

Settlement Agreement Between
The State of Maryland and the United States Department of Justice

FOURTH MONITORS' REPORT

For the Baltimore City Juvenile Justice Center (BCJJC)
For the Period of January 1, 2009 through June 30, 2009

Submitted by

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June 30, 2009

Monitoring Team Members' Areas of Responsibility and Tour Dates

Kelly Dedel, Ph.D.

Lead Monitor

Protection from Harm and Suicide Prevention

February 17-20, 2009

March 25-26, 2009

April 21-24, 2009

Peter Leone, Ph.D.

Education

February 12, 13, 17, 19, and 20, 2009

April 16, 20, 21, and 22, 2009

June 3 and 11, 2009

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Introduction and Major Findings

On June 29, 2005, the State of Maryland entered into a Settlement Agreement with the United States Department of Justice concerning the conditions of confinement at the Cheltenham Youth Facility (CYF) and the Charles H. Hickey, Jr. School (Hickey), two juvenile detention centers operated by the Maryland Department of Juvenile Services (DJS). A Monitoring Team was appointed to review, assess and report independently on the State's implementation of and compliance with the Settlement Agreement (the Agreement). In June, 2007, the State and the Department of Justice amended the Agreement to include the Baltimore City Juvenile Justice Center (BCJJC). The Parties agreed to a one-year timeline for reforms to be made at BCJJC. A total of 29 provisions spanned the areas of Protection from Harm, Suicide Prevention, Mental Health, Special Education, and Quality Assurance. The Agreement placed the burden of demonstrating compliance on the State, which needed sufficient documentation and other evidence to demonstrate the proper implementation of all policies and procedures.

During the initial one-year compliance phase, the State was able to reach substantial compliance with 18 of the 29 provisions, including portions of the Suicide Prevention section and the entire Mental Health and Quality Assurance sections of the Agreement. However, the State did not reach substantial compliance with several of the Protection from Harm provisions, a few of the Suicide Prevention provisions, and some of the Special Education provisions. As a result, the Agreement was extended, giving the State an additional 12 months to reach substantial compliance on the remaining 11 provisions in these areas. The new expiration date for the Agreement is June 29, 2009.

This is the Fourth Monitors' Report covering the period January 1, 2009 through June 29, 2009. The Monitoring Team is comprised of Dr. Kelly Dedel (Protection from Harm and Suicide Prevention) and Dr. Peter Leone (Special Education). The report is organized as follows: using the numbering system from the Agreement, each of the remaining 11 provisions is provided, verbatim, followed by a compliance rating for the period, a discussion of the Monitors' findings, recommendations for reaching compliance, and the evidentiary basis for the Monitors' conclusions. Three compliance ratings were developed jointly by the Parties:

- Substantial Compliance. Substantial compliance with all components of the rated provision. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain sustained compliance. At the same time, temporary compliance during a period of sustained non-compliance shall not constitute compliance. The standards against which compliance will be assessed are those that are constitutionally required and required by Federal statute. Adherence to best practice is not required to achieve compliance with the Agreement.
- Partial Compliance. Compliance has been achieved on most of the key components of the provision, but substantial work remains.
- Non-Compliance. Non-compliance with most or all of the components of the provision.

The State is in substantial compliance with 5 of the 11 provisions (45%) in the amended Agreement and in partial compliance with 6 provisions (55%). None of the provisions was in non-compliance.

Table 1. BCJJC Rates of Compliance as of June 30, 2008				
Area	Total Provisions	Substantial Compliance	Partial Compliance	Non-Compliance
Protection from Harm	5	1 (20%)	4 (80%)	~
Suicide Prevention	3	3 (100%)	~	~
Special Education	3	1 (33%)	2 (66%)	~
TOTAL	11	5 (45%)	6 (55%)	~

Ratings on individual provisions are listed in Table 2 below.

Table 2. Individual Compliance Ratings		
No.	Provision	Rating
Protection From Harm		
III.B-1.i	Protection from Youth on Youth Violence	Partial Compliance
III.B-1.ii	Reporting of Youth on Youth Violence	Partial Compliance
III.B-1.iii	Senior Management Review	Partial Compliance
III.B-1.iv	Behavior Management Program	Partial Compliance
III.B-1.vi	Staffing	Substantial Compliance
Suicide Prevention		
III.C-1.i	Implementation of Policy	Substantial Compliance
III.C-2.iii	Supervision of Youth at Risk of Self-Harm	Substantial Compliance
III.C-2.v	Documentation of Suicide Precautions	Substantial Compliance
Special Education		
III.F-1.i	Provision of Required Special Education	Partial Compliance
III.F-1.ii	Screening and Identification	Substantial Compliance
III.F-1.iv	IEPs	Partial Compliance

In its Findings Letter issued August 7, 2006, the DOJ cited a number of dangerous conditions and practices at BCJJC. Many of these have been cured through the diligent efforts of DJS, BCJCC, and MSDE staff. Among the deficiencies the State has ameliorated are:

- **Staffing**. The DJS has reduced the vacancy rate among direct care positions from an astounding 42 % in the latter part of 2004 to less than 5 % throughout the first half of 2009. Staffing difficulties were eased by the reduction in facility capacity from 144 to 120 beds.
- **Staff Training for Direct Care Staff**. DJS training curricula now meet contemporary standards in terms of both content and intensity. Direct care staff undergo a 120-hour Entry Level Training to acquire essential skills in de-escalation, physical restraint, CPR, child abuse reporting, and suicide prevention, among others. These skills are refreshed via a 40-hour in-service training each calendar year.
- **Environmental Security Hazards**. The DOJ's findings letter cited a variety of incidents in which youth used chairs, broomsticks and sharpened toothbrushes as weapons, thereby increasing the risk of serious injury from youth-on-youth violence. The facility has taken affirmative steps to identify items posing a security hazard and to control access to or replace them with safer alternatives. Further, the units' stairway railings were fitted with Plexiglas barriers and all rooms were fitted with suicide-resistant bunks, which significantly reduce the likelihood of a serious suicide attempt.
- **Medical Attention Following an Incident**. Youth routinely receive prompt medical attention following their involvement in a serious incident.
- **Boys and Girls Club**. DJS contracted with the Boys and Girls Club to provide culturally competent programming for the youth at BCJJC. All youth attend the BGC at least twice per week, and the programming is consistently rated by both youth and staff as the facility's strong suit.
- **Limits on the Use of Seclusion**. The facility's use of seclusion now complies with State law in that it is used only as a method to reduce tensions following an incident and its duration is no longer than necessary to fully de-escalate the youth involved.
- **Supervision of Youth At-Risk of Self Harm**. Direct care staff consistently supervise youth at elevated risk of self-harm to ensure they cannot obtain dangerous implements and to monitor their emotional state. In addition, staff effectively use the facility's GuardTour system to verify the safety and welfare of all youth while locked in their rooms overnight.
- **Mental Health Care**. DJS entered into an effective partnership with Hope Health Systems to provide high-quality screening, assessment and on-going treatment of youth with mental illnesses and those at elevated risk of self-harm. Hope Health staff communicate effectively with DJS direct care staff to ensure adequate protection of these youth.
- **Screening and Assessment for Special Education**. The Maryland State Department of Education (MSDE) effectively screens and identifies youth who are eligible for special education services, ensuring that these students do not enter the BCJJC school program without needed supports.
- **Involving Parents in Special Education Decision Making**. Teachers consistently invite parents to participate in planning the special education program for their children.

- **Classroom Enhancements.** The available instructional space improved during this reporting period with the addition of one new classroom and new office space. For the first time since it opened in September 2003, the number of classrooms appears to be adequate for the population of youth currently detained at BCJJC.
- **Quality Assurance.** DJS's Quality Improvement team conducts high-quality audits of facility operations on a semi-annual basis and assists the facility in constructing Improvement Plans to rectify any identified deficiencies.

While the facility has implemented a wide range of significant reforms, additional steps are needed to fully meet the requirements of the Agreement. These are discussed in detail within each of the remaining 9 provisions that make up the body of this report and are summarized below.

