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OKLAHOMA COMMISSION ON
Children & Youth

Detaining Youth in Oklahoma County: Recommendations Report

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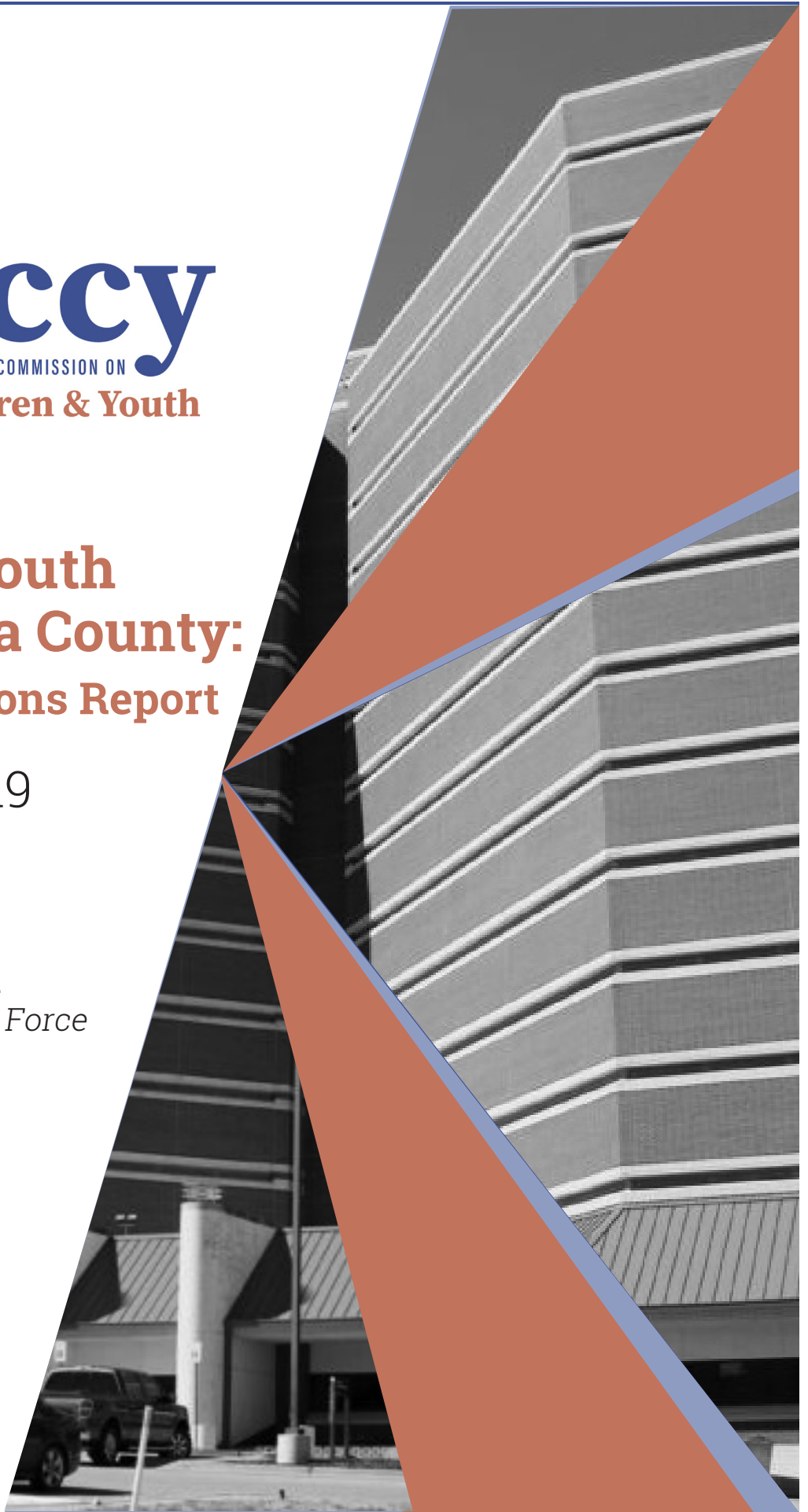




