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

THIRD MONITORS' REPORT

For the Baltimore City Juvenile Justice Center (BCJJC)
For the Period of July 1, 2008 through December 31, 2008

Submitted by

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December 31, 2008

Monitoring Team Members' Areas of Responsibility and Tour Dates

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September 16-17, 2008
November 10-14, 2008

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July 27, 2008
August 28, 2008
October 10, 2008
November 6, 7, 10, 13, 14, and 20, 2008

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Introduction

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 available to demonstrate the proper implementation of all policies and procedures.

During the original 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 Third Monitors' Report covering the period July 1, 2008 through December 31, 2008. The Monitoring Team now includes only Drs. Kelly Dedel (Protection from Harm and Suicide Prevention) and Dr. Peter Leone (Special Education).

The report is organized as follows: using the same 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.

Major Findings

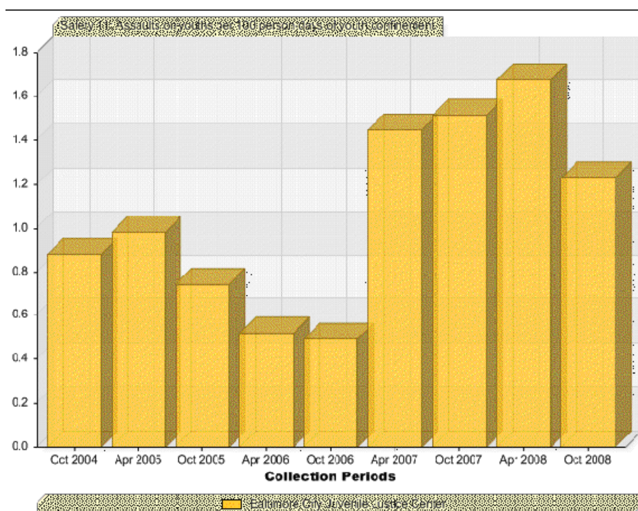
The Baltimore City Juvenile Justice Center (BCJJC) was originally designed as a 144-bed detention facility in downtown Baltimore. The facility is operated by the Maryland Division of Juvenile Services (DJS) and houses both pre-adjudication youth (i.e., detained youth) and those who have been adjudicated delinquent and are awaiting transfer to a placement elsewhere (i.e., pending placement youth). The physical structure of BCJJC includes three pods; one houses pending placement youth, while the other two pods house detained youth. Each pod has four separate living units. The living units each contain 12 individual rooms, six on the top tier and six on the bottom tier. Each unit has a small day room area, and the units are joined together by a large, common "pod area" that is used for a variety of activities. The facility also includes a cafeteria and kitchen, gymnasium and outdoor recreation areas, medical clinic, and classrooms.

During the current monitoring period, DJS closed two of the housing units at BCJJC in order to reduce the size of the population. With a rated capacity of 120 youth, the smaller population at BCJJC has somewhat eased staffing difficulties. Further reductions are scheduled to take place over the next few months, with the population further reduced to 96 youth to be housed in 8 units. Two of the original 12 units are being renovated to permit permanent, on-going programming by the Boys & Girls Club. The other two closed units will be utilized for facility-based staff training.

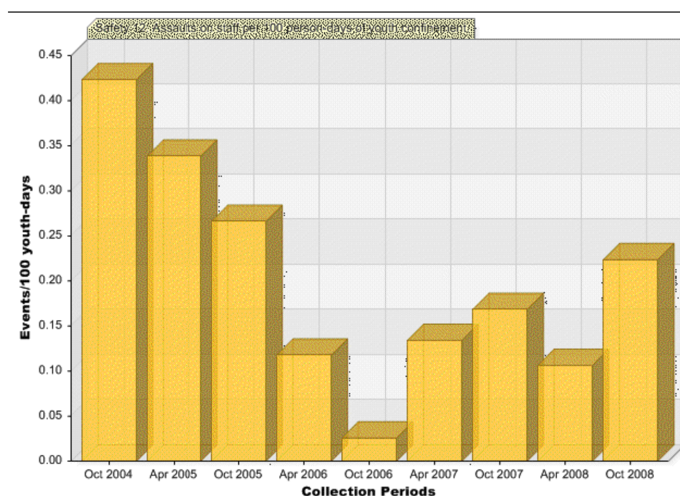
Although the first 12 months of the reform effort witnessed substantial progress in over half of the original 29 provisions, progress in reaching substantial compliance with the remaining 11 provisions remains slow. The level of violence at the facility remains high, as shown by the facility's data from the Performance Based Standards (PbS) project as well as the DJS' own data captured by its incident report database. In large part, the continued high rate of youth-on-youth assault is one result of a staffing configuration that relies heavily on very new, relatively inexperienced staff. Absent strong, well-developed supervision skills, many BCJJC staff can do little to prevent the violence that erupts among the boys housed at BCJJC. In addition to intensified training efforts for staff, the facility must also begin to use its incident data more strategically to identify the particular circumstances (e.g., environmental, interpersonal, individual) that create the opportunity for youth-on-youth violence to occur.

For example, a rough analysis of incident report data in September and October 2008 revealed that large numbers of youth at BCJJC were involved in only a single youth-on-youth assault during their stay at BCJJC. Meanwhile, a large proportion of the violence at the facility involved a relatively small number of youth. If these youth can be identified early, efforts to control their violent behavior could create substantial reductions in the overall rate of violence at the facility. This type of strategic analysis, focused on the people, places, times and other circumstances in which patterns of violence occur, should be used to craft specific violence reduction strategies at BCJJC.

PbS data permit the facility to track the rates of key outcomes over time. The PbS standard *Safety 11* tracks the rate of youth-on-youth assaults, represented as a rate which accounts for changes in the size of the youth population. As shown in the table below, the rate of youth violence reached an all-time high in April 2008 (rate=1.675), but decreased about 25 percent in the October 2008 reporting period (rate = 1.229). While this decrease is encouraging, the rate of violence remains very high, at least double the PbS rates of violence in 2006. Although most systems experience spikes in their data when new reporting mechanisms are implemented (as they were in late 2006), once the data have stabilized as they have at BCJJC, these explanations are no longer relevant. In order to reduce the rates of youth-on-youth violence, the facility must first undertake an analysis to understand the times, places, and circumstances that give rise to violence so that effective strategies can be implemented.



