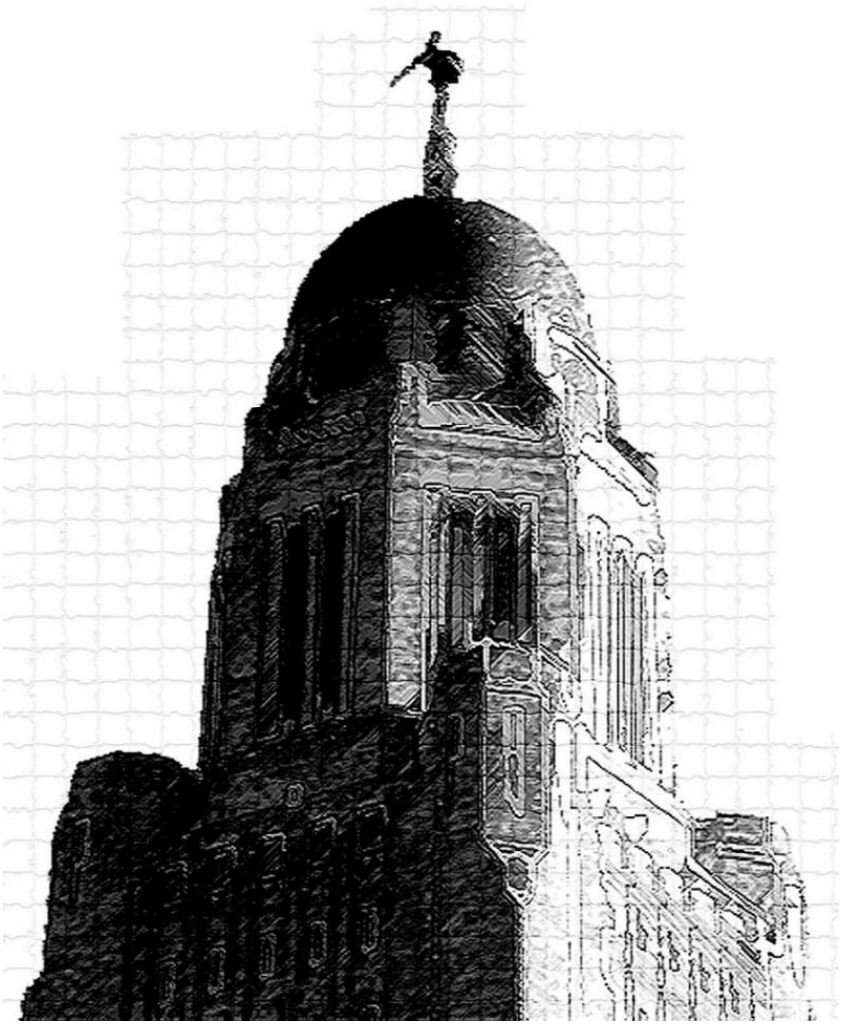
2022-2023
Annual Report

Juvenile Room Confinement in Nebraska



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Office of Inspector General of Nebraska Child Welfare

Providing oversight and accountability for the Nebraska child welfare and juvenile justice systems.

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Executive Summary

The Office of Inspector General of Nebraska Child Welfare (OIG) is mandated by statute to review reported juvenile room confinement data annually and provide an analysis of the use of juvenile room confinement in Nebraska's juvenile facilities. The aim of this report is to establish a foundational understanding of juvenile room confinement, compare Nebraska's data to established best practices, and highlight significant findings regarding the application and trends of juvenile room confinement within the state.

While Nebraska's juvenile room confinement statutes incorporate key best practices, those best practices are not always reflected in its application. The juvenile room confinement statutes, though robust in intent, are inconsistently applied across facilities, leading to varied interpretations and applications of juvenile room confinement. This inconsistency hampers efforts to gauge the full scope of juvenile room confinement's use and its impact on the welfare of juveniles affected.

The Crime Commission Jail Standards Board, the Department of Correctional Services, and the Department of Health and Human Services —including both the Office of Juvenile Services and the Division of Public Health—are the entities responsible for creating consistent interpretations, standards, and practices, and for enforcing the legal requirements in the facilities under their jurisdiction. As the OIG has noted repeatedly in its Juvenile Room Confinement reports, these entities have not provided facilities with a clear and consistent interpretation of the law or clear guidance on how to document and report juvenile room confinement. Nor do these agencies verify how juvenile room confinement is being used or the data reported. The OIG continues to recommend that clear guidance be provided by these agencies with oversight of the juvenile facilities.

Regarding the data itself, the OIG's analysis of the available data raises significant areas of concern, notably an increase in the usage and duration of confinement practices across juvenile facilities in Nebraska. When compared to Fiscal Year (FY) 2021-2022, current data indicates a 44% increase in the total number of confinement incidents, a 32% increase in total confinement hours, and a 24% increase in the total number of confined youth. For example, the number of confinement hours reported by the Youth Rehabilitation and Treatment Center in Kearney increased from 2359 in FY 21-22 to 9010 in FY 22-23. In addition, facilities sometimes use confinement for several consecutive days, although most facilities limit the number of consecutive days confinement may be used to between two and eight days. However, the data reported shows that at the Lancaster County Youth Services Center one youth was

confined for at least 13 hours for 129 out of 133 days, for safety and security reasons including protective custody.

Overall, the data clearly indicates a move away from best practices. The increase in the use and duration of confinement across facilities indicates that confinement is not being used as a last resort or in a time-limited manner.

This year's data highlights the need for stricter adherence to state law and more robust monitoring and enforcement mechanisms to ensure that juvenile room confinement in Nebraska is utilized in a manner consistent with established best practices. Continued monitoring and efforts to align practices with best standards are essential to ensure the well-being of youth in confinement and to meet the intended objectives of these best practices and statutory requirements.

To achieve a true reduction in the use of juvenile room confinement, the OIG suggests facilities implement dedicated staff for oversight within the facilities and the Legislature must understand the needs of these facilities better in order to provide the resources necessary to ensure the safety and security of youth and staff without relying as heavily on the problematic practice of juvenile room confinement.

Juvenile Room Confinement– Contextual Overview

Juvenile room confinement is a practice used in institutional juvenile settings to manage adolescents' behavior by separating them from others resulting in limited social interaction, often including minimal access to educational or recreational activities.

Purpose

The rationale for using juvenile room confinement often centers on the need to protect the safety and security of the facility. In the context of a juvenile justice facility, the term "safety and security" refers to policies and procedures to promote a sense of physical and psychological safety among youth, families, and staff.[1] This can encompass measures to prevent physical harm, violence, and injuries within the facility. Safety and security can also extend beyond physical well-being to include emotional and psychological safety. This means creating an environment where juveniles are safe from intimidation, harassment, bullying, or any form of emotional harm. Ensuring that juveniles do not pose a risk to themselves is also included as an aspect of facility safety and security, requiring measures to prevent self-harm, suicide, or any behavior that might jeopardize a juvenile's well-being.

Becoming familiar with circumstances in which juvenile room confinement is used to maintain safety and security provides insight into the practice, noting that specific terminology may differ from one facility to another.

Danger to Self and Others

In these situations, room confinement is a measure used to prevent harm and maintain order. The purpose is to enhance safety and security within the facility by isolating juveniles who pose immediate risks to themselves or others due to exhibiting violent or disruptive behaviors.

Corrective Action

Another perspective emphasizes the role of room confinement in discipline and rule enforcement. The practice is a means of responding to rule violations and teaching juveniles about consequences for their actions. It is meant to serve as a deterrent, discouraging further misconduct and promoting compliance with facility rules.

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[1] Branson, C. E., Baetz, C. L., Horwitz, S. M., & Hoagwood, K. E. (2017, February 6). Trauma-Informed Juvenile Justice Systems: A Systematic Review of Definitions and Core Components. Psychological Trauma: Theory, Research, Practice, and Policy.

Time-Out

Additionally, the practice can provide staff with a tool to manage crisis situations. It allows for the separation of a juvenile from the general population during moments of heightened tension or emotional distress, with the intention of de-escalating the situation and preventing further conflicts. For instance, if a juvenile becomes agitated or disruptive, a short period of isolation can be used as a time-out to provide an opportunity for the juvenile to regain composure and self-control before rejoining the general population.

Protective Custody

Finally, room confinement can be used as a means of providing protective custody. Protective custody is primarily used to safeguard youth from potential harm or threats posed by other youth due to factors such as gang affiliations, conflicts with others, or general concerns for risk to their well-being. In some cases, protective custody is voluntary, meaning the youth requests it because they fear for their safety. However, protective custody can also be involuntary when staff determine that a youth's safety requires isolation from the general population.

There are also other situations that result in the use of confinement which may be considered less essential to safety and security.

Medical

In cases where juveniles require medical, or in some cases mental health assessments, temporary isolation may become necessary. For example, a juvenile displaying symptoms of a contagious illness may be placed in isolation until a healthcare professional can assess their condition and determine the appropriate steps for treatment. This use of juvenile room confinement for medical purposes became particularly critical during the COVID-19 pandemic. Room confinement of a medical nature may also be applicable when a youth has undergone a medical procedure or presents with a medical condition that, according to a healthcare provider's assessment, poses a risk to the youth if they are returned to the general population. The primary purpose of confinement for medical issues is to contain potential health risks and ensure the well-being of the juvenile, as well as other juveniles in the facility and staff.

Intake and Orientation

When a new juvenile enters a facility, temporary room confinement may be employed during the intake and orientation process. This allows staff to assess the juvenile's needs, perform necessary health screenings, and ensure that they are introduced to the facility's rules and procedures.

Investigations

When allegations of misconduct or rule violations arise within the facility, room confinement may be employed to temporarily separate individuals during the investigation. This separation can prevent interference with the investigative process, allowing for the collection of information.

Staff Meetings or Training

Room confinement can also be utilized to allow for staff meetings or training sessions. By isolating juveniles briefly during such times, staff can convene for important discussions or training without interruptions, ensuring the smooth operation of the facility.

Facility Emergency

A facility emergency can encompass a wide range of situations, including those that pose threats to security. These emergencies require action to preserve order, but are typically limited in duration.

Distinguishing Juvenile Room Confinement from other Practices

Juvenile room confinement has conceptual similarities with restrictive housing in the adult correctional system, where incarcerated adults are isolated for extended periods of time in small cells, often under stringent conditions which can include little human contact and severely restricted access to activities and privileges. Two key components of restrictive housing are the amount of time an individual is allowed out of their cell and a procedure to appeal the placement. These are important differences from juvenile room confinement which does not typically incorporate the right to time out of the room or cell and does not provide a procedure for appealing the confinement. However, when excessively applied, juvenile room confinement can begin to mirror the characteristics of restrictive housing, blurring the distinction between the two practices.

Juvenile room confinement is also sometimes compared to parental grounding, where a child loses privileges as a form of discipline. This comparison is misleading. Grounding in a family context differs significantly from institutional confinement, both in terms of power dynamics and psychological impact. Equating parental guidance with the institutional practice of confining youth overlooks the profound differences between a parent grounding a child and a facility staff member placing a youth in confinement.

Recognizing these distinctions is crucial for conceptually understanding juvenile room confinement and acknowledging its unique challenges and considerations separate from adult correctional practices or family disciplinary techniques.

Concerns with Juvenile Room Confinement

Until recently the use of juvenile room confinement has been generally accepted as a necessary practice. However, after 40 years of accumulated research, there are clear findings indicating that the practice is traumatic and has little therapeutic value outside of limited medical settings. Concerns with the use of juvenile room confinement and suggested guidelines to address them are described below.[2]

Mental Health

Isolating young individuals for extended periods can lead to severe psychological distress, exacerbating feelings of loneliness, anxiety, and depression. Mental health professionals contend that the negative impact on mental health can have long-lasting and sometimes irreversible effects on juveniles, and potentially exacerbate existing mental health issues, particularly for those who have been victims of prior abuse or trauma.

Social and Emotional Growth

Another concern centers on the developmental harm inflicted on adolescents. Adolescence is a critical stage of development, both emotionally and socially. Research suggests that isolation disrupts the social and emotional growth of young individuals, hindering their ability to develop essential life skills and healthy relationships. Research suggests that the practice can have detrimental long-term consequences on the prospects of youth's successful reintegration into society.

Exacerbation of Problematic Behavior

Additionally, it has been found that room confinement can sometimes lead to an escalation of problematic behaviors rather than promoting positive behavior change in juveniles. Instead of addressing the underlying causes of delinquent behavior, isolation may reinforce negative patterns as a means of coping with the stress and maladaptive behavior, potentially increasing the likelihood of future misconduct.

Guidelines and Best Practices

There is a tension between using juvenile room confinement as a potentially necessary tool for safety and security in a facility and the harm that confinement can cause. As research has drawn more attention to the practice of juvenile room confinement, it has influenced the development of guidelines

[2] For a complete list of references see Appendix E for a list of selected references along with previous reports found at http://oig.legislature.ne.gov/?page_id=380.

and best practices and raised ethical concerns about the treatment of young offenders and their access to due process and fair treatment within juvenile facilities. As a result, the use of juvenile room confinement has become increasingly constrained, including legislation at the federal level which has limited its use.

