Cuyahoga County Juvenile Justice Center
Conditions Assessment Narrative Report

September 2018

CENTER FOR Children's Law and Policy

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INTRODUCTION

In April 2018, the Cuyahoga County Juvenile Court and the George Gund Foundation agreed to support an independent assessment of conditions at the Cuyahoga County Juvenile Justice Center's Detention Center (hereinafter "Juvenile Justice Center") in Cleveland, Ohio. To complete the assessment, staff of the Center for Children's Law and Policy (CCLP) in Washington, DC, and a team of experts in education, medical care, and mental health care reviewed materials and conducted the assessment of the Juvenile Justice Center's Detention Facility during May and July 2018. This narrative report, along with the corresponding assessment checklist, constitute the team's findings and recommendations.

METHODOLOGY

The assessment team consisted of the following:

- **Mark Soler**, Executive Director, Center for Children's Law and Policy
- **Jason Szanyi**, Deputy Director, Center for Children's Law and Policy
- **Jennifer Lutz**, Staff Attorney, Center for Children's Law and Policy
- **Andrea Weisman**, Ph.D., Consultant and Mental Health Expert
- **Robert Cohen**, M.D., Consultant and Medical Expert
- **Peter Leone**, Ph.D., Professor, Department of Counseling, Higher Education, and Special Education at the University of Maryland, and Education Expert

The members of the team have significant experience conducting conditions of confinement assessments. Mark Soler has worked on juvenile justice reform, with a special focus on conditions of confinement, for 40 years – 28 years at the Youth Law Center and the last 12 as founder and Executive Director of CCLP. Jason Szanyi has worked at CCLP since 2009, where he has focused on improving conditions in juvenile justice facilities. He has particular expertise in implementation of the Prison Rape Elimination Act (PREA) standards for juvenile facilities. Jennifer Lutz has been a staff member at CCLP since 2015, where she manages the Center's campaign to end the solitary confinement of youth and trains individuals on conditions in juvenile facilities.

Dr. Andrea Weisman, the assessment team's mental health expert, has experience directing health and behavioral health services in juvenile and adult facilities in Washington, DC, and Maryland for two decades and has served as a mental health consultant to the U.S. Department of Justice and the U.S. District Court for the Southern District of Ohio. Dr. Robert Cohen, the team's medical expert, is a member of the New York City Board of Correction and the former director of health services at Rikers Island and the former Vice President for Medical Operations at the New York City Health and Hospital Corporation. He has also served as a federal court appointed monitor of medical conditions in correctional facilities in several states. Dr. Peter Leone, the team's education expert, is a Professor in the Department of Counseling, Higher Education, and Special Education at the University of Maryland. Dr. Leone has evaluated education services, monitored educational programs, and provided technical assistance in

juvenile detention centers, state juvenile commitment facilities, jails, and prisons in a number of states. He is the former Director of the National Center on Education, Disability, and Juvenile Justice at the University of Maryland.

During two separate visits on May 23-25 and July 16-18, 2018, team members conducted on-site assessments of the Juvenile Justice Center. Following an introductory meeting and brief tour of the facility, the team engaged in interviews, observations, and review of records at the facility. As part of the assessment, team members interviewed facility administrators, medical and mental health clinicians and staff, direct care staff, supervisors, unit managers, maintenance and food service staff, educational professionals, youth, and other staff. Prior to the on-site visits, team members requested and received policies, incident reports, grievances, data reports, and a wide variety of other records about the Juvenile Justice Center's operations. The team also conducted an exit interview with Juvenile Court and facility staff.

When conducting the assessment, the team used the most demanding set of standards for juvenile detention facilities in this country, the Annie E. Casey Foundation's Juvenile Detention Facility Assessment Standards. The standards were co-authored by CCLP and the Youth Law Center for the Foundation's Juvenile Detention Alternatives Initiative (JDAI). The standards are used to assess and improve conditions in over 300 JDAI sites in 39 states and the District of Columbia. The State of Ohio and Cuyahoga County participate in JDAI. In 2014, a team of local officials and individuals conducted an assessment of the Juvenile Justice Center using the JDAI standards.

The JDAI standards have been cited in investigations by the U.S. Department of Justice's Civil Rights Division. They have also served as the basis for federal and state legislation, as well as many agencies' policies. For example, CCLP staff worked with legislative task forces in Louisiana and Mississippi in recent years to help those states develop comprehensive mandatory statewide standards for their juvenile facilities following numerous lawsuits and concerns about conditions in those states.

The JDAI Detention Facility Assessment Standards were initially released in 2006 and revised in 2014. The standards were developed following an extensive review of applicable federal statutes; federal and state court decisions; settlement agreements in conditions of confinement lawsuits brought by the U.S. Department of Justice and public interest law offices; professional standards, including those of the American Correctional Association, the National Commission on Correctional Healthcare, and Performance-based Standards; best practices in jurisdictions throughout the country; and consultation with over three dozen recognized subject matter experts, including former facility administrators.

The standards are organized into eight categories that cover all major areas of a facility's operations and form the acronym CHAPTERS:

- Classification and intake;
- Health and mental health services;
- Access to family and counsel through mail, telephone, and visitation;
- Programming, including education, special education, recreation, and religious services;
- Training and supervision of staff;

- Environment, including issues related to sanitation and the physical plant;
- Restraints, room confinement, due process, and grievances; and
- Safety of youth and staff in the facility.

The team used these standards to prepare this narrative report and a checklist of conformance or non-conformance with each individual JDAI detention facility standard.

There are inherent limitations in this type of assessment. The team did not interview every staff member at the facility, nor did it visit the facility over an extended period of time. Nevertheless, the comprehensiveness of the assessment standards; the extensive interviews conducted with administrators, staff, and youth; the experience of the members of the assessment team; the review of available data and records; the observations made throughout the facility; and the receipt of consistent information from multiple sources provided a strong foundation of information for developing this report.

In addition, the assessment process inherently focuses attention on areas of concern, and it may not fully explore all of the strengths in the facility. The assessment team appreciates the effort that Chief Administrative Judge Kristin Sweeney, Court Administrator Terease Neff, Superintendent Delbert Montgomery, facility administrators, their staff, and others put into making the assessment process a success. We extend special thanks to Renee Edel, Court Improvement Project Manager for Juvenile Court, who spent significant time and energy preparing for and skillfully coordinating the team's assessment among her many other responsibilities.

FINDINGS AND RECOMMENDATIONS

We first outline general findings and recommendations with respect to the facility, as they provide important context for the entire report. We begin with general areas of strength, and then outline general areas of concern. The report then outlines findings and recommendations in each of the eight areas of the CHAPTERS framework. The report concludes with recommendations for prioritizing the recommended changes outlined in this report. As outlined below, the Juvenile Justice Center faces a number of serious, long-standing challenges that directly impact the well-being of young people and the staff charged with their care. However, these are challenges that facilities throughout the country have confronted and overcome. With a concerted and focused effort, the assessment team believes that officials in Cuyahoga County can achieve the same results for the Juvenile Justice Center.

GENERAL STRENGTHS

The assessment team identified a number of overall strengths of facility operations.

The Juvenile Justice Center has some energetic and highly motivated leaders who are interested in raising the level of practice at the facility. The team was very impressed with many of the facility administrators during its assessment. Although the facility is facing a number of serious challenges, as discussed below, it is clear that there are dedicated professionals at the Juvenile Justice Center who are committed to tackling long-standing problems and improving conditions, policies, and practices at the facility. At the time of the team's first on-site visit, the County had just hired a new superintendent, Delbert Montgomery, who has a history of working to remedy conditions in troubled juvenile facilities. The team believes that Mr. Montgomery's experience will help the facility implement policies and practices that will improve consistency and accountability across all areas of facility operations. We hope that Mr. Montgomery takes advantage of existing networks of juvenile justice professionals, such as the JDAI community. We are committed to working with facility leadership to identify peers and learning opportunities that can help the team advance its mission and vision for the facility.

Some staff demonstrate high levels of skill and professionalism. The Juvenile Justice Center has staff members who have a spent many years working at the facility, as well as some staff members who have recently come to the facility. It was obvious that many staff members took pride in their work with young people. The experience and dedication of staff was apparent in our conversations with these individuals. As mentioned below, these staff have worked to operate the institution in the face of significant staffing and other challenges. As one example, the team was very impressed with the quality of programming, leadership, and interactions between direct care staff and young people on the housing unit for girls.

Although the facility suffers from design shortcomings, the physical plant also presents opportunities for programming that are not possible in other juvenile facilities. The history of challenges with the Juvenile Justice Center's physical plant has been well documented, and this report does not attempt to document all of those problems here. Nevertheless, the facility

does have significant assets that can allow for programming that is not possible in other juvenile facilities. Specifically, the facility has large and light-filled common areas in each of the housing units and two large gymnasiums. As outlined below, staffing challenges and other problems have limited the use of these spaces for expanded programming opportunities.

The Juvenile Justice Center has recently invested in new hiring efforts to recruit additional staff members and, specifically, staff members who are interested in working with youth. As mentioned below, staffing shortages stemming resulting from a range of interconnected issues have created serious problems at the Juvenile Justice Center. However, the team was pleased to hear that administrators had recently made a concerted effort to recruit additional direct care staff members, with a focus on individuals with an interest in working with young people. The team encourages administrators to continue to invest in this effort given concerns with the safety and security of youth and staff and the impact that staffing has on access to education and programming.

The creation of a Community Intervention Center to assess and divert young people from the juvenile justice system should help lower the population of youth at the facility. The team was pleased to hear that the Cuyahoga County and the Juvenile Court are planning to open a new intake and assessment center that will help connect children who come in contact with the justice system with community-based services, such as mental health services and trauma counseling. This is consistent with a national movement to screen and divert young people away from the juvenile justice system and toward more responsive and effective community resources. The Community Intervention Center holds potential to reduce the number of young people who end up with formal involvement with Juvenile Court and, therefore, reduce the number of young people who end up in detention.

The facility's new partnership with University Hospital's Rainbow Babies & Children's Hospital presents opportunities to connect young people to needed medical care. The team's first visit coincided with the transition of the facility's medical services to a new provider. As described in additional detail below, the team sees great potential in this new relationship with a medical provider that has a special focus on medical care for children and adolescents. This partnership is a significant asset for the Juvenile Justice Center. The team recommends a number of ways that officials can partner to strengthen opportunities to identify and meet medical needs of young people at the facility.

The facility has the infrastructure and capacity for data collection on a range of important indicators. The team requested and received data on a variety of operations at the Juvenile Justice Center, from the amount of time that youth spent in room confinement to the number of minutes of seat time in school that youth received per week. The fact that the detention center shares personnel and administrators with the Juvenile Court allows for the opportunity for more detailed data collection and presents opportunities to create quality assurance mechanisms that are not possible in other facilities. This is a definite strength. As described below, however, concerns about the quality and reliability of data being collected in certain areas, coupled with limitations on how data are used to inform policy and practice, have meant that data collection is not used to its full potential at the facility.

Other strengths of the Juvenile Justice Center's operations are discussed below in the body of this report.

GENERAL AREAS OF CONCERN

During the assessment, the team identified a number of concerns that impact all aspects of facility operations.

Staffing problems and the use of overtime are hindering the ability to supervise youth in a safe and humane manner. The team was particularly concerned about staffing problems at the Juvenile Justice Center, which have led to a number of very concerning conditions and practices, outlined below. The team understood the staffing problems as being a product of many interrelated factors. These include (1) turnover resulting from low staff morale and high levels of stress, (2) the frequent use of overtime, which contributes to staff member exhaustion and poor interactions between staff and youth, (3) a significant number of staff being out for extended periods on some form of medical leave, (4) the fact that the facility allows senior staff to opt into positions that focus on transporting youth throughout the facility (as opposed to supervising them on housing units or during other programming), (5) a collective bargaining agreement that allows senior staff to opt into consecutive double shifts, which limits those staff members' effectiveness and clusters junior staff with less experience together on undesirable shifts. As mentioned above, the team appreciated the recent hiring efforts being made to recruit additional direct care staff. However, the team believes that many of the staffing problems do not stem solely from the number of staff at the facility. The factors listed above are limiting the effectiveness of existing staff members. And, as noted below, there are other systematic problems that are creating barriers to a safe and supportive environment for young people and staff.

A poor dynamic between direct care staff and youth is fueling negative feelings and hostility among both groups at the facility. Even before we arrived on site at the Juvenile Justice Center, our team members had identified concerns with the relationships between staff and youth at the facility – particularly the staff member's characterizations of young people in incident reports and responses to grievances. We describe these characterizations in more detail below. However, the team's on-site observations confirmed that, with some notable exceptions, the relationship between direct care staff and young people at the facility is poor. Interviews with staff and young people, and observations of interactions between staff and youth, revealed that many staff view youth at the facility as being far along the path to a life of crime, with little potential for rehabilitation. For example, team members observed many living units where staff members sat apart from youth, with interactions limited primarily to commands and redirection. Interviews with staff and young people also revealed that many staff fear young people at the facility, expecting them to engage in disruptive and violent behavior at any moment. Team members understood that group disturbances at the facility earlier this year contributed to this perception, but also that this perception predated those incidents, as well as the 2012 state law providing that most youth charged as adults should be held at the detention facility instead of the County jail. As we discuss in more detail throughout the report, this negative dynamic limits the ability of staff members to build productive relationships with young people, and it sets low expectations for the behavior of young people at the facility.

The existing management structure for the facility, and the division of responsibilities between detention facility administrators and Juvenile Court staff, have generated gaps in leadership and accountability for core operational issues. As mentioned above in the discussion of data capacity, the co-location of the detention facility with Juvenile Court presents an opportunity for collaboration and improved services. In general, however, team members encountered a lack of clarity in defining individual responsibility for specific areas of facility operations. Some areas were described as shared responsibilities among multiple individuals, but there were other areas where it did not appear that any one individual had a clear authority and mandate to enforce expectations. For example, as described below, many youth were not receiving access to legally required educational and recreational opportunities. This was a well-known fact throughout the facility, but no one individual seemed empowered to address it. The team understood that the facility's new superintendent had already identified a new leadership structure that would create clearer lines of accountability for core operational issues.

Although the facility has introduced a new training curriculum for staff members, training does not do enough to equip staff with skills for working with adolescents, particularly youth with trauma histories and mental health needs. The team learned that Juvenile Justice Center leadership had recently addressed long-standing concerns about the lack of standardized training for staff by contracting with a local educational institution to deliver needed training on a range of topics. The team applauds officials' efforts to equip staff with new and needed knowledge. However, as described in more detail in the Training section of this report, the team is concerned with the lack of training material focused on working specifically with adolescents, specifically young people with mental health challenges and trauma histories that impact behavior in an institution such as the Juvenile Justice Center. Indeed, the facility's training partner was attempting to add adolescent-specific information into a curriculum that was largely geared toward law enforcement and interactions with adults. The job of a direct care staff member in a juvenile facility is one of the most demanding and difficult professions in this country. Staff members should have access to the most current and effective training curricula that are geared specifically at working effectively with at-risk young people. As described in the report below, the team recommends much more training on a range of topics, including adolescent development, mental illnesses and trauma manifestation in youth, and de-escalation and crisis management strategies for youth.

The Juvenile Justice Center has a significant and dangerous dependence on the use of room confinement. The team was struck by how much time most youth at the Juvenile Justice Center spend alone in their cells. Team members observed some units where only half of the youth were allowed out into the dayroom at any given time. In other units, youth spent hours in their room at various points during the day for a variety of reasons: for shift changes, because of a staff member's decision that it would be unsafe to allow youth on the day room for programming or recreation, because scheduled programming had been canceled, or because a staff member decided on an early bedtime for a unit. When assessment team members inquired about the use of room confinement, staff members most commonly attributed its use to not having enough staff to program youth safely. This is not an adequate response to concerns about safety, as half of all suicides of young people in juvenile facilities occur while young people are in room confinement.

Most youth at the Juvenile Justice Center have extremely limited access to programming, and many youth are not receiving legally required education, special education, and recreation. As mentioned above, staff often cited safety concerns as the reason for high rates of room confinement. The team also observed many situations where staff did not transport youth off of their living units for school, meals, recreation, or other programming, which staff also attributed to safety concerns. Safety concerns are not served by depriving youth of the opportunity to engage in meaningful programming. To the contrary, keeping young people cooped up in the same confined space for hours on end often serves to heighten tensions and rule-breaking behavior, which harms both youth and staff. Moreover, the lack of movement from many housing units means that the majority of young people are not receiving anything close to the required number of minutes of educational instruction mandated by Ohio law, let alone the special education services to which many youth are legally entitled. Indeed, there were young people receiving as little as four hours of educational instruction per week at the facility. Many youth's access to outdoor and indoor recreational and exercise opportunities were also severely limited, which is inconsistent with the needs of growing adolescents. In well-run facilities, youth are engaged in education, recreation, and other programming the majority of waking hours in order to keep youth busy and create opportunities for positive interactions among young people and staff. The opposite is currently occurring on most housing units, which creates an unsafe and unpleasant environment for both youth and staff.

Up until recently, the facility lacked any meaningful behavior management system focused on incentivizing positive behavior. At the time of the team's first visit, the facility did not have a structured and operational behavior management system in most housing units. Staff relied heavily on room confinement as a response to disciplinary issues, which does nothing to address the underlying issues that led to a behavior, nor does it incentivize a young person to avoid the behavior in the future. In well-run juvenile facilities, youth participate in a behavior management system where they earn privileges for following rules and going above and beyond expectations, which capitalizes on the power of incentives to shape adolescents' behavior. The team was pleased to learn about the facility's efforts to implement such a program in each of the housing units, and the team saw administrators implementing components of that system during its second visit. However, the fact that the facility did not have such a system in place for so many years was certainly a contributor to rule-breaking behavior and incidents at the facility in the past.

The facility's physical plant and youth uniforms do not convey positive or high expectations for young people. The team was struck by how little positive imagery, let alone any color at all, appears within the Juvenile Justice Center given the vast expanses of open wall space in living units, hallways, and other spaces. The one notable exception to this is the school area, which does include colorful imagery and which features young people's art and school work. Many living units had little more posted than the rules of the facility in plain text. Many juvenile facilities incorporate positive messages, murals, and other imagery to shift the feel of the facility toward that of a safe and supportive space and away from that of a jail. The report below includes examples of such work, which creates for a much more positive and pleasant environment for both young people and staff. Additionally, as described in more detail below, youth are dressed in correctional-style jumpsuits instead of the khakis and polo shirts seen in many juvenile facilities. Staff and administrators from facilities that have transitioned from

jumpsuits to school uniforms have noted the positive impact that such a transition had upon youth behavior and staff interactions with young people.

Many individuals feel that the groups responsible for various aspects of facility operations are operating in "silos," which impedes collaboration that would benefit everyone involved with the Juvenile Justice Center's operation. The team encountered many individuals who were making concerted efforts to improve operations within the Juvenile Justice Center. These included, but were not limited to, detention facility staff and administrators, administrators within the Juvenile Court, and mental health professionals. However, almost all of these individuals also expressed disappointment with the lack of collaboration among various groups at the facility, particularly given the need for collaboration to solve difficult and long-standing problems. For example, many individuals stated that the insights and recommendations from mental health professionals about chronically disruptive youth were not incorporated into direct care supervision, or were dismissed as being unhelpful to direct care staff altogether. Other individuals noted that the collective bargaining agreement for direct care staff limited the ability of education staff to conduct classes on the living units, notwithstanding the fact that a lack of educational programming during the day leads to significant idle time for staff and young people. However, the biggest apparent division was between facility staff and Juvenile Court administrators, with the former often perceiving the latter as issuing directives and requirements without consultation or collaboration with facility staff. As outlined in other sections of this report and in the roadmap of recommendations, collaboration and coordination among the groups mentioned above is the cornerstone of a well-run facility. The problems with the relationships between these groups are exacerbating the issues outlined in this report, and they require significant attention.

CLASSIFICATION AND INTAKE

Detention can be highly stressful and potentially traumatic event for a young person. From the moment the youth arrives at the facility, staff need to gather information quickly, make critically important decisions, and address the young person's emotional, health, mental health, and physical needs. The Classification and Intake section addresses these "front end" considerations, including intake, criteria governing who comes into detention, housing and programmatic assignments to keep youth safe, and mechanisms to reduce crowding and unnecessary detention. This section also covers the orientation process necessary for youth to understand what to expect in the facility, what rights they have, and how to ask for services or help.

In general, youth are brought to the Intake area by law enforcement, either police officers or sheriff's deputies. Immediately after a youth walks in, a Detention Officer at the booking desk takes the youth's property and escorts the youth to the Admissions Screening Office. There the Admissions Screening Officer (ASO) conducts an initial interview to determine if the youth suffers from injury, intoxication, or acute illness, and if the youth is Limited English Proficient (LEP). If the youth is injured, intoxicated, or ill, the ASO directs the law enforcement officer to take the youth to a nearby hospital for medical clearance. If the youth is LEP, the ASO identifies a staff member on duty who is bi-lingual (usually in Spanish) to complete the interview.

After the initial interview, the ASO escorts the youth back to the booking area, where the youth passes through the metal detector and is frisk searched in the Search Room. Then the youth sits down with clerical staff and a Detention Officer to complete the remainder of the Admission Form. The youth is then assigned to a housing unit. The Detention Officer then takes the youth to a Processing Station to complete the property inventory, sign necessary forms, have the youth take the Initial Mental Health Screening Form, and allow the youth to make one 6-minute phone call or two 3-minute calls. The Detention Officer then takes the youth to the property room and provides the youth with clean clothing, shower shoes, face cloth, and towel. The Detention Officer provides toiletries and allows the youth to shower. The youth is provided with an identification wristband. Then the youth takes the Massachusetts Youth Screening Instrument (MAYSI), which is a self-reporting instrument that identifies acute mental health needs. The youth is then taken to their housing unit, where the social worker provides orientation to the rules and programs at the facility.

The Classification and Intake process has a number of important strengths. It is an orderly process that is well-known to staff and youth at the facility. Youth who are brought to CCJDC with a serious medical or mental health condition are not admitted, and are sent to Rainbow Babies and Children's Hospital for clearance, either by the police officer or sheriff's deputy who brought the youth, or, if they have left by the time the condition is identified, by CCJDC staff. For youth who have limited English proficiency, there are multiple resources to provide intake and orientation. Intake staff first look to see if any other staff are bi-lingual in the youth's native language. If not, there are several translation services available. Most youth who are LEP speak Spanish as a first language, and there are several staff at CCJDC who are fluently bi-lingual in Spanish.

The new Community-Based Intervention Center is an alternative to detention for moderate-to high-risk youth which operates from 8:00am to 8:00pm, providing youth with education, cognitive behavioral therapy, behavioral health clinicians, and supportive programming. It has a capacity of 30, including 15 full-day slots for youth and 15 available after school as a half-day option.

Newly-admitted youth are given the Massachusetts Youth Screening Instrument (MAYSI) to identify behavioral health concerns. The MAYSI is the accepted standard for such screening and is used in juvenile facilities all over the country. Youth fill out the questionnaire on a computer, which eliminates any language problems because the instrument is available in multiple languages. If youth responses indicate a need to see a clinician, intake staff contact the facility's behavioral health clinicians to do an interview and possible assessment.

In spite of these strengths, there were several areas of concern with the classification and intake process.

DETENTION SCREENING INSTRUMENT

There are a number of concerns about the detention, classification, and intake process. First, the detention screening instrument, known as the DASI (Detention Assessment Screening Instrument) is supposed to enable intake staff to make objective decisions about which youth to admit to detention by scoring points in several relevant categories: seriousness and type of current offense, prior adjudications, open juvenile court cases, and current supervision or legal status. In theory, the instrument applies objective standards, and youth with high scores (15 or more) are detained, those with middle-level scores are sent to community-based supervision, and youth with low scores are released to parents or guardians. This is consistent with the general goal of reserving secure detention for youth who are most likely to present a danger to themselves, a threat to the community, or to fail to appear at future court hearings.