Table of Contents

Task Force Authorization and Purpose..... 5

The OCCY Office of Juvenile
System Oversight Investigation..... 6

Adolescent
Brain Development..... 6

Task Force Areas for Review:
Placement of Youth in the OCDC..... 8

Suicide Prevention/Precaution Policies..... 9

Training and Supervision..... 11

Facilities..... 11

*The Juvenile Justice Act of 2018 and Prison
Rape Prevention Elimination Act*..... 11

Areas of Concern..... 13

Recommendations for
Oklahoma Statutes..... 14

Recommendations for
OCDC Policy and Practice..... 14

Recommendations for
OCJDC Policy and Practice..... 15

Areas for Future Exploration
for the OCDC..... 15

Acknowledgments..... 16

References..... 17

“How do we hold people accountable for wrongdoing while at the same time remain in touch with their humanity enough to believe in their capacity to be transformed?”

— Bell Hooks, author



Task Force Authorization and Purpose

Oklahoma youth are detained anywhere from a couple of days to perhaps months while they are awaiting their court date or transfer to another facility because of alleged delinquent activity. Youth may spend years in the custody of the State of Oklahoma if they are adjudicated delinquent.

During this past year, the Oklahoma Commission on Children and Youth (OCCY) investigated the deaths of two individuals from suicide while they were in Oklahoma facilities. For this reason, time was set aside at the May 17, 2019 OCCY Commission Meeting to discuss best practices related to detaining youth and presentations were provided by Office of Juvenile Affairs professionals (Bailey & McClung 2019a).

One of the investigated deaths occurred at the Oklahoma County Detention Center (otherwise known as the Oklahoma County Jail). As reported by multiple news outlets, a 16-year old male died on May 1, 2019 after a suicide attempt on April 23, 2019 (Bailey & McClung 2019 b). Immediately following the young man's death, District One County Commissioner Carrie Blumert and Oklahoma County Sheriff P.D. Taylor requested a review by the OCCY (Douglas, 2019).

"We have worked hard since I became sheriff to ensure the safety of our staff and the detainees in our facility. Taylor continued, Having OCCY review and make recommendations regarding how youths are held in adult facilities makes good sense."

For this reason, OCCY Director Annette Wisk Jacobi utilized the director's authority under Title 10 O.S. §601.5¹ to convene the "Detaining Youth Task Force" (Task Force) to review and make recommendations on the following:

- 1) laws, policies, and procedures relating to detaining youth in both juvenile and adult facilities;
- 2) best practices relating to detaining youth in both juvenile and adult facilities; and
- 3) best practices relating to well-being and suicide prevention of youth being detained in juvenile and adult facilities.

Due to the specific request by County Commissioner Blumert and Sheriff Taylor, this first phase of the Task Force's work and this report is limited to Oklahoma County.

To date, the Task Force has met on June 27, July 11, and July 25, 2019. In addition, the Task Force has toured the Oklahoma County Detention Center (OCDC) as well as the Oklahoma County Juvenile Detention Center (OCJDC).

¹Title 10 O.S. §601.5 - The director may periodically convene issue-specific task groups for the purpose of improving services for children and youth. A copy of any report or recommendations which result from meetings of a task group shall be provided to the Commission, Governor, Speaker of the House of Representatives, President Pro Tempore of the Senate and the director of each state agency affected by the report or recommendations.



The OCCY Office of Juvenile System Oversight Investigation

The Office of Juvenile System Oversight (OJSO), a division within OCCY, provides external auditing and investigations for public and private child-serving agencies. Oklahoma Law² requires OJSO to conduct regular oversight visits at juvenile facilities throughout the state and investigate complaints concerning the services provided and the treatment of juveniles at these facilities.

Youth in facilities that house adults and juveniles, such as an adult county detention center/jail, have not been recognized as part of the juvenile system the OJSO routinely monitors. However, youth in such a facility would come to the attention of the OJSO and be subject to an investigation should a complaint be submitted. Such is the case involving the death of the 16-year-old male at the OCDC. For that reason, the OJSO did conduct a routine complaint investigation of the OCDC to determine whether any law or policy violations contributed to the minor's death.

