Andrew K. Block, Jr.
Director

COMMONWEALTH OF VIRGINIA

Department of Juvenile Justice

August 5, 2016

The Honorable Thomas Norment, Jr., Co-Chair
Senate Finance Committee

The Honorable Emmett W. Hanger, Jr., Co-Chair
Senate Finance Committee

The Honorable Ryan McDougle, Chair
Senate Finance, Public Safety Subcommittee

The Honorable Chris Jones, Chairman
House Appropriations Committee

The Honorable Scott Lingamfelter, Chair
House Appropriations, Public Safety Subcommittee

The Honorable Thomas Greason, Chair
House Appropriations, General Government and Capital Outlay Subcommittee

Mr. Daniel Timberlake, Director
Department of Planning & Budget

Dear Senator Norment, Senator Hanger, Senator McDougle, Delegate Jones, Delegate Lingamfelter, Delegate Greason, and Mr. Timberlake:

Attached is the Interim Report of the Task Force on Juvenile Correctional Centers issued by the Department of Juvenile Justice as required by the Appropriations Act, Chapter 780 (2016), Item 415, C.

Sincerely,

Andrew K. Block, Jr.
Director

Attachment

2016

Secretary of Public Safety and Homeland Security

JUVENILE CORRECTIONAL CENTER TASK FORCE: INTERIM REPORT

In response to Item 415, Paragraph C of the 2016 Appropriation Act, Chapter 780, 2016 Acts of the General Assembly.

EXECUTIVE SUMMARY

This interim report of the Interagency Task Force on Juvenile Correctional Centers (Task Force) addresses those areas of consideration required by the authorizing language in the 2016 Budget Bill (HB 30) that are most relevant to the design and construction of a new juvenile correctional center (JCC) in Chesapeake, Virginia. HB 1344 (Bonds; certain capital projects) authorized funding for this new facility during the 2016 session of the General Assembly. The Task Force will cover fully all required areas of consideration, including whether to renovate or construct a second JCC, in the final report, which is due by July 1, 2017.

It is also important to note that the Task Force is focusing on just one, albeit important, aspect of the overall juvenile justice transformation that is taking place in Virginia. Specifically, the Task Force, as directed by the General Assembly, is focusing on JCCs - the most restrictive placements in the statewide continuum of alternative placements and evidence-based services that the Department of Juvenile Justice (DJJ) is developing, simultaneous to the work of the Task Force.

In formulating its recommendations for what the Commonwealth's infrastructure of JCCs should look like in the future, the Task Force understands the narrowly focused role that JCCs will play in the transformed juvenile justice system taking shape in Virginia. Extensive research suggests, and the Task Force recognizes, that committing juveniles to a JCC should, in almost all cases, be a last resort, to be pursued only after less restrictive and more community-based interventions have been exhausted. JCCs are just one element of the continuum of interventions DJJ provides for committed juveniles and are the most costly and restrictive placements. For that reason, they merit the kind of analysis and thoughtful deliberation that the Task Force process will provide.

The Task Force also recognizes that based on continuing decreases in the number of juvenile commitments and changes in the Length of Stay Guidelines for Indeterminately Committed Juveniles (LOS Guidelines), the official forecast for juveniles in direct care (state-responsible committed juveniles) predicts that the direct care population will continue to decline in the next several years. Moreover, a decreasing share of the committed population will require placement in a JCC as DJJ expands the range of evidence-based services and community-based placements available for committed juveniles. To finance the development of a statewide continuum of such interventions, the General Assembly, through the same legislation that authorized and established the Task Force, authorized DJJ to reinvest operational savings from the declining JCC population into community-based services.

The work of the Task Force and the development of the continuum of services and placements are linked in that a smaller number of JCC beds will create greater operational savings to invest in the ongoing development of the statewide continuum.

Although this report is focused on the design and construction of the new JCC, it is critical to note that (i) this new construction is *not* the addition of new JCC beds; rather, it involves decreasing the number of beds and improving the care provided for committed youth, and (ii) these "deep-end" services are part of a system response that focuses on community interventions as the preferred option whenever possible, including the provision of diversion, intensive support

services, community supervision, and placement of committed youth in local community-based alternatives.

The Task Force recognizes that, as the JCC population declines, the small number of juveniles still held in JCCs likely will have a complex array of challenges including substantial exposure to trauma, behavioral health issues, educational challenges, and serious offense histories. In order to increase their chances of successful rehabilitation and reduce the likelihood of reoffending upon release, it is imperative that new or renovated facilities are built to (i) maintain safety and security of staff, residents, and the surrounding community and (ii) incorporate design features that are most likely to promote rigorous and sustained treatment and rehabilitation.

The Task Force heard presentations and reviewed research showing that the current JCCs in Virginia are larger than is either desirable (presenters and public commenters recommended that new facilities should be 2 to 10 times smaller than either of the current JCCs) or necessary (more than 40% of the current JCCs' operational capacity is unused). For these reasons, the Task Force believes that new or renovated facilities can and should be significantly smaller than the current JCCs.

The Task Force also recommends that new or renovated JCCs be located as close as possible to the home communities of the juveniles they hold. The Task Force considered research that demonstrates that maintaining and strengthening family ties during commitment are factors associated with safety and educational advancement during and with successful rehabilitation after release from commitment. Family proximity to the facility is the best predictor of such engagement and continued contact.

For the time being, the Task Force understands that juveniles requiring long-term secure placements will continue to be served in the existing JCCs currently located in the metro-Richmond area. However, given the large percentage of juveniles committed to DJJ from the Tidewater (Hampton Roads) area, creation of a JCC in Chesapeake is imperative to the rehabilitation of these juveniles.

Up until the submission of the final report, the Task Force will continue its work planning future facilities, and that work will continue to inform the design objectives for the Chesapeake facility and may influence the interim recommendations made now. At this time, however, the Task Force is submitting this interim report with initial recommendations for design principles for the Chesapeake facility based on the service needs of the population, presentations to the Task Force from both stakeholders and national experts, and research and best practices concerning the rehabilitation of juvenile offenders. The preliminary recommendations are as follows:

Housing Units and Sleeping Rooms

- Small 8 to12 bed living units in separate buildings, which would have no more than two such units in each, built to reinforce and enable a small group treatment approach;
- Securable but minimally institutional sleeping rooms (e.g., no concrete slab beds);
- Flexible and comfortable common, multipurpose space that is on, or accessible from, the living units;
- Private, dedicated treatment and family visitation space;
- Private space for staff meetings (e.g., treatment planning and consultation);

- Outdoor space, sufficient for recreation, adjacent to and accessible from the living units;
- Single rooms for a large proportion of bed capacity with consideration for small dormitories for certain segments of the direct care population (e.g., a transition unit);
- No linear designs in housing units;
- No double-bunking in sleeping rooms; and
- No large, shared sleeping rooms.

Education Space

- Equipped with instructional technology to address academic and career readiness needs of a population ranging in age from 11 to 21 including credit recovery, enrichment needs, and access to distance learning;
- Technology infrastructure and digital space to manage online instructional and career readiness software, curriculum, assessments, performance-based projects, and data collection;
- Able to accommodate project-based learning activities, distance learning labs, and celebratory events (e.g., graduation);
- Delineated areas for diploma-seeking students and post-secondary programs; and
- Able to accommodate career readiness and post-secondary programs.

Facility Characteristics

- As small as possible, given funding limitations, economies of scale, and the need for safety and operational efficiencies;
- Trauma-responsive design and furnishings and architectural features such as:
    - Open interior spaces with views to the outside,
    - Natural lighting, as well as adjustable lighting,
    - Ready access to outdoor spaces from housing and program areas,
    - Light colors, and
    - Sound absorbing materials;
- Open environment with no internal fences, inside a safe and secure perimeter;
- External secure egress areas outside the main campus;
- Sufficient space for staff to take breaks, store personal belongings, and have access to computers;
- Close proximity of housing units to shared spaces (e.g., medical, education, visitation, recreation, food services);
- Open sight lines; and
- Incorporation of elements of a welcoming and stabilizing environment, such as
    - Movable furnishings that permit changing use of space throughout the day and over time while offering control over the environment, and
    - Familiar and variable construction materials that do not present an overt expectation of damaging behavior.

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PREFACE

During the 2016 General Assembly Session, the legislature received, examined, and acted on proposals by Governor Terrance R. McAuliffe to reshape Virginia's juvenile justice system by 1) granting authority to the Department of Juvenile Justice (DJJ) to reinvest operational savings from a declining population in DJJ's juvenile correctional centers (JCCs) and 2) providing bond funding to construct two small, treatment-oriented facilities to replace Beaumont and Bon Air JCCs. Both the Senate Finance Committee and the House Appropriations Committee devoted considerable time to examining these proposals, and in the General Assembly's final approved budget granted DJJ the authority to reinvest operational savings into developing an array of community-based treatment and rehabilitative programs. Additionally, the General Assembly included funding in the bond package for the planning and construction of a 64-bed JCC in Chesapeake[1] and planning for developing an alternative plan to meet the additional JCC needs in the Commonwealth.

In addition, the General Assembly required that the Secretary of Public Safety and Homeland Security (SPSHS) convene an Interagency Task Force on JCCs (Task Force) to examine DJJ's capital needs and to issue both an interim and final report. Upon submission of the interim report, DJJ will receive planning money to start the design process for the facility in Chesapeake.

TASK FORCE COMPOSITION AND ACCOMPLISHMENTS

The Task Force first met on May 12, 2016. The Task Force consists of the following members: SPSHS Brian Moran, DJJ Director Andy Block, Jeffrey Aaron and Janet Lung from the Department of Behavioral Health and Developmental Services, Kimberly Lipp from the Department of Corrections, and Scott Reiner from the Office of Children's Services. Deputy Secretary of Public Safety and Homeland Security Victoria Cochran serves as staff to the Task Force.

At the Task Force's first meeting, DJJ Director Block presented on the history of the juvenile justice transformation in Virginia, and SPSHS Moran reviewed the budgetary and Task Force expectations. The Task Force members commented that Virginia is in a unique position to make real change in the outcomes for juveniles in the juvenile justice system using the best of evidence-informed data and outcome-driven approaches to improve the way the Commonwealth works with juveniles, their families, and communities.

As required by the authorizing language, at the second meeting, the Task Force solicited comments from a range of juvenile justice and public safety stakeholders including the judiciary, attorneys for the Commonwealth, local government, law enforcement, private providers, and other stakeholders (specifically, the Virginia Council of Juvenile Detention Administrators, the RISE for Youth Coalition, and the NAACP), and members of the public.[2] Generally, the

[1] The proposal includes a 48-bed locally-operated juvenile detention center.

[2] The following individuals provided solicited input: Kelly Harris-Braxton representing Virginia's First Cities, James Taylor representing the Virginia Association of Local Human Services Officials, Timothy Smith representing the Virginia Council of Juvenile Detention Administrators, Laura Goren and Kate Duvall representing the RISE Coalition, Nancy Parr representing the Virginia Commonwealth's Attorneys Association and presenting as the

commenters stated that the current JCC infrastructure does not support best practices for rehabilitating committed juveniles and offered opinions as to how new facilities should be constructed. Most stakeholders and those offering comments were in support of DJJ's direction and the mission of the Task Force. The commenters disagreed on what size the new facilities should be (e.g., the RISE Coalition stated that facilities should house no more than 25 residents, and the Commonwealth's Attorney for the City of Chesapeake stated that the DJJ plan for less than a 200-person capacity does not provide for enough beds). Additionally, most commenters stated that juveniles who require secure confinement have better outcomes when they are close to their home communities to promote family engagement and enhanced community supports.[3]

At its third meeting, the Task Force heard presentations from DJJ Deputy Director for Residential Services Jack Ledden regarding the profiles of committed juveniles and DJJ's new approach to treatment and rehabilitation in the JCCs, and national experts in the field of juvenile justice who focused on JCC design and construction. Below is a brief summary of the presentations and recommendations:

- Jack Ledden, DJJ's Deputy Director for Residential Services, presented on the profiles of juveniles committed to DJJ, the new rehabilitation-oriented programming being adopted in the JCCs, challenges with the existing JCCs, and recommended characteristics of future JCCs. These portions of Mr. Ledden's presentation are summarized in section III, Level and Type of Services, of this report. In reviewing what is recommended for structure and design, Mr. Ledden stated it is important to have (i) designated treatment space, (ii) multipurpose space for group activities, (iii) conference rooms for case and treatment planning, (iv) family visitation and therapy areas that promote engagement, and (v) locations close to juveniles' home communities.
- Krista Larson, M.S.W., Director of the Center on Youth Justice with the Vera Institute for Justice, presented that family engagement is a critical element of effective juvenile justice programming. She reviewed research that has shown that visitation (i) improves residents' facility adjustment and symptoms of depression, (ii) has been linked to fewer incidents or rule violations in the facilities and reduced recidivism. In Ohio, the rate of visitation was generally correlated with distance to facilities, with the geographically closer families visiting more frequently. She reviewed a survey of Virginia's committed juveniles which found that 40% had never had a visit during their commitment and 40% receive two or fewer visits a month. In reviewing what works in structure and design, Ms. Larson stated that it is important to have (i) a warm, inviting environment, (ii) the ability for families to have privacy, and (iii) space for activities for small children and to encourage family-resident interaction.
- Monique Marrow, Ph.D., with the Center for Trauma Recovery and Juvenile Justice at the University of Connecticut and the Center for Trauma and Children at the University of Kentucky presented that creating trauma-responsive programs to serve justice-involved juveniles is essential for successful outcomes. She noted that juvenile justice

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Commonwealth's Attorney for the City of Chesapeake, Col. Kelvin Wright and Dr. Wanda Barnard-Baily representing the City of Chesapeake, and Roy Bryant and Lynetta Thompson representing the NAACP. Public comment was also received.

[3] However, the NAACP did not support any new construction and the focus should be on investing in diversion programs and not "prisons."

research has found that 93% of juvenile offenders reported at least one traumatic experience, with six being the average number of different traumas reported. Traumatized juveniles are often hyper-aroused and have difficulty managing their environments. In reviewing aspects of structure and design that are the most effective with juveniles who have experienced trauma, Dr. Marrow recommended the following: (i) increased connection to nature and natural light (with reduced reliance on overhead fluorescent lighting), (ii) reduction of noise, glare, and air quality environmental stressors (e.g., high ceilings that contribute to a loud sound level), (iii) safe sleeping areas, with a preference for private rooms,[4] (iv) sufficient storage, (v) safe rooms and spaces residents may use as a calming place, (vi) space for staff storage and breaks away from residents to refocus when needed, (vii) a security alert system that does not involve an overhead paging system, (viii) adequate space for programming with lower occupancy density, (ix) room for modesty in showers and restrooms, (x) the ability for families to have privacy during visitation, (xi) the ability for medical information to be communicated confidentially, and (xii) group rooms that are not on the living unit.

- Edward J. Loughran, Executive Director of the Council of Juvenile Correctional Administrators, presented on the ideal configurations of juvenile correctional facility units which, he said, should be deigned to promote safety, treatment, and rehabilitation. In reviewing what works in structure and design, Mr. Loughran recommended the following: (i) small facilities that are not institutional in character, (ii) small (8-12 residents) housing units with a normative environment, (iii) single occupancy rooms, (iv) natural light and views, (v) open day room with contiguous sleeping rooms, (vi) single-user showers and bathrooms with one per eight residents, (vii) space for on-unit activities, (viii) access to outside space for recreation and group activities, (ix) central dining or family-style dining, (x) the ability for families to have privacy during visitation, and (xi) a separate education building. Mr. Loughran reviewed alternative unit configurations that could be adopted (double-bunked rooms, dormitory style, toilets in sleeping rooms or "wet cells," and bi-level units). He opined that the alternative unit configurations are not the preferred practices for achieving the best outcomes in juvenile justice.

The Task Force also solicited, and members were provided with copies of written public comments. Appendix A summarizes all written public comments received.

FUTURE AND ONGOING TASK FORCE WORK

Stakeholder Input

[4] Those who have experienced trauma feel the greatest sense of vulnerability when asleep. Sleep time needs to be a time when youth feel safe enough to sleep. Many of the youth in programs are on psychotropic medication, and this medication may cause a very deep level of sleep. The youth already know their capacity to wake and respond is limited which is why some youth refuse medication: they have no ability to defend themselves. Dorm rooms or semi-private double-bunking rooms compromise the ability for an individual to feel safe. The rooms are not private. Dr. Marrow's recommendation includes having spaces flexible enough to allow for a good number of private rooms for individuals.

During the public comment period, various stakeholders have urged the Task Force to be as open and transparent as possible and to provide alternative opportunities, beyond meetings held during traditional business hours, to solicit input. The Task Force has taken several steps in an effort to be responsive to these concerns. First, DJJ established a page on its website devoted entirely to the work of the Task Force. It contains minutes and presentations of previous meetings, dates and times of future meetings, a copy of this report, and a summary of public comment received to date. In addition, the Task Force continues to receive written public comment through DJJ.

Second, DJJ will hold town hall meetings outside of normal business hours to solicit input from the public. The first public, town hall will be held in the Central Virginia area in August. The input from the town hall will be recorded, and minutes will be posted on the DJJ website as well as shared with Task Force members. Other town halls will be scheduled at future dates in other areas of the state.

In addition to these efforts, DJJ and the Task Force will provide opportunities to hear from direct care staff currently working with committed juveniles for feedback on the best design options based on their real-world experience and expertise. It will also provide opportunities to hear from currently and previously committed juveniles and their families.

Future Work

The next meeting of the Task Force is scheduled for August 23, 2016 at 9:00 a.m. The agenda for that meeting will include a presentation from school architects discussing optimizing educational design and likely will include a presentation from the Annie E. Casey Foundation (AECF) about (i) its assessment of Virginia's juvenile justice system, (ii) the reform progress to date, and (iii) a discussion of how Virginia is incorporating components of the so-called "Missouri Model" of juvenile justice into DJJ's programs and practices as well as a presentation on DJJ's plans for developing a statewide continuum of services and alternative placements.

Additional meetings of the Task Force will take place through the fall of 2016 and will include presentations on such topics as utilization of current DJJ facilities and opportunities for renovation, optimizing opportunities for partnerships with locally-operated secure juvenile detention centers (JDCs), and population forecasting and modeling.

Even after submitting these interim recommendations, the Task Force will continue to assess different approaches to construction to optimize both outcomes and cost savings.

REPORT OVERVIEW

This report is the interim report of the Task Force as required by the General Assembly. It is the product of research, presentations to the Task Force, and substantial oral and written stakeholder input.

As the interim report, it focuses primarily on those required areas of inquiry critical to begin the planning and design of the JCC in Chesapeake. The Task Force will address the additional areas of inquiry as required by the authorizing language in the final report.

To promote optimal rehabilitative and public safety outcomes, the report presents the following important structure and design objectives that the new facility should meet:

1) Proximity to the home communities of the juveniles secured in the new facility.
2) Configuration and design of building(s), unit size, sleeping rooms, and treatment and educational space that
    - Optimizes DJJ's new approach to rigorous rehabilitation,
    - Supports DJJ's efforts to work with juveniles with significant histories of trauma exposure and behavioral and mental health challenges, and
    - Promotes safety and security for residents, staff, and the neighboring community.
3) A balance between cost efficiency and best practices for optimizing outcomes.

