August 7, 2006

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

Re: Investigation of the Baltimore City Juvenile Justice Center in Baltimore, Maryland

Dear Governor Ehrlich:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Baltimore City Juvenile Justice Center (the "Justice Center"), in Baltimore, Maryland. On June 30, 2005, we notified you of our intent to conduct an investigation of the Justice Center 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"). CRIPA and Section 14141 give the Department of Justice authority to seek remedies for any pattern or practice of conduct that violates the constitutional or federal statutory rights of children in juvenile justice institutions.

In September and October 2005, we conducted on-site inspections of the Justice Center with expert consultants in various disciplines. Before, during, and after our site visits, we reviewed a wide variety of relevant State and facility documents, including policies, procedures, and juvenile corrections and other records relating to the conditions of confinement of hundreds of Justice Center residents. During our visits, we also interviewed Justice Center and State administrators, professionals, staff, and residents, and observed youths in their living areas, in activity areas, in classrooms, and during meals. In keeping with our pledge of transparency and to provide technical assistance where appropriate regarding our investigatory findings, we conveyed our preliminary findings to State counsel and to State and facility administrators and staff during verbal exit presentations at the close of each of our on-site visits.

We would like to express our appreciation to the State for the extensive cooperation and assistance provided to us throughout by officials from the Department of Juvenile Services and by the Justice Center administrators, professionals, and staff. We also appreciate the State's receptiveness to our consultants' on-site recommendations. It is particularly noteworthy that after our initial investigatory visits the State immediately corrected, or developed corrective action plans to address, many of the issues identified during our tours. Indeed, on February 6, 2006, the State provided us with a list of 17 specific improvements made at the facility since our last facility tour. Many of these items purport to address issues identified by our consultants and reflected in this letter.[1] We applaud the efforts by the State to promptly address the identified areas of concern. Given the systemic nature of many of these problems however, it will understandably take time to fully correct many of these problems. To be clear, our findings of conditions at the facility reflect information available to us and evaluated by our consultants at the time of our investigatory tours. We hope to continue to work with the State and officials at the Justice Center in the same proactive and cooperative manner going forward.

Consistent with our statutory obligations under CRIPA, I now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimal remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that a number of conditions and practices at the Justice Center violate the constitutional and federal statutory rights of its youth residents. In particular, we find that children confined at the Justice Center suffer significant harm and risk of harm from the facility's failure to: (i) adequately protect children from youth violence; (ii) adequately safeguard youths against suicide; and (iii) adequately provide behavioral

---

[1] For example, the State indicated that since the time of our tours, the Maryland State Department of Education has assumed responsibility for educational services at the facility, the State has developed and implemented a new suicide training prevention program for facility staff, and the State has implemented a "watch tour" system at the facility where staff-conducted room checks and seclusion checks will now be electronically documented. Additionally, the State indicated that it was planning on issuing a request for proposal for a qualified provider of mental health services at the facility with provisions for additional staffing and staff hours and with a target implementation date of July 1, 2006.

health care services. In addition, the facility fails to provide required education services pursuant to the Individuals with Disabilities Education Act (IDEA), 20 U.S.C.A. §§ 1400-1482 (West, Westlaw through July 3, 2006).

In the course of our investigation, we also reviewed staff use of force, medical care, environmental health conditions, and fire safety. We found no systemic constitutional deficiencies in these additional areas, and commend the State for its commitment to ensuring that youths at the facility are subject to adequate conditions in these areas.

I. BACKGROUND

The Justice Center is a 144-bed facility for boys aged 12 to 18, with an average age of 15. The facility opened for operation in October 2003. It is operated by DJS and serves as both a pre-adjudication facility and as a facility for youths who have already been adjudicated delinquent and committed to DJS care but are awaiting placement elsewhere in a treatment facility. On the date of our last visit the residential population was 112. The average length of stay at the Justice Center ranges from 15 to 19 days, but some "awaiting placement" youths have remained at the facility for as long as four months. The layout of the facility includes three pods with one pod containing primarily youths awaiting placement, and the other two pods housing youths in detention. Each pod includes four separated living areas.

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); Slade v. Hampton Roads Regional Jail, 407 F.3d 243 (4th Cir. 2005). 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. 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. 20 U.S.C.A. §§ 1400-1482 (West, Westlaw through July 3, 2006). See Wilson v. Fairfax County School Board, 372 F.3d 674, 678 (4th Cir. 2004). As described below, the State has fallen 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. INADEQUATE PROTECTION FROM HARM

Our investigation revealed constitutional deficiencies in the protection from harm measures in place at the Justice Center. In particular, the facility fails to adequately protect youths from youth-on-youth assaults and suicide risks.

1. Inadequate Protection from Youth-on-Youth Violence

Generally accepted professional standards require that juvenile detention facilities must protect youths from assault by other youths. Facilities must maintain sufficient structure, safeguards, and staffing to ensure safety. The Justice Center experiences unacceptably high levels of youth-on-youth violence. The number of youth-on-youth assaults at the facility was 47% higher than the national average. According to Performance Based Standards ("PbS") data for the October 2005 semi-annual reporting cycle, the Justice Center reported a rate of assaults per 100 days of youth confinement at 0.745.[2] The national field average rate was 0.396. This data represents an improvement over the April 2005 PbS reporting cycle data indicating that youth-on-youth assaults were 59% higher than the national average. Inadequate staffing levels, an ineffective behavior management plan, and the availability of environmental weapons, have contributed greatly to the high level of youth violence.