The investigation is concluded. Based on the available documentation and surveillance video, the OJSO believes the OCDC staff followed all policy and procedures which were in place at the time of the incident.

Adolescent Brain Development

The unique needs of juvenile offenders in placement as well as suicide prevention has been a focus of developmentalists for decades. It has long been accepted by psychologists that adolescence is a unique developmental period. In 2009, Steinberg (2009) addressed the American Psychological Association at its annual convention and presented information about changes that occur within the brain during the adolescent period. In the past, emphasizing such changes has led policy makers to view neurological research as superior to behavioral research. Steinberg (2009) cautioned against this thinking and pointed out neurological research was not more valid/reliable or somehow superior to behavioral research. He also stated that past research supported the concept that adolescent risk-taking is influenced by susceptibility to being aroused by rewards paired with lower levels of self-regulation; however, the theory of the changing adolescent brain allowed policymakers to restrict or delay the rights of adolescents as well as provide support to advocates who seek the creation of policies which protect adolescents from harm.

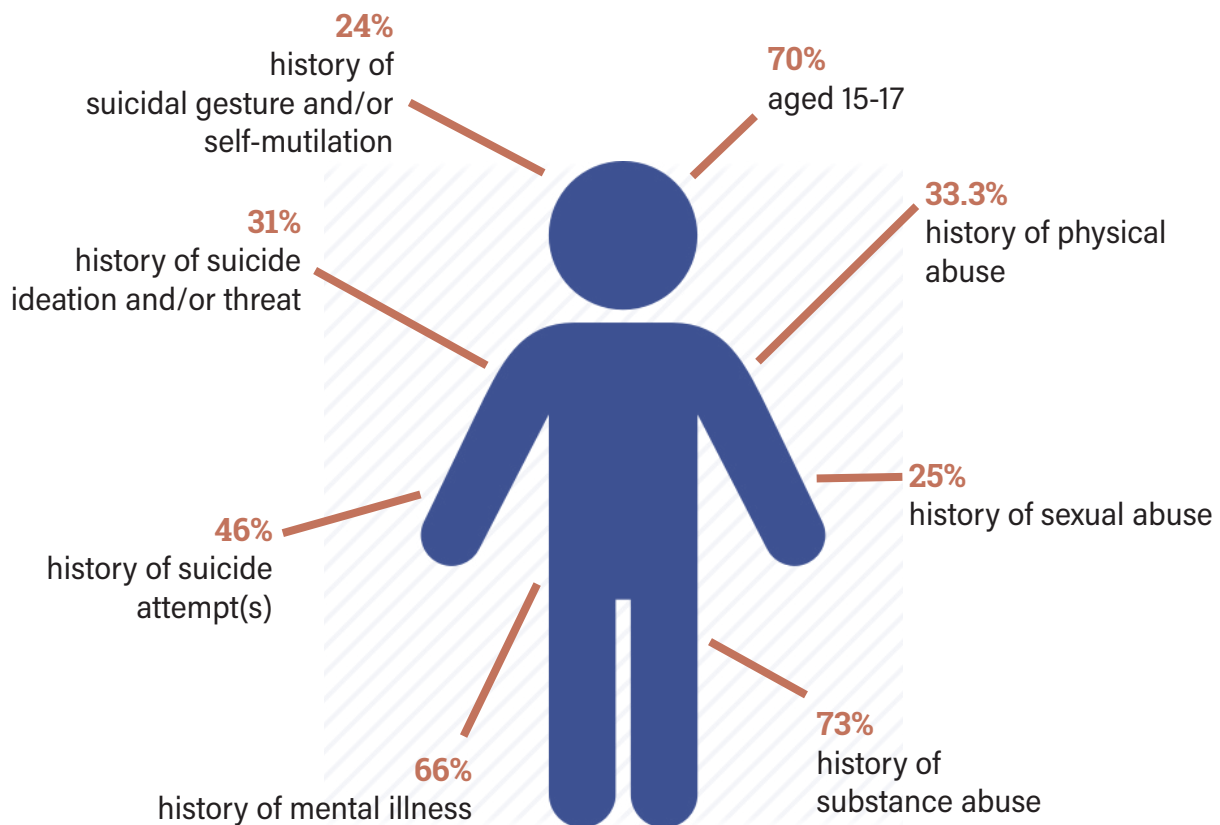
Sercombe and Paus (2009) took a similar stance on the question as to whether development is a result of nature (biological) or nurture (environment). They claim the debate is no longer necessary as the answer is both. Their work consisted of reviewing advances in cognitive neuroscience. They believe key developmental periods for brain development occur during three phases: 1) the first two years of life, 2) just before puberty, 3) and around age 16 years. The researchers connected these neurological critical periods with the influence of the environment when they stated, "If the environment is poor, cruel, or chaotic during