Protection from Harm

- The State is in substantial compliance with 1 of the 5 provisions (20%) related to protecting youth from harm. It is in partial compliance with the remaining 4 provisions (80%).
- Incident reports are the primary vehicle for analyzing the underlying causes of youth-on-youth assaults and group disturbances so that effective prevention strategies can be crafted. If they are to be effective toward this end, incident reports must provide a complete and accurate record of what occurred. Most do not yet include sufficient detail to enable supervisors to identify the circumstances surrounding the incident and the situation that may have created the opportunity for violence to occur. A number of incident reports were identified in which staff did not accurately and completely recount the events that occurred.
- Because the incident reports often lack essential details, Shift Commanders' reviews were limited to a discussion of the sparse details contained in them. Improvements to incident report content will allow Shift Commanders' reviews to delve deeper into the underlying causes of the incident. If reviews are to be helpful to staff and to the objective of reducing violence, they must identify the specific decisions made or actions taken that either promoted or compromised youth safety so that staff can refine their responses. Further, senior managers' audits were not completed consistently throughout the monitoring period. When they were completed, staff were often non-responsive to requests for corrections. The review process, therefore, did little to enhance staff supervision skills.
- Although behavior management program records are complete and well organized, they reveal serious gaps in accountability for youth who are involved in assaultive behavior. Other than point deductions, no meaningful consequences for misbehavior have been implemented. Although levels of increasing privilege are articulated in the program, youth and staff report that in reality, the levels are rather indistinguishable and therefore are a weak incentive for youth. On the whole, the lack of integrity in implementation renders the behavior management program ineffective for many youth.
- Although the facility remains in substantial compliance with the provision related to staffing, serious concern remains about the frequency with which staff call-out (i.e., do not report for their shift) and the frequency with which staff

are held over to work a second 8-hour shift. Particularly with new and inexperienced staff, the quality of youth supervision suffers when staff are tired, frustrated, or otherwise feel unsupported.

Suicide Prevention

- The facility has achieved substantial compliance with the 3 remaining provisions related to suicide prevention (100%).
- The facility has established procedures for supervising youth on suicide precautions and for documenting these observations. Suicide logs maintained by Hope Health staff provide a complete chronology of the youth's movement up and down the levels of suicide precautions and offer clear guidelines for direct care staff in managing these youth.
- Procedures for ensuring the well-being of youth in high-risk settings (e.g., locked in a room, by themselves) are followed consistently. Seclusion observation forms and GuardTour reports indicate that welfare checks are done at the required intervals throughout the period of time youth are locked in their rooms.

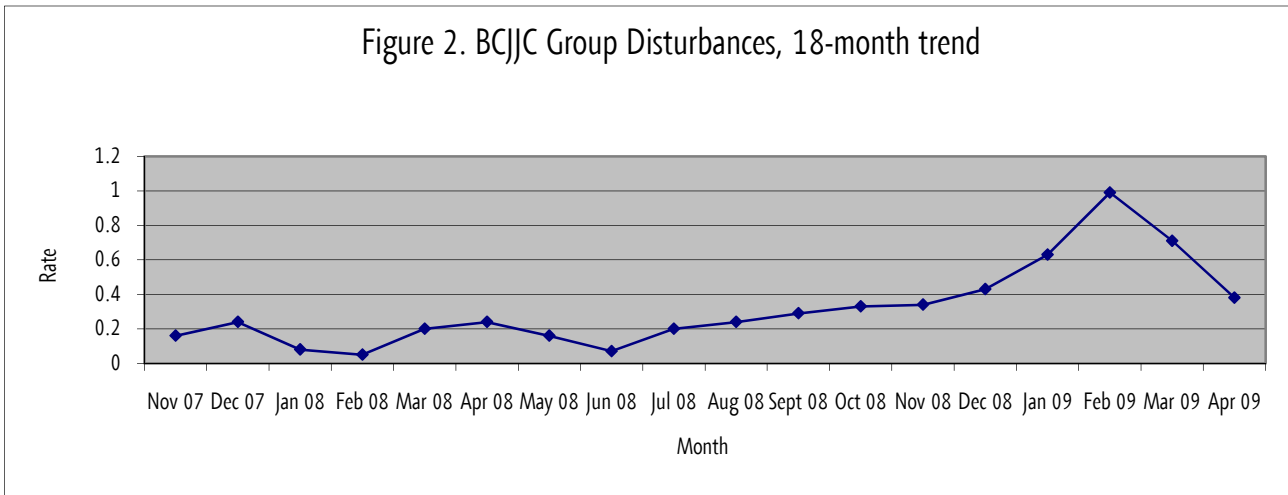
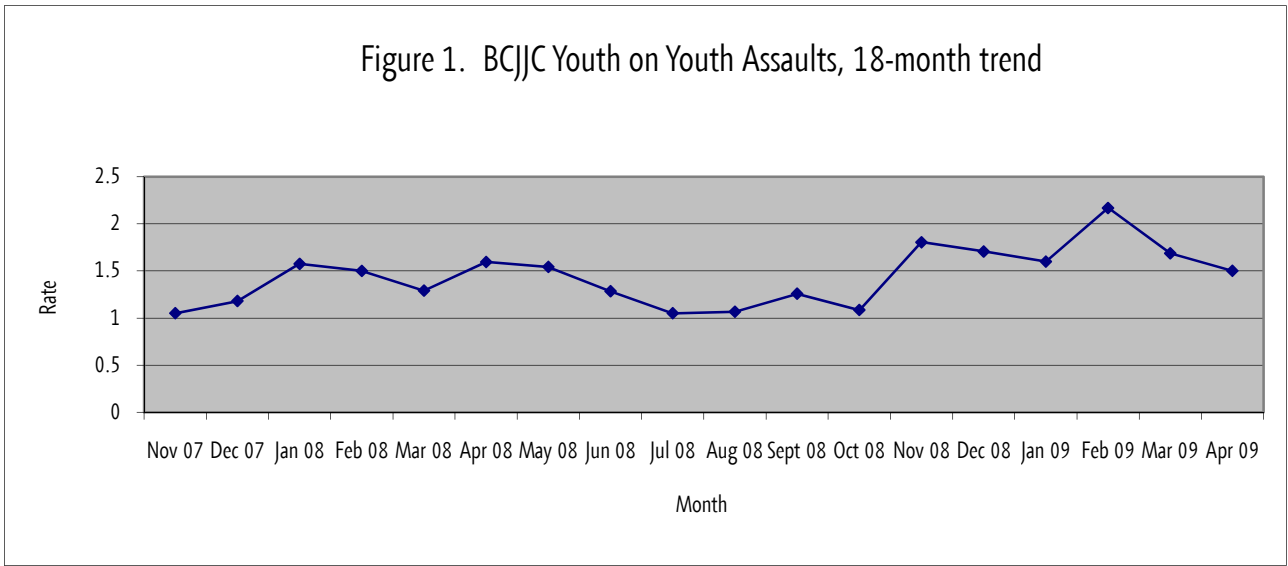
Special Education

- The State continues to be in substantial compliance with 1 of the 3 remaining provisions (33%). It remains in partial compliance with the other 2 provisions (66%).
- A number of very positive changes have occurred in the schools at BCJJC since the last reporting period. Morning meetings between DJS and MSDE staff to review the status of students are now held daily.
- In several classes, students are receiving high quality instruction and are actively engaged. DJS staff has assumed a more active role in supporting instruction and assisting students.
- The primary impediments to substantial compliance on the remaining two issues are teacher vacancies and absenteeism. Because of teacher and instructional assistant absenteeism, classes are canceled on a regular basis.
- A special education teacher vacancy was filled during this period but three professional positions – a media specialist/librarian, math teacher, and computer teacher – remain vacant although MSDE has interviewed candidates for these positions. Two of these vacancies remain from the summer of 2008 and one from September 2008. As a consequence of these vacancies and high rates of absenteeism among teachers, some special education staff has primary responsibilities teaching in other areas.
- There is greater accountability for the arrival of units on time for school though late breakfast and late lunch on occasion results in units missing the first period class in the morning or the first period after lunch. The four DJS staff stationed in the school wing continues to have a very positive effect on the school and students' behavior. In spite of best efforts of these staff, some youth and some units create behavior problems in school.