Many professional and accrediting organizations in the field of juvenile justice, mental health, and education have developed guidelines and standards to govern the use of room confinement. The goal is to strike a balance between maintaining safety and security within juvenile facilities while safeguarding the well-being of youth. These guidelines reflect a commitment to the promotion of positive behavior change among juveniles, rather than punitive measures that may have long-term negative consequences, and the implementation of oversight practices crucial for ensuring the responsible and ethical use of room confinement.

These guidelines include using juvenile room confinement as a last resort, only when less restrictive alternatives have been exhausted or when there is an immediate safety concern. It should be time limited in duration and not extend beyond what is necessary to address the specific safety or security concern. Each case should undergo an individualized assessment to determine the appropriateness of room confinement, taking into account the juvenile's age, mental health, and developmental needs. While in confinement the child should continue to receive educational and therapeutic programming, including access to mental health services.

Staff should receive specialized training in the use of room confinement, emphasizing de-escalation techniques, crisis intervention, and the importance of humane treatment and specifically staff should be trained to recognize signs of distress and respond appropriately when a youth is in confinement.

Facilities should actively seek and implement alternatives to room confinement, such as restorative justice practices, structured behavior modification programs, and graduated sanctions. Juveniles' legal rights should be protected, including access to due process, legal representation, and the ability to challenge their confinement.

Finally, the use of room confinement should be documented—facilities should collect data on the use of room confinement, analyze it for trends and disparities, and use this information to inform policy and practice improvements—and its use should be transparent and monitored. Facilities should maintain accurate records of room confinement incidents, including the reasons, duration, and outcomes. This

information should be subject to regular oversight and monitoring. As part of that there should be a regular and rigorous review process to assess the continued necessity of room confinement.

There are guidelines for oversight of the use of juvenile room confinement. Some of these guidelines are noted above—there should be clear requirements for documentation and transparency, training and education of staff, and a rigorous review process. In addition, the use of juvenile room confinement must start with clear and comprehensive policies and procedures governing its use. These policies should define the circumstances under which room confinement is permissible, the maximum duration of confinement, the conditions under which it can be used, and should ensure that these policies align with relevant laws and regulations.

It is recommended that a facility appoint specific individuals or teams responsible for internal oversight. This oversight team can conduct or review regular internal inspections and audits to assess compliance with policies and procedures. Data regarding the use of room confinement in a facility should be analyzed for the demographics of juveniles subjected to confinement, the reasons for confinement, its duration, and any adverse outcomes. Data analysis can help identify trends, disparities, and areas for improvement. Facilities should establish mechanisms for feedback and input from staff and juveniles within the facility regarding confinement. Oversight personnel should review their findings and make recommendations for improvement when necessary and use the insights gained from oversight to make continuous improvements in the use of room confinement.

Facilities should ensure transparency by regularly reporting on the findings of internal oversight to relevant authorities, including facility administrators, governing bodies, and external oversight agencies. Facilities can collaborate with external oversight agencies, such as independent ombudsmen or oversight boards, to complement internal oversight efforts.

Juvenile Room Confinement in Nebraska Statute

Definition of Room Confinement

In Nebraska, juvenile room confinement is defined as, "[. . .] the involuntary restriction of a juvenile placed alone in a cell, alone in a room, or alone in another area, including a juvenile's own room, except during normal sleeping hours, whether or not such cell, room, or other area is subject to video or other electronic monitoring."[3]

The definition of room confinement within Nebraska statute is broad. As noted above, it includes any time a youth is involuntarily placed alone in a cell, room, or another area, including their own room. This description can apply to a range of practices that facilities label as: rest periods, cooling off periods, time outs, seclusion, room restriction, restrictive housing, segregation, disciplinary confinement, investigative safekeeping, protective custody, medical quarantine, modified operations, alternative placement, and lockdown for the purpose of head count, shift change, staff training, or facility emergencies. All of these practices physically separate a youth from the general population placing them alone, resulting in social isolation.

The statutory definition does not contain qualifiers based on the intent or the purpose for the use of juvenile room confinement. The behavior or emotional state of the youth is not considered as a factor in whether or not the incident qualifies as room confinement. Compliance with being placed in juvenile room confinement is not an allowable substitute for free will. If a youth complies with the separation, having no other choice in the matter, the confinement is involuntary.

Simply, any instance of a youth involuntarily placed alone in a room is considered to be juvenile room confinement under Nebraska law regardless of circumstances or the period of time. If a youth given no other options due to facility policy, practice, or scheduling, who is sitting calmly, alone, in a room, unable to leave the room during shift change, staff breaks, or staff training, the youth is considered to be in room confinement.

Similarly, a youth (being defiant and verbally aggressive) who is placed alone, in a room, unable to leave the room due to an act of violence against another youth or staff, is considered to be in room confinement because the youth is involuntarily placed alone.

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[3] Neb. Rev. Stat. §83-4,125 (4).

It is important to note that juvenile room confinement is not prohibited in Nebraska. However, its use must be balanced with the potential psychological and physical harm, noted above, that it can cause to the individual youth.

Designated Juvenile Facilities Subject to Reporting Requirements

While the Nebraska juvenile room confinement definition is inherently broad and could apply to any number of practices within a range of facilities, the Nebraska juvenile room confinement documentation and reporting statutes only apply to a well-defined set of facilities that serve the juvenile population. These facilities specifically fall under the following four categories, comprising a current total of 31 facilities within the state:

Residential-Child Caring Agencies

At the time of this report there are 21 total Residential-Child Caring Agencies (RCCA) acting as out-of-home placements, providing 24-hour care for four or more children, and not a foster family home licensed by the Department of Health and Human Services Division of Public Health (Public Health). Often these facilities are inclusive of mental health and substance abuse treatment centers. The total number of such facilities varies from year to year and has been as high as 25. For the most current list of facilities, including location, capacity and program description see Appendix B.

DHHS Public Health regulations for RCCAs govern seclusion, a form of room confinement. By regulation, seclusion can only be used in emergencies and cannot be used as a form of punishment or discipline, for staff convenience, or as a substitute for care, and cannot be used by peers or untrained staff. Facilities that use seclusion must have detailed policies on its use. Historically RCCAs have reported only a few isolated incidents of confinement.

Juvenile Detention Centers

There are currently four juvenile secure and staff secure detention facilities in Nebraska operated by individual counties, and overseen by the Jail Standards Board of the Nebraska Commission on Law Enforcement and Criminal Justice (Jail Standards Board). These facilities primarily serve youth under 18 years old after an initial arrest, youth who are sent to detention after probation violations, and youth awaiting placement while on probation.

- Douglas County Youth Center (Douglas County) is a secure juvenile detention center in Omaha;
- Lancaster County Youth Services Center (Lancaster County) provides secure detention services for juveniles and is located in Lincoln;

- Northeast Nebraska Juvenile Services Center (Madison County) is located in the town of Madison within Madison County and provides both staff secure and secure detention to juveniles 18 years of age and younger; and,
- Patrick J. Thomas Juvenile Justice Center (Sarpy County) in the town of La Vista is a staff-secure detention center located within Sarpy County.

The Jail Standards Board has the authority and responsibility to "develop standards for juvenile detention facilities and staff secure juvenile facilities, including, but not limited to, standards for physical facilities, care, programs, and disciplinary procedures, and to develop guidelines pertaining to the operation of such facilities."[4] In addition to creating standards, the Jail Standards Board is responsible for auditing facilities for compliance and providing technical assistance to facilities.

The standards for juvenile detention facilities were last updated in 1992 and contain a number of provisions about juvenile room confinement. Under the Juvenile Detention Facilities Standards promulgated by the Jail Standards Board, there are at least nine different practices in the regulations that may meet Nebraska's definition of room confinement (segregation, confinement, administrative segregation, disciplinary detention, protective custody, temporary confinement, room restriction, separate confinement, and disciplinary confinement). However, the terms are used inconsistently within regulations, and some are undefined.

Youth Rehabilitation and Treatment Centers

There are currently three Youth Rehabilitation and Treatment Centers (YRTCs) administered and overseen by the Nebraska Department of Health and Human Services (DHHS) Office of Juvenile Services (OJS) located in Hastings (YRTC-Hastings), Kearney (YRTC-Kearney), and Lincoln (YRTC-Lincoln). Each facility serves youth in the juvenile justice system, ages 14 through 18. Every youth at a YRTC facility is committed there by a court that determines that the youth has already "exhausted all levels of probation supervision and options for community-based services."[5] The YRTC-Hastings campus serves female youth only. The YRTC-Kearney campus serves male youth only, while the YTRC-Lincoln facility serves both males and females.

[4] Neb. Rev. Stat. §83-4,126(1) (c).
[5] Neb. Rev. Stat. §43-286.

DHHS rules and regulations, as outlined in Nebraska Administrative Code, authorize the use of room confinement either for reasons of safety and security or as a disciplinary sanction if the youth has violated a facility rule. Regulations distinguish between two different kinds of room confinement — room restriction, which is considered a cooling off period and can last up to an hour, and disciplinary segregation which can last for up to 5 days.[6]

Nebraska Department of Correctional Services (NDCS)

NDCS or the Department of Corrections operates facilities that house individuals convicted of crimes in Nebraska's criminal courts and sentenced to prison terms. While most of its incarcerated individuals are 19 years of age (the age of majority in Nebraska) or older, some NDCS inmates are considered juveniles. These youth have been tried, convicted, and sentenced to prison terms in adult criminal court, rather than juvenile court which handles the majority of cases against children. NDCS does not report incidents of confinement after a youth has reached their eighteenth birthday. This is different from all other facilities which report through the eighteenth year.

Historically, of the ten NDCS facilities, three have reported the utilization of juvenile room confinement with housed juveniles: Nebraska Correctional Youth Facility (NCYF) in Omaha, the Nebraska Diagnostic & Evaluation Center in Lincoln, and the Nebraska Correctional Center for Women (NCCW) in York.

The Reception and Treatment Center (RTC), which incorporates the Diagnostic & Evaluation Center is a maximum custody facility that serves a number of functions, including diagnostic evaluations for the purpose of mental health assessment. RTC has historically reported the use of juvenile room confinement very infrequently and involving very few individuals.

NCCW houses all female youth for NDCS. The facility usually only houses one or two female youth under 18 years of age each year. NCCW most often finds the use of juvenile room confinement is a result of physical plant issues in combination with the Prison Rape Elimination Act (PREA) which requires sight, sound, and physical separation between incarcerated juveniles (defined as those who are younger than 18 years of age) and incarcerated individuals 18 years and over.[7]

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[6] 401 NAC 7-007. http://www.sos.ne.gov/rules-and regs/regsearch/Rules/Health_and_Human_Services_System/Title-401/Chapter-7.pdf.
[7] Prison Rape Elimination Act (PREA) National Standards, 28 C.F.R. § 115.14 (2012).

NCYF is a facility that specifically houses male offenders who are aged 21 and under. NCYF is the most consistent reporter of juvenile room confinement data, both in terms of frequency of use and the greatest number of individual youth.

As of March 2020, under Nebraska law, any incarcerated individual who is aged 18 or younger is considered to be a member of a vulnerable population, and can no longer be placed in restrictive housing.[8] This new legislation has required significant changes to the use of restrictive housing for incarcerated individuals 18 years or younger. NCYF successfully discontinued the use of restrictive housing with the last Longer-Term Restrictive Housing placement in December 2019 and the last Immediate Segregation placement in April 2020. The facility also discontinued the use of Room Restriction as a disciplinary sanction in May 2020 in order to comply with state law.

Data Collection Requirements

Nebraska law requires regular data reporting on the use of room confinement by the facilities described above. The intent of the legislation, as noted by the bill's introducer, was to cast a wide net in capturing information on youth being involuntarily placed alone, "In light of the fact that the oversight of the placement of juveniles falls under different jurisdictional umbrellas, including county and state facilities, [. . .] it is especially important that the Legislature has access to the full array of data from all applicable sources."[9]

Nebraska Revised Statute §83-4,134 requires facilities to collect the following information when a juvenile has been confined for longer than one hour during a 24-hour period:

- Written approval by a supervisor in the juvenile facility;
- The date of the occurrence;
- Demographic information including race, ethnicity, age, and gender of the juvenile;
- Reason for placement of the juvenile in room confinement;
- An explanation of why less restrictive means were unsuccessful;
- The ultimate duration of the placement in room confinement;
- Facility staffing levels at the time of confinement; and,

[8] Neb. Rev. Stat. §83-173.03(1).
[9] "Transcript: Judiciary Committee – January 20, 2016."
http://www.nebraskalegislature.gov/FloorDocs/104/PDF/Transcripts/Judiciary/2016-01-20.pdf

- Any incidents of self-harm or suicide committed by the juvenile while he or she was isolated.

