ATTACHMENT

Site Visit Report
State Training School
Eldora, Iowa
December 5, 2015

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This two-step consultation was requested by the State Training School (STS) in Eldora for the purpose of program review and appraisal of consistency of their practice with relevant national standards. In particular, the STS requested a review of assessment procedures, rehabilitation planning, interventions, and the use of seclusion and restraint. The reports for each step are included in this final report, accompanied by a final Conclusions and Recommendations section.

FIRST CONSULTATION VISIT

Description of Procedures

The site visited was conducted on April 16-17, 2015. Before coming, I spoke by telephone with STS Superintendent Mark Day and STS Program Director Lynn Allbee. As part of the site visit, I spoke with the directors of all cottages, facilities, security, and religious services in a meeting organized by Mr. Day. I was provided with a detailed "walking tour" of the STS by Mr. Day in the morning and Ms. Allbee in the afternoon of 4-16-15. This allowed me to see all cottages, the educational and recreational facilities, and a number of the vocational work areas (woodworking and mechanical). I was able to talk with 12-15 STS students, and was introduced to a number of others. On the following day, I was also able to see the old detention facility (now closed) and a small museum devoted to STS history. Based on this information, in light of my awareness of national trends in best practice and relevant standards, I offer the following appraisal.

STS Strengths

Excellent leadership. STS Superintendent Mark Day and Program Director Lynn Allbee appear dedicated, well-informed, and highly competent. Their relationship with middle management staff, including cottage directors and other service directors, seems to be a good combination of informal and professional. It is clear that both are well respected by staff at all levels. They are also very familiar with the students and the operations at STS from broad to very specific. In my walking tour with Mr. Day, he greeted nearly every student we passed by name and talked briefly with several, who appeared both pleased and respectful during the interaction. Both Day and Albee set an excellent example for the "firm but fair and caring" approach that is optimal in working with justice-involved youth.

Committed, competent, experienced mid-level leadership and line staff. There were two striking impressions I had from talking with various cottage directors and service directors. The first is that most have been at STS for a long time, ranging (among the staff I

met) from 14 years to 40+ years. The second is the virtual absence of indicators of burnout, or a sense that "I'm in this for the paycheck and counting the time until I can retire." Considering the challenges of working with justice-involved youth who come to STS because they have (a) been adjudicated delinquent for a serious offense, or (b) had major problems in adjusting to previous placements, this shared attitude and commitment among staff is remarkable. One staff member commented that he thought it was "parents and grandparents who have good Midwestern core values." Having such a stable and committed staff provides major advantages in delivering effective services to these youth.

Rapport and obvious caring about kids. I saw numerous instances of interactions between STS students and staff. Each was characterized by familiarity with the youth, including any recent problems or concerns (some related to a rating on the behavioral system that is in place), and offering feedback in a way that reflected good rapport but also good advice. These interactions were also realistic. Staff members were clearly trying to be fair, but not at the expense of being firm about adhering to expectations and achievements.

Use of rapport and de-escalation in discipline. One of the major challenges in delivering residential services to youth who are often impulsive and may become aggressive is to convey the expectation for respectful and non-violent interactions without being harsh, authoritarian, provocative, or too quick to use physical restraint or punishment. It is increasingly recognized within the fields of psychology, psychiatry, and criminology that a high proportion of justice-involved individuals have backgrounds that include traumatic and otherwise highly adverse experience. Staff who are too quick to restrain, or respond in an arbitrary or punitive way, are likely to trigger responses among some youth for such reasons. By contrast, it was quite clear that STS leadership and staff have committed to the use of rapport and de-escalation as primary strategies for avoiding unnecessary aggression. What was particularly impressive was the familiarity of security staff with such techniques; it seems that sometimes STS students will even ask to have a security tech come talk with them at a difficult time—and the security staff reportedly staff spend significant time (e.g., an hour) in such de-escalation.

