

JUNE 2019

# NOT IN ISOLATION

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HOW TO REDUCE ROOM CONFINEMENT  
**WHILE INCREASING SAFETY**  
IN YOUTH FACILITIES



**Stop**  
Solitary  
for Kids

## **ACKNOWLEDGEMENTS**

### **ABOUT STOP SOLITARY FOR KIDS**

Stop Solitary for Kids is a national campaign to end solitary confinement of youth in juvenile and adult facilities in the United States. The campaign is a joint effort by the Center for Children’s Law and Policy, the Center for Juvenile Justice Reform, the Council of Juvenile Correctional Administrators, and the Justice Policy Institute. Stop Solitary for Kids aims to end solitary confinement by working with key decision makers in all three branches of government at the federal, state, and local levels through research, public education, policy reform, improved facility practices, legislative changes, training, and technical assistance. To learn more, please visit our website: [www.StopSolitaryforKids.org](http://www.StopSolitaryforKids.org).

### **CAMPAIGN PARTNERS**

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In 2006, the DYS Clinical Advisory Council endorsed the use of Dialectical Behavior Therapy (DBT), developed by Marsha Linehan (1993), as the therapeutic framework for clinical services in DYS residential programs and developed a DBT Manual for all DYS residential programs.

As part of the DYS DBT Manual, Dr. Sparling wrote "[Dialectical Behavior Therapy as a Behavior Management Approach](#)," which established the fundamentals of DBT practice within the agency and has been used in efforts to decrease the use of room confinement.

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## Executive Summary

In 2016, the Center for Children’s Law and Policy, Council of Juvenile Correctional Administrators, Center for Juvenile Justice Reform at Georgetown University, and Justice Policy Institute launched the Stop Solitary for Kids campaign. The Campaign’s goal is to safely reduce and ultimately end the dangerous practice of solitary confinement for young people in juvenile and adult facilities. Collaboration between stakeholders both inside and outside youth facilities is a key Campaign philosophy. The Campaign works with advocates, lawmakers, state and local government official, state juvenile justice agency directors, superintendents of state and local juvenile facilities, parents, youth, and community leaders to highlight effective strategies to reduce and eliminate solitary confinement.

There is widespread and growing awareness of the harms and ineffectiveness of solitary confinement within the youth justice field and among the public at large. The practice – alternatively described as “room confinement,” “isolation,” “separation,” or “seclusion” – is the involuntary placement of a youth alone in a room or other area for any reason other than as a temporary response to behavior that risks immediate physical harm. As demonstrated throughout this publication, the harms of solitary confinement are experienced most acutely by youth with mental illness, youth with trauma histories, youth of color, and LGBTQ and gender non-conforming youth.

Not in Isolation is a practical guide to help leaders and agencies develop roadmaps to reducing room confinement in their facilities. Because there are multiple existing resources documenting the negative effects of room confinement on youth and staff, Not in Isolation instead focuses on ways to avoid and prevent the practice of room confinement altogether.

### **ANSWERING THE QUESTION: “IF NOT ROOM CONFINEMENT, THEN WHAT?”**

As national developments and standards call for limits on the use of room confinement, the challenge of implementation falls largely on state and local facilities. In 2015, the Council of Juvenile Correctional Administrators published the [Toolkit on Reducing Isolation](#), which outlined several core strategies for reducing room confinement. However, throughout the Campaign’s work, agency directors and facility superintendents ask additional questions such as, “How can I reduce room confinement while keeping youth and staff safe?” and “How have other facilities like mine started this process?” Many administrators want information on effective strategies to reduce room confinement *and* real-world examples of how to implement strategies in practice.

This first-of-its-kind publication tells the stories of how three state agencies and one county sheriff’s department operating a juvenile detention facility undertook efforts to safely reduce the use of room confinement: Colorado Division of Youth Services; Massachusetts Department of Youth Services; Oregon Youth Authority; and Shelby County Sheriff’s Department in Memphis.

## NOT IN ISOLATION IS A PRACTICAL RESOURCE. EACH CHAPTER INCLUDES:

- Perspectives, quotes, and examples from facility and agency staff;
- Sample policies, forms, tools, and other materials; and
- Details from each site about challenges, lessons learned, and results (qualitative and quantitative).

While none of the jurisdictions featured in this publication are perfect models, they achieved measurable reductions in the frequency and duration of room **CONFINEMENT**. *Not in Isolation* includes data from each jurisdiction to show that it is possible to reduce room confinement without increasing violence in a facility. Moreover, shifting youth justice facility practices away from punitive isolation and toward models that focus on emotional regulation and behavioral skills helps youth successfully transition back into their communities.

The title of this publication reflects that understanding that reforms related to room confinement do not occur in isolation from other aspects of facility operation. Reducing room confinement is inseparably related to changes in staffing, training, mental health services, programming, behavior management, and other factors.

## WHY NOW IS THE TIME TO REDUCE ROOM CONFINEMENT

Room confinement has recently been catapulted into the national spotlight due to a convergence of mainstream media attention, litigation, legislation, policy developments, and investigative reports. As awareness about room confinement grows, so does public scrutiny and legal jeopardy for jurisdictions that continue the practice unchecked. It is more critical than ever that youth justice facility and agency administrators develop alternatives to room confinement consistent with evolving best practices, professional standards, and an understanding of adolescent development. Several recent developments highlight the urgency to reduce room confinement for facilities that house young people:

- Federal courts in four states have entered orders against facilities for putting **YOUTH IN ISOLATION, RESULTING IN HUNDREDS** of thousands of dollars in litigation costs.
- Legislation in seven states in the past three years has limited the use of isolation in youth facilities. Several other states are currently considering similar legislation.
- In December 2018, Congress passed bipartisan legislation to limit isolation called the [First Step Act](#), which permits isolation only when there is an immediate physical harm – never as a sanction or punishment – for youth in federal custody.
- In 2018, Congress also reauthorized the [Juvenile Justice and Delinquency Prevention Act](#) (JJDP), which requires states to provide data on the use of isolation and describe their strategies to reduce its use.

## HOW TO USE THIS PUBLICATION

This report can be used by youth justice system administrators, supervisors, staff, practitioners, and advocates, as well as policymakers and other key stakeholders, to:

1. Provide concrete examples of how several jurisdictions have reduced room confinement;
2. Give practical guidance on how to translate strategies to reduce room confinement into practice;
3. Generate new ideas about how youth facilities and agencies can successfully reduce room confinement;
4. Encourage comprehensive efforts to reduce room confinement that focus on multiple areas of operation (behavior management, training, staffing, mental health) to improve overall outcomes for youth and staff;
5. Provide credible perspectives from staff and administrators on why and how to reduce room confinement;
6. Highlight the need for state and local youth facilities to reexamine and change their use of room confinement;
7. Demonstrate that it is possible to reduce room confinement in a diverse range of youth facilities without sacrificing staff safety. This includes facilities and agencies with large youth populations, detained and committed youth, older youth, youth charged as adults, and youth with violent charges; and
8. Develop a better understanding of the resources, time, and supports necessary for facilities to create lasting reductions in room confinement.

## TAKEAWAYS ON REDUCING ROOM CONFINEMENT

*Not in Isolation* demonstrates that there are multiple paths to reducing room confinement. Each jurisdiction was driven to reduce room confinement by different external and internal circumstances, and each used a slightly different approach to achieve success. However, there are several common strategies and lessons learned:

- Structure efforts to reduce room confinement around a central principle or approach that connects policies, practice, and culture.
- Include staff in planning, developing, and implementing changes.
- Provide strong leadership committed to reducing room confinement despite setbacks and challenges.
- Create a communication plan to message changes in room confinement to staff.
- Prepare administrators, supervisors, and senior staff to explain why reducing room confinement is the right thing to do.
- Understand the use of room confinement in relation to other aspects of facility operation, (e.g.

level of staffing, programming for youth, adequacy of staff training, utilization of mental health professionals, and effectiveness of the behavioral management systems).

- Use data to identify problem areas and create targeted solutions.
- Prioritize positive relationships between staff and youth as a tool to maintain safety.
- Redefine alternatives to room confinement as proactive interventions (versus reactive approaches of waiting until behavior has escalated to the point of requiring room confinement).
- Develop tools and practices to help youth exit room confinement as quickly as possible.
- Be prepared to make a case for additional resources by documenting your current practice, progress, results, and needs.
- Leverage external relationships with unlikely allies.

## HIGHLIGHTS FROM EACH JURISDICTION

### COLORADO DIVISION OF YOUTH SERVICES

1. Developed an organizational model to change agency culture and improve practices;
2. Used the legislative process to request additional staffing resources;
3. Implemented an incentive-based behavior management system;
4. Remodeled physical environments to align with principles of adolescent development and rehabilitation; and
5. Relied on regular data analysis to steer reforms.

### MASSACHUSETTS DEPARTMENT OF YOUTH SERVICES

1. Integrated Dialectical Behavior Therapy (DBT) into the behavior management system and living unit management;
2. Redefined accountability based on skill-building – rather than punishment – to change behavior;
3. Identified positive youth-staff relationships as a critical tool for facility safety;
4. Developed “exit strategy” guidelines to help youth transition out of room confinement quickly;
5. Created individual support plans for youth who continuously acted out or could not respond to programming.

### SHELBY COUNTY JUVENILE DETENTION CENTER

1. Implemented daily circle-up groups;
2. Enhanced staff training on how to work with youth and Safe Crisis Management;
3. Established a standardized review of videos and documentation of room confinement incidents;

4. Hired an additional staff to enhance programming and volunteer activities; and
5. Relied on assistance and examples from consultants (including other facilities).

### **OREGON YOUTH AUTHORITY**

1. Changed culture before changing policy;
2. Developed a culture based on Positive Human Development (PHD);
3. Used data strategically to create Skill Development Counselors and specialized units;
4. Leveraged the political process to secure funding; and
5. Created a 10-Year Plan that included redesigning physical plants to support alternatives to room confinement.

## **SECTIONS OF THE REPORT**

### **CHAPTERS ON FOUR JURISDICTIONS**

Each chapter describes how a jurisdiction reduced room confinement over time.

### **HIGHLIGHTS AND KEY EXAMPLES**

*Not in Isolation* also includes section headings, bullet-pointed guidelines, images, and graphics to direct practitioners to specific areas of interest. Each heading contains links to useful policies, forms, and examples.

### **APPENDIX OF RESOURCES AND TOOLS FROM EACH JURISDICTION**

This publication includes a section listing resources (policies, forms, training materials, and videos) from each jurisdiction.

### **APPENDIX OF QUOTES FROM ADMINISTRATORS AND STAFF**

*Not in Isolation* tells the story of each jurisdiction through the insights and experience of administrators and staff. The publication contains an appendix of quotes from these individuals.

## Introduction

In 2016, the Center for Children’s Law and Policy, Council of Juvenile Correctional Administrators, Center for Juvenile Justice Reform at Georgetown University, and Justice Policy Institute launched the [Stop Solitary for Kids campaign](#). The Campaign’s focus has been to safely reduce and ultimately end the dangerous practice of solitary confinement for young people in juvenile and adult facilities. The Campaign currently has the [support of over 50 national professional associations](#), including associations representing youth justice agencies and facility directors, medical and mental health professionals, advocates, and others.

There is widespread and growing awareness of the many harms of solitary confinement within the youth justice field and among the public at large. This includes a recognition that the different terms that are used to describe solitary confinement—“room confinement,” “isolation,” “separation,” “segregation”—all describe the same thing. This publication refers to the practice either as room confinement, isolation, or by the term used in the jurisdiction described. What matters, and what is harmful, is the practice of involuntarily placing a youth alone in a room for any reason other than as a temporary response to out-of-control behavior that threatens immediate harm to the youth or others. Once the youth calms down, the youth should be released from his or her room and returned to regular programming.

In the years since the Campaign’s launch, many [state and local jurisdictions](#) have [taken significant steps](#) to reduce or end the use of room confinement through legislation, litigation, or policy changes. In December 2018, Congress took an important step toward ending youth isolation by passing the bipartisan [First Step Act](#), which prohibits facilities that house youth in federal custody from using isolation as punishment and permits isolation only when youth behavior poses a risk of immediate physical harm that cannot otherwise be de-escalated. In 2018, Congress also reauthorized the [Juvenile Justice and Delinquency Prevention Act](#) (JJDP), which now requires states to provide data on the use of isolation and describe their strategies to reduce its use.

When we work with agency directors and facility superintendents to reduce solitary, the first question we are asked is, “How can I reduce room confinement while keeping youth and staff safe?” In this first-of-its-kind report, we provide detailed case studies of how four jurisdictions undertook efforts to safely reduce the use of isolation. As readers will see, reforms related to room confinement did not occur in isolation. They required a comprehensive look at staffing, training, mental health services,

**I** f the clinicians are just writing up an ISP and telling people what to do, it will fail. If you get everyone’s input, there is more follow-through and buy in. All of this stuff leads to less room confinement. *Daniel O’Sullivan, Metropolitan Regional Director, Massachusetts DYS*

programming, behavior management, and other factors. While none of the jurisdictions featured in this publication are perfect models, they achieved measureable reductions in the frequency and duration of room confinement through promising practices. And while the impetus for undertaking this work and the particular strategies varied across each jurisdiction, the results were the same: sharp reductions in the use of room confinement along with improved safety for youth and staff.

Unlike previous publications, this report does not detail the harms of room confinement. Those have been widely documented and accepted by youth justice professionals, and we provide references to that literature. This report provides practitioners with concrete, practical, and effective tools and strategies in the context of real-world reforms. It also provides public officials, parents, and other advocates for youth with examples of success and models that they can work to adopt in their own communities. Ending room confinement for young people is no longer a distant dream; it has been achieved in a variety of settings and facilities in different parts of the country, and the lessons learned here can be applied to any juvenile facility seeking more humane treatment of youth in custody.



Photo credit: Richard Ross

# NOT IN ISOLATION

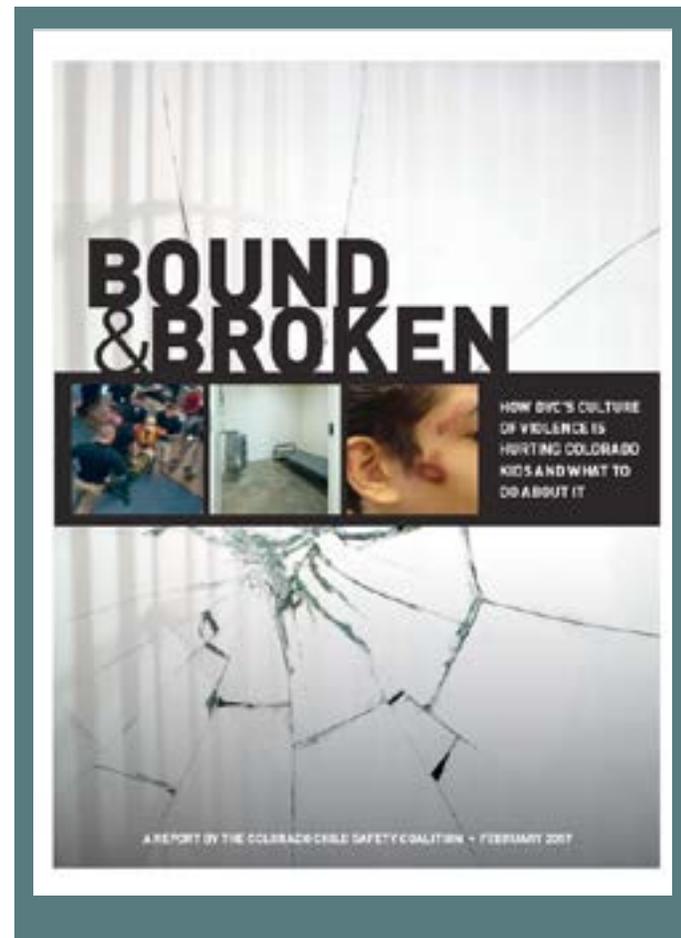
HOW TO REDUCE ROOM CONFINEMENT  
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IN YOUTH FACILITIES

**COLORADO DIVISION  
OF YOUTH SERVICES**

## Bound and Unbound: Colorado's Efforts to Reduce Isolation

### IMPETUS FOR CHANGE

On March 2, 2017, the Colorado Child Safety Coalition released a report, [Bound and Broken: How DYC's Culture of Violence is Hurting Colorado's Kids and What to Do About It](#), which painted a picture of regular and violent abuse of young people in facilities operated by the Colorado Division of Youth Corrections (DYC). The report was based on interviews with youth who were or had been in 11 of the state's 13 juvenile justice facilities (10 operated by DYC), a review of over 1,000 pages of internal DYC documents, and videos and medical reports of incidents between 2013 and 2016. It found that fights and assaults in DYC facilities increased 42% between 2013 and 2016, that DYC staff physically restrained youth at least 3,611 times from January 2016 through January 2017, and that staff placed youth in solitary confinement 2,240 times during the same period. This happened while the number of young people held in DYC facilities *decreased* and staffing and funding for the facilities *increased*.



The report also found that DYC staff commonly used “pain compliance” techniques including knee strikes and pressure points. Perhaps most concerning, the report included photos that documented a full body physical restraint device known as the WRAP, which was similar to a straitjacket. DYC staff put young people in the WRAP at least 253 times from January 2016 through January 2017. The report included photos and quotations from youth who had been subjected to the painful practices.

The report recommended prohibiting the use of the WRAP, the pain compliance techniques, and the use of solitary confinement. It also recommended adopting the “Missouri model” of small facilities with homelike environments and strong positive relationships between youth and their peers and between youth and staff.

At the time of the report, Anders Jacobson was newly appointed as the Director of DYC (and continues in that position today). Concerns about mistreatment of youth in DYC facilities were not new to him. In fact, he had been appointed temporary director of DYC in September 2016, when the former director left his position following reports of violence in the Spring Creek Youth Services Center, a DYC facility in Colorado Springs. Three months later, in December 2016, Jacobson was formally appointed to the director position.

The concerns also were not new to members of the Colorado Child Safety Coalition: the ACLU of Colorado, Disability Law Colorado, the Colorado State Public Defender, and the Colorado Juvenile Defender Center (CJDC). In June 2014, the ACLU, Disability Law, and CJDC notified the Executive Director of the Department of Human Services, who oversaw DYC, that youth in DYC facilities had been placed in seclusion for days, weeks, and longer, as a form of “treatment.”<sup>2</sup> By July 1, 2014, DYC agreed to stop using seclusion in a punitive way. However, on October 4, 2015, the Colorado Springs Gazette reported that, based on a review of DYC records, 299 youth had been placed in isolation since DYC changed its policy.<sup>3</sup> The Gazette article highlighted the story of a 14-year-old boy who spent 22 days in seclusion, often for 23 hours a day, at Spring Creek. That month, DYC [updated its policy](#)<sup>4</sup> to limit the use of seclusion to emergency situations, which were defined by statute as situations involving “a serious, probable, imminent threat of bodily harm.”<sup>5</sup> Generally, seclusion was limited to four hours, but could be extended if the emergency continued.<sup>6</sup>

## STATE LEGISLATION

In May 2016, with strong support from the Child Safety Coalition, the Colorado legislature approved [HB16-1328](#),<sup>7</sup> a bill to strengthen protections for youth in state-run facilities with respect to restraint and seclusion. The new law codified into statute the Division’s policy that seclusion could never be used as punishment, sanction, retaliation, or as part of a treatment plan. The bill limited seclusion to emergency situations when “a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm.”<sup>8</sup> The bill prohibited the use of isolation for more than four hours unless a prescribed protocol was followed, including examination by a mental health professional, and prohibited isolation for more than eight hours in two consecutive days without a court order. HB16-1328 also established the Youth Seclusion Working Group to advise DYS on policies, procedures, and best practices related to seclusion and alternatives to seclusion.<sup>9</sup>

### Requirements Established by HB16-1328

- Seclusion could never be used as punishment, sanction, retaliation, or as part of a treatment plan;
- Limited seclusion to emergencies when “a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm;
- Required increasing approval at four and eight hours;
- Created a statewide Youth Seclusion Working Group to review data and make recommendations on reducing seclusion and restraints.

## LIMITED STAFF

In late 2016 and early 2017, Jacobson hoped that increasing the number of staff—and thereby decreasing staff-to-youth ratios and improving supervision—would improve the situation. The ratio at that time was 1:11, while the national standard and accepted practice in the field was 1:8.<sup>10</sup> Governor

John Hickenlooper requested \$5 million to add 80 full-time employees to DYC, and another \$3 million for enhanced mental health and physical health care.<sup>11</sup> At the time, the agency only received funding for a portion of the requested staff positions. However, with continued legislative advocacy, the agency eventually received funding necessary to maintain a 1:8 ratio.<sup>12</sup>

The Bound and Broken report was a wake-up call. DYC had previously begun reforms, including limiting the use of seclusion by policy and training staff in a trauma-responsive approach. However, the Bound and Broken report made it clear that more effort was needed. In May 2017, again with strong support from advocates, the legislature passed a new bill, [HB17-1329](#), designed to bring about major culture change in DYC facilities.<sup>13</sup>

The Missouri Youth Services Institute,<sup>14</sup> led by former Missouri DYS Director Mark Steward, was brought in as a consultant on the pilot project.

## ENCOURAGING RESULTS

Within a year there were important developments. In November 2017, DYS issued [a formal policy](#)<sup>15</sup> (which it amended in 2018), defining the criteria and limits for use of involuntary seclusion in a locked room or area; voluntary youth-initiated time outs (not to exceed 60 minutes, usually in an open area); and staff-initiated time outs (not to exceed 60 minutes, usually in an open area). The WRAP devices were removed from DYS facilities. The staff-to-youth ratios were 1:8 in seven of the 10 DYS facilities.

Staff members were consistently assigned to the same group of youth, allowing the development of stronger relationships between youth and

## Changes Made by HB17-1329

Changed the name of the Division of Youth Corrections to the Division of Youth Services (DYS) (at the request of the Division);

Clarified as its primary mission to focus on rehabilitation;

Established a 20-bed pilot program with a low staff-to-youth ratio to test the effectiveness of a therapeutic group treatment approach and the ability of the Division to keep youth and staff safe without the use of seclusion and restraints other than handcuffs;

Provided additional training to staff of the pilot program as needed;

Called for the integration of trauma-responsive principles and practices into all elements of programming;

Codified the phase-out of physical strikes on youth, pain-compliance and pressure-point techniques, the WRAP, and the use of isolation that the Division had already prohibited via policy;

Expanded the role of the statewide Youth Seclusion and Restraint Working Group;

Required an independent assessment of the Division;

Created community boards in each region of the Division; and

Required extensive documentation of each instance of the use of restraint or seclusion in DYS facilities.

staff. The job title of correctional officers was changed to “youth services specialists.”<sup>16</sup> The job description for the position sought candidates who want to “engage with youth and build positive relationships.”<sup>17</sup> Routine strip searches after family visits were discontinued because they can be traumatic for youth. Strip searches were only conducted if there was probable cause and with approval from facility administration. Youth dressed in school uniform-type polo shirts and khaki pants rather than prison-like hospital scrubs. A number of the units were remodeled, with more homelike furniture, softer colors on the walls, and plants. Metal beds and 3” mattresses were replaced with more homelike beds and 7” mattresses. Simple blankets were replaced with comforters. Jacobson described the reforms as part of the culture change: “It really feeds into our vision of where we are going.”<sup>18</sup>

### Encouraging Progress in Colorado

- Developed new policy on seclusion
- Banned the WRAP
- Stopped routine strip searches after family visits
- Youth clothing switched to polo shirts and pants
- Remodeled units to be more homelike
- Increased staffing
- Changed job title to “youth service specialist” to prioritize positive relationships with youth
- Remodeled units to create less institutional environments and more comfortable beds

### Key Elements of New Seclusion Policy

Seclusion only permitted during an emergency as defined by Colorado Revised Statute 26-20-102(3), or when there is a serious imminent threat of bodily harm and the present ability to cause such bodily harm;

Staff must attempt less restrictive alternatives or determine that such alternatives would be ineffective or inappropriate;

Seclusion may be used only for the period of time necessary to prevent the continuation or renewal of an emergency;

Staff must conduct visual checks at least every 5 minutes;

Staff must conduct a verbal check and try to engage the youth back into programming every 5-15 minutes;

The shift supervisor, direct care staff, and behavioral health staff must meet to discuss a plan to process the youth out of seclusion as soon as possible;

Seclusion may not exceed 4 hours except in rare circumstances involving input from a mental health professional and approval from the Director of DYS;

Seclusion exceeding 72 hours requires a court order; and

Facility directors review a monthly report on seclusions, including the incident leading up to seclusion and the staff members involved.

Equally importantly, seclusion incidents were down from a high of 302 in October 2016 to 97 in July 2018, a reduction of 68%. The median length of time in seclusion also decreased to 37 minutes for the period of March to August 2018. Average isolation time has been under one hour since September 2016.<sup>19</sup>

FIGURE 1

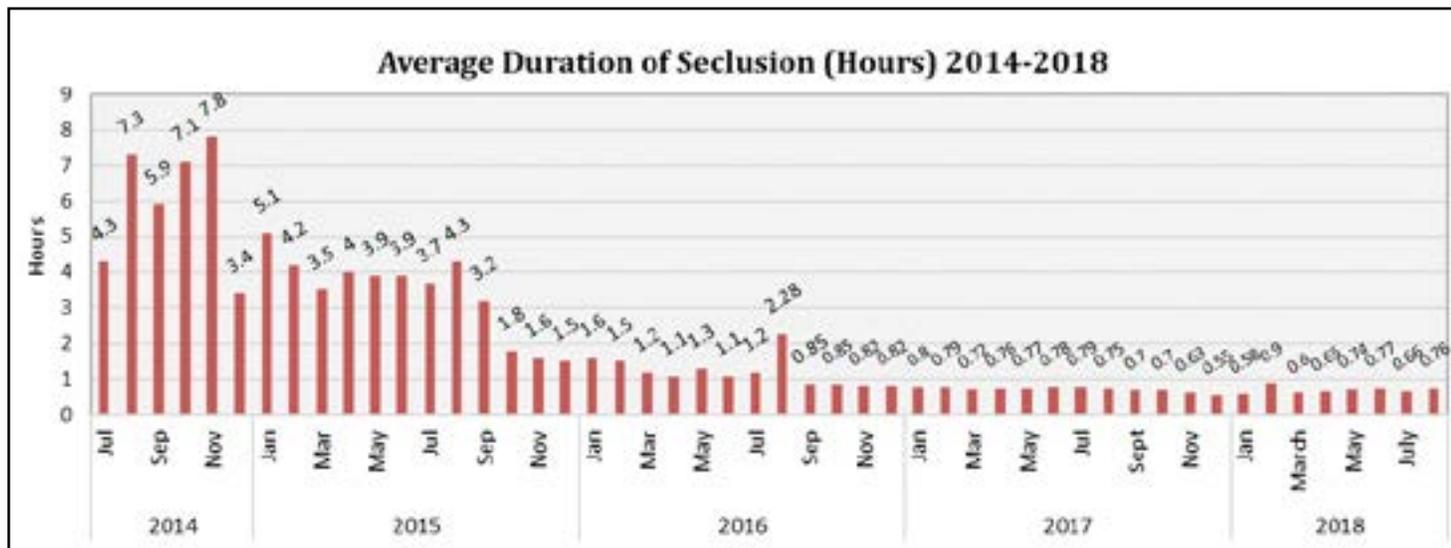
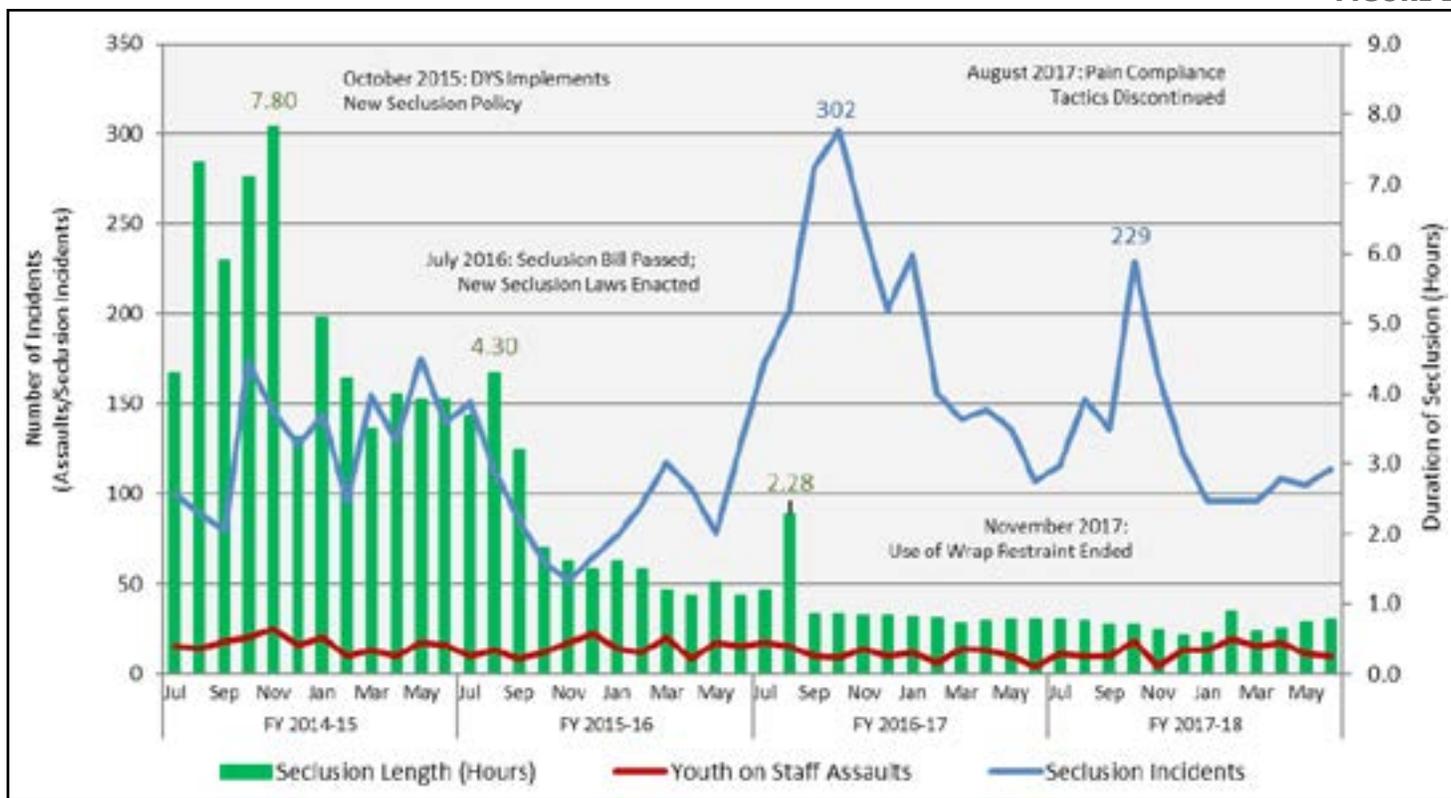


FIGURE 2



## CHALLENGES FOR DYS

### DEEPLY ENTRENCHED CORRECTIONAL PRACTICES

DYS faced a number of major challenges. First, the correctional practices—reliance on restraints and seclusion—were deeply entrenched in the facilities and in the agency. Staff had been trained on the practices for many years. Agency policies either authorized the practices or were broad enough to allow their use. As a result, some veteran staff felt helpless during the transition to the new culture. They found it difficult to give up the old ways of doing business when they were not yet confident of the effectiveness of the new policies and practices. These staff may have been in a minority among all DYS staff, but they demonstrated the stresses of making the changes.