---

[2] Performance-based Standards for Youth Correction and Detention Facilities is a self-improvement and accountability system used in 31 states and the District of Columbia to better the quality of life for youths in custody. PbS gives agencies the tools to collect data, analyze the results to design improvements, implement change, and measure effectiveness with subsequent data collections from within the facility and against other participating facilities. See http://www.pbstandards.org.

Adequate staffing levels and effective incentives for good behavior are particularly important in maintaining a safe environment. A lack of these tools at the Justice Center results in a high number of group altercations. We reviewed several incidents involving several attackers and lone victims. The attacks appeared to be both brazen and premeditated. This reflects that the system is so ineffective that certain youths feel comfortable in orchestrating such activity. For example, in a June 2005 incident, the facility experienced a large-scale group disturbance in three separate units that required the intervention of the Baltimore City Police Department in order to restore order. In a July 2005 incident, six youths repeatedly kicked and punched a victim in the presence of staff. In another July incident, three youths repeatedly hit and kicked a victim, also in front of staff. Both victims required medical treatment.

Adequate staffing levels are also essential to ending youth-on-youth assaults quickly before serious harm occurs. We reviewed several incidents where youth altercations resulted in serious physical injury requiring treatment at a local hospital emergency room. Consider the following examples of incidents resulting in emergency room visits:

- In a September 2, 2005 incident, a youth assaulted another youth striking him several times in the face with a closed-fist. The victim sustained injuries to his left eye, which was swollen and bleeding, a laceration to the corner of his left eye and nose, a laceration on the lower lid of his left eye, a bloody nose, and injuries to the back of his head.

- In an August 31, 2005 incident, one youth struck another youth several times in the face with a closed-fist. The victim sustained injuries to his left eye, lip, neck, and shoulder. The victim’s left eye was injured so severely that he could not see out of that eye.

- In a June 4, 2005 incident, as officers were escorting youths back from recreation, two youths began arguing. Staff directed the youths to separate, but one youth ultimately struck the other youth. During the ensuing melee, the victim fell back, “splitting open the back of his head.”

As discussed above, the pervasiveness and seriousness of the violence at the Justice Center appears to result primarily from an inadequate behavior management plan, chronic shortages in trained direct-care staff, and the presence of environmental security hazards. Each of these topics are discussed below in

detail.

a. Inadequate Behavior Management Plan

Generally accepted professional standards require that facilities confining youths provide 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 within the facility. For youths identified as having behavioral health problems, behavior management programs need to be coordinated with a treatment plan. The behavior management plan needs to be based on proven techniques and focused on achieving lasting change through the integration of evidence-based (or scientifically measurable) outcomes. Facilities must continuously track behaviors of their juvenile population and adjust their behavior management plan to achieve a desired result.

At the time of our visit, the Justice Center's behavior management system did not appear to be adequate to the task of managing children at risk and preventing youth violence and aggressive and planned group behaviors. The available sanctions at the Justice Center appeared demonstrably ineffective at deterring deliberate premeditated behaviors. On December 5, 2005, the Justice Center implemented a modified Point System ("New System"). Because the New System was implemented several weeks after our tours of the facility, we are unable to properly evaluate its effectiveness.

At the time of our tours, the Justice Center was utilizing an incentive-based behavior management point system ("Point System"). The Point System had three levels. Each level provided a continuum of incentives including, among other things, additional telephone calls, television and radios on the living units, video gaming privileges, and evening recreation time. Level three youths were also permitted to use points to purchase incentives such as additional visitations, movie night attendance, and commissary items.

If a youth received no point deductions for negative behavior, the minimum length of time required to achieve the second level was seven days, and the minimum length of time required to achieve the third and highest level was 20 days. The average length of stay in the facility fluctuates between 15 and 19 days. As a result, many youths were unable to achieve the program's most prized incentives. Sanctions for negative behavior were limited to point deductions under the Point System.

Due to Maryland regulations, disciplinary confinement is not available as a sanction.[3] The maximum number of points that may have been deducted from a youth in a single day is 60. By contrast, a youth earned 50 points in a single day for good behavior. Accordingly, available rewards under the Point System appeared to be inadequate at encouraging positive behavior, and available sanctions appeared to be entirely inadequate at deterring serious aggressive and assaultive behavior.

Under the New System implemented in December of 2005 youths must earn points by demonstrating positive behavior, instead of points being awarded automatically with deductions for negative behavior. With consistent good behavior, a youth may reach the second level after three days, and the third level after a total of seven days. Also, youths at all levels can now earn tokens to purchase incentives such as extra telephone calls and additional visitation. Sanctions for negative behavior now include verbal correction, inability to earn points, social separation,[4] and a deduction of tokens. Youths who fail to advance under the New System are referred to the treatment team for possible intervention. As indicated above, we have not had the opportunity to properly assess the New System. However, based on documents the facility recently provided, the New System appears to be a significant improvement from the old Point System.

b. Staffing Levels

We commend DJS for working diligently to secure adequate staffing levels at the facility. Current staffing levels permit DJS officials to comply with their goal of 1:6 staffing ratios and avoid problems associated with staff frequently being required to work double shifts. We strongly encourage DJS to maintain these appropriate staffing levels.

The absence of sufficient numbers of trained and skilled staff in a detention facility makes it virtually impossible to

---

[3] COMAR 16.05.02.03. Use of Locked Door Seclusion A. A facility employee may not place a youth in locked door seclusion as punishment. B. A facility employee may place a youth in locked door seclusion only: 1) When it is clearly necessary to protect the youth or other individuals or to prevent escape; and 2) After less restrictive methods have been tried or cannot reasonably be tried.