AUTHORITY FOR THE STUDY

Chapter 780, 2016 Appropriations Act - Item 415(C) of the Virginia General Assembly provides that:

> *1. There is hereby established a task force on juvenile correctional centers comprised of the Secretary of Public Safety and Homeland Security, and the Directors of the Departments of Juvenile Justice, Corrections, and Behavioral Health and Developmental Services, and the Office of Children's Services, or their designees. The Secretary of Public Safety and Homeland Security shall chair the task force. The task force shall present an interim report by November 1, 2016, and a final report by July 15, 2017, to the Governor, the Director of the Department of Planning and Budget, the Chairman of the Virginia Commission on Youth, and the Chairmen of the Senate Finance and House Appropriations Committees.*
>
> *2.a. The task force shall consider the future capital and operational requirements for Virginia's juvenile correctional centers, including the construction of a new facility in the City of Chesapeake, for which planning was authorized by the 2016 General Assembly, and also including (i) the projected population of state-responsible juvenile offenders, including an assessment of the impact of the Department of Juvenile Justice's length of stay guidelines, (ii) the number of juveniles expected to be held in each facility, (iii) the level and type of mental health, medical, academic and vocational education, and other services to be provided, (iv) the design and size of spaces needed to accommodate the necessary services within state facilities, (v) the accommodation of the treatment needs of state-responsible juvenile offenders with diagnoses of serious mental or behavioral health issues, (vi) the appropriateness of alternative housing models, including cells and rooms (including both single and double-bunking), dormitories, cottages, and other housing configurations, (vii) the number and geographical location of facilities, and (viii) the potential for contracting for the use of space in existing local and regional secure detention facilities, group homes, and private residential facilities.*
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> *b. The task force shall identify existing juvenile correctional centers, including facilities which are not currently operational, and other property currently owned by state agencies, and consider the extent to which the recommendations developed pursuant to Paragraph C.2.a. of this item may be accommodated within such properties, along with the costs of construction or renovation of existing facilities to accommodate these recommendations. The task force shall conduct a cost-benefit analysis to compare the potential revenues realized from the sale of existing real property owned by state agencies, with the projected replacement costs which would be incurred to provide replacement facilities, should existing properties be sold. This analysis should include an assessment of the impact of locational factors on expected program*

outcomes and on the objective of maintaining the juvenile offenders' relationships with their families and communities.

c. In evaluating these alternatives, the task force shall give consideration to and report on the estimated costs of construction, operation and maintenance of facilities, and the potential impact of these alternatives to the outcomes for state-responsible juvenile offenders, including recidivism. The task force shall also give consideration to the projected requirements for state funding for local and regional secure detention facilities, and alternatives to detention, including but not limited to, the Virginia Juvenile Community Crime Control Act.

FUTURE CAPITAL AND OPERATIONAL REQUIREMENTS FOR VIRGINIA'S JUVENILE CORRECTIONAL CENTERS

The 2016 General Assembly authorized planning for the construction of a new facility in the City of Chesapeake. The information below fulfills the required reporting requirements outlined in Item 415, Paragraph C of the 2016 Appropriation Act, Chapter 780, 2016 Acts of the General Assembly, including the following:

1) The projected population of state-responsible juvenile offenders, including an assessment of the impact of the DJJ's length of stay (LOS) guidelines;
2) The number of juveniles expected to be held in each facility;
3) The level and type of mental health, medical, academic, and vocational (referred herein as career readiness) education, and other services to be provided;
4) The design and size of spaces needed to accommodate the necessary services within state facilities;
5) The accommodation of the treatment needs of state-responsible juvenile offenders with diagnoses of serious mental or behavioral health issues;
6) The appropriateness of alternative housing models, including cells and rooms (including both single and double-bunking), dormitories, cottages, and other housing configurations;
7) The number and geographical location of facilities; and
8) The potential for contracting for the use of space in existing local and regional secure detention facilities, group homes, and private residential facilities.

I. PROJECTED POPULATION

In order to fulfill the requirements of Item 376 of Chapter 665 of the 2015 Acts of Assembly, SPSHS adopts the Commonwealth's official forecasts annually for correctional populations, including DJJ's direct care population. The forecasts, approved in October 2015, were based on the statistical and trend information known at the time and were adopted through a consensus approach after considering relevant policy implications. SPSHS has reconvened the forecasting committees which will update the approved forecast no later than October 15, 2016.

Juveniles in direct care are committed by a juvenile and domestic relations or circuit court to DJJ. There are three categories of juvenile commitments: indeterminate commitments, determinate commitments, and blended sentences.

- For a juvenile with an indeterminate commitment, DJJ determines how long the juvenile will remain in direct care based on LOS Guidelines. The average actual LOS for an indeterminate commitment was 14.1 months in FY 2015, but that is expected to decrease under the revised guidelines.
- For a juvenile given a determinate commitment to DJJ, the judge sets the commitment period to be served (up to age 21), although the juvenile can be released at the judge's discretion prior to serving the entire term. Nonetheless, determinately committed juveniles remain in DJJ facilities longer, on average, than juveniles with indeterminate

commitments to DJJ. The average actual LOS for a determinate commitment was approximately 28.5 months in FY 2015.

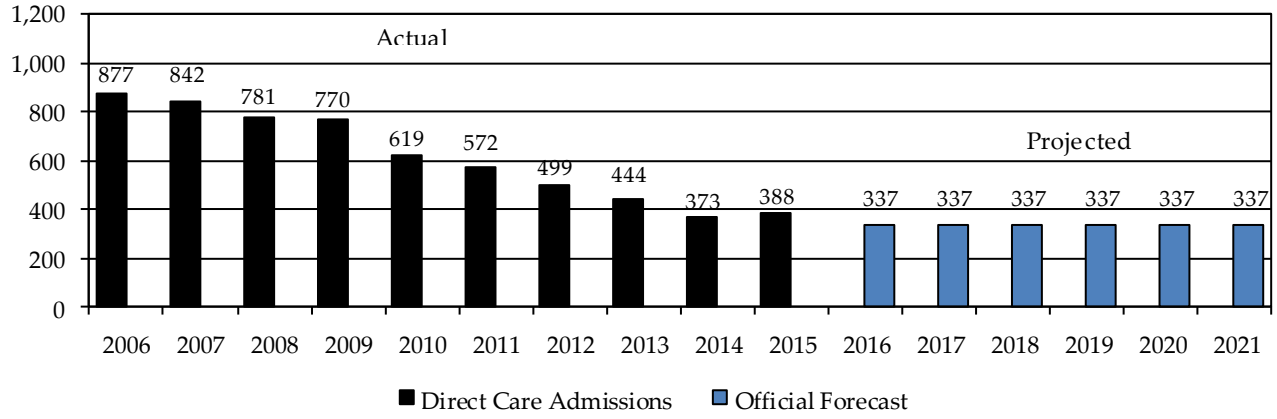
- A juvenile tried and convicted as an adult in circuit court can be given a blended sentence; the juvenile can serve up to age 21 with DJJ before being transferred to the Department of Corrections to serve the remainder of the term in an adult facility. The average actual LOS for the DJJ portion of a blended sentence was approximately 33.6 months in FY 2015.

As a result of research on best practices, national norms, empirical findings, and Virginia data, in 2015 the Board of Juvenile Justice approved changes to the LOS Guidelines. DJJ expects that the new LOS Guidelines, which took effect on October 15, 2015, will result in shorter LOSs for most juveniles indeterminately committed to DJJ. Whereas the previous LOS guidelines used committing offenses, prior offenses, and length of prior delinquency or criminal offense record, the new guidelines are based on the most serious committing offense and the juvenile's risk level, as determined by the Youth Assessment and Screening Instrument (YASI), which includes information on every contact a juvenile has with the juvenile justice system.

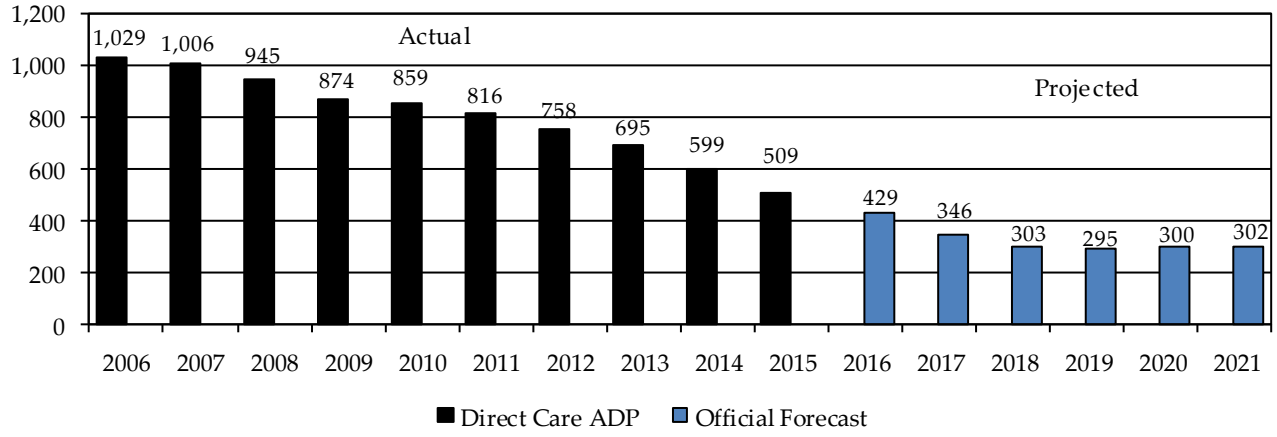
The highest range of the new LOS guidelines is 9 to 15 months, compared to a high-end range of 24 to 36 months under the previous LOS Guidelines. Each case is individualized; however, the actual duration of commitment is dependent on the progress in treatment, behavior, and facility adjustment. DJJ believes the new LOS Guidelines are consistent with research and best practices and has in place an assessment plan to evaluate and assess the impact of and outcome from the changes.

The approved forecast accounted for these changes in the LOS Guidelines to the extent that was possible at the time. For instance, the forecast projected the same proportion of indeterminate commitments as in recent years, but with assigned LOS categories based on offense and risk characteristics and the revised LOS Guidelines. DJJ also examined historical data to determine how long juveniles in each LOS category actually served under the previous guidelines and applied that proportion to the juveniles assigned to the new LOS categories; however, actual shifts in the population as a result of the changes may differ from the projection. Throughout the coming year, the offender populations will be monitored closely in order to identify any changes as soon as they occur, and the final task force report will include an updated forecast from the 2016 forecasting process.

The direct care admissions forecast is one of the key inputs into DJJ's forecasting model. The official forecast predicts that the decrease in admissions will not continue indefinitely. For the current forecast, DJJ originally developed and proposed a forecast of 302 admissions in FY 2016. The approved forecast projects a flat rate of 337 admissions, which is calculated from an average of the actual number of admissions in FY 2014 (373) and the number of admissions for FY 2016 according to DJJ's statistical model (302).



The approved forecast also creates a projection, using admissions and LOSs to predict the average daily population (ADP) for the direct care population. The approved forecast projects that the population will continue to decline through FY 2019, when the population is expected to reach 295 juveniles. Beginning in FY 2019, however, the population is expected to level off. This leveling can be attributed to the flat admissions forecast. By FY 2021, the total direct care population is projected to be 302.[56]



FORECAST ACCURACY TO DATE

The actual direct care admissions for FY 2016 followed the trends projected by the forecasts. In FY 2016, there were 321 direct care admissions.[7] The official forecast projected 337 admissions

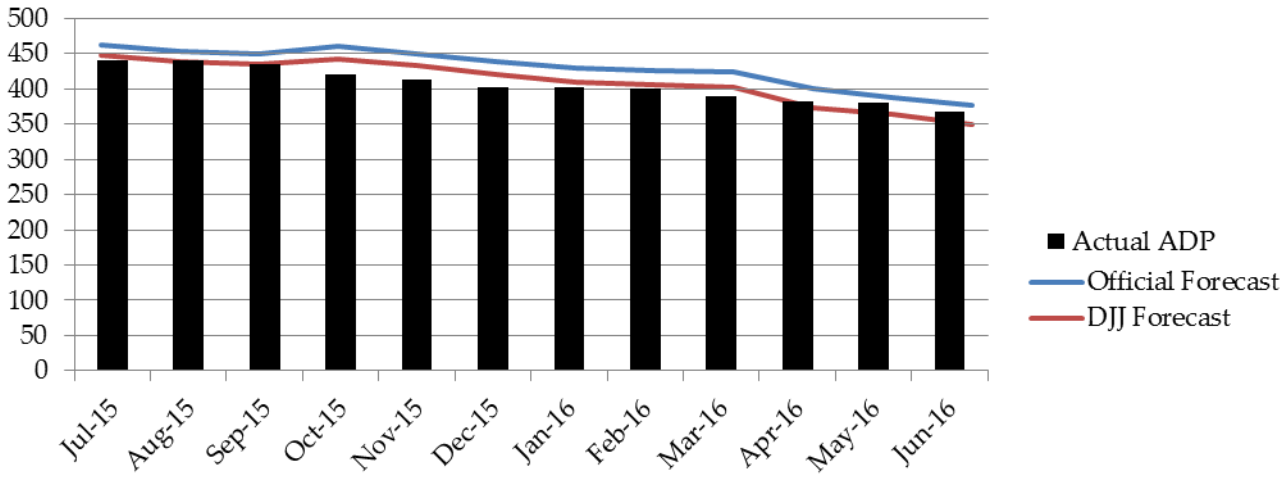
[5] In addition to the official forecast, DJJ created a population forecast using their originally proposed admissions forecast. In this forecast with 35 fewer admissions in FY 2016, approximately 16 fewer juveniles were projected for the ADP in FY 2016 compared to the official forecast.

[6] It is important to note that this number of the overall population of committed youth, but given the increasing availability of alternative placements as described below does not represent the actual number of necessary JCC beds.

[7] The count of admissions may differ from other DJJ reports that exclude canceled, rescinded, and successfully appealed commitments.

for the year, a difference of 16 admissions.[8] Therefore, the actual admissions were slightly lower than expected for FY 2016.

The actual direct care ADP also followed the trends projected by the forecast. For FY 2016, the ADP was 406 juveniles. The approved forecast projected an ADP of 429, a difference of 23 juveniles. Therefore, the actual ADP was slightly lower than expected for FY 2016.[9]



As stated above, the population trends will continue to be monitored to determine the impact of the continued decline in admissions and of the revised LOS Guidelines. Additionally, the forecast, updated in October 2016, and any changes to the projections and the impact that may have on the projected number of necessary JCC beds, will be included in the Task Force's final report.

PRELIMINARY PROJECTED JCC POPULATION

While the official forecast projects the total direct care population, it also is important to consider the number of juveniles who will be in JCCs versus other direct care placement options. Juveniles committed to DJJ are currently housed in JCCs, Community Placement Programs (CPPs), or detention reentry programs. In the future other placement options, as described herein, will be available as part of a continuum of care.

DJJ had years of budget reductions diminishing the placement options available for the direct care population (See Appendix B). In response to research indicating that the least restrictive environment is most effective for successful outcomes with committed juveniles, DJJ plans to

[8] The forecast originally proposed by DJJ projected 302 admissions in FY 2016, a difference of 19 juveniles from the actual number of admissions. Therefore, the number of actual admissions was slightly higher than expected by DJJ's projections for FY 2016.

[9] The forecast based on the admissions originally proposed by DJJ projected an ADP of 413 for FY 2016, a difference of seven juveniles from the actual ADP. Therefore, the actual ADP is slightly lower than expected by DJJ's projections for FY 2016.

expand direct care placement options. While JCCs, CPPs, and detention reentry currently provide secure placement options for juveniles in direct care, additional placement options are planned to provide a comprehensive continuum of care. DJJ plans to expand direct care placement options to include the following:

- **Community Supervision, Plus Services.** The equivalent of parole supervision with services targeted to criminogenic needs (e.g., substance abuse, gang prevention, outpatient mental health)
- **Intensive Non-Residential Programs.** Comprehensive programs that combine supervision with intensive treatment (e.g., multi-systemic treatment, wraparound services, day treatment programs)
- **Non-Secure Residential Programs.** Treatment programs that work in family-like residential settings (e.g. treatment foster care, residential treatment centers) or in staff-secured residential placements (e.g., group homes)
- **Short-Term Secure Treatment.** Placement in a secure residential setting for shorter periods, typically 9 months or less (e.g., CPPs)
- **Long-Term Secure Treatment.** Placement in a secure residential setting for longer periods, typically longer than one year (primarily JCCs, with the option for psychiatric hospital beds as needed)

(See Appendix C for a preliminary list of services that may be provided in DJJ's continuum of care.)

DJJ will make placement decisions on an individualized basis, balancing consideration of:

- Commitment type (determinate, indeterminate, or a blended sentence),
- Risk to public safety (e.g., the risk of reoffending), and
- Need for accountability (e.g., the severity of the offenses for which they are committed).

DJJ is in the process of completing several analyses to estimate the number of juveniles who require secure confinement in JCCs:

1. Subject matter experts on an individual basis.
2. The official direct care population forecast will be modeled using the projected LOS categories once the approved forecast is updated in the fall, with an additional assessment of the changes to the LOS Guidelines to identify the longer-staying population of committed juveniles who are expected to represent the bulk of the JCC population.
3. AECF will analyze proportions of the projected direct care population based on risk level and offense severity in each placement type of the continuum.

In an individual case review analysis, subject matter experts review cases of admissions to determine the best placement decisions within the developing continuum of care. A preliminary case review analysis of admissions over six months shows that approximately one third of admissions may require placement for some or all of the period of commitment in a JCC. (See Appendix D for the preliminary projections of direct care placements in the continuum.) However, additional analysis is required to determine the impact of this assessment on the ADP in the JCCs.

Two forecast analyses will use the official direct care population forecast to model subcategories of admissions based on risk level, offense severity, commitment type, and LOS to project the number of committed juveniles who may require placement in a JCC.

Preliminary data from FY 2016 show that the ADP in direct care, including JCCs, CPPs, and detention reentry, was 406 juveniles. Of these juveniles, 188 per day were from DJJ's Eastern Region.[10] Of all juveniles in direct care, 161 per day had determinate or blended sentence commitments. Of these juveniles, 75 per day were from DJJ's Eastern Region.

Applying these ratios to the projected population for FY18 and beyond, suggests that the direct care ADP from the Eastern region, given the official population forecast, would be roughly 141 juveniles in total and 56 juveniles committed on blended or determinate sentences. The actual direct care ADP in FY16 was roughly 5% below the official forecast, and if the forecast for FY18 and beyond was adjusted downward by the same amount, then the expected ADP from the Eastern region would be 134 juvenile in total and 53 juveniles committed on blended or determinate sentences.

DJJ will continue to assess the impact of initial and step-down placement types and the impact of the updated forecast and changes to LOS in determining the total direct care population and, of those, juveniles requiring placement in a JCC through an ADP analysis. As DJJ and the Task Force continue to track population trends, and when the official forecast is updated, they will update the number of juveniles expected in the overall direct care, JCC, and continuum of care populations.

II. JUVENILES EXPECTED IN EACH FACILITY

DJJ proposed to design and construct a new-model facility in Hampton Roads in partnership with the City of Chesapeake. The proposed dual facility will consist of a state-operated JCC and a locally-operated secure detention facility on 11 acres of property owned by the city. With a total of 112 beds, DJJ would operate a 64-bed JCC, and the City of Chesapeake would operate a 48-bed detention facility.

The 64-bed JCC will serve committed juveniles in need of a long-term secure placement whose home community is in the Tidewater area. Remaining juveniles in a JCC will be housed at Bon Air JCC until further plans are made for future facilities. Details for these plans will be provided in the final report.