### CULTURE CHANGE

DYS staff also had to learn alternative ways to relate to youth and to address conflict and confrontation situations. For example, the effort to change the culture meant that the Division would be an agency that first and foremost provided services and care, rather than control and discipline. The legislature signaled this clearly in HB17-1329 by adding, as the first purpose of the agency, to “increase public safety by providing rehabilitative treatment....”

The culture change also meant staff needed to develop a relationship-based approach to youth, rather than relying on their authority to set rules and impose discipline. Staff also needed to think in terms of identifying and building on youth’s strengths, rather than applying consequences for misbehavior.

Some staff have continued to be skeptical, complaining that youth could assault staff and only get a writing assignment as a consequence. Staff have been concerned about gang members in DYS facilities who they say have initiated fights and group confrontations. Staff have also been concerned about the older youth (18 to 21-year-olds) who have also been confined in DYS facilities. Some staff have felt that, although DYS has given them a lot of tools, those tools don’t work for the older age group. Some staff have complained

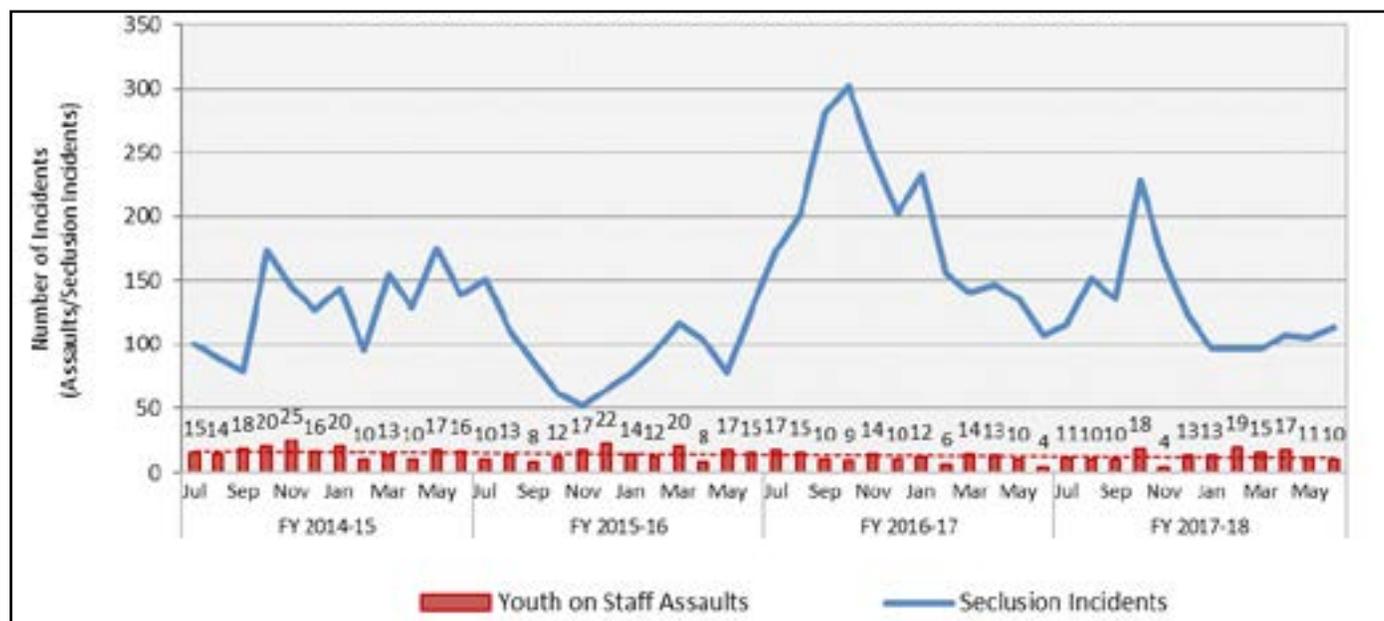
## ASSAULTS ON STAFF TRENDING DOWN

**A**ny youth-on-staff assault is a matter of great concern. However, the most recent DYS data show that youth assaults on staff have remained flat and at a relatively low level for the past four years, notwithstanding the number of older youth being held by DYS. In February 2019 there were 18 youth assaults on staff across all 10 facilities operated by DYS.

Anders Jacobson

that, with the new policies, they have been afraid to put their hands on youth—to use physical control techniques on which they had been trained—even when such actions were necessary to break up fights.

FIGURE 3



### NEED FOR NEW STAFF TRAINING

DYS had been training staff on trauma-responsive care for some time. HB17-1329 codified the focus on creating trauma-responsive environments. In HB17-1329, the legislature explicitly acknowledged that many youth committed to the Division have experienced trauma, including physical and sexual abuse, abandonment, violence in their homes or communities, or loss of a family member. For these youth, a safe, humane, and nurturing environment was necessary for youth to develop coping skills and trusting, healthy relationships. The legislature defined trauma-responsive care to mean care in which staff were trained to expect trauma in the youth they saw, to recognize how staff behavior and agency practices could trigger painful memories and retraumatize youth, and to resist taking actions or using words that might retraumatize youth in their care.<sup>20</sup> Thus, staff had to be trained on trauma-responsive care, the reasons for it, and the implications for how they would act toward youth in the facilities.

Staff also needed to learn other skills, including how to de-escalate conflict situations before they became major confrontations. HB17-1329 also required staff assigned to the pilot program to have training on rehabilitative treatment, adolescent behavior modification, trauma, safety, and physical management techniques that do not harm youth.

Finally, staff had to be confident that the new skills they would learn would actually work. As in many other facilities, some DYS staff had a genuine fear of some youth in the facilities who had shown violent tendencies. Without being able to use restraints and seclusion as in the past, staff needed to be confident of their own safety, so that they could safely implement the new training and policies that they received.

## **STAFF SHORTAGES**

Adequate staffing is a critical component of efforts to reduce the use of isolation. The national standard of 1:8 staff-to-youth ratio<sup>21</sup> is based on decades of correctional experience. Supervising troubled adolescents in a locked environment is a difficult task under any circumstances. When the ratio goes above 1:8, staff can't provide the attention, supervision, support, and accountability that each youth needs. Additionally, without adequate supervision, youth are free to misbehave or get involved in more serious misconduct.

In addition, in many facilities across the country, as a result of staff vacancies and sick days, staff must work involuntary double shifts. Staff may report to work at 8 a.m., expecting to leave at 4 p.m., only to be told that they must continue to work until midnight. As difficult as it is to properly supervise youth for eight hours, it is much more difficult to do so for 16 hours straight. Moreover, inadequate numbers of staff cause burnout by staff who do work, and some of those staff ultimately decide to leave. Staff shortages also lead to staff retention problems, which further exacerbate staffing shortages.

As facilities under pressure seek to hire new staff, they keep the job requirements at a minimum, often requiring only a GED.<sup>22</sup> Pay scales in juvenile justice facilities are often low. The applicants for those jobs are often young, just past high school age, meaning that they are only a few years older than the youth they supervise.

DYS facilities had all of these problems. The staff-to-youth ratio in most facilities was usually 1:11, but sometimes went even higher. At times, staff were required to work involuntary double shifts. Staff retention was a problem. State personnel policies required only a high school diploma, and new staff often had few qualifications for the demanding jobs.<sup>23</sup> Pay was low. And many new staff were in their early 20s.

## **WHAT WORKED**

### **EXPOSURE OF THE PROBLEMS**

The members of the Colorado Child Safety Coalition performed an important public service by investigating reports of abusive conditions in DYS facilities, putting their findings into a

widely-publicized report, and continuing to prod DYS to do better. The Bound and Broken report did not initiate reforms in the Division, but it strongly accelerated the pace of reforms that were in process. The report is a well-researched and careful analysis of the Division's own data and reports as well as a powerful collection of the voices of young people who were subjected to seclusion and restraint. For example, one youth described isolation as "like being treated like an animal. You're doing bad, go to your cage."<sup>24</sup> Sometimes a single statement is as powerful as a raft of data. Figure 4 shows a typical DYS isolation cell prior to the reform process.

### **MULTIPLE LEGISLATIVE RESPONSES**

HB16-1328 and HB17-1329 were important for codifying reforms that DYS had already undertaken and for prompting more change. The Missouri-like pilot project authorized by HB17-1329 was a thoughtful effort to try a different approach on a limited scale before expanding it to the entire agency. The legislature provided an opportunity to demonstrate the effectiveness of small groupings with low staff-to-youth ratios, without using seclusion or restraints, in actual practice.

### **DIRECT CONFRONTATION OF THE PROBLEMS BY AGENCY LEADERSHIP**

Jacobson began working on the problems with seclusion and restraints when he took over as temporary director of DYS and continued those efforts when he became permanent director. As noted above, his first approach, particularly at Spring Creek, was primarily to increase the number of staff at facilities, in order to bring down the staff-to-youth ratios and make supervision more effective. When that proved inadequate to the scope of the problems, he developed a more comprehensive approach. When the Bound and Broken report came out, he expressed concern about some of the allegations, but largely agreed with many of the policy recommendations.<sup>25</sup> Even before the Bound and Broken report was released, he traveled to Missouri with Representative Pete Lee, who represented Colorado Springs and was a legislative leader in reform efforts; Rebecca Wallace, staff attorney at the ACLU of Colorado; and other agency leaders, to see that system firsthand.<sup>26</sup> He continued to push the legislature for more staff for DYS facilities. He was committed

**FIGURE 4**



to changing the culture of the agency. He developed a model with a sound, evidence-based foundation. DYS had been training staff on the Sanctuary Model since 2014, but Jacobson increased the agency's efforts once he became the director.

### **TALKING WITH STAFF ABOUT THEIR CONCERNS**

A critical element of reform at DYS was the commitment of leaders to talk with unit staff to hear their concerns about the reforms. Reforms such as those needed at DYS cannot be imposed solely from the top down. Staff have genuine, sincere concerns about their own safety when the traditional disciplinary methods are removed. Staff must develop new skills to provide alternatives to seclusion and restraints, and must feel confident that their new skills will protect them as well as the youth. A central part of the process for administrators is listening to staff concerns, and addressing those concerns in new trainings, policies, and practices.

### **SETTING SPECIFIC LIMITS ON THE USE OF SECLUSION**

HB16-1328 set specific limits for the use of seclusion and conditions for extending those limits. After the Bound and Broken report demonstrated that the practices continued, the legislature passed the much more comprehensive HB17-1329. The two pieces of legislation were important for codifying limits that DYS had previously put into policy.

### **LIMITATIONS OF LEGISLATION**

Legislation and policies do not guarantee compliance. Legislation is not self-executing and agency policies are not always implemented properly. However, there is a considerable benefit in having the desired policy—very limited use of seclusion—on the record in state law for agency leaders and staff, and for the public. At a minimum, a formal statutory statement of desired policy provides a goal for agency personnel and a standard by which to hold them accountable.

### **DEVELOPMENT OF STRATEGIC GOALS AND OBJECTIVES**

To provide a foundation for its operations and reform efforts, DYS developed a model with several components. Its "vision" lists youth first: "Achieving youth success and safer Colorado communities."<sup>27</sup> In addition, its "strategic goal" reflects the transition it has undergone: "The Division will operate healthy trauma-responsive organizational environments as demonstrated through prosocial, safe, and nonviolent interactions."

To accomplish this goal, DYS has adopted the Sanctuary Model, a theory-based, trauma-informed, evidence-supported whole culture approach to changing organizational culture which is used in many states throughout the country.<sup>28</sup> A critical part of the Sanctuary

Model is the Seven Commitments: non-violence, emotional intelligence, open communication, social responsibility, democracy and shared governance, inquiry and social learning, and growth and change. All DYS staff are trained on the Sanctuary Model and the Seven Commitments.

Further, DYS utilizes five “key strategies”: the right services at the right time, safe environments, proven practices, quality staff, and restorative justice principles and practices.

Operationally, DYS has nine objectives for achieving its strategic goal:

1. Increase DYS senior leadership presence and engagement across the organization;
2. Create DYS small group processes to address day-to-day behavioral issues;
3. Shift the atmosphere of secure facilities to a more “homelike” atmosphere;
4. Create DYS “teams” of youth and staff in all facilities;
5. Optimize the use of residential state-operated and contract capacity;
6. Use the Behavioral Health Framework to develop the DYS treatment approach;
7. Condense and simplify DYS staff training;
8. Integrate trauma-responsive principles and practices into all elements of the DYS organization; and
9. Recruit, hire, and retain quality staff.

All of these come together in the Colorado Model, shown on the next page. The Colorado Model provides an overview of DYS’s approach to care and custody of young people.

### **ADDITIONAL STAFF**

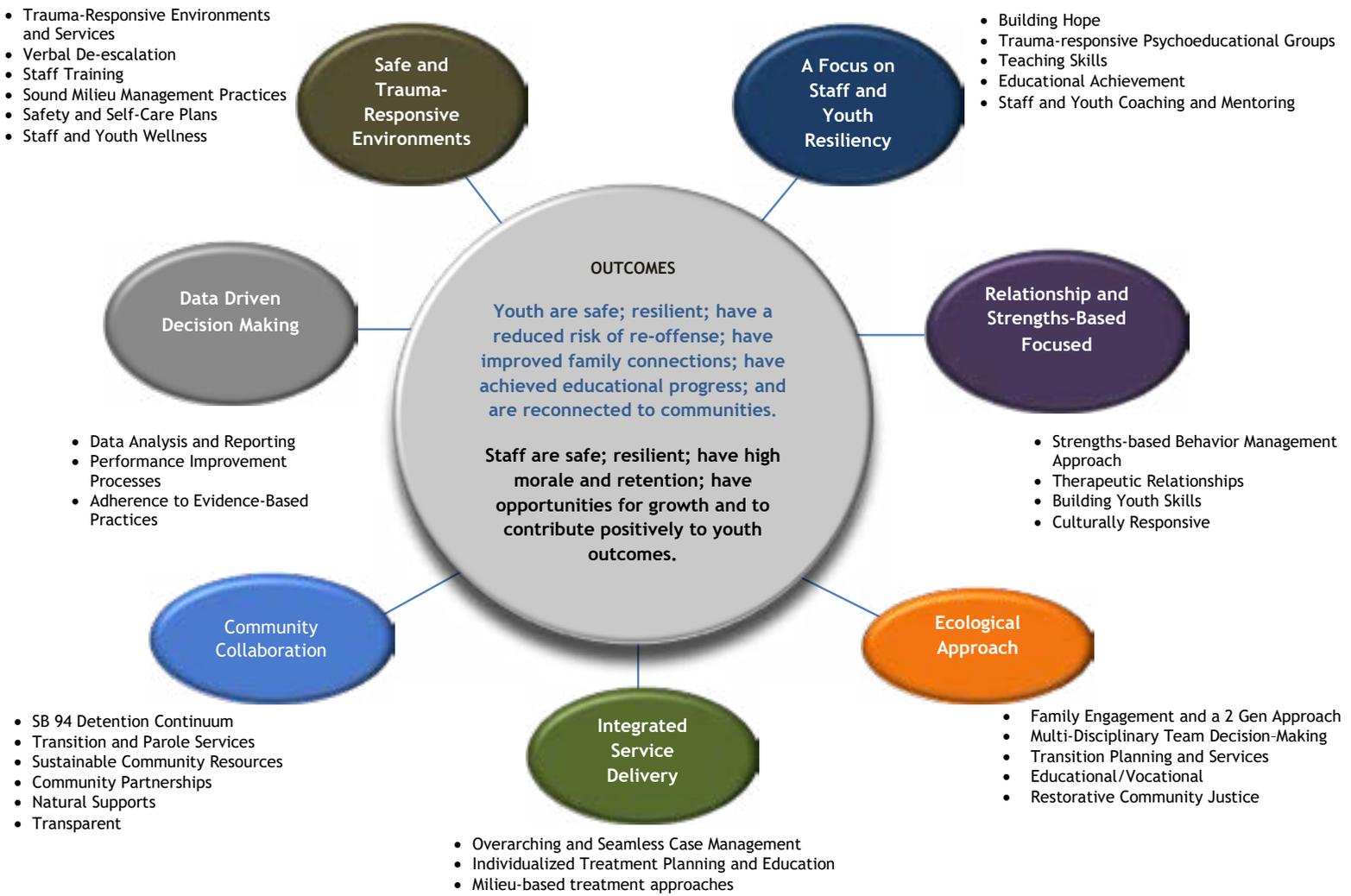
Jacobson’s first response to the problems at Spring Creek was to request additional staff. He continued to press the legislature for additional staff for DYS facilities. Between 2014 and 2017, DYS requested 280 new positions, but only received funding for 143.<sup>29</sup> However, by 2018, DYS received funding for all the needed positions, so that all DYS facilities maintained a 1:8 ratio (some with lower ratios, such as Lookout Mountain with 1:6).

## **COLORADO’S STEPS TO SECURE ADDITIONAL STAFF POSITIONS**

- Established internal working group
- Interviewed facility directors and staff
- Internal staffing analysis
- Compared current ratios to ratios needed to meet PREA standards
- Created a legislative decision item and made specific request for resources from the Joint Budget Committee
- Provided testimony regarding staffing needs.

**FIGURE 5**

**The Colorado Model**



June 2017

In order to receive additional funding, DYS established an internal working group, conducted interviews with all facility directors, and put together an internal staffing analysis. This allowed DYS to compare staffing ratios to ratios needed to meet PREA ratios in all juvenile justice facilities. DYS officials created a legislative decision item based on information from the working group along with a specific request for staffing resources the agency needed. Once the decision item was introduced and discussed in the Joint Budget Committee, DYS administrators testified about their staffing needs.<sup>30</sup>

## **NEW TRAINING**

After the Spring Creek issues were addressed, DYS adopted Verbal Judo<sup>31</sup> as a strategy for de-escalation. Staff also were trained on Motivational Interviewing,<sup>32</sup> which can be useful in helping youth get through emotional barriers to change.

## **INCENTIVE-BASED BEHAVIOR MANAGEMENT PROGRAM**

All DYS facilities have incentive-based behavior management programs. All facilities use the same framework, but some have variations. For example, one facility uses a behavior management program called SOAR, which stands for Show Safety, Own Behaviors, Achieve Results Through Problem Solving, and Respect and Help Others. There is a [Phase Behavior Matrix](#) which functions as a behavioral expectations chart. The chart lists negative behaviors to be avoided (“refrains from destruction of property”) and positive behaviors to emulate (“uses appropriate voice level”). Youth are graded on whether they meet the standards (1) sometimes, (2) consistently, or (3) almost always, and earn points on SOAR Cards that can be cashed at the SOAR Store for snacks and other rewards. DYS facilities also apply incentives by naming a Student of the Month and, for staff, an Employee of the Month.

## **MORE HOMELIKE PHYSICAL ENVIRONMENT**

DYS closed its seclusion rooms and created “relaxation rooms” for youth to calm down or spend brief periods alone. The rooms, such as the ones in Figure 6, feature soft furniture like beanbag chairs, carpeting, pillows, books, stuffed animals, and pictures on the walls. In addition to changing youth clothing to school uniform-like polo shirts and khakis, DYS changed staff uniforms to more casual shirts and pants.

## **EXTENSIVE PROGRAMMING**

Providing engaging programming is an important part of efforts to reduce isolation. When youth are idle or bored, they get restless. Weekends can be particularly challenging because there is no school and often little programming. On the other hand, when youth are occupied in interesting activities, they are much less likely to get into trouble. The most effective juvenile justice facilities provide extensive programming all day and into the evening. DYS

provides a minimum of 14 hours of programming during weekdays, and a minimum of 12 hours of programming each day on the weekends.

## BEHAVIORAL HEALTH STAFF

Research shows that between 40% and 80% of incarcerated youth have at least one diagnosable mental health disorder.<sup>33</sup> Every youth admitted to a DYS facility gets assigned to a behavioral health staff member. Those staff have small caseloads, usually 7–9 youth. This allows behavioral health staff to follow up with individual youth and intervene quickly when appropriate.

## REGULAR DATA COLLECTION

Regular data collection and analysis provide a concrete foundation for monitoring and accountability. One DYS staff said, “We collect data on everything. We use data every day.”<sup>34</sup> The Youth Seclusion & Restraint Working Group collects and reports detailed data on seclusion and restraint semi-annually.<sup>35</sup> DYS collects data monthly. For example, data from the Gilliam Youth Services Center, a pre-adjudication juvenile justice facility operated by DYS, indicated that 61% of the fights in the facility occurred on Saturdays. That made it possible to identify the underlying problem and develop a solution.

**Ideas for Analyzing**  
Data: Youth Seclusion &  
Restraint Working Group  
Reports.

In semi-annual reports, the Colorado Working Group summarizes key data on seclusion and restraints. The format of the report is a helpful example for facilities and agencies considering how to analyze and display data in useful ways. [A sample report from March to April 2018](#) is available as an example.

## CONCLUSION

DYS has made enormous progress over the past two years in reducing the use of seclusion. Many people, inside and outside of DYS, made the changes possible. DYS needs to continue monitoring its own progress to ensure the sustainability of the reforms.

Some problems remain. Advocates are concerned that the reductions in the use of room confinement have not been accompanied by overall change in the agency culture. Some staff are unable or unwilling to become part of the reforms. In addition, although use of the WRAP ended in November 2017, DYS instituted a different restraint procedure, called the Side Hold, in January 2018. Although advocates have expressed concerns about the restraint, records show that the restraint is used infrequently—an average of one time a month in each facility, which may demonstrate the effectiveness of the reforms that DYS has implemented. The Division will continue to monitor its use to ensure that it remains rare.<sup>36</sup>

Overall, DYS has done a remarkable job of reducing the use of isolation in a relatively short period of time. The strategies it found effective should be useful to other jurisdictions making similar efforts.

DIVISION OF YOUTH SERVICES NUMBER AND AVERAGE DURATION OF SECLUSION INCIDENTS September 2017 - August 2018												
FACILITY	AOP	NUMBER OF SECLUSION INCIDENTS		PERCENT CHANGE [Period1 vs. Period2]	NUMBER OF SECLUSION CLIENTS [Unique] <sup>1</sup>		PERCENT CHANGE [Period1 vs. Period2]	AVERAGE SECLUSION LENGTH IN HOURS		PERCENT CHANGE [Period1 vs. Period2]	MEDIAN SECLUSION LENGTH IN HOURS	
		Mar18-Aug18 (AVG)	Sep17-Feb18		Mar18-Aug18	Sep17-Feb18		Mar18-Aug18	Sep17-Feb18		Mar18-Aug18	Sep17-Feb18
Adams	22.6	78	67	-14%	36	45	25%	0.50	0.32	-36%	0.44	0.23
Betty K. Marler	29.6	16	0	-100%	11	0	-100%	0.50	N/A	N/A	0.38	N/A
Gulliam	42.6	30	13	-57%	16	10	-38%	0.30	0.13	-58%	0.65	0.10
Grand Mesa	59.8	65	55	-15%	29	31	7%	0.50	0.58	18%	0.21	0.55
Lookout Mountain	147.4	176	90	-49%	68	49	-28%	0.60	0.75	26%	0.45	0.70
Marvin W. Foote	61.1	108	91	-16%	46	43	-7%	0.80	0.74	-8%	0.47	0.58
Mount View	97.9	197	45	-77%	93	33	-65%	0.60	0.50	-16%	0.60	0.47
Platte Valley	93.7	55	132	240%	36	59	64%	0.70	0.92	31%	0.62	0.87
Pueblo	13.9	10	0	-100%	4	0	-100%	0.70	N/A	N/A	0.58	N/A
Robert E. Denier	13.3	9	0	-100%	4	0	-100%	0.70	N/A	N/A	0.91	N/A
Spring Creek	47.9	91	73	-20%	55	38	-31%	0.80	0.80	0%	0.75	0.73
Debuson Pike	58.8	37	53	43%	11	19	73%	0.80	0.75	-7%	0.85	0.68
<b>TOTAL</b>	<b>648.7</b>	<b>872</b>	<b>619</b>	<b>-29%</b>	<b>373</b>	<b>313</b>	<b>-16%</b>	<b>0.68</b>	<b>0.70</b>	<b>3%</b>	<b>0.57</b>	<b>0.62</b>

<sup>1</sup>Total is not a sum of unique clients by facility (112 Sep-Feb; 127 Mar-Aug), as a client may have been included at multiple facilities within the reporting period.

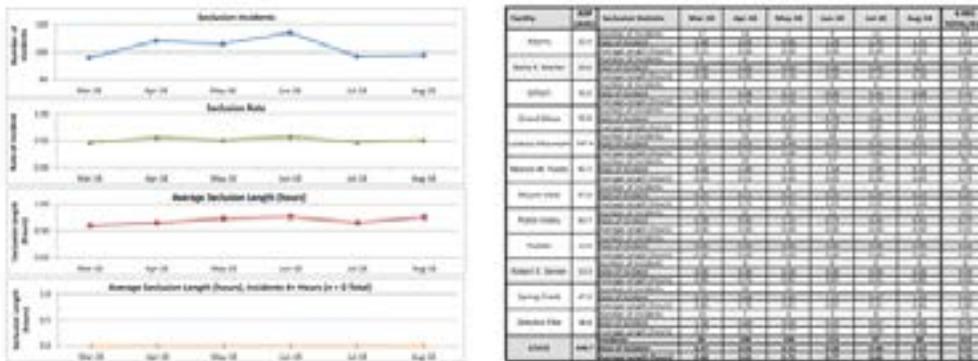


FIGURE 7 SAMPLE DATA FROM COLORADO SECLUSION & RESTRAINT WORKING GROUP<sup>264</sup>

<p><b>Six-Month Period Totals (per facility and agency total)</b></p> <ul style="list-style-type: none"> <li>• Number of seclusion incidents</li> <li>• Number of unique seclusion clients</li> <li>• Average duration of seclusion (hours)</li> <li>• Median duration of seclusion (hours)</li> <li>• % change from previous six-month period</li> </ul>	<p><b>Monthly Data (per facility)</b></p> <ul style="list-style-type: none"> <li>• Number of seclusion incidents</li> <li>• Rate of seclusion incidents (per 100-bed days)</li> <li>• Average duration of seclusion</li> </ul>
<p><b>Aggregate Summary on Demographics of Secluded Youth</b> (by seclusion incidents and unique secluded clients)</p> <ul style="list-style-type: none"> <li>• Age</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Gender</li> </ul>	<p><b>Aggregate Trends Over Six-Month Period (agency total)</b></p> <ul style="list-style-type: none"> <li>• Number of seclusion incidents</li> <li>• Rate of seclusion incidents</li> <li>• Average duration of seclusion (hours)</li> </ul>



Photo credit: Richard Ross

# NOT IN ISOLATION

HOW TO REDUCE ROOM CONFINEMENT  
**WHILE INCREASING SAFETY**  
IN YOUTH FACILITIES

**MASSACHUSETTS  
DEPARTMENT OF  
YOUTH SERVICES**

# The Massachusetts Department of Youth Services

## TRAGEDY SPARKS ACTION

In 2003, a 15-year-old boy hanged himself with a sheet while alone in his room at the Metro Youth Services Center in Dorchester, MA.<sup>37</sup> Shortly thereafter, another child completed suicide. Both took their own lives while alone in their cells in facilities operated by the Massachusetts Department of Youth Services (DYS). As DHS struggled to find a path forward, administrators wanted to understand what factors were contributing to high rates of self-harming behavior.

