Office of

Inspector General of Nebraska Child Welfare

Juvenile Room Confinement in Nebraska

Fiscal Year 2023-2024

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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 analyze the use of juvenile room confinement in Nebraska juvenile facilities. The purpose of this report is to establish a foundational understanding of juvenile room confinement, compare Nebraska data to established best practices, and highlight any significant findings regarding the application and trends of juvenile room confinement within the state.

As has been mentioned in the OIG's previous juvenile room confinement reports, Nebraska juvenile room confinement statutes are robust in intent and incorporate best practices. However, these best practices are not reliably followed and the juvenile room confinement statutes are inconsistently applied across Nebraska juvenile facilities, leading to significant variations in the use and reporting of juvenile room confinement. This inconsistency hampers the OIG's ability to gauge the full scope of how juvenile room confinement is used and its impact on the welfare of youth. Based on the OIG's review and analysis of the Fiscal Year (FY) 2023-2024 juvenile room confinement data, the disconnect between the law and the practical application of juvenile room confinement in Nebraska appears to remain.

This past fiscal year, the OIG observed various concerning trends regarding juvenile room confinement in Nebraska. Namely, compared to the previous fiscal year, there was a significant increase in the total number of hours that youth were confined across all the facilities combined. Together, facilities reported approximately 119,300 total hours of juvenile room confinement in FY 2023-2024. This is a 110% increase from the approximately 56,900 total hours of confinement reported in FY 2022-2023.

There was also a significant increase in the number of incidents of confinement. The number of confinement incidents increased by 48%, from over approximately 4,000 incidents in FY 2022-2023 to approximately 5,900 in this past fiscal year. This data is broken down by facility in Table 3 of this report.

Based on the data alone, it appears that these increases are contrary to Nebraska law and best practice which state juvenile room confinement should be time-limited and used as a last resort.

However, the OIG acknowledges that the data alone does not fully explain the complexity of juvenile room confinement nor the extensive challenges that many individual juvenile facilities face in reducing the reliance on the practice. For most of the reporting facilities, the number of youth being served has increased after several years of decreases in their populations due to the COVID pandemic. In addition, these facilities are serving more youth that have gang affiliations, adult criminal charges, mental health issues, and highly aggressive and assaultive behaviors, all of which create challenges that may increase the risk of disruption and threats to facility safety and security. Juvenile room confinement may occasionally be necessary for such reasons, so long as it is used reasonably, sparingly, and in compliance with Nebraska law and best practices.

That said, this past year also had several positive trends and improvements regarding the practice of juvenile room confinement in Nebraska. For example, despite the increase in total room confinement hours and incidents, most of the incidents were resolved more quickly than those in the previous year. In other words, confinement may have been used more frequently, but each occurrence may have been for a shorter period of time, making its overall use more time-limited. Other notable positive trends from this past year include an across-the-board decrease in the use of consecutive days of room confinement, as well as a drastic decrease in room confinement for medical reasons (94% decrease) as compared to the previous fiscal year.

While Nebraska 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 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.

The OIG appreciates the juvenile facilities and agencies for their cooperation in reporting the data, and in providing our office with the data clarification and context necessary to understand juvenile room confinement in Nebraska.

Juvenile Room Confinement—Background & Overview

Juvenile room confinement is a practice used in institutional juvenile settings to manage youths' behaviors by separating them from others, resulting in limited social interaction, often with 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, "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. It includes emotional and psychological safety, creating an environment where youth are safe from intimidation, harassment, bullying, or emotional harm. Ensuring that youth do not pose a risk to themselves is also an aspect of facility safety and security, including measures to prevent self-harm, suicide, or any behavior that might jeopardize a youth's well-being.

Listed below are the various circumstances in which juvenile room confinement might be used to maintain safety and security, or for other administrative reasons. The specific terminology that is used to describe the reason for confinement may differ from one facility to another.

Danger to Self and Others

When youth present a danger to themselves or others, room confinement can be used to prevent harm and maintain order. The purpose is to enhance safety and security within the facility by isolating youth who pose immediate risks to themselves, other youth, or staff due to violent or disruptive behaviors.

[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.

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 youth that their actions have consequences. It is meant to serve as a deterrent, discouraging further misconduct and promoting compliance with facility rules.

Time-Out

Room confinement can provide staff with a tool to manage crises. It allows youth to be separated from the general population during heightened tension or emotional distress, de-escalating the situation and preventing further conflicts. If a youth becomes agitated or disruptive, for instance, a short period of isolation can be used as an opportunity for the youth to regain composure and self-control before rejoining the general population.

Protective Custody

Room confinement can also be used to provide protective custody. Protective custody primarily safeguards youth from potential harm or threats posed by other youth due to 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.

Other situations that result in room confinement that may be considered less essential to safety and security are as follows.

Medical

In cases where youth require medical or mental health assessment, temporary isolation may become necessary. For example, a youth 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 has 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 youth, as well as other youth and staff in the facility.

Intake and Orientation

When a new youth arrives at a facility, they may be placed in room confinement temporarily during the intake and orientation process. This allows staff to assess the youth's needs, perform necessary health screenings, and ensure the youth 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 used to temporarily separate youth during the investigation. This separation can prevent interference with the investigative process, allowing for information to be properly collected.

Staff Meetings or Training

Room confinement can also be used to allow for staff meetings or training sessions. By isolating youth 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 also lead to room confinement. These emergencies encompass a wide range of situations, including those that pose security threats. They 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 that can include little human contact and severely

restricted access to activities and privileges. When excessively applied, however, 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 in terms of both power dynamics and psychological impact. Equating parental discipline and guidance with a facility staff member placing a youth in confinement in an institutional setting overlooks the profound differences between the practices.

Recognizing these distinctions from adult correctional practices and family disciplinary techniques is crucial to understanding juvenile room confinement and its unique challenges and considerations.

Concerns with Juvenile Room Confinement

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

Mental Health

Isolating youth for extended periods can cause severe psychological distress and increase feelings of loneliness, anxiety, and depression. Mental health professionals contend that the practice can have a long-lasting and often irreversible negative impact on youths' mental health and potentially exacerbate existing mental health issues, particularly for those who have been victims of prior abuse or trauma.

[2] For a complete list of the selected references consulted in preparing this summary of the concerns with juvenile room confinement, and selected references consulted in summarizing some evidence-based best practices on the use of juvenile room confinement, see Appendix C: Selected References.

Social and Emotional Growth

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

Exacerbation of Problematic Behavior

Additionally, some research has found that juvenile room confinement can lead to an escalation of problematic behaviors rather than promoting positive behavioral change. 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.

Best Practices

A tension exists between using juvenile room confinement as a potentially necessary tool for safety and security in a facility and the harm that the confinement can cause. As research has drawn more attention to the practice of juvenile room confinement, it has influenced the development of best practices and raised ethical concerns about the treatment of youth 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 by legislation at the federal level.

Many professional and accrediting organizations in the fields of juvenile justice, mental health, and education have developed best practice 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 the youth. Such efforts reflect a commitment to promoting positive behavior change among youth, rather than punitive measures that may have long-term negative consequences, and to implementing oversight practices crucial for ensuring the responsible and ethical use of room confinement.

These best practices include using juvenile room confinement as a last resort and only when less restrictive alternatives have been exhausted or when there is an immediate safety concern. It should also be time-limited and not extend beyond what is necessary to address the specific safety or security concern. Each case should undergo an individualized assessment to determine whether room confinement would be appropriate, considering the youth's age, mental health, and developmental needs. While in confinement, the youth 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. 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. Youths' legal rights should also 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, monitored, and transparent. Facilities should collect and maintain accurate records of all room confinement incidents, including the reasoning, duration, and outcomes. Facilities should then analyze that data for trends and disparities and use that information to inform policy and practice improvements. This information should be subject to regular oversight and monitoring with a regular and rigorous review process to assess the continued necessity of room confinement.

Best practices recommend that a facility appoint specific individuals or teams to be responsible for that internal oversight. This oversight team could conduct or review regular internal inspections and audits of room confinement incidents to assess compliance with policies and procedures. Facilities should analyze room confinement data to gather the demographics of the youth subjected to confinement, the reasons for and duration of confinement, and any adverse outcomes that the confinement has. Data analysis can also help identify trends, disparities, and

areas for improvement. Facilities should establish mechanisms for feedback and input from internal staff and youth regarding confinement. The oversight personnel should review their findings and use the insights gained from oversight to make continuous improvements, when necessary, to 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 these external oversight agencies, such as independent ombudsmen or oversight boards, to complement internal oversight efforts.

As is discussed below, Nebraska juvenile room confinement statutes incorporate many of these best practices, creating a statutory foundation for facilities to implement the best practices.

