**U. S. Department of Justice**

Civil Rights Division

*Office of the Assistant Attorney General* *Washington, D.C. 20035*

April 9, 2004

The Honorable Robert L. Ehrlich, Jr.
Governor of Maryland
100 State Circle
Annapolis, Maryland 21401

Re: Investigation of the Cheltenham Youth Facility in Cheltenham, Maryland, and the Charles H. Hickey, Jr. School in Baltimore, Maryland

Dear Governor Ehrlich:

I write to report the findings of the Civil Rights Division's investigation of conditions at the Cheltenham Youth Facility ("Cheltenham") and the Charles H. Hickey, Jr. School ("Hickey"). On August 30, 2002, we notified then-Governor Parris Glendening of our intent to conduct an investigation of Cheltenham and Hickey pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). As we noted, both CRIPA and Section 14141 give the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of children in juvenile justice institutions.

Between April 28 and June 12, 2003, we conducted on-site inspections of Cheltenham and Hickey with expert consultants in juvenile justice, medical care, mental health care, education, and sanitation. We interviewed staff, youth residents, medical and mental health care providers, teachers, and school administrators at both facilities. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, youth detention records, medical and mental health records, grievances from youth residents, investigations of the Department of Juvenile Services'

("DJS") Office of Professional Responsibility and Accountability ("OPRA"), reports of the Office of the Independent Juvenile Justice Monitor ("Independent Monitor"),[1] unit logs, orientation materials, staff training materials and school records. Following each tour, we conducted exit conferences with facility and DJS officials, during which our consultants described their initial impressions and concerns.

We commend the staff of both facilities and the DJS central offices for their helpful and professional conduct throughout the course of the investigation.[2] Once granted access, we received full cooperation with our investigation. We also appreciate the State's receptiveness to our consultants' on-site recommendations.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. As described more fully below, we conclude that certain deficiencies violate the constitutional and federal statutory rights of the youth residents. In particular, we find that children confined at Cheltenham and Hickey suffer harm or the risk of harm from constitutional deficiencies in the facilities' confinement practices, suicide prevention measures, mental health and medical care services, and fire safety. In addition, the facilities fail

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[1] This office is created by statute, Md. Code, Art. 49D, § 41, to monitor conditions in all DJS facilities and report its findings to the Governor, the Maryland General Assembly and the DJS Secretary. Several staff members are assigned by region to visit the facilities, conduct announced and unannounced tours, and write detailed reports of their findings, recommendations, and DJS responses. Independent Monitor officials have identified similar systemic violations as those identified in this letter at both facilities, and reported these problems to DJS and others. Their reports reflect continuing frustration at DJS's failure to institute effective remedies to the patterns cited.

[2] Our tours of Cheltenham and Hickey were initially delayed nearly seven months by negotiations with the State regarding the terms of our access to the facilities and confidentiality of documents. Shortly after we met with DJS Secretary Kenneth C. Montague, Jr. in March 2003, we were able to commence our document review and on-site facility tours.

to provide required education services pursuant to the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1401, and Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794.

## I. BACKGROUND

At the time of our tours, Cheltenham was a 180-bed facility for boys aged 12 to 18.[3] The facility, which is operated by DJS, serves primarily as a pre-adjudication detention center. Some youth confined at Cheltenham have already been adjudicated delinquent and committed to DJS care, but are confined at Cheltenham "pending placement" in a treatment program elsewhere. A youth's average length of stay at Cheltenham is approximately 25 days, although some youth are there in excess of 200 days.

Hickey is a facility for boys aged 12 to 20 that is owned by the State but which, at the time of our tours, was operated by a private company, Youth Services International (YSI), through a contract with DJS.[4] Hickey has a 330-bed capacity, and at the time of our tour, had a total of 263 youth in residence. The facility consists of two separate campuses, one within a secure fence and one outside the fence. Within the secure area, there is a detention facility for youth awaiting adjudication, and two programs for youth committed to DJS care: the Intermediate program (6-10 months) and the Enhanced Program (12-18 months). Youth who have been adjudicated delinquent and are pending placement in other treatment programs are confined in the secure campus at Hickey. Outside the fenced area is a short term program (30-90 days) for committed youth, known as the Impact Program. The average length of stay for a youth at Hickey is 325 days, although some youth have been there in excess of 700 days.[5]

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[3] The State reports that it has closed a number of housing units and that the population at Cheltenham is now under 60 youth residents. At the time of our tours, Cheltenham housed 216 youths.

[4] The State reports that it is has taken over management of Hickey, as it has not renewed its contract with YSI, which expired at the end of March 2004.

[5] We are aware that the General Assembly is currently considering legislation which may alter the future plans for serving youth in DJS custody. These efforts appear aimed, in part, at reducing the size of facilities such as Cheltenham and Hickey and, presumably, improving the quality of care for youth.

## II. LEGAL STANDARDS

As a general matter, States must provide confined juveniles with reasonably safe conditions of confinement. See Youngberg v. Romeo, 457 U.S. 307, 315-24 (1982); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979). Such constitutionally mandated conditions include the right to adequate medical care, a concept that embraces both mental health treatment and suicide prevention measures. See Patten v. Nichols, 274 F.3d 829, 835 (4th Cir. 2001); Shrader v. White, 761 F.2d 975, 978 (4th Cir. 1985); Gordon v. Kidd, 971 F.2d 1087, 1094 (4th Cir. 1992). Further, confined juveniles are entitled to protection from physical assault and the use of excessive force by staff. Youngberg, 457 U.S. at 315-16. The State is also obliged to provide special education services to juveniles with disabilities pursuant to the IDEA. As described below, the State has fallen well short of these constitutional and federal statutory obligations.

In assessing whether the constitutional rights of institutionalized juveniles have been violated, the governing standard is the Due Process Clause of the Fourteenth Amendment. See Youngberg v. Romeo, 457 U.S. 307, 315-16 (1982); Patten, 274 F.3d at 840-41. Accordingly, the proper inquiry focuses on whether the conditions substantially depart from generally accepted professional judgment, practices, or standards. See Youngberg, 457 U.S. at 323.

## III. FINDINGS

### A. PROTECTION FROM HARM

Our investigation revealed major constitutional deficiencies in the harm protection measures in place at Cheltenham and Hickey. In particular, both facilities fail to protect youth from: (i) staff violence; (ii) unsafe restraint practices; (iii) youth violence; (iv) excessive isolation; and (v) other abusive practices.

#### 1. Staff Violence

The evidence unearthed in our probe indicates a deeply disturbing degree of physical abuse of youth by staff at both Cheltenham and Hickey. The following examples are illustrative:

- In January 2004, the Maryland State Police filed criminal assault charges against four Cheltenham staff members who allegedly restrained a youth and beat him. The police investigation reveals that after the youth resisted going to bed early, four staff members grabbed him. The unit supervisor put the youth's arms "in a chicken wing hold" over his head while other staff members punched him in his face and kicked him in the ribs and back. By the end of the incident, staff had dragged the youth back to his room and his pants and underwear had been ripped and pulled down to his ankles. Medical records document injuries to the youth's forehead, eye area and lip. In addition, the youth reported pain in his ribs. The youth was sent to the hospital for care.

- In January 2004, the Maryland State Police filed criminal assault charges against two Hickey staff members for assaulting a youth. A police investigation revealed that the youth, upset because a routine staff search of his room left it in disarray with some items missing, kicked his door. A staff member then slapped the youth in the face with an open hand and attempted to wrestle him to the ground. Although two staff members attempted to intervene to stop the assault, another staff member grabbed the youth from behind and began striking him with a closed fist. The youth was left injured in his room for three hours before being seen by the nurse. Photographs taken by the nurse reportedly depict injuries to the youth's face and body consistent with being grabbed around the neck and being struck in the face.

- In a May 2003 incident, Child Protective Services found that a Hickey staff member struck a youth in the face, which another staff member witnessed.

- In a May 2003 incident, a Hickey staff member assaulted a youth who refused to leave a school classroom. The staff member grabbed the youth around the neck and slammed him against the wall outside the classroom. The youth then threw a plastic chair towards the staff member, but missed him. The staff member slammed the youth to the ground, choking, punching and kicking him. During our visits, we observed injuries to the youth's face and neck.

- In a March 2003 incident, a youth at Cheltenham was involved in an altercation with a staff member at the school. After another staff member restrained the youth and escorted him to a transportation van, the staff member involved in the altercation entered the van and struck the youth with his fist.

- In a March 2003 incident, a Hickey staff member, breaking up a youth-on-youth fight, hoisted one of the youth in the air and "slammed him to the floor," injuring his left arm. The facility failed to inform the youth's parents, who filed a report with Child Protective Services after seeing a cast on their son's arm on visiting day a week later. Staff reports failed to describe any injuries to the youth. OPRA investigators described the incident as "another example of [Hickey] staff trying to conceal incidents."

- In a February 2003 incident at Cheltenham, a youth, upset that a staff member had thrown his breakfast away, tried to push past the staff member to get out of his room. The staff member grabbed him by the throat and pushed him back onto the bed, choking and cursing him. The youth was treated for injuries to his neck and pain in his throat.

Our interviews with direct care staff, youth, and other DJS employees confirmed that the above examples are representative of recurrent problems at the facilities and are not aberrational. Our review of incident reports and information from OPRA investigators reveals that incident reporting by staff frequently fails to provide any detail regarding the incidents. Indeed, most OPRA investigations are not initiated by staff incident reports, but rather from informal sources of information. The recurrent nature of the incidents reflects a lack of appropriate training, reporting, supervision, and quality assurance practices at Cheltenham and Hickey. While incidents that come to light are appropriately investigated by OPRA, and often lead to disciplinary measures against involved staff, the facilities have failed to implement systemic measures to ensure that similar incidents do not recur.

In addition, our investigation revealed that individuals with felony convictions and histories of excessive force against juveniles may, at times, be hired as staff members at these facilities. Notably, we found several instances where we believe

that staff with either felony convictions or previous histories of excessive force in a juvenile detention facility were involved in incidents of abuse. This is, quite obviously, entirely unacceptable.

### 2. Unsafe Restraint Practices

Although restraint may be an appropriate tool when used properly, the methods used by staff at Hickey to restrain unruly youth depart substantially from generally accepted practices and create grave risk of harm to youth. In a technique the facility terms "lock and drop," staff take a youth to the ground and force him into a prone position (lying with stomach to the ground), placing weight on the youth's upper torso to hold him to the ground. This position, demonstrated to us by training staff, can prevent the youth from breathing and cause asphyxiation. As we informed staff in our exit interviews, the practice should cease immediately.