Level system works well and is clearly understood. The level system at STS has 30 steps, and has been in place for many years. It seems to be well understood by both staff and students. When decisions regarding points or downgrades are made, this is usually communicated directly to the student. There is a reasonable appeal system in place that runs up to the clinical director and then to the director. Despite the absence of external security surrounding the campus, there are very few elopements. Mr. Day attributes this to the clear expectations provided through the level system and STS staff; students are aware that certain behaviors result in loss of points. Serious infractions can result in transfer to the disciplinary wing of one particular cottage. In some respects this is punitive, although students in this wing typically stay between 1-4 days, have two hours of recreation per day, and remain in school. They are confined to single rooms for the remaining time. There should be a justification for such transfer that goes beyond being punished for misbehavior,

however. Such a justification might involve risk of harm to others, likelihood of other serious misconduct unless removed from present cottage for a brief time, or something related. Considering the options for deciding on a consequence that range from two hours at this cottage (for youth who acknowledge misbehavior and accept responsibility for it) and 1-4 days (for those who do not), it would appear that the consequence is a combination of reasonable justification for removal from cottage as well as placement for a brief time at a lower level on the level system.

Selection and implementation of CBT programming (Risk and Decisions) that is consistent with level system. The evidence base on interventions for youth in residential or community settings strongly supports the use of CBT-based interventions that include specific components of antisocial cognition and problem-solving. The Risks and Decisions intervention which has now been adopted campus-wide has 30 sessions and corresponds well to the level system. This is a reasonable decision, as the evidence base does not provide a clear advantage to one specific kind of CBT—only that it include certain components. One component that would be very helpful to expand involves the families of STS students.

Facilities and grounds. The facilities and grounds are clean and well-tended. Some of the buildings are older; others (e.g., the gym and the school) are fairly new. There is a striking absence of external security—no fences or gates—and security forces were not seen. (Even when they are around, I understand that they are not dressed in uniform.) This combines to create the impression that resembles a community college more than a residential program for antisocial youth. Even without such security, there have been few elopements. Several staff attributed this to the clear expectations for behavior combined with the reasonable and even supportive conditions of incarceration. Whatever the explanation, this is a noteworthy finding considering that many STS students have adjusted poorly to community-based programs, including by running off.

Quality and extensiveness of vocational programming. Vocational training for STS students appeared to be fairly extensive and well supervised. I visited the mechanical and the woodworking training sections. Both were spacious, clean, and well-equipped. Several of the students spoke about the value of their vocational training. Supervisors appeared to be highly experienced and competent.

Training. The STS leadership recognizes that geographic isolation can sometimes keep staff from the mainstream of developments in the field. They compensate for this by sending staff off-site for training as often as possible. The frequency of such training trips has been reduced in recent years due to budgetary limitations. I suggested that the STS make more use of available technology to present trainings such as webinars and talks delivered from off-site to most efficiently use training funds and to keep an updated library of presentations on different topics available for staff viewing at their convenience—and for the orientation of new staff.

Suicide prevention and risk management. This is taken very seriously at STS, which reportedly has not had a successful suicide since 1982 (one account) or 1972 (a second account). This is impressive in light of the high proportion of STS youth with behavioral health challenges (a reported 60% receive psychotropic medication). A series of steps were described for youth judged to be at risk for suicide to implement, and then to downgrade, precautions. The staff psychologist is very involved in this process.

Aftercare planning. The interventions addressing post-discharge are impressive. First, STS students receive 40 sessions of community reentry planning on topics ranging from activities in daily living to risky situations. (My recommendation was to certainly continue these sessions, but move some of them earlier in the STS stay. For youth who are amenable to learning these skills, an earlier beginning would yield more time to learn and practice them. For those who are not, it would create additional time for staff to work with youth to promote their learning.)

Second, several STS contract employees offer group meetings on topics of interest to STS youth and relevance to reentry. As much as anything, this offers a means of community contact that can sometimes be limited for facilities that may be geographically remote from youths' communities. Take together, the first and second interventions provide a strong approach to training in relevant skills and focusing youth on the challenges of returning to the community and remaining crime-free.

STS Areas for Potential Modification

Have RNR play a larger role in assessment, treatment planning, and program development. Substitute a validated juvenile risk-need measure such as YLS-CMI or SAVRY for Locus of Control. (Other measures appeared relevant to youth needs and should be retained, in my view.) Ensure that programming is available for top 8-10 criminogenic risk factors.

Increase psychiatric coverage if possible. The current psychiatrist providing services to STS students is part-time, and described as very good. But he has also talked for several years about the possibility of retirement in the near future. This should be anticipated; it is possible that a replacement might require more than the current .40 FTE coverage—particularly if the percentage of STS students with behavioral health problems continues to grow.

Recruit at least one more psychologist. One psychologist in a school for 130 youth is insufficient. At least one position, and possibly two, should be added. In addition to their clinical duties, such individuals could also provide program evaluation services and possibly supervise interns or practicum students who could be placed at the STS.