The PbS project also tracks the safety of staff as an outcome in *Safety 12,* presented in the graph below. In October 2008, the rate of assaults on staff was 0.224, double that of the previous reporting period, and the highest it has been in three years.

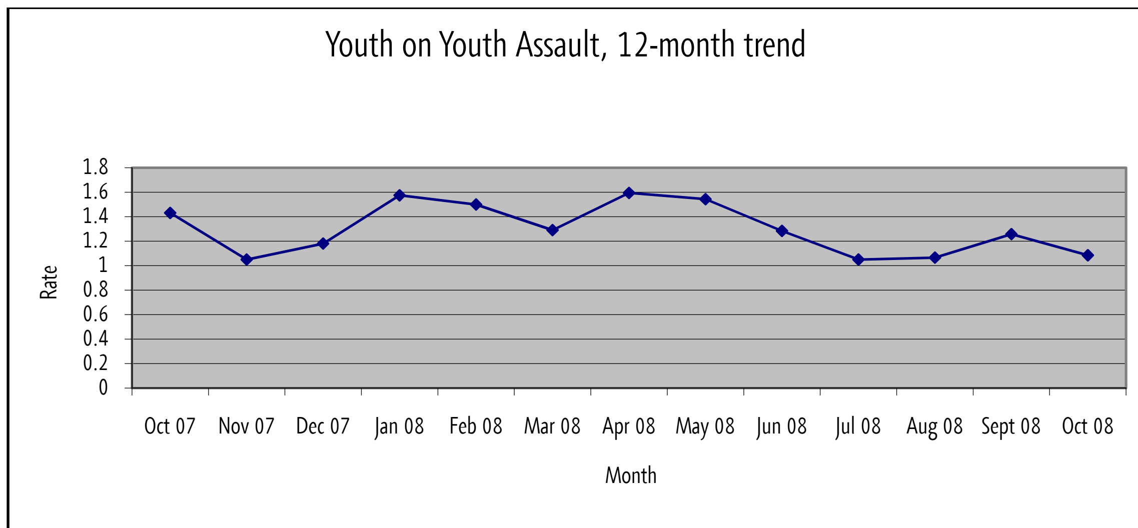


The working conditions for staff are also revealed in *Safety 14* (graph not shown). The proportion of staff who feared for their safety was 68 percent in April 2008, but decreased by one-third to 45 percent in October, 2008. Although improved, it is noteworthy that nearly half of all staff at BCJJC fear for their safety.

PbS data also reveal a recent spike in the rate of injuries sustained by youth at BCJJC. Standards focused on all injuries (including those from sports and non-incident related injuries; *Safety 2*), injuries to youth by other youth (*Safety 4*), injuries to youth by staff (*Safety 5*), and youth injured during the application of physical restraint (*Safety 10*) all rose sharply during 2008. In particular, the rate of injuries to youth by staff increased significantly. Additional analysis is needed to determine the source and severity of these injuries so that targeted interventions can be crafted.

This facility portrait, in which rates of youth-on-youth assaults remain at historically high levels and rates of violence against staff are on the rise, is of great concern and indicates a facility in dire need of systematic interventions that address the root causes of violence.

The Department's own data parallel the trends revealed by the PbS data for BCJJC. All incident reports are entered into DJS' electronic database. To calculate the rates presented in the charts below, the number of assaults was multiplied by 100, and then divided by the average daily population multiplied by the number of days in the month to create a rate that is comparable to the PbS data reported above (incidents x 100 / ADP x number of days in month = rate). The graph below presents these data for the past 12-months.[1]



As shown above, the facility's rate of youth on youth assaults was at its highest point in April and May, 2008 (during the previous monitoring period). Rates of youth on youth assault since July 1, 2008 have been somewhat lower than seen previously and relatively stable (between 1.04 and 1.08 assaults per youth, per 100 bed days), except for a slight uptick in violence in September 2008 (1.25 assaults per youth, per 100 bed days). These results are encouraging, however it should be noted that the rates of violence at BCJJC have yet to decrease substantially from their levels at the inception of the Agreement.

Thus, although the facility has made important progress in building the infrastructure envisioned by the various provisions in the Agreement, it remains challenged by high rates of youth violence and injuries. If the facility is to reach substantial compliance with the remaining 11 provisions by June 2009, it must identify the causes of youth violence and must effectively interventions specific interventions to impact the conditions that create the opportunity for youth violence to occur. Each of the previous Monitors' reports has made this recommendation, but the DJS has yet to undertake such an analysis.

Key issues in each substantive area of the Agreement are discussed below.

[1] These data were extracted from DJS' OIG database. These calculations depart from PbS' in that PbS uses the ACTUAL population on each day of the month whereas the rates generated for this report use the AVERAGE daily population, multiplied by the number of days in the month.

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%).

- The quality of incident reporting did not improve significantly during the current monitoring period. 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.

- Senior management reviews of incident reports often lacked substance. Audits by senior managers were not timely and often failed to comment on the substantive issues and problems that lead to the incident's occurring. 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.

- Although behavior management program records are far better organized than in the previous monitoring period, they reveal serious gaps in accountability for youth who are involved in assaultive behavior. 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 in reducing youth violence.

- The use of seclusion increased substantially during the monitoring period as did the duration of each seclusion episode. The reasons for these increases are unknown, but should be further investigated to determine if they are legitimate safety precautions or unnecessary exclusions of youth from the general population.

- Although the facility is in substantial compliance with the provision related to staffing, serious concern remains about the quality of supervision provided by new, inexperienced staff and the frequency with which the 1:6 staffing ratios are broken throughout the day. Poor staff retention contributes to this problem, as the facility staff is continually dominated by new staff lacking expertise in effective youth behavior management strategies.

Suicide Prevention

- The facility is not in substantial compliance with any of the 3 provisions related to suicide prevention. It is in partial compliance with all 3 provisions (100%).

- The facility has established procedures for supervising youth on suicide precautions and for documenting these observations. However, the suicide log does not provide a complete chronology of the youth's movement up and down the levels of suicide precautions.

- Procedures for ensuring the well-being of youth in high-risk settings (e.g., locked in a room, by themselves) are not always followed. In particular, staff using the GuardTour system do not verify the safety of youth at the required intervals or throughout the entire period of time youth are locked in their rooms.