Staff and youth also reported seeing staff members grab disruptive youth by the neck, another inappropriate method of restraint. One youth described his restraint experience as being "slammed on the neck and arms bent way back." Another youth described the experience as "they put a knee in your back, one hand on the back of your neck and the other hand bends your arm up in back."

The danger associated with this practice is not merely theoretical; our investigation revealed an incident in which a youth required treatment at the emergency room following a restraint. Another youth restrained in March 2002 vomited and appeared to have inhaled some of the vomitus, triggering a loss of consciousness. He was sent to the emergency room where he was diagnosed with transient asphyxia. An Independent Monitor official has also documented various incidents at Hickey in which youth were harmed during restraint. In one incident, a youth suffered neck and shoulder injuries. In another restraint, a youth suffered a seizure and required hospitalization. In still another, a 300-pound staff member sat on a youth and the staff mocked the youth when he complained that he could not breathe.

These incidents reflect a serious risk of harm to youth. The State must establish a safe method of restraint and ensure that staff are trained in its appropriate and safe use.

### 3. Youth Violence

Generally accepted professional practices require that facilities confining youth must protect youth from assault by other youth. Facilities must maintain sufficient structure, safeguards, and staffing to ensure safety. Both Hickey and Cheltenham experience unacceptably high levels of youth-on-youth violence. Consider the following illustrative examples:

- The Independent Juvenile Justice Monitor reported that six fights broke out in a single day in November 2003 at Cheltenham.

- During our June 2003 tour of Hickey, we were made aware of a fight on the Kennedy Unit in which three youth allegedly assaulted another individual, who required 30 stitches to close the wound on his face.

- In a May 2003 incident, a youth at Cheltenham assaulted another youth who was sleeping in the day room during free time, resulting in a fracture of the youth's left orbit. The one staff member responsible for supervising the day room had fallen asleep and saw none of the incident. This staff member had worked several forced double shifts that week, and could not stay awake due to exhaustion.

- In a May 2003 incident at Hickey, one youth received stitches in his head after several youth assaulted him in the day room and hit him with a wooden chessboard.

- In an April 2003 incident, a group of youth at Hickey assaulted another youth. The assault lasted for a period of minutes without staff intervention. The youth had a bruised forehead and swollen finger, but staff did not refer him for medical care. Staff also failed to report the incident as required by policy and procedure.

- In another April 2003 incident, a youth at Hickey suffered a broken jaw after youth attacked him with a stick during outdoor recreation time.

- In a third April 2003 incident, a youth at Cheltenham, intending to punch one particular youth, struck a third youth who was knocked unconscious. The injured youth was hospitalized for 2 days.

- In March 2003, Cheltenham experienced a riot to which local law enforcement authorities had to respond in order to regain control of the facility. The incident began during a program in the facility gymnasium for youth from all of the units. Youth from Rennie cottage attacked youth from Whyte cottage, after which they were separated. However, some youth from Rennie ran out of the gym and chased and assaulted staff and youth from other cottages. Two youth were hospitalized, one with a head injury and another with bruised ribs. Other youth were physically assaulted and forced to remove their clothes. Youth were able to use a crowbar-like object to pry open some room doors. OPRA issued a report which included recommendations for corrective action. The measures had not been implemented at the time of our tours.

- In a January 2002 incident at Cheltenham, three youth attacked one youth, resulting in eye injuries that required hospital treatment.

The pervasive violence at Cheltenham appears to result, in part, from the lack of sufficient numbers of adequately trained staff. Youth-to-staff ratios at Cheltenham have been as high as 20:1 during the day and 60:1 at night. These ratios deviate substantially from generally accepted professional practices. Many states require one staff per eight youth during the day and one staff per sixteen youth at night. Further, due to the physical layout of the housing units and the multiple supervisory responsibilities for each staff member, staff are not always present when youth-on-youth violence occurs. Furthermore, due to the volatile nature of the youth, staff report that they are often too busy attempting to maintain a minimal level of control in the housing units to engage in meaningful activities to help youth develop more acceptable behavioral skills or to develop relationships with youth. Thus, staff abilities to identify problems and intervene meaningfully to avert violence are

limited.[6] Furthermore, staff are frequently required to work double shifts, often without advance warning, leaving them tired, short-tempered and less alert.

At Hickey, inadequate training of staff contributes to youth violence. Our investigation revealed that staff at both facilities lack skills and training in de-escalating crises and youth-on-youth conflicts. This absence of training impedes the ability of staff to intervene successfully in volatile situations of which they are aware, and can even lead to escalation of youth aggression during a crisis.

Staff at both facilities also fail to report many serious incidents that occur. A DJS internal investigation revealed that Cheltenham staff were reporting only 27 percent of incidents that required reporting. At Hickey, staff reported only 66 percent of incidents requiring reporting. Furthermore, even those incident reports that are submitted lack important information such as details of who was present during the incident, what happened during the incident, and what precipitated the incident.

The absence of an adequate classification system is another contributing factor to the frequency of youth assaults. Generally accepted professional standards require that youth be housed and supervised in accordance with their classification. Reliable classification systems take into consideration such information as a youth's age, charged offense, history of violence and escape, gang membership or affiliation, health and mental health concerns, and institutional history. Neither Cheltenham nor Hickey has an adequate classification system.

At Cheltenham, staff do not separate violent and non-violent youth. Youth are classified by age and, for some age groups, seriousness of charged offenses, but youth who should be housed separately often are not. For example, two youth at Cheltenham required hospital treatment following a fight; one boy had serious injuries to his face. The youth returned to Cheltenham at different times, but were both housed in the infirmary where

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[6] The lack of sufficient staff even impacts the ability of youth who are injured to obtain prompt medical care. For example, Cheltenham staff reported that one youth who was in a fight on a Saturday night and sustained a shoulder injury had to wait until Sunday night to be taken to the hospital for medical treatment. Staff reported that a lack of security/transportation staff caused the delay.

they were in close proximity. While the youth did not continue their assaultive behavior, the facility apparently undertook no preventative measures in response to the incident. The youth were not reclassified to ensure their separation nor were staff caring for them informed that these youth were prone to violence against one another.

We are likewise very troubled by the fact that, at Hickey, youth with identified mental illness are placed on the same units with youth who have poor impulse control and other behavioral disorders. This practice places the youth with serious mental illness at an especially high risk of victimization.

The high degree of youth violence at Hickey and Cheltenham is a partial byproduct of inadequate security measures. At Hickey, youth are not sufficiently supervised, allowing them to tamper with locking mechanisms on youth room doors, disable the locks, and enter other youth rooms to assault one another. For example, one youth at Hickey was able to enter another youth's room undetected and urinate in his bed. The victim of this incident was then able to enter the perpetrator's room and defecate in his bed. Following this incident, the original perpetrator then entered the original victim's room to assault him, all of which occurred without staff intervening to defuse the escalating conflict and prevent harm.

A further example of insufficient supervision occurred in April 2003, when staff from the Independent Monitor's office visited a Hickey living unit. The monitor reports that he asked to inspect a bathroom where the showers appeared to be running and had a foul smell. The bathroom was locked, and when the monitor asked the staff member on duty why the showers were running, the staff member indicated that no youth were in the locked bathroom, but that the showers sometimes do not turn off completely. When the bathroom was unlocked, however, two youth were found showering, unsupervised, locked in completely without staff knowledge.

In addition to incubating an environment extraordinarily receptive to violence, the lack of sufficient staff supervision also contributes to opportunities for youth to attempt escape. For example, a youth at Hickey attempted to scale the fence on July 1, 2003, but became caught in the razor wire. The fence alarm sounded 23 times, but the youth's attempt to scale the fence went undetected. Supervision was so poor that the youth was able to return to his unit, severely bleeding, and hide in the bathroom before staff discovered his injuries or his attempt at escape.

Meanwhile, on May 22, 2003, two youth at Cheltenham escaped through the perimeter fence with the help of an individual on the other side. During the previous night, the fence security alarm had sounded numerous times, but staff failed to detect that the fence had been cut.

### 4. Excessive Use of Disciplinary Isolation/Lack of Procedural Protections

The facilities' isolation[7] practices substantially depart from generally accepted professional practices in that juveniles are isolated for excessive periods of time, for minor offenses, and without appropriate procedural protections. Isolation should be used only to the extent necessary to protect youth from harm to themselves or others or to maintain institutional discipline. Youth placed in disciplinary isolation are entitled to notice of their charges, a hearing before an independent decision-maker, and an opportunity to present evidence in their defense. Hewett v. Jarrard, 786 F.2d 1080, 1089 (11th Cir. 1986); Mary and Crystal v. Ramsden, 635 F.2d 590, 599 (7th Cir. 1980).

The facilities have no procedure for providing due process to youth who are isolated for more than 24 hours. No hearing procedures exist at either facility. Facility and DJS staff described to us policies under which (i) an upper-level manager must approve isolation of youth, and (ii) the youth must be released when he is back under control. However, interviews with staff revealed that, while the supervisory staff might come by and check in on youth, supervisory staff are not actively engaged in deciding when it is appropriate to end an isolation. Instead, the staff member who places the youth in isolation decides when he may be released, resulting in a substantial departure from generally accepted practices by allowing the involved staff member -- rather than some neutral party -- to make this decision. The result is that youth remain in isolation, often

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[7] Isolation includes all times in which a youth is placed alone in a locked room for the purposes of discipline or due to out of control behavior. Staff at Cheltenham and Hickey generally use the term isolation to refer to locking youth alone in their own rooms, and use seclusion to describe locking youth alone somewhere other than their rooms. Professionals use the terms isolation and seclusion interchangeably to refer to both practices. We choose the term isolation in this discussion for the sake of clarity.

sleeping, long after they are in complete control of their behavior. In addition, youth isolation is not consistently documented in log books; during our visit to Hickey, senior staff were unaware of some isolation incidents that occurred.

### 5. Other Abusive Practices

#### a. Inappropriate Staff-Youth Relationships

Our investigation revealed incidents of misconduct at both facilities in which female staff were found to have engaged in inappropriate relationships with male youth residents as young as 14 years old. For example, in June 2003, during an investigation of a physical assault by a staff member on a youth at Hickey, the staff member admitted to sexual abuse of another youth. In February 2003, a missing youth was found driving a car registered to a female staff person at Hickey. In April 2002, a staff member resigned after it was revealed that she had engaged in sexual intercourse with a youth resident at Cheltenham. Relationships of this variety clearly violate the Constitution. Unfortunately, the facilities have failed to institute adequate measures to prevent incidents such as these from recurring.