²Title 10 O.S. §601.5 - The Office of Juvenile System Oversight shall have the responsibility of investigating and reporting misfeasance and malfeasance within the children and youth service system, inquiring into area of concern, investigating complaints filed with the Office of Juvenile System Oversight, and performing issue-specific systemic monitoring as directed by the Commission on Children and Youth of the children and youth service system to ascertain compliance with established responsibilities.



these periods, that may determine many of the circuits that are laid down, if not the way they are laid down (p.30).” Despite some debate as to whether gray matter decreases or its signal is overshadowed by an increase in white matter³ in the brain, the authors reiterate adolescence is a developmental time period in which white matter increases significantly. This process is called myelination. As stated by Steinburg (2009), this process is key in the development of executive functioning⁴ beginning in adolescence and continuing into early adulthood. Although some may view this as an attempt by psychologists to excuse adolescent criminogenic behavior, Steinberg and Scott (2003) previously cautioned against this in favor of a mitigating factor perspective. This theory is a main justification for a juvenile justice perspective over inclusion within the adult criminal justice system.

Behavioral research has also played a key role in understanding the risk factors youth face as well as suicidal ideation and behavior. Hayes (2009) conducted research considered to be a classic study within juvenile justice. Seventy-nine suicide deaths within secure placements (i.e., secure facilities, detention centers, residential treatment centers, reception/diagnostic centers) were examined. Of these, 37 percent occurred within juvenile detention centers. Some key findings of this study were:



³The definition of “white matter” according to Merriam-Webster Dictionary is “neural tissue especially of the brain and spinal cord that consists largely of myelinated nerve fibers bundled into tracts, has a whitish color, and typically underlies the cortical gray matter.”

⁴The definition of “executive function” according to Merriam-Webster Dictionary is “a group of complex mental processes and cognitive abilities (such as working memory, impulse inhibition, and reasoning) that control the skills (such as organizing tasks, remembering details, managing time, and solving problems) required for goal-directed behavior.”



An additional important finding of this research was that those in detention were less likely to have their suicidal history known to staff members. Bhatta et al. (2014) examined suicidal behavior of youth in detention. When asked if they had ever thought about suicide or attempted suicide, ideation was reported by 19 percent and 11.9 percent reported an attempt. Data was also collected on adverse experiences. Sexual abuse emerged as the strongest predictor of ideation of attempts. Independently, homelessness and running away from home were significant variables with suicide attempts. These studies are examples of the extensive research addressing the histories and risks youth bring with them when placed in secure detentions or jails. Taking into consideration the trauma histories of youth who are detained in secure facilities, it is preferable such youth are placed in facilities in which staff members are specially trained and skilled in meeting the needs of juveniles and providing developmentally appropriate care.

One argument for housing some violent offenders within adult facilities is that their placement among delinquent youth would subject lower level offenders to the contagion effect. Oklahoma is not the only state with a youthful offender law or with a mechanism to exclude some youth from the juvenile system. Research by Bechtold and Cauffman (2014) examined youth in California who were tried as an adult, but housed with juvenile court youth within the same facility. While at the facility, results found juvenile court youth committed more nonviolent incidents with no differences found when control variables were addressed statistically. Juvenile court youth also had higher incidents of violent offenses at the facility even when control variables were included in the analysis. The finding that adult court youth entered the facility with more violent offenses, but did not exhibit the most nonviolent or violent behaviors within the facility is important to consider. The researchers also noted this finding was not a result of adult court youth being removed from the unit. Lastly, this study stated Oklahoma (along with six other states) should reconsider the practice of automatically housing some youth in adult facilities in favor of placement within juvenile facilities.

