



U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

AUG 22 2012

The Honorable Mitch Daniels
Governor, State of Indiana
Office of the Governor
State House, Room 206
Indianapolis, Indiana 46204-2797

Re: Investigation of the Pendleton Juvenile
Correctional Facility, Pendleton, Indiana

Dear Governor Daniels:

We write to report the findings of the Civil Rights Division's investigation of conditions at the Pendleton Juvenile Correctional Facility ("Pendleton" or "the Facility") in Pendleton, Indiana. On January 9, 2008, the Department of Justice ("Department" or "DOJ") notified you of our intent to conduct an investigation of Pendleton pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA") and the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141").¹ We completed our on-site inspections of Pendleton in October 2010. In July 2011, we notified the State that we were prepared to issue our findings. However, as discussed below, we have held our findings in abeyance in an effort to resolve this matter in a manner that would support the State's recent efforts to expand community-based treatment for youth, while addressing unsafe conditions in Indiana's juvenile facilities. Regrettably, although it initially signaled an openness to that approach, the State has now indicated that it is not interested in such a resolution. Accordingly, we now issue our findings of our investigation of Pendleton.

We find that Pendleton exposes incarcerated youth to significant harm in violation of their constitutional and federal statutory rights. Pendleton fails to take reasonable steps to prevent youth from committing suicide, fails to provide reasonably safe conditions of confinement for youth, fails to provide youth with adequate mental health care, and fails to provide youth with

¹ CRIPA authorizes the Department of Justice to investigate and take appropriate action to enforce the constitutional and federal statutory rights of juveniles in juvenile justice facilities. 42 U.S.C. § 1997. Section 14141 prohibits any governmental authority responsible for incarcerating juveniles from engaging in a pattern or practice of conduct that deprives those juveniles of constitutional or federal statutory rights. 42 U.S.C. § 14141. Both statutes grant the Attorney General authority to file a civil action to eliminate any pattern or practice. *Id.*; 42 U.S.C. § 1997.

adequate special education services, in violation of the Constitution and the Individuals with Disabilities Education Act (“IDEA”), 20 U.S.C. §§ 1400-1482. See Youngberg v. Romeo, 457 U.S. 307 (1982);² Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974), 20 U.S.C. §§ 1400-1482.

Pendleton is one of several juvenile facilities in IDOC that has been the subject of an investigation by the Department pursuant to CRIPA and Section 14141. In 2004 and 2005, we investigated, and found unlawful conditions and practices at, the South Bend Juvenile Correctional Facility (“South Bend”), Plainfield Juvenile Correctional Facility (“Plainfield”), and Logansport Juvenile Intake/Diagnostic Facility (“Logansport”). Thereafter, the State closed Plainfield, and we entered into a settlement agreement (“Agreement”) with the State addressing our findings at South Bend and Logansport in February 2006. The Agreement terminated in February 2010, after the State substantially complied with its terms. In addition, we opened an investigation of the Indianapolis Juvenile Correctional Facility, which is now known as the Madison Juvenile Correctional Facility, on January 28, 2008, and issued findings of unconstitutional conditions in that facility on January 29, 2010.

DOJ first became concerned about Pendleton in 2005. We received reports about problems in the Facility and discussed them with the State. The State voluntarily pledged to implement reforms contained in the Agreement to Pendleton as well. Following continued reports of unsafe conditions at Pendleton, the State invited us to visit the Facility, to see first-hand the conditions and its voluntary compliance with the Agreement. We accepted this invitation and, in October 2007, we visited Pendleton, accompanied by a juvenile justice expert. Our visit to the Facility confirmed our concerns about conditions of confinement at Pendleton. For example, on September 27, 2007, just days before our visit, a youth violently assaulted his 59-year-old teacher, knocking out two of her teeth, breaking her uvula, causing multiple lacerations, and sending her to the hospital. The next day, a youth assaulted another youth, putting the victim into a coma and nearly killing him.

Following notice of the Department’s intent to open an investigation of Pendleton, the Department and its expert consultants conducted on-site inspections at the Facility from June 3 to 6, 2008, September 22 to 24, 2008, and October 5 to 7, 2010. In each of these inspections, we observed unsafe, violent and non-rehabilitative conditions, notwithstanding repeated representations on behalf of the State that it was working to reform Pendleton.

More broadly, in our series of investigations of juvenile facilities in Indiana Department of Correction (“IDOC”), we have become increasingly concerned that the State has been unable to maintain a system of constitutionally adequate protections in its juvenile facilities. Rather, as the

² Youngberg’s articulation of the substantive due process rights of confined individuals is particularly noteworthy. In Youngberg, the mother of an individual with a developmental disability who was held in a state institution filed a lawsuit against the institution after her son suffered numerous injuries at the facility. 457 U.S. at 301. The Supreme Court held that an individual in state custody has substantive due process rights under the Fourteenth Amendment, including the right to safe conditions of confinement and freedom from restraint. Id. The Court also found that the State had a duty to provide the plaintiff with adequate training to “ensure his safety and to facilitate his ability to function free from bodily restraints.” Id. at 324. Moreover, the State must provide “essentials” of care, *i.e.*, adequate medical care, food, shelter, and clothing. Id. The Court further made clear that its holding applied to individuals who are incarcerated, noting that “the right to personal security constitutes a historic liberty interest . . . that . . . is not extinguished by lawful confinement, even for penal purposes.” Id. at 315 (citations and internal quotation marks omitted).

focus and resources shift from facility to facility, additional problems appear to emerge at other facilities. The State's ability to provide adequate assurances of constitutional conditions system-wide thus is likely to be a factor for consideration in the resolution of our investigation. More fundamentally, it is widely recognized that the unnecessary institutionalization of children is deleterious, and that the harm of institutionalization can be irreparable. This is particularly the case in an institution as dangerous and lacking in rehabilitative services and treatment as Pendleton.

At the same time, we recognize that the State has made significant efforts in recent years to reduce its reliance on secure confinement and bolster community services for youth who otherwise many come into IDOC custody. For this reason, we delayed issuing our Pendleton findings in an effort to reach a system-wide resolution that would address the unsafe conditions in Indiana's juvenile facilities within the framework of Indiana's progress in expanding community-based treatment for youth. As noted above, the State has rejected this approach. However, in rectifying the deficiencies identified below, the State nonetheless must address the fundamental question of whether its institutional model of juvenile corrections adequately serves the State's public safety and rehabilitative objectives in a manner consistent with the State's obligations under federal law.

Constitutional conditions in juvenile facilities are essential, as a matter of law, and important, as a matter of policy. In any given year, approximately 100,000 youth are confined in residential correctional placement facilities in the United States. Office of Juvenile Justice and Delinquency Prevention ("OJJDP") Statistical Briefing Book, Custody Data (1997-present), Sept. 12, 2008. Nearly all of these youth will return to their communities. Adequate conditions and effective rehabilitative treatment during confinement have been shown to greatly increase the likelihood of successful reintegration and diminish rates of recidivism. In fact, effectively implemented Cognitive Behavior Treatment programs that equip youth to address maladaptive behaviors have been shown to reduce recidivism rates by as much as 50 percent. See OJJDP Model Programs Guide, Cognitive Behavioral Treatment, *available at* <http://www.ojjdp.gov/mpg/progTypesCognitiveRes.aspx> (last visited July 19, 2012). Such programs are also important because many youth in juvenile facilities face significant challenges, including the lack of stable family and community environments.

We recognize and appreciate the assistance, professionalism, and courtesy that IDOC officials and Pendleton administrators and staff have shown to us throughout the course of our investigation of Pendleton. During the exit conferences the State expressed a genuine interest in remedying Pendleton's deficiencies. Many Pendleton staff genuinely care about the well-being and rehabilitation of the youth at the Facility. Additionally, we commend the State on taking steps to decrease its juvenile facility population and to increase the community-based treatment options available to youth in recent years.

We look forward to continuing to work with the State, including Pendleton officials, in the same cooperative manner we have thus far enjoyed. We hope the State will reconsider its rejection of our offer to work toward a State-wide remedy. We will contact the State's attorneys shortly to discuss resolution of this matter in further detail.

I. SUMMARY OF FINDINGS

We find that the following unconstitutional and unlawful conditions exist at Pendleton:

- Gross failures in screening, identification, housing, supervision, and treatment of suicidal youth. These failures include housing suicidal youth in punitive, anti-therapeutic isolation that is likely to increase youth's risk of suicide or other self harm. Pendleton's inadequate mortality-morbidity reviews, along with its failure to provide adequate suicide prevention training to staff, contribute to the Facility's unconstitutional suicide prevention practices.
- Failure to adequately protect youth from sexual misconduct, as evidenced both by internal documents and by internal and external statistical reports concluding that Pendleton has one of the highest rates of sexual victimization in the nation.
- Failure to protect youth from violence by other youth, including fights and assaults leading to serious injuries.
- Failure to provide youth with adequate rehabilitative treatment, including by the extended isolation of some youth in their rooms for 23 hours per day. Pendleton's inadequate staffing patterns, incarceration of youth in a traumatizing, anti-therapeutic environment, and inadequate grievance processes are among the most significant causes of the Facility's inability to keep youth reasonably safe.
- Failure to provide adequate mental health screening and assessment, including failing to accurately diagnose youth's serious mental health disorders.
- Failure to provide adequate treatment planning, management of psychiatric medications, and mental health contacts and counseling.
- Failure to provide adequate transition planning, leaving youth who need mental health care with no documentation of their needs and recommended treatment upon discharge. Pendleton's inadequate staffing, inadequate quality assurance processes, and traumatizing environment contribute to the Facility's failure to provide constitutional mental health care to youth.
- Failure to comply with IDEA's requirements for youth with disabilities regarding: Child Find, which requires identification, location, and evaluation of youth in need of special education services; general education interventions; Individual Education Plans ("IEPs"); access to special education services; access to the general education curriculum; behavioral supports; and transition services. This failure includes providing school for only one hour per day to many youth in the Facility's Behavior Modification Unit ("BMU"). Many of these youth are mechanically restrained during school. Moreover, the Facility's unsafe school environment impedes students' rights to receive a free and appropriate public education, as required under IDEA.

We recognize that the State has taken steps to begin to remedy violations at Pendleton since our initial tours in 2008. For example, the State has attempted to move toward a more youth-focused rehabilitation model, reduced Pendleton's population, adopted improved grievance and suicide prevention policies, and improved education policies and procedures.

Additionally, as noted above, we recognize that the State has made significant progress in diverting youth from institutions and moving toward community-based alternatives to incarceration. Notwithstanding these strides, however, deficiencies in the State's system for reintegrating youth who are discharged from IDOC facilities prevent those youth, particularly youth with disabilities, from receiving the supports and services necessary to ensure adequate rehabilitation and reintegration back into their families, schools and communities.

II. INVESTIGATION

Our review of Pendleton focused on the treatment of youth in the Facility, specifically with respect to juvenile justice issues and the provision of suicide prevention, mental health, and special education services. Before, during, and after our visits, we reviewed documents, including policies and procedures, incident reports, youth detention records, mental health records, grievances from youth residents, unit logs, orientation materials, staff training materials, and school records. During our visits, we also interviewed staff members, youth residents, mental health care providers, teachers, and administrators. In keeping with our pledge to share information and to provide technical assistance, at the conclusion of each of our tours we conducted an exit conference with State officials and attorneys. During these conferences, our consultants conveyed their preliminary observations and concerns.