#### b. Denial of Access to Bathrooms

Youth must have opportunities for personal hygiene including the use of toilets. Because only a small number of cells at Hickey and Cheltenham are equipped with toilets and sinks, most youth must request that staff let them out of their rooms to use the restroom. Staff at both facilities fail to meet this fundamental need. Youth frequently wake in the middle of the night and are unable to attract staff attention to let them use the restroom. Several cells smelled strongly of urine during our visits; we learned that youth sometimes urinate on their window sills or into bed linens if they are not permitted to use the restroom. Aside from the obvious sanitary problems of such behavior, leaving youth to resort to such humiliating measures is unconscionable.

## B. SUICIDE PREVENTION

Juvenile institutions must protect youth from self-harm. Cheltenham and Hickey fail to protect youth in the following ways: (i) staff fail to assess suicidal youth adequately; (ii) youth on suicide precautions receive insufficient mental

health services; (iii) youth at risk of self-harm are housed in unsafe circumstances; (iv) supervision of youth on suicide precautions and in seclusion is insufficient; and (v) staff lack preparation to respond appropriately to suicide attempts.

### 1. Insufficient Assessment of Suicidal Youth

At Cheltenham, security staff consistently identify youth in suicidal crisis and place them on appropriate levels of security precautions to prevent self-harm. However, initial evaluation by mental health staff is often delayed, particularly if a youth is placed on suicide precautions over the weekend, thus restricting the youth's activities without providing needed care.

At Hickey, staff often fail to use the instrument available to assess potential lethality either before a youth is placed on suicide precautions or when deciding whether to change the level of suicide precautions. While the State of Maryland (including Cheltenham) uses a reliable measure of lethality -- the Inventory of Suicidal Orientation (ISO-30) -- staff at Hickey use an untested screening tool that may not accurately assess lethality.

### 2. Insufficient Mental Health Services for Youth on Suicide Precautions

Youth on suicide precautions should receive appropriate follow-up care from mental health staff to assess whether there is an ongoing need for the youth to be placed under the restrictions associated with such precautions, and to provide treatment if necessary. In addition, a competent mental health professional must be available for consultation during hours when staff are not scheduled to be at the facility, and should be able to respond promptly when a youth requires crisis evaluation.

At Cheltenham, staff provide only inconsistent follow-up for youth on suicide precautions. Youth often spend many days in the "Observation Room" of the Infirmary without the benefit of regular clinical contact, despite a department policy which is consistent with generally accepted standards, requiring that youth be seen daily by mental health staff. Nor do staff help youth develop any skills to reduce their suicidal ideations or behaviors.

At Hickey, staff also fail to monitor youth on the highest suicide precautions with sufficient frequency. Responsibilities for care of youth in crisis during hours when mental health staff are not routinely at the facility have not been clearly defined. Infirmary staff reported that pages to on-call mental health

staff often are not answered for extended periods of time. Psychiatric backup is not provided when the staff psychiatrist is unavailable, despite a commitment by the facility to have 24-hour psychiatric on-call coverage. The person assigned by the contract mental health service provider to be on call during non-business hours and on weekends, who is also the clinical director, is a physician not currently licensed to practice in the United States either as a physician or mental health professional; she has not even completed a psychiatric training program approved in the United States. Therefore, the facility fails to provide on-call crisis care in keeping with professional standards.

### 3. Unsafe Housing of Youth at Risk of Self-Harm

It is widely known that the first 48 hours that individuals, particularly youth, are detained in an institution present especially dangerous risks for attempted suicide. Institutions must ensure that intake area staff monitor newly arrived individuals closely to maintain their safety. At both Cheltenham and Hickey, staff are unable to maintain an appropriate watch on youth residents in the intake areas to ensure their safety.

At Cheltenham, the intake area has one holding cell. At times during the day, the staff member expected to monitor this area is also responsible for answering the telephone for the entire institution, questioning newly arriving youth about their medical, mental health, and physical conditions, and logging activity on the unit. The office in which that person is posted does not provide a sight line into the holding cell, so a youth could be attempting self-harm, or one youth could be harming another, and staff would likely not see it while attending to one of their many other duties. Indeed, the staff member has too many duties to provide adequate security. Furthermore, because there is only one holding cell, staff are unable to separate incoming youth in this area to protect them from one another.

At Hickey, there are more cells available for youth in the intake area, but the one staff member assigned to this area is also responsible for helping process youth being transported out of the institution and youth arriving at the institution, as well as overseeing the area in which youth on suicide precautions and disciplinary seclusion are confined. While facility management may assign additional staff to monitor youth on suicide precautions, youth on disciplinary seclusion present a heightened suicide risk as well.

In addition, we found that the cells at both facilities had fixtures on which youth could hang themselves. We warned staff at Hickey that the exposed sprinkler heads in the intake/seclusion area cells posed opportunities for youth to attempt suicide. We learned later that youth in two incidents seven weeks apart attempted to hang themselves from these sprinkler heads in this area, thus evidencing that the risks described above are quite real. In a July 21, 2003 report, the Independent Monitor recounted the two attempted suicides by hanging in the seclusion area:

- On April 26, a youth tied a sheet around his neck and around a sprinkler head. Staff observed the youth hanging and intervened.

- On June 15, another youth tied his bed sheet to sprinkler head. Staff again intervened.

In the report, the Independent Monitor also acknowledged our warnings to the State by stating that the "federal government auditor had also cited the facility for the exposed sprinkler head in May," and warned, "a youth will lose his life if sprinkler heads are not covered as required." In addition, at Cheltenham, the beds were constructed in such a way that youth could hang themselves. DJS administrators did inform us before the end of our tours that new beds had been ordered for seclusion cells.

Furthermore, at Cheltenham, youth on heightened suicide precautions are frequently housed in the infirmary, where their opportunities to participate in programs and outdoor activities are restricted. At Hickey, youth on suicide precautions are sometimes housed in the infirmary or seclusion area, where similar restrictions exist. At both facilities, such housing may be brief, but it sometimes lasts for two weeks or longer. Such restrictive housing for lengthy periods of time may exacerbate youth's suicidal and self-mutilation behaviors, especially when they are not receiving consistent mental health services, as discussed above.

### 4. Inadequate Supervision of Youth on Suicide Precautions and in Seclusion

It is a generally accepted professional standard to require staff conducting periodic checks of youth on suicide precautions or disciplinary seclusion to document their observations and the times of their checks on youth. At both facilities, we observed

that staff certified on forms that they had conducted checks at a certain time well before that time actually arrived, for example writing at 9:30 a.m. that a check had been done at 10:15 a.m. Because these forms are to be completed when an actual visual check has been conducted, pre-completed forms suggest that staff assigned to these high-risk youth were actually not monitoring them in conformance with safe practices. This falsification of records calls into question the reliability of supervision for youth on such special security status, and suggests that supervision is insufficient to ensure that staff uphold these serious responsibilities. We also observed forms in which staff documented checks that were too far apart to comply with their own policies or accepted standards for suicide precautions. And we found, not unexpectedly given the documentation discrepancies identified above, that staff could not keep track of certain youth on suicide precautions. For example:

- One youth at Cheltenham housed in the infirmary after an attempt to overdose on hoarded medicine still managed to acquire glass and cut his arm in a second suicide attempt while allegedly on the highest level of suicide precautions. One of the youth's roommates had to inform custody staff that this youth was lying on the floor of the dorm room bleeding.

- At Cheltenham, there were youth listed in the log book to be monitored but they were no longer in the infirmary.

- One youth on suicide precautions at Cheltenham was housed in his unit, but the unit staff were unaware that he was supposed to be on precautions.

- We observed one youth at Hickey who was moved between units and inadvertently dropped from suicide precautions.

Despite recent updates to DJS suicide policies, insufficient training, supervision, coordination of care and staffing levels contribute to these unsafe circumstances.

### 5. Lack of Preparedness for Suicide Attempts and Other Self-Harm

Staff must be prepared with adequate skills and appropriate tools to intervene should a youth attempt self-harm.

Staff lack knowledge and strategies for de-escalating youth engaging in self-harming behaviors. At Cheltenham, even staff assigned to monitor youth on the highest level of suicide precautions have no guidance as to how to respond to youth who make statements indicating they are considering self-harm.

The facilities lacked cut-down tools for staff to use if they encountered youth attempting to hang themselves. One staff member explained she would have to wait for someone to bring scissors from the infirmary, several buildings away, if she found a youth hanging. Staff at both facilities lacked guidance as to how to respond if they found a youth hanging. When we raised this emergent concern, senior DJS administrators promptly ordered cut-down tools for all staff, and were preparing to distribute them and train staff by the end of our visits.

## C. INADEQUATE MENTAL HEALTH CARE

Neither Cheltenham nor Hickey provides adequate mental health care for youth with serious mental health needs. Deficiencies include: (i) inadequate mental health screening, identification and assessment; (ii) inadequate clinical assessment, treatment planning, and case management; (iii) inadequate medication management practices; (iv) inconsistent and ineffective mental health counseling; and (v) the failure to place youth in appropriate treatment settings even when ordered by a court.

### 1. Inadequate Screening, Identification and Assessment

Generally accepted professional standards require that all youth entering secure facilities receive a reliable, valid and confidential initial screening and assessment to identify emergent suicide risks and psychiatric, medical, substance use, developmental, and learning disorders. Staff must refer youth for needed care. Staff should gather available information such as a youth's previous records from past admissions and glean important information needed to care for and treat the youth. The information must be communicated to appropriate personnel so that a youth's needs are addressed in a timely manner.

At both Cheltenham and Hickey, the initial screening and assessment process fails to achieve its primary goals; the process does not identify youth who need immediate services, refer them for services in a timely manner, screen out youth who should be hospitalized rather than admitted to the institution, or gather and disseminate necessary information to share with

staff caring for the youth. Mental health staff do not share appropriate information with personnel such as security staff, education staff, case managers or health care staff, all of whom need this information in order to supervise youth safely and meet their needs.

Although good screening forms and policies have been developed, the intake process at Cheltenham is inadequate. We observed staff at Cheltenham asking youth important questions at the same time that they were being strip searched. Further, areas of the intake unit were chaotic, loud and unsettling. The environment and manner of interviewing were not conducive to obtaining important information about recent drug use, treatment by arresting officers, feelings of suicidality and current medical conditions.

During hours when intake officers do not staff the facilities, security staff may be responsible for administering intake questionnaires and providing important information to youth upon admission. These officers have not been trained in these intake functions and do not ask questions or provide information consistently. On certain shifts at Cheltenham, the person asking the intake questions must supervise the holding cell and answer the telephone while administering the intake screening. These circumstances present the risk that staff will lack information needed to protect youth from harm and ensure that youth receive needed services.

