April 19, 2004

The Honorable Jennifer M. Granholm
Governor of Michigan
P.O. Box 30013
Lansing, Michigan 48909

Re: CRIPA Investigation of W.J. Maxey
Training School Whitmore Lake, MI

Dear Governor Granholm:

I am writing to report the findings of the Civil Rights Division's investigation of conditions at the W.J. Maxey Training School in Whitmore Lake, MI. On June 6, 2002, we notified then-Governor John Engler of our intent to investigate Maxey pursuant to both 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"). 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.

As part of our investigation, we reviewed a large variety of documents regarding the facility. We also interviewed residents and direct care, program, and administrative staff. In addition, on March 11-13 and April 2-4, 2003, we conducted on-site inspections with expert consultants in juvenile justice management, medical and mental health care, fire safety protection, and education. As promised, at the conclusion of each tour, we conducted exit conferences with staff during which time our consultants described their initial impressions and concerns.

We would like to thank both the staff at Maxey as well as Michigan state officials for the extraordinary level of cooperation we received. We also appreciated the candor and openness of the facility's staff and administration. State and facility staff all reacted positively and constructively to the observations and recommendations for improvement made by our consultants during the site visits, which gives us great confidence that the issues identified will be corrected in a timely fashion.

Consistent with our statutory obligation under CRIPA, we now write to formally advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies set forth below. As described more fully

below, we conclude that certain conditions at Maxey violate the constitutional and statutory rights of youth at the facility. In particular, we find that youth at Maxey suffer harm or the risk of harm from constitutional deficiencies in juvenile justice management, medical and mental health care, and fire safety. We also find that Maxey deprives certain youth of required educational services.

I. BACKGROUND

Maxey houses youth who have been adjudicated as juvenile offenders and committed to State custody. Youth range in age from 13 to 20. At the time of our visits to the facility, Maxey's population consisted of approximately 200 youth residing in three separate units: (i) Sequoyah Center, (ii) Woodland Center East, and (iii) Woodland Center West.[1]

Sequoyah Center contains one unit divided into three halls: a hall for youth with mental illnesses or other special needs, a medium security general population hall, and a hall for youth needing substance abuse programming. Woodland Center, which the State opened in 2002, contains two units — Woodland Center East and Woodland Center West. Woodland Center East houses adjudicated sex offenders. Woodland Center West houses youth with mental illnesses and those who need substance abuse and sex offender programming. Woodland Center West also houses the most
violent offenders and is the unit with the highest level of security.

II. FINDINGS

A. JUVENILE JUSTICE MANAGEMENT

Our investigation revealed that Maxey appears to subject youth to unconstitutional uses of restraints and isolation, deprives youth of their constitutionally-protected right to an adequate grievance system, and maintains staffing levels which, although not themselves unconstitutional, incubate an environment ripe for danger.

As a general matter, the State must provide confined adjudicated juveniles with reasonably safe conditions of confinement. See Youngberg v. Romeo, 457 U.S. 307, 315-16 (1982) (recognizing that a person with mental retardation in state custody has substantive due process rights under the Fourteenth Amendment); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979) (applying the Fourteenth Amendment standard to facility for adult pre-trial detainees);

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[1] At the time we initiated this investigation, Maxey had a larger population than it did at the time we toured and consisted only of older housing units like the Sequoyah Center. All of the youth and staff we talked to characterized the opening of Woodland Center, which has modern security features that significantly reduce the potential for violence, as an important positive step.

Danese v. Asman, 875 F.2d 1239, 1243-44 (6th Cir. 1989) (discussing application of Fourteenth Amendment standard in case involving adult pre-trial detainee's protection from harm claim).

1. Restraints

We found the use of certain restraints on youths at Maxey to be quite disturbing. Our concerns were most acute with respect to those individuals confined in the "Life Safety Unit," a pod within Woodland Center West where youth are typically assigned for such reasons as behavior management, suicide prevention, physical illness, and mental health stabilization.[2]

Youth at Maxey have a right to be free of undue bodily restraints. See Youngberg, 457 U.S. at 316. The use of restraints without penological justification does not comport with the Constitution. See Hope v. Pelzer, 536 U.S. 730, 737-46 (2002) (the unnecessary handcuffing of an inmate to a hitching post after his disruptive behavior ended violated the Eighth Amendment). Although Maxey's restraint policy prohibits the use of mechanical restraints as punishment and mandates written documentation any time restraints are employed, the facility consistently fails to adhere to its documentation requirements. As a result, it is virtually impossible for supervisors to monitor the use of restraints and prevent their improper deployment. And the anecdotal evidence we received of frequent, improper usage of restraints by staff is a cause for serious concern.

We also were troubled by reports regarding peer restraint practices at Maxey. Peer restraint (the use of youth to physically subdue other youth) is prohibited by virtually all jurisdictions, even those that subscribe to the "positive peer culture" theory from which the practice originated. See, e.g., S.D. v. Faulkner, 705 F. Supp. 1361, 1366-67 (S.D. Ind. 1989) (juvenile justice facility discontinued peer restraint after lawsuit over its use was filed; court found that plaintiffs' claim was not frivolous, unreasonable or groundless). While Maxey administrators informed us that peer restraint is being used less often than it was in the past, and some suggested it was being phased out, it is a dangerous practice, and we recommend that it be immediately suspended. To be clear, we make no finding that the use of peer restraint amounts to a violation of the Constitution. But considering the nearly unanimous expert criticism of this device in juvenile justice facilities, Maxey should carefully consider whether such a practice should continue to be employed in the future.

