minimum ratio of one (1) shower for every eight (8) juveniles. Water for showers is thermostatically controlled to temperatures ranging from 100 to 120 degrees Fahrenheit to ensure the safety of juveniles and to promote hygienic practices.
- (c) Each facility shall be designed and constructed so that juveniles can be separated and housed according to the facility's classification plan.
- (d) Each facility shall have a dayroom for each cellblock or cluster of rooms. Dayrooms shall have a minimum of thirty-five (35) square feet of floor space per juvenile and be separate and distinct from the sleeping area, but be immediately adjacent to and accessible from it.
- (e) Each facility shall have at least one (1) special-purpose cell or room that is designed to prevent injury to a juvenile who is under the influence of alcohol or narcotics, or for juveniles who are uncontrollably violent or self-destructive. This room shall be subject to direct observation from a twenty-four (24) hour staff position.
- (f) Each facility shall provide an intake and release area outside juvenile living areas, with the following components:

- (1) Weapons locker, located outside security area, equipped with individual compartments and lock and key;
  - (2) Temporary holding cell(s) or room(s) with fixed benches to seat all juveniles at rated capacity (twenty (20) square feet per juvenile), have operable water closets, lavatories, and drinking fountain available;
  - (3) Booking area;
  - (4) Medical examination room;
  - (5) Shower facilities;
  - (6) Secure vault or room for storage of juveniles' personal property;
  - (7) Telephone facilities; and
  - (8) Interview room.
- (g) Each facility shall have sufficient storage room space and inventory for clothing, bedding, and facility supplies.

Discussion:

General guidelines which may be useful for planning are: two (2) cubic feet per juvenile for personal clothing; one (1) cubic foot per juvenile for personal property; two (2) cubic feet per juvenile for institutional clothing and bedding; and 5.25 cubic feet per mattress, for twenty-five (25%) percent of rated capacity. This storage room should be well ventilated.

- (h) Each facility shall have an automatic fire-alarm system in accordance with Fire Codes (Reference NFPA 72-e-1974).
- (i) Any safety vestibule or sally port shall be of sufficient size to permit passage of a loaded ambulance. cot between interlocking doors.
- (j) Each facility shall have an emergency lighting system in case of power failure.
- (k) Space for visiting should be planned so that it is separate from the juvenile housing area and communal activity space.

#### 5595 FACILITIES CONSTRUCTED FROM JULY 2007, TO THE PRESENT

Unless otherwise noted, this standard applies to all facilities which became operational or for which plans were submitted and approved from July 2007, to the present.

#### 5596 STAFF/JUVENILE INTERACTION

Physical plant design facilitates continuous contact and interaction between staff and juveniles.

Discussion:

Separation of supervising staff from juveniles reduces interpersonal relationships and staff awareness of conditions in the housing units. Staff effectiveness is limited if the only staff available are isolated in control centers as observers or technicians in charge of electrical management systems.

5597 FACILITY LOCATION

If the facility is on the grounds of any other type of detention or correctional facility, it is a separated, self-contained unit.

5598 JUVENILE HOUSING

- (a) All cells, rooms, or dormitories shall have access to natural light and have, at a minimum, fifty (50) square feet of unencumbered floor space per juvenile if single occupancy. For multiple occupancy cells, rooms, or dormitories there shall a minimum of thirty-five (35) square feet of unencumbered floor space per juvenile.

Discussion:

At least one dimension of the unencumbered space is no less than seven (7) feet. Unencumbered space is determined by multiplying the length and width of the room and subtracting from this figure the total number of square feet not occupied by bed(s), plumbing fixtures, desk(s), locker(s), and other fixed equipment.

- (b) All housing units and activities areas shall have, at a minimum:
- (1) Artificial lighting shall be provided of at least twenty (20) foot-candles at desk level and in the personal grooming area, and natural light shall be available from an opening or window that has a view to the outside, or from a source within twenty (20) feet of the room. Other lighting requirements for the facility should be determined by tasks to be performed. Night light should provide good visibility for supervision, but should not hinder restful sleep;
  - (2) Natural light;
  - (3) Forced air circulation of at least ten (10) cubic feet per minute of fresh or purified air per juvenile;
  - (4) Any cell, room, or area to which juveniles are confined (locked in) shall have one (1) operable water closet for every twelve (12) juveniles in male facilities and one (1) for every eight (8) juveniles in female facilities, and shall have a minimum ratio of one (1) operable lavatory with running water for every (12) occupants that are accessible twenty-four (24) hours a day. (Urinals may be substituted one-for-one for water closets in male areas; however, two thirds of fixtures shall be water closets.) All housing units with five (5) or more juveniles shall have a minimum of two (2) water closets;
  - (5) Bed; desk, table, or shelf; storage space or hooks; and adequate accessible seating; and
  - (6) Juveniles have access to operable showers with temperature-controlled hot and cold running water at a minimum ratio of one (1) shower for every eight (8) juveniles. Water for showers is thermostatically controlled to temperatures ranging from 100 to 120 degrees Fahrenheit to ensure the safety of juveniles and promote hygienic practices.
- (c) Each facility shall be designed and constructed so that juveniles can be separated and housed according to the facility's classification plan.