- Earlier reports noted that some students refused to attend special education classes. While this problem has improved somewhat, the high rate of staff absences and variability in teachers assigned to specific courses compounds the problem of getting students to their assigned classes.
- Following the publication of the draft of this 4th Monitors' Report, the Maryland State Department of Education (MSDE) submitted a letter outlining concerns with several of the findings. Dr. Leone revisited each of these issues, reviewing documents and interviewing staff, and ultimately reconfirmed his initial findings.

Protection From Harm

<p>¶ III.B-1.i</p>	<p><u>Protection from Youth-on-Youth Violence.</u> The State shall take all reasonable measures to assure that youth are protected from violence by other youth.</p>
<p>Compliance Rating</p>	<p>Partial Compliance</p>



<p>Discussion</p>	<p>All of the subsequent provisions—incident reporting, behavior management and staffing—are oriented toward a common goal: reducing the rate of youth-on-youth assaults and group disturbances. As shown in Figure 1, above, the rate of youth-on-youth assaults has increased significantly since</p>
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November, 2008.¹ The average rate for the past 6 months is roughly 27 % higher than the average rate for the preceding 12 months. Similarly, the rate of group disturbances has increased markedly since January, 2009 (see Figure 2). The average rate for the past 4 months is roughly 205 % higher than the average rate for the preceding 12 months.

Several things contribute to these trends. First, although the facility assigns the proper number of staff to housing units to meet required staffing ratios (see III.B-1.vi), BCJJC is plagued by endemic levels of call-outs (i.e., staff who do not report for their scheduled shift). When this occurs, staff currently on shift must be held over to work a second shift so that required ratios can be maintained. Staff reported that they work an average of 3 double shifts per week. Their exhaustion and inability to attend to their personal lives was staff's top complaint about their jobs. Indeed, a review of facility staffing during February, March and April, 2009 revealed an average of 4 call-outs per shift, for three shifts per day. This means that each day, an average of 12 staff are required to work double shifts to cover the call-outs. On top of this, additional staff may be held-over to cover for staff vacancies (approximately 2 throughout the monitoring period), staff on medical leave, suspension, or vacation. Administrators should identify the underlying reasons for call-outs and begin to address those within their control as soon as possible. Significantly reducing the rate of call-outs and hold-overs will likely improve the quality of supervision and therefore reduce the rate of youth-on-youth assaults and group disturbances at BCJJC.

The level of overtime duty compounds problems noted in the quality of youth supervision by direct care staff. Incident reports and videotapes are replete with examples of staff leaving their posts temporarily (i.e., providing an opportunity for youth to fight), failing to supervise the youth in their care (e.g., allowing them to go into another area without supervision) or hesitating to intervene in fights among youth. Improving staff supervision skills is essential to meeting the requirements of this Agreement.

As discussed in previous Monitors' Reports, the facility has not effectively analyzed the information available in incident reports to uncover patterns that contribute to youth-on-youth assaults and group disturbances. Such analysis is needed to accurately target the conditions that create the opportunity for violence to occur. Whether identifying youth at high risk of assaultive behavior, discovering vulnerable places in the facility, or identifying situations (e.g., following court appearances) in which frustrations are likely to run high, the facility must take a critical eye to the way in which violence manifests itself so that prevention strategies can be designed.

For example, two obvious themes emerged from the incident reports and videotapes reviewed during the April, 2009 site visit: a) multiple fights involving the same group of youth, with alternating roles of aggressor and victim, suggesting that efforts to mediate or resolve the underlying disputes were ineffective; and b) ineffective boundaries and security around the doors to units, pods, and classrooms, allowing youth to enter areas without authorization and assault other youth. Incident reports need to be sufficiently detailed to reveal these commonalities so that patterns can be identified. Targeted prevention strategies could significantly reduce the rates of assault and disturbances at BCJJC.

¹ These data were provided by DJS Research & Evaluation Unit on May 5, 2009.

	<p>Finally, the facility has yet to implement a behavior management program with sufficient integrity to deter negative behavior and encourage prosocial behavior. The program has no real consequences aside from point deductions, which many youth do not care about. More troubling is that the program lacks the ability to reward youth for the behaviors that staff desire or to teach youth the skills they need to tolerate frustration, resolve interpersonal disputes or resist peer pressure. As a result, the behavior management program is ill-equipped to reduce assaults and disturbances. (See III.B-1.v for a more detailed discussion of the behavior management program).</p>
Recommendations	<p>To reach substantial compliance with this provision, the State must:</p> <ol style="list-style-type: none"> 1. Develop and implement policies, procedures and documentation strategies sufficient to achieve compliance with the other Protection from Harm provisions. 2. Address staff call-outs and other reasons that staff do not report to work so that, except in emergency situations, staff are required to work only one shift per day, 5 days per week. 3. Provide on-the-job training to improve the quality of supervision of youth by direct care staff. Ensure that staffing ratios are maintained throughout the day; that staff are able to identify and intervene effectively in situations that result in youth-on-youth violence; and that staff are able to maintain the security of the facility at all times.
Evidentiary Basis	<ul style="list-style-type: none"> ▪ All documents, interviews, and observations listed in the subsequent provisions of the Protection from Harm section of this Agreement.

<p>¶ III.B-1.ii</p>	<p><u>Reporting of Youth-on-Youth Violence.</u> The State shall develop and implement appropriate policies, procedures, and practices to enhance the reporting to appropriate individuals of incidents of youth-on-youth violence and to provide that such reporting may be done through confidential means, without fear of retaliation for making the report. The State shall document and report appropriately and with sufficient detail all such incidents.</p>
<p>Compliance Rating</p>	<p>Partial Compliance</p>
<p>Discussion</p>	<p>As discussed in previous Monitors’ Reports, DJS’ Incident Reporting policy and training provide a solid foundation upon which to build staff skill in reporting incidents. Several excellent written tools were developed and a Report Writing in-service training has been implemented. A review of training records for current BCJJC staff revealed that approximately 65 percent participated in this training in the past 12 months. Ensuring that the other 35 percent of staff receive this training may increase the quality of the incident reports, as discussed in more detail below.</p> <p>The overall purpose of incident reporting is to inform facility administrators and staff about the situations (people, places, procedures, etc.) that appear to increase the risk of youth violence so that targeted prevention strategies can be developed. Incident reports (IRs) at BCJJC do not yet include sufficient detail to serve this function. Further, when comparing incident report descriptions to the corresponding video footage, it became clear that several incident reports omitted essential details (e.g., did not name and discuss all of the youth involved; did not account for all physical restraints; did not indicate that the youth involved were unsupervised in the case manager’s office for several minutes; etc.). Similar problems have been discussed in previous Monitors’ Reports. Had these details been included, Shift Commanders and senior managers who audit the incident reports would have been able to provide more constructive feedback to enhance staff skill in responding to similar incidents in the future.</p> <p>In addition to comparing approximately 15 written incident reports to the video footage, a larger sample of incidents reports were analyzed for their quality and completeness. Approximately 40 incident reports (IRs) were purposefully selected from those generated between January 1, 2009 and April 14, 2009 describing youth-on-youth assaults or group disturbances. A similar set of problems to those discussed in the previous Monitors’ Report were noted. (The lack of progress is likely related to problems with the supervisory reviews, as discussed in III.B-1.iii). Areas in need of improvement include:</p> <ul style="list-style-type: none"> ▪ <u>Contextual Information.</u> The IR format requests information on precipitating factors along with details about the event itself. The purpose of discussing the factors that precipitated the event is to highlight dynamics and actions that could have helped staff to anticipate or prevent the assault. Many staff interpreted this section very literally. For example, they stated that “youth were eating breakfast,” without mentioning that the same two youth had been involved in an altercation

the night before. While at times these immediate precursors can be helpful toward prevention efforts (e.g., they may suggest that a new showering procedure is needed), more often, assaults at BCJJC appeared to be catalyzed by events that happened hours or days before the incident actually occurred. Interestingly, many of these details can be found among staff's entries in the Unit Logs, indicating that they are aware of the tensions among youth. They simply need to import this information into the IR so that it can become part of the prevention strategy.