During the investigation, DHS found that most incidents of self-harm occurred when youth were in room confinement.<sup>38</sup> This connection is now well-documented in juvenile justice facilities across the country. According to a study commissioned by the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP), more than 50% of suicides in juvenile justice facilities occur when youth are in room confinement.<sup>39</sup> In Massachusetts, there were 39 suicide attempts by children in DHS custody in 2003.<sup>40</sup> Agency leaders agreed that something had to change.

Over the next decade, DHS pushed forward with a series of reforms to drastically reduce room confinement as a way to increase safety. "It's not just about room confinement," current DHS Commissioner Peter J. Forbes explains. "It's about staff being assaulted, fights among the kids, any kind of property damage that you track, room confinement, and restraints."<sup>41</sup> These related problems shared common solutions: clear policies, positive behavior management, integrated clinical services, and well-resourced staff. Between 2008 and 2016, DHS cut the number of room confinements by over 65% while also reducing restraints and assaults.

FIGURE 8<sup>22</sup>



Source: Massachusetts DHS. Data excludes unit wide confinements, threat to self, population management (see definition), or confinement during investigation of an incident.

### DYS Room Confinements, Average Duration & Assaults on Staff

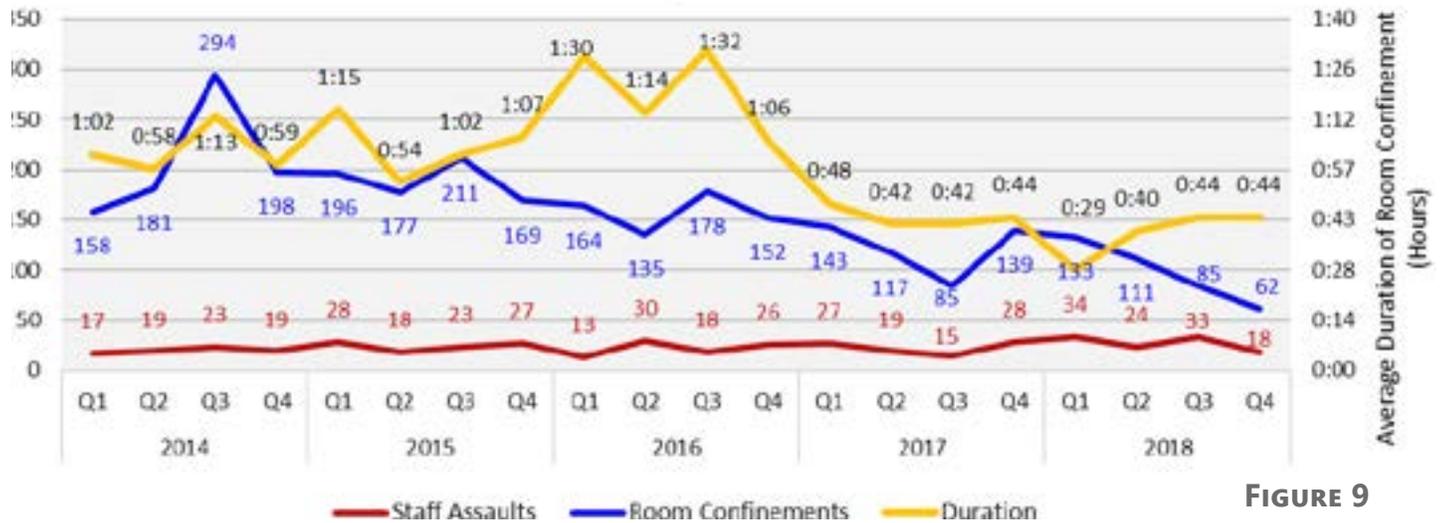


FIGURE 9

### AGENCY HISTORY

DYS operates Massachusetts’ juvenile justice services. In addition to a continuum of residential programs, reception centers, foster care, and community-based services, DHS has 15 secure residential programs for young people up to the age of 21. The agency also contracts with providers to operate 9 additional secure programs in DHS buildings. Seven programs are for secure detention, while the remaining programs house committed youth.

Each DHS program serves 12–15 youth.<sup>33</sup> Each program is staffed with a program director, clinical director, clinicians, and 21–24 full-time direct care staff, or “group workers.” DHS is organized into five geographic regions, each with a regional director who oversees individual programs. Forbes leads the agency along with an executive team housed in the Central Office in Boston. Other executives include Ruth Rovezzi, the Deputy Commissioner for Operations and Support Services, and Margaret

“Putting kids in their rooms makes them less safe,” says Forbes.

“There is an impulsivity that makes kids act in ways that they wouldn’t outside of room confinement.”

Chow-Menzer, the Deputy Commissioner of Administration and Finance. The agency's mission is to make communities safer by improving the life outcomes of youth through effective treatment and skill development.<sup>44</sup>

In 2004, DYS faced challenges that impacted the safety and security of its youth population. Over 3,200 youth cycled through the agency's 19 secure facilities each year. In order to compensate for overcrowding and high youth-to-staff ratios, DYS relied primarily on room confinement to manage residents. Many youth spent a large percentage of their time isolated in their rooms every day. Under these conditions, it was only a matter of time until another youth died or was seriously injured.

Over the next few years, DYS made several changes to limit the use of room confinement. When reforms began, the agency had no policy, data, or practice expectations around room confinement. Administrators needed baseline data on how programs were using room confinement to determine whether changes were working. As a first step, DYS began collecting and reviewing data on room confinement with a simple telephone reporting system. Each evening, a second shift supervisor called Central Office to report which youth had been in room confinement that day, the reason, and for how long. This initial approach helped set an expectation of transparency and accountability around the use of room confinement.

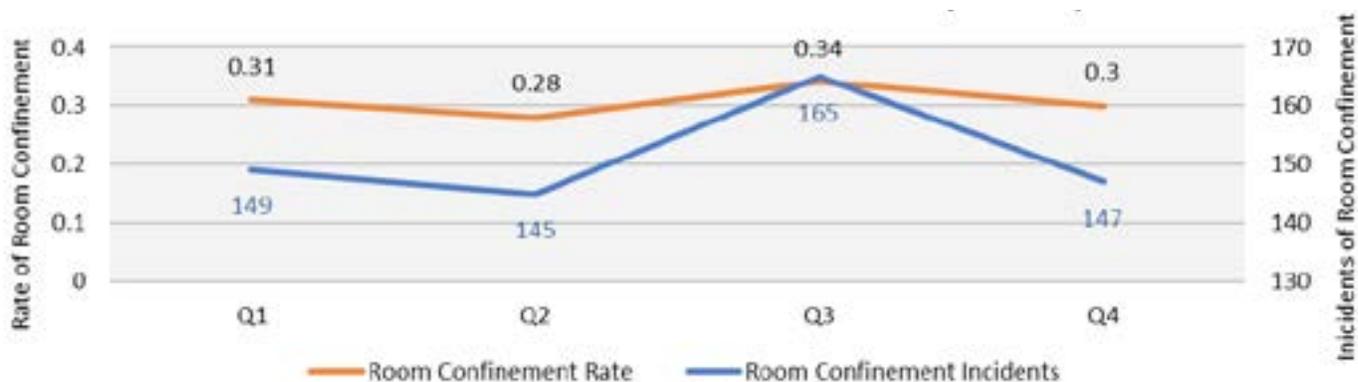
## USING DATA TO ADVANCE REFORM

Not every facility or agency has an advanced data collection system. Fortunately, this is not necessary to begin the process of reducing room confinement. The most important step for DYS was making a start, however modest. Recognizing the value of data from the outset increases the chance that efforts to reduce room confinement will succeed. Data also is an important tool to maintain focus on safety during the improvement process. DYS uses data in several key ways.

DYS measures the duration and frequency of room confinement. Frequency can be displayed as actual number of room confinements or by the number of room confinements per 100 client-days. The per client-days ratio allows DYS to compare the rate of room confinement relative to the number of youth. A client-day equals one youth for one day. Ten youth over 30 days is 300 client-days. A per 100 client-day rate of 0.5 in a program with 10 youth means one-half a room confinement over 10 days (10 youth x 10 days = 100 client-days or 1 ½ room confinements over 30 days (10 youth x 30 days = 300 client days).<sup>45</sup> Figure 10 on the next page illustrates the difference in the two measurements using DYS data from 2016.

- DYS views room confinement within the broader context of agency safety. Administrators and program leaders use data to determine how room confinement trends compare to other important safety indicators: assaults on youth, assaults on staff, restraints, property damage, industrial accidents, and staff time out of work.
- DYS administrators use data to help anchor conversations with union officials and other stakeholders around a shared set of facts.

**FIGURE 10 NUMBER OF INCIDENTS VS. RATE OF ROOM CONFINEMENTS (DYS 2016)**



Source: Massachusetts DYS, excludes unit wide confinement and confinement for population management.

## A MAJOR POLICY SHIFT

In 2008, DYS took a significant step toward reducing room confinement by introducing a new policy that dramatically limited its use. Although room confinement had decreased since 2003, the agency needed a clear written policy to advance and sustain improvements. The biggest change in the new policy was that staff could no longer use room confinement as punishment, retaliation, or as a response to non-compliant behavior.<sup>46</sup> Staff could only use room confinement as a last resort to ensure the safety of youth or staff, to calm a youth exhibiting seriously disruptive dangerous behavior, or for population management in limited circumstances. Although Massachusetts does not impose a fixed time limit on room confinement, the policy does require increasing levels of approval and clinical involvement over time.

## SUICIDE PREVENTION

DYS is acutely aware of the connection between room confinement and the elevated risk of self-harm. Shortly before introducing the new room confinement policy, DYS also revised its [Suicide Assessment Policy](#). The agency consulted with nationally renowned expert Lindsay Hayes to create the updated suicide policy. Dr. Hayes is a nationally recognized expert in the field of suicide prevention within jails, prisons, and juvenile justice facilities,<sup>47</sup> and conducted seminal research showing that over half of youth suicides in juvenile justice facilities occur in room confinement.<sup>48</sup>

Taken together, the policies clarify two critical points:

1. *Youth at risk of suicide require intensive supervision:* Staff provide constant 1:1 “eyes-on” supervision to youth on full or elevated suicide watch, even during sleeping hours.<sup>49</sup>

2. *Room confinement is not appropriate for youth on any level of suicide watch:* The room confinement policy establishes a clear prohibition on room confinement of youth who are at risk of self-harm or suicide.

## TALKING TO STAFF ABOUT REDUCING ROOM CONFINEMENT

Administrators at the state level were responsible for drafting the revised room confinement policy. To secure buy-in from all levels of staff across the state, the agency focused on a communication strategy. Regional directors and program directors spoke to staff at all secure residential programs during in-person meetings. This showed that agency leaders were invested in the change. It also created an opportunity for staff to hear why ending room confinement was important. DYS framed the conversation about reducing room confinement around the issue of safety, which was a shared goal for almost all staff. In Massachusetts, the policy roll out involved meaningful and direct participation from agency leaders. Forbes describes that “It require[d] people getting in their cars and driving out to the secure programs and meeting with people at shift change in the facility to talk about the purpose and the why and the implementation plan.”<sup>50</sup>

Despite careful planning about communication, the new policy was met with considerable push back from staff who felt that administrators were taking away an essential tool. The American Federation of State, County and Municipal Employees (AFSCME), Local 1368, represents almost 80% of DYS secure care staff. AFSCME voiced concerns about how the policy change would impact staff safety.

In retrospect, administrators offer two insights about reassuring staff when making changes around the use of room confinement. First, administrators should involve all levels of direct care staff in the process of creating the policy. “Policy development is a great place to get people on board,” says Forbes. “Getting a policy written is really important, but the process is as important as the substance.”<sup>51</sup> Second, administrators can anticipate concerns for staff safety when communicating about the policy change. Before DYS introduced the new policy to staff, the buzz was that it banned room confinement in all circumstances, which was not true. “The biggest mistake we made was we said, ‘no room confinement’

### Insights from Staff - How to Talk About Room Confinement

“Staff think, ‘if I cannot lock this kid in his room for 12 hours or the weekend, then I am unsafe.’ We are trying to say ‘you are safer if the kid has a relationship with you.’”<sup>265</sup>

“Change is difficult for everyone, but all everyone wants to know about change is ‘how is it going to affect me and how to do my job, and how to keep me safe.’ The benefit has to be personalized. We should have said ‘here’s the benefit to reducing room confinement because you are building positive relationships with the kids.’ If we can get kids out [of room confinement] faster into the population, it increases the safety in the moment and long term.”<sup>266</sup>

rather than a 'reduction' [in room confinement]," recalls a regional administrator.<sup>52</sup> "When we said 'no,' staff felt like there was never a circumstance that it could be useful, even if the youth was extremely violent. In reality it is still a tool, but it needs to be used under specific circumstances. Messaging is so important."

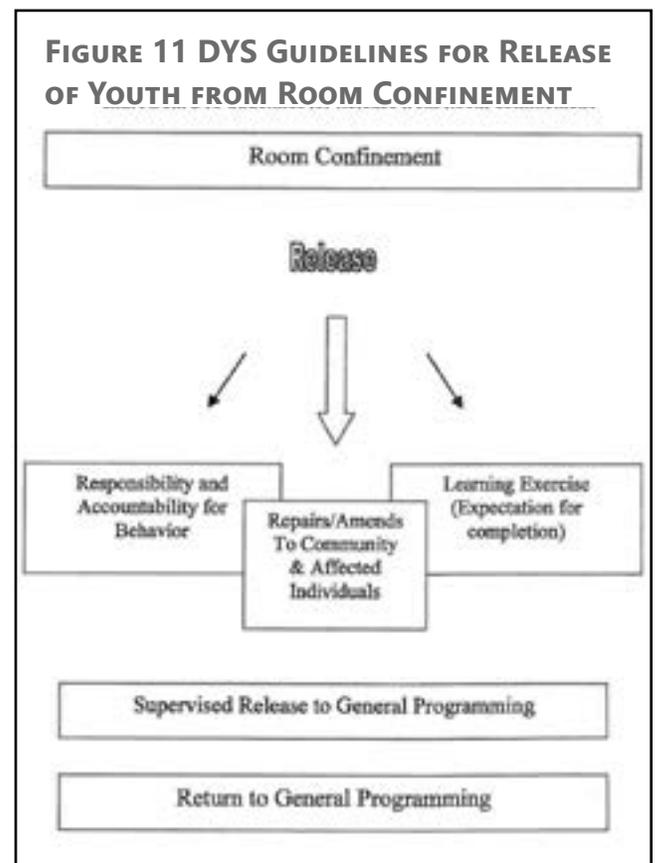
## EXIT STRATEGIES

In addition to limiting the permissible use of room confinement, DYS also focused on shortening the amount of time that youth spent in room confinement. The new room confinement policy outlined a release process for staff to follow when a young person is in room confinement.<sup>53</sup> According to policy, this process typically takes anywhere from 5 to 30 minutes. "How they get out [of room confinement] is just as important as how they get in," says Forbes.<sup>54</sup> Group workers and clinical staff immediately begin talking to youth in room confinement to help them process emotions. "We don't just close the door and leave them in there to calm down on their own. That's not helpful if we want them to regain control," notes a DYS clinician.<sup>55</sup>

As soon as youth are calm, staff begin a process of small steps to get youth out of the room confinement space. These steps may include:

- Opening the door while youth are still inside;
- Allowing youth to move slightly outside the doorway of the cell/room;
- Taking youth outside the room to an area away from other residents;
- Discussing the incident with youth using the Dialectical Behavioral Therapy (DBT) Coaching Protocol for Conflict Resolution;
- Using DBT tools to help youth process the incident (e.g., Behavior Chain Analysis, repair assignments);
- Using relationships with youth to determine whether they are calm enough to exit room confinement; and
- Assessing whether a youth needs to complete conflict resolution work with other residents before rejoining the program.

Release from room confinement does not necessarily mean that a resident immediately returns to regular group programming. A facility administrator explains that "[i]nitially staff thought that there was no room



confinement and we were going to put the kids in the population no matter what—and that’s not what we do.”<sup>56</sup> In 2016, DYS and AFSCME developed the [DYS Guidelines for Release from Room Confinement](#),<sup>57</sup> which give staff additional guidance on getting youth out of room confinement.<sup>58</sup> The Guidelines instruct staff to create an individualized set of activities or steps to help youth successfully transition back into general programming.

After introducing the room confinement policy in 2008, DYS leaders balanced concerns for staff safety with a firm resolve to stay the course. The agency invested heavily in a new behavior system framework over the next few years to equip staff with skills and alternatives to avoid room confinement. By April 2011, almost all cases of room confinement lasted less than four hours.<sup>59</sup>

## **TRANSFORMING RESPONSES TO YOUTH BEHAVIOR: DIALECTICAL BEHAVIOR THERAPY**

While DYS was developing the room confinement policy, it was also testing a new clinical approach that would eventually become a touchstone for all agency programs—DBT, originally developed by Marsha Linehan at the University of Washington to treat chronically suicidal clients. Dialectical Behavior Therapy (DBT) has since been adapted for people who are impulsive and have difficulty controlling their emotions.<sup>60</sup> Research shows that DBT is associated with reductions in recidivism for justice-involved youth and has positive effects on reducing aggression.<sup>61</sup>

DYS adapted Linehan’s original model as a behavioral management framework to decrease the use of room confinement. The DYS Director of Clinical Services, Dr. Yvonne Sparling, first piloted DBT at the Grafton short-term residential program for girls in 1999.<sup>62</sup> The results were impressive. Girls who received DBT had fewer restraints and moved through the behavioral level system more quickly. The following year, a second pilot program for boys yielded similar results. In 2006, the DYS Clinical Advisory Council endorsed the use of DBT as the therapeutic framework in all secure care facilities and developed a DBT Manual for all DYS secure facilities.

As part of the DYS DBT Manual, Sparling wrote “[Dialectical Behavior Therapy as a Behavior Management Approach](#),” which established the fundamentals of DBT practice within the agency. In addition to the DBT program practices (described below), all clinical staff within the first six months of hire complete an online training course developed by Dr. Linehan through Behavior Tech, a Linehan Institute Training Company. DYS also hired DBT coaches for each region of the state to provide training and consultation to facility leaders and staff.<sup>63</sup>

The core premise of DBT is that problem behavior is caused by a deficit in skills, not a moral failing or disregard for consequences.<sup>64</sup> In other words, youth engage in dysfunctional behaviors because they do not know how or when to use more effective strategies. They may not even understand how their current behaviors contribute to undesirable outcomes. DBT focuses on four main areas of skill development: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness.

The goal of DBT is to help youth learn skills to understand and change their behavior, especially in difficult situations.<sup>65</sup> Under this theory, room confinement will not deter negative behavior because it doesn't teach youth the skills they need to behave differently.

As practiced in DYS facilities, DBT is rooted in key values about young people:

- Youth are doing the best they can;
- Youth want to improve and must learn and practice new behaviors;
- Staff can help youth change to meet their goals;
- Relationships with youth are a core strategy in helping youth change their behavior;
- Behavioral principles apply to both youth and staff;
- Youth learn by seeing staff model positive skills and behaviors; and
- Staff need support when using DBT.

### Dialectical Behavior Therapy

DBT helps young people understand their behaviors and replace them with more effective coping skills. DBT doesn't just replace room confinement—it replaces the underlying behavior that triggers room confinement.

Eventually, DYS incorporated elements of DBT in many aspects of facility programming. DBT became a common language for youth, clinical staff, direct care staff, and administrators across all DYS programs. Perhaps most importantly, it created alternatives to room confinement.

DYS used four primary practices to integrate DBT into the daily lives of youth and staff.

#### 1. Weekly DBT Skills Groups

Building positive relationships between staff and youth is a core strategy to manage youth behavior. Each unit is assigned a clinician who is physically located in the living area. Assigned clinicians conduct two DBT group sessions each week. They designate a DBT "Skill of the Week" and assign DBT homework to youth. Clinicians also conduct weekly individual sessions and daily groups on substance abuse, high-risk situations, health relationships, and communication techniques.<sup>66</sup> Thanks to physical proximity and regular interaction, group workers learn de-escalation and coaching skills modeled by trained clinicians.

For Massachusetts, the most effective aspect of DBT is the high level of participation from line staff. Group workers co-teach DBT groups alongside clinical staff and reinforce DBT skills in the living unit. One advantage of co-facilitated groups is that line staff are much more likely to observe youth using skills within the program. Group workers can teach certain DBT skills more effectively than clinical staff because they are more likely to be similar to youth in gender, race, and ethnicity. As Sparling points out, "It's really important to have youth see that a skill is something that adults use and it's not just a clinical tool."<sup>67</sup>

## 2. Distress Tolerance Plans

Every youth works with an assigned advocate (staff member) to create a [Distress Tolerance Plan](#), which is updated weekly. Each direct care staff, including educators, must be familiar with all Plans. Youth's Distress Tolerance Plans covers five areas:

1. Behaviors youth will try to achieve;
2. Behaviors youth will try to avoid;
3. Triggering events that might cause youth to lose control;
4. Skills youth can use in the program; and
5. Ways that adults can help youth.

## 3. DBT Coaching Protocol for Conflict Resolution (FAVOR)

Most young people in juvenile justice facilities across the country have mental illnesses, histories of trauma, or difficulty regulating their emotions. When young people become upset or frustrated, many facilities respond by threatening physical force to control the situation. DYS realized that these traditional responses didn't work for most adolescents. In fact, those responses escalated conflicts. To teach staff another way to respond to youth in crisis, Sparling developed the DBT Coaching Protocol for Conflict Resolution.<sup>68</sup> Using this five-step approach, staff respond to youth experiencing behavioral or emotional difficulties by engaging, validating youth's feelings, and helping them use DBT skills to process emotions. All group workers and clinical staff are trained to use the protocol, which is represented by the acronym "FAVOR."<sup>69</sup>

- F Focus on Yourself  
When approaching a tense situation, staff first focus on regulating their own emotional state, body language, and voice.
- A Assess the Situation for Safety  
Staff may separate a youth from the group while continuing to engage the youth in a positive way. Separation does not mean room confinement.
- V Validate Youth Feelings and Perception  
Validation techniques are based on research that people calm down faster when they feel understood. Validation doesn't necessarily mean agreement with a youth's point of view. Staff ask questions and listen rather than debating the accuracy of the youth's perceptions.
- O Offer Skill Alternatives  
Once a youth has regained control, staff offer suggestions about what DBT skills the youth could use in similar situations. To do this effectively, staff must be familiar with youth's Distress Tolerance Plans and DBT skills.

- R Reinforce Youth’s Attempt to Try New Skills  
Staff reinforce youth’s attempts to use positive skills, even if the youth was not fully successful. Learning new behavior takes practice, and youth are more likely to try again if their attempts are recognized.

#### 4. Behavior Chain Analysis

When a youth exhibits negative behavior that results in a repair or major rule violation, he or she completes a Behavior Chain Analysis.<sup>70</sup> Behavior Chain Analysis is a DBT tool to help youth process what happened and understand why they acted the way they did. Youth review all behavior chains with their clinicians, although they may complete an analysis worksheet with line staff immediately after the negative behavior. Behavior Chain Analyses require youth to identify five things about their behavior(s).

1. Their thoughts and feelings before the event;
2. The triggering event;
3. Their own actions;
4. The consequences of their actions; and
5. Possible alternative actions or tools they could use.

## USING BEHAVIOR MANAGEMENT TO REDUCE ROOM CONFINEMENT

In 2014, DYS issued a [Positive Based Residential Programming Advisory](#),<sup>71</sup> that replaced the previous behavior modification policy. Under the old model, staff were spending most of their time policing negative behavior rather than interacting with youth and encouraging positive behavior. Existing sanctions did nothing to address the underlying issues behind youth behavior.

Text Box: Focusing on Efforts to Improve Skills, Not Compliance

An excellent example of staff focusing on individual improvements rather than compliance and capitalizing on an opportunity to treat all behavior as a learning experience can be seen in this video clip. In [this video example](#), a DYS Facility Administrator describes a particular incident. Insert video link.

The advisory combined positive-based behavior management, positive youth development,<sup>72</sup> and DBT principles. DYS outlined certain mandatory requirements, but allowed each program to decide certain details of its behavior management system with input from residents and staff. In addition to preventing negative behavior inside DYS facilities, the policy was designed to give youth skills to successfully transition back into the community. The new DYS behavior management system relies on five important tools:

## 1. PROGRAM ADVANCEMENT BASED ON SKILLS, NOT COMPLIANCE

The new behavior management system used a “stage” system based on competency in social and emotional DBT skills. It replaced a hierarchical “level” system based on compliance. Staff address misbehavior through repairs and other internal processes, not by taking away youth’s phase status. Under the old point-based level system, some youth spent weeks climbing to the next level only to lose multiple levels in one day due to misbehavior. Other youth with preexisting mental illness or trauma were not able to meet the behavior requirements to reach higher levels or earn incentives.

## 2. DIARY CARDS

DYS replaced the daily point system with [diary cards](#) to track behavior based on each individual youth’s progress. One side of the diary card lists youth’s short-term behavioral goals and the other side lists DBT skills they are learning. Youth can earn incentive points for demonstrating DBT skills and improved behavior. Youth cannot lose points—they can only fail to earn incentive points. Each program developed its own diary card based on DBT skills taught in the program. Each day, youth spend 5–10 minutes with staff to individually review their diary cards, explaining what they did well and what DBT skills they could use to do better next time. Staff guide the conversations and sign the diary card. Many programs do this in the evening, shortly before lights out.

## 3. REPAIRS

Staff use repairs to hold youth accountable for negative behavior instead of room confinement. Repair is a DBT term for actions to compensate or rectify a harm that someone has caused. When youth misbehave or break rules, they must complete repairs. Repairs are meant to show youth that consequences exist for their actions. However, as the Director of Clinical Services clarifies, the “[g]oals for repairs are totally the opposite from [goals for] isolation.” Room confinement teaches young people what it’s like to be isolated, while repairs teach them the value of healthy connections with other residents and staff. The two main goals of repairs are (1) to help youth understand the impact of their actions on themselves and others and (2) to give youth the skills necessary to process and change their behavior.

Repairs include an acknowledgment of the negative behavior, an apology to the affected person or group, and actions to compensate for the harm done. Programs created their own repair systems with menus of activities for each category of behavioral infraction. Some activities involve staff or other residents.

**Figure 12. Sample Guidance for Repair Assignments**

	Repair 1	Repair 2	Repair 3
Triggering Event	Class 1 Infraction	Class 2 Infraction	Class 3 Infraction
Duration	Up to one active shift	1–3 active shifts	3–7 active shifts
Activities	Two items from List 1 One item from List 2	Two items from List 1 Four items from List 2 One item from List 3	Three items from List 1 Four items from List 2 Three items from List 3

Sample	Repair			Activities
	<u>Repair List 1</u>	<u>Repair List 2</u>	<u>Repair List 3</u>	
	Behavior Chain Analysis	Clean bathroom	Whole unit apology	
	Written apology	Fold laundry	DBT posters and role plays	
	Mindfulness worksheet	Sweep room	Co-facilitate DBT group/activity	
	Infraction essay	Clean windows	Write speech for community meeting	
	Journaling assignment	DBT poster	Extra/personalized DBT skill packets	

During a repair, youth are separated from other residents for a period of time (usually measured in shifts) or until they complete the assigned repair activities. Separation during a repair is not a substitute for room confinement. Youth on repair status remain in the same physical space with other youth. They participate in regular school, DBT groups, and other programming, usually sitting at a separate table or in a chair several feet away from other youth. During recreational activities, youth work on repair assignments, which often involve assistance from staff. The length of the repair and the assigned actions are based on the level of infraction.

The introduction of repairs helped DYS chip away at opposition from staff who believed that room confinement was necessary to hold youth accountable. The concept of repairs highlighted an important distinction between accountability and punishment. While both concepts may require youth to do things they don't enjoy, accountability means that youth take responsibility for their actions. The difference between accountability and punishment is that repairs (accountability) require the youth to make amends with those negatively affected by the youth's behavior, while punishment is just a sanction. All repairs involve a written task the youth must present to a group of staff. As the Director of Clinical Services explains, youth must demonstrate that they "understand how their actions affected other people and how they will act differently in the future, so there's a lot of work."<sup>73</sup> Meanwhile, youth miss out on recreational programming and incentives. Repairs also require that youth acknowledge their misbehavior to another resident(s) or staff, which is a difficult task for most people—especially teenagers.

## 4. INCENTIVES

The positive-based behavior management system is based on recognizing behavioral progress. Evidence from many criminal justice and youth-serving contexts shows that incentives are more effective at changing youth behavior than sanctions.<sup>74</sup> As an agency, DYS has worked to create an environment where staff are searching for opportunities to “catch youth doing something right.” Programs recognize and reward youth who practice positive skills and behaviors with a range of incentives that include verbal praise and group recognition. “We don’t look to punish our kids while they are here. The fact that they are here losing their freedom, we feel is hard enough,” explains a program director. “In order to have our kids buy into our system and follow our rules we offer them incentives.”<sup>75</sup>

## 5. INDIVIDUAL SUPPORT PLANS

Another tool used by DYS to prevent room confinement is the Individual Support Plan (ISP). An ISP is a short-term intervention plan for youth who continuously act out or cannot respond to programming. The DYS Assistant Commissioner of Program Services describes the [Individual Support Plan Policy](#)<sup>76</sup> as an “all-hands-on-deck approach.”<sup>77</sup> When DYS implemented the new room confinement policy, “we recognized . . . this challenge in either assisting youth preventing or minimizing the recurrence of another isolation incident.”<sup>78</sup>

The ISP process can be initiated by a request from any staff member, a family member, or a young person. Within 48 hours, the program director organizes an interdisciplinary team that includes the youth and his or her parent or guardian. The team holds a meeting and produces a written plan that identifies the youth’s needs and lists specific interventions that the youth or staff may use. The collaborative structure of ISP meetings is critical. As one regional director explains, “If the clinicians are just writing up an ISP and telling people what to do, it will fail. If you get everyone’s input, there is more follow-through and buy in. All of this stuff leads to less room confinement.”<sup>79</sup>

ISPs list the youth’s strengths, behavioral triggers, warning signs, interventions, and incentives. Room confinement cannot be part of an ISP, although an ISP can state that staff may use room confinement if the youth engages in specific violent behavior that causes an immediate risk of physical harm. All direct care, clinical, and educational staff are expected to be familiar with the ISP.