Task Force Area for Review: *Placement of Youth in the OCD*

According to OCD Policy 4210.03 dated September 13, 2017, juveniles are defined as, "Persons under the age of eighteen (18) who are to be considered adults for certain offenses committed as established in 10A O.S. 2-5-101." This statute was repealed in 2018 by Senate Bill 224. This statute was replaced by youthful offender law changes to offenses in which a youth could be considered an adult. The OCD has not updated their policy to reflect these changes.

Oklahoma has three potential outcomes for an adjudicated youth which could result in an out of home placement: 1) adjudicated Delinquent and placed in the custody of the Office of Juvenile Affairs (OJA), 2) adjudicated Youthful Offender and placed in the custody of the OJA, 3) adjudicated Youthful Offender and placed in the custody of the Oklahoma Department of Corrections. Only one offense by Oklahoma law completely removes a youth aged 15-17 from the juvenile system. As stated in Title 10A O.S. § 2-5-205 (B),

"Any person fifteen (15), sixteen (16) or seventeen (17) years of age who is charged with murder in the first degree at that time shall be held accountable for his or her act as if the person was an adult and shall not be subject to the provisions of the Youthful Offender Act or the provisions of the Juvenile Code for certification as a juvenile."



Youth aged 13 or 14 who are alleged to have committed murder in the first degree would be considered an adult only if they were subject to the provisions of subsection H of the above law. Only murder in the first degree alleged to be committed by youth aged 15 or older or 13-14 who met the criteria by state law would be exempt from the juvenile system. All other offenses fall under the delinquency or youthful offender law; however, a judge could sentence a youthful offender as an adult under some circumstances by statute. As delinquents and youthful offenders go through the adjudication process, they may be held in either a juvenile or adult detention/jail. Once adjudicated and placed in custody, they are typically held in either a juvenile or adult detention/jail while awaiting placement.

A youth is only excluded from the juvenile system and placed within the purview of the adult legal system as outlined in two state statutes: Title 10A O.S. §2-5-205 (B) and Title 10A O.S. § 2-5-204 (H), mentioned above. Youth not charged with murder in the first degree per these statutes would be subject to the Delinquent and youthful offender laws. It is possible for a youth charged with murder in the first degree and facing conviction within the adult system to have the charges amended at prosecutor discretion, agreement of the parties, or order of the Judge. For this reason, it is important to note not all youth charged as an adult will remain in the adult system. An initial adult charge of murder in the first degree may not be sufficient for the youth to be placed within an adult facility.

Once a youth is convicted as an adult, the youth must be held either in a detention/jail or prison for adults as the youth is no longer eligible for placement within the juvenile system. These youth are legally adults and may not be housed in juvenile facilities. Youth under the age of 18 convicted in the adult system would remain "sight and sound separate" within the adult centers, meaning they cannot be housed in a location in which they could see or hear adult inmates, until they turn 18 years of age.

OCDC Policy 4210.03 (I), (B) states, "The detention of juveniles will be limited to those cases involving protecting the public, preventing self-injury, ensuring appearance at hearings, or transfer." Public safety, risk of not appearing for court, or transfer may be reasons for a judge to order detention. It is unclear why the OCDC policy would cite preventing self-injury as a justification for admission to the facility. The criteria for detainment of a juvenile listed in Title 10A O.S. § 2-3-101 (B), (1-5) does not include self-injury. Further, Title 10A O.S. § 2-3-101 (E), (1) lists the criteria a youth may be held in jail, adult lockup, or other adult detention facility. Self-injury is not included in the criteria.

Task Force Area for Review: Suicide Prevention/Precaution Policies

Suicide is the second leading cause of death among 10-34 year-olds, second only to unintentional injury (CDC, 2019). Further, the most common method of suicide overall is by firearm with suffocation as second. For males age 15-24, suffocation remains second to firearms; yet, for females of the same age, suffocation becomes the most common method (Means of Suicide, n.d.).