Publish an article about the nature and effectiveness of soft restraints ("wrap"). One of the concerns that apparently has been raised about the use of the current restraint

system (the "wrap") is that it has not been investigated or even described in the professional literature. Hence, it may be regarded as "novel" or "untested." This is a reasonable concern, but the response should be to collaborate with an adolescence researcher with an interest in restraint to determine whether the wrap is actually an advance in terms of being more humane and less likely to result in an injury to the youth being restrained or the staff doing the restraining. There is no question that the use of physical restraint should be rare, and considered as a third or fourth option after de-escalation, counseling, and behavioral intervention. But in the rare instances that it is needed, the effectiveness of this approach could be investigated using a quasi-experimental pre-post design, as well as through surveying staff for their perceptions of its advantages and disadvantages.

Watch language that could be perceived in a pejorative way. People-first language guides us to think about youth as adolescents who should first be considered as human, although displaying histories (e.g., patterns of offending or misconduct) and characteristics that should inform their treatment. The level of respect for, and rapport with, STS youth displayed by staff was striking. The rare instances in which a youth was first characterized by his offense or a cottage named for a typology were inconsistent with this broader respect and rapport. Talking about kids, and naming levels and cottages, can usefully be brought into line with this respect through people-first language.

Expand aftercare planning to begin shortly after admission rather than waiting for last 40 days. This would give STS staff additional time to either teach and model appropriate skills to receptive students, or persuade reluctant students that such skills will be very useful.

Use Skype, Facetime, and other existing technology to provide more frequent personal and professional contact with families. Family-based interventions are a very important part of rehabilitating antisocial youth. They are also very challenging to implement from a remote placement that many families cannot regularly visit. The use of technology to bring families, STS students, and STS staff closer can help with this problem.

Figure out how to allow kids to call home if they don't have money in their state accounts. I'm not sure how much of a problem this is. It was mentioned at lunch by two students. Clearly every effort should be made to allow students to communicate with their families at least weekly, whether they have sufficient funds to cover the long-distance calling costs or not.

Motivating kids to work through the level system. This was an interesting comment from an STS student at lunch. He said that he had spent his first several months at STS denying that he needed to behave in a way that would allow him to progress up through the level system. It was only after several months, when he "challenged myself to do it to leave sooner," that he began to make significant progress. Incorporating the use of

personal challenge, to the extent that it is not already done, seemed like an idea worth noting. Use the motivation of challenge particularly for kids likely to respond to it.

Consider additional specific interventions. There are some fairly new and empirically-supported interventions that might be considered in addition to those already being provided at STS. Such interventions should be selected only if they provide a better means of addressing an existing programmatic need, or they fill a need that is not currently being covered. I am attaching a pre-print of a chapter on residential interventions that describes such interventions and their supporting evidence.

Summary

The STS has a number of substantial strengths and no major weaknesses in its current operation. These strengths, as well as some areas for possible modification, have been described in this report. I would prioritize two areas for possible change: (a) enhanced staffing in the areas of psychiatry and psychology, and (b) more focus on Risk-Need-Responsivity in assessment and rehabilitation planning. I am happy to work with the STS during the planned second phase of this consultation to help facilitate any changes they would like to make.

SECOND CONSULTATION VISIT

This will summarize the results of the second of a two-part site visit consultation requested by the State Training School (STS) in Eldora, Iowa. The first report (4-29-15) described an appraisal of the consistency of STS practice in light of national standards. This second report summarizes a review of STS practice with respect to youth with very substantial behavioral health and significant criminogenic needs—youth who are at high risk for violence and reoffending, are acutely aggressive in placement, and who also have needs for mental health treatment.

Description of Procedures

The second site visit was conducted on November 5-6, 2015. Prior to coming, I spoke with STS Superintendent Mark Day and Clinical Director Lynn Allbee. While on site, I reviewed the detailed records of two STS students, had a discussion of these cases with STS psychologist Louis Wright and Youth Counselor Scott Starr (as well as Mr. Day and Ms. Allbee), interviewed both students jointly with Mr. Wright and Mr. Starr, and discussed the broader implications of these cases for programmatic needs at STS with Mr. Day and Ms. Allbee.