Special Education

- The State is in substantial compliance with 1 of the 3 remaining provisions (33%). It remains in partial compliance with the other 2 provisions (66%).
- Adequate classroom space continues to be a serious problem, but has diminished somewhat with the recent population reductions.
- There are several teacher vacancies at BCJJC, including one special education teacher.
- Students continue to arrive late (or not at all) to afternoon classes due to a variety of behavioral problems. However, the addition of four direct care staff to the school wing has had a very positive effect on the school.
- Some students still refuse to attend special education classes and staff often lack effective means of persuading students to attend.
- While IEPs appear to be well-written, teacher vacancies, students refusal to attend class, and staff's failure to deliver youth to school on time consistently has compromised the ability to implement IEPs for many students.
- Collaboration and a shared sense of accountability between DJS and MSDE is essential for the State to achieve substantial compliance with the remaining two provisions.

Overall Compliance

The State is in substantial compliance with 2 of the 11 provisions (18%) in the amended Agreement and in partial compliance with 9 provisions (82%). None of the provisions were 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	0 (0%0	3 (100%)	~
Special Education	3	1 (33%)	2 (66%)	~
TOTAL	**11**	**2 (18%)**	**9 (82%)**	**~**

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	Partial Compliance
III.C-2.iii	Supervision of Youth at Risk of Self-Harm	Partial Compliance
III.C-2. v	Documentation of Suicide Precautions	Partial 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

Protection From Harm

¶ III.B-1.i	Protection from Youth-on-Youth Violence. The State shall take all reasonable measures to assure that youth are protected from violence by other youth.
Compliance Rating	**Partial Compliance**
Discussion	Violence in youth correctional facilities is controlled by a variety of mechanisms including adequate numbers of well-trained staff and behavior management programs. More specific responses to reduce youth violence can be crafted once the nature of the problem is fully understood, which requires a system for identifying the conditions and circumstances that create the opportunity for youth violence to occur. The BCJJC's incident reports require additional detail about precipitating factors, positioning of staff, and methods of staff intervention. Shift commanders' reviews continue to lack foundation, often miss obvious issues, and do not always gather missing information as required. Audits of incident reports are rarely completed in a timely manner and thus the ability to provide guidance to staff to improve their supervision skills is lost. For these reasons, the incident reporting mechanism does not provide the level of detail and information needed to inform effective violence prevention strategies. Further, the facility is on its fourth incarnation of the behavior management program, which has yet to be fully implemented over a substantial period of time. Although records are far better organized than in the previous monitoring period, they reveal serious gaps in accountability for youth who are involved in assaultive behavior. 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 in reducing youth violence. Although the facility assigns the proper number of staff to housing units to meet required staffing ratios, one of the more obvious contributors to the problem of youth violence at BCJJC is the lack of direct care staff skill in supervising youth. Incident reports are replete with example of staff abandoning their posts temporarily (providing an opportunity for youth to fight) or failing to fully account for the youth in their care (allowing them to go into another area undetected) or ignoring obvious signs of tension or frustration among youth that escalate into violence. Improving staff skill in this area is essential to meeting the requirements of this Agreement. Further, the facility has not effectively analyzed the information available in incident reports to uncover patterns that contribute to violence. 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, from the time of the DOJ's initial investigation to the present, a significant proportion of incidents involved the use of chairs—either as weapons thrown at other youth and staff or used to erect barricades to prevent staff entry onto a housing unit. In addition, numerous examples of youth using mops and brooms as weapons can be found throughout the incident reports. Despite the obvious patterns, the facility has been slow to respond with effective strategies for controlling access to these potentially dangerous items. Although new, blocky chairs were purchased and although reminders to secure the janitorial closets on the units were issued, there has been no follow up to assess the effectiveness of these measures. (They do not appear to have been particularly effective, given that very recent examples of all of these behaviors were found among the incident reports). As discussed in the Introduction to this report, the facility could potentially effect a significant drop in the rate of youth-on-youth assaults by identifying the small number of offenders who are involved in a large proportion of assaults and crafting effective behavior contracts and supervision plans for them. Finally, the facility has had <u>little success stemming the tide of contraband flowing into the facility</u>. Although the frequency of shakedowns has increased, youth continue to be caught "in the act" of using contraband. Most often, this takes the form of smoking, both tobacco and marijuana, although youth have also been discovered using cell phones. Renewed efforts to discover the source of the contraband (i.e., staff or visitors), the deficits in the search procedures for staff and visitors, weaknesses in the shakedown and youth search procedures, and the motivations for providing contraband must be undertaken to effectively resolve the issue. Although tobacco and marijuana are the most frequently-found forms of illicit contraband, in a small number of cases, youth have been found in possession of sharpened sporks, which could be used as a weapon against another youth or staff. Improvements to shakedown and youth searching procedures would have a positive impact on reducing this type of contraband as well.
Recommendations	To reach substantial compliance with this provision, the State must: 1. Develop and implement policies, procedures and documentation strategies sufficient to achieve compliance with the other Protection from Harm provisions. 2. Provide additional training to improve the quality of supervision of youth by direct care staff. Ensure that staff—youth ratios are maintained throughout the day and that staff are able to identify and intervene effectively in situations that, if left alone, may result in youth-on-youth violence. 3. Enact specific violence prevention strategies that reduce the rate of youth-on-youth assaults.
Evidentiary Basis	▪ All documents, interviews, and observations listed in the subsequent provisions of the Protection from Harm section of this Agreement.

¶ III.B-1.ii	<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.
Compliance Rating	**Partial Compliance**
Discussion	The following DJS policies and facility operating procedures are relevant to this provision: ▪ Use of Crisis Prevention Management Techniques [RF-02-07] ▪ Incident Reporting [MGMT-03-07] ▪ Incident Reporting Facility Operating Procedure **Policy.** The DJS' Incident Reporting policy articulates staff's responsibility to report all incidents of youth-on-youth violence and other types of incidents up the chain of command, by indicating the individuals who must be contacted and the person responsible for making the contact. As part of its annual training program, the DJS developed an excellent manual, *A Step-by-Step Guide to Completing the Maryland DJS's Incident Reporting Form*, that provides staff with detailed instructions for completing incident reports. Not only does the manual identify the purpose and required procedures of each section, it describes the type of information staff should provide and gives concrete examples of how to complete each section of the report. It is an excellent training tool for staff. In addition, BCJJC has a facility operating procedure discussing the responsibilities of staff for completing and routing incident reports. Together, these resources provide a solid foundation upon which to build staff skill and knowledge. **Training**. A four-hour report writing training program is mandatory for all direct care staff. Rates of participation in this training were high in 2007, but dropped off significantly in 2008. Using a roster of direct care staff at BCJJC as of 11/24/2008, two groups of staff were identified: 1) 104 staff who were employed throughout 2007; and 2) 169 staff who were employed on the date the roster was created. For the first group, the rate of participation in training was 96 percent (100 of 104 staff received the training in 2007). However, for the second group, the rate of participation in training was only 33 percent (56 of the 169 staff received the training in 2008). Thirty-three of the 169 individuals on staff in 2008 (19%) did not receive report writing training in either 2007 or 2008. Ensuring all staff are fully trained to write high quality incident reports should be a priority. **Practice**. The quality of incident reports did not change significantly during the current monitoring period. 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. Simply reporting that an incident occurred is necessary, but not sufficient, to reduce youth violence. Incident reports must be detailed and the information contained in them must be analyzed in order to craft effective violence