Initially, the law only required facilities to collect this data if the incident of confinement lasted an hour or longer. However, in 2020, the juvenile room confinement statutes were revised to require documentation and reporting any time the *total* confinement of a youth during a 24-hour period exceeded an hour – meaning if a juvenile was confined for a half hour in three separate incidents during a 24-hour period, those incidents must be taken cumulatively.

The statutory change fundamentally altered when a facility is required to start documenting the required information as incidents are accumulative.

Data Reporting Requirements

After collecting the required information, juvenile facilities are then mandated to submit a quarterly data report to the Legislature. The reports must redact all personal information, such as names, but provide individual, not aggregate, data. During FY 2022-2023 two facilities, Lancaster County and Douglas County, reported aggregate data – not the required individual data.[10] The reports must include the following data points for each individual incident of confinement:

- Length of time each juvenile was in room confinement;
- Demographic information including the race, ethnicity, age, and gender of each juvenile placed in room confinement;
- Facility staffing levels at the time of confinement; and,
- The reason each juvenile was placed in room confinement.

For each incident of juvenile room confinement lasting longer than four hours the report must also include reasons why attempts to return the juvenile to the general population of the juvenile facility were unsuccessful.

Limits & Requirements Specific to the Use of Juvenile Room Confinement

Nebraska law places certain parameters and conditions around the documentation of and use of juvenile room confinement. In 2020, Nebraska Revised Statute §83-4,134.02 was updated so that juvenile detention facilities, facilities operated by NDCS, and YRTCS operated by DHHS are now required

[10] Lancaster County reported two quarters of the fiscal year as individual data, and then reverted to aggregate data for the final two reporting periods.

to adhere to the following practices[11] when using juvenile room confinement. Per state law a juvenile shall not be placed in room confinement for any of the following reasons:

- As a punishment or a disciplinary sanction;
- As a response to a staffing shortage; or
- As retaliation against the juvenile by staff.

Second, youth placed in any of the above facilities may only be held in room confinement according to the following conditions:

- A juvenile shall not be placed in room confinement unless all other less-restrictive alternatives have been exhausted and the juvenile poses an immediate and substantial risk of harm to self or others.
- A juvenile shall not be held in room confinement longer than the minimum time required to eliminate the substantial and immediate risk of harm to self or others and shall be released from room confinement as soon as the substantial and immediate risk of harm to self or others is resolved;
- A juvenile shall only be held in room confinement for a period that does not compromise or harm the mental or physical health of the juvenile; and
- Any juvenile placed in room confinement shall be released immediately upon regaining sufficient control so as to no longer engage in behavior that threatens substantial and immediate risk of harm to self or others.

Third, requirements for the standard of care provided to youth in confinement have also been implemented into the law and include:

- All rooms used for room confinement shall have adequate and operating lighting, heating and cooling, and ventilation for the comfort of the juvenile. Rooms shall be clean and resistant to suicide and self-harm. Juveniles in room confinement shall have access to drinking water, toilet facilities, hygiene supplies, and reading materials approved by a licensed mental health professional.

[11] Based on the description of facilities required to collect and report data discussed earlier in this report, this section of statute applies to all defined facilities except residential child caring agencies.

- Juveniles in room confinement shall have the same access as provided to juveniles in the general population of the facility to meals, contact with parents or legal guardians, legal assistance, and access to educational programming.
- Juveniles in room confinement shall have access to appropriate medical and mental health services. Mental health staff shall promptly provide mental health services as needed.
- Juveniles in room confinement shall be continuously monitored by staff of the facility. Continuous monitoring may be accomplished through regular in-person visits to the confined juvenile which may also be supplemented by electronic video monitoring.

Finally, Nebraska Revised Statute §83-4,134.02 specifically states the use of consecutive periods of room confinement to avoid the intent and purpose of the section is prohibited.

Oversight

The Office of Inspector General of Nebraska Child Welfare (OIG) is charged with reviewing all the required juvenile room confinement data reported by facilities pursuant to statute to assess the use of room confinement.[12] Additionally, the OIG must submit an annual report of findings to the Legislature, including any policies and practices that "may lead to decreased use of such confinement."[13] As part of the review requirement, the OIG has met with facility administrators over the years to discuss actions, efforts, and procedures related to the issue, and made requests for data clarification, when needed, from individual facilities. It should be noted that the OIG does not have the authority or the obligation to verify the data provided by the facilities. The OIG does not conduct unannounced onsite inspections, or interviews with front line facility staff or juveniles placed at the facilities for the purpose of collecting anecdotal information. As a result, the OIG's assessment and oversight of data is based only on data independently submitted by facilities.

As noted several times in previous reports, there is no standard interpretation of Nebraska's juvenile room confinement statute – what counts as room confinement and what needs to be documented. It differs from facility to facility and occasionally even within an individual facility. As a result, it is not possible for the OIG to draw conclusions about the use of room confinement across different facilities.

[12] The reports facilities provide to the Legislature are submitted as PDFs. The PDF format does not allow the OIG to sort and analyze the data using a program such as Microsoft Excel. As a result, since 2016, the OIG has requested individual facilities provide data to the OIG in a spreadsheet format which facilitates data analysis.
[13] Neb. Rev. Stat. §83-4,134.01(2)(d).

The OIG can compare each facility to itself and to prior years in that facility. Therefore, the OIG's review can only result in a general understanding of how often room confinement is used, the length of time for incidents of confinement, and the reasons for confinement.

Juvenile Room Confinement in Nebraska & Best Practices

As discussed in the overview, comprehensive guidelines have been established as a means of balancing the necessity and risk associated with juvenile room confinement. Many professional and accrediting organizations in the field of juvenile justice, mental health, and education have developed standards and best practice policies to govern the use of room confinement based on the guidelines. Nebraska's statute is thoughtfully constructed in alignment with these guidelines, and effectively incorporates six impactful best practices. According to Nebraska Revised Statute §83-4,134.01 and §83-4,134.02, juvenile room confinement should be (1) used as a last resort, (2) time limited, (3) recognize the potential physical and psychological harm, (4) closely monitored, (5) provide youth with access to their own belongings, and (6) provide accountability and oversight regarding the use of juvenile room confinement.

The following section analyzes the data reported by facilities through the lens of best practices to glean implementation within Nebraska facilities. The analysis incorporates data submitted by eight juvenile facilities and the six generally accepted best practices articulated in Nebraska statute.

In total, facilities reported over 4,000 incidents of juvenile room confinement involving 503 youth, confined for more than 56,900 hours.[14] The data and analysis that follows should be considered a broad reporting of how Nebraska facilities performed in regards to utilizing best practices during the fiscal year based on the totality of the data.

Overall, the usage of juvenile room confinement increased this fiscal year in both the number of incidents, youth confined, and amount of hours confined. Additionally, fewer incidents were completed within 24 hours as compared to last fiscal year.

[14] For detailed information about the data analysis process conducted as part of this report see Appendix D: Report Process.

Chart 1. FY Data Comparisons[15]

Facility	FY 21-22	FY 22-23
Douglas County Detention		
Total Incidents	232	332
Total Youth Confined	117	169
Total Hours	18849	34036
% of Incidents resolved by 8 hrs.	14%	11%
Lancaster County Detention		
Total Incidents	1097	1642
Total Youth Confined	121	124
Total Hours	3238	5135
% of Incidents resolved by 8 hrs.	87%	89%
Madison County Detention		
Total Incidents	25	19
Total Youth Confined	22	15
Total Hours	103	190
% of Incidents resolved by 8 hrs.	96%	58%
Sarpy County Detention		
Total Incidents	36	96
Total Youth Confined	18	35
Total Hours	78	282
% of Incidents resolved by 8 hrs.	100%	97%

Facility	FY 21-22	FY 22-23
YRTC-Kearney		
Total Incidents	277	506
Total Youth Confined	71	84
Total Hours	2359	9010
% of Incidents resolved by 8 hrs.	75%	50%
YRTC-Hastings		
Total Incidents	39	107
Total Youth Confined	18	29
Total Hours	1305	1219
% of Incidents resolved by 8 hrs.	49%	52%
YRTC-Lincoln		
Total Incidents	87	178
Total Youth Confined	18	35
Total Hours	1847	4483
% of Incidents resolved by 8 hrs.	52%	46%
NCYF		
Total Incidents	163	38
Total Youth Confined	22	12
Total Hours	15474	2576
% of Incidents resolved by 8 hrs.	74%	19%

[15] The data in this chart excludes confinement incidents reported as medical necessity.

Chart 2: FY 22-23 Confinement Duration Ranges by Facility[16]

Sarpy County Detention	Count	%
Within 4 hours	83	86%
Within 8 hours	11	11%
Within 24 hours	1	1%
More than 24 hours	1	1%
Grand Total	**96**	

YRTC-Lincoln	Count	%
Within 4 hours	61	34%
Within 8 hours	21	12%
Within 24 hours	46	26%
More than 24 hours	50	28%
Grand Total	**178**	

Madison County Detention	Count	%
Within 4 hours	8	42%
Within 8 hours	3	16%
Within 24 hours	6	32%
More than 24 hours	2	11%
Grand Total	**19**	

NCYF	Count	%
Within 4 hours	6	16%
Within 8 hours	1	3%
Within 24 hours	7	18%
More than 24 hours	24	63%
Grand Total	**38**	

Lancaster County Detention	Count	%
Within 4 hours	1274	78%
Within 8 hours	186	11%
Within 24 hours	180	11%
More than 24 hours	2	0%
Grand Total	**1642**	

Douglas County Detention	Count	%
Within 4 hours	32	10%
Within 8 hours	3	1%
Within 24 hours	13	4%
More than 24 hours	284	86%
Grand Total	**332**	

YRTC- Hastings	Count	%
Within 4 hours	42	39%
Within 8 hours	14	13%
Within 24 hours	19	18%
More than 24 hours	32	30%
Grand Total	**107**	

YRTC-Kearney	Count	%
Within 4 hours	202	40%
Within 8 hours	53	10%
Within 24 hours	141	28%
More than24 hours	110	22%
Grand Total	**506**	

[16] The data in this chart excludes confinement incidents reported as medical necessity.

Chart 3. 24-hour Completion Data 2016-2023

	NCYF	Douglas Co.	Lancaster Co.	Madison Co.	Sarpy Co.	YRTC-K	YRTC-L	YRTC-H
2016-2017	0%	21%	100%	100%	100%	34%	-	-
2017-2018	0%	24%	100%	100%	100%	59%	-	-
2018-2019	31%	34%	100%	100%	100%	28%	-	-
2019-2020	87%	35%	100%	100%	100%	77%	-	-
2020-2021	54%	32%	100%	91%	100%	88%	81%	-
2021-2022	47%	25%	100%	96%	100%	95%	76%	64%
2022-2023	**37%**	**15%**	**100%**	**90%**	**98%**	**78%**	**72%**	**70%**

Chart 4. FY 22-23 Facility Reported Reasons for Confinement

Sarpy County

Reasons for Confinement	Count	%
Safety/Security	**95 total**	**98%**
Danger to Other Youth	90	
Danger to Staff	5	
Administrative	**1**	**1%**
Transfer to Secure Facility	1	
Medical	**1**	**1%**
COVID Quarantine	1	
Total Incidents	**97**	

Madison County

Reasons for Confinement	Count	%
Safety/Security	**19 total**	**100%**
Danger to Staff	12	
Danger to Other Youth	7	
Total Incidents	**19**	

Douglas County

Reasons for Confinement	Count	%
Safety/Security	**332 total**	**100%**
Fighting	198	
Assault, Attempted Assault	92	
Assaulting Staff or Volunteer, or Attempt	11	
Possession or Manufacture of Drugs or Intoxicants	9	
Destruction of Property	7	
Possession of Contraband	3	
Escape, Attempted Escape	2	
Gang Activity	2	
Intimidating or Threatening Behavior	2	
Unauthorized Possession of Prescribed Medication	2	
Harassing Others	1	
Sexual Activities	1	
Simple Assault	1	
Terrorist Threats	1	
Total Incidents	**332**	

Lancaster County

Reasons for Confinement	Count	%
Medical	**1339 total**	**45%**
COVID Quarantine	1281	
Confidential/Medical	24	
Medical emergency in the facility	16	
Per Medical Directive	16	
COVID Precaution	2	
Safety	**882 total**	**30%**
Juvenile is a danger to other residents	360	
Juvenile is a danger to other residents, staff, in danger due to behaviors of others	271	
Juvenile is a danger to other residents and staff	84	
Juvenile is a danger to staff	81	
Juvenile is in danger due to behaviors of others	47	
Escape Risk	13	
Corrective Action for rule violation	11	
Juvenile is a danger to other residents, and in danger due to behaviors of others	5	
Juvenile is a danger to self	6	
Juvenile is a danger to self and staff	4	
Administrative: Staffing	**389 total**	**13%**
Shift Change/Facility Safety Check/Resident Count	186	
Behavior Management staff training	157	
Emergency all staff meeting	25	
Mandatory Staff Meeting	21	
Administrative: Facility Safety/Security	**324 total**	**11%**
Operational safety need	258	
Shift Change/Facility Safety Check	38	
Multiple safety and security issues	23	
Facility Lockdown	4	
Intake processing	1	
Administrative: Emergency/Weather	**41 total**	**1%**
Security Equipment Malfunction	21	
Central Control went down	20	
Administrative: Facility Safety/Operational Need	**6 total**	**<1%**
Court transports	6	
Total Incidents	**2981**	