Some youth whose serious mental health needs cannot be met at the facilities are admitted anyway. While DJS policy (as well as generally accepted practice) dictates that youth with emergent medical or mental health needs will not be admitted to the facilities, this policy is implemented much more consistently for physiological emergencies such as acute intoxication or observable physical injuries than for mental health crises. Because mental health professionals do not play a role at intake to determine the appropriateness of admitting youth who display serious mental health symptoms upon arrival, youth who are suicidal or otherwise experiencing serious mental illness are admitted despite policy and the facilities' inability to provide the services these youth need. Security staff administering the brief questionnaire given to every youth upon arrival are insufficiently trained to ask the questions and interpret answers in order to screen out youth with emergent mental health needs. Thus, some youth in need of psychiatric hospitalization are admitted to the facilities and present special challenges for staff -- challenges the staff is systematically unable to meet.

Our review of records consistently demonstrated that intake screening was not functioning as needed. For example, a 16-year-old youth with a diagnosis of schizophrenia was discharged from a hospital and admitted to Cheltenham. According to the Intake Database Face Sheet for this youth, while the youth was in the intake area, he was yelling, "I'm going to hurt myself," and reporting that he was "not mentally stable." Despite this youth's overt symptoms, the admissions officer conducting the screening answered "No" to questions on the intake screening form asking whether the youth was exhibiting bizarre or unusual behavior, whether the youth was thinking about hurting himself, and whether he showed any sign of current suicide risk.[8] Thus, even though the screening instrument provides that "Yes" answers to any of these questions require refusal of admission and transport to a hospital for immediate care, this youth was admitted to Cheltenham.

At Hickey, a youth with both substance abuse and mental health disorders was admitted with an active prescription for Adderall, a medication for Attention Deficit/Hyperactivity Disorder ("ADHD"). It took five days to restart his medication following his arrival. Despite the fact that he arrived at this facility after failing to complete a court-ordered residential substance abuse treatment program, he was only referred for "Substance Abuse Education" classes rather than the treatment his substance abuse history required. No one administered the mental health screening tool to him, and it was a month before he began treatment.

Furthermore, youth who arrive at the facilities on weekends, when mental health staff are not on site except for emergencies, may not receive mental health screening for several days. Delays in conducting these screenings place youth who are in need of treatment at risk for self-harm and may pose risk to others, since they may be placed into any housing unit without receiving mental health services. Other youth often target youth with mental illness, putting them at risk for physical and emotional abuse. Because custody and health care staff lack training to

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[8] Nor was there any indication of malingering by the youth. While we of course acknowledge the possibility that some youth may fabricate symptoms to avoid incarceration, there must be some sort of clinical or documented follow-up before the type of symptoms exhibited here (which, on their surface, appeared to be entirely legitimate) can be dismissed.

recognize signs and symptoms of mental illness and substance abuse, youth may not receive needed services until they are screened or experience crises.

In addition, many youth who might not meet the criteria for hospitalization nonetheless have serious mental health needs that go far beyond the current capacity of the facilities to provide adequate treatment. Both our file review and reports from staff indicate that there are youth at these facilities whose needs go well beyond the facilities' capacity to provide care. At both institutions, security staff complained of the number of youth whose mental health conditions present them with serious challenges in controlling behavior, communicating with the youth, and maintaining safety. We heard consistently from staff at both facilities that they wished there were a mental health unit at each facility.

### 2. Inadequate Clinical Assessment, Treatment Planning, and Case Management

Generally accepted professional standards require timely specialized clinical assessment of those youth with potential mental health needs, development of treatment plans to guide youths' care, and implementation of those plans. Mental health providers at Cheltenham and Hickey fail to provide appropriate clinical assessments or treatment plans.

#### a. Clinical Assessment

Youth who are identified at intake as exhibiting behaviors associated with mental illness and/or substance abuse disorders must receive a timely assessment that includes the gathering of prior assessments, treatment history, and other information in order to confirm a diagnosis and determine an effective course of intervention. This process does not occur at Cheltenham or Hickey, and the consequence for youth is haphazard and uncoordinated care.

At neither facility are staff identifying which youth need services most immediately so that their care can be prioritized. As a result, some youth with serious immediate needs slip through the cracks and receive services far too late, or never, due to insufficient staffing levels.

We reviewed files of youth being treated by the psychiatrists. The assessments we reviewed were grossly inadequate. They lacked sufficient information to support a diagnosis or formulate a viable treatment plan. Instead,

medication treatment decisions are based on superficial impressions gained through brief interviews the psychiatrists conduct with the youth. The psychiatrists rarely seek to review prior treatment records or contact community therapists, parents or probation officers for critical developmental and treatment histories. Many files of youth at Cheltenham on psychotropic medications contained no diagnosis at all. These practices are substantial departures from generally accepted standards of care.

Clinical assessments should guide all mental health clinical interventions for a youth, and should identify target symptoms that psychotropic medications are designed to address in tandem with other clinical treatment. The psychiatric assessments at Cheltenham rarely address any clinical intervention other than medication management. They are superficial and barely legible. The benefits of psychotropic medication are lessened without a coordinated therapy approach, as youth rarely have mental disorders that are remedied by medication alone.

The evaluations at Cheltenham conducted by contract mental health staff from Johns Hopkins were more comprehensive and clinically useful. However, the roles of these clinicians in the provision of services at Cheltenham was not effectively coordinated and their involvement appeared marginalized partly based on the assumption that their contract was near termination.

Assessments at Cheltenham rarely identify Post Traumatic Stress Disorder ("PTSD") as a diagnosis, even though a high percentage of youth (60%) score in the "Warning" range on the Trauma Scale in the intake mental health screening instrument. Symptoms of this disorder often manifest themselves in increased irritability, difficulty trusting adults, and depression, which, if untreated, could leave youth without the tools to cope with a juvenile detention environment. Similarly, youth in the juvenile justice system with Fetal Alcohol Syndrome experience treatment resistant impulsivity and cognitive problems. No evidence was observed that appropriate interventions are recommended or conducted to help youth with these disorders function in this environment.

The clinical assessments and mental status examinations conducted by the contract mental health service provider at Hickey generally fail to gather the requisite developmental and diagnostic information that would justify the interventions that are proposed. Thus, mental health interventions may not be addressing the actual histories and problems of youth.

Some youth require additional assessment over time, to clarify a diagnosis or determine whether a youth is experiencing a cognitive or neuropsychological impairment. At Cheltenham, we found no psychological or cognitive assessments administered after the initial assessments, despite the fact that some of the most troubled youth stay at Cheltenham for many months. The following examples are illustrative:

- One youth at Cheltenham in May 2003 had a history of depression, substance abuse and migraine headaches, for which he had received medications when detained at the facility only three months before. Despite mental health staff assessments that the youth was becoming increasingly agitated, he did not receive a referral for psychiatric assessment which might have provided for his medications to be restarted.

- At Hickey, we encountered a youth who had been admitted to DJS facilities multiple times, with a significant history of aggressive and out of control behavior, as well as suicide attempts. His diagnoses include ADHD, chemical dependency, impulse control disorder, mixed anxiety, and depression, with suicidal and homicidal ideation. His arrival at Hickey created an immediate crisis in how to handle his behavior. He was placed on suicide precautions multiple times and was restrained on at least three occasions after making a variety of self-harming gestures, including attempting to hang himself on at least one occasion. At one point the psychiatrist attempted to hospitalize this youth, but he was not admitted by the hospital and returned to the facility. The psychiatrist, mental health and health care staff attempted to de-escalate this youth's explosive and violent behavior at various times, but he remained in seclusion for extended periods of time, without a coordinated plan for meeting his needs. During our visit, staff decided to place this youth back on his unit, which engendered further suicidal threats and other crisis behavior. It took more than three weeks after this youth's admission to the facility for staff to complete an admission assessment, and another three weeks for a psychiatric evaluation, which provided no guidance as to new treatment strategies to redirect the uncoordinated, chaotic care he had been receiving. Generally accepted practice for the care of a youth with these needs would include

development of a crisis plan that would clearly guide staff in responding to and managing this youth's crises. The lack of such a plan was confusing this youth and exacerbating his behavioral disorder.

- Another youth at Hickey had been diagnosed at various times with psychotic symptoms, ADHD, behavioral problems, substance abuse, and destructive behaviors to himself and others. The psychiatrist treated this youth on a complex combination of medications without conducting a psychiatric assessment. Without a determination of his actual needs through assessment, this youth's treatment could not be tailored to meet his needs. This youth continued to experience hallucinations and inability to control his aggressive behavior.

### b. Inadequate Treatment Planning and Case Management

Treatment planning, including identifying symptoms and behaviors as targets for intervention and strategies for addressing them, is a critical part of effective treatment for serious mental illness. But treatment plans at both facilities fail to target specific symptoms or articulate meaningful strategies, and provide no mechanism for measuring whether a plan is working. At Hickey, treatment plans rarely identify co-occurring substance abuse disorders as primary goals of treatment, even though effective treatment of mentally ill youth with substance abuse disorders must address these issues hand in hand.

Case managers should communicate treatment plans for mentally ill youth to all staff involved in the management of youth in a detention facility, and coordinate their implementation. Although all youth at both facilities are assigned case managers in their residential units, these individuals have no mental health training, and they serve primarily as liaisons between the facility and the probation officer, rather than focusing on coordinating care at the facilities for mentally ill youth. They write "treatment plans" for all youth, but these are generally uniform sets of exercises designed to help youth develop insights about their delinquent acts and their future plans, and are unrelated to mental health treatment. Many case managers were unaware of even the diagnoses of mentally ill youth on their caseloads.

Custody staff and others who come in daily contact with youth must have sufficient information about youth's mental health symptoms so that they can understand and respond appropriately when youth manifest them. Communication between mental health staff, health staff, custody staff, teachers, community probation officers and parents regarding the treatment of youth at both Cheltenham and Hickey is manifestly inadequate. Custody staff do not receive guidance about the behaviors that mentally ill youth display which stem from their mental illnesses. As a result, staff misconstrue psychiatric symptoms as intentional behaviors, and inappropriately apply ineffective discipline to reduce the troubling behavior. Other youth often target these youth and exacerbate their symptoms as well. At Cheltenham, mentally ill youth are transferred between units and to other DJS facilities with minimal attention to critical issues related to their psychiatric status and without consultation with mental health staff.

