Office of

Inspector General of Nebraska Child Welfare

Juvenile Room Confinement in Nebraska

Fiscal Year 2024-2025

Jennifer A. Carter
Inspector General

Logan Chitty
Assistant Inspector General

Website: oig.legislature.ne.gov

Email: OIG@leg.ne.gov

State Capitol
P.O. Box 94604
Lincoln, NE 68509-4604

402-471-4211 | 855-460-6784 (toll free)

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Executive Summary

The Office of Inspector General of Nebraska Child Welfare (OIG) is required by law to annually review juvenile room confinement data reported by juvenile facilities and analyze the use of juvenile room confinement in those facilities. The purpose of this report is to establish a foundational understanding of juvenile room confinement, provide transparency regarding current Nebraska room confinement data, compare that data to national best practices, and highlight any significant findings regarding the application and trends of juvenile room confinement within the state.

In Fiscal Year (FY) 2024-2025, the OIG observed both concerning and positive juvenile room confinement trends in Nebraska.

Table 1.

Juvenile Room Confinement at a Glance: All Facilities (2022–2025) (Excluding Medical Necessity Incidents)			
	FY 22–23	**FY 23–24**	**FY 24–25**
Total Incidents of Confinement	2,918	5,887	**8,479**
Total Hours of Confinement	56,931	119,300	**127,276**
Average Time of Confinement Per Incident	19h 31m	20h 16m	**15h 2m**
% of Incidents of Youth Confined for 0-4 Hours	59%	61%	**62%**
% of Incidents of Youth Confined for 24+ Hours	17%	15%	**9%**
#1 Reported Reason for Confinement	Safety/Security: Danger to Other Youth	Administrative: Youth Refused to Comply	**Safety/Security: Danger to Other Youth**

One negative trend was a significant increase in the total number of confinement incidents. There were 8,479 incidents reported in FY 2024-2025, up 44% from the 5,887 incidents in FY 2023-2024. Relatedly, there was a relatively slight increase in the total number of hours that youth were confined. There were 127,276 reported hours of confinement in FY 2024-2025. This was an approximately 7% increase from the 119,300 hours reported in FY 2023-2024. The total number of room confinement hours and incidents in FY 2024-2025 are both the highest

numbers that have ever been reported, since facilities were first required to report juvenile room confinement data in 2016.

Based on this data alone, it appears that these increases are, as in previous years, contrary to Nebraska law and best practices, which both in essence state that juvenile room confinement should be used only for brief periods, generally not to exceed four hours and very rarely to exceed 24 hours, and should end as soon as it is safe to do so and when the immediate security threat has subsided.

However, the OIG again acknowledges that the data alone does not fully explain the complexity of juvenile room confinement nor the extensive challenges that many individual juvenile facilities face in reducing the reliance on the practice. Juvenile room confinement may occasionally be necessary to address threats caused by youth to facility safety and security, so long as it is used reasonably, sparingly, and in compliance with Nebraska law and best practices.

One noteworthy improvement and positive trend in the data—for the second consecutive year—is that most confinement incidents in FY 2024-2025 were resolved more quickly than in the previous year. In other words, confinement may have been used more frequently, but each occurrence was for a shorter period, making its overall use more time-limited. Specifically, 62% of all incidents were resolved within 0-4 hours, and youth were confined for more than 24 hours in only 9% of all incidents in FY 2024-2025, a significant improvement from the 15% in the previous year and the 17% in FY 2022-2023. For the confinement incidents lasting longer than 24 hours, facilities most commonly reported that continued confinement was necessary for safety and security reasons due to the danger that the youth posed to other youth or staff.

Another positive trend identified this year was that more confinement incidents were reportedly due to safety and security reasons, as opposed to administrative reasons, which were the leading reasons for confinement in the previous year. Across all facilities, safety and security reasons for confinement accounted for 72% of all reported incidents in FY 2024-2025, followed by administrative reasons for confinement at 25%, then medical necessity reasons at 3%. This data could suggest that the facilities better complied with Nebraska law and the best

practice that state juvenile room confinement should be reserved for serious and imminent safety and security concerns or exigent emergencies and used only as a last resort when other de-escalation methods and less restrictive alternatives have failed.

After the OIG's analysis of all reported data and comparing that data to Nebraska law and juvenile room confinement best practices, the OIG made the following findings:

1. Overall, the use of juvenile room confinement in Nebraska remained high compared to past years, with the number of confinement hours and the number of confinement incidents the highest they have ever been.
2. Despite the increase in total confinement hours and incidents, most individual incidents were generally shorter in duration for the second consecutive year, which indicates better compliance with best practices.
3. Juvenile room confinement was primarily used for safety and security reasons and there were significantly fewer administrative reasons for confinement than in the previous year, which aligns with best practices.
4. Enhanced internal and external oversight of room confinement at the juvenile facilities and more consistent and standardized juvenile room confinement statutory interpretations and practices continue to be needed.

While Nebraska statutes align with best practices on juvenile room confinement, it appears that, based on the reported data as a whole, some significant gaps in the practical application of these principles remain. To address these gaps and reduce the reliance on juvenile room confinement within Nebraska juvenile facilities, the Legislature may need to further engage with these facilities to fully understand their challenges and determine what additional supports or resources are required.

The Legislature and the juvenile facilities may also achieve this reduction, in part, by accepting some of the OIG's recommendations below, some of which have been recommended in past years.

1. The Jail Standards Board, Nebraska Department of Correctional Services, and Nebraska Department of Health and Human Services' Office of Juvenile Services should collaborate to establish a standardized and consistent interpretation of current juvenile room confinement statutes and practices across all juvenile facilities.
2. Each juvenile facility should have internal staff dedicated to juvenile room confinement oversight, data analysis, and improving and reducing confinement practices.
3. The Legislative Audit Office should conduct a performance audit of the juvenile facilities regarding the practice of juvenile room confinement to independently verify reported room confinement data and practices and assess facilities' compliance with the Nebraska juvenile room confinement statutes.
4. Juvenile facilities should be required to report room confinement data in a format that the Division of Legislative Oversight, particularly the OIG and Legislative Audit Office, determines is necessary for its review.
5. To better comply with best practices, juvenile facilities should conduct multidisciplinary reviews, including an urgent mental health evaluation, of every youth who has been confined for 24 consecutive hours.

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

Juvenile Room Confinement—Background & Overview

Purpose

Juvenile room confinement is a practice used in institutional juvenile settings that separates youth from others in the facility, resulting in limited social interaction, often with minimal access to educational or recreational activities. There are various circumstances that facilities may report as the reason room confinement was necessary, many of which are listed below. However, not all of these listed reasons for using confinement are permitted under Nebraska law, and the specific terminology that is used to describe the reason for confinement may differ from one facility to another.

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

Juvenile room confinement might also be used for administrative and medical reasons. Rather than confining a youth to manage their behavior or to ensure facility safety and security, staff might also find it necessary to confine a youth for a brief period to maintain the proper operation of the facility.

Potential Uses of Juvenile Room Confinement

Safety & Security

Danger to self or others: Isolation of youth who pose immediate risks to themselves, other youth, or staff because of violent, aggressive, threatening, or disruptive behavior. Used to prevent harm and maintain order.

Corrective action:[1] Isolation as a method of responding to rule violations and to provide consequences for youth actions. Used as discipline and rule enforcement, to deter and discourage further misconduct and promote compliance with facility rules.

Time-out: Separating youth from the general population during heightened tension or emotional distress, allows a disruptive or agitative youth to regain composure and self-control. Used as a crisis management tool.

Protective custody: Separating youth to safeguard them from potential harm or threats posed by other youth because of gang affiliations, conflicts, or other well-being concerns. May be used voluntarily at a youth's request or involuntarily when staff determines the youth's safety requires isolation from the general population.

Facility emergency: Isolation for a limited duration when an emergency or security threat requires action to preserve order. These emergencies can range from defective security systems to extreme weather events.

Medical

Medical: Temporary isolation for medical or mental health assessment or to protect the health and well-being of the youth or others in the facility from contagion. Allows medical staff to assess a youth's condition and determine appropriate treatment, or to protect a youth with a medical condition or after a medical procedure if a healthcare provider believes returning to the general population would pose a risk to the youth.

Administrative

Intake and orientation: Temporary room confinement during the intake and orientation process. Allows staff to assess a youth's needs, perform health screenings, and introduce the youth to the facility's rules and procedures.

Investigations: Separating youth during an investigation into alleged misconduct or a rule violation. Used to ensure proper collection of information and to prevent interference in the investigative process.

Staff meetings or training: Isolation of youth while staff are engaged in meetings or training activities. Allows staff to convene for important discussions and training without interruption or leaving youth unsupervised with each other.

[1] Neb. Rev. Stat. § 83-4,134.02(2)(a) explicitly states that youth "shall not be placed in room confinement . . . [a]s a punishment or a disciplinary sanction."

Distinguishing Juvenile Room Confinement from Other Practices

Juvenile room confinement has conceptual similarities with restrictive housing in the adult correctional system, where incarcerated adults are isolated for extended periods of time in small cells, often under stringent conditions that can include little human contact and severely restricted access to activities and privileges. Although juvenile room confinement is intended to be a different practice, when excessively applied, it can begin to mirror the characteristics of restrictive housing, blurring the distinction between the two practices.

Juvenile room confinement is also sometimes compared to parental grounding, where a child loses privileges as a form of discipline and guidance in a family context. This comparison is misleading and overlooks the profound differences between the two practices, in terms of both power dynamics and psychological impact.

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

Concerns with Juvenile Room Confinement

Until recently, juvenile room confinement was generally accepted across the country as a necessary and effective practice that did not warrant much oversight. However, after over 40 years of accumulated research, many national organizations have found that the practice can be traumatic and has little therapeutic value outside of limited medical settings. Several organizations recommend that the practice of juvenile room confinement should not be used at all in institutional settings, and instead be entirely replaced with trauma-informed responses, therapeutic interventions, mental health care, and clinically driven alternatives. The primary concerns with the use of juvenile room confinement are briefly described below.

Mental Health

Isolating youth for extended periods can cause severe psychological distress and increase feelings of loneliness, anxiety, and depression. Mental health professionals contend that the practice can have a long-lasting and often irreversible negative impact on youths' mental health

and potentially exacerbate existing mental health issues, particularly for those who have been victims of prior abuse or trauma. The mental health concerns caused by room confinement increase the longer that a youth is confined.

Social and Emotional Growth

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

Exacerbation of Problematic Behavior

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

Best Practices

Given these concerns, a tension exists between using juvenile room confinement as a potentially necessary tool for safety and security in a facility and the harm that the confinement can cause. As research has drawn more attention to the practice of juvenile room confinement, it has influenced the development of best practices and raised ethical concerns about the treatment of youth and their access to due process and fair treatment within juvenile facilities. As a result, the use of juvenile room confinement has become increasingly constrained, including by legislation at the state and federal levels, and many professional and accrediting organizations in the fields of juvenile justice, mental health, and education have developed best practice standards and policies to govern the use of room confinement.

The goal of these efforts is to strike a balance between maintaining safety and security within juvenile facilities while safeguarding the well-being of the youth. Such efforts reflect a

commitment to promoting positive behavior change among youth, rather than punitive measures that may have long-term negative consequences, and to implementing oversight practices crucial for ensuring the responsible and ethical use of room confinement.

Although there are many national best practices for how juvenile room confinement should be used, if at all, the practices that are most often recommended fall into the following main categories and are summarized below.[2] Each of these categories will be discussed later in this report in the OIG's analysis of the room confinement data that was reported in FY 2024-2025. As will be discussed later, almost all of these leading best practices are also captured in current Nebraska statutes that establish the legal requirements for Nebraska facilities when confining youth and documenting and reporting data regarding that confinement.