YRTC-Kearney

Reasons for Confinement	Count	%
Safety/Security	**277 total**	**47%**
Danger to Other Youth	177	
Danger to Staff	84	
Danger to Other Youth & Staff	9	
Danger to Self	7	
Administrative	**229 total**	**39%**
Corrective Action	88	
Intake Processing: Sight/Sound Separation	60	
Escape Risk	37	
Investigation	33	
Staffing	11	
Medical	**86 total**	**15%**
Sickbay	51	
Intake Processing: New Admit	20	
COVID Quarantine	11	
COVID Protocol	3	
Substance Use	1	
Grand Total	**592**	

YRTC-Hastings

Reasons for Confinement	Count	%
Administrative	**46 total**	**26%**
Reintegration Plan	36	
Corrective Action	4	
Intake Processing Quarantine	2	
Escape Risk	1	
Group Disturbance with Property Destruction	1	
Pending Investigation	1	
Staffing	1	
Medical	**68 total**	**39%**
Sickbay	47	
COVID Quarantine	8	
COVID Protocol	6	
Intake Processing	5	
Pending Investigation	1	
Substance Use	1	
Safety/Security	**61 total**	**35%**
Danger to Staff	27	
Danger to Other Youth	23	
Danger to Self	5	
Danger to Other Youth & Staff	3	
Danger from Other Youth	2	
Protective Custody	1	
Total Incidents	**175**	

YRTC-Lincoln

Reasons for Confinement	Count	%
Safety/Security	**110 total**	**53%**
Danger to Other Youth	60	
Danger to Staff	29	
Danger to Self	11	
Danger to Other Youth & Staff	7	
In Danger from Other Youth	2	
Protective Custody	1	
Administrative	**68 total**	**33%**
Reintegration Plan	36	
Corrective Action	19	
Investigation	7	
Escape Risk	4	
Pending Investigation	1	
Staffing	1	
Medical	**29 total**	**14%**
Illness	14	
COVID Quarantine	8	
Medical Emergency on Unit	4	
Surgical Procedure	1	
Pending Investigation	1	
Under the Influence	1	
Total Incidents	**207**	

NCYF

Reasons for Confinement	Count	%
Administrative	**19 total**	**50%**
Facility Emergency	11	
Orientation Status	5	
Investigative Needs	3	
Safety/Security	**18 total**	**47%**
Danger to Other Youth	14	
Danger to Staff	2	
Danger from Other Youth	1	
Unauthorized Area	1	
Other	**1 total**	**3%**
Refusing Directives	1	
Total Incidents	**38**	

1. Juvenile Room Confinement Should Be Used as a Last Resort

Room confinement should be used only in cases of threats to the safety of the individual or other residents and when other less intrusive interventions have failed. Room confinement should not be used for:

- Punishment;
- Retaliation by staff; or,
- A matter of administrative convenience.

Best practice dictates the use of juvenile room confinement is appropriate only in situations where a youth's behavior poses an immediate and imminent danger of serious physical harm to self or others, and should be discontinued as soon as the danger of harm has dissipated.

When reporting juvenile confinement, facilities have discretion in categorizing the reasons for the confinement. The OIG bases its analysis on these reported reasons, assuming their accuracy—for example, that a safety threat was indeed a safety threat. However, the OIG cannot confirm if confinement incidents align with imminent danger cases or if less intrusive options were considered first.

Reported data, categorized by the facilities, indicates that confinement is predominantly used for safety and security, accounting for 42% of all reported cases. Only three facilities reported other primary reasons for confinement: YRTC-Hastings and Lancaster County for medical necessities, and NCYF for administrative purposes. The OIG cannot discern from the reported data whether confinement incidents were associated with punishment, staff retaliation, or administrative convenience.

Notably, there's been a significant increase in incidents reported as corrective actions, especially from YRTC-Kearney, suggesting a potential policy change or reporting language modification. The largest portion of the noted increase came from the YRTC-Kearney facility, which was responsible for 72% of all corrective action related confinements.

DHHS rules and regulations and the YRTC Operations Memorandums conflict to some extent. As outlined in Nebraska Administrative Code, room confinement is authorized for safety and security or as a disciplinary sanction if a facility rule is violated. These regulations distinguish between room restriction (a short-term cooling-off period) and disciplinary segregation (which can last up to five days). Despite this, the Youth Rehabilitation & Treatment Center Operational Memorandum Governing Juvenile

Conduct (OM-302.1.6b) explicitly states that YRTC facility policy does not permit juvenile room confinement for punishment, discipline, staff convenience, or retaliation.[17]

In a related trend, reporting also showed an increase in confinement incidents due to escape risks. All three YRTC facilities, along with Lancaster County and Douglas County, reported confinement related to escape risks. YRTC-Kearney showed the largest increase in using confinement for escape risk. Previously, escape risks have not been reported as often as a reason for confinement by the facility, but YRTC-Kearney was responsible for over 60% of all the confinements related to escape risks across these facilities. As noted above, it is unclear if this trend reflects a new policy or a change in reporting language.

While statutes specifically prohibit juvenile room confinement for administrative convenience, this term remains undefined. Review of Nebraska facility data shows that confinement for administrative reasons not directly linked to immediate, serious physical harm often includes shift changes, staff meetings, or training sessions. Lancaster County again notably reported a higher incidence of confinement for administrative needs, which may encompass administrative convenience, compared to other facilities. For the current fiscal year, the Lancaster facility reported 427 incidents of confinement due to administrative need. The OIG cannot conclude what factors are contributing to this disparity in reporting administrative use of juvenile room confinement between facilities.

The Public Health regulations for RCCAs, which deal with seclusion (a type of room confinement), mandate that seclusion is exclusively for emergencies and cannot be used for punishment, discipline, staff convenience, or as a care substitute. It's also prohibited for use by peers or untrained staff. Facilities employing seclusion must have comprehensive policies on its usage. Among the facilities that shared their policies with the OIG, most restrict seclusion use or have outright prohibitions on seclusion or other forms of confinement. Since FY 2016-2017, the OIG has received very few reports of confinement from RCCAs. However, it's important to note that Public Health is tasked with informing licensed facilities of their obligation to report juvenile room confinement.[18]

[17] Previously, YRTC administration has indicated to the OIG that they adhere to the more specific OM-302.1.6b policy despite the broader permissions granted by Nebraska Administrative Code.
[18] The OIG does not actively monitor new facilities for data collection or policy documentation, suggesting possible underreporting of confinement usage in RCCAs.

2. Juvenile Room Confinement Should Be Time-limited

Room confinement is a behavioral control measure which may pose medical and psychological danger that increases as the segregation is prolonged. Best practice recommends that youth should be released from room confinement as soon as they are safely able. Specifically, standards recommend that room confinement of youth should not last longer than 24 hours.[19] It is generally accepted that most incidents of room confinement can be limited in duration; the use of confinement for a day or more is considered unnecessary in all but a very few cases.[20]

During this past fiscal year, the use of juvenile room confinement in Nebraska rose. There were more incidents involving more youth, for longer periods of time with many instances exceeding 24 hours. Effectively evaluating the time-limited aspect of juvenile room confinement requires analyzing the duration, regularity, and the continuousness of incidents. It is not solely about measuring the length of time for each single confinement period. A better understanding of time-limited confinements includes assessing how long each specific occurrence lasts, how often incidents are happening within a given timeframe, and the duration over which incidents continuously occur. Nebraska statute defines room confinement as the involuntary restriction of a juvenile placed alone—including a juvenile's own room—except during normal sleeping hours. This caveat does create a complicating factor when evaluating the time-limited nature of confinement as not all facilities report sleeping hours similarly.

Seven facilities include normal sleeping hours as part of the total duration of a confinement period when normal sleeping hours occur in between the start and end time of the confinement period. For example, if a youth is placed into confinement at noon on a given day and is not let out of confinement until noon the next day, normal sleeping hours for that day are included in the reported total length of confinement.

In contrast to the other seven facilities, Lancaster County does not include normal sleeping hours when reporting the duration of a confinement in which normal sleeping hours occur in between the incident start and end time. Reporting this way leads to data inconsistencies when compared to other facilities and raises concerns about the actual duration of a given confinement incident. As a consequence of not

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[19] The exception on time limits is the American Correctional Association which allows up to five days of disciplinary room confinement.

[20] National Commission on Correctional Health Care, Standards for Health Services in Juvenile Detention and Confinement Facilities, Standard Y-E-09 (2001), available at http://www.jdcap.org/SiteCollectionDocuments/Health%20Standards%20for%20Dention.pdf.

including sleeping hours, it appears as though a youth is confined only for 13 hours at a time, rather than continuously over a 24-hour period. Instances of consecutive days of confinement are recorded as multiple 13-hour periods, which appear to conclude at the onset of normal sleeping hours and recommence the following day as a new incident.[21] As a result, Lancaster County's data typically shows fewer overall confinement hours—due to not including sleeping hours— but a higher number of individual incidents. Moreover, as noted, best practice requires each incident of confinement to end within 24 hours. Lancaster County's method of reporting duration, which limits each incident to 13 hours by excluding sleeping hours, makes it appear as though the facility is meeting the best practice of limiting confinement to less than 24 hours per incident nearly 100% of the time.

The Use of Consecutive Days of Confinement

As noted earlier, the issue of time-limited confinement is not solely evaluated based on the duration of single incidents. Analysis must also include the use of continuous or consecutive incidents of confinement.

Different facilities have different rules and language regarding the use of consecutive days of confinement. Juvenile county detention centers have Detention Standards that allow the use of disciplinary confinement for up to seven days for major rules violations. Disciplinary confinement is not specifically defined in the standards, although disciplinary detention is.

The data from Lancaster County showed a significant use of consecutive days of confinement due to its interpretation of the juvenile room confinement law. This underscores how important a consistent interpretation of the law between facilities can be.

At Lancaster County, a 14-year-old youth, due to safety and security reasons, was reported to have undergone 82 consecutive days of 13-hour confinements. Following a two-day break, the youth was subjected to another 31 days of similar confinement, and after a further two-day interval, an additional 16 days of 13-hour confinement. This pattern resulted in the youth being in consecutive 13-hour periods of confinement for a total of 129 days out of 133. Despite being confined essentially for full 24-hour periods over multiple consecutive days, the reporting method portrayed these as separate 13-hour confinements. Thus, Lancaster County reported that 99% of their confinements concluded within 24

[21] For the current fiscal year, Lancaster County did report 4 out of 2,981 incidents of confinement lasting for over 24 hours. The OIG is unable to discern the reason why these four incidents included sleeping hours.

hours. However, by reporting this way the reality of these extended confinement periods is masked and does not reflect the significant deviation from the intended practice of time-limited juvenile room confinement.

In contrast, an examination of data from the remaining seven facilities, which include sleeping hours, indicates that multiple consecutive days of confinement at these facilities tended to span from two to seven days, and, these incidents were generally spaced apart. To be fair, it should be noted that a portion of the 129 day confinement discussed above was reportedly due to the need for protective custody – when juvenile room confinement is used to safeguard youth from potential harm or threats posed by other youth due to factors such as gang affiliations, conflicts with others, or general concerns for risk to their well-being. Lancaster County is transparent in the reporting of protective custody; not all facilities follow this same practice. Excluding Lancaster County, less than five incidents of protective custody were reported. It is unknown to the OIG if this is because it was infrequently used at the other facilities, or if it is because other facilities interpret reporting requirements differently and thus do not include it in the data.

Consecutive occurrences of juvenile room confinements can also closely resemble the adult correctional practice of restrictive housing. As the OIG reviewed data related to consecutive days of confinement it was noted that the consecutive confinements often stem from safety and security concerns, and those facilities that use restrictive housing adhere to established facility policies and procedures regarding duration, and in some facilities, youth are allowed time outside of the confinement area under staff supervision but separated from their peers.[22]

It should be noted, however, that the law has changed regarding the use of restrictive housing for youth in correctional facilities. As of March 2020, Nebraska law dictates that any incarcerated individual placed in a NDCS facility, who is aged 18 or younger, is considered to be a member of a vulnerable population, and can no longer be placed in restrictive housing. NCYF confinement incidents that extend past 24 hours are now generally categorized as a “Security lay-in” placement. Security lay-in is used when an

[22] Douglas County provided the OIG with data related to out of cell time for each individual youth in confinement for consecutive days.

incarcerated youth is involved in an incident that needs to be evaluated due to a safety or security concern.[23]

COVID-19 & Time-Limited Use of Juvenile Room Confinement

Some consecutive days of confinement were expected during the fiscal year due to medical quarantine for COVID-19. Facilities that followed CDC recommendations may have placed youth exhibiting COVID-19 symptoms under quarantine pending test results or isolated youth who had tested positive for the virus. Depending on a facility's sickbed policies, quarantining a youth could result in the need to report the quarantine as confinement due to the youth being involuntarily alone for more than one hour.