	reduction strategies. Of serious concern is the fact that throughout the monitoring period, several incidents were identified in which staff did not accurately and completely recount the events that occurred via the incident reporting process. For example, while on-site in August, 2008, the Monitor requested video footage of staff completing their rounds during the overnight shift. While searching for this footage, we came across footage of a group disturbance on one of the housing units in July, 2008. Contrary to the incident report, which describes a relatively unremarkable incident of non-compliance by youth lasting just under a half hour, the video footage revealed *a group disturbance lasting approximately three hours*. Not only did the report not capture the severity of the incident, it also did not accurately portray the precipitating events that, if properly identified and handled, could have prevented the escalation that was witnessed on the tape. In another example, while on-site in November, 2008, video footage was reviewed of an incident that involved an initial act of non-compliance by a single youth but that escalated to multiple youth being physically restrained. Again, the accompanying incident report drastically underplayed the severity of the situation and did not accurately identify the number of youth involved (five youth were restrained, not three as reported) or the large number of staff involved (only 8 staff witness statements were collected, when the videotape showed approximately 20 staff involved in the physical restraint of the 5 youth involved). These two incidents were not isolated occurrences. Several administrators, DJS staff, and Quality Assurance staff reported that their reviews of incident reports uncovered similar inconsistencies, along with periodic failures of staff to report legitimate incidents *at all*. Obviously, underreporting calls into question the validity of the data submitted to PbS and to the incident reporting database. Further, without full and accurate details, the incident reporting process is not a useful tool for preventing youth-on-youth violence as it is the specific nuances of the incidents that are ripe for systematic interventions. In addition to comparing a small number of written incident reports with the video footage, a larger sample of incidents reports were analyzed for their quality and completeness. A total of 46 incident reports (IRs) were purposefully selected from those generated from July 1, 2008 through October 31, 2008 describing youth-on-youth assaults or group disturbances. Although some progress was reported in the Second Monitors' Report (e.g., improvements in describing the sequence of events, securing staff and youth witness statements), these improvements did not endure over time. (This slippage may be due to a lack of timely supervisory review, as discussed in III.B-1.iii). Areas in need of improvement include: ▪ Descriptions of the event. 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 "just before the assault, the youth were preparing to take showers," while excluding the fact of an altercation between the same two youth 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. Further, staff did not always give a complete account of the event. Although most incident reports provided the essential details of the assault (concerns discussed at length above, notwithstanding), a significant number of IRs did not discuss how staff ultimately brought an end to the situation.

- Specific names and positions of staff. Information about staff positioning is essential for providing feedback on supervision strategies that could help to prevent or limit the harm to the youth involved in an assault and on ways to properly secure vulnerable places in the facility. While most of the IRs included the *number* of staff and youth who were present at the time of the event, a significant number did not clearly state the name of each staff person and where each staff person was posted at the time the event occurred. In particular, if one staff person had left the unit, the duration of and reason for their departure was not clearly stated.

- Descriptions of staff intervention. Staff's response to an altercation is an important method for limiting the risk of injury sustained by youth. Rather than providing a precise description of the physical restraint techniques employed, the staff and youth involved, and how it was executed, many of the incident reports used vague language (e.g., "youth were separated") or did not account for all youth who were involved in the event. These problems were evident in both the narrative of the IR and in the staff witness statements attached to the main report.

- Securing 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.

Ensuring that youth receive prompt medical attention is another way to reduce the harm sustained by youth involved in physical altercations. Across the 46 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.

	The facility's success in meeting this measure has varied over time. Early in the monitoring period, a large proportion of Body Sheets evidenced long delays (i.e., 3 to 6 hours) in securing medical treatment. Slight improvements were noted later in the monitoring period, where only 20 percent of Body Sheets were completed outside the two-hour window. 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 violence at BCJJC.
Recommendations	To reach substantial compliance with this provision, the State must: 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. 3. Ensure that staff report <u>all incidents</u> accurately and completely. Simultaneous review of incident reports and videotape footage could be useful toward this end.
Evidentiary Basis	▪ Policy review ▪ Staff interviews, n=14 ▪ Administrator interviews ▪ Incident reports, n=46, randomly selected from those generated July 1 through October 31, 2008 related to youth-on-youth violence and group disturbances ▪ Video footage of approximately 10 incidents occurring between July 1 and October 31, 2008

¶ III.B-1.iii	Senior Management Review. The State shall develop and implement a system for review by senior management of youth-on-youth violence.
Compliance Rating	**Partial Compliance**
Discussion	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 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. Across the 46 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 Commander reviews are not as insightful as they need to be in order to function as an effective strategy to combat youth violence. Over half of the Shift Commanders' reviews were inadequate in that: ▪ Conclusions were made without foundation (i.e., conclusions about the quality of staff response were made, despite the fact that the narrative lacked essential details and not all staff witness statements were obtained); and ▪ Obvious issues were not raised (e.g., staff—youth ratio; bedtime procedures; failure to supervise all youth on the unit; failure to secure vulnerable areas (closets, dining hall doors, etc.); failure to deal with youth's visible frustration effectively). If these reviews are to be helpful to staff, they must 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. As currently written, the Shift Commander reviews miss many opportunities to develop staff supervision skills that could effectively prevent youth violence. 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. Over the past 18 months, the responsibility for the audits has shifted among the Group Life Managers and Assistant Superintendents. The timeliness of the audits reported in the Second Monitor's Report did not endure over time. Of the 26 incident reports reviewed in the latter half of the monitoring period, just over 80 percent of the audits were completed