Further, additional details are needed regarding the altercation itself—who hit whom, how they were hit, whether contact was made, etc. These details are needed to ensure that the youth's injuries can be explained, particularly in the event of a child abuse allegation. Finally, a complete listing of staff who were present at the time of the event and who responded to the call for staff assistance is needed to ensure that all staff prepare and submit witness statements. Particularly in the case of group disturbances, these witness statements are essential to the task of piecing together what occurred during the incident.

- Physical Intervention. In approximately half of the IRs reviewed, staff did not discuss how they ultimately brought an end to the situation using only generic statements such as “staff responded to the call for assistance and broke up the fight.” These problems were noted both in the IR narrative and in the staff witness statements. Staff often said they “restrained” youth, but did not describe how. A new trend has emerged in which staff indicate they used “directive touch” to separate two youth fighting. “Directive Touch” is a new label used by DJS, but its meaning is unclear and its usage is inconsistent. Some staff use it to indicate they simply guided a youth when walking down the hallway by placing their hand on the youth's shoulder or back. Other staff use it to mean that they used physical intervention to stop two youth from fighting, but that the intervention is not one of the CPM techniques on which they have been trained (e.g., staff step between two fighting youth, place their hands on the youth's chests, and push them apart). While either situation is perfectly reasonable, the use of the phrase “directive touch,” without further explanation does not provide sufficient information to evaluate the safety and appropriateness of the staff's response. There will always be situations in which CPM techniques are not suited to the immediate task and thus staff will have to make decisions about how to intervene safely. Their actions in this regard must be fully described.
- Staff Witness Statements. Staff witness statements provide important supplementary information to the IR narrative. The individual writing the main report could not possibly observe and remember all of the actions taken by other staff who were present at the time or who responded to the call for staff assistance. However, a complete set of staff witness statements was not available in approximately two-thirds of the incident reports reviewed.

	<p>The multiple layers of IR review need to identify and respond to these deficiencies so that a complete record of each assault and group disturbance can be analyzed for factors that contributed to their occurrence.</p> <p>Ensuring that youth receive prompt medical attention is another way to reduce the harm sustained by youth involved in physical altercations. Across the 40 IRs reviewed, a complete “Body Sheet” was located for all of the youth involved, indicating that they received medical attention at some point following the incident. Policy dictates that youth must receive an assessment of injury by a medical professional within two hours of the incident. About 90 percent of the IRs reviewed met this threshold, a marked improvement from the previous monitoring period.</p> <p>A well-written incident report will not reduce violence by itself, but high-quality incident reports are essential tools for any effort to reduce the rate of youth-on-youth assaults. These reports must contain the information needed to understand the causes of youth violence and to craft strategies and interventions that are properly targeted. Producing high-quality incident reports and analyzing the information contained in them are essential steps to reducing assaults and disturbances at BCJJC.</p>
Recommendations	<p>To reach substantial compliance with this provision, the State must:</p> <ol style="list-style-type: none"> 1. Ensure all staff receive adequate training in the mechanics of incident report writing. 2. Ensure that all incident reports contain detailed and complete descriptions of the event and staff’s responses to it. Simultaneous review of incident reports and videotape footage could be useful toward this end.
Evidentiary Basis	<ul style="list-style-type: none"> ▪ Training records for sample of 29 of 142 BCJJC direct care staff (20%) ▪ Staff interviews, n=7 ▪ Administrator interviews ▪ Incident reports, n=40, randomly selected from those generated January 1 through April 15, 2009 related to youth-on-youth assault and group disturbances ▪ Video footage of approximately 15 incidents occurring between January 1 and April 15, 2009

¶ III.B-1.iii	<u>Senior Management Review.</u> The State shall develop and implement a system for review by senior management of youth-on-youth violence.
Compliance Rating	Partial Compliance
Discussion	<p>By DJS policy, each incident report must be reviewed by the Shift Commander. These reviews should critique staff performance in preventing, anticipating, or intervening in the incident. Feedback surrounding the use of de-escalation and physical intervention techniques, staffing ratios and posts, supervision strategies, institutional security, conflict resolution, environmental hazards, policy and procedures will help to improve staff skill and knowledge and may lead to a decline in youth violence over time.</p> <p>Across the 40 incident reports reviewed, all of the Shift Commanders at least attempted to critique the incident — no longer are they simply summarizing the event as they were at the time of the First Monitors’ Report. However, as a whole, the Shift Commanders’ reviews are not as insightful as they need to be in order to function as an effective tool for reducing youth violence. The primary impediment here is that Shift Commanders attempt to review the incident without a complete set of facts. As discussed in the previous provision (III.B-1.ii), over half of the incident reports were lacking contextual details, descriptions of the use of force, or statements from all staff who participated in the resolution. Lacking this information, most of the Shift Commanders’ reviews are superficial or make conclusions that appear to be without proper foundation. Prior to critiquing the incident, the Shift Commanders must ensure that the IR package provides a full and complete account of what occurred. Once armed with all of the information, Shift Commanders should identify the specific decisions made or actions taken that either promoted or compromised youth and staff safety so that staff can refine their responses when next placed in a similar situation.</p> <p>By DJS policy, once reviewed by the Shift Commander, a member of the senior management team must review the complete incident report packet within 72 hours. These audits should not only verify the completeness of the incident reporting package, but should also comment on the quality of the staff’s responses to each portion of the incident report and confirm that all of the sources of information hang together without contradiction. Most importantly, the audits should form the initial phases of analyzing the problem of youth violence, observing patterns to identify vulnerable places, high risk youth, and faulty procedures that could be targeted by a violence prevention strategy.</p> <p>As was the case in the last Monitors’ Report, problems with executing these audits limited their usefulness to the overall violence prevention effort. In the first half of the current monitoring period, none of the incident reports reviewed had been audited, as senior managers’ priorities were shifted elsewhere. In March and April, 2009, the audits resumed but they were plagued by the same problem as the Shift Commanders’ reviews — insufficient information to properly critique the incident. Further, staff did not respond to the request for corrections in two-thirds of the IRs reviewed.</p>

	<p>The result of the substandard Shift Commanders’ reviews and senior management audits were incident reports that never quite came together and that therefore were not particularly useful to efforts to identify and address the factors that are contributing to violence at BCJJC.</p> <p>Shift commanders and administrators could use video footage to improve both the quality of incident reporting and their reviews and audits. The presence of stationary video cameras throughout the facility means that nearly all incidents can be reviewed after the fact. Critiquing an incident using a written description versus actual video footage of the event are completely different experiences, and some supervisors may be more suited to one format than the other. Either way, supervisors should provide concrete guidance to staff about the choices they make when supervising youth. The review of video footage, coupled with one-on-one coaching with staff could further the skill-building effort among new staff and could ameliorate many of the deficits in the incident reports themselves, as discussed in III.B-1.ii.</p>
Recommendation	<p>To reach substantial compliance with this provision, the State must:</p> <ol style="list-style-type: none"> 1. Ensure that Shift Commanders review and critique all incident reports in terms of the way in which staff handled the incident and any contextual factors that could have prevented the incident from occurring. Conclusions should be supported by specific information available in the incident report and therefore Shift Commanders must ensure that all required information is present before undertaking a critique. 2. Complete management-level audits within the 72 hours required by policy, focusing on substantive issues that may have prevented the incident from occurring. Managers are encouraged to utilize videotaped footage in their critique of incidents involving violence or physical restraint. 3. Ensure that staff make corrections to substandard incident reports.
Evidentiary Basis	<ul style="list-style-type: none"> • Administrator interviews • Incident reports, n=40, randomly selected from those generated January 1 through April 15, 2008 related to youth-on-youth violence and group disturbances. • Videotapes, n=15, randomly selected from incident reports generated January 1 through April 15, 2008 related to youth-on-youth violence and group disturbances.