As reported in the 2018-2019 Juvenile Room Confinement Report, facilities have various practices related to sickbed and medical quarantine. During the pandemic, facilities reported to the OIG varying approaches to managing COVID-19. Some facilities tested and quarantined based on symptom onset, while others used quarantine as a preventive measure upon a youth's arrival at the facility. Consequently, the OIG cannot ascertain whether some facilities are not reporting medical quarantine incidents due to the virus, whether there was genuinely no need for medical quarantine during that time, or if the absence of medical quarantine reports was a result of the facility's own sickbed policies and interpretation of the law as not requiring such reporting.

Last year (FY 2021-2022) data indicated a 76% decrease in confinement due to medical quarantine compared to medically related confinement during the peak of the pandemic. Data for the current fiscal year (FY 2022-2023) showed there were a total of 1,523 incidents of medical-related confinement, resulting in approximately 21,300 hours of confinement for 257 individual youth. The data again marked further decline in incidents by about 43%, suggesting that confinement due to COVID-19 is declining in line with adjusted CDC guidelines. However the OIG noted some concerning incidents during the past fiscal year. Notably, at Lancaster County, three youth were confined for 17, 18, and 20 days due to COVID-19, respectively. While the OIG has no reason to believe that the facility is using medical quarantine inappropriately, it raises questions about the issue of some facilities not reporting juvenile

[23] The Warden or designee must approve the placement, and the youth is secured in their assigned cell with full access to their personal property. Security lay-in placements are reviewed every business day by executive staff to determine whether the juvenile should be removed from the status. Youth 17 years old or younger are allowed a minimum of four hours of out of cell time daily while on security lay-in. Out of cell time is meant to promote positive social interaction in a controlled environment and generally consists of out of cell time on the unit wing, but can also include programming involvement, attending school classes and meetings with other NCYF Intentional Peer Support Specialists (staff).

room confinement data related to medical quarantine at all and the lack of reporting consistently as it relates to the use and documentation of medically related confinement.

3. Juvenile Room Confinement Practices Should Recognize the Potential Physical and Psychiatric Consequences of Prolonged Confinement

Best practices strive to minimize the use of juvenile room confinement due to the potential consequences that include:

- Increased risk of self-harm and suicidal ideation;
- Greater anxiety, depression, sleep disturbances, paranoia, and aggression;
- Exacerbation of the on-set of pre-existing mental illness and trauma symptoms; and,
- Increased risk of cardiovascular related health problems.[24]

Empirical knowledge has long substantiated the negative impact juvenile room confinement has on a youth's psychological, physical and social development, concluding that if it must be utilized it should only be used in conjunction with best practices.

Standards and best practice experts have been clear in articulating that juvenile room confinement should not be used when a youth is potentially suicidal. Self-harming youth require immediate trauma-informed intervention—not the social isolation associated with room confinement.

This element of best practice is especially concerning when considering the detriment juvenile room confinement contributes to youth with existing mental health conditions and significant trauma histories. As many as 70% of children in the U.S. juvenile justice system already suffer from diagnosable mental health conditions.[25] At least 75% of youth in the U.S. juvenile justice system have experienced

[24] Haney, C. (2001). The Psychological Impact of Incarceration on Post-prison Adjustment. In Prison to Home: The Effect of Incarceration and Reentry on Children, Families, and Communities. Retrieved from http://aspe.hhs.gov/basic-report/psychological-impact-incarceration on October 24, 2018.
[25] National Ctr for Mental Health and Juvenile Justice, United States of America, Models for Change, & United States of America. (2013). *Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System*. http://cfc.ncmhjj.com/wp-content/uploads/2014/01/Whitepaper-Mental-Health-FINAL.pdf.

traumatic victimization. More than 90% have reported adverse childhood experiences (ACEs) that include child abuse, violence, and serious illness or a combination of these experiences. [26,27,28]

Any juvenile facility utilizing juvenile room confinement must recognize the potential psychiatric consequences of prolonged solitary confinement including depression, anxiety, and psychosis, and that, due to their developmental vulnerability, juveniles are at particular risk for such adverse reactions. [29,30]

Nebraska facilities are required to consider any physical or mental health clinical evaluation results when deciding to place a juvenile in room confinement or to continue room confinement, and report any incidents of self-harm or suicide committed by the juvenile while he or she was isolated. The juvenile room confinement statutes state that detention centers, facilities operated by NDCS, and YRTCs are only allowed to hold a youth in room confinement for a period that does not compromise or harm their mental or physical health. These facilities must also provide juveniles in room confinement access to appropriate medical and mental health services with mental health staff promptly providing mental health services as needed.

When the reason for the confinement is categorized as "Danger to self" those incidents are inclusive of the youth experiencing mental health issues or displaying self-harming behaviors. The OIG's data review found few incidents of juvenile confinement that included a concern for a mental health crisis or incidents of self-harm or attempted suicide. While this does not appear to be a large scale problem, facilities continue to place youth experiencing a mental health crisis or displaying self-harming behaviors in confinement. In addition, facilities must report any time there is an incident of self-harm or attempted suicide while a youth is in confinement, even if the youth was not initially confined for reasons having to do with a mental health crisis or self-harm. The OIG reviews both types of data when assessing the frequency of juvenile room confinement incidents in conjunction with mental health or

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[26] Baglivio, M. T., Epps, N., Swartz, K., Sayedul Huq, M., Sheer, A., & Hardt, N. S. (2014). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice, 3*(2).
[27] Clark, A. (2017). Juvenile Solitary Confinement as a Form of Child Abuse. *The Journal of the American Academy of Psychiatry and the Law 45*. p. 353.
[28] CJCA. (2017). *Trauma informed care in juvenile justice.* Retrieved from http://cjca.net/wp-content/uploads/2018/02/CJCA-Position-paper-TIC-002.pdf.
[29] American Academy of Child & Adolescent Psychiatry, Policy Statements: Solitary Confinement of Juvenile Offenders (April 2012), available at http://www.aacap.org/cs/root/policy_statements/solitary_confinement_of_juvenile_offenders.
[30] Juvenile Detention Alternatives Initiative, A Guide to Juvenile Detention Reform: Juvenile Detention Facility Assessment 2014 Update, available at http://www.aecf.org/m/resourcedoc/aecf-juveniledententionfaciltyassessment-2014.pdf.

self-harm issues. Due to the serious nature of exacerbated mental health issues in conjunction with the practice of juvenile room confinement, the OIG will continue to closely monitor reported incidents of juvenile room confinement that are inclusive of youth experiencing a mental health crisis or youth displaying self-harming behaviors.

4. Youth in Juvenile Room Confinement Should Be Closely Monitored

Best practice calls for youth in room confinement to be checked on by staff frequently while in room confinement. It is also recommended that all instances of room confinement be recorded and reviewed through a quality assurance program at each facility. Additionally, best practice also suggests administrative approval should be sought to use room confinement in certain instances.

Nebraska statute mandates that juveniles in room confinement be continuously monitored by staff of the facility. Continuous monitoring may be accomplished through regular in-person visits to the confined juvenile or be supplemented by electronic video monitoring. Additionally, confinement lasting longer than one hour during a 24-hour period requires written approval by a supervisor in the juvenile facility. Based on information required to be reported, the OIG is unable to assess the level to which facilities are in compliance with this statutory requirement and best practice.

5. Youth Should Be Provided Access to Personal Belongings

Best practice recommends that youth have access to personal hygiene items, books, and programming while on room confinement status. Nebraska statute has specifically incorporated this best practice by requiring detention centers, facilities operated by NDCS, and YRTCs provide juveniles placed in room confinement access to the following:

- Confinement rooms with adequate and operating lighting, heating and cooling, and ventilation for the comfort of the juvenile, and rooms that are clean and resistant to suicide and self-harm;
- Access to drinking water, toilet facilities, hygiene supplies, and reading materials approved by a licensed mental health professional; and,
- The same access as provided to juveniles in the general population of the facility to meals, contact with parents or legal guardians, legal assistance, and access to educational programming.

The OIG is not able to verify compliance with these parameters based on statutorily required data submitted by individual facilities. However, Nebraska's statutory policy does reflect best practice.

6. Internal and External Accountability and Oversight

As noted earlier, juvenile room confinement guidelines recommend robust oversight – both internal and external – of the use of confinement. Nebraska's statute meets the oversight guidelines with regard to requiring the collection, documentation, and sharing of data regarding the use of confinement. The law is also clear on the conditions that must be followed when confinement is used, including the notification to parents and attorneys of record within one business day every time a youth is placed in confinement.

Importantly, Nebraska falls short of the guideline's recommendation that there be clear and comprehensive policies and procedures governing the use of confinement. While the law provides some definite parameters for its use, there is no consistency between facilities—even facilities of the same type—regarding the interpretation of certain requirements of the law, how confinement should be documented, and how and whether documentation and use of confinement will be verified. The different approaches regarding whether sleeping hours are to be counted is a salient example. Similarly, different facilities have different protocols such as restrictive housing and protective custody and the application of the juvenile room confinement laws to those practices is not clearly laid out.

The inconsistency in the application of the law can be attributed to the absence of effective enforcement mechanisms or their inadequate utilization by the relevant authorities. The Jail Standards Board, NDCS, and DHHS—including both OJS and Public Health—are the entities responsible for creating consistent interpretations, standards, and practices, and for enforcing the legal requirements in the facilities under their jurisdiction.

Public Health and the Jails Standards Board, as mandated by statute, oversee RCCAs and juvenile detention centers. They have the authority to initiate disciplinary actions if these facilities fail to meet juvenile room confinement reporting requirements. Despite their authority, their involvement in overseeing juvenile room confinement has been limited. Legislative changes in 2020 which introduced limitations and requirements for the use of juvenile room confinement underscore the need for more robust monitoring and enforcement by Public Health and the Jail Standards Board.

NDCS and OJS oversee compliance with juvenile room confinement at juvenile correctional facilities and YRTCs, respectively, which are within their own departments. These juvenile facilities do not have an external, independent body to enforce reporting requirements unlike the oversight provided by the Jail Standards Board and Public Health.

Despite the expectation for facilities to adhere to juvenile room confinement laws, clear guidelines on how the departments responsible for oversight should monitor compliance with these statutory practices are lacking.

The guidelines also recommend having dedicated staff to provide internal oversight and to review the use of confinement, analyze the data, and make improvements to policy and procedure. It is the OIG's understanding that each facility subject to the reporting requirements has someone on staff who is responsible for collecting and reporting the data. But the OIG is not aware of staff dedicated to oversight, data analysis, or improving – and reducing – confinement.

The most robust oversight provided in the juvenile room confinement statutes is the assessment and report required to be done by the OIG. However, as noted, this oversight is also limited. The OIG's role in oversight involves data analysis. Notably, the OIG primarily collects and reports quantitative data, relying on facilities to provide contextual information about room confinement. This aids the Legislature in monitoring its use. However, the OIG's assessment does not typically include a review of the facilities' internal documentation for validation, nor does it conduct unannounced onsite inspections or interviews with juveniles for collecting anecdotal information. The OIG's analysis is thus solely based on the data as submitted by the facilities, which, when unverified, can be unreliable.

Previous OIG reports have highlighted the inconsistent interpretation and application of juvenile room confinement laws across and sometimes within facilities. This inconsistency leads to a wide range of reporting practices, potentially resulting in skewed data, including the possibility of underreporting or over reporting based on an individual facility's interpretation of the law. For instance, a facility that develops a program allowing youth to enter an alternative placement program, which technically qualifies as room confinement, may not report the segregation if it was voluntary. However, there is no oversight authority to verify the absence of coercion in such alternative placement programs or to confirm whether the confinements are truly voluntary.

As the OIG has repeatedly recommended, there is a pressing need for a consistent interpretation and application of the law, as well as a means to verify how facilities are using room confinement practices. Such oversight efforts need to be accurate and effective and should be conducted by agencies specifically responsible for overseeing these facilities.

Reducing the Use of Juvenile Room Confinement in Nebraska Facilities

Since being tasked with producing an annual juvenile room confinement report, the OIG has spoken to facility administrators numerous times about the challenges facilities face in reducing the use of juvenile room confinement. In general the OIG has learned that in the opinion of these administrators, the biggest challenges to reducing use is youth with significant mental health needs, gang affiliation both in and out of the facility, and youth whose length of stay is so long they are no longer invested in making progress. Additionally it was noted that the youth most frequently confined are often deemed the "toughest cases" in that those youth were perceived to pose the greatest challenge to the system and least likely to have adapted to the institutionalized setting.