### Examples of ISP Interventions

- Youth “will receive multiple staff check-ins during a shift to receive attention; these check-ins will be conducted at minimum three times per shift and documented in the log.”
- “I can ask to speak to my clinician when I am feeling stressed out.”
- Youth “will be permitted to take a time out when frustrated and may read, complete word searches, crossword puzzles, utilize music and stress-balls, or draw.”
- “I will receive ramen on Sundays if I have not received any repairs for the week.”
- “Staff will approach me when I look heated (am showing warning signs) and review coping skills with me.”

## STEPS TO SUPPORT STAFF SAFETY

Staff and labor unions voiced concerns about how changes to the room confinement and behavior management policies affected staff safety. They pointed out other problems including mandatory overtime, burnout, and high staff turnover. DYS took several steps to affirm the importance of staff safety and provide resources and support to staff.

### AGENCY SAFETY COMMITTEE

To create a regular and structured process for addressing concerns from staff, DYS established a state Safety Committee. Members include management and frontline staff from DYS Regional and Central Offices, human resources staff, labor relations and workers' compensation staff from the Executive Office of Health and Human Services, and representatives from all major labor unions. The committee structure allows union leaders to discuss concerns in an open problem-solving forum. The Safety Committee meets every two months to review data in safety index areas, evaluate potential reforms, and make recommendations to DYS. Safety Committee reports begin with data on room confinement, assaults on youth, assaults on staff, restraints, property damage, industrial accidents, and staff time out of work.

DYS also founded a Workforce Planning and Development work group to address issues and make recommendations regarding recruitment, on-boarding, training, coaching, retention, and evaluations.

### INCIDENT RESPONSE TEAM PROCEDURE

DYS created an [Incident Response Team Procedure](#)® to provide a consistent response to serious incidents in DYS facilities involving youth violence against other youth, youth violence against staff, escape attempts, and significant property damage. If an IRT is requested, administrators convene a team within two business days to review all reports, statements, and video footage. The IRT includes the DYS caseworker, program or facility director, director of residential services, regional director,

## DYS BEHAVIOR MANAGEMENT IN A NUTSHELL

Youth earn incentive points/opportunities for positive participation in programming and using DBT skills.

Youth must make repairs for negative behavior. Youth lose the opportunity to participate in recreational programming or redeem previously earned incentives during the repair period.

Repairs are categorized by the severity of the rule violation. Violence against other youth or staff are the most serious. Youth have a menu of incentives and repairs and can make choices based on the situation.

Youth who continuously act out or cannot respond to programming may receive an ISP.

Serious behaviors may result in an agency-level Incident Response Team (IRT) hearing.

regional clinical coordinator, the resident, any staff who were involved, and the youth’s parent or guardian. The team discusses the treatment plan and all parties have a chance to speak and give input. The IRT can support the program’s response, change the consequences imposed by the program, transfer the youth to another program, or take other actions.

In some situations when a young person seriously injured staff, the IRT could recommend that the youth go to a program called the Stabilization Unit, a small (10–12 bed) program for youth who were violent or struggled in other DYS programs. Youth could stay anywhere from 30 days to 6 months. DYS administrators stress that the Stabilization Unit was not designed to be or operated as an isolation or punishment unit. It operated like other DYS secure facilities, except all programming and clinical sessions were individual and the staff to youth ratio was very high. DYS ultimately closed the Stabilization Unit in 2018 because they no longer had a need for such a program.<sup>81</sup>

“The really difficult kid is one who punches a staff person. Staff are going to confront you with that, and you have to have a response. We have a detailed protocol in the event that it happens.”

**MOU TO SUPPORT STAFF**

In response to a recommendation from the Safety Committee, DYS and AFSCME Local 1368 created a protocol if a staff member chooses



to pursue a criminal complaint against a youth. DYS does not require staff to press charges, but it supports staff who elect to do so. The protocol was reflected in a Memorandum of Understanding (MOU) designed to help staff navigate the court process. The MOU established communication duties between staff, agency administrators, union representatives, law enforcement, and the local prosecutor. Assaults on staff have remained similar with a slight decrease per quarter between Calendar Year (CY) 2015 to CY 2016 and CY 2016 to CY 2017.<sup>82</sup>

**FIGURE 13**<sup>83</sup>

## WHAT HAPPENS WHEN YOUTH ASSAULT STAFF?

Youth who commit an assault do not necessarily receive room confinement. If a youth is de-escalated and has regained control, room confinement is not necessary.

Staff use the behavior management system to respond to youth's behavior (repairs, "freezing" incentives, Behavior Chain Analysis, updating a Distress Tolerance Plan).

If a young person is physically violent and less restrictive interventions have failed, staff may use room confinement to ensure safety.

If a youth is in room confinement, staff follow the DYS room confinement policy and Guidelines for Release from Room Confinement to help youth exit as quickly as possible.

Staff or youth may request an ISP.

The program follows the IRT procedure.

Staff initiate the MOU process if they choose to pursue criminal charges.

## DYS BASIC TRAINING TOPICS

Adolescent development

Trauma-informed care

Positive youth development

Suicide awareness and prevention

Safety, security, and searches

De-escalation and DBT

Practical application of physical restraints and defensive disengagement techniques

Educational services

Working with girls

Working with gang-involved youth

## **ANNUAL RECERTIFICATION TRAINING TOPICS**

Positive youth development  
Adolescent brain development  
Suicide prevention  
De-escalation  
Use of force  
Situational awareness  
Defensive and disengagement techniques

### **DYS STAFFING**

DYS programs have an average of 21 FTE direct care staff for each 12–15 bed program. Staff in the pilot staffing program work overlapping 10-hour shifts.

### **DIRECT CARE STAFF**

First shift: 1:5  
Second shift: 1:4  
Third shift: 1:7 (minimum of three direct care staff)

### **CLINICAL STAFF**

Clinical staff are on site during evening and weekend hours.  
Clinical director (psychologist or licensed independent social worker).  
Two master's level clinicians who are licensed or license-eligible.  
Each of the five regions of the state has a licensed clinical psychologist, a Regional Clinical Coordinator, and a Regional Clinician who is licensed clinical psychologist or licensed independent social worker, in addition to the Clinical Directors and clinicians who are program based.

## TRAINING

DYS invested heavily in ongoing training to give staff skills to prevent room confinement and the use of force. New hires attend three weeks of Basic Training at the DYS Training Academy.<sup>84</sup> During Basic Training, staff receive a full day of training on de-escalation techniques, and another eight hours on suicide prevention. Direct care staff also attend an annual recertification training at the Academy. Both Basic Training and recertification require staff to participate in scenarios and demonstrate proficiency in DYS-approved physical restraint techniques.<sup>85</sup> When staff are confident in their ability to physically intervene if necessary, they are less likely to preemptively use room confinement.

"We've also done a lot of training with our staff on adolescent brain development," says Rovezzi. "That has helped our staff step back a little bit and think 'this isn't necessarily personal, this is the way this young person reacts.'"<sup>86</sup>

## SUICIDE PREVENTION TRAINING

Suicide prevention is a priority topic in Basic Training and annual recertification. Staff learn how to distinguish between situations which require suicide assessment and situations that may require room confinement.<sup>87</sup> The DYS Director of Clinical Services Sparling explains that trainers spend a lot of time with both new and experienced staff "on how placing the youth in room confinement really increases the likelihood that they may make a serious suicide attempt. [They] really stress the importance of doing everything you can to keep a kid out of room confinement."<sup>88</sup>

**"IF YOU HAVE A  
RELATIONSHIP WITH A  
YOUNG PERSON, YOU CAN  
ENGAGE THEM IN MAKING  
DIFFERENT CHOICES  
BEFORE IT COMES TO THE  
NEED TO PUT SOMEONE IN  
THEIR ROOM."**

## RELATIONSHIPS EQUAL SAFETY

Training also highlights the role of positive relationships with youth as a tool to keep staff safe. One shift supervisor observes: "It's safer now from when I started 17 years ago. There is much more training for us. Less restraints are happening because staff are communicating between themselves and talking to the kids, building the relationships with the kids to make them understand that we are not here just to put hands on them. We are here to talk to them, to help them make a better change in their life."<sup>89</sup> Another facility administrator agrees that "[t]hose conversations build trust... those conversations that we have with them equal safety and security."<sup>90</sup>

## PILOT STAFFING PROGRAM

Although DYS has high staffing ratios compared to many other systems,<sup>91</sup> facility staff have challenging and complex jobs. In 2018, DYS began piloting a new schedule to reallocate staffing resources without increasing full time employee (FTE) positions. The pilot program also reduces stress by giving staff an additional day off and reducing the likelihood of forced overtime. Staff in the pilot program work four consecutive 10-hour days with three days off rather than five consecutive eight-hour days. This schedule provides more staff positions during times when assaults are most likely to occur, which data

show are between dinner and bedtime.<sup>92</sup> Staff in the pilot reported feeling more rested and, because shifts overlap, they have more time to communicate information from one shift to another.<sup>93</sup>

### **LOST TIME AND STAFF TURNOVER**

Many of the strategies discussed in this report cannot be implemented without enough qualified staff. Two data indicators to support the need for additional staff positions are lost time and turnover or attrition rates. DYS measures lost time by dividing lost time workers' compensation claims by the agency's FTEs. Massachusetts disaggregates this data by category of staff. Between FY 2015 and FY 2018, the rates of lost staff time for all levels of group workers decreased from 27 to 17.4.

DYS also tracks group worker attrition by calculating the turnover rate within one year of hire and the turnover rate during the initial six-month probationary period. As outlined in the DYS Safety Task Force, this information is straightforward if administrators know what information to track. Based on the example below, which does not disaggregate turnover by staff position, DYS reduced its turnover rate for new hires by more than 50%.<sup>94</sup>

**FIGURE 14 DYS GROUP WORKER 1 ATTRITION**

Calendar Year	Total Group Worker 1 Hires	Turnover Rate Within Year of Hire	Turnover Rate During Probationary Period
2014	88	31.8%	4.5%
2015	87	42.5%	4.6%
2016	114	39.5%	12.3%
2017	103	14.6%	1.0%

## **STATE LEGISLATIVE ACTION**

### **THE STATE TASK FORCE**

Although assaults on staff have gone down, several staff were seriously injured by youth in 2015 and 2016. In response, DYS and AFSCME created the DYS Safety Task Force.<sup>95</sup> Task Force members included representatives from DYS, AFSCME, the state legislature, and other child-serving and oversight agencies. The Task Force's purpose was to make recommendations to the secretary of the Executive Office of Health and Human Services on how to increase safety for DYS staff and youth. Over the course of a year, the Task Force held six meetings and conducted a comprehensive review of relevant policies and best practices. Members reviewed data on risk indicators including assaults, use of restraints, room confinement, suicidal behaviors, and staff injuries resulting from being assaulted or using restraints. The Task Force also heard from national experts and DYS staff.

In February 2018, the Task Force released its [DYS Safety Task Force Final Report](#).<sup>96</sup> The report

included several recommendations to enhance resources and support for staff. The Task Force also recommended that DYS review the internal communication structure—especially with respect to room confinement—so that “practice expectations articulated at the DYS executive level are understood and embraced throughout agency operations.”<sup>97</sup> Specifically, the Task Force addressed situations when youth become suddenly violent without warning. While infrequent, situations where verbal de-escalation is not practical and staff need to use room confinement immediately to prevent physical harm are possible. Although this is consistent with the room confinement policy, DYS administrators agreed to work more closely with unions and regional directors to ensure clear communication with direct care staff.

### STATE LAW FOLLOWS AGENCY POLICY

In 2018, Massachusetts passed legislation that codifies DYS policy limits on room confinement. The change was part of a broad criminal justice reform bill.<sup>98</sup> Section 10B of Bill S. 2371 prohibits DYS from putting youth in room confinement “as a punishment, harassment or consequence for noncompliance or in retaliation for any conduct.”<sup>99</sup> The law took effect on December 31, 2018.

FIGURE 15 DYS SUICIDAL BEHAVIOR IN SECURE FACILITIES



### CONCLUSION

The average duration of room confinement in DYS programs was 44 minutes during the last quarter of 2018 and 39 minutes for the 2018 calendar year.<sup>100</sup> Some staff quoted in this report couldn’t remember the last time they saw a youth in room confinement. Although the Massachusetts story of reducing room confinement was rooted in policy change to protect youth from self-harm. To be sure, the rate of suicide and self-harm has gone down, but the agency’s story of reducing room confinement evolved into part of a broader transformation of how the agency works with young people. As a deputy commissioner said, the agency’s “work as a juvenile justice agency is preparing young people to return to their communities as citizens, as contributing members of their community. For that, they need skills. They need to be able to manage the demands of life. They need to have an education that prepares them for employment. They need to have positive relationships with others. They are not going to get any of that locked in a room somewhere.”<sup>101</sup>



Photo credit: Richard Ross

# NOT IN ISOLATION

HOW TO REDUCE ROOM CONFINEMENT  
**WHILE INCREASING SAFETY**  
IN YOUTH FACILITIES

**SHELBY COUNTY, TN**

## Shelby County, TN: Major Reforms by a Sheriff's Office

### IMPETUS FOR CHANGE

On April 26, 2012, the U.S. Department of Justice (DOJ) issued a [Findings Report](#)<sup>102</sup> notifying the Juvenile Court of Memphis and Shelby County that the court was violating the civil rights of youth detained at the Shelby County Juvenile Detention Center by failing to provide them with reasonably safe conditions of confinement and freedom from undue bodily restraint. The report also found that the court violated the due process rights of children appearing for delinquency hearings, and that the court's administration of justice violated the equal protection rights of the children by discriminating against black children.

The report was the culmination of an extensive investigation by the DOJ. In January 2007, the DOJ's Civil Rights Division had received a complaint about a variety of issues from the Juvenile Court Ad Hoc Committee, a committee of the Shelby County Board of Commissioners.<sup>103</sup> Later that year, the National Center for State Courts<sup>104</sup> and the Memphis Bar Association<sup>105</sup> issued reports on the ongoing problems.<sup>106</sup> The DOJ investigation began in August 2009. It included consultation with experts in the field; interviews with court personnel, children appearing before the court on delinquency matters, and administrators; and review of policies and procedures, court documents, recordings of hearings, case files, materials, and statistical data. The Juvenile Court fully cooperated with the assessment.

After the Findings Report was issued, the Juvenile Court quickly decided to cooperate with the DOJ to remedy the deficiencies. It retained national suicide prevention expert Lindsey Hayes to assess the facility and make recommendations, which were subsequently adopted. In addition, the Health Department agreed to assist in providing round-the-clock medical and mental health care.

### MEMORANDUM OF AGREEMENT

On December 17, 2012, the DOJ, the Juvenile Court, and the county announced a [Memorandum of Agreement](#)<sup>107</sup> (MOA) with detailed reforms and timelines for their implementation. With respect to the use of physical restraints and seclusion, the MOA provided that staff would use the least amount of force necessary to stabilize the situation and protect the safety of the child and others; prohibited unapproved forms of physical restraint and seclusion; limited restraint and seclusion to those circumstances where a child posed an immediate danger to self or others, and when less restrictive means had been attempted but were unsuccessful; required prompt and thorough documentation of all incidents; required that staff be held accountable for excessive and unpermitted force; required immediate evaluation of all children involved in incidents by medical staff; and called for formal reviews of all uses of force and allegations of abuse.<sup>108</sup>

The MOA also prohibited routine use of isolation for children on suicide precautions unless specifically authorized by a qualified mental health professional, and such situations had to be documented in incident reports.<sup>109</sup>

The MOA included other provisions. It prohibited the use of a restraint chair and pressure point controls. It required improvements in suicide prevention. It also included extensive provisions regarding due process in delinquency hearings and protection from racial discrimination. To assess the implementation process and compliance with the MOA, the agreement appointed two monitors, one each for due process and equal protection violations, and a facility consultant, also known as the protection from harm consultant, who would receive documentation and visit the county every six months.

The facility consultant was David Roush, Ph.D., who ran secure juvenile programs and served as a consultant to many jurisdictions across the country.

The Findings Report noted several times that the Annie E. Casey Foundation's [Juvenile Detention Alternatives Initiative](#) (JDAI) had begun work in Shelby County earlier in 2012.<sup>110</sup> JDAI is a national initiative to reduce unnecessary incarceration of young people without jeopardizing public safety.<sup>111</sup> It operates in almost 300 jurisdictions throughout the country. Core strategies for JDAI include using objective instruments to determine admissions of young people to juvenile justice facilities, developing alternatives to secure facilities, reducing racial and ethnic disparities in the juvenile justice system, and ensuring safe and humane conditions of confinement for young people who are incarcerated. Thus, there was considerable overlap between JDAI's mission and core strategies and the provisions of the MOA. The MOA recommended continued engagement by the county and Juvenile Court in JDAI.<sup>112</sup>

### **TRANSFERRING OPERATION OF THE DETENTION CENTER TO THE COUNTY SHERIFF**

In August 2014, Dan Michael was elected judge of the Juvenile Court of Memphis and Shelby County (the county also has multiple magistrates or referees to handle juvenile cases). In July 2015, after extensive discussions, assessments, planning, reorganizing, and budgeting, Judge Michael and the Juvenile Court transferred operation of the Juvenile Detention Center to the Shelby County sheriff. There was significant concern about having a law enforcement agency run a juvenile justice facility,<sup>113</sup> but the effort had several potential benefits. The sheriff was able to hire juvenile justice facility staff into his office at higher salary levels and was able to provide more extensive training for correctional staff than had been available. The DOJ already operated a facility, Jail East, for young people transferred to prosecution in adult criminal court. The Sheriff's Office was a large agency, with more than 2,000 employees, and therefore had more staff who could be assigned to the juvenile facility. It already had contracts in place for food and medical services, which could quickly be utilized for youth in juvenile justice facilities. In addition, as a law enforcement organization, the Sheriff's Office had a clear chain of command structure that could help in implementing changes in policies and practices.

At the time of the transfer, the juvenile justice facility had multiple problems, including and beyond the ones identified in the DOJ Findings Report. The physical plant was old and outmoded. There were only three classrooms, so many youth were not able to go to school or went only for a few hours per day, which was itself a violation of the law. Other than school, two hours of recreation, and two

hours of “leisure” time, young people generally spent the rest of their time confined to their rooms. There was no other programming. With little to do most of the day, many youth got bored, noisy, and disruptive. Youth were regularly put into room confinement for three days for discipline. There were chronic staff shortages, so single staff on duty were often responsible for 16–24 youth at a time, when professional standards limit staff-to-youth ratios to 1:8.<sup>114</sup> In addition, youth wore prison-type jumpsuits.

## CHALLENGES

After the transfer of responsibility and development of a new system of reporting remedial actions, the key indicators of safety and well-being of youth went the wrong way. According to the Consultant’s Sixth Report,<sup>115</sup> between July and October 2015 there was a 12% increase in the reported use of disciplinary room confinement. There also was a 30% increase in the reported average duration of room confinement. In addition, during that period, there was a 58% increase in suicidal behaviors, a 31% increase in the rate of assaults of youth on youth, a 36% increase in the use of physical restraints, and a 303% increase in the use of mechanical restraints. Frequent staff turnover exacerbated these problems.<sup>116</sup>

Parts of the increases were a result of documentation practices. Staff were documenting the use of restraints during routine transportation for medical and dental visits as uses of force within the facility. Likewise, staff were documenting routine time in rooms for sleeping as isolation, room confinement, and suicide watch precautions.



**FIGURE 16 YOUTH RECREATION AT SHELBY COUNTY JUVENILE DETENTION CENTER**

Some changes requested by Roush were implemented prior to his visit in September 2015, including improved food service, larger meals and healthy snacks, improved room lighting and painting, and allowance of books in youths’ rooms. In addition, all staff had received 40 hours of training and were certified by the State of Tennessee for the first time.

By April 2016, there had been more improvements that affected the use of isolation.<sup>117</sup> Programming and group activities were added, a full-time counselor was hired to expand programs for young people, visits were extended, and additional phone calls were allowed. The Positive Behavior Management System (PBMS) was implemented and all staff were trained on

it. Youth received information about PBMS in the Detainee Handbook which they could keep in their rooms.<sup>118</sup>

At the same time, youth complained of a “22/2” program on weekends which kept them confined in their rooms for all but two hours a day. Youth also identified issues with “Red Card” disciplinary status, which carried 23/1 room confinement for three days and the use of handcuffs and shackles during the one hour out of their rooms.<sup>119</sup> In addition, documentation of room confinement incidents was unreliable; too much information was collected by hand, data forms were not completed consistently, and there were problems with storage and retrieval of data.<sup>120</sup> Roush labeled the situation “...unacceptable. It is the ‘canary in the coal mine,’ a reliable indicator of more serious problems.”<sup>121</sup>

Six months later, there were additional improvements. Staff were conducting daily [circle-up groups](#), or ad hoc counseling sessions, in the units, sometimes multiple times a day. The groups provided youth with information about the daily schedule, including upcoming activities during the shift. They also provided a “safety valve” for youth who needed to vent or express emotions. The groups also provided youth with staff models of respectful, caring adults.<sup>122</sup>

PBMS had begun to take root, with colorful posters about the system being displayed throughout the building. Youth and staff described positive outcomes as a result of the new token economy system. A youth advisory committee provided information to the director of PBMS about any youth concerns.<sup>123</sup>

Staff also began receiving a variety of new trainings. Chief Inspector of Juvenile Detention Deidra Bridgeforth implemented a 16-hour

## Initial Improvements in Shelby County

- State certification of all staff
- Positive Behavior Management System
- Training on how to work with youth
- Improved data metrics tracking key behaviors
- Standardized review of videos and documentation of room confinement incidents
- A full-time staff position to expand programs for young people
- Additional programming
  - Daily circle-up groups
- Youth advisory committee
- Improved conditions in youth rooms
- Increased visitation and phone calls

## Definition of Room Confinement in Shelby County Juvenile Detention Center

Room confinement is defined as the placement of the youth in any secured room away from general population, with authorization. The youth’s behavior and/or the safety and security of the youth and the Assessment for Release determine when the youth leaves the room.

Shelby County measures room confinement as involuntary confinement for longer than 59 minutes. The data does not include periods of involuntary confinement of less than 59 minutes, which they consider “time-outs.”

training on differences between youth and adults, and how to work with youth who are incarcerated. With funding from OJJDP, two outside consultants delivered a 40-hour training for trainers on youth-specific issues. The training clarified adult learning styles and helped the trainers understand how to teach in ways that were effective for staff. The Sheriff's Office also sent a staff member to a training on safe crisis management with special emphasis on de-escalation skills.<sup>124</sup>

The data system, used for tracking room confinements and uses of force, showed significant improvement, due to a focused effort by the lead data researcher from the Juvenile Court and her counterpart in the Sheriff's Office. They developed an improved data metrics plan that identified key behaviors to track. Monitoring of the use of restraints also improved with a standardized review of videos and documentation of all incidents.<sup>125</sup>

At the same time, however, Roush reported that room confinement remained an ongoing concern, as did the use of physical restraints.<sup>126</sup> Youth complained of widespread inconsistencies among staff in awarding points under the PBMS. Youth also complained of favoritism and group punishment, and a level of disrespect and profanity toward them by a majority of the male staff.<sup>127</sup>

By April 2017, the number of room confinements had dropped significantly, but the average duration of room confinements increased substantially. The facility consultant<sup>128</sup> reported that "youth are remaining in their rooms after incidents for a far longer time than is necessary for them to 'cool down' or reduce their agitation to near normal levels."<sup>129</sup>

## **THE TURNING POINT**

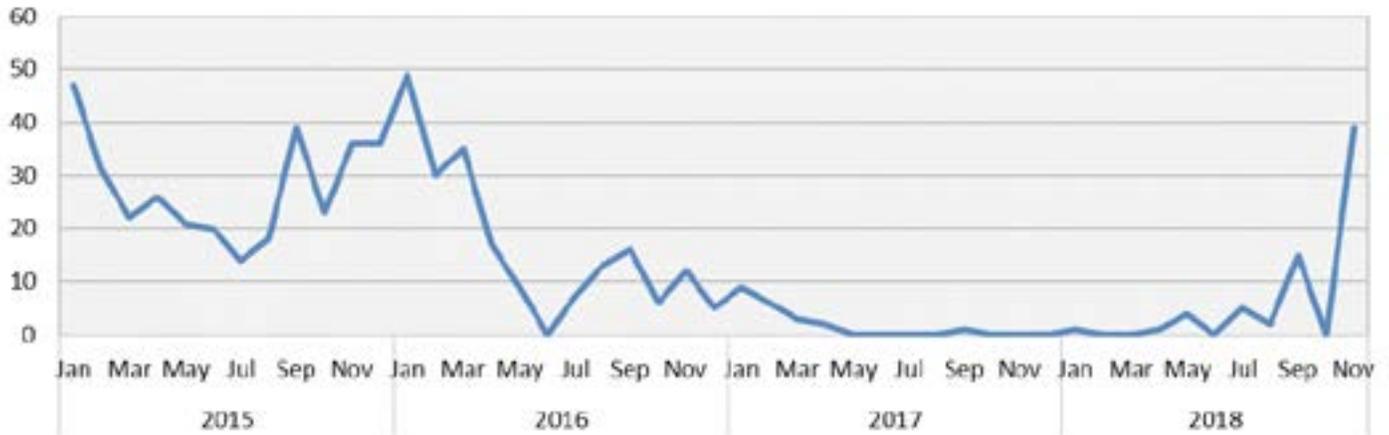
But by October 2017, just six months later, things had changed significantly. Staff more fully incorporated their training, new facility policies, and the developmental approach to adolescents into their relationships with youth and responses to misbehavior. Programming increased to fill up time when youth had been idle. The facility consultant noted that use of room confinement longer than one hour "has dropped to zero," and he pronounced the facility in compliance with the room confinement provision of the MOA.<sup>130</sup>

For 2018, juvenile justice facility records show a very low level of room confinement—none at all in February, March, June, and October; only one instance in January and April; and five each in July and September. November was an outlier: there were 19 uses of room confinement on 39 youth.

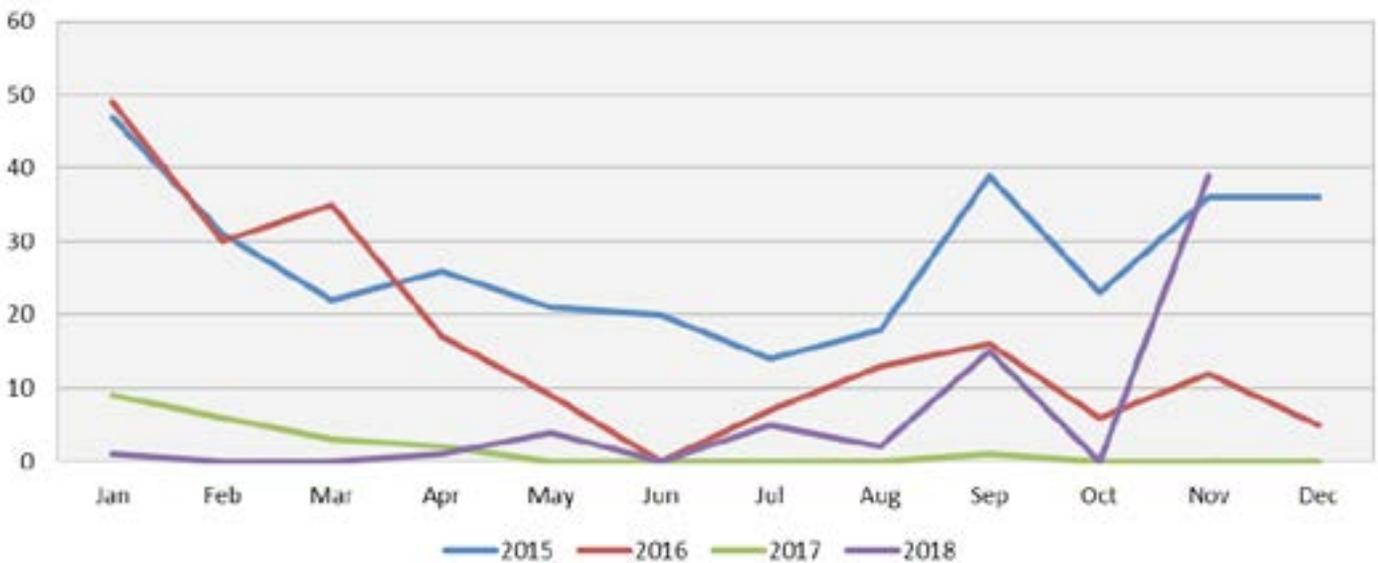
Facility administration attributes that primarily to a group of 10 youth who were arrested together and detained in early November, who proceeded to cause considerable disruption on November 3 and for days afterward. All in all, however, the data show a very strong reduction in room confinement, completely or virtually eliminating it for most months of the year. The figure below shows two useful ways that administrators viewed data to determine the overall chronological trend in room confinement incidents, but also to determine during which months more incidents occurred.