Youth with receptive language deficits often misunderstand staff orders and end up being punished because staff think they are refusing to comply, when they actually do not understand. Similarly, youth with ADHD frequently have difficulty staying on task and following directions. We found no indication that staff were given information so that they could understand the differences of youth with mental health or developmental disabilities or make appropriate modifications in their handling of such youth.

One youth at Cheltenham had an IQ placing him in the borderline range of intellectual functioning. He was consistently disciplined for using profanity and oppositional behavior. There was no indication in his education, mental health or detention files that any staff understood the difficulty he would have understanding verbal requests and following expectations, or what accommodations might be appropriate. Records of another youth at Cheltenham with ADHD showed that he was routinely disciplined for non-compliant behavior despite his inability to follow directions consistently.

Furthermore, contrary to generally accepted professional standards of care, neither Hickey nor Cheltenham staff complete periodic treatment summaries or discharge summaries with enough information to facilitate treatment in future placements. Such failure to communicate the goals and successes and failures of treatments tried at the institutions may compromise future attempts at treatment in other settings.

Insufficient security staffing at Cheltenham also contributes to the lack of adequate mental health care. Mental health workers are unable to use the offices assigned to them within the secure area of the facility for counseling sessions because security staff is not available to monitor the area and they do not feel safe from youth residents. Instead, mental health staff use space outside the secure area, requiring security staff escorts to transport youth.

### 3. Inadequate Psychotropic Medication Management

Generally accepted professional standards include the use of psychotropic medications to augment a comprehensive mental health treatment plan with the youth's compliance and active participation. Medications prescribed should have a known benefit to treat the symptoms identified, based on a valid diagnosis and understanding of the root causes of the illness, and medication changes should follow documented monitoring of the effects of previous medication choices and reasons for abandoning a previous approach. Generally accepted professional practices require that youth and their parents or guardians be informed about the benefits and risks of medications and give informed consent for their use.[9] Careful monitoring through laboratory tests is necessary to ensure that youth do not experience harmful side effects of many psychotropic medications. At both Hickey and Cheltenham, staff fail to carry out these essential responsibilities.

At Cheltenham, some youth are placed on medications that are not designed to impact the symptoms they are experiencing. Other youth are not provided with medications to treat the symptoms they have. Psychiatric assessments fail to meet generally accepted professional standards, and at times do not result in any diagnosis; even though the psychiatrist may prescribe several medications, at times the files reflect no conclusion as to what condition is being treated. Medication treatment decisions appear to be based on superficial impressions, gained through brief interviews with the psychiatrist, who has limited input from other sources of information. Many files lack records of

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[9] Under Maryland law, youth aged 16 or older have the same capacity as adults to consent to treatment for a mental disorder. Maryland law also allows treatment staff to inform parents, guardians, and custodians about treatment needed by minors aged 16 and older. Md. Code Ann., Health-Gen. II § 20-104 (a)(1), (b) (2003).

even the most basic of clinical observations, the mental status exam. Such departures from appropriate care not only fail to provide relief to youth, but can cause youth to become resistant to medications and treatment. The psychiatrist appears to function in a clinical vacuum, rarely interacting with other mental health staff, often increasing, adding, or discontinuing medications based only on brief meetings with youth, without the benefit of input from clinicians, custody staff, or teachers who may work with the youth on a daily basis.

- One youth at Cheltenham was diagnosed with a schizophrenic disorder and reported experiencing auditory hallucinations. Even though he had a history of taking antipsychotic medications, the psychiatrist did not prescribe a medication to alleviate his hallucinations. There was no notation in the record indicating that the psychiatrist attempted to address these symptoms.

- Another youth had ADHD and passive-aggressive personality disorder. The psychiatrist placed him on a mood stabilizer and an antipsychotic agent used for significant behavioral difficulties, which were not appropriate medications for treating the condition that had been diagnosed.

- Another youth was prescribed Strattera, a new medication used to treat ADHD. The FDA has not approved this medication at more than 60 mg per dose. Yet this youth was receiving 80 mgs in a single dose per day, rather than 40 mg twice a day. This practice can increase the risk for side effects, such as headache, nausea, vomiting, diarrhea or sleepiness. Physicians sometimes prescribe medications "off-label" (in a dosage or manner not approved by the FDA), but physicians must inform youth and their parents of the risks and benefits associated with such choices. There was no such informed consent regarding the use of Strattera in this manner for this youth.

At Hickey, psychotropic medications are frequently prescribed without the benefit of appropriate evaluations or systematic physiological monitoring. Medication decisions appear to be directed at behavior control rather than improved functioning, a practice that represents a substantial departure from generally accepted standards of treatment. For example, youth are often prescribed sleep medications with little justification. These medications are often administered late in

the afternoon, thus unnecessarily sedating youth early, making them less able to participate in evening programs. In addition, the psychiatrist reported that the average time he spends with a youth, even for an initial evaluation, is less than 15 minutes, grossly below the amount of time needed to do an adequate evaluation. The psychiatrist often changes medications with no indication in the medical or mental health chart as to the justification. The records also do not identify target symptoms for the medications. Some examples of questionable medication practices are:

- Several youth at Hickey were treated with Neurontin, an anticonvulsant medication, for the purpose of controlling impulsive-aggressive behavior or bipolar disorder. This medication is not designed to treat these disorders. Furthermore, research has not supported its effectiveness for these purposes.

- At Hickey, some youth prescribed medications such as Wellbutrin, an antidepressant medication, were maintained at subtherapeutic doses that failed to resolve their symptoms.

Contrary to generally accepted professional practices, at neither facility do medical or mental health staff routinely discuss benefits and risks of medications with the parents or guardians of youth being treated, although some files do indicate such discussions. At Hickey, a staff member obtains consents from both youth and families. While she routinely checks off on a form that she reviewed and explained the goals and potential side effects of the medications, she was unable to articulate knowledge of these matters, and could not produce any reference materials which she would consult. Our records review demonstrated that staff at Cheltenham also fail to fulfill this necessary function.

Furthermore, although nurses dispense psychotropic medications to youth, they do not monitor youth for unwanted side effects of medications and do not dispense medications in a setting where confidential discussions could occur. Nurses we interviewed could not articulate even the most dangerous potential side effects of the medications they were administering, and did not engage in any such discussions with youth during medication distribution. The following examples are illustrative:

- Youth at both Cheltenham and Hickey were prescribed the antidepressant medication Trazodone to aid with sleep. A less common potential side effect of Trazodone is preapism (a painfully persistent erection). There was no evidence in the file that the youth or their parents or guardians had been warned of the potential risks of this medication.

- A youth at Cheltenham refused to take his Ritalin, a medication commonly used to treat ADHD. While the nurse asked him to sign a refusal sheet, the nurse did not question him about why he was refusing, or explain the potential risks of abruptly discontinuing this medication. Such risks include agitation and the possibility of impulsiveness.

- Youth at Hickey on neuroleptics, medications used to treat psychotic disorders and sometimes prescribed off-label for behavioral control, did not receive sufficient information regarding common and serious side effects of these medications. Furthermore, documentation did not evidence explanation to these youth of the reasons why they were being placed on such medications. Among the more dangerous potential side effects of neuroleptics is tardive dyskinesia, a potentially irreversible movement disorder.

- The psychiatrist at Hickey frequently prescribes Wellbutrin to treat ADHD, despite the lack of FDA approval to use the medication for this purpose. Many files we reviewed lacked sufficient discussions with youth and parents or guardians when medications are used off-label.

- The psychiatrist at Hickey placed a youth on medications for impulsive-aggressive behavior, ADHD and sleep disturbance. This youth had a history of oppositional behavior, altercations with other youth on his unit and needing frequent redirection by staff. The youth frequently refused all medications. There is no documentation that the psychiatrist discussed with him the potential physiological and behavioral consequences of inconsistent medication compliance.

Psychiatrists at both facilities also fail to order and perform needed follow-up regarding appropriate laboratory work to monitor the emergence of problematic side effects. For example:

- At Cheltenham, youth on Imipramine, a tricyclic antidepressant medication which can cause cardiac arrhythmia including cardiac arrest, did not have electrocardiograms to ensure that such symptoms were not present.

- Youth on Depakote, a mood stabilizing medication that can affect the white blood cell and platelet counts and cause liver damage, do not routinely receive necessary liver and blood tests.

- Youth on Lithium, a mood stabilizing medication that can cause kidney damage and alter thyroid functioning, do not receive kidney function and thyroid tests as needed.

- Medications such as Guanfacine and Clonidine used to treat ADHD, may lower blood pressure. Youth are at risk for fainting when they stand up if blood pressure and pulse are not monitored. None of the psychiatric files we reviewed contained evidence of blood pressure monitoring (e.g., blood pressure and pulse measurements).

Furthermore, many of the medications administered to youth require that a certain level be maintained for them to be effective. The facilities' failure to test blood levels increases the possibility that the medication will be ineffective or potentially toxic.

Youth at Cheltenham are discharged from the facility without medication or prescriptions, thus making it likely that youth leaving the facility to anywhere other than an institution will experience disruption in those medicines that require consistent intake.

### 4. Inadequate Mental Health Counseling and Other Rehabilitative Services

Generally accepted professional standards require that mental health counseling be provided frequently and consistently enough to provide meaningful interventions for youth. Treatment should utilize approaches that are generally accepted as effective. Youth with mental illness should receive treatment in settings appropriate to their needs.

At Cheltenham, mental health counseling is inadequate to the needs of mentally ill youth in both frequency and content. The limited counseling records that exist do not evidence consistent use of effective treatment strategies. At Hickey, despite some caring, dedicated counselors, interventions are not structured toward specific goals and do not consistently involve approaches accepted as effective. Even for youth who are regularly placed on suicide precautions, counseling frequently fails to identify strategies to deal with problems of self-regulation or depression. For others, mental health staff failed to utilize strategies to deal with identified anxiety, hyperactivity or trauma. Many youth are prescribed psychotropic medications to manage their behavior, but receive no counseling whatsoever. The school lacks any mental health professionals to provide services directed at the goals and objectives set forth in the Individualized Education Programs (IEPs) of youth with such needs. A representative of the contract mental health provider for the facility reported that these mental health staff do not address special education-related needs in their treatment.

For example:

- A 15-year-old youth admitted to Cheltenham with a documented history of ADHD and bi-polar disorder received only one crisis intervention visit from a mental health counselor during three weeks in which he repeatedly angered easily and got into fights, resulting in his being disciplined. The only intervention this clinician prescribed was to see the therapist assigned to his unit on an "as needed basis." Despite this youth's inability to control his behavior, no additional counseling was reflected in his chart.