The OIG recognizes that reducing reliance on juvenile room confinement is not an easily obtained goal, nor is it accomplished in isolation. The OIG has previously made several recommendations concerning the need for strategic planning[31] by facilities and the utilization of supportive technical assistance from outside agencies.[32] To successfully reduced room confinement facilities have to make significant and ongoing changes to facility culture, policy, and practice; they must find new and different ways to respond to youth behavior and safety concerns.[33]

Successful efforts to reduce room confinement focus on changing facility culture by way of staff training and education initiatives, as well as changes in facility approaches to behavior management which can often begin with an internal review of the data. For example, while analyzing data for the current fiscal year, the OIG found that in one facility incidents of room confinement significantly increased on Wednesday and Thursday afternoons. By initiating an internal review of the data at a basic level, this facility could conceivably make simple changes that have the potential to reduce the total number of incidents of confinement.

Even with decades of research, national standards, organizational best practices, and legislative action, the task of implementation and changing facility culture falls to the individual facilities and the agencies designated to provide them assistance and oversight. Doing so requires commitment to the process,

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[31] Delaney,K. R. (2006). Evidence Base for Practice: Reduction of Restraint and Seclusion Use during Child and Adolescent Psychiatric Inpatient Treatment. *Worldviews on Evidence-Based Nursing 3*(1).19–30.
[32] Council of Juvenile Correctional Administrators. "Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation [Toolkit]." and, LeBel,. et. al. (2012).
[33] Effective strategies used by other states and facilities have been documented in detail in previous annual reports and can be found here: Link to OIG JRC reports here

which can be complex and multifaceted, requiring a clearly articulated plan. The process can be time-consuming, staff-intensive, and bring to surface uncomfortable situations and difficult decisions. However, in light of the risks and ill effects to youth, staff, and facility safety in general, the required commitment, resources and time are worth the investment.

Conclusions

The OIG's analysis of juvenile room confinement data from across the state's facilities reveals that best practices in juvenile room confinement are largely reflected in the law but not always in practice.

Overall, there was an increase in the use and duration of juvenile room confinement during FY 22-23. While these increases are likely driven by several factors, it raises the question of whether juvenile room confinement is really being used as a last resort and is being used for longer period of times than necessary. Are facilities unable to decrease its use given their resources and the challenges facing the youth they serve or is it a matter of long-standing culture which relies on confinement? The OIG's analysis of the data makes clear that juvenile room confinement is still being used for corrective action, administrative reasons, and when youth are a risk of harm to themselves, all of which are contrary to best practice. Similarly, the increase in the duration of incidents, including the use of confinement for consecutive days, is contrary to the best practice of ensuring confinement is time limited.

Reducing and improving the use of juvenile room confinement in Nebraska will require enhanced internal oversight at the juvenile facilities and other broad strategies to change the culture within the facilities. As noted earlier, best practice requires robust internal oversight practices. A sustained commitment to continuous improvement in juvenile room confinement practices is vital. Stronger external and internal oversight mechanisms are needed to ensure that juvenile room confinement is used appropriately, and that facilities comply with statutory requirements. This includes regular audits, staff training, and adherence to established guidelines. It involves regularly assessing the effectiveness of current practices, being open to adopting new approaches, and ensuring that the well-being of juveniles is at the forefront of any confinement decision. To do this, it is important that facilities have dedicated staff for overseeing juvenile room confinement use.

In addition, in past Juvenile Room Confinement Annual Reports the OIG has repeatedly noted expert-recommended best practice strategies for reducing juvenile room confinement and included information about the successful reduction of juvenile room confinement in other states which could guide Nebraska toward adopting more effective practices. Juvenile room confinement usage is not solely a policy issue but also a cultural one within facilities. A comprehensive approach involving policy reform, staff training, facility culture change, and alternative behavioral management strategies is essential. Facilities must adopt innovative practices that provide safety without overly relying on confinement. These strategies must encompass consistency in data reporting and interpretation. Uniformity in

interpreting and applying juvenile room confinement laws is also crucial. All facilities should adopt a standardized approach to data collection, reporting, and interpretation to ensure accuracy and comparability of information across the state.

In conclusion, while Nebraska's statutes align with best practices on juvenile room confinement, there remains a significant gap in the practical application of these principles. Addressing this gap requires a multi-faceted approach involving policy reform, culture change within facilities, rigorous oversight, and a commitment to continuous improvement. Reducing reliance on juvenile room confinement is a challenging but necessary goal to ensure the well-being of juveniles in Nebraska's facilities. If the goal of the state is to truly reduce the use of juvenile room confinement within juvenile facilities, the Legislature may need to further engage with these facilities to fully understand their challenges and determine what additional supports or resources are required to successfully facilitate the reduction in juvenile room confinement usage.

Appendices

Appendix A: Recommendations — 2017-2021

The OIG's annual report on the use of juvenile room confinement must contain identified changes which may lead to a reduction of reliance on room confinement in Nebraska.[34] The following section accounts for all recommendations made by the OIG and published in Annual Nebraska Juvenile Room Confinement Reports.

(2021) Require facilities to report all incidents of room confinement.

Currently, facilities should be *documenting* all incidents of room confinement but are only required to *report* incidents lasting over an hour – either a single incident lasting over one hour for an individual youth or multiple incidents that together add up to an hour for an individual youth in a 24-hour period. Reporting all incidents of room confinement will provide the OIG and the Legislature with a more accurate and complete understanding of the use of juvenile room confinement in Nebraska.

(2021) Require facilities to provide an annual summary for the reporting year of key data points.

The data currently submitted by facilities often contains errors, duplications, and missing information. It appears from the data submitted that the facilities are focused on compiling the data but are not necessarily analyzing or even reviewing the data prior to reporting it to the Legislature. Requiring facilities to review their own data and provide an annual summary of key data points should have several helpful results. The review should alert the facility to any errors within its data and provide an opportunity for the facilities to correct that data and provide more accurate information to the Legislature. Requiring the facilities to compile these key data points will encourage facilities to shift away from simply compiling information for the purpose of submission and move towards utilizing the data for the purpose of understanding the use of juvenile room confinement in the facility and, ideally, reducing the use of confinement.

(2021) Require facilities required to report juvenile room confinement to submit a quarterly statement of fact when there has been no incidents of juvenile room confinement within the facility.

Currently facilities are only required to report when there have been incidents of juvenile room confinement lasting or accumulating to one hour or more during a 24-hour period, as a result the majority of facilities never submit a juvenile room confinement report. By requiring facilities to provide a

[34] Neb. Rev. Stat. §83-4,134.01 (d).

quarterly statement when there is no confinement data to report creates a written record attesting to the fact that the facility did not have any incidents of confinement for the reporting period.

(2020) Examine oversight and enforcement mechanisms for juvenile room confinement reporting.

As noted in the findings, Neb. Rev. Stat. 83-4,134.01 provides an avenue for Public Health and the Jail Standards Board to enforce the reporting requirements under that same section. While facilities under the jurisdiction of the Jail Standards Board and Public Health have generally complied with reporting requirements, the two agencies responsible for oversight have been minimally involved in reporting oversight, including disregarding the OIG recommendation to proactively incorporate relevant statutes into their own regulations. OJS and NDCS do not have those same tools for enforcement in the law. There is no administrative avenue for enforcement since these facilities are not licensed by another state entity. While these facilities may work to comply with the law, there is no consequence for non-compliance except perhaps that it may be reflected in the OIG's reporting, assuming the information reported is accurate.

However, greater oversight and enforcement by all four entities with authority over the facilities that use juvenile room confinement – Public Health, Jail Standards Board, NDCS, and OJS – would be extremely helpful. Requiring greater oversight by these main agencies could provide some consistency in reporting by clarifying and standardizing the definition of juvenile room confinement across the facilities under those agencies' jurisdiction; by creating standard procedures for recording room confinement; by verifying the room confinement data reported by those facilities; and by creating a consistent and coordinated reporting format. Creating an enforcement mechanism for OJS and NDCS to ensure reporting would also be helpful.

(2020) Examine juvenile room confinement enforcement mechanisms for provisions within Legislative Bill 230.

The passage of LB 230 implements juvenile room confinement practice requirements, creating a greater need for quality oversight and enforcement for facilities. If the long-term goal is to reduce the use of room confinement, the research previously noted shows that a fundamental shift in culture and practice is required. It is important, then, to understand how these new standards of the use of juvenile room confinement are being implemented. At the moment the law does not specify any oversight or enforcement mechanisms to ensure the correct and consistent implementation of those standards. The Legislature might consider ways to create independent oversight and enforcement of the standards implemented in LB 230.

(2020) Require facilities to create formal facility juvenile room confinement reduction plans to be submitted to the Legislature and monitored through the Jail Standards Board, Public Health, Office of Juvenile Services, Department of Corrections, and the OIG.

As has been noted in the prior three annual juvenile room confinement reports, research has long established that a change within the facility culture is necessary to reduce the use of room confinement and the change in culture is best achieved through the implementation of a comprehensive plan. As the 2019 publication, *Not In Isolation: How to Reduce Room Confinement While Increasing Safety in Youth Facilities* demonstrates, such plans have been created and implemented successfully reducing reliance on juvenile room confinement practices. Nebraska facilities that allow for juvenile room confinement, or similar practices would benefit from a formal plan to incorporate best practices, including programming, training, implementation strategies, and the internal monitoring of data to inform change.

As stated in the 2018-2019 Annual Juvenile Room Confinement in Nebraska Report, if not mandated, any further changes by facilities to reduce reliance on the practice will be unlikely. If the Legislature's goal is to significantly reduce the use of room confinement, it may be necessary and helpful to require comprehensive plans by the facilities to reduce the use.

(2019) Extension of the Crime Commission and Department of Health and Human Services-Division of Public Health responsibilities related to juvenile room confinement to include, at a minimum, on-site verification and standardized data collection and content.

The OIG recommends all DHHS, and Crime Commission administrative language be revised to conform to Neb. Rev. Stat. §83-4,125 and Neb. Rev. Stat. §83-4,134.01. There are at least 16 different definitions of confinement language in the Nebraska Administrative Code, as well as other language in facility and agency polices. These expressions range from "time out" and "seclusion" to "solitary confinement." See Appendix B.

The current role of DHHS and the Crime Commission is limited to verifying that documentation is collected and submitted to the legislature as set out in statute. Increased involvement is needed to verify the manner in which juvenile room confinement is used in the facility and the accuracy of the data collection and content.

(2019) The OIG recommends that legislation be passed that requires the following:

- All facilities adhere to best practices to reduce reliance on juvenile room confinement.
- Room confinement should only be used as a last resort, be time-limited, and be closely monitored. Facilities will make changes if they are legislatively required to do so. If not mandated, any further changes on its reliance will be unlikely.
- Clarification of current legislative provisions related to juvenile room confinement.
- Specific language is recommended to clearly define the meanings of "facility" and "agency," with explicit guidance on which organizations are required to report, and which are exempt. For example, Psychiatric Residential Treatment Facilities such as Immanuel/CHI and Boys Town do not report the use of juvenile room confinement. Whether they should do so is a legislative decision.

Legislation should include specific determinations of what constitutes voluntary confinements, in contrast to involuntary confinements. Clear definitions should also include what constitutes sickbed and other medical quarantines.

(2018) For reduction with the goal of eliminating juvenile room confinement, facilities should:

1. **Revise facility policies to reflect best practice:** Room confinement should only be used as a last resort, be time-limited, and be closely monitored. Facility policies should be gradually modified to reflect these best practices. Some facility policies on juvenile room confinement are not in line with best practices or national recommendations. Policy change without the development of appropriate alternatives at facilities may not effectively and safely reduce room confinement. Nonetheless, as part of wider strategies to reduce room confinement, revisions to policy to reflect best practices is essential.
2. **Focus on workforce development:** Facilities should ensure that each is staffed appropriately, administrative efficiencies are sought, and the facility's workforce is well-trained and supported in alternatives to room confinement. Many strategies that have been shown to successfully reduce room confinement have been linked to staff-intensive positive behavioral intervention and therapeutic programs.[35] In order to reduce room confinement, facility staff must have the support and training to implement alternatives to room confinement. Furthermore, staffing

[35] *Id.*

issues (shortages, training, shift changes, etc.) were directly related to room confinement incidents at Nebraska facilities. Facilities should ensure juvenile room confinement is not being used to accommodate administrative tasks such as headcount and training, in the effort to reduce unnecessary room confinement.