1. *Juvenile Room Confinement Should Be Reserved for Serious and Imminent Safety and Security Concerns or Exigent Emergencies and Used Only as a Last Resort When Other De-escalation Methods and Less Restrictive Alternatives Have Failed.*
    - Juvenile room confinement should not be used as a punishment or for discipline, administrative convenience, minor rule violations, staffing shortages, or act as a primary behavior management tool.
    - Confinement should only be used when other interventions have failed. Facilities should actively seek and implement alternatives to room confinement, such as restorative justice practices, trauma-informed mental health care and interventions, structured behavior modification programs, and graduated sanctions.
    - Confinement should most often be used in cases of threats to the safety of other youth or staff. It will usually only be appropriate when a youth's actions pose an immediate, serious, and imminent danger of serious physical harm to others.

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

- Each instance should undergo an individualized assessment to determine whether room confinement would be appropriate, considering the youth's age, behavior, developmental needs, and mental health, including any history of self-harm or suicide attempts.

2. *Juvenile Room Confinement Should Be Used Only for Brief Periods, Generally Not to Exceed Four Hours and Very Rarely to Exceed 24 Hours, and Should End as Soon as It is Safe to Do So and When the Immediate Security Threat Has Subsided.*
    - Most incidents of room confinement should be limited in duration, and the use of confinement for one day or more is generally considered unnecessary in most cases.
    - Any use of confinement beyond four hours should be justified and approved by the facility administration, and the facility should document why other less restrictive alternatives to confinement were unsuccessful and why the confinement period could not end.
    - Any use at or beyond 24 hours must trigger an immediate multidisciplinary review by the facility, including an urgent mental health evaluation of the youth.
    - Confinement should not be for a pre-determined amount of time. Each confinement period should last only as long as necessary to address the reason why the youth was initially confined.

3. *Youth in Room Confinement Should Be Closely Monitored and Continuously Evaluated for Mental Health; Provided Education, Therapeutic Programming, and Access to Mental Health and Legal Services; and Receive an Adequate Room, Food and Water, Hygiene Items, and Personal Belongings.*
    - Given the potential negative physical, psychiatric, and social consequences of prolonged confinement, including increased risk of self-harm, suicidal ideation, anxiety, depression, sleep disturbances, paranoia, aggression, and more, each youth should be closely watched by staff and evaluated by mental health professionals for any crises for the duration of the confinement.

    - Staff should frequently observe the youth in their room while in confinement, preferably every 15 minutes.
    - Staff should be trained to recognize signs of distress and respond appropriately when a youth is in confinement.
    - Youth should not be placed in room confinement if they are potentially suicidal.
    - Mental health professionals should offer services to confined youth and proactively plan for their safe return to the general population.
- To emphasize the rehabilitation of confined youth instead of punishment, for the duration of the confinement, the youth should continue to receive the facility's regular education and therapeutic programming, access to all mental health services, legal services, and contact with legal guardians that all facility youth normally receive.
- The physical conditions of room confinement should not be harsh, and the confined youth must retain access to personal hygiene items and toilet facilities, nutritious meals, drinking water, reading materials, and exercise opportunities.

4. Facilities Should Properly Document and Report Room Confinement Data, and There Should be Both Internal and External Accountability and Oversight of the Confinement.

- Facilities should collect and maintain accurate records of all room confinement incidents, including the frequency, reasoning, duration, outcomes, and any interventions attempted.
- Facilities should analyze the confinement data collected for trends and disparities and use that information to inform policy and practice improvements.
    - This information should be subject to regular oversight and monitoring with a regular and rigorous review process to assess the continued necessity of room confinement.
- Facilities should appoint specific individuals or teams to be responsible for that internal oversight. This oversight team could conduct or review regular internal

inspections and audits of room confinement incidents to assess compliance with policies and procedures.

- Facilities should establish mechanisms for feedback and input from internal staff and youth regarding confinement. The oversight personnel should review their findings and use the insights gained from oversight to make continuous improvements, when necessary, to the use of room confinement.
- Facilities should ensure transparency by regularly reporting on the findings of internal oversight to relevant authorities, including facility administrators, governing bodies, and external oversight agencies. Facilities can collaborate with these external oversight agencies, such as independent ombudsmen or oversight boards, to complement internal oversight efforts.

Juvenile Room Confinement in Nebraska

Definition of Room Confinement

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

This statutory definition of room confinement in Nebraska is broad. It includes any time a youth is involuntarily placed alone in a cell, room, or another area, including their own room. This definition can apply to a range of practices that facilities label as rest periods, cooling off periods, time-outs, seclusion, room restriction, restrictive housing, segregation, disciplinary confinement, investigative safekeeping, protective custody, medical quarantine, modified operations, alternative placement, and lockdown for headcounts, shift changes, staff trainings, or facility emergencies. All these practices physically separate youth from the general population, placing them alone and resulting in social isolation.

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

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

[3] Neb. Rev. Stat. § 83-4,125(4).

It is important to note that juvenile room confinement is not prohibited in Nebraska. However, best practices suggest that its use should be balanced with the potential psychological and physical harm that it can cause to each youth.

Designated Juvenile Facilities Subject to Reporting Requirements

While the Nebraska juvenile room confinement definition is inherently broad and could apply to any number of practices within a range of facilities, the Nebraska juvenile room confinement documentation and reporting statutes[4] only apply to a well-defined set of facilities that serve the juvenile population and which fall under the four main categories presented in the table below.

[4] See Neb. Rev. Stat. §§ 83-4,134.01 and 83-4,124.02.

Table 2. Facilities Subject to Room Confinement Reporting Requirements

Facility Type	Description	Rules/Administration	Locations	Misc.
Residential Child Caring Agencies (RCCA)	Out-of-home placement facilities with 24-hr care that each house 4+ youth. Often also mental health and substance treatment centers. Number of RCCAs varies each year; currently 24 such facilities.[5]	-Governed by statute and Public Health regulations. -Allow for seclusion—which can only be used in emergencies and not as a form of punishment or discipline, staff convenience, or as a substitute for care.	-Numerous private facilities across state -Lincoln Regional Center (LRC), Whitehall Campus	-Rarely report any room confinement incidents. In FY 2024-2025, the only reportable incidents at a RCAA were once again for medical necessity[6] at the LRC—Whitehall Campus, which provides residential treatment programs for male youth.[7]
Juvenile Detention Facilities	Facilities for youth under 18 years old after an initial arrest, Probation violation, or while awaiting placement on Probation.	-Governed by statute, operated by county boards or non-profit board, all overseen by Jail Standards Board of Nebraska Crime Commission. - Jail Standards Board develops standards and guidelines for the facilities' care of youth, programs, disciplinary procedures, and operation.[8] Board also responsible for auditing facilities for compliance and providing technical assistance.	-Douglas Co. Youth Center (Douglas Co. Detention) -Lancaster Co. Youth Services Center (Lancaster Co. Detention) - Northeast Nebraska Juvenile Services Center (Madison Co. Detention); A non-profit, contracts with 13 counties. - Patrick J. Thomas Juvenile Justice Center (Sarpy Co. Detention)	-Standards for juvenile detention facilities allow for: segregation, confinement, administrative segregation, disciplinary detention, protective custody, temporary confinement, room restriction, separate confinement, and disciplinary confinement. -Douglas County and Lancaster County are secure detention facilities; Madison County is a secure and staff secure facility, and Sarpy County is a staff secure facility.

[5] For the list of current RCCA facilities, see https://dhhs.ne.gov/licensure/Documents/ResidentialAndChildCaringRoster.pdf.
[6] As will be reflected in the summary of the FY 2024-2025 room confinement data later in this report, these few Whitehall incidents are excluded in all data calculations, as all such incidents were the result of medical necessity.
[7] Just as in the previous year, the only other RCCA to notify the OIG that it did not have any juvenile room confinement incidents in FY 2024-2025 was the Masonic-Eastern Star Home for Children in Fremont.
[8] See Neb. Rev. Stat. § 83-4,126(1)(c).

Youth Rehabilitation and Treatment Centers (YRTC)	-Youth 14–18 years old committed by court order after all levels of Probation and community-based services have been exhausted.[9]	-Governed by statute and Nebraska Department of Health and Human Services (DHHS) regulations, administered and overseen by DHHS' Office of Juvenile Services (OJS).	-YRTC–Hastings (female youth) -YRTC–Lincoln (male and female youth) -YRTC–Kearney (male youth)	-Allow for: room confinement or disciplinary sanction if facility rule is violated. Distinguishes between room restriction, which is a cooling-off period that can last up to one hour, and disciplinary segregation, which can last up to 5 days.[10]
Nebraska Department of Correctional Services (DCS) Facilities	-Small part of population includes youth who have been tried, convicted, and sentenced in criminal courts as adults. -DCS only reports room confinement incidents until a youth reaches their 18th birthday.	-Governed by statute and DCS regulations, operated by DCS.	-Reception and Treatment Center (RTC) -Nebraska Correctional Youth Facility (NCYF) -Nebraska Correctional Center for Women (NCCW)	-RTC rarely reports room confinement. - NCYF typically houses incarcerated population that is younger than 21 years old. NCYF is the most consistent reporter of room confinement. -NCCW normally only houses a couple unique female youth a year. Room confinement typically a result of facility limitations and the Prison Rape Elimination Act (PREA), which requires sight, sound, and physical separation between inmates younger than 18 years old and inmates 18 and older.[11] -Since 2020, DCS facilities no longer use restrictive housing and room restriction for inmates 18 years old or younger.[12]

[9] See Neb. Rev. Stat. § 43-286.
[10] 401 NAC 7-007; http://www.sos.ne.gov/rules-and regs/regsearch/Rules/Health_and_Human_Services_System/Title-401/Chapter-7.pdf.
[11] Prison Rape Elimination Act (PREA) National Standards, 28 C.F.R. § 115.14 (2012).
[12] See Neb. Rev. Stat. § 83-173.03(1).

Data Documentation and Reporting Requirements

Nebraska law requires the facilities described above to regularly document and report juvenile room confinement data.[13] The Legislature enacted the various data documentation and reporting requirements "to provide increased accountability and oversight" regarding the use of juvenile room confinement in juvenile facilities.[14] The intent of the legislation passed in 2016 was to cast a wide net in capturing information on youth being involuntarily confined.[15]

Specifically, Neb. Rev. Stat. § 83-4,134.01(2) requires facilities to document and report when a youth has been confined for a *cumulative* period[16] longer than one hour during a 24-hour period. In such confinement incidents, facilities must then also document and report numerous other data points regarding the circumstances surrounding the confinement. The reported data must be submitted quarterly to the Legislature and redact all personal information, such as youth names, and provide individual rather than aggregate data.[17]

Although there is some overlap between what the facilities must document and report, the reported juvenile room confinement information is only a subset of the documented information.

[13] See Neb. Rev. Stat. § 83-4,134.01.
[14] *Id.*
[15] See "Transcript: Judiciary Committee – January 20, 2016," http://www.nebraskalegislature.gov/FloorDocs/104/PDF/Transcripts/Judiciary/2016-01-20.pdf ("In light of the fact that the oversight of the placement of juveniles falls under different jurisdictional umbrellas, including county and state facilities . . . it is especially important that the Legislature has access to the full array of data from all applicable sources").
[16] See 2020 Neb. Laws, LB 230. This clarification to the law in 2020 means that if a youth was confined for a half hour in three separate incidents during a 24-hour period, those incidents would be taken cumulatively, and if a youth was confined for a cumulative time of less than one hour during a 24-hour period, the data would not need to be documented and reported.
[17] See § 83-4,134.01(2)(c).