In practice, however, the DASI does not determine admissions. Intake staff reported that it is the practice of the facility not to admit youth to detention on new charges unless they are charged with a Class 1 or Class 2 felony, or are charged with an offense that carries mandatory detention, i.e., possession of a firearm, gross sexual imposition with victim in the home, domestic violence, assault on law enforcement, assault on school personnel, or aggravated riot.

At the same time, the daily Severity Report for one of the days of the assessment, July 16, shows that, of the 127 youth in the facility on that day, only 75 were charged with Class 1 or Class 2 felonies. One youth was detained on a hold, while all of the others were charged with lower level felonies or misdemeanors.

Of course, youth are also admitted to detention pursuant to a jurist's order, e.g., for violation of probation or a bench warrant. Some of the 17 youth charged with misdemeanors in detention that day were likely held for that reason. However, since youth charged with minor offenses such as misdemeanors are generally not admitted to detention, one could ask why a youth is detained for a court order when the underlying offense would not justify detention.

In addition, some judges detain youth for being "unruly," a status offense that would not be a crime for an adult. The federal Juvenile Justice and Delinquency Prevention Act and the JDAI standards prohibit the secure detention of status offenders. Federal law makes an exception for youth who are in violation of a valid court order, i.e., for being "unruly" after a previous court order directing the child to stop being unruly. However, youth who are "unruly" are not a significant danger to the community, even for multiple offenses. In addition, the definition of "unruly" is quite broad. See Ohio Revised Code § 2151.022. Staff told the assessment team that jurists detain some girls on "unruly" orders because they fear that the girls will be involved in trafficking. Potential trafficking is certainly a serious concern, but there are other and better ways to handle such girls. The National Juvenile Justice Network and the Coalition for Juvenile Justice have developed resources on status offenders (http://www.njjn.org/uploads/digital-library/CJJ_Making-Case-for-Status-Offense-Systems-Change-Toolkit_2014.pdf), as has the Vera Institute for Justice, through its Status Offender Reform Center (https://www.vera.org/projects/status-offense-reform-center).

Data on detention of "unruly" youth provided to the assessment team illustrate the concerns about this practice. In August 2017, there were 13 detentions of youth on "unruly" charges. Five of those detentions were for boys. Eight of those detentions were not for violations of court orders. Moreover, while youth not detained for violations of court orders were generally released the same day, some youth detained for violations were held for long periods of time: 9, 11, 37, and 45 days.

Data provided for January 2018, shows a much better picture. There were only two youth detained for being unruly that month, and both were released within two hours of being detained.

> **Recommendation:** Re-visit the issue of the "purpose of detention" that was raised when Cuyahoga County became a JDAI site. Bring jurists, probation personnel, detention staff, law enforcement, prosecutors, and defense counsel together to take a fresh look at the "purpose of detention" in CCJDC and to reach a consensus among all parties on which youth should be detained, which should be released to supervision in the community, and which can be released to parents or guardian. Youth charged with being "unruly" should not be detained at all.
>
> **Recommendation:** Review the recommendations and standards developed by the National Juvenile Justice Network, the Coalition for Juvenile Justice, and the Vera Institute for Justice for suggestions on handling "unruly" youth without resorting to secure detention.

YOUTH AGE 12 AND UNDER

Another concern is that records show that youth as young as nine years old have been detained in the facility. During the on-site assessment, the team interviewed a 10-year-old who was detained. Youth this young should not be incarcerated in a detention facility. Their physical, mental, and emotional immaturity creates enormous difficulties in terms of safety, security, and programming, and incarceration can be a particularly traumatic experience for them. The JDAI

standards provide that juvenile detention facilities do not hold youth age 12 or under. During the on-site assessment, there were a 10-year-old, an 11-year-old, and a 12-year-old at the facility.

> **Recommendation:** Do not detain youth age 12 or younger at CCJDC. Create a committee of jurists, probation personnel, detention staff, and other stakeholders to identify the supervision, security, and programming needs of the 12-and-under youth population and to develop alternatives to secure detention for those youth.

LIVING UNIT CLASSIFICATION

Staff reported that youth are primarily assigned to houses based on age and gender. Staff also consider other factors such as physical size and aggressiveness. According to the Post Order on housing, staff may also consider whether a youth should be separated from a co-defendant or sibling, whether mental or physical disability may dictate that youth be assigned to a unit different from the age-appropriate unit, and whether a youth may be in physical danger from a current resident in the same unit.

Assigning youth to a house based primarily on age, size, and aggressiveness is reasonable. Within a house – i.e., in the different pods – it may be desirable to consider other factors such as level of cognitive and emotional development, presence of mental health needs, and history of trauma.

> **Recommendation:** Within each house, consider whether additional factors may be relevant to assignment to specific pods.

RESIDENT HANDBOOK

The Resident Handbook does a good job of summarizing major programs, services, and rules in the facility. The JDAI checklist identifies a number of topics that are covered verbally by the social worker when youth are admitted to their units but are not included in the resident handbook.

> **Recommendation:** Include the items identified on the JDAI checklist in the resident handbook.

There are several ways that the handbook could be improved. First, the design of the handbook could be more engaging. At present, it is largely a series of text sections with titles ("Orientation," "Arraignment," "Clothing/Valuables"), one after the other. The handbook would be more engaging if it included photographs and drawings, and if there were more use of different fonts, different font sizes, and color, to provide visual variety.

> **Recommendation:** Ask staff and youth for suggestions about how to make the Resident Handbook more engaging. Incorporate photographs, drawings, and other visual variety into the design of the Handbook.

In terms of content, there are some sections that could use clarification. Under "Mail," the handbook states that "All non-attorney correspondence is subject to search *and review* by Detention Center Staff" (emphasis added). As discussed below in the "Access" section, a blanket policy to read all incoming mail violates youths' rights under the U.S. Constitution and is contrary to the JDAI standards.

> **Recommendation:** Delete the words "…and review" in the "Mail" section of the handbook. Limit review of correspondence to situations where there is a reasonable suspicion based on specific information that the mail itself involves a criminal act or threatens the security of the facility.

In addition, the "Grievance" section of the handbook will need to be revised to match new practices at CCYDC. As noted in the section on Grievances later in this report, the grievance system has largely been dysfunctional at CCJDC. A new grievance coordinator has been named, and she is developing new policies and practices to make the system more effective. For example, there should not be a requirement that residents submit grievances within five days of the incident: the short time line is inappropriate and counter to the purpose of the grievance system, which is to encourage youth to notify administrators about potential problems in the facility. In addition, the grievance coordinator should meet with the resident who submits the grievance much sooner than the fourteen-day maximum cited in the handbook.

> **Recommendation:** Revise the section on "Grievance" to be consistent with new policies and practices, eliminate the requirement that grievances be submitted within five days of the incident, and provide a new timeline for the grievance coordinator to get back in touch with the resident within a few days of submission of the grievance.

In addition, the "Harassment" section of the handbook states, "You should not be afraid of revenge for raising any concerns you have about this." The sentiment is appropriate but the message could be stated more clearly. Many facilities use the term "retaliation" rather than "revenge." Also, it's not clear who might be looking for revenge. Presumably the sentence refers to other youth who are accused of harassment. It would be better to clarify that, so that youth who are the victims of harassment are not afraid to report the harassment to staff.

> **Recommendation:** Use the word "retaliation" instead of "revenge" in the "Harassment" section of the handbook. Add words so that the sentence reads, "You should not be afraid of retaliation from other youth or staff for raising any concerns you have about this."

Finally, the section on "Telephone" does not notify youth that their phone calls are monitored and recorded.

> **Recommendation:** In the "Telephone" section, add a sentence at the end of the first or second paragraph that says, "All telephone calls may be monitored by staff and recorded." Also add this sentence to the appropriate section in the Parent Handbook.

ORIENTATION PACKET

The Orientation Packet is a set of forms for youth information and guidelines that youth must acknowledge they have reviewed. The list of prohibited behaviors is straightforward (although the title of the page, "Welcome to the Unit," is unintentionally ironic, since there's not much "welcome" in the list, just a listing of things that youth should not do).

The section on "Expectations of Our Residents and Resident Responsibility," item 5, says that "Talking is not permitted in cafeteria or while the television is on." Administrators and staff gave the assessment team conflicting information about whether youth can talk during mealtimes: some said youth are allowed to talk, others said no talking was allowed. During their lunches with residents, the assessment team observed that youth may not sit directly across from each other at tables in the cafeteria, thereby making conversation more difficult. At the very least, there is some confusion among administrators and staff, and likely among youth, about whether youth are, in fact, allowed to talk during meals. This issue is discussed further in the "Environment" section of this report.

> **Recommendation:** Establish a clear policy that youth are allowed to talk during meals, and allow youth to sit directly across from each other at tables. Clarify the statement in the Orientation Packet.

On the same page of the Orientation Packet, under "Unit Consequences," item 5 states, "Out of control behavior, verbal, and/or aggression will result in isolation as a means of safety and security to protect others and yourself from harm." It's not clear what "verbal" means in that sentence: verbal outbursts, name-calling, questioning staff, arguing with another youth? In addition, the sentence says "…will result in isolation…" However, isolation should not be the first response to disruptive behavior, and it is clearly not mandatory. On the contrary, staff should respond to disruptive behavior using de-escalation, and should use other sanctions, such as early bedtime and loss of level in the behavior management system. Isolation (room confinement) should be limited to situations in which youth are out of control and an immediate threat to themselves or others.

> **Recommendation:** Revise the sentence to say something like, "Out of control behavior, verbal aggression aimed at a particular person, and/or physical aggression will result in consequences such as early bedtime, loss of privileges, required letter of apology, report on the incident to the court, or isolation as a means of safety and security to protect others and yourself from harm."

The orientation packet also has a page called the "assaultive behavior questionnaire." It has ten questions. The first six questions are related to sex and sexual abuse. The tenth question is "Have you ever had counseling or treatment for sexual inappropriateness?" The federal regulations for the Prison Rape Elimination Act (PREA) have specific requirements for screening of youth in juvenile facilities:

> (1) Prior sexual victimization or abusiveness;

(2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, questioning, or intersex (LGBTQI), and whether the resident may therefore be vulnerable to sexual abuse;
(3) Current charges and offense history;
(4) Age;
(5) Level of emotional and cognitive development;
(6) Physical size and stature;
(7) Mental illness or mental disabilities;
(8) Intellectual or developmental disabilities;
(9) Physical disabilities;
(10) The resident's own perception of vulnerability; and
(11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

Some of these requirements are met in other components of the intake and screening process at CCJDC. Some are covered by the first six questions in the assaultive behavior questionnaire. There is no question that addresses PREA requirement (2) about gender nonconforming appearance or manner or identification as LGBTQI. The tenth question on the questionnaire refers to counseling or treatment for "sexual inappropriateness," which is a vague term. The eighth question asks, "Do you use drugs or alcohol?" While this question may be relevant to an individual treatment plan for a youth, it does not address assaultive behavior, which is the focus of the questionnaire.

> **Recommendation:** Ensure that, within the intake and classification process, staff ask youth about any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, questioning or intersex, and whether the resident may therefore be vulnerable to sexual abuse. In the tenth question, use the terms "sexual abuse or victimization" rather than "sexual inappropriateness. Ask the question about use of drugs or alcohol at a more appropriate place in the intake and classification process.

Another page of the orientation packet is entitled "Sexual Abuse and Sexual Assault." It provides definitions of "sexual abuse" and "sexual assault," and discusses prevention, intervention, self-protection, and reporting. It does not include a definition of "sexual harassment," which should be included. It also has a paragraph that states the following, with lines at the bottom for the youth's signature and the date:

> Some adults are called mandated reporters. They are legally required to report sexual abuse and sexual assault to the police or Job and Family Services. You can ask the adult if they are a mandated reporter *and then decide what you want to do.* The following are some examples of mandates [sic] reporters: teachers, counselors, social workers, doctors, nurses, juvenile detention staff and coaches. (Emphasis added)

The signature line implies that the youth understands the paragraph. However, the italicized passage is vague and ambiguous. The paragraph should make it clear what will happen if the youth discloses sexual abuse or sexual assault to a mandated reporter, i.e., that the adult will

contact the police or Job and Family Services and reveal what the youth has told the adult. In addition, the paragraph should state that the youth's own attorney is not a mandated reporter and will keep confidential any and all information that the youth discusses with them.

> **Recommendation:** Revise the paragraph to (1) add that the reason mandated reporters report sexual abuse and sexual assault is to protect the youth from further abuse or assault, (2) make it clear what will happen if the youth discloses sexual abuse or sexual assault to a mandated reporter, i.e., that the adult will contact the police or Job and Family Services and tell them what the youth has told the adult, and (3) make it clear that the youth's own attorney is not a mandated reporter and will keep confidential all information from the youth.

LENGTH OF STAY

Juvenile Court staff collect information on detention admissions and releases, and average and median length of stay in detention, disaggregated by race, gender, and type of offense. A striking finding from the calendar 2017 data is that, while the *average* (mean) length of stay was just over 22 days, the *median* length of stay (the number of days for half of the population) was only 3 days. Some youth at the facility have been there for hundreds of days (one youth was there for more than 600 days at the time of the on-site visit), which tends to skew the average upward. Therefore, the median is a better indicator of how long most youth stay in detention.

The fact that at least half of all youth in detention are there for three days or less is very troubling. Three days is such a short period of time that it calls into question the validity of the decision to detain the youth at all. Obviously youth are no *less* dangerous after being in detention for three days, yet jurists release them, so the question is why they were detained in the first place. Some youth are detained for mandatory holds (e.g., possession of a firearm, domestic violence), and it may be that, once the youth are detained for several days, jurists decide to release them until their adjudication hearing.

Some youth may be released because the court believes that a short period of incarceration will teach the youth a lesson, i.e., that it is effective as a short-term punishment for the youth's behavior. However, at the early stage of the process, the youth has not been adjudicated of anything. Therefore, punishment is premature, inappropriate, and a violation of due process. Some youth are detained by jurists for self-protection. The discussion of detention of "unruly" girls and status offenders, above, applies here.

Some staff reported that some youth are detained for several days, even though they could be released to supervision in the community, because the policy is that youth going to shelters must first be "cleared" by both medical and mental health clinicians. Medical personnel are available 24/7, but mental health clinicians primarily work on weekdays during normal business hours. Thus, a youth taken into custody on a Friday night who is eligible for release to a shelter may nevertheless be detained over the weekend until the mental health clinicians return to the facility on Monday. Other staff reported that only youth who have a history of mental health problems or suicidal ideation or behavior are required to be cleared by mental health clinicians. It appears that policy should be clarified on this point so that all staff know which youth require mental health

clearing. This issue may affect a large number of youth. In 2017, at least 436 youth were released from detention in three days or less.

Staff also reported that youth may be detained because some shelters don't accept youth 24/7. That may be a reason for detaining a youth overnight, but not for longer than that. Because so many youth are released in three days or less, it would be worthwhile to collect and analyze data on those youth to determine (1) how many youth were detained before going to a shelter or other program, (2) whether those youth were detained because of delays in obtaining medical clearance, mental health clearance, or other reasons, and (3) the average and median numbers of days those youth were detained.

> **Recommendation:** Collect and analyze data on youth detained for three days or less to determine how many were detained, and for how long, due to medical or mental health clearances.

HEALTH AND MENTAL HEALTH CARE

Youth often come into detention with medical and mental health conditions needing prompt attention. Many youth have not received adequate health care in the community and have unrecognized health needs. Other youth have chronic medical or mental health care needs. Still others have care needs arising from the incident leading to detention. The Health and Mental Health section highlights key elements in meeting the medical and mental health needs of youth, including initial screening for medical and mental health problems, full health assessments, ongoing health services, emergency services, and mental health services.

The team's medical and mental health experts reviewed documents in advance of the team's on-site visits, in addition to conducting interviews with clinical staff, reviewing documents and clinical meeting spaces while on site, and speaking with young people, staff, and administrators. In addition to identifying a number of strengths with the medical and mental health programs at the Juvenile Justice Center, the team identified the following areas of concerns and recommendations.

GENERAL MEDICAL SERVICES

The medical program at the Juvenile Justice Center was historically contracted to MetroHealth Medical Center. This program was terminated through the normal Cuyahoga County bidding process, and a new contract was awarded to University Hospitals Rainbow Babies and Children's Hospital (Rainbow), effective, January 1, 2018. Rainbow's designated medical services administrator for the Juvenile Justice Center had been in that position for approximately three months at the time of the team's first visit. The program had yet to develop a policy and procedure manual for the facility, in part due to the recency of the transition.

> **Recommendation:** Revise and adopt a policy and procedure manual and train all clinical staff on the revised manual.

Rainbow has qualified and enthusiastic staff who are committed to providing quality and compassionate care to the residents of the facility. The fact that the program's physicians are also active clinicians at the Rainbow Hospitals and Clinics is positive and will facilitate access to consultative services when indicated. According to the contract, 20 hours per week of physician services are to be provided (10 of these can be from a nurse practitioner). At the present time, the two physicians are only present on site four days a week. The contract does not require five days a week of physician (or nurse practitioner) presence, although this would be preferable.

There are several areas where improvements in the medical program should be made in order for the facility to meet JDAI standards and improve the medical care of young people at the facility. The new contract with Rainbow provides the opportunity for the facility's medical program and to review and revise its policies, procedures and practices. Additionally, the medical program does not have a quality assurance program in place at this time.

> **Recommendation:** Establish and implement a quality assurance program for medical and mental health services.

The medical unit includes two "observation rooms" located in the medical area. Given the limited capacity of the medical program, these use of these rooms should be extremely limited, and policy should be established that the rooms should only be used for observation and temporary isolation of youth with infectious conditions, not for the treatment of youth with any serious illness.

> **Recommendation:** Establish clear policy that the medical unit's "observation rooms" should only be used for temporary observation and isolation of youth with infectious conditions.

Finally, medical staff reported that interpretation services were only available for medical staff from 9 a.m. to 5 p.m. on Monday through Friday, which would limit the ability of medical staff to speak with youth and family members during evenings and weekends.

> **Recommendation:** Arrange for availability of interpretation services for medical staff at all times, as needed.

INTAKE SCREENING

The team had six primary concerns with respect to medical intake screening. First, the facility had a functioning and successful program of HIV testing and counseling in previous years, but the program ended within the past 12 months. Given the high-risk nature of the population at the Juvenile Justice Center, there is an urgent need to reinstate the program.

> **Recommendation:** Reinstate HIV testing and counseling.

Second, there have been substantial increases in the prevalence of sexually transmitted infections (STIs) nationally and within Cuyahoga County during the past several years. These include syphilis (particularly congenital syphilis), gonorrhea, and chlamydia).

> **Recommendation:** Hold discussions with Cuyahoga County officials and the Ohio Department of Health about providing syphilis and other STI screening to all youth.

Third, the facility does not conduct routine hearing screenings as part of intake examinations. These screenings should occur to identify any youth with hearing difficulties.

> **Recommendation:** Initiate hearing screenings during intake examinations.

Fourth, the facility does conduct visual acuity screening via Snellen Test, but follow-up optometry services for youth who need glasses or contact lenses is inadequate. Optometry visits are difficult to obtain and glasses are not routinely provided because of delays in access to examinations and the production of glasses. This is a critical area of concern, as youth cannot fully participate in school if they cannot see. This problem had been identified in medical team meeting minutes this past spring, which suggested that parents were not allowed to bring in their child's eyeglasses at the present time.

Recommendation: Arrange for adequate optometry services for young people at the facility and ensure that youth who require glasses or contacts are able to obtain them or receive existing pairs from family members.

Fifth, medical staff do not currently screen for signs of intellectual, developmental, or learning disabilities. There is no screening by medical staff for mental health history, prior mental health treatment, prior suicide attempts, or history of suicide attempts by family members or close friends.

Recommendation: Ensure that the medical screening includes screening for signs of intellectual, developmental, and learning disabilities. Ensure that the screening also includes mental health history, prior mental health treatment, prior suicide attempts, or history of suicide attempts by family members or close friends.

Sixth, medical staff do not conduct screenings pursuant to the requirements of the federal Prison Rape Elimination Act (PREA) for juvenile facilities. Additionally, awareness of PREA by medical staff was extremely limited, which may be a product of the recent transition to a new medical provider.

Recommendation: Ensure that medical staff complete any components of screening required by PREA that are not covered by other aspects of the intake process and that medical staff convey information to individuals making housing, programming, and other placement decisions. Ensure that medical staff receive required training on PREA and the facility's policies and procedures on sexual misconduct prevention, detection and response.

DENTAL SERVICES

The facility does not offer dental screenings, nor does it offer prophylactic dental services. This is a serious deficiency. The room originally designed as a dental office when the facility was constructed was not provided with plumbing, so no water is available. Emergency dental care is available, but the lack of dental services is an urgent problem that requires immediate attention.

Recommendation: Obtain adequate dental screening services and dental services.

MENTAL HEALTH SERVICES

As a general matter, young people had positive comments about their interactions with mental health staff at the Juvenile Justice Center and the interventions that mental health staff members employed. However, there were several areas of concern with the mental health services as currently contracted.

First, the contract does not adequately detail the kinds of services that clinicians are expected to provide at the facility. For example, the contract does not specify the kinds of therapeutic groups the clinicians are expected to run. Currently, there are no trauma-focused interventions or

substance abuse treatment sessions offered by mental health professionals. Indeed, during the team's visit, clinicians were running life skills groups. While these groups are helpful to youth, other practitioners can take responsibility for running these psychoeducational groups and free up mental health clinicians to run more therapeutic groups.

Second, the contract does not provide for mental health staff training of direct care staff members. Pre-employment training for Detention Officers does not include critical components necessary for working with incarcerated youth. These components include adolescent development, brain development, mental health issues among incarcerated youth and the trauma experienced by this population and how it manifests itself. The behavioral health staff should be contracted to provide this training.

> **Recommendation:** Modify the contract for mental health services to include specifics about the types of therapeutic interventions that clinical staff should offer and require mental health staff to deliver training on core topics necessary for Detention Officers to work with the youth population at the Juvenile Justice Center.

Third, behavioral health staff is not involved in the development of service plans or individual treatment plans. The team was told that Social Service Coordinators develop a service plan following a Care Team Meeting, but behavioral health staff is not a participant in the Care Team Meetings or the development of service plans. The development of a service plan is a critical component of service delivery. It is the contract between the youth and facility-based service providers regarding what the focus of treatment will be during their period of incarceration.

> **Recommendation:** Ensure that behavioral health staff are included in the formulation of service plans and individual treatment plans.

Fourth, clinicians meet with youth on their units in the common areas, attempting to obtain as much privacy as possible given other movement within the facility. This does not ensure that there is privacy or confidentiality, and it is not conducive to therapeutic interactions.

> **Recommendation:** Identify and dedicate space on the units for clinicians to meet privately with youth.

MEDICAL AND MENTAL HEALTH SERVICES STAFFING

As mentioned above, the facility currently has four days of physician or nurse practitioner staffing. However, a facility of this size would benefit from five days of staffing by physicians or nurse practitioners.

> **Recommendation:** Provide physician (or nurse practitioner) staffing five days per week.

Two nurses are available on each shift at the facility, which the team determined was adequate. However, there were three open nursing lines at the time of the team's first visit, an approximately 30% shortage. The medical provider was filling the deficit with the use of registry nurses, which is acceptable for urgent and emergent situations, but not as an effective long-term

approach to the care of young people at the facility. If staffing shortages persist, nursing salaries and benefits should be reviewed.

> **Recommendation:** Monitor nursing shortages and determine whether adjustments should be made to nursing salaries and benefits to ensure full staffing.

Additionally, the number of hours of mental health services being provided under the Applewood contract are inadequate given the size of the facility and the level of acuity among young people at the Juvenile Justice Center. The combination of the lack of specificity in the contract regarding the kinds of services to be offered and the limited number of qualified mental health professionals at the facility (4) has resulted in mental health staff members spending most of their time responding to crises at the facility.

Additionally, the psychiatrist comes in two consecutive days a week for 4 hours each day. The psychiatrist reports that the deployment schedule and the number of hours allotted are not sufficient to meet the needs of the youth. The psychiatrist rarely gets through the list of youth scheduled to be seen on any given day, and if a youth comes in on a day the psychiatrist is not at the facility, the young person may need to wait as long as 5 days before he or she can see the psychiatrist.