III. LEVEL AND TYPE OF SERVICES

Commitments to DJJ are generally a last resort based on public safety considerations and not the needs that committed juveniles may have for treatment or services as alternatives to commitment available in the community. In serving committed juveniles, DJJ needs to be able to identify and respond to those needs. Based on the profiles that DJJ assembles for every committed juvenile, it

[10] DJJ's Eastern Region consists of the following court services units: 1st District (Chesapeake); 2nd District (Virginia Beach); District 2A (Accomack and Northampton); 3rd District (Portsmouth); 4th District (Norfolk); 5th District (Suffolk, Isle of Wight, and Southampton); 7th District (Newport News); and 8th District (Hampton).

is clear that most committed juveniles are in need of specialized treatment, programs, and services due to their complicated backgrounds. For example, in recent years, juveniles admitted to direct care have had the following characteristics[11]:

- Average of 1.3 grade levels behind in school
- Average intelligence quotient (IQ) of 87 (while the IQ of the general population is 100)
- 41% with special education needs
- 89% had experienced at least one of the following risk factors, and 50% experienced three or more:
    - 59% had experienced physical assault/abuse (24% by family)
    - 58% had a parent involved in criminal activity
    - 46% had a parent who had been incarcerated
    - 39% had a parent with substance abuse problems
    - 20% had experienced a parental death
    - 16% had experienced family domestic violence
    - 14% had experienced sexual assault/abuse (7% by family)
    - 13% had demonstrated self-injurious behavior (SIB) or were suicidal
- 61% had a history of psychotropic medication use
- 64% had significant symptoms of a mental health disorder (excluding Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, Substance Abuse Disorder, and Substance Dependence Disorder) (See Appendix E.)

According to the forecast using the current LOS Guidelines, the total direct care population is expected to continue to decline. Additionally, as DJJ continues to expand its capacity of CPPs, detention reentry, and other alternative placements across the state, the number of juveniles requiring placement in a secure JCC setting will decrease further. As a result of these changes, the small number of juveniles remaining in the JCCs will be the most challenging to serve: juveniles who are committed for long periods, juveniles who pose high risks of reoffending, and many with complicated needs for treatment and services. With this population in mind, the mental health, medical, academic, and other services described below will be provided in the Chesapeake facility.

COMMUNITY TREATMENT MODEL (CTM) PROGRAM

In May 2015, the JCCs began implementing the CTM program to promote juvenile rehabilitation while decreasing inappropriate behaviors during commitment. The CTM program incorporates the principles of positive youth development that builds on strengths, engages residents as resources and active participants, and focuses on the development of positive relationships and connections with staff, peers, and family or other natural supports.

The main tenets of the model include a highly structured interactive program with meaningful and therapeutic activities while using consistent staffing and a team approach on each housing unit. The model stresses keeping the unit together (both staff and residents), and therefore keeps residents on the same housing unit throughout their commitment. Juveniles and staff utilize the

[11] Education data represent admissions between FY 2011 and 2015. Trauma, family, and SIB data represent admissions from FY 2014. Mental health and treatment need data represent admissions from FY 2015.

group process including check-in meetings three times a day and circle-ups as needed in order to address concerns or accomplishments of the unit. Other more formal scheduled groups like Mutual Help and Settlement groups also are used to help the residents bring about permanent change. Additionally, through this approach, juveniles and staff foster meaningful relationships, providing residents with mutual support and motivation. Utilizing this approach supports positive youth development and has proven to be successful in reducing incidents in secure facilities and improving outcomes upon return to communities.

Job descriptions and security staff positions were changed from Correctional Model titles and roles (e.g., Major, Sergeant, juvenile correctional office [JCO], and rank) to CTM titles and roles (e.g., Community Manager, Community Coordinator, Resident Specialist I and II) to reflect the change in responsibilities and job duties. Police/military-style uniforms also were modified to reflect a more therapeutic atmosphere.

DJJ developed CTM internally based on best practices and agency-specific needs with an influence from the nationally-renowned model in Missouri. Consequently, staff teams receive intensive training from the Missouri Youth Services Institute (MYSI), the Vera Institute of Justice, and the DJJ Training Academy before starting the CTM program in their housing unit. DJJ is developing capacity to assume responsibility for this training in January of 2017. In the meantime, funding for the outside trainers has been provided, in large part by the AECF. After formal training, each new CTM unit receives on-the-floor coaching from MYSI. The CTM units also undergo a "face lift" or modification in order to better utilize space for group rooms, library, and family visits. As one unit is trained at a time to ensure fidelity to the program guidelines, the transformation is estimated to be completed in a total of 17 housing units by the end of 2016.

The key components of the CTM are as follows:

- Small groups of residents who live, learn, recreate, and habilitate together in a "positive peer culture;"
- Consistent, dedicated, and highly trained Resident Specialists (RS) who are assigned to work solely with one group/unit and are members of an interdisciplinary treatment team which includes Behavioral Services Unit (BSU) qualified mental health professionals, rehabilitation counselors, and education personnel;
- A safe and secure environment achieved through a vigilant "eyes on, ears on, and hearts on" ethos of staff engagement with residents;
- A therapeutic relationship-oriented group treatment approach;
- Shorter work shifts (i.e., 8 hours versus 12 hours);
- An atmosphere where residents are encouraged and supported to explore the roots of their past and current behaviors, develop and test new behaviors, practice healthy interactions, build relationships, and use the here and now to heal old wounds;
- Residents involved in various levels of campus government;
- High levels of family engagement beginning immediately after commitment and throughout the treatment process;
- Robust reentry planning and community re-integration services;
- Prosocial therapeutic activities;
- Optimal population of 12 residents per unit;
- Keeping the group together; and

- A personal advocate for each resident.

As CTM becomes the core philosophy of the JCCs, all other services will be provided in a way that promotes and enhances the CTM. Case management and treatment staff collaborate to coordinate and deliver services for juveniles based on risk and treatment needs. The former JCO position's job responsibilities have been bifurcated between the newly created RS position and security specialist position. The security specialists', a small number of former JCOs, primary responsibilities will be to ensure the physical safety of the facility (e.g., conducting searches at the entrance, conducting perimeter inspections). The RSs, while concurrently responsible for ensuring the safety of the facility, work directly with residents in supporting the implementation of the CTM.

ADMISSION

The Central Admission and Placement (CAP) Unit oversees the assessment phase of direct care that includes intake, orientation, and evaluation of newly committed juveniles. Evaluations provided include medical, psychological, behavioral, academic/career readiness, and sociological. The assessment process is no longer than three weeks so that juveniles can begin living with their CTM unit as soon as possible. At the conclusion of the assessment process, a team meets to discuss and identify the juveniles' treatment and mental health needs and to determine LOS, classification level, parole plan details, and placement recommendations. These assessments currently take place at Bon Air JCC, Beaumont JCC, or at some of the CPPs, based on a determination by the CAP Unit, considering the appropriate placement option. The CAP Unit will continue to oversee the assessment phase for youth placed in the facility at Chesapeake.

DIVISION OF EDUCATION

The Division of Education operates the Yvonne B. Miller High School as a local education agency (LEA), providing academic and career and college readiness opportunities to both diploma-seeking students and post-secondary residents. The Division of Education addresses the needs of diploma-seeking students through academic offerings, credit recovery, career and technical education (CTE) completer options, transferable electives, enrichment opportunities, and participation in standards of learning (SOL) assessments. The Division of Education addresses the needs of post-secondary juveniles through enrichment opportunities, academic remediation, credential and certification programs, and college course offerings. The school is staffed by administrators and teachers who are licensed by the Virginia Department of Education (VDOE).

DJJ Central Office and school administrators participate in VDOE-led school improvement efforts. This is a collaborative partnership to identify and implement effective instructional strategies and best practices to increase student achievement and to build the capacity of the leadership team to improve the quality of instruction and raise the academic achievement of students.[12] Division of Education initiatives focus on these areas through reorganization, implementation of an accountability system, and providing quality instruction.

[12] The transformative power of an effective teacher is the focus of *Linking Teacher Evaluation and Student Learning*, Pamela Tucker and James Stronge, April, 2005.

Reorganization included a review of staffing to ensure Standards of Quality (SOQ) compliance, hiring of staff to implement instructional technology initiatives, and review of Employee Work Profiles to ensure alignment with VDOE expectations. Implementation of accountability included establishing an evaluation system that addressed the Board of Education Teacher Performance Standards & Evaluation Criteria and provided feedback throughout the school year as opposed to one end-of-year review. DJJ established classroom observation protocols, implemented a student assessment monitoring system, and coordinated required training to ensure that teachers were able to attend trainings over the summer to limit absences during instructional time.

DJJ works with local school divisions to obtain juveniles' school records upon notification of commitment to DJJ. The Division of Education administers the Measure of Academic Progress (MAP), a research-based, computerized assessment, to help educators assess instruction and to measure student progress over time. Academic study classes aid students who are deficient in verified credits. Academic support classes support students with disabilities in compliance with Individualized Education Plan (IEP) needs. DJJ provides a continuum of academic courses to include all federal core content courses, sequential electives, CTE offerings, and economy and personal finance.

DJJ adheres to VDOE guidelines with regard to Individual Student Alternative Education Plan (ISAEP) and General Education Development (GED). Juveniles have the opportunity to earn certificates and/or credentials through post-secondary programs. Programming includes enrichment opportunities, options that focus on employability skills, targeted remediation, and college course offerings.

DJJ has a strong partnership with the VDOE. The DJJ central office education leadership team participates on the VDOE State Superintendent Leadership Council and the VDOE State Special Education Advisory Council to ensure DJJ is fully represented in matters related to general education and special education. Upon request, VDOE conducted a compliance audit in November, 2015, followed by a results audit in May, 2016. The goal of these audits was to improve educational results and functional outcomes for students with disabilities and to ensure that DJJ meets program requirements. In the most recent audit, the findings for DJJ were dramatically improved.

The Division of Education outlined goals for the Strategic Plan to include:

- Commit to Recruitment, Retention, and Evaluation of Quality Staff;
- Provide Quality Instructional Practices and Programs;
- Develop and Maintain Effective Communication Among All Stakeholders;
- Establish and Implement Data Analysis Systems; and
- Ensure Compliance in Educational Programs.

These goals are reviewed annually and have accompanying work plans that cite specific responsibilities for each school administrator.

To continue to improve the educational offerings in the JCCs, the Division of Education has entered into the following partnerships:

- The Division of Education has a partnership with the Center for Educational Excellence in Alternative Settings (CEEAS) since September, 2014. This partnership is to assist DJJ to improve educational programming and outcomes for juveniles. The partnership includes membership in a consortium of state juvenile justice agencies which provides an opportunity to network to learn what works across the nation, an annual learning retreat, and onsite visits.
- In response to the adjustment to a CTM, the Division of Education has partnered with Larry Thompson of Responsibility-Centered Discipline (RCD). The idea is to move from an obedience-based model to a model that is centered on students taking responsibility for their own behavior and their academic success. The RCD model encourages teachers to become more purposeful in teaching curriculum, applying assessment, and enriching instruction.
- The Division of Education has entered a partnership with Commonwealth Autism to implement positive behavioral strategies, specifically targeting students with special needs. The partnership will provide a Board Certified Behavior Analyst to work directly with instructional staff on effective behavioral interventions and strategies. Commonwealth Autism also will provide a Registered Behavior Technician (RBT) academy of 40 hours of training for staff in an effort to build capacity.

Post-secondary options were previously not addressed by Division of Education staff; rather, DJJ historically relied on JCOs and volunteers to provide programs. The Division of Education repurposed staff to meet the needs of this population. Certification and credentialing programs are now an option to include courses that align to degree work through a community college. To combat the poor results of college placement assessment, Education added a remediation component. This past semester, five students successfully completed college courses. DJJ continues to work to expand offerings and is looking to technology to aid that work.[13] DJJ is currently working to overcome the current facilities lack of infrastructure needed for effective distance learning, robust online programs for multiple users, and space to accommodate various vendors with whom we might partner to expand offerings.

BSU

BSU is the organizational unit responsible for providing clinical treatment services to juveniles at the JCCs. The primary services provided by BSU staff include mental health, aggression management, substance abuse, and sex offender treatment, as well as intake psychological evaluations and pre-release risk assessments. As the DJJ expands the CTM, in which all staff participate in the treatment process, the role of BSU staff is changing. Rather than being the ones solely responsible for "treatment," they are now members of a larger team focusing on a single group of residents.

[13] John Hattie, Professor of Education and Director of the Melbourne Education Research Institute, identifies the largest barrier to student learning as the variability in the effectiveness of the teacher (June, 2015). He states that teachers need to be able to reliably diagnose and implement interventions and evaluate the impact of their teaching. Hattie cites the capacity of technology as a promising route to improve teaching and learning.

Specifically, BSU therapists are part of each CTM team and provide clinical direction and coordination to the CTM units. The assigned therapist, in consultation with the treatment team, plans therapeutic interventions for the unit staff to perform that reinforce the current stage of the therapeutic groups or addresses unit problems. They also work as practice coaches for resident specialists, counselors, and the community coordinators to help them better interact therapeutically with their assigned residents and will be providing family therapy to the residents in their unit and their families. In this manner, they help assure a uniform therapeutic approach to treatment on the unit.

The main types of treatment provided by BSU include the following:

- Mental Health Services: BSU conducts comprehensive psychological evaluations of all juveniles committed to DJJ. At each facility, BSU provides 24-hour crisis intervention; individual, group, and family therapy; mental status evaluations; case consultations and development of individualized behavior support protocols; program development and implementation; and staff training. Staff complete risk assessments for all serious and major offenders when they are considered for release.
- Aggression Management Treatment: Aggression management treatment services are provided in both specialized units and in the general population. Juveniles must complete core objectives that address anger control, moral reasoning, and social skills as well as demonstrate aggression management in their environment. The primary treatment program utilized is Aggression Replacement Training, which is an evidence-based approach proven effective for working with court-involved juveniles. Core therapeutic activities focus on teaching improved emotion regulation, interpersonal effectiveness, distress tolerance, mindfulness, and self-management skills.
- Substance Abuse Treatment: Cognitive-behavioral substance abuse treatment services are provided in specialized treatment units and in the general population. Treatment emphasizes motivation to change, drug and alcohol refusal skills, addiction and craving coping skills, relapse prevention, problem solving, effective communication, transition to the community, and other skills.
- Sex Offender Treatment: Cognitive-behavioral sex offender evaluation and treatment services are provided in specialized treatment units and in the general population. Juveniles in sex offender treatment units receive intensive treatment from a multidisciplinary treatment team that includes a unit manager, counselor, and qualified mental health professionals. Specialized sex offender treatment units offer an array of services, including individual, group, and family therapy. Each juvenile receives an individualized treatment plan that addresses programmatic goals, competencies, and core treatment activities.

HEALTH SERVICES

The Health Services Unit provides quality healthcare services to juveniles in the JCCs. DJJ maintains a staff of medical providers, dentists, and nurses on-site who provide assessment, treatment, and care to meet the medical and dental needs of the juveniles, including operating an infirmary where residents received 24-hour care. In addition, contracted psychiatrists and optometrists provide healthcare services to the juveniles. On-site staff are supplemented by a

network of hospitals, physicians, and transport services to ensure all medically necessary healthcare services are consistent with community standards.

FAMILY ENGAGEMENT

DJJ has partnered with the AECF, Vera Institute for Justice, Justice System Partners, and other youth-serving organizations to develop family engagement and support initiatives. Research suggests that parental and family engagement has been proven effective for better juvenile outcomes and is associated with better behavior and improved academic performance. DJJ data from FY 2015 indicate that 73% of committed juveniles live more than one hour's drive from Bon Air or Beaumont JCCs. The location of the JCCs in comparison to the proximity of many of the juveniles' homes causes a barrier for numerous families who want to visit.

To support enhanced family engagement during commitment, DJJ has established the following initiatives:

- Video Visitation: The Division of Community Programs has developed partnerships across the state to enable families to use video conferencing to connect with residents housed in the JCCs. Families who participate in the Roanoke area use Straight Street for video visitation, which is a center for teenagers. Families in the Danville area use the Danville Redevelopment and Housing Authority office for their visits. DJJ has partnered with Assisting Families of Inmates (AFOI) to expand video visitation around the state. The first location in the expansion will be the AFOI office in Richmond.
- Transportation Initiative: DJJ has partnered with AFOI, James River Transportation, and VanGo Transportation to provide transportation services for parents and families to both JCCs and CPPs. The program commenced on Sunday, May 22, 2016, and provided transportation services for 27 families in both the eastern and western parts of the state. There are six pick-up sites across the state, and the program has the capacity to expand, depending upon the need.
- CTM Activities: DJJ also is expanding visitation and family engagement through the CTM. For example, CTMs are holding visitation on the units, holding family days, and providing more contact between CTM staff, residents and families;
- Reentry Procedures: DJJ has overhauled its reentry procedures and practices to require more family involvement and engagement at every step of the process.

REENTRY ADVOCATES

The Division of Community Programs has developed reentry advocate positions to collaborate with the residential counselors and parole officers to coordinate the reentry process for committed juveniles. These professionals assist the juvenile with their personal action plans, work with staff to coordinate family engagement, and participate in planning meetings with other DJJ professionals. There will be five reentry advocates, one for each of the DJJ's regions of the state.

DESIGN RECOMMENDATIONS BASED ON SERVICES

Based on (i) CTM; (ii) the services (e.g., education, treatment, family engagement, reentry) required in a JCC to promote the rehabilitation of juveniles with various and severe

criminogenic, educational, mental health, and trauma-related needs; and (iii) the input received and research conducted to date, the Task Force recommends that the design process for Chesapeake and any other facilities incorporate the following design values and priorities:

- Small 8-12 bed living units in separate buildings, built to reinforce and enable the small group treatment approach. Ideally, and if space and cost allow, each residential building will have no more than two living units;
- Dedicated spaces accessible to each living unit for group activities, treatment, relaxation, and indoor and outdoor recreation;
- Trauma-responsive furnishings, lighting, and other architectural features;
- Welcoming family visitation spaces with privacy;
- Education space equipped with instructional technology to address credit recovery, enrichment needs, hands-on career-readiness training, and access to distance learning to meet student needs;
- Technology infrastructure and digital space to manage online instructional software, curriculum, assessments, performance-based projects, and data collection to be used by the instructional staff;
- Increased use of technology to promote security, case-planning, and training;
- Education space to accommodate project-based learning activities, distance learning labs, and celebratory events (i.e., graduation, assemblies, family/student events), delineating areas for diploma-seeking students and post-secondary programs;
- No concrete slab beds; and
- No security fencing inside the perimeter.

Additional details on the overall facility and housing unit designs, including research and best practices, are provided in the following sections.

IV. Design and Size of Spaces Needed

In order to provide the necessary services within the JCCs, the design and size of the facility must be planned to promote both safety and engagement in programming. The new space should create a living/learning/working environment that is designed specifically to support the rehabilitative process employed within the campus and help juveniles reach the desired positive outcomes both during their stay and after release to the community. Treatment, education, behavior management (i.e., CTM), family engagement, and activities encouraging positive youth development are key factors to consider when designing the facility. For example, adequate technology must be incorporated in the design of educational space to accommodate a variety of student levels and needs, as described above. Constructing a new facility that purposefully supports these priorities is essential to helping the staff do their work, helping the juveniles be more amenable to the change process, helping draw families into the treatment process, and helping make Virginia's communities safer by lowering recidivism.

In her presentation to the Task Force, Krista Larson, M.S.W., Director of the Center on Youth Justice with the Vera Institute, stated that family engagement is a critical element of effective juvenile justice. She reviewed research that has shown that visitation (i) improves residents' facility adjustment and symptoms of depression and (ii) has been linked to fewer incidents or rule violations in the facilities and reduced recidivism. In Ohio, the rate of visitation was

generally correlated with distance to facilities, with the closer families visiting more frequently. She reviewed a survey of Virginia's committed juveniles which found that 40% had never had a visit during their commitment and 40% receive two or fewer visits per month. In reviewing what works in structure and design, Ms. Larson stated that it is important to have (i) a warm, inviting environment, (ii) the ability for families to have privacy, and (iii) space for activities for small children and to encourage family-resident interaction.