Table 3. Room Confinement Data Statutory Requirements[18]

Information from Facility	Must be Documented	Must be Reported
Facility supervisor written approval of confinement	✓	☐
Date of room confinement occurrence	✓	☐
Demographic information (race, ethnicity, age, gender) of each confined juvenile	✓	✓
Reason for placing each juvenile in room confinement	✓	✓
Explanation of why less restrictive means were unsuccessful	✓	☐
Total length/duration of time each room confinement	✓	✓
Facility staffing levels at time of confinement	✓	✓
Any incidents of self-harm or suicide during confinement	✓	☐
Reasons why attempts to return juvenile to general facility population were unsuccessful when juvenile confined for 4+ hours	☐	✓

Restrictions & Conditions Specific to the Use of Juvenile Room Confinement

Nebraska law also places certain parameters around the use of juvenile room confinement. In 2020, Neb. Rev. Stat. § 83-4,134.02 was revised so that juvenile detention facilities, facilities operated by DCS, and YRTCs operated by DHHS would be required to adhere to various restrictions and conditions when using juvenile room confinement.[19] These limitations on the use of juvenile room confinement in Nebraska, as well as the room confinement data documentation and reporting requirements in § 83-4,132.01, were thoughtfully constructed as an attempt to model most of the current leading national room confinement best practices, many of which were listed at the beginning of this report. As highlighted earlier, these

[18] See § 83-4,134.01(2)(a) and (c).
[19] The restrictions on the use of juvenile room confinement outlined in § 83-4,134.02 do not apply to residential child caring agencies.

limitations can generally be grouped into categories regarding the reasons for using room confinement, the time-limits on the confinement, the conditions afforded to the youth during the confinement, and confinement data and oversight of the confinement.

First, a juvenile shall not be placed in room confinement for any of the following reasons:

- As a punishment or a disciplinary sanction.[20]
- As a response to a staffing shortage.[21]
- As retaliation against the juvenile by staff.[22]

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

- Unless all other less restrictive alternatives have been exhausted and the juvenile poses an immediate and substantial risk of harm to self or others.[23]
- Held no longer than the minimum time required to eliminate the substantial and immediate risk of harm to self or others and shall be released from room confinement as soon as the substantial and immediate risk of harm to self or others is resolved.[24]
- For a period that does not compromise or harm the mental or physical health of the juvenile.[25]
- Shall be released immediately upon regaining sufficient control so as to no longer engage in behavior that threatens substantial and immediate risk of harm to self or others.[26]

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

[20] § 83-4,134.02(2)(a).
[21] § 83-4,134.02(2)(b).
[22] § 83-4,134.02(2)(c).
[23] § 83-4,134.02(3).
[24] § 83-4,134.02(4)(a).
[25] § 83-4,134.02(4)(b).
[26] § 83-4,134.02(5).

- All rooms used for confinement shall have adequate and operating lighting, heating and cooling, and ventilation for the comfort of the juvenile. Rooms shall be clean and resistant to suicide and self-harm.
- Juveniles shall have access to drinking water, toilet facilities, hygiene supplies, and reading materials approved by a licensed mental health professional.[27]
- Juveniles shall have the same access as provided to juveniles in the general population of the facility to meals, contact with parents or legal guardians, legal assistance, and access to educational programming.[28]
- Juveniles shall have access to appropriate medical and mental health services. Mental health staff shall promptly provide mental health services as needed.[29]
- Juveniles shall be continuously monitored by staff of the facility. Continuous monitoring may be accomplished through regular in-person visits to the confined juvenile which may also be supplemented by electronic video monitoring.[30]

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

OIG Oversight

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

[27] § 83-4,134.02(7).
[28] § 83-4,134.02(8).
[29] § 83-4,134.02(9).
[30] § 83-4,134.02(10).
[31] Neb. Rev. Stat. § 83-4,134.01(2)(d).
[32] *Id.*

have the authority, obligation, or capacity to verify the data provided by the facilities. The OIG does not conduct unannounced onsite inspections nor interview front-line facility staff or youth placed at the facilities to collect anecdotal information. As a result, the OIG's oversight and assessment of the juvenile room confinement data is based only on the data submitted by the facilities.

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

Despite these limitations, the OIG's review and this report nonetheless provide several key benefits, namely, transparency regarding the data of how juvenile facilities are confining youth, the identification of current juvenile room confinement trends and challenges, and the provision of recommendations for how to improve the practice in Nebraska.

FY 2024-2025 Nebraska Juvenile Room Confinement Data

The following sections summarize the juvenile room confinement data reported in FY 2024-2025 by eight Nebraska facilities. Although the OIG's analysis of the data is limited by certain factors that will be discussed below, it still provides a broad reporting of how the facilities used juvenile room confinement during this past fiscal year.

FY 2024-2025 Aggregate Juvenile Room Confinement Data

As was highlighted at the beginning of this report, across all reporting facilities, there was a relatively slight increase in the total number of hours that youth were confined. There were 127,276 reported hours of confinement in FY 2024-2025, compared to 119,000 in FY 2023-2024. While this increase is not nearly as significant and concerning as that from FY 2022-2023 to FY 2023-2024, when the total number of hours of confinement doubled, it is still the highest number of hours ever reported since the OIG began receiving the data in 2016.

There was a more marked increase in the total number of confinement incidents. Excluding a small number of incidents reported as medical necessities, the number of confinement incidents rose from 5,887 incidents in FY 2023-2024 to 8,479 in FY 2024-2025.

However, a noteworthy positive trend in the data—for the second consecutive year—is that despite the increase in total incidents and hours, most confinement incidents in FY 2024-2025 were resolved in less time than in the previous year. Specifically, 62% of all incidents were resolved within 0-4 hours, and 19% of incidents were resolved within 4-8 hours, positive increases from 61% and 14%, respectively, in the previous year. Perhaps most notable of all was the decrease in the number of incidents that took longer than 24 hours to be resolved. Youth were confined for more than 24 hours in only 9% of all incidents in FY 2024-2025, a significant improvement from the 15% in the previous year and the 17% in FY 2022-2023.

The 8,479 reported incidents in this past year involved approximately 593 unique individual youth. While this number is certainly higher than the 460 known unique youth in the previous year, the extent of the difference cannot be known due to two of the juvenile county detention centers not providing individual identifying information for half of the previous year.

Table 4.

FY 2024-2025 Confinement Totals: All Facilities (Excluding Medical Necessity)[33]		
	Count	**% of Total**
Total Incidents of Confinement	**8,479**	
Quarter 1 (July–September)	**2,841**	**33%**
Quarter 2 (October–December)	**1,944**	**23%**
Quarter 3 (January–March)	**1,951**	**23%**
Quarter 4 (April–June)	**1,743**	**21%**
Total Hours of Confinement	**127,276**	
Average Time of Confinement Per Incident	**15h 2m**	
Incident Duration Ranges		
Confined for 0-4 hours	**5,221**	**62%**
Confined for 4-8 hours	**1,614**	**19%**
Confined for 8-24 hours	**850**	**10%**
Confined for More Than 24 hours	**794**	**9%**
Unique Youth Confined	**593**[34]	

Youth were confined the most in the first quarter of FY 2024-2025, from July to September 2024, and the subsequent quarters had roughly fewer incidents as the year went on. This was a continuation of a trend in the previous fiscal year, which had more incidents as the year went on, with the third and fourth quarters, from January to June 2024, having the most incidents. The high number of incidents in 2024 and the decrease in incidents in 2025 are consistent with what facilities have communicated to the OIG, which is that 2024 was a particularly challenging year for youth behavior that resulted in more room confinement, but that the situation has improved since then.

As mentioned previously, although each facility uses different terminology and descriptions for why each room confinement incident was necessary, the reported reasons for confinement in Nebraska generally fall into three broad categories: (1) administrative reasons, (2) safety and

[33] The data from each facility in this table excludes confinement incidents reported as medical necessity. It thus excludes the eight confinement incidents reported from the Whitehall Campus in FY 2024-2025, as all such incidents were the result of medical necessity.
[34] This number is the sum of the unique youth confined at all facilities and assumes that no youth was confined at more than one facility within the same fiscal year.

security reasons, and (3) medical necessity reasons. There is often some overlap between these categories, and incidents can qualify as more than one type. Similarly, facilities have different definitions for these reasons. What some facilities consider an administrative reason for room confinement, other facilities consider a safety and security or a medical reason, and vice versa. In FY 2024-2025, safety and security reasons for confinement made up the large majority, nearly three-fourths, of all reported incidents, followed by administrative reasons for confinement at a quarter of all incidents. There were once again few medical necessity incidents reported.

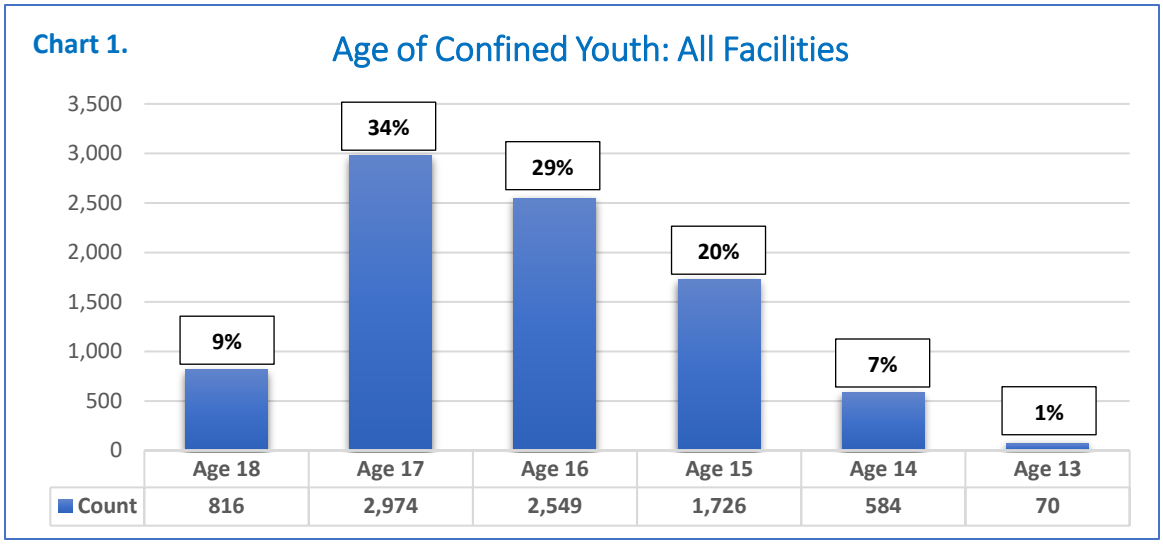
Table 5.

FY 2024-2025 Reasons for Confinement: All Facilities (Including Medical Necessity)		
	Count	**% of Total**
Safety/Security	**6,263**	**72%**
#1 Reason: Danger to Others	**1,976**	
#2 Reason: Safety Rotation	**1,552**	
#3 Reason: Danger to Staff	**1,044**	
Administrative	**2,216**	**25%**
#1 Reason: Refused to Comply	**1,401**	
#2 Reason: Sight/Sound Separation	**343**	
#3 Reason: Investigation Status/Needs	**246**	
Medical	**240**	**3%**
#1 Reason: Illness	**219**	
#2 Reason: Recovery	**10**	
#3 Reason: Other	**9**	
Total Incidents	**8,719**	

Facilities are required by law to document and report the race, ethnicity, age, and gender of all youth subject to room confinement. This demographic information that the OIG receives is specific only to those youth who were confined. The OIG does not receive demographic information for the entire population in the facility. Therefore, the OIG cannot compare the demographics of the youth who were confined to the population at the facility in general. As a

result, the OIG cannot draw any concrete conclusions about whether or not there were disparities in the use of juvenile room confinement based on race, ethnicity, gender, or age. The demographic data reported to the OIG and presented here speak only to the data for youth who were in juvenile room confinement in FY 2024-2025. The following charts reflect this demographic data of youth confined in the past year.[35]

In FY 2024-2025, in alignment with past years, older youth were generally confined more often than younger youth, with 17-year-old youth confined the most, closely followed by 16-year-old youth, then 15-year-old youth. Each of the four juvenile detention facilities reported that 13-year-olds were their youngest population to be confined.