> **Recommendation:** Increase the number of qualified mental health professionals from 4 to at least 6 to ensure that there are sufficient staff to provide therapeutic services and not just crisis intervention.

> **Recommendation:** Increase psychiatric service staffing levels by at least eight additional hours, spaced throughout the week, to meet the needs of the youth population.

SUICIDE PREVENTION AND INTERVENTION

The team had two primary concerns with respect to suicide prevention and intervention. First, while Detention Officers receive training on suicide prevention and their responsibilities when a youth is placed on a suicide precaution status, the efficacy of this training is of concern. While the team was on site, a youth who had engaged in continuous self-harm (cutting) and who was on constant watch was able to obtain implements to harm herself on multiple occasions. The last of the occasions during the team's on-site visit resulted in her transfer to an inpatient psychiatric hospital.

> **Recommendation:** Provide additional training on how to conduct one-on-one observations to ensure that youth on constant watch are not able to gain access to self-harming implements.

Second, youth on constant watch are frequently held in a padded cell in the intake area. This room is observed via closed circuit television. While in this cell, youth do not have access to school or other activities. Youth on constant watch should remain on their units with a one-to-one staff member and should be given opportunity to engage in both school and other unit activities.

Recommendation: Do not rely on closed circuit monitoring of youth. Require that youth on constant suicide watch continue to have access to school and other programs and activities.

INTEGRATION OF MENTAL HEALTH PROFESSIONALS WITH DIRECT CARE STAFF

In well-run youth facilities, mental health staff and facility staff work side-by-side to manage youth behavior and troubleshoot problems. At the Juvenile Justice Center, the only truly interdisciplinary meeting is the Staff Meeting held at the end of each day to review the day's events and provide updates on institutional matters. Attendees include administrators, Unit Managers, medical and behavioral health staff, and the volunteer coordinator, among others.

However, the team's observations and interviews revealed a deep and significant divide between mental health professionals and Detention Officers. Mental health professionals reported that Detention Officers do not take clinical recommendations seriously, and facility staff rarely spoke of behavioral health staff as a helpful resource. For example, Care Team Meetings are held at least weekly in order to share relevant information and coordinate work efforts among staff for youth who are on Suicide Watch or who require specialized services and programs (i.e., because of mental health needs, disabilities, etc.). The Care Team is chaired by the youth's assigned Social Service Coordinator, with the youth's Unit Manager in attendance. It is noteworthy that behavioral health staff are not routinely included in these meetings. Behavioral health staff should not be sidelined in clinical discussions regarding youth.

Recommendation: Integrate behavioral health professionals with other disciplines at the facility, particularly direct care staff and unit management.

COORDINATION OF MEDICAL AND MENTAL HEALTH SERVICES AND RECORDKEEPING

The team found that the facility would benefit from increased collaboration between the medical and mental health programs. In general, clinical referrals from the medical staff to the mental health staff do not generate any follow-up clinical information. The exception is when the referral is for medication continuation from a psychiatrist, in which case the psychiatrist's order is provided to nursing staff. No joint case conferencing between medical and mental health staff occurs, and there is no joint quality assurance process.

Recommendations: Increase coordination between medical and mental health service providers, including through the use of joint case conferencing and implementation of a joint quality assurance process.

Currently, health and mental health records are kept separately. Medical has its own record keeping system. The mental health provider keeps its records separately in two locations: one is a paper record of assessments and other intake data, and the second is an electronic record used for communicating with the service provider regarding the interventions that staff provide at the Juvenile Justice Center.

Recommendation: Develop an integrated health and mental health record so that all providers can ensure they have the most current up to date knowledge of youth's issues to inform their interventions. Explore the possibility of an electronic medical and mental health record system.

Additionally, outside providers connected to community agencies from which the youth was receiving services frequently come in to the Juvenile Justice Center to provide services to youth while they are detained. While this is, in principle, a good practice in terms of ensuring continuity of care, these outside providers do not document their interactions with the youth they see, nor do they communicate with on-site mental health clinicians about the nature of their encounters with youth. These interactions may substantially impact a youth's behavior or experience at the Juvenile Justice Center.

Recommendation: Develop a means of exchanging and documenting information between outside service providers and facility mental health staff.

MEDICATION ADMINISTRATION

The nation's opioid overdose has not spared young people and adults in Cuyahoga County. The Juvenile Justice Center would benefit from a supply of Naloxone that is available to medical staff if needed.

Recommendation: Make Naloxone available on-site for use by nurses and physicians and train all staff members in its use.

TRAUMA

The medical program would benefit from a more detailed documentation of youth's trauma histories. Trauma is among the most common, significant, and preventable medical problem encountered in the Juvenile Justice Center. Documentation of trauma should occur at two points: upon admission to the facility and after any traumatic incident (e.g., fight, accident, use of force, incidence of self-harm).

Recommendation: Include documentation of trauma history at the time of young people's admission to the facility in the youth's medical record, and make referrals to mental health staff as appropriate.

Recommendation: Include documentation of each traumatic incident that occurs at the facility (e.g., fight, accident, use of force, incidence of self-harm), to include the location of the incident, time of day of the incident, resident and staff involved, nature of the injury (posterior and anterior anatomic schematic pre-printed provided to document location and extent of injury), and the clinical evaluation and treatment provided.

INFORMED CONSENT AND CONFIDENTIALITY

Families are not routinely contacting regarding medical information upon youth's admission to the facility. Additionally, family members are not routinely notified when youth are hospitalized or have other medical emergencies. The team was informed that one resident who had been taken to the emergency room recently was able to call his family from the hospital, but that this was deemed to be a violation of facility rules.

> **Recommendation:** Ensure that policies, procedures, and actual practices provide for parent and family member notification upon youth's admission to obtain medical information, as well as when youth are hospitalized or have other medical emergencies.

Additionally, the current informed consent form used by the facility asks family members to assume responsibility for the cost of medical treatment during the time their child is at the Juvenile Justice Center, which is contrary to the JDAI standards. It was not clear to the team when, if ever, parents were billed for medical services, but if parents are not billed, this language should be removed.

> **Recommendation:** Do not bill parents or legal guardians for medical services provided to youth while they are at the Juvenile Justice Center. Adjust the informed consent form to reflect that policy.

QUALITY ASSURANCE

As mentioned above, there are no quality assurance activities or programs for the medical or mental health programs at the Juvenile Justice Center. Quality assurance programs provide a vital opportunity to determine if policies are being followed, if documentation is being maintained, and if programs are having their intended impact.

> **Recommendation:** Implement a quality assurance program that can begin to address the issue outlined above, as well as other programmatic positions. Consider establishing a quality assurance monitoring position for medical and mental health services at the Juvenile Justice Center.

ACCESS

Success in the community is often linked to supportive relationships that youth have with family and others. This section addresses the rights of detained youth to have access to the outside community through visitation, correspondence, and access to the telephone. It also addresses the need for youth to be able to visit with and communicate with their attorneys and other advocates about their cases, problems in the facility, or other issues requiring legal assistance. Standards also ensure that administrators and staff value the input and participation of families.

In general, youth at the Juvenile Justice Center reported being satisfied with their level of contact with parents, legal guardians, and grandparents. We were pleased to see professional and friendly interactions between families and Juvenile Justice Center staff during visitation, and we were pleased to see a welcoming visitation area that allows for contact visits.

The team was concerned with limits on certain types of contact in policy and practice, procedures regarding incoming mail, access to telephone calls, the use of a collect calling system, the routine recording of certain telephone calls absent individualized reasonable suspicion, a lack of confidentiality with attorney mail and telephone calls, visitation dress codes, and the accessibility of orientation materials for families with limited literacy.

MAIL

In general, youth reported being happy with mail service at the facility and understood the rules around delivery and receipt of mail. There were two main areas of departure from the JDAI standards, however. First, some youth and staff reported that opportunities for letter writing only occurred once per week on some living units. The team recommends that the facility provide youth with the opportunity for letter writing during any downtime at the facility, in addition to any scheduled times. It is worth encouraging youth to express their feelings in writing if they choose to do so. Moreover, given the limitations on phone and visitation contact, letters may be the best avenue to stay connected to certain individuals while youth are detained.

> **Recommendation:** Do not limit youth to set scheduled periods for letter writing.

Second, staff and youth reported that staff routinely "scan" incoming and outgoing mail, and that this has included legal mail. Additionally, some youth and staff reported that non-legal mail is opened and inspected for contraband prior to delivery to youth and out of a youth's presence.

Staff should only read non-legal mail upon reasonable suspicion that the content of the mail contains a specific threat to the safety or security of the institution. In situations where mail is opened to inspect for contraband, it should be opened in front of the youth so that the youth can see that staff do not read the mail. Staff should never read mail marked as legal mail under any circumstances, as such correspondence is protected by the attorney-client privilege.

> **Recommendation:** Clarify in written policy, procedure, and actual practice that staff should not read incoming or outgoing non-legal mail unless there is reasonable suspicion

that the letter contains a specific threat to the safety or security of the institution. Ensure that any mail that is opened to inspect for contraband is opened in front of the youth.

Recommendation: Clarify in written policy, procedure, and actual practice that staff are never to open or read incoming or outgoing legal mail.

TELEPHONE

We were pleased to see that Juvenile Program Managers allowed youth to use their telephone privileges to contact a broad range of individuals outside of the facility who are meaningful to youth. As with mail service, we had concerns about three main areas of departure from the JDAI standards.

First, the facility's phone system relies, in part, on a collect calling system. The team understood that Social Service Coordinators would facilitate phone calls if a youth's family could not afford to establish or maintain an account for phone calls. However, the current system pegs availability to some phone privileges to the financial resources of a youth's family. It is rare that our team members visit a juvenile facility that employs a collect calling system. We strongly urge the facility to allow youth to make free phone calls at any time, not just when making calls through the Social Service Coordinators. Additional access to free phone calls would serve as a powerful incentive as part of the facility's behavior management system.

Recommendation: Discontinue use of the collect calling system. Allow youth to make free phone calls from the housing unit phones, in addition to making free calls through the Social Service Coordinators.

Second, some staff and youth reported that youth in room confinement are not allowed to make or receive phone calls. The team's review of logbooks appeared to confirm this, with several entries stating that youth were not allowed calls for "fighting" or "confinement." While the team agrees that access to additional phone time can serve as an incentive for good behavior, all youth should receive a minimum amount of phone time regardless of disciplinary status. A phone call with a family member can be particularly valuable for youth who may be struggling at the facility.

Recommendation: Allow all youth, including youth in room confinement, access to phone calls unless their behavior presents an immediate threat to the safety of the youth or others.

Third, although staff reported that they do not routinely listen in on youth's conversations, calls from Social Service Coordinators' offices – including legal calls – are made with staff present in the room. Moreover, calls that are made through the collect calling system are recorded, although staff reported not routinely monitoring conversations in real time. As mentioned above with mail service, staff should only listen to non-legal phone calls with reasonable suspicion that the call constitutes a threat to the safety or security of the facility. Staff should <u>never</u> listen to calls with attorneys, which are protected by attorney-client privilege. Many facilities have found ways to make accommodations that allow staff to maintain supervision of youth without listening in on

phone calls, including by maintaining eyes on supervision of youth through a window while they are placing a call from an office.

> **Recommendation:** Clarify in written policy, procedure, and actual practice that staff should not routinely listen in to non-legal calls unless there is reasonable suspicion that the call contains a specific threat to the safety or security of the institution. Discontinue routine recording of telephone calls.

> **Recommendation:** Clarify in written policy, procedure, and actual practice that staff are never to listen in on legal calls and identify accommodations to allow youth to make calls confidentially.

VISITATION

The team had an opportunity to observe two visitation periods for detained youth during the on-site visit. We were impressed with how well the facility staff managed the process, as well as how professional and respectful staff's interactions were with parents and family members. We observed staff members answering questions of family members regarding their child, and staff were knowledgeable and responsive to those family members' questions. Additionally, youth and families generally expressed being happy with the visitation process with three exceptions, which are also deviations from the JDAI standards.

First, visitation, as a general matter, is overwhelmingly restricted to parents, legal guardians, and grandparents, as is reflected in policy, procedure, and actual practices. While exceptions for special visits are occasionally made, the team's review of visitation logbooks indicates that these types of visits are very infrequent relative to visits from parents, legal guardians, and grandparents. Additionally, there is nothing in policy, procedure, or practice that explicitly encourages visitation by children of young people at the facility. Given the number of youth who are at the Juvenile Justice Center for extended periods, these restrictions on permissible visitors can disrupt positive and significant relationships that are particularly important to young people.

> **Recommendation:** Allow youth to visit with parents or guardians, siblings, other family members, the parents of a youth's child, mentors, community-based service providers, educators, and clergy members, and other supportive adults as a matter of course.

Second, although every housing unit has two visitation periods during the week, some weekday house and pod visitation hours occur during standard business hours (e.g., 9a.m.-5p.m.) when some parents are likely to be working. Additionally, weekday visits are limited to 30 minutes. Some parents may decide that it is not worth the time needed to travel to the facility and get through security for such a short visit.

> **Recommendation:** Ensure that visiting hours occur outside of normal business hours whenever possible.

> **Recommendation:** Ensure that all visitation periods are at least one hour in length.

Third, the stated dress code for visitation is very restrictive and encompasses common articles of clothing. While all facilities make an effort to prohibit revealing or suggestive clothing, the dress code also prohibits "sweatshirts, sweatpants, and hoodies." Many facilities are able to maintain the security of the visitation process without prohibiting such common articles of clothing. Additionally, some of the guidance regarding appropriate dress is confusing. For example, some of the stated limits on clothing provide that shorts or skirts must be "at least 1 inch above the knee." The intent of this is likely to be "no more than 1 inch above the knee."

> **Recommendation:** Reconsider restrictions on clothing that can be worn in visitation to avoid unintentionally excluding visitors who are dressed in common articles of clothing. Ensure that any remaining guidance regarding permissible dress is clear and concise.

ACCESS TO COUNSEL

The team reviewed records of attorney visits and spoke with youth about their experience with their lawyers. The team had two primary concerns with access to counsel.

First, as mentioned above, youth and staff reported that staff routinely open and scan legal mail and that staff are present when youth are making legal calls from the Social Service Coordinators' offices. Communications between young people and attorneys is privileged and should be treated as such.

> **Recommendation:** Clarify in written policy, procedure, and actual practice that staff are never to listen in on legal calls, and identify accommodations to allow youth to make calls confidentially.

> **Recommendation:** Clarify in written policy, procedure, and actual practice that staff are never to open or read incoming or outgoing legal mail.

Second, some staff and youth reported screening youth requests to call attorneys by requiring youth to submit requests for attorney calls. Other staff and youth reported limiting calls to normal business hours. Staff should not serve as the gatekeeper to a young person contacting his or her attorney. Additionally, limiting calls to attorneys during normal business hours is problematic, as those are the hours when attorneys are most likely to be in court.

> **Recommendation:** Allow youth to make calls to attorneys at any reasonable time. Do not require youth to state the justification or reason for needing to call his or her attorney.

FAMILY ENGAGEMENT

The team reviewed the family brochure provided to parents and legal guardians, which is very dense and written at a level that would be difficult to understand for someone with limited literacy. Additionally, the team did not observe much information posted for family members within the facility about their rights, the ways of reporting problems, and other essential information beyond the list of rules outside of the facility front door. The facility lobby is a good place to provide information such as this, as well as information about other programs and

services that may be of interest to family members. This is particularly true given that parents may be waiting 15 minutes or more before visitation begins.

Recommendation: Revise the text to lower the reading level of the family member brochure and find ways to make presentation of the information more visually appealing. See the suggestions in the Classification and Intake section on revisions to the Resident Handbook.

Recommendation: Post more information for family members about rights within the facility, avenues for reporting problems, and other information that may be of interest and use. Consider developing a video that could be played in the lobby area where parents are waiting for visitation to begin.

PROGRAMMING

Youth in detention are, first and foremost, adolescents. They need to be involved, to the extent possible, in the same kinds of age appropriate, healthy, educational activities youth would experience in the community. This section outlines the requirement that detained youth receive a full academic education, with special services for youth with disabilities or limited English proficient youth. Youth are also entitled to go outdoors regularly, engage in physical exercise, participate in a range of recreational activities, and have the opportunity to practice their religion. This section also covers the ways youth are encouraged and motivated through positive reinforcement and incentives for good behavior.

EDUCATION

Education services at the Juvenile Justice Center are provided by the Cleveland Metropolitan School District (CMSD). The school at CCDJC is referred to as the DEC or Downtown Education Center. At the time of our visit, there were approximately 130 youth at the facility. Of that number, 100 were boys and 30 were girls. The majority of the youth at the detention center previously attended schools in the CMSD. At the Cuyahoga County Juvenile Detention Center students attend classes with other youth on their housing units and remain in one classroom during the time they are in school each day. The exception is those students with special education eligibility, some of whom are also served by instructional specialists (special education teachers) in the classroom. Occasionally these students leave the classroom for individualized instruction.

None of the students at Juvenile Justice Center receive the instructional time to which they are entitled by state regulations.[1] Access to school and instructional time varies widely among the housing units. Interviews with staff and students revealed that some youth receive only four hours of class time each week while other units receive as many as 20 hours each week. Insufficient instructional time, failure to implement IEPs, and lack of instructional support for students leaves Cuyahoga County vulnerable to litigation.

The primary means of instruction is web-based, on-line coursework. At the time of our visit we observed no group instruction. There is no Career and Technical Education (CTE) at the Juvenile Justice Center. The web-based instructional program appears to meet the needs of some students, but many are not well-served. Interviews with students and some teachers indicated that listening to music is a primary reason some students like to attend class. Many students appeared to race through the web-based content and assessment with minimal understanding of content and inadequate mastery of material. Teachers have the ability to reset quizzes and other assessments; a process that allows some students second or third opportunities to demonstrate proficiency. For other students resetting the computers gives them the opportunity to keep guessing answers until

[1] The Ohio Department of Education requires schools serving secondary school students to receive from 900 to 1001 hours of instruction each year. Under the current school schedule at JUVENILE JUSTICE CENTER it would be impossible for students to receive the number of hours of instruction to which they are entitled. See http://education.ohio.gov/Topics/Finance-and-Funding/Finance-Related-Data/Guidance-on-Schedule-Change-from-Days-to-Hours/Minimum-Hours-and-What-Hours-Count.

they get them right. The current computer network serving the DEC is inadequate for the number of users according to correspondence shared with the team during our visit and our discussions with staff. High demand for the computer system at times and inadequate bandwidth for the more than 140 daily users results in delays in loading instructional content, the inability of students to save their work, and occasional system crashes.

Approximately 35-40% of students at the Juvenile Justice Center are identified as eligible for special education services. The education staff does a good job of promptly requesting and receiving records from students' prior schools and school districts with the exception of students who were previously attending community or charter schools. However, services at the Juvenile Justice Center are woefully inadequate and do not appear to follow students' IEPs.

While most students at Juvenile Justice Center were previously enrolled in CMSD, some attended other school districts in Cuyahoga County. CMSD charges these school districts a daily rate for services they provide even though students at Juvenile Justice Center do not receive a full-time education program. When compared to detention programs serving similar populations in other jurisdictions, education does not appear to be a priority at the Juvenile Justice Center.

The instructional program at the Juvenile Justice Center is modeled on the "School of One" platform. This approach relies on individually tailored instruction delivered via the web and accessed by students on laptops in the classrooms. The approach looks good on paper, but its implementation at Juvenile Justice Center leaves much to be desired. According to staff, students like the system because of their ability to listen to popular music with headphones while working on academic tasks. Some students relish the opportunity to work independently, complete units and courses, and accrue academic credits. Others struggle with the material and miss the contact with teachers that is associated with direct instruction and group work.

Education policies and practices at Juvenile Justice Center are inadequate to meet the needs of the youth detained at the facility. Youth do not receive the instructional time to which they are entitled and CMSD charges other school districts for services children do not receive. The education space at the Juvenile Justice Center is not well utilized. A culinary arts room is not used for instruction, and other spaces within the school area were not being used for small group work by instructional specialists at the time of our visit. While many youth at the Juvenile Justice Center spend a relatively short time at the facility, our review of lengths of stay at the time of our visit showed that 54 youth had been at the facility more than 100 days and that 18 youth had been at the facility more than 6 months. The narrative below addresses in some detail two broad areas: (1) Educational Access, Leadership and Support Services, and (2) Special Education.

Educational Access, Leadership, and Support Services

The assessment team examined the education program at Juvenile Justice Center during the last week of the spring semester, 2018. On the third day of our visit, students began a four-week half-day summer school program. Students nominally attend school for three hours each day. An even and odd day schedule has different units attending school for different time blocks. The schedules provided to the team suggest that for most students and most units, all instructional activities are done by 11:30 a.m. or 1:00 p.m. each day. An inadequate number of unit and

security staff contributes to problems with students' access to school. According some instructional staff, the school schedule, in addition to severely limiting students' access to a full day of instruction, appears to cater to teachers' preferences for teaching time and not students' needs.

The school program at the Juvenile Justice Center, also referred to as the Downtown Education Center, provides no career and technical education (CTE) courses in spite of the fact that a considerable number of students remain in detention for more than three months. There do not appear to be any regularly scheduled school-wide activities or events. Currently there is nothing available for students who have graduated with their high school diploma or who passed the GED tests.

> **Recommendation:** Develop a career and technical education (CTE) program for youth in detention. Short-term courses and certifications fit well into detention facilities and should be added to the curriculum. There are a range of short-term CTE certificate programs including ServeSafe (food handlers' license) and OSHA 10 (job site health and safety certificate) that are available to youth at other detention facilities.

The education space at the Juvenile Justice Center does not appear to be well utilized. For example there appeared to be several vacant classrooms next to library area. A room designed for a culinary arts class was not being used for instruction.

Policies are in place and classrooms are have adequate supplies and instructional materials. Inadequate bandwidth compromises the quality and accessibility of the on-line coursework that is the primary means of instruction. Staff shortages as well as the potential for conflict among youth were used to rationalize not providing a full-time school program to youth. The current administrator for the Downtown Education Center at Juvenile Justice Center is responsible for 12 sites in addition to the school at the Juvenile Justice Center. While the administrator is available by phone to talk with staff, there is no one available on a day-to-day basis to confer with unit staff and to negotiate how to best serve youth.

> **Recommendation:** Hire or appoint an on-site administrator for the school program.

There are no school guidance counselors at the Juvenile Justice Center. Each teacher assesses his or her students, reviews transcripts, determines what courses students should take in the on-line program. Teachers are also expected to provide instruction and support to a classroom of 15-18 students that includes students with special education needs. School counselors are typically part of the instructional support team in juvenile facilities. Their role is critical in detention centers with a highly mobile student population.

> **Recommendation:** Hire two school counselors to manage school transcripts, determine students' instructional placements, and support the behavioral management program.

According to the education staff, Detention Officers make decisions about when and how often units attend school. The lack of regularly-scheduled meetings between educators and Detention Officers is atypical for detention centers where daily meetings or conversations about

programming and responding to the needs of individual youth are common. We heard the comment "the students don't want to attend school" from staff. This is not something the team heard from students.

Detention Officers unnecessarily restrict student access to reading material. Students reported that they were either not allowed to have books in their rooms or that they were only allowed one or two books. Limiting access to books as a general policy is counterproductive. Students who are engaged are less likely to be involved in physical disturbances and more likely to engage in positive prosocial behavior. Book policies should be developed facility-wide and should involve discussions with unit, security, and school staff. The detention center would benefit from reviewing policies and practices at detention facilities in other jurisdictions.

> **Recommendation:** Hire a librarian, library assistant, or media specialist to increase access to reading material and support literacy activities throughout the facility.

> **Recommendation:** Develop policies that enable students to have greater access to books and other reading material on the living units.

A quality assurance system for education exists but did not appear to have an impact on the lack of services. The issues identified here should be a call for collaboration among CMSD leadership, the new Juvenile Justice Center leadership, and the Juvenile Court in resolving the problems identified here.