Our concern with peer restraint is its deleterious impact on the juvenile facility's positive peer culture program, which is designed to teach youthful offenders to create a healthy and harmonious living situation. The development and continuity of such an environment depends on youth understanding and enforcing acceptable standards of conduct, such as mutual respect, support, and care. Teaching youths to physically restrain other youths in potentially violent

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[2] The Life Safety Unit at Maxey consists of ten rooms. Each room contains a bed, sink, and toilet. Every room is equipped with a camera monitor and a large observation window. There are three private showers and a multipurpose day room.

situations, however, destroys the positive culture that Maxey is trying to create. Moreover, many of Maxey's youth have displayed violent and aggressive behaviors in the community, have cognitive learning disabilities, or have serious mental health issues. The danger to these individuals created by the use of peer restraint, even with staff supervision, seems to be an extraordinary and unnecessary risk.

2. Isolation

The isolation practices at Maxey raise additional constitutional concerns. Youth who are deemed assaultive, threatening, disruptive, or have committed a rule infraction are typically transferred to the Life Safety Unit and isolated as a form of behavior management. There is nothing inherently improper about this practice; youth may of course be isolated and locked briefly in their rooms in response to out-of-control behavior. The problem is that Maxey often metes out this form of punishment for longer than is appropriate and without affording individuals their due process rights. It is well settled in the correctional context that extended isolation for punitive purposes may only be imposed if a youth is afforded notice of the charges against him and an opportunity to present a defense in an informal hearing before a staff member not involved in the incident. See Martucci v. Johnson, 944 F.2d 291, 293 (6th Cir. 1991); Benjamin v. Fraser, 264 F.3d 175, 188-90 (2d Cir. 2001); Rapier v. Harris, 172 F.3d 999, 1002-04 (7th Cir. 1999); Mitchell v. Dupnik, 75 F.3d 517, 523-26 (9th Cir. 1996).

Unfortunately, Maxey does not have a system to ensure that youth receive due process before being isolated for disciplinary purposes. Although facility administrators informed us that use of the Life Safety Unit is limited both in scope and duration, we found many examples of youth being isolated for extended periods of time — with no hearing or chance to rebut charges — based on relatively minor infractions. A youth from Pod Two, for instance, was held in the Life Safety Unit for more than 48 hours for "refusal to follow program expectations," even though his logging form shows that he was never out of control or a threat to either himself or others. Facility logs indicated that other youth were routinely sent to isolation for two to three days (and occasionally as many as five days), for a variety of *de mimimis* transgressions without ever receiving a due process hearing. These lengthy isolations can have serious negative consequences for residents. Indeed, lengthy periods of isolation can be psychologically damaging to youth, who generally experience time differently from adults. Youth may experience symptoms such as paranoia, anxiety, and depression even after short periods of isolation.

Maxey's use of isolation also appears to be frequently arbitrary and unequal. As a result, youth who have committed the same offense are treated significantly differently without any justification or the protection of due process. The disparate sanctions are in large part the byproduct of the facility's lack of a formal disciplinary system. Maxey has no objective policies stating who should be placed into the Life Safety Unit, what a youth must do to be released, how long a youth may remain there, or even how often a youth must be contacted by mental health personnel.

Instead, youth at Maxey are given time in the Life Safety Unit completely at the discretion of correctional staff. Although the Constitution certainly does not require a formal and rigid sanctioning algorithm akin to the Federal Sentencing Guidelines, the lack of *any* guidance has contributed to great confusion among both staff and youth as to how much time a youth should spend in the Life Safety Unit. There is near universal recognition that isolation is not consistently imposed. On December 21, 2002, for example, a staff member wrote in a unit log book, "[s]taff & team should be wondering what kind of confused message we are giving [youth, when] if you threaten[] a female staff you get 1 day in [the Life Safety Unit, and] you get 3 days for exposing or masturbation?" Similarly, according to the February 2003 Behavior Management notebook, one youth was held in the Life Safety Unit for 125 hours for "kick[ing] another youth" and "sw[inging] at staff," whereas another youth was given 48 hours for the same offense. Meanwhile, one youth was held in the Life Safety Unit for 48 hours for "sex play,"[3] while another youth received 49 hours for pulling a chair away from another youth and refusing to follow staff instructions.

Not only does time in the Life Safety Unit vary within individual pods, it varies greatly between pods. For example, a youth from Pod Four was held in the Life Safety Unit for 48 hours for out of control behavior, while a youth from Pod Nine was held for two hours for the same violation. Both youths' logging forms showed that neither youth was out of control while in the Life Safety Unit. While we readily acknowledge that it is impossible to know the specific gravity of the behavior triggering the youths' removal to the Life Safety Unit in these two incidents — and thus there may in fact be a valid basis for the different treatment — the lack of documentation and standards clearly fosters an arbitrary disciplinary regime.