Description of Two STS Students

These two cases were identified because they represent unusual challenges. The students currently placed at STS, as the residential juvenile treatment facility for the state of Iowa, typically have serious charges, multiple failures at prior placements, or both. About 60% are prescribed psychotropic medications. Common challenges among these youth include behavioral health problems, antisocial behavior, and criminal thinking.

But a small proportion of STS students experience all three challenges, at high levels. These are youth who could be described as "high risk, high need" with respect to criminogenic risk factors such as family dysfunction, educational problems, substance abuse, antisocial peers, criminal thinking, anger/impulsivity, and poor use of leisure time. But they also experience serious behavioral health problems, such as major mood disorders, early-stage schizophrenia, and Post Traumatic Stress Disorder. Finally, they are frequently aggressive within their current placement at STS, attacking staff members and other students.

Both behavioral health and criminogenic needs were apparent in the two cases reviewed. Both students had been assessed and had measured intellectual functioning in the Intellectually Disabled to low Borderline range, meaning that interventions with a cognitive component would be largely ineffective. Both displayed frequent serious misconduct (e.g., sexually aggressive behavior and threats by one; frequent aggression toward staff and peers by the other) during their residence at STS. Both had histories of substantial family

problems, instability, and genetic risk for serious mental illness. One student, in addition, appeared to have a serious history of experiencing sexual trauma.

These students were each housed in an STS cottage that is designed to provide short-term stabilization of youth aggression, to be followed by return to their original cottage. However, neither student had achieved the kind of stability that would allow them to progress past their currently restricted treatment status. The risk of continued aggression toward staff and peers remained high and ongoing. Neither student, upon being interviewed, showed the capacity to use CBT-type interventions effectively, so progress would likely occur through a combination of structure, carefully-planned behavioral interventions, intensive monitoring, and medication.

Review of STS Assessment and Intervention Procedures

The standard STS battery of psychological tests administered when a youth is admitted to the STS was reviewed. This battery currently includes the Slosson, Locus of Control (LOC), several other measures, and the MAYSI-2 (administered by cottage staff). Two specific suggestions were made regarding this battery. First, the LOC can be eliminated and a standard, structured professional judgment measure of risk and needs for juveniles (the Structured Assessment of Violence Risk in Youth, or SAVRY) could replace it, providing useful information about students' violence risk and risk-relevant needs. This can be a useful supplement to the current Iowa-specific tool, which provides risk and needs information based on a large sample of justice-involved youth in Iowa. Second, an alternative to the Slosson might be considered to assess intellectual functioning.

These measures were discussed in the context of Risk-Need-Responsivity theory, which is the most relevant and useful contemporary theory for juvenile risk-need assessment. Focusing on the risk principle allows staff to make plans for the intensity and duration of needed interventions; considering needs helps to individualize the planning for each STS student in terms of rehabilitation intervention priorities. We had a discussion involving Ms. Allbee, Mr. Wright, and a number of counselors regarding the interventions that are now available at STS. Everyone agreed on the importance of the relationship between staff and students, which allows counselors to use rapport and mutual respect to promote the acquisition and rehearsal of skills from other interventions, and to model good communication and decision-making. We reviewed all areas of risk and protective factors on the SAVRY. With the review of each risk factor, we considered whether there is an intervention at STS that addresses it. Notably, the Risk and Decisions intervention uses a cognitive behavioral approach to address thinking, impulse control, decision-making, communication, peers, and other relevant areas. The review did not uncover any areas of risk or protection that were not addressed at least in part by existing interventions.

Implications for STS Programming

Assessment. Relatively minor adjustments are recommended for the current assessment battery. These involve adding the SAVRY, dropping the LOC, and possibly substituting a different measure of intellectual functioning for the currently-administered Slosson. This modified battery would allow a more straightforward appraisal of each STS student in Risk-Need-Responsivity terms, and facilitate intervention planning and progress tracking relevant to discharge readiness and reentry needs.

Interventions. There do not appear to be any areas in which major interventions are needed but not available at STS. The major focus—cognitive behavioral intervention focusing on risk and decisions—is consistent with empirical evidence and good practice with youth in juvenile residential facilities. The discussion about relating each youth's appraised risk and needs to their areas of emphasis in their rehabilitation plan underscored the value of having counselors emphasize priority areas of risk and protective factors through individual work with students. Continued emphasis on rapport with and respect/caring for youth is important, as this is one of the ways in which STS has developed an approach that maximizes the impact of each counselor's work.