FIGURE 17 COMPARISON OF DISPLAYING TRENDS IN ROOM CONFINEMENT

**Shelby County Room Confinements 2015-2018**



**Shelby County Room Confinements by Month**



Reducing room confinement in a sustainable, meaningful way was a challenge that, in Fessenden’s words, “required all hands, and brains, on deck.”<sup>131</sup> It began with staff engaging the youth in their rooms every 15 minutes to see if they were calm, safe to be around others, and had insight into what triggered the bad behavior and how to control it moving forward. This process could go on for long periods of time as staff tried different approaches to reach the youth. Sometimes the discussions resulted in behavior “contracts” written by the staff and youth. Now youth occasionally ask staff to allow them be alone in their rooms when they are struggling with emotions or issues that they feel will cause them to be disruptive. This process underscores the importance of relationships between youth and staff.

Staff must now obtain permission for room confinement at every level up the command chain, including medical and a Chief Inspector. Not surprisingly, staff realized it was more efficient to utilize de-escalation and adolescent behavior techniques to resolve the problem.

Room confinement reduction and PBMS went hand in hand. As staff became more creative in offering meaningful rewards, such as increased visitation and phone calls, they realized that removing some of those rewards could be a significant deterrent. Staff complained in the beginning that youth were not being sufficiently “punished” for assaultive behavior, so staff were asked to participate in developing a disciplinary matrix that would ensure consistency on each shift. Youth were also allowed input, since they were very vocal about inconsistencies.

Recently, Roush suggested rewarding staff for positive outcomes, particularly de-escalation. An officer appreciation program is now in place. Peers nominate each other for monthly honors which include gift cards and meals with the Chiefs.

## WHAT WORKED

There were many factors that made it possible for the Sheriff’s Office to achieve significant reductions in the use of room confinement.

### LEADERSHIP

The chief architects of reform at the Sheriff’s Office were Sheriff Bill Oldham, who supported reforms and made the financial commitment to train current staff, add new staff, improve food services, add programming, and make improvements to the physical plant; Assistant Chief Kirk Fields, who became the director of the juvenile justice facility when responsibility was transferred from the Juvenile Court; and Bridgeforth, who was promoted to assistant chief and director of the facility in September 2018, when Fields was promoted to chief jailer.

Fields and Bridgeforth were committed from the beginning to making changes and going beyond the mandates of the MOA. Early on, they wanted to be proactive. They were particularly concerned about the extensive use of room confinement. When Bridgeforth asked why there was so much use of solitary, staff told her that it was because of staff shortages. “It hurt me so much to see children in rooms like that,” she said. She also felt that isolation was the wrong approach. “Room confinement causes mental illness,” she says. “You’re teaching violence when you use force.”<sup>132</sup>

## DEPARTMENT OF JUSTICE INVESTIGATION AND THE MOA

Although agreements between the DOJ and state or local governments are often sources of friction, the overall experience was positive for the Sheriff’s Office. The close involvement by Roush and the many suggestions he made for new policies, practices, and training were particularly valuable. Debra Fessenden, the sheriff’s legal advisor, helped connect the Sheriff’s Office to the National Partnership

for Juvenile Services as a way to bring in more training, as well as to other resources recommended by Roush. Bridgeforth says that “DOJ was a great learning experience.”<sup>133</sup>

Roush was particularly helpful in explaining what makes “behavior management” work: not the type or severity of the sanctions, but rather the importance of developing rewarding relationships between youth and staff,<sup>134</sup> and having extensive programming to keep youth occupied throughout the day. Bridgeforth also says that Fessenden, who was positioned between the DOJ attorneys and the Sheriff’s Office, “kept us accountable.”

## NEW POLICIES AT THE JUVENILE JUSTICE FACILITY

The Sheriff’s Office revised a number of policies that had been in effect at the juvenile justice facility and wrote new ones. The policy on [Involuntary Room Confinement](#),<sup>135</sup> put into effect a year after the transfer of responsibility, states that staff may only put a youth in room confinement if the youth poses an immediate danger to self or others, and less restrictive crisis intervention techniques have failed. Room confinement requires approval and documentation by a lieutenant, a captain, the chief inspector, and medical personnel. When the youth is put in his or her room, staff must advise the youth on the reason for the confinement and the expectations for release. Cited examples of expectations for release are the youth appearing calm for 2–5 minutes and verbally stating that they are ready to return to regular activities. Each incident is reviewed by a Multidisciplinary Review Team that includes correctional senior staff, the director of mental health, and a health department senior representative. The members of the team also view all videos of confrontation incidents.

A new policy on [juvenile justice services](#),<sup>136</sup> put into effect in February 2017, sets forth four levels in the use of force continuum and clear parameters as to when and what kind of physical force can be used. The policy is keyed to training for staff by [Safe Crisis Management](#)<sup>137</sup> and [Crisis Prevention Institute](#),<sup>138</sup> two programs of verbal and non-physical intervention that have been very successful in other jurisdictions. Importantly, the policy states that “The use of physical force *or seclusion* as a disciplinary sanction, punishment, or as a training or behavior modification technique is strictly prohibited” (emphasis added).



FIGURE 18 SHELBY COUNTY PROGRAMMING

At the same time, in February 2017, the facility put into effect a [new policy on the Positive Behavior Management System](#).<sup>139</sup> The PBMS outlines positive behavioral expectations in five areas such as

cooperation, participation, and positive reinforcement by youth of good behavior by other youth. It also lists basic skills—following instructions, accepting consequences, showing respect, showing concern—for which youth can be rewarded with coupons redeemable for snacks. The facility created a [list of items](#) available to youth in the Adams’s Street Corner Store, which is named after the street on which the juvenile justice facility is located. It is called a “store” instead of a “commissary” to avoid an association with jails and prisons. In addition to the snacks and treats on the list, youth also can sleep late, get extra time on phone calls, or get extra visitors. Prior to the transfer of responsibility to the sheriff, there had been a positive behavior management point system, but the rewards were more limited.

## NEW TRAINING FOR JUVENILE DETENTION FACILITY STAFF

Correctional administrators were well aware that, as Bridgeforth says, “To change something, you need to replace it with something better.”<sup>140</sup> With recommendations from Roush, the Sheriff’s Office brought in a variety of new training for correctional staff.

First, staff working in juvenile justice facilities at the time of the transfer of responsibility had to be trained and certified as corrections deputies. Bridgeforth conducted much of the training, which provided an opportunity for her to develop relationships with the staff who were now working under her command.

The staff benefitted from new training on Safe Crisis Management, a program that is recommended by the DOJ and has been effective in reducing the use of force and isolation in many juvenile facilities across the country. Before the transfer of responsibility, staff said that “room confinement was the only punishment we had.”<sup>141</sup>

Some correctional staff could not or would not go along with the new program and had to leave. Most, however, did cooperate and appreciated the new training.

**Equally important, the new training was evidence-based and developmentally appropriate; Bridgeforth says the staff was trained “on the science of rewards.” This required a real adjustment from their previous orientation, but staff eventually saw the improvements firsthand in their new roles as teachers, coaches, and mentors. “It worked” she says.**

## NEW PROGRAMMING

One of the first moves after the transfer of responsibility was to hire a new program manager. This provided a point of focus for new programming opportunities. The number of volunteers coming into the facility was increased from 15 to the current 45. The sheriff built a new classroom so that all youth can go to school every day. There is enrichment programming after school, and group circle-ups several times a day, with an emphasis on positive developments in the units. In the evening, table games, television, and other programs are available, including mentoring programs, baptisms, and “Wild Wednesdays” with speakers such as a former television news reporter, judges, police officers, ministers, and fraternity brothers. Community partners who help to broaden youths’ cultural horizons

also are involved. These include a famous artist who helped youth create a mural of historical figures in the dining room, a Shakespeare company that puts on plays and teaches dramatics, and musicians providing gospel, blues, and classical music. "I want all kids out all day," Bridgeforth says.<sup>142</sup>

### **VISIT TO ANOTHER JUVENILE JUSTICE FACILITY**

It was also helpful for juvenile correctional administrators and staff to visit another facility that already had several of the components they wanted to bring to Shelby County. In June 2017, two administrators and three juvenile officers visited the [Youth Center of High Plains](#) in Amarillo, TX. They had discussions and round tables with administrators, staff, and youth on the individual responsibility value system and [Rational Behavior Therapy](#)<sup>143</sup> in use in the facility, disciplinary management, and the token economy. The Shelby County group found that the site visit helped them to better understand the behavior management training materials provided to them by Roush and the training presented by the National Partnership for Juvenile Services consultants.

### **ADDITIONAL STAFFING**

There was a staffing analysis<sup>144</sup> done in 2016 that showed the need for more staff and more programming. The Sheriff's Office brought in new people for intake and added three sergeants and two captains from its adult corrections facility, in addition to new staff in the units. All new staff had to complete 40 hours of youth-specific training.

There was general agreement on the need to keep an appropriate ratio of youth to staff. This was challenging because the daily population at the facility fluctuates, ranging from over 100 to as low as 40 during 2018. Youth can be situated in nine areas of the facility: the boys north unit, the boys south unit, the girls unit, four classrooms, and two gyms. The incidents of room confinement decreased substantially in 2017 and 2018 at the same time as additional staff were added and training was enhanced.<sup>145</sup>

### **MENTAL HEALTH RESOURCES**

There also was an increase in availability of mental health clinicians. A qualified mental health professional is onsite during the day Monday through Friday, and part-time on the weekends. A clinician is available on call during other times. Clinicians now facilitate programs with youth, conduct one-on-one counseling, and are more involved in the workings of the facility.

### **SUPPORT AND APPRECIATION FOR STAFF**

The emphasis on positive youth behavior was accompanied by increased support for correctional staff. The additional training showed staff that administrators wanted them to have the tools to do their job better. Administrators added specific positive reinforcers for staff. There is now an employee of the month and an employee of the quarter, and staff can receive breakfast or lunch with the chief. One staff reported, "I feel more appreciated than ever before."

## ENVIRONMENT IN JUVENILE JUSTICE FACILITIES

The physical plant for the juvenile justice facility is older and has design flaws. Nevertheless, correctional administrators made some important positive changes in the experience of living in the facility. The youth no longer wear prison-like jumpsuits, and instead have t-shirts and khakis. They are referred to as “youth” or “children” instead of “juveniles.” The time for lights out increased two hours—from 6 p.m. to 8 p.m. After a visit from members of the county commission and a supplemental appropriation, the facility stopped charging parents for calls from their children. Now all calls are free, which has made a substantial difference to youth and their families.<sup>146</sup>

For a time, there were no regular hair cutting services available to youth in the facility. After the transition, facility administrators brought in hair cutting services monthly to attend to youths’ needs.

**“When we cut their hair, their whole demeanor changed,” says Bridgeforth. “Children saw we cared about how they looked, so they cared about how they looked.”<sup>267</sup>**

## ACCOUNTABILITY

Correctional administrators also acted to provide greater accountability of staff. At the time of the transfer of responsibility, review of incidents was inconsistent. Now the [Major Incident Review Form<sup>147</sup>](#) provides three levels of review and specifically asks whether there was any wrongful conduct by staff or any violations of policies and procedures, and if so, what steps were taken to address and correct any violations. Staff who violate the rules or use force in a way contrary to Safe Crisis Management are subject to progressive discipline, from verbal warnings to written reprimands to suspensions from work for one, three, or five days.

The teams that review videos of incidents focus on what happened just before the confrontation occurred. Where was the officer located on the unit? What was he or she doing? Were they aware that a confrontation was brewing? What action could they have taken to resolve the conflict before a confrontation occurred? This focus on antecedents enables administrators to counsel individual staff, modify training, and clarify policies as needed.

## CONCLUSION

Detention administrators and staff in Shelby County have not resolved all issues involving room confinement. A sudden uptick in the use of isolation in November 2018 shows that a group of very disruptive youth can test the patience and commitment of even the best administrators and staff. After ten months of an average of 1.8 room confinements per month, a group of youth flooded their rooms the day before a facility audit by the American Correctional Association.

**FIGURE 19 SHELBY COUNTY ROOM CONFINEMENTS, RESTRAINS, ASSAULTS & AVERAGE DURATION OF CONFINEMENT**



DATA ON YOUTH AND STAFF ASSAULTS NOT AVAILABLE FOR 2015.

In addition, the [new written policy on Detainee Discipline](#)<sup>148</sup> provides for room restriction for up to five days as a sanction for misbehavior, which is inconsistent with the Involuntary Room Confinement and Juvenile Detention Services policies, and which seems unnecessary in light of the very rare use of room confinement during 2018.

Furthermore, the population of the facility varies considerably during the year, usually decreasing early in the year until reaching a low point during the summer, then growing from October to the end of the year, when the population can be almost double that of the summer months. This creates challenges for the plan to have no more than eight youth in each area of the facility other than classrooms and special programs during daytime activities.

Moreover, reform in the use of room confinement is time-consuming and staff-intensive, and requires patience. Correctional administrators and staff in Shelby County stayed committed to their duties during the transfer of responsibility, and have brought together the necessary components for significant reductions in the use of isolation. However, they are aware that continued success

will depend on constant attention to detail and regular review of behavior by both youth and staff. Their efforts toward that end include posting of monthly statistics on assaults, de-escalations, and use of force; daily observation of staff performance by supervisors to ensure compliance with policies and procedures; and facilitation of Youth Advisory Council meetings twice a month, which provide detained youth with opportunities to discuss and have input on ways to improve the Positive Behavior Management System.

Nevertheless, the reductions in the use of room confinement at the Shelby County Juvenile Detention Center are impressive. The many changes in policies, practices, training, programming, staffing, environment, and available resources put correctional administrators and staff in a strong position to continue the reforms.

The sheriff's continuing commitment to reform is shown through the ongoing partnership with the judge and the court. The DOJ had terminated many provisions of the MOA in the intervening years, as the county came into compliance. On October 19, 2018, the DOJ terminated the final provisions, removing DOJ oversight of the juvenile detention facility.<sup>149</sup> However, on December 11, less than two months later, Sheriff Floyd Bonner reached out to Roush to serve as a consultant to ensure the forward trajectory. Roush continues to provide technical advice and support.



Photo credit: Richard Ross

# NOT IN ISOLATION

HOW TO REDUCE ROOM CONFINEMENT  
**WHILE INCREASING SAFETY**  
IN YOUTH FACILITIES

**OREGON YOUTH  
AUTHORITY**

# Oregon Youth Authority

## INTRODUCTION

When current Oregon Youth Authority (OYA) Director Joe O’Leary joined the agency as the deputy director in 2012, the agency was experiencing significant challenges managing youth with disruptive behaviors. OYA’s average length of stay in isolation was twice the national average.<sup>150</sup> “A lot of bad outcomes were happening for the kids. Kids were ending up in the Behavior Management Unit for a long time. Luckily, we had no suicides during that time. A lot of bad outcomes were happening for the staff. The staff burnout was super high. The staff morale was super low. We were putting staff in an untenable situation. We realized that we had a big issue. And it was cyclical and deeply engrained in the culture.”<sup>151</sup>

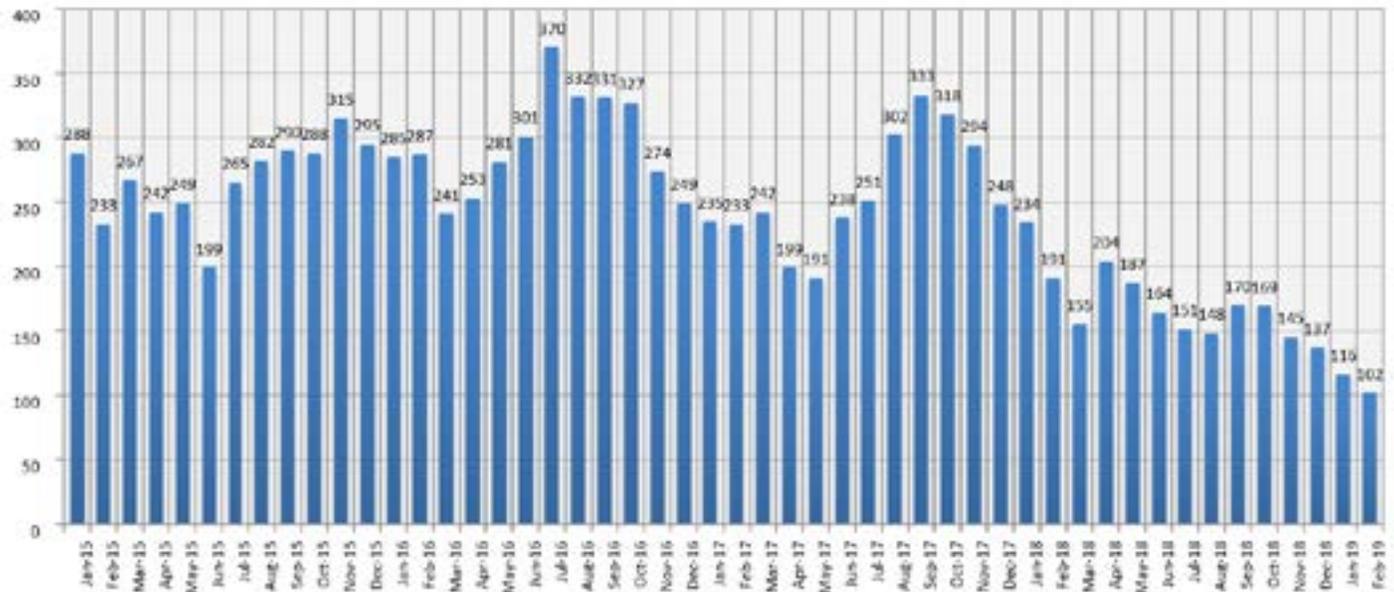
Oregon’s story of reducing room confinement is unconventional. While many of the ingredients of reform are similar to those used by other agencies, OYA followed a very different recipe. In order to create an environment that would support and sustain policy changes, OYA began by changing the institutional culture around the use of room confinement. Implementing a new policy was one of the final steps in the process. Agency leaders saw that nationally accepted practices were shifting away from the use of isolation and decided to change the practice on their own terms rather than wait for a tragedy, lawsuit, or external litigation. “The research about the impact of isolation on kids is there. If we didn’t take it head-on and start to change our own practices, then other people were going to do it for us,” Erin Fuimaono, OYA’s assistant director of development services said.<sup>152</sup>

Despite an older population charged with serious offenses, OYA was able to make significant reductions in isolation and implement a policy that bans isolation as punishment. Under Oregon state law, youth sentenced as adults may remain in OYA custody until age 25. Almost 60% of youth in OYA facilities are 18 years or older. Oregon’s story sets an important example for other jurisdictions as the recently reauthorized federal Juvenile Justice and Delinquency Prevention Act (JJDP A) prevents states from housing youth charged as adults in adult facilities and jails, which means that facilities across the country will soon accommodate more youth charged with serious offenses.<sup>153</sup>

The number of incidents of isolation in OYA facilities dropped from 370 in July 2016 to 140 in December 2018.<sup>154</sup> Violence has decreased and staff report feeling safer. Rather than isolation, staff rely on proactive approaches and intervene at the earliest point, versus reactive approaches of waiting until behavior has escalated to the point of requiring isolation.<sup>155</sup> Despite these improvements, OYA administrators acknowledge that they still have a long way to go. While the frequency of isolation has gone down, the average duration of isolation incidents is still longer than average. The average duration of isolation in February 2019 was just under 24 hours, while national data from Performance-based Standards<sup>156</sup> shows that more than 80% of isolation incidents in other juvenile justice correctional facilities end in less than eight hours. Administrators explain that the duration of isolation remains high because the threshold for isolation has increased to include only serious

behavior. The current OYA policy threshold for isolation requires actual violence or an imminent threat of violence. OYA is working to reduce duration by creating specialized positions and developing reintegration requirements, as discussed below. "This is not easy," said O'Leary. "We are mid-stream in our transition, and it takes a long time and a lot of intentionality."<sup>157</sup>

**FIGURE 20 TOTAL ISOLATION INCIDENTS (2015-FEBRUARY 2019)**



**FIGURE 21 ISOLATION DURATION IN HOURS (JAN 2017-FEB 2019) (HH:MM)**

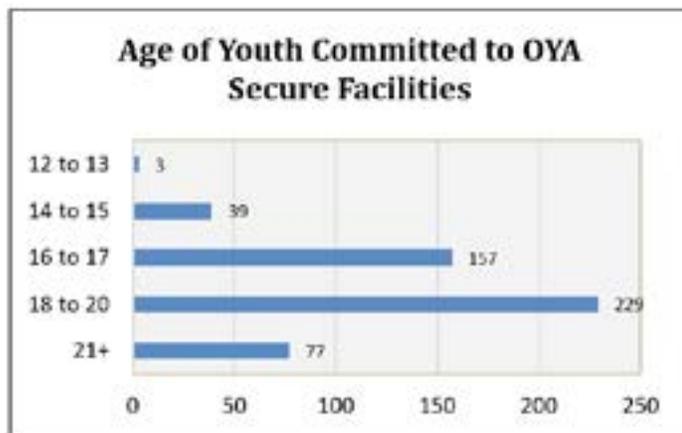


**I. AGENCY BACKGROUND**

The OYA was created by Senate Bill 1 in 1995. OYA is responsible for the supervision, management, and administration of juvenile justice commitment facilities; state parole and probation services; and community out-of-home placements for youth. The agency has nine secure facilities, which are also called close custody facilities. Five are secure commitment facilities and four are camp facilities with transitional and vocational programs. Approximately 505 young people are committed to OYA close custody facilities. In 2017, OYA closed two facilities, including one of its largest correctional facilities, Hillcrest Youth Correctional Facility.

OYA works with many older youth with serious charges. In 1994, Oregon passed Ballot Measure 11, which required youth as young as 15 years old to be charged and sentenced to mandatory sentences as adults for certain offenses.<sup>158</sup> To minimize the impact of youth charged as adults on the Department of Corrections, state legislation also permits youth who are sentenced as adults to stay in OYA custody up to age 25.<sup>159</sup> Almost 45% of the youth in OYA secure facilities are serving adult sentences. As of January 2019, 280 youth were committed to OYA through the juvenile justice system, while 225 were committed by the Department of Corrections. In 2019, 45% of youth in OYA close custody facilities were ages 18–21. Youth ages 21 years and older made up 15% of the population.<sup>160</sup>

**FIGURE 22 AGE OF OYA YOUTH**



**FIGURE 23 MOST SERIOUS OFFENSES OF OYA YOUTH**

Most Serious Charge	Youth Number of Youth	Percentage of Youth
Sexual Offense	128	25%
Property	111	22%
Person-to Person	110	22%
Robbery	72	14%
Homicide Related	41	8

Although the population of youth in OYA secure programs has decreased by 55% since 2000,<sup>161</sup> a large part of the population is made up of older youth, youth charged with serious offenses, and youth with significant mental health and trauma histories. More than 75% of youth committed to OYA facilities have diagnosed mental health disorders.<sup>162</sup> Almost 43% of girls and 16% of boys are victims of sexual abuse,<sup>163</sup> while 29% of girls and 12% of boys have exhibited past suicidal behavior.<sup>164</sup>

Notably, Oregon just enacted legislation that would reverse many aspects of Measure 11. In May 2019, the Oregon House of Representatives passed [Senate Bill 1008](#), which would require all cases to

begin in juvenile court and establish a “second look” process for youth sentenced as adults halfway through their sentence.<sup>165</sup> The bill, which would apply to matters pending after January 1, 2020, passed by two-thirds of both chambers of the state legislature and is on the way to the governor, who has indicated she will sign it into law.

## THE CHALLENGES

### LACK OF CLEAR POLICY GUIDANCE ON ISOLATION

Like many juvenile justice facilities and agencies, OYA historically relied on isolation to control youth behavior. Although OYA prohibited room confinement as punishment in 2005, there was little policy guidance, and staff continued to use the practice as a punishment or sanction. Prior to 2010, youth with serious and chronic behavioral issues frequently spent periods of 60 to 90 days in the agency’s Behavior Management Unit, which was housed in an isolation unit. Staff also could impose consecutive periods of isolation, and there was no limit on the maximum length of time youth could spend in isolation.

In 2010, OYA introduced a behavior matrix to create consistency in behavior management responses across the agency. The matrix system created categories of behavioral offenses and corresponding “refocus options” that staff could use. A refocus option was defined as an “appropriate response to, or sanction for, behavior.” Because a refocus option could be either a sanction or a response to youth behavior, the behavior matrix listed isolation as a refocus option without technically violating OYA’s existing policy against isolation as punishment. However, the behavior matrix did cap the amount of isolation that staff could use at five days.

In practice, facility staff continued to use isolation as a punishment even after the behavior matrix was introduced. Although the matrix banned consecutive periods of isolation and established an upper time limit on isolation, it did not provide any other guidance for staff. Staff continued to use isolation as punishment, generally for the maximum allowable time.<sup>166</sup> As one facility administrator explains, “Where people got stuck is [the behavior matrix] still had isolation listed as ‘up to five days.’ Just because the matrix said up to five days doesn’t mean it needed to be five days, or it’s the right thing to do.”<sup>167</sup>

## II. HOW OYA MADE REDUCTIONS IN ISOLATION

### LETTING STAFF LEAD THE REFORM PROCESS

In 2013, OYA administrators put the task of reducing isolation on the top of their agenda. Securing buy-in from all levels of staff was critical. Former OYA Director Fariborz Pakseresht explained why OYA could not successfully implement changes in isolation practices without the front-line staff: “The culture we have in the organization predates us by many years. In attempting to shift the culture some staff may see us as just another flavor of the day, week, month.... Those who are resistant to

change may be fairly confident that they can outlast us and the new initiative. In most cases they are correct.”<sup>168</sup> OYA administrators structured staff participation in the isolation reduction process so that staff could feel ownership and pride in the results.

## INTERNAL ISOLATION AND REINTEGRATION OVERSIGHT COMMITTEE

OYA did not eliminate isolation, but the agency asked staff to reshape the way it was used. In October 2014, OYA established an Internal Isolation and Reintegration Oversight Committee (Internal Isolation Committee) made up of management staff from facilities, direct care staff (called Group Life Coordinators or GLCs), union representatives, and treatment staff. OYA instructed the committee to use research and national best practices to do two things: (1) create a new definition of isolation, and (2) redefine when and how staff could use isolation. The Internal Isolation Committee recommended the following revisions to the definition and threshold for the use of isolation:<sup>169</sup>

### THE ISOLATION DEFINITION IMPLEMENTATION WORKGROUP

Once the Internal Isolation Committee developed recommendations for the new isolation definition and threshold, OYA faced the larger task of mapping out a successful implementation process. To do this, administrators again formed a diverse committee of staff in early 2015 to develop alternative interventions to isolation and to identify the necessary resources to make those alternatives work.

As with the Internal Isolation Committee, the Isolation Definition Implementation Workgroup (Implementation Workgroup) included a broad range of approximately 30–40 staff throughout the agency with multiple layers of direct care workers from every facility. This included supervisors, mental health professionals, training staff, and GLCs. Diverse representation on the workgroups was critical, said Fuimaono, “because it allowed for the cross section of folks to become much more educated on the issue of why reducing isolation was the right choice for everyone and the different factors at play. We chose that group of folks carefully because we wanted them to be message carriers when they went back to their facilities and to speak about their own experiences on the workgroup when [other staff] had questions about the process.”<sup>170</sup>

“YOU CAN’T GO AWAY IN THE LAB AND COME UP WITH A GREAT POLICY. YOU HAVE TO GO OUT THERE AND GET THE FOLKS THAT ARE DOING THE WORK, KNOW THE KIDS, KNOW THE OPERATIONS, KNOW THE CLINICAL PIECE, KNOW YOUTH DEVELOPMENT, AND GET THEM AROUND THE TABLE TO BE PART OF THIS EFFORT. YOU CAN’T GO FROM THE TOP DOWN.”

—ASSISTANT DIRECTOR CLINT McCLELLAN<sup>268</sup>

## COMMUNICATING CHANGE TO THE WORKFORCE

Acting on recommendations of the Implementation Workgroup, Fuimaono and OYA Assistant Director Clint McClellan went to all 38 housing units in OYA secure facilities to meet with staff. Their goals were to explain that a major change was coming in the isolation policy and to ask staff what resources they needed to make this change happen. The plan was for Fuimaono, McClellan, and members of the Implementation Workgroup to continue these conversations with staff over a period of months.