3. **Create a Juvenile Room Confinement Reduction Plan and include technical assistance and oversight:** National research and information suggests facilities that have reduced juvenile room confinement successfully, have done so by implementing a variety of different strategies, tailored for their specific circumstances. Many facilities have benefitted from technical assistance and oversight from outside entities in creating and implementing plans to reduce juvenile room confinement. Each juvenile facility that uses room confinement should have a plan to reduce its use. To the extent possible, these facilities should receive assistance from state regulators and others experts in developing, implementing, and monitoring plans to reduce the use of room confinement.
4. **Publicly report information on the use of room confinement, including seclusion:** Facilities that use any form of room confinement for children and youth in their care should report such. Many facilities over the past year did report room confinement numbers on a quarterly basis, but several did not. Without full and complete reporting, a comprehensive review of juvenile room confinement in Nebraska cannot be undertaken. Transparent public reporting about the use of room confinement, including seclusion, can only help monitor and reduce its use.

(2018) Agency based recommendations include the following:

The **Nebraska Department of Correctional Services (NDCS)** runs the prisons and sets forth rules and regulations for the prison system in dealing with inmates under 19 years of age. NDCS should take steps to: Provide Additional Details in NDCS Rules and Regulations on Restrictive Housing as it Relates to Best Practices and Youth Under 19: NDCS has already initiated the process of developing a plan to reduce the use of restrictive housing across all of their correctional facilities. So far, however, the promulgated regulations and other changes apply generally to the correctional system and not specifically to issues related to juvenile inmates. There are no formal policies or strategies to reduce the use and duration of room confinement of juveniles across the correctional system.

Specifically Adopt Time Limits for Inmates in Restrictive Housing under the Age of 19: NDCS rules and regulations do not adequately address room confinement limits for inmates under 19 years old. Rules and regulations should be changed to implement time limits.

Conduct a study on youth who spend particularly long periods of time in room confinement: Further study is needed to examine the youth who spend long periods of time in longer-term restrictive housing to determine what resources are needed to allow them to integrate into general population.

The **Office of Juvenile Services (OJS)**, under the Department of Health and Human Services Division of Children and Family Services, oversees the Youth Rehabilitation and Treatment Centers. OJS should take steps to:

Develop and Implement a Strategic Plan to Reduce Room Confinement: OJS should ensure that both YRTCs develop and implement concrete plans to reduce the use and length of time youth spend in room confinement over the next 12 months.

Change OJS Rules and Regulations to Align with Best Practices: Though internal operating memos are updated, current rules and regulations authorize the use of room confinement either for reasons of safety and security or as a disciplinary sanction if the youth has violated a facility rule. Best practices do not contemplate the use of room confinement for disciplinary purposes. Formal rules and regulations should be updated to reflect current best practices.

The **Nebraska Jail Standards Board**, housed at the Nebraska Commission on Law Enforcement and Criminal Justice, develops standards, or rules and regulations, for the operation of juvenile detention facilities. Steps should be taken to:

Clarify definitions of different forms of room confinement within Juvenile Detention Jail Standards: Current Juvenile Detention Jail Standards use a variety of terms that could be considered "room confinement". Some of these are defined and others are not (e.g. – room restriction). Some terms appear to be applied inconsistently – for example disciplinary confinement and disciplinary detention. It would be helpful to update Jail Standards to ensure all terms are defined and that requirements for each form of room confinement are appropriately specified.

Update Jail Standards to reflect room confinement reporting requirements: In light of requirements on room confinement documentation and reporting, incorporating specific documentation and reporting requirements and integrating them with current definitions in standards should be completed as required by law.

Update Jail Standards to eliminate the use of room confinement for disciplinary purposes: All detention and staff secure facilities in Nebraska reported no longer using room confinement for

disciplinary purposes. Jail standards should be updated to recognize this current best practice and revise other standards as necessary to be consistent with this practice.

The **Department of Health and Human Services, Division of Public Health** licenses all mental health centers, health care facilities, residential child-caring agencies, and substance abuse treatment centers. The Division of Public Health should take steps to:

Update licensing rules and regulations to reflect juvenile room confinement reporting requirements: In light of requirements on room confinement documentation and reporting, incorporating specific documentation and reporting requirements and integrating them with current definitions in rules and regulations should be completed.

(2017) Recommendation

> **Clarification on what practices constitute room confinement** would help make clear what practices need to be reported as juvenile room confinement. Currently, some Mental Health Centers do not consider their practice of seclusion to be a form of room confinement and are not reporting on its use. This should be resolved through statutory change.
>
> **Clarification on which facilities should report** would help ensure there is a comprehensive understanding of room confinement among public and private agencies across the state and would help ensure uniform reporting. Currently, "juvenile facilities" include residential child-caring agencies: facilities that are not foster family homes and provide 24-hour care to four or more children under age 19. The OIG included only those facilities specifically licensed as residential child-caring agencies in its notices and reviews. However, there are facilities provide 24-hour care to four or more children under age 19 includes that are not licensed as a residential child-caring agencies. This would include those entities operating under other licensing requirements –hospitals with behavioral health units serving children under the age of 19, like Richard H. Young Hospital Behavioral Health Adolescent Unit and the Bryan Medical Center's mental health inpatient hospitalization program, for example, among other mental health centers and inpatient programs. It could also include county jails.
>
> Whether the desire is to include or exclude these facilities from future reporting, statutory clarifications will help future OIG reports and analysis of the practice of room confinement in Nebraska.

Creation of a Reporting Enforcement Mechanism for Facilities: The current requirement that facilities report to the Legislature has no enforcement mechanism. From July 2016 through June 2017, a number of facilities did not report full information on their use of room confinement to the Legislature. Most of the facilities that failed to fully report are privately-administered.

Nebraska's current law on juvenile room confinement reporting should be revised to create an enforcement mechanism, especially for the numerous privately or locally-administered facilities over which the Legislature has no direct enforcement authority. Most of these facilities are either licensed through the Nebraska Department of Health and Human Services (DHHS) Division of Public Health or regulated by the Jail Standards of the Crime Commission. One approach of reporting enforcement would be to include room confinement reporting, already law in Nebraska, in current public health licensing requirements or juvenile detention standards. Then room confinement reporting could be enforced and verified by DHHS and the Crime Commission.

Appendix B: Current Residential Child-Caring Agencies in Nebraska Roster as of 11/15/23

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health

Roster of Licensed
Roster of Residential-Child Caring Agencies
Licensed In Nebraska

Residential Child-Caring Agency: Person, Partnership, Limited Liability Company, or Corporation that provides care for four or more children and that is not a foster family home as defined in section 71-1901.

This roster:

- Is a listing of all Licensed Residential Child-Caring Agencies in the State of Nebraska
- Includes Residential Child Caring Agencies:
    - Approved to provide emergency shelter care
    - Approved to provide group home care
    - Approved to provide PRTF/RTC care
- Is organized by zip code starting with Nebraska's lowest zip code - 68002
- The licensed programs are in alphabetical order within each zip code.
- Is updated monthly

The roster contains the following information:

- Name of licensed Agency
- Name of owner/Licensee
- Address and phone number of licensed Agency
- Phone number of licensed Agency
- License number
- License capacity, gender, and ages of children served of each licensed Agency

To check if any disciplinary action has been taken against a Residential Child-Caring Agency or Child Caring Agency, go to: https://dhhs.ne.gov/licensure/Pages/Disciplinary-Actions-Against-Health-Care-Professionals-and-Child-Care-Providers.aspx

If you have questions, please call:
1-800-600-1289 (toll free in NE) or 402-471-9211 (in Lincoln) or FAX 402-471-7763

Nebraska Department of Health and Human Services
Division of Public Health
Licensure Unit
Office of Children's Services licensing
Child Welfare Licensing

RESIDENTIAL CHILD CARING & CHILD CARING AGENCIES ROSTER

ZIP CODE / PROVIDER NAME / LICENSEE NAME / PHONE NUMBER	LICENSE NUMBER / LICENSE TYPE / EFFECTIVE DATE	COUNTY / ADDRESS	
Residential Child-Caring Agency			
68010		**Douglas**	
Father Flanagan's Boys' Home Father Flanagan's Boys' Home (402) 498-3090	RCCA015 Residential Child-Caring A 08/23/2014	13603 Flanagan Blvd Boys Town NE 68010	Capacity: 617 Gender: Both Ages from: 7 YRS Ages to: 19 YRS
68025		**Dodge**	
Masonic - Eastern Star Home for Children Masonic - Eastern Star Home for Children (402) 721-1185	RCCA007 Residential Child-Caring A 02/10/2014	2415 N Main St Fremont NE 68025	Capacity: 44 Gender: BOTH Ages from: 9 YRS Ages to: 19 YRS
68071		**Thurston**	
Winnebago Youth Facility WINNEBAGO TRIBE OF NEBRASKA (402) 878-3100	RCCA040 Residential Child-Caring A 06/21/2015	PO BOX 687 Winnebago NE 68071	Capacity: 12 Gender: BOTH Ages from: 0 YRS Ages to: 19 YRS
68104		**Douglas**	
Nebraska Youth Justice Initiative DBA Radius Radius (531) 895-0036	RCCA051 Residential Child-Caring A 07/11/2023	5040 Grand Ave Omaha NE 68104	Capacity: 24 Gender: Both Ages from: 12 yrs Ages to: 19 yrs
Omaha Home for Boys Omaha Home for Boys (402) 457-7000	RCCA024 Residential Child-Caring A 12/17/2014	4343 N 52 St Omaha NE 68104	Capacity: 16 Gender: MALE Ages from: 12 Ages to: 18
Omaha Home for Boys - Shelter/Crisis Stabilization Unit The Omaha Home for Boys (402) 457-7800	RCCA047 Residential Child-Caring A 05/19/2020	4343 North 52nd Street Omaha NE 68104	
68111		**Douglas**	
The Blueprint Initiative, LLC The Blueprint Initiative LLC/Hughes, Michael (531) 466-8383	RCCA048 Residential Child-Caring A 07/06/2021	3701 Saratoga St Omaha NE 68111	Capacity: 6 Gender: Male Ages from: 12 Ages to: 19
68112		**Douglas**	
Rite of Passage, Inc.- Uta Halee Academy Rite of Passage, Inc. (303) 588-7304	RCCA002 Residential Child-Caring A 10/22/2015	10625 Calhoun Road Omaha NE 68112	Capacity: 30 Gender: FEMALE Ages from: 13 YEARS Ages to: 19 YEARS
68122		**Douglas**	
Care-RIE Chrystol Spraling/ReColla Rimmer (402) 609-0780	RCCA049 Residential Child-Caring A 04/25/2022	8020 Howell Street Omaha NE 68122	Capacity: 6 Gender: Both Ages from: 5 Ages to: 19
68132		**Douglas**	
Child Saving Institute, Inc. Child Saving Institute, Inc. (402) 553-6000	RCCA020 Residential Child-Caring A 09/28/2014	4545 Dodge St Omaha NE 68132	Capacity: 12 Gender: BOTH Ages from: 0 YRS Ages to: 18 YRS
68152		**Douglas**	
NOVA Treatment Community, Inc. NOVA Treatment Community, Inc. (402) 455-8303	RCCA033 Residential Child-Caring A 03/11/2015	8502 Mormon Bridge Road Omaha NE 68152	Capacity: 27 Gender: BOTH Ages from: 13 YEARS Ages to: 18 YEARS
68361		**Fillmore**	
Heartland Boys Home LLC Heartland Boys Home LLC (402) 759-4334	RCCA006 Residential Child-Caring A 02/10/2014	914 P Road P.O. Box 423 Geneva NE 68361	Capacity: 16 Gender: MALE Ages from: 10 YRS Ages to: 19 YRS
68502		**Lancaster**	

RESIDENTIAL CHILD CARING & CHILD CARING AGENCIES ROSTER

ZIP CODE / PROVIDER NAME / LICENSEE NAME / PHONE NUMBER	LICENSE NUMBER / LICENSE TYPE / EFFECTIVE DATE	COUNTY / ADDRESS	
Women In Community Service Inc. Women In Community Service Inc. (402) 477-5256	RCCA042 Residential Child-Caring A 07/13/2015	1935 D Street Lincoln NE 68502	Capacity: 11 Gender: FEMALE Ages from: 12 YRS Ages to: 19 YRS
68502-2154		**Lancaster**	
HopeSpoke Lincoln and Lancaster County Child Guidance Center, Inc. (402) 475-7666	RCCA034 Residential Child-Caring A 06/30/2014	904 Sumner Street Lincoln NE 68502-2154	Capacity: 12 Gender: MALE Ages from: 12 YRS Ages to: 18 YRS
68506		**Lancaster**	
Cedars Youth Services - Emergency Shelter Cedars Youth Services Inc. (402) 434-5437	RCCA017 Residential Child-Caring A 09/21/2015	6601 Pioneers Blvd Ste 1 Lincoln NE 68506	Capacity: 23 Gender: Both Ages from: 0 YRS Ages to: 19 YRS
68509		**Lancaster**	
Lincoln Regional Center Whitehall Program Nebraska Department of Health and Human Services, State of Nebrasl (402) 471-6969	RCCA022 Residential Child-Caring A 09/11/2014	5845 Huntington Ave. Lincoln NE 68509	Capacity: 24 Gender: MALE Ages from: 13 YRS Ages to: 19 YRS
68701		**Madison**	
Norfolk Group Home Norfolk Group Home, Inc. (402) 379-0295	RCCA005 Residential Child-Caring A 02/01/2014	201 N 12 St Norfolk NE 68701	Capacity: 12 Gender: Female Ages from: 7 YRS Ages to: 19 YRS
691030655		**Lincoln**	
Nebraska Youth Center Nebraska Youth Center (308) 534-4164	RCCA019 Residential Child-Caring A 09/01/2014	2300 E. 2nd Street North Platte NE 69103-0655	Capacity: 12 Gender: Both Ages from: 12 YRS Ages to: 19 YRS
69151		**Lincoln**	
Independence Rising - Shelter Center for Independent Living of Central Nebraska (308) 258-1914	RCCA050 Residential Child-Caring A 03/20/2023	102 S Cedar Maxwell NE 69151	Capacity: 8 Gender: All Ages from: 7 yrs Ages to: 19 yrs
69356		**Scotts Bluff**	
Optimal Family Preservation Optimal Family Preservation, LLC (308) 633-3703	RCCA046 Residential Child-Caring A 01/11/2019	120105 County Road 33 Minatare NE 69356	Capacity: 12 Gender: BOTH Ages from: 0 Ages to: 18
69361		**Scotts Bluff**	
Panhandle Youth Shelter Community Action Partnership of Western Nebraska (308) 635-7777	RCCA025 Residential Child-Caring A 12/10/2014	2426 Broadway Scottsbluff NE 69361	Capacity: 14 Gender: BOTH Ages from: 0 Ages to: 19

Total Number of Programs: 21

Appendix C: Nebraska State Statutes

Neb. Rev. Stat. §83-4,125. Detention and juvenile facilities; terms, defined.