In her presentation to the Task Force, Monique Marrow, Ph.D. with the Center for Trauma Recovery and Juvenile Justice at the University of Connecticut and the Center for Trauma and Children at the University of Kentucky, stated that creating trauma-responsive programs to serve justice-involved juveniles is essential for successful outcomes. She noted that 93% of juvenile offenders reported at least one traumatic experience, with six being the average number of different traumas reported. Traumatized juveniles are often hyper-aroused and have difficulty managing their environments. In reviewing aspects of structure and design that are the most effective with juveniles who have experienced trauma, Dr. Marrow recommended the following: (i) increased connection to nature and natural light (with reduced reliance on overhead fluorescent lighting), (ii) reduction of noise, glare, and air quality environmental stressors (e.g., high ceilings that contribute to a loud sound level), (iii) safe sleeping areas,[14] (iv) sufficient storage, (v) safe rooms and spaces residents may use as a calming place, (vi) to address staff stress and their own exposure to traumatic experiences while on the job, features that make them comfortable including space for staff storage and breaks, (vii) a security alert system that does not involve an overhead paging system, (viii) adequate space for programming with lower occupancy density, (ix) room for modesty in showers and restrooms, (x) the ability for families to have privacy during visitation, (xi) the ability for medical information to be communicated confidentially, and (xii) group rooms that are not on the living unit.

The Task Force reviewed research and best practices and took into account the expert presentations on the important design components necessary to encourage family engagement, successfully work with a population that has high rates of trauma, and adopt practices known to work in juvenile justice. In addition to the recommendations in the previous section relating to accommodations for the CTM and services, the following is recommended specifically related to design:

- Open environment inside the perimeter fence with no internal fences;
- Easy and quick transfer time between housing units and other buildings;
- External secure egress areas outside the main campus;
- Close proximity to shared spaces (e.g., medical, education, visitation, recreation); and
- Open sight lines to increase security.

Additionally, Kaplan McLaughlin Diaz (KMD), DJJ consultants who completed a comprehensive assessment of the JCCs in 2013, assessed the costs of operating current facilities versus constructing new facilities to serve committed juveniles, finding that new construction would result in significant reductions in operations and maintenance costs due to the following:

[14] Dr. Marrow noted that dorm or semi-private rooms compromise the ability for an individual to feel safe due to the lack of privacy. She recommended construction to include having spaces flexible enough to allow for private rooms for most individuals.

- Higher quality standards resulting in less frequent maintenance and lower life cycle costs in general;
- Higher building performance standards, particularly those that affect energy; and
- Substantially smaller and more efficient footprint for DJJ's physical plant.

(See Appendix G for details of these cost-saving findings.)

Even those that manage adult populations in secure settings are approaching facility design in ways that are consistent with treatment and rehabilitation. For example, according to Beck (2006), nationwide, many are starting to adhere to the "New Generation" approach of jail design, including the American Jail Association, the American Correctional Association, and the Committee on Architecture for Justice of the American Institute of Architects. The goal of this approach is to manage human behavior in a safe, positive, consistent, and fair manner. For example, the use of carpets in housing units helps reduce noise and promote a calmer environment. Overall, the aims of this new approach are to implement design principles and amenities that promote comfort, which is conducive to rehabilitation (Lopez, 2014). Furthermore, this approach aligns well with current recommendations that emphasize a treatment-oriented environment.

According to Lopez (2014), a corrections analyst and planner who works with architects to promote and develop correctional institutions that promote rehabilitation and successful reintegration into the community, a treatment-oriented environment has numerous benefits on residents' social, mental, and physical wellbeing, all of which promote rehabilitation. Correctional centers that promote rehabilitation include access to natural light, fresh air, nature, and some elements of comfort.

Experts on secure juvenile justice facilities and their programming agree that the environment should be "normative," meaning the campus should look and feel more like one would expect at a school, not a traditional prison. McMillan summarizes the features of a normative environment as:

- Open interior spaces with views to the outside;
- Natural lighting that reduces perceptions of crowding;
- Ready access to outdoor spaces from housing and program areas so that the sense of confinement is minimized while program options are expanded;
- Movable furnishings that permit changing use of space throughout the day and over time while offering some control over the environment;
- Spatial variety throughout the day, with changing spatial scale and shapes that reflect those normally encountered in daily experience;
- Sound absorbing materials that mitigate the often disruptive and disturbing noise usually generated by juvenile populations living together;
- Familiar and variable construction materials that present no overt expectation of damaging behavior, often a self-fulfilling prophecy; and
- Access to varying program activities at all times with appropriate space for residents to engage in satisfying formal and casual pursuits through daytime and evening hours so that residents and staff have options and no unproductive down time.

FACILITY SIZE

Because larger facilities tend to be harder to manage and more prone to ineffective correctional practices, new or renovated facilities in Virginia should be built on the smallest scale that is fiscally and operationally feasible, balancing bed space needs, economies of scale, and the need for administrators, staff, and residents to develop personal relationships with each other and identify effective ways to solve problems that may arise. Smaller campus populations allow residents to receive more personalized attention that promotes both accountability and rehabilitation (Alexander and Twomey, 2006; Lopez, 2014).

There is ample room for debate about how large facilities can become before these benefits of "smallness" diminish. Some stakeholders have urged the Task Force to only recommend very small facilities (i.e., capacities of 25 or less), citing Missouri as a state that only uses such facilities. However, this characterization of Missouri's system is inaccurate. Missouri operates facilities of various sizes, including two facilities (the Watkins Mill and Sears Youth Centers) that average about 60 youth per day and one property (Missouri Hills in St. Louis) with six self-contained programs that houses more than 100 youth per day. Missouri's most secure facilities, including one that houses youth up to 21 years of age, are designed to hold 30 to 40 youth. Missouri has shown that it can successfully operate facilities of varying sizes by 1) creating small (10-12 youth) living units that function in a semi-autonomous manner, in effect capturing the benefits of smallness within a range of small-to-moderate-sized facilities, and 2) providing rigorous and ongoing rehabilitation to the youth in each unit. This approach provides the underpinning of DJJ's CTM approach which is, as described above, adapted from Missouri's juvenile correctional approach.

When DJJ chose the Missouri approach as an inspiration for the model it wanted to create, it did so advisedly. Missouri's approach is highly regarded nationwide, and has both inspired and informed correctional reforms in at least five other states. Researchers have noted how well-aligned the Missouri approach is with the principles of "what works" in juvenile justice interventions, and comparative studies indicate that Missouri achieves impressive results in terms of keeping youth safe and promoting desistance from crime. Yet there are limitations to this body of evidence: as noted by the National Academy of Sciences, there has not to date been any rigorous scientific study of the Missouri model's effects on recidivism (nor, for that matter, of any comprehensive approach to juvenile corrections) that controls for youth-specific and system-specific factors. The Missouri approach is a multifaceted model that has evolved over decades, making it very difficult to implement. In addition, there are noteworthy structural differences between Virginia's juvenile justice system and that of Missouri (discussed in Appendix F), which would render any effort to simply mimic Missouri's system in Virginia impractical and unwise.

Recognizing these complexities, DJJ, with support from the Annie E. Casey Foundation, reached out to the field's leading experts on the Missouri approach, MYSI. DJJ drew heavily on the knowledge and advice of these experts in developing the CTM and has worked hand-in-hand with them, not only to implement and adapt the CTM within the current JCCs, but also to strategically plan for the further adaptation and implementation of that approach in new facilities. The Task Force applauds DJJ for its diligence and attention to these important details and endorses the Department's direction in seeking to transpose the Missouri approach to fit the needs of Virginia, rather than to simply replicate it.

It is also important to note that given the complex needs of the committed population, the diverse demographics (age range, treatment, educational, and service needs) and the duration of commitments requiring complex longitudinal programming, any new construction in Virginia must have sufficient infrastructure to accommodate the broad spectrum of services necessary to continually and progressively rehabilitate, educate, and treat youth who may be confined in the new facility for multiple years, and keep them engaged and moving toward more successful futures.

For whatever number of juveniles it is designed to accommodate, a facility needs to provide adequate square footage of interior and exterior space for those residents to live, learn, and grow. Facilities that do not provide adequate physical space for their populations (facilities that have what psychologists describe as too much "spatial density") tend to create an environment of heightened stress, anxiety, and social distress (Wandersman, 2010). Factors that can influence the amount of spatial density in a facility include the building site footprint, campus location relative to the majority of residents' home communities, as well as current and anticipated future population levels. Regarding the overall size of the facility footprint and its built spaces, architect Michael McMillan reports the industry standard for long-term juvenile facilities needs to allow for at least 700 – 850 square feet per resident of total interior space, with the vast majority of that space (more than 70 percent) dedicated to housing and programing for the residents. To the maximum extent possible, given the dimensions of the building lot, exterior space within the security perimeter also should be provided for exercise, access to nature and fresh air, and outdoor assemblies (both as part of programming and in the event of an emergency evacuation). This is driven by the need for juveniles to receive considerable education, recreation, career readiness, and rehabilitative programming. Facility space should be multifunctional so that it can be used for therapeutic, educational, physical, and treatment purposes (Alexander, Farrell, Roy, & Twomey, 2006; Lopez, 2014).

In his presentation to the Task Force, Edward J. Loughran, Executive Director of the Council of Juvenile Correctional Administrators, described what best practices have found to be the ideal configurations of juvenile correctional units. In reviewing what works in structure and design, Mr. Loughran recommended the following: (i) small facilities that are not institutional in character, (ii) small (8-12 residents) housing units with a normative environment, (iii) single occupancy rooms, (iv) natural light and views, (v) open day room with contiguous sleeping rooms, (vi) single-user showers and bathrooms with one per eight residents, (vii) space for on-unit activities, (viii) access to outside space for recreation and group activities, (ix) central dining or family-style dining, (x) the ability for families to have privacy during visitation, and (xi) a separate education building.

The Task Force is supportive of the 64-bed proposed size of the JCC in Chesapeake and would note that this size is more than 70% smaller than the 282-bed capacity at Beaumont JCC which it will effectively replace.

FACILITY LAYOUT

Facility design can follow a centralized layout or campus-style layout. The two options are described below, including research and best practice recommendations. Current DJJ JCCs have a combination of these two styles.

Additionally, the presentations provided by subject matter experts to the Task Force provided a wealth of information to inform campus design.

In a centralized layout, the entire facility is housed in one large building. This type of facility layout is common among jails and maximum security correctional facilities. While such a layout increases the efficiencies in moving residents within the facility, it minimizes residents' opportunities to be outside and breathe fresh air for any purpose other than recreation time. There tends to be less natural light throughout the facility. As a result, this type of layout often lacks in many of the design principles demonstrated to promote rehabilitation, autonomy, and prosocial behavior (Lopez, 2014; Krueger & Macallister, 2015).

Instead, a campus-style layout, characterized by multiple decentralized buildings, is more conducive to the CTM. Under this design, different programs are spread out across campus and connected by walking paths. Typically, campus-style layouts have a central grassy area for aesthetic and practical purposes (Krueger & Macallister, 2015).

While "campus-style" sometimes refers to large, sprawling, geographically isolated designs, the campus design in Virginia, and proposed in Chesapeake in particular, must fit within geographical constraints as well as balance space and compactness in an urban environment. This location reflects the importance of locating the facility close to juveniles' home communities to promote family engagement and successful reentry (See Section III: Level and Type of Services and Section VII: Number and Geographical Location of JCCs), but it limits the sprawl of the campus. It is also important to situate housing units within a short walking distance from programming and educational space to avoid substantial periods of the day devoted to movement. Therefore, in Chesapeake, housing units or groups of housing units should be stand-alone buildings with adequate sleeping, group, treatment, and office space to conduct most day-to-day activities within the CTM unit. A separate building with educational spaces and other common areas provides the benefits of the campus-style layout within the confines of the geographical location that best serves the population.

The campus-style facility layout promotes autonomy and rehabilitation by allowing residents to move across campus to different buildings for different needs and programs. Additionally, a campus-style layout is similar to that found in higher education settings which can detract from the institutional setting and thereby create a sense of normality. Promoting and achieving a sense of normality is conducive for resident rehabilitation. A normative environment facilitates rehabilitation because it encourages positive resident response and participation (McMillen, n.d.; Krueger & Macallister, 2015), greater resident autonomy and prosocial interactions (Van der Laan & Eichelsheim, 2013), and use of positive coping skills (Lambie & Randall, 2013). Greater freedom of movement and exposure to nature and fresh air also has been associated with positive rehabilitative outcomes (Lopez, 2014).

As part of the campus-style layout, cottage housing units are free-standing from all other campus facilities (e.g., education, recreation, dining, central administration). Each cottage has its own housing unit, utilizing various housing design principles, along with a common living area; however, residents must exit their cottage and enter a different building for other activities or services that are not delivered in-unit. As cottages in a campus-style layout require residents to walk between buildings, it follows that residents are able to benefit from a degree of normality, autonomy, and exposure to nature that promotes rehabilitation.

Some key features of campus-style facilities that are desirable include:

- Open environment inside the perimeter fence with no internal fences;
- Easy and quick transfer time between housing units and other buildings;
- External secure egress areas outside the main campus and view of residents;
- Close proximity of housing units to shared spaces (medical, education, visitation, recreation, etc.); and
- Open sight lines to increase security.

FACILITY SECURITY

Without safety and security, residents and staff will be "on edge" and unable to do the deeper treatment work designed to help them develop into pro-social citizens. Therefore, a secure campus perimeter to prevent access to and egress from the facility is a design imperative. The perimeter fence line should make sightlines as straight as possible to minimize blind spots and the number of patrols. The perimeter fence should be a minimum of 20 to 25 feet from the outside of all facility buildings. An interior-curving fence constructed of anti-climb material is recommended by KMD.

Other security considerations include ceiling heights and materials. Alexander, Farrell, Roy, and Twomey (2006) assert that all ceilings should be a minimum of 10 feet tall and made of security ceiling tiles to prevent residents from scaling walls and accessing ceiling space to escape or conceal contraband.

MYSI points out that the built environment should support safety and security through an open layout that facilitates awareness, supervision, and group interaction. But MYSI, McMillan, and other experts agree that an overtly "hard" environment is a detriment to residents and staff safety. McMillan states, "security construction in itself cannot replace the safety and security achieved primarily by staff working with residents, treating them fairly, and responding to problems as they occur. Facility designs seek to ensure that all spaces used by residents are easily supervised, easily accessed and appropriately configured to support unhindered interaction between staff and residents."

VIRGINIA REGULATIONS ON CONSTRUCTION

In addition to the national and international standards set forth, juvenile correctional facilities must be constructed in accordance with the *Code of Virginia* and *the Virginia Administrative Code*. (See Appendix H for a non-exhaustive list of regulations regarding construction of JCCs.) It is important to note that these regulations stipulate the minimal requirements and not guidelines for implementing best practices; facilities will likely exceed these requirements.

Under 6VAC35-71-410 concerning space utilization, every juvenile correctional facility must have: (i) an indoor recreation area with appropriate recreation materials; (ii) an outdoor recreation area; (iii) kitchen facilities and equipment to prepare and serve meals; (iv) a dining area for eating; (v) laundry equipment and space; (vi) storage space; (vii) a designated visiting area; (viii) space for administrative use, including having confidential conversations and storing confidential records; and (ix) a medical examination space with appropriate equipment. If the correctional facility operates a school, classrooms must comply with state and local

requirements. Spaces may serve multiple functions; however, they should maintain functionality for their designated purpose.

According to 6VAC35-71-360 governing sleeping areas, there must be at least 80 square feet of floor area in single-bunk cells and at least 60 square feet of floor area per person in double-bunk cells. All beds must be at least three feet apart at the head, foot, and sides. Bunked beds must be at least five feet apart at the head, foot, and sides. Ceilings in sleeping areas must be at least seven and one half feet high and without any protrusions, duct work, or dormers. Additionally, 6VAC35-71-340 concerning drinking water dictates that potable water must be available in every sleeping area, and 6VAC35-71-350 concerning toilet facilities dictates that there must be at least one toilet, sink, and shower or tub for every four inmates in all buildings constructed or structurally modified after December 28, 2007.

Due to the conversion to the CTM and transformation of juvenile justice in Virginia, these regulations are under review by the Board of Juvenile Justice. The work of the Task Force likely will influence any future modifications.

V. ACCOMMODATIONS FOR JUVENILES WITH SERIOUS MENTAL HEALTH ISSUES

Just as it is important to note that youth in the juvenile justice system, including those with mental health issues, are best served in their communities with effective and evidence-based services, it is also important to note that effectively delivering these services is not solely the responsibility of DJJ. The most effective interventions are delivered early and comprehensively, and local schools, community service boards, family assessment and planning teams, and community policy and management teams all have critical roles to play.

Statewide initiatives that bring together child-serving agencies are also critical to providing support and guidance to local efforts to meet the needs of at-risk youth. Examples of these initiatives include the following:

- The Children's Cabinet's "Classrooms not Courtrooms" workgroup, which recommends policy changes to improve the likelihood of youth remaining and being successful in schools rather than entering the juvenile or criminal justice systems for school-related behavioral issues;
- The Department of Behavioral Health and Developmental Services' Children's Mental Health Transformation, which proposes a uniform comprehensive array of behavioral health services to be available and accessible in every Virginia community; and
- Ongoing efforts to improve and reform the work of the Children's Services Act.

The Task Force urges members of the General Assembly to support these and other efforts to deliver effective services to all young people in the Commonwealth and, whenever possible, to divert them from involvement in the juvenile justice system.

For those limited number of juveniles with significant mental and behavioral health issues who penetrate to the deepest end of the juvenile justice system and require confinement in a JCC, it is critically important that the new facility in Chesapeake, and any other facilities developed or renovated later, have the right setting and supports necessary to provide effective treatment and rehabilitation.

In the mental health literature, evidence-based practices for residential programs are increasingly focusing on family engagement, reentry planning, and wraparound services to get juveniles stabilized and into treatment, then as quickly as possible transition them towards home with the appropriate services and supports. In recent years, groups as diverse as the National Mental Health Association (2004), the Magellan Health Services (MHS) Children's Services Task Force (2008), and the Ontario Centre for Excellence in Child and Youth Mental Health (2013) have surveyed the research to identify the factors most associated with effective treatment in residential facilities for juveniles with serious mental health and behavioral problems. Their surveys all addressed two key dilemmas of residential treatment for troubled juveniles:

- Gains made while in placement frequently are not maintained after discharge. Researchers, program operators, and family members attribute this deterioration to a lack of services in the community after release, poor coordination between residential care providers and community providers where post-discharge services are available, and self-regulation skills and habits that juveniles have developed while in placement that are not well-adapted to life outside the institution (Magellan Health Services, 2008).
- A heavy emphasis on control for the sake of safety in many residential facilities can create an environment that impedes effective treatment by increasing stress and anxiety while decreasing trust and communication between residents and staff (Zelechoski, Sharma, Beserra, Miguel, DeMarco & Spinazzola, 2013). Instead, focusing on collaboration and engagement improves treatment efficacy and leads to improvement in both immediate and long-term safety (van der Laan & Eichelsheim, 2013).

Magellan Health Services found that the facilities that overcome these challenges often exhibit strengths in the following areas:

- Family engagement: "The best programs partner with families and make sure there is meaningful family involvement during residential treatment. … it is preferred to have youth not only stay in residential programs that are family-centered in approach, but are in close proximity [to where their families live] so as to facilitate family involvement."
- Reentry planning and services: "The more successful residential treatment programs begin planning discharge at the time of admission. … Gains are more likely to be maintained and readmissions decreased when attention is paid to what services and/or placement is needed post-discharge and the plan is executed."
- Community involvement: "Effective residential treatment facilitates community involvement and services while the youth are in residential treatment. Teaching youth the skills needed for reintegration into their community increases the chances of successful outcomes."