- A youth at Cheltenham with current prescriptions for Depakote and Risperdal required surgery for an undescended testicle while detained in April 2003. Such surgery will likely result in a variety of mental health concerns, including anxiety and being at risk for harassment by peers. Thus it would be expected that both the psychiatrist and a mental health counselor would provide services to this youth following his return from the hospital. The youth's chart reflects only one mental health visit, charted in his medical records, in which the youth appeared to be quite concerned about his future ability to father children, and the possibility that the doctors had

found cancer. Although the social worker wrote that the youth should receive continued mental health follow-up and supportive intervention, his records reflect no further mental health counseling.

- The psychiatrist at Hickey ordered Cognitive Behavioral Therapy (CBT) for a youth with impulse control disorder. Nothing in the youth's records suggests that the youth received such treatment.

- A youth with conduct disorder as well as potential ADHD and substance abuse was prescribed three medications by the psychiatrist, who also ordered individual therapy twice a week and group therapy twice a week. Instead, this youth received only one individual therapy session every one to two weeks.

- A youth at Hickey with ADHD and history of substance abuse since age ten, as well as prenatal cocaine and alcohol exposure, received no substance abuse treatment.

Mental health staff must keep records in a manner that allows future providers to track treatment previously provided. The lack of adequate record keeping could place youth at risk in circumstances requiring prompt intervention, particularly when a youth threatens self-harm. Records of prior interventions are important in order to guide staff about effective ways to intervene in crises. Counseling records at Hickey lack sufficient specificity, while records at Cheltenham are disorganized and at times nonexistent.

At both facilities, group treatment sessions are often cancelled. Security staff are insufficient in numbers to provide needed supervision during group sessions to ensure a safe and productive atmosphere. At neither facility do counseling staff routinely involve youth's families in their treatment interventions, thus reducing the effectiveness of any attempt at rehabilitation for youth who plan to return to their families following detention. At Cheltenham, confidentiality in group settings is often compromised. This circumstance leaves youth unwilling to communicate sensitive personal concerns where professional and custody staff cannot assure protection from teasing and recrimination. Furthermore, some youth with mental illness are expected to participate in groups that are inappropriate for their illnesses.

Youth with developmental disabilities are not receiving the care they need at the facilities. For example, one developmentally disabled youth whose testing indicates that the youth's performance "falls within 1st percentile and is within the Mentally Deficient range of intellectual functioning" frequently got in fights on his unit. This youth was consistently disciplined for engaging in behaviors which were largely a function of his developmental and cognitive deficits. His treatment plan includes no guidance for custody staff on what strategies can help this youth function more successfully with his peers and staff. While there was useful information available through his school records that could benefit both his mental health care and his care on the living unit, there is no indication that the information was shared outside the school.

Generally accepted professional practices require that facilities confining youth provide opportunities for rehabilitation that include effective behavior management systems. Effective behavior management systems generally involve incentive-based programs for promoting appropriate behavior throughout the day, and clearly defined guidelines that are consistently applied across each institution. For youth identified as having behavioral health problems, behavior management programs need to be coordinated with a treatment plan. Appropriate rehabilitative services for youth confined in juvenile justice facilities include programs that address family conflict, substance abuse, anger management, gang affiliation and other issues that involve them in the juvenile justice system. At Hickey and Cheltenham, however, the behavior management systems have little or no input from the mental health staff. Thus, goals of custody staff and mental health treatment providers are not coordinated, and youth do not benefit from mental health treatment gains within the unit structure. Moreover, both facilities lack an effective behavior management system that is consistently applied and that provides appropriate opportunities for youth to regulate their behavior.

### 5. Failure to Place Youth in Court-Ordered Treatment

Once a court has ordered that a youth be placed in a suitable facility for treatment and rehabilitation, it is incumbent upon the State to find timely placements for such youth. In the meantime, these facilities are left with many youth whose mental health needs cannot be met by the resources available at the facility. The frustration and anger youth develop from lack of appropriate treatment makes them difficult to manage, and leaves them less receptive to future interventions. Youth may be detained at Cheltenham and Hickey

awaiting placement into other DJS or private treatment programs for six months or longer. The State must find alternatives to meet the mental health needs of these youth whom the courts have ordered DJS to serve.

## D. INADEQUATE MEDICAL CARE

Facilities must provide confined juveniles with medical care consistent with generally accepted professional practices. The programs for providing medical care at Cheltenham and Hickey are inadequate and substantially depart from generally accepted professional standards in the following areas: (i) access to medical treatment; (ii) health assessments; (iii) treatment of chronic conditions and physical injuries; (iv) medication administration practices; and (v) dental care.

### 1. Inadequate Access to Medical Treatment

Youth at Cheltenham are not provided timely access to medical care. The following examples are illustrative:

- A youth requested sick call on July 25, 2002. He was seen on July 26 and complained of a sore throat lasting two weeks. He was referred to the physician, but not seen until July 29. By that time, his condition had deteriorated and the youth was hospitalized with a peritonsillar abscess, a serious deep tissue throat infection. Timely attention by a medical practitioner and treatment with antibiotics would likely have prevented his hospitalization.

- A youth with severe asthma was admitted to Cheltenham in May 2003. At the time of admission, the youth's respiratory rate was 20, indicating acute asthma and the need for further assessment by the physician. Nothing further was done to evaluate or treat his asthma at the time of his admission. Untreated asthma symptoms can result in respiratory crisis.

- At Cheltenham we encountered a youth in disciplinary seclusion who had been in a fight with another youth. His tooth had been left very loose as a result of the fight, but he had not received medical care for this injury when we spoke with him. The dentist was due to be at the facility the next day for his weekly visit, so a senior administrator who was accompanying us on our tour instructed a nurse to ensure that the youth got to see the dentist the following day. We checked

> back with this youth mid-afternoon the following day, and found that no one had spoken with him further regarding his tooth. We were able to intervene just in time to catch the dentist who was packing up to leave for the day. The dentist had received no word that a youth housed just down the hall needed his care.

For juvenile facilities to provide adequate medical care, generally accepted professional practices require that there be sufficient medical staff. Our investigation revealed that there was insufficient medical staff at both Cheltenham and Hickey to provide an adequate health program, given the needs of the youth housed there.

At the time of our tours, at Cheltenham there was one nurse supervisor and four nurses during the day shift, three nurses during the evening shift, and one nurse during the overnight shift. Nurse staffing at Hickey was virtually identical, although the facility housed more youth. Our observations, document review, and interviews with staff and youth confirmed that these levels of medical staffing contribute to the medical care deficiencies described in this section. In addition to a shortage of nursing staff, physicians are not on-site for sufficient hours. At Cheltenham at the time of our tours, a physician was on-site for only three and a half days each week, which was largely spent on initial examinations of newly admitted youth. This schedule and staffing pattern left physicians little time to devote to the care and treatment of acute and chronically ill juveniles. The shortages also explain why juveniles at both Cheltenham and Hickey complained that requests for sick call are unanswered for days.

Insufficient security staffing similarly impacts the delivery of medical care for youth at Cheltenham and Hickey. A youth at Cheltenham sustained a shoulder separation during an April 2003 incident. Although the youth required x-rays, he was not transported to the hospital for more than 24 hours because of security staff shortages. Medical staff at Hickey reported that youth often miss outside appointments that are very difficult to reschedule, such as optical and dental appointments, due to lack of security staff to transport youth. In the satellite medical office at Hickey, the nurse reported that there was insufficient security staff to supervise youth and also provide adequate security for her. As a result of this lack of security, the nurse conducts sick call through a window from behind a locked door, significantly limiting her clinical interaction with youth.

## 2. Inadequate Health Assessment

Generally accepted professional standards require that a standardized health evaluation be performed upon admission. This evaluation is necessary to ensure that youth are maintained on necessary medications, that significant health problems are not overlooked, and that tuberculosis skin tests and laboratory screening to detect communicable diseases are performed. Significant health problems should be identified on a "problem list" so that appropriate treatment and follow-up care is provided. Medical records from prior placements should be obtained promptly for appropriate assessment, and current medical records must be maintained adequately and updated in a timely manner. The failure to treat an unrecognized health problem can result in serious medical harm. Both facilities fail to conduct adequate initial health assessments and document the health records adequately.

At Cheltenham, we found several examples of the failure to continue required medications on admission, the adverse health consequences of which can be severe. For example, a youth with a history of seizures was admitted on March 28, 2003. The nurse noted that he was being treated with Tegratol, an anti-seizure medication. Nothing was done to continue the youth on this medication, even though the medication was available on-site. On March 30, the youth suffered a seizure. Notably, his problem list, where all significant health problems should have been listed, and his physical examination form were left blank, even though his condition was known to the facility.

Our file review at both Cheltenham and Hickey revealed that important medical information, such as medical problems and treatment provided, is not documented so as to be readily identifiable, representing a substantial departure from generally accepted professional practices. For example, a Cheltenham youth's February 2003 initial medical assessment indicated "none" for allergies, although a prior chart entry from the previous July reported allergies to penicillin and aspirin. Youth with histories of scoliosis (curvature of the spine), high blood pressure, and prior positive tuberculosis skin tests reported their histories to medical staff, but these medical problems were not documented on the youths' problem lists so that they would be readily observed by medical care providers. The failure to document youths' medical problems and courses of treatment clearly in their medical files impedes medical practitioners from providing adequate care, and places youth at risk of receiving medical treatment which could actually harm them.

Medical staff at Hickey and Cheltenham fail to perform needed follow-up regarding abnormal lab results. Urine tests are a standard screening test given to youth as part of the initial health assessment. Abnormal results may be indicia of serious medical conditions. The presence of protein or blood in the urine can indicate chronic kidney disease; the presence of white blood cells and nitrate in the urine may indicate bladder or kidney infection. Our file review revealed that staff received such abnormal laboratory results for youth at both facilities, yet failed to take appropriate steps as a result of this information, thus placing youth at risk of harm.

Generally accepted professional standards also require that the immunization status of youth be assessed and immunizations be brought up to date. Neither Cheltenham nor Hickey has an organized immunization program. The facilities do conduct routine antibody testing for Hepatitis B for all admissions; however, youth whose antibody tests do not show that they have developed immunity should be vaccinated. Our review revealed youth at both facilities who had no immunity, yet no vaccine was ordered for them. Youth should also be screened to determine whether they have active Hepatitis B or C infections. Hickey staff fail to determine whether youth have active infections of these contagious diseases.

Similarly, youth who have not had chickenpox are at risk for more serious complications from the disease, including chickenpox pneumonia and chickenpox encephalitis, which can result in mental retardation and seizures, if they contract chickenpox when they are older. Youth who have not had the condition should be vaccinated. Youth at both Cheltenham and Hickey reported never having chickenpox but were not vaccinated.