III. BACKGROUND

Pendleton is a 360-bed maximum security juvenile facility in Pendleton, Indiana. At the time of our 2010 tour, the Facility's population was approximately 185 adjudicated delinquent male adolescents. Youth sent to Pendleton generally are at high risk for violence against others, and/or have serious mental health needs or histories of escape. Pendleton also incarcerates all the State's male juvenile sex offenders.

Pendleton incarcerates most youth in one of three residential areas, each of which contains four living units. In each unit, up to four youth are generally housed in each sleeping room. Youth are locked in their rooms during sleeping hours, and the rooms are not plumbed. Each room opens into a large shared dayroom. A network of security cameras offers live video of much of the interior of the living units, as well as of other parts of the Facility. Some of Pendleton's living units house youth in the general population, based on age and risk level, while other units have programs ostensibly tailored to specific needs, including a unit for sex offenders; a unit that focuses on spiritual, moral, and character development; and a unit for youth interested in military service. The BMU holds up to 24 youth in individual rooms and is reserved for aggressive youth. There also is a Segregation Unit, where most suicidal youth are held, but which also holds youth in segregation as punishment. Youth in segregation are housed in individual rooms.

The Facility has smaller residential units, including the admission/orientation unit, which houses newly arrived youth. The intensive treatment unit houses youth with severe mental health needs and youth assessed as having low IQs. The sheltered housing unit (“SHU”), which contains a padded cell, a two-bed room, and a four-bed dormitory, houses youth with long-term medical issues, as well as suicidal youth.

IV. FINDINGS

A. **Pendleton Fails to Take Reasonable Steps to Prevent Youth from Committing Suicide, in Violation of the Constitution**

The Constitution requires that Pendleton take reasonable steps to prevent youth from committing suicide or otherwise harming themselves. See Youngberg, 457 U.S. at 315-16; K.H. ex rel. Murphy v. Morgan, 914 F.2d 846, 851 (7th Cir. 1990) (“Youngberg v. Romeo made clear . . . that the Constitution requires the responsible state officials to take steps to prevent children in state institutions from deteriorating physically or psychologically”). Youth in juvenile institutions are particularly vulnerable to suicide and other self-inflicted harm. Pendleton fails to adequately screen youth for risk of suicide, inappropriately relies on room confinement to manage suicidal youth, and fails to provide suicidal youth with adequate supervision and mental health services, in violation of the Constitution.

Many of the unconstitutional deficiencies in Pendleton’s suicide prevention practices are illustrated by the June 2008 suicide of AA (the initials used to refer to youth in this letter are pseudonyms to protect their privacy). According to Facility records, AA had a long and well-documented history of self-injurious behavior, suicide attempts, suicidal ideation, and mental illness. Despite this history, records show that on multiple occasions throughout his three years at Pendleton, mental health staff inappropriately assessed AA as a low risk for suicide and failed to provide him with adequate follow-up treatment and supervision.

AA’s overt suicidal behavior escalated in 2008. On May 17, 2008, medical staff evaluated AA after he ingested several pills, but Facility records contain no indication that he received a referral to mental health staff for an assessment. Four days later, staff observed AA punching a wall several times. He subsequently refused his medication and, again, the records are devoid of any indication of a referral to mental health staff. Just five days later, on May 26, 2008, AA attempted suicide by tying one end of his bed sheet around his neck and the other end to his bed. Staff intervened and escorted AA to the Health Care Unit (“HCU”), where a nurse examined him and he signed a “safety contract.” A safety contract is a signed agreement in which a youth promises not to harm him or herself; the use of such contracts is outmoded and generally considered by mental health professionals to be ineffective. The records contain no indication that AA was placed on suicide precautions after this attempt or ever assessed by mental health staff.

Approximately two weeks later, on June 13, 2008, a staff member once again found AA with one end of a bed sheet tied around his neck and the other end tied to his bed. This time, however, AA was unconscious. Staff initiated cardiopulmonary resuscitation, and emergency personnel arrived approximately 21 minutes later and took AA to the hospital. Tragically, AA

sustained permanent brain damage and died four days later, just a few weeks after his 17th birthday.

The events leading up to AA's death include examples of Pendleton's failure to provide adequate assessment, supervision, and mental health services to a suicidal youth. Unfortunately, our October 2010 visit confirmed that the unconstitutional conditions that facilitated AA's death largely remain at Pendleton. Below we discuss the specific deficiencies in Pendleton's current suicide prevention practices.

1. Pendleton Fails to Adequately Screen and Identify Youth at Risk of Suicide

Pendleton's pre- and post-intake suicide screening is unconstitutional. Youth held in juvenile correctional facilities present a heightened risk of suicide throughout their confinement. Minimum protections from harm require that facilities adequately screen youth for suicidal ideation upon entry to the Facility, and monitor and identify suicide risk factors throughout the youth's confinement. Pendleton's screening and monitoring are unconstitutional.

Upon admission to Pendleton, youth are screened by an intake counselor. The data relied upon by the intake counselor are often inaccurate. The State uses a computerized management information system, called the "Juvenile Data System" ("JDS"), which provides classification information and "special alerts," including a "suicide history" alert. The "suicide history" section, however, is not consistently updated in JDS when a youth is subsequently placed on suicide precautions at Pendleton. This results in inaccurate suicide risk assessments in subsequent screenings for youth re-entering Pendleton. For example, during our 2010 tour, we reviewed records for youth currently at Pendleton who had been on suicide precautions during a previous incarceration. This information, however, was not noted in the JDS and, therefore, was not considered in current intakes.

Pendleton's post-intake suicide screening and identification practices are not sufficient to reasonably protect youth from suicide. Although Pendleton's suicide prevention policy provides clear guidelines regarding the behaviors that trigger an assessment of suicide risk and how that referral process should be made, Facility personnel fail to follow this policy. Although the Facility has two forms for evaluating and identifying suicide risk after a youth is escorted to the HCU, we found no evidence that medical personnel used either form in their evaluations. Indeed, the medical staff members we interviewed were unaware that the forms existed.

Similarly, the Facility has an initial mental health assessment form that summarizes the youth's prior mental health history and includes a current mental status examination, suicide risk inquiry, provisional diagnosis, and treatment plan. We found no evidence that the psychologist completes this assessment form. Mental health professionals do not consistently conduct suicide risk assessments in person before releasing a youth from suicide precautions. This failure continues to occur despite a recent change to Pendleton policy specifically requiring a face-to-face assessment by a mental health professional before taking such action.

Mental health staff do not always take threats of suicide seriously. In 2008, some mental health staff we interviewed rationalized their failure to take action on threats, claiming that many youth threaten self injurious behavior because they feel unsafe in their housing units and seek a

transfer to segregation. This is troubling on two grounds. First, it suggests that violence and fear of violence is pervasive. Second, it is dangerous because manipulation and suicidal behaviors are not necessarily mutually exclusive. In addition, youth who exhibit manipulative suicidal behavior may in fact accidentally commit suicide. Accordingly, a multidisciplinary team must properly evaluate any expression of suicidal ideation.

2. Pendleton Houses Suicidal Youth in Inappropriate and Unsafe Conditions

Pendleton houses suicidal youth in inappropriate and unsafe conditions that are likely to increase the youth's risk of suicide or other self harm. This violates the Constitution. More than 50 percent of all juvenile suicides occur while a youth is in isolation or room confinement. Hayes, Lindsay M., *Characteristics of Juvenile Suicide in Confinement*, Juvenile Justice Bulletin, OJJDP, Feb. 2009, available at <http://www.ncjrs.gov/pdffiles1/ojjdp/214434.pdf>. The use of isolation often not only escalates the youth's sense of alienation and despair, but also further removes youth from proper staff observation. At Pendleton, suicidal youth are removed from the general population and are segregated within the Facility. Most are housed in the Segregation Unit, which contains single cells with closed circuit television ("CCTV") monitoring. Other suicidal youth, generally those who are on higher levels of suicide watch and require constant observation are housed in the padded cell in the SHU. Segregating suicidal youth in either of these locations is punitive, anti-therapeutic, and likely to aggravate the youth's desperate mental state. Our suicide prevention consultant, a nationally recognized expert in the field who toured Pendleton in both 2008 and 2010, reports that conditions for housing suicidal youth at Pendleton are among the most punitive he has ever observed.

We raised serious concerns about these inappropriate housing practices during our 2008 exit meeting. Nevertheless, Pendleton continues to house most youth on suicide precautions in the Segregation Unit, and youth continue to make dangerous and alarmingly undetected suicide attempts while on that unit. For example, in June 2010, a youth tied a string around his neck for more than 15 minutes before staff observed the incident on CCTV and responded.

Moreover, while housed in segregation, suicidal youth are subject to extraordinarily severe and, in effect, punitive conditions in violation of the Constitution. They are locked in their cells for approximately 23 hours per day and have only one hour to shower and engage in recreation. They are clothed in nothing but a "safety smock," to which many of the youth refer as a dress, and are permitted no other possessions in their cells. These extreme conditions increase the risk of harm. First, as discussed below, these conditions typically escalate a youth's sense of alienation and despair, thereby increasing the youth's risk of suicide or other self-harm. Second, by staff's own admission, these conditions deter Pendleton's mental health staff from placing or keeping youth on suicidal precautions, exposing youth to the risk of inadequate supervision during critical times. Third, under these punitive conditions, it is likely impossible to accurately assess whether a youth continues to be a suicide risk. Faced with the prospect of remaining isolated in a segregation cell for most of the day, clothed only in a smock and with nothing to do, a youth may deny suicidal ideation even if he is experiencing it, simply to get out of segregation. Indeed, many youth confirmed this during our tours. For example, one youth reported to us in 2010, "Oh no, I'm not suicidal because the last time I had to wear a green dress."

Pendleton's use of its padded cell to house youth exhibiting suicidal behavior presents additional concerns. This cell does not contain a bunk, sink, toilet or any other furnishings. As in segregation, youth are permitted only a safety smock and are on "lockdown" status, confined to the cell for 23 hours a day. Pendleton has no written guidelines regarding use of the padded cell and, therefore, the potential for misuse is particularly high. We became aware of a highly disturbing example of this during our 2010 tour. GG is 15 years old, reportedly has a developmental disability, and has a history of smearing and eating his feces. Pendleton staff expressed the belief that Pendleton was not an appropriate placement for GG, yet he remained there for 12 months, and was released approximately two weeks prior to our arrival. According to facility records, on a number of occasions, GG was placed in the padded cell for "time-outs" relating to incidents that did not involve any self-injurious behavior. Moreover, in August 2010, GG was confined to the padded cell for nearly 24 hours after threatening suicide and draping his jumpsuit around his neck. Confining a youth to a barren, padded cell for anything less than to prevent ongoing, self-injurious behavior, or for an extended period of time, is non-therapeutic, extremely punitive, and violates the Constitution.

3. Pendleton Fails to Adequately Supervise Youth at Risk of Suicide

The prompt provision of emergency first aid and medical services to an acutely suicidal youth can save his life. The promptness of the response is often determined by the level of supervision afforded the youth. Pendleton has policies that set forth adequate levels of supervision for youth with suicidal behavior. However, Pendleton does not consistently adhere to its policies. We found numerous examples of suicidal youth left unsupervised in the Segregation Unit for long enough to make serious suicide attempts.