<p>¶ III.B-1.v</p>	<p><u>Behavior Management Program</u>. The State shall develop and implement an effective behavior management program at the facility throughout the day, including during school time and shall continue to implement the behavior management plan. The State shall develop and implement policies, procedures and practices under which mental health staff provide regular consultation regarding behavior management to direct care and other staff involved in the behavior management plans for youth receiving mental health services, and shall develop a mechanism to assess the effectiveness of interventions utilized.</p>
<p>Compliance Rating</p>	<p>Partial Compliance</p>
<p>Discussion</p>	<p><u>Behavior Management Program</u></p> <p>The development and implementation of an effective behavior management program (BMP) should be one of the key strategies for reducing youth violence and addressing some of the behavioral issues that challenge the academic program at BCJJC (as discussed in the “Special Education” section of this report).</p> <p>The current program was implemented in mid-September, 2008 although minor modifications have been made from time to time. The basic structure of the current BMP is solid—youth are able to earn up to 100 points per day and as points accumulate, youth are promoted to a higher level that comes with greater privileges. Point deductions, or fines, are issued when youth do not follow facility rules. Although simple in concept, the system is actually quite complex, which may account for the implementation problems discussed below. These problems may also limit the BMP’s usefulness in reducing assaults and disturbances at BCJJC.</p> <p>On a positive note, behavior management records are complete and well-organized. A full set of documents could be produced for all 10 units for all of the days requested. Further, visual inspection indicated that point sheets are posted on each unit, each day, and most of the youth knew what level they were on. A sample of point sheets from all 10 units over approximately 30 days in February, March and April, 2009 was reviewed. Across these point sheets, there were very few calculation errors and nearly all of the point deductions were explained on the back side of the point sheet.</p> <p>However, many of the point sheets revealed point deductions in excess of those permitted by the BMP guidelines (e.g., staff deducted 50 points for refusing a directive, when the guidelines allow only 25 points to be deducted). Further, youth were not always held accountable for their behavior via point deductions. Using the incident report log, youth involved in youth-on-youth assaults on all three pods during March and April, 2008 were identified. Cross referencing these with the point sheets revealed that points were not deducted for about one-third of the youth involved in the assaults. While this has improved somewhat from the previous reporting period (when point deductions were not taken in two-thirds of the cases reviewed), the lack of accountability limits the overall effectiveness of the BMP. Further, a review of point sheets from several units suggested that point</p>

deductions do not have any real deterrent value for a small subset of youth. Across several weeks, these youth routinely received between 5 and 10 fines for misbehavior each day. They frequently lost significantly more points than they earned. These were the same youth who were involved in more serious forms of misconduct (assaults and group disturbances). This pattern leads to a few plausible theories: youth do not perceive the points to be valuable and thus do not care if they earn or lose them; or, youth cannot control their behavior and are not being taught how to do so in an effective manner; or, youth do not know or do not want to demonstrate alternative ways to handle these situations. Whatever the underlying cause, point deductions as the sole consequence for misbehavior appear to be of limited utility.

Perhaps because of the State’s legislative limitation on the use of seclusion (i.e., it cannot be used as punishment), the State has been careful when implementing structured sanctions for misbehavior that include segregation from the general population. The practice of isolating (i.e., placing them behind a locked door, by themselves) youth who commit major rule violations does not have support in the research on creating long-term behavior change in adolescents. However, segregating these youth (meaning keeping them separate from the general population until a series of interventions designed to suppress assaultive behavior and to teach new skills for managing frustration, anger and peer pressure can be implemented, for example) could be an effective response for the small proportion of youth who are undeterred by the regular behavior management program. The State is encouraged to continue to consider this type of segregation among the range of consequences to be added to the existing behavior management program.

When interviewed, youth complained that there was little distinction between the levels—only their bedtimes were different—and thus many felt that earning points “isn’t worth it.” Others indicated that, aside from commissary, they cannot purchase anything meaningful with their points. Still others complained that the written guidelines for the BMP promised a greater array of incentives that were not available to youth. Staff echoed these problems and reported their feelings of “helplessness” in the face of non-compliance because they have too few options for holding youth accountable.

Of additional concern is that the current structure does not provide a mechanism for staff to reward the behaviors they want the youth to demonstrate. Either on-the-spot or over the long term, staff must notice, comment on, and reward the pro-social behaviors they seek in order to increase the likelihood that the youth will replicate them. These behaviors could include things like refraining from the use of profanity for an entire day, exhibiting appropriate behavior upon returning from court, staying out of a group disturbance among other members of the housing unit. If staff could promote such behaviors more effectively, youth may be more likely to choose pro-social behaviors instead of maladaptive ones the next time they find themselves in a similar situation.

Thus, while the basic structure of the current BMP is solid and while the mechanics have improved, the program still lacks integrity and therefore has very limited utility in reducing

the level of youth violence in the facility.

Mental Health Consultation

Case management and mental health staff are involved in the behavior management of certain youth with serious behavioral and mental health problems, through the development of a Guarded Care Plan (GCP). The concept of the GCP is right on target with the requirements of this provision; however, the GCPs as currently executed are not of sufficient quality.

A total of 14 GCPs for youth in custody in February and April 2009 were reviewed. Most were developed by a case manager with some input from direct care, education and mental health staff. Overall, the plans lacked originality. Not only did they all bear a striking resemblance to each other, they did not describe behavioral interventions that are any different from how staff would respond to a youth in the general population (e.g., separate the youth from the group, process with him, seek mental health consultation). Many of the plans did not identify any specific incentives for the youth to comply with the plan and most were not reviewed on a regular basis.

While the GCP is a solid strategy for addressing youth involved in a disproportionate number of serious incidents, the plan must be both individualized and specific. The plan should define a baseline (i.e., type and frequency of problem behaviors at the time of referral), identify the skills the youth needs to develop in order to display more appropriate behaviors, set specific behavioral goals and how progress toward them will be measured, and specify a range of rewards and incentives for youth who meet these goals. GCPs must be reviewed routinely and youth must be given access to rewards if they have earned them in order to have an impact on youth's behavior.

Toward the end of the monitoring period, the GCP was overhauled and a new policy, procedure and forms were developed. Hope Health staff will reportedly be taking the lead on GCP development, which will likely lead to a higher-quality and more effective product.

Seclusion

While the facility is not permitted to use disciplinary isolation as a sanction, seclusion may be used to provide youth with an opportunity to calm down after an altercation or other tense situation. Practices designed to protect the safety of youth in seclusion are discussed in a subsequent section (III.C-1.iii). Given that seclusion is permissible only in situations where the safety of youth and staff or the security of the facility is compromised, the justification for the use of seclusion is relevant here. By DJS policy, in order to be released from seclusion, a youth must discuss his behavior with staff, must take responsibility for himself, and articulate how he could have behaved differently.

The previous Monitors' Report described significant increases in the use of seclusion and its duration and expressed concern that seclusion was overused during that 6-month period. The current monitoring period witnessed a brief swing to the opposite pole—the near

cessation of seclusion—followed by a rebalancing of the practice. Toward the end of 2008 and in early 2009, the facility recorded approximately 150 uses of seclusion per month. Following an incident in which staff were disciplined for their failure to follow seclusion procedures, staff all but halted the practice, using seclusion only 10 times in February, 2009. Staff were cautioned that while seclusion should not be used as punishment and youth should not languish in seclusion, seclusion serves an important safety function in the facility by providing an opportunity to process with youth and to restore calm and more reasonable thinking. In March and April, 2009, rates of seclusion hovered at approximately 100 per month. It is not the Monitor’s intention to prescribe a specific number of seclusions, but merely to point out that swings in one direction or the other should be analyzed to ensure they do not represent an over- or under-reliance on the practice. Supervisors and administrators must use their judgment to determine whether seclusion in each instance would promote safety or would amount to an unnecessary exclusion from the general population.

Along with reductions in the use of seclusion, the recent monitoring period also witnessed significant reductions in the duration of seclusion. In general, youth should be held behind a locked door only when a legitimate safety concern exists. Otherwise, the downsides of this practice (i.e., the risk of self-harm dramatically increases; after an initial cooling off period, youth tend to get more aggravated when excluded from the general population; absent specific programming, youth do not learn anything from being isolated) far outweigh the benefits. As such, limiting the duration of seclusion is encouraged. At the end of 2008 and beginning of 2009, the duration of seclusion averaged approximately 12 hours. In March and April 2009, the average duration of seclusion was only 2 hours. Providing that the underlying dispute is actually resolved, this reduction is a significant achievement. The effectiveness of these shorter periods of seclusion should be confirmed by examining the youth’s subsequent involvement in serious incidents. If immediate retaliation or continued non-compliance are evident, seclusion practices should be reviewed.