They began conversations by asking staff members why they decided to work for OYA. “Almost everyone said they wanted to make a positive difference with kids, or to help communities by helping kids,” said Fuimaono.<sup>171</sup> If some staff disagreed with this, Fuimaono and McClellan pushed. The goal was to get everyone to agree on some shared positive values. “We acknowledged that there was a time when [isolation] was thought of as the appropriate thing to do, but we are shifting mindsets and have new research and an understanding of skill development in behavior change,” Fuimaono said. “None of us would be using computers from 2000. The same is true in how we interact with young people.”<sup>172</sup> Administrators focused on linking the impetus for reducing isolation directly to OYA’s mission and values.<sup>173</sup>

Fuimaono elaborated, “We clarified that OYA was not eliminating the use of isolation, but we were talking about how to use it differently. We had to balance our message about what is effective for kids with the acknowledgement that our staff are in harm’s way sometimes. [Isolation] would still be an option as a safety intervention, but not as a punishment. Because that doesn’t work.”<sup>174</sup>

The message to staff from the beginning was that the agency was moving toward a model where staff used isolation only if violence was imminent.<sup>175</sup> However, they explained that the agency would create alternatives and ensure that the culture was ready to support the change.<sup>176</sup> “Messaging it this way was great because it didn’t freak everyone out,” said McClellan, “but there was still a lot of inconsistency in how staff and facilities were using isolation.”<sup>177</sup>

## ONGOING COMMUNICATION WITH STAFF

Implementation Workgroup members traveled to individual units two to three times over the next year, continuing discussions at the team level, reinforcing that the leadership at the highest level was listening to their concerns and fears about what could happen.<sup>178</sup> With time and support from other agency initiatives to change culture and provide more resources like Skill Development Coordinators, most staff began to accept the idea that reducing isolation was possible. However, despite careful messaging, some staff still interpreted the information to mean that the agency would eliminate isolation without workable alternatives. As McClellan emphasized, “The key about culture change is that key messages have to go out over and over again. You will still have people say that what they heard was that we’re taking away their tools. You just have to get the message out as many times and ways as possible.”<sup>179</sup>

## STAFF AS CREDIBLE MESSENGERS

One of the ways that administrators reinforced reasons to reduce isolation was by relying on local staff members as credible messengers. Leaders worked to support and energize those credible messengers so they could reach others. Alicia Cozad, then the deputy superintendent at Oak Creek Youth Correctional Facility (Oak Creek) said, “What we found were some champions. Those who understood the facility’s vision and goals to reduce isolation. They were able to carry those words forward because other staff respected them.”<sup>180</sup>

## MAKING A COMPELLING CASE AGAINST ISOLATION

Clear and frequent communication with staff about the impending policy change was only half the battle. The agency also needed staff to understand *why* the change was necessary. “It’s not enough to just to tell our employees that they will have to do things differently. We must take the time to put a compelling case together that makes sense to staff. Is the change going to improve safety? Is it going to create a more pleasant working environment? Is it going to create better futures for youth?” Pakseresht explained.<sup>181</sup> OYA made a compelling case against isolation with some of the following messages:

- Administrators and Implementation Workgroup members showed staff data that high rates of isolation were correlated with high rates of youth-on-staff violence. “Youth-on-youth violence was steady, but youth-on-staff violence went up. That got a lot of people’s attention,” said McClellan.<sup>182</sup>
- “What is the human cost of continuing to do business as usual? For example, the trauma that could be inflicted on youth, potentially increasing the numbers of future victims and compromising the safety of the community. At the same time there is the fiscal impact and a monetary cost of continuing the current practice. For example, longer stays in youth correctional facilities, potential transfer to adult prison, and the unquantifiable cost of future crime and victims,” said Pakseresht.<sup>183</sup>
- “When I was out working in community programs and we would get youth who experienced isolation, they would struggle when they were in the community. In the community, our main tool is to work with them, talk to them—we don’t use isolation. But their go-to was to run away from the community programs. It took a lot of time to figure out how we could work with them in the community. Shifting the approach in a facility away from punitive isolation and teaching how to regulate and problem-solve before they ever leave gives them a better chance at successful reentry,” said Program Director Jamie McKay.<sup>184</sup>
- “When you rely on a door between you and a kid as your primary source of safety, you create an ‘us vs. them’ environment. Then, when you have to open that door for something, now it’s ‘you vs. them.’ That dynamic doesn’t go away automatically, and bad things can happen,” said Operations Policy Analyst Heber Bray.<sup>185</sup>

## CHANGING CULTURE BEFORE POLICY

In 2015, the Implementation Workgroup made a critical recommendation: OYA should change the culture around isolation *before* implementing a new policy on isolation. As OYA shifted from a punitive model to a developmental model, administrators faced the challenging process of countering an existing culture.

### WHY FOCUS ON CULTURE FIRST?

OYA administrators and staff expressed the importance of changing culture in order to achieve sustainable reductions in the practice of isolation. Pakseresht noted, “We can rewrite policies and procedures, develop the best manuals and practice models, issues directive and decrees, but if [we] are not able to shift those shared values and beliefs and understandings that define the present culture, very little will change.”<sup>186</sup>

In addition, Fuimaono recalled, “[We] started out thinking that we needed more staff, we needed in-between spaces where kids can go when they need a break, but not isolation. We thought about creating rooms with calming furniture and paint and music. Then we thought, ‘Well wait a minute—we can throw staff at this issue, we can create these spaces, but if staff aren’t thinking differently about how to intervene with these behaviors and address them, we are just going to use those things in the same way.’”<sup>187</sup> Without a culture change, staff would continue to use new resources as punishments. Likewise, youth would interpret them as punishments. “You can’t just throw out a policy and hope that it sticks,” McClellan reiterated.<sup>188</sup>

### ROLE OF LEADERSHIP IN CULTURE CHANGE

Leaders at different levels of the agency played a critical role in changing the culture. OYA leaders describe their approach:

- “Leadership plays a critical role in organizational change. We must understand the impetus for the change and explain it to others. Why are [we] moving in this direction and what is the price that [we] might pay for inaction? We always want to be ahead of the wave of change rather than being overtaken by it,” said Pakseresht.<sup>269</sup>
- “We have a saying: ‘Executive team leaders are here to support and develop our managers, who support and develop our staff, who support and develop our youth.’ You can’t have one of those out of place. They all have to be in alignment,” said McClellan.<sup>270</sup>
- “We have to be the message—not the messengers. There’s a huge difference. People look for weakness in the armor. They think if you are not really bought in [to a practice or policy change], they don’t have to do it,” said Superintendent Dan Berger.<sup>271</sup>
- “We must model the change that we want to implement. To change behavior and culture consistently, as an organization, we as top leaders as well as our executive team, our managers at every level of the organization, must walk the talk. How we treat staff as leaders and how effectively we listen will translate directly and indirectly to how staff exhibit the same behavior with youth,” said Pakseresht.<sup>272</sup>
- “Don’t say, ‘Central Office says we have to do this thing.’ If you are a leader here, you should be out there saying, ‘Here’s what we are doing. Here’s why we are doing it. And here’s how you are a part of this,’” said Berger.<sup>273</sup>

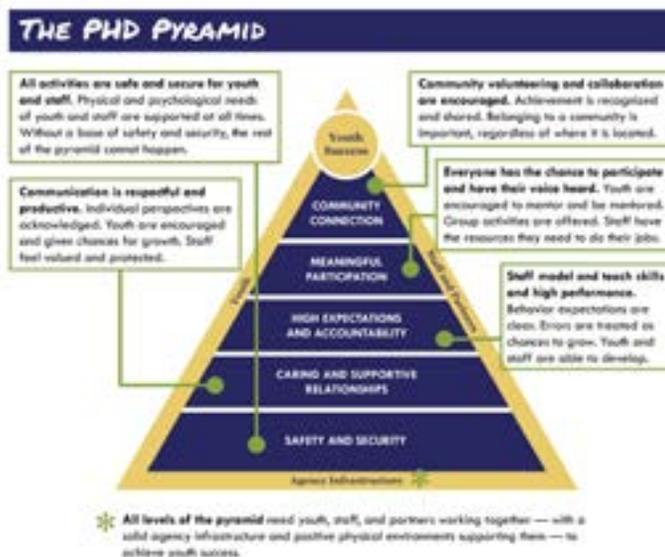
## A CULTURE OF POSITIVE HUMAN DEVELOPMENT

As OYA was working to reduce isolation, the agency was simultaneously making a shift to a developmental approach. OYA anchored its new approach around Positive Human Development (PHD). The core principles of PHD effectively reinforced the agency's efforts to prevent isolation.

### Defining Positive Human Development

Positive Human Development, which is based on the underlying model of Positive Youth Development (PYD), relies on research on adolescent brain development and developmental psychology to help youth become healthy, productive, and crime-free adults.<sup>109</sup> To represent the five elements of PHD, OYA uses the PHD Pyramid, which is included in training materials, brochures, and on posters throughout facilities. A summary of PHD is available in the agency's online publication, [Positive Human Development at a Glance](#).<sup>100</sup>

FIGURE 24 POSITIVE HUMAN DEVELOPMENT PYRAMID



PHD prioritizes safe and normative environments that support healthy adolescent brain development and maximize positive changes in youth and staff. Isolation does the exact opposite.

### **POSITIVE HUMAN DEVELOPMENT (PHD) vs. POSITIVE YOUTH DEVELOPMENT (PYD)**

In 2017, the Council of Juvenile Correctional Administrators (CJCA) released the [CJCA Toolkit: Positive Youth Development](#) which defined PYD as “a way of seeing young people in terms of who they are becoming, rather than their past behaviors or current situations.”<sup>101</sup> The CJCA Toolkit highlights several core components of PYD:

- Youth are resources to be developed, not problems to be fixed;
- Young people have strengths and the ability to develop new competencies and pro-social skills;
- People behave negatively as a normal response to unmet needs (for adolescents these are often status, belonging, autonomy, and excitement);
- Change occurs when youth build skills and receive support to meet their needs; and
- Primary strategies to work with youth are skill development, attachment, and engagement.<sup>192</sup>

PHD differs from PYD primarily in the recognition that staff also benefit from PYD approaches.<sup>193</sup> O’Leary described an experience that led OYA to adopt PHD: “Initially we thought OYA would adopt the PYD model. We sent some of our staff to PYD trainings. They came back and told us that they could buy into the PYD approach of treating youth as resources, but *they* wanted to be viewed as resources as well. Staff said, ‘If OYA can get to a place where I feel as though I’m being viewed as a resource, then I can do that with the kids [who] we work with every day.’”<sup>194</sup>

FIGURE 25 WHY POSITIVE HUMAN DEVELOPMENT

The [Why Positive Human Development Guide](#) includes a visual break down of how the PHD culture is integrated into OYA living units.<sup>195</sup>

## SAFETY

The foundation of PHD (as can be seen in the PHD pyramid) is safety—both emotional and physical. OYA’s experience shows that isolation undermines safety. Administrators knew that staff were most likely to be injured when attempting to use isolation.<sup>196</sup> As the agency reduced isolation, several safety indicators in facilities improved. Although success was not linear and the agency faced setbacks, data trends showed that, over time, fewer staff were injured and more staff felt safe.



FIGURE 26

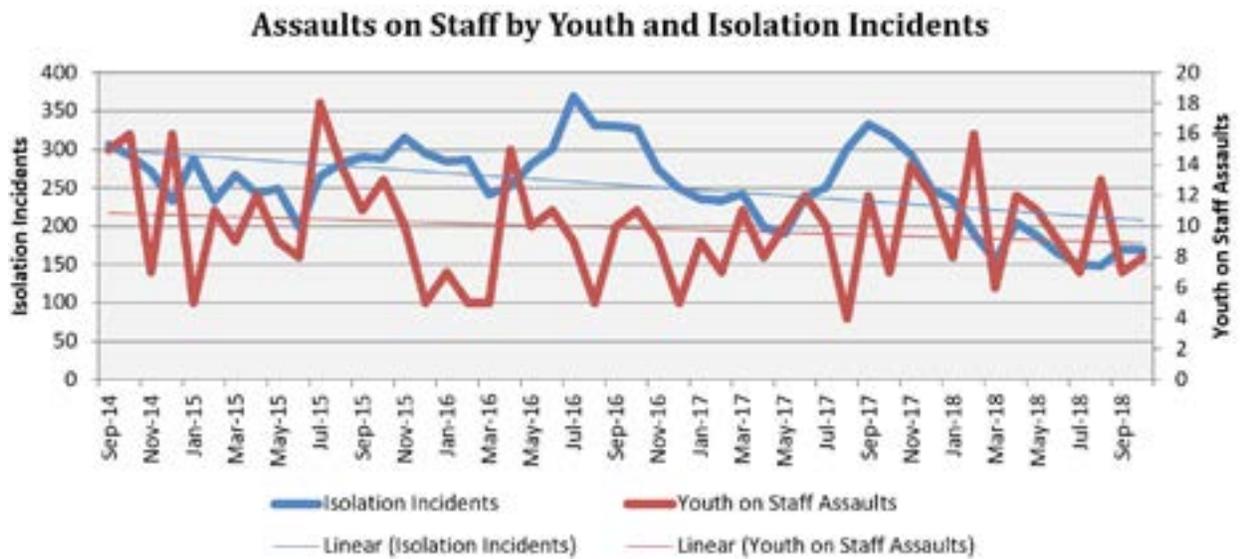
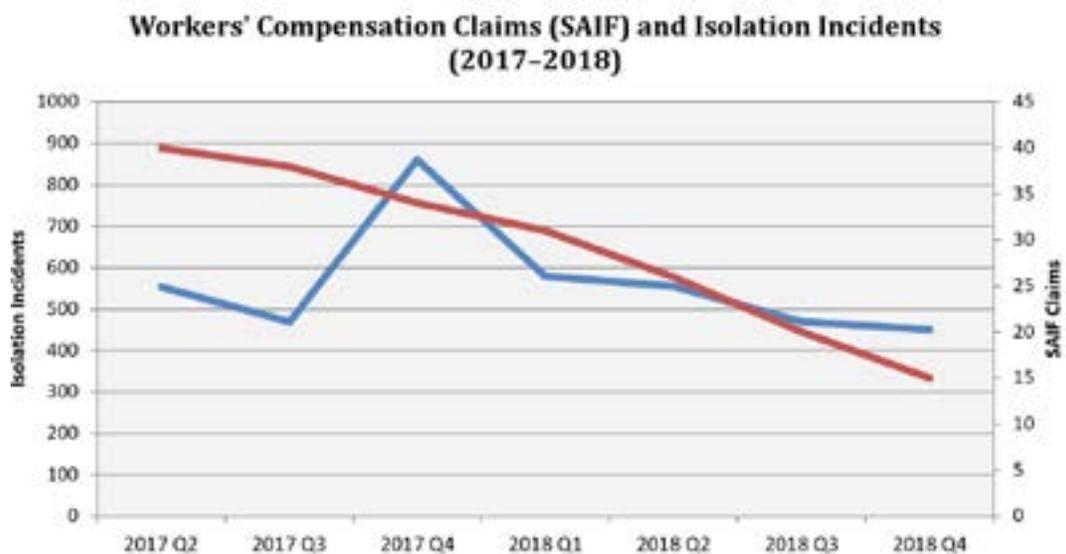


FIGURE 27



## FUNDAMENTAL PRACTICES GUIDE

In 2018, OYA Facility Services designed, developed, and disseminated [Fundamental Practices for Living Units—Moving PHD Into Practice](#)<sup>197</sup> to support the application of PHD in OYA facilities. The practice guide gives OYA staff practical and specific examples of how to use PHD.<sup>198</sup> Berger describes Fundamental Practices as a “playbook for the living units” on using five important practices to help operationalize PHD. “We had to find something tangible for people,” he said.<sup>199</sup> Each fundamental practice links back to a core element of PHD.

## FUNDAMENTAL PRACTICES

1. Clean, Safe, and Organized Living Units
2. Youth and Staff Engagement
3. Developmentally Appropriate Milieu Services
4. Building Community
5. Community Skill Building

FIGURE 28 SAMPLE FROM FUNDAMENTAL PRACTICES FOR LIVING UNITS GUIDE<sup>200</sup>

Fundamental Practices for Living Units

3

Developmentally Appropriate Milieu and Services

PHD Alignment	Actions
<p><b>Level:</b> High Expectations and Accountability</p> <p><b>Developmental Principle:</b> People as resources</p>  <p><b>Why?</b> This practice is where the rubber meets the road. It is skill-building. Everyone is different and we all come with a variety of skills. In order for us to develop, we need to have high expectations that are reasonable and rising for our skill level. Expectations and goals are tailored to allow successes and challenge growth. Consequences are effective if they relate to the issue, are immediate, and include a learning component.</p>	<p>Youth expectations are individualized, reasonable, and rising.</p> <p>Services, consequences and incentives are developmentally appropriate, individualized and focused on skill building and shaping behavior.</p> <p>Safe opportunities are provided for youth to practice making reasonable choices and decisions when appropriate.</p> <p>Youth have input on the level system, consequences, and incentives.</p> <p>Emphasis is on positive reinforcement, including verbal, nonverbal, written, and environmental.</p> <p>Behavior is addressed appropriately and timely.</p> <p>Staff role modeling skills:</p> <ul style="list-style-type: none"> <li>• Behavior</li> <li>• Communication</li> <li>• Interpersonal skills</li> </ul> <p>Recognition and celebration of achievements and accomplishments.</p> <p>Youth individually assigned services and progress are visually available for youth and staff (White/magnetic board).</p> <p>Positive signage is posted neatly and prominently to visually reinforce program principles.</p>

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Moving PHD into Practice

Developmentally Appropriate Milieu and Services

What it looks like:

	Youth move toward identified goals or achievement
	Youth are developing and practicing new skills
	Youth support each other
	Youth and staff feel they are viewed as a resource
	Youth progress through level system based upon their individual skill set and capabilities

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When staff raised concerns that they could not hold youth accountable without isolation, administrators focused on redefining accountability. For McClellan, that meant giving youth “the skills to be able to learn from their mistakes and hold themselves accountable. Because that’s really the only way they’re going to create safety in the community . . . Isolation is not a place where you can develop skills at all. There are plenty of things we have to develop to hold kids accountable in terms of consequences. Isolation just isn’t one of them.”<sup>201</sup>

Cozad described shifting the narrative away from behavioral control to behavioral support at Oak

Creek: "It has taken time to pivot. Just because one kid is taking advantage or doing something doesn't mean they all will. What we need to put into perspective for staff is that we have not gone through what most of these kids have experienced. So when [staff] think that punishing a little bit harder is the key to success, our culture has pushed back. What we need is empathy and to have high expectations. In essence, treating these kids as your own children goes a long, long way."<sup>202</sup>

## EXTERNAL PARTNERSHIPS

### COMMUNITY ADVISORY GROUP

To the surprise of many staff, OYA administrators reached out to a group of advocates and organizations as part of the external Isolation Community Advisory Group (Advisory Group). The Advisory Group's role was to give feedback on Internal Isolation Committee recommendations. Members included Youth Rights and Justice, Disability Rights Oregon, Partnership for Safety and Justice, a child psychiatrist, a juvenile court judge, a juvenile detention manager, a juvenile prosecutor, a public defender, the American Civil Liberties Union, and the Oregon Commission on Black Affairs.

O'Leary saw the benefit of involving a group that he describes as "essentially, everyone who would sue us" early in the process.<sup>203</sup> McClellan says, "Initially, we were a bit skeptical about doing workgroups and then inviting [the external Advisory Group members] in and them tearing it apart, but that didn't happen."<sup>204</sup> [W]e wanted these people close to us during the process, but the beauty of the execution was how they embraced the partnership and the insights we got from them," said O'Leary.<sup>205</sup> While the Advisory Group was not involved in drafting policy, they were invited to give advice and perspective. When outside stakeholders who might otherwise challenge agency practices with lawsuits or legislation were allowed insight into the process of reducing isolation through a transparent process, they were more likely to support the agency's plan.

## LEVERAGING POLITICAL AND LEGISLATIVE RELATIONSHIPS

The state legislature controls OYA's budget and resources. Strategic involvement and communication with state political leadership was an essential component of OYA's process of reducing isolation. O'Leary pointed out that "changes around isolation would not have worked if we had not been given budget flexibility, if we were not given additional funding through creative means to modify some of our physical environments. So having engagement with political leadership was critical."<sup>206</sup>

In 2015, the legislature considered legislation that would have banned isolation but would have been challenging for OYA to implement. The bill was drafted without input from OYA or other juvenile justice practitioners. The bill ultimately did not pass. OYA then asked the Joint Committee on Ways and Means to create a 2015 budget note requiring OYA to study the issue of isolation and create a set of recommendations to reduce the practice by February 2016.<sup>207</sup> The Ways and Means Committee is the legislative appropriations committee that determines state budget policy and sets the biennial

state budget. “The request for a budget note and our subsequent recommendations were literally a nail banged into the wall on which we could hang some funding requests. And some policy requests too,” stated O’Leary.<sup>208</sup> As a result of the [response that OYA submitted](#),<sup>209</sup> the 2017–2019 biennial budget allocated OYA funding for additional staff and physical structures to reduce isolation.

### OYA Supports Legislation to Reduce Isolation

Even though it had failed to pass, the 2015 bill to ban isolation allowed OYA leaders to highlight the urgent need for the agency to invest in steps to reduce isolation on its own terms. “It gave us the opportunity to go to our staff and say, ‘[L]ook, this is coming. We can choose to get ahead of this, or we can let something happen to us that may or may not be administrable. What do you want to do?’ That helped to create a mandate to drive planning and action to reduce isolation. In the next legislative session, we offered our own bill,” said O’Leary.<sup>210</sup>

OYA sponsored [Senate Bill 82](#),<sup>211</sup> which was passed in 2017. The bill adopted OYA’s policy that youth cannot be placed alone in a locked room as “sanctions and punishment for violation of rules regulating the conduct of youth offenders and any other persons in the custody of the youth authority.”

The law doesn’t apply to local juvenile detention facilities.<sup>212</sup> Part of OYA’s stated purpose in sponsoring the law was that the agency policy banning isolation as punishment could be reversed if not codified in state law.<sup>213</sup>

## III. WHAT WORKED

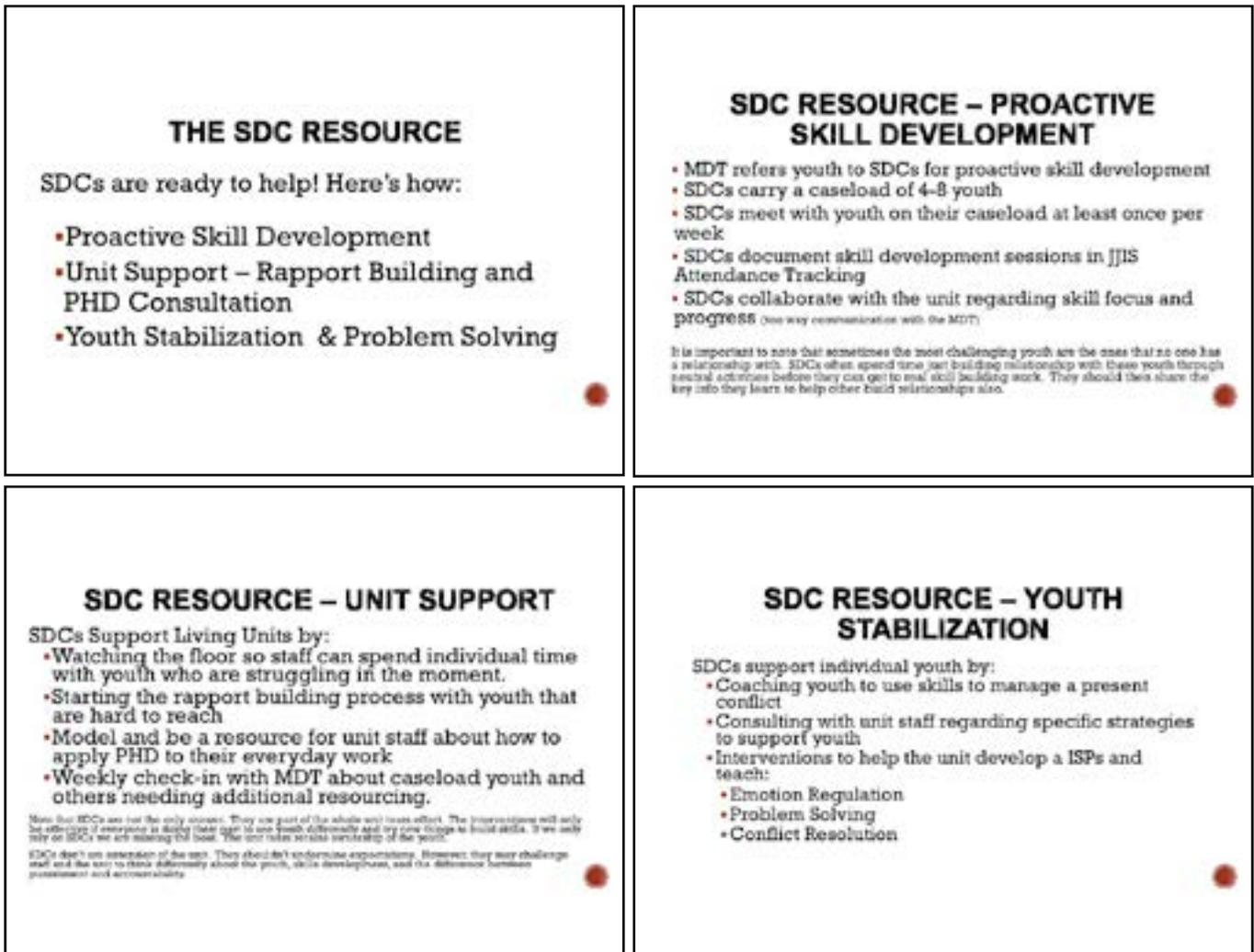
### **SKILL DEVELOPMENT COORDINATORS**

In 2013, OYA closed its Behavior Management Unit, which relied primarily on isolation, and repurposed staff positions to create 11 Skill Development Coordinators (SDCs). SDCs are specially trained staff who work with youth with the long-term goal of reducing isolation and helping youth reintegrate out of isolation as quickly as possible.

Rather than moving challenging youth to another unit, SDCs are designed to help youth be successful in regular housing. “When staff asked us what to do about difficult youth,” recounted Bray, “we said, ‘You’re going to keep them on your unit. And we’re going to give you these extra staff to help that kid ‘skill up.’”<sup>214</sup>

In February 2015, OYA used existing vacancies to create and deploy an additional nine SDCs at four facilities. Several of the agency’s strategies to reduce isolation required additional funding. “We had to commit to being proactive instead of reactive,” said Bray. “Making that shift is really hard. It costs money up front to save money on the back end, and that’s not the way our society is wired.”<sup>215</sup>

FIGURE 29 OYA SDC RESOURCE



**SKILL DEVELOPMENT COORDINATOR FUNCTIONS**

SDCs serve three main functions:

1. *Work Regularly with Youth to Prevent Isolation*

SDCs work multiple times a week with youth who are prone to behavior that could result in isolation to develop and practice self-regulation and appropriate interaction with peers and staff.<sup>216</sup> “We teach them how to problem-solve, stabilize themselves, take ‘no’ for an answer without getting into conflict. We reduce isolation by teaching kids how to act in the system and how to ask for resources,” one SDC explained.<sup>217</sup> MaLaren Youth Correctional Facility (MaLaren) has six campus SDCs who staff the facility, including weekends.<sup>218</sup>

## 2. *Assist with Unit Management to Allow Unit Staff to Work with Youth*

When a youth escalates or acts out, unit staff help the youth use skills to process their emotions and calm down. In order to do this, an SDC can “sub in” and help manage other youth while the assigned GLC works with the individual youth. SDCs are not meant to replace unit staff in dealing with crisis situations.

## 3. *Help Youth in Isolation Transition Back to Living Units Quickly*

In some OYA facilities, youth who meet the new threshold for isolation are transferred to a separate physical unit until staff determine they are ready to reintegrate back to their living unit. MacLaren, for instance, has an Intervention Unit (IU). Four SDCs staff the IU for sixteen hours a day. According to Berger, youth on the IU “spend most of their time in what’s called Core, which is like a dayroom. They go out, work with SDCs, and have meals together out in the Core. As long as there isn’t a serious conflict between kids, they are out in Core together.”<sup>219</sup> Once a youth on the IU is emotionally regulated and ready to engage in reintegration planning, OYA policy requires that the youth spend as much time as possible out of the isolation room.<sup>220</sup> Superintendent of the Rogue Valley Youth Correctional Facility Ken Jerin noted, “Once [youth] are regulated—they are no longer hitting the walls, threatening other people, when they are talking reasonably—which may take an hour or two, they may not be able to be safely reintegrate back into the living unit immediately. SDCs work with the kids at this moment to move them along.”<sup>221</sup> During that period, SDCs also communicate with the living unit leadership team to create a plan to bring the youth back to the unit as quickly as possible.

In order to enhance the staffing pattern for the IU at MacLaren, Berger selected additional staff when the Hillcrest and MacLaren facilities were combined in 2017. Before the new staffing pattern became operational, the IU staff took a two-week team retreat. “We completely rebuilt the program in the light of PHD,” he said. “We didn’t want kids to just go down there and sit. If kids had to go to isolation and had to go to IU, they were engaged in skill development when they were there. That was the basis of rebuilding this program.”<sup>222</sup>

## **ENVIRONMENTS MATTER: CHANGING PHYSICAL SPACES**

The traditional design of OYA facilities and living units contributed to overuse of isolation. OYA structures and staffing plans were built around the concept of group milieu management, so staff had two choices for managing youth behavior: one large group living space or isolation. If a youth couldn’t handle the group environment, it was impossible to separate him or her to allow for re-regulation without isolation.

