OFFICE OF INSPECTOR GENERAL OF CHILD WELFARE
SUMMARY OF JUVENILE ROOM CONFINEMENT
ANNUAL REPORT (FY 2024-2025)

The OIG is required by law to provide oversight and accountability of juvenile room confinement in Nebraska by annually reviewing reported room confinement data and analyzing the use of room confinement in Nebraska's juvenile facilities.

- Juvenile room confinement (JRC) in Nebraska is the involuntary restriction of a juvenile placed alone in a cell, room, or 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.[1]
- Nebraska law provides for various restrictions and conditions for how facilities can use JRC,[2] which generally mirror the leading national best practices and research regarding JRC.
- Eight juvenile facilities in Nebraska regularly document and report JRC data.[3]

The OIG's review of the reported data in FY 2024-2025 found that the use of JRC 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.

- 127,276 total hours of JRC were reported to the OIG in FY 24-25 compared to 119,300 in FY 23-24 (~7% increase).
- 8,479 total separate incidents of room confinement were reported in FY 24-25 compared to 5,887 in FY 23-24 (~44% increase).

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.

- Youth were confined for 4 hours or less in 62% of all incidents in FY 24-25, a slight improvement from the 61% in FY 23-24.
- Youth were confined for more than 24 hours in only 9% of all incidents in FY 24-25, a significant improvement from the 15% in FY 23-24.
- This data indicates that facilities better complied with the best practice that room confinement should generally not exceed 4 hours and very rarely exceed 24 hours.
- For incidents lasting more than 4 and more than 24 hours, facilities most commonly reported that continued confinement was necessary for safety and security because of the danger that youth posed to others, primarily due to verbally and physically abusive, escalated, or threatening behavior, as well as fighting and assaults against youth and staff.

JRC 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.

- Safety and security reasons for confinement accounted for 72% of all reported incidents in FY 24-25, followed by administrative reasons at 25%, then medical necessity reasons at 3%.
- This data reflects a return to the typical trend of facilities primarily confining youth for safety and security reasons. This was mostly because of the large decrease in administrative reasons for confinement compared to the previous year, where administrative reasons were the leading reasons for confinement at 50% of all incidents.

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[1] Neb. Rev. Stat. § 83-4,125(4).
[2] See Neb. Rev. Stat. § 83-4,134.02.
[3] See Neb. Rev. Stat. § 83-4,134.01.

- This also suggests that facilities better complied with the best practice that 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.

Enhanced internal and external oversight of JRC and more consistent and standardized JRC statutory interpretations and practices continue to be needed.

- To continuously improve and reduce JRC usage across Nebraska, 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 JRC statutory interpretations and practices renders this difficult.
- All facilities thus need to adopt a standardized approach to data collection, reporting, and interpretation of Nebraska JRC statutes and best practices to ensure accuracy and consistency across the state.
- Enhanced oversight of JRC would also include regular facility reviews of 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 JRC practices.
- While Nebraska statutes align with best practices on JRC, based on the reported data, there remains some significant gaps in the practical application of these practices. To address these gaps and reduce the reliance on JRC 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 by accepting the OIG's recommendations below, some of which have been recommended in past years.

The OIG made the following recommendations:

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.