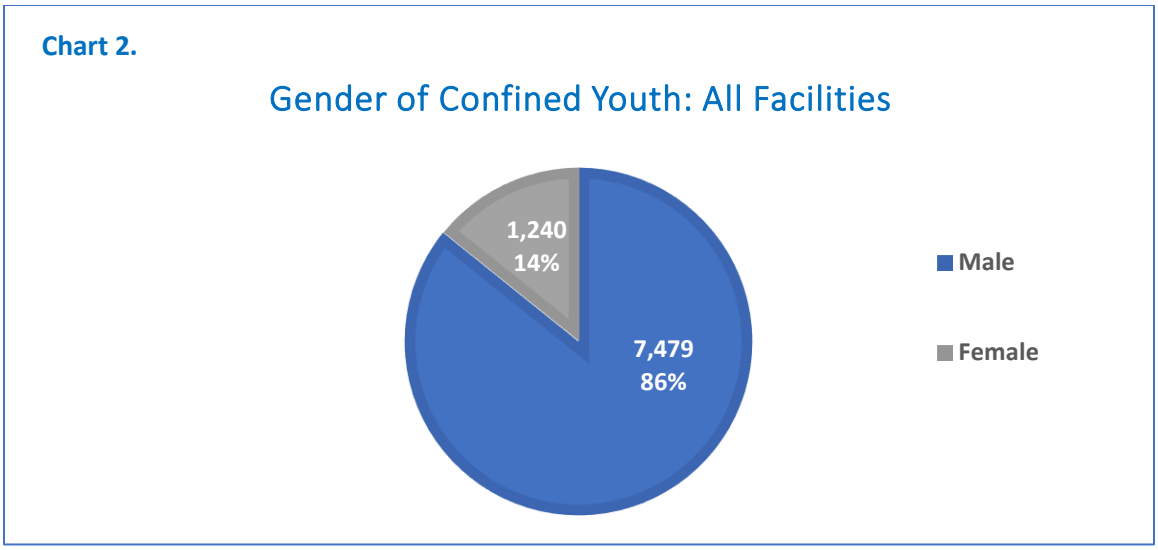


Just as in past years, there were also many more male youth who were confined than female youth, accounting for 89% of all confinement incidents in FY 2024-2025, similar to the 88% male youth in the previous year.[36]

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

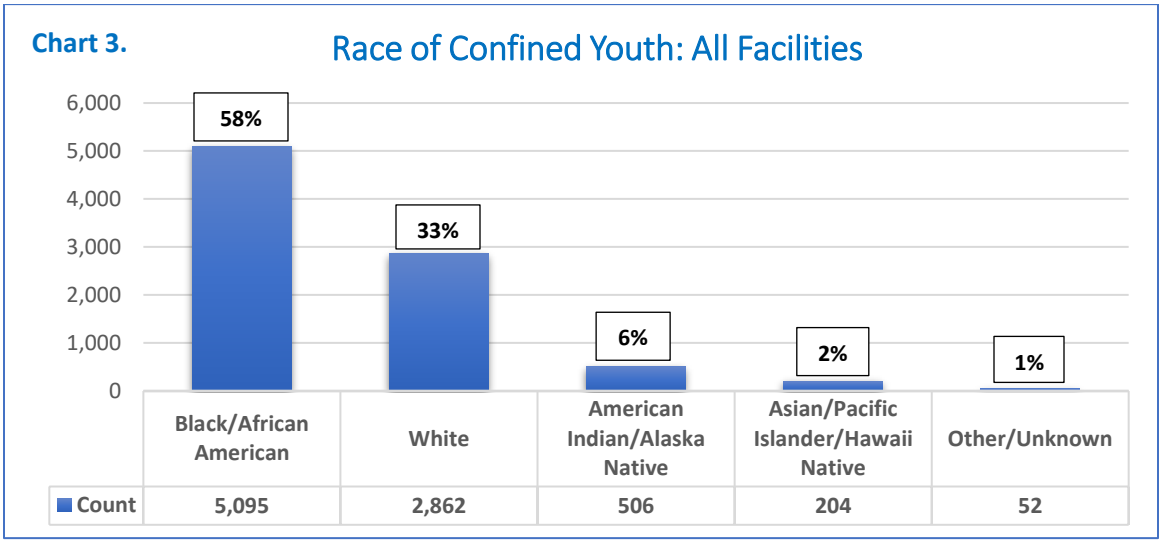
[36] Every facility but YRTC-Kearney and YRTC-Hastings reported confinement incidents for both male and female youth. YRTC-Kearney only serves male youth, and YRTC-Hastings only serves female youth.

Chart 2.



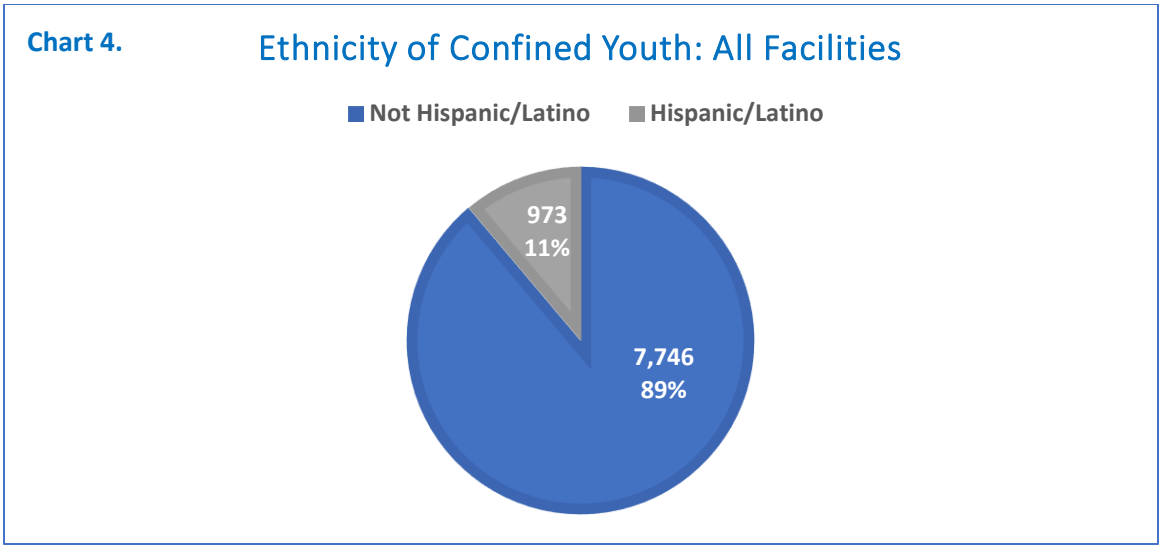
In addition, Black and White youth were confined much more than any other race, with Black youth once again being confined the most, by a slightly greater margin from the next most frequently confined race than in the previous year. In FY 2024-2025, 58% of confined youth were Black and 33% were White, whereas 47% were Black and 39% were White in the previous year. There were also fewer youth with reported races other than Black or White than in the previous year.

Chart 3.



Lastly, also in keeping with the reported data in previous years, the vast majority of confined youth in FY 2024-2025 were not Hispanic or Latino, at 89%, comparable to the 86% not Hispanic or Latino in the previous year.

Chart 4.



FY 2024-2025 Confinement Data by Juvenile Facility

The table below provides a more detailed look at the separate data from each of the eight facilities that reported juvenile room confinement incidents in FY 2024-2025, including each facility's total number of confinement incidents, hours of confinement, unique youth confined, and average time of confinement incidents, as compared to the two previous years of reported data. According to the data:

- Douglas County Detention once again reported the highest number of total hours of confinement and the highest average time that each youth spent in confinement per incident.
- Sarpy County Detention reported the lowest number of separate confinement incidents, total hours of confinement, unique youth who were confined, and the lowest average time that each youth spent in confinement per incident.
- Lancaster County Detention reported the highest number of separate confinement incidents and the most unique youth who were confined.
- As compared to the previous year, in FY 2024-2025, YRTC-Lincoln saw the largest percentage increase in total separate confinement incidents, whereas Douglas County Detention and YRTC-Hastings were the only facilities to report a decrease in total separate confinement incidents.

- Madison County Detention saw the largest percentage increase in total confinement hours, whereas Sarpy County Detention reported the smallest percentage increase.
- Four of the eight facilities reported confining more unique youth than in the previous year.
- Five of the eight facilities reported a lower average time of confinement per incident than in the previous year.

Table 6. Fiscal Year Data Comparisons, by Facility (2022–2025)[37]

Douglas County Detention			
Total	FY 22-23	FY 23-24	FY 24-25
Incidents	332	466	448
Hours	34,036	67,899	73,756
Unique Youth Confined	169	75+	113
Avg. Time per Incident	102h 31m	145h 42m	164h 36m

YRTC-Hastings			
Total	FY 22-23	FY 23-24	FY 24-25
Incidents	107	108	78
Hours	1,219	1,485	2,082
Unique Youth Confined	29	36	35
Avg. Time per Incident	11h 24m	13h 45m	26h 42m

Lancaster County Detention			
Total	FY 22-23	FY 23-24	FY 24-25
Incidents	1,642	1,760	3,016
Hours	5,135	8,802	11,543
Unique Youth Confined	124	83+	140
Avg. Time per Incident	3h 7m	5h	3h 49m

YRTC-Kearney			
Total	FY 22-23	FY 23-24	FY 24-25
Incidents	506	3,050	2,838
Hours	9,010	29,764	18,223
Unique Youth Confined	84	153	130
Avg. Time per Incident	17h 48m	9h 46m	6h 25m

Madison County Detention			
Total	FY 22-23	FY 23-24	FY 24-25
Incidents	19	27	100
Hours	190	280	2,081
Unique Youth Confined	15	20	71
Avg. Time per Incident	10h	10h 22m	20h 49m

YRTC-Lincoln			
Total	FY 22-23	FY 23-24	FY 24-25
Incidents	178	352	1,566
Hours	4,483	6,846	10,811
Unique Youth Confined	35	55	24
Avg. Time per Incident	25h 11m	19h 27m	6h 54m

Sarpy County Detention			
Total	FY 22-23	FY 23-24	FY 24-25
Incidents	96	39	42
Hours	282	108	110
Unique Youth Confined	35	21	19
Avg. Time per Incident	2h 56m	2h 46m	2h 37m

DCS			
Total	FY 22-23	FY 23-24	FY 24-25
Incidents	38	85	391
Hours	2,576	4,109	8,670
Unique Youth Confined	12	17	25
Avg. Time per Incident	67h 47m	48h 21m	22h 10m

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

Nebraska Facility Data Compared to Juvenile Room Confinement Best Practices

The OIG analyzes the use of juvenile room confinement in Nebraska by comparing the facilities' data to certain juvenile room confinement best practices provided at the beginning of this report. However, it is important to note the limitations of that analysis. When reporting juvenile confinement, facilities have discretion in categorizing the reasons for the confinement. The OIG bases its analysis on these reported reasons, assuming their accuracy. For example, the OIG does not question whether a reported safety threat was indeed a safety threat. The OIG cannot confirm if confinement incidents followed cases of imminent danger or if less intrusive options were first considered. Therefore, the following analysis is based only on the data, as reported by the facilities.

1. *Juvenile Room Confinement Should Be Reserved for Serious and Imminent Safety and Security Concerns or Exigent Emergencies and Used Only as a Last Resort When Other De-escalation Methods and Less Restrictive Alternatives Have Failed.*

FY 2024-2025 data indicated that room confinement was most often used for safety and security reasons, accounting for over 6,200 incidents, or 72% of all reported cases. This is a considerable increase from only 49% of incidents being for safety and security in the previous year. Safety and security-related confinement accounting for the majority of reported reasons for confinement is more aligned with the data that has been typically reported in previous years. FY 2023-2024 was an anomaly as there was a vast jump in administrative reasons for confinement, with 50% of confinements attributed to administrative reasons—a 163% increase from FY 2022-2023 and significantly more than in any prior year. In FY 2024-2025, administrative reasons only accounted for over 25% of all confinement incidents.