Physical environments play a critical role in healthy adolescent development. If facilities put youth in institutional environments, youth are more likely to become institutionalized, which prevents successful transitions back to the community. In order to prevent institutionalized thinking and behavior, the agency also needed to create secure environments that were as normal as possible.<sup>223</sup>

In 2013 the Oregon Legislature directed OYA to produce a 10-year plan for secure facilities to address the decreasing youth population and develop long-term goals to align physical spaces with best practices, including reducing the use of isolation.<sup>224</sup> In 2014, OYA worked with consultants to develop a [10-Year Strategic Plan for Facilities](#) (10-Year Plan)<sup>225</sup> for creating physical environments that support PHD. In 2015, the state legislative budget fully funded the 10-Year Plan.<sup>226</sup> The consultants who conducted assessments as part of the 10-Year Plan found that “The current mix of facilities within the OYA system does not support the vision, mission, and culture of OYA. Housing and living areas reflect the most serious gap between vision and reality. The majority of youth are housed (with long lengths of stay) in densely populated dormitory living units. Program and treatment space is not adequate to support relief and break-out space.”<sup>227</sup>

## 10-YEAR PLAN RECOMMENDATIONS

The 10-Year Plan recommended several major environmental changes:

- Environments that support relationships by creating open, comfortable spaces to connect;
- Living spaces with natural lighting and views of nature and the horizon;
- Environments with non-institutional furniture, fixtures, and decor;
- Display boards that show youth accomplishments; and
- Increased access to recreational and treatment spaces to develop skills with staff and better prepare youth to transition back to the community.<sup>228</sup>

## NEW UNITS

Another key feature of the 10-Year Plan is reducing the size of living units from 25 beds to 16 beds. In 2017, OYA consolidated two large correctional facilities. As part of the 10-Year Plan for smaller living units and to help absorb the additional population from consolidating MacLaren with now-closed Hillcrest facility, OYA built six 16-bed living units at MacLaren. The new living buildings house the intake units, two mental health units, and a pilot trauma unit called the University of Life. The new units include individual rooms, two living rooms, an outside porch, and several multipurpose detention-secure rooms

with natural light. The individual rooms have visual display boards that youth may decorate, large windows, and light switches that youth control.<sup>229</sup> OYA created the [Letting in the Light video](#) to showcase the design process and benefits of the new buildings.<sup>230</sup>

**FIGURE 30 OYA LETTING IN THE LIGHT VIDE**



**FIGURES 31-35 BEFORE AND AFTER**





**“If it’s more institutionalized, it looks more like prison, like a dungeon, then obviously we’re not going to change. We’re just going to be what we’re looked at upon as, like criminals, or animals.” — Youth at MaLaren<sup>274</sup>**



Moreover, OYA secured meaningful youth participation during the process of designing the new buildings. A youth intern participated in all design meetings and a team of youth worked with a local artist to create artwork throughout the buildings.<sup>231</sup> OYA also organized a visioning

charrette—“a technique for consulting with some of the most interested stakeholders”<sup>232</sup>—with 15 youth to structure input to designers. It involved meetings where participants discussed challenges and opportunities to develop a shared vision and goal for the project.<sup>233</sup>

### In-Between Spaces

As discussed, the design of older OYA structures prevented youth from stepping away from the group milieu to calm down and process emotions. This was especially problematic for adolescents, who are more impulsive, emotional, and susceptible to peer influence than adults. Because OYA houses a population of especially reactive adolescents more likely to have experienced trauma or mental illness, the traditional correctional design model wasn't helpful for their situation. As part of the 10-Year Plan, OYA focused on creating spaces and rooms that allowed youth to be somewhere between the large group and an individual cell, or “in-between” spaces. Staff also identified and used pre-existing in-between spaces such as repurposed buildings or rooms and outdoor areas. For example, Oak Creek removed the door from a room, painted it, and added rocking chairs and comfortable furniture. “Now it's a playing space, so girls can come and go freely. It's not a place where they get placed,” says Denessa Martin, chief of operations for Facility Services.<sup>234</sup>

## **STAFFING AND HIRING**

### **STAFFING**

In order to transition away from using isolation, OYA needed to hire additional staff and repurpose existing staff. Each living unit is made up of a Unit Leadership Team, which consists of the Living Unit Manager (LUM), a Case Coordinator (CC), and a dedicated Qualified Mental Health Professional (QMPH or Q). OYA's staffing numbers vary based on the needs of youth, but all units have a 1:8 staff-to-youth ratio. On specialty mental health or trauma units, the agency adds an additional GLC and keeps the youth population at 16 or less. Specialty units also share an additional QMPH to provide coverage seven days a week, or 1.5 FTE per unit.

### **CURRENT HIRING PRACTICES**

All OYA direct care positions require a high school diploma or a GED. Almost 90% of direct care staff are Level II GLCs, which also requires six months experience working with young people. If applicants do not have that experience, they can start as Level I GLCs and move their way up.<sup>235</sup> OYA's hiring goals are to select applicants with a “youth-first” mindset who are interested in working with youth in close custody settings. “We don't want corrections officers. We want folks who can work with kids and can learn security protocols as well,” explained Berger.

To attract qualified candidates, OYA’s human resources recruitment team attends jobs fairs and conducts outreach at local colleges and universities. They also created an [Oregon Youth Authority Recruitment Video](#).<sup>236</sup> Application materials are also designed to convey the agency’s PHD philosophy. Cozad described Oak Creek’s tailored application package: “We send out a hiring letter to potential applicants about the work we do. In essence—working with girls is challenging and rewarding at the same time. There will be accountability when youth make mistakes, which is inevitable with teenagers. What we want to tell [applicants] is that we expect kids to be kids.”<sup>237</sup>

**FIGURE 36 OYA RECRUITMENT VIDEO**



## USING DATA TO TARGET ISOLATION

### OREGON’S STATEWIDE JUVENILE JUSTICE CASE MANAGEMENT AND REPORTING SYSTEM

OYA has a well-developed data collection system. When the agency was established in 1995, one of its initial activities was to create a statewide, collaborative, integrated information management system that became known as the Juvenile Justice Information System (JJIS).<sup>238</sup> OYA provides training and technical support on JJIS to juvenile justice facilities in all Oregon counties and more than 100 external partner agencies.<sup>239</sup> Counties can access data on juvenile recidivism and programs as well as track individual youth information from initial contact with the juvenile justice system throughout all stages of their involvement.<sup>240</sup> According to OYA, Oregon is one of only three states with a statewide data system for youth in the justice system.<sup>241</sup> As discussed below, OYA requires staff to complete a series of online forms when placing a youth in isolation. Because the forms capture information through drop down menus, the agency can track why youth are placed in isolation and, at every 15-minute interval, why the youth is not ready to exit isolation.

## USING DATA STRATEGICALLY

OYA uses data to identify underlying factors (or as seen through a PHD lens, unmet needs) associated with isolation and responds by developing staffing resources, specialized units, and behavior management interventions to address those factors. For instance, OYA executive staff knew that a large percentage of the youth population had mental health issues and past trauma histories. However, by backing up this knowledge with quantifiable data, they were able to justify requests for additional resources and allocate those resources in effective ways.

### **EXAMPLE OF SMART DATA USE**

Bray asked staff to track serious behavior incidents in a unit over a three-month period by day and time. While he suspected that most incidents would occur at bedtime, he was wrong. Most incidents occurred around 4 p.m., the time that youth returned to the unit from recreation. "Kids were still amped up. There was no cooling-down time," said Bray. "They had to shift from outside rules to inside rules with the snap of a finger. You'd think that 15, 16, 17-year-olds could shift, but shifting from one set of rules to another is actually an advanced cognitive skill. We would have fights in the line and fights right when we got inside. We'd have kids blowing up because they wanted to get a drink of water and it wasn't their turn yet." As a team, staff decided to end recreation five minutes early and take steps to ease the transition for youth. "We'd have kids walk one slower deep-breathing lap before they came inside. While they walked the lap, staff reminded them of the inside rules in a nice calm voice by saying, 'Hey, remember guys, we're going inside. We're going to take our shoes off, we're going to line up, and table by table, we're going to go to the drinking fountain.'" <sup>242</sup> After making these small changes, isolation incidents during the 4–5 p.m. period dropped dramatically.

## FACILITY SAFETY INDEX

The Facility Safety Index is one method that OYA uses at both an agency and facility level to evaluate the progress or problems in facilities.

### Facility Safety Index Measures

- Number of isolation placements
- Frequency of isolation placements (adjusted to account for unit and facility population)
- Average duration of isolation placements
- Restraints
- Youth-on-youth assaults
- Youth-on-staff assaults
- Youth fights
- Contraband

While managers can check the safety index factors at any time, the agency performs quarterly target reviews. Administrators meet to discuss the safety index data and discuss what factors are “behind the numbers.” Berger said that leaders ask questions such as: What do these numbers mean? Why have they gone up? Why have they gone down? Are the data points connected with programs, resources, or management? “Then we come up with actual plans to see what we need to move,” he said. “Is this a one-off? Is this a rough month? Or do we have a trend here we that need to do a major shift?”<sup>243</sup> Another important aspect of the safety index as a tool is the ability to see the trends in data. “One point about following numbers is that we have to focus on the trendlines and not react extremely to any one point in time,” explained O’Leary.<sup>244</sup>

When interpreting data to guide reforms, OYA leaders also stress the importance of disaggregating data. “In Oregon we have big facilities. We have 13 living units in one facility,” said McClellan, “so getting one big conglomerate of data doesn’t tell us a lot. We have to break those [data] down to the individual living units, shifts, or other factors.”<sup>245</sup>

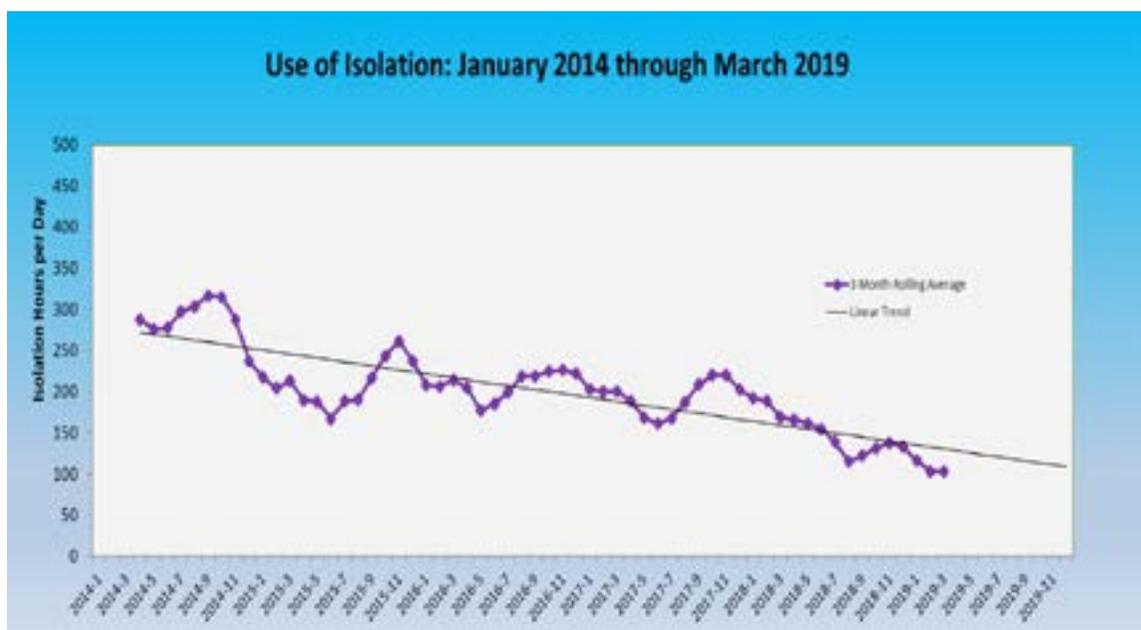
## ROLLING AVERAGE

OYA also uses a “rolling average” as a measure of the agency’s overall use of isolation. The rolling average uses a measure of isolation hours per day by combining the number of incidents and duration. “One youth in for 10 hours and 10 youth in for 1 hour will still tell us that we relied on 10 hours of isolation to maintain a safe environment,” explained Bray. Also, because the number of isolation incidents varies considerably from month to month—especially when data includes all facilities or units within a facility—the monthly rolling average is the average of the past three months. This allows the agency to better see trends over time. Finally, the rolling average corrects for the youth population. In other words, the use of isolation may decrease simply because there are fewer youth in a facility or agency. The rolling average allows administrators to see true isolation use and change over time. Based on the rolling average, OYA has reduced the use of isolation by 71% in five years.<sup>246</sup>

### Tips When Using Data

- Ask what is “behind the numbers.”
- Meaningful data is disaggregated.
- Change takes time—focus on trends.
- Expect trend lines to go up and down.

FIGURE 37 ROLLING AVERAGE—OYA USE OF ISOLATION



## SPECIALIZED UNITS AND OPPORTUNITIES

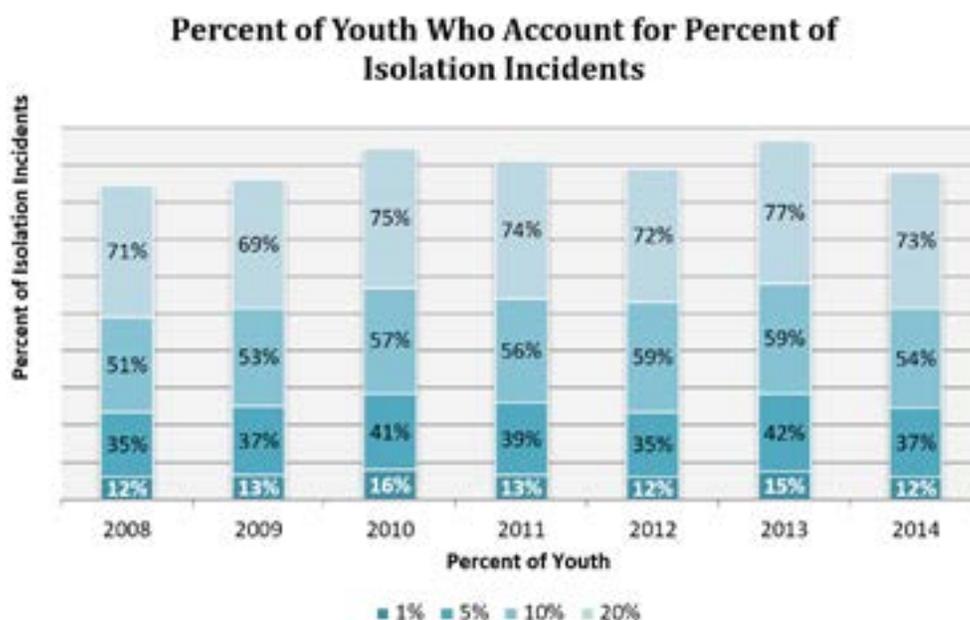
### MENTAL HEALTH UNITS

As mentioned above, many youth in OYA facilities have significant mental health needs. Bray explained that “we can look at the data and say that 83% of our kids have a mental health diagnosis.”<sup>247</sup> According to OYA budget documents, “[a]s of 2018, 45% of OYA youth were previously served by the child welfare system and 41% were served by the I/DD system.”<sup>248</sup> Based on this information, OYA created specialized mental health units to address the staffing and behavioral support needs of youth with mental health issues.

### THE UNIVERSITY OF LIFE

Another part of the Internal Isolation Committee’s work was to make recommendations on how to prevent isolation. “One way we’ve done this,” said Bray, “is by looking at the youth who account for isolation incidents.”<sup>249</sup> In 2014, OYA identified that approximately 20% of youth account for 73% of isolation episodes.<sup>250</sup>

FIGURE 38



This information allowed OYA to do two things: (1) focus SDCs’ efforts on those youth to reduce isolation, and (2) develop a specific unit-based community and programming to better address this group’s needs. When the agency took a closer look at the population involved in most isolation incidents, they found that most were emotionally reactive youth with a history of trauma or mental health issues. The agency created a trauma-informed pilot unit at MaClaren called the University of Life. The unit is housed in one of the facility’s new buildings. OYA designed a staff-intensive environment and curriculum focused on skill development and emotional regulation rather than behavioral compliance. For this particular subset of youth, OYA leaders realized that using isolation and force to control behavior wasn’t working. “As soon as you meet resistance with resistance, you’re going to get escalation—every time,” stated Bray. “You just can’t do it with these kids.”<sup>251</sup>

Asking staff to make the switch to focusing on emotional regulation was not easy. Bray summarized the challenges that OYA staff faced when making the change: “Now we are asking [staff] to think of [themselves] not as corrections officers but as brain developers. This kid’s brain wasn’t developed normally because of trauma, and his ‘How do I calm down?’ mental pathway isn’t fully formed. We have to develop it. Staff on the [University of Life] will tell you that it’s the hardest work they’ve ever done and also the most rewarding.”<sup>252</sup>

For youth entering the University of Life, there was a 77% decrease in incidents and an 84% decrease in isolation.<sup>253</sup>

## **PROGRAMMING AND VOCATIONAL OPPORTUNITIES FOR OTHER YOUTH**

Although many isolation incidents involved emotionally reactive youth, data showed that the second largest group who ended up in isolation were more aggressive or gang-involved youth. For these young people, the prospect of valuable vocational and education programs was a powerful incentive. "We had all these older kids here," said Berger. "Some of them were very entrenched gang members and there was violence because frankly, they didn't have anything else to do here. We weren't making the program about them. We were making it about control."<sup>254</sup> OYA has since focused on enhancing college and vocational programming. The agency now has more than 50 work and training programs and more than 30 professional certifications or achievements available to youth, including computer science, construction/woodshop, culinary arts, horticulture, HVAC Assistant Worker, welding, barbering license, LBME Electrician's License, and Automotive Service Excellence Certificates. At MacLaren, 40 youth are working on their bachelor's degree.<sup>255</sup> "As we build programs to really have them engage in developing their own futures," Berger continued, "these guys kind of pulled out of that mindset. We saw huge reductions in incidents in all of our units, especially kids that had longer-term Department of Corrections sentences."<sup>256</sup> Current data shows that less than 20% of isolation incidents are caused by youth committed as adults.

## **SAFETY PROGRAMS**

When less restrictive interventions are not effective, OYA may create a safety program for youth. A safety program is defined as an "intensive, youth-specific, time-limited intervention that modifies a youth's activities to focus on developing the youth's emotion regulation and problem-solving skills." The two types of safety programs include Individual Safety Plans (ISPs) and Community Safety Protocols (CSPs). ISPs are used to create on-unit programming for youth who need more structure and skill-building. Youth who demonstrate a pattern of unsafe behavior that may lead to violence may receive an ISP.<sup>257</sup>

Some youth may also receive a CSP, which may require youth to spend time on the IU or another space outside their housing unit. Staff may use a CSP if a youth demonstrates "continuously violent or aggressive behavior that creates significant safety concerns for the living community milieu or if they have a significant incident that results in serious bodily harm or extreme property damage that jeopardizes youth or staff safety and has significant living community negative impact."<sup>258</sup> A CSP may result in youth spending a longer period of time in isolation, which presents concerns. However, youth on CSP must spend at least 8 hours of awake time each day out of their room (out of isolation) working with staff and other youth. These hours are tracked electronically and

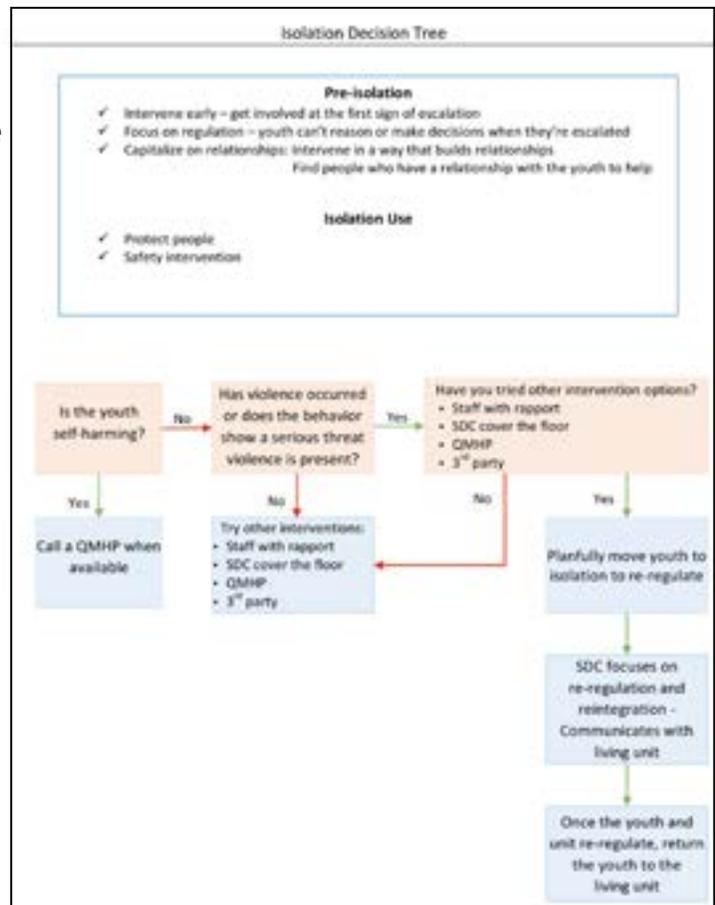
monitored. CSPs are meant to slowly reintegrate youth back into normal programming. CSPs are heavily regulated, and the agency uses them as a last resort. A multi-disciplinary committee must agree to place a youth on a CSP and administrators in the OYA Central Office in Salem, OR, review the CSP weekly. As of June 12, 2019, OYA has three youth on CSPs agency-wide.

## THE NEW POLICY AND BEHAVIOR MATRIX

Although the Internal Isolation Committee’s recommendations in 2015 determined where the agency’s isolation threshold would be, the new policy based on those recommendations did not go into effect until July 2018.<sup>259</sup> The previous threshold permitted isolation if there was danger to institutional order, which allowed staff to use almost unlimited discretion. “You could drive a truck through that,” said O’Leary. “When we changed our policy, we took away that catchall and adopted a much more unambiguous threshold.”<sup>260</sup> [Policy II-B-1.2, Use of Time-out, Room-lock Other, Isolation, and Safety Programs in OYA Facilities](#) permits isolation only: (1) if a youth is in danger of physically harming others; (2) where a serious threat of violence is present; or (3) violence has occurred.

FIGURE 39 ISOLATION DECISION TREE

The policy also contains a prescriptive process and timeline for moving a youth out of isolation. To help clarify the isolation threshold for staff, the agency created an [isolation decision tree](#). If staff use isolation, they must complete an electronic isolation checklist to be reviewed by the superintendent. As seen in Figure 40, the form reminds staff that isolation must be used only to manage a youth’s crisis behavior when the youth is in danger of physically harming others, where a serious threat of violence is present, or violence has occurred. Staff must indicate yes or no to questions about each one of the three threshold questions as well as whether or not the youth was in crisis.



The [updated version of the behavior matrix](#) no longer includes isolation as a refocus option for any type of youth behavior. When the agency implemented the revised policy on isolation in 2018, it also implemented two related policies on behavior management:

- [Incentives and Reinforcing Behavior](#)<sup>261</sup>
- [Youth Refocus Options](#)<sup>262</sup>

## REINTEGRATION FROM ISOLATION

A subgroup of the Internal Isolation Committee was charged with making recommendations for a reintegration protocol to ensure that youth exit isolation as quickly as possible. The subgroup's recommendations were adopted as part of OYA's new policy:

- A reintegration plan for each youth with specific interventions to help youth re-regulate and transition back to the living unit. The [Youth Reintegration Form](#) prompts staff to describe the underlying or triggering event, what intervention or conflict resolution has been done, and what skills youth will use to reintegrate back into a group setting. This must also be completed and submitted electronically via the form shown in Figure 42.
- Interventions provided by living unit staff, QMHPs, and SDCs. Interventions could include peer or staff mediation, emotion management/re-regulation skills and strategies, behavior analyses, and goal setting. Staff must also complete an electronic form detailing
- Evaluation every 15 minutes for behavioral changes, and continuous updates in a "youth engagement readiness" assessment. As shown in Figure 41, staff must indicate whether the youth is re-regulated and ready to exit his or her room and begin reintegration planning. If the staff marks that the youth is not re-regulated, the electronic system requires staff to select one of three reasons why: verbally aggressive, physically agitated, or non-communicative.

FIGURE 40 ELECTRONIC INITIAL ISOLATION PLACEMENT REVIEW CHECKLIST

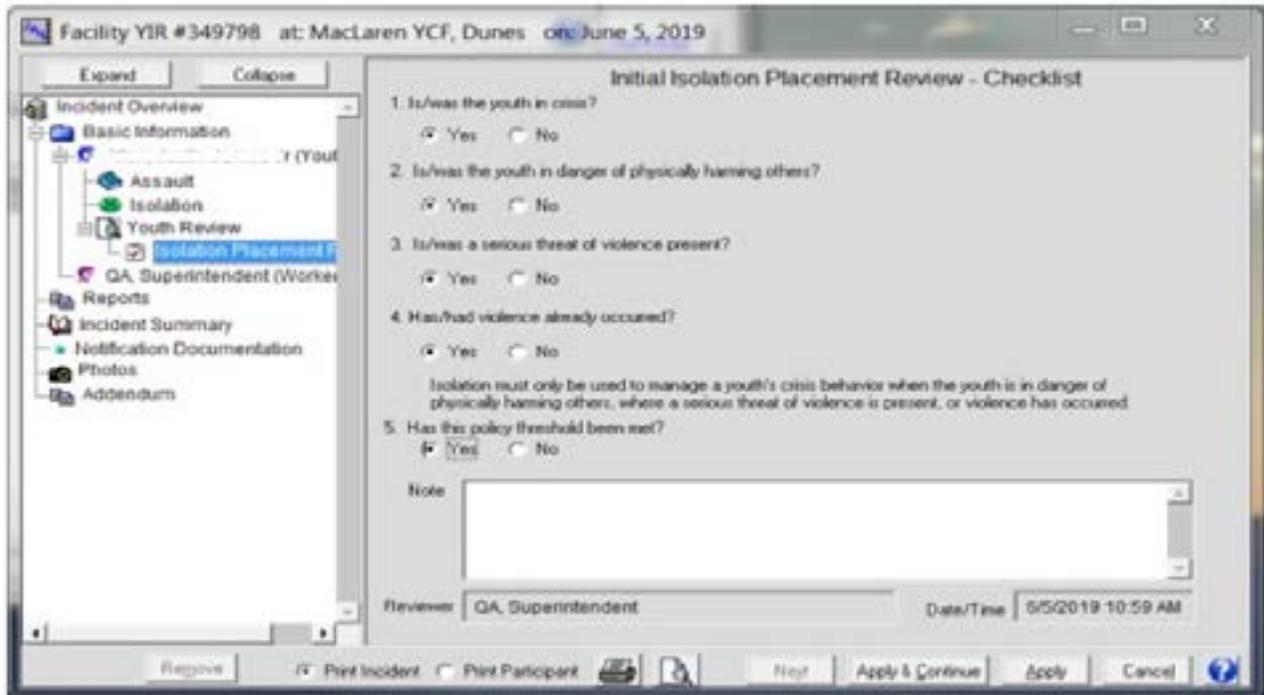
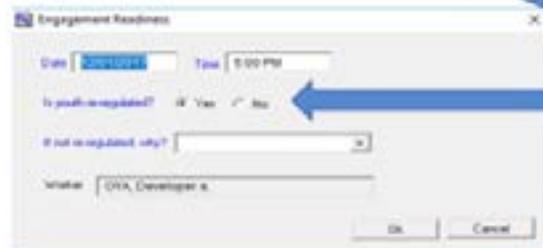
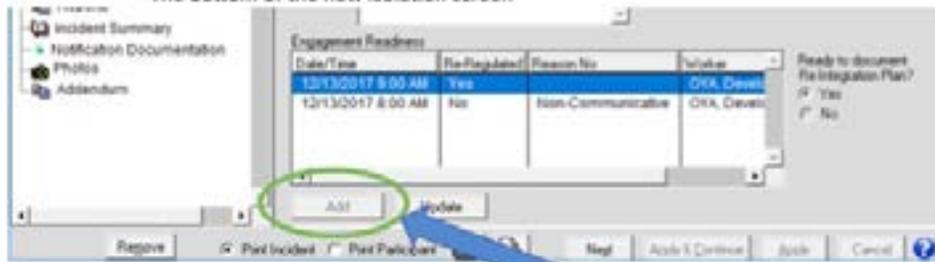


FIGURE 41 ELECTRONIC 15-MINUTE READINESS CHECK FOR YOUTH IN ISOLATION

## Engagement Readiness Checks

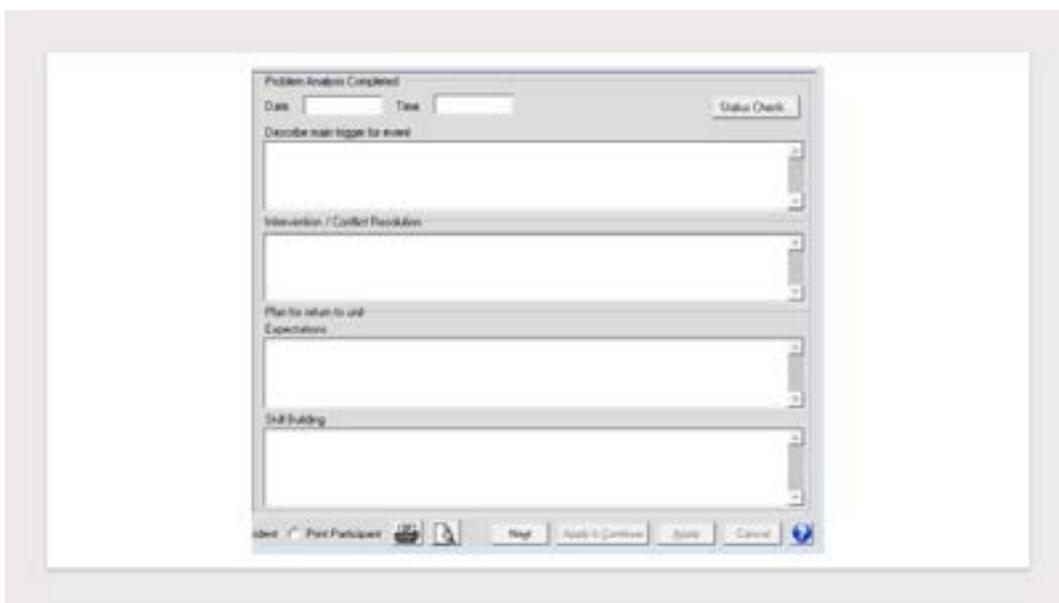
The bottom of the new isolation screen



By clicking Add, the engagement readiness check screen pops up requiring a yes or no. If no, there are 3 choices in the drop down

- Verbally aggressive
- Physically agitated
- Non-communicative

FIGURE 42 ELECTRONIC REINTEGRATION PLAN

The image shows a screenshot of a software interface for creating an electronic reintegration plan. The window is titled "Problem Analysis Completed". It contains several text input fields: "Date" and "Time" at the top right, followed by a "Status Check" button. Below these are four large text areas labeled "Describe main trigger for event", "Intervention / Conflict Resolution", "Plan for return to unit Expectations", and "Skill Building". At the bottom of the window, there is a toolbar with buttons for "Print", "Add to Calendar", "Save", and "Cancel", along with a small globe icon.