Juvenile Room Confinement in Nebraska

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]

This statutory definition of room confinement in Nebraska is broad. It includes any time a youth is involuntarily placed alone in a cell, room, or another area, including their own room. This definition 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 headcounts, shift changes, staff trainings, or facility emergencies. All these practices physically separate youth from the general population, placing them alone and resulting in social isolation.

The statutory definition does not contemplate the intent or purpose of the room confinement. Nor is the behavioral or emotional state of the youth considered a factor in whether the incident qualifies as room confinement. Even if a youth complies with being placed in confinement at a facility and calmly sits alone in the room, the confinement is still involuntary if the youth is given no other option due to facility policy, practice, scheduling, shift changes, staff breaks, or training. A defiant and aggressive youth who is involuntarily placed alone in a room in response to an act of violence against another youth or staff member is in room confinement regardless of the actions that precipitated the confinement.

In other words, any instance where a youth is involuntarily placed alone in a room qualifies as juvenile room confinement under Nebraska law, regardless of the circumstances or duration of their confinement.

[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 should be balanced with the potential psychological and physical harm that it can cause to each 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[4] only apply to a well-defined set of facilities that serve the juvenile population. These facilities specifically fall under the following four categories.

Residential-Child Caring Agencies

The first category is Residential-Child Caring Agencies (RCCA), which act as out-of-home placements and provide 24-hour care to four or more children, and are not a foster family home licensed by the Department of Health and Human Services' (DHHS) Division of Public Health (Public Health). Often, these facilities operate mental health and substance abuse treatment centers. The number of such facilities varies annually and has been as high as 25 in previous years, but there are currently 22 such facilities.[5]

Public Health regulations for RCCAs govern seclusion, a form of room confinement, which can only be used in emergencies and not as a form of punishment or discipline, staff convenience, or as a substitute for care. Facilities that use seclusion must have trained staff and detailed policies in place. Historically, RCCAs have reported only a few isolated incidents of confinement. In FY 2023-2024, the only reported incidents of juvenile room confinement at a RCAA occurred at the Lincoln Regional Center Whitehall Campus in Lincoln, which provides residential treatment programs for male adolescents.[6] However, as will be reflected in the summary of the

[4] See Neb. Rev. Stat. §§ 83-4,134.01 and 83-4,124.02.
[5] For the list of current RCCA facilities, see https://dhhs.ne.gov/licensure/Documents/ResidentialAndChildCaringRoster.pdf.
[6] The only other RCCA to notify the OIG that it did not have any juvenile room confinement incidents in FY 2023-2024 was the Masonic-Eastern Star Home for Children in Fremont.

FY 2023-2024 room confinement data later in this report, the Whitehall incidents are excluded from all data calculations, as all such incidents were the result of medical necessity.

Juvenile Detention Centers

The second type of facility that reports juvenile room confinement data is juvenile detention centers. There are currently four juvenile secure and staff secure detention facilities in Nebraska that are 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 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) is a secure juvenile detention center in Lincoln;
- Northeast Nebraska Juvenile Services Center (Madison County) is both a staff-secure and secure juvenile detention center in Madison; and
- Patrick J. Thomas Juvenile Justice Center (Sarpy County) is a staff-secure juvenile detention center in La Vista.

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."[7] 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

[7] Neb. Rev. Stat. § 83-4,126(1)(c).

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, these terms are used inconsistently within the regulations, and some terms are undefined.

Youth Rehabilitation and Treatment Centers

The third type of facility subject to juvenile room confinement reporting requirements is Youth Rehabilitation and Treatment Centers (YRTCs), administered and overseen by DHHS' Office of Juvenile Services (OJS). There are currently three YRTCs, 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 court order after the court determines that the youth has already "exhausted all levels of probation supervision and options for community-based services."[8] The YRTC-Hastings campus serves only female youth, the YRTC-Kearney campus serves only male youth, and the YTRC-Lincoln campus serves both male and female youth.

DHHS rules and regulations, outlined in the Nebraska Administrative Code, authorize the use of room confinement for either safety and security or as a disciplinary sanction if a youth has violated a facility rule. The 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.[9]

Nebraska Department of Correctional Services (NDCS)

NDCS operates facilities that house individuals convicted of crimes in Nebraska criminal courts and sentenced to terms of imprisonment. While most of NDCS' incarcerated individuals are 19 years of age (the age of majority in Nebraska) or older, some NDCS inmates are youth under the age of majority. These youth have been tried, convicted, and sentenced to terms of

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[8] Neb. Rev. Stat. § 43-286.
[9] 401 NAC 7-007. http://www.sos.ne.gov/rules-and regs/regsearch/Rules/Health_and_Human_Services_System/Title-401/Chapter-7.pdf.

imprisonment in adult criminal court rather than juvenile court, which handles the majority of cases against children. Unlike all other facilities, NDCS does not report incidents of juvenile room confinement after a youth has reached their eighteenth birthday.

Historically, of the ten NDCS facilities, only three have reported juvenile room confinement: the 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 includes the Diagnostic & Evaluation Center, is a maximum custody facility that serves numerous functions, including diagnostic evaluations for mental health assessments. RTC has historically reported juvenile room confinement very infrequently and involving very few individuals.

NCCW houses all the female youth in NDCS custody. The facility usually only houses one or two female youth under 18 years of age each year. NCCW most often uses juvenile room confinement as a result of facility issues in combination with the Prison Rape Elimination Act (PREA), which requires sight, sound, and physical separation between incarcerated juveniles who are younger than 18 years of age and incarcerated individuals 18 years of age and older.[10]

NCYF is a facility that houses male offenders 21 years of age and younger. Of the NDCS facilities, NCYF is the most consistent reporter of juvenile room confinement data.

Since March 2020, under Nebraska law, any incarcerated individual 18 years of age or younger is considered to be a member of a vulnerable population and cannot be placed in restrictive housing.[11] NCYF successfully discontinued the use of restrictive housing and room restriction as a disciplinary sanction shortly after that legislation was passed.

Data Collection Requirements

Nebraska law requires the facilities described above to regularly report juvenile room confinement data.[12] The intent of the legislation passed in 2016 was to cast a wide net in

[10] Prison Rape Elimination Act (PREA) National Standards, 28 C.F.R. § 115.14 (2012).
[11] Neb. Rev. Stat. § 83-173.03(1).
[12] See Neb. Rev. Stat. § 83-4,134.01.

capturing information on youth being involuntarily confined, "[i]n 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."[13]

Neb. Rev. Stat. § 83-4,134.01(2)(a) requires facilities to collect the following information when a youth 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,
- 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 one 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 one hour,[14] meaning that if a youth was confined for a half hour in three separate incidents during a 24-hour period, those incidents must be taken cumulatively. If a youth was confined for a cumulative time of less than one hour during a 24-hour period, the data does not need to be reported.

[13] "Transcript: Judiciary Committee – January 20, 2016." http://www.nebraskalegislature.gov/FloorDocs/104/PDF/Transcripts/Judiciary/2016-01-20.pdf.
[14] See 2020 Neb. Laws, L.B. 230.

Data Reporting Requirements

After collecting the required information, juvenile facilities must submit a quarterly data report to the Legislature.[15] The information that facilities must report is only a subset of the juvenile room confinement information that must be collected. The reports must redact all personal information, such as names, but provide individual rather than aggregate data.[16] The reports must include the following data points for each incident of confinement:

- The 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[17]

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.[18]

Limits & Conditions Specific to the Use of Juvenile Room Confinement

Nebraska law places certain parameters and conditions around the use of juvenile room confinement. In 2020, Neb. Rev. Stat. § 83-4,134.02 was revised so that juvenile detention facilities, facilities operated by NDCS, and YRTCs operated by DHHS must adhere to the following practices when using juvenile room confinement.[19] Per Neb. Rev. Stat. § 83-4,134.02, a juvenile shall not be placed in room confinement for any of the following reasons:

- As a punishment or a disciplinary sanction;[20]

[15] See Neb. Rev. Stat. § 83-4,134.01(2)(c).
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] The restrictions on the use of juvenile room confinement set forth § 83-4,134.02 do not apply to residential child caring agencies.
[20] § 83-4,134.02(2)(a).

- As a response to a staffing shortage;[21] or
- As retaliation against the juvenile by staff.[22]

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.[23]
- 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;[24]
- 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;[25] 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.[26]

Third, requirements for the standard of care provided to youth in confinement have also been incorporated 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

[21] § 83-4,134.02(2)(b).
[22] § 83-4,134.02(2)(c).
[23] § 83-4,134.02(3).
[24] § 83-4,134.02(4)(a).
[25] § 83-4,134.02(4)(b).
[26] § 83-4,134.02(5).

access to drinking water, toilet facilities, hygiene supplies, and reading materials approved by a licensed mental health professional.[27]

- 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.[28]
- 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.[29]
- 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.[30]

Finally, Nebraska Revised Statute § 83-4,134.02(11) states the use of consecutive periods of room confinement to avoid the intent and purpose of the section is prohibited.