The OCDC Policy 4520.01 titled "Suicide Prevention/Suicide Precautions" is the policy for both juvenile and adult inmates. Inmates do not have access to the overall most lethal method of suicide, firearms. This would make suffocation/hanging the available method of concern to staff. This policy does not specifically address the method of death by suicide most likely to occur in a jail. Contraband such as sharp objects, medication, etc. are always areas of concerns within secure facilities. Inmates, whether juvenile or adult, are wearing the most common and deadly means of suicide available to them.

The following areas of concerns were noted relating to OCDC Policy 4520.01 Suicide Prevention/Precaution:

- Youth are not specifically addressed within the suicide prevention policy.
- In the absence of access to a firearm within secure facilities, the next common method of suicide, suffocation, is not addressed other than instructions for security and location of the "cut down tool."
- The acronym "LMHP" is listed as a worker responsible for the care and treatment of suicidal inmates. It may be assumed this term refers to a Licensed Mental Health Professional or Practitioner; however, the term is not clearly defined. Examples in the policy for the LMHP include mental health counselor or social work. These job titles may or may not be licensed in the state of Oklahoma.
- The policy allows for the "LMHP" to utilize a designee. There is no explanation as to what position(s) would qualify as a LMHP designee.
- The policy alternates the identification of staff members who are required to fill out forms associated with documenting risk of suicide. The Policy's Attachment #1, Section I, includes the wording "Detention Staff/Medical or Mental Health Staff Action" with space to check either Level I or Level II suicide precautions; yet, the policy does not allow detention staff to make this specific classification. Section II of the same form allows the Charge Nurse to change the level of precautions. Section III requires the signature of the Psychiatric Treatment Team Leader.
- Level 1 Suicide Precautions require that the inmate is to be "observed continuously on a 24 hour basis." The policy does not state if this observation shall be in person and/or if observation via video monitoring or other means is permissible.
- For release of an inmate off of suicide precautions, the policy first states only the "LMHP or designated Medical Authority is authorized to make the decision to release the inmate from Suicide Precautions." Under documentation requirements, the policy then states, "Only a physician may release an individual from Suicide Precaution Level 1 status and only after a face to face evaluation has been conducted." A physician would be a higher designation than was initially listed within the policy as an example of the LMHP.

The following areas of concern were noted relating to policy 4519.02 Management and Control of Suicide Prevention Gowns

- The policy states an inmate "shall" be placed in a suicide gown when on Level II Suicide Precautions. Policy 4520.01 gave this discretion to the LMHP. The policy did not address Level I, which by OCDC policy, is a higher level of supervision than II.



- The policy does not address undergarments while the suicide gown is in use.
- The policy does not address what actions are prohibited or allowed should a youth refuse to wear the suicide gown.

Task Force Area for Review: *Training and Supervision*

Title 10A O.S. §2-3-101(E)(g)(3) requires a juvenile in an adult facility must be separated from adult inmates by sight and sound as well have, “separate juvenile and adult staff, specifically direct care staff such as recreation, education and counseling.” It is unknown if separate juvenile and adult staff members are employed at the OCDC. Nor is it known if staff members who work with juveniles receive any specialized training to aid in their interaction with them.

Task Force Area for Review: *Facilities*

In preparation of this report, the Task Force toured the OCDC on July 11, 2019. On July 17, 2019, the Task Force Chair, Ellen Harwell, toured the OCJDC and the Task Force members toured on July 25, 2019. According to the American Correctional Association website, both facilities are currently accredited. Within the OCJDC, youthful offenders are prohibited from being housed with delinquents. An administrative order issued by Judge Prince dated June 6, 2019 stated, “During the period while any person subject to the Youthful Offender Act is detained at the Oklahoma County Juvenile Detention Center he/she shall be detained in an area separated from the juvenile delinquent population.” This order is specific to the OCJDC.

The State of Oklahoma has 17 juvenile detention facilities. Per the OJA, which certifies juvenile detention facilities, the separation of youthful offenders and delinquents is not a standard for certification. Title 10A O.S. §2-5-209(B)(7) states, “It is the intent of the Oklahoma Legislature that youthful offenders be held insofar as is practical separate from the juvenile delinquent population.” The OJA confirmed the agency does not separate delinquents and youthful offenders within facilities owned and operated by the OJA or contract facilities (i.e., detention centers, group homes) nor is this a requirement of institutional licensing.