As was explained in last year's report, the unusual increase in administrative reasons for confinement was mostly due to one facility, YRTC-Kearney, reporting a significant increase in administrative reasons for confinement, the large majority of which listed the reason for confinement as the youth "refusing to comply." The facility clarified to the OIG that those types of confinement were most often related to safety and security issues and could have justifiably

classified at least some of the incidents as anticipated facility safety and security concerns. The facility clarified that it made administrative decisions to use limited-duration room confinement to separate the youth and resolve conflicts between them as they arose and to prevent the youth from causing further harm. That practice at YRTC-Kearney appears to have remained, as the facility reported administrative "refused to comply" incidents as the predominant reason that confinement was used at YRTC-Kearney in FY 2024-2025.

The challenge with confining a youth for refusal to comply is that doing so might also amount to confining a youth to discipline or punish them for failing to comply with a facility directive, which is contrary to Nebraska law. However, without the ability to verify the reasons listed, the OIG assumes that the context for confining youth at YRTC-Kearney for refusal to comply is consistent with the explanation given last year, namely, the need to prevent an imminent safety and security concern.

Overall, the noted decrease in administrative reasons of confinement across all facilities in FY 2024-2025, including at YRTC-Kearney, and the increase in safety and security reasons accounting for the large majority of all incidents could indicate better compliance with the best practice that confinement should be reserved only for serious and imminent safety and security concerns or exigent emergencies.

Table 7. FY 2024-2025 Facility Reported Reasons for Confinement.[38]

Douglas County Detention		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**448 Total**	**100%**
Fighting	279	
Assault	106	
Intimidating or Threatening Behavior	34	
Staff Assault	20	
Terroristic Threats	7	
Possession of Manufacturing of a Weapon	2	
Total Incidents	**488**	

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

Lancaster County Detention		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**3,016 Total**	**100%**
Juvenile is a Danger to Others	1,563	
Juvenile is a Danger to Staff	1,453	
Total Incidents	**3,016**	

Madison County Detention		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**71 Total**	**71%**
Danger to Others	36	
Riot with Law Enforcement Involvement	18	
Danger to Staff	12	
Danger from Others	4	
Danger to Self	1	
Administrative	**29 Total**	**29%**
Facility Emergency: Code Blue to Get Order	19	
Multiple Emergencies at One Time	6	
Corrective Action: Continuous Loud and Disruptive Behaviors	4	
Total Incidents	**100**	

Sarpy County Detention		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**42 Total**	**95%**
Danger to Others	36	
Danger to Staff	2	
Danger to Self	2	
Medical	**2 Total**	**5%**
Sickbed	1	
Quarantine	1	
Total Incidents	**44**	

YRTC-Hastings		
Reasons for Confinement	**Count**	**% of Total**
Medical	**51 Total**	**40%**
Illness	39	
Other	9	
Recovery	3	
Safety/Security	**44 Total**	**34%**
Danger to Staff	21	
Danger to Youth	15	
Danger to Others	4	
Danger to Self	1	
Danger from Youth	1	
Property Destruction	1	
Safety Rotation	1	
Administrative	**34 Total**	**26%**
Intake	16	
Refused to Comply	15	
Investigation Status	3	
Total Incidents	**129**	

YRTC-Kearney		
Reasons for Confinement	**Count**	**% of Total**
Administrative	**1,640 Total**	**60%**
Refused to Comply	1,343	
Intake	140	
Investigation Status	136	
Facility Lockdown	12	
Safety Rotation	7	
Danger to Youth	1	
Danger to Staff	1	
Safety/Security	**1,198 Total**	**40%**
Safety Rotation	754	
Danger to Staff	191	
Danger to Youth	185	
Danger to Others	59	
Refused to Comply	5	
Intake	2	
Property Destruction	2	
Medical	**152 Total**	**5%**
Illness	145	
Recovery	7	
Total Incidents	**2,990**	

YRTC-Lincoln		
Reasons for Confinement	**Count**	**% of Total**
Safety/Security	**1,421 Total**	**89%**
Safety Rotation	797	
Danger to Staff	358	
Danger to Others	228	
Property Destruction	20	
Danger to Youth	16	
Investigation Status	1	
Danger from Youth	1	
Administrative	**145 Total**	**9%**
Investigation Status	99	
Refused to Comply	43	
Intake	2	
Safety Rotation	1	
Medical	**35 Total**	**2%**
Illness	35	
Total Incidents	**1,601**	

DCS		
Reasons for Confinement	**Count**	**% of Total**
Administrative	**368 Total**	**94%**
Sight/Sound Separation	343[39]	
Orientation Status	11	
Investigative Needs	8	
Modified Operations	6	
Safety/Security	**23 Total**	**6%**
Danger to Others	15	
Danger to Staff	6	
Danger from Others	2	
Total Incidents	**391**	

DCS' facilities were the only other facilities to report administrative reasons as the primary reason for room confinement in FY 2024-2025. These administrative incidents at DCS were much higher in FY 2024-2025 than has been reported in recent years. This increase appears to

[39] As mentioned previously, DCS reports juvenile room confinement incidents from both NCYF and NCCW. In FY 2024-2025, 301 of the 391 incidents at DCS involved four female youth at NCCW, and the other 90 incidents involved the 21 male youth at NCYF.

be mostly attributable to several unique female youth at the Nebraska Correctional Center for Women (NCCW) who were each incarcerated at the facility for extended periods of time during the fiscal year, over numerous continuous months. NCCW is the adult female prison. Since there is no facility for female youth convicted as adults, those female youth must be housed at NCCW and "sight and sound" separation must be maintained between the youth and the adult incarcerated individuals to comply with the Prison Rape Elimination Act (PREA).[40] According to the facility, given the facility's design, youth had to be confined for lengthy durations each day to achieve "sight and sound separation" between the two populations. It appears to the OIG that this type of separation may only technically be reportable under Nebraska law due to the involuntary isolation of these youth in a room or area of the facility because of this sight and sound separation, and the confinement may not look as it does at other facilities. DCS facilities and the Legislature may need to examine whether other options for housing female youth should be explored. NCCW's design and operations make it challenging to house this type of youth population because it necessitates lengthy room confinement periods solely to achieve a separation from the adult population for lack of other options.

Beyond youths' refusal to comply and sight and sound separation reasons, utilizing room confinement in response to a facility investigation, a facility intake process for a new youth arrival, or an exigent facility emergency accounted for almost all other of the administrative reasons for confinement at the facilities that reported such reasons for confinement in FY 2024-2025: Madison County Detention, all three YRTCs, and DCS. Douglas County Detention and Sarpy County Detention again reported no administrative reasons for confinement, and Lancaster County Detention also reported no administrative reasons for confinement, down from the nearly 800 administrative reasons for confinement it reported in FY 2022-2023 and the 50 in the previous year. Although it may seem unlikely that a facility would have no administrative reasons for confinement throughout an entire year, many administrative reasons that a youth could be confined are, according to the facilities, often quite short in

[40] Federal PREA standards and regulations require there to be sight and sound separation between inmates younger than 18 years old and inmates 18 years old and older.

duration and would not need to be reported under Nebraska statutes if the total amount of such time for each youth did not exceed one hour.

Even though the OIG cannot discern from the reported data the exact circumstances behind any administrative reasons for confinement, nor the veracity of what was reported, the data itself suggests a continuation of a positive trend towards best practices. Compared to previous years, fewer confinement incidents in FY 2024-2025 appear to have been corrective actions or punishments, and there were overall very few instances of facilities confining youth for more than one hour for administrative convenience or other facility purposes such as staffing shortages, training, or facility operations.

Safety and security reasons for confinement were the leading reported reason for confinement at five of the eight facilities, and were the only reported reasons for confinement at both Douglas County and Lancaster County Detention. Of the safety and security reasons reported across all the facilities, the leading specific reasons for confining youth were because of the danger those particular youth presented to other youth, facility staff, or both. In many of the confinement incidents and in the reported details for what type of danger the youth posed to others or staff, it was noted that the youth presented safety and security concerns due to fighting, assaults, and other physically or verbally threatening and aggressive behavior. These reasons mirror the reasons that have previously comprised this category of incidents in past years.

In the OIG's conversations with facility administrators, and through the OIG's review of some isolated incidents reported to the OIG as serious injuries at the YRTCs and complaints to the OIG of youth injuries at some of the juvenile detention facilities, it is apparent that many of the youth population at the reporting facilities struggle with violence, aggression, and threatening behavior, and that some of the fighting and assaults do happen and can be severe and cause injuries. These behaviors are often amplified in an institutional setting and are quite challenging to deal with. Further, almost all of the youth at such facilities carry some level of trauma due to their past lived experiences, which contributes to their behavioral challenges. In many of the

reported safety and security-related reasons for confinement, the facilities' youth and staff likely faced a legitimate, serious, and imminent safety and security threat that needed to be addressed by separating the youth to allow them to cool off and to remove active safety threats to prevent physical harm. Based on the reasons that were reported, at least, it thus appears that all the facilities generally adhered to the best practice that confinement should be used in response to major safety and security concerns, not minor rule violations.

With that said, the high number of safety and security instances begs the question of whether the facilities' staff are complying with the best practice that room confinement should be used as a last resort and that less restrictive alternatives to confinement to address youth behavior should be exhausted first, or if they are instead automatically confining youth as a primary behavior management tool or as an immediate response when a safety or security concern first arises. The facilities do train staff on how to appropriately handle these situations, and the facilities' policies do align with this best practice. But the OIG cannot verify from the data alone whether the training is effective or whether staff are being as effective as possible in their de-escalation tactics, nor whether the policies are always being followed in practice.

After danger to others due to fighting, assaults, and aggressive or threatening behavior, "safety rotation" was the next most frequent category of safety and security reasons for confinement. YRTC-Kearney and YRTC-Lincoln reported the vast majority of all such reasons, which were also the number one safety and security reason at both facilities, and were significantly more reported than in past years. These safety rotation incidents were nearly all for brief durations.

Lastly, there were 240 medical reasons for confinement in FY 2024-2025, up from 85 in the previous year. Despite this increase, medical reasons for confinement still only accounted for 3% of all confinement incidents across the facilities, and the total number still pales in comparison to the over 1,500 medical incidents reported two years prior. Further, nearly all of the medical incidents were reportedly due to youth illness, and such youth were confined to prevent the spread of that illness to other youth and staff at the facility. YRTC-Hastings was the only facility to report medical reasons for confinement as the primary reason youth were

confined, but most of those incidents were due to youth illness. Douglas County, Lancaster County, and Madison County Detention, and DCS, did not report any medical reasons for confinement.

2. *Juvenile Room Confinement Should Be Used Only for Brief Periods, Generally Not to Exceed Four Hours and Very Rarely to Exceed 24 Hours, and Should End as Soon as It is Safe to Do So and When the Immediate Security Threat Has Subsided.*

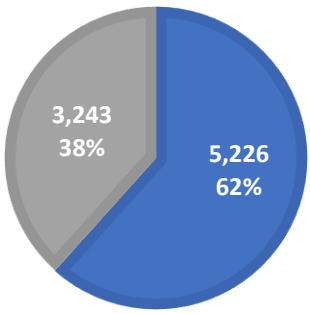
As for this time-related best practice, FY 2024-2025 reported data continued to trend in the right direction, with most incidents of confinement being shorter than in previous years. This positive trend may indicate a continuation towards compliance with the best practice about how confinement should be brief and time-limited. This data also aligns with what several facility administrators have communicated to the OIG, which is that they have found it more effective to confine youth more frequently but for shorter durations, rather than the other way around, so that the facility can quickly address and resolve problems as they arise and to provide youth the opportunity to calm down and reflect before situations escalate to a point where more severe safety and security concerns and potentially longer confinement would be necessary.