Documentation deficiencies likewise prevent supervisors from effectively monitoring the use of isolation to ensure fairness and consistency. From the documentation, it is often difficult to ascertain the exact reason a youth was sent to the Life Safety Unit or how much time he stayed there. We found many examples of logging sheets in which youth were released from the Life Safety Unit when staff was recording the youth's behavior as "youth out of control & a threat." Rarely was the "date out," "time out," or "cum. total" filled out on a youth's logging sheet. Often, if a youth is in the Life Safety Unit for more than 24 hours, dates are not even included on the logging sheets. Not only would documentation improvements lead to greater predictability in Maxey's disciplinary structure, but it likely would also inspire greater confidence in the system and be more effective as a deterrent and behavioral modification device.

3. Programming and Safety

Finally, we turn to the staffing shortages that Maxey is experiencing. We understand that the facility has been forced to operate with a minimal number of staff due to budgetary constraints and cutbacks. We also concede that understaffing — like overpopulation — is not itself a constitutional violation. But we flag this issue for the State because low staffing levels

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[3] The youth was allegedly simulating masturbation in front of another peer.

often interfere with the provision of programming and the protection of youth safety.

During our tours, we noted that pods, which house approximately 20 youths, were frequently understaffed. On January 13, 2003, the Pod Seven log book states, "6:40 no other staff on Pod . . . . Operations replied . . . yeah we know you're the only one . . . we're working on it. [Because of the] cover situation I am only allowing one group at a time to shower. Medication with [the] exception of controlled medication administered." On the same date in Pod Six, a staff member notes that they could not leave their pod to assist in an emergency call from Pod Seven because of minimal staffing. Entire units are confined to their hall or pod because all hall or pod staff are required to attend treatment team meetings, and there is insufficient "floating" staff to provide coverage.

Staff informed us that because of the lack of coverage, there is no formal shift report. This omission creates a very dangerous situation as it renders the unit log book as the chief communication device for documenting the unit activities and culture of the previous eight-hour shift. The unit log book, however, is, at best, a cursory summary of comments from staff. It should not be used as the primary tool for communicating important information. Moreover, many staff do not have the time to read the unit log book before they start their shift and thus never receive important shift information.

Finally, Maxey's staff told us during our tours that staff shortages often limit programming. For example, recreational activities and level privileges are all impaired by the current staffing levels. Similarly limited is the observation of suicidal youth; as a consequence, such youth are isolated and transferred to the Life Safety Unit. We emphasize once again that we are not suggesting that the problems flowing from these staffing shortages are necessarily *constitutional* violations. But they are inconsistent with generally accepted practices in juvenile justice facilities, and the State would be wise to take whatever steps necessary to address the issue.

B. EDUCATION

Maxey's education program does not satisfy the federal statutory requirements applicable to disabled youths confined at the facility. Accommodations required by Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794, for example, are grossly deficient. Moreover, numerous special education mandates set forth in the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 et seq., are being violated, including those requiring the identification of youth eligible for special education, the evaluation of the specific special education needs of youth, the development of an individualized program for the youth, and the delivery of special education services.

1. Section 504

Section 504 prohibits discrimination against individuals with physical or mental impairments that substantially limit their participation in one or more life activities (including

education). Key v. Grayson, 179 F.3d 996, 1000 (6th Cir. 1999) (holding that Section 504 applies to correctional institutions). To comply with Section 504, Maxey must develop accommodations for students with qualifying disabilities, including those individuals with short-term or chronic medical conditions that could impair their ability to learn.

In general, to meet the requirements of Section 504, there must be regular meetings between education and other personnel (typically medical staff) to identify youth with qualifying conditions, design strategies to accommodate the students' needs, and ensure that those strategies are implemented and effective. Parents must also be notified of their child's eligibility for Section 504 services.

Maxey makes little pretense about its adherence to Section 504. While the education director was fully aware of the Section 504 requirements, he acknowledged that Maxey has no policies or procedures to satisfy these statutory mandates, and in facts makes no effort to provide its students with services required by Section 504.

2. Special Education

The IDEA requires that schools have policies and procedures to ensure that "all children with disabilities . . . who are in need of special education and related services, are identified, located and evaluated." 20 U.S.C. § 1412(a)(3)(A). Once a student is determined to require special education and/or related services, and is properly evaluated, an individualized education program ("IEP") must be developed and implemented. 20 U.S.C. § 1414(d). In contravention of the IDEA, Maxey fails to identify and evaluate students for special education needs, develop appropriate IEPs, or provide required special education services.

a. Screening

To identify adequately all youth at Maxey who require special education services, the facility must recognize youth who have been previously certified as requiring such services. Additionally, it must have a process to identify students who have not been previously certified, but who in fact do have qualifying disabilities and are thus currently eligible for special education services.

Maxey fails to ensure that it is identifying students who were previously receiving special education services. Adequate identification procedures depend on a reliable mechanism for securing school records from the youth's prior placements. Maxey, however, lacks any such mechanism. It is likely, therefore, that youth who have been previously declared eligible are not identified as such.