A total of 35 seclusion episodes were randomly selected from those occurring between January and April 15, 2009 to assess the reasons for keeping the youth in seclusion. Shift Commanders are required to visit with the youth every two hours to assess his readiness for release. Documentation supports that these visits occurred at required intervals approximately 90 percent of the time. Shift Commanders properly justified the continued used of seclusion (i.e., the presence of a legitimate safety concern) about 80 percent of the time. The quality of their justifications improved noticeably toward the end of the monitoring period, a trend which needs to be maintained over time.

In summary, the facility has drastically reduced the use of seclusion and its duration since the Agreement was signed. Building on this accomplishment, additional methods for addressing crises and de-escalating tensions should also be sought so that staff’s responses can be customized to the particular needs of individual youth.

	<p><u>Programming</u></p> <p>The facility continues to struggle to engage youth in structured programming each day. The facility's limited indoor programming space and outdoor recreation space is a serious detriment to this objective. Direct care staff frequently conduct groups on the unit that serve mostly to set behavioral expectations and review the day's activities. Mental health staff conduct Aggression Replacement Training (ART) groups on the units, but these are frequently cut short because of problems maintaining the facility's schedule (e.g., lunch is ready late, youth are delayed in returning from school, etc.). All of the youth interviewed complained of boredom and indicated that while they participated in some sort of structured program 1 or 2 nights per week, they were not engaged in anything meaningful the other 5 or 6 nights or on the weekend days. When they are not in school, youth reported that they spend most of their time watching TV and playing cards and videogames.</p> <p>The arrival of the Boys & Girls Club programming (BGC) in late 2008 was an extremely positive development. The BGC program was repeatedly identified as the facility's strongest program and the time of day when youth felt the least stressed and most interested in what was going on around them. Facilities throughout the country notice a direct correlation between youth violence and idle time. The more structured programming available to youth, the fewer assaults and group disturbances. Continued investments in this area are likely to yield a substantial return in terms of the reduction in youth violence at BCJJC.</p>
Recommendations	<p>To reach substantial compliance with this provision, the State must:</p> <ol style="list-style-type: none"> 1. Fully and properly implement the BMP and audit its operation to ensure that staff are using it properly and that youth are rewarded for positive behavior and held accountable for non-compliant behavior. 2. Ensure that BMP levels are distinct from each other and that youth on higher levels receive all of the privileges to which they are entitled. 3. Expand the array of rewards and consequences to increase their significance to youth and to provide staff with additional tools for managing youth behavior. 4. When youth are placed in seclusion, ensure that Shift Commanders consistently describe the youth's statements and behaviors that cause the Shift Commander to conclude that the youth should remain in seclusion, rather than returning to the general population. 5. Implement the proposed changes to the Guarded Care Plans to ensure that difficult-to-manage youth have an individualized, specific and structured plan to encourage prosocial behavior. Review and update the plans on a weekly basis. 6. Increase the amount and variety of structured programming available for youth.
Evidentiary Basis	<ul style="list-style-type: none"> ▪ <i>Student Handbook</i> ▪ Behavior Management Point Logs, all 10 units, February, March and April, 2009 ▪ Guarded Care Plans for approximately 15 youth, written since January 1, 2009 ▪ Staff interviews, n=7 ▪ Youth interviews, n=10

	<ul style="list-style-type: none">• Seclusion Log, January 1 through April 15, 2009• Seclusion records, n=35, randomly selected from those occurring January 1 through April 15, 2009• <i>DJS Office of Quality Improvement Draft Report, March 2009</i>
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¶ III.B-1. vi	<p><u>Staffing.</u> The State shall employ sufficient numbers of adequately trained direct care and supervisory staff to supervise youth safely, protect youth from harm, and allow youth reasonable access to mental health, education services, structured rehabilitative programming, and adequate time spent in out-of-room activities, and that it shall continue to provide sufficient numbers of staff at the facility.</p>
Compliance Rating	<p>Substantial Compliance</p>
Discussion	<p>DJS' standard staff:youth ratios are 1:8 during waking hours and 1:16 during sleeping hours. These are within the range of those accepted in the field as necessary to protect youth from harm. However, these ratios should be considered minimal staffing ratios—they are sufficient only to the extent that the physical plant and risk profiles of the youth are amenable to supervision. Given the two-tiered structure of the housing units at BCJJC, the local policy is to staff the facility at 1:6 during waking hours and 1:12 during sleeping hours.</p> <p>To assess the extent to which required staffing ratios were met, shift staffing reports were requested for 18 days from January through April, 2009. On each of three shifts for these 18 days, shift schedules indicated that all of the housing units were staffed within the required 1:6 and 1:12 ratios. There was only one occurrence, in March, when 1st shift did not have sufficient staff to allow all youth to be out of their rooms at the times indicated on the unit schedules. Instead, the facility went to a “6 up-6 down” procedure in which half of the youth were locked in their rooms while the other half were allowed to go about the normal activities on the unit.² This was the only such occurrence during the current monitoring period.</p> <p>In contrast to the time when DOJ launched its investigation and vacancy rates were approximately 40 percent, the vacancy rate has hovered at approximately 5 percent for the past 12 months. Of the 114 full-time direct care positions allocated to the facility, 106 are currently filled (93%). DJS staff have provided assurances that the allocated number of RA positions is sufficient to fully staff the facility without the use of overtime, except in emergency situations. From a purely quantitative perspective, the facility meets the requirements of this provision. Unfortunately, the facility has yet to feel the benefits of being fully staffed because of the endemic levels of call-outs discussed in III.B-1.i above. Filling the remaining 8 positions as soon as possible would alleviate some of this strain.</p> <p>Although it is not advisable for many reasons related to the deterioration of effective youth supervision, the Agreement does not preclude the use of overtime to meet staffing ratios. This provision focuses rather exclusively on the number of direct care staff employed and the fact that they must be “adequately trained.” The State satisfied the provision related to</p>

² Such situations are recorded in the seclusion log because the same safety procedures are engaged for youth who are locked in their rooms due to staff shortages. While an unfortunate situation, this is an excellent practice for protecting the safety of these youth.

	<p>training during the previous monitoring period—all staff received the required number of hours of entry level (120 hours) and annual training (40 hours) in the required topics. Further, the number of staff assigned to work on each housing unit on a daily basis satisfies the 1:6 and 1:12 ratios. Youth are not denied access to programming, education or mental health services for reasons related to staffing. On these grounds, the State is in substantial compliance with this provision.</p>
Recommendations	<p>The State is in substantial compliance with this provision. However, it is strongly recommended that the State:</p> <ol style="list-style-type: none"> 1. Address the endemic levels of call-outs in order to minimize the frequency with which staff are held over. 2. Take immediate steps to fill the remaining 8 direct care staff vacancies.
Evidentiary Basis	<ul style="list-style-type: none"> ▪ Policy review ▪ Shift staffing reports for 18 days randomly selected from January to April, 2009 ▪ Seclusion Log, January through April, 2009 ▪ Youth interviews, n=10 ▪ Staff interviews, n=7 ▪ Administrator interviews ▪ <i>DJS Office of Quality Improvement Draft Report, March 2009</i> ▪ Email communication with Dr. Sheri Meisel, DJS Deputy Secretary of Operations, received April 28, 2009

Suicide Prevention

¶ III.C-1. i	<u>Implementation of Policy.</u> The State shall take all reasonable measures to assure that all aspects of its suicide prevention policy are implemented.
Compliance Rating	Substantial Compliance
Discussion	<p>The DJS' Suicide Prevention policy is aligned with contemporary standards of care.</p> <p>The policy requires youth at risk of self-harm to be supervised at different intensities, depending on the level of precaution required. As discussed in III.C-1.v, observations of operations, youth and staff interviews and documentation all confirm that dependable procedures are in place to monitor the well-being of youth on suicide precautions. In addition, the individual suicide prevention logs maintained by Hope Health staff provide a chronological account of the youth's movement up and down the levels of precaution and also effectively provide guidance for direct care staff responsible for managing these youth.</p> <p>Similarly, procedures for ensuring the welfare of youth in high-risk settings (i.e., in a locked room by themselves) are well-established and consistently implemented. Staff routinely observe youth on seclusion and those locked in their rooms overnight to verify their safety and welfare. Significant progress in the use of the GuardTour technology was witnessed during the current monitoring period.</p>
Recommendations	The State is in substantial compliance with this provision.
Evidentiary Basis	<ul style="list-style-type: none"> See sources of information listed under each provision, below.