To that point, facilities have communicated to the OIG that they most often use room confinement for periods cumulatively lasting less than one hour in a day for each youth because of safety and security-related “time-outs” or “cool-off” periods, or for other administrative-related reasons such as staff shift changes, which comports with best practices. But those incidents do not have to be reported under Nebraska law because they do not meet the duration threshold. Including those numerous incidents that are less than one hour in the reported data would likely result in an even higher percentage of confinement incidents being resolved more quickly, but documenting and reporting every confinement incident could place a significant administrative burden on the facility.

Juvenile Room Confinement Should Generally Not Exceed Four Hours

For the specific best practice recommendation that a singular confinement incident should generally not exceed four hours unless necessary, 62% of all incidents across the facilities in FY 2024-2025 were resolved within 0-4 hours. Four of the facilities—Lancaster County Detention, Sarpy County Detention, YRTC-Kearney, and YRTC-Lincoln—reported an increase in incidents resolved in four hours or less compared to FY 2023-2024, and four facilities—Douglas County Detention, Madison County Detention, YRTC-Hastings, and DCS—reported a decrease.

Chart 5. Best Practice Compliance, Confinement Incidents Lasting 4 Hours or Less: All Facilities (Excluding Medical)



When a youth is confined for longer than four hours, facilities must report why less restrictive alternatives to room confinement were unsuccessful, why each confinement period could not end, and why the youth could not be returned to the general population. The data reported from the facilities in FY 2024-2025 was quite similar to past years. The primary types of confinement incidents that lasted longer than four hours in FY 2024-2025 related to safety and security with facilities reporting that youth continued to pose a danger to others, by being verbally and physically abusive or threatening, assaultive to staff and causing injuries, or destroying property. For administrative reasons for confinement over four hours, facilities reported that youth continued to pose a risk because of how escalated they were, as well as intake processes or pending investigations not yet being completed. And for medical reasons

for confinement, facilities reported that youth continuing to be ill and posing a risk of contagion were the main reasons why youth had to be confined beyond four hours.

Again, the OIG is not in a position to question the veracity behind these reported reasons for confinement. To best determine how closely facilities are following best practices, the OIG would need to understand how effective facility staff are in their de-escalation tactics and whether some of these safety and security threats could have been resolved, and the confinement period ended sooner.

Sarpy County Detention, followed by YRTC-Kearney, then Lancaster County Detention, reported the highest percentage of incidents where youth were confined for four hours or less and in compliance with this best practice. Slightly more than half of all incidents at Madison County Detention and YRTC-Lincoln, and approximately a quarter of incidents at YRTC-Hastings, were resolved in four hours or less. DCS and Douglas County Detention, at 8% and 4% of all incidents, respectively, had the lowest percentage of incidents resolved in four hours or less.

Table 8. Confinement Incidents Lasting 4 Hours or Less, by Facility (2022–2025)[41]

Douglas County Detention			
	FY 22-23	FY 23-24	FY 24-25
Confined for 0–4 Hours / Total Incidents	32 / 332	45 / 466	17 / 448
% of Total	10%	10%	4%

Lancaster County Detention			
	FY 22-23	FY 23-24	FY 24-25
Confined for 0–4 Hours / Total Incidents	1,274 / 1,642	1,075 / 1,760	1,997 / 3,016
% of Total	78%	61%	66%

Madison County Detention			
	FY 22-23	FY 23-24	FY 24-25
Confined for 0–4 Hours / Total Incidents	8 / 19	21 / 27	62 / 100
% of Total	42%	78%	62%

Sarpy County Detention			
	FY 22-23	FY 23-24	FY 24-25
Confined for 0–4 Hours / Total Incidents	83 / 96	29 / 39	35 / 42
% of Total	86%	74%	83%

YRTC-Hastings			
	FY 22-23	FY 23-24	FY 24-25
Confined for 0–4 Hours / Total Incidents	42 / 107	52 / 108	26 / 78
% of Total	39%	48%	27%

YRTC-Kearney			
	FY 22-23	FY 23-24	FY 24-25
Confined for 0–4 Hours / Total Incidents	202 / 506	2,188 / 3,050	2,174 / 2,838
% of Total	40%	72%	77%

YRTC-Lincoln			
	FY 22-23	FY 23-24	FY 24-25
Confined for 0–4 Hours / Total Incidents	61 / 178	135 / 352	885 / 1,566
% of Total	34%	38%	56%

DCS			
	FY 22-23	FY 23-24	FY 24-25
Confined for 0–4 Hours / Total Incidents	6 / 38	29 / 85	30 / 391
% of Total	16%	34%	8%

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

DCS' low percentage of incidents resolved in four hours or less appears to be attributable to the increase in the administrative "sight and sound separation" incidents discussed previously, where the youth would be confined for most of every day that they were at that facility to achieve the required separation from the adult population. As for Douglas County Detention, the low number of incidents resolved in four hours or less, and the low number of incidents resolved in less than 24 hours for that matter, which will be discussed below, can perhaps be explained by the facility's unique policy on only reporting confinement incidents lasting for as long as the youth is on room confinement "status," which depends on the severity of the youth's safety and security violation and their behavior while on their room confinement status.

The facility's administration has explained to the OIG that when a youth commits a violation and causes a safety and security concern, such as assaulting another youth, the offending youth will be placed on room confinement status as a result and not be placed off of that status until they sufficiently demonstrate that they are no longer a safety and security threat. Staff purportedly regularly assess the youth while they are on room confinement status to make that determination. However, unlike some other facilities, Douglas County has taken the approach of reporting the total duration the youth was on the "room confinement status," even if the youth is let out of their room for whatever reason—such as for the one hour minimum of out-of-room time that Jail Standards requires be provided each day, as well as education, recreation time, phone calls, showering, etc.—and is therefore not technically confined for that period of time. Rather than reporting separate, but consecutive confinement incidents for the same youth that are shorter in duration, the facility thus reports the entire time that a youth was on room confinement status as one continuous confinement period. In reality, however, that youth may not have been confined to their room for that entire time. The facility has further explained that, unlike some other facilities, room confinement for their youth does not look all that different from the time that the youth would be in their room when not on room confinement status, as the confinement always occurs in the youth's normal room, and the youth continue to have access to many of their normally-provided amenities and services, and can even watch television and see and converse with other youth through their room's doors.

This could, in part, explain why the youth appear to be in confinement for longer durations. It is unclear to the OIG, however, how much time these youth are actually isolated in their room or another area of the facility, without their peers.

Douglas County's practice may not adhere as closely to the best practices and Nebraska room confinement statutes that state a room confinement incident should not be for a set amount of time and last only as long as necessary to address the reason why the youth was initially confined. Facility staff purportedly continuously monitor and regularly assess the youth on room confinement status each shift to determine if they can be taken off the status and let out of room confinement because they are no longer a threat. But perhaps another reason why Douglas County's practice is to confine youth for longer durations is that the facility has expressed to the OIG that they house especially challenging youth, who often have spent time at the other juvenile facilities, have a higher rate of adult criminal charges, and have extensive trauma and backgrounds with violence and gang activity. Further, many of the youth at the facility reportedly have conflicts with each other that began before they arrived at the facility. The facility has stated that these factors lead to an abnormally high amount of violence, both fighting and targeted assaults. It has been the facility's approach to use room confinement only to maintain the safety of their youth, and report that youth are only put in room confinement, and let out of room confinement, because of this violence.

While many of these reasons may be true, the OIG's inability to independently verify the reported data and determine how quickly the youth at Douglas County Detention should be released from their room confinement status prevents the OIG from stating for certain whether the facility could reasonably be resolving confinement incidents more quickly. The facility has expressed that its recent increased involvement from the community and various programs, such as its restorative justice program and group led by their gang and gun coordinator, who has lived experiences similar to some of the youth population, have been successful and contributed to the improvement in youth behavior and decrease in reported room confinement usage in 2025.

Consecutive Days of Confinement

Another example of facilities' varying interpretations of the Nebraska juvenile room confinement statutes that impacts the OIG's ability to analyze the time-limited aspect of the reported data is that of sleeping hours and its impact on consecutive days of confinement, which the OIG has discussed at length in past years' reports. Specifically, the statutes define room confinement as the involuntary restriction of a juvenile placed alone—including in the juvenile's room—except during normal sleeping hours. In FY 2024-2025, it appears that six of the facilities included normal sleeping hours as part of the total duration of a confinement period if the confinement was continuous with those sleeping hours. However, Lancaster County Detention does not include sleeping hours for any of their incidents, and DCS did not include sleeping hours for some of their incidents. Excluding sleeping hours from the reported duration of a confinement period creates inconsistencies with the data at other facilities, making comparison difficult, and raises concerns about the actual duration of any given confinement incident. To be fair, Nebraska law omits sleeping hours from the hours that must be documented and reported. But excluding sleeping hours when the sleeping hours are continuous with an ongoing confinement incident can result in an under-reporting of how long a youth was actually isolated.

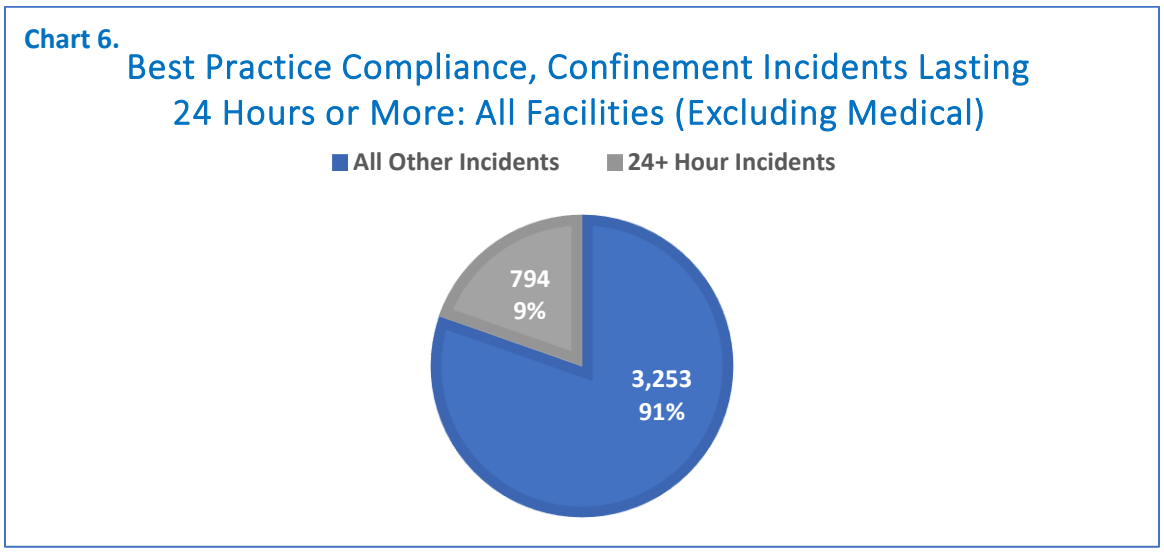
When sleeping hours are excluded, it would appear as if a youth is confined for only 13 hours at a time rather than continuously over 24 hours. Incidents of consecutive days of confinement are recorded as multiple 13-hour periods, which appear to conclude when normal sleeping hours begin and resume the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

This year, the data from all facilities again showed the use of consecutive days of confinement. However, like in FY 2023-2024, the OIG did not observe any period of consecutive confinement as lengthy as in past years. Lancaster County Detention reported numerous separate instances of 10 to 15 consecutive days of confinement, and DCS reported numerous separate instances of 15 to over 20 consecutive days of confinement, almost all of which were due to the "sight and sound separation" circumstance discussed earlier. The reporting method for these two facilities, however, often portrayed these incidents as separate periods of confinement, each up to 13 hours, masking the reality that the youth were confined for 24 hours for consecutive days. At the other six facilities, which did include normal sleeping hours for each confinement incident that extended beyond a day, multiple consecutive days of confinement most often lasted only two to four days at a time, and a couple of the facilities reported upwards of six to eight consecutive days at a time on numerous occasions.