We viewed an especially disturbing example of the lack of adequate supervision at Pendleton in 2008, leading us to send an emergency letter to the State regarding Pendleton's alarming suicide prevention practices. The video recording showed a youth obstructing the view of the camera in his cell with a wad of toilet paper. For nearly one hour of the video coverage, the camera's view remained blocked without staff intervention. Eventually, the youth removed the obstruction and revealed that he had secured a noose to the ceiling vent. The next several minutes of video showed him testing the noose's strength and height. Ultimately, the youth hung himself for several minutes and passed out before staff members finally cut him down and revived him. On June 16, 2008, we sent a letter to then-Commissioner Donahue, expressing our serious concerns about this youth's attempted suicide and the overall lack of supervision at Pendleton. In this letter, we urged the State to take immediate measures to ensure that Pendleton youth were adequately supervised. See June 16, 2008 Letter to Commissioner Donahue from Shanetta Y. Cutlar, then-Chief of the Special Litigation Section.

Following AA's suicide in 2008, Pendleton implemented an electronic watch tour system that requires correctional officers to conduct room checks in the Segregation Unit at five-minute intervals 24 hours per day and at five-minute intervals in the overnight hours in all other housing units. Although a commendable initiative, segregation staff report that it is difficult to comply with this policy due to staffing limitations. Indeed, during our 2010 tour, we observed the Segregation Unit on a morning during which one youth in segregation was on constant observation (i.e., observation by a staff member on a continuous, uninterrupted basis) and three others were on "close observation," (i.e., observation by a staff member at staggered intervals not

to exceed every 15 minutes). Only three staff members were assigned to the unit: the first officer was in the control booth, the second was stationed outside the cell of the youth on constant observation, and the third was responsible for supervising all of the other youth on the unit that morning, including the three on close observation, as well as several others in the recreation yard and shower. It was clear from our observations that the third officer could not comply with all of his supervision responsibilities.

4. Pendleton Fails to Provide Adequate Follow-Up Treatment for Suicidal Youth

To keep youth who have exhibited suicidal behavior reasonably safe, it is critical that Pendleton provide adequate follow-up treatment after a suicide attempt or other suicidal behavior. We found countless examples, during both of our tours, where the follow-up treatment was grossly deficient or entirely absent, in violation of the Constitution. Below are examples from our 2010 tour:

- PP entered Pendleton in July 2009. In early March 2010, he threatened suicide and tied a cloth around his neck and to the bed post in his room. A couple of weeks later, on March 14, he threatened to commit suicide and the decision was made not to place the youth on suicide precautions, apparently after he agreed to sign a safety contract. PP returned to suicide precautions in early May after expressing suicidal ideation. Although a multidisciplinary team meeting was convened about him the following day, the note in his record from this meeting states only that the youth is “dysthymic which runs in the family.” Dysthymia is a chronic depression, which is less severe than major depressive disorder. PP saw the psychiatrist in both May and June, but the notes from those visits do not mention his suicidal ideation. In July, he was observed eating glass and was placed on close observation status. The following day, he tried to hang himself with a towel and his status was changed to constant observation. A treatment plan was then developed for PP, containing goals to “reduce potential for self-harm,” and “manage feelings of anger with appropriate coping skills,” and an objective of attending therapy “5 times within 30 days.” PP was placed on suicide precautions in both July and August 2010 for a possible overdose as well as for self-injurious behavior. For this entire time period, there are no notes from any mental health clinician reflecting any work on PP’s treatment plan objectives. PP was released from Pendleton in September 2010. Incredibly, his discharge summary states that the focus of treatment was “suicidal ideation and feelings of depression” and that his “treatment goals were met.”
- LL had a history of suicide attempts in the community, and several of his friends and a cousin had committed suicide. His record described him as extremely sad and depressed. In August 2010, he was placed on suicide precautions after staff found a notebook in which he wrote about suicide. He was reassessed a few days later and denied any suicidal ideation and claimed that “he is being punished on this watch.” He was discharged from suicide precautions and a treatment plan was developed that included objectives to “identify positive coping skills to manage suicidal ideation” and to attend therapy eight times per month. Although several subsequent psychiatric notes refer to LL’s need to “work in therapy on coping skills,” there are no mental health notes from any clinician that reflect any work on his treatment plan objectives from September through November 2010.

5. Pendleton's Inadequate Mortality-Morbidity Reviews, Inadequate Staffing, and Inadequate Staff Training Program Contribute to the Facility's Unconstitutional Suicide Prevention Practices

We found that Pendleton does not consistently conduct adequate mortality-morbidity reviews after a completed suicide or a serious suicide attempt. Moreover, when it does conduct a review, critical features, such as a thorough review of the surrounding circumstances, possible precipitating factors and medical and mental health services/reports involving the youth victim, as well as identification of corrective actions, are lacking. For example, following AA's suicide in 2008, Pendleton conducted a mortality review. The review lasted approximately 45 minutes and failed entirely to identify a large number of blatant inconsistencies and obvious deficiencies, including that: staff had previously failed to place AA on suicide precautions and refer him to mental health; staff had been grossly uninformed about AA's history; and key staff provided entirely differing and conflicting accounts about a prior serious suicide attempt by AA. Further, the review did not assess staff training, relevant policies, or staff's 10-minute delay in notifying outside emergency personnel. Finally, the review did not specify any corrective action.

Our 2010 tour confirmed that Pendleton continues to conduct inadequate mortality-morbidity reviews. For example, the August 2010 morbidity review for PP's suicide attempt in July was largely incomplete, with many sections of the document left blank and no corrective action identified. The fact that Pendleton fails to conduct adequate mortality-morbidity reviews for suicides and serious suicide attempts – even after a youth recently committed suicide at the Facility – increases the likelihood that another youth will successfully commit suicide, or suffer serious harm during an attempt in the future.

Additionally, Pendleton's inadequate staffing patterns contribute to the Facility's unconstitutional suicide prevention practices. As discussed throughout this letter, the facility lacks adequate staffing to keep youth safe. The facility lacks sufficient custody staff to adequately monitor youth, including suicidal youth, on a day-to-day basis, and lacks adequate mental health staff to address youth's serious mental health needs, including the risk of suicide.

Finally, deficiencies in the scope, content, and duration of Pendleton's suicide prevention training program also contribute to its unconstitutional conditions in this area. Properly trained staff is essential to ensuring that youth in Pendleton are reasonably safe from suicide and self-harm. Although Pendleton revised its training program following AA's suicide and after we raised concerns about this training during our 2008 exit remarks, the program still does not address basic, essential suicide prevention topics, such as removing obstacles to suicide prevention, identifying suicide risk despite the denial of risk, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, and the proper response to a suicide attempt.

B. Pendleton Fails to Provide Reasonably Safe Conditions of Confinement to Youth, in Violation of the Constitution

The Fourteenth Amendment to the Constitution requires States to provide reasonably safe conditions of confinement to juveniles who are incarcerated after having been adjudicated delinquent. See Deshaney v. Winnebago County, 489 U.S. 189, 200 (1989) (“[W]hen the State

... so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs – e.g., food, clothing, shelter, medical care, and reasonable safety – it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.”); Youngberg, 457 U.S. at 315-16 (recognizing that a person with mental retardation held in state custody has substantive due process rights under the Fourteenth Amendment, including the right to safe conditions of confinement); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979) (applying the Fourteenth Amendment standard to a facility for adult pre-trial detainees); K.H. ex rel. Murphy v. Morgan, 914 F.2d 846, 851 (7th Cir. 1990) (noting that Youngberg requires the State to ensure that youth in its institutions do not suffer physical or psychological deterioration); Nelson, 491 F.2d at 357, 360 (applying both the Eighth Amendment and substantive elements of the Due Process Clause of the Fourteenth Amendment in determining the rights of juveniles in a medium security facility).

The State violates the Constitution by failing to provide Pendleton youth with reasonably safe conditions of confinement. The State fails to adequately protect youth from sexual abuse, fails to adequately protect youth from violence at the hands of other youth, and fails to provide youth with adequate rehabilitative treatment. These deficiencies are caused in part by Pendleton's inadequate staffing, anti-therapeutic environment, and deficiencies in the Facility's grievance process.

1. Pendleton Fails to Adequately Protect Youth from Sexual Misconduct

The State must keep juveniles in its institutions reasonably safe from harm inflicted by other juveniles. See J.H. ex rel. Higgin v. Johnson, 346 F.3d 788, 791 (7th Cir. 2003) (“[C]hildren in state custody have a constitutional right not to be placed in a foster home where the state knows or suspects that the children may be subject to sexual or other abuse.”); see also Farmer v. Brennan, 511 U.S. 825, 834 (1994) (noting that “[b]eing violently assaulted in prison is simply not ‘part of the penalty that criminal offenders pay for their offenses against society.’”) (citing Rhodes v. Chapman, 452 U.S. 347, 337 (1981)). The State violates the Constitution by failing to adequately protect confined youth from sexual victimization.

Internal documents at Pendleton show a disturbing number of incidents of sexual misconduct. The following are just a few examples:

- An investigation confirmed that a youth had sexually assaulted another youth after an officer found the youth together in a unit shower on September 10, 2010. The investigation further found that staff had failed to adequately supervise the youth.
- On June 18, 2010, a youth reported to an officer that his roommates were having oral and anal sex.
- A youth reported to an officer that his roommates had raped him and forced him to perform oral sex on March 28, 2010.
- On March 12, 2010, an officer observed two youth engaging in oral sex. The youth were removed from their rooms and placed in time out. During the escort, one of the youth stated that a third youth also had been involved in the sexual activity. Later, the third

youth told a nurse that one of the first two youth had grabbed him by the back of the head forced him to perform oral sex on the other youth.

- On March 9, 2010, a youth reported to staff that two other youth had engaged in oral and anal sex. One of the involved youth admitted to the incident while the other denied it. The youth who admitted the activity initially said it was “consensual” but later said he feared “repercussions” if he did not participate.³

In addition, statistical reports from a number of sources, including the Facility, Performance-based Standards (“PbS”)⁴, and the Bureau of Justice Statistics (“BJS”), show that Pendleton is one of the most sexualized juvenile facilities in the United States. Although the State has taken a number of measures to improve safety for youth confined to the Facility, the rates of sexual abuse and sexual activity at the Facility remain strikingly high. Indeed, according to April 2010 PbS data, 10.256% of interviewed Pendleton youth reported they were forced to engage in sexual activity within the previous six months. This is more than three times the national field average (“NFA”) of 3.369%. Although the PbS national field average is neither a representative nor a random sample and is based on facilities’ self-reporting, it is a useful data set for external comparisons related to the occurrence of critical incidents.

Similarly, a BJS Special Report found that Pendleton youth reported some of the highest rates of sexual victimization in the nation, also at a rate triple the national average. *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-2009*, (“BJS Report”), United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, January 7, 2010. According to the BJS report, an astounding 36.2% of Pendleton youth reported that they had been sexually victimized at the Facility; the national average is 12.1%. Moreover, 31.5% of Pendleton youth reported sexual victimization by staff. This is more than triple the national average of 10.3% and nearly triple the national average of 10.8% for males. Seven percent of Pendleton youth reported sexual victimization by another youth. This is 3.5 times the national average of 2% for males, and nearly triple the national average of 2.6%. All Pendleton youth reporting sexual victimization reported that it was nonconsensual, more than three times the national average of 2%. Moreover, 18.1% of youth reported staff sexual misconduct that included force, more than four times the national average of 4.3%.