Oversight

The OIG is statutorily charged with reviewing all juvenile room confinement data reported by facilities to assess the use of room confinement.[31] Additionally, the OIG must submit an annual report of its findings to the Legislature, including identifying any changes in policies and practices that "may lead to decreased use of such confinement."[32] As part of the review requirement, the OIG has met with facility administrators over the years to discuss actions, efforts, and procedures related to juvenile room confinement and made requests for data clarification, when needed, from individual facilities. The OIG does not have the authority, obligation, or capacity to verify the data provided by the facilities. The OIG does not conduct

[27] § 83-4,134.02(7).
[28] § 83-4,134.02(8).
[29] § 83-4,134.02(9).
[30] § 83-4,134.02(10).
[31] Neb. Rev. Stat. § 83-4,134.01(2)(d). 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 that each facility provide data to the OIG in a spreadsheet format that facilitates data analysis.
[32] § 83-4,134.01(2)(d).

unannounced onsite inspections nor interview front-line facility staff or youth placed at the facilities to collect anecdotal information. As a result, the OIG's oversight and assessment of the juvenile room confinement data is based only on the data submitted by the facilities.

As has been noted in previous reports, there is no standard interpretation of Nebraska juvenile room confinement statutes, including what counts as room confinement and what needs to be documented. Instead, the interpretation differs at each facility and occasionally within the same facility. As a result, the OIG cannot make conclusions about the use of room confinement across different facilities. The OIG can compare each facility to itself and to prior years' data from that facility. Therefore, the OIG's review can only provide a general understanding of how often room confinement is used, the length of time for incidents of confinement, and the reasons for confinement.

FY 2023-2024 Data & Juvenile Room Confinement Best Practices

As discussed above, comprehensive guidelines have been established to balance the necessity of juvenile room confinement with its risks. Many professional and accrediting organizations in the fields 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 statutes are thoughtfully constructed in alignment with these guidelines and effectively incorporate six best practices. According to Neb. Rev. Stat. § 83-4,134.01 and § 83-4,134.02, juvenile room confinement should (1) be used as a last resort, (2) be time-limited, (3) recognize the potential physical and psychological harm, (4) be closely monitored, (5) provide youth with access to their belongings, and (6) provide accountability and oversight regarding the use of juvenile room confinement.

The following sections analyze the data reported in FY 2023-2024 by eight Nebraska facilities through the lens of these six generally accepted best practices articulated in Nebraska statutes. The data and analysis that follows should be considered a broad reporting of how Nebraska facilities adhered to juvenile room confinement best practices during this past fiscal year.

FY 2023-2024 Aggregate Juvenile Room Confinement Data

As was highlighted at the beginning of this report, facilities reported significant increases in the total number of hours that youth were confined and the total number of times that youth were confined. There were 5,887 separate incidents of juvenile room confinement in FY 2023-2024, excluding the 85 incidents reported as medical necessities. There were only approximately 4,000 total incidents in the previous fiscal year. Most concerning, however, was that youth were confined for 119,293 total hours in FY 2023-2024. Facilities reported approximately 56,900 hours in the previous year, less than half as many. More youth were confined in FY 2023-2024 as the year went on, with the fourth quarter having the most incidents.

As mentioned, a noticeable positive trend in the FY 2023-2024 data is that most confinement incidents were resolved in less time than in the previous year. Specifically, 61% of incidents were resolved within 0-4 hours, and 14% of incidents were resolved within 4-8 hours. Ten

percent of incidents were resolved within 8-24 hours, and the remaining 15% of incidents were resolved in more than 24 hours. The incidents reported in FY 2022-2023 were each generally longer in duration.

Based on the information available to the OIG, the 5,887 reported incidents in this past year involved at least 460 different individual youth. This number is likely higher. A definite number could not be ascertained as the individual identifying information, such as youth identification numbers, was missing in two quarters of the data from two of the facilities.[33] The OIG assumes that within the approximately 1,400 confinement incidents that did not have youth identification information, it is very likely that some of those incidents involved additional youth distinct from those already accounted for. As a result, it is likely that the number of distinct youth confined was over 460. There were 503 distinct youth confined in the previous year.

The aggregate data reported from all facilities in FY 2023-2024 is reflected in the tables below.

[33] These two facilities with missing youth identification numbers were Douglas County Detention and Lancaster County Detention. The OIG contacted these facilities to obtain the missing identification but did not receive a timely response.

Table 1. FY 2023-2024 Incidents of Confinement Totals: All Facilities[34]

Confinement Totals: All Facilities (Excluding Medical Necessity)		
	Count	% of Total
Total Incidents	**5,887**	
Quarter 1 (July–September)	**680**	**12%**
Quarter 2 (October–December)	**1,561**	**26%**
Quarter 3 (January–March)	**1,752**	**30%**
Quarter 4 (April–June)	**1,894**	**32%**
Incident Duration Ranges		
Resolved within 0-4 hours	**3,574**	**61%**
Resolved within 4-8 hours	**837**	**14%**
Resolved within 8-24 hours	**598**	**10%**
Resolved in More Than 24 hours	**878**	**15%**
Distinct Youth Confined	**460**[35]	
Total Hours	**119,293**	
Average Time of Confinement Per Incident	**20h 16m**	

As mentioned previously, although each facility uses different terminology and descriptions for why each room confinement incident was necessary, the reported reasons for confinement in Nebraska fall into three broad categories: (1) administrative, (2) safety and security, and (3) medical. There is often some overlap between these categories and incidents can qualify as more than one type. Similarly, facilities have different definitions for these reasons. What some facilities considered an administrative reason for room confinement other facilities considered a safety and security or a medical reason, and vice versa. Nonetheless, in FY 2023-2024, administrative reasons for confinement accounted for the narrow majority of all reported incidents, closely followed by safety and security. There were only a few medical necessity incidents.

[34] The data from each facility in this table excludes confinement incidents reported as medical necessity. It thus excludes the 27 confinement incidents reported from the Whitehall Campus, as all such incidents were the result of medical necessity.

[35] This number is the sum of the distinct youth confined at all facilities and assumes that no youth was confined at more than one facility within the same fiscal year.

Table 2. FY 2023-2024 Reasons for Confinement Totals: All Facilities[36]

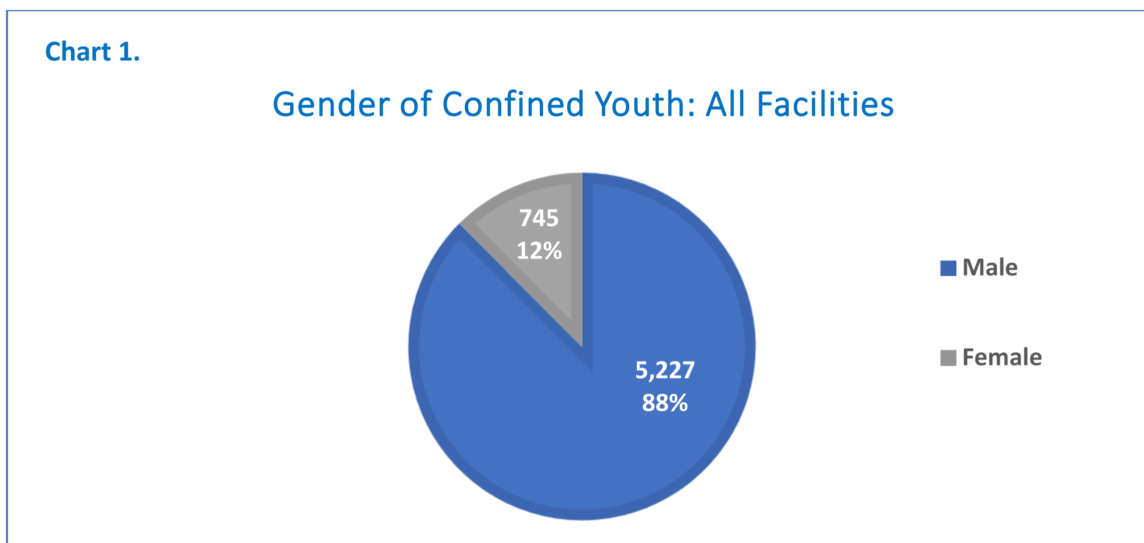
Reasons for Confinement: All Facilities (Including Medical Necessity)		
	Count	% of Total
Administrative	2,961	50%
#1 Reason: Refused to Comply (Including for Disruptive Behaviors and Property Damage/Destruction)	2,331	
#2 Reason: Intake	169	
#3 Reason: Investigation	138	
Safety/Security	2,926	49%
#1 Reason: Danger to Other Youth	1,157	
#2 Reason: Danger to Staff	1,041	
#3 Reason: Danger to Other Youth or Staff: Assault and Attempted Assault	252	
Medical	85	1%
#1 Reason: Sickbay: Illness/Injury	53	
#2 Reason: Directive from Medical Personnel	22	
#3 Reason: Quarantine: COVID or Influenza	6	
Total Incidents	5,972	