[4] The New System defines “social separation” as the practice of moving a youth to his room, with the door open, for up to 59 minutes.

provide youths with consistent care, maintain custody and supervision, and provide a safe environment. Until recently, chronic understaffing at the Justice Center contributed to violent and dangerous conditions. Typical vacancy rates for effective juvenile facilities are between five and 12 percent of budgeted staffing levels. Based on the number of Justice Center direct-care staff positions budgeted at the time of our review, approximately 146, the facility direct-care staff vacancy rate has been as high as 50%, and averaged 42% for the last six months of 2004. As recently as July 2005, the direct-care staff vacancy rate was 23%. Facility direct-care staff have historically been required to work frequent double shifts in order to provide minimal coverage to compensate for staffing shortages.[5] Prolonged continuation of mandatory overtime generally reduces effective supervision, creates significant morale issues, and contributes to increased numbers of adverse incidents.

Despite a chronic history of severe understaffing, the Justice Center has recently been able to significantly increase staffing levels and reduce vacancy rates in most categories of employees, including direct-care staff. Direct-care staff vacancies for the last six months of 2005 have averaged 10%. During our second facility visit, we were informed by Justice Center personnel that all direct-care staff vacancies had been filled as of October 16, 2005. Further, overall facility staffing levels have increased 41% in the last six months of 2005 compared to the last six months of 2004.

c. Environmental Security Hazards

Certain environmental hazards have exacerbated the seriousness of incidents of youth violence at the Justice Center. For example, and as partly illustrated by the examples below, removable chairs were used as weapons in at least eight incidents of assault, brooms were used in at least three incidents of assault,[6] and shanks (improvised sharp weapons) made from toothbrushes were present in at least two incidents of assault. In at least two incidents involving chairs, youths required

---

[5] "Direct-care staff" includes Resident Advisors, Resident Advisor Supervisors, Group Life Manager I, and Group Life Manager II staff. See Memorandum from Rodney Pegram, Director of Detention, to All Staff, dated May 2, 2005, re: Staffing Levels for Direct Care Staff.

[6] On February 6, 2006, the State informed us that since the time of our tours, all potential weapons such as brooms, have been removed from unsecured rooms into secured closets.

treatment at hospital emergency rooms and one of the victims required emergency surgery for apparent brain trauma. Consider the following illustrative examples:

- In an August 25, 2005 incident, two youths began fighting and one youth was struck in the face with a chair. The injuries were so severe that the victim required treatment at a local hospital emergency room.

- In an August 3, 2005 incident, two youths began arguing. Despite staff attempting to separate the youths, one youth picked up a chair and threw it at the victim hitting the victim in the face. The victim's face began to swell very badly and the Justice Center physician ordered the victim to immediately be taken to the hospital emergency room. The victim needed emergency surgery, and may have sustained internal injuries to his head and neck.

- In a June 8, 2005 incident, three youths assaulted another youth, who was seated in the unit, by punching him in the face and throwing chairs at him. The victim responded by brandishing a plastic shank and attempting to stab one assailant in the throat. The victim was then struck in the face with a chair and required medical treatment.

These known environmental security hazards should be eliminated by replacing these items with immovable or unliftable chairs, better control of brooms and cleaning equipment, and toothbrushes made with shorter handles and flexible nylon. Additionally, frequent and thorough cell searches could reduce the use of weaponized contraband.

2. Inadequate Protection from Risks of Suicide

Suicidal behavior in juvenile detention facilities represents a major threat to the lives and well being of the youths. Generally accepted professional standards require juvenile institutions to protect youths from self harm. By permitting known environmental suicide hazards and by failing to properly monitor youths in seclusion and youths on suicide watch status, the Justice Center fails to meet this requirement.

a. Environmental Suicide Hazards

There are a host of known environmental suicide hazards at the Justice Center. These hazards pose an unacceptably high risk of self harm for youths at the facility. The suicide hazards include mezzanine railings in the housing units, the design of

the bed frames in the sleeping units, and the configuration of the bathroom safety rails. We reviewed numerous incidents and reports of youths tying ligatures around their necks and attempting to hang themselves from the second-story railings. In two unrelated incidents on April of 2005, two youths attempted suicide from the railing on the same day. We also reviewed several reports of youths trying to commit suicide by tying themselves to the bed frames. One incident requiring emergency resuscitation and emergency room treatment resulted from a youth hanging himself from a bathroom hand rail.

The danger posed by the mezzanine railings is of particular concern. The facility has been aware of this hazard at least since January 2005. In quarterly reports released on January 14, 2005 and March 11, 2005 by the then Office of the Independent Juvenile Justice Monitor ("Independent Monitor")[7], the Independent Monitor expressed concerns about the risk posed by the railings. In his June 27, 2005 report, the Independent Monitor recounted several prior warnings to the facility administration about the dangers posed by the railings. Notwithstanding the Independent Monitor's admonitions and several subsequent suicidal behaviors involving the railings, the hazard had not been remedied as of the date of our last visit, six months after the date of the report.

Indeed, in the monitor's report for the period ending December 31, 2005, the JJMU expressed concern about the railings, and indicated that the danger caused by the railings "decreases the number of beds legitimately available [at the facility] to only the lower tier, which will house 72 [youths]." The JJMU further reported:

> Although this Office has repeatedly insisted that the second tier railings be suicide proofed and although this issue was addressed again in a Special Timely

---

[7] The Office of the Independent Juvenile Justice Monitor was a State office created to monitor conditions in all DJS facilities and report its findings to the Governor, the Maryland General Assembly, and the DJS Secretary. Staff members visited the facilities, conducted announced and unannounced tours, and authored detailed reports of their findings, recommendations, and DJS responses. Independent Monitor officials have previously identified similar violations as those identified in this letter and reported those problems to DJS. This office has been restructured and is now the Juvenile Justice Monitoring Unit of the Office of the Attorney General ("JJMU") pursuant to Maryland House Bill 1342 which became law on January 19, 2006.