- (d) Each facility shall have a dayroom for each cellblock or cluster of rooms. Dayrooms shall have a minimum of thirty-five (35) square feet of floor space per juvenile and be separate and distinct from the sleeping area, but be immediately adjacent to and accessible from it.
- (e) Each facility shall have at least one (1) special-purpose cell or room that is designed to prevent injury to a juvenile who is under the influence of alcohol or narcotics, or for a juvenile who is uncontrollably violent or self-destructive. This room shall be subject to direct observation from a twenty-four (24) hour staff position.
- (f) Each facility shall provide an intake and release area outside juvenile living areas, with the following components:
  - (1) Weapons locker, located outside security area, equipped with individual compartments and lock and key;
  - (2) Temporary holding cell(s) or room(s) with fixed benches to seat all. Juveniles at rated capacity (twenty (20) square feet per juvenile), have operable water closets, lavatories, and drinking fountain available;
  - (3) Booking area;
  - (4) Medical examination room;
  - (5) Shower facilities;
  - (6) Secure vault or room for storage of juveniles' personal property;
  - (7) Telephone facilities; and
  - (8) Interview room.
- (g) Each facility shall have sufficient storage room space and inventory for clothing, bedding, and facility supplies.

Discussion:

General guidelines which may be useful for planning are: two (2) cubic feet per juvenile for personal clothing; one (1) cubic foot per juvenile for personal property; two (2) cubic feet per juvenile for institutional clothing and bedding; and 5.25 cubic feet per mattress, for twenty-five (25%) percent of rated capacity. This storage room should be well ventilated.

- (h) Each facility shall have an automatic fire-alarm system in accordance with Fire Codes (Reference NFPA 72-e-1974).
- (i) Any safety vestibule or sally port shall be of sufficient size to permit passage of a loaded ambulance. cot between interlocking doors.
- (j) Each facility shall have an emergency lighting system in case of power failure.
- (k) Space for visiting should be planned so that it is separate from the juvenile housing area and communal activity space.
- (l) Indoor and outdoor space for the juveniles to exercise is provided. Indoor exercise may be conducted in the dayroom or in the multi-purpose room. Outdoor

areas shall be at least fifty (50) feet by thirty (30) feet, except that in facilities such as those which are designed for direct supervision, when outside exercise space is provided for individual housing units, minimum space requirements are as follows:

(1) General Population Units:

Outdoor exercise areas shall provide at least fifteen (15) square feet per juvenile for the maximum number of juveniles who are expected to use the area at one time, but not less than 750 square feet of unencumbered space, with none of the dimensions less than fifteen (15) feet.

(2) Segregation/ Maximum Security Units

Outdoor exercise areas shall provide at least fifteen (15) square feet per juvenile for the maximum number of juveniles who are expected to use the area at one time, but not less than 200 square feet of unencumbered space.

## **5610 JUVENILE PROGRAMS AND ACTIVITIES**

- (a) Each facility shall provide an array of programs that includes social services, religious services, library services, counseling, and educational courses as mandated by South Carolina Code of Laws, Section 20-7-6845.
- (b) Juveniles should not be required to work except to do personal housekeeping.
- (c) Each facility shall allow juveniles access to recreational opportunities and equipment, including outdoor exercise when the climate permits.
- (d) A canteen/commissary may be operated in the juvenile facility.

## **5620 VISITATION**

Each facility shall develop and implement a juvenile visiting plan which shall include the following:

- (a) Parents, guardians, or custodians, as well as teachers, and tutors of juveniles, shall be allowed to visit at any appropriate time as designated by the facility. Restrictions on visitation should not be imposed unless such privileges have been suspended and/or restricted based on legitimate government interests related to the safe and secure operation of the facility; to prevent continued criminal activities; or other similar concerns.
- (b) Visitors shall be treated with courtesy. An explanation shall be given of visitors' rights and restrictions; and procedures visitors must follow to file complaints should either be posted conspicuously or provided in written handouts.
- (c) Special visiting hours and arrangements shall be made available for visitors who have transportation problems, who have handicaps, or who are working on regular visiting days.
- (d) Appointments for visits at any time may be required.