## ISOLATION POLICY (2018) KEY COMPONENTS:

- Staff must carefully deliberate and consider the risk and needs of a youth and situation prior to using isolation as an intervention.
- Isolation cannot be used for administrative convenience, as a substitute for staff supervision, or as a substitute for individualized treatment.
- Staff must use other less restrictive interventions when appropriate.
- A staff member not involved in the incident must try to help the youth with regulation and problem solving prior to using an isolation intervention.
- The manager on duty must immediately be notified and approve the isolation.
- A QMHP must conduct a mental health status assessment within one hour of isolation.
- Self-harming behaviors may not result in isolation unless deemed appropriate by a QMHP.<sup>263</sup>
- Staff must monitor the youth in isolation every 15 minutes for well-being and possible return to the general population.
- A documented assessment must be completed every two hours of youth's

engagement and readiness to begin the reintegration process.

- Once a reintegration plan is created, the manager on duty must document and review the plan twice daily to ensure the youth's quick return to unit programming.
- The facility superintendent and facility services assistant director must approve placement in isolation at 72 hours and five days, respectively.

OYA chose not to implement a new isolation policy until alternatives were in place and the institutional culture was ready to support the change. Since implementing the revised isolation policy in July 2018, isolation incidents have continued to go down. The total number of isolation incidents initially increased in September and October of 2018, and data for the following months shows a steady decline, reaching an all-time low in January 2019.



## Guidelines for Contact with Jurisdictions in This Report

This report highlights examples of how state agencies and local juvenile justice facilities have implemented developmentally appropriate and youth-centered responses to successfully reduce room confinement.

The state and local examples in this paper should be understood largely as promising approaches, not perfect examples. We greatly appreciate the time and resources that these jurisdictions dedicated to making this publication possible and ask that readers credit the four jurisdictions when adopting their materials. Also, we ask that readers respect administrators' time and contact the jurisdictions only with serious and clear requests for information. Please follow the jurisdictions' preferred method of contact:

### **COLORADO DIVISION OF YOUTH SERVICES**

Please contact:

Heidi Bauer

Director of Communications and Legislative Affairs

Division of Youth Services, Office of

[Heidi.Bauer@state.co.us](mailto:Heidi.Bauer@state.co.us)

[www.colorado.gov/cdhs/dys](http://www.colorado.gov/cdhs/dys)

### **MASSACHUSETTS DEPARTMENT OF YOUTH SERVICES**

DYS prefers that requests are forwarded the Center for Children's Law and Policy. Please contact:

Jenny Lutz

Attorney, Center for Children's Law and Policy

Campaign Manager, Stop Solitary for Kids

[jlutz@cclp.org](mailto:jlutz@cclp.org)

### **OREGON YOUTH AUTHORITY**

Please contact:

Benjamin Chambers

Communications Director

Oregon Youth Authority

[Benjamin.chambers@oya.state.or.us](mailto:Benjamin.chambers@oya.state.or.us)

### **SHELBY COUNTY JUVENILE DETENTION CENTER**

Please contact:

Debra Fessenden

Legal Advisor

Shelby County Sheriff's Office

[debra.fessenden@shelby-sheriff.org](mailto:debra.fessenden@shelby-sheriff.org)

## Jurisdiction-Based Resources

### COLORADO DEPARTMENT OF YOUTH SERVICES: POLICIES AND RESOURCES

- Colorado Division of Youth Services policies and associated links: <https://www.colorado.gov/pacific/cdhs/policies-3>.
- Colorado Division of Youth Services, *Phase Behavior Matrix*, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Colorado-Phase-Matrix.pdf>.
- *Policy S 14.3 B, Time-out; Seclusion and Program Refusal*, Colorado Division of Youth Services, (effective 11-1-2017, amended 04-01-2018), <https://drive.google.com/file/d/0B32vshZrERKsUTBqZjFMcnNUS28/view>.
- *Youth Services Specialist I Job Description – Mount View Youth Services Center*, Colorado Division of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Job-Description.pdf>.
- Colorado HB16-1328, Use of Restraint and Seclusion on Individuals, 2016 Regular Session, <https://leg.colorado.gov/bills/hb16-1328>.
- Colorado HB17-1329, 2017 Regular Session, Reform Division of Youth Corrections, <https://leg.colorado.gov/bills/hb17-1329>.
- Youth Seclusion & Restraint Working Group, *Semi-Annual Report: March 1, 2018 – August 31, 2018* (Colorado Office of Children, Youth & Families, Division of Youth Services, January 1, 2019). [http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Seclusion-Restraint\\_COMMITTEE\\_Mar18-Aug18\\_Jan2019\\_Report\\_FINAL\\_1-1-19-2.pdf](http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Seclusion-Restraint_COMMITTEE_Mar18-Aug18_Jan2019_Report_FINAL_1-1-19-2.pdf).

### MASSACHUSETTS DEPARTMENT OF YOUTH SERVICES: POLICIES AND RESOURCES

- Massachusetts Department of Youth Services policies: <https://www.mass.gov/lists/dys-policies-regulations>.

- *Policy on Involuntary Room Confinement 03.03.01(a)* (effective 03-13-2013), Massachusetts Department of Youth Services, <https://www.mass.gov/lists/dys-policies-regulations>.
- *Policy on Suicide Assessment in Secure Facilities 02.02.05(c)* (effective 11-01-2005), Massachusetts Department of Youth Services, <https://www.mass.gov/lists/dys-policies-regulations>.
- *Incident response team procedure in support of the management guidelines for responding to traumatic workplace incidents*, Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/IRT-Procedure.pdf>.
- *Policy on Individual Support Plan 02.02.02(c)* (effective 03-15-2013), Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/02.02.02c-Individual-Support-Plan.doc>.
- *DYS Guidelines for Release from Room Confinement*, 11-21-2016, Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Guidelines-for-Release.pdf>.
- Dr. Yvonne Sparling, *DBT as a Behavior Management Approach*, Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/DBT-as-BMA.pdf>.
- *Sample Distress Tolerance Coping Plan*, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Sample-DTP.pdf>.
- *Sample DBT Diary Card*, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Sample-Diary-Card.pdf>.
- *Based Residential Programming Advisory*, 06-11-2014, Massachusetts Department of Youth Services, *Positive* <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Advisory.pdf>.
- *Job Description for Group Worker I*, Massachusetts Department of Youth Services, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Youth-Services-Group-Worker-I-Central-Region.pdf>.

- Lenny Beatty, Facility Administrator, Video Clip on Positive-Behavior Management, <https://youtu.be/bTj5XLJhgfs>.

## **SHELBY COUNTY JUVENILE DETENTION SERVICES: POLICIES AND RESOURCES**

- Policy Procedure Manual (June 2015), Shelby County Juvenile Detention Services Bureau, <https://www.shelbycountyttn.gov/DocumentCenter/View/11670/Detention-Policy-Procedure-Manual?bidId=>.
- *Policy on Juvenile Detention Services, Standard Operating Procedure 356* (effective 02-08-2017), Shelby County Sheriff's Office, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/MEMPHIS-JDS-SOP-356.pdf>.
- *JDS Positive Behavior Management System, Standard Operating Procedure 357* (effective 02-08-2017), Shelby County Sheriff's Office, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Positive-Behavior-Management-System-SOP.pdf>.
- *JDS Detainee Involuntary Room Confinement, Standard Operating Procedure 713*, (effective 07-06-2016), Shelby County Sheriff's Office, <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/JDS-SOP-713-Detainee-Involuntary-Room-Confinement.pdf>.
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## QUOTATIONS

- *"We collect data on everything. We use data every day." Jamie Nuss, Director, Gilliam Youth Services Center*
- *"It's not just about room confinement. It's about staff being assaulted, fights among the kids, any kind of property damage that you track, and room confinement and restraints." Peter Forbes, Commissioner, Massachusetts DYS*
- *"[P]utting kids in their rooms makes them less safe." There is an impulsivity that makes kids act in ways that they wouldn't outside of room confinement." Peter Forbes, Commissioner, Massachusetts DYS*
- *"It require[d] people getting in their cars and driving out to the secure programs and meeting with people at shift change in the facility to talk about the purpose and the why and the implementation plan." Peter Forbes, Commissioner, Massachusetts DYS*
- *"Policy development is a great place to get people on board. Getting a policy written is really important, but the process is as important as the substance." Peter Forbes, Commissioner, Massachusetts DYS*
- *"The biggest mistake we made was we said 'no room confinement' rather than a 'reduction' [in room confinement]. When we said 'no' staff felt like there was never a circumstance that it could be useful, even if the youth was extremely violent. In reality, it's still a tool, but it needs to be used under specific circumstances. Messaging is so important." Daniel O'Sullivan, Metropolitan Regional Director, Massachusetts DYS*
- *"Staff think, if I cannot lock this kid in his room for 12 hours, or the weekend – I am unsafe. We are trying to say, you are safer if the kid has a relationship with you." Ruth Rovezzi, Deputy Commissioner, Massachusetts DYS*
- *Change is difficult for everyone, but all everyone ever wants to know about change is 'how is it going to affect me and how to do my job, and how to keep me safe'. The benefit has to be personalized. It should have said 'here's the benefit to reducing room confinement because you are building positive relationships with the kids.' If we can get kids out [of room confinement] faster into the population, it increases the safety in the moment and long term. Lynn Allen, Facility Administrator, Massachusetts DYS*
- *"How they get out [of room confinement] is just as important as how they get in." Peter Forbes, Commissioner, Massachusetts DYS*

- *"We don't just close the door and leave them in there to calm down on their own. That's not helpful if we want them to regain control." Lynn Allen, Facility Administrator, Massachusetts DYS*
- *"Initially staff thought that there was no room confinement and we were going to put the kids in the population no matter what – and that's not what we do." Lenny Beatty, Facility Administrator, Massachusetts DYS*
- *"It's really important to have youth see that a skill is something that adults use and it's not just a clinical tool." Yvonne Sparling, Director of Clinical Services, Massachusetts DYS*
- *"How do you address staff concerns but not concede that we are going back to model with room confinement. "We need to acknowledge it. We need to have a response to it. Then locally, we have to look at the underlying causes." Ruth Rovezzi, Deputy Commissioner, Massachusetts DYS*
- *"Goals for repairs are totally the opposite from [goals for] isolation." Yvonne Sparling, Director of Clinical Services, Massachusetts DYS*
- *"They need to understand how their actions affected other people and how they will act differently in the future, so there's a lot of work [in repairs]." Yvonne Sparling, Director of Clinical Services, Massachusetts DYS*
- *"We don't look to punish our kids while they are here. The fact that they are here losing their freedom, we feel is hard enough. In order to have our kids buy into our system and follow our rules we offer them incentives." Elisa Samuels, Program Director, Massachusetts DYS*
- *"We recognized when we revamped our room confinement practices in 2007 this challenge in either assisting youth preventing or minimizing the recurrence of another isolation incident." Robert Turillo, Assistant Commissioner of Program Services, Massachusetts DYS*
- *"If the clinicians are just writing up an ISP and telling people what to do, it will fail. If you get everyone's input, there is more follow-through and buy in. All of this stuff leads to less room confinement." Daniel O'Sullivan, Metropolitan Regional Director, Massachusetts DYS*
- *"The really difficult kid is one who punches a staff person. Staff are going to confront you with that and you have to have a response. We have detailed protocol in the event that it happens." Peter Forbes, Commissioner, Massachusetts DYS*
- *"We've also done a lot of training with our staff on adolescent brain development. . . That has helped our staff step back a little bit and think - this isn't necessarily personal, this is the way*

*this young person reacts.” Ruth Rovezzi, Deputy Commissioner, Massachusetts DYS*

- *“We spend a lot of time [in training] on how placing the youth in room confinement really increases the likelihood that they may make a serious suicide attempt. We really stress the importance of doing everything you can to keep a kid out of room confinement.” Yvonne Sparling, Director of Clinical Services, Massachusetts DYS*
- *“If you have a relationship with a young person, you can engage them in making different choices before it comes to the need to put someone in their room.” Ruth Rovezzi, Deputy Commissioner of Massachusetts DYS*
- *“It’s safer now from when I started seventeen years ago. There is much more training for us. Less restraints are happening because staff are communicating between themselves and talking to the kids, building the relationships with the kids to make them understand that we are not here just to put hands on them. We are here to talk to them, to help them make a better change in their life.” Rudy Kolaco, Shift Administrator, Massachusetts DYS*
- *“I believe that those conversations build trust... those conversations that we have with them equal safety and security.” Lenny Beatty, Facility Administrator, Massachusetts DYS*
- *“Our work as a juvenile justice agency is preparing young people to return to their communities as citizens, as contributing members of their community. For that they need skills. They need to be able to manage the demands of life. They need to have an education that prepares them for employment. They need to have positive relationships with others. They are not going to get any of that locked in a room somewhere.” Ruth Rovezzi, Deputy Commissioner, Massachusetts DYS*
- *“It hurt me so much to see children in rooms like that. Room confinement causes mental illness. You’re teaching violence when you use force.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*
- *“DOJ was a great learning experience.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*
- *“I want all kids out all day.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*
- *“To change something, you need to replace it with something better.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*
- *“When we cut their hair, their whole demeanor changed. Children saw we cared about how they looked, so they cared about how they looked.” Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff’s Office*

- *"This required a real adjustment from their previous orientation, but staff eventually saw the improvements firsthand in their new roles as teachers, coaches, and mentors: "It worked." Deidra Bridgeforth, Assistant Chief, Shelby County Sheriff's Office*
- *"A lot of bad outcomes were happening for the kids. Kids were ending up in the Behavior Management Unit for a long time. Luckily, we had no suicides during that time. A lot of bad outcomes were happening for the staff. The staff burn out was super high. The staff morale was super low. We were putting staff in an untenable situation. We realized that we had a big issue. And it was cyclical and deeply engrained in the culture." Joe O'Leary, Director, OYA*
- *"The research about the impact of isolation on kids is there. If we didn't take it head on and start to change our own practices, then other people were going to do it for us." Erin Fuimaono, Assistant Director of Development Services, OYA*
- *"Where people got stuck is [the Behavior Matrix] still had isolation listed as 'up to 5 days.' Just because the Matrix said up to 5 days doesn't mean it needed to be 5 days, or it's the right thing to do." Alicia Buettner, Superintendent, OYA*
- *"The culture we have in the organization predates us by many years. In attempting to shift the culture some staff may see us as just another flavor of the day, week, month.... Those who are resistant to change may be fairly confident that they can outlast us and the new initiative. In most cases they are correct." Fariborz Pakseresht, Former Director, OYA*
- *"You can't go away in the lab and come up with a great policy. You have to go out there and get the folks that are doing the work, know the kids, know the operations, know the clinical piece, know youth development, and get them around the table to be part of this effort. You can't go from the top down." Clint McClellan, Assistant Director, OYA*
- *"We acknowledged that there was a time when [isolation] was thought of as the appropriate thing to do, but we are shifting mindsets and have new research and an understanding of skill development in behavior change. None of us would be using computers from 2000. The same is true in how we interact with young people." Erin Fuimaono, Assistant Director of Development Services, OYA*
- *"We clarified that OYA was not eliminating the use of isolation, but we were talking about how to use it differently. We had to balance our message about what is effective for kids with the acknowledgement that our staff are in harm's ways sometimes. [Isolation] would still be an option as a safety intervention, but not as a punishment. Because that doesn't work." Erin Fuimaono, Assistant Director of Development Services, OYA*
- *"Messaging it this way was great because it didn't freak everyone out, but there was still a lot of inconsistency in how staff and facilities were using isolation." Clint McClellan, Assistant Director, OYA*

- *“The key about culture change is that key messages have to go out over and over again. You will still have people say that what they heard was that we’re taking away their tools. You just have to get the message out as many times and ways as possible.” Clint McClellan, Assistant Director, OYA*
- *“What we found were some champions. Those who understood the facility’s vision and goals to reduce isolation. They were able to carry those words forward because other staff respected them.” Alicia Buettner, Superintendent, OYA*
- *“It’s not enough to just to tell our employees that they will have to do things differently. We must take the time to put a compelling case together that makes sense to staff. Is the change going to improve safety? Is it going to create a more pleasant working environment? Is it going to create better futures for youth?” Fariborz Pakseresht, Former Director, OYA*
- *“Youth on youth violence was steady but youth on staff violence went up. That got a lot of people’s attention.” Clint McClellan, Assistant Director, OYA*
- *“What is the human cost of continuing to do business as usual? For example, the trauma that could be inflicted on youth, potentially increasing the numbers of future victims and compromising the safety of the community. At the same time there is the fiscal impact and a monetary cost of continuing the current practice. For example, longer stays in youth correctional facilities, potential transfer to adult prison, and the unquantifiable cost of future crime and victims.” Fariborz Pakseresht, Former Director, OYA*
- *“When I was out working in community programs and we would get youth who experienced isolation, they would struggle when they were in the community. In the community, our main tool is to work with them, talk to them – we don’t use isolation. But their go-to was to run away from the community programs. It took a lot of time to figure out how we could work with them in the community. Shifting the approach in a facility away from punitive isolation and teaching how to regulate and problem solve before they ever leave gives them a better chance at successful reentry.” Jamie McKay, Program Director, OYA*
- *“When you rely on a door between you and a kid as your primary source of safety, you create an us vs. them environment. Then when you have to open that door for something, now it’s you vs. them. That dynamic doesn’t go away automatically, and bad things can happen.” Heber Bray, Operations Policy Analyst, OYA*
- *“We can rewrite policies and procedures, develop the best manuals and practice models, issues directive and decrees, but if [we] are not able to shift those shared values and beliefs and understandings that define the present culture, very little will change.” Fariborz Pakseresht, Former Director, OYA*
- *“[We] started out thinking that we needed more staff, we needed in-between spaces where kids can*

*go when they need a break but not isolation. We thought about creating rooms with calming furniture and paint and music. Then we thought, 'well wait a minute - we can throw staff at this issue, we can create these spaces, but if staff aren't thinking differently about how to intervene with these behaviors and address them, we are just going to use those things in the same way.' Erin Fuimaono, Assistant Director of Development Services, OYA*

- *"You can't just throw out a policy and hope that it sticks." Clint McClellan, Assistant Director, OYA*
- *"Leadership plays a critical role in organizational change. We must understand the impetus for the change and explain it to others. Why are [we] moving in this direction and what is the price that [we] might pay for inaction? We always want to be ahead of the wave of change rather than being overtaken by it." Fariborz Pakseresht, Former Director, OYA*
- *"We have a saying: 'Executive team leaders are here to support and develop our managers, who support and develop our staff, who support and develop our youth.' You can't have one of those out of place. They all have to be in alignment." Clint McClellan, Assistant Director, OYA*
- *"We have to be the message – not the messengers. There's a huge difference. People look for weakness in the armor. They think if you are not really bought in [to a practice or policy change], they don't have to do it." Daniel Berger, Superintendent, OYA*
- *"We must model the change that we want to implement. To change behavior and culture consistently, an organization, we as top leaders as well as our executive team, our managers at every level of the organization, must walk the talk. How we treat staff as leaders and how effectively we listen will translate directly and indirectly to how staff exhibit the same behavior with youth." Fariborz Pakseresht, Former Director, OYA*
- *"We tell staff, 'don't say, 'central office says we have to do this thing.' If you are a leader here, you should be out there saying, 'Here's what we are doing. Here's why we are doing it. And here's how you are a part of this.'" Daniel Berger, Superintendent, OYA*
- *"Initially we thought OYA would adopt the PYD model. We sent some of our staff to PYD trainings. They came back and told us that they could buy into the PYD approach of treating youth as resources, but they wanted to be viewed as resources as well. Staff said, 'If OYA can get to a place where I feel as though I'm being viewed as a resource, then I can do that with the kids [who] we work with every day.'" Joe O'Leary, Director, OYA*
- *Accountability is "[giving] them the skills to be able to learn from their mistakes and hold themselves accountable. Because that's really the only way they're going to create safety in the community . . . Isolation is not a place where you can develop skills at all. There are plenty of things we have to develop to hold kids accountable in terms of consequences. Isolation just isn't one of them." Clint McClellan, Assistant Director, OYA*

- *"It has taken time to pivot. Just because one kid is taking advantage or doing something doesn't mean they all will. What we need to put into perspective for staff is that we have not gone through what most of these kids have experienced. So when [staff] think that punishing a little bit harder is the key to success, our culture has pushed back. What we need is empathy and have high expectations. In essence, treating these kids as your own children goes a long, long way." Alicia Buettner, Superintendent, OYA*
- *"Initially, we were a bit skeptical about doing workgroups and them inviting [the external Advisory Group members] in and them tearing it apart, but that didn't happen." Clint McClellan, Assistant Director, OYA*
- *"[W]e wanted these people close to us during the process, but the beauty of the execution was how they embraced the partnership and the insights we got from them." Joe O'Leary, Director, OYA*
- *"Changes around isolation would not have worked if we had not been given budget flexibility, if we were not given additional funding through creative means to modify some of our physical environments. So having engagement with political leadership was critical." Joe O'Leary, Director, OYA*
- *"It gave us the opportunity to go to our staff and say, '[L]ook, this is coming. We can choose to get ahead of this, or we can let something happen to us that may or may not be administrable. What do you want to do?' That helped to create a mandate to drive planning and action to reduce isolation. In the next legislative session, we offered our own bill." Joe O'Leary, Director, OYA*
- *"The request for a budget note and our subsequent recommendations were literally a nail banged into the wall on which we could hang some funding requests." Joe O'Leary, Director, OYA*
- *"When staff asked us what to do about difficult youth, we said 'you're going to keep them on your unit. And we're going to give you these extra staff to help that kid 'skill up.'" Heber Bray, Operations Policy Analyst, OYA*
- *We had to commit to being proactive instead of reactive. Making that shift is really hard. It costs money up front to save money on the back end, and that's not the way our society is wired." Heber Bray, Operations Policy Analyst, OYA*
- *"We teach them how to problem-solve, stabilize themselves, take 'no' for an answer without getting into conflict. We reduce isolation by teaching kids how to act in the system and how to ask for resources." Corey Ramsay, Skill Development Coordinator, OYA*
- *Youth on the IU "spend most of their time in what's called Core, which is like a dayroom. They go out, work with SDCs, and have meals together out in the Core. As long as there isn't a serious conflict between kids, they are out in Core together." Daniel Berger, Superintendent, OYA*

- *“Once [youth] are regulated – they are no longer hitting the walls, threatening other people, when they are talking reasonably – which may take an hour or two, they may not be able to be safely reintegrated back into the living unit immediately. SDCs work with the kids at this moment to move them along.” Ken Jerin, Superintendent, OYA*
- *We completely rebuilt the program in the light of PHD,” he says. “We didn’t want kids to just go down there and sit. If kids had to go to isolation and had to go to IU, they were engaged in skill development when they were there. That was the basis of rebuilding this program.” Daniel Berger, Superintendent, OYA*
- *“If it’s more institutionalized, it looks more like prison, like a dungeon, then obviously we’re not going to change. We’re just going to be what we’re looked at upon as, like criminals, or animals.” Youth at MacLaren Youth Correctional Facility*
- *“We don’t want corrections officers. We want folks who can work with kids and can learn security protocols as well.” Daniel Berger, Superintendent, OYA*
- *“We send out a hiring letter to potential applicants about the work we do. In essence – working with girls is challenging and rewarding at the same time. There will be accountability when youth make mistakes, which is inevitable with teenagers. What we want to tell [applicants] is that we expect kids to be kids.” Alicia Buettner, Superintendent, OYA*
- *“Kids were still amped up. There was no cooling down time. They had to shift from outside rules to inside rules with the snap of a finger. You’d think that 15, 16, 17-year-olds could shift, but shifting from one set of rules to another is actually an advanced cognitive skill. We would have fights in the line and fights right when we got inside. We’d have kids blowing up because they wanted to get a drink of water and it wasn’t their turn yet. We’d have kids walk one slower deep-breathing lap before they came inside. While they walked the lap, staff reminded them of the inside rules in a nice calm voice by saying, ‘Hey, remember guys, we’re going inside. We’re going to take our shoes off, we’re going to line up, and table by table, we’re going to go to the drinking fountain.’” Heber Bray, Operations Policy Analyst, OYA*
- *“One point about following numbers is that we have to focus on the trendlines and not react extremely to any one point in time.” Joe O’Leary, Director, OYA*
- *“In Oregon we have big facilities. We have 13 living units in one facility. So getting one big conglomerate of data doesn’t tell us a lot. We have to break those [data] down to the individual living units, shifts, or other factors.” Clint McClellan, Assistant Director, OYA*
- *“As soon as you meet resistance with resistance, you’re going to get escalation - every time. You just can’t do it with these kids.” Heber Bray, Operations Policy Analyst, OYA*

- *“Now we are asking [staff] to think of [themselves] not as corrections officers but as brain developers. This kid’s brain wasn’t developed normally because of trauma, and his ‘how do I calm down’ mental pathway isn’t fully formed. We have to develop it. Staff on the [University of Life] will tell you that it’s the hardest work they’ve ever done and also the most rewarding.” Heber Bray, Operations Policy Analyst, OYA*
- *“We had all these older kids here. Some of them were very entrenched gang members and there was violence because frankly, they didn’t have anything else to do here. We weren’t making the program about them. We were making it about control.” Daniel Berger, Superintendent, OYA*
- *“As we build programs to really have them engage in developing their own futures, these guys kind of pulled out of that mindset. We saw huge reductions in incidents in all of our units, especially kids that had longer term Department of Corrections sentences.” Daniel Berger, Superintendent, OYA*
- *“When we changed our policy, we took away that catchall and adopted a much more unambiguous threshold.” Joe O’Leary, Director, OYA*
- *“After implementing the University of Life, there was a 77% decrease in incidents and an 84% decrease in isolation.” Fariborz Pakseresht, Former Director, OYA*

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- 2 Chester R. Chapman, Mark Silverstein, and Kim Dvorchak, *Letter to CDHS Director Reggie Bicha*, June 18, 2014, <http://static.aclu-co.org/wp-content/uploads/2017/02/2014-06-18-Letter-to-DHS-Executive-Director-Bicha.pdf>, cited in *Bound and Broken*, 8.
- 3 Megan Schrader, Debbie Kelley, and Maria St. Louis-Sanchez, "Youth Lockups: Trouble behind bars, Solitary confinement, History lesson, Fixing the problem," *The Gazette* (Colorado Springs, CO), October 4, 2015, [https://gazette.com/news/youth-lockups-trouble-behind-bars-solitary-confinement-history-lesson-fixing/article\\_faf8bfd8-d24b-5590-84d6-582f4a84884f.html](https://gazette.com/news/youth-lockups-trouble-behind-bars-solitary-confinement-history-lesson-fixing/article_faf8bfd8-d24b-5590-84d6-582f4a84884f.html).
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- 7 Colorado HB16-1328, *Use of Restraint and Seclusion on Individuals*, 2016 Regular Session, <https://leg.colorado.gov/bills/>
- 8 *Ibid.*
- 9 "Youth Seclusion Working Group," Colorado Department of Human Services, accessed May 9, 2019, <https://www.colorado.gov/pacific/cdhs-boards-committees-collaboration/youth-seclusion-working-group>.
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- 11 Debbie Kelley, "'Culture of violence' in Colorado Youth Corrections includes physical restraints, solitary," *Colorado Springs Gazette* (Denver, CO), March 2, 2017, <https://kdvr.com/2017/03/02/new-report-puts-colorado-division-of-youth-corrections-under-fire/>.
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- 17 "Youth Services Specialist I – Mount View Youth Services Center," State of Colorado, accessed May 6, 2019. <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Job-Description.pdf>.
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- 19 Mark Soler and Anders Jacobson, "More States Need to Limit Solitary Confinement, Which Doesn't Work," *Juvenile Justice Information Exchange*, September 12, 2018, <https://jjie.org/2018/09/12/more-states-need-to-limit-solitary-confinement-which-doesnt-work/>.
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- 21 *Juvenile Detention Facility Assessment: Guidelines for Conducting a Facility Assessment*.
- 22 Passage of the General Education Development (GED) test is considered by some, but not all, as equivalent to a high school diploma.
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