The recommendations below address broad issues in the design, delivery, and management of education, and are followed by a discussion and recommendations about special education services.

> **Recommendation:** Carefully review the implementation of the web-based instructional program. Embrace a blended learning format in which instruction is a mix of individually tailored web-based instruction along with hands-on and small group activity.

> **Recommendation:** Consider developing an intake classroom where students spend the first week at the facility. Conduct initial screening and assessments, review students' records, and provide instruction in numeracy, literacy, and current events. An intake classroom can help socialize students who may have been out of school for an extended period of time as well as provide basic instruction for students who may be at the detention centers for just a few days.

> **Recommendation:** Ensure that all teachers provide instruction in areas in which they are certified.

> **Recommendation:** Develop a system of positive behavioral interventions and supports (PBIS). PBIS, widely used in the public schools, is also used in a number of juvenile correctional facilities. Discontinue punitive, unproductive discipline systems.

Special Education

The education services provided to youth at the Juvenile Justice Center are not consistent with services described on students' IEPs. The school fails to implement the IEPs as written. There is no evidence that the school conducts functional behavioral assessments (FBAs) or implements behavior intervention plans (BIPs) even for those students whose records included BIPs. There is no on-site coordination of special education services. All students are educated via an inclusive service delivery model in spite of previously receiving intensive services in a small group setting. Students whose needs require intensive supports including those with low levels of literacy are educated in classrooms with 15-18 other students. Special education teachers, referred to as instructional specialists, report that they are often not able to provide one-to-one support outside the general education classroom as specified on students' IEPs. The three instructional specialists currently working at the Juvenile Justice Center are not sufficient to provide services as specified on students' IEPs. In addition to proving instructional services, instructional specialists schedule IEP meetings and confer with general education teachers about students IEP goals and needed accommodations.

Prior to our visit and the findings reported here, the ACLU lodged a complaint with the Ohio Department of Education (ODE) in March 2015 concerning the lack of special education services for some youth at the Juvenile Justice Center. In spite of remedial measures taken by CMSD and other districts, current practices do not appear to have changed during the past few years. For example, in addition to all students receiving less than full-day instruction, instructional specialists reported that they were unable to take students from classes to work on a one-to-one basis with individual students in part because there were an insufficient number of Detention Officers available to supervise students outside of the general education classrooms.

There is no evidence that the education staff is involved in discussions with the Detention Officers about discipline involving students with disabilities. The education staff reports that it does not suspend students. However, there was no indication that education staff engaged the Detention Officers about discipline policy. There was no indication that the facility conducts manifestation determinations of the nexus between students' disabling conditions and behavioral problems.

> **Recommendation:** Conduct a comprehensive review of special education services; ensure staffing is adequate to provide services as indicated on students' IEPs.
>
> **Recommendation:** Hire additional special education teachers and instructional assistants.
>
> **Recommendation:** Develop dedicated space for teachers to deliver instructional services and supports outside of the general education classroom.
>
> **Recommendation:** Review and implement existing Behavior Intervention Plans (BIPs) for students. Confer with Detention Officers about BIPs. Conduct functional behavioral assessments (FBAs) for students who exhibit behavior problems.

Recommendation: Develop a system of positive behavioral interventions and supports that enable students to achieve success and access to preferred activities for exhibiting positive behaviors.

Overall, the Juvenile Justice Center conforms to some of the JDAI standards for education. The education program at the Juvenile Justice Center has a number of positive features. In addition to having web-based curriculum that meets the needs of some students, the program does a very good job of managing student records including IEPs and other special education records. However, in many respects the education program at the Juvenile Justice Center is woefully inadequate. The Juvenile Court and CMSD need to carefully review the operation of the school program to ensure that it meets statutory requirements. As noted earlier, current practices deny students of services to which they are entitled and leave the County vulnerable to litigation.

GENERAL PROGRAMMING

Each living unit or "house" in the Juvenile Justice Center has an Activity Coordinator, a Unit Supervisor, a Social Service Coordinator, and an assigned therapist. The Activity Coordinator for each unit is responsible for organizing programming, providing access to recreational materials, creating activity schedules, and organizing volunteer services.

The Center employees a Volunteer Coordinator who is tasked with identifying volunteers and volunteer programs. The Volunteer Coordinator is easily accessible to interested volunteers who contact the facility. She has organized a wide range of volunteer activities over the past few years, including religious programming, various art programs with students from local universities, a Black history program, mentorship programs, music therapy, and "recovery resource" programs. One of the most consistent volunteer programs, the Carroll Ballers program, brought students from John Carroll University to play basketball and engage in positive mentorship with residents on a weekly basis. This program was suspended in January 2018 due to a group disturbance at the facility. Although the Volunteer Coordinator had reason to believe that the program would resume after the summer break, the Carroll Ballers program had not resumed at the time of our visit.

The Juvenile Justice Center is in the process of implementing a new behavior management program (BMP). The Programming, Training, and Quality Assurance Unit (PTQA) undertook a collaborative process with staff to create the BMP. Housing units began adopting the BMP at different points during 2018, with the final housing unit implementing the program shortly before our second visit. The BMP represents a significant step forward in providing consistent and incentive-based responses to youth behavior. Developing and implementing the BMP in less than eighteen months was an extremely challenging project. PTQA and the Center's administrators faced direct challenges from detention staff when implementing a more structured approach to youth behavior that limited detention staff's discretion.

Despite the strengths of the Juvenile Justice Center in the areas mentioned above, we have serious concerns about programming available to young people in custody.

The team's first concern is an overall lack of organization and communication with respect to programming, especially volunteer programming. Other than the posting of flyers, we could not

discern any formal coordination or method of communication between the Volunteer Coordinator and the unit Activity Coordinators. As a result, there is no way to ensure that Activity Coordinators are aware of the content and availability of new volunteer programs, and the Volunteer Coordinator is not always aware of what volunteer programming actually occurs on the housing units, since this is the Activity Coordinators' responsibility. Some units provide programming schedules to the Volunteer Coordinator while other housing units do not. The Volunteer Coordinator is unable to track which volunteers provided services to which youth, or even which pods. The only way to track that information is to check the handwritten visitors log.

> **Recommendation**: The Juvenile Justice Center should create a process to increase coordination between the Volunteer Coordinator and Activity Coordinators with oversight from a designated senior administrator who focuses on programming. This process should require Activity Coordinators to provide programming schedules to the Volunteer Coordinator. Activity Coordinators should also provide information on how many youth participated in programming on specific dates and times and whether there were deviations from the programming schedule.

> **Recommendation**: Activity Coordinators and the Volunteer Coordinator should meet regularly to share information. The Volunteer Coordinator can remind Activity Coordinators of available volunteer programing and introduce new volunteer programming. Activity Coordinators should conduct regular surveys of youth requests and feedback for programming (including volunteers) to be shared with other Activity Coordinators and the Volunteer Coordinators during these meetings.

The Juvenile Justice Center can also do more to ensure that the volunteer programming meets needs and interests of residents, not just the interests of the adults who volunteer. Staff described incidents of volunteers who wanted to "scare youth straight," by explaining how residents' current lifestyles would lead to incarceration or death. Not only do such programs make unfair assumptions about the youth in the facility, but they are also ineffective. Youth stated that they quickly "tune out" volunteers who scold, lecture, or use heavy-handed religious approaches. Youth and staff reported that many volunteers, other than the Carroll Ballers, "talk at" youth as an audience rather than allowing them to actively participate.

> **Recommendation**: The Juvenile Justice Center should develop a volunteer orientation on key points of the Center's values and mission. The Volunteer Coordinator should select volunteers who can relate to residents' experiences and, whenever possible, represent their communities. Our team observed at least two volunteers speaking to seated groups of youth, some of whom were clearly disinterested. Not all youth process information through the discussion group format. The facility should prioritize "hands-on" volunteer and programming activities that allow youth to interact, move, and create.

> **Recommendation**: The Volunteer Coordinator should work with the PTQA Unit and a designated programming administrator or committee to develop specific goals for the volunteer programs and ways to measure how volunteer programs are meeting the needs and interests of youth. This may involve observation, youth and family surveys, and contact with probation and court staff who interact with youth during and after detention.

Recommendation: The Volunteer Coordinator should work with Court administrators to seek funding opportunities and develop contracts for additional programming that meets the interests and needs of residents.

The team's second concern is the insufficient quality and content of programming. The Juvenile Justice Center does not offer comprehensive programming on a range of interesting activities. Because programming and recreation is decentralized, there is significant inconsistency in programming from unit to unit. Youth spend long periods of time either in their rooms or unengaged for multiple reasons noted elsewhere in this report. At least one reason is that youth and staff have little to do, creating situations ripe for conflict among youth who feel frustrated, angry, or overwhelmed about their current situations. Some housing units have a posted schedule, while others do not. When our team asked youth what they would like to do, they requested activities such as drawing, learning how to write music lyrics, journaling, reading more books, engaging in meditation and mindfulness activities, accessing the weight room, and writing letters in the privacy of their own rooms. These are all activities that, if available to youth, would keep them occupied and away from problem behavior.

One additional observation was that multiple youth on units reported inappropriately early bedtimes of 7:00 pm or 8:00 pm. Extended bedtimes may be used as incentives, but there is no legitimate reason to impose a 7:00 pm bedtime for an entire housing unit.

Although the list of programs provided by the Juvenile Justice Center is lengthy on paper, there is minimal documentation on the content or method of the programs. There is no quality assurance to determine whether and how most programs and activities are provided, if they are effectively engaging youth, or how many youth agree or decline to participate. According to written documents, the Center provides art programs and yoga programs, but few youth with whom we spoke had engaged in these activities on a regular basis. The Volunteer Coordinator showed us flyers that were created to advertise various programming activities. Unfortunately, many of the advertised events pre-dated 2015. One notable exception was the girls unit, House 5, which participated in a "paint night" and outdoor yoga organized by their Activity Coordinator during our visit – exactly the type of activities that should be consistently part of unit schedules.

There is also a critical absence of programming at the Juvenile Justice Center designed to give youth skills that they can actually use upon returning to their communities. We spoke to youth who expressed interest in programs that would help them learn how to apply for jobs, dress for interviews, get photo identification, or open savings accounts. Many youth have not had the opportunity to learn life skills they need to prepare them for success in the community. Programming is one of the Center's most powerful tools to encourage youth to follow rules while at the Juvenile Justice Center and to set positive goals after they leave the facility.

Recommendation: The Juvenile Justice Center should form a diverse programming committee to consult with juvenile justice stakeholders, youth, and parents. This committee should identify a list of core programming needs and interests of youth. The committee and the Volunteer Coordinator should then identify individuals and organizations in the community qualified to meet those needs and interests through

programming. The Volunteer Coordinator should develop a targeted outreach plan and communication materials designed to recruit volunteers. A designated administrator or member of the programming committee should conduct strategic community outreach to identify local entities (e.g. non-profits, universities, professional organizations, and current Center staff) that can provide programming designed to meet residents' interests and needs.

Recommendation: Rather than relying only on organizations and individuals with established youth programs, Juvenile Justice Center staff should be prepared to help develop programs with volunteers based on youth interest. While some activities requested by youth may be unconventional, they can be powerful incentives for positive behavior. One example is partnering with community artists to discuss the historical origins of rap music and allowing youth to craft appropriate lyrics.

Recommendation: The Center should consider applying for grant funding to support programming, which will require the Volunteer and Activity Coordinators to work more closely with the PTQA Division.

Recommendation: As recommended above, the Center should create an oversight process for programming. A detention administrator or group should review weekly and monthly unit schedules to ensure that activities and programming are specific and not listed generically as "recreation time," "free time," or "leisure time." This oversight process should ensure that youth have age-appropriate bedtimes.

Our third concern is that programming is not accessible to all youth on a regular basis. While the Volunteer Coordinator was able to provide an impressive list of volunteer programming offered at to youth in the Juvenile Justice Center, some of the programs occurred only once, for a short period of time, or were offered only to a small number of housing groups. For example, the Center's list of volunteer programs includes United for Girls, which is described as a mentorship program covering many topics, including parenting. However, during a seven-month period, United for Girls was only listed on the House 5 schedule once per week during a single month of that seven month stretch.

Several programs included in the Center's list of programming brochure are not regularly listed in unit schedules or unit logs. Furthermore, there is no available documentation on the actual frequency and number of youth reached by volunteer programming. Activity Coordinators and Detention Officers control youth access to programming and may decide to cancel programming. Staff reported that activities can be canceled if some youth on the unit have engaged in poor behavior or if the unit is short-staffed. Staff also reported that, due to safety concerns, some volunteer activities are only accessible to a relatively small number of youth at a time.

Recommendation: The Juvenile Justice Center should ensure that activities and programs are available to as many residents as possible. Staff should be embedded in activities and programming with youth rather than observing. If staff are present to facilitate youth participation, the chances of violence or disruption will be greatly reduced.

Recommendation: Activity Coordinators should plan and monitor unit conditions to ensure that youth are permitted to participate in all scheduled activities.

The team's fourth concern is the lack of specialized programming or incentives for youth who remain in the detention facility for extended periods of time. While many youth remain in the Juvenile Justice Center for multiple months, the Center does not offer programming designed to meet the needs of these youth. The Center does not provide career and technical education courses or vocational training for youth who have graduated or passed GED tests. While the new behavior management system incorporates incentives, there are no enhanced goals for youth who remain at the Center for multiple months. After a certain point, there are no additional goals or benefits to for youth to strive toward. Youth facing extended stays in detention and potentially lengthy sentences can present significant behavior challenges if they are unoccupied and frustrated. On the other hand, these youth can benefit greatly from structured programs designed to keep them motivated and to build meaningful skills that they can use in the community.

Recommendation: As recommended in the Education section of this report, the Juvenile Justice Center should offer career and technical education (CTE) programs for youth in detention such as ServeSafe (food handlers' license) and OSHA 10 (job site health and safety certificate). The Center should also consider a specialized track of programming and behavior management for youth expected to remain in detention for more than 30 days. The Center could consider piloting a longer-term unit in one housing pod to provide services adapted for these youth. These residents could be identified at intake based on their charges. Behavior health staff should also assist in developing supports such as trauma-based programs appropriate for youth in custody beyond 30 days.

The team's fifth concern is the lack of a formal process for youth to provide input on programming. The Juvenile Justice Center policy states that unit staff should encourage resident suggestions on recreation. Youth can speak to staff and administrators, but there is no structured opportunity or active effort to solicit recommendations from youth on programming or recreation.

Recommendation: Create a process to encourage youth, families, and staff to express recommendations for programming. Housing unit teams and the Volunteer Coordinator can create short youth surveys to collect feedback from youth. Unit staff can also facilitate group sessions with youth to discuss programming ideas. The Center can build upon the internal committee system to create a channel for feedback and input from staff. This could be done through staff surveys, "idea lists" circulated during staff meetings, or suggestion boxes. Regularize a process of surveys and focus groups facilitated by staff to routinely engage youth in cultivating programming ideas.

RECREATION

Engaging and developmentally appropriate recreation programming can help solve some of the Juvenile Justice Center's systemic problems, help teach young people appropriate and positive behavior, and reduce future recidivism. The facility's school employees an experienced and

dedicated physical education teacher who understands the challenges facing youth at the Juvenile Justice Center and the transformative power of recreation for at-risk youth. The school provides the teacher with an adequate budget to purchase equipment and supplies for new and creative activities.

The facility has an exercise room with weights and cardio machines, although some staff reported that youth have not been permitted to use the room since January 2018. The Juvenile Justice Center has an impressive and well-maintained indoor gymnasium and a large outdoor space. Unfortunately, the Juvenile Justice Center does not have a recreation director. As a result, Activity Coordinators and staff are responsible for planning recreational activities for youth which leads vastly different experiences for youth on each unit. On living units, youth have access to televisions and, in some cases, video games. The school maintains supplies of some reading materials and we observed a small amount reading materials available on some living units.

In spite of the strengths outlined above, the team has four concerns about the current state of recreational programming at the Juvenile Justice Center.

First, youth spend too much time in their rooms and do not have sufficient access to non-athletic recreation supplies. The current supplies vary from unit to unit and there is no clear responsibility to track or update these items. There are games available in the newly created canteen room, but it is unclear whether youth must purchase them or whether they are provided to Activity Coordinators. Many youth expressed boredom and frustration with the lack of recreational options on their units other than TV and video games.

> **Recommendation**: The Juvenile Justice Center should invest in additional recreational activities such as games, puzzles, and art supplies for youth. Activity Coordinators should inventory the quality and quantity of current recreation supplies and create a regular process for replenishing new supplies. Detention Officers should keep these supplies visible yet secure on living units so that they are more likely to be used by all staff. Unit staff should survey youth to learn which recreation activities and games interest youth.

> **Recommendations**: Activity Coordinators should provide more creative recreation options for youth, including drawing and music. Art supplies should be easily accessible, including colored pencils, pastels, and handheld dry erase or chalkboards for sketching. Activity Coordinators should allow youth to listen to music individually or as a group. Youth reported that some staff let them listen to music during free periods, although the list of available music depends entirely on what the Activity Coordinator provides. Music is an important part of adolescent life. Activity Coordinators should provide diverse and regularly updated music options. The Center should also permit individual youth to listen to approved music on iPods as a behavior incentive.

> **Recommendation**: The physical education teacher, therapists, and Social Service Coordinators should partner with Activity Coordinators and Detention Officers to brainstorm potential recreational activities for youth. The physical education teacher and behavioral health staff expressed interest in supporting Detention Officers to build

relationships and skills with youth during recreation activities, maximize resources, and devise more activities and therapeutic recreation options for youth.

Second, youth rarely access the Juvenile Justice Center's ample outdoor space. Staff and youth reported that, after the group disturbance in January 2018, a number of activities and incentives were suspended due to safety concerns. Unfortunately, these activates have not resumed. We understand that court and detention administrators have concerns about violence and property damage due to the incident in January 2018. However, some degree of risk is always present in youth detention facilities. The degree of risk can be significantly reduced through the training, education, programming, and behavior management recommendations in this report. The Juvenile Justice Center must weigh this risk against the well being and future of all the young people in the Juvenile Justice Center.

Many youth stated that they had not been outside in over 30 days. We received conflicting information about whether youth are currently allowed to use the weight room in the gym. While the physical education teacher is a notable resource, he is not consistently involved in organizing unit recreational activities (as opposed to the physical education period during school, for which he creates lesson plans). As a result, recreation in the gym is generally basketball. Notably, almost all youth who we interviewed stated that, although they enjoy basketball, they would prefer to have other recreation options. Many youth reported that staff frequently did not take them to the gym for recreation due to behavior or staffing concerns.

Based on our conversations with staff and reviews of logbooks, the only youth who regularly go outside are girls on House 5. The fact that most youth do not have the chance to go outside and breathe fresh air is a serious concern. Restricting adolescents in an institutional building is dangerous for their physical and psychological health. If youth cannot expend energy and spend time outside, they are far more likely to act out, jeopardizing youth and staff safety.

> **Recommendation**: The Juvenile Justice Center should resume outdoor recreation without delay. Activity Coordinators should plan outdoor activities whenever possible and document whether recreation occurs outside. The Superintendent has expressed concerns about the structural integrity of the fencing around the outdoor area. Basic maintenance to ensure that there are no holes or gaps in the fence and the ground below is appropriate, but it may not be necessary to install completely new outdoor fencing. Ultimately, the Juvenile Justice Center must immediately prioritize outdoor recreation, make necessary security adjustments, and provide enough engaged staff to supervise recreation.

> **Recommendation**: Juvenile Justice Center leadership should direct the physical education teacher and Activity Coordinators to resume use of the weight room.

Third, it is unclear if youth on confinement status consistently receive one hour of physical activity outside their room. This information was not documented in handwritten unit logs and staff could not offer consistent responses. Several staff stated that youth in isolation cells on the intake unit do not receive physical activity.

Recommendation: Require staff to supervise and document at least one hour of large muscle exercise for youth on confinement status. This exercise must occur outside the confinement area and youth should be given several options for the time and type of exercise.

Fourth, youth do not have adequate access to reading materials. We spoke to several staff, none of whom were certain about who had the responsibility for implementing and monitoring the Center's library policy. The Center's principal was able to provide a list of reading materials. Staff provided different answers on how or when youth had access to reading materials. The Juvenile Justice Center's policy requires that Activity Coordinators arrange library access. We were not able to determine any regular system for providing youth access to reading materials, especially during the summer. Library time was not listed on any unit schedules.

Youth do not feel that the available reading materials match their interests or experiences. Several youth told us that they were not permitted to read "urban" books, though it is not clear who makes that determination and on what basis. Staff do not encourage reading or recommend interesting books. This is a significant missed opportunity. Reading can open up new worlds to young people, expand their goals, and increase their academic performance.

Recommendation: The Center should designate a reading material coordinator or librarian. This individual should work with the school staff to maintain a broad range of reading materials geared to the diverse interests of confined youth. This staff member should communicate regularly with youth, staff, and teachers to ensure that available reading materials are updated to reflect the interests of youth and recently published books. The designated staff member should also share information about interesting and enriching books and graphic novels with unit staff and youth.

Recommendation: Activity Coordinators should schedule dedicated library time at least once per week for all residents. Coordinators should recommend specific books or subjects based on the individual interests of youth. Detention Officers should familiarize themselves with available reading materials and encourage youth to read.

Youth on certain levels of the behavior system can keep a small number of books in their rooms. Some staff and Court administrators expressed concerns that youth might misuse books to cause damage if they were permitted to take books inside their cells. It is not acceptable to deny access to a valuable resource to all youth because of a concern about potential property damage caused by a small group of residents. This is especially true when youth spend hours in their rooms due to staffing shortages or early bedtimes. Furthermore, this concern is an example of the negative light in which many administrators view youth. Most youth with whom we spoke expressed a strong interest in reading more books, going to far as to ask our team for recommendations.

Recommendation: Youth on all behavioral levels should be permitted to take at least one book in their rooms, and the number of books should increase as a positive behavioral incentive. Youth should be permitted to read more than one book at a time. If youth engage in destruction or misuse of books, Center staff should address this with the individual youth.

Recommendation: Youth should be permitted to read books in their room during free times and bedtime.

Finally, there is no clear policy on whether youth are able to take religious reading materials in their room. The facility policy states that "all religious material are subject to review before entering the facility," and does not make clear that the Center must provide religious reading materials. The facility policy on library materials does not require that the facility maintain materials to meet the religious needs of residents.

Recommendation: The Center's policy should ensure that a wide variety of religious materials and texts are available on site. Policies should specify a plan for how and where the facility will acquire additional religious materials if necessary.

BEHAVIOR MANGEMENT

In 2017, the Juvenile Justice Center began developing a behavior management program (BMP). Prior to that time, there was no uniform system of behavioral expectations, interventions, sanctions, or incentives. Detention Officers had the discretion to determine the seriousness of behavior violations and the resulting consequence(s). We commend the Juvenile Justice Center for undertaking the process of developing a behavior management program from scratch. In August 2017, the Center hired a Training and Quality Improvement Specialist who is housed in the Programming, Training, and Quality Assurance Unit (PTQA). The Specialist has worked diligently to create the BMP with input and feedback from Detention Officers and administrators.

The current BMP relies on a daily behavior point sheet, dividing each day into ten time periods. For each period, youth earn 0, 5, or 10 points. Based on an accumulation of days with certain "successful" point values, youth can move through five levels: Orientation and Levels 1 through 4. According to the BMP, 5 points on the daily point sheet represents adequately meeting all behavior expectations, while 10 points are awarded "exceeding expectations and demonstrating exemplary behavior." In order to advance to the next behavior level, youth must maintain a high number of points for six consecutive days and pass a written test on the seventh successful day. Once a youth has attained a particular level, he or she must maintain the level by achieving an increasingly high number of points. As part of the incentive program, the Center designated a room to store an impressive supply of incentives like Gatorade, candy, brand name toiletries, and boxed and board games. At the time of our visit, youth were not permitted to go to the incentive room.