As recently as June 2010, the State itself acknowledged the seriousness of Pendleton’s sexual victimization problem. At a June 3, 2010 hearing regarding the findings in the BJS report, State officials readily admitted that the Facility is “failing . . . in providing [its] staff with the training where they can effectively manage and deal with adolescent development” and that the

³ We note that, regardless of whether sexual activity in a juvenile justice facility is overtly coercive, it is never appropriate. As this example illustrates, coercion sometimes is subtle or implied, or is the result of manipulation of a vulnerable youth. Accordingly, sexual activity in a juvenile confinement setting cannot be “consensual.”

⁴ Performance-based Standards for Youth Correction and Detention Facilities is a self-improvement and accountability system voluntarily used by hundreds of facilities across the country to better the quality of life for youth in custody. PbS gives agencies tools to collect data, analyze the results to design improvements, implement change, and measure effectiveness with subsequent data collections from within the facility and against other participating facilities. See Council of Juvenile Correctional Administrators, Performance-based Standards (PbS), available at <http://pbstandards.org/initiatives/performance-based-standards-pbs> (last visited July 19, 2012).

Facility is “way behind in providing staff with the tools to be able to deal with that development process.” Hearings on Sexual Victimization in Juvenile Correctional Facilities Before the Review Panel on Prison Rape, U.S. Department of Justice, Office of Justice Programs (2010) (statement of Michael Dempsey, Executive Director, Indiana Department of Correction, Division of Juvenile Services, Pendleton) (“Prison Rape Hearings”); see also The Indychannel.com, Federal Panel Questions Sex Abuse At Juvenile Prison, June 4, 2010, <http://www.theindychannel.com/news/23790528/detail.html> (last visited July 19, 2012). Moreover, when the hearing panel pointed out that the sexual assault prevention section of the Pendleton manual lists “non-consensual sexual acts” as examples of serious incidents and asked the State whether consensual sex could ever exist in a juvenile facility, the State admitted that it is “behind” in this area as well. Prison Rape Hearings (statement of Edwin Buss, Commissioner, Indiana Department of Correction, Pendleton).

Consistent with the data, many youth and some staff with whom we spoke commented on the sexual atmosphere at Pendleton. For example, one youth stated that, although he believed that incidents of overt sexual behavior (“OSB”) and low-key fights had declined, OSB nonetheless occurred frequently. Another youth and an officer each separately alleged that sexual activity occurred most frequently on the Sex Offender Unit.

Pendleton’s housing of sex offenders further exacerbates the frequency of sexual abuse and exploitation, as well as the likelihood that such activity will go undetected by staff and administrators. Treatment programs for young sex offenders, who are often also victims of sexual abuse, typically house residents in single sleeping rooms. At Pendleton, however, all youth in the Facility’s sex offender program are housed in units that consist entirely of four-person sleeping rooms. Housing youth sex offenders in small group cells poses obvious opportunities for sexual activity. Although some facilities also may house sex offenders in double rooms after careful screening and risk assessment, most youth at Pendleton reported that they would feel unsafe in a double room.

2. Pendleton Fails to Adequately Protect Youth from Violence by Other Youth

The Constitution requires that incarcerated youth be protected from physical violence from other youth. See Youngberg, 457 U.S. at 315 16; Bell, 441 U.S. at 535 36 & n.16, K.H., 914 F.2d at 851; Nelson, 491 F.2d at 360. The State, however, fails to provide youth at Pendleton with this protection. Although Facility safety has improved since our 2008 tours, conditions at Pendleton remain dangerous and volatile. In particular, violent assaults are commonplace and often result in serious injuries.

We reviewed incident reports and summaries for a 25-day period in August 2010. Those reports documented 57 separate youth-on-youth fights and assaults. Many of these incidents resulted in significant injuries, including: a swollen and discolored eye resulting from multiple blows to a youth’s face and head; a groin injury; multiple bruises to a youth’s torso and arms; a swollen eye and abrasions to a youth’s elbow and knee; a bilateral eye injury; a swollen and bruised eye; and a head injury. Other incidents included: a youth who had a chemical thrown in his face; a youth who was hit and kicked in the face; a youth who was hit with a chair; a youth who was poked in the stomach with a broom handle; and a youth who was stabbed with a pencil.

Indeed, youth at Pendleton are subjected to violence and injuries at rates dramatically higher than national averages. The rate of youth-on-youth assaults is approximately 240% greater than the PbS NFA, and the rate of injuries resulting from youth-on-youth assaults is approximately 540% greater than the NFA. Unsurprisingly, nearly half of Pendleton youth reported that they had feared for their safety at the Facility within the last six months, a rate approximately twice the national average. The following table illustrates Pendleton's outlying rates of violence and youth's fears about their safety.

**Pendleton and the National Field Average
Performance Based Standards – April 2010⁵**

Standard	Pendleton Rate (April 2010)	PbS National Field Average (April 2010)	Analysis
Injuries to youth by other youth per 100 days of youth confinement.	0.358	0.070	Pendleton's rate is 5.4 times the national field average.
Injuries to youth per 100 person days of youth confinement. ⁶	1.468	0.574	Pendleton's rate is 2.5 times the national field average.
Assaults and fights involving youth per 100 days of confinement.	0.888	0.364	Pendleton's rate is approximately 2.4 times the national field average.
Percent of youth interviewed who report that they feared for their safety within the last six months.	46.701	23.016	Pendleton's rate is approximately twice the national field average.

Pendleton's internal data show that April was not an outlier month, but that the Facility's rates of such incidents remain very high throughout the year. The following table illustrates the high rates of youth violence and injuries from January 2010 through September 2010, as compared to the April 2010 PbS NFA:

**Youth-On-Youth Assaults and Injuries
January-September 2010**

Month	Pendleton Rate of Youth Assaults (compared to NFA)	PbS Rate	Pendleton Rate of Injuries Resulting from Youth Assaults (compared to NFA)	PbS Rate
January	0.508 (1.40 times)	0.364	0.390 (5.57 times)	0.070

⁵ PbS data collection periods occur twice annually, in April and October. At the time of our tour in early October 2010, the most recently available published PbS data for Pendleton was for April 2010.

⁶ This category includes injuries from any incident category.

Month	Pendleton Rate of Youth Assaults (compared to NFA)	PbS Rate	Pendleton Rate of Injuries Resulting from Youth Assaults (compared to NFA)	PbS Rate
	NFA)		NFA)	
February	0.998 (2.74 times NFA)		0.333 (4.76 times NFA)	
March	0.836 (2.30 times NFA)		0.306 (4.37 times NFA)	
April	0.889 (2.44 times NFA)	0.364	0.543 (7.76 times NFA)	0.070
May	0.542 (1.49 times NFA)		0.433 (6.19 times NFA)	
June	0.620 (1.70 times NFA)		0.372 (5.31 times NFA)	
July	0.664 (1.82 times NFA)		0.362 (5.17 times NFA)	
August	0.754 (2.07 times NFA)		0.542 (7.74 times NFA)	
September	0.588 (1.62 times NFA)		0.376 (5.37 times NFA)	

As the above table indicates, Pendleton’s rate of injuries from fights or assaults is disturbing. Indeed, for the nine-month period of January to September 2010, Pendleton’s rate was never below the NFA.

These statistics are drawn from reported incidents. The actual rate of youth violence at Pendleton is likely even higher. During interviews in 2008 and 2010, staff and residents candidly discussed unreported incidents. In fact, almost every youth we interviewed talked about the occurrence of clandestine fights. Both youth and staff refer to these as “low key fights” or “fights on the low key,” and nearly all staff and youth whom we asked purported to know the location of security camera blind spots. Although it is not possible to quantify the extent of the “low key” fighting, given the number of youth who mentioned this, the similarity and consistency of their separate descriptions, and youth’s and staff’s purported knowledge of camera blind spots, this is a significant issue.

3. Pendleton Fails to Provide Youth With Adequate Rehabilitative Treatment

Youth confined to Pendleton have a right to adequate rehabilitative treatment. Nelson, 491 F.2d at 360. See also K.H., 914 F.2d at 851 (noting that Youngberg made clear that “the Constitution requires the responsible state officials to take steps to prevent children in state institutions from deteriorating physically or psychologically.”). Rehabilitative treatment includes, but is not limited to, education, counseling, mental health services, and community reintegration planning and supports. OJJDP has noted that, because youth often lack social and communication skills, juvenile facilities should focus on educational skills such as problem solving, moral

reasoning, and conflict resolution. Stephens, Ronald D. and Arnette, June Lane, *From the Courthouse to the Schoolhouse: Making Successful Transitions*, OJJDP Bulletin, Feb. 2000, at 5 (“Making Successful Transitions”). The State violates the Constitution by failing to provide adequate rehabilitative programming to youth at Pendleton, particularly to those confined in the BMU, and by failing to provide reintegration planning and supports reasonably necessary for youth to be reintegrated back into their homes, schools and communities.

As noted above, the BMU ostensibly is aimed at providing intensive programming for youth whom the Facility deems aggressive and/or who have had difficulties adjusting to the general population. At the time of our October 2010 tour, the BMU housed 17 youth. Youth housed in the BMU at the time of our 2010 tour had histories including assaults on other youth and staff and overt sexual behavior. Rather than providing an intensive rehabilitative program to enable youth to return to the general population, however, the BMU program consists of isolating youth in their cells for up to 23 hours per day with no due process prior to their placement in the program. A more extensive discussion of the Facility’s failures in rehabilitative treatment is in the mental health section, below.

The BMU program’s physical plant is essentially identical to that of the Segregation Unit. The State considers the BMU to be a stand-alone housing unit. Accordingly, the State considers assignments to the BMU unit to be housing assignments rather than placements in segregation that would trigger due process rights. Nonetheless, the result is that the State is isolating youth for prolonged periods without affording them adequate due process.

The BMU handbook sets out a relatively intense intervention system for the program and provides that youth must work through the program’s four levels to be permitted to return to the general population. The day-to-day reality on the unit does not reflect these objectives. Youth on Level One, which lasts a minimum of two weeks, spend 22-23 hours each day locked in their cells, with only one hour for recreation and one hour for education. The hour of education is provided only if the youth’s behavior permits, with the youth attending class on the unit in mechanical restraints. Weather permitting, outdoor recreation occurs in an outdoor fenced-in area that youth call a “cage.” As they progress through levels, youth are permitted additional time outside of their cells, though it is unclear how much additional time they actually receive at the higher levels. Moreover, the Unit handbook provides no explanation for how the Facility determines when a youth is ready to return to his unit. Indeed, at least one youth on Level Four both expressed confusion about the criteria for exiting the program and noted that the program had not helped him make any lasting changes.

In short, we find that the BMU program is not effective at rehabilitating its residents. Although the concept of a special management unit for violent and disruptive youth is not inconsistent with nationally accepted standards, Pendleton’s excessive reliance on isolation in the BMU undermines the unit’s rehabilitative goals and objectives. At Pendleton, the BMU operates in practice as a holding facility that separates troubled youth from the general population, relying on long periods of cell confinement to achieve compliance while failing to provide any meaningful structured rehabilitation. This in turn is likely to exacerbate youth’s existing difficulties upon their return to the general population and release from the Facility. Additionally, the program as a whole is an indication that the Facility lacks adequate resources to address

youth's challenging behaviors, because it isolates troublesome behaviors rather than addressing them through adequate rehabilitative programming provided by trained staff.