- (e) All policies and procedures related to visitor searches should be reviewed by competent legal authority.
- (f) Persons providing juvenile services and assistance, such as ministers, attorneys or officers of the court, among others, will be allowed to visit during normal hours of operations.
- (g) Nothing contained herein shall prevent the Facility Manager from refusing to permit a visit based on circumstances related to legitimate concerns that would interfere with the orderly operation of the facility and/or pose a threat to security. Refusals shall not be arbitrary; and all refusals, along with the reasons for denial, shall be documented and kept on file.
- (h) Video visitation may be used as a substitute for, and/or to supplement, direct physical parental, legal, and/or ministerial visitation.

#### 5630 CORRESPONDENCE

Each facility shall develop and implement a written plan for the handling of juvenile mail. Such a plan shall include the following provisions:

- (a) Juvenile mail shall not be read except where there is reasonable suspicion that a particular item of correspondence threatens the safety or security of the institution, threatens the safety of any person, or is being used for furtherance of illegal activities. All official mail shall be opened in the presence of the juvenile to whom it is addressed.

Official mail is defined as mail from officials or organizations including, but not limited to: courts, counsel, officials of the confining authority, government officials, administrators of grievance systems, Jail and Prison Inspection Division, Department of Juvenile Justice, Department of Corrections, Department of Public Safety, and members of the Parole Boards.

- (b) Juveniles shall be permitted to send sealed letters to a specified class of persons and organizations as defined in (a), above.
- (c) The facility shall not limit mail to or from a juvenile except when there is clear and convincing evidence to justify such limitation.
- (d) If a juvenile is indigent, he/she shall be provided sufficient postage, envelopes, and writing materials to write two (2) personal letters per week if he/she wishes to do so. Like provisions apply should an indigent juvenile wish to communicate with his/her lawyer(s) and court officials.
- (e) Outgoing mail shall be collected and incoming mail shall be delivered without unnecessary delay.

#### 5640 TELEPHONE

Each facility shall develop and implement a written plan for the use of the telephone. Juveniles may be required to pay for telephone calls. If telephone calls are to be monitored and/or recorded, notice shall be provided.

Restrictions on making telephone calls should not be imposed unless such privileges have been suspended and/or restricted based on legitimate government interests related to the safe and secure operation of the facility; to prevent continued criminal activities; or for other similar concerns.

A newly admitted juvenile shall be permitted to complete at least two (2) telephone calls during the admission process. Additional telephone calls maybe made at the discretion of the Facility Manger.

Telephone terminal devices for the deaf, interpreters, and other reasonable accommodations shall be provided to juveniles with hearing or other special needs.

#### 5650 ACCESS TO LEGAL COUNSEL AND COURTS

Each facility shall establish policies and procedures to ensure the right of juveniles to have access to legal counsel and courts and assist juveniles in making confidential contact with attorneys and their authorized representatives. Such contact includes but is not limited to telephone communications, uncensored correspondence, and visits.

##### Discussion:

While it should not be considered the responsibility of the facility to pay for a juvenile's legal counsel, the facility must provide the assistance necessary for the juvenile to have effective access to counsel.

#### 5660 GRIEVANCE PROCEDURE

There shall be a written grievance procedure made available to all juveniles.

##### Discussion:

A grievance procedure is an administrative means of expressing and resolving juveniles' problems. The facility's grievance mechanism should include provisions for the following:

- (a) Written responses to all grievances, including the reasons for the decision;
- (b) Responses within prescribed, reasonable time limit, with special provisions for responding to emergencies;
- (c) Advisory review of grievances;
- (d) Participation by staff in the design and operation of the grievance procedure;
- (e) Access by all juveniles, with guarantees against reprisal;
- (f) Applicability over a broad range of issues; and
- (g) Means for resolving questions of jurisdiction.

While the procedure need not be as detailed as outlined in the discussion above, some mechanism should exist for resolving juvenile grievances.

## 5700 MEDICAL SERVICES

### 5710 RESPONSIBLE PHYSICIAN

Each facility shall have a written agreement or arrangement with a licensed or certified physician or medical authority for the review and approval of the facility's medical services.

Discussion:

The medical authority may be the county or a public health department, a physician group, a hospital, a clinic, a health care vendor, or the county medical society.