Common sense dictates that screening for active infectious diseases, such as tuberculosis, be a part of any correctional setting. Yet when tuberculosis screening tests are ordered at Hickey, there often is no follow-up by nursing staff to determine whether a youth tested positive. This failure to track and appropriately treat youth who need care places both staff and youth at risk of contagion from untreated youth.

Finally, medical staff fail to take sufficient steps to obtain complete medical records from prior facility placements, even those within DJS. At Hickey, a nurse tracks whether medical records are received, but does not assess the completeness of the records. For example, a physical examination record may be received without laboratory results, but no follow-up would be

done to acquire these results. Nurses apparently assume that tuberculosis screening tests are conducted at prior placements, but often this has not occurred and there is no documentation of tuberculosis screening from the previous facility.

### 3. Inadequate Medical Treatment of Chronic Conditions and Physical Injuries

Generally accepted professional standards require that appropriate treatment be provided for youth with chronic medical conditions. A common, yet serious, medical condition among youth is asthma. At Cheltenham and Hickey, staff fail to provide critical aspects of asthma care consistently with current standards. Health staff only see youth for asthma symptoms, rather than at regular intervals to monitor the illness. Staff do not review how youth are responding to treatment, assess airflow using a peak flow meter, review side effects of medications, provide patient education, and adjust the management of the disease to achieve the least disability. Peak flow meters are available at the facilities, but rarely used. Certain types of asthma inhalers are prescribed for use when patients find themselves urgently short of breath. The documented use of such inhalers is necessary to manage this serious medical condition, as the use of inhalers for urgent relief more than twice a week is an indication that providers should consider intensification of the daily treatment regimen. Although custody staff confirmed that they store asthma inhalers, which youth use on the housing units, the medical charts we reviewed contained no documentation of administration of asthma inhalers on the housing units.

Youth with other chronic illnesses receive inadequate care at both facilities. For example, two youth at Hickey had sickle cell anemia. Generally accepted professional standards call for daily folic acid supplements to support the bone marrow's rapid production of red blood cells in sickle cell patients. Neither youth was prescribed these preventative measures. In another example, a youth who tested positive for Hepatitis C was not provided a vaccine for Hepatitis A. Such vaccination is a standard treatment for youth with Hepatitis C, since they are more susceptible to liver infection from other hepatitis strains. Our investigation also revealed a number of youth with diabetes at Cheltenham and Hickey. Generally accepted standards of care for this serious disease call for routine testing to monitor diabetics for eye and kidney complications, but records contained no indication that these tests were ordered. A special urine test to detect small amounts of protein in the urine is

appropriate for youth who have had diabetes for 3 years or more, but records contained no indication that this test is ordered. Additionally, at Cheltenham physicians fail to order appropriate diets for diabetics.

### 4. Inadequate Medication Administration Practices

Prescribed medications are not administered appropriately at either facility. Our review of medication administration records revealed many significant gaps in medication that were unexplained. The following examples are illustrative:

- A youth did not receive his Paxil, an anti-anxiety medication, and Risperdal, an antipsychotic medication, on two dates in June 2003.

- A youth was prescribed Keflex, an antibiotic, three times a day, but missed two doses every day.

- A youth who had his jaw wired shut was prescribed Ensure, a liquid protein supplement for nourishment. Over a three week period, he received only 31 of 100 cans ordered.

- A youth was prescribed Risperdal to help control his anger, and reported that the medication was helpful. When he was interviewed on June 10, 2003, he reported that his medication had been stopped without explanation at the end of May. He had made a sick call request to discuss this medication interruption and was still waiting to see the medical staff. A review of his chart revealed that the medication had been stopped because both nursing and mental health staff had failed to flag it for renewal and the prescription had expired unintentionally.

- A youth's medical chart revealed that he suffered from chronic inflammatory bowel disease for which he was prescribed mineral oil daily. On two occasions his mineral oil prescription expired without renewal and he had to pursue sick call requests to continue this medication.

- A youth with high blood pressure was treated with the medication Atenolol, a beta blocker commonly used to treat this condition. After his admission to Hickey, his medication was stopped for two days because staff failed to renew it. The sudden cessation of Atenolol may cause chest pain or heart attack.

These practices represent substantial departures from generally accepted standards of care.

### 5. Inadequate Dental Care

In keeping with generally accepted practices, services to restore and maintain dental health must be available to youth. See Ramos v. Lamm, 639 F.2d 559, 576 (10th Cir. 1980). Both Cheltenham and Hickey fail to provide adequate dental care.

At Cheltenham, our review of dental records revealed an absence of routine dental examination on admission, and a lack of restorative and preventative care. At the time of our tours, Cheltenham had a dentist on-site once a week for 6-8 hours. There was no dental assistant or dental hygienist. The dentist provides only acute care when youth are referred to him by sick call request. According to the dentist, services are basically limited to emergencies. No preventative services, such as cleaning, scaling, or topical fluoride application, are provided. Given the length of stay for some youth at Cheltenham, the failure to provide preventative care falls outside generally accepted professional standards.

Hickey has no on-site dental staff, and preventative services are not provided. Dental services are provided by a community dentist, who limits the number of appointments per week. Our review of dental referrals, medical files, and interviews with staff revealed significant delays in necessary dental treatment for youth in pain and with serious dental needs. The failure to treat dental conditions such as cavities can result in need for more extensive root canal therapy or tooth loss. For example:

- A youth submitted sick call requests on May 20 and 21, 2003 for dental pain. He was not scheduled to be seen by the dentist until July 9, the next available appointment.

- A youth requested dental care for pain on May 1, 2003, but was not referred to the dentist. On May 15, he complained of severe pain, and only then was he seen by the dentist.

- A youth had a dental exam on February 13, 2003, which showed five cavities. At the time of our April 2003 tour, he had received no treatment for these cavities.

- A youth was suffering from a dental abscess on May 22, 2003 and was treated with Amoxicillin, an antibiotic. At the time of our June 2003 tour, the youth had not seen the dentist and no appointment was scheduled.

Hickey also fails to provide dental care for chronic conditions. For example, we interviewed a youth at Hickey with severe disabling displacement of his teeth (the youth had numerous teeth growing out of his gums above and perpendicular to his front teeth) but he was not referred for orthodontic evaluation. A nursing assessment at intake described this youth's mouth as "normal," indicating that this nurse had received inadequate training in dental screening.

## E. INADEQUATE EDUCATION INSTRUCTION OF YOUTH WITH DISABILITIES

With regard to the education provided to confined youth, the facilities violate the statutory rights of youth with disabilities by failing to provide them with adequate special education instruction and resources. In states that accept federal funds for the education of children with disabilities, as does Maryland, the requirements of the IDEA apply to juvenile facilities. See 20 U.S.C. § 1412(a)(1)(A); 34 C.F.R. § 300.2(b)(1)(iv). The deficiencies we observed stem from: (i) inadequate assessments of youth who are eligible for special education services; (ii) inadequately developed Individualized Education Programs ("IEPs"); (iii) lack of related services; (iv) lack of adequate instruction for youth with disabilities; and (v) inadequate vocational instruction for youth with disabilities.

### 1. Inadequate Assessment

Pursuant to the IDEA, staff at Cheltenham and Hickey are responsible for screening, evaluating and identifying youth with qualifying disabilities that would entitle them to special education services. Prevalence data from national studies

suggests that between 20% and 60% of youth in juvenile justice facilities have an educational disability.[10] At the time of our tour only 15% of youth at Cheltenham were identified as having an educational disability and only one youth was identified with a qualifying disability of other health impaired (OHI). The OHI designation is used for children with ADHD, a commonly identified qualifying disability. Indeed, observations by our psychiatrist and psychologist indicate that the facility had not identified a number of youth with this condition who likely were entitled to special education services.

At Hickey, we found that a number of youth had significant mental health diagnoses, such as psychotic disorders, major depression and schizophrenia, yet many of these children did not have IEPs. Assessments failed to include intelligence and achievement testing. At Cheltenham, we found that the special education coordinator was new to this position and plans for assessing youth were still in the formative stages.

- One 17-year-old youth at Cheltenham diagnosed with schizophrenic disorder experienced auditory hallucinations. Despite these severe symptoms that would clearly interfere with his ability to learn, he was not identified or assessed for special education services.

- Another 17-year-old youth at Cheltenham, who had been placed there at least four times, who had a history of prior psychiatric hospitalizations, and who had been identified with a learning disability, emotional disorder, and behavior disorder, was not receiving adequate special education services. Despite receiving some special education services, his most recent testing found he had only a first grade level in reading and spelling, and a third grade level in math. In his April 2003 progress report, his teacher noted that he was not attending class and that when he did, he failed to do the work. He received failing grades

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[10] Robert B. Rutherford, et al., Youth with disabilities in the corrections system: Prevalence rates and identification issues (2002).

in all subjects except keyboarding. Such lack of success requires that additional interventions be attempted for such a youth, but no such interventions were put into place.

- Another 17-year-old youth at Cheltenham had been diagnosed with a mood disorder, anxiety disorder, ADHD, and cannabis dependency. He had been receiving special education services since the fourth grade for behavioral problems. However, a recent court evaluation reported that the youth was at only a third grade reading level, which may indicate learning disability. The facility did no IQ testing or further attempt any new educational interventions.

- One 17-year-old youth at Hickey with polysubstance abuse and conduct disorder tested at seven to eight years below grade level in reading, math and spelling. Such lack of educational achievement would indicate an underlying learning disability. This youth received no special education services.

- A 14-year-old youth at Hickey with a verbal IQ of 67 was receiving limited special education services for an emotional disability. Despite the fact that the emotional disability was the condition that made him eligible for special education services, the one hour per week of mental health treatment that the youth received was provided by the facility's contract mental health provider, which was neither monitored by the school nor coordinated with his educational needs. In addition, the youth's testing, which showed him to be seven years behind in reading, indicates a likely learning disability, which was not being assessed or addressed at all.

- An 18-year-old youth at Hickey with impulse control disorder and likely ADHD had notes on his most recent IEP indicating that he was rarely on task, often failed to complete work, and was argumentative with peers and adults. Despite this youth's testing at five to seven years below grade level in spelling and math, and reports that current interventions were ineffective at improving his school performance, the IEP team determined that he did not require any further evaluation.