> Report submitted on 8/5/05 and again in last quarter's report, the upper tier railing system is still not suicide proof. Attempts to commit suicide and other safety concerns regarding the upper tier railings continue.

The design of the facility bed frames has also been a longstanding concern of the Independent Monitor. In his quarterly report released on June 14, 2004, the Independent Monitor recommends that:

> DJS should secure the services of a professional architectural and design firm specializing in secure correctional facilities in order to review all equipment and furnishings to ensure that it meets acceptable standards for a secure detention facility.

In that same report, the annual report for the period ending June 30, 2004, and the quarterly report released on January 14, 2005, the Independent Monitor indicated that the existing bed frames posed a suicide hazard and should be replaced. Indeed, in the January report, the Independent Monitor admonishes:

> The protruding posts and openings on all the bed frames must be eliminated. The beds have a number of openings on the frame similar to the openings on the bed used in the March 2002 completed suicide at the Waxter Children's Center in Laurel. The beds also have protruding posts extending from the frame, which may also be used to tie off from in a suicide attempt. On August 22, 2004, a youth [at the Justice Center] was found with a sheet tied to a bed frame around his neck. Supervisory staff performed CPR and first aid on the youth.

The same longstanding concerns regarding unsafe bed frames and the mezzanine railings voiced by the Independent Monitor remained unresolved as of the date of our last tour. The State recently acknowledged the threat posed by the bed frames in its Facilities Master Plan.[8]

b. Inadequate Suicide Watch and Seclusion Monitoring

Residents in seclusion or identified as suicide risks are in significant danger of self harm. To mitigate the danger to youths in seclusion, generally accepted professional standards and DJS policy require that direct-care staff monitor residents

---

[8] Released January 16, 2006; Appendix A-15 ("The metal cots in the rooms could be a suicide threat.").

in seclusion every ten minutes and record their rounds on a door sheet or log.[9] There is insufficient documentation to confirm that the checks at the Justice Center are consistently performed in accordance with policy or within generally accepted professional standards.

We found several cases where cell checks for youths who were in seclusion for significant periods of time were not adequately documented. For example, on September 20, 2005, youth KJ[10] was placed in seclusion for over 24 hours. During the entire length of seclusion, cell checks were documented for only a two-and-a-half hour period. In addition to missing documentation regarding cell checks, we found numerous discrepancies between the DJS seclusion observation policy and the Justice Center's practices. Of the 12 cases of seclusion documentation we reviewed, only three indicated that staff had performed all required cell checks. In at least three cases there were discrepancies between the unit log book entries and the door sheets. For example, in at least four cases, there were no recorded checks by the nursing staff. In two cases, we were not even able to determine the length of time the youths were held in seclusion.

Like youths in seclusion, youths identified as having suicidal tendencies are in significant danger of self-harm. To mitigate the danger to suicidal youths, generally accepted professional standards and a DJS directive require juvenile detention centers to provide close observation of youths who exhibit suicidal behaviors.[11] The Justice Center utilizes a three-tier suicide watch level system which provides for a continuum of observation for at-risk youths. At a minimum the system requires that staff observe suicidal youths six times per hour, and at staggered intervals of between one and ten minutes apart during waking hours. Youths deemed to be at particularly high risk of suicidal behavior must receive continuous observation during waking and sleeping hours. All observations and monitoring must be coherently documented.

The Justice Center has not consistently adhered to generally accepted professional standards and DJS policy regarding the

---

[9] See DJS Policy number 03.14.04 re: Limits on Use of Restraints and Seclusion, eff. February 18, 2000.

[10] To protect the privacy of youths referenced in this letter, initials have been used in place of actual names.

[11] See DJS Secretary's Directive number SD E2270-01-01 re: Suicide Prevention Policy (revised 11/06/02).

observation and protection of youths at risk of committing suicide. We found numerous examples of youths on suicide watch where there were no documented staff observations or consultations by the mental health staff. Moreover, none of the cases we reviewed contained any graduated step-down release plan. Among the cases we reviewed for September 2005, five of the youths were on the highest suicide watch status, requiring continuous one-on-one staff observation. Of these five cases, the facility was unable to document staff observation for significant periods in four of the cases. The facility also was unable to document psychological consultations with the youths in four cases. In one case, we found observation gaps totaling 43 hours. In two other cases, we found gaps totaling more than 20 hours.

These apparent gaps in seclusion and suicide watch monitoring create a very high risk for self harm among known suicidal youths.

B. INADEQUATE MENTAL HEALTH CARE

The Justice Center is lacking in several areas with regard to mental health care. Deficiencies include inadequate mental health assessments, inadequate mental health treatment and case management, inadequate communication and record keeping, and inadequate confidentiality safeguards.

As a preliminary matter, it is worth noting that many of these deficiencies described below are attributable to staffing shortages. Three part-time fellows in child psychiatry from the University of Maryland provide only ten hours of psychiatry services per week. At the time of our tour, the Justice Center's mental health personnel were roughly half the number needed to meet generally accepted professional standards. Four of eight social worker positions were vacant, three of four addiction counselor positions were vacant, and two of three supervisory positions were vacant. Although the supervising psychologist has considerable experience providing mental health care to youths in detention, the front-line clinicians tend to be very inexperienced. These staffing limitations inevitably affect the quality of mental health care.