Youth receive benefits upon reaching higher Levels. Currently, these benefits are far less motivational than those offered at other facilities and more closely resemble positive programming to which all youth should have access. Privileges at the Juvenile Justice Center include: playing cards or games, watching television and listening to the radio as programming allows, having either one or two books in their room, a later bedtime, one or two photographs in their room, a 20 minute phone call, a movie night once per week, one or two food commissary

items, eligibility for pod clean up duties, one or more items from the incentives store, and extra gym or weight room time.

The team commends the Juvenile Justice Center for designing a behavior program that incentivizes positive behavior and provides a supply of tangible incentives. The BMP given to residents includes a list of positive behavior expected from youth rather than simply a list of what youth must *not* do. However, we recommend several adjustments to improve the effectiveness of the BMP. Because the current BMP represents compromises between PTQA and detention staff, we understand that our recommendations may require negotiations with the union and education of staff.

First, many detention staff and Unit Managers are skeptical of the BMP. Because the PTQA Unit is located in the Court administration and PTQA staff do not work detention shifts, Detention Officers perceive the PTQA staff as outsiders. While both the Director of PTQA and the Specialist spend time on housing units and enlist detention staff in committees to change policies, some Detention Officers still actively resist anything seen as a PTQA-initiated change. This is evidenced by the implementation of the BMP. Although the Specialist involved focus groups of detention staff in developing the BMP, the program faced resistance in most units.

Second, there are aspects of the BMP that are confusing and inappropriate for youth, especially youth with varying degrees of reading comprehension. For instance, the BMP document provided to youth is long and difficult to digest. It outlines one page of youth rights, five pages of behavior expectations for youth, and another seven pages explaining the point system and consequences for failing to follow it.

Although all staff receive training on the BMP, each housing unit implements the BMP differently. Staff do not prioritize age-appropriate and trauma-informed responses to youth behavior. There is inconsistency and perceived arbitrariness in the way staff respond to negative behavior. Sanctions are not related to underlying behavior and are not designed to build skills to prevent that behavior.

According to the BMP section on "Unacceptable Behavior," staff may select from a range of consequences for rule violations. These consequences include removing Level privileges for one day, suspending access to group activities, resetting the consecutive number of days at the youth's current level, dropping a youth's Level, or putting the youth in room confinement. However, each Level section in the BMP also lists a more specific rule consequences for "Minor Rule Violations," "Major Rule Violations," and "Serious Rule Violations. The examples of behavior that can trigger each type of violation include vague terms that allow a great deal of staff discretion and include normal adolescent behavior. These examples include "challenging behavior," "rough, loud, or disorderly conduct," and anything that "causes a distraction or disruption."

> **Recommendation**: The Juvenile Justice Center should edit the BMP to include youth-appropriate language and more photos and graphics. For youth with low reading levels or low vision, the Center should create an audio recording of the BMP.

Recommendation: The Juvenile Justice Center has dedicated and capable quality assurance staffing working to increase consistency in facility discipline. The PTQA Unit currently gauges the effectiveness and fidelity of the BMP through observation on the units. According to the PTQA Unit, Activity Coordinators track the use of the point and level system. It is unclear what information is captured and whether it is available in electronic form. The Center should invest in resources for Activity Coordinators to track the use of the BMP. For instance, what is the average number of points youth receive per day, how many days does it take youth to advance to specific levels, how long can youth maintain levels, what are the main reasons youth lose levels?

Recommendation: The Center should clarify the permissible consequences that staff can impose on youth for minor, major, and serious rule violations. The Center should eliminate vague terms in the BMP that could encompass normal adolescent behavior. Argumentative or challenging behavior, for example, should not necessarily constitute a minor rule violation. Any act that causes distraction or disruption should not constitute a rule violation. We recommend that the Center be more specific and list actual examples to make the nature of rule violations clear to youth and staff.

Third, the BMP is structured around policing rule violations and avoiding negative behavior. Rather than sanctioning negative behavior and rewarding the absence of negative behavior, the BMP should focus on recognizing youth's strengths and positive behavior. The most effective behavior management programs allow youth to gain, rather than lose points. On paper, this is how the Center's BMP functions. However, in practice, youth know that they will receive 10 points per period unless they do something wrong. Detention Officers told our team that they routinely entered in 10 points for each youth for every segment of the day. Our review of daily point sheets showed a line entered across the time period for every youth, suggesting that these forms may even be completed in advance.

Youth stated that it takes much more time and effort to advance and maintain levels in the BMP than to lose a level. Moreover, it takes too long for youth in the facility to earn incentives. Given the average length of stay, many youth will leave the Center before ever receiving an incentive. While we appreciate the need for the Orientation Level, there is no way that these youth can receive incentives for at least seven days, assuming that they have no behavior violations and pass their level test successfully the first time. That means that new residents, no matter how well they behave, will not receive a phone call, have a photograph in their room, receive an item from the food commissary, or visit the incentive store for at least one week. A youth may not visit the incentive store, have a bedtime later than 8:00pm, or be eligible for extra gym time until they have been in the Center at least 21 days. Only youth who have 28 consecutive days of positive behavior are eligible to have computer or video game time.

The number of points required to maintain a current level is also too high. If 10 points is described as exemplary behavior that exceeds expectations, requiring 85 points per day to earn and maintain a Level 1 or 2 is unrealistic. Youth must maintain six consecutive days at 100 points (exemplary behavior during every period during the day) to remain on Level 4. Many youth will have setbacks, especially as they adjust to the detention setting.

Effective behavior management systems secure buy-in from youth by demonstrating immediate positive consequences for desired behavior. If youth quickly see that they can succeed and trust a behavior management program, they are much more likely to show positive behaviors. If residents perceive the system to be arbitrary or unfair, they are unlikely to comply with the program or trust the Detention Officers implementing it. Adolescents have difficulty weighing future-oriented results above more immediate ones (e.g. "I will get one snack later this week if I don't break this rule right now" vs. "If I follow almost all rules for 21 days, I can go to the incentive room). Behavior management systems should permit all youth to earn some type of incentives for behavior on the current day, regardless of setbacks on the prior days.

> **Recommendation**: One possible approach to address the concerns listed above is to alter the format of points in the BMP. Other facilities have successfully adopting a "positive point" system where youth cannot lose behavior points, only earn them. This approach is based on the premise that attainable incentives are a better motivator than losing points.

We recommend that the Juvenile Justice Center consider implementing a positive point system where Detention Officers award points to youth for adhering to behavior expectations. Youth could earn extra points for going beyond basic expectations. Staff could not deduct points, but could use other sanctions to respond to negative behavior: fixing any damage caused, verbal direction, brief timeouts, working through an incident and triggers with therapist, apologizing to the unit, and suspension from robust and interesting unit programming. Youth's points could also be suspended for a period of time, but not taken away. This approach prevents youth from giving up on positive behavior because they are back at square one.

The Center can also change the point system to incorporate immediate incentives that better motivate youth. At the end of each day, youth could use a certain number of points to purchase incentives. The number of points that a youth could spend should be based on their Level. For instance, youth on Orientation Level could spend 50 points while youth on Level 3 could spend 150 points. Youth could also choose to save their points. The result is that all youth, even new admissions, could gain access to incentives.

In order to structure the Level system, a staff committee should agree on desired behavior expected for youth at each level. The Level system should reflect a youth's accumulation of a certain number of points and demonstrating specific goals for each Level.

> **Recommendation:** The Juvenile Justice Center should add as many incentives as possible to the BMP. The Center can identify new and effective incentives by actively soliciting input from youth and staff through resident committees, focus groups, and unit discussions facilitated by Detention Officers. The Center should challenge staff to brainstorm creative incentives that rely on donations from local businesses. For example, one facility we visited was able to collect unsold pastries every night and provide them as a treat the next day for youth on positive status. Examples of creative incentives associated with higher levels are pizza or Chinese food delivered on Fridays and opportunities to assist with environmental services (e.g., laundry, painting, or cleaning). Although tangible incentives are important, other options such as longer phone calls, special or extended visits, mentorship responsibilities, positions as tour guides, selecting

movies or music for the unit, video games, listening to music on an iPod, or meals with a select staff. Creating a more incentive-rich behavior system is another reason to consider piloting a separate programming and incentive track for youth staying in the Center for over 30 days.

Recommendation: As the BMP gains traction, the Juvenile Justice Center should permit one youth at a time to visit the canteen/incentive room. The room is impressive and organized. The impact of visually seeing potential incentives could be highly motivational to youth.

Recommendation: Even if the Juvenile Justice Center does not adopt a positive point system, the Center should change the BMP to limit consequences affecting youth's levels. Rather than dropping a level, staff should temporarily suspend a level. Likewise, the Center should change the structure of the Level system to offer many of the privileges in the current Level system at lower Levels. For example, youth on Orientation should be permitted to make a phone call, and all youth without serious behavior incidents should be able to participate in weekly movie nights.

Under the current BMP, there is no way for youth to earn additional points for positive behavior. As noted elsewhere in this report, the Juvenile Justice Center does not foster a culture of staff recognition of positive youth behavior. We interviewed staff who do not intentionally identify or promote positive behavior. Moreover, many Detention Officers do not understand the value of recognizing positive behavior. Current research shows that adolescents respond more favorably to incentives for positive behavior than to punishment for negative behavior. Much like adults, youth are likely to form respectful positive relationships with staff who they believe see their positive qualities rather than seeing them as criminals. Revisiting the facility's commitment to identifying positive behavior both through the BMP and other means will improve the dynamic between Detention Officers and youth.

Recommendation: Incorporate positive recognition, verbal and otherwise, as a regular part of the behavior management system. Include a list of possible incentives on materials posted in the living units which are readily visible to staff. Court and detention leaders should stress the importance of "catching youth doing something right." One suggestion is to create a positive reinforcement section on behavior reports, requiring officers to document positive reinforcements they provided. The Center can also incentivize and publicly commend staff who provide frequent positive recognition to youth.

Recommendation: It is critical that staff make every effort to honor the BMP incentive system. Adjustments should not be made to accommodate staff preference or convenience. When adjustments to the BMP are truly necessary, Detention Officers, Unit Managers, and Deputy Superintendents should explain the reasons to youth. For example, we were disturbed to learn that after youth were initially told that Level 4 residents would receive later bedtimes on weekends, the "unit policy" was changed to permit Level 4 late bedtimes only on certain days. Several youth had worked hard for weeks to attain Level 4. Youth told our team that this change happened after a staff meeting. This modification

appears to be inconsistent with the BMP as written, and youth understandably felt manipulated.

Fourth, youth require greater access and input from therapists. Each housing unit has an assigned therapist, although his or her office is not located on the living unit. Therapists are not always present for meetings between unit staff to discuss individual and group developments. Individual treatment plans created by some therapists are often never received or disregarded by detention officers, often because they are not trained on how and why the plans will benefit both youth and staff. Social Service Coordinators write court reports, sometimes without input from therapists. We learned that the therapists often use the offices belonging to the Activity Coordinator or the Social Service Coordinator when they visit youth, which reportedly causes resentment between staff on some units. This contributes to the division between clinical staff and Detention Officers addressed in earlier sections of this report.

This lack of teamwork between professionals is unacceptable and harmful to youth. A consistent exchange of information and interaction between clinical staff and Detention Officers would allow Detention Officers to observe therapeutic responses and examples of Core Correctional Practices (CCP) in action, and to see youth behavior as an opportunity for clinical support rather than non-compliance. For several of the recommendations below, it may be beneficial to have staff or administrators from other facilities (which have successfully implemented reforms) speak to groups of Detention Officers and Unit Supervisors about the benefits of these approaches.

Recommendation: Create a protocol for regular communication and team-building between Detention Officers and unit therapists. Administration should consider organizing regular meetings and providing pizza, soda, or another incentives to motivate staff and therapists to attend the regular meetings and engage with each other informally.

Recommendation: The facility should train Detention Officers on the practical benefits of involving therapists in unit activities and behavior. Ideally, the assistance of therapists and individual treatment plans should make Detention Officers' work easier. Therapists can help officers by developing strategies to deal with difficult youth. We also recommend cross training between therapists and detention officers where members of both groups are invited to share training responsibilities on relevant topics.

Recommendation: Consider creating satellite offices or additional space for therapists in living units to increase collateral exposure and avoid tension over sharing offices.

Recommendation: Create opportunities to integrate clinical and unit staff, such as joint programming. Clinical staff can schedule time to spend on living units assisting detention staff with activities and programming. The Center should certify direct care staff in delivery of group sessions as part of CCP, Anger Replacement Training, Dialectical Behavior Therapy, or other programming. Direct care staff in Massachusetts Department of Youth Services facilities, for example, co-facilitate weekly DBT sessions with clinical staff on housing units. Because all Juvenile Justice Center staff receive training on CCP, we recommend gradually integrating group CCP sessions facilitated by staff and

therapists. This would encourage Detention Officers to see the practical benefits of CCP in daily operation of the units.

YOUTH WITH SPECIAL NEEDS

The team was pleased to see that Juvenile Justice Center has a policy prohibiting discrimination against youth with disabilities, which also requires medical staff to assist youth perform basic life functions (dressing, bathing, feeding). However, there are several important components missing from the policy that are necessary to protect youth with disabilities. In general, the policy provides for the basic physical care of youth with disabilities rather than outlining a process to meet the programming needs of youth in a meaningful way. While administrators and staff assured us that they would meet the needs of youth with disabilities, it is unclear who would be responsible for making these accommodations.

> **Recommendation**: The Center should designate a person with knowledge and experience to ensure that the legally required accommodations are made for youth with disabilities.

> **Recommendation**: The Center should modify existing policy to outline how staff will ensure effective communication with youth with disabilities, including youth who have intellectual or developmental disabilities and youth who are hearing-impaired or blind. Rather than preparing for youth with every possible type of disability that may enter the facility, the Center should focus on developing a clear policy and process to determine how to meet the youth's needs.

The Juvenile Justice Center has a process for providing foreign language and sign language interpreters during the intake process, but it is unclear if these services are available in all areas of programming.

> **Recommendation**: The Juvenile Justice Center should create a language access policy that outlines who will be responsible for identifying the needs of limited English proficient youth and determining how to meet those needs. Like accommodations for youth with disabilities, it is not necessary that the Center prepare interpretation services for every possible language. However, the Center should create a policy and process for determining the needs of limited English proficient youth and deciding how the Center can best meet those needs. The language access policy should prohibit using other youth as interpreters.

TRAINING AND SUPERVISION OF EMPLOYEES

The quality of any facility rests heavily upon the people who work in it. This section requires that the facility hire properly qualified staff and provide the necessary pre-service and continuing training they need to work with troubled youth. Staff should also perform their work in an operational setting that enables them to do their work well – through appropriate staffing ratios and proper administrative supervision. The section further requires that facility staff engage in ongoing quality assurance and self-improvement through documentation of serious incidents, citizen complaints, and child abuse reports.

The team met many Juvenile Justice Center staff members who are deeply committed to serving young people. Residents mentioned several staff members by name who they felt helped them and cared about them. Unfortunately, staff shortages, vacancies, and forced overtime create a constellation of issues around staff and staffing that undermine facility operations and jeopardize the safety of residents and staff.

Prior to 2016, the Juvenile Justice Center did not have an organized method to provide new employee or refresher training. In 2016, the Center entered into a contract with the Cuyahoga Community College, or Tri-C, to provide new staff and annual update training to all Detention Officers. Tri-C training consists of three weeks, or 140 hours, at the Tri-C training academy. New staff also receive on the job training (OJT) with a lead Detention Officer or Unit Manager upon returning to the facility after the Tri-C Academy. OJT requires that staff demonstrate a list of skills as part of a 6-week review period. The facility maintains training records.

As mentioned below, despite these recent efforts to formalize delivery of staff training, the training program omits several key topics required by the JDAI standards – topics that are of critical importance to working with an at-risk youth population. Additionally, the current training provider has no expertise in providing training geared towards working with adolescents. We review these concerns with training and other issues related to staffing and supervision of staff below.

QUALIFICATIONS AND STAFFING

The Juvenile Justice Center is designed to house up to 180 youth. The Center normally operates five housing units, or "houses." Each housing unit has three enclosed pods with 10 rooms. Each pod has a small common area, and the pods are connected by a large open area or center.

Most staff at the Juvenile Justice Center are Detention Officers. Detention Officers are grouped into two categories: Housing Detention Officers and Security Detention Officers. For the most part, Detention Officers are consistently staffed in one housing unit. According to ideal staffing numbers, there should be 15 Detention Officers assigned (in general – not per shift) to each living unit. There are approximately 25 Security Detention Officers who are responsible for transporting youth to medical units, mental health, and visitation areas. Security Detention Officers also staff intake and admission and release.

Activity Coordinators work from 11:00 a.m. to 7:00 p.m., and Social Services Coordinators are assigned based on the visitation schedule. A recent staffing change required Managers on Duty to work ten hours shifts, ensuring that one is always on duty.

The Juvenile Justice Center is facing three significant staffing challenges. First, the facility is understaffed. Roughly six years ago when the Juvenile Justice Center relocated to the current building, it commissioned a staffing study. Unfortunately, many of the recommendations were not implemented. Several staff and administrators told our team that the Center was never adequately staffed. In 2017, the Center conducted an internal staffing analysis that recommended hiring 30 additional Detention Officers. The report concluded that the cost of necessary overtime would exceed the cost of hiring the additional officers.

There were several Detention Officer vacancies and one Unit Manager position vacancy at the time of the team's assessment. Unfortunately, the facility can only maintain its staffing plan by using regular forced overtime. There is also a high frequency of sick calls and FMLA time caused in part by an aging population of Detention Officers. Almost ten staff members are on intermittent FMLA at any given time. The team also learned that some Unit Managers blocked out shifts during the week so that weekend shifts were short on staff.

Almost all staff expressed anxiety about and frustration with the impact of short staffing and the amount of forced overtime. Staff are regularly required to work double shifts. The selection process for forced overtime operates on reverse seniority, which increases the proportion of new and inexperienced staff on each shift, particularly on the least desirable shifts (e.g., weekends). No one can expect staff, no matter how experienced, to be effective in the very demanding jobs at the Juvenile Justice Center for consecutive shifts.

The team was pleased to hear that the facility recently conducted a "hiring blitz" to hire multiple Detention Officers at once. The hiring process involves a panel of Juvenile Justice Center staff, sometimes including both court and detention staff. The panel presents hypothetical scenarios to determine how prospective staff will react. We were not able to gain access to the scoring mechanism for hiring panels, although we received feedback from some staff that candidates with previous corrections experience tend to score higher than candidates who do not have such experience.

> **Recommendation**: The Center should review hiring hypotheticals and scoring procedures to ensure that candidates are selected who have appropriate skills to work with at-risk adolescents. Hypothetical scenarios should be designed to identify candidates with skills aligned with the Center's goal to rehabilitate young people through strength-based and skill-building interactions. Experience in corrections or law enforcement may be helpful, but it also may not – staff who have worked in adult prisons are not necessarily appropriate for working with young people.

> **Recommendation**: Hire additional Detention Officers to maintain a staff to youth ratio of 1:8 or less in each housing unit during waking hours, as required by PREA standards and the JDAI standards, without the use of forced overtime.

Second, the Center struggles to recruit and retain qualified staff. Administrators described difficulties hiring and keeping skilled staff who can meet the needs of the facility. According to the 2017 staffing analysis, 53 staff left the Center and 11 were terminated. As a result, a significant percentage of staff at the facility have less than two years of experience. Additionally, the education and experience requirements for Detention Officers do not require the type of experience that would be most helpful for working with at-risk youth, meaning that many new hires quit after a short period of time. The Juvenile Justice Center only requires that Detention Officers have a high school diploma or the equivalent. As a result, there are staff at the Juvenile Justice Center who have little or no experience working directly with youth.

> **Recommendation**: Create a recruitment plan involving internship and recruiting programs through schools of social work, psychology programs, and local colleges. Involve testimonials from youth who benefitted from the help and guidance that Juvenile Justice Center staff provided to them as well as Detention Officers who have positive experiences working with youth. Detention Officer positions are opportunities for recent graduates to assist Cleveland's most vulnerable children. With adequate staffing resources, the Juvenile Justice Center could do more to attract applicants with more interest and experience in working with troubled youth.
>
> **Recommendation:** Develop a strategic plan to alter the way that youth in the Juvenile Justice Center are seen, both by staff and the community. Enlist the help of staff, youth, the Community Advisory Board, and the Center's Public Information Officer to create several core messages about the Center and the young people held there. Involve the Community Advisory Board in a meaningful way to reach out to local community organizations and educational institutions. This is a way to develop culturally appropriate volunteer programs and to generate donations that can enhance the Center's incentive program.
>
> **Recommendation**: Re-title staff positions to reflect an emphasis on working closely with youth on behavior change and skill development, such as Youth Development Specialist or Youth Behavior Specialist. Consider creating additional positions that allow staff opportunities for professional advancement, such as staff positions with special focus on specialized programming such as Core Correctional Practices, de-escalation, or trauma.

Third, the current staffing patterns impede staff's ability to work effectively with youth. As mentioned above, new Detention Officers are often clustered together because senior officers select positions as Security Detention Officers. While the Center has experienced staff members who could mentor new Detention Officers, these two staffing groups may never overlap. Multiple staff told the team that serious incidents at the facility often occur on Friday and Saturday nights, when youth are bored and when senior staff and therapists are less likely to be in the building. These scheduling patterns, along with insufficient mental health resources and training, result in unsafe conditions for youth and staff.

The current staffing patterns assign one Detention Officer to each pod, creating a 1:10 (or higher) ratio. Because the Center has many staff without adequate training, assigning one Detention Officer to supervise at least 10 youth results in inadequate and often dangerous supervision. Not

only can staff not rely on a partner to immediately intervene in conflict situations, they cannot interact with youth to build relationships and deliver incentives and positive feedback. For example, one Detention Officer described an incident where a fight broke out inside a pod while the pod door was closed. The Detention Officer, who happened to be in the House common area, and other staff were not able to quickly get inside the pod to assist the single officer in separating the youth.

Our team encountered many examples of commendable skills of Detention Officers, Activity Coordinators, and Social Service Coordinators. In many cases, youth described staff members who the youth felt cared about their well-being and treated them fairly. Youth then "showed respect" by following rules and notifying these staff members about any concerns on the unit. The skills to appropriately supervise young people while building trust can only be taught through a combination of training, on-going mentorship by experienced staff, and an institutional culture that prioritizes these goals. As mentioned in the introduction, staffing shortages have contributed to low morale, overworked staff, and a negative perception of youth in the facility.

> **Recommendation**: The Juvenile Justice Center should reconsider the distinction between Security Detention Officers and Housing Detention Officers. Clustering the experience of senior staff in positions with minimal youth contact is counter-productive and places unnecessary stress on other staff and the young people in the Center's care. Furthermore, the fact that these Security Detention Officer positions are viewed as "more desirable" because they involve less contact with youth sends the wrong message to staff about the facility's mission. The Center could consider increasing compensation or benefits for senior staff who serve as mentors or "specialists" on less desirable weekend and evening shifts.
>
> **Recommendation**: The Juvenile Justice Center should maximize the use of existing staff by combining pods when possible to allow multiple Detention Officers to work together.
>
> **Recommendation**: The Center should conduct an updated review of staffing ratios against days, times, and locations where critical incidents occur. Although hours for Activity Coordinators and Unit Managers have been altered to provide coverage later in the day and on weekends, further adjustments are likely needed.

Fourth, the Juvenile Justice Center should provide more recognition and incentives to staff. The individuals who serve as Detention Officers, unit staff, and therapists are the facility's most valuable resource. Our team did not learn of an existing employment appreciation committee. As mentioned in the introduction, there is also a clear division between Court administrators and detention staff. Detention staff perceive that court administrators do not accept responsibility for many detention issues, including staff morale. In a well-run facility that serves the needs of young people, Detention Officers must feel that supervisors "have their backs," hear their concerns, value their work, and support their efforts. This culture must originate with the top administrators responsible for running a facility.