### 5720 MEDICAL PROCEDURES

Each facility shall develop and implement written standard operating procedures, which are approved by the responsible physician or medical authority, for the following:

- (a) Receiving screening; (See 5700)
- (c) Non-emergency medical services;
- (d) Emergency medical and dental services;
- (e) Deciding the emergency nature of illness or injury;
- (f) First aid;
- (g) Convalescent care;
- (h) Delousing;
- (i) Detoxification;
- (j) Pharmaceuticals;
- (k) Screening, referral, and care of mentally ill and of mentally retarded juveniles;
- (l) Notification of next of kin or legal guardian in case of serious illness, injury, attempted suicide, or death;
- (m) Prompt notification of parents or guardian and DJJ when a juvenile requires medical treatment of a non-routine nature;
- (n) Prohibition against conducting medical or pharmaceutical testing for experimental or research purposes; and
- (o) Suicide prevention.

### 5730 SCREENING

Each facility shall perform medical, dental, and mental health screening of all juveniles, excluding intrasystem transfers, immediately upon admission to the facility, with the findings recorded on a form approved by the responsible physician or medical authority. In every case such screening shall occur before the juvenile is placed in the general population or housing area and shall include inquiry into:

- (a) Current illnesses and health problems, including those specific to women, and including sexually transmitted diseases and other infectious diseases, if appropriate;
- (b) Medications taken and special health requirements;
- (c) Screening of other health problems designated by the responsible physician;
- (d) Behavioral observation, including state of consciousness and mental status, appearance, conduct, tremor, and sweating;

- (e) Notation of body deformities, trauma markings, scars, birthmarks, tattoos, bruises, lesions, ease of movement, jaundice, and other physical characteristics of medical interest;
- (f) Condition of skin and body, including rashes and infestations, and needle marks or other indications of drug abuse;
- (g) Disposition/referral of juveniles to qualified medical personnel on an emergency basis;
- (h) Past or present treatment, hospitalization or likelihood of mental disturbance or suicide attempt by juvenile;
- (i) Dental problems;
- (j) Use of alcohol and other drugs, which includes types of drugs used, mode of use, amounts used, frequency of use, date or time of last use, and a history of problems that may have occurred after ceasing use (e.g., convulsions); and
- (k) Medical disposition regarding housing of juveniles:
  - (1) general population;
  - (2) general population with appropriate referral to health care service; or
  - (3) referral to appropriate health care service for emergency treatment.

#### 5731 HEALTH APPRAISAL

The health appraisal data collection shall be completed within seven (7) days after admission and shall include:

- (a) Review of earlier receiving screening;
- (b) Completion of medical, dental, and psychiatric history;
- (c) Taking of height, weight, pulse, blood pressure, and temperature;
- (d) Other examinations deemed appropriate by the responsible physician or his/her designee; and
- (e) Screening for communicable disease and, if medically indicated, testing for communicable disease.

#### 5732 PHARMACY STANDARDS

All medications at each facility shall be safely and properly accounted for and managed according to Department of Health and Environmental Control Pharmacy Standards.

#### 5740 EMERGENCIES

Each facility shall provide twenty-four (24) hour emergency medical and dental care availability, as outlined in a written plan which includes arrangements for:

- (a) Emergency evacuation of juveniles from the facility;
- (b) Use of an emergency medical vehicle;
- (c) Use of one (1) or more designated hospital emergency rooms or other appropriate health facilities; and
- (d) Emergency on-call physician and dentist services when the emergency health facility is not located in a nearby community.

A juvenile detainee has the right to refuse medical, psychological, or psychiatric treatment. However, if a juvenile or his/her parents or guardians refuse treatment that is

deemed necessary, those special needs should be presented to the Family Court for resolution.

Discussion:

Refusal of such routine treatment should be documented.

#### 5750 SICK CALL

The facility shall have written policies which ensure adequate medical attention for those juveniles requesting it.

Discussion:

Sick call is the procedure through which each sick juvenile reports his/her illness and receives non-emergency medical services by a physician or a medically trained person working under the physician's standing orders.

#### 5760 JUVENILE CLOTHING AND PERSONAL HYGIENE

##### 5765 CLOTHING ISSUE

Any juvenile detained longer than six (6) hours in a facility shall be issued a uniform and footwear.

Clean juveniles' personal clothing (if available) may be substituted for institutional clothing at the discretion of the facility administrator. Juvenile holdover facilities are encouraged to issue clothing and/or to launder personal clothing regardless of the brevity of the juvenile's detention. When a juvenile is detained longer than six (6) hours this provision is mandatory.