1. Inadequate Mental Health Screening and Assessments

Generally accepted professional standards require that all youths entering secure facilities receive a reliable, valid and confidential initial screening and assessment to identify

emergent suicide risks and psychiatric, medical, substance abuse, developmental, and learning disorders. Staff should refer youths for any required care. To do this, staff must 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 then be communicated to appropriate personnel so that each youth's needs are appropriately and timely addressed.

Initial mental health and substance abuse screening occurs as youths are admitted into the Justice Center, and the standardized questioning during that process appears to be thorough and consistently applied. The intake worker first administers the Facility Initial Reception/Referral Screening Tool – Health Care ("FIRRST-HC"), which asks whether the youth is conscious, coherent, intoxicated, and/or thinking of harming himself or others. Subsequent tests include the Massachusetts Youth Screening Instrument ("MAYSI"), a 52-item yes/no questionnaire designed to discover symptoms of mental illness, and the Adolescent Substance Abuse Subtle Screening Inventory ("SASSI"), a questionnaire designed to identify youths with a high probability of having a substance abuse disorder. Screening with positive results (especially regarding suicidality) triggers a rapid and more extensive assessment by a clinician, but it is not entirely clear what criteria are used to identify a need for further immediate assessment. Moreover, potential dangers revealed in youth responses to the questionnaire are not systemically detected. In particular, the manner in which the intake case manager uses the MAYSI includes no follow-up inquiry in response to answers that reflect thought disorders, trauma exposure, or answers that might be ambiguous.

Youths with identified mental health needs should be provided a full mental health assessment (subsequent to the intake assessment), and such assessments should include actual opinions (with support and reasoning) on a five-axis psychiatric diagnosis, risk assessment and management, and specific mental health treatment recommendations. The Justice Center's records generally do not contain such information. Most youths admitted to the detention center are evaluated by a clinician on the day of admission or the following day. However, the assessment process is unstructured, consisting of informal interviewing and casual information gathering. The assessments are not thorough, are poorly documented, and are often internally inconsistent. The records do not reflect clear mental status data nor do they contain explicit diagnostic or functional analysis. Assessments do not include any tests or other structured instruments beyond the initial mental health and substance abuse screening tests. We were told that the school psychologist conducts psychological

testing in the context of individual educational planning, but we did not see any evidence of such testing in any of the mental health records we reviewed. Assessments are particularly lacking with regard to substance abuse: no substance abuse evaluations of any kind are conducted beyond the initial screening.

As discussed further below, the Justice Center's assessments often do not include information regarding prior treatment in the community or at other residential facilities and hospitals. Similarly, the facility's efforts to engage residents' families in overall assessment and in mental health assessment and treatment are inadequate. We understand that some families may not be interested in, or responsive to, outreach from facility clinicians. However, families are an extremely important source of clinical information, and it is not possible to conduct an adequate overall functional or mental health assessment without including current and historical information from families.

2. Inadequate Mental Health Treatment and Case Management

Treatment planning requires the identification of symptoms and behaviors that need intervention and the development of strategies to address them. Such planning is a critical part of generally accepted professional standards and it is necessary for effective treatment of serious mental illness. As noted above, mental health assessments often lack necessary diagnostic information, thus it is not surprising that treatment plans fail to target specific symptoms or articulate meaningful strategies and provide no mechanism for measuring whether the plan is working.

Mental health treatment at the time of our visit consisted of informally-scheduled individual contacts with clinicians and participation in psycho-educational groups. There is some effort to note particular functional problems (though not with diagnostic clarity) and to supply supportive or educational services roughly addressing these problems. However, we observed no effort to articulate particular individual characteristics or strengths in youths that would dictate the provision of specific treatment approaches. And, as noted previously, there is little family involvement in treatment.

Substance abuse treatment is even less targeted, consisting largely of non-specific psycho-educational groups for all youths. Staff also provide informal individual counseling designed to improve awareness of the emotional bases for substance abuse, and staff sometimes counsel youths about community resources

available to substance abusers. However, staff generally do not examine individual patterns of use, abuse, addiction, or motivation, nor do they instruct youths in alternative stress management or abstinence support techniques. Accordingly, substance abuse treatment services are inadequate.

Clinical interventions are organized around crisis issues such as suicide risk evaluation but, even in cases where such risk is recognized, records do not reflect implementation of specific treatment aimed at alleviating the youth's discomfort and reducing the risk (beyond the suicide watch process). There is no standard format for assessment of suicide risk, or for assigning a watch level. When we asked to see the approved suicide risk scale used by clinicians in assessing appropriate suicide watch status, we were told that such a scale did not exist. This is a stark departure from generally accepted professional standards. Because there is no suicide threat scale, the Justice Center's policy sets almost no threshold for responding to suicidality, i.e., the staff are required to respond to seemingly minor risks. Nonetheless, the vast majority of recorded incidents include explicit and substantial suicidal behavior, suggesting that there may be a lack of sensitivity to voiced indicators of risk that occur prior to such behavior. A well-developed assessment system typically would identify a higher percentage of suicidal youths before they actually attempt suicide. The Justice Center policy calls for regular follow-up and assessment of suicidal youths by clinicians, but the documentation of clinical visits for this purpose was inconsistent.