Maxey also fails to identify adequately students who had not been *previously* certified as requiring special education services, but who should be so identified now. While Maxey does have an informal referral procedure for students who may need special education services, it is

not sufficiently structured to ensure that youth are not missed. There is no formal procedure for identifying youths struggling in general education programming, developing modifications designed to support those students, monitoring and evaluating their success, or testing the students for special education eligibility if the modifications fail to solve the problem. Moreover, prior education records need to be systematically reviewed for signs that special education services are required. We reviewed, for example, the special education file of a student who was not referred by Maxey for special education eligibility evaluation, even though his records stated that he had been referred for such an evaluation at a previous placement (a referral that had not been completed).

b. Evaluation and Certification

Maxey also fails to meet the IDEA's requirements for evaluating and certifying students once they are identified as potentially requiring special education services. In its efforts to comply with the IDEA's requirements regarding parental consent for special education evaluations, Maxey unnecessarily delays the evaluation of students. Maxey sends out an initial request seeking parental consent to an evaluation, but fails to adequately follow-up with unresponsive parents.[4] Several students at Maxey whose records we reviewed had been waiting over a year for the consent form to be returned. Another student had not been evaluated 18 months after the initial request had been mailed; this delay occurred even though various sources of information in his file documented that his custodial parents had essentially abdicated all responsibility for his care, thus allowing for the appointment of a surrogate parent to consent to an evaluation.

Such delays can and should be avoided. We reviewed the file of a student who had been waiting 11 months for parental consent for an evaluation. In the meantime, the student was not receiving any special education services despite clear indicators of eligibility. This denial of services was particularly troublesome because the student still had a current, valid evaluation in his file, making a new evaluation unnecessary. By making prompt, documented good faith efforts to seek consent, and by using surrogates when required, Maxey can eliminate these long delays.

Even where consent is obtained, Maxey still fails to conduct the required evaluations in an adequate fashion. Rather than using a battery of tests to describe a student's level of

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[4] Under federal and state law, youth who have been previously identified as eligible for special education services can be evaluated after reasonable good-faith documented attempts to obtain consent from the parents. 34 C.F.R. § 300.505; Mich. Admin. Code R 340.1721. For youth who have not previously been identified, consent is required, but a surrogate parent may be used after reasonable good-faith attempts to obtain parental consent have occurred. 34 C.R.R. § 300.515; Mich. Admin. Code R 340.1725f.

intelligence, skill in processing information, use of language, perceptual abilities, and emotional development, Maxey often relies exclusively on in-depth clinical interviews. A clinical interview is not sufficient to measure the aspects of cognitive functioning listed above. A comprehensive evaluation is critical to identifying correctly all disabilities for which the youth requires services.

Finally, Maxey changes students' certifications of eligibility for services without sufficient justification. For example, one student was certified as being "learning disabled" in his previous placement, but Maxey re-certified him as being "emotionally impaired" without explaining why it was making the change. Two other students had previously been certified as both "emotionally impaired" and "other health impaired." However, in each case, Maxey ignored the certification as "other health impaired," denying the student the services to address that condition. While it is appropriate to change the disability category based on an appropriate evaluation of assessment data, there is no justification in the record for the change in either of these students' cases, and no evidence that it was modified based on legitimate criteria.

c. IEP Development

The IEP is a critical document for ensuring that students receive the services required to address their special education needs. It must, among other things, identify a student's present level of performance, set measurable goals and objectives, and specify the related services and program modifications the student requires. To ensure that the IEP fulfills these functions, it must be developed by an interdisciplinary team. Maxey fails to satisfy these content and procedural requirements and, in the process, provides its students with inadequate IEPs that impair the proper delivery of special education services.

In general, the IEPs developed by the Maxey team are not sufficiently detailed to provide a comprehensive picture of the student, the way his disability affects his participation in the curriculum, his strengths and weaknesses, and the way in which services will be organized to support progress toward goals. Although the content of the IEPs differ from one another and do not suggest rote preparation, they fail to include the depth of information required by the IDEA.

For example, one student's IEP did not include any information in the "Present Level of Performance" section other than the student's standardized test scores. Standing alone, these results are insufficient to establish an understanding of the youth's current challenges. Furthermore, despite the fact that this student was certified as "emotionally impaired," none of his goals were related to addressing this disability. Similarly, despite the fact that Maxey provides a comprehensive array of transition services, the transition section of another student's IEP was vague and lacked any concrete information about the student's preferences and what services would be engaged to support them.

Some IEP documents did not confirm participation of all of the parties who are required to attend an IEP meeting. Despite the fact that all of Maxey's students (as explained in more detail below) have at least some involvement in the general education program, many of the IEP

meetings were not attended by a general education teacher. Particularly in the case where a student is served primarily in the general education setting, it is essential that the general education teacher actively contribute to the assessment of the individual's needs and the development of a concrete IEP plan to address those needs.