	outside the 72 hour window required by policy. Most were completed two to three weeks after the incident occurred. As time passes, the learning possibilities for staff evaporate. After two or three weeks, staff are unlikely to remember the context of the incident or the reasons they made the choices they did. In addition to their tardiness, many of the audits focused only on small issues (e.g., dates or signatures missing) and remained silent on the many larger issues that contributed to the incidents' occurring. Finally, in many cases when staff were asked to add to the substance of the report, the corrections were never made, leaving an incident report that never quite came together and that therefore cannot be useful to any efforts to analyze the factors that are contributing to violence at BCJJC. Shift commanders and administrators could use video footage to improve the quality of incident reporting and to provide concrete guidance to staff about the choices they make when supervising youth. The presence of stationary video cameras throughout the facility means that nearly all incidents can be reviewed after the fact. Given the number of incidents that occur at BCJJC, a triage process to focus on the most serious incidents would be prudent (e.g., youth-on-youth assaults and physical restraints). 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.
Recommendation	To reach substantial compliance with this provision, the State must: 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	▪ Administrator interviews ▪ Incident reports, n=46, randomly selected from those generated July 1 through October 31, 2008 related to youth-on-youth violence and group disturbances.

¶ III.B-1.v	<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.
Compliance Rating	**Partial Compliance**
Discussion	*<u>Behavior Management Program</u>* The development and implementation of an effective behavior management program (BMP) is one of the key strategies needed to reduce youth violence and to address some of the behavioral issues that challenge the academic program at BCJJC (as discussed in the "Special Education" section of this report). Its full implementation is an essential step for coming into compliance with this Agreement by June 30, 2009. The BMP is now in its fourth incarnation. The current program was implemented in mid-September, 2008. 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. Both staff and youth were given instruction as to how the new system works and written documentation has been updated. Visual inspection indicated that point sheets are posted on each unit, each day—a finding confirmed by youth interviews. Early in the monitoring period, the implementation of the former BMP exhibited many problems: inadequate record keeping; failing to award points throughout the day; calculation errors; exceeding guidelines for point deductions; and failing to document the reasons for point deductions. The shift to the current BMP was intended to resolve these problems. A sample of 41 point sheets from all 10 units from September and October, 2008 (when the new BMP was started) 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. Documents were much better organized and now can be useful to internal efforts to monitor the quality of the BMP. However, <u>about two-thirds of the point sheets revealed point deductions in excess of those permitted by the BMP guidelines</u> (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 October, 2008 were identified. Cross referencing these with the point sheets indicated that <u>for over two-thirds of the youth involved (as the aggressor, or in mutual combat) in the assaults, points were</u>

	not deducted on the day the assault occurred. This problem was also reported by a couple of the RA supervisors. Given that the BMP is the only youth-focused (as opposed to staff-focused or environmentally-focused) violence reduction strategy in use, its inconsistent application is a serious concern. 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. 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* These problems with the implementation of the BMP have precluded an effective collaboration between direct care and mental health staff regarding the behavior management of the typical youth receiving mental health services. However, 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. Approximately 10 plans developed for youth since July 1, 2008 were reviewed. Most were developed by a representative of the mental health staff and a case manger, and some also included a direct care staff. Most described the youths behavior in general and discussed strategies for the youth to cope with rising frustrations, anxieties, anger, and other emotional issues that may lead to his acting out. A list of incentives was also provided. For some youth, progress was reported on a weekly basis, and changes to the plans were made periodically. While the Guarded Care plans have many elements that would make them an effective supplement to the regular BMP, they do not include specific behavioral objectives (e.g., "Involvement in no more than one serious incident per week" or "Must earn 100 points on 4 of the 7 days this week") that could anchor them directly to the BMP and, ultimately, to the youth's involvement in institutional violence. If such targets were set, linking incentives directly to their achievement would bring additional integrity to the behavior management program for these youth. That said, the Guarded Care plans may already satisfy a compelling behavioral health objective and thus changing them may not be prudent. In that case, a similar behavior contract for youth involved in a significant number of incidents could help the facility to achieve the reductions in institutional violence it seeks.

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. 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 use of seclusion increased substantially during the monitoring period. The DJS Office of Quality Improvement calculated that the number of youth secluded increased steadily between May and September, 2008. The Monitor repeated these calculations for June and July and September and October, 2008 and found a 20 percent increase in the number of youth placed in seclusion from September to October alone. Further, although the previous monitoring period witnessed a marked decrease in the duration of seclusion (from 23 hours in March 2008, down to 8 hours in May 2008), the duration of seclusion increased throughout the current monitoring period, reaching a high of approximately 12.5 hours in October 2008. The precise reasons for these increases are not known but should be further investigated by the facility to determine if they are legitimate safety precautions or unnecessary exclusions of the youth from the general population.

A total of 22 seclusion episodes (an episode may involve multiple youth who were involved in a single incident) were randomly selected from those occurring between July 1 and October 31, 2008 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. However, in approximately 25 percent of the cases, the Shift Commander did not properly justify the continued used of seclusion (i.e., the reason the Shift Commander decided the youth was not ready to return to the general population). Most of these offered only vague statements such as "still a threat" or statements such as "youth standing at window" that do not explain why the youth was judged to be a continued safety threat. These reasons for the continued use of seclusion must be better articulated in order to substantiate that seclusion is used only as a mechanism to control a legitimate threat to safety, and not as a punitive measure.

Finally, in a few cases, the Shift Commanders' comments were at odds with the observations of direct care staff monitoring the youth. Seclusion documents from September and October 2008 revealed a few inconsistencies, such as the Shift Commander indicating he could not process with the youth because the "youth was at medical," while the direct care staff indicated that the youth returned from medical approximately 30 minutes prior to the Shift Commander's visit. Such inconsistencies bring the veracity of the Shift Commanders' comments into question.