Facilities are statutorily mandated to document and report the age, gender, race, and ethnicity of the youth subject to room confinement. The demographic information that the OIG receives is specific only to those youth who were confined. The OIG does not receive demographic information for the entire population in the facility. Therefore, the OIG cannot compare the demographics of the youth who were confined to the population at the facility in general. As a result, the OIG cannot draw any concrete conclusions about whether or not there were disparities in the use of juvenile room confinement based on ethnicity, race, gender, or age. The demographic data reported to the OIG and presented here speaks only to the data for youth

[36] The data from each facility in this table includes confinement incidents reported as medical necessity.

who were in juvenile room confinement in FY 2023-2024. The following charts reflect this demographic data of youth confined in the past year.[37]

In FY 2023-2024, older youth were generally confined more often than younger youth, as it appears that 17-year-old youth were confined the most, closely followed by 16-year-old youth, then 15-year-old youth.[38] There were also many more male youth who were confined than female youth.[39]

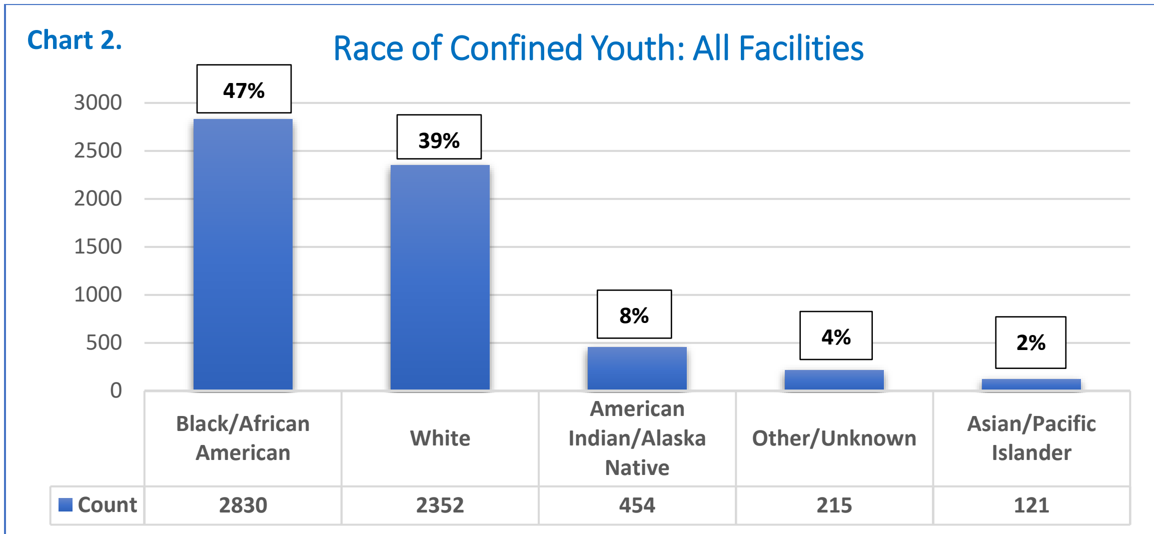


[37] The data in the charts below includes youth who were confined as the result medical necessity, but it excludes the youth confined for medical necessity at the Whitehall Campus, as the data from that facility is excluded elsewhere in this report. In addition, the data reflects the youth demographics of each individual confinement incident, even though many youth were confined more than once and had the same demographic information for each.

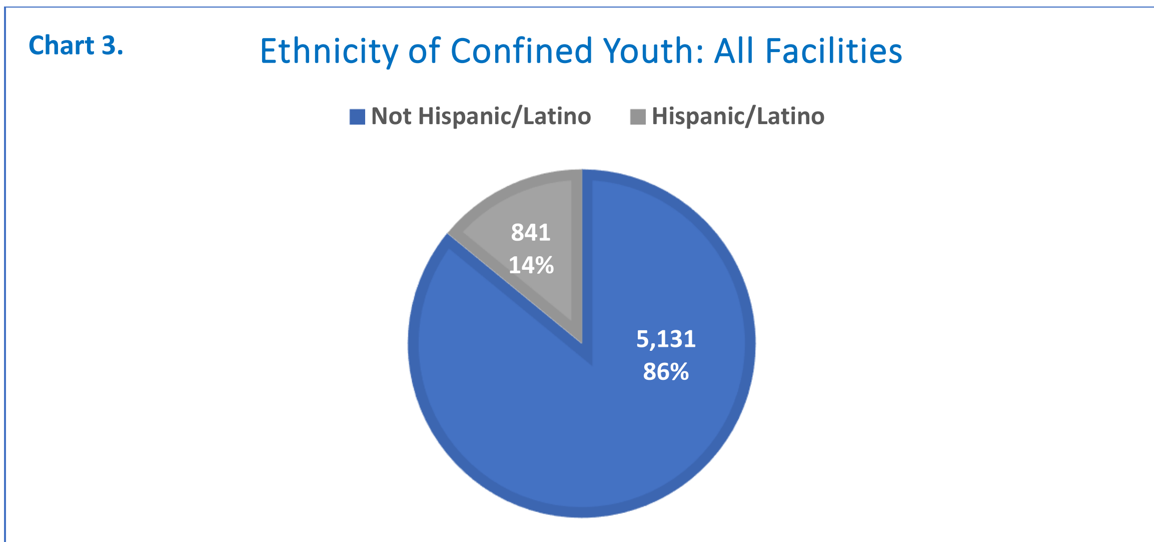
[38] In reviewing the reported ages of confined youth, the OIG discovered a technical error in the calculation of the ages of youth confined in certain facilities. Because it is possible that this technical error could have impacted other, if not all, of the reported ages of confined youth at these facilities, the OIG cannot concretely report the exact age of each confined youth this past year. Only generalizations regarding the ages can be made. It should be noted that every facility reported confinement incidents for 14, 15, 16, 17, and 18-year-old youth. Douglas County Detention, Lancaster County Detention, and Sarpy County Detention were the only facilities to report 13-year-olds in room confinement.

[39] Every facility but YRTC-Kearney and YRTC-Hastings reported confinement incidents for both male and female youth. YRTC-Kearney only serves male juveniles, and YRTC-Hastings only serves female juveniles.

In addition, Black and White youth were confined much more than any other race, with Black youth being confined the most.



Lastly, the vast majority of confined youth were not Hispanic or Latino.



The table below contains more detailed data from each of the eight facilities that reported juvenile room confinement incidents in FY 2023-2024, including each facility's total number of confinement incidents, distinct youth confined, hours of confinement, and average time of confinement incidents.

Table 3. Fiscal Year Data Comparisons, by Facility[40]

Douglas County Detention		
Total	FY 22-23	FY 23-24
Incidents	332	466
Distinct Youth Confined	169	75[41]
Hours	34,036	67,899
Avg. Time per Incident	102h 31m	145h 42m

YRTC-Hastings		
Total	FY 22-23	FY 23-24
Incidents	107	108
Distinct Youth Confined	29	36
Hours	1,219	1,485
Avg. Time per Incident	11h 24m	13h 45m

Lancaster County Detention		
Total	FY 22-23	FY 23-24
Incidents	1,642	1,760
Distinct Youth Confined	124	83[42]
Hours	5,135	8,802
Avg. Time per Incident	3h 7m	5h

YRTC-Kearney		
Total	FY 22-23	FY 23-24
Incidents	506	3,050
Distinct Youth Confined	84	153
Hours	9,010	29,764
Avg. Time per Incident	17h 48m	9h 46m

Madison County Detention		
Total	FY 22-23	FY 23-24
Incidents	19	27
Distinct Youth Confined	15	20
Hours	190	280
Avg. Time per Incident	10h	10h 22m

YRTC-Lincoln		
Total	FY 22-23	FY 23-24
Incidents	178	352
Distinct Youth Confined	35	55
Hours	4,483	6,846
Avg. Time per Incident	25h 11m	19h 27m

Sarpy County Detention		
Total	FY 22-23	FY 23-24
Incidents	96	39
Distinct Youth Confined	35	21
Hours	282	108
Avg. Time per Incident	2h 56m	2h 46m

NDCS[43]		
Total	FY 22-23	FY 23-24
Incidents	38	85
Distinct Youth Confined	12	17
Hours	2,576	4,109
Avg. Time per Incident	67h 47m	48h 21m

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[40] The data from each facility in this table excludes confinement incidents reported as medical necessity.
[41] As noted above, Douglas County Detention did not provide identification numbers for confined youth in two quarters in FY 2023-2024. This number is based on the quarters that youth identification numbers were provided.
[42] Same as preceding footnote as for Lancaster County Detention in FY 2023-2024.