Finally, Maxey consistently fails to provide reports to parents regarding their children's progress in IEP goals. This communication is an explicit requirement of the IDEA. While Maxey reliably provides parents with their children's grades each semester, those reports do not include information pertaining directly to the individual goals and objectives contained in each student's IEP. An expansion of current grade and progress reporting is required to comply with federal law.

d. Service Delivery

Finally, Maxey's special education program fails to provide its students with the full range of services they require. The IDEA requires that Maxey furnish its students with a continuum of placement options that may include consultative (where a general education teacher provides instruction but receives regular consultations from a special education teacher); collaborative (where the special education and general education teacher provide instruction in tandem in a single classroom); resource (where the student spends part of the day in a special education classroom and the majority of the day in a general education classroom); and self-contained (where the student spends more than half of the day in a special education classroom and therefore has limited exposure to his non-disabled peers). The specific model of service delivery must be selected based on each student's needs, and schools must make available all models its students require.

A Maxey student's school schedule is determined almost entirely by the housing pod or hall to which he is assigned. Yet only eight of the twelve teachers who teach general education have some form of special education certification. As a result, whether a student is being taught by a certified special education teacher depends entirely on whether he is on a pod or hall that is taught by one of the eight special education teachers. Moreover, teachers and administrators told us that there are no qualitative differences in the type of instruction provided to special education students, as opposed to general education students.

This class placement process, which disregards education criteria, prevents the IEP document and process from being used as the IDEA mandates, i.e., to guide decisions about special education service delivery. The IEP committee's decisions about the level of special education services to be provided appear to be based entirely on the one service delivery model available at Maxey (consultative), rather than an assessment of individual need. In other words, because Maxey only provides the consultative option, it deprives those individuals who require a collaborative, resource, or self-contained model from receiving the higher level of service.[5]

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[5] Even for those students who only require consultative placement, Maxey's implementation of this placement option is flawed. The consultation focuses primarily on those students with upcoming IEP committee meetings. Students for whom an IEP

A review of records confirms that students at Maxey are suffering this kind of service deprivation. For example, one student's IEP from his previous school required that he be placed in a self-contained program for "emotional impairment." However, the IEP created at Maxey reduced the level of service to one segment of special education and four segments of general education per day, with no apparent justification. Another student's IEP from his previous school required that he be placed in a special education classroom for all classes. The IEP developed at Maxey placed him in general education for 50% of the school day and in special education for the other 50%. This change was not justified anywhere in the IEP document.

These records demonstrate not only that Maxey reduced these youth's level of service without proper written explanation, but also that Maxey failed to provide even the lower level of service required by the revised IEP. Indeed, inasmuch as Maxey only provides the consultative model and offers services based solely housing assignment rather than educational need, it simply cannot provide the mix of services required even by these revised IEPs. For example, it cannot provide a student half a day's instruction in a general education classroom and half a day's instruction in a special education classroom (which would be a resource placement) because it only provides the consultative model.

In regard to the provision of related services, a number of the IEPs of Maxey students that were created during prior placements indicate the need for specialized counseling from a school counselor or school social worker. Maxey does not have a school counselor or school social worker. Maxey does have social workers assigned to each housing group. If properly trained in working with students with disabilities and implementing IEPs, the existing social workers may be able to provide these services. However, there is no indication that this is being done, leading to the conclusion that these related services were simply discontinued without justification.

C. MEDICAL CARE

Maxey fails to provide youth with adequate medical care. This failure results from deficiencies in the provision of care and the absence of an effective sick call system. See Horn v. Madison County Fiscal Court, 22 F.3d 653, 660 (6th Cir. 1994); Danese, 875 F.2d at 1243.

1. Provision of Care

Maxey fails to receive sufficient medical history information about youth entering the facility. It also fails to assess adequately their medical condition or document their medical history. There are also deficiencies in the facility's medical charting system. These documentation failures render the facility's provision of medical care inadequate.

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committee meeting is not forthcoming are rarely the subject of these consultations.

a. Inadequate Intake Health Screening

A complete medical screening of new admissions is required to provide adequate medical care. Maxey's policy properly requires that all students receive an initial intake health screening (including the taking of medical history) and a physical examination (including lab tests). Yet the charts we reviewed demonstrated widespread non-adherence to this policy.

While youth receive adequate physical examinations soon after admission, they do not consistently receive required lab work. Facility policy requires that all youth be given a urinalysis and a tuberculosis screening upon intake. However, none of the charts we reviewed had evidence of a urinalysis being obtained and some of the charts did not indicate that a tuberculosis screening had been done.

We were told by medical staff that, at best, only one-third of the new admissions to Maxey have accompanying health records. For example, one youth informed staff upon his arrival at Maxey that he was on coumadin, a potentially lethal blood thinner. But Maxey received no records to explain his diagnosis or treatment plan. In another case, a youth with hemophilia was admitted without any medical records. This omission is glaring in light of the fact that records are particularly critical to understand the seriousness of the disease, and whether there needs to be restrictions on the youth's activity while at the facility. In addition, youth with diabetes and asthma have arrived at the facility without any records regarding these serious diseases. We recognize that it often may be difficult to obtain such records. But the need for this documentation is extremely significant and Maxey lacks an effective system for seeking this information.

b. Charting

Maxey's medical record-keeping system is also inadequate. Where appropriate, all medical and mental health encounters should be documented in a single medical chart in order to ensure proper care and to prevent adverse drug interactions. However, at Maxey, only medical staff are permitted to chart in the medical record.[1] Neither the psychiatrists, who prescribe a range of psychotropic medications, nor the security staff (who serve as the "first responders" in the event of an emergency or an illness during hours when medical staff are not available) provide any information for the medical chart.