"In order to maintain gains after discharge, three common variables have been identified:

1. The amount of family involvement in the treatment process prior to discharge,
2. Placement stability post-discharge, and
3. Availability of aftercare supports for youth and their families." (Magellan Health Services, 2008)

As the experts presented to the Task Force, it is essential when working with juveniles in the juvenile justice system to engage the family and adopt a trauma-informed approach. In DJJ programming, the CTM is being adopted to address many concerns found in the mental health research. As discussed above, CTM uses relationships to support and encourage rehabilitation and prosocial relationships. BSU staff are available to provide ongoing support for the work of each CTM and additional clinical, family therapy, and other interventions as necessary.

Most significantly, with the enhancements of reentry services and the continuum of care, DJJ will have increasing ability to place residents who are not appropriate for placement in a secure setting in more appropriate settings, including privately-operated residential treatment centers, to address their specific mental and behavioral health needs.

VI. ALTERNATIVE HOUSING MODELS

In addition to planning for the overall design of the facility layout (See Section IV above), there are several design options for the sleeping areas and housing units. In designing JCCs that promote safety rehabilitation, a foundation of evidence-based and best practices is critical. Sleeping areas may be single occupancy, double occupancy, or dormitory-style (i.e., groups sleeping in the same room). For single or double rooms, the housing unit may be arranged linearly along a corridor or centered by a common area with sleeping rooms along the perimeter. Locks and bathroom facilities also are important factors to consider within each housing unit. It is important to note that research on sleeping room architecture focuses mainly on the influence on safety within the facility rather than longer-term outcomes such as recidivism, educational attainment, and employment.

No area in a juvenile residential facility poses greater safety challenges than the sleeping room. Residents spend a greater share of their day in these rooms than in any other, and they typically spend that time under more relaxed supervision than they receive during waking hours or in other parts of the facility. Sleeping rooms are among the most common locations in which injuries and victimizations occur and the most common location for suicides, suicide attempts, and other self-harm. (Gallagher & Dobrin 2006, Beck et al 2013, Hayes 2004) It is during time that juveniles typically spend in those areas (the hours immediately before and after bedtime, between 6:00 p.m. and midnight) that suicides, sexual victimizations, and other dangers are most likely to occur (Hayes, 2004, Beck et al., 2013).

Creating and maintaining a safe environment in sleeping rooms is therefore a central challenge of juvenile residential care. This is not solely, or even predominantly, a question of architecture. In fact, research and experience indicate the most important factor in ensuring safety in sleeping rooms, as in other areas of a facility, is the presence of sufficient numbers of attentive, well-trained, and caring staff members. No architectural configuration in a living unit can be considered safe if it is not appropriately staffed, if there is not a well-functioning grievance process in place, and if day-to-day staff practices and resident-staff interactions do not embody a healthy therapeutic environment (e.g., Sedlak et al., 2013). However, to the extent that the built environment affects the facility staff's ability to create a safe sleeping environment, or conversely, to the extent that the built environment requires a higher level of staffing to create a safe sleeping environment, choices about the architecture of sleeping rooms can be very consequential.

Some of the key sleeping area attributes that a facility design should address are applicable to any type of housing. Sleeping rooms should be comfortably furnished, clean, quiet, and tranquil; they should provide appropriate lighting and ventilation; and they should be convenient to bathing and toileting facilities, as well as to common areas where bedtime and early morning routines of the living unit are conducted. In addition, some attributes are particularly important considerations for juvenile facilities:

- Visibility and accessibility to staff: Because sleeping rooms are high-risk areas, and because staff attention is the primary and most effective way to prevent problems in high-risk areas, it is crucial that staff members are able to observe sleeping rooms and to gain access to them quickly when needed.
- Privacy: Developmentally, all juveniles have some need for privacy and solitude; those needs may be greater among juveniles who are confined in a group-living arrangement, especially when they are confined for lengthy periods. Moreover, for juveniles who are especially vulnerable or who have experienced some kinds of trauma (e.g. violent or sexual victimization), having a personal space can be an important factor in providing them with a sense of psychological and emotional safety.
- Personalization: Developmental psychology suggests that during adolescence, when the sense of identity is evolving at its most intensive rate, it is particularly important for residents to be able to personalize their living and sleeping spaces. This can be accomplished by having or displaying personal items (e.g. pictures, artwork, or correspondence) in the sleeping area to clearly differentiate the individual juvenile's space from that of other residents.

There is inevitably some tension between the attributes of visibility (which implies minimal physical obstructions or boundaries around an individual juvenile's sleeping area) and privacy (which implies some physical barrier that provides solitude and demarcates the juvenile's personal space). There is no one correct way to strike that balance that will work equally well for all juveniles, and facility designers need to make trade-offs, incorporating what is known or expected about (i) the attributes of the juvenile who will be living in the facility that would affect their need for privacy, (ii) aspects of the treatment approach that would affect staff members' needs for visibility and access, and (iii) the expressed opinions of juveniles and staff, who should be asked for their ideas and preferences about how to balance and prioritize these important attributes. Personalization of the sleeping room can be provided in any architectural design and is also a design element in which the suggestions of residents and staff should be solicited and incorporated.

Additionally, each housing unit should have adequate space for a number of activities and purposes, including:

- Comfortable common seating area for residents to relax, play games, read, and socialize;
- Family visitation and gathering/celebration space (an important component of the CTM);
- Private room for family therapy sessions;
- Private space for staff meetings;
- A dedicated room for mutual help groups with wall space to display treatment work; and
- Outdoor space adjacent to and accessible from the unit.

MYSI provides the following check-list for housing units:

- The facility has a juvenile-friendly environment.
- The facility is neat, clean and organized.
- Unit expectations and/or norms are posted in the unit.
- Multiple examples of student work are displayed on the walls (e.g. work from group meetings/certificates of recognition).
- Bathrooms (showers and toilets) allow privacy for residents, as well as appropriate supervision for staff.
- The furniture and facilities are in good condition and adequate to support a group of 10 residents and supervising staff.
- The unit has sufficient comfortable seating for the group, supervising staff, and family visitors.
- The condition and color of the paint on the unit is satisfactory and appropriate.
- The unit has sufficient coverage of carpet and/or rugs to support a more home-like environment.
- The unit has a designated area/room that is conducive for family visits.
- A group meeting area is available and separate from the sleeping and day room areas.
- The unit has a well-stocked library with relevant reading material, and the residents are allowed to use it.
- The unit has a day room area that allows the group and supervising staff to use it like a family room. It includes appropriate equipment such as television, game tables, reading areas etc.

Overall, research and national and international standards for the treatment of individuals housed in secure facilities suggests that campus-style layouts and single-bunk cells are recommended for housing serious inmates in order to promote rehabilitation, maintain safety, and respect human privacy. Considerations for this style and others are described below.

SINGLE ROOMS AND SMALL DORMITORIES

Single-bunk housing units have been the predominant correctional facility housing arrangement in the United States for adult prisons as well as juvenile facilities for generations. The prevalence of this model is due to the widespread belief that it is safer and more humane, a belief that traces its roots to the prison reform movement of the Christian Knowledge Society, founded in England in 1699 (Alexander, Farrell, Roy, & Twomey, 2006). Even when prison populations skyrocketed in the 1990s, generating pressure to double- or multiple-bunk as a way to accommodate a burgeoning inmate population, the consensus of the correctional field continued to uphold the preference for single rooms (e.g., Adwell, 1991). This consensus is reflected in juvenile correctional standards set forth by the American Correctional Association, the National Advisory Commission on Criminal Justice Standards and Goals, the U.S. Department of Justice, the United Nations (2015), and the American Bar Association (2010). For example, the United Nations Standard Minimum Rules for the Treatment of Prisoners (2015) articulates that double-bunk cells should only be used under special circumstances, such as temporary overcrowding.

Advocates of single-bunk housing point to a wide range of benefits, drawing on research and experience from the management of both adult prisons and juvenile facilities. They argue that

single-bunk sleeping rooms are more humane and provide inmates with more dignity than shared rooms due to enhanced privacy and space ownership. This enhanced privacy in turn can promote inmates' self-concept and autonomy (Bleich, 1989; Lopez, 2014), psychological traits that have been shown in research on juvenile adaptation to incarceration to promote rehabilitation and general well-being (Van der Laan & Eichelsheim, 2013). The Department of Behavioral Health and Developmental Services (DBHDS) tries to utilize single-bunk housing units as much as possible in their psychiatric and rehabilitative facilities, asserting that single-bunk housing allows for greater flexibility and security. DBHDS does not house more than two occupants per sleeping room.

Additionally, in his presentation to the Task Force, Mr. Loughran reviewed alternative unit configurations that could be adopted when constructing a new JCC: double-bunked rooms, dormitory style, wet rooms, and bi-level units. He opined that the alternative unit configurations are not the best practices for achieving the best outcomes in juvenile justice. Dr. Marrow, who presented on trauma responsive facilities, also argued for single rooms for housing juveniles with significant trauma exposure.

In summary, the National Institute for Corrections and many state agencies recommend single-occupancy rooms because:

- They offer some degree of privacy and personal space for young people;
- They can facilitate bed checks and other administrative tasks for staff; and
- They make it possible to separate residents from others when needed, whether to provide a protected space for a vulnerable resident or to allow a resident who is acting out to be separated from others while calming down.

This consensus is not universal, however. Missouri's Division of Youth Services, frequently cited as one of the best juvenile corrections agencies in the nation (Mendel 2009), uses small living units of 10 to 12 residents housed in open dorms, where there is a large room with several single or bunk beds. Many of these dorms have no structural separation between beds at all, while some units have short "privacy walls," reaching about three or four feet high, to separate groups of beds. Drawing on this experience, MYSI endorses small dormitories as the preferred housing arrangement (MYSI, 2015) because:

- They give staff better visibility for direct observation and supervision of the unit;
- They reinforce the ethos of group solidarity, and the orientation to address behavior problems without separating residents from the group that are instrumental to the small-group treatment model; and
- They provide more flexibility in the use of living unit space at a lower cost for construction and maintenance.

MYSI's experience has been that these small open dorms are safer than separated rooms, due to decreased risk of victimization by roommates or residents pulled into another room and significantly lower risk of suicide. While some research points to increased danger in dormitories (Parent, 1994), this research is often based on large dormitories with poor staffing and not employing a behavioral model such as MYSI's. With small unit size, an open design with clear

sight lines, and a highly trained and committed residential treatment staff, MYSI believes dormitories are appropriate and safe.

Although DJJ and the Task Force will continue to assess and reassess all interim recommendations up until the submission of the final report, based on the weight of the literature as well as the presentations of national experts, the Task Force recommends that single rooms should make up at least a large proportion of bed capacity in newly constructed facilities, with consideration given to some portion of small dormitories, which may be appropriate for certain segments of the direct care population (e.g., those transitioning to less restrictive settings). Final determinations about how many living units of each type to construct will be based on the attributes of the expected populations in each facility and on input from stakeholders received during the design phase.

OPTIONS ELIMINATED FROM CONSIDERATION

Some housing models clearly go against best practices and can be eliminated from consideration during the planning process. Linear designs, double rooms, and dormitories for large numbers of residents are consistently cited as unwise correctional housing models.

Linear Designs

Beck (2006) argues that nearly all standards for correctional design principles advise against the use of linear designs, which involve long corridors of cells. Linear designs impede the ability to maintain continuous observation as staff must patrol the hallways at regularly scheduled intervals and look into each cell window. As a result, staff-resident interaction and supervision decrease while liability increases as a result of unobserved behavior, such as physical altercations, sexual assaults, medical emergencies, inmate suicides, and homicides. Instead, design should facilitate direct and indirect supervision of inmates at all times (Alexander, Farrell, Roy, & Twomey, 2006; Beck, 2006). Linear designs also create obstacles for transporting inmates to a centralized location for activities and services. Therefore, planning for future facilities should not incorporate linear housing unit designs.

Double Rooms

As each expert discussed in their presentations to the Task Force, double rooms provide all of the disadvantages of a single-occupancy configuration (lack of visibility, lack of flexibility in the use of space) without its chief advantage (a sphere of privacy), and would offer none of the benefits of a small open dormitory style. MYSI agrees that double bunked sleeping rooms are the least appropriate option. While there may be marginal construction cost savings, the disadvantages are significant. Residents in double bunk rooms tend to get less square footage allotted to them than single rooms; they lose the privacy of a single room but are at risk for victimization because staff cannot keep continual eyes on/ears on supervision of locked rooms. Therefore, planning for future facilities should not incorporate double-occupancy rooms in the design.

Large Shared Sleeping Rooms ("Dormitories")

Large shared sleeping rooms, sometimes referred to as dormitory-style housing units, are typically utilized to house low-risk offenders in minimum security correctional centers (Zoukis,

2013; Peguese & Koppel, 2003). If constructed, research, experience, and industry standards recommend against sleeping rooms that are shared by more than 10 residents (NIC/NPJS Desktop Guide 2015).

Parent (1994) argued that dormitory-style housing units, compared to cell configurations, are associated with a greater number of violent incidents against staff and inmates as well as less staff control. A large body of research has found a positive association between the number of juveniles in a group and aggressive behaviors (van der Laan & Eichelsheim, 2013). When individuals lack personal and environmental autonomy, they can develop a sense of learned helplessness that detracts from rehabilitation efforts (van der Laan & Eichelsheim, 2013).

Single-bunk housing units promote autonomy and rehabilitation among juveniles. Furthermore, after conducting a substantive review of juvenile correctional facilities nationwide, OJJDP (Parent, 1994) recommended "that large dormitories be eliminated from juvenile facilities. No new facilities should be built that contain large dormitories. In existing facilities, large dormitories should be replaced as soon as possible" (p. 17).

Given the numerous recommendations of juvenile justice, correctional justice, and social welfare agencies and the inappropriateness of large dormitory-style housing for high-risk offenders, DJJ should refrain from implementing this housing design in any of their JCCs. The research and standards instead recommend the implementation of mostly single-bunk housing units in campus-style facilities, with potential options for small dormitory units for select segments of the population.

Additional Housing Design Considerations

Locked vs. Unlocked Sleeping Rooms

Within a housing unit with single sleeping rooms, the sleeping rooms can remain locked or unlocked. In the largest national survey of conditions of juvenile confinement, the Survey of Youth in Residential Placement, those juveniles who had been placed in secure correctional settings (particularly males and juveniles ages 16 and over) reported feeling less fearful of being attacked by other residents or staff when their sleeping rooms were unlocked (Sedlak & McPherson, 2010, unpublished analysis by AECF 2016). Locked sleeping rooms are closely associated with the use of room confinement, which is itself strongly associated with the prevalence of suicide and self-harm along with other symptoms of mental health distress (Sedlak et al., 2013, Beck et al., 2013). Also, a 2006 study found that the use of locked sleeping rooms was one of the most significant factors contributing to elevated fatality risks for incarcerated juveniles (Gallagher & Dobrin 2006). Further, locked sleeping rooms are typically required to be equipped with in-room toilets and sinks, so that juveniles can access these facilities when needed without needing the help of a staff member. These additional fixtures can contribute to elevated suicide risks (Roush & McMillan 2000, NIC/NPJS 2015).

However, locking sleeping rooms may be determined a necessary security measure. Failure to account for this during construction could result in substantial renovation costs in the future. In an effort to balance security and a normalized environment, DBHDS utilizes locked sleeping rooms at Western State Hospital which are capable of being unlocked and opened by staff and the resident assigned to that room. Residents are able to unlock only their own bedroom doors

through the use of electronic bracelets. DBHDS asserts that this method helps to normalize residents' daily activities by allowing greater freedom within a controlled environment.

The Task Force recommends lockable doors on each room with a presumption that they remain unlocked, with DJJ adopting procedures and protocols governing when lockable doors may be locked.

Wet vs. Dry Rooms

As mentioned above, a living unit with individual sleeping rooms can be configured so that each sleeping room has its own sink and toilet (i.e., "wet" rooms) or so that bathroom facilities are located in a common area to be used by all the residents, with no water supply provided to the individual sleeping rooms (i.e. "dry" rooms). As noted above in the discussion about locked vs. unlocked sleeping rooms, wet rooms are most prevalent in living units where residents are locked into their sleeping rooms at night, and dry rooms are more common where sleeping rooms are typically unlocked. MYSI standards consider wet rooms to be inappropriate and not normative; and as noted above, the additional plumbing fixtures required for a wet room configuration lead to higher construction and maintenance costs, while also posing safety risks.

In his presentation, Mr. Loughran, expressed a strong preference for dry rooms, as they are more sanitary, more developmentally appropriate, and less like adult correctional facilities.

In Virginia, 6VAC35-71-340 dictates that potable water must be available in every sleeping area (See Appendix H); however, regulations do not stipulate that every individual sleeping room must have its own sink and/or toilet.

The Task Force will continue consider the implications of wet and dry room configurations when developing the final report, including alignment with best practices, Virginia regulations, and programmatic requirements of the CTM. If wet rooms are selected, staffing levels and supervision procedures must be adopted to ensure safety in the sleeping rooms and to guard against misuse or damage of the in-room plumbing fixtures. If dry rooms are selected, staffing levels must be adequate to ensure that safe, supervised access to shared toilets and sinks can be provided whenever needed.

Space Requirements for Sleeping Rooms

Within any given living unit configuration, sleeping areas need to provide sufficient space, not only to accommodate furnishings, storage, door clearances, and other architectural features, but also to provide residents with a psychological sense of spatial openness. When designing cell configurations, occupancy plays a key role in determining the size of the cell. According to Alexander, Farrell, Roy, and Twomey (2006), in single-bunk cells the minimum floor area is approximately 70 to 80 square feet; in contrast, the minimum floor area in double-bunk cells is approximately 100 square feet. For every eight inmates, there must be at least one shower. Minimum design standards dictate that cells must be seven feet wide and 10 feet deep with 35 square feet of unencumbered space. When cell confinement is more than 10 hours per day, standards call for 80 square feet of unencumbered space.

The relevant standards in terms of sleeping rooms are those set in Virginia regulations (6VAC35-71-360), and national standards established by the American Correctional Association will be considered. These are minimum standards, and DJJ will consider designs that provide more space for sleeping rooms, while balancing the need for sleeping space against other space needs (programmatic, recreational, educational, etc.) within the total square footage available.

VII. NUMBER AND GEOGRAPHICAL LOCATION OF JCCS

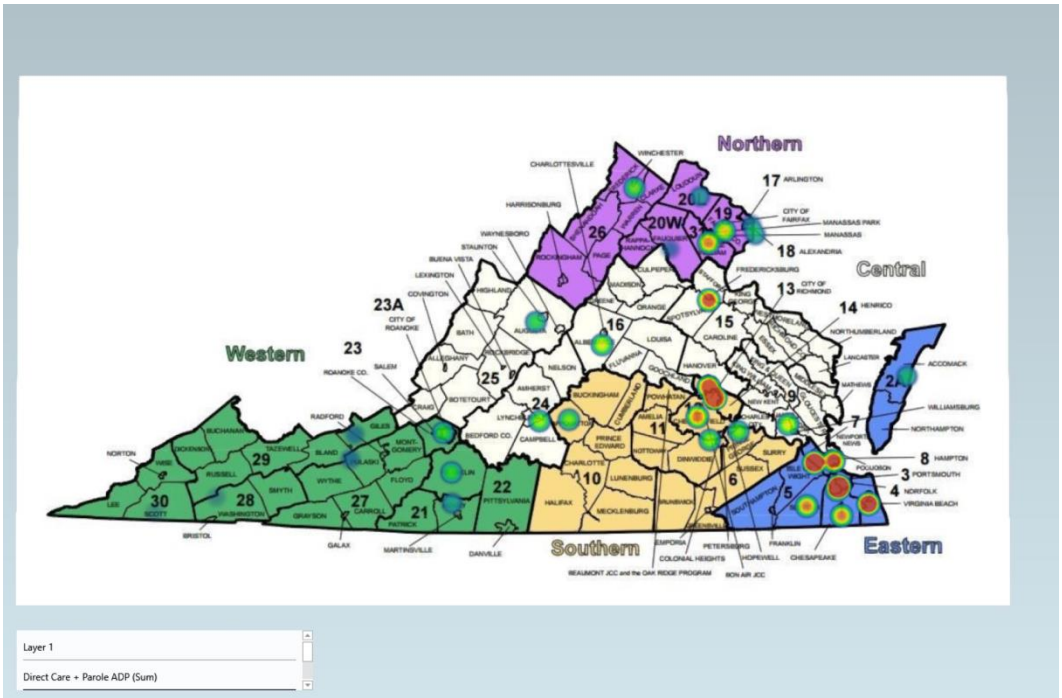
Two of the key components of the DJJ rehabilitative approach are family engagement and community reentry. The Magellan Health Services Children's Services Task Force (2009) found three factors significantly associated with positive outcomes after release from a juvenile justice facility:

- The amount of family involvement in the treatment process prior to discharge,
- Placement stability post-discharge, and
- Availability of aftercare supports for juveniles and their families.