Nebraska Facility Data Compared to Juvenile Room Confinement Best Practices

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

Room confinement should be used only as a last resort, such as in cases of threats to the safety of the youth 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.[44]

More specifically, best practices suggest that 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.[45]

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, the OIG does not question whether a reported safety threat was indeed a safety threat. The OIG cannot confirm if confinement incidents followed cases of imminent danger or if less intrusive options were first considered. In compliance with best practices and statutory reporting requirements, facilities must also report why less restrictive means to room confinement were unsuccessful and the various interventions attempted by staff before the room confinement.

Some of the more common reasons provided by facilities in the FY 2023-2024 data included the youth continuing to pose a safety and security risk due to assaultive behavior, continued escalation and disruption, continued verbal abuse and threats, and more, despite repeated

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[44] Various juvenile facilities have adopted policies and procedures incorporating these best practices. At the YRTCs, for example, the YRTC Operational Memorandum Governing Juvenile Conduct (OM-302.1.6b) states the YRTC facility policies do not permit juvenile room confinement to be used for punishment, discipline, staff convenience, or retaliation.

[45] See also Neb. Rev. Stat. § 83-4,134.02(3).

staff interventions. The OIG is not in a position to question these reasons for why less restrictive alternatives to room confinement were unsuccessful, and cannot verify whether staff sufficiently attempted to intervene with the youth before resorting to room confinement.

FY 2023-2024 data indicated that room confinement was typically used for administrative reasons, accounting for 50% of all reported cases. Although confinement was used for safety and security reasons nearly the same amount, at 49% of all reported cases, the total number of administrative reasons was 163% higher than the previous year and significantly more than in any prior year. Each facility's reported reason for confinement is provided below.

Table 4. FY 2023-2024 Facility Reported Reasons for Confinement.[46]

Douglas County Detention		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**466 Total**	**100%**
Fighting	221	
Assault or Attempted Assault	189	
Assaulting Staff	16	
Intimidating or Threatening Behavior	15	
Destruction of Property	7	
Possession or Manufacture of Drugs or Intoxicants	5	
Unauthorized Possession of Facility Prescribed Medication	4	
Possession of Manufacturing a Weapon	3	
Assaulting Staff or Volunteer, or Attempt	3	
Assault, Attempted Assault, Stealing	1	
Possession of Contraband	1	
Stealing	1	
Total Incidents	**466**	

[46] The data from each facility in this table includes confinement incidents reported as medical necessity.

Lancaster County Detention		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**1,710 Total**	**96%**
Juvenile is a Danger to Other Residents	834	
Juvenile is a Danger to Staff	797	
Juvenile is a Danger to Other Residents, and In Danger Due to Behaviors of Others	30	
Power Surge/Failure: Impacted Critical Security Systems	28	
Juvenile is a Danger to Other Residents and Staff	11	
Juvenile is in Danger Due to Behaviors of Others	8	
Juvenile is a Danger to Other Residents, Administrative: Staffing, Security System Failure	2	
Administrative	**50 Total**	**3%**
Staffing: Facility Safety Check/Shift Change/Resident Count	42	
Corrective Action: Rule Violation, Danger to Other Residents	4	
Sentenced in Adult Court Awaiting Court Transport	3	
Staffing, Safety: Danger to Other Residents and Staff, Medical	1	
Medical	**22 Total**	**1%**
Directive from Medical Personnel	22	
Total Incidents	**1,782**	

Madison County Detention		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**25 Total**	**89%**
Danger to Other Youth	23	
Danger to Staff	1	
Escape Risk	1	
Administrative	**2 Total**	**7%**
Corrective Action/Behavioral Management	2	
Medical	**1 Total**	**4%**
Quarantine: COVID	1	
Total Incidents	**28**	

Sarpy County Detention		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**39 Total**	**89%**
Danger to Other Youth	36	
Danger to Staff	2	
Danger to Self	1	
Medical	**5 Total**	**11%**
Quarantine: Influenza	5	
Total Incidents	**44**	

YRTC-Hastings		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**79 Total**	**67%**
Danger to Other Youth	51	
Danger to Staff	14	
Danger to Self	8	
Danger to Other Youth and Staff	4	
Danger from Other Youth	2	
Administrative	**29 Total**	**25%**
Refused to Comply: Disruptive Behaviors, Property Damage and Destruction	15	
Medical	8	
Investigation	4	
Intake	2	
Medical	**10 Total**	**8%**
Sickbay: Illness/Injury	8	
Sickbay: Substance Abuse	2	
Total Incidents	**118**	

YRTC-Kearney		
Reasons for Confinement	**Count**	**% of Total**
Administrative	**2,645 Total**	**86%**
Refused to Comply	2,167	
Intake	163	
Investigation	113	
Medical	80	
Refused to Comply: Disruptive Behaviors	41	
Security Rotations	36	
Reintegration Plan	22	
Danger to Other Youth	7	
Property Destruction	6	
Danger to Staff	5	
Escape Risk	3	
Facility Emergency: Lock Down	1	
Danger to Self	1	
Safety/Security	**405 Total**	**13%**
Danger to Staff	177	
Danger to Other Youth	121	
Danger to Other Youth: Group Disturbance	31	
Danger to Other Youth: Physical Altercation	20	
Danger to Other Youth: Assault or Attempted Assault	13	
Danger to Staff: Assault	10	
Danger to Self/Self-Injurious Behaviors	9	
Danger to Staff: Abusive/Threatening Language	6	
Danger/Safety from Other Youth	5	
Danger to Other Youth: Abusive/Threatening Language	4	
Danger to Other Youth: Contraband Possession	3	
Security Rotations	3	
Investigation	2	
Property Destruction	1	
Medical	**18 Total**	**1%**
Illness/Injury	16	
Procedure/Operation	1	
Substance Abuse	1	
Total Incidents	**3,068**	

YRTC-Lincoln		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**194 Total**	**51%**
Danger to Other Youth	86	
Danger to Staff	48	
Danger to Other Youth: Abusive/Threatening Language	24	
Danger to Staff: Assault or Attempted Assault	14	
Danger to Other Youth: Assault or Attempted Assault	10	
Danger to Self	6	
Danger to Staff: Abusive/Threatening Language	5	
Danger from Other Youth	1	
Administrative	**158 Total**	**41%**
Refused to Comply	86	
Refused to Comply: Disruptive Behaviors, Property Destruction	22	
Medical	20	
Investigation	19	
Property Destruction	6	
Intake	4	
Danger to Others: Contraband Possession	1	
Medical	**29 Total**	**8%**
Sickbay: Illness	29	
Total Incidents	**381**	

NDCS		
Reasons for Confinement	**Count**	**% of Total**
Administrative	**77 Total**	**91%**
Modified Operations	30	
Facility Emergency	28	
Sight/Sound Separation	10[47]	
Orientation Status	7	
Investigation	2	
Safety/Security	**8 Total**	**9%**
Danger to Other Youth	6	
Danger to Staff	2	
Total Incidents	**85**	

[47] As mentioned previously, NDCS reports juvenile room confinement incidents from both NCYF and NCCW. In FY 2023-2024, 75 of the 85 incidents at NDCS involved the male youth population at NCYF, and the other 10 incidents involved the same one female youth at NCCW.

As depicted above, the significant increase in administrative reasons for confinement was mostly due to YRTC-Kearney reporting over 2,000 such incidents, approximately 89% of all the administrative reasons for confinement reported across the facilities. The large majority of the administrative incidents at YRTC-Kearney listed the reason for confinement as "Refused to Comply." Confining a youth for their refusal to comply could imply that the confinement was used as a form of punishment, which is not only counter to best practices, but prohibited by Nebraska law.[48] However, YRTC-Kearney reported that this unusual increase in administrative reasons for confinement was most often related to safety and security issues. The OIG cannot determine what percentage of confinements for administrative reasons were for these safety and security-related issues. However, YRTC-Kearney did report that most of the incidents where a youth refused to comply reportedly involved the youth's assaultive, violent, or threatening behavior, which was usually compounded by the youth's gang affiliation and conflict with other youth at the facility.