	The facility no longer uses "social separation" (where youth spent time in their room with the door open) as a response to non-compliant behavior. The Facility Superintendent prohibited the use of social separation in August 2008 as she felt that staff were relying too heavily on it, rather than using more constructive modes of behavior management. While this is certainly laudable, direct care staff must be adequately trained in other forms of de-escalation and crisis intervention. Interviews with staff revealed that many felt they had far too few tools for responding to and managing youth behavior. Seclusion, because of the State's limits on its use, is not an available option, but other strategies for intervening and de-escalating youth are essential in order to avoid more serious conflicts. *Programming* The facility continues to strive 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. However, 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. The arrival of the Boys & Girls Club programming at the tail end of the current monitoring period is a very positive development.
Recommendations	To reach substantial compliance with this provision, the State must: 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. Consider expanding 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 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. Promote collaboration between mental health staff and direct care staff in the use of the behavior management program (e.g., use behavior contracts or other written plans for youth who exhibit persistent aggressive behavior). Ensure that behavioral objectives are specified and that incentives are granted only when goals are met. 6. Increase the amount and variety of structured programming available for youth.
Evidentiary Basis	▪ *Student Handbook* ▪ Administrative Interviews ▪ Guarded Care Plans for approximately 10 youth, written since July 1, 2008 ▪ Staff interviews, n=14

	▪ Youth interviews, n=12 ▪ Seclusion records, n=22, randomly selected from those occurring July 1 through October 31, 2008 ▪ *DJS Office of Quality Improvement Targeted Review: Seclusion*

¶ III.B-1. vi	Staffing. 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.
Compliance Rating	**Substantial Compliance**
Discussion	Policies and standards related to this provision include: ▪ Selection and Certification Standards for Mandated Positions [HR-2-03] ▪ Post Orders [RF-07-07] ▪ Maryland Correctional Training Commission [COMAR 12.10.01] ▪ Youth Movement and Count [RF-02-06] The Department's standard staff 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. To assess the extent to which required staffing ratios are met, shift staffing reports were requested for 18 days from July through October 2008. 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 July, when 1st shift did not have sufficient staff to allow all youth 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. The reliance on overtime decreased somewhat during the current monitoring period, but remains the key mechanism for complying with staffing ratios. From August to October, 2008, an average of 5 staff were held over per shift. Although there are a relatively small number of vacancies (approximately 5% of the 153 direct care positions), endemic levels of call-outs and high numbers of youth on 1x1 suicide precautions force Shift Commanders to hold staff over on a daily basis. The continued use of staff working double shifts has serious consequences for the quality of supervision, engagement of youth and the ability to protect youth and staff from harm.

[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.

	Being required to work a double shift remains staff's biggest concern about their jobs and many perceived a lack of concern for the staff's responsibility to their own families. Further, the frequent call outs preclude stable job assignments. As one staff commented, "The facility is constantly in flux. We never work with the same people. We have no teamwork, no sense of unit pride, and so we don't support each other very well." While the use of overtime staff does allow the facility to maintain required staff to youth ratios, it is not a workable long-term strategy nor one that is likely to reduce youth violence as required by this Agreement. Finally, the low vacancy rate of 5 percent disguises a persistent problem with staff retention. The inability to retain staff means the facility staffing pool is continually dominated by new, inexperienced staff who have yet to develop an array of effective supervision skills. At BCJJC, staff are hired continuously; unfortunately, they also frequently resign or are terminated. According to DJS staff, in one recent class of new hires, only 59 percent of the new RAs were still working at the facility after only one month. Administrators indicated their belief that many staff are initially excited about the job, but once they begin working, they realize that the duties are not what they expected or feel ill-equipped to carry them out. Hopefully, as DJS makes efforts to improve the quality of facility-based staff training, staff will feel more comfortable in their roles and the rates of retention will increase. Although it is not advisable for the reasons discussed above, 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 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. However, significant concerns related to the quality of supervision these staff provide, due in large part to their experience and skill levels, and to the maintenance of the 1:6 and 1:12 ratios throughout the day. Together, these two factors appear to compromise the facility's ability to adequately protect youth from harm, as discussed in more detail in III.B-1.i.
Recommendations	The State is in substantial compliance with this provision. However, it is strongly recommended that the State: 1. Address the endemic levels of call-outs in order to minimize the frequency with which staff are held over. 2. Determine the average number of youth on 1x1 suicide precautions on any given day

	and build this capacity into the normal staffing allocation for the facility. 3. Ensure that staffing ratios are *constantly* maintained, and that staff do not leave their assigned posts without first obtaining relief from a supervisor. 4. Provide additional facility-based training to ensure that staff are properly equipped to meet the challenges of the job and that their supervision of youth adequately protects youth from harm.
Evidentiary Basis	▪ Policy review ▪ Shift staffing reports for 18 days randomly selected from July to October 2008 ▪ Seclusion Log, July through October, 2008 ▪ Youth interviews, n=12 ▪ Staff interviews, n=14 ▪ Administrator interviews ▪ *DJS Quality Improvement Targeted Review: Staffing*

Suicide Prevention

¶ III.C-1. i	Implementation of Policy. The State shall take all reasonable measures to assure that all aspects of its suicide prevention policy are implemented.
Compliance Rating	**Partial Compliance**
Discussion	The DJS' Suicide Prevention policy is aligned with contemporary standards of care. The policy requires youth to be supervised at different intensities, depending on the level of precaution required. As discussed in III.C-1.v, available documentation demonstrates that dependable procedures are in place to monitor the well-being of youth on suicide precautions. However, the log tracking their movement up and down the levels of precaution was at times incomplete. Similarly, while procedures for ensuring the welfare of youth in high-risk settings (i.e., in a locked room by themselves) are established, as discussed in III.C-1.iii, they are not always followed. Although improving, the well-being of youth in seclusion was not always verified according to policy, particularly toward the end of the current monitoring period. Finally, the GuardTour procedure has yet to be properly implemented, as shown by serious errors apparent in approximately 75 percent of the shifts reviewed.
Recommendations	To reach substantial compliance with this provision, the State must: 1. Ensure that youth who are locked in their rooms at night or while on seclusion are monitored according to established procedures. 2. Ensure that documentation of suicide precautions includes both a chronology of movement up and down the levels of precautions and a record of safety observations at required intervals.
Evidentiary Basis	▪ 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	**Partial Compliance**
Discussion	The policies relevant to this provision include: ▪ Seclusion ▪ Youth Movement and Count 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. Staff interviews confirmed that staff are aware of the procedures required for ensuring the safety of youth in seclusion. When interviewed, youth who had been in seclusion confirmed that staff checked on them regularly. In addition to these reports, the practice of supervision can be assessed using documentation—as such, this review focuses on the adequacy of that documentation to substantiate compliance with the requirements of this provision and DJS policy. *Youth in Seclusion*. A total of 22 seclusion episodes, randomly selected from those occurring in July through October, 2008, were audited. 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. Of the 22 episodes reviewed, about 25 percent revealed errors in the supervision of youth in seclusion. For the most part, these were relatively minor errors (e.g., gaps of less than 30 minutes, usually at shift change, a few instances of predicable patterns of observation such as exact 10 minute intervals). Toward the end of the monitoring period, a few more serious problems were noted—longer gaps in time, missing observation forms—affecting just under 50 percent of the sample reviewed. 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 missed at least one two-hour check in as many as two-thirds of the cases, medical checks were performed on schedule in approximately 75 percent of the cases. *Youth Locked in their Rooms Overnight*. 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. GuardTour reports for 19 days in August through November 2008 were reviewed to determine the level of compliance with