These three factors are interrelated and can be greatly influenced by where a JCC is sited. Campuses far from families limit the opportunity for regular visits with their child and to be active participants in the therapeutic process. This inhibits building family stability, which may in turn negatively impact the resident's placement stability after release.

These factors are virtually unavailable for the majority of juveniles committed in Virginia as the JCCs are located in the metro-Richmond area and only approximately one quarter of committed juveniles are from this area. Placement far from home also means it is much more difficult for DJJ to have service providers and other community-based supports (e.g., education, work, faith-based) engage with residents prior to their release back to the community, limiting the effectiveness of aftercare services. Siting facilities as close as possible to the communities where many juveniles will return is advantageous to treatment success as well as safety after release.

To this end, juveniles should reside in a facility as close to their home community as possible. Below is a heat map showing the location of the home communities of DJJ's JCC residents, with the highest concentration of committed juveniles represented by red circles, followed by green and then blue. The map shows that the ideal siting location to accommodate the majority of juveniles likely housed in a new facility is in the Tidewater region of the state.



As discussed above, the majority of juveniles in a long-term secure placement (i.e., JCC) will be serious offenders. An analysis was conducted based on a snapshot of the serious offenders in direct care on December 9, 2015, and only 27% were within a one-hour drive of either Bon Air or Beaumont JCCs. (Supervising locality was used as a proxy for the juveniles' home locations.) Conversely, 77% of these serious offenders were within a one-hour drive of either Hanover or Chesapeake, with 53% in the Chesapeake area, indicating that a JCC site in Chesapeake greatly increases the number of families able to drive to visit in an hour or less. (See Appendix I.)

Commitments over time confirm that the Tidewater region consistently commits a large proportion of juveniles to direct care. Over a 17-year period, Richmond had the highest number of commitments, followed by Norfolk, Virginia Beach, and Newport News. (See Appendix J, where the top ten localities are highlighted blue, with the top five in darker blue.)

Finally, as preliminary data show, juveniles committed from the Eastern region (CSUs 1, 2, 2A, 3, 4, 5, 7, and 8) comprised approximately 46% of both the overall direct care population ADP (199 of 406) and the serious offender ADP (75 of 161) in FY 2016.

Therefore, based on the preliminary analyses described in section I ("Projected Population"), it is imperative that a JCC be located in the Tidewater region, close to these localities with high numbers of commitments. Based on the land availability in the urban setting and the partnership with the City of Chesapeake, the facility size is planned for 64 beds as described above.

Secure beds, however, will not only come from JCCs; they currently and will continue to exist within the CPPs, the number of which will eventually expand to cover all regions of the state.

VIII. CONTRACTING WITH OTHER FACILITIES

DJJ currently contracts with existing local and regional secure detention facilities to serve appropriate juveniles in direct care in CPPs and detention reentry, and additional contracted placement options are underway as the comprehensive continuum of care takes shape. These contracts will be described in detail in the final report, and the Task Force will have an opportunity to hear specific presentations on this subject and consider what additional opportunities may be available.

EXISTING JCCS AND OTHER STATE PROPERTY

As of June 30, 2016, DJJ operated two JCCs (Beaumont JCC and Bon Air JCC) with a combined operating capacity of 520 beds[15]. An additional 76 beds were available in the CPPs operated at Blue Ridge, Chesapeake, Chesterfield, Lynchburg, Merrimac, Rappahannock, Shenandoah Valley, and Virginia Beach JDCs, with additional locations and beds planned in the near future. Juveniles also may be housed in detention reentry programs at the participating JDCs. As stated above, alternative non-secure placements will be available as well.

In 2013, DJJ administration awarded KMD a contract to conduct a broad-level assessment of existing building conditions and site infrastructure of the JCCs. KMD also reviewed applicable codes and standards, including the Americans with Disabilities Act and American Correctional Association for general conformance of current DJJ juvenile facilities. Additionally, AECF assessed the status of the current facilities. These findings and additional information on the existing JCCs will be reviewed in future Task Force meetings and will be included in the Task Force's final report.

[15] The combined operational capacity is 520. The combined constructed capacity is 889; however, 369 rooms are unusable because they were converted into office, treatment, and storage space; the housing units were closed; or rooms operationally house fewer juveniles in the designated space (e.g., bunk beds removed from large dormitory-style housing units).

PROJECTED REQUIREMENTS FOR STATE FUNDING

Projected requirements for state funding, specifically secure detention facilities and Virginia Juvenile Community Crime Control Act (VJCCCA) programs, will be provided in detail in the final report.

CONCLUSION

This interim report from the Task Force focuses on the new Chesapeake facility and makes recommendations that are critical to beginning the initial design process for that facility. The design process itself, in addition to the continuing work of the Task Force, will provide an additional opportunity to examine and, if necessary, supplement or modify the recommendations made here.

While continuing to gather input on the recommendations made in this report, the Task Force will evaluate the remaining areas of consideration required by the General Assembly, many of which center on meeting DJJ's capital needs outside of the Tidewater region. Some of these topics will include the optimal use of current DJJ facilities, opportunities through continued or expanded partnerships with local or regional JDCs, and final population and bed needs.

The Task Force is grateful for the significant stakeholder interest in its work, the extensive input it has received, and the support provided by numerous DJJ staff members who have contributed greatly to the quality of the meetings and the production of this interim report.

APPENDICES

Appendix A: Public Comments

Appendix B: Consequences of Budget Reductions on Direct Care Placement Options

Appendix C: Services in the Comprehensive Continuum of Care

Appendix D: Preliminary Projection of Direct Care Placements

Appendix E: Mental Health, FY 2015 Admissions

Appendix F: "Missouri Model"

Appendix G: Cost-Savings for New Construction

Appendix H: Virginia JCC Construction Regulations

Appendix I: Juveniles' Homes Within One-Hour Drive of Facility Sites

Appendix J: Commitments by Committing Locality

Appendix K: References

APPENDIX A: PUBLIC COMMENTS

To: The Honorable Brian Moran, Secretary of Public Safety and Homeland Security

From: The Department of Juvenile Justice

Re: Public Comments to Task Force on Juvenile Correctional Centers

Date: June 14, 2016

Below please find a summary of the written public comments submitted for consideration by the Task Force on Juvenile Correctional Centers.

Name of Commenter	Summary of Comments Provided
Janet Areson Virginia Municipal League (VML)	VML supports reform efforts that will allow the state and local governments to work in partnership to better serve youth involved in the juvenile justice system and improve outcomes, as long as those efforts are a true partnership and do not put the onus for funding and administration on local governments." VML does not have a position on the closing of Beaumont Juvenile Correctional Center (JCC) but supports the City of Chesapeake's "efforts to work in cooperation with the state to co-locate facilities that will better serve youth in the Hampton Roads region and keep them closer to their families."
Nora Berson Citizen Liz Ryan Citizen	Ms. Ryan requested the Commonwealth to "[p]lease invest in their communities, instead of prisons." Virginia has poor outcomes for committed youth in the traditional prison model (high cost with a three year, three quarter rearrest rate). Youth in "juvenile prison" for more than 15 months are 44 % more likely to be rearrested in a year from release. Last year only 28% of committed youth passed the English standard of learning (SOL) test and 7 % passed the math SOL. "The Task Force must engage individuals and communities most impacted by the current juvenile justice system, and be transparent about its decision making process." For youth requiring secure confinement, "Virginia should create or renovate small, group home like settings that keep more youth closer to their communities…staffed in a way conducive to individualized treatment, rather than a traditional prison model that utilize a number of correctional officer staff solely for security. Let's spend our taxpayer dollars on models and alternatives to youth incarceration that we know work. Invest in kids remaining in their homes and in community-based programs and placements rather than prison."
Blue Ridge Juvenile	The Blue Ridge Juvenile Detention Commission "supports DJJ's transformation efforts which are data-driven and guided by national best practices…Blue Ridge

Name of Commenter	Summary of Comments Provided
Detention Commission: Doug Walker Deputy County Executive, County of Albemarle; Michael Murphy, Assistant City Manager City of Charlottesville; John Egertson County Administrator, Culpeper County; Steven Nichols County Administrator, Fluvanna County; John Barkley County Administrator, Greene County	Juvenile Detention is currently partnering with DJJ [as a Community Placement Program (CPP)] in their transformation efforts and plans to continue providing programs and services to state-committed youth." The Task Force should remember "that there are state funding streams that support locally operated programs, including secure detention centers and detention alternative programs. Those funding streams (the block grant for secure detention operations and the Virginia Juvenile Community Crime Control Act funding) need to be preserved." "[L]ocal programs and services, in part financially supported by the Commonwealth…provide alternatives to commitment…please keep in mind the need for independent local programs tailored to the needs of the youth and families in our communities… it is essential to future success to remember the inherent differences between state-operated juvenile correctional centers and locally operated juvenile detention centers as it pertains to size, staffing, population, available community resources, and the widely varying treatment needs of the juveniles served… DJJ's new initiatives must also provide a means to maintain the integrity of effective youth correctional services currently provided by our Center and others like it around the Commonwealth."
Judy Clarke Executive Director Virginia Center for Restorative Justice	"The National Partnership for Juvenile Services (NPJS) believes that youth should be served in the least restrictive environment possible. Repurposing facilities allows local jurisdictions to provide secure care and/or alternatives that may be accessed when such an environment is essential to protect the youth and the community… repurposed facilities create opportunities for programming and education that address the behavioral health needs of the youth and provide access to community resources designed to successfully reintegrate the youth back into society as a productive citizen." Construction of juvenile correctional centers (JCCs) should "accommodate Sensory Rooms for restorative justice practices… in order to give an immersive sensory experience for people with various abilities…

Name of Commenter	Summary of Comments Provided
	which helps youth de-escalate." The Sensory Room "should be designed to accommodate dialogue circles for addressing conflict in the facility, victim-offender conferencing and re-entry circles of support."
Laurie Coleman Director of Community Services County of York	"In general, York County is supportive of the Department of Juvenile Justice's transformational initiatives and the efforts to place juveniles back into the communities… construction of a new facility in Chesapeake would benefit the region since research has shown that keeping juveniles closer to their communities, where educational and wrap around services can more easily be provided, results in better outcomes and a reduction in recidivism. Smaller facilities located in the community provide for better family engagement in treatment and training programs." The expansion of community placement programs (CPPs) "offers the potential for an increase in revenues for our local Merrimac Center and has the "potential to reduce some of the [localities] funding liability…The State's transformational process appears to have enhanced opportunities for these [transitioning from commitment] juveniles and their families without shifting the funding liability for these programs to localities. As long as this support continues, the likelihood of positive outcomes is expected to continue and localities and supporting community organizations remain viable partners in this process."
Christy Evanko The Virginia Association for Behavior Analysis Public Policy Committee (VABA)	VABA "agree that systems transformation is needed specifically as it pertains to developing a continuum of community-based services that supports in lieu of operating a continuum of restrictive facilities….[and] urges the Commonwealth to consider the current and future research to inform a thoughtful dialogue on the purpose of these facilities, the population to be served and the anticipated outcomes. We also recommend that the majority of youth (including those with disabilities) access interventions and supports in community-based settings not facilities." To support its position VABA provided a list of resources and stated: (i) residential placement away from home should be a last resort and utilized for only the small number who pose a significant and persistent risk to public safety as informed by a validated risk assessment and not based solely upon the offense charged; (ii) detainment exacerbate pre-existing trauma, disrupt a youth's development, and "often expose young people to extreme physical and sexual violence, restraint and isolation" with non-violent youth served in the community; (iii) individualized reentry planning should begin at admission with coordination between staff, youth, their families, and other agencies and service providers; (iv) at-risk and delinquent youth grouped together for interventions and residential programs has a detrimental effect; (v) punitive practices and long periods of incarceration are harmful to youth; (vi) Applied Behavioral Analysis is established

Name of Commenter	Summary of Comments Provided
	as the most effective intervention for individuals experiencing developmental delays, and correctional staff who received ongoing behavior analytic supervision were more likely to utilize positive based procedures and use less punishment; (vii) community based interventions are more effective at addressing the developmental needs of justice-involved youth, reducing recidivism, engaging the whole family, and producing long term outcomes; and (viii) examining the research that exists (e.g., "The Morningside Model of Generative Instruction") is necessary to inform decisions that will affect Virginia youth.
Juvenile and Domestic Relations District Court Judges (submitted anonymously through the Office of the Executive Secretary of the Supreme Court of Virginia)	*Response 1*: Policy makers consider the serious mental health issues in serious delinquency cases in decision-making. "Many traditional correction methods in my experience simply do not, will not and cannot work among such suffering persons." Sufficient resources should be allocated for effectively rehabilitating. "[T]he problem is the lack of resolve to provide the funding." "[P]ublic safety (and the safety of juveniles themselves while incarcerated) must always be our number priority. We are nothing if we are not safe. Build facilities and staff them accordingly." Youth must be kept on track academically and taught skills to enter the workforce. *Response 2*: "Please consider geographically in the construction of any new facilities. Neither Chesapeake nor Ashland are in any way accessible to the children of Southwest Virginia. A facility in Charlottesville or Roanoke would give parents of committed children a reasonable chance of visitation. Impoverished parents cannot drive six hours or more to see their children." *Response 3*: "In several years the total population of children will increase so the number of children committed will probably increase as well." Commitment is a last resort for judges and the juvenile crime rate has dropped due to more interventions to "keep children in school and put services in the family and school to support the child." The level and types of services "will need to be intensive and specialized to the child because the community has exhausted all local services" including residential placements. Regarding housing models, "[c]ottages may give personnel more of a chance to work with [the] child and find [a] way to develop incentive." "The juvenile system is at the far left of the pendulum swing. It will come back to the center and there has to be a plan of how to handle the uptick in number committed. At least one facility should be centrally located to the state so that the farthest corners can reach it and families can physically visit the child.

Name of Commenter	Summary of Comments Provided
	Probably most detention centers have excess capacity. Those spaces should be utilized. Post-[Dispositional] Detention has been a tremendous success. It keeps the child in the locality with local services." *Response 4*: "Safety, including the ability to separate codefendants, and to separate younger juveniles from older one. This is particularly important when we realize that delinquent youth are not always automatically transferred to the city jail upon turning 18…the design of the detention centers should envision this and there is a significant developmental difference between a 14 and an 18 year old. Also, the dining space should be designed with this in mind." "There needs to be sufficient room in the facility to meet these [mental health and substance abuse] needs, to run group programs and for individual counseling. A reasonable place to meet with family members, and to conduct family counseling – crucial in meeting the needs of these juveniles…. It is still critical to have sufficient space to avoid overcrowding" as overcrowding is "a very unsafe and non-rehabilitative environment." With population decline, facilities are looking to repurpose empty living units (e.g., day treatment, girls' programs), "[f]or example, a detention center could be built with an eye toward conversion of a portion to a day treatment center by framing out exterior doors which could later be added to the center," etc. There should be space for artistic endeavors which seem to have therapeutic value and appropriate educational spaces are necessary. "[I]t is still critical to place detention facilities sufficiently close to communities that there can be regular family interaction…because these kids are returning home and the better we can prepare the family for that event the less likelihood that the juvenile will return." *Response 5*: "I am deeply disturbed by the notion that the new centers should be demographically centered – that is to say in Tidewater or other areas east of I-95. Those of us in the western part of the state are a long, long way away from the east…if I send a child to DJJ in Tidewater, he or she will see [his or her] family rarely if ever. I would urge DJJ to consider either building several facilities in the easily ignored parts of the Commonwealth or repurposing existing detention facilities in the less populated areas to house children committed to the agency."
LaBravia Jenkins President Virginia Association of	VACA objects to the decision to close Bon Air and Beaumont Juvenile Correctional Centers (JCCs) "containing 549 beds in exchange for the creation of alternative juvenile facilities housing 152 beds." The present plan [smaller and more conveniently located JCCs] is not to "convert" the JCCs, "it is to eliminate

Name of Commenter	Summary of Comments Provided
Commonwealth's Attorneys (VACA)	the, with no corresponding secure placement as an alternative for the majority of juvenile offenders… DJJ cannot unilaterally reduce the number of secure placements without creating a serious risk to public safety…The Department is on a path to release (or keep) hundreds [300] of the most dangerous juvenile offenders in our communities without adequate alternatives to assure the safety of the public" with the "same level of supervision and services that failed in preventing the behavior in the first place." The Department has lost track of the mission of juvenile court (to protect the community and hold offenders accountable). Committed juveniles are either repeat offenders who have not been successful with services in the community or violent offenders. "[T]hese offenders, who need the highest level of security in order to prevent more crimes and more victimizations, will not be secure – and the public will not be protected."
Loudoun County: Michelle Smith; Manager of Loudoun County Juvenile Detention Center Hope Stonerook; Deputy Director of Family Services	Loudoun County is supportive of the Department's transformation efforts. "The ability to house youth closer to their communities for reentry and family engagement is key to overall success." Loudoun County requested the Task Force to consider the "state funding streams that support locally operated programs, including detention centers and detention alternative programs. Those funding streams, the block grant for secure detention operations, and the Virginia Juvenile Community Crime Control Act funding need to be preserved. These dollars ensure that localities have sufficient funding to operate programs that work to prevent youth from being committed…" Loudon County noted that "no one from local detention was asked to serve on the Task Force and there has been little discussion from the Department of Juvenile Justice with regards to the impacts or the role local detention will play in the future."
Jessica Philips Executive Vice President and Chief Operating Officer Commonwealth Autism	"[W]e advocate for the development of a continuum of community-based services and supports in lieu of operating a continuum of restrictive facilities… Commonwealth Autism urges the Commonwealth of Virginia to divert youth including those with developmental disabilities from restrictive facilities to community based settings where they can access interventions and supports… Residential placement away from home should be a last resort and utilized for only the small number who pose a significant and persistent risk to public safety as informed by a validated risk assessment and not based solely on the offenses charged. In these cases, treatment programs should be small, therapeutic and located close to the youth's home so that the family relationships can be repaired and community supports can be provided."
Christa Pierpont	"[Y]outh of color and those with disabilities were more likely to be suspended