> **Recommendation**: If an employee appreciation committee does not exist, one should be formed. The committee (and Unit Supervisors) can select employee(s) of the month,

organize luncheons and cook outs for staff and their families, and handout Juvenile Justice Center "swag" such as shirts, water bottles, and rubber bracelets. In particular, this "swag" offers an opportunity to include elements of the Center's mission (e.g. "all youth have the talent to succeed," "we believe in changing futures," etc.). One facility the team recently toured provided free massages on site for staff to address work-related stress. While these items have a price tag, staff appreciation efforts cost a fraction of other facility expenses and can produce immediate improvements in staff morale. Recognition for staff can also include donated tickets to local sporting events, donated food items, a free class at a local gym, or donated movie tickets. Our team has seen staff appreciation committees in other jurisdictions secure these donations by combining compelling descriptions of the facility and its dedicated staff along with simple requests to retailers.

Recommendation: Juvenile Justice Center detention and court administrators should recognize Detention Officers in person. In some cases, the most powerful recognition from supervisors and court administrators requires very little effort or cost. Many staff have shared that a brief handwritten note from a supervisor thanking the detention officer for good work witnessed by the supervisor was particularly meaningful. Regular verbal recognition from supervisors and coworkers can also be very powerful.

TRAINING

Prior to the creation of the Training and Quality Improvement Specialist position in 2017, staff at the Juvenile Justice Center received no consistent or uniform training. To provide staff with organized training as soon as possible, the Center contracted with the Cuyahoga Community College, or Tri-C, to provide training for Detention Officers. This occurs at a location approximately 30 minutes from the Juvenile Justice Center. In addition, the PTQA staff provide in-house training on certain youth-specific areas such as PREA (Prison Rape Elimination Act), room confinement, Core Correctional Practices, the behavior management program, and suicide response and prevention.

While we understand the reasons for contracting for staff training, the team had serious concerns about the current training model. Administrators at the Center shared some of the team's concerns and have secured funding to hire five training instructors. Along with the PTQA staff, these instructors will be responsible for providing all staff training on-site. Three will be internal hires, while two will be hired from outside the Juvenile Justice Center. We commend administrators for making this change, which should allow the facility to develop its own training capacity and should allow for greater tailoring of training content to issues specific to youth and the facility itself.

We understand that the content and delivery of training will change under this new approach. Nevertheless, some of the team's observations regarding the approach to training at the time should inform future plans. First, the Tri-C training is designed for adult corrections and law enforcement. Adult correctional trainings often rely heavily on physical methods of control that are inappropriate for youth and counter to accepted practices in youth justice. United States Supreme Court jurisprudence and overwhelming scientific consensus has made it clear that

adolescents are fundamentally different from adults. Our team reviewed all training materials provided by Tri-C. While we were pleased that the Tri-C materials stress the importance of building positive relationships with adult inmates and using verbal de-escalation skills, this material is not sufficient to prepare staff to work with vulnerable youth, many of whom suffer from histories of mental illness, trauma, and abuse.

Second, the Juvenile Justice Center's training curriculum does not offer sufficient training on crisis intervention and verbal de-escalation techniques. The current curriculum using SCI and CPI includes content on verbal de-escalation, but neither model was developed specifically for youth. Both models place a premium on training staff to protect themselves with physical control techniques. Given the significant trauma and mental health histories of youth at the Juvenile Justice Center, staff need a more specific training program with an even greater emphasis on verbal de-escalation and adolescent crisis intervention.

Verbal de-escalation and conflict management skills are necessary to keep staff and youth safe. Staff should build confidence in managing aggressive residents and difficult situations using verbal and non-verbal techniques through regular proficiency training that incorporates role play. There are specific training curricula designed to help staff work to develop effective verbal and physical de-escalation skills with youth.

> **Recommendation**: Provide pre-service and in-service training on the use of conflict management and verbal de-escalation strategies with youth. Adopt a training model with a focus on non-physical interventions, such as Safe Crisis Management: http://www.jkmtraining.com/.

Third, the contract between the Juvenile Justice Center and the staff's union requires Detention Officers to receive OPOTA (Ohio Peace Officer Training Academy), an adult-based law enforcement model. OPOTA training is designed for sheriffs, police officers, and security personnel. Skills listed in the OPOTA training overview include advanced driving skills, firearms training, first aid, subject control, physical conditioning, hazmat training, law enforcement radio procedures, and crime scene processing. It is our understanding that the staff union required that OPOTA training be provided, largely due to its focus on subject control and physical interventions against youth. Not only do many parts of the OPOTA curriculum fail to equip staff with the necessary skills for work in a youth facility, they undermine the Juvenile Justice Center's training by imparting inappropriate information for work with youth. For instance, the new Resident Incident Report used by the Center asks staff to indicate whether SCI (Subject Control Intervention) and CPI techniques were used. These include pressure point controls, joint manipulation, and defensive counter striking. These types of physical interventions are inappropriate for use with young people. The fact that they remain on a revised version of an incident report makes it more likely that Detention Officers will see them as viable options.

> **Recommendation**: The Juvenile Justice Center should revise the Resident Incident Report to remove inappropriate physical interventions and add more detailed aspects of verbal de-escalation.

Recommendation: The Juvenile Justice Center should begin negotiations with the staff union to prioritize training approaches such as Safe Crisis Management in order to eliminate OPOTA from union contract. If necessary, our team can provide contact information for administrators at other facilities who have adopted Safe Crisis Management and found that incidents of violence, especially against staff, have been significantly reduced.

Fourth, the Juvenile Justice Center does not provide adequate training on trauma responsiveness. Based on the team's interviews and observations, some staff view youth who have experienced trauma as defensive and non-compliant. Staff must receive practical skills training on how to respond to this behavior and help traumatized youth develop new behaviors. This training should be a substantial part of pre-service and regular in-service training for all staff who have direct contact with youth.

Recommendation: The Juvenile Justice Center should deliver training on the impact of traumatic events on youth development and behavior. This includes the impact of incarceration and how to recognize and respond to youth whose behavior is affected by post-traumatic stress.

Recommendation: Juvenile Justice Center administrators and supervisors should conduct regular reviews of incident reports and video with Detention Officers and therapists, using those videos as opportunities to provide constructive feedback on how to appropriately interact with youth using a trauma lens.

Fifth, volunteers do not receive training on PREA or how to prevent and respond to victimization of youth. Although the facility policy requires that the Volunteer Coordinator provide volunteers with PREA training, in practice volunteers sign a three paragraph zero tolerance form stating that they will read the facility's PREA policy.

Recommendation: Develop and deliver a PREA training for volunteers.

Sixth, Juvenile Justice Center staff are not sufficiently prepared by the on-the-job training program to safely supervise youth. During on-the-job training, new staff are supervised by a current Detention Officer. Because of staffing shortages, the supervising Detention Officer may not be someone with a particular skill set in mentoring new staff.

Recommendation: Ensure that newly hired training officers either provide OJT or assist in recruiting field training officers who provide OJT.

Recommendation: Include positive youth development skills in the required certification skills for on-the-job training (e.g., developing activities for youth, using positive feedback on a regular basis, and spending time interacting with youth).

Seventh, although some staff demonstrated impressive skill sets and compassion, many Detention Officers refuse to engage in Core Correctional Practices (CCP). Although Detention Officers receive training in CCP, many Detention Officers ignore or reject CCP techniques. We

heard from Detention Officers and Unit Managers expressing open hostility toward CCP and the PTQA Unit. Some staff expressed that CCP requires them to "be therapists." This reaction is unfortunate, since CCP is a model that would support many of the recommendations included in this report that are geared toward creating a safer and more developmentally appropriate environment.

In addition to other training provided by the PTQA Unit, CCP is actively undermined by Detention Officers and Unit Managers. In part, this is because PTQA staff are seen as outsiders who do not have experience working in detention. Even as the Center moves forward with a new in-house training model, several of the training topics traditionally delivered by PTQA staff will likely face continued skepticism. Although the Center can make changes to the format of the CCP curriculum, additional support and buy-in from detention and court leaders is necessary.

> **Recommendation**: The Juvenile Justice Center should redesign the CCP training to include practical examples, additional videos, and potential trainers from outside facilities. The CCP training is highly technical and should be modified for an audience that is more concerned with how CCP can positively impact their day-to-day job.
>
> **Recommendation**: Detention and Court leaders should visibly commit to the CCP approach, explaining personally to staff why it is part of the Juvenile Justice Center's mission, and why it will improve results for youth and staff. The PTQA Unit and a handful of supervisors should not be expected to defend new approaches by themselves when some senior staff actively undermine the message.

The Juvenile Justice Center complies with many of the JDAI standards related to training. In other areas, staff receive training in required topics, but the training is inadequate based on content or duration. These topics include:

1. Communicating effectively and professionally with youth. This subject is covered in the Tri-C and Core Correctional Practices, but training needs to be increased to reflect special considerations when working with youth, youth with mental illness, youth with trauma histories, and youth with disabilities.
2. Adolescent development for girls and boys, including sexual health and sexual development.
3. Signs of physical, intellectual, and developmental disabilities, the needs of youth with such disabilities, and the ways to work and communicate effectively with youth with those disabilities.
4. Signs of mental illness and the needs of and ways of working with youth with mental illness, including working effectively with mental health staff.
5. Signs and symptoms of mental illness and emotional disturbance.
6. Access to mental health and crisis intervention services for youth, including information on best practices for assisting youth connect with these services.
7. Procedures for appropriate referrals of health and mental health needs, including transportation to medical or mental health facilities.
8. Signs and symptoms of medical emergencies, including acute manifestations of chronic illnesses (e.g., asthma, seizures) and adverse reactions to medication.

9. Signs and symptoms of chemical dependency, including withdrawal from drugs and alcohol.
10. How to work and communicate with lesbian, gay, bisexual, transgender, questioning, and intersex (LGBTQI) youth, as well as how to recognize, prevent, and respond to harassment of LGBTQI youth. The Juvenile Justice Center has an LGTBQ Youth policy, but we were not able to locate dedicated training on this subject.
11. Gender-specific needs of youth in custody, including special considerations for boys and girls who have experienced trauma, pregnant girls, and health protocols for both boys and girls.

Recommendation: Develop and implement training curricula on the topics outlined above.

SUPERVISION

The team had several concerns about the supervision at the Juvenile Justice Center. The team's first and overarching concern regarding supervision is a lack of meaningful interaction between many direct care staff and youth. We observed a noticeable sense of tension and mistrust between youth and staff, especially on housing units during time without off-unit or volunteer programming. Youth repeatedly described feeling bored and frustrated during time on the unit where there were no constructive or stimulating activities planned. During unit time, most staff remained standing or seated away from youth. For the most part, staff did not seem motivated to engage with young people or help them learn lessons or build skills. Staff, especially younger Detention Officers, described their roles as to observe youth and enforce rules and behavior expectations. We learned that the Security Detention Officer positions were most desirable specifically because they involved less contact with youth.

There are several reasons why staff may not prioritize engagement with youth. Staff are emotionally taxed by forced overtime and demanding work. They do not have training to deal with the unique needs of the young people at the Juvenile Justice Center. They may not understand that youth misbehavior is not necessarily a deliberate decision or personal affront. Youth who have experienced violence or trauma may not understand how to react appropriately to attempts by staff to control behavior if they do not feel safe. If staff feel unsafe, they may psychologically distance themselves from youth (i.e., viewing the environment as "us vs. them") and attempt to impose control on youth behavior rather than engaging with youth. The history of major incidents at the Center appear to have led staff to become even further entrenched in an "us vs. them" mentality. As discussed earlier in this report, one of the team's primary concerns is that staff generally view youth in the facility in a negative light. Unfortunately, the youth in the Juvenile Justice Center are aware of this fact. One youth asked, "why should we try to do good if all they expect from us is to do bad."

One common theme that emerged from our conversations with staff and administrators was a concern that any activity that allows youth to get too excited would result in a loss of staff control and reversion back to a natural state of violence or criminality. This concern reflects a fundamental misunderstanding of young people and the positive effects of developmentally appropriate programming. Rather than attempting to "control" or extinguish normal adolescent

behavior, staff should assist youth with developing new behaviors and skills. By building relationships and participating in activities *with* youth, staff can both increase safety and improve outcomes for youth. Staff who take time to get to know individual youth and establish trust are more successful at getting compliance from youth and de-escalating situations without the use of force.

While the culture of poor interaction between youth and staff is a concern, we did observe many examples of positive communication between staff and young people. Youth at the Juvenile Justice Center reported that they trust some staff, mostly those who they believe cared about their well-being. As with many other practices within the Center, the nature of staff-youth engagement also varied greatly from unit to unit. On House 5, for example, we observed conversations and relationship building during programming and during free time on the unit. The Activity Coordinator, Social Service Counselor, therapist, and Unit Supervisor clearly worked well together. The girls on the unit stated that they had positive relationships with most of the staff working on the unit. When one youth learned that she was being discharged from the Juvenile Justice Center, she became upset because she would have to leave one of the Detention Officers who had supported her.

> **Recommendation**: Prioritize positive relationships with youth in the institutional culture and mission statement. This includes Court administrators and detention administrators demonstrating a positive and strength-based view of young people in the facility.
>
> **Recommendation**: Change policy, training, and supervision to require direct care staff to help develop and actively engage in unit programming for youth. Encourage staff to view their role as both maintaining security and developing the skills of residents.

Second, there is no mechanism to ensure that staff regularly engage with individual youth to understand their triggers and problem behaviors. Earlier in this report, we observed that incident reports did not reflect an understanding that negative behavior was triggered by underlying causes, events, or conditions. We were pleased to see that the new detention incident report form includes a section on "Who, what, and where events leading to the incident." However, one concern is that officers, without ongoing training, may simply use this section to list events immediately preceding an incident without considering deeper triggers. For example, a report might indicate that "Johnny became upset because Eddie was sitting at his table during free time, Johnny became verbally aggressive and then pushed Eddie." A more appropriate summary might be that "Johnny received news during court that his grandmother's illness had gotten worse. Johnny became upset when Eddie sat near him and began asking questions about why he looked so sad. After Eddie asked several times, Johnny pushed Eddie." The second example addresses an underlying stressor, a triggering event, and information about the nature of the relationship between Johnny and Eddie – all of which are important for staff to know about in order to plan to avoid future incidents.

> **Recommendation**: Train staff on the importance of identifying and describing behavioral triggers so that staff use information to develop strategies to avoid similar incidents in the future.

Third, staff do not receive frequent and specific feedback from senior supervisors. New staff at the Juvenile Justice Center staff receive performance reviews at three months, six months, and one year. Regular detention officers receive quarterly performance reviews. However, these reviews are largely superficial.

Although the Center's updated incident report form has space to indicate whether video footage was reviewed, it was unclear whether the Superintendent, Deputy Superintendent, or Unit Managers have any formal process of reviewing video footage or incident reports to provide specific feedback, be it bad or good. Although administrators review reports noting whether major incidents or room confinement occur through a "shift email," it is unclear when and if there is any delegated responsibility to review the actual incident reports or video footage or whether they address any concerns with staff behavior as part of an immediate review process. Other than a number, there is no identifying information listed in the email. It often takes administrative staff several weeks to enter incident reports by hand into an electronic system. Because of this delay, administrators would need to find the original paperwork for individual incidents to learn details quickly.

Fourth, despite an established process for supervision, the facility culture does not encourage Detention Officers to develop a positive environment for youth. Staff do not document the use of verbal de-escalation, crisis intervention, or incentives. The Juvenile Justice Center's policies require staff to model appropriate social skills and avoid profanity or intimidation. However, many youth reported that staff routinely swear at them. Our review of youth grievances also revealed a pattern of some staff are treating youth inappropriately. On July 12, 2017, for instance, a youth reported that several staff threw urine on him. The Cuyahoga County Division of Children and Family Services investigated and deemed these allegations "indicated." Based on reports from staff, several employees who were involved in this incident have returned to work at the Juvenile Justice Center.

> **Recommendation:** Hold staff accountable for actions that undermine the facility's goal of creating a positive and safe environment for youth and staff. Ensure that there are full investigations of, and appropriate follow up to, youth allegations of staff mistreatment or misconduct.

QUALITY ASSURANCE

As mentioned, there is an entire division within the Juvenile Justice Center dedicated to Quality Assurance. Two PTQA staff members devote a significant amount of time and energy to improving detention policies and practices. Their goals include restructuring the training process, developing a room confinement dashboard, and improving quality assurance of the Behavioral Management Plan. For the most part, PTQA is working to create a quality assurance system that captures relevant information. We have made several suggestions in this report that pertain directly to the PTQA Unit. Unfortunately, the poor relationship between the PTQA Unit and detention center staff has limited the effectiveness of the PTQA Unit's efforts to date.

Due to a transition in leadership during our visit, the team was unable to discern if there is an organized system for reviewing incident reports, although administrative staff enter all reports by hand. This process creates a delay for administrators to review individual incidents or trends. We observed an electronic system that, at some point, was capable of generating various data reports including incidents by location, monthly incidents, individual youth incidents, confinement by unit and staff, and gang affiliations. We were not able to learn whether the Center's current data system currently collects data to populate these reports or if these reports were generated on a regular basis.

> **Recommendation**: The Juvenile Justice Center should create a written protocol for reviewing various aspects of facility operations. For instance, one Deputy Superintendent could be responsible for reviewing all incident reports within 3 days, including video footage when appropriate, and providing feedback to staff. Administrators should review all critical incidents weekly and monthly through an "incident mapping" chart. The recent development of facility committees could be used as a tool to track and discuss data on various aspects of facility operations (or determine what data is not currently being collected).

> **Recommendation**: Schedule weekly meetings between detention administrators and detention staff to support and exchange of information and reinforce facility culture. Data from incident mapping could be helpful to share with all detention staff.

> **Recommendation**: Update necessary incident report forms and streamline data entry to allow administrators to track data on the use of incentives, discipline, assaults, use of force, room confinement, promotions and demotions in the Behavior Management Program, and programming. The Center should be able to track this information based on date, time, staff, youth, gender, age, race, and ethnicity.

The Juvenile Justice Center has not scheduled or completed a PREA audit, and the facility would benefit from a focus on PREA implementation efforts. The Center has developed and begun delivering PREA training, and the facility has a sexual misconduct prevention, detection, and response policy. However, there are many additional steps that the facility needs to take in preparation for an audit. Some of those key steps are outlined below.

> **Recommendation**: Add content to the current PREA training to include how staff should interact with and respond to a youth during and after a disclosure.

> **Recommendation**: Ensure that all contractors and volunteers receive training as required by PREA.

> **Recommendation**: Adjust staff training, develop youth educational materials, and create visuals aids to clarify (1) how to report retaliation, and (2) the ways that youth can make a report of sexual misconduct. While staff seemed to understand their role as mandatory reporters, many Detention Officers did not know whether and how to report retaliation against youth or other staff for reporting an incident. Youth were not familiar with the way to use an independent reporting channel.

Recommendation: Create a policy, standard form, and process to monitor retaliation.

Recommendation: Modify policy to require the Superintendent to report any allegations of child abuse to the child welfare system caseworker (if applicable) and the child's attorney or other legal representative, as current policy only requires that the facility notify the parent or guardian.

Recommendation: Ensure that the Superintendent or designee advises those making reports of the results of the complaints or child abuse reports that they file.

ENVIRONMENT

Juvenile detention facilities should not look like or be operated as jails. This section encourages facilities to provide a non-penal environment appropriate for youth who need to be held in a secure setting. It requires that the facility is clean, meets fire and safety codes, has properly functioning temperature controls, light, and ventilation, and offers youth appropriate living conditions. This section also encompasses quality of life issues – assuring that youth will have clean, properly-fitting clothing; pleasant, healthy eating experiences; permission to retain appropriate personal items; and some measure of privacy.

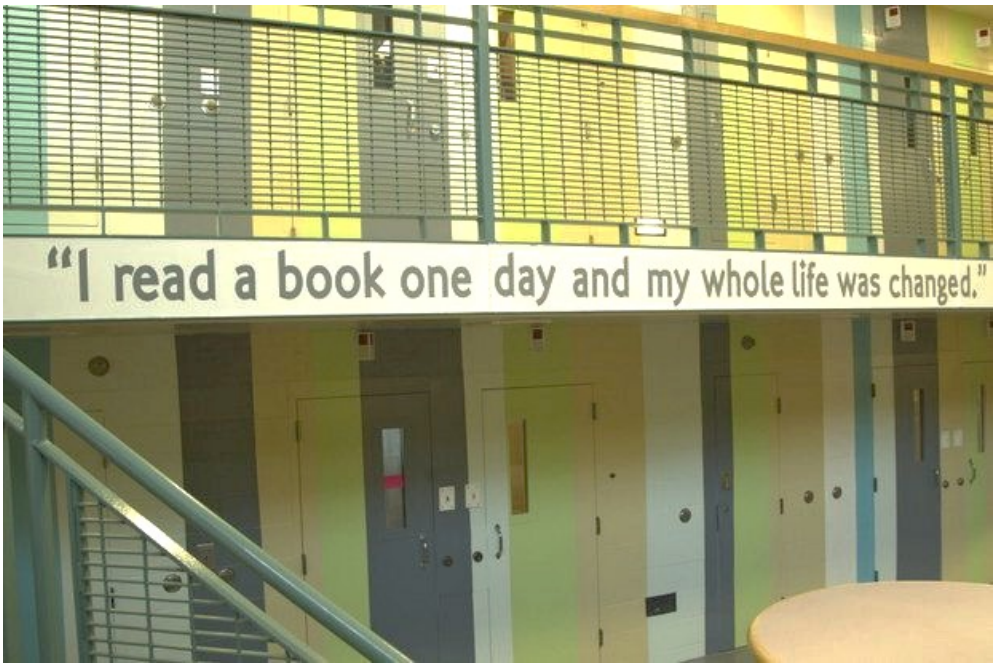
There were several strengths in this area of the standards. First, the facility itself was generally clean and well-maintained, with some exceptions outlined below. Youth are involved in a significant amount of sanitation activities at the facility, but they perform them under close staff supervision. As mentioned in the introduction, there are definite shortcomings to the facility's physical plant, but the facility also benefits from large, light-filled spaces that could be much more conducive to a therapeutic environment and that could allow for programming that is not possible in other facilities.

POSITIVE INSTITUTIONAL ATMOSPHERE

As outlined in the JDAI standards, a positive institutional atmosphere depends on two factors: (1) the atmosphere conveyed by the physical plant and decor of the living units and other spaces where youth and staff spend time, and (2) the atmosphere created by the nature of staff interaction with youth.

With respect to the first factor, the facility has not been altered much to avoid feeling like an adult jail. There are notable exceptions, including the girls housing unit and the school area. Additionally, facility officials were in the process of adding some color to one of the five housing units during the team's first visit. In general, though, living units were very stark and had limited or no imagery or information posted to convey high expectations for youth. We recommend introducing more murals, artwork, and positive imagery into the living units and other parts of the facility. The two photographs below from the Worcester Reception Center in Massachusetts and the Multnomah County (Portland) Juvenile Detention Center illustrate two examples of how color and imagery can create a more positive and relaxed environment in living units, even those that are built on a correctional model. Making these changes would be more than just cosmetic. The would help create a more pleasant environment for young people and staff, and they would be a way of conveying higher expectations for the young people at the Juvenile Justice Center.

> **Recommendation:** Introduce more murals, artwork, and positive imagery into the living units and other parts of the facility. Involve youth and staff members who have an interest and skill in art, and consider capitalizing on Cleveland's vibrant arts community.



Additionally, youth are allowed minimal opportunities to personalize living spaces. Given the amount of time that many youth spend at the Juvenile Justice Center, particularly youth charged as adults, the facility should reconsider limitations on allowing young people to decorate or post photos or other materials that do not represent a security risk. The facility could also consider application of chalkboard paint in cells (which can be easily erased), which could help cut down on the amount of tagging and graffiti found throughout the facility. Finally, the team understood that youth's mail was supposed to be stored in a secure location on the unit, yet the team observed at least one housing unit where youth's mail was left unsecured in a dayroom. There is

no reason to prohibit youth from retaining letters and other personal correspondence in their rooms.

Recommendation: Allow for greater personalization of youth's living spaces.

Recommendation: Allow youth to store personal mail in their individual rooms.