To address these concerns, YRTC-Kearney reportedly made administrative decisions to use limited-duration room confinement to separate the youth and resolve conflicts between them as they arose and to prevent the youth from further harming themselves, each other, and staff members. Therefore, although such confinement incidents were listed as administrative, YRTC-Kearney could have likewise justifiably classified at least some of the incidents to be for facility safety and security. This nuanced distinction in the terminology that a facility uses to describe its room confinement incidents further illustrates how the reported data alone only provides a limited insight into the complexity of juvenile facilities utilizing room confinement and the unique challenges their youth populations present.

Beyond YRTC-Kearney, NDCS was the only other facility to report administrative reasons as the primary reason for room confinement in FY 2023-2024. However, such incidents at NDCS were few. Across all facilities, utilizing room confinement in response to the youths' failure to comply, disruptive behaviors, and property damage accounted for most of the administrative

[48] See § 83-4,134.02(2)(a).

reasons for confinement. Although the OIG cannot discern from the reported data the exact reasoning for these administrative reasons for confinement, the data suggests a positive trend in that fewer confinement incidents in FY 2023-2024 were corrective actions or punishments than in the previous fiscal year. In addition, although the next highest administrative reasons for confinement were youth intakes and facility investigations, the data indicates that there were very few instances of facilities confining youth for convenience or other facility purposes such as staffing, training, shift changes, or facility operations or emergencies. Lancaster County Detention, for example, reported nearly 800 administrative reasons for confinement in FY 2022-2023 that involved staffing, facility emergencies, or facility operational needs. In this past fiscal year, however, Lancaster County Detention only reported 50 such incidents. Notably, Douglas County Detention and Sarpy County Detention did not report any administrative reasons for confinement in FY 2023-2024.

The overwhelming majority of all other reported reasons for confinement across the facilities in FY 2023-2024 were safety and security, as has been the case in previous years. Safety and security were the primary reasons for confinement at the remaining six facilities. More specifically, the data indicates that most facilities confined youth in FY 2023-2024 in response to the danger that the youth posed to other youth residents and staff because of fighting and physical altercations, assaults and attempted assaults, and other threatening behavior. Danger to other youth and staff accounted for nearly all reported safety and security reasons for confinement. In an improvement from some previous years, there were fewer reported confinement incidents associated with escape risks, self-harm, or unauthorized possession of various types of contraband.

Lastly, there were only 85 medical reasons for confinement in FY 2023-2024, a dramatic 94% decrease from the more than 1,500 medical incidents reported in the previous fiscal year, most of which involved medical quarantines because of COVID-19.

2. Juvenile Room Confinement Should Be Time-Limited

Room confinement is a behavioral control measure that may pose medical and psychological dangers, which increase the longer a youth is confined. Best practices recommend that youth be released from room confinement as soon as they are safely able.[49] Specifically, standards recommend that room confinement of youth should not last longer than 24 hours.[50] 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 most cases.[51]

The time-related juvenile room confinement data reported from each Nebraska facility in FY 2023-2024 follows below.

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[49] See also Neb. Rev. Stat. § 83-4,134.02(4)(a) and (5).
[50] The exception to time limits is the American Correctional Association, which allows up to five days of disciplinary room confinement.
[51] 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.

Table 5. FY 2023-2024 Duration Ranges of Confinement Incidents, by Facility[52]

Douglas County Detention	Count	% of Total
0-4 hours	45	10%
4-8 hours	5	1%
8-24 hours	13	3%
More than 24 hours	403	86%
Total	466	

YRTC-Hastings	Count	% of Total
0-4 hours	52	48%
4-8 hours	10	9%
8-24 hours	30	28%
More than 24 hours	16	15%
Total	108	

Lancaster County Detention	Count	% of Total
0-4 hours	1,075	61%
4-8 hours	495	28%
8-24 hours	185	11%
More than 24 hours	5	<1%
Total	1,760	

YRTC-Kearney	Count	% of Total
0-4 hours	2,188	72%
4-8 hours	286	9%
8-24 hours	249	8%
More than 24 hours	327	11%
Total	3,050	

Madison County Detention	Count	% of Total
0-4 hours	21	78%
4-8 hours	3	11%
8-24 hours	1	4%
More than 24 hours	2	7%
Total	27	

YRTC-Lincoln	Count	% of Total
0-4 hours	135	38%
4-8 hours	21	6%
8-24 hours	105	30%
More than 24 hours	91	26%
Total	352	

Sarpy County Detention	Count	% of Total
0-4 hours	29	74%
4-8 hours	10	26%
8-24 hours	0	0%
More than 24 hours	0	0%
Total	39	

NDCS	Count	% of Total
0-4 hours	29	34%
4-8 hours	7	8%
8-24 hours	15	18%
More than 24 hours	34	40%
Total	85	

[52] The data from each facility in this table excludes confinement incidents reported as medical necessity.

Table 6. Percentage of Confinement Incidents Resolved within 24 Hours, 2016–2024[53]

Fiscal Year	Douglas Co.	Lancaster Co.	Madison Co.	Sarpy Co.	YRTC-H	YRTC-K	YRTC-L	NDCS
2016-2017	21%	100%	100%	100%	-	34%	-	0%
2017-2018	24%	100%	100%	100%	-	59%	-	0%
2018-2019	34%	100%	100%	100%	-	28%	-	31%
2019-2020	35%	100%	100%	100%	-	77%	-	87%
2020-2021	32%	100%	91%	100%	-	88%	81%	54%
2021-2022	25%	100%	96%	100%	64%	95%	76%	47%
2022-2023	15%	100%	90%	100%	70%	78%	72%	37%
2023-2024	**14%**	**100%**	**93%**	**100%**	**85%**	**89%**	**74%**	**60%**

[53] The data from each facility in this table excludes confinement incidents reported as medical necessity.

During this past fiscal year, there were significantly more total incidents of confinement and hours of confinement than in the previous fiscal year. The only facility to report a decrease in these data points from FY 2022-2023 to FY 2023-2024 was Sarpy County Detention, with half as many of each. However, despite the increase in the number of confinement incidents and hours in FY 2023-2024, every facility but Douglas County Detention resolved more confinements within 24 hours than in the previous fiscal year. Relatedly, every facility but Douglas County Detention had a significant increase in incidents resolved in between either 0-4 or 4-8 hours than in the previous fiscal year. Several of the facilities that reported room confinement also had a lower average duration of confinement incidents than in the previous fiscal year. The facilities with the largest increase in either the total number of confinement incidents or confinement hours in FY 2023-2024—Douglas County Detention, Lancaster County Detention, YRTC-Kearney, and YRTC-Lincoln—each reported more incidents that were shorter in duration and resolved more quickly.

In the case of YRTC-Kearney, this trend of utilizing room confinement more frequently but in shorter durations was explained in part above. YRTC-Kearney not only nearly doubled its average census in FY 2023-2024 from the previous year, but more youth with gang affiliations, serious adult criminal charges, and highly aggressive and assaultive behaviors were sent to the facility, often from Omaha. Despite that increase, 72% of all juvenile room confinement at the facility, nearly 2,200 separate incidents, were resolved between 0-4 hours. This was a significant improvement from last year when only 40% of incidents were resolved within that shorter timeframe.

All facilities must also report data on the barriers preventing a youth in confinement from returning to the general population. In many of the incidents from this past year, especially when the initial listed reason for confinement was safety and security or refusal to comply with disruptive behaviors, facilities reported that it was the youths' actions and continued behavior that prevented the room confinement incident from being resolved promptly.

The Use of Consecutive Days of Confinement

Effectively evaluating the time-limited aspect of juvenile room confinement requires analyzing incidents' duration, regularity, and the use of continuous or consecutive incidents of confinement. Determining when consecutive confinement is used can be challenging given each facility's different interpretations of the Nebraska juvenile room confinement statutes.

Specifically, as mentioned, the statutes define room confinement as the involuntary restriction of a juvenile placed alone—including the juvenile's room—except during normal sleeping hours. This caveat for sleeping hours creates a complication when evaluating the time-limited nature of confinement, as not all facilities report sleeping hours the same. As has been explained in previous juvenile room confinement reports, seven facilities include normal sleeping hours as part of the total duration of a confinement period, whereas Lancaster County Detention does not. Excluding sleeping hours from the reported duration of a confinement period creates inconsistencies with the data at other facilities, making comparison difficult, and raises concerns about the actual duration of any given confinement incident.