Additionally, we find that the State fails to provide reintegration planning and supports for youth, particularly youth with disabilities. The State largely excludes youth discharged from DOC facilities from the supports and services it provides to other children in its child welfare system, including case management services and substance abuse and mental health treatment. This is true even if the youth was eligible for such services before entering DOC custody. This denial of services results in part from the funding structure for children's services in Indiana, which creates disincentives for inter-agency cooperation. Further, transition programs specifically for youth leaving restrictive placements are limited, and youth in most counties do not have access to such programs. Mental health services, in particular, are not adequately available to meet the needs of youth leaving DOC facilities. As a result of these deficiencies, many youth, particularly those with disabilities, are discharged from DOC facilities without supports and services that are critical to their successful reintegration into their homes, schools and communities.

4. Pendleton's Inadequate Staffing, Anti-Therapeutic Environment, and Deficiencies in the Facility's Grievance Process Contribute to the Facility's Failure to Keep Youth Reasonably Safe

Some of the most significant causes of Pendleton's failure to provide youth with a reasonably safe environment are the Facility's inadequate staffing, the Facility's anti-therapeutic environment, and deficiencies in the grievance process.

First, Pendleton's grossly inadequate staffing levels are perhaps the single largest contributor to many of the Facility's unconstitutional deprivations of youth's safety. A critical element to providing a safe environment in a juvenile facility is the staff-to-resident ratio. Absent a well-supported justification for more lenient ratios for particular youth, national standards require at least one staff to every eight youth during waking hours, and at least one staff to every sixteen youth during sleeping hours.

Staff counted in these ratios include only employees whose exclusive responsibility is the direct and continuous supervision of juveniles. National Partnership for Juvenile Services Position Statement: *Minimum Direct Care Staff Ratio in Juvenile Detention Centers*, Oct. 25, 1998. Although staffing ratios improved since our 2008 tours, Pendleton continues to fall far below these standards. During our 2010 tour, Pendleton continued to have dangerously and unacceptably high staff-to-youth ratios of up to 1:24 on the Sex Offender Unit, and 1:14 or 1:12 on the general population units. Moreover, during both tours, staff consistently expressed their views that the living units were understaffed.

Pendleton's population dropped sharply from approximately 270 youth in early June 2010, to 214 youth 11 days prior to our October 5-7, 2010 tour, to approximately 185 youth on the day of our arrival. Although this population reduction improved youth-to-staff ratios, we note that many of the youth who left were transferred to other IDOC facilities. Indeed, in the two months prior to our tour, 38 of the approximately 100 youth who left Pendleton were transferred to another IDOC facility; nearly 70% of these transfers occurred during the first two weeks of

September. This high rate of transfer to other IDOC facilities represents a significant departure from Pendleton's practice in the preceding three months. In May, no youth were transferred to other facilities, and in June and July combined, only six youth were transferred to South Bend (which had been newly designated the State's facility for the youngest boys). During our 2010 tour, youth and staff consistently alleged that the timing of the August and September transfers to other IDOC facilities was not coincidental and that the transfers were aimed at reducing Pendleton's population and increasing staffing ratios in time for our arrival.

Second, Pendleton's anti-therapeutic environment contributes to the Facility's inability to protect youth from harm. We have received numerous credible reports that some Pendleton staff treat youth in an anti-therapeutic and highly unprofessional manner, including the use of strikingly abusive, offensive, and combative language. For example:

- Youth reported that staff refer to youth on the Sex Offender Unit as "baby fuckers" and "baby rapists."
- A youth reported that a staff member tried to provoke the youth by making comments about his grandmother, who had passed away recently.
- Another youth reported that a staff member allegedly told the youth, "I'll have the students beat your ass." The youth further alleged that the officer placed his hands in the youth's face to provoke the youth, and that he routinely calls youth "bitches."

Many of the youth grievances we reviewed contained allegations consistent with these reports.

Derogatory comments by State employees responsible for youth, about youth's family, sexual orientation, or even hometown or neighborhood, are inappropriate and should not be tolerated. Indeed, unprofessional or provoking behaviors by staff often needlessly precipitate incidents resulting in avoidable youth-on-youth violence and staff-on-youth force.

Finally, although we find that the Facility's current grievance policy is appropriate, deficiencies in the implementation of Pendleton's grievance process appear to contribute to the Facility's inability to keep youth safe. During our tours, many youth told us that they did not receive responses to their grievances, or that the responses they did receive were superficial. Others indicated that they are required to obtain grievance forms from direct care staff, and that sometimes staff were an impediment to obtaining the forms. Overall, youth indicated that they had little or no faith in the fairness or reliability of the grievance system. In addition, disturbingly, we identified at least one grievance alleging abuse that apparently had not been investigated or referred to an external reporting agency.

A well functioning grievance process serves several critical functions that contribute to a safe environment for youth. First, it creates an orderly mechanism to resolve disputes and de-escalates tension. Second, it provides information to the institution about risks and emerging problems that need to be addressed. Third, it provides youth with confidence in the process that will encourage them to use proper channels as opposed to self-help.

C. Pendleton Fails to Provide Adequate Mental Health Care to Youth in Violation of the Constitution

The Constitution requires that youth in juvenile justice facilities receive adequate mental health care. Youngberg, 457 U.S. at 323 n.30; Nelson, 491 F.2d at 359-60; see also K.H., 914 F.2d at 851; A.M. v. Luzerne County Juvenile Det. Ctr., 372 F.3d 572, at 585 n.3 (3d Cir. 2004) (noting, with agreement, the view that “a state-run juvenile detention center at least has a duty to protect detainees from harm (whether self-inflicted or inflicted by others) and provide, or arrange for, treatment of mental and physical illnesses, injuries, and disabilities.”). The State must provide youth held in its facilities with rehabilitative treatment, which includes mental health care services. Nelson, 491 F.2d at 359-60 (noting that “the juvenile process has elements of both the criminal and mental health processes”). Like all services that the State provides to confined youth, mental health services may not depart from accepted professional judgment, practice, or standards. See Youngberg, 457 U.S. at 320-23. We find that the State violates the constitutional rights of youth at Pendleton by failing to provide them with adequate mental health care services.

As an initial matter, as most tragically demonstrated by the suicide of AA in 2008, discussed above, Pendleton fails to provide adequate mental health services to youth who require them. AA had a long history of self-injurious behavior at the Facility, yet he received grossly inadequate mental health care. Two years later, and despite some improvements, the Facility continues to provide inadequate mental health care to youth in its care, in violation of the Constitution.

Indeed, Pendleton’s failure to provide constitutionally adequate mental health care prevents youth from being able to fully benefit from any rehabilitation offered to them. This failure exacerbates youth’s difficulties in school, delays their progression through the Facility’s level system (thereby prolonging their stay at the Facility), and increases their risks of recidivism and future incarceration.

Specifically, Pendleton violates the Constitution by failing to provide youth with adequate mental health screening and assessment, adequate treatment planning, adequate mental health treatment, and adequate transition planning. These unconstitutional practices are further exacerbated by the Facility’s inadequate mental health staffing, inadequate quality assurance practices, and traumatizing environment.

1. Pendleton Fails to Provide Adequate Mental Health Screening and Assessment

Pendleton fails to adequately screen and assess youth for mental health needs, in violation of the Constitution. See Youngberg, 457 U.S. at 323 n. 30; Nelson, 491 F.2d at 359-60. The intake process fails to engage youth in a way that is likely to identify their true needs. Pendleton requires youth to answer personal questions in a non-private area and requires them to answer an officer’s questions about their medical history while the youth are undressed. Further, for youth referred for a mental health assessment after the initial screening, the assessment process fails to result in accurate diagnoses. Youth are routinely undiagnosed, underdiagnosed, and misdiagnosed, making it virtually impossible for the Facility to create adequate treatment plans and provide treatment for mental illness. During our 2010 tour, our consultant interviewed two

youth whom she determined had current, severe psychosis requiring urgent intervention. Neither youth had been identified as psychotic; accordingly, neither youth was receiving adequate treatment to address this serious mental health disorder. Although one of the youth had seen the psychiatrist during the prior week and had been appropriately medicated, he was not receiving close follow-up care because of the psychiatrist's limited hours at the Facility. The Facility responded quickly when we shared our concerns about both youth, however, and informed us that they received prompt mental health attention.

These failures are consistent with conditions we observed during our 2008 tour. During that tour, we found youth who had not been identified as having mental health disorders despite clear signs to the contrary, or who had been recognized as having such disorders, but whose needs were far greater than those the Facility had recognized.

Rates of diagnoses of mental health disorders within Pendleton are inconsistent with the rates of similar diagnoses at other juvenile facilities. Just prior to our 2010 visit, only approximately 2% of Pendleton youth had been diagnosed with post-traumatic stress disorder ("PTSD"), despite a general prevalence of this disorder of more than 30% in juvenile facilities. Steiner, H. et al., *Posttraumatic Stress Disorder in Incarcerated Juvenile Delinquents*, Journal of the American Academy of Child and Adolescent Psychiatry, 36:357-65 (1997). At the same time, only approximately 6% of Pendleton youth were diagnosed with attention deficit hyperactivity disorder ("ADHD"), while studies have found a prevalence of approximately 7-10% on the low end, to 45%, in juvenile facilities. Steiner, Hans et al., *The Assessment of the Mental Health System of the California Youth Authority*, Report to Governor Gray Davis, Dec. 21, 2001; M. Rösler et al., *Prevalence of Attention Deficit/Hyperactivity Disorder (ADHD) and Comorbid Disorders in Young Male Prison Inmates*, EUROPEAN ARCHIVES OF PSYCHIATRY AND CLINICAL NEUROSCIENCE, 254:365-371 (Nov. 2004), available at <http://www.springerlink.com/content/tu96frqffcxq64bd/fulltext.pdf>. In the opinion of our consultant, 7 of the 17 youth she interviewed during our 2010 tour had ADHD, which is more consistent with the expected prevalence in a facility like Pendleton, which houses youth with the most severe mental health needs in the State. Moreover, only 42% of youth at Pendleton had diagnoses of two psychiatric disorders, despite an expected rate of approximately 63% for incarcerated youth. Ulzen, Thaddeus PM, Hamilton, Hayley; *The Nature and Characteristics of Psychiatric Comorbidity in Incarcerated Adolescents*, CAN. J. PSYCHIATRY, 43:57-63 (1998), available at http://ww1.cpa-apc.org:8080/publications/archives/cjp/1998/feb/feb98_or1.htm. No youth carried diagnoses of substance-induced mood disorder or substance-induced psychotic disorder, despite the history of substance abuse or dependence within Pendleton's population. Finally, youth who had prior histories of hospitalization for depression and exhibited current signs of the disorder nonetheless were not diagnosed with depression.

Misdiagnosed or undiagnosed mental health disorders can be debilitating. An increase in depressive episodes increases the likelihood of recurrence, while time spent in mania or psychosis worsens a youth's long-term prognosis for being able to function in daily life, and diminishes his degree of recovery.

Pendleton's only assessment tool is the Massachusetts Youth Screening Instrument-Second Version ("MAYSI-2"). Although the MAYSI-2 is an established screening tool, in other areas, Pendleton fails to use standardized, established tools that screen youth for a

variety of mental health disorders, such as ADHD, depression, and obsessive-compulsive disorder. The use of standardized measurements with objective criteria is critically important because youth generally see multiple health care providers both within and outside the Facility.