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination against persons with a disability by any agency receiving federal funds. The protections of this law, which apply to state prisons, see Pennsylvania Dep't of Corrections v. Yeskey, 524 U.S. 206 (1998) (holding that the terms of Title II of the Americans with Disabilities Act, the relevant provisions of which are identical to Section 504, are applicable to the states), are extended to any person who: (i) has a physical or mental impairment that substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment. The law requires that an accommodation plan be developed for students who qualify for services under Section 504. Our investigation revealed no assessment measures and, consequently, no accommodation plans for youth who would not be covered under the IDEA, but who may be eligible for accommodations under Section 504.

### 2. Inadequate Individualized Education Programs

The IDEA describes the required components of an IEP, including that each IEP must include measurable goals. 34 C.F.R. § 300.347(a)(2)(2004). Many of the IEPs we reviewed at Hickey lacked measurable goals and objectives. For example, one IEP objective stated, "[t]he student will display empathy towards peers and adults with 80% criteria." Other IEP objectives included criteria stated as percentages, but did not describe the quanta being measured. For example, an 80% criteria could refer to 80% of opportunities during free time, 80% of observed interactions during class time, or 80% of interactions during lunch over three consecutive days. Without more concretely stated measures, "an 80% criteria" is meaningless. Indeed, the criteria, even without a required percentage, would be incapable of measurement. The IEP goals and objectives we reviewed lacked realistic and measurable terms, based on individual needs.

At Hickey, IEPs include recommendations for mental health treatment, but the school has no mental health professionals. A representative of the contract mental health services provider reported that they do not routinely coordinate mental health treatment with youths' IEP goals and objectives, even where youths' eligibility for special education is based on emotional disability.

### 3. Lack of Related Services

The IDEA requires that students with disabilities be provided with related services to address their specific needs. Our investigation revealed that students at Cheltenham whose IEPs indicated that they should receive speech and language therapy once a week were not receiving these services because Cheltenham had not contracted with a speech and language therapist for some time. Successful rehabilitation of mentally ill youth must involve coordinated efforts of mental health and education professionals, and this does not occur at either facility.

Educational mastery, for many detained youth, is the cornerstone of their rehabilitation. Many youth at Cheltenham and Hickey have mental illnesses which impact their educational performance, but do not receive appropriate special education related services to address their educational deficits. In general, mentally ill youth often have poor school attendance and performance due to shame over their lack of skills or histories of failure and conflict in school settings. Therefore, coordination between mental health professionals and educators is essential for youth at both facilities. Such coordination does not occur at Cheltenham or Hickey.

At Hickey, although the majority of youth served by the contract mental health provider also receive special education services, the mental health staff rarely attend IEP meetings or provide information regarding management of the youth's mental illness and treatment goals. The school frequently lists mental health services among the interventions a youth will receive when officials write IEPs, even though the school does not provide these services. School officials believe that the youth are receiving mental health services somewhere in the institution, but school officials do not ensure that such care is provided, or that it coordinates with the other IEP goals and objectives. Since school behavior is often the target of medication management, it is a generally accepted professional practice for psychiatrists to work with educators in the treatment of youth. The lack of this important collaboration undermines the rehabilitative function that the youth's detention is supposed to achieve.

### 4. Lack of Adequate Instruction for Youth with Disabilities

The IDEA requires that students with disabilities be provided an appropriate public education. Students with

disabilities at Hickey are served in the general education classrooms under an inclusion model. These students receive assistance from special education teachers in the classroom. Student education records revealed a number of students who were reading far below grade level. For example, a 17-year-old youth was reading at a 2.8 grade level. A 16-year-old youth was reading at a 2.2 grade level. Students like these, with profound reading deficits, require more individualized instruction than what was being delivered at Hickey.

Students with disabilities at both Cheltenham and Hickey are also denied appropriate education when they are placed in restricted settings. Our investigation revealed that youth in the segregation units at both facilities received no academic instruction. Youth housed in the infirmary for medical reasons or to provide them with protective custody, received extremely limited academic instruction. At Cheltenham, youth in the infirmary reported that teachers of four subject matters each spent approximately one-half hour per day with them, and that most of the time was occupied watching movies. During our tour, we saw youth watching "The Matrix" during regular school hours. Youth on some units at Cheltenham attend school only three hours a day. This level of educational services for youth with disabilities is a substantial departure from generally accepted practices.

### 5. Inadequate Vocational Education for Youth with Disabilities

The IDEA also requires that students' IEPs emphasize special education and related services designed to meet their unique needs and prepare them for employment and independent living. IEPs for students at both Cheltenham and Hickey lack consideration of career planning, job training or other employment goals.

Vocational classes are offered at Hickey through the Alternative Learning Center, a facility at which courses are offered in auto mechanics, printing, agriculture and barbering. While providing these courses is laudable, our observations revealed that the quality of instruction and materials was inadequate and that students were not engaged in the lessons. In the auto mechanics class we observed, the instructor was seated at his desk while four students watched a video and two students slept. The print shop equipment is outdated and in need of repair. While we were told that most of the printing work is done on computer, the students we observed were using the

computers for playing games because the system was down. Our observations of the agriculture class revealed two students moving dirt and a plant around a turtle, two students studying a catalog, and a fifth student who told us he was "just chilling out." Cheltenham offers no vocational or career education courses.

## F. INADEQUATE FIRE SAFETY

Inadequate fire safety precautions at both Cheltenham and Hickey place residents at an extremely serious risk of harm. Indeed, in October 2000, State inspectors noted in a report that "[e]xisting doors and locks are damaged beyond repair, [and] cannot be opened in case of fire for ventilation. Most of the locks are not secure to doors." The report goes on to note under "Consequences": "Possible loss of life in case of fire, or other emergencies that may occur."[11] Because these buildings were projected to be demolished eventually, the State did not provide funding for these important safety repairs.[12] This report evidences that the State knew about both the safety and security risks involved in not repairing door locking mechanisms in these cottages; however, the State did not repair them.

Additionally, a number of residential cottages at Cheltenham lacked appropriate fire and smoke suppression systems. Hickey has a campus-wide automated fire alarm system, but the failure to maintain that system places youth at risk of serious harm in the event of a fire emergency. In the March 2003 inspection of the fire alarm system, numerous deficiencies that are easily remedied but nonetheless serious and could result in the loss of life were identified: fire control panels were not functional; batteries needed to be replaced; heat and smoke detectors did not work; and many sprinklers were painted over which caused them to be clogged and unusable. In view of the broad range of serious defects identified by the inspectors in both the 2002 and 2003 inspections, it is apparent that the fire alarm system is not kept functioning at an acceptable level on a regular basis. Unless these conditions are remedied, there is a grave risk that any fire at the facilities will lead to a significant injuries, including deaths.

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[11] Project Justification Form, October 4, 2000, submitted by Maryland Department of Juvenile Justice to Maryland Department of General Services, October 24, 2000.

[12] We understand that a number of these cottages are not currently used to house youth.

## IV. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional and statutory rights of youth confined at Cheltenham and Hickey, these facilities should implement, at a minimum, the following remedial measures:

1. Ensure that youth are adequately protected from physical violence committed by staff and other youth, and sexual misconduct by staff.

2. Ensure that there is sufficient, adequately trained staff to safely supervise youth.

3. Ensure that staff are adequately trained in safe restraint practices, that only safe methods of restraint are used, and that restraints are used only in appropriate circumstances.

4. Ensure that staff adequately and promptly report incidents.

5. Ensure that personnel officials engage in appropriate background and reference checks for all staff.

6. Develop and implement an adequate classification system to place youth appropriately and safely.

7. Ensure that adequate security systems, including individual room door locks, are maintained.

8. Develop and implement policies and procedures to ensure the appropriate use of isolation, to include adequate due process protections.

9. Ensure that there is an adequate and appropriate behavior modification system in place.

10. Ensure that youth have adequate access to restroom facilities.

11. Develop and implement adequate suicide prevention policies to identify and assess, safely house and supervise, and adequately treat suicidal youth.

12. Provide staff with adequate training and equipment to identify and supervise youth at risk for suicide, and to intervene effectively in the event of a suicide attempt.

13. Provide adequate mental health treatment to include appropriate mental health screening, identification and assessment, adequate specialized mental health assessment, treatment planning, case management, psychiatric services and counseling, and provide for placement outside Cheltenham and Hickey for those youth whose mental health needs cannot be met adequately at the facilities.

14. Ensure that mentally ill youth are not unfairly disciplined for behavior resulting from their disabilities. Ensure that appropriate accommodations are made so that mentally ill youth can participate in programs and services at the facilities.

15. Develop and implement appropriate rehabilitative and drug treatment programs, including opportunity to communicate with family members.

16. Ensure that youth are timely placed in appropriate treatment settings as ordered by courts.

17. Develop and implement policies, procedures and practices for appropriate discharge planning.

18. Provide youth with adequate access to medical treatment, including youth with acute, emergent and chronic medical conditions.

19. Ensure that adequate health assessments are conducted and documented for all youth admitted to the facilities.

20. Develop and implement policies, procedures and practices to ensure that adequate medication administration practices are followed.

21. Develop and implement policies, procedures and practices to ensure adequate documentation of youth medical records, adequate laboratory analyses, appropriate immunizations, and appropriate screening for communicable diseases.

22. Provide adequate dental care.

23. Ensure timely and appropriate assessment and identification of students with disabilities for special education services.

24. Provide youth with disabilities adequate special education instruction.

25. Develop and implement adequate individualized education programs; provide necessary related services; and provide vocational education for youth with disabilities.

26. Develop and implement appropriate Section 504 plans for all eligible youth.

27. Implement adequate fire safety measures.

During the exit interviews at our on-site tours, we provided State officials with preliminary observations made by our expert consultants. State officials and facility staff reacted positively and constructively to the observations and recommendations for improvements. The collaborative approach the parties have taken thus far has been productive. We hope to be able to continue working with the State in an amicable and cooperative fashion to resolve deficiencies previously noted. In addition, due to the State's cooperation in this matter and State officials' expressed desire to improve conditions, we will send, under separate cover, reports from our consultants that provide their more detailed findings and recommendations to address the inadequacies they found in the operation of the facilities. Although the expert consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, the observations, analyses, and recommendations of our consultants provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that 49 days after receipt of this letter, the Attorney General may institute a lawsuit pursuant to CRIPA to correct the noted deficiencies. 42 U.S.C. § 1997b(a)(1). Accordingly, we will soon contact State officials to discuss in more detail the measures that must be taken to address the deficiencies identified herein.

Sincerely,

/s/ R. Alexander Acosta

R. Alexander Acosta
Assistant Attorney General

cc: The Honorable J. Joseph Curran, Jr.
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Secretary, Department of Juvenile Services
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The Honorable Thomas M. DiBiagio
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