Task Force Area for Review: *The Juvenile Justice Act of 2018 and Prison Rape Elimination Act*

Section 205 of the Juvenile Justice Act of 20018 addressed state plans. Subsection (11) (B), (i), stated,

“not later than 3 years after the date of enactment of the Juvenile Justice Reform Act of 2018, unless a court finds, after a hearing and in writing, that it is in the interest of justice, juveniles awaiting trial or other legal process who are treated as adults for the purpose of prosecution in criminal court and housed in a secure facility – (I) shall not have sight or sound contact with adult inmates; and (II) except as provided in paragraph (13), may not be held in any adult jail or lockup for adults.”



The State of Oklahoma must comply with these federal requirements. As stated on congress.gov, this Act became law on December 21, 2018 when the president signed it. If the State were to continue with the current practice of placing some youth at the OCDC for up to three days before being considered for transfer to the OCJDC, the State would be out of compliance given the language requiring a hearing for placement in an adult jail/facility. As stated in Section 205 (B) (ii),

"in determining under clause (i) whether it is in the interest of justice to permit a juvenile to be held in any jail or lockup for adults, or have sight or sound contact with adult inmates, a court shall consider—

- (I) the age of the juvenile;**
- (II) the physical and mental maturity of the juvenile;**
- (III) the present mental state of the juvenile, including whether the juvenile presents an imminent risk of harm to the juvenile;**
- (IV) the nature and circumstances of the alleged offense;**
- (V) the juvenile's history of prior delinquent acts;**
- (VI) the relative ability of the available adult and juvenile detention facilities to not only meet the specific needs of the juvenile but also to protect the safety of the public as well as other detained youth; and**
- (VII) any other relevant factor;"**

The Act goes on to state that a hearing must be held every 30 days or 45 days for rural counties. The language in this section also requires that the court determine if the juvenile should continue to have sight and sound contact with adults. Previously the section of the Act used the word "or" for this process as to whether a juvenile was to be held in an adult facility or have sight and sound contact with adults. If the State determined after a hearing and through a court order a youth was to be placed in an adult facility/jail, the youth could not be ordered to have sight and sound contact with adult inmates. Pairing the ability of a judge to order such a placement with the requirements of the Prison Rape Elimination Act (PREA), youth could be court ordered to an adult facility, but would not be permitted to have sight and sound contact with adult inmates. As stated in PREA § 115.14 youthful inmates,

"(a) A youthful inmate shall not be placed in a housing unit in which the youthful inmate will have sight, sound, or physical contact with any adult inmate through use of a shared dayroom or other common space, shower area, or sleeping quarters.

(b) In areas outside of housing units, agencies shall either:

- (1) maintain sight and sound separation between youthful inmates and adult inmates, or**
- (2) provide direct staff supervision when youthful inmates and adult inmates have sight, sound, or physical contact.**

(c) Agencies shall make best efforts to avoid placing youthful inmates in isolation to comply with this provision. Absent exigent circumstances, agencies shall not deny youthful inmates daily large-muscle exercise and any legally required special education services to comply with this provision. Youthful inmates shall also have access to other programs and work opportunities to the extent possible."



Areas of Concern: Oklahoma County Detention Center (OCDC) and Oklahoma County Juvenile Detention Center (OCJDC)

After review and discussion, the Task Force voted on the following areas of concern and the subsequent recommendations. The concerns and recommendations take into account the current practices of the both facilities as well as existing and forthcoming federal requirements regarding the placement of youth in adult facilities.