With respect to the second factor contributing to a positive institutional atmosphere – staff's interactions with youth – the team observed that most interactions between staff and youth were focused on orders and redirection as opposed to engaging with young people in activities or conversation. To be sure, team members observed some staff engaging in very positive and supportive conversations with youth. However, we observed many staff who clearly did not see this kind of interaction as a priority.

During lunch time, for example, we saw units where staff sat at their own tables separate from youth, which was also true of meals in the cafeteria. We observed other programming periods where staff were either behind the unit's desk or limiting their communication with youth to directives. These types of interactions do not build rapport between staff and youth, and they fuel a feeling of "us vs. them" between youth and staff that can lead to tension, defiance, and altercations. As mentioned above, the team recognizes that many new staff do not have adequate training on working effectively with young people, and that overtime has strained some detention officers' patience with youth. However, it is everyone's interest to have a positive institutional atmosphere, which promotes safety and security of youth and staff.

Additionally, as mentioned elsewhere in this report, many grievances reported name calling and other disrespectful interactions between staff members and young people. While it is almost certainly the case that some of these grievances were false, the sheer volume of grievances and the fact that a number were investigated and substantiated suggests a greater need for accountability regarding maintenance of respectful interactions between staff and youth. It is difficult to expect young people to follow a set of rules regarding language and appropriate behavior when staff members are not following those same rules in their interactions with youth.

As mentioned in the introduction, a poor dynamic between direct care staff and youth is fueling negative feelings and hostility among both groups at the facility, with many staff viewing youth at the facility as being far along the path to a life of crime, with little potential for rehabilitation. This negative dynamic limits the ability of staff members to build productive relationships with young people, and it sets low expectations for the behavior of young people at the facility.

Recommendation: Enhance training to equip new staff members with additional skills for communicating and working with youth.

Recommendation: Ensure that policy, procedure, and actual practice require staff to interact with youth in a positive and developmentally appropriate way. For example, the facility could have a policy of providing free lunch to staff members, so long as staff members eat and communicate with residents while they do so.

FOOD SERVICE AND NUTRITION

Consistent, high-quality food service can help maintain a positive institutional atmosphere and reduce the number of incidents involving physical aggression and violence. The team reviewed many grievances related to the quality and quantity of food provided to youth prior to arriving on site. Interviews with staff and youth, coupled with the team's experience with meal service while on site, provided additional information about shortcomings within the food service and delivery at the Juvenile Justice Center.

The team recognized that the kitchen had recently implemented a new menu, and we learned about changes in providers of food to address previous concerns about quality. As any juvenile facility administrator knows, problems with these areas of food service and delivery lead to unhappy youth who are more likely to engage in disruptive behavior.

First, the team heard consistent complaints from youth during our on-site visits and reviewed numerous grievances regarding the quality and quantity of food that was provided. Part of this may be due to the fact that more than 12 hours elapse between the evening meals on housing units and breakfast, which is contrary to the JDAI standards and counter to most recent guidance from American Academy of Pediatrics that the time period should not exceed 12 hours. The team recognizes that the facility's adherence to the federal school lunch guidelines can present challenges in preparing food that youth enjoy eating, but we have seen many facilities that provide a much stronger food service program within those guidelines. For example, the facility could create a salad bar station to encourage youth to eat an array of healthy vegetables, which is an offering that is consistent with the federal guidelines. Additionally, the facility could survey youth about their preferred meals and make those available on a more regular basis.

> **Recommendation:** Consider the feasibility of a meal schedule that does not allow for more than 12 hours to elapse between breakfast and dinner.

Second, many units receive Styrofoam trays for meals as opposed to being transported to the cafeteria for meals. Staff cited staffing shortages and safety concerns as the reason that more youth could not consume meals in the cafeteria. This arrangement has created multiple problems. For one, the trays that youth receive on the units are not transported in any type of temperature-controlled cart, and no temperature is taken of meals when they reach the housing units. Additionally, individual Styrofoam trays are stacked on one large plastic tray, which is carried to the unit. The team observed, and youth reported, that the jostling of trays during transportation means that food often runs together and that bread and other grains soak up liquid from trays before they reach youth. Indeed, the team reviewed many grievances related to "soggy bread."

> **Recommendation:** If meals continue to be brought to youth on housing units, invest in temperature-controlled carts that are used in other larger correctional facilities.

> **Recommendation:** Ensure that food is transported in a way that preserves the integrity of individual meal portions.

Third, when youth were transported to the cafeteria, they were allowed 15 minutes for meals, with no talking allowed during that time. When asked by team members about the silent meal rule, staff members stated that such a rule was necessary for youth to eat during the allotted time. The JDAI standards provide that youth should have at least 20 minutes for meals, and that talking should be allowed absent a specific and individualized security reason. Many facilities allow youth to speak during meals, which are important times to model appropriate social interactions.

> **Recommendation:** End the general prohibition on speaking during meals and add any extra time needed to accommodate the change.

Second, when the team asked youth about the one thing they would change at the facility, almost every single youth stated the quality and quantity of the food. Many youth reported that the meals left them hungry later in the day. One reason is that many youth were not eating much of the prepared meals. Indeed, the team observed female residents taking an apple and packets of peanut butter in lieu of a lunch tray without any questions by staff as to why they did not take a tray. Finally, many youth stated that the evening snack was often the same from day to day.

> **Recommendation:** Ensure that meals are both visually appealing and appetizing to youth.

> **Recommendation:** Solicit youth input on preferred meals and offer such meals more regularly than those that many youth decline to eat.

> **Recommendation:** Reconsider whether participation in the federal school lunch guidelines is consistent with the needs of the growing adolescent population at the facility.

> **Recommendation:** Ensure that prepared meals follow what a licensed dietician has approved as the designated meal that day.

> **Recommendation:** Introduce a salad bar as a means for exposing youth to healthy vegetables.

> **Recommendation:** Create a rotating schedule that ensures variety in evening snacks.

> **Recommendation:** Develop a meal schedule that does not allow for more than 12 hours to elapse between dinner and breakfast.

> **Recommendation:** Consider whether a partnership with the facility's Culinary Arts program could help enhance the quality of food service.

Finally, policy provides that youth with special dietary needs, youth with medical conditions, and youth with religious beliefs can receive alternative meals. The team had two concerns about how those accommodations were being made in practice. First, the team encountered a youth who was regularly vomiting and clearly had some sort of gastrointestinal problem. The facility's

medical staff were in the process of settling on a diagnosis for his condition, but no accommodations had been made by the medical or food service staff for alternative meals in the meantime. Second, the alternative menus if youth refuse to eat or cannot eat a main course are very limited – the substitute is peanut butter or cheese on most days. If there is a youth at the facility for an extended period with a special dietary need (e.g., a vegan youth or a youth who is observing Ramadan), they are not likely to see much, if any, diversity in food service.

> **Recommendation:** Ensure that there is a process for communicating regularly with medical staff about youth who have needs for special diets, even prior to a formal diagnosis.

> **Recommendation:** Introduce a broader range of alternative menu items for youth with special dietary needs.

EMERGENCY PREPAREDNESS AND FIRE SAFETY

The facility has an emergency preparedness plan that accounts for different types of emergencies and natural disasters, as well as designated evacuation sites. We applaud the facility for thinking through how it would manage those situations, which many facility officials have neglected to do. We have several recommendations that we believe would strengthen the plans. First, it does not appear that the identified evacuation sites would have the capacity if a total evacuation of the Juvenile Justice Center was necessary when the facility is near to its rated capacity or anywhere above that number (which the facility was at the time of our initial visit). The facility must have a plan for a total evacuation of the facility in the unlikely event that it is ever necessary.

> **Recommendation:** Ensure that identified evacuation sites can accommodate a total evacuation of the Juvenile Justice Center when it is near or above capacity.

Second, the team was not able to obtain any written agreements between the Juvenile Justice Center and designated evacuation sites (e.g., Cuyahoga Hills and the Cuyahoga County Jail). Such agreements should be in place to outline roles and responsibilities, such as transportation assistance, in the event of an evacuation.

> **Recommendation:** Develop written agreements with all designated evacuation sites that outline roles and responsibilities in the event of an evacuation.

Finally, it appeared that the facility had not drilled on its emergency preparedness plans in recent months, and some staff members demonstrated little knowledge of how they would respond in the event of an emergency or evacuation. Drills serve a vital function of showing where there are weaknesses in emergency response policies and procedures. Those lessons should not be learned from actual emergencies.

> **Recommendation:** Resume regularly scheduled emergency and “man down” drills and ensure that staff receive regular training on roles and responsibilities in the event of an evacuation.

PHYSICAL PLANT AND SANITATION

As outlined in the checklist, the physical plant at the Juvenile Justice Center suffers from significant shortcomings, many of which have existed since the facility opened. Administrators and staff at the Juvenile Justice Center are all too familiar with the challenges presented by the facility, including obscured sight lines in hallways, a lack of toilets in individual youth's rooms, and two-story pods that present challenges for supervision. There is, unfortunately, no easy or cheap remedy to these problems.

Although the facility is generally well-maintained and clean, the team had three concerns with facility-wide sanitation practices. First, the facility does not have functioning soap dispensers within restrooms on the living units. Youth must leave restrooms and request soap from staff, then return to the restroom to wash their hands. This practice likely means that some youth forego washing hands, and others will still touch door handles and possibly other parts of the unit in between when they leave and return to the restroom. Many facilities have corrections-grade soap dispensers that can easily be installed to avoid this unnecessary practice.

> **Recommendation:** Install tamper- and suicide-resistant soap dispensers in unit restrooms.

Second, many shower areas suffered from significant corrosion, which warrants attention. The corrosion can also affect the functionality of suicide resistant break-off hooks.

> **Recommendation:** Address corrosion in shower areas and regularly check and lubricate break-off hooks to ensure that they function as intended.

Third, many of the facility's mattresses were in poor condition with rips and tears. These mattresses have an antimicrobial coating to resist transmission of bacteria and other parasites, but they do not function when there is damage to that coating. These mattresses should be repaired or taken out of circulation and replaced. Additionally, many youth complained of dirty or damaged pillows, which team members also observed in some youth's rooms.

> **Recommendation:** Repair or replace damaged mattresses.

> **Recommendation:** Replace soiled or damaged pillows.

The team also had two primary observations with respect to youth's personal hygiene. First, the team heard from several youth and staff members that youth on suicide watch were not always offered an opportunity to shower or otherwise make themselves presentable for court if they were on watch during a scheduled hearing. A youth's appearance can have an impact on the outcome of a hearing and how the parties perceive them. Youth should be afforded the opportunity to make themselves presentable, regardless of whether they are on suicide watch.

> **Recommendation:** Ensure that youth on suicide watch have adequate opportunities to engage in personal hygiene activities and otherwise make themselves presentable before court appearances.

Second, many youth and some staff members reported that the standard personal hygiene products offered by the facility were not culturally appropriate for African American youth. High expectations for youth depend, in part, on youth taking pride in themselves. Such products should be made available as a matter of course.

> **Recommendation**: Provide more culturally appropriate hygiene products.

CLOTHING

Laundry services at the facility were generally strong, although the facility would benefit from larger capacity washers and dryers given the volume of laundry done in a facility the size of the Juvenile Justice Center. The team had three primary concerns regarding clothing.

First, youth are dressed in prison-style jumpsuits with "CCJJC" lettering down the front, similar to uniforms that we see in adult jails and prisons. Many juvenile facilities have moved away from jumpsuits and toward school uniforms, recognizing that uniforms convey a powerful message about how the facility staff perceive youth and what is expected of them. The JDAI standards prohibit the use of jumpsuits for this reason.

> **Recommendation:** Discontinue use of prison-style jumpsuits in favor of school uniform-style clothing.

Second, many youth complained about soiled or reused undergarments being provided to them upon arrival at the facility, and other youth reported that undergarments were not always adequately cleaned. Several grievances also reflected these complaints. All youth should be entitled to clean undergarments.

> **Recommendation:** Ensure that newly admitted youth are provided with new undergarments or allowed to wear their own undergarments. Ensure that undergarments are sanitized and cleaned appropriately.

Third, the team observed that the facility gave pink shirts to the girls, which some girls complained about. Others noted that if a transgender boy was housed on the girls' unit (as has occurred in the past), he might be forced to wear pink clothing, something that could signal rejection of his gender identity. There is no need for pink clothing when other neutral colored shirts are readily available.

> **Recommendation:** Retire or donate the pink shirts for girls and replace them with a more neutral color.

SEARCHES AND SUPERVISION

The team learned that the facility had been in the practice of conducting "shakedowns" of groups of youth at various times, which involved youth stripping down to their underwear in groups while staff searched youth's outer garments. We understood that the new superintendent at the facility was taking steps to discontinue this practice, which is unnecessary, intrusive, and degrading.

Recommendation: Discontinue group "shakedowns."

RESTRAINTS, ROOM CONFINEMENT, DUE PROCESS, AND GRIEVANCES

Security and good order in a facility are best achieved when expectations are clear; the facility encourages compliance with rules through positive behavior interventions; staff are well-trained to help prevent and de-escalate crises; and there are positive relationships between youth and staff. This section addresses what happens when those protective factors are insufficient. This section includes the facility's rules for restraint, use of physical force, room confinement, discipline, provisions for due process, and disciplinary sanctions. This section also addresses the facility response to concerns and complaints by youth through an effective grievance process.

This category of the assessment is about what happens when youth violate the rules at the facility (or, in the case of grievances, when youth allege that staff have violated the rules). It also provides a picture of the atmosphere at the facility. Is the focus on discipline and control, or care and support? Are staff responses proportionate to youth misbehavior? Is discipline fair? Are youth concerns taken seriously?

At CCJDC, this is an area where the approach of the new Director is particularly important. Prior to his arrival, the facility failed on many fronts. He and his management team are clearly working to reform many of the problematic conditions, policies, and practices. He will need the strong support of the Juvenile Court if his efforts are to be successful.

The assessment team was provided with a summary of incidents at CCJDC from January 1, 2018, through May 24, 2018. There was a total of 646 incidents. By far the most common type of incident was "failure to comply," which totaled almost one-third of the incidents. The second most common type of incident was fighting or assault, which comprised more than 170 incidents. The third most common incident was threat to other youth or staff, which totaled more than 100 incidents.

This information shows a high degree of conflict between youth and staff at the facility. This amount of conflict had been present for some time. Detained youth who belonged to gangs were responsible for many assaults. Responses by some staff were egregious. In 2016, it was revealed that two staff had facilitated multiple "fight nights" among youth at the facility. In 2017, staff were videotaped throwing urine on a youth in retaliation for an earlier incident.

At the same time, the trend of incidents over that period of time demonstrates progress in reducing these conflicts. More than 40% of the reported incidents occurred in January, when six youth were responsible for a serious disturbance and widespread property damage in the facility. By April, the last full month reported, the incidents had declined by 50% to 85% in the major problem areas. Hopefully those declines will continue.

USE OF FORCE AND RESTRAINTS

Staff generally follow appropriate policy in the use of handcuffs as mechanical restraints. Staff use handcuffs when necessary to gain control of a youth and to move the youth to his or her room, then they remove the handcuffs. Staff routinely use leg shackles for transporting youth.

The JDAI standards prohibit routine use of shackles and require particularized reasons for using leg shackles on a specific youth.

With respect to physical restraints and use of force, a draft "Incident Report Form" provided to the assessment team raises several serious concerns. First, on page 3 of the form, there is a question whether CPI techniques were used. CPI techniques are those covered in staff training for de-escalating and gaining control of a confrontation situation. If the answer is "yes," there is a block for staff to check off which techniques were used. The block lists "verbal de-escalation" among a list of twelve techniques, which include "kick block" and "one hand hair pull release."

Verbal de-escalation should be required in every situation. By listing "verbal de-escalation" along with 11 other techniques, the format of the form implies that it is only one of many techniques. Instead, the format should demonstrate that verbal de-escalation should be the primary response strategy. Also, to the extent that any of the other techniques listed are aggressive moves by staff (as opposed to defensive measures when staff are attacked), they are inappropriate. Certainly staff can and should protect themselves from assaults, but they should not use attack moves on youth in the facility.

In a similar vein, on page 4 of the form there is a question whether Subject Control Techniques were used. Subject Control Techniques are those covered in staff training on gaining physical control of youth in the facility. If the answer is "yes," there is a block that lists 47 of the techniques. Many of these techniques are methods of physical attack, including ten types of strikes and three types of kicks ("Close Range Strike," "Palm Hand Strike," "Upper Body Strike," "Front Kick"), choke holds ("Two-hand Choke from the Front," "Arm Choke from the Rear"), and methods of twisting limbs against the joint ("Joint Manipulation"). Staff told members of the assessment team that these techniques were mentioned during training (implying that they are acceptable) but not discussed or demonstrated.

These techniques are dangerous and completely inappropriate for a juvenile facility. They inevitably lead to injuries of young people as well as staff. When improperly applied, they can cause dislocated joints, broken bones, and death from asphyxiation. They are also counterproductive: youth will not develop supportive and trusting relationships with staff if they know that staff are going to kick, beat, and choke them. These techniques are specifically prohibited by the JDAI standards. The techniques also violate CCJDC Policy 9.6, which provides that the use of physical force by staff on youth shall be limited to self-protection, protection of other youth or staff, protection of property, and prevention of escapes, and then only as a last resort. In all instances, according to the policy, staff are required to use the least amount of physical force necessary. The techniques listed above should be discontinued as part of staff training, deleted from facility policies and practices, and removed from incident report forms.

Staff training also includes the use of pressure points. This technique is also inappropriate and dangerous, and some staff were very skeptical that it could ever be used effectively. This technique should also be prohibited at CCJDC.

In addition, although the form provides for tracking involvement by medical staff, there are no provisions for contacting behavioral health clinicians or tracking their involvement. As noted in

several places in this report, behavioral health clinicians may be very helpful in defusing confrontation situations, learning from youth the underlying causes of problem behavior, and debriefing incidents with youth and staff.

> **Recommendation:** Establish, by policy and practice, that verbal de-escalation should be the primary response to confrontations with residents. Revise the incident report form to reflect this emphasis.
>
> **Recommendation:** Prohibit staff from using kicks, strikes, choke holds, and joint manipulation, and revise the incident report form to reflect these prohibitions.
>
> **Recommendation:** Prohibit the use of pressure point techniques at the facility
>
> **Recommendation:** Engage behavioral health clinicians early in confrontation situations and require reporting on their involvement on incident report forms.

Quality Assurance staff told the assessment team that they are revising the incident report form, so this is an opportune time to make these changes.

ROOM CONFINEMENT

The policy as written appropriately limits the use of room confinement to a temporary response to behavior that threatens immediate harm to a youth or others. This is consistent with the JDAI standards and other national standards such as the Council of Juvenile Corrections Administrators' Performance-based Standards (PbS). The policy provides for appropriate monitoring of youth in room confinement and reporting on incidents that lead to the use of room confinement.

One section of the written policy raises significant concerns. Paragraph 7 of the procedure for use of room confinement allows the use of room confinement beyond four hours with the approval of a Unit Manager, Manager on Duty, or Shift Supervisor, and allows the use of room confinement longer than 24 hours with the authorization of the Superintendent. This is not appropriate. If a youth continues to threaten immediate harm to themselves or others after four hours, then behavioral health clinicians, who have the required experience and special training, should decide whether the youth should be transferred to another more appropriate facility such as a psychiatric hospital, or whether other extraordinary measures should be utilized. For the same reason, no youth should be on room confinement at CCJDC for 24 hours. It is very rare for a youth to continually pose an immediate threat of harm for such long periods of time. To put it another way, authorization of room confinement for such extended periods makes it possible for staff to use room confinement as punishment or staff convenience rather than protection from harm.

In practice, youth have been held in room confinement for long periods of time when they are clearly not an immediate threat to harm themselves or other youth or staff. Part of the problem is that youth have been in school for a limited amount of time, if at all, as discussed in the

Programming section of this report, and there has been limited additional structured programming. In the absence of programming, staff have put youth in their rooms. Another part of the problem is that some staff have used room confinement as punishment for misbehavior. For example, in one incident, a youth was held in room confinement for three and a half hours for "failure to comply."

Yet another part of the problem is that, when Quality Assurance staff revised the room confinement policy, they did not get sufficient input from unit staff. Consequently, many unit staff did not agree with the policy, did not think that Quality Assurance staff understood conditions in the units, and refused to follow the policy. Thus, the policy has been good on paper, with the exception noted above, but deficient in implementation.

Quality Assurance staff plan to create a dashboard to facilitate monitoring of room confinement hours and critical incidents. They have worked on revising the incident report form and coordinating with the IT department to create the necessary computer programming and database.

> **Recommendation:** Revise the room confinement policy to require return of a youth to the general population, development of special individualized programming for the youth, or consultation with a qualified mental health professional about whether a youth should be transferred to a mental health facility, for any youth who are in room confinement for four hours.
>
> **Recommendation:** Significantly increase the amount of school time and other structured programming for youth at the facility, as discussed in other parts of this report.
>
> **Recommendation:** Monitor the use of room confinement closely to ensure that youth are released from their rooms promptly as soon as they no longer pose an immediate threat to themselves or others, and to prevent room confinement from being used as punishment for misbehavior or staff convenience.
>
> **Recommendation:** Include representatives of unit staff in revisions of the room confinement policy and monitoring of the use of room confinement. Provide opportunities for staff to express their concerns about their own safety as recommendations in this area are implemented.

In general, six factors are critically important in a facility's efforts to reduce the use of room confinement: staff training, staff availability, involvement of behavioral health clinicians, adequacy of the behavior management program, the amount of programming in the facility, and the development of individualized behavior plans.

1. <u>Staff training.</u>

As discussed in the Training and Supervision section of this report, in past years there was no organized training program for staff at the facility. Some staff attended the classes that were available, but others did not. Some refused to attend, with no consequences. The JDAI standards

list critical topics that should be included in a staff training program. Many of the topics were not covered in any trainings for staff at CCJDC. The training that was provided was inadequate on verbal de-escalation and authorized staff, explicitly or implicitly, to kick, hit, and choke youth. Staff at CCJDC need much more training on both the rationale and the implementation of verbal de-escalation. The assessment team recommends a staff training program called "Safe Crisis Management" (SCM), which is considered the gold standard for training on verbal de-escalation. It has been used effectively in many facilities across the country to reduce the incidence of physical confrontations and avoid the use of room confinement, including in settlements of investigations or litigation by the U.S. Department of Justice. Quality Assurance staff have had some contact with SCM. The assessment team urges follow-up on those contacts.

> **Recommendation:** Provide Safe Crisis Management training to all staff at the facility, or have SCM "train the trainers" so that there are qualified trainers among the staff who can conduct trainings for new staff and refresher trainings on an annual basis.

2. Staff availability.

As discussed above in the Training and Supervision of Employees section of this report, there have been significant staff shortages at CCJDC. That has led to inadequate supervision of youth in some units and a youth-to-staff ratio of 10:1, while JDAI and other professional standards require a ratio of 8:1 during the first and second shifts. Inadequate numbers of staff on the units means that staff who are there are over-worked, get tired more quickly, and get more impatient with youth who misbehave. One indicator of the stress of working in units is that senior staff prefer to work in transportation – i.e., moving youth from one location to another – rather than on the units.

> **Recommendation:** Fill vacant staff positions and, if necessary, increase the number of staff at CCJDC so that the facility can maintain an 8:1 youth-staff ratio during the first and second shifts.

3. Involvement of behavioral health clinicians.

As noted above, behavioral health clinicians are not involved early in confrontation situations, even though they have specialized training and experience in understanding behavior and resolving conflicts. The incident report form does not even include a space to record involvement of behavioral health clinicians, and the incident reports provided to the assessment team had no record of behavioral health engagement.

A complicating factor is that the assessment team was told that unit staff do not want behavioral health clinicians on the units because they claim there is a "conflict of interest." Fortunately, the Director of the detention facility takes a different view: he wants behavioral health clinicians on every unit. His efforts should be supported.

> **Recommendation:** Support the Director's plan to have behavioral health clinicians on the units.

4. Behavior management program.

An effective behavior management program is a critical component in a juvenile facility's efforts to reduce the use of room confinement. Ideally, the program should provide rewards that are sufficiently attractive to motivate youth to obey the rules in the facility and to avoid being dropped from one level to a lower one with fewer privileges.