Name of Commenter	Summary of Comments Provided
Public School Educator	(often without alternative educational programming) or expelled from school. The Task Force should consider the recent Just Children report "Suspend Progress" which includes facts about Virginia's school suspension and expulsion during the 2014 and 2015, interventions and alternatives to suspensions and expulsions, and recommendations for the legislative and policy makers. "[W]here it becomes necessary to detain youth, a strong educational and workforce preparation strategy would go a long way toward strengthening youth towards goals that will serve them well in the future." DJJ should employ three strategies: (i) preventative strategies like those outlined in "Suspended Progress;" (ii) alternative school settings and/or staff at student's assigned school with class assignments for a few students who they mentor through challenging times; and (iii) strong educational and workforce training options for students who are detained.
Donna Sayegh City of Portsmouth	Ms. Sayegh provided comments presented to the Portsmouth City Council on the future capital and operational requirements for Virginia's juvenile correctional centers. Ms. Sayegh recommends focusing on prevention and not construction as "using the 'Whole School Change" program model, [in schools] will assist in repairing the harm and restoring the relationships with students in the public schools. It will create a dramatic drop in the use of detention centers and spending of taxpayers' dollars." Ms. Sayegh recommended the Task Force meetings have a mechanism to engage the attendees such as setting up the agenda in "classroom style" and having work groups discuss and report out recommendations using an Action Work Sheet and a facilitator. Ms. Sayegh also provided comments and questions as follows: (i) why are we having the Task Force; (ii) how are we going to implement what is being discussed; (iii) what is being presented that is considered to be implemented; and (iv) the Task Force should consider a fair process with engagement, explanation and expectation clarity. Ms. Sayegh also provided public comments provided to the Portsmouth School District and documents on whole-school change through restorative practices, a "How are you feeling today" face chart; a document on the logical, emotional, and survival brain; and "Defining Restorative" by the International Institute for

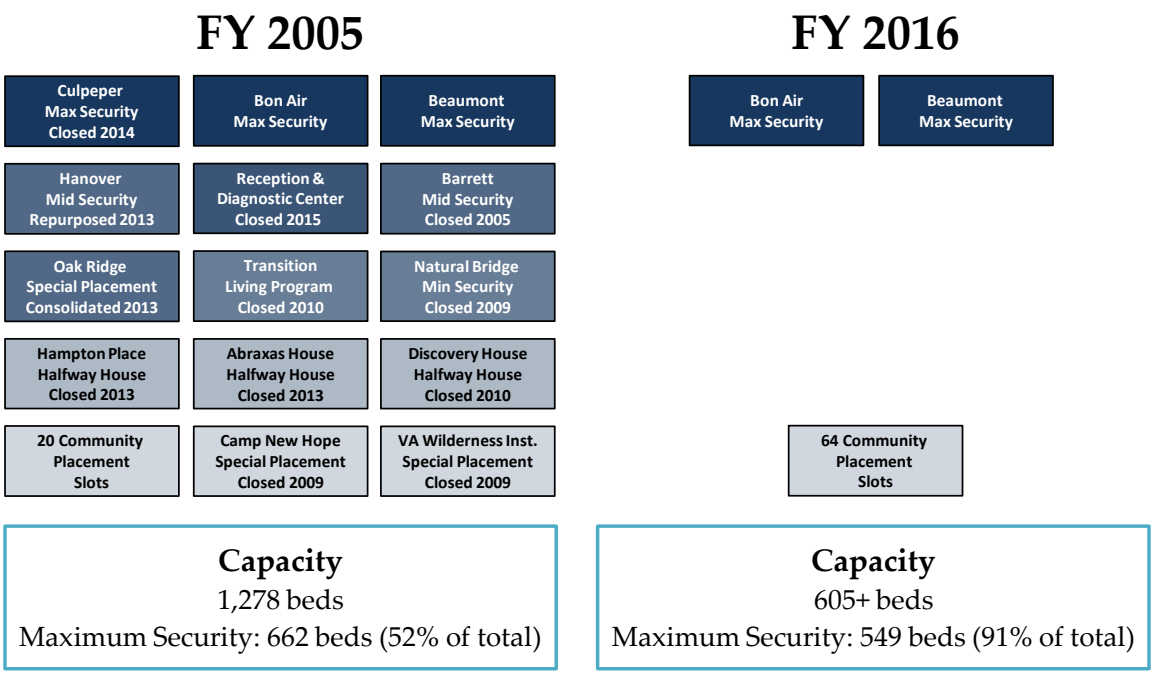
Name of Commenter	Summary of Comments Provided
	Restorative Practices.
Dana Schrad Executive Director Virginia Association of Chiefs of Police Foundation Member Board of Juvenile Justice	"State budget cuts over the past ten years have systematically eliminated the Department's continuum of alternatives that allowed it to individualize placement and programming needs for each juvenile offender… It can be easy to lean towards what appears to be the economic efficiency of larger facilities, but what that leads to is the very thing we know doesn't work, and that's the warehousing of our youth. The larger facilities are more difficult to manage, and are less amenable to a good environment for rehabilitative programming. A network of a few large facilities creates greater distances for family members to travel to maintain contact with their children…The plan to create a new and improved facility in Chesapeake and to either renovate or replace the Bon Air JCC gives the Commonwealth the opportunity to place modernized facilities in the places where they are most needed. That approach will facilitate the connections between incarcerated youth and their families that is critical to their rehabilitation. The Bon Air and Beaumont facilities were built on a correctional model that is not optimal for deploying best practices to rehabilitate incarcerated youth. There is not enough treatment, education, and career readiness space for appropriate services, and the unit sizes are not appropriate (20+) for effective interventions, supervision, and group processing. Modern facilities should not be constructed for double-bunking, but instead should use either a single cell approach or a limited use of step-down group bunking. We need to ensure that we are following a rehabilitative model as we move forward with the construction and renovation plans for Virginia juvenile correctional centers… Currently, 75% of our direct care youth are rearrested within 3 years of release from commitment. This is the direct result of our failure to provide sufficient education, treatment and transitional services in our facilities, and our under-utilization of pre-trial diversion and alternative community placement. Having community placement programs is a great alternative to incarceration when appropriate for some juvenile offenders. However, for high-risk and longest commitment durations, we still require state-operated facilities to address these youths' needs, and most of our juvenile detention centers are not equipped with the space and services needed to effectively serve higher-risk youth. In the end, improved juvenile correction facilities with step-down and continuum alternatives improve our chances of successfully preparing these juveniles to return to the community, which is the optimal concern of our public safety professionals..."
Joseph Scislowicz	"We fully support the building of a new community-based facility in our city, as we understand the 'one size fits all' model is no longer effective. This type of facility will provide our residents a strong continuum of services, treatment and

Name of Commenter	Summary of Comments Provided
Chair Community Criminal Justice Board City of Chesapeake	placement, while focusing strongly on family engagement, education, re-entry planning and services, as well as being more conveniently located to the resident' families… we believe the proposed facility will greatly enhance the future of our children returning to their communities to become productive citizens." "Community-based interventions are more effective at addressing the developmental needs of justice-involved youth, reducing recidivism, engaging the whole family, and producing positive, long-term outcomes." The Department should consider the Family Home Program (FHP) at Boys and Girls Town as a model for addressing maladaptive behavior. "Outcome data report that the dependence upon punitive practices and long periods of incarceration [are] harmful to young people. These factors are related to increased rates of reoffending, harmful effects to family relationships, decreased educational and academic attainment, and further incarceration later in life.
Anne Smith A.B. Smith Consulting, L.L.C.	Beaumont and Bon Air Juvenile Correctional Centers (JCCs) are "fraught with design and operational problems" which convinced policy and funding decision makers "that as few of your youthful offenders as possible" were sent to the JCCs. The JCCs "are oversized, inadequate for treatment purposes and costly to maintain and operate…serve less than 10% of the juveniles supervised by DJJ but account for almost 40% of the DJJ budget…[and] are historically ineffective – approximately 80% of youth re-arrest in the three year period after returning home." The Department's plan to replace the existing JCCs with "smaller, more effective and efficient facilities in these locations close to those localities that send the greatest number of youth in state custody…with the intent to reinvigorate the state and local partnership and re-invest savings in community placements and support of locally operated services…represents a possible and much needed transformation" of juvenile justice in the Commonwealth. "It is my hope and that of many others…that you will support construction projects that have the potential to provide better services in a far more cost-effective manner."
Jeree Thomas Re-Invest in Supportive Environments (RISE) for Youth	The Task Force membership "should reflect the diverse stakeholders impacted by the Task Force's decision to build new facilities for committed youth" as over 67% of committed youth are African American and the highest committing communities are Newport News and Hampton Roads. The Task Force neither includes parents of youth in the juvenile justice system nor formerly incarcerated youth. "Recruiting diverse and directly impacted youth and families to serve as members of the Task Force will be key to transforming the system in a way that reflects the needs and feedback of those most impacted by new juvenile facilities." The Task Force process should be open and transparent through July 2017 with public given notice of the date, time, and location of meetings a minimum of one-

Name of Commenter	Summary of Comments Provided
	week in advance. The meeting should be accessible to the public such as being held outside normal business hours. "The interim and final reports "should be publicly accountable for review and accountability purposes." The model for new juvenile correctional centers (JCCs) does not have to align with "the traditional prison model" and "should align its model to best practices and implement effective elements of nationally recognized and researched models like the 'Missouri Model'" which reduced recidivism in Missouri and follows six premises: (i) youth stay in small, regional facilities close to their family; (ii) youth are given treatment; (iii) healthy peer and staff relationships are achieved through group interaction rather than coercive techniques; (iv) youth have the opportunity to work toward academic and career goals; (v) families are partners in treatment and planning; and (vi) planning for reentry begins at entry and reentry support follows into the community. The Department's current plan [close existing JCCs and replace with a facility in the City of Chesapeake (112 beds with 64 for committed youth) and Hanover County (88 beds for committed youth)] is projected to cost $90.5 million with nearly $700,000 allotted on secure perimeter fencing. The largest secure facility in Missouri has 50 beds with the average bed capacity of 20 to 30 beds even with a higher average daily population of committed youth than Virginia. Smaller facilities assist to individualize the relationship between youth and staff. Also, the Missouri facilities do not resemble prisons and are not run like prisons including having few locked doors inside the facility and less security hardware and do not employ armed guards, cells, pepper spray, prolonged isolation, etc. "The Task Force should consider how to implement the Missouri model to replace Virginia's current model…. Shift in how Virginia has traditionally run its secure youth facilities" (e.g., running multiple small facilities). Beaumont and Bon Air JCCs cost $408 and $367, respectively, per day per youth to operate, with an average of $140,000 for each youth committed per year. In Missouri, secure facilities cost an estimated $375 per youth per day with an average of $137,000 per youth per year. The Department's proposed JCCs will not only cost $90 million to build but will cost over $200,000 per youth per year to operate. "Virginia can and should put in place more effective Missouri model facilities around the Commonwealth for less costs than DJJ's proposed plan. Not only would these kinds of facilities cost less in the short term, but they would also save the Commonwealth in costs related to recidivism in the long term."
William C. Tignor Rappahannock Juvenile Detention Commission	Rappahannock Juvenile Detention Center (JDC) is an 80 bed facility with 45-65 % local-placement utilization. Rappahannock JDC operates a community placement program for transitioning and low-risk committed youth where individuals "in secure facilities away from the large state facilities closer to their families…The expansion of this program to include females is a positive development…" I think

Name of Commenter	Summary of Comments Provided
	we do a disservice to the taxpayers of our state if we do not assess the current facilities under the purview of DJJ and determine the viability of those facilities to house these [our most challenging] juvenile offenders. Renovations of existing facilities must be more cost effective than buying land and constructing new buildings." Mr. Tignor further stated that "if facilities under the jurisdiction of local governments are part of the equation, attention MUST be made to state allocated resources being available to local facilities."

APPENDIX B: CONSEQUENCES OF BUDGET REDUCTIONS ON DIRECT CARE PLACEMENT OPTIONS



APPENDIX C: PRELIMINARY ASSESSMENT OF THE COMPREHENSIVE CONTINUUM OF CARE SERVICES

The following services are indicated through the preliminary assessment of services for each region:

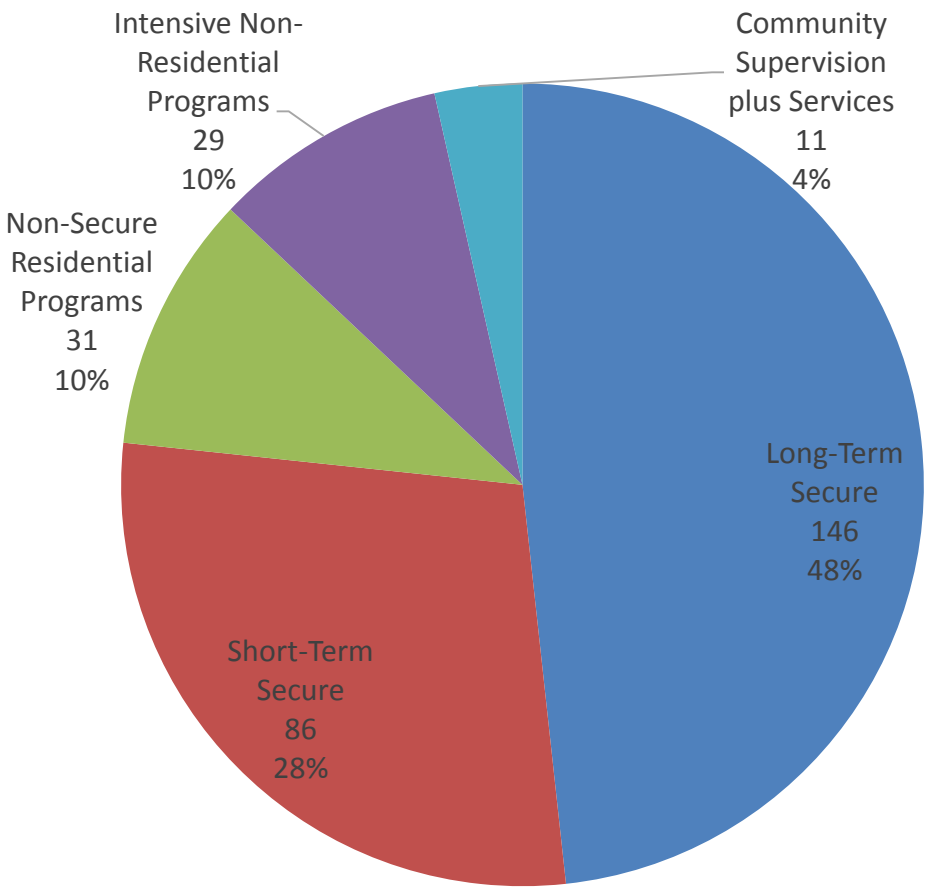
- Individual Clinical Services
  - Individual therapy, individual substance abuse treatment, individual substance abuse relapse prevention, individual sex offender treatment, and individual sex offender relapse prevention
- Family Focused Interventions
  - Functional Family Therapy (FFT) and/or Multi-Systemic Therapy (MST);
- Individual Cognitive Skills Training
  - Life Skill Coaching and Gang Intervention Services
- Group-Based Cognitive Skills Training
  - Cognitive skills group (Aggression Replacement Training (ART) or Thinking for a Change (T4C) groups)
- Group Based Clinical Services
  - Substance abuse treatment groups and sex offender treatment groups when there are 6 or more referrals within a 90 day period
- Assessment and Evaluations
  - Psychological Evaluations, Psychosexual Evaluations, Psychiatric Evaluations, Substance Abuse Assessments, Mental Health Assessments, Trauma Assessments, Sex Trafficking Evaluations, Sex Offender Polygraph Evaluations, Sex Offender Plethysmograph Evaluations
- Monitoring Services
  - Surveillance, Electronic Monitoring, and GPS
- Residential Services
  - Mental Health Inpatient Treatment, Inpatient Substance Abuse Treatment, Inpatient Sex Offender Services, Independent Living Beds, Group Home Beds, Treatment Foster Care, and Emergency Respite / Shelter Care Beds; when services do not exist within the region, services should be sought that are within close proximity; must provide reentry services for juveniles upon release from a residential setting

Additional services may include the following:

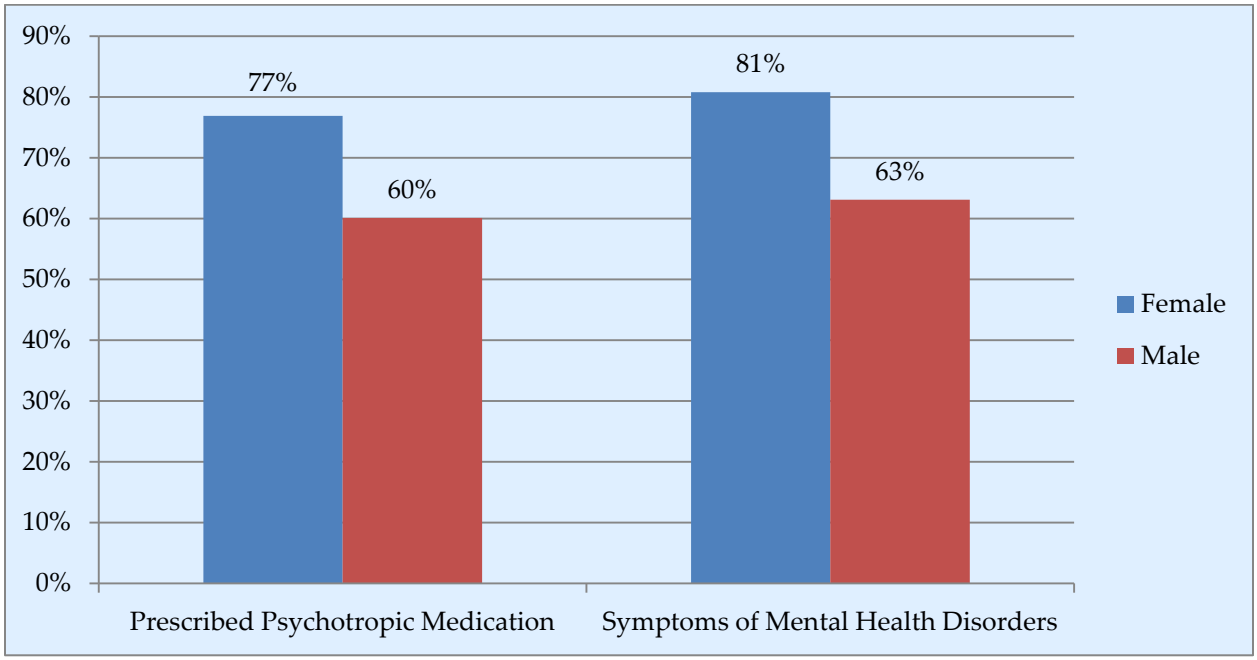
- Individual Clinical Services
  - Anger management therapy, trauma-focused individual therapy
- Family Focused Interventions
  - Family-based groups using Strengthening Families curriculum, Family Focused Sex Offender Treatment; Family Focused Substance Abuse Treatment
- Individual Cognitive Skills Training
  - Other evidence-based, manualized cognitive behavioral skills training
- Group-Based Cognitive Skills Training
  - Other evidence-based, manualized cognitive behavioral group

- Monitoring Services
    - Voice Verification, Appointment reminder
- Coordination Services
    - High Fidelity Wraparound or Other Intensive Care Coordination Service Coordination
- Workforce Development and Employment Services
    - Career/College Readiness Skills
    - Employment Skills Coaching

APPENDIX D: PRELIMINARY PROJECTIONS OF DIRECT CARE PLACEMENTS



APPENDIX E: MENTAL HEALTH, FY 2015 ADMISSIONS



*Data include juveniles who appeared to have significant symptoms of a mental health disorder, according to diagnostic criterion the DSM. Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, Substance Abuse Disorder, and Substance Dependence Disorder are not included.

APPENDIX F: "MISSOURI MODEL"

The "Missouri Model" focuses on continuous case management, decentralized residential facilities, intensive and ongoing treatment, small groups with peer interactions, trusting relationships developed from ongoing work between consistent teams of staff and youth, and a restorative treatment-centered approach. It is consistently touted as a promising practice and one of the best approaches in juvenile justice corrections, but there has not to date been any rigorous scientific study of the Missouri model's effects on recidivism (nor, for that matter, of any comprehensive approach to juvenile corrections) that controls for youth-specific and system-specific factors. The elements of the "Missouri Model," however, are consistent with best practices in juvenile justice and trauma-responsive and positive youth development approach to juvenile justice Therefore, DJJ is collaborating with MYSI to transpose the Missouri tenets that are most appropriate for Virginia's system rather than attempting to replicate their program identically.