- 1) Youth in the OCDC are not permitted to attend classes once they turn 18 years of age. Upon turning 18, they are removed from sight and sound separation and placed with the adult population. By contrast, a resident at the OCJDC continues to receive educational services after they turn 18.
- 2) When a youth in the OCDC is the only juvenile, placement in the OCDC is equivalent to solitary confinement.
- 3) OCDC and OCDC staff reported if a youth refused to wear the suicide gown, staff members would engage in a use of force to remove the youth's clothing. This practice is a concerning considering the likelihood of a juvenile's past trauma, including a history of sexual abuse and/or rape.
- 4) OCDC has inconsistencies in its suicide prevention and precaution policies.
- 5) OCDC staff does not provide training specific to working with juveniles.
- 6) OCDC does not provide a clear and obvious complaint system for juvenile concerns.
- 7) Youth placed at the OCDC are required to pay for phone calls and visitations through video. face-to-face visitation is not permitted.
- 8) At the OCJDC, delinquent youth are separated from youthful offenders. This practice can be burdensome and could require the opening of additional pods to accommodate one or very few youth. Once youth are adjudicated as youthful offenders and placed into custody of the Office of Juvenile Affairs (OJA), there is not a separate youthful offender facility. Youthful offenders and delinquents are placed together at the two Oklahoma medium secure juvenile facilities, OJA-contracted group homes, and other juvenile detention centers across Oklahoma. The separation of youthful offenders and delinquents within juvenile detention is not a requirement by law or OJA. Title 10A O.S §2-5-209(B) (7) states, "It is the intent of the Oklahoma Legislature that youthful offenders be held insofar as is practical separate from the juvenile delinquent population."



Recommendations for Oklahoma Statutes

- 1) Create statute identifying juvenile detentions as the default placement for all youth. In order to comply with the Juvenile Justice Reform Act of 2018, this process shall include a hearing and court order for juveniles ages 15 – 17 alleged to have committed the offense of murder in the first degree. Those juveniles that are 13 or 14 years old and alleged to have committed murder in the first degree will be held in juvenile detention. Even if subject to the provisions under Title 10A O.S. §2-5-204 (H), a youth aged 14 years old or under shall not be placed in any adult facility unless convicted as an adult.
- 2) Create statutory authority for OCCY to administer a grievance process for youth, pre and post adjudication/conviction, being held in adult detention centers. This process would be similar to the process afford to youth being detained in juvenile detention facilities. Grievances should be directed to the OCCY Office of Juvenile System Oversight (OJSO) for investigation, resolution, and/or referral to the appropriate agency. The OJSO has statutory authority to investigate complaints of misfeasance and malfeasance. The OJSO would notify the OJA when a complaint is received if it was known or discovered the youth was in the custody of OJA and/or the Oklahoma Department of Human Services.

Recommendations for OCDC Policy and Practice

- 1) Develop policy/protocol to meet the needs of a youth who may be the sole juvenile resident in order minimize the impact of isolation.
- 2) Revise suicide prevention policies to address the unique needs of juveniles (i.e., risk factors, trauma focused interventions, de-escalation, death daring behaviors) including:
 - a. clearly define levels of suicide precautions;
 - b. identify who is responsible for the placement and removal of suicide precautions;
 - c. improve documentation by creating forms consistent with policy including adequate space for staff members to provide greater detail of the juvenile's initial need for placement on precautions and while being monitored; and
 - d. revise policies to state when and how the suicide gown will be utilized and who can order its use. Prohibit the forcible removal of clothing in order to place a youth in the suicide gown.
- 3) Create policy requiring specialized training for staff who work with juveniles.
- 4) Institute a no-cost mechanism for youth to contact persons such as parents, children, guardians, lawyers, the OJA, and the OKDHS via phone and/or video.



Recommendations for OCJDC Policy and Practice

- 1) Revise the suicide prevention policies so that the forcible removal of clothing in order to place a youth in the suicide gown is prohibited.
- 2) Revise practice/orders preventing the commingling of delinquents and youthful offenders. At this time, youthful offenders and delinquents may be mixed once in the custody of the OJA. If the OJA were to create a separate facility for youthful offenders, it would be unlikely that there would be a need to separate delinquents from youthful offenders at the detention level. Most rural county juvenile detention facilities would find such a mandate difficult due to the configuration of their building structures.

Areas for Future Exploration for the OCDC

- 1) The possibility of providing services and activities that would meet the unique needs of juveniles.
- 2) The possibility of providing educational opportunities for those are 18 years or older.
- 3) The possibility of developing policy and procedure for face-to-face visits.



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