For purposes of sections 83-4,124 to 83-4,134.01:

(1) Criminal detention facility means any institution operated by a political subdivision or a combination of political subdivisions for the careful keeping or rehabilitative needs of adult or juvenile criminal offenders or those persons being detained while awaiting disposition of charges against them. Criminal detention facility does not include any institution operated by the Department of Correctional Services. Criminal detention facilities shall be classified as follows:

(a) Type I Facilities means criminal detention facilities used for the detention of persons for not more than twenty-four-hours, excluding nonjudicial days;

(b) Type II Facilities means criminal detention facilities used for the detention of persons for not more than ninety-six hours, excluding nonjudicial days; and

(c) Type III Facilities means criminal detention facilities used for the detention of persons beyond ninety-six hours;

(2) Juvenile detention facility means an institution operated by a political subdivision or political subdivisions for the secure detention and treatment of persons younger than eighteen years of age, including persons under the jurisdiction of a juvenile court, who are serving a sentence pursuant to a conviction in a county or district court or who are detained while waiting disposition of charges against them. Juvenile detention facility does not include any institution operated by the department;

(3) Juvenile facility means a residential child-caring agency as defined in section 71-1926, a juvenile detention facility or staff secure juvenile facility as defined in this section, a facility operated by the Department of Correctional Services that houses youth under the age of majority, or a youth rehabilitation and treatment center;

(4) Room confinement means the involuntary restriction of a juvenile placed alone in a cell, alone in a room, or alone in another area, including a juvenile's own room, except during normal sleeping hours, whether or not such cell, room, or other area is subject to video or other electronic monitoring; and

(5) Staff secure juvenile facility means a juvenile residential facility operated by a political subdivision (a) which does not include construction designed to physically restrict the movements and activities of juveniles who are in custody in the facility, (b) in which physical restriction of movement or activity of juveniles is provided solely through staff, (c) which may establish reasonable rules restricting ingress to and egress from the facility, and (d) in which the movements and activities of individual juvenile residents may, for treatment purposes, be restricted or subject to control through the use of intensive staff supervision. Staff secure juvenile facility does not include any institution operated by the department.

83-4,134.01. Juvenile facility; legislative intent; placement in room confinement; provisions applicable; report; Inspector General of Nebraska Child Welfare; duties; disciplinary action.

(1) It is the intent of the Legislature to establish a system of investigation and performance review in order to provide increased accountability and oversight regarding the use of room confinement for juveniles in a juvenile facility.

(2) The following shall apply regarding placement in room confinement of a juvenile in a juvenile facility:

(a) Room confinement of a juvenile for longer than one hour shall be documented and approved in writing by a supervisor in the juvenile facility. Documentation of the room confinement shall include the date of the occurrence; the race, ethnicity, age, and gender of the juvenile; the reason for placement of the juvenile in room confinement; an explanation of why less restrictive means were unsuccessful; the ultimate duration of the placement in room confinement; facility staffing levels at the time of confinement; and any incidents of self-harm or suicide committed by the juvenile while he or she was isolated;

(b) If any physical or mental health clinical evaluation was performed during the time the juvenile was in room confinement for longer than one hour, the results of such evaluation shall be considered in any decision to place a juvenile in room confinement or to continue room confinement;

(c) The juvenile facility shall submit a report quarterly to the Legislature on the juveniles placed in room confinement; the length of time each juvenile was in room confinement; the race, ethnicity, age, and gender of each juvenile placed in room confinement; facility staffing levels at the time of confinement; and the reason each juvenile was placed in room confinement. The report shall specifically address each instance of room confinement of a juvenile for more than four hours, including all reasons why attempts to return the juvenile to the general population of the juvenile facility were unsuccessful. The report shall also detail all corrective measures taken in response to noncompliance with this section. The report shall redact all personal identifying information but shall provide individual, not aggregate, data. The report shall be delivered electronically to the Legislature. The initial quarterly report shall be submitted within two weeks after the quarter ending on September 30, 2016. Subsequent reports shall be submitted for the ensuing quarters within two weeks after the end of each quarter;

(d) The Inspector General of Nebraska Child Welfare shall review all data collected pursuant to this section in order to assess the use of room confinement for juveniles in each juvenile facility and prepare an annual report of his or her findings, including, but not limited to, identifying changes in policy and

practice which may lead to decreased use of such confinement as well as model evidence-based criteria to be used to determine when a juvenile should be placed in room confinement. The report shall be delivered electronically to the Legislature on an annual basis.

(3) The use of consecutive periods of room confinement to avoid the intent or purpose of this section is prohibited.

(4) Any juvenile facility which is not a residential child-caring agency which fails to comply with the requirements of this section is subject to disciplinary action as provided in section 83-4,134. Any juvenile facility which is a residential child-caring agency which fails to comply with the requirements of this section is subject to disciplinary action as provided in section 71-1940.

83-4,134.02. Placement of juvenile in room confinement; restrictions on placement; conditions; release; facility; duties; monitoring.

(1) This section applies to placement of a juvenile in room confinement in the following facilities: A juvenile detention facility, staff secure juvenile facility, facility operated by the Department of Correctional Services, or youth rehabilitation and treatment center operated by the Department of Health and Human Services.

(2) A juvenile shall not be placed in room confinement for any of the following reasons:

(a) As a punishment or a disciplinary sanction;

(b) As a response to a staffing shortage; or

(c) As retaliation against the juvenile by staff.

(3) A juvenile shall not be placed in room confinement unless all other less-restrictive alternatives have been exhausted and the juvenile poses an immediate and substantial risk of harm to self or others.

(4) A juvenile may only be held in room confinement according to the following conditions:

(a) A juvenile shall not be held in room confinement longer than the minimum time required to eliminate the substantial and immediate risk of harm to self or others and shall be released from room confinement as soon as the substantial and immediate risk of harm to self or others is resolved; and

(b) A juvenile shall only be held in room confinement for a period that does not compromise or harm the mental or physical health of the juvenile.

(5) Any juvenile placed in room confinement shall be released immediately upon regaining sufficient control so as to no longer engage in behavior that threatens substantial and immediate risk of harm to self or others.

(6) Not later than one business day after the date on which a facility places a juvenile in room confinement, the facility shall provide notice of the placement in room confinement to the juvenile's parent or guardian and the attorney of record for the juvenile.

(7) All rooms used for room confinement shall have adequate and operating lighting, heating and cooling, and ventilation for the comfort of the juvenile. Rooms shall be clean and resistant to suicide and self-harm. Juveniles in room confinement shall have access to drinking water, toilet facilities, hygiene supplies, and reading materials approved by a licensed mental health professional.

(8) Juveniles in room confinement shall have the same access as provided to juveniles in the general population of the facility to meals, contact with parents or legal guardians, legal assistance, and access to educational programming.

(9) Juveniles in room confinement shall have access to appropriate medical and mental health services. Mental health staff shall promptly provide mental health services as needed.

(10) Juveniles in room confinement shall be continuously monitored by staff of the facility. Continuous monitoring may be accomplished through regular in-person visits to the confined juvenile which may also be supplemented by electronic video monitoring.

(11) The use of consecutive periods of room confinement to avoid the intent and purpose of this section is prohibited.

(12) Nothing in this section shall be construed to authorize or require the construction or erection of fencing or similar structures at any facility, nor the imposition of nonrehabilitative approaches to behavior management within any facility.

Appendix D: Report Process

In preparing this report, the OIG undertook a number of activities to assist facilities with understanding reporting requirements and accurately reporting room confinement use. The OIG took steps to assure the interpretation of reported data was consistent, taking into consideration each facility's unique physical building and youth population.

Beginning with FY 21-22, the OIG no longer reviews facility data for duplication, errors, and other inconsistencies. This work is not statutorily mandated and diverts the OIG's limited resources from other statutorily required duties. As a result, the information presented in this report is based on the data exactly as it was submitted, with one exception. When substantial issues with the submitted data were discovered individual facilities were given a brief period of time to clarify or make corrections and resubmit data prior to analysis.

Data Reported

The OIG analyzed the use of room confinement by facility type to provide context around factors that influence the use of room confinement. These factors include the differences in facility function, type of population served, and specific policies and standards.

In order to analyze the use of room confinement at each type of juvenile facility, the OIG reviewed available data and when possible, calculated statistical measures as a means of ascertaining a descriptive analysis of the use of juvenile room confinement in all reporting facilities.

The following measures were calculated at facilities that reported any instances of room confinement in the fiscal year:

- Total Incidents/Total Youth/Total Hours: The total number of room confinement incidents and the associated total confinement hours, and the number of individual youth confined for both standard utilization and medical or COVID-19 quarantine.
- Median Duration of Room Confinement: The median duration statistic represents the midpoint of incidents based on the length of time. In general it represents the middle point in the data with half the incidents below the median and half above. The OIG made the decision to report this number instead of the average duration statistic because the average can be distorted by a few incidents of low or high duration. The median is more robust and reflects more accurately the central tendency of room confinement duration.

- Percentage of Room Confinement Incidents Ending in Four Hours or Less: Of the total incidents of room confinement, the number that ended in four hours or less.
- Percent of Room Confinement Incidents Ending in Eight Hours or Less: Of the total incidents of room confinement, the number that ended in eight hours or less.
- Percent of Room Confinement Incidents Ending in 24 Hours or Less: Of the total incidents of room confinement, the number that ended in 24 hours or less.
- Longest Incident: The incident of room confinement that represents the longest duration.

Data Collection and Review

Each year, the OIG spends hundreds of hours compiling this report. Before drafting this report, the OIG requests data, and policy/procedure updates made by each facility from July 1, 2022 through June 30, 2023.

Administrators are provided with an opportunity to discuss efforts made towards reducing the use of room confinement by their facility that may not have been reflected in policy and procedure documents.

The OIG reviewed the following material for this report:

- Quarterly facility room confinement reports submitted to the Legislature and/or to the OIG covering July 1, 2022 through June 30, 2023;
- Federal and state regulations that govern juvenile facilities' use of room confinement;
- Individual facilities' written policies and procedures for utilizing different forms of room confinement; and,
- Academic research and available reports on the history, impact and appropriate use of juvenile room confinement, and effective methods for reducing its use.

This report covers thousands of incidents of room confinements. This office made all calculations using Excel functions. Time was rounded by the quarter hour: if a time difference was seven minutes or less, the total time was rounded down to the nearest quarter hour; if a time difference was eight minutes or more, the total time was rounded up. A confinement from 11:00 to 12:22 was recorded as lasting for one hour and 15 minutes. Total time was then converted to decimal form for consistent calculation purposes. A confinement lasting 1:45 – one hour and 45 minutes – is represented as 1.75 hours. Similarly, all data results were computed to the nearest hundredth and rounded up if the final number was five or above. To resolve spelling inconsistencies Excel was used to cross reference names and ID numbers to locate individuals who had different names but the same identification. Where ever

possible, the OIG relied on the use of individual ID numbers to calculate the total number of youth confined and to review the confinement of individual youth.

Appendix E: Selected References

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