	overnight check procedures. A total of 194 shifts were reviewed (the number of housing units varied given unit closures for renovation). Across the 194 shifts, only 44 (23%) were done correctly. The remaining 77 percent of the shifts were plagued by some or all of the problems below: ▪ The onset of supervision was not staggered according to youth's bedtimes. Instead, safety checks sometimes began for all youth at 11 or 12 at night. ▪ The cessation of supervision did not coincide with wake-up times. Instead, checks sometimes stopped at 3 or 4 in the morning. ▪ Many intervals exceeded the 30 minutes prescribed by policy. Many shifts showed two or more gaps of 60 minutes or more during the shift. The facility has enacted a thorough auditing procedure of GuardTour records that accurately identifies the problems discussed above. Corrective action, the step prior to a letter of counseling in the DJS progressive discipline system, has been the primary strategy for bringing about compliance with policy. However, it has not been particularly effective. Staff who received a large number of corrective actions in September (e.g., between 10 and 15), continued to receive corrective actions throughout October, suggesting that this method may not be effective in bringing about behavior change. Although there were plenty of serious errors (e.g., starting late or ending early) to bring to staff's attention, many of the corrective actions focused instead on less consequential errors (e.g., a single check that exceeded the required interval by only 10 minutes). More effective methods for ensuring that staff routinely verify the well-being of youth when locked in their rooms overnight are needed to satisfy the requirements of this provision. As a side note, several of the incident reports and videotapes revealed situations in which youth were placed in mechanical restraints and placed in their room. This is a very dangerous practice both in terms of the risk of self-harm and also accidental injury. Generally accepted practices and DJS policy require such youth to be under *constant observation* throughout the period of time they are handcuffed. This safety precaution was not routinely implemented.
Recommendations	To reach substantial compliance with this provision, the State must: 1. Ensure that staff supervise youth in seclusion according to policy and require medical staff to assess the youth's medical condition at two-hour intervals, as required by policy. Reduce the rate of serious errors to 10 percent or lower. 2. Ensure that staff verify the safety and welfare of youth locked in their rooms at night at 30-minute intervals and document this verification using the GuardTour system. It is recommended that supervisors focus on serious errors when implementing accountability measures and evaluate the extent to which these measures bring about the needed behavior change among staff. 3. Ensure that youth who are handcuffed remain under constant supervision until the restraints are removed.
Evidentiary Basis	▪ Policy review ▪ Seclusion Observation Forms for n=22 youth, randomly selected from those placed in

	seclusion at some point from July to October, 2008 ▪ GuardTour reports for 19 days in March and April, 2008 ▪ Youth interviews, n=12 ▪ Staff interviews, n=14 ▪ Administrative interviews

¶ III.C-1.v	Documentation of Suicide Precautions. The following information shall be thoroughly and correctly documented, and provided to all staff at the facility who need to know such information: 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	**Partial Compliance**
Discussion	The policies relevant to this provision include: ▪ Suicide Prevention Mental health staff complete a handwritten log on each housing unit that should include 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 22 of the youth who were placed on suicide watch during July-October, 2008. About 50 percent of these log entries did not include all of the required information (e.g., they did not include a full chronology of the youth's movement up and down the suicide watch levels, or did not indicate when the youth was ultimately taken off precautions). Each of these errors was discussed with clinical staff and appropriate remedies have been designed to improve recordkeeping at this level. To assess part (e) of this provision, suicide precaution observation forms were reviewed for these same 22 youth who were on some level of precaution from July through October, 2008. An observation form is required for each shift, each day the youth is on SWL (with the exception of SWL I in which the youth does not have to be monitored on 3rd shift). At the beginning of the monitoring period, about 25 percent of the observation forms could not be located. At the end of the monitoring period, a complete set of forms for each youth was located. Nearly all of the observation forms were complete and demonstrated adherence to policy. While some had errors, they were generally minor and the rate of more significant errors was very small. There were two cases involving youth who were actively suicidal that provided excellent

	documentation as to the youth's welfare throughout the period of time the youth was on the highest level of precautions. Not only were the youth's actions recorded in detail, but the staff's response to the actions were noted (e.g., "called mental health" "asked Staff X to assist in holding youth still"). This type of documentation would provide excellent protection to staff in the event of an unfortunate negative outcome. Finally, one of the mechanisms the facility uses to improve the quality of documentation is for the Shift Commanders to confer with the supervising staff at least once per shift to verify that practice complies with policy. Shift Commanders routinely signed off on the observation forms within the chronological record which verifies the accuracy of the entries made after theirs.
Recommendations	To reach substantial compliance with this provision, the State must: 1. Ensure that the handwritten suicide logs maintained by mental health staff provide a chronological record of a youth's movement up and down the levels of suicide precautions. 2. Continue to maintain documentation showing that all youth on suicide precautions are monitored according to policy.
Evidentiary Basis	▪ Policy Review ▪ Suicide Precaution Observation Forms and Individual Suicide Tracking Logs for n=22 youth, randomly selected from those on suicide precautions at some point from July through October, 2008