The Justice Center's own internal review of cases of suicidal youths revealed that the frequency of clinician meetings with youths on suicide watch often was less than required by generally accepted professional standards and DJS policy. That review further revealed that documentation and implementation of intervention plans often was incomplete. In one case, a suicidal youth returned from hospitalization on the highest watch level and was discharged to his appointed placement two days later. There was no indication that he was seen by mental health staff during those two days. Three other youths were put on watch levels and were never seen by mental health clinicians at all. At least one youth on the highest watch level was released directly into the community without any plans for follow up or community treatment.

In general, mental health planning and treatment for suicidal youths has been inadequate. Communication among staff and documentation of watch level assessments is poor, and mental health staff have failed to provide proper notifications to

families and community workers when a youth is put on suicide watch. Facility staff have had difficulty coping with cases involving co-occurring problems of depression, irritability, suicidal ideation, and manipulativeness, as well as cases in which professionals have disagreed regarding the nature of the disorder and the degree of risk it represents.

In general, psychiatric treatment services at the facility are inadequate. According to Justice Center policy, mental health staff and nurses refer youths to a psychiatrist for pharmacological assessment and treatment whenever a youth arrives from a psychiatric hospital; whenever a youth has been on the highest suicide watch level for three days; whenever a youth has been on the lower suicide watch levels for seven or more days; whenever a youth arrives taking psychiatric medication; whenever a youth asks to see a psychiatrist; whenever a youth has a "recent history of psychotropic medication" ("recent" is not defined); and whenever a youth displays "behavioral signs of symptoms suggestive of a mental health or behavioral disorder."[12] Psychiatrists have limited, or no access, to previous psychiatric records or summaries and lack necessary background information to treat patients effectively. They are not involved in treatment team meetings and do not have direct access to residential staff. Accordingly, psychiatrists are isolated from other mental health clinicians at the facility and lack appropriate background information to provide for adequate levels of care.

Psychiatric attention to youths who require psychotropic medications appears reasonably thorough, with well-documented assessments, adequate follow-up, and reasonable treatments prescribed. However, family involvement in the development of patient history is lacking, and staff sometimes fail to obtain the consent of a parent or guardian to treat a patient. Psychiatry fellows would benefit from closer supervision and should bring to their supervisor notes and contributing information for each patient at least once per week. As noted previously, psychiatric involvement in the overall provision of mental health care is inadequate. In order to meet generally accepted professional standards, a facility such as the Justice Center should budget at least 16-18 hours per week for on-site psychiatric care.

3. Inadequate Communication and Record Keeping

---

[12] The latter criteria is so broad that, if implemented, it would require the referral of virtually every youth in the facility.

Generally accepted professional standards require that records be kept to aid in patient diagnosis and treatment, and to measure patient progress. Most of the mental health clinicians' progress notes showed evidence of having been introduced to the standard "SOAP" format, but the entries suggest these personnel were not trained to implement it properly. The SOAP format divides a note into four parts: "S" (subjective) describes the patient's subjective account of problems and symptoms; "O" (objective) describes findings observed by the clinician or learned about from others; "A" (assessment) provides the clinician's understanding and opinion of the current situation based on the subjective and objective findings; and "P" (plan) provides the clinician's recommendations for intervention. Notes in the records we reviewed commonly included a line or two of information following "S", another line or two following "O" (with no distinction between them in terms of the type of information), and then considerably more information following "A" (but no actual assessment, formulation, or opinion), with some recommendation then following "P."

More importantly, critical information often was not included in the charts or was overlooked in subsequent interviews. The case of HC is illustrative:

> HC was admitted twice in the Spring of 2005. HC's first assessment noted that he had a history of psychiatric medication and hospitalization. The second assessment reflected no history of psychiatric contact or hospitalization. HC was admitted again for a week in August and then released to a group home. There is no mental health note from this period. HC was re-admitted on September 14, 2005 with higher MAYSI scores than those recorded in previous stays, including a high score for suicidal ideation. Nonetheless, a mental health evaluation regarding his suicide watch level said the "boy has never had suicide ideation." The clinician did not inquire into the boy's two positive responses on the MAYSI thought disorder scale. The next day he was seen by a different clinician, who noted that he showed a depressed mood, had been hospitalized in 1999, and had been receiving psychiatric medication previously. The latter clinician referred HC to psychiatry, but he was not seen until one week later.
>
> A psychosocial assessment included some cursory history about school problems, his hospitalization at age nine, and vague information about substance abuse. The report included no attention to his trauma exposure, and no attention to the issue of suicide ideation or risk. When

the psychiatrist saw HC, the patient was described as having no history of hospitalization and no history of medication.

The treatment team process provides a valuable opportunity for routine informal information sharing among clinical staff, which should then result in appropriate, specific action plans for each youth needing care. However, the current team process does not produce detailed assessments nor does it produce specific treatment plans.

4. Inadequate Confidentiality Safeguards

Generally accepted professional standards require that mental health information be kept confidential. This standard protects the privacy of patients, and it allows them to speak freely and to disclose all the information necessary for diagnosis and treatment. We were told by Justice Center mental health staff that they inform youths that the youths' information will be kept in confidence, except for information about risk of harm to themselves or others, and except for information sharing among treatment team members. Youths may, or may not, also be told that the clinician may be called to court to answer questions. We were assured that the Justice Center would not produce a youth's mental health record to the court, but we were also told that these records are routinely made available upon request to the clinicians working on behalf of the court to conduct forensic mental health evaluations.

This is a distinction without a difference. If records are made available to an agent of the court, or if Justice Center clinicians are compelled to testify, then patient records are not confidential. Accordingly, under generally accepted professional standards, youths should be told that their communications with clinicians may be revealed to the court. Moreover, when a youth refuses non-confidential treatment or when a clinician determines that confidential treatment is in the patient's best interest, the Justice Center should provide third-party or otherwise truly confidential mental health services. In any event, youths should receive complete and accurate information regarding the extent to which the information they provide will remain confidential.