Further compounding these deficiencies, Pendleton fails to reassess youth for emerging mental health concerns after their initial intake screening. The Facility has no protocol for periodic reassessment and fails to refer to the mental health team youth who exhibit physical symptoms of possible mental distress. Ongoing reassessments and referrals are particularly important because mental health issues may emerge at any time during a youth's confinement at a facility and may present as physical complaints.

2. Pendleton Fails to Provide Adequate Treatment Planning

The central purpose of mental health assessments is to provide adequate treatment planning for youth. Without adequate treatment planning, Pendleton cannot provide effective treatment of serious mental illness, ensure that youth are receiving appropriate services, or adequately track youth's progress.

Treatment planning at Pendleton is incomplete and misdirected. The Facility has no meaningful treatment plan document. Facility documents entitled "treatment plan" are unacceptably brief at one to two sentences. They fail to include critical components, such as: the youth's strengths; information about the youth's progress and/or deterioration; planned frequency of treatment (other than non-psychiatric staff assigning psychiatric treatment "every 30 days"); the range of treatment methods; information about family interventions; psychopharmacology; or plans for counseling. Treatment plans are not timely reviewed and adjusted in response to changes in status, including significant time in segregation or suicidal behavior. Treatment plans further fail to include necessary structural interventions for youth who need them. Finally, we note that it is a basic tenant of child psychiatry that the family of a youth experiencing significant mental health needs should actively participate in the youth's treatment planning process, absent specific clinical factors to the contrary. Although Pendleton has taken some steps in this direction, its mental health staff does not routinely engage families.

Pendleton's treatment planning appears to fail in part because of lack of coordination among staff. Although the Facility holds regular mental health staff meetings, we found these meetings are not useful for mental health treatment planning. The meetings are too short to allow for more than a cursory review of the youth discussed. In most instances we observed, staff did not even discuss a youth's diagnosis, which is a standardized mechanism for understanding and addressing behavior. Staff also failed to communicate about high-risk youth who were not necessarily verbally expressing their mental health needs or acting out, but whose behaviors may merit additional mental health follow up. For example:

- In one meeting, staff failed to address the notable behaviors of one youth who had been eating apart from his unit for several days. This was one of the youth our consultant later identified as actively psychotic and in need of immediate mental health attention.

- In another meeting, after a non-mental health staff member noted that a youth was having hallucinations, the team recommended consulting probation staff, rather than referring the youth to the psychiatrist.

3. Pendleton Fails to Provide Adequate Mental Health Treatment

Adequate medication management and adequate mental health contacts and counseling are critical components of constitutionally adequate mental health treatment. Pendleton fails in these areas, in violation of the Constitution.

a. Pendleton fails to adequately manage psychiatric medications prescribed to youth

We found severe underuse of psychiatric medications, an inadequate formulary, and a flawed medication consent process at Pendleton.

First, Pendleton appears to withhold necessary medications from youth who require them. Only 14% of youth at Pendleton were on any psychiatric medication. This is far below the expected prevalence at a facility like Pendleton, which houses the most severely mentally ill and violent youth in the State system, along with all the State's youth sex offenders. Although medication is not the sole treatment for mental health disorders, it is often a cornerstone of treatment. At Pendleton, medication appears to be significantly under-prescribed, particularly for youth with ADHD. Although medication generally is critical for ADHD treatment, only three out of the 13 youth diagnosed with this disorder were receiving any psychopharmacological treatment at the time of our visit, and only one was receiving the type of medication considered consistent with evidence-based standards of care.⁷ We saw no clinical justification for Pendleton's strikingly low use of well-established pharmacological interventions even for the limited mental health disorders the Facility does diagnose. It consequently appears that many youth incarcerated there are experiencing significant mental health disorders that are essentially untreated.

Second, Pendleton's formulary is inadequate. The formulary omits a variety of psychiatric medications that are consistent with accepted practices for treating mental health disorders, including depression, bipolar disorder, schizophrenia, autism, and ADHD. For example, the formulary excludes the accepted medications for treating ADHD, which may contribute to the lack of psychopharmacological treatment for youth with this disorder, as discussed above. The formulary further includes medications that are not the accepted first-line treatments for adolescents with mental health disorders. Although Pendleton's psychiatrist is permitted to seek permission from the medical director to prescribe medications that are not on the formulary, given the limitations of the formulary, this practice is impractical, inefficient, and can severely hamper youth's timely access to medications necessary for their treatment.

Finally, the Facility's consent process for psychiatric medications is inadequate. Although the superintendent holds the ultimate authority for medication consent, youth are provided a

⁷ Although facility psychologists informed us that they use "mindfulness training" and "coping skills" for ADHD treatment, these approaches alone are not consistent with the accepted practices for treating this disorder.

consent form for their medications. The form contains generic side effects of psychiatric medications, and the area designated for listing the most common side effects on the form consists only of a blank line. The form also is written at a level that far exceeds the reading level of the youth we interviewed. Accordingly, the form does not sufficiently inform youth about the risks and benefits of their medications.

b. Pendleton fails to provide youth with adequate mental health contacts and counseling

We found that youth's contacts with mental health staff and any counseling they receive are insufficiently frequent, ad-hoc, unpredictable, and inadequately documented.

First, youth's contacts with mental health staff are infrequent. State policy provides that mental health staff should see youth on the mental health caseload at least every 30 days, with a suggested two-week follow-up for youth with severe mental health issues. This is insufficient for youth who have serious mental health needs. In practice, many youth reported that they had no contact with the psychiatrist or a psychologist unless they had been recently segregated. In fact, we found at least one youth who had been in segregation for six days and was clearly in crisis, yet did not receive a psychiatric assessment. The psychiatrist disturbingly provided a verbal order to discontinue a medication without examining the youth. At intake, automatic referrals to the psychiatrist occur only if a youth is on medication, and many youth wait for several weeks or longer for an appointment. Insufficient staffing likely contributes to the Facility's failure to provide youth with sufficient contacts with mental health staff.

Second, when mental health counseling/therapy does occur, it is ad-hoc, unstructured and unreliable, rendering it ineffective. For example, treatment notes for PP and LL, both of whom had severe mental health needs and histories of suicidal behavior, do not indicate work on their treatment plan objectives for significant periods of incarceration. Additionally, access to psychological treatment appears to depend, at least in part, on youth's affirmative requests for care. This may exclude youth who are in most need of care but do not actively seek it. Further compounding these deficiencies, the Facility's attempts to use cognitive behavioral therapy ("CBT") and dialectical behavioral therapy ("DBT"), have been unsuccessful. CBT is offered on an ad-hoc basis, rather than in the formalized manner necessary for effective treatment. DBT was in the early stages at the time of our 2010 tour, was not yet available to all youth who could benefit from it, failed to include the necessary communication and coordination among staff to make this therapy effective, and used complicated, generic materials that are difficult for youth to understand, further limiting the treatment's effectiveness. Additionally, our consultant had concerns about deficiencies in the sex offender treatment program, including the lack of any sex offender treatment for sex offenders housed in the BMU. This is particularly disturbing because sex offenders likely have some of the most serious mental health needs at the Facility.

Third, the length of mental health treatment sessions is varied and unpredictable. This unreliability in turn may encourage youth to act out to receive additional attention. It is particularly inappropriate for youth with many psychiatric illnesses, especially for those experiencing components of attachment disorders.

Finally, inaccuracies in documentation of mental health treatment contribute to the unconstitutional inadequacies in Pendleton's mental health services. For example, a psychologist's note near the time of our 2010 tour described a suicidal youth's mood as "euthymic," meaning a normal, non-depressed, reasonably positive mood. For another youth, a note from a mental status examination near the time of our 2008 tour began with a statement that the youth was not exhibiting any signs of psychosis or mania, but proceeded to describe a youth who was agitated, grandiose, disorganized, and distracted – all signs of manic psychosis. Although one part of the mental status examination stated that the youth was of average intellect, the same note later referred to a diagnosis of mental retardation. The examination was also replete with unsupported opinions, such as notations that the youth had "very poor" reasoning, impulse control, judgment, and insight. Moreover, during our 2010 tour, youth reported that they had not been asked questions indicating whether they were oriented to time, date, and place during sessions with mental health clinicians after their initial intake, even though their charts documented that they indeed were oriented.

4. Pendleton Fails to Provide Adequate Transition Planning for Youth with Mental Health Disorders

Adequate transition planning is critical for ensuring continuity of care so that youth's mental health needs can be addressed after they leave Pendleton. Pendleton fails to provide adequate transition planning for youth with mental health disorders, in violation of the Constitution.

Of greatest concern, Pendleton fails to timely complete discharge summaries for youth on the mental health caseload. This dangerous failure leaves youth who require mental health care with no discharge document as they depart the Facility. Alarming, the discharge summary for GG, the youth discussed above who had severe mental illness and a long history of suicidal behavior, was dated October 6, 2010, even though GG had been discharged from Pendleton more than two weeks prior, on September 20, 2010. Indeed, in addition to GG's late summary, 9 of 11 other discharge summaries we reviewed for recently released youth were dated two to three days after the youth were discharged. Of these, five were dated October 6, 2010 – the date of our request for these documents. This suggests, at best, a strange coincidence, or, at worst, that the Facility created them only in response to our request.

The discharge planning summaries that Pendleton does create are very poor. They contain little documentation and exclude even basic information, like the youth's MAYSI-2 score, prior diagnoses that have been resolved, or reasons for prescribed medications. For example, despite GG's severe mental health needs, his discharge summary was skeletal, failing to mention important information like the severity of his suicidal actions at the Facility, as well as the fact that he functioned at a pre-school level. Additionally, we found inaccuracies in the little information that is contained in the summaries. Diagnoses appeared on the wrong DSM-IV axes,⁸ and global assessment of functioning ("GAF") scores documented in summaries were

⁸ The DSM-IV, the standard classification of mental disorders used by mental health professionals in the United States, uses a widely accepted diagnostic system to classify illnesses and disorders on five different axes. Taken together, these five axes provide a complete diagnosis, which is critical for treatment planning. The inaccurate use of the axes further calls into question the practitioners' understanding of this standard diagnostic system.

unrealistically low.⁹ We also found “N/A” referrals, a term that was undefined in the documents, but appeared to indicate a lack of recommended follow-up for youth who appeared to have significant mental health needs.

Pendleton’s deficiencies in discharge planning may severely hamper the ability of subsequent mental health care providers to timely and adequately address a youth’s mental health needs. This may result in potential lost progress, regression of the condition, an exacerbation of mental health problems, and a greater potential for negative outcomes, including recidivism and future incarceration.

5. Pendleton’s Inadequate Mental Health Staffing, Inadequate Quality Assurance Practices, and Traumatizing Environment Contribute to the Facility’s Unconstitutional Mental Health Care Practices

Deficiencies in staffing, quality assurance practices, and the Facility’s traumatizing environment contribute greatly to Pendleton’s inability to provide constitutional mental health care to youth.

First, mental health care staffing at Pendleton is grossly inadequate, particularly in light of the acuity and high level of mental health needs within the Facility’s population. Notably, shortly before our October 2010 tour, the Facility had 100% turnover among its three key mental health staff; the Facility’s new (and only) psychiatrist began in September 2010, and its only two psychologists began in May and August 2010. Pendleton’s psychiatrist, whose duties include providing direct care services, assisting with crisis management, attending multidisciplinary team meetings, working closely with the psychologists, reviewing prior records, and documenting visits, is allocated only eight hours per week at the Facility. During our 2008 tour, the State stated that the psychiatrist’s hours would increase immediately from eight to 12 hours per week. During our 2010 tour, however, the psychiatrist’s hours remained at eight hours per week.