Treatment of High Risk, Aggressive Students with Serious Behavioral Health Needs. These two cases are not unique within the current STS population. A review of all youth currently at STS indicated that there are about 14 who had nearly comparable levels of need in both criminogenic and behavioral health areas. This raises the question of how such youth can most effectively be treated while at STS.

There appears to be a need for 6-10 dedicated beds at STS comprising a small unit that would specialize in this kind of treatment. It would treat acutely aggressive youth with significant behavioral health needs (major mood disorders, severe mental illness, disabling brain dysfunction, intellectual disability) combined with criminogenic high risk and needs. Such youth would be experiencing very significant behavioral adjustment problems, showing aggression toward others and/or self-harm that would be extremely difficult to treat in a non-specialized unit. The establishment of such a specialized unit, when appropriately staffed and physically configured to provide intensive intervention, would make it more likely that this very challenging group could receive the best available treatment designed to both improve behavioral health and reduce aggression and subsequent offending risk. It would also mean that the programming in other cottages for STS students would be minimally disrupted. Youth in the specialized unit would have limited interaction with other STS students until their behavior and symptoms were sufficiently stabilized to allow such interactions with minimal tension.

To benchmark this kind of programming against that of other states in the region, we reviewed the applicable law and policies for Illinois, Kansas, Minnesota, Missouri, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, and Wisconsin (see Appendix A). The main question was how these states house and rehabilitate juvenile

offenders with serious behavioral health needs who are also very aggressive. Seven of these ten states apparently have such youth treated in facilities operated by the state Department of Corrections. This does not necessarily mean that they are sent to adult prisons; apparently only New Mexico and Wisconsin allow such transfers, while the remaining five states (plus Wisconsin) have the youth treated in juvenile correctional facilities that are nonetheless operated by DOC.

Apparently all seven of these states have explicit provisions for treating youth meeting this description. The remaining three states—Illinois, Missouri, and Oklahoma—are harder to gauge as to whether they have dedicated beds for such youth. Nebraska, North Dakota, and Wisconsin in particular have descriptions of programming that look like it was developed specifically for youth like this. (Contact information is available for most facilities cited in Appendix A.)

CONSULTATION CONCLUSIONS AND RECOMMENDATIONS

1. STS has excellent leadership. This includes Mr. Day, Ms. Allbee, and a number of committed, competent, experienced mid-level staff. Many of these leaders are approaching retirement, however, and the challenge for STS over the next 5-10 years will be to replace these leaders with others who can develop into comparably strong leaders.

2. One of the most noteworthy strengths of STS staff was the quality of the relationship they displayed with STS students. It combined firmness, respect, rapport, and caring. It is this relationship that facilitates the usefulness of various interventions, as it allows staff to encourage students to develop new skills and change in positive ways while simultaneously modeling these skills.

3. There is largely appropriate use of strategies for the necessary control of aggression and other misconduct (although see #4, below). These strategies include

    a. a well-developed, consistently-implemented, and clearly-understood level system;
    b. verbal de-escalation techniques used by both line staff and security staff (who are not in uniform) that are consistently and productively used before physical restraint;
    c. a cottage that separates misbehaving youth from the larger population for relatively short periods, but does not isolate them from essential activities and allows them to earn their way back fairly soon;
    d. seclusion that appears to be used for short periods of time and with appropriate frequency; and
    e. restraint ("the wrap") that may be less likely to harm youth and staff because it uses cloth rather than metal.

4. There is a small number of youth currently at STS (an estimated 5-12) who have serious behavioral health needs accompanied by very frequent threats, aggression, or other serious misconduct. These youth need more specialized and intensive programming than they can receive with current STS resources. The construction of a small specialized unit with 5-10 beds, more intensively staffed and with the clearly-defined goal of providing all reasonable interventions available to reduce the risk of ongoing aggression while enhancing life skills and addressing behavioral health needs, is recommended.

5. The current assessment battery for STS students is largely consistent with national standards and appropriate for intervention planning at STS. Two changes are recommended. First, I suggest that the Structured Assessment of Violence Risk in Youth (SAVRY) be added, and the measure of locus of control be dropped. Second, I recommend that those providing the assessment even more strongly link their

results with intervention-planning efforts, so youths' risk, needs, and responsivity (measured at assessment) are explicitly guiding intervention-planning and ongoing progress tracking.