C. INADEQUATE EDUCATIONAL INSTRUCTION OF YOUTH WITH DISABILITIES

Youths with disabilities have federal statutory rights to special education services under the IDEA. In states that accept federal funds for the education of children with disabilities,

such as Maryland, the requirements of the IDEA apply to juvenile facilities. See 20 U.S.C. 1412(a)(1); 34 C.F.R. § 300.2(b)(1)(iv). At the time of our tour, 45 percent of the Justice Center's youths had been identified as qualifying for special education services under the IDEA. The average age for youths at the Justice Center is 15 and the median reading level is fifth grade. Many of the youths have been truant, suspended, or expelled from their previous schools and, consequently, may not have been in school for some time prior to their detention. The Justice Center violates the rights of youths with disabilities secured under the IDEA by failing to provide such youths with adequate special education and resources. Specifically, the education program at the Justice Center is deficient in that it fails to provide adequate access to education by youths who are eligible for special education services and fails to provide adequate development and implementation of Individualized Education Programs ("IEPs").

At the outset, we note that there are several positive aspects of the educational program at the Justice Center. For example, the Justice Center's teachers are dedicated, knowledgeable, and enthusiastic. A new computer lab has been set up and a new reading curriculum has been introduced. Moreover, the Maryland State Department of Education has recently assumed control of education programming at the facility and there are plans for space expansion for classroom use. Nevertheless, our investigation revealed that the Justice Center fails to provide adequate special education services required under IDEA.

1. Inadequate Access to Special Education

The IDEA requires that all students with disabilities have access to free and appropriate public education (FAPE) which meets the standard of the State education agency. 20 U.S.C. §§ 1401(8)(b) [eff. July 1, 2005: 20 U.S.C. §§ 1401(9)(b)]; 1412(a)(1)(A). See also 34 C.F.R. § 300.600(a)(2)(ii). Maryland state education standards require that school teams with responsibility for developing IEPs meet to review existing data and instructional interventions and strategies utilized for the student. See COMAR 13A.05.01.04(A)(2). Although retrieval of student records to provide information on special education needs should be completed within five days of arrival at the Justice Center, we determined that educational records were delivered within five days for only four of 36 special education students. The failure to secure these records on a more timely basis delays students with disabilities from access to appropriate educational services.

Even in cases where the educational plan has been clarified, there remain significant problems with access to services. Students with disabilities, in particular, require consistent attendance at school in order to access the general education curriculum and have an opportunity to achieve academic success. In general, the Justice Center's population has substantial academic deficits and many students are at risk for academic failure. Despite these risks, the Justice Center documentation indicates that students with disabilities do not consistently attend school. Among the examples we uncovered: entire units were kept away from school for days at a time; on July 19, 2005 an episode of vandalism closed the school for the entire day; on May 24, 2005 a lock-down closed the school; on May 27, 2005 unit 43 attended school for only three hours of the five hour school day. While visiting a class at the Justice Center, we noted the class was dismissed 15 minutes before its scheduled dismissal time after the students "reminded" the teacher that it was the time when class routinely ends. The Justice Center's failure to provide adequate instructional hours to students with disabilities deprives them of opportunities to receive an appropriate education.

Furthermore, students with disabilities were denied special education services when they were placed in restricted settings such as segregation or lock-down. We were told that such students were provided with educational packets by a resource teacher. Five students reported to us in interviews that they had not been given educational materials while in segregation. Whether the packet was delivered or not, we find that the delivery of educational materials by a teacher who stays with the student for a few minutes does not constitute a full lesson. Moreover, such students in lock-down status are not permitted to have a pencil with which to do the school work in the packet. Given the correlation between time spent on instruction and academic success, the Justice Center is contributing to students' failure by denying students with disabilities the minimum amount of academic instruction that they would receive in a community public school.

The typical public school system offers a continuum of services for students with disabilities, including all-day or partial-day instruction in self-contained resource rooms, and all day instruction in general education classrooms with support from special education teachers. To its credit, the Justice Center operates an inclusion school model, as envisioned under IDEA, 34 C.F.R. 300.550(b)(1), where special education students, who comprise 45 percent of the student body, spend most of their school day in general education classes. However, the IEPs of some students indicate that they need special individualized

instruction outside the regular classroom. Those students do not receive appropriate services at the Justice Center. Our review of the Justice Center's records revealed several instances where a youth's individual special education services were dramatically lower at the Justice Center than at his previous educational setting. For example: H.A. received only 40 percent of educational time in differentiated instruction outside the regular classroom, rather than 66 percent as required by his prior IEP. C.C.'s and S.J.'s prior IEPs call for at least 98 percent of instructional time outside regular class, but both students received no resource time outside the regular class at the Justice Center. Drastic reductions in services such as the foregoing, without adequate justification, suggest that the Justice Center is tailoring the instruction of students with disabilities to what is available, rather than to the students' individualized needs. The Justice Center's practice of providing fewer than required hours of appropriate instruction denies students the special education to which they are entitled.