The Facility also employs two full-time psychologists, neither of whom was fully licensed at the time of our 2010 tour, as well as at least one social worker. This is not sufficient, particularly in light of the fact that the Facility itself has identified approximately half the population as having mental health care needs, and our finding that, with proper screening and assessment, an even greater number of youth should be on the mental health caseload.

During both of our tours, mental health staff consistently reported that they were understaffed. One staff member stated that the Facility’s mental health providers were operating under “crisis management.” This staff member was unable to tell us whether the staff member’s identified “favorite” resident was on medications, even though the youth was on suicide precautions at the time and was to be meeting with mental health staff daily. At best, this appears to be a symptom of an overwhelmed staff that is unable to devote adequate attention to youth on its caseload.

⁹ GAF is a measure of an individual’s overall level of functioning and carrying out the activities of daily living, which in turn indicates the level of care he or she will require. Of ten discharge summaries our consultant reviewed, seven indicated unrealistically low GAF scores of 50-55, which show extremely high levels of impairment, near the level at which a psychiatrist would consider hospitalization.

Second, Pendleton fails to maintain adequate quality assurance practices in its mental health services. Although a regional psychiatrist conducts an annual review of the Facility psychiatrist, this review consists simply of a chart review and does not include any follow-up with youth to ensure that the charts accurately reflect the youth's treatment and status. Indeed, the State's reviews, which found compliance with the contents of charts, are contrary to our findings of Pendleton's continuing failures to provide constitutionally adequate mental health care.

Finally, rather than fostering a therapeutic environment in which treatment can occur, Pendleton provides an environment that further traumatizes youth and hinders any treatment the Facility does offer. This environment exacerbates maladaptive behaviors, creates additional difficulties in resolving prior trauma, and hampers the effectiveness of treatment.

D. Pendleton Fails to Provide Adequate Special Education Services to Youth, in Violation of IDEA

Youth with disabilities have federal statutory rights to special education services under the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §§ 1400-1482. See Honig v. Doe, 484 U.S. 305, 310 (1988) (noting that the Education for All Handicapped Children Act, as amended by IDEA, "confers upon disabled students an enforceable substantive right to public education in participating States"). IDEA requires States that accept federal funds to provide educational services to all children with disabilities between the ages of 3 and 21, even if the children have been suspended or expelled from school. 20 U.S.C. § 1412(a)(1)(A). The State must provide such services to youth in juvenile justice facilities. See id. (conditioning funds on the availability of services to "all children with disabilities" (emphasis added)); 34 C.F.R. § 300.2(b)(1)(iv) (applying IDEA requirements to "all political subdivisions of the State that are involved in the education of children with disabilities, including . . . State and local juvenile and adult correctional facilities"); see also Donnell C. v. Ill. State Bd. of Educ., 829 F. Supp. 1016, 1020 (N.D. Ill. 1993) (finding IDEA applicable to "school-aged pretrial detainees" in county jail); IDEA also requires schools to have procedures for identifying and testing students with disabilities. 34 C.F.R. § 300.111(a)(1)(I).

The overarching issue identified in our review of the Pendleton school is safety. Although school safety has improved since our 2008 tours, during our 2010 tour, our consultant found "an observed paralysis from both education and corrections staff when youth refused to comply, used profanity towards adults, walked away from staff, refused to participate in academic activities, provoked peers, and slept in class." This inability to act inhibits the ability of Pendleton staff to intervene appropriately when students misbehave. It is evident that verbal assaults and physical violence permeate all aspects of the Facility, including the school, and are insufficiently addressed. This unsafe environment impedes students' rights to receive an appropriate public education, as required under IDEA. In addition, Pendleton violates IDEA with respect to Child Find requirements, general education interventions, IEPs, access to special education services and the general education curriculum, student behavior, and transition services. The Facility has made improvements in special education since our 2008 tours, including: the use of SIMS, improvements in lesson plans and classroom instruction, professional development for teachers, improvements in policies and procedures, increased general education interventions, timely IEP reviews after youth are removed from class, improved individual accommodations in classes,

significant progress regarding manifestation determinations and development of functional behavior analyses, an acceptable plan for the use of substitute teachers, and improved student access to vocational and technical education. Nonetheless, significant violations of IDEA remain.

1. Pendleton Fails to Comply with Child Find

Pendleton fails to comply with IDEA's requirement that the State have policies and procedures to ensure that all children with disabilities who are in need of special education and related services and who reside in the State are identified, located, and evaluated. 34 C.F.R. § 300.111(a)(1)(i). This provision is known as Child Find. Pendleton's procedure to identify students with disabilities at intake fails to ask about special education history. Additionally, Pendleton lacks documented academic interventions for struggling general education students, a central component of the Child Find process. These deficiencies, along with a lack of general education interventions for students experiencing academic and/or behavioral failure, result in an ineffective and incomplete Child Find system.

2. Pendleton Fails to Provide Adequate General Education Interventions

IDEA requires that, prior to evaluation of a student for special education, the State must consider whether the student is being provided appropriate instruction by a highly qualified teacher and review data-based documentation of the student's progress. 34 C.F.R. § 300.309(b)(1)-(2). The State further must document the student's behavior in that student's learning environment, including in the regular classroom setting.

Although the Facility has protocols to implement various tiers of interventions for youth who have been identified as needing additional behavioral or academic supports but who have not yet been referred for special education evaluations, we found no evidence that interventions at the higher tiers are being implemented. The Facility fails to collect and analyze data to determine whether current interventions are effective. The Facility also fails to use segregation/exclusion data, which inhibits the school's ability to identify students who need higher level interventions or evaluations for special education services. Youth in need of, and qualified for, special education are at risk of not being identified and referred for evaluation for special education services.

3. Pendleton Fails to Provide Adequate IEPs to Youth with Disabilities

Pendleton fails to comply with IDEA's requirement that each student with a disability have an adequate IEP to ensure that the student receives adequate special education services. Specifically, Pendleton fails to: timely complete and/or review IEPs upon intake; adequately justify inconsistencies between previous and current levels of special education; adequately involve parents/guardians in the IEP process; adequately implement IEPs and collect data; provide related services; ensure that IEPs are adequately individualized; and include the required accommodations for youth with disabilities to participate in Statewide testing. See 34 C.F.R. §§ 300.323(c)(1), (e), (f); 300.323(e); 300.321(a); 300.323(c)(2); 300.323(a)(3); 300.320(a); 300.320(a)(6)(i).

First, the Facility fails to timely update and/or complete IEPs upon a youth's entrance into the Facility. Although timelines for initial IEP reviews vary depending on whether the youth has

an initial determination of a disability and whether the youth is moving from within or outside the State, IEP reviews and implementation of IEPs for students with disabilities should be conducted as quickly as possible upon intake. See 34 C.F.R. § 300.323(c)(1), (e), (f). Despite the State's articulated commitment to review all student IEPs within ten days of enrollment, we found that students at Pendleton often wait months for IEP reviews. In fact, their IEPs are often not reviewed until the next scheduled review date as indicated in the IEP. These delays violate IDEA.

Second, Pendleton fails to comply with IDEA's requirement that the Facility provide services comparable to those described in the youth's IEP from the previous public agency, or provide adequate justification for why the services have changed. See 34 C.F.R. § 300.323(e). During our tours in 2008 and 2010 we found significant discrepancies between previous and current IEPs without adequate justification. For example, prior to entering the Facility in 2008, one youth had been receiving 250 minutes of special education instruction per school week. At the time of our tour, the youth was receiving special education services, on a consultation basis only, twice a month for 15 minutes. Ten other youth had Behavior Intervention Plans ("BIPs") as part of their previous IEPs, but, no such programs were provided in their Pendleton IEPs, with no justification for the change. Although special education instructional minutes should be specified in each IEP, in 2010 we found IEPs that provided for special education services only on an "as needed" basis. This lack of specificity makes it impossible to gauge whether the services provided at Pendleton are consistent with the youth's prior IEP. Additionally, the rationale for statements on some IEPs was troubling. For example, although behavior that interferes with learning is part of the definition of emotional disturbance ("ED"), IEPs for two students who were classified as ED stated without explanation that their behavior did not interfere with learning.

Third, IDEA requires that, to the extent possible, IEP meetings include parents/guardians, as well as other IEP team members. 34 C.F.R. § 300.321(a). Parental involvement is lacking at Pendleton. In 2010, only one in ten IEPs we reviewed included a parental signature. Similarly, in 2008, seven of 17 IEPs we reviewed contained no team or parental signatures, and three had parental signatures only. In two cases in 2008, IEPs were enacted even though the parents did not consent.

Fourth, Pendleton fails to adequately implement IEPs and to collect and report data on student progress on annual goals in violation of IDEA. See 34 C.F.R. §§ 300.1(a); 300.320(a)(3); 300.323(c)(2). We found no evidence that behavioral interventions in IEPs are being implemented. The data the Facility collects fails to measure whether a youth is showing progress on behavioral or academic IEP goals.

Fifth, Pendleton fails to offer related services in violation of IDEA. See 34 C.F.R. § 300.323(c)(2). Related services are supportive services required to assist a youth in benefitting from special education. Such services may include speech, language, and occupational therapy, psychological services, and counseling. Although we found youth whose IEPs indicated needs for speech, language, and/or occupational therapy during our 2010 tour, the Facility indicated that no students required these services (nor were they receiving services). Similarly in 2008, we found Pendleton offered virtually no related services.

Sixth, Pendleton's IEPs lack individualization in violation of IDEA. See 34 C.F.R. § 300.320(a). IEPs lack distinct goals for individual students; indeed, the goals on eight IEPs we reviewed during our 2010 tour referred only to the Facility-wide behavioral rating scale used for all youth. Moreover, most IEPs we reviewed contained identical accommodations, further indicating a lack of individualization.

Finally, Pendleton's IEPs fail to include the IDEA required accommodations for youth with disabilities to participate in statewide testing. 34 C.F.R. §§ 300.320(a)(6)(i). None of the IEPs we reviewed in 2010 showed any evidence that Pendleton participates in Indiana's Statewide educational progress testing program. Pendleton does not have a school report card system that provides a summary of student scores on State assessments.

4. Pendleton Fails to Provide Adequate Access to Special Education Services and the General Education Curriculum

Pendleton fails to comply with IDEA's requirement that students with disabilities have access to the general education curriculum by delaying enrollment of youth in school after intake, failing to provide adequate coursework, and failing to provide adequate instructional time. See 34 C.F.R. §§ 300.110; 300.304(b)(1)(ii); 300.305(a)(2)(iv); 300.320(a)(2)(i)(A); 300.101; 300.11(2).

First, the State's own policy limits the time between intake and school enrollment to two days. Contrary to this requirement, the Facility indicated that it completes school enrollment within five days, while youth reported spending up to two weeks in the intake process, sitting in their cells and watching television. Either period is too long.

Second, Pendleton fails to provide youth with disabilities with appropriate coursework. Pendleton fails to provide access to certain elements of the "Core 40," the basis for general education in Indiana, and fails to offer sufficient coursework to youth in the BMU. Indeed, in the BMU, many students attend class for only one hour per day, in mechanical restraints, if they attend class at all. These deficiencies result, at least in part, from inadequate teacher staffing. Specifically, Pendleton lacks sufficient licensed and highly qualified teachers in core content areas to provide instruction in all the necessary courses. See 34 C.F.R. § 300.156. Pendleton's current staffing plan fails to address the Facility's deficiencies in this area.