As a consequence of excluding sleeping hours, it would appear as if a youth is confined for only 13 hours at a time rather than continuously over 24 hours. Incidents of consecutive days of confinement are recorded as multiple 13-hour periods, which appear to conclude when normal sleeping hours begin and resume the following day as a new incident. As a result, Lancaster County Detention's data in FY 2023-2024 showed fewer overall confinement hours—due to not including sleeping hours—but a higher number of individual incidents. Moreover, as noted, best practices suggest that each confinement incident end within 24 hours. Lancaster County's method of limiting each incident to 13 hours by excluding sleeping hours makes it appear as if the facility is meeting the best practice of limiting each confinement incident to less than 24 hours nearly 100% of the time.

Different facilities have varying rules and language regarding using consecutive days of confinement. Juvenile county detention centers have Detention Standards that allow

disciplinary confinement for up to seven days for major rule violations. Disciplinary confinement is not explicitly defined in the standards, although disciplinary detention is.

The practice of consecutive days of juvenile room confinement can also closely resemble the adult correctional practice of restrictive housing. As was noted above, since 2020, Nebraska law considers any incarcerated individual in an NDCS facility who is 18 years old or younger to be a member of a vulnerable population who cannot be in restrictive housing. Non-NDCS facilities, however, are still using consecutive days of confinement, and at a concerning rate.

This year, the data from Lancaster County Detention again showed the use of consecutive days of confinement. The facility often reported upwards of 10, 15, or 20 consecutive days of confinement for an individual youth at a time. The reporting method, however, portrayed these incidents as separate periods of confinement, each up to 13 hours, masking the reality that youth were confined for 24 hours for consecutive days, which is a significant deviation from the intended practice of time-limited juvenile room confinement. In addition, there were short intervals between the next period of consecutive days of confinement.

However, the total reported consecutive days of confinement at Lancaster County Detention in FY 2023-2024 were much less than the many consecutive days of confinement at the facility in the past. The OIG also did not observe any period of consecutive confinement as excessively lengthy as in the previous year. But frequently confining youth for between 10 and 20 days at a time is still counter to best practices and harmful to the youth.

The FY 2023-2024 data from the remaining seven facilities, which do include normal sleeping hours for each confinement incident that extends beyond a day, indicated that multiple consecutive days of confinement again tended to last only two to seven days at a time, with larger intervals between any other multi-day periods of confinement. In addition, the number of consecutive days of confinement in FY 2023-2024 also appeared to significantly decrease due to the continuous decline in COVID-19 medical quarantines, where, as was the case in FY 2021-2022 and FY 2022-2023, facilities followed CDC recommendations to confine many youths who exhibited symptoms or tested positive for COVID-19 for numerous consecutive days.

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 onset of pre-existing mental illness and trauma symptoms; and
- Increased risk of cardiovascular-related health problems.[54]

Empirical information has long substantiated the claim that juvenile room confinement harms a youth's psychological, physical, and social development, concluding that it should only be used if necessary and 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.

Room confinement's negative impact on youth is especially concerning because many of the confined youth have 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.[55] At least 75% of the youth in the U.S. juvenile justice system have experienced traumatic victimization, and more than 90% have reported adverse childhood

[54] 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.

[55] 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.

experiences that include child abuse, violence, serious illness, or a combination of these experiences. [56]

Any juvenile facility utilizing juvenile room confinement must recognize the potential psychiatric consequences of prolonged solitary confinement, including depression, anxiety, and psychosis. Juvenile facilities must also recognize that because of juveniles' developmental vulnerabilities, they are at particular risk for such adverse reactions. [57]

Nebraska facilities are required to consider any physical or mental health clinical evaluation when deciding to place a juvenile in room confinement or to continue room confinement. They must also report any incidents of self-harm or suicide committed by the juvenile while they were isolated. The juvenile room confinement statutes state that detention centers, facilities operated by NDCS, and YRTCs are only permitted to hold youth in room confinement for a period that does not compromise or harm their mental or physical health.[58] 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 include the youth experiencing mental health issues or displaying self-harming behaviors. The OIG's review of the FY 2023-2024 data found 25 incidents of juvenile room confinement involving four different facilities where youth were confined because there was a concern for a mental health crisis or the youth had self-harmed and posed a danger to themself. While this does not appear to be a large-scale problem, facilities have continued to place youth experiencing a

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[56] 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); 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; CJCA. (2017). *Trauma informed care in juvenile justice.* Retrieved from http://cjca.net/wp-content/uploads/2018/02/CJCA-Position-paper-TIC-002.pdf.

[57] 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; 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.

[58] Neb. Rev. Stat. § 83-4,134.02(4)(b).

mental health crisis or who are displaying self-harming behaviors in confinement. In addition, facilities must report any 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. There were similarly few reported incidents of self-harm or attempted suicide for confined youth in FY 2023-2024. The OIG reviews both types of data when assessing the frequency of juvenile room confinement incidents in conjunction with mental health or self-harm issues. Due to the serious nature of exacerbated mental health issues of confined youth, in conjunction with the practice of juvenile room confinement itself, the OIG will continue to closely monitor reported incidents of juvenile room confinement, where youth often experience a mental health crisis or display self-harming behaviors.

4. Youth in 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. Best practice also recommends that all incidents of room confinement be recorded and reviewed through a quality assurance program at each facility. Additionally, best practices suggest that staff seek administrative approval to use room confinement in certain instances.

Nebraska statutes mandate that juveniles in room confinement be continuously monitored by facility staff.[59] Continuous monitoring may be accomplished through regular in-person visits with the confined youth or 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 the information required to be reported, the OIG cannot assess facility 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, programming, and other personal belongings while on room confinement status. Nebraska

[59] Neb. Rev. Stat. § 83-4,134.02(10).

statutes have incorporated this best practice by requiring detention centers, facilities operated by NDCS, and YRTCs to 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.[60]

Although Nebraska statutes reflect this best practice, the OIG cannot verify individual facilities' compliance with these parameters based on the data that must be reported.

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 statutes meet the oversight guidelines by 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.

Nebraska falls short of the guidelines' recommendations that there be clear and comprehensive policies and procedures governing the use of confinement. While current law provides some definite parameters for its use, there is no consistency between facilities—even facilities of the same type—regarding how certain aspects of the law should be interpreted, how confinement should be documented, and how and whether room confinement data will be verified. The different approaches regarding whether sleeping hours should be counted in the total duration

[60] Neb. Rev. Stat. § 83-4,134.02(7) and (8).

of a confinement incident is a salient example. Similarly, some facilities have unique protocols, such as restrictive housing and protective custody; the application of the juvenile room confinement laws to those practices has not been clearly defined.

The inconsistency in the application of the juvenile room confinement law can be attributed, in part, to the absence of effective enforcement mechanisms. 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.

NDCS and OJS oversee juvenile room confinement compliance at juvenile correctional facilities and YRTCs, respectively. These types of juvenile facilities, however, do not have an external, independent body like the Jail Standards Board and Public Health to enforce reporting requirements.

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

The guidelines also recommend having dedicated staff to provide internal oversight and review the use of confinement, analyze the data, and improve policy and procedure. It is the OIG's understanding that each facility subject to the reporting requirements has a staff member responsible for collecting and reporting the data. But the OIG is not aware of any 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 from 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 to collect

anecdotal information. The OIG's analysis is thus solely based on the data 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 the facilities, and sometimes within the same facility. This inconsistency leads to a wide range of reporting practices, potentially resulting in skewed data and the possibility of underreporting or overreporting 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 use room confinement practices. Such oversight efforts must be accurate and effective and should be conducted by agencies specifically responsible for overseeing these facilities.

Conclusions

The OIG's analysis of the FY 2023-2024 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 a striking increase in the total number of juvenile room confinement hours and incidents. While these increases are likely somewhat driven by several factors, such as elevated facility censuses, the increases were much more drastic than any previous year. The increase raises the question of whether juvenile room confinement is truly being used as a last resort and whether it is being used for longer than necessary. Are facilities unable to decrease its use given their limited resources and the significant challenges posed by the youth they serve, or is it a matter of convenience or a long-standing culture reliant on confinement? Similarly, counter to the best practice that room confinement be time-limited, facilities still often confined youth for consecutive days at a time, although there were fewer extreme cases of consecutive days of confinement and total consecutive days than in the previous year.

Juvenile room confinement was primarily used for administrative and safety and security reasons. The unusual uptick in administrative reasons, which can be contrary to best practice, was likely partially attributable to a difference in the terminology used to describe many safety and security-related incidents at one facility. Beyond administrative reasons, facilities once again confined youth for safety and reasons a large amount of the time, often citing danger to other youth and staff due to the prevalence of assaultive and threatening youth behavior. Medical reasons for confinement were also drastically fewer than in previous years, primarily due to hardly any COVID-19 quarantines.