2. Inadequate Development and Implementation of Individualized Education Plans

The IDEA requires that each student with a disability have an IEP, and it describes the IEP components required to ensure that each student receives adequate special education services. 34 C.F.R. §§ 300.346, 300.347. The IEPs that are used to guide the delivery of special education services at the Justice Center do not adequately address the students' needs. For example, goals and objectives on IEPs written at public schools may no longer be appropriate for students in a correctional setting and may need to be reformulated. To effectively assist students in achieving the goals and objectives listed in the IEPs, the goals and objectives must be written in realistic, measurable terms based on individualized needs. Many of the IEPS that we reviewed contained goals which cannot be objectively evaluated. For example, there are no criteria listed for evaluation of progress on a Justice Center goal such as, "[t]o improve math skills." In several instances, the goal in the IEP referenced the baseline skill but did not set any specific target or an identified measurement tool. For example, one goal we discovered, "J. will increase broad reading skills from a 2.1 grade level," does not set out any specific goal or a way of measuring improvement toward the goal.

In general, instruction for students with disabilities at the Justice Center is not implemented to align with the students' needs. The IDEA requires that students with disabilities receive specially-designed instruction in which the content, method,

and/or delivery of instruction is adapted as necessary to meet the unique needs of the student, and to ensure the student's access to the general curriculum. 20 U.S.C. § 1401(29); 34 C.F.R. 300.26(a). Justice Center students are grouped for classes by their housing unit rather than academic criteria such as grade level, credits earned, skill levels, or cognitive abilities. In the inclusion model operating at the Justice Center, the general education teacher typically is responsible for implementing the instructional adaptations identified in the IEPs. However, we observed teachers giving lectures to the entire class, i.e., to both general education and special education students alike, and using the same books and materials for all students. When asked, some teachers were unaware of which students in their classes even required special education services and were not able to specify the individual IEP goals of their students. The lack of differentiated instruction at the Justice Center for students with disabilities adversely affects their ability to succeed in their schoolwork. The inclusion service delivery model that we observed at the Justice Center is not sufficient or appropriate for students with disabilities.

In addition, IDEA requires that students with disabilities receive related services to address their specific needs and allow them to benefit from instruction. 34 C.F.R. 300.24. "Related services" include transportation and such developmental, corrective, and other supportive services (including, but not limited to, speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, social work and counseling services, and orientation and mobility services) as may be required to assist a child with a disability to benefit from special education. The term also includes school health services, social work services and parent counseling and training. 20 U.S.C. § 1401(26); 34 C.F.R. 300.24. Our investigation revealed that there were two students at the Justice Center whose IEPs indicated they needed speech and language therapy and who were not receiving those services. We were told that the Justice Center had been unable to develop a contract with a speech and language therapist to provide these services. Another youth's IEP required the provision of occupational therapy, but the Justice Center has not been able to retain a therapist to provide that related service. The Justice Center's failure to implement IEPs by providing identified related services violates the right of students with disabilities to receive an appropriate education.

IV. REMEDIAL MEASURES

To remedy the identified deficiencies and protect the constitutional and statutory rights of Justice Center youth residents, the State should implement promptly, at a minimum, the remedial measures set forth below:

A. Protection from Youth Violence

1. Ensure that youths are adequately protected from physical violence committed by other youths.

2. Ensure that the facility maintains sufficient levels of adequately trained direct-care staff to supervise youths safely.

3. Ensure that there is an adequate and effective behavior management system in place, and that the system is regularly reviewed and modified in accordance with evidence-based principles.

4. Remove and replace known and identified environmental security hazards, e.g., chairs that can be used as weapons or toothbrushes that can be made into shanks.

B. Protection from Risk of Suicide

1. Remove and replace, or remedy, known and identified environmental suicide hazards.

2. Ensure that youths placed in seclusion are monitored consistently and that such monitoring be consistently documented in accordance with DJS policy and generally accepted professional standards.

3. Ensure that youths placed on suicide watch are monitored consistently, and that such monitoring be consistently documented in accordance with DJS policy and generally accepted professional standards.

C. Behavioral Health and Psychiatric Services

1. Ensure that mental health staffing (including case managers, clinicians, and psychiatrists) levels are adequate to meet the mental health needs of youths.

2. Provide adequate mental health and substance abuse screening and assessment.

3. Provide adequate mental health and substance abuse treatment and case management.

4. Provide adequate mental health record-keeping and communications between and among the treatment teams, psychiatry staff, and the youths' families.

5. Ensure that youths are provided with accurate information regarding the confidentiality of communications with the Justice Center clinicians.

D. Special Education

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

2. Provide students with disabilities adequate special education instruction.

3. Develop and implement adequate individualized education programs and provide necessary related services.

* * *

As stated above, we appreciate the cooperation we have received from DJS officials and facility staff throughout this investigation. We hope to be able to continue working with the State in an amicable and cooperative fashion to resolve the deficiencies found in the Justice Center's protection from harm measures, mental health care services, and special education services. Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. Although these reports are the consultants' work – and does not necessarily reflect the official conclusions of the Department of Justice – the observations, analyses, and recommendations contained in the reports provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them.

In the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to institute a lawsuit pursuant to CRIPA to correct the deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will be contacting your attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please contact Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Wan J. Kim
Wan J. Kim
Assistant Attorney General

cc: The Honorable J. Joseph Curran, Jr.
Attorney General
State of Maryland

Kenneth C. Montague, Jr.
Secretary, Department of Juvenile Services
State of Maryland

Rodney Pegram, Director
Baltimore City Juvenile Justice Center

The Honorable Rod J. Rosenstein
United States Attorney
District of Maryland

The Honorable Margaret Spellings
Secretary
United States Department of Education

Mr. John H. Hager
Assistant Secretary
Office of Special Education and Rehabilitative Services
United States Department of Education

Mr. Troy Justesen
Director
Office of Special Education Programs
United States Department of Education