##### 5770 PERSONAL CARE ITEMS

Each juvenile detained longer than six (6) hours shall be provided the following items, as appropriate:

- (a) toothbrush;
- (b) toothpaste or tooth powder;
- (c) soap;
- (d) shaving implements (upon request);
- (e) comb (upon request); and
- (f) feminine hygiene items (if female).

Juveniles may be required to purchase replacement personal care items. However, basic hygiene items shall be provided to indigent juveniles by the facility.

##### 5775 SHOWERING

- (a) Juveniles will be given the opportunity to shower daily.
- (b) Shower activity, to include refusal, must be monitored and annotated in both the Housing Unit log and annotated in the notes file.

**5780 HAIR CARE SERVICES**

The facility shall make hair care services available to juveniles.

There shall be no restrictions on the rights of juveniles to determine the length and style of hair except in individual cases where such restrictions are necessary for reasons of health and safety.

**5785 BEDDING AND LINEN ISSUE**

Each juvenile who is detained overnight shall be provided with the following standard issue:

- (a) One clean, serviceable, fire-retardant mattress;
- (b) Clean sheets and/or clean mattress cover;
- (c) Sufficient clean blankets to provide comfort under existing temperature conditions; and
- (d) One clean towel.

**5787 LAUNDERING OF BEDDING AND LINENS**

An adequate supply of bedding and linens shall be maintained so that the following laundry or cleaning frequencies may be adhered to:

- (a) Issued linens shall be changed and washed at least once a week;
- (b) Mattresses shall be disinfected or sanitized monthly and before re-issue;
- (c) Blankets shall be laundered, or otherwise sterilized, monthly and before re-issue; and
- (d) A clean towel shall be issued at least twice weekly.

**5790 FOOD**

**5800 FREQUENCY OF SERVICE**

Each facility shall provide three (3) nutritional meals at regular meal times during each twenty-four (24) hour period, with no more than fourteen (14) hours between the evening meal and breakfast.

A snack for juveniles should be provided between the evening meal and lights out.

**5830 DIETARY ALLOWANCES**

- (a) The food must be of sufficient nutritional value and quantity to satisfy, within reason, the juveniles' needs.
- (b) Reasonable arrangements shall be made to provide special diets prescribed by authorized medical personnel and when juveniles' religious beliefs require their adherence to dietary restrictions.
- (c) There is documentation that the facility's system of dietary allowance is reviewed

at least annually by a dietician to ensure compliance with nationally recommended food allowances.

**Discussion:**

A facility that follows this system of dietary allowances, as adjusted for age, sex, and activity, ensures the provision of a nutritionally adequate diet. The Recommended Dietary Allowances stated by the National Academy of Sciences should be used as a guide to basic nutritional needs.

**5840 MENUS AND FOOD PREPARATION**

Menus shall be planned in advance and approved by the facility administrator and/or designee. Meals prepared and served at the facility shall always be under the supervision of an employee or contract service provider. If meals are purchased from the local economy, an employee should be responsible for their distribution.

**5850 SANITATION AND FOOD STORAGE**

Sanitation, food handling, and food storage shall comply with standards set forth by the South Carolina Department of Health and Environmental Control.

**5860 KITCHEN STAFF**

Food service workers shall comply with applicable standards set forth by the South Carolina Department of Health and Environmental Control.

**5870 GENERAL SANITATION AND MAINTENANCE REQUIREMENTS**

**5875 HOUSKEEPING REQUIREMENTS**

Each facility shall develop and implement a written plan for the maintenance of an acceptable level of cleanliness and sanitation throughout the facility. Such plan shall include the following:

- (a) The sweeping and mopping of floors, removal of trash, and dusting, each day;
- (b) The cleaning of toilets, shower facilities, and janitor's closets each day;
- (c) A thorough cleaning of living units, each week;
- (d) The thorough cleaning of mops and other sanitation tools after each use, and their storage in a well-ventilated place;
- (e) Suitable containers easily cleaned and with tight fitting lids, shall be provided for the storage of solid waste material to control unpleasant odors, vermin, and insects. If plastic containers are used, they must be tested and approved against toxic reaction by a national testing laboratory;
- (f) Trash and garbage shall be removed at least daily and disposed of in a sanitary manner; and
- (g) Grease shall be disposed of in compliance with DHEC Regulations.