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[1] Medical health services at Maxey are provided through a contract with Secure Care, Inc. Secure Care provides the facility with a doctor who works 15 hours per week and serves as Maxey's Medical Director. In addition to the Medical Director, there is a Registered Nurse and a Licensed Practical Nurse who each work 40 hours per week.

As a result of this system, the use and reasons for the use of anti-psychotic medication are not always clearly documented in the medical chart. A youth may be prescribed a psychotropic medication by a psychiatrist for a mental illness or for a contraindicated use,[2] but because the medication would not be documented in the medical chart, the facility physician could be unaware of the existence, purpose, or reason for the medication. This leads to a dangerous situation where follow-up on medical care may not be done, or adverse drug interactions may occur.

2. Sick Call

In order to provide adequate medical care, youth must be able to communicate directly and confidentially with medical and mental health staff. During our visit, we encountered a variety of "sick call" systems in the facility, none of which permit direct and confidential contact with medical providers. Some staff required youth to complete a written request form in order to get an appointment with the doctor, while others took medical complaints orally and then submitted them to the clinic as they deemed appropriate. Still others explained that they document requests to see the doctor in the daily activity log and then the appropriate staff member communicates this request to medical staff. The failure to have an adequate sick call system encourages youth to withhold critical requests for medical appointments rather than give up their right to privacy by sharing confidential medical information with direct care staff. Also, staff who do not have medical training may inappropriately screen requests for medical treatment.

We are not suggesting that youth must have immediate, direct, and confidential access to a medical provider at any time. Indeed, the sick call system in place at Maxey may be perfectly adequate at times. But there needs to be adequate opportunities for youth to communicate directly and confidentially with a health care provider without first going through a screening process that sacrifices the youth's privacy on the most sensitive of medical issues.

E. MENTAL HEALTH

Maxey fails to provide adequate mental health care. Specifically, Maxey fails to treat adequately youths with severe mental illnesses, lacks important protocols for psychotropic medication, and does not provide treatment planning tailored to the needs of the individuals with mental illness.

1. Youth with Severe Mental Illness

During our tour, we encountered at least two youths who suffered from mental illness too severe to be adequately treated or safely housed at Maxey. Maxey has a policy regarding

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[2] Psychotropic medication may be used for behavioral management in the non-psychotic youth or for sleeping disorders.

involuntary hospitalization, but it was not being implemented for these youths. As a result, both staff and youths were exposed to heightened degrees of danger. Furthermore, because of the manifestations of their mental illnesses, the two individuals in question were regularly isolated in the Life Safety Unit and subjected to all of that Unit's restrictions. In effect, they were punished for their disability. This is not a proper method of treatment. Maxey must either transfer such youths to a more appropriate facility, or provide the higher level of care that they require.

2. Psychotropic Medications

The care of youth on psychotropic medications requires proper assessment and management by a psychiatrist. Based on our review, both the management of youth on psychotropic medications as well as the administration of psychotropic medications are seriously deficient at Maxey.

First, individuals who have been prescribed psychotropic medication prior to their admission to Maxey are automatically continued on those medications until they are seen by a facility psychiatrist. This means that instead of verifying the medication and obtaining a verbal order from one of the Maxey's psychiatrists (thus sanctioning the use of the medication until the youth can be seen for an in-person evaluation), the medical staff assumes that the youth is taking the medication pursuant to a valid prescription, and that it is being prescribed for the appropriate reasons. This practice is particularly dangerous because, as discussed above, in a majority of cases, the medical records do not accompany the youth to Maxey. We saw many cases where youths were admitted with a history of taking psychotropic medications, but without medical records to document diagnosis, side effects, or past efficacy of treatment efforts.

Second, Maxey does not have protocols for periodic reassessment or monitoring of youths on psychotropic medications.[3] The frequency of psychiatric follow-up is left to the clinical judgment of individual psychiatrists. We found a wide range of follow-up frequency, from several weeks to over 60 days. A minimum standard should be set. Moreover, many of these medications require laboratory tests prior to and during the course of the treatment. Yet we found no protocols for the administration of appropriate tests to monitor the efficacy and side effects of psychotropic medications in accordance with professional medical standards.

Third, Maxey uses non-medical staff to dispense medications. Given that the staff have no training in pharmacology, side effect recognition, psychological aspects of medication compliance, or symptom management, this practice places both the youth and the facility at great risk. Furthermore, several of Maxey's medical providers expressed concern with this policy.

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[3] Maxey also lacks a formal policy regarding youth and/or parental consent to medication. Staff gave various answers when asked about the facility's practice regarding consent, evidencing the absence of a consistent practice.

We observed several occasions where medical personnel took it upon themselves to dispense especially dangerous medications.