Despite the increase in total confinement hours and incidents, most individual incidents were generally shorter in duration. All but one facility reported more incidents resolved within shorter periods, including within 0-4 hours, 4-8 hours, and 24 hours. This is a positive trend that moves the use of room confinement closer to best practice.

Juvenile facilities face significant challenges in serving youth. Since being tasked with producing an annual juvenile room confinement report, the OIG has spoken to facility administrators numerous times about the challenges their 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 room confinement are the increase in committed youth with aggressive and violent tendencies and significant mental health needs, the gang affiliations of the youth inside and outside of the facility, and youth whose length of stay is so long that they are no longer invested in making progress. Additionally, it was noted that the youth most frequently confined were often deemed the "toughest cases," in that those youth were perceived to pose the greatest challenge to the system and were the least likely to adapt to an institutionalized setting.

As the OIG has repeatedly stated in previous juvenile room confinement reports, 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. A sustained commitment to continuous improvement in juvenile room confinement practices is vital. 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[61] from facilities and technical assistance from outside agencies.[62] To successfully reduce room confinement, facilities must make significant and ongoing changes to facility culture, policy, and practice; they must find new ways to respond to youth behavior and safety concerns.[63] These changes require staff training, education initiatives, and innovative behavioral management strategies that not only

[61] 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.
[62] Council of Juvenile Correctional Administrators. "Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation [Toolkit]," LeBel, et. al. (2012).
[63] Effective strategies used by other states and facilities have been documented in detail in the OIG's previous juvenile room confinement annual reports.

address the complex needs of the youth, but also provide the necessary safety and security to the youth and staff within the facility without overly relying on room confinement.

To improve and reduce the use of room confinement, facilities much also commit to 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. Juvenile facilities and the agencies responsible for them must commit to rigorous data collection and reporting and to enhanced internal and external oversight practices. This includes regular audits of the room confinement data and the assessment of whether each room confinement incident is in compliance with statutory requirements and best practices. To do this, facilities need more staff dedicated to overseeing their juvenile room confinement practices. All facilities should also adopt a standardized approach to data collection, reporting, and interpretation of Nebraska juvenile room confinement statutes and best practices to ensure accuracy and consistency across the state.

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 that could guide Nebraska toward adopting more effective practices.

In conclusion, while Nebraska 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 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

The OIG's annual report on the use of juvenile room confinement must identify changes in policy and practice that may lead to a decreased use of room confinement in Nebraska.[64] The following section lists all prior juvenile room confinement recommendations made by the OIG. Additional details and rationale regarding each recommendation are published in each recommendation's respective Juvenile Room Confinement in Nebraska annual report published by the OIG.

2021

- Require facilities to report all incidents of room confinement.
- Require facilities to provide an annual summary for the reporting year of key data points.
- Require facilities to submit a quarterly statement of fact when there have been no incidents of juvenile room confinement within the facility.

2020

- Examine oversight and enforcement mechanisms for juvenile room confinement reporting.
- Examine juvenile room confinement enforcement mechanisms for provisions within Legislative Bill 230.
- 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.

2019

- Extend 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 that legislation be passed that requires:

[64] Neb. Rev. Stat. § 83-4,134.01(2)(d).

- All facilities adhere to best practices to reduce reliance on juvenile room confinement.
- Room confinement be used as a last resort, be time-limited, and be closely monitored.
- Clarification of current legislative provisions related to juvenile room confinement.
- Specific language to clearly define the meanings of "facility" and "agency," with explicit guidance on which organizations are required to report, and which are exempt.
- 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:
    - Revise facility policies to reflect best practice.
    - Focus on workforce development.
    - Create a Juvenile Room Confinement Reduction Plan and include technical assistance and oversight**.**
    - Publicly report information on the use of room confinement, including seclusion.
- Agency based recommendations include the following*:*
    - The Nebraska Department of Correctional Services:
        - Specifically Adopt Time Limits for Inmates in Restrictive Housing under the Age of 19.
        - Conduct a study on youth who spend particularly long periods of time in room confinement.
    - The Office of Juvenile Services:
        - Develop and Implement a Strategic Plan to Reduce Room Confinement.
        - Change OJS Rules and Regulations to Align with Best Practices.
    - The Nebraska Jail Standards Board:

        - Clarify definitions of different forms of room confinement within Juvenile Detention Jail Standards.
        - Update Jail Standards to reflect room confinement reporting requirements.
        - Update Jail Standards to eliminate the use of room confinement for disciplinary purposes.
    - The Department of Health and Human Services, Division of Public Health:
        - Update licensing rules and regulations to reflect juvenile room confinement reporting requirements.

2017

- Recommendation:
    - Clarification on what practices constitute room confinement.
    - Clarification on which facilities should report.
    - Creation of a Reporting Enforcement Mechanism for Facilities.

Appendix B: Report Process

In preparing this report, the OIG took numerous steps to ensure the interpretation of reported data was consistent and analyzed within a proper context, taking into consideration each facility's unique function, policies, physical campus, and type of youth population.

Beginning in FY 2021-2022, however, the OIG decided to no longer correct facility data for duplications, errors, and other inconsistencies. This work is not statutorily mandated and diverts the OIG's limited resources from other statutorily-required duties. Attempting to correct the data that facilities report, or determining which data is accurate and which is not, is a task better suited for the facilities and agencies and creates the danger of the OIG unintentionally altering the data. 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, such as facilities unintentionally omitting certain data points that must be reported, individual facilities were given a brief period to clarify or make corrections and resubmit the data before the OIG's report was released. It should be noted that in this past fiscal year, the submitted data contained far fewer duplications, errors, and other inconsistencies than in years prior.

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

The OIG reviewed the following material for this report:

- Quarterly facility room confinement reports submitted to the Legislature and the OIG from July 1, 2023, through June 30, 2024;
- 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. The OIG made all calculations, and verified those calculations, using Microsoft 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. For example, a confinement incident from 11:00 to 12:22 was recorded as lasting one hour and 15 minutes. Total time was then converted to decimal form for consistent calculation purposes. A confinement incident lasting 1:45—one hour and 45 minutes—is represented as 1.75 hours. Similarly, most final data results were computed to the nearest hundredth and rounded up if the final number was five or above; percentages were rounded up to the nearest whole number. When possible, the OIG relied on individual youth ID numbers to calculate the total number of distinct youth confined and to review the confinement of individual youth.

Appendix C: Selected References

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).

Council of Juvenile Correctional Administrators (CJCA). (2015). *Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation [Toolkit].* Retrieved from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/JJS/CJCA%20Toolkit%20Reducing%20the%20use%20of%20Isolation.pdf.

CJCA. (2017). *Trauma informed care in juvenile justice*. Retrieved from http://cjca.net/wp-content/uploads/2018/02/CJCA-Position-paper-TIC-002.pdf.

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.

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.

Dierkhising, C. B., Lane, A., & Natsuaki, M. N. (2014). Victims Behind Bars: A Preliminary Study of Abuse During Juvenile Incarceration and Post-Release Social and Emotional Functioning. Psychology, *Public Policy, and Law 20*(2). 181-190.

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

Hayes, L. M. (2009). *Characteristics of juvenile suicide in confinement.* Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/213691.pdf

Kaba, F. et al. (2014). Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *American Journal of Public Health 104*(3). 442-447.

LeBel, J., Mohr, W. K., Nunno, M., & O'Halloran, R. (2012). Restraint and Seclusion Use in U.S. School Settings: Recommendations from Allied Treatment Disciplines. *American Journal of Orthopsychiatry 82*(1).
http://img2.wikia.nocookie.net/__cb20141006144827/specialeducation/images/d/de/Lebel_Restraint_Seclusion_in_Schools_2012.pdf

National Association of State Mental Health Program Directors [ASMHPD]. (2008). *Six Core Strategies for Reducing Seclusion and Restraint.* Available from www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf.

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.

National Commission on Correctional Health Care (NCCHC). (2019). *Suicide Prevention and Management in Juvenile Correctional Settings*. Retrieved from https://www.ncchc.org/suicide-prevention-and-management-in-juvenile-correctional-settings.

NCCHC (2016). *Policy Statement: solitary confinement.* https://www.ncchc.org/filebin/Positions/Solitary-Confinement-Isolation.pdf. The NCCHC recommends that juveniles should be excluded from solitary confinement of any duration.

Performance-*based* Standards. (2019). *Reducing Isolation*. p. 2. Retrieved from https://pbstandards.org/cjcaresources/158/PbSReducingIsolationJune2019.pdf

Roush, D. W. (1996). *Desktop Guide to Good Juvenile Detention Practice*. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. https://www.ojp.gov/pdffiles/desktop.pdf