5890 VERMIN, INSECTS, AND PESTS

- (a) Each facility shall have a regularly scheduled program of pest and vermin control and extermination.
- (b) Effective measures shall be taken to keep flies, rodents, and other vermin out of the confinement facility and to prevent their breeding or continued presence on the premises. The facility shall be kept neat, clean, and free of litter. All openings to the outer air shall be effectively protected against the entrance of insects and rodents by self-closing doors, closed windows, 16 mesh or finer screening, and/or other effective means.

5900 DRINKING FOUNTAINS

Drinking cups (individual) or drinking fountains shall be provided. If drinking fountains are provided, they shall be made so that there is a mouth guard and that there is a free vertically angled flow of water. The use of the common drinking cup is prohibited.

## Lauren Lynch

---

**From:** Annie E. Andrews <AAndrews@charlestoncounty.org>  
**Sent:** Friday, June 19, 2020 1:11 PM  
**To:** Patrick Wooten  
**Subject:** FW: Reported problems with the Juvenile Detention Center

**Importance:** High

◀External Email▶ - From: AAndrews@charlestoncounty.org

---

**From:** Ashley Pennington <APennington@charlestoncounty.org>  
**Sent:** Thursday, December 12, 2019 1:15 PM  
**To:** Willis Beatty <wbeatty@charlestoncounty.org>  
**Cc:** Annie E. Andrews <AAndrews@charlestoncounty.org>; Maryellen Rankin <MRankin@charlestoncounty.org>; J Tim. Taylor <JTTaylor@charlestoncounty.org>; Holly J. Bendure <HBendure@charlestoncounty.org>; Caroline M. Bickley (cbickley@homesc.com) <cbickley@homesc.com>  
**Subject:** Reported problems with the Juvenile Detention Center  
**Importance:** High

Dear Chief,

The Berkeley County Public Defender is concerned about the following issues with her clients:

- Juvenile's Being Placed on "Lock Down" - [REDACTED] - now 13, but 12 at the time) - Detained from October 17, 2019 - October 31, 2019. I visited him on October 23, 2019 and he was on "lock down" for 48 Hours. I asked the guards on duty why and nobody knew. I asked [REDACTED] and he indicated it was for "playing in the showers."
- Juvenile's Not Being Pulled for School (and don't know why) - [REDACTED] (Detained 10/3/19 - 11/20/19) - He indicated he wasn't getting pulled for school many days and didn't know why. / [REDACTED] and [REDACTED] also indicated to me they weren't being pulled for school at all. They both have been in and out of Headquarters many times.
- Juvenile's Continuing to Have No Access to Outside (in particular those who end up at the facility for extended periods): Across the board for the last year, I have not had a Juvenile client from Berkeley County indicate that they had any access to the outdoors. [REDACTED] (13) was unfortunately detained from August 8, 2019 to November 21, 2019 (yesterday). His charge is set for trial and no Judge would release him until yesterday. During all of that time, he never went outside. Another client, [REDACTED] - now 17), was on Headquarters Road long term to get an adult charge remanded back to family court. He confirmed that he never went outside. [REDACTED] was detained from August 8, 2019 - November 14, 2019 and never went outside.
- Putting 3 Juvenile's in One Cell - [REDACTED] family was upset by this because there was a period of time he was sleeping on the floor on a mat with 3 juvenile's in a cell. The family felt this was inappropriate. [REDACTED] and myself received e-mails regarding this. I visited [REDACTED] on September 13, 2019 and he was no longer sleeping on the floor because the facility was less crowded.
- Ongoing Issues with Flooding and Mold

I am told the same things by Charleston Public Defenders. Please look into these problems.

Thanks!

Ashley

D. Ashley Pennington  
Ninth Circuit Public Defender  
101 Meeting Street, 5th Floor  
Charleston, SC 29401-2214

(843) 958-1850

(843) 958-1870(direct)

(843) 478-1230(mobile)

(843) 958-5149(facsimile)

[apennington@charlestoncounty.org](mailto:apennington@charlestoncounty.org)

[www.lowcountrydefenders.org](http://www.lowcountrydefenders.org)

Confidential Notice: This electronic mail transmission and any and all accompanying documents and information contain data and matters belonging to the sender which may be confidential and legally privileged. This information is intended ONLY for the use of the individual entity to whom it is addressed. If you are not the intended recipient, any disclosure, copying, distribution or action of any sort taken in reliance on the contents of the information contained in this transmission or any attachments is strictly prohibited and objected to. If you have received this transmission in error, please immediately notify us by telephone at (843) 958-1870 and also delete the message. Thank you.