6. Current programming is consistent with national standards, and with an approach using risk/needs/responsivity. Particular strengths include CBT-based counseling (Risk and Decisions), vocational training, and aftercare planning. The interventions at STS appear strong and appropriate, and no additional recommendations (beyond that in #5, above) are made in this area.

7. Additional staffing will be important, particularly if STS moves in the direction of establishing specialized behavioral health/aggression management beds. The current staffing includes only one psychologist and one part-time psychiatrist under contract. An estimate 30-50% of STS students have behavioral health needs that should be reviewed and assessed by mental health professionals. I strongly recommend increasing the staff coverage in both psychology and psychiatry. This may mean exploring opportunities for additional contract coverage, if it is not feasible to employ such individuals full-time.

8. The grounds are clean, well-kept, and contribute to the rehabilitative orientation that characterizes STS.

9. Staff might make more use of technology for purposes of ongoing training and continuing education. It would be feasible to develop a series of one-hour webinar presentations by individuals from around the country, addressing specific questions of interest to STS, and maintaining those webinars in a training library.

Thank you very much for the opportunity to provide this consultation.

Kirk Heilbrun, PhD.

Appendix A

Selected Comparison States and Programming for Highly Aggressive Juvenile Youth with Serious Behavioral Health Problems

State	Programming Description	Contact Information
Illinois	Juveniles should not be committed to the Department of Juvenile Justice, save a finding that justifies commitment outlined in 705 ILCS 405/5-750, which includes treatment needs and risk to public safety. It's unclear if the DOC-affiliated juvenile facilities have any special management units or where particularly challenging juveniles are placed, but some of them house high-risk offenders. All juveniles move through one facility and are designated into an appropriate location based on a risk designation.	Illinois Youth Center - St. Charles: (630) 584-0506 Illinois Youth Center - Kewanee: (309) 852-4601 Illinois Youth Center - Warrenville: (630) 983-6231 Illinois Youth Center - Harrisburg: (618) 252-8681
Kansas	DOC operates two juvenile correctional centers: Larned Juvenile Correctional Facility and Kansas Juvenile Correctional Complex. Larned houses one special management unit; in total, Larned has 128 beds, but it isn't specified how many are SMU beds.	Kansas Juvenile Correctional Complex: (785) 354-9800 Larned Juvenile Correctional Facility: (620) 285-0300 Names and contact information for facilities DOC might contract with when placing justice-involved youth: https://www.doc.ks.gov/juvenile-services/provider/providers/detention
Minnesota	Minnesota DOC operates one juvenile facility at Red Wing. Statutory law suggests that Red Wing should be used as a commitment facility of last resort, only to be used	Minnesota Correctional Facility - Red Wing: (651) 267-3600

	when local options are exhausted by the committing county. It's unclear if there is a specialized housing unit.	
Missouri	Missouri has commitment facilities, but doesn't favor transferring aggressive youth to alternative placements or segregating them for any length of time. It's unclear if there are any specialized beds.	
Nebraska	Nebraska DOC runs the Nebraska Correctional Youth Facility, which contains one special management unit but doesn't specify the number of beds.	Nebraska Correctional Youth Facility: (402) 595-2000
New Mexico	New Mexico statutory law provides that juveniles who are violent towards juvenile detention center staff may be transferred to adult correctional facilities.	
North Dakota	North Dakota DOC runs North Dakota Youth Correctional Center, which contains two sites that have special management programs: Pine Cottage and Maple Cottage, each 25 beds. It is not specified what treatment resources are available to individuals in these beds.	North Dakota Youth Correctional Center: 701-667-1400
Oklahoma	In Oklahoma, it appears that there is a strong presumption against placing juveniles in secured facilities akin to special management beds in other jurisdictions.	Central Oklahoma Juvenile Center: (405) 598-2135 Southwest Oklahoma Juvenile Center: (580) 397-3511
South Dakota	The South Dakota DOC runs Aurora Plains Academy, which is a specialized placement targeted at the state's most violent and unmanageable offenders. It can	Aurora Plains Academy: (605) 942-5437

	house 66 individuals: 48 males and 18 females.	
Wisconsin	Wisconsin statutory law allows for unmanageable juveniles to be transferred to adult correctional facilities. Wisconsin DOC also runs Mendota Juvenile Treatment Center, which is designed to treat the most unmanageable justice-involved youth. Number of beds is unclear.	Mendota Juvenile Treatment Center: (608) 301-1193