Juvenile Room Confinement Should Very Rarely Exceed 24 Hours

Facilities were generally in compliance with the other specific best practice recommendation that states youth should very rarely be confined for more than 24 hours at a time, as the youth in FY 2024-2025 were confined for more than 24 hours in only 9% of all incidents, a significant improvement from previous years.

Chart 6.



All facilities but Douglas County Detention, Madison County Detention, and YRTC-Hastings reported a decrease in incidents resolved in 24 hours or more, as compared to FY 2023-2024. Over half of all of the 24-hour-or-more confinement incidents occurred at Douglas County Detention. In fact, almost all of Douglas County's confinement incidents—92%—lasted longer than 24 hours. While this high number is likely partially attributable to the unique way the youth at that facility are confined based on their status, it is still a cause for concern.

Leading research states that confinement lasting for a day or more is most often considered unnecessary, and best practices and Nebraska law state that confinement should last only as long as necessary to address the reason why the youth was initially confined. As such, besides some unusual circumstances, either due to extreme youth behavior or situations beyond the facility's control, best practices suggest that it should not regularly take a facility longer than 24 hours to address the reason why confinement was necessary and to return the youth to the general population. This is especially true when, as Douglas County Detention has explained, the facility has staff who continuously monitor and regularly assess the youth on room confinement status to determine if they can be taken off confinement status and let out of confinement because they are no longer a threat. Doing so should, in theory, result in more than just 8% of the facility's total incidents being resolved in less than 24 hours. Notably, for every room confinement incident that Douglas County reported, including the 24+ hour incidents, the reason why the youth could not be released from confinement was the "safety of other juveniles on the unit."

YRTC-Hastings reported the next highest percentage of incidents lasting longer than 24 hours. After Douglas County Detention, YRTC-Kearney and YRTC-Lincoln reported the next most total 24-hour-or-more incidents, but both reported fewer such incidents than in the previous year. Lancaster County and Sarpy County Detention both reported no confinement incidents lasting longer than 24 hours, and DCS reported the greatest percentage decrease in incidents lasting longer than 24 hours compared to the previous year.

Table 9. Confinement Incidents Lasting 24 Hours or More, by Facility (2022–2025)[42]

Douglas County Detention			
	FY 22-23	FY 23-24	FY 24-25
Confined for 24+ Hours / Total Incidents	284 / 332	403 / 466	414 / 448
% of Total	86%	86%	92%

Lancaster County Detention			
	FY 22-23	FY 23-24	FY 24-25
Confined for 24+ Hours / Total Incidents	2 / 1,642	5 / 1,760	0 / 3,016
% of Total	<1%	<1%	0%

Madison County Detention			
	FY 22-23	FY 23-24	FY 24-25
Confined for 24+ Hours / Total Incidents	2 / 19	2 / 27	20 / 100
% of Total	11%	7%	20%

Sarpy County Detention			
	FY 22-23	FY 23-24	FY 24-25
Confined for 24+ Hours / Total Incidents	1 / 96	0 / 39	0 / 42
% of Total	1%	0%	0%

YRTC-Hastings			
	FY 22-23	FY 23-24	FY 24-25
Confined for 24+ Hours / Total Incidents	32 / 107	16 / 108	30 / 78
% of Total	30%	15%	38%

YRTC-Kearney			
	FY 22-23	FY 23-24	FY 24-25
Confined for 24+ Hours / Total Incidents	110 / 506	327 / 3,050	237 / 2,838
% of Total	22%	11%	8%

YRTC-Lincoln			
	FY 22-23	FY 23-24	FY 24-25
Confined for 24+ Hours / Total Incidents	50 / 178	91 / 352	76 / 1,566
% of Total	28%	26%	5%

DCS			
	FY 22-23	FY 23-24	FY 24-25
Confined for 24+ Hours / Total Incidents	24 / 38	34 / 85	17 / 391
% of Total	63%	40%	4%

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

Best practices and Nebraska law require that facilities report the reasons why attempts to return a youth to the general facility population were unsuccessful when the youth has been confined for four or more hours. In 84% of all of the incidents lasting 24 hours or more across the facilities, the youth were initially confined because of a safety and security reason, most of which were because of the danger the confined youth posed to other youth. Eight percent of the 24+ hour incidents were administrative reasons for confinement, and eight percent were medical reasons.

Table 10.

FY 2024-2025 Barriers Preventing Return to General Population, 24+ Hour Incidents: All Facilities (Including Medical Necessity)		
Reasons for Barriers Preventing Return	**Count**	**% of Total**
Safety/Security	**670**	**84%**
Danger to Other Youth	583	
#1 Reason: Verbally Abusive or Threatening		
#2 Reason: Assaulted Youth or Fighting		
#3 Reason: Assaultive or Dangerous Behavior		
Danger to Staff	59	
#1 Reason: Verbally Abusive, Threatening, or Resistant		
#2 Reason: Threatened or Assaulted Staff		
#3 Reason: Continued Escalated or Aggressive Behavior		
Property Destruction	10	
#1 Reason: Continued Risk or Escalated Behavior		
Danger from Youth	3	
#1 Reason: Pending Investigation: Assault or Threats from Others		
Medical	**63**	**8%**
#1 Reason: Illness / Recovery		
#2 Reason: Quarantine		
Administrative	**61**	**8%**
#1 Reason: Pending Investigation		
#2 Reason: Continued Risk or Escalated Behavior		
#3 Reason: Intake		
Total 24+ Incidents of Confinement	**794**	

According to the reported data, most youth continued to be confined beyond one day because of verbally abusive or threatening behavior towards other youth, because they assaulted other

youth or engaged in fighting, or because they otherwise demonstrated dangerous behavior toward other youth. These were almost the same types of reported barriers preventing a return to the general population for 24+ hour incidents when the reported reason for confinement was the youth posing a danger to staff. There were a few safety and security incidents lasting 24+ hours where the reported barrier preventing the youth's return was because the youth continued to be escalated and a risk after being confined for destroying property, or because the youth needed protection from other youth while an investigation into an incident was pending. For the much smaller number of incidents where a youth was confined for 24+ hours for an administrative reason, the facility having a pending investigation, the continued risk and escalation of the youth, and the intake process for a new youth still being ongoing were the main reasons why youth could not be returned to the general population. Despite the OIG's limitations in verifying this data and confirming whether these various circumstances truly warranted continued confinement for more than 24 hours, the data nonetheless provides a helpful insight into why facilities believed the best practice of confining youth for less than 24 hours could not be achieved in certain cases.

Regardless of the reason why any youth may be confined for 24 hours or more, best practice research is clear that confinement for that duration could have an especially detrimental impact on the youth's mental health. It is for this reason that additional recent research and best practices have recommended that, as is noted earlier in this report, whenever a youth is confined for 24 consecutive hours, that should trigger an immediate multidisciplinary review of the youth's case by the facility, including an urgent mental health evaluation of the youth.

3. *Youth in Room Confinement Should Be Closely Monitored and Continuously Evaluated for Mental Health; Provided Education, Therapeutic Programming, and Access to Mental Health and Legal Services; and Receive an Adequate Room, Food and Water, Hygiene Items, and Personal Belongings.*

There is little reported data for the OIG to review and compare against this best practice to assess the facilities' level of compliance. The only data related to this best practice that is reported by facilities relates to the mental health services provided to confined youth. Facilities report "danger to self" as a reason for confinement and must note when staff observe a confined youth display self-harming behaviors or attempt suicide while in confinement. The OIG's review of the FY 2024-2025 data found very few incidents of room confinement where youth were confined because of a "danger to self" or a concern for a mental health crisis or because the youth had self-harmed. Similarly, very few incidents were reported where it was noted that a confined youth self-harmed while confined. These are improvements from past years, when youth were more frequently placed in confinement despite the youth experiencing a mental health crisis or displaying self-harming behaviors in confinement.

In addition, Nebraska juvenile room confinement statutes mirror this best practice. Nebraska facilities are required by law to continuously monitor confined youth through in person visits or electronic monitoring; to provide confined youth the same access as youth in the general population to educational programming, medical and mental health and legal services; and to provide the confined youth a clean and safe room with adequate lighting, heating and cooling, and ventilation, as well access to hygiene supplies, toilets, meals, drinking water, and reading materials.

Similarly, all eight of the room confinement reporting facilities in Nebraska have policies in place that provide for their youth populations to be afforded these standards of care, conditions, and services when confined. Facility administrators have also communicated to the OIG that such conditions and services are, in fact, provided. Further, through speaking with many of the youth and staff at these facilities, and when visiting the facilities and observing

where youth are confined, the OIG has not received complaints or observed anything to indicate that the related statutory requirements are not being met.

Otherwise, because facilities are not required to report any other data about this best practice, the OIG cannot fully assess the facilities' compliance with the best practice.

4. Facilities Should Properly Document and Report Room Confinement Data, and There Should be Both Internal and External Accountability and Oversight of the Confinement.

As noted earlier, juvenile room confinement best practices recommend robust oversight—both internal and external—of the use of confinement. Nebraska statutes do meet the oversight best practice by requiring the collection, documentation, and sharing of data regarding the use of confinement. Nebraska facilities comply with this best practice and the statutes by documenting and reporting the necessary confinement information, including confinement frequency, reasoning, duration, outcomes, and any interventions attempted.

Nebraska falls short, however, of clear and comprehensive policies and procedures governing the use of confinement. While current law provides some definite parameters for its use, there is no consistency between facilities—even facilities of the same type—regarding how certain aspects of the law should be interpreted, how confinement should be documented, and how and whether room confinement data will be verified.

The inconsistency in the application of the juvenile room confinement law can be attributed, in part, to the absence of clear guidelines and consistent interpretation of the juvenile room confinement laws, as well as the absence of effective enforcement mechanisms.

Best practices also recommend that facilities have dedicated staff responsible for providing internal oversight who could review the use of confinement, analyze the data for trends, conduct audits and inspections of confinement incidents, and improve facility policy and procedure. It is the OIG's understanding that each facility subject to the reporting requirements has a staff member responsible for collecting and reporting the data. Some facilities appear to review and analyze their own room confinement data better than others. For example, Douglas County Detention has a staff member solely dedicated to data analysis, oversight, identifying

juvenile room confinement trends, and improving and reducing confinement practices. Other facilities seem to conduct a similar type of data review, but the OIG recommends that the facilities be given more resources, staff, and finances to do so properly and strengthen their internal oversight abilities.

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

Lastly, as was alluded to in this report and as previous OIG reports have discussed in more detail, the inconsistent interpretation and application of juvenile room confinement laws across the facilities, and sometimes within the same facility, leads to a wide range of reporting practices, potentially resulting in skewed data and the possibility of underreporting or overreporting based on an individual facility's interpretation of the law. It is for this reason that the OIG again recommends a consistent and standardized interpretation and application of the law, as well as a means to verify how facilities use room confinement practices. Such oversight efforts must be accurate and effective, and should be conducted by agencies specifically responsible for overseeing these facilities.

Findings

The OIG's analysis of the FY 2024-2025 juvenile room confinement data from across the state's facilities again illustrates that best practices for juvenile room confinement are largely reflected in Nebraska law and in practice for some areas, but not always for others.

1. **Overall, the use of juvenile room confinement in Nebraska remained high compared to past years, with the number of confinement hours and the number of confinement incidents the highest they have ever been.**

In FY 2024-2025, there was a slight increase in the number of confinement hours and a considerable increase in the number of confinement incidents from the previous year. The elevated use of juvenile room confinement and this year's increases continue to raise the question of whether juvenile room confinement is being used as best practices recommend, which is that it should be reserved for more serious and imminent safety and security concerns and used only as a last resort when other de-escalation methods and less restrictive alternatives have failed. The facilities face significant challenges from many of the youth they serve, and the safety of the staff and youth is an ever-present and urgent concern. It is not realistic to think that the use of room confinement could be eliminated entirely in Nebraska. However, the continual increase in the use of room confinement begs the question of whether it is being used as a primary tool for behavior management or for discipline, contrary to best practices.