DJJ and the Task Force must consider several system and population differences between Missouri and Virginia in order to make the best decisions for programming and physical plant design. None of these differences would render the core philosophy and practices of the Missouri approach inapplicable to Virginia, but they could impact the way that Virginia applies them in DJJ's specific context. These factors include, but are not limited to, the following:[16]

System

- **Upper Age of Jurisdiction:** *Missouri has a lower age of jurisdiction.*
  - Missouri: The upper age of jurisdiction is 17.
  - Virginia: The upper age of jurisdiction is 18.
- **Committable Offenses:** *Missouri commits a wide range of offenses whereas Virginia commits only more serious offenses.*
  - Missouri: Any offense is committable.
  - Virginia: Only a felony, a Class 1 misdemeanor with a prior felony, or four Class 1 misdemeanors that were not part of a common act are committable.
- **Status Offenses:** *Missouri commits status offenders.*
  - Missouri: Status offenses were the eighth most common committing offense in FY 2015.
  - Virginia: Status offenses are not committable offenses.
- **Certifications to Adult Court:** *The number of cases certified to criminal court is decreasing at a faster pace in Virginia than in Missouri.*
  - Missouri: Cases certified to criminal court have decreased 37.4% from 2007 to 2014.

[16] Sources include the following: Juvenile Justice Geography, Policy, Practice & Statistics, 2016a; Juvenile Justice Geography, Policy, Practice & Statistics, 2016b; Missouri Department of Social Services, 2015; Office of Juvenile Justice and Delinquency Prevention, 2016; Virginia Department of Juvenile Justice, 2015a; Virginia Department of Juvenile Justice, 2015

- Virginia: Cases certified to criminal court have decreased 45.5% from 2007 to 2014.

Population:

- **Total Juveniles:** *More juveniles are committed in Missouri.*
  - Missouri: There were 713 commitments in FY 2015. In 2013, the commitment rate was 146 per 100,000 juveniles.
  - Virginia: There were 378 commitments in FY 2015. In 2013, the commitment rate was 122 per 100,000 juveniles.
- **Average Age:** *Juveniles committed in Virginia are older.*
  - Missouri: The average age of commitment was 15.2.
  - Virginia: The average age of commitment was 16.8.
- **Offense Severity:** *Juveniles committed in Virginia have committed more serious offenses that are more often person offenses.*
  - Missouri: In FY 2015, 47% were committed for felonies, 39% were for misdemeanors or probation violations, and 14% were committed for juvenile offenses (truancy and curfew violations). The most common offenses were assault, property damage, and obstruction of the judicial process. 68% of juveniles were placed for non-person offenses in 2013.
  - Virginia: In FY 2015, 86% of commitments were for felonies, 14% were for misdemeanors, and none were for probation violations or status offenses. The most common offenses were robbery, assault, and burglary. 56% of juveniles were placed for non-person offenses in 2013.

APPENDIX G: COST-SAVINGS FOR NEW CONSTRUCTION

Kaplan McLaughlin Diaz (KMD), DJJ consultants who completed a comprehensive assessment of the JCCs in 2013, assessed the costs of operating current facilities versus constructing new facilities to serve committed juveniles, finding that new construction would result in significant reductions in operations and maintenance costs. DJJ considered renovating and upgrading Barrett, Beaumont, and Bon Air, but estimated costs suggest renovations would not be cost-effective.

Barrett campus would cost an estimated total of $41,500,000 to upgrade and renovate, including:

- $35,500,000 for renovations to facilitate transformation to CTM and
- $6,000,000 for deferred and current maintenance costs.

Beaumont campus would cost an estimated total of $55,950,000 to upgrade and renovate, including:

- $42,550,000 for renovations to facilitate transformation to CTM,
- $7,000,000 for deferred and current maintenance costs,
- $5,500,000 for projected near-future capital funding needs, and
- $900,000 for currently funded capital projects.

The existing renovated cottages at Beaumont, Caskie and Beattie, are 7,452 square feet each with open dormitory-style sleeping rooms. Built in 1930 with wood-framed floors and roofs, their renovation cost is estimated at approximately $3,100,000 each to incorporate updated construction techniques and materials.

Bon Air campus would cost an estimated total of $51,184,441 to upgrade and renovate, including:

- $23,000,000 for renovations to facilitate transformation to CTM,
- $10,000,000 for deferred and current maintenance costs
- $16,884,441 for currently funded capital projects, and
- $1,300,000 for projected near-future capital funding needs.

DJJ has undergone a comprehensive and in-depth analysis of the Commonwealth's juvenile justice correctional system. In 2013, the McDonnell administration awarded KMD a contract in which KMD assessed DJJ's operations and maintenance (O&M) expenditures for Fiscal Year 2013 which ended in June 2013. Although the assessment used 2013 data, the results provide an excellent baseline for expected expenditures and cost savings. Expenditures were divided into five broad categories that would permit additional analysis: Energy/Utilities, Services, Maintenance & Repair (M&R), Transportation (Vehicles and Fuel), and Miscellaneous/Supplies. DJJ's expenditures were distributed across these categories as follows:

Energy/Utilities	$4,800,400
Services	$686,400
Maintenance & Repair (M&R)	$4,930,000

Transportation	$576,500
Miscellaneous/Supplies	$170,000

Energy and M&R were the two single biggest components of annual O&M costs and typically comprised about 40-50% of annual O&M expenditures. DJJ's FY13 M&R and Energy costs actually consume almost 90% of annual O&M expenditures reflecting the age and poor energy performance of its physical plant relative to current standards. As the biggest and most recently constructed components of DJJ's physical plant, namely Beaumont's Maximum Security and Oak Ridge Complex and the two Medium Security Complexes, and Bon Air's Maximum Security Expansion Complex, go beyond their 20 year milestones, M&R costs are predicted to spike significantly. Further, this spiking is predicted to recur approximately every five years thereafter. The other major category, Energy/Utilities, will not spike with the same regularity and predictability, but should undergo a steady and consistent upward trend that increasingly diverges from building performance best practice standards that have advanced significantly since Beaumont, Bon Air, and Culpeper were constructed.

KMD concluded that implementation of the new physical plant model should result in significantly reduced O&M costs due primarily to:

- Higher quality standards resulting in less frequent maintenance and lower life cycle costs in general.
- Higher building performance standards, particularly those that affect energy.
- Substantially smaller and more efficient footprint for VADJJ's physical plant.

Following are the projected comparative costs for the new physical plant model in four key categories: Maintenance and Repair, Energy, Transportation, and Security Electronics/IT.

Security Electronics and IT Costs. Included in the O&M $40 million savings are the security electronics and IT costs calculated as follows: DJJ's FY13 costs for security electronics and IT services amounted to about $660,000. It is estimated that annual security/IT expenditures for a new facility would be about $333,000. This would mean an annual savings of about $326,400 annually or about $3,264,000 cumulatively at the end of ten years.

For Maintenance and Repair (M&R) costs in particular the cost savings will be substantial. The basis for DJJ's current M&R costs is the data furnished by VADJJ but includes M&R costs only for Beaumont, and Bon Air and RDC (formerly Oak Ridge) as these facilities would be those replaced by the new physical plant model. These costs also reflect spiking in M&R costs predicted to occur roughly every five years by Whitestone Research Facilities Operations Cost Reference as the existing facilities reach their long life milestones. Projected M&R costs for the new physical plant model were derived from the same Whitestone cost reference, reflect a medium level of service for a secure correctional facility, and are adjusted to reflect the Richmond, Virginia area. The M&R cost avoidance resulting from constructing the new facility grows cumulatively to about $40 million that DJJ will have saved by 2028 assuming FY18 as the first year of operation for the new facility. The projected M&R costs for both the current and proposed facilities reflect 2013 dollars and are not escalated beyond 2013 so the actual cost avoidance will likely be significantly larger.

Energy will be a significant factor in future O&M costs. DJJ's FY2013 energy costs for its physical plant were about $3.6 million per year. Projecting these same costs, un-escalated, would mean that by FY28 DJJ will have spent, cumulatively, almost $40 million on energy. For a new facility of about 635,000 gsf, based on an operational energy usage benchmark rate of 80 kBtu/SF, unit energy costs are estimated to be approximately $3.05/SF in 2013 dollars. This would mean about $1.9 million per year, cumulatively adding up to approximately $21 million (again, in 2013 dollars) by FY28, or almost a 50% reduction in energy costs.

DJJ's FY13 transportation costs of $576,500 reflect the maintenance of a sizable fleet of 26 service vehicles, 37 juvenile transport vehicles, and 228 staff vehicles needed to serve DJJ's footprint. Even facilities that have been officially closed, such as Barrett, Hanover, and Natural Bridge, continue to consume servicing and maintenance costs, substantially so the case of Hanover.

Cost savings with a new facility are expected to be achieved in several ways including through the greenfield construction of a brand-new facility in which maintenance and repair (M&R) costs will be greatly reduced from projected levels in the existing facilities. It is anticipated that meaningful cost savings will be derived from energy efficiency improvements that are cheaper to employ and more easily implemented in a new-build facility than can be accommodated through a retrofit of a much older facility.

APPENDIX H: VIRGINIA JCC CONSTRUCTION REGULATIONS

6VAC35-71-280. Buildings and Inspections.

A. All newly constructed buildings, major renovations to buildings, and temporary structures shall be inspected and approved by the appropriate building officials. There shall be a valid, current certificate of occupancy available at each JCC.
B. A current copy of the facility's annual inspection by fire prevention authorities indicating that all buildings and equipment are maintained in accordance with the Virginia Statewide Fire Prevention Code (13VAC5-51) shall be maintained. If the fire prevention authorities have failed to timely inspect the facility's buildings and equipment, the facility shall maintain documentation of its request to schedule the annual inspection, as well as documentation of any necessary follow-up. For this subsection, the definition of annual shall be defined by the Virginia Department of Fire Programs, State Fire Marshal's Office.
C. The facility shall maintain a current copy of its compliance with annual inspection and approval by an independent, outside source in accordance with state and local inspection laws, regulations, and ordinances, of the following:

1. General sanitation;
2. The sewage disposal system, if applicable;
3. The water supply, if applicable;
4. Food service operations; and
5. Swimming pools, if applicable.

6VAC35-71-290. Equipment and Systems Inspections and Maintenance.
A. All safety, emergency, and communications equipment and systems shall be inspected, tested, and maintained by designated staff in accordance with the manufacturer's recommendations or instruction manuals or, absent such requirements, in accordance with a schedule that is approved by the superintendent.

1. The facility shall maintain a listing of all safety, emergency, and communications equipment and systems and the schedule established for inspections and testing.
2. Testing of such equipment and systems shall, at a minimum, be conducted quarterly.

B. Whenever safety, emergency, and communications equipment or a system is found to be defective, immediate steps shall be taken to rectify the situation and to repair, remove, or replace the defective equipment.

6VAC35-71-300. Alternate Power Source.
Each JCC shall have access to an alternate power source to maintain essential services in an emergency.

6VAC35-71-310. Heating and Cooling Systems and Ventilation.

A. Heat shall be distributed in all rooms occupied by the residents so that a temperature no less than 68°F is maintained, unless otherwise mandated by state or federal authorities.

B. Air conditioning or mechanical ventilating systems, such as electric fans, shall be provided in all rooms occupied by residents when the temperature in those rooms exceeds 80°F.

6VAC35-71-320. Lighting.

A. Sleeping and activity areas shall provide natural lighting.

B. All areas within buildings shall be lighted for safety, and the lighting shall be sufficient for the activities being performed.

C. Night lighting shall be sufficient to observe residents.

D. Operable flashlights or battery-powered lanterns shall be accessible to each direct care staff on duty.

E. Outside entrances and parking areas shall be lighted.

6VAC35-71-330. Plumbing and Water Supply; Temperature.

A. Plumbing shall be maintained in operational condition, as designed.

B. An adequate supply of hot and cold running water shall be available at all times.

C. Precautions shall be taken to prevent scalding from running water. Hot water temperatures should be maintained at 100°F to 120°F.

6VAC35-71-340. Drinking Water.

A. In all JCCs constructed after January 1, 1998, all sleeping areas shall have fresh drinking water for residents' use.

B. All activity areas shall have potable drinking water available for residents' use.

6VAC35-71-350. Toilet Facilities.

A. There shall be toilet facilities available for resident use in all sleeping areas for each JCC constructed after January 1, 1998.

B. There shall be at least one toilet, one hand basin, and one shower or tub for every eight residents for facilities certified on or before December 27, 2007. There shall be one toilet, one hand basin, and one shower or tub for every four residents in any building constructed or structurally modified on or after December 28, 2007.

C. There shall be at least one bathtub in each facility.

D. The maximum number of employees on duty in the living unit shall be counted in determining the required number of toilets and hand basins when a separate bathroom is not provided for staff.

6VAC35-71-360. Sleeping Areas.

A. Male and female residents shall have separate sleeping areas.

B. Beds in all facilities or sleeping areas established, constructed, or structurally modified after July 1, 1981, shall be at least three feet apart at the head, foot, and sides; and double-decker beds in such facilities shall be at least five feet apart at the head, foot, and sides. Facilities or sleeping areas established, constructed, or structurally modified before July 1, 1981, shall have a bed placement plan approved by the director or designee.

C. Mattresses shall be fire retardant as evidenced by documentation from the manufacturer, except in buildings equipped with an automated sprinkler system as required by the Virginia Uniform Statewide Building Code (13VAC5-63).

D. Sleeping quarters established, constructed, or structurally modified after July 1, 1981, shall have:

1. At least 80 square feet of floor area in a bedroom accommodating one person;
2. At least 60 square feet of floor area per person in rooms accommodating two or more persons; and
3. Ceilings with a primary height at least 7-1/2 feet in height exclusive of protrusions, duct work, or dormers.

6VAC35-71-370. Furnishings.

All furnishings and equipment shall be safe, clean, and suitable to the ages and for the number of residents.

6VAC35-71-410. Space Utilization.

A. Each JCC shall provide for the following:

1. An indoor recreation area with appropriate recreation materials;
2. An outdoor recreation area;
3. Kitchen facilities and equipment for the preparation and service of meals;
4. A dining area equipped with tables and seating;
5. Space and equipment for laundry, if laundry is done on site;
6. Space for the storage of items such as first aid equipment, household supplies, recreational equipment, and other materials;
7. A designated visiting area that permits informal communication between residents and visitors, including opportunity for physical contact in accordance with written procedures;
8. Space for administrative activities including, as appropriate to the program, confidential conversations and the storage of records and materials; and
9. A central medical room with medical examination facilities equipped in consultation with the health authority.

B. If a school program is operated at the facility, school classrooms shall be designed in consultation with appropriate education authorities to comply with applicable state and local requirements.
C. Spaces or areas may be interchangeably utilized but shall be in functional condition for the designated purpose.

APPENDIX I: JUVENILES' HOMES WITHIN ONE-HOUR DRIVE OF FACILITY SITES

Current JCCs

Both Facilities	35	23%
Bon Air Only	3	2%
Beaumont Only	3	2%
Neither Facility	111	73%
Total	***152***	***100%***

Potential Future Locations

Both Locations	0	0%
Chesapeake	81	53%
Hanover	36	24%
Neither Location	35	23%
Total	***152***	***100%***

* Based on Serious Offenders in Direct Care on 12/9/15. Supervising locality was used as a proxy for the juveniles' home locations.

CSU	Fiscal Year																	Total
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	
01 - Chesapeake	75	53	50	46	48	29	20	19	16	12	13	15	8	16	13	15	8	456
02 - Virginia Beach	104	137	110	108	90	81	39	61	46	51	54	47	31	28	31	32	23	1,073
2A - Accomac	32	27	40	26	20	17	15	7	10	11	10	7	12	4	3	7	9	257
03 - Portsmouth	44	66	51	48	38	33	26	24	30	23	37	20	16	23	22	15	15	531
04 - Norfolk	126	104	92	68	77	101	76	81	60	39	48	50	34	54	53	45	38	1,146
05 - Suffolk	52	43	37	41	34	44	34	24	30	30	25	20	19	16	17	22	11	499
06 - Hopewell	39	58	41	30	32	34	16	15	12	20	12	16	9	12	10	9	9	374
07 - Newport News	78	101	88	86	77	71	67	51	50	55	48	55	33	39	39	37	40	1,015
08 - Hampton	56	53	61	49	37	49	31	29	24	28	24	37	27	29	28	16	12	590
09 - Williamsburg	47	35	36	31	27	24	32	15	18	16	14	14	19	20	21	22	7	398
10 - Appomattox	38	37	30	21	18	17	15	5	10	5	13	16	5	6	4	7	11	258
11 - Petersburg	44	47	58	37	37	42	37	34	52	31	27	38	29	18	19	6	9	565
12 - Chesterfield	57	47	36	36	31	28	31	33	46	33	28	36	31	35	17	27	30	582
13 - Richmond	74	79	79	66	101	107	75	88	91	50	61	67	48	40	39	58	26	1,149
14 - Henrico	66	58	50	39	45	30	24	17	36	49	36	51	53	42	36	24	19	675
15 - Fredericksburg	102	89	66	55	60	75	74	70	61	62	54	49	39	42	26	37	14	975
16 - Charlottesville	98	67	80	75	53	48	36	32	40	40	31	31	20	31	21	17	9	729
17 - Arlington	52	54	37	34	24	13	14	17	20	28	18	15	15	11	16	7	6	381
17F - Falls Church	1	3			2		1			1								8
18 - Alexandria	18	12	10	12	12	14	17	9	18	14	11	12	4	4	9	2	5	183
19 - Fairfax	104	104	94	58	31	29	32	37	30	32	31	40	30	18	17	8	15	710
20L - Loudoun	16	8	7	13	7	5	7	10	4	9	8	11	4	3	4	5	4	125
20W - Warrenton	4	2	1	3	7	5	3	3	6	6	6	2	4	3	0	1	4	60
21 - Martinsville	21	11	21	18	16	23	15	10	10	17	8	10	11	11	11	5	5	223
22 - Rocky Mount	36	29	51	47	32	36	39	32	32	26	36	25	24	23	18	16	5	507
23 - Salem	17	20	19	11	7	3	9	3	3	2	4	2	6	1				107
23A - Roanoke	36	38	19	19	21	14	10	10	21	20	18	21	17	7	7	4	8	290
24 - Lynchburg	49	54	53	46	51	44	26	39	16	22	22	12	19	17	12	9	13	504
25 - Staunton	55	41	49	35	47	30	23	13	11	24	20	12	4	11	10	5	4	394
26 - Winchester	39	24	18	18	19	26	16	19	19	24	22	19	18	14	7	6	7	315
27 - Pulaski	20	14	18	8	4	17	6	11	8	3	5	3	8	4	3	6	1	139
28 - Abingdon	21	17	10	8	11	4	4	1	1	3	4	5	1	2			1	93
29 - Pearisburg	9	14	8	11	9	9	11	2	1	8	3	4	2	4	3	2	1	101
30 - Gate City	5	10	9	8	7	6	7	7	5	4	1	3	3		1		1	77
31 - Manassas	45	15	11	32	45	39	25	34	34	38	35	33	27	14	21	16	24	488
Total	*1,680*	*1,571*	*1,440*	*1,243*	*1,177*	*1,147*	*913*	*862*	*871*	*836*	*787*	*798*	*630*	*602*	*538*	*488*	*394*	*15,977*

APPENDIX K: REFERENCES

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