Special Education

¶ III.F-1.i	Provision of Required Special Education. 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	Special education services continue to improve at BCJJC though some problems remain. During this reporting period, the screening and assessment process (section ii, below) continued to improve and is now in substantial compliance. MSDE removed and replaced two special education teachers at BCJJC and several other staff left. Currently there are several teaching vacancies including one special education teacher. A DJS teacher on-loan to MSDE is currently serving youth in the infirmary. Adequate classroom space continues to be a serious problem but has diminished with the reduction in the population at BCJJC. One social studies teacher continues to teach on the living units daily. MSDE is currently recruiting for several vacant positions. Finalists have been interviewed for special education, math, and orientation unit teachers and for a media specialist. Interviews are currently being conducted for an additional records clerk. If all of these positions are filled there will be only one vacancy on the education staff at BCJJC. There have been improvements in the ability of units to arrive on time for school in the morning. However, after lunch, units struggle to return to school on time and some units because of behavior of youth on the units do not bring students back to school in the afternoon. DJS has assigned four staff to the school (and school hours) to assist with the management and movement of pupils. Observations and discussion with staff indicate that this has had a very positive effect on the operation of the school. A continuing concern is the refusal of some students to go to special education classes. There is stigma associated with being assigned to special education at BCJJC even if for just part of the school day. MSDE has increased special education staffing and provides special education to most students in an inclusive general education classroom. In these classes, a general education teacher is teamed up with a special education teacher to serve students. This has had a beneficial effect in some classrooms but in other settings teacher absences and the current vacancy in special education has limited the effectiveness of this approach. Other students with more significant academic needs have been scheduled into special education classes for the majority of their school day. Some of these students have attended their assigned classrooms but others appear to be given a choice as to whether they will attend class with other students from their unit or the special education class. This has created a number of confrontations between students and staff who argue about

	where students belong during any given class period. When students with significant academic needs are allowed to attend class in general education classrooms, it has a significant impact on the quality of instruction and learning opportunities of other students in classroom. DJS and some MSDE staff have directed some students with statements like "get down to special education, you know that's where you're supposed to be this period." Naturally, this has had a chilling effect on students' desire to participate classes. Also, according to some MSDE staff, DJS direct care staff appear to let students decide whether to attend the general education classes with the other students from their unit or attend the special education classes. Several special education teachers reported and I observed class periods where no students were in special education teachers' classes. At the same time, some general education classes could best be characterized as chaotic. Near the end of this reporting period, the education monitor met with special education teachers and support staff to discuss how to best address the problem of students not attending their assigned classes. He also met with Superintendent McNair and the BCJJC leadership team to address these issues. Out of both of these meetings have come ideas and changes in procedures that are being implemented as this reporting period closes. Dr. Mark Mechlinski reported that Dr. Kathleen White, Special Education Coordinator for the Adult Correctional Education Program, will visit BCJJC during the next reporting period, review special education schedule, and procedures and confer with him to bring the last two areas into compliance.
Recommendations	The school is reviewing its current schedule and may propose to DJS a new schedule to more adequately respond to students needs and address some of the problems noted here. Additionally, MSDE is considering publishing a daily school schedule that indicates not just where units are supposed to be each class period but also where individual students are supposed to be. The current schedule makes it difficult for DJS staff (and the education monitor) to determine where students belong at various times during the school day. The school is also creating two additional classrooms in existing school and detention center space. This new space and a new teacher's office will address some of the space problems discussed in earlier reports. Collaboration between MSDE and DJS leadership and staff and a shared sense of accountability for education is essential for the State to move to substantial compliance on the remaining education provisions.
Evidentiary Basis	Site visits, classroom observations, review of residential services and school logbooks, interviews with DJS and MSDE staff, meeting with MSDE and with DJS staff.

¶ 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	During this reporting period, MSDE took a number of steps to ensure that the screening process at BCJJC identifies students eligible for special education in a timely manner and refers for assessment those students potentially eligible for service. Students continue to receive initial assessments within one to three days of their arrival at the BCJJC. An instructional assistant administers the STAR reading and math assessments (computer-based achievement tests) and interviews all new students. Earlier in the year, MSDE hired a lead special education teacher who has among other things, assumed responsibility to ensure that the intake screening and initial assessment occur as appropriate. The lead teacher along with two records clerks has assumed responsibility for documentation and file management. Now intake screening and assessment data and reports from prior schools are reviewed and used to make interim placement decisions. On average, two "child find" meetings are held each month to review screening and intake assessment data. While scheduling youth for initial intake interviews and assessments is sometimes a challenge, there has been a marked improvement in both the procedures and the outcomes associated with this process. A problem noted in earlier report, the disproportionate representation of youth with low academic performance and potential special education eligibility among students receiving disciplinary write ups, was not an issue during this reporting period.
Recommendations	The State is in substantial compliance with this provision. It is further recommended that: 1. The lead special education teacher and the principal should periodically review the screening and intake process to ensure the improvements made since the last reporting period are maintained.
Evidentiary Basis	Site visits, review of students' files, review of 122 student behavior reports, review of special education student rosters, discussion with MSDE staff.

¶ III.F-1.iv	<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.
Compliance Rating	**Partial Compliance**
Discussion	On November 13, 2008, there were 29 students at BCJJC identified as eligible for special education services with one student identified for accommodations and support with a 504 Plan. Review of student files, interviews with students, and classroom observations indicated that some students appear to receive appropriate services. However the problems noted above (III.F-1.i) compromise the ability of educators to implement IEPs for many students. The 9 IEPs reviewed during a November 2008 site visit appeared to be well written. IEPs contained meeting notes that indicated what adaptations teachers were making as they implemented existing IEPs. Meetings were well attended and showed input from case managers, general education teachers, and support staff. All IEP folders contained service logs for students receiving supplementary support such as counseling and speech therapy. The special education team scheduled 25 IEP meetings during November. Meetings were scheduled to create new IEPs, review and update existing IEPs, and to schedule and /or review functional behavioral assessments (FBAs) and create behavioral support plans (BIPs). At least three youth and possibly more were released prior to their scheduled meetings. The special education group also conducted two "child find" meetings during November. A problem noted in earlier reports and discussed above, students refusing to go to their scheduled special education classes, continued during this reporting period.
Recommendations	Special education service continues to be a concern. During the next reporting period, the education monitor will meet periodically with teachers, DJS leadership and supervisors, and the school principal to address the remaining problem areas. The principal and special education lead teacher need to carefully monitor and address the problem of students refusing to work with specific teachers. The school should 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.

	In order to achieve substantial compliance with this provision, the State must demonstrate that it has addressed problems associated with students' refusing services and the ensuing chaos that occur in some classrooms. The on-going meetings with the education monitor are designed to collaboratively address these problems.
Evidentiary Basis	Review of 9 student files, interviews with 7 students, observation of 11 classes, and meeting with special education teachers.