2. **Despite the increase in total confinement hours and incidents, most individual incidents were generally shorter in duration for the second consecutive year, which indicates better compliance with best practices.**

In particular, more incidents were resolved in four hours or less, and fewer incidents lasted longer than 24 hours than in the previous year. This continuation of the positive trend of youth generally being confined for shorter durations moves the use of room confinement closer to the best practice that confinement should only be used for brief periods and should end as soon as it is safe to do so and when the immediate safety threat has subsided.

3. **Juvenile room confinement was primarily used for safety and security reasons and there were significantly fewer administrative reasons for confinement than in the previous year, which aligns with best practices**.

There was a return to the typical trend of primarily confining youth for safety and security reasons in FY 2024-2025. This was mostly because there was a large decrease in administrative reasons for confinement compared to the previous year. Those safety and security reasons primarily fell into the category of assaultive and threatening behavior that created a danger to other youth and staff. There were once again few medical reasons for confinement reported, although there were more than in the previous year.

4. **Enhanced internal and external oversight of room confinement at the juvenile facilities and more consistent and standardized juvenile room confinement statutory interpretations and practices continue to be needed.**

As the OIG has repeatedly noted over the years in its juvenile room confinement reports, to continuously improve and reduce room confinement usage across Nebraska facilities, facilities must commit to achieving the best practice requirement of robust internal and external oversight of room confinement, as well as rigorous room confinement data collection and reporting. However, the current lack of clarity, consistency, and standardization in juvenile room confinement statutory interpretations and practices renders this difficult. A salient example of this inconsistency is Douglas County Detention's unique method of reporting the entire duration that a youth was on room confinement status, without stopping the clock whenever the youth is outside of their room for more than one hour if they then go back into the room within the same confinement period and remain on room confinement status. Another primary example is that of Lancaster County Detention's and DCS' unique practice of excluding sleeping hours from a confinement period lasting longer than one day, resulting in the appearance that the confinement did not last continuously for over 24 hours.

All facilities need to adopt a standardized approach to data collection, reporting, and interpretation of Nebraska juvenile room confinement statutes and best practices to ensure

accuracy and consistency across the state. To do this, the OIG once again recommends that the Jail Standards Board, Nebraska Department of Correctional Services (DCS), and Nebraska Department of Health and Human Services' Office of Juvenile Services (OJS) should collaborate to establish a standardized and consistent interpretation of current juvenile room confinement statutes and practices across all juvenile facilities.

Enhanced oversight of room confinement also includes a commitment to regularly assessing the effectiveness of current practices, being open to adopting new approaches, and ensuring that the well-being of juveniles is at the forefront of any confinement decision. Enhanced oversight should also include regular facility reviews of the room confinement data to assess whether the use of room confinement complies with statutory requirements and best practices. To do this, facilities need more internal staff dedicated to overseeing their juvenile room confinement practices.

Reducing reliance on juvenile room confinement is a challenging but necessary goal to ensure the well-being of juveniles in Nebraska facilities. If the goal of the state is to truly reduce the use of juvenile room confinement within juvenile facilities, the Legislature may need to further engage with these facilities to fully understand their challenges and determine what additional supports or resources are required to successfully facilitate the reduction in juvenile room confinement usage. The Legislature and the juvenile facilities may achieve this reduction, in part, by accepting some of the OIG's recommendations below.

Recommendations

Previous relevant OIG recommendations have included:

1. **The Jail Standards Board, DCS, and OJS should collaborate to establish a standardized and consistent interpretation of current juvenile room confinement statutes and practices across all juvenile facilities.**
2. **Each juvenile facility should have internal staff dedicated to juvenile room confinement oversight, data analysis, and improving and reducing confinement practices.**

New Recommendations:

1. **The Legislative Audit Office[43] should conduct a performance audit of the juvenile facilities regarding the practice of juvenile room confinement to independently verify reported room confinement data and practices and to assess facilities' compliance with the Nebraska juvenile room confinement statutes.**

The OIG cannot independently verify the juvenile room confinement data reported by the facilities. The OIG does not have the operational capacity to regularly visit the facilities and interview staff and youth to gather information regarding specific room confinement incidents. Nor does the OIG have the capacity to review the facilities' data-tracking systems and any internal documentation related to each confinement incident. As such, the OIG's review of juvenile room confinement is limited only to the data that the facilities report.

The Legislative Audit Office, however, could conduct an audit to truly assess facilities' compliance with juvenile room confinement best practices and Nebraska law. The Legislative Audit Office would have the expertise and tools necessary to audit facilities' data collection and reporting practices and could potentially review a sample of confinement incidents to verify whether facilities' usage of room confinement—including the frequency and duration—aligns with what is being reported. This audit could more accurately determine whether facilities are

[43] See generally Neb. Rev. Stat. §§ 50-1201 to 50-1216; https://nebraskalegislature.gov/divisions/auditor.php.

complying with Nebraska law and national best practices for why and how juvenile room confinement should be used.

2. **Juvenile facilities should be required to report room confinement data in a format that the Division of Legislative Oversight, particularly the OIG and Legislative Audit Office, determines is necessary for its review.[44]**

Current Nebraska law requires the juvenile facilities to submit quarterly room confinement reports to the Legislature, but it does not specify the report format.[45] In practice, the facilities submit the reports to the Legislature as PDFs. It is the OIG's understanding that all facilities use a spreadsheet format to document their room confinement data, then convert that spreadsheet into a PDF to submit to the Legislature. The PDF format does not allow the OIG to sort and analyze the data, which includes thousands of room confinement incidents and hours. As a result, since 2016, the OIG has requested that each facility provide data to the OIG in a spreadsheet format that facilitates data analysis, using a program such as Microsoft Excel, and the facilities have generally complied with that request. LB 1155 (2026) would remove the duplicate reporting and better align the law with actual practice by requiring facilities to only report the room confinement data directly to the newly created Division of Legislative Oversight, in a format determined by the Division, such as Microsoft Excel, necessary for its review, rather than filing their reports as PDFs with the Clerk of the Legislature.

3. **To better comply with best practices, juvenile facilities should conduct multidisciplinary reviews, including an urgent mental health evaluation, of every youth who has been confined for 24 consecutive hours.**

As was discussed above, due to the adverse mental health consequences of confining youth for extended periods, recent best practice research suggests that whenever a youth is confined for 24 consecutive hours or more, the facility should conduct an immediate multidisciplinary review of the youth, including performing an urgent mental health evaluation of the youth. This

[44] See LB 1155 (2026).
[45] See Neb. Rev. Stat. § 83-4,134.01(2)(C).

mental health evaluation could help youth who are having especially negative physical, psychiatric, and social responses to the prolonged confinement, and prevent crises by better identifying youth who are at risk of self-harm and suicidal ideation. Currently, facility staff appear to be monitoring youth in confinement by periodically checking on them during each shift. But best practices would require a more vigorous and in-depth evaluation and conversation with a youth when the youth has been confined for more than 24 hours to more accurately assess the youth's mental health and prepare them for a safe return to the general population.

Importantly, this mental health evaluation is specific to the 24-hour confinement and is intended to assess the condition of the youth because they have been confined for that long. That evaluation should be separate from any mental health services that the youth normally receives when not in room confinement, even if the facility has continued to provide those services to the youth while in confinement, as Nebraska law requires.

Appendices

Appendix A: Past Recommendations

The OIG's annual report on the use of juvenile room confinement must identify changes in policy and practice that may lead to a decreased use of room confinement in Nebraska.[46] The following section lists all prior juvenile room confinement recommendations made by the OIG. Additional details and rationale regarding each recommendation are published in each recommendation's respective Juvenile Room Confinement in Nebraska annual report published by the OIG.

2021

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

2020

- Examine oversight and enforcement mechanisms for juvenile room confinement reporting.
- Examine juvenile room confinement enforcement mechanisms for provisions within Legislative Bill 230.
- Require facilities to create formal facility juvenile room confinement reduction plans to be submitted to the Legislature and monitored through the Jail Standards Board, Public Health, Office of Juvenile Services, Department of Corrections, and the OIG.

2019

- Extend Crime Commission and Department of Health and Human Services-Division of Public Health responsibilities related to juvenile room confinement to include, at a minimum, on-site verification and standardized data collection and content.
- The OIG recommends that legislation be passed that requires:

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

- All facilities adhere to best practices to reduce reliance on juvenile room confinement.
- Room confinement be used as a last resort, be time-limited, and be closely monitored.
- Clarification of current legislative provisions related to juvenile room confinement.
- Specific language to clearly define the meanings of "facility" and "agency," with explicit guidance on which organizations are required to report, and which are exempt.
- Specific determinations of what constitutes voluntary confinements, in contrast to involuntary confinements. Clear definitions should also include what constitutes sickbed and other medical quarantines.

2018

- For reduction with the goal of eliminating juvenile room confinement, facilities should:
  - Revise facility policies to reflect best practice.
  - Focus on workforce development.
  - Create a Juvenile Room Confinement Reduction Plan and include technical assistance and oversight**.**
  - Publicly report information on the use of room confinement, including seclusion.
- Agency based recommendations include the following*:*
  - The Nebraska Department of Correctional Services:
    - Specifically Adopt Time Limits for Inmates in Restrictive Housing under the Age of 19.
    - Conduct a study on youth who spend particularly long periods of time in room confinement.
  - The Office of Juvenile Services:
    - Develop and Implement a Strategic Plan to Reduce Room Confinement.
    - Change OJS Rules and Regulations to Align with Best Practices.
  - The Nebraska Jail Standards Board:

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

2017

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

Appendix B: Report Process

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

Beginning in FY 2021-2022, however, the OIG decided to no longer correct facility data for duplications, errors, and other inconsistencies. This work is not statutorily mandated and diverts the OIG's limited resources from other statutorily-required duties. Attempting to correct the data that facilities report, or determining which data is accurate and which is not, is a task better suited for the facilities and agencies and creates the danger of the OIG unintentionally altering the data. As a result, the information presented in this report is based on the data exactly as it was submitted, with one exception. When substantial issues with the submitted data were discovered, such as facilities unintentionally omitting certain data points that must be reported, individual facilities were given a brief period to clarify or make corrections and resubmit the data before the OIG's report was released.

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

The OIG reviewed the following material for this report:

- Quarterly facility room confinement reports submitted to the Legislature and the OIG from July 1, 2024, through June 30, 2025;
- Federal and state regulations that govern juvenile facilities' use of room confinement;
- Individual facilities' written policies and procedures for utilizing different forms of room confinement; and
- Academic research and available reports on the history, impact, and appropriate use of juvenile room confinement, and effective methods for reducing its use.

This report covers thousands of incidents of room confinements. The OIG made all calculations, and verified those calculations, using Microsoft Excel functions. Time was rounded by the quarter hour: if a time difference was seven minutes or less, the total time was rounded down to the nearest quarter hour; if a time difference was eight minutes or more, the total time was rounded up. For example, a confinement incident from 11:00 to 12:22 was recorded as lasting one hour and 15 minutes. Total time was then converted to decimal form for consistent calculation purposes. A confinement incident lasting 1:45—one hour and 45 minutes—is represented as 1.75 hours. Similarly, most final data results were computed to the nearest hundredth and rounded up if the final number was five or above; percentages were rounded up to the nearest whole number. When possible, the OIG relied on individual youth ID numbers to calculate the total number of unique youth confined and to review the confinement of individual youth.

Appendix C: Selected References

Primary Sources of Current Best Practice Information[47]

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[47] The OIG is greatly appreciative of the Legislative Research Office (LRO) for its assistance in identifying these primary sources of information and credits the LRO for conducting updated research on current juvenile room confinement best practices and synthesizing and providing that research to the OIG.

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