3. Treatment Planning

Upon admission to Maxey, each youth is given a "Residential Treatment Plan." This plan is supposed to be produced by the social workers, with input from other members of the treatment team.[4] It appears that this plan is meant to serve as the master plan for the mental health services provided to each youth. Unfortunately, these plans are boilerplate in their approach to mental health care and fail to document comprehensively, or capture accurately, a youth's clinical condition or list treatments specially designed to address the condition.

Moreover, beyond the deficiencies in the "Residential Treatment Plan," the lack of communication and clear lines of authority between staff hampers Maxey's ability to provide a coordinated response to a youth's mental health needs. The psychologist and psychiatrist each perform their own assessment, set their own goals, and devise their own treatment plans, which are often unrelated to the Residential Treatment Plan. Further, because of the lack of clear lines of authority within the treatment team, no member of the team is obligated to follow any of the psychologist's or psychiatrist's assessments.

These practices lead to inconsistent and deficient mental health treatment for youths. For example, in one treatment team meeting in April 2003, it appeared that the program manager was nominally in charge, but the entire team spoke at will and without direction. There was no organized information sharing on the youth. Neither the psychiatrist nor psychologist attended the entire team meeting. The social worker appeared to take notes that evidently were to be incorporated into an updated treatment plan. However, there was never a consensus from the team as to which aspects of the discussion would in fact be incorporated into the youth's treatment plan. Of most concern in the treatment team meeting was when the youth under discussion was asked to sit with the treatment team. What proceeded was a disorganized and destructive questioning of the youth by various
members of the team. Individualized care and treatment planning are necessary to ensure that treatment goals for individuals with serious mental health needs are identified and addressed, and that service among various systems is coordinated.

a. Clinical Supervision

Maxey does not have a policy regarding clinical supervision, adding to the deficiencies in treatment planning described above. The clinical director's function is administrative, rather than clinical. Moreover, as she readily admits, she does not have the educational qualifications

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[4] The treatment team consists of a program manager, social worker, youth specialist, general education teacher, psychiatrist, and psychologist.

to provide any direct clinical supervision. The absence of any type of clinical supervision was confirmed by all members of the multi-disciplinary staff. As with the lack of clear lines of authority within the treatment teams, the absence of clinical supervision leads to inconsistent care of varied quality being provided to the youth.

b. Maxey Model

The "Maxey Model" is the framework from which all treatment proceeds. The Model is a cognitive behavioral approach for dealing with the issues that brought the youth to the attention of the juvenile justice system. Regrettably, there has never been a systematic review of the model to evaluate its overall efficacy. This is especially problematic given its widespread application at the facility.

In addition, as noted above in the “Juvenile Justice Management” section, at least one aspect of the model, the peer restraint portion, is potentially physically dangerous and psychologically damaging to the youth involved. Furthermore, the model has never been normed for use with youth with mental illness and/or cognitive impairment. The model sets very high behavioral and performance standards. A youth will receive sanctions if he is not able to perform adequately up to these standards. This occurs even if his lack of performance is due to mental illness and/or cognitive impairment. The result is often the loss of privileges and freedoms. Unfortunately, Maxey has no formal policy allowing for any modification of the model for youths with a mental illness and/or cognitive impairment. Such reasonable modifications are required by the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12131. See Pennsylvania Dep’t of Corrections v. Yeskey, 524 U.S. 206, 213 (1998) (ADA requires reasonable modifications for those who are incarcerated); see also Key, 179 F.3d at 997-98 (finding that ADA applied to claim that disability prevented inmate from participating in group therapy session, but dismissing based on qualified immunity).

F. FIRE SAFETY

There is "no question" that deficiencies in fire safety can violate the constitution. French v. Owens, 777 F.2d 1250, 1257 (7th Cir. 1985); see also Standish v. Bommel 82 F.3d 190, 191 (8th Cir. 1996); Hoptowit v. Spellman, 753 F.2d 779, 784 (9th Cir. 1985); Santana v. Collazo, 714 F.2d 1172, 1183 (1st Cir. 1983).

Current fire safety protections in some buildings at Maxey are insufficient to allow for the safe evacuation of youth in the event of a fire. Unless these conditions are remedied, there is a substantial risk that any fire at the facility will cause a significant loss of life.

Sequoyah’s sleeping areas do not have a sprinkler system, smoke detectors, or a smoke evacuation system. Thus, should a fire start in this building, there are no sprinklers to spray water and therefore dampen any fire, smoke detectors to alert youth and staff to the presence of a fire, or a smoke evacuation system to remove smoke and the other deadly products of combustion from the corridors. As a result, by the time youth or staff were alerted to a fire, and

the staff could manually unlock each youth from his room (a process that would be complicated by flames, smoke and panic), there is a substantial risk that youth and staff would be killed by the flames and smoke.

The Maxey Academic Center ("MAC") also does not have sprinklers or smoke detectors, nor does it have emergency windows. Again, these conditions pose a grave risk that youth could not be evacuated in time in the event of a fire.

III. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional and statutory rights of the youth confined at Maxey, the facility should implement, at a minimum, the following measures:

A. JUVENILE JUSTICE MANAGEMENT

1. Ensure that restraints are only used in conformity with generally accepted standards.

2. Ensure that all uses of isolation are appropriate and consistent with applicable standards. This includes:

    a. developing and implementing consistent and appropriate policies, procedures, and practices for isolating youth for disciplinary purposes;

    b. reducing the use of isolation of youth without due process to only those circumstances in which it is necessary for the safety of the youth or others; and

    c. ensuring that youth are afforded sufficient due process before extended isolation for disciplinary purposes.

3. Develop and implement policies, procedures, and practices to document fully the use of restraints and isolation.

4. Develop and implement policies, procedures, and practices to create a formal and adequate grievance system.

5. Employ and maintain sufficiently trained staff to ensure programing and safety and develop and implement an effective shift reporting system.

B. EDUCATION

1. Create and implement policies and procedures to serve youth eligible for accommodations under Section 504 and ensure that these polices and procedures are consistently followed.[5]

2. Adopt procedures for identifying youth who were declared eligible for special education in a prior placement. This can include, in addition to promptly acquiring school records (as discussed above), telephoning the previous school district to confirm eligibility and to learn what services the student was receiving. This verification should occur, absent exceptional, documented circumstances, within three business days of the student's admission.

3. Screen and assess youth with previously unidentified disabilities. This includes reviewing education records and court-ordered assessments, and observing classroom performance. Such review should occur, absent exceptional, documented circumstances, within three days of the receipt of records.

4. Expedite the consent process for special education evaluations when parents are unresponsive. The facility should adopt a policy appropriately limiting the time interval it waits between attempts to gain consent, specifying that the facility may re-evaluate a previously identified student after reasonable good-faith attempts at obtaining consent have failed, and providing that a surrogate may be used after reasonable good-faith attempts to contact the parents of a child who has not previously been identified.

5. Ensure that all students referred for eligibility assessment receive comprehensive evaluations for all suspected disability categories and related services needs. This includes:

    a. clearly articulating assessment requirements for each category of disability;

    b. creating a checklist to ensure that all required education and psychological tests, behavioral observations, functional assessments, and social history information is compiled for each student.

6. Create IEPs that satisfy all requirements of the IDEA. This includes:

    a. clearly and adequately filling out each required section of the IEP; and

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[5] Many jurisdictions incorporate Section 504 responsibilities into an existing Student Support Team. This type of team is primarily responsible for identifying youth who require special education services, but have not previously been so identified.

b. providing additional training to facility staff on IEP completion including providing facility staff with concrete examples of quality IEP documents.

7. Ensure that all students receive the amounts of special education instruction, and all related services required by their IEPs (including school counseling).

8. Provide students requiring special education services with the full range of placement options, and ensure that all students receive a placement that meets their needs. Develop policies and procedures that articulate the differences between special education placement options; specify the circumstances in which each option is appropriate; and explain how to assess the level of service needed by individual students.

9. Provide that parents are sent all required notifications and progress reports regarding special education services.

C. MEDICAL CARE

1. Institute a system to obtain effectively medical records for youth entering Maxey.

2. Ensure that all youth receive adequate health screening including obtaining a medical history and conducting all required labwork.

3. Develop and implement a policy to ensure that all relevant and appropriate mental health and medical information is contained in one chart accessible to all clinicians who need such information.

4. Institute a confidential and effective sick call system.

D. MENTAL HEALTH CARE

1. Ensure that all youth with mental illness who cannot safely and appropriately be treated at Maxey are transferred to an alternative placement.

2. Develop and implement policies requiring appropriate medical authorization for the dispensing of psychotropic medication to new admissions; protocols for obtaining youth and/or parental consent and for the reassessment and monitoring of psychotropic medication; and procedures that ensure that all psychotropic medication are dispensed by appropriately trained medical care staff rather than direct care staff.

3. Ensure that all youth with mental health needs have adequate and current comprehensive individual treatment plans that reflect the appropriate input of the youth and the treatment team.

4. Develop and implement policies, procedures, and practices to ensure adequate clinical supervision of mental health practitioners.

5. Develop and implement policies, procedures, and practices for treatment teams that clearly define the clinical and administrative lines of authority, and designate as the team leader the person with the highest clinical qualifications.

6. Cease placement of youth with mental illness in programs and units where they cannot receive adequate mental health care or where they face a likelihood of punishment or other harm in response to their mental illness.

7. Develop and implement policies, procedures, and practices for the modification of the Maxey Model for use with youth with mental illness and/or cognitive impairment, and conduct a systematic review of the Maxey Model to determine its efficacy.

E. FIRE SAFETY

1. Provide adequate fire safety protection in Sequoyah.

2. Provide adequate fire safety protection in MAC.

* * *

We hope to work with the State in an amicable and cooperative fashion to resolve our outstanding concerns regarding Maxey.

We will be sending our consultants' evaluations of the facility under separate cover. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations 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 Section 14141. The Attorney General may also initiate a lawsuit under CRIPA to correct deficiencies of the kind identified in this letter forty-nine 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 attorney to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ R. Alexander Acosta

R. Alexander Acosta
Assistant Attorney General

cc: The Honorable Mike Cox
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