The Behavior Management Program at CCJDC is described in detail in a document titled "Behavior Management Program/Level System." There are five levels in the program – Orientation and Levels 1 to 4. At each successive level, youth get additional privileges. Youth may get up to 10 points per activity, and staff record behavior ten times each day. Earning 10 points requires "exceeding expectations and demonstrating exemplary behavior, indicating a high level of performance **and** participation in programming **and** activities" (emphasis in original). To get from Orientation to Level 1, youth must have six consecutive days at 85 points or higher. To get from Level 1 to Level 2, six more consecutive days at 85 points or higher. To get from Level 2 to Level 3, and from Level 3 to Level 4, six more consecutive days at 95 points or higher. To continue on Level 4 once on that level, youth must complete six consecutive days at 100 points.

At the end of six consecutive days at the required number of points on each level, youth must take a test on the level. This takes an additional day, so the minimum number of days to get from one level to the next is seven days.

As discussed briefly earlier in this report, there are several problems with the Behavior Management Program. First, it takes too long to get from Orientation to the upper levels. It takes a minimum of one week, with very good to perfect behavior, to get from one level to the next. However, the median length of stay at CCJDC is 3 days. Thus, more than half the youth detained are released long before they can move from Orientation to Level 1. Accordingly, for at least half the youth detained, the Behavior Management Program is irrelevant.

Second, requiring six consecutive days of very good to almost perfect behavior is too restrictive. It is normal for adolescents to challenge the authority of adults, to be influenced by peers in disobeying rules, and to do foolish and sometimes dangerous things, even in a secure juvenile facility. In addition, a number of youth at the facility have significant mental health problems, which may lead to violation of the rules. All of these behaviors result in loss of points. Consequently, it is difficult for youth to maintain the high level of performance for six days straight. In addition, adolescents are notoriously poor at thinking about future consequences of their behavior. Thus, the threat of failure to advance to the next level may not be a sufficient deterrent to problematic behavior.

Third, the program would likely be more effective if it were somewhat less complicated. When the program was developed, there was consideration of having a maximum of 10 points per day, and having staff award points fewer times during the day. That would be preferable, since it would be easier to understand and would cut in half the amount of time staff would have to spend awarding points.

The title of the document is somewhat misleading. Only four and a half pages of the 20-page document are about the level system. The rest is largely about what youth are required to do or, conversely, are not permitted to do. It would be more appropriate to refer in the title to "rules for resident behavior" or some similar phrase.

On page 13 of the document there is a list of "Guidelines for Administering Consequences for Unacceptable Behavior." The list has ten items in ascending order of severity, from "verbal warning" to "filing of additional delinquency charges." The problem is that the unit staff often don't follow the guidelines. Several unit staff told members of the assessment team that they had only two tools to use when youth misbehave or break the rules: verbal de-escalation or room confinement. Needless to say, this undermines the whole purpose of having graduated consequences. This is not to say that all staff at CCJDC believe there are only two options for them, but the fact that some staff feel this way means that the system is inconsistent across the facility, at times overly harsh, and therefore ineffective.

CCJDC Policy No. 14.1 on "Rules of Conduct, Rule Violations and Behavior Management" is inconsistent with the list on page 13. It provides for verbal warning, privilege loss, and room restriction as responses to minor rule violations. The policy was apparently last updated in 2013. It should be revised to reflect the broader range of responses listed on page 13 of the Guidelines. Policy 14.1 also provides for "group restriction," i.e., room confinement for the whole unit. Group restrictions are inevitably unfair because they punish youth who did not engage in misconduct along with those who did engage in misconduct. Group restrictions should be eliminated from CCJDC policy.

> **Recommendation:** Revise the Behavior Management Program so that youth can move from Orientation to Level 1 within two days.
>
> **Recommendation:** Revise the program to allow youth to move to the next level within two or three days if their behavior meets the requirements.
>
> **Recommendation:** Simplify the program by basing it on fewer points and fewer staff assessments during the day.
>
> **Recommendation:** Re-title the document to include "rules for resident behavior" or something similar.
>
> **Recommendation:** Revise staff training and other aspects of facility operations to ensure that practice follows policy.
>
> **Recommendation:** Revise CCJDC Policy 14.1 to include additional guidelines for addressing misbehavior and to delete provisions for group restriction.

One other aspect of the behavior management program warrants comment. Quality Assurance staff worked with a committee including unit staff for a year to negotiate the details of the program. While it is completely appropriate to develop such a program through participation by QA and a variety of staff, it would be a disservice to both youth and staff at CCJDC to require

another extended period to make the necessary revisions. The behavior management program should be the engine that promotes good behavior by youth at the facility. The revisions should be made, and youth and staff should be notified of the changes (and staff trained on them) as quickly as possible.

> **Recommendation:** Consider revision of the behavior management program a very high priority for facility operations.

5. Programming.

As noted above, the facility should provide a full day of schooling every weekday, as well as other structured activities during the day. Youth who are engaged in organized activities throughout the day are much less likely to misbehave or get into confrontation situations. The assessment team observed several examples of outside programming for youth in the units, but also observed long periods when youth were idle or playing cards or other games.

> **Recommendation:** Provide a full day of school and additional structured programming throughout the day in every unit in the facility.

6. Individualized behavior plans.

For youth who are repeatedly disruptive, an individualized special management plan is an important strategy to address the problem behavior. Behavioral health clinicians must be involved in the development of such plans, since they have the specialized training and experience to address the behavioral problems. Unfortunately, as noted above in the mental health section of this report, at CCJDC the behavioral health staff are not involved in the development of individualized treatment/service plans. Social workers and unit managers develop service plans following Care Team meetings, but behavioral health staff do not participate in those meetings or in the development of the plans.

> **Recommendation:** Involve the behavioral health clinicians in developing effective individualized treatment/service plans for youth who repeatedly engage in disruptive behavior.

DISCIPLINE

The description of the facility's behavior management system in the Programming section of this report and the associated recommendations capture many of the team member's concerns regarding facility discipline. One additional concern was the lack of timely due process for youth who are charged with violating facility rules. The facility's post orders provide that youth should receive a hearing for certain rule violations "as soon as possible but not to exceed 7 days after the alleged incident." This is a much longer time than many facilities allow to pass between an incident and a disciplinary hearing. Indeed, the facility had scrapped its due process policy because youth were held in their rooms prior to their hearing, which meant that youth were being punished prior to a hearing to begin with.

An effective and fair behavior management system must incorporate timely due process procedures. The team was encouraged that a Due Process manager had been appointed to manage this process in between the team's first and second visits.

> **Recommendation:** Ensure that youth receive timely hearings prior to any assigned punishment for serious rule violations, and ensure that those hearings comply with the due process requirements outlined in the JDAI standards.

GRIEVANCES

An effective grievance system is a critical component of juvenile facility operations. A grievance system acts like a pressure escape valve for youth at the facility: the more youth believe that the grievance system will address their concerns, the less likely they are to become frustrated and confrontative. At the time of the assessment, the grievance system at CCJDC was ineffective and potentially counter-productive. The boxes available for youth to submit grievances were made of clear plastic, so that anyone passing by could see the writing and potentially the names on grievances. Thus, confidentiality, which is necessary to an effective system, was not maintained. In addition, grievances were not collected on a daily basis, and often sat in the grievance boxes for a week or longer. A review of the 205 grievances provided to the team revealed that responses took one week or longer for 45% of the grievances.

Youth told members of the assessment team that they did not have any faith in the grievance system. In the grievances submitted, youth repeatedly raised issues in certain areas. For example, 22 of the grievances were about medical care, 22 were about unfair consequences imposed on youth by staff for alleged misbehavior, and 21 were about communication conflicts between youth and staff. Of course, the filing of a grievance does not mean that the grievance is sustained: some young people may exaggerate in their grievances, some may intentionally misrepresent what happened, some may misunderstand a rule or policy, and some may file grievances to get specific staff in trouble. However, in an effective grievance system, in addition to investigating individual grievances, repeated grievances about particular policies, practices, or staff should trigger concern and a broader investigation by facility administrators. Finally, during the first on-site visit by the assessment team, some staff intentionally acted to interfere with the ability of assessment team members to review grievances.

The CCJDC Director has made some valuable changes since the assessment team's first on-site visit. The clear plastic grievance boxes have been replaced so that grievances cannot be read by anyone passing by. The employees who tried to hide grievances from the assessment team have been disciplined. The Director has named a new Grievance Coordinator to address the deficiencies in the system.

> **Recommendation:** Revise the grievance system so that policies and practices meet the JDAI standards. Keep all information about grievances confidential. Provide responses to youth who submit grievances within three business days. If an investigation is not complete by then, advise youth of the status of the investigation and when the investigation is expected to be completed.

Recommendation: Conduct serious and meaningful investigations of individual grieved incidents. When there are multiple grievances about particular policies, practices, or staff, determine whether broader administrative action is warranted.

Recommendation: Collect and maintain data on grievances submitted, including youth submitting the grievance, date submitted, subject of the grievance, staff member(s) identified in the grievance, findings of the investigation, date youth was notified of the results of the investigation, and any action taken. Provide this information in aggregated form at least quarterly to the Director and Deputy Directors of the facility, all jurists at CCJDC, the Court Administrator, Quality Assurance staff, and others who are responsible for policies and practices that are the subject of grievances (e.g., the chief cook if there are grievances about food).

SAFETY

Although safety is the last section of this assessment tool, physical and emotional safety for youth and staff is the overarching principle underlying all of the other sections. This section identifies the facility's responsibilities to protect youth and staff, respond quickly and appropriately when incidents occur, provide support to alleged victims, and investigate allegations of misconduct.

As we have described throughout this report, a combination of factors has led to conditions and practices that raise safety concerns for youth and staff. This is not to imply that the administrators in charge of facility safety and security are ignoring safety issues or taking their responsibilities lightly. To the contrary, it was these individuals who recognized the severity the challenges confronting the Juvenile Justice Center, as well as shortcomings that warranted immediate attention.

For example, the team learned that the facility was in the process of obtaining an upgrade to its video monitoring system, which is needed given the limits on detail that can be obtained from video footage.

> **Recommendation:** Secure needed upgrades to the video monitoring system at the facility.

The team had other concerns, many of which are also outlined in other parts of this report, related to youth and staff safety, investigations, and the facility's efforts to prevent, detect, and respond to sexual misconduct.

YOUTH AND STAFF SAFETY

As mentioned in the introduction and other sections of this report and noted in the JDAI checklist, the team had concerns about the safety of youth and staff at the facility. We do not restate those details here, except to say that those findings and observations impact the facility's compliance with the JDAI standards in this area.

Chief among these findings is around the lack of timely multidisciplinary team meetings to review incidents at the facility to understand what went wrong, and what could be done differently next time. The team understands that some level of review of incidents does occur, but the documentation reviewed showed significant delays from the times of incidents to documentation of administrator review. Additionally, the definition of "critical incident" in policy that triggers a more comprehensive review is narrow and does not provide for review of other types of incidents that could reveal insights about changes that could improve safety for youth and staff.

> **Recommendation:** Convene multidisciplinary teams comprised of facility administrators, mental health professionals, direct care staff, and others to review critical incidents and identify recommended changes to policy, practice, or training that could improve safety of the facility.

Recommendation: Broaden the definition of "critical incidents" that trigger a more comprehensive review process.

Recommendation: Ensure that administrators review incidents in a timely manner (e.g., within two business days of an incident).

Additionally, at the time of the team's first visit, facility officials had implemented Alert Response Officers to respond to incidents and altercations that occur at the facility. These teams were designed to help de-escalate and manage fights and other confrontations that arise by providing staff members with additional staff support on an on-call basis. While teams such as these have been used to help manage situations well in other facilities, the implementation of the teams appears to have generated confusion around staff members' ability to restrain youth prior to the arrival of the Alert Response Officers. Additionally, some staff stated a reluctance to use restraints out of fear of being subjected to a child abuse report and investigation. Other staff stated that they felt ill-equipped to manage youth behavior using their current skill set.

Recommendation: Clarify when staff members can and should use physical restraints during incidents, particularly given the introduction of Alert Response Officers.

Recommendation: Provide staff with additional training to help build skills and confidence in managing youth behavior through verbal de-escalation techniques and through strategies to work with youth with mental health needs and trauma histories.

Recommendation: Partner more intentionally with mental health staff to develop plans to help work with youth who demonstrate chronically disruptive behavior.

Finally, the facility does not have an undue familiarity policy or policy that addresses communication with youth when released from the facility, including via social media. Such a policy is needed, particularly given the proliferation of social media as a means of communication.

Recommendation: Develop an undue familiarity and social media policy that addresses staff member responsibilities for and restrictions on communication with youth following youths' release from the Juvenile Justice Center.

INVESTIGATIONS

The team had two primary concerns with respect to investigations into allegations of inappropriate behavior of staff.

The first area of concern, mentioned in the section above, is the timeliness of response to some grievances. The team reviewed many grievances with 10 days or more between the date filed and the official response. A timely response to all grievances is necessary to ensure that reports of abuse and neglect are identified and addressed right away. It is also necessary for youth to see that the grievance process is a process that will respond to any concerns that they have. As

mentioned earlier, many youth had been released by the time their grievances were reviewed, with little or no documentation of any follow up on those grievances.

> **Recommendation:** Ensure that all grievances receive a timely response according to the timeframes outlined in the JDAI standards.

> **Recommendations:** Ensure that policy, procedure, and actual practices require retrieval and review of grievances each day, regardless of whether the designated grievance officer is on duty.

Second, it was not clear that all grievances that alleged improper staff behavior resulted in an investigation into that alleged behavior. This problem, discussed in more detail above, is particularly problematic given the nature of some of the conduct alleged to have taken place by staff. Moreover, it was not clear that mandatory reporting occurred for all grievances alleging staff misconduct that potentially rose to the level of child abuse or neglect. The assessment team does not have expertise in Ohio's mandatory reporting laws, but the team strongly encourages a review of the reporting responsibilities and an alignment of policies and practices with those requirements.

> **Recommendation:** Ensure that officials fully investigate grievances involving alleged staff member misconduct, document the outcomes of those investigations, and take appropriate remedial actions.

> **Recommendation:** Review Ohio's mandatory reporting laws and ensure that any grievances alleging staff misconduct rising to the level of abuse or neglect is reported as required.

PREVENTION, DETECTION, AND RESPONSE TO SEXUAL MISCONDUCT

The Juvenile Justice Center has undertaken initial work to comply with the federal Prison Rape Elimination Act (PREA) standards for juvenile facilities. The team was pleased to hear that administrators had begun training staff on sexual misconduct prevention, detection, and response practices, and that the facility had a policy on prevention, detection and response to sexual abuse and sexual harassment.

Administrators recognized that the facility still has many steps to undertake in order to fully implement the PREA standards and operationalize a comprehensive approach to sexual misconduct prevention, detection, and response. Rather than outline all of the needed steps for the facility to become PREA compliant, the team emphasizes the importance of three particular areas.

First, to the extent that the grievance system serves as a vehicle for reporting sexual abuse or sexual harassment, officials must ensure that the grievance process includes the requirements for reporting mechanisms outlined in the PREA standards. In addition to the other recommendations for the grievance process outlined in this report, officials must ensure that grievances are investigated fully, even if a young person has been released, and that referrals are made to

appropriate authorities where grievances allege conduct that rises to the level of reportable abuse or criminal activity. The grievance process cannot require youth to attempt to resolve grievances involving alleged sexual abuse, nor can it establish time limits for reports of alleged sexual abuse – both of which the current process does.

> **Recommendation:** Ensure that the grievance policy and actual practices provide for investigation of all grievances alleging sexual abuse or sexual harassment, even if a youth has been released from the facility.

> **Recommendation:** Ensure that any grievance alleging sexual abuse or sexual harassment that would constitute child abuse or criminal conduct is reported to appropriate authorities.

> **Recommendation:** Eliminate the requirement to attempt informal resolution of grievances involving sexual abuse and eliminate the requirement of filing a grievance within five days for any alleged incident of alleged sexual abuse.

Second, youth receive some basic information about reporting sexual abuse and sexual harassment through the resident brochure, but the facility does not have a PREA-compliant system for youth education about sexual misconduct prevention, detection, and response at admission and within 10 days of admission. There are many examples of developmentally appropriate youth education materials that convey the key messages about the right to be safe, the ways to report a problem, and the right to be free from retaliation from reporting. For example, the palm card below from New York City's Administration for Children's Services and the handout from the Indiana Division of Youth Services are much more engaging, easy to understand, and developmentally appropriate. We recommend working with young people at the facility to develop more visually engaging and age-appropriate youth education materials.

> **Recommendation:** Develop engaging youth education materials that use simple language and that focus on key messages and information. Involve youth in the creation of these materials.

You have the right to...

- Be safe and supported!
- Get help if someone is doing or saying things that make you uncomfortable.
- Ask for help without being punished or bothered by anyone.
- See someone from medical or mental health.

Krystal

No adult or other youth should...

- Touch any of your private parts.
- Stare at you while you are changing clothes, showering, or using the bathroom.
- Do or say things about your body or the way you act that make you feel uncomfortable or unsafe.
- Bother you because of who you date or how you look or act.
- Ask or force you to kiss them or touch them in a sexual way.

Pablo

How can I get help?

- Ask a staff member to help you call the Justice Center at 1-855-373-2122. You don't have to tell the staff member why.
- Ask your lawyer, a friend, or family member to request help for you.
- Tell any adult you trust, including staff.
- Write down what's going on and give it to any adult.
- You don't even have to share your name or the name of the person who is hurting you if you don't want to.

How can I support someone who is being bullied or hurt?

- You can ask for help for them.
- You can be a friend to them.

Where can I get more information?

- You can learn more about keeping yourself and others safe by talking to your caseworker or the ombudsman.

DON'T FORGET your safety is really important and being threatened or afraid is not part of detention!

NYC Administration for Children's Services

STAYING SAFE AT INDIANA DYS

Everyone has a right to be safe and supported during their stay with DYS. Here are some tips to help you do that.

YOU HAVE RIGHTS

You have the right to be safe while here. That means being free from any kind of physical, sexual, or emotional abuse and harassment– either either by youth or by staff. These kinds of things are **never allowed**, and we take it seriously if we hear about it.

WHAT'S NOT ALLOWED

We expect all staff, other adults, and youth to follow the same rules. That means nobody should ever:

- Do or say things about your body that make you feel uncomfortable or unsafe
- Bother you because of who you date or like, how you look or act, or what your charges are
- Expose their private parts to you
- Ask you to expose your private parts outside of proper searches
- Touch any of your private parts
- Ask you to kiss our touch them in a sexual way
- Demand sex in exchange for offers of protection, favors, or special treatment
- Tell you that you will be punished or hurt if you report a problem

WE TAKE ALL REPORTS SERIOUSLY

If we see or hear about any of the things above, we will it seriously and conduct an investigation. If we find that youth or staff did any of these things, they will be punished. If someone has threatened or hurt you, we will separate you until we can investigate.

TIPS ON STAYING SAFE AT DYS

Everyone has a right to be safe and supported during their stay with DYS. Here are some tips to help you do that.

REPORT ANY PROBLEMS

If someone is doing or saying things that make you uncomfortable, report it right away by:

- Telling any staff member
- Telling another adult you trust, like family member or attorney
- Filing a grievance
- Calling #22 from any phone or dialing 1-877-385-5877
- Clicking "Sexual Abuse Report" on the JPay kiosk

You can keep your report confidential, and you do not have to tell anyone why you are making a report.

NO RETALIATION ALLOWED

Nobody is ever allowed to bother you for making a report or helping with an investigation. We have staff watching to ensure nobody gives you a hard time for speaking up. Anyone who does will be punished immediately.

RIGHT TO TREATMENT AND COUNSELING

If you are injured or require medical or mental health care, you have a right to receive it free of charge. We have people who have special training to work with victims of abuse, and any sessions will be confidential.

QUESTIONS?

If you have any questions, talk to any staff member or supervisor here at any time.

Additionally, the facility has little information posted about youth's right to be free from sexual abuse and sexual harassment, the right of young people to report and how to report a problem, and available resources for survivors of sexual misconduct.

> **Recommendation:** Post the information outlined above on living units and in other places throughout the facility.

Third, facility officials indicated that Cleveland Rape Crisis would provide rape crisis counseling and victim advocacy services to youth who alleged to have been victims of sexual abuse, but the facility does not have a written memorandum of understanding or agreement with the organization to provide those services.

> **Recommendation:** Develop an MOU that outlines roles, responsibilities, and expectations regarding rape crisis and victim advocacy services.

FINAL RECOMMENDATIONS

The assessment team was aware of many of the challenges facing the Juvenile Justice Center prior to our visit, several of which have been long-running issues at the facility. Our experience on-site puts the seriousness of some of these problems into a sharper perspective.

Juvenile Court and facility leadership should be applauded for undertaking this review, which involved a close and comprehensive look at current practices as compared with the most demanding national standards for juvenile detention facilities. Leaders understood that this assessment would identify and report on problems in a number of areas, yet these leaders also recognized the need to identify those problems and the recommendations that will help set the facility on a better path.

The challenge now is for Juvenile Court, facility leadership, and service providers within the facility to work together on the steps that will result in the biggest and most important improvements for young people and staff at the Juvenile Justice Center. We have outlined below our recommendations for the eight short-term goals that the team believes must be achieved in order to implement the other recommendations outlined in this report.

The team recommends the creation of a multi-disciplinary committee to plan and oversee these reforms. The team should meet at least monthly and should be comprised of representatives from Juvenile Court, facility leadership, education, mental health, and direct care staff and supervisors. The problems outlined below have been long-standing and difficult to tackle. Given the scope of the issues outlined below, no one group can or should be solely responsible for the solutions. Moreover, the responsibility for the conditions and practices at the Juvenile Justice Center is shared among the groups listed above. It will take a joint effort these groups to develop and implement an action plan in each of these areas. The team would be happy to assist any committee that is formed with these activities.

1. **Priority:** Resume a school schedule for all youth that meets the minimum required minutes of educational instruction required under Ohio law (including piloting alternative classroom arrangements that would allow for students to attend a full school day), and resume a full schedule of recreational and other programming for youth.

2. **Priority:** Implement an incentive-based behavior management system that reflects the recommendations outlined in this report and develop an oversight mechanism to ensure the system is being implemented in a fair and consistent manner.

3. **Priority:** Identify and introduce new training for staff designed to provide insights about the young people at the Juvenile Justice Center that will counter the perception of youth as irredeemable criminals. Prioritize training on strategies specific to working with adolescents, effective verbal and non-physical de-escalation techniques, and strategies for working with youth with mental health needs and trauma histories.

4. **Priority:** Track the use of room confinement by housing units and begin to identify ways of reducing its use for administrative purposes, perceived staffing shortages, and group

punishment.

5. **Priority:** Restructure leadership responsibilities within facility administration and Juvenile Court to assign clear responsibilities for (1) programming, including access to education, recreation, and other programming opportunities; (2) behavior management, including implementation of an incentive-based behavior management system and development and implementation of individualized behavior management plans for disruptive youth in collaboration with mental health professionals; (3) safety, including staffing levels and facility transportation; (3) grievances and investigations, including guaranteeing a timely investigation and response to youth grievances; and (4) training, with a focus on identifying and delivering training specific to working with adolescents, effective verbal and non-physical de-escalation techniques, and strategies for working with youth with mental health needs and trauma histories.

6. **Priority:** Make changes to the environment within the Juvenile Justice Center to convey a more positive and pleasant space for youth and staff to interact. Specifically, introduce murals and artwork on housing units and in other parts of the facility, and replace prison-style jumpsuits with school-style uniforms.

7. **Priority:** Conduct a length of stay analysis to identify delays and other issues in the juvenile justice process that are contributing to longer lengths of stay than are necessary. Identify strategies to reduce length of stay, which can help significantly reduce the number of youth at the facility.

8. **Priority:** Ensure that the officials use and follow recommendations from the detention screening instrument, and ensure that youth are not admitted to detention solely to "clear" them for medical and mental health issues.