¶ III.C-1.iii	<u>Supervision of Youth at Risk of Self-Harm</u> . The State shall sufficiently supervise youth in seclusion to maintain their safety.
Compliance Rating	Substantial Compliance
Discussion	<p>Even when they have not verbalized any suicidal ideation or intent, youth are at heightened risk of self-harm when they are isolated in a locked room (e.g., when secluded, overnight, etc.). By checking on youth periodically during these times, staff can respond to any needs or otherwise verify the youth’s safety.</p> <p><i>Youth in Seclusion.</i> The use of seclusion, and the justification offered for it, was discussed previously (see III.B-1.v). Regardless of the reason for placement, this provision requires the State to adequately supervise youth in seclusion to ensure their safety. Staff are required by policy to make observations at random intervals, no less than six per hour. A total of 35 seclusion episodes, randomly selected from those occurring in January through April 2009, were audited. A complete set of observation forms was located for each of these. About 20 percent of the documents revealed relatively minor errors in the supervision of youth in seclusion (e.g., gaps of less than 30 minutes, usually at shift change, a few instances of predictable patterns of observation such as exact 10 minute intervals). No major errors were identified.</p> <p>Policy also requires medical staff to verify the well-being of youth at two-hour intervals during their stay in seclusion. In contrast to previous monitoring periods in which medical staff missed at least one two-hour check in as many as two-thirds of the cases, medical checks were preformed as required in nearly all cases.</p> <p>Overall, procedures for ensuring the safety of youth who are in seclusion have been properly implemented and meet the requirements of this provision.</p> <p><i>Youth Locked in their Rooms Overnight.</i> Youth at BCJJC are locked into single rooms overnight. The facility is equipped with an electronic GuardTour system that records staff’s routine observations of youth while in their rooms. DJS policy requires staff to verify the well-being of youth at 30-minute intervals.</p> <p>GuardTour reports for 527 shifts in January through April 2009 were reviewed to determine the level of compliance with overnight check procedures. Criteria for assessing compliance were as follows:</p> <ul style="list-style-type: none"> ▪ Observations began at bedtime (approximately 8pm) and ended when youth were awakened in the morning (approximately 6am); and ▪ Staff did not miss more than 2 checks throughout this 10 hour period. <p>Approximately 85 percent of the shifts reviewed met these criteria. Some housing units</p>

	performed better than others—those continuing to struggle should be targeted for additional training or staff accountability measures. Overall, this is an acceptable rate of error that has been maintained for approximately 4 months and thus satisfies the requirements of this provision.
Recommendations	The State is in substantial compliance with this provision.
Evidentiary Basis	<ul style="list-style-type: none"> ▪ Seclusion Observation Forms for n=35 youth, randomly selected from those placed in seclusion at some point from January through April, 2009 ▪ GuardTour reports for 527 shifts in January through April, 2009 ▪ Staff interviews, n=7 ▪ Administrative interviews

¶ III.C-1.v	<p><u>Documentation of Suicide Precautions.</u> The following information shall be thoroughly and correctly documented, and provided to all staff at the facility who need to know such information:</p> <ol style="list-style-type: none"> a. the times youth are placed on and removed from precautions; b. the levels of precautions on which youth are maintained; c. the housing location of youth on precautions; d. the conditions of the precautions; and e. the times and circumstances of all observations by staff monitoring the youth.
Compliance Rating	Substantial Compliance
Discussion	<p>Hope Health staff complete a handwritten log on each housing unit that includes all of the information required by this provision. It also provides useful guidance and instructions to direct care staff who interact with youth on precautions. These handwritten logs were reviewed for 21 youth who were placed on suicide watch during January through April, 2009. The great majority of log entries contained all of the information required by this provision and provided a chronological record of the youth’s movement up and down the levels of precaution. Useful guidance for direct care staff responsible for managing these youth was also clearly communicated.</p> <p>To assess part (e) of this provision, suicide precaution observation forms were reviewed for these same 21 youth who were on some level of precaution during January through April, 2009. An observation form is required for each shift, each day the youth is on suicide precautions (with the exception of Level I which does not require monitoring on the 3rd shift).</p>

	<p>A complete set of observation forms was located for all but one youth (i.e., 2 of the approximately 120 forms reviewed were missing, or about 1 percent). The observation forms revealed consistent documentation of the youth’s behavior and emotional state throughout the period he was on suicide precautions. Several staff submitted excellent detailed entries for youth having a particularly difficult time adjusting. Staff supervision, and the documentation of it, continued throughout the facility, when the youth was in court, and when a couple of the youth were transported to the hospital. Very minor errors were noted on some of the forms (e.g., gaps in supervision of no more than 30 minutes; temporary predictable patterns of observation; etc.), but all were caught by the facility’s internal monitoring process. Shift Commanders review the forms at least once per shift and sign off on staff’s compliance with policy within the chronological entries.</p> <p>In summary, the State has sufficient documentation to substantiate their compliance with all of the requirements of this provision.</p>
Recommendations	The State is in substantial compliance with this provision.
Evidentiary Basis	<ul style="list-style-type: none"> ▪ Suicide Precaution Observation Forms and Individual Suicide Tracking Logs for n=21 youth, randomly selected from those on suicide precautions at some point from January through April, 2009.

Special Education

¶ III.F-1.i	<u>Provision of Required Special Education</u> . The State shall provide all eligible youth confined at the facility special education services as required by the IDEA, 20 U.S.C. §1400 et seq., and regulations promulgated thereunder.
Compliance Rating	Partial Compliance
Discussion	<p>Special education services have experienced tremendous growth at BCJJC during the nearly two years of the Agreement. Among other things, MSDE and DJS have collaborated to create additional classroom space, coordinate training activities, schedule bi-weekly meetings, and hold daily briefings. The Monitor observed high levels of student engagement in several classes he visited during this reporting period. Problems noted in earlier reports including inadequate screening and identification have been addressed and the school at BCJJC does an effective job of managing the intake of a large number of students and their school records.</p> <p>Other notable events during this period include a team-building workshop conducted by MSDE for teachers and support staff in February. The focus of the meeting was developing ways for teachers to connect with their students. The school also conducted two special activities that involved bringing community resources inside the facility. “Winterfest,” held in December, enabled students to meet with representatives from agencies and programs who may be useful to them following their return to the community. In April, “Careers Day” enabled a number of students from BCJJC to meet with representatives from Baltimore City Community College to discuss post-secondary education opportunities.</p> <p>Another positive development has been the convening of a daily “morning meeting” between MSDE and DJS staff to review the status of each unit, review any scheduling changes, and address emerging problems. Representatives of the school and DJS leadership team also meet on a bi-weekly basis to review operations as they pertain to the school. During this reporting period, MDSE and DJS leadership staff jointly traveled to the Ferris School in Wilmington, Delaware to observe a state-operated juvenile correctional facility that at one time, experienced some of the same challenges to providing education and special education services as BCJJC. Leadership staff reported that they plan to make a similar visit to the Fairfax County Juvenile Detention Center in Virginia.</p> <p>For the first time since BCJJC opened in the fall of 2003, there now appears to be sufficient classroom space for the approximately 120 youth detained at the facility. With the opening of one new classroom and several office spaces, there are now 11 classrooms including the library. This space represents the bare minimum needed for the instructional program. Increases in the population at the facility could jeopardize the instructional arrangements and scheduling, issues that have contributed to the problems experienced by</p>

the school during the past two years.

There have been modest improvements in the ability of units to arrive on time for school in the morning and after lunch, though late meal times continue to deprive students on some units 1st period class in the morning and 4th period class after lunch. While there continues to be improvement at BCJJC, problems remain that seriously compromise the ability of students with special education eligibility to receive appropriate services.

Teacher vacancies and absenteeism.

The primary challenge associated with compliance on this provision (Provision of Required Special Education, III. F-1.i) and the related provision (Individualized Education Programs, III. F-1.iv) involves teacher vacancies and absenteeism. Two of the three teaching vacancies date from last summer and one from last September. The classes assigned for these positions in math, computer education, and the library continue to be covered by other teachers or by instructional assistants. Currently, one special education teacher is teaching math full time and another is teaching language arts on a regular basis. MSDE has screened, interviewed, and selected candidates for several positions but for various reasons has not been able to hire professionals for these positions for eight or more months.

A related issue that seriously compromises the education program is teacher absenteeism. MSDE staff members at BCJJC are state employees and work a calendar similar to that of other state employees and the calendar for the education program in adult corrections in the State. Teachers do not work a typical school calendar with time off around religious holidays and during the summer. Consequently, teachers and instructional assistants take vacation time and personal days throughout the school year and occasionally large numbers of staff are out on days when school is in session.

Some instructional staff also has been approved by their physicians for Family Medical Leave Act (FMLA) time off. According to one staff member, the vast majority of teaching and instructional support staff at BCJJC has been approved for FMLA leave, though this was not independently verified by the Monitor. The combination of staff vacation and leave time, sick days, FMLA days, and most recently furlough days has resulted in classes being cancelled for lack of teachers or teaching assistants. Special education teachers are often assigned to other responsibilities so that classes can be held. When classes are cancelled, students remain on their units or return to their units if already in school. The lack of teachers in a school without access to substitute teachers makes for a school environment that is, at times, chaotic.

A review of education staff vacancies during a few weeks during this monitoring period sheds light on the severity of the problem. During the period from March 11 to April 7, there were 59 full- or partial-day staff absences.³ On the six consecutive Fridays from

³ A “staff absence” is each day or partial day a staff member is not at BCJJC. On the majority of days during this period, more than one teacher or instructional assistant was absent.

	<p>March 13 to April 17, there were four, six, three, five, six, and ten instructional staff out.⁴ The Classroom Status Reports compiled by DJS staff working in the school document the effects of teacher and instructional assistants' absences. Notes at the bottom of the pages include statements such as "31 does not have a teacher to instruct them 1st or 2nd period. 31 does not have a teacher...1st period. Unit 22, 33, and 32 do not have an instructor 4th period. Units 21, 40, 32, and 20 have no 5th period teacher...Unit 31 got to the door of their class and refused to enter..."</p> <p>The Monitor met with special education teachers and support staff, the school principal, the DJS CRIPA liaison, and the Superintendent of BCJJC to review these issues. Administrative staff has an understanding of these problems and have indicated their desire to address them, but feel constrained by the state calendar issue and staff ability to take FMLA time. While instructional staff absence and canceling classes is a serious problem on its own, an unanticipated consequence is the message sent to students about the value placed on their education</p>
Recommendations	<p>The State is in partial compliance with this provision. To reach substantial compliance, the State should:</p> <ol style="list-style-type: none"> 1. Assign the highest priority to creating a positive school culture at BCJJC and address the problem of on-going vacancies among teaching staff and high rate of teacher and instructional assistant absences. 2. Consider adopting a school calendar that more closely resembles public school calendars with time off for winter and spring breaks and a specialized summer school schedule. Employment options that enable teachers to work 9 1/2 or 12 month contracts and the development of 2 month summer school contracts could be a valuable way to attract new teachers and fill vacancies. 3. Designate space where DJS or school staff can privately meet with students who create disruptions in class or in the hallways to reduce the number of behavioral incidents at school. 4. Continue collaborative efforts between DJS and MSDE to identify and prepare new classroom space for the school. 5. Continue on-going meetings between school and custody staff as well as site visits to nearby correctional school programs.
Evidentiary Basis	Site visits, classroom observations, review school logbooks, interviews with DJS and MSDE staff.

⁴ On Good Friday, 4/10/09, three staff took furlough days, one took annual leave, one took a personal day, and one called in sick. On the following Friday, 4/17/09, ten staff members with instructional responsibilities were out.

¶ III.F-1.ii	<u>Screening and Identification</u> . Qualified professionals shall provide prompt and adequate screening of facility youth for special education needs, including identifying youth who are receiving special education in their home school districts and those eligible to receive special education services who have not been so identified in the past.
Compliance Rating	Substantial Compliance
Discussion	<p>MSDE continues to screen and identify youth who may be eligible for special education services promptly after their admission to BCJJC. Records are promptly requested from students' prior schools and treatment centers; most records are requested within the first 2 or 3 days after students arrive at BCJJC. School staff receives records via mail or fax within a week of the request and often within a day or two.</p> <p>The files clearly document the intake and assessment process. In addition to prior records, contacts with parents, and scheduled meetings to determine eligibility that are well documented, "Child Find" meetings are held bi-weekly to review screening and intake assessment data. Students in the intake unit regularly come to the school for initial screening and preliminary assessments within the first two or three days of arriving at BCJJC. Staff proceed with initial evaluations and reevaluations independently of students' detention or pending placement status and sometimes indeterminate length of stay.</p>
Recommendations	The State continues to be in substantial compliance with this provision.
Evidentiary Basis	Site visits, review of students' files, review of school roster, discussion with staff.

<p>¶ III.F-1.iv</p>	<p><u>Individualized Education Programs</u>. The State shall develop and/or implement an adequate IEP, as defined in 34 C.F.R. §300.320, for each youth who qualifies for an IEP. Consistent with the requirements of 34 C.F.R. §300.323(c), within 30 days of a determination that a youth is eligible for special education and related services, the State shall conduct an IEP meeting and develop and IEP. As part of satisfying this requirement, the State must conduct required re-evaluations of IEPs, adequately provide and document all required instructional services, conduct appropriate assessments and comply with the requirements regarding student and teacher participation in the IEP process. Mental health staff shall be involved in development of IEPs of all youth with identified mental illness. Goals and objectives shall be stated in realistic and measurable terms.</p>
<p>Compliance Rating</p>	<p>Partial Compliance</p>
<p>Discussion</p>	<p>On April 20, 2009, there were 32 students at BCJJC identified as eligible for special education services. One student was identified for accommodations and support with a 504 Plan. Review of student files, classroom observations, interviews with students, and review of 29 classroom status reports (maintained by DJS staff) indicated that some students receive appropriate services. The Monitor observed excellent instructional practices in several classrooms. In these instances, students were excited and proud about what they were accomplishing in class and were not shy about demonstrating their competence in front of their peers.</p> <p>The IEPs reviewed during February and April site visits appeared to be well written. Meeting notes described adaptations and accommodations on students’ IEPs. IEP folders contained service logs for students receiving supplementary supports such as counseling and speech therapy. IEP meetings were well-attended and included input from case managers, general education teachers, and support staff. Several files reviewed contained behavioral support plans and evidence of new as well as updated IEPs.</p> <p>The special education “self-contained” class has been renamed “intensive education” and staff appropriately uses this term to avoid stigma associated with earlier terminology. Also, the addition of a second special class for students with potential to complete requirements for a GED while detained has lessened the stigma of a special class for other students.</p> <p>However the problems noted above (III.F-1.i) including the frequency with which classes are cancelled because of teacher absences and the assignment of special educators to other responsibilities because of teacher vacancies and absences indicate that special education services as designated on students’ IEPs are not being provided.</p>
<p>Recommendations</p>	<p>The state is in partial compliance with this provision. In order to achieve substantial compliance, the State must:</p> <ol style="list-style-type: none"> 1. Address the problem of on-going vacancies among teaching staff and high rate of teacher and instructional assistant absences.

	<ol style="list-style-type: none"> 2. Carefully monitor and address the problem of students refusing to work with specific teachers. Demonstrate that problems associated with students' refusing services and the ensuing chaos that occurs in some classrooms have been addressed. 3. Review and revise the schedule in consultation with DJS staff. A daily schedule that indicates where each student belongs each class period would address some of the problems discussed in this report. <p>During the next reporting period, the Monitor will meet periodically with teachers, DJS leadership and supervisors, and the school principal to address the remaining problem areas.</p>
Evidentiary Basis	<p>Review of 11 student files; reviewed attendance rosters from April 22-June 3, 2009 and crossed referenced with special education student roster from June 3, 2009; interviews with 4 students; observation of 16 classes; observation of students on living units during the school day; meetings and individual interviews with teachers, instructional assistants, and school support staff; meetings with MSDE administrators.</p>