Additionally, although science and social studies are offered, approximately 30% of the records we reviewed in 2010 indicated that youth were not receiving these core curricula because of a time conflict with a counseling class, again denying them access to the appropriate coursework.

Finally, in violation of IDEA, Pendleton fails to provide students with disabilities the same number of daily and weekly instructional minutes as other students in the State's schools. At Pendleton, youth in exclusionary settings, *e.g.*, segregation, within the Facility do not receive the six daily and 30 weekly hours of instructional time to which they are entitled, as required for all Indiana public school students. During our 2010 visit, youth in the BMU were receiving only one hour of school instruction per day. In fact, some youth on that Unit who were confined to their rooms were receiving no school at all. Similarly, during our 2008 visit, youth on another unit

were receiving only 45 minutes of instructional time per day. Further, instructional time for all students is regularly interrupted by counseling, group sessions, treatment team meetings, and recreation.¹⁰

5. Pendleton Fails to Provide Adequate Behavioral Supports to Youth with Disabilities

As noted above, the overarching issue in our review of special education services for students with disabilities at Pendleton is the unsafe atmosphere at the school. Moreover, in the three months prior to our tour, 70% of uses of force were against youth with disabilities. To ensure a safe learning environment and a free and appropriate public education to students with disabilities as required under IDEA, Pendleton needs an effective system to address student behavior. See 34 C.F.R. § 300.324(a)(2)(i). The Facility lacks a systemic behavioral plan for students and individualized, data-driven behavioral interventions.

First, contrary to IDEA, the Facility lacks an effective school/system-wide behavioral plan. See 34 C.F.R. § 300.324(a)(2)(i).¹¹ Pendleton teachers have little recourse for inappropriate student behavior, other than to have students sent to segregation or to the Care Team room, a room that ostensibly is aimed at de-escalating student behavior, but does not appear to be particularly effective. Indeed, because of its lack of behavioral supports in the general population, the Facility inappropriately uses segregation and exclusionary settings as its system-wide behavioral plan.

Pendleton's lack of an effective behavioral plan contributes to the Facility's repeated and extended segregation of youth with disabilities and lack of adequate behavioral interventions to prevent or limit the recurrence of behavioral violations, in contravention of IDEA. See 34 C.F.R. § 300.101(a), 300.530(d)(1)(ii). Indeed, during both of our tours, we found that certain youth were frequently confined to their rooms and denied access to education. For example, in 2010, records indicated that seven youth were confined to their rooms in BMU from 12 to 59 days. Disturbingly, not one of these youth had attended even the allotted one hour of school in the BMU. Similarly, in 2008, we found at least 25 youth with disabilities who had spent excessive time in segregation: 16 youth spent 10-20 total days in segregation; six spent 20-30 days; two spent 30-40 days; and one had been in segregation for 73 days and remained there as of the time of our visit. None of these youth had a BIP that was being implemented; indeed we found that the Facility has entirely failed to implement any BIPs.

The long-term use of isolation as the primary system-wide method for addressing inappropriate behavior of youth with disabilities is inappropriate, ineffective, and

¹⁰ Although we observed adequate direct instruction to students with disabilities during our 2010 tour, youth consistently reported that teachers engaged in direct instruction only when DOJ was visiting.

¹¹ The facility's Progressive Discipline Plan, which was designed to link positive student behavior to rewards, had been in effect for a few weeks prior to our 2010 tour. Students, however, did not understand the link between school behavior and token points used for reward, and did not observe any teachers mentioning the behavior system or reminding students of points earned during class. The Why Try? program, which offers cognitive-behavioral counseling, also had recently begun and counselors had not yet been trained on it at the time of our tour.

counterproductive. It is also inconsistent with IDEA. Instead of such practices, the Facility needs a proactive and positive approach to motivate youth and ensure that students with disabilities are provided the support necessary to be educated with non-disabled peers.

Second, Pendleton fails to comply with IDEA's requirement for individualized interventions for youth with disabilities by failing to consider the use of positive behavioral interventions and supports to address behavior that interferes with learning. See 34 C.F.R. § 300.324(a)(2)(i). Indeed, we found youth who required, but did not have, individualized behavior interventions, *e.g.*, some youth in the BMU. Additionally, even when the Facility does consider and create a BIP, as noted above, it fails to implement the plans. Pendleton's BIPs also are vague, inappropriate, lack individualization, fail to contain measurable objectives, and improperly focus on teacher behavior rather than on student behavior. The Facility further fails to collect or analyze individualized behavioral data.

6. Pendleton Fails to Provide Youth with Adequate Transition Services

Pendleton fails to provide adequate transition services to facilitate a youth's movement from school to post-school activities (*e.g.*, postsecondary or vocational education, employment, independent living) for youth who are 16 years old or older, in violation of IDEA. See 34 C.F.R. § 300.43(a)(1)-(2). The Facility has made improvements to career training and transition supports since our 2008 visit. Its transition plans and activities remain inadequate, however, because they fail to include methods for assessing student progress and therefore fail to provide a results-oriented process.

Of additional concern, the Facility's transition summaries inappropriately include highly sensitive information, such as information about prior abuse; issues of behavioral deviance, including sexual deviance; and segregations or offenses during the youth's time at the Facility. Although such information may be appropriate for future therapy, it is inappropriate for inclusion in a transition plan, which may be accessible by a broader range of professionals and even by a potential employer.

V. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies identified above and protect the constitutional and federal statutory rights of youth at Pendleton, the State should, first and foremost, assess its system of institutionalizing youth in unsafe facilities where they are subjected to harm and risk of harm, and expand its system of community-based treatment for youth, particularly those with disabilities. During our discussions of a State-wide resolution, we provided the State with a detailed remedial plan. Specifically with respect to Pendleton, the State should promptly implement the minimum remedial measures set forth below:

A. Providing Youth With Adequate Suicide Prevention Services

To prevent youth from attempting and committing suicide, Pendleton should provide adequate suicide risk screening and assessment. Pendleton should ensure that information in JDS is updated regularly to reflect incidents where suicide precautions are put in place. A user-friendly, standardized suicide assessment form should be completed for all youth who exhibit suicidal behavior. All potentially suicidal youth should be placed on suicide precautions unless a psychologist determines, following a face-to-face evaluation, that the youth is not suicidal.

Pendleton should house youth exhibiting suicidal behavior in the most integrated setting possible, *e.g.*, in the general population units, and should limit the use of segregation for suicidal youth only to circumstances where a youth is acutely suicidal and/or is already housed in segregation serving a behavioral sanction. Pendleton should not house *any* youth who is suicidal in the BMU unless it makes the cells in the unit “suicide-resistant” from hanging attempts. Pendleton should avoid wherever possible the removal of suicidal youth’s clothing (and issuance of safety smocks), removal of mattresses/blankets during daytime hours, cancellation of routine privileges (visits, telephone calls, showers, recreation, etc.), and cancellation of school or group therapy. These measures should be used only as a last resort when a youth is physically engaging in self-destructive behavior, and only for as long as that period lasts.

Pendleton should prohibit use of the padded cell for any youth who threatens, but does not engage in, self-injurious behavior, as well as for use as “time out” for violation of Facility rules. Pendleton should develop and implement a clear, specific policy that limits the use of the padded cell to only when all other, less restrictive measures have been tried and have failed to control a youth’s serious self-injurious behavior.

Pendleton should ensure that all youth on suicide precautions are provided the level of supervision required in the Facility’s current suicide prevention policy. Pendleton should ensure sufficient staffing on each shift to provide the required levels of supervision to youth on suicide precautions in the most integrated setting possible.

Pendleton should require that mental health clinicians “assess,” not simply “see,” youth on suicidal precautions on a daily basis and that clinicians adequately document such visits by entering an adequate progress note into the EMR. The progress note should be in a standardized format (*e.g.*, Subjective, Objective, Assessment, and Plan, or “SOAP”). The progress note should provide a sufficient description of the current behavior and justification for a particular level of observation. Pendleton should require that meaningful, individualized treatment plans be developed and implemented for all youth placed on suicide precautions. These treatment plans should be integrated with the youth’s rehabilitation program plan (“Individual Growth Plan”). The plan should include treatment goals and specific interventions. The plan further should describe signs, symptoms, and circumstances under which the risk for suicide or other self-injurious behavior is likely to recur, how recurrence can be avoided, and actions both the youth and staff can take if the behaviors do occur. The plan should identify the clinician responsible for both developing and implementing the treatment goals and specific interventions. Use of safety contracts should be discontinued.

Pendleton should conduct mortality-morbidity reviews of all suicides and serious suicide attempts. The Mortality-Morbidity Review Team should ensure that reviews occur and documentation is complete. When appropriate, the Mortality-Morbidity Review Team should develop a written plan to address areas that require corrective action.

All staff who have direct contact with youth should be required to complete at least eight hours of initial suicide prevention training and two hours of annual suicide prevention training on the following topics: avoiding obstacles to prevention, juvenile suicide research, why facility environments are conducive to suicidal behavior, identifying suicide risk despite denial of risk, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, the proper role of responding to a suicide attempt, and components of Pendleton's suicide prevention program. Staff should be evaluated on their comprehension of any training received.

B. Protecting Youth From Harm

To adequately protect youth from youth violence and sexual victimization, Pendleton should provide an adequate number of qualified and appropriately trained direct care staff. Specifically, the Facility should provide direct care staff-to-youth ratios of 1:8 during waking hours and 1:16 during sleeping hours. Moreover, Pendleton should provide a minimum of two direct care staff on each unit during waking hours. On certain units, the Facility should provide higher levels of staffing as may be required to ensure youth safety, *e.g.*, on the BMU, Sex Offender Unit, and/or other units experiencing significant violence. Pendleton also should ensure safe and appropriate housing for sex offenders by housing them in single sleeping rooms. In addition, Pendleton should ensure that critical and/or unusual incidents, whether or not referred to external reporting agencies, are systematically reviewed administratively to determine whether additional staff training or other systemic corrective action may be appropriate.

To ensure that the administration is capable of adequately addressing youth violence and sexual victimization, Pendleton should improve its youth grievance system, including by making grievance forms readily accessible on all living units and providing a locked grievance submission box on all units. Direct care staff should not have access to the grievance lock box, and staff should be trained that any substantiated retaliation for submitting a grievance will result in disciplinary action. Grievances should be logged, classified and tracked. Youth should be permitted one level of appeal if they are not satisfied with the outcome of the grievance. The Facility should establish clear criteria for when a grievance alleges staff misconduct or child abuse, and grievances meeting these criteria should be formally referred for investigations consistent with State law. Internal investigations should be well documented.

To ensure adequate rehabilitative programming, Pendleton should reduce the number of days youth are required to remain on the first and second levels of the BMU. In addition, Pendleton should decrease the number of hours youth on all levels of the BMU are required to spend in their cells. Further, youth in the BMU should receive more out-of-cell structured rehabilitative programming. Pendleton should provide youth in the BMU with additional education about what specifically is required to achieve a higher level and, ultimately, what expectations are required to "graduate" back to general population.

Pendleton further should strive to eliminate its traumatic environment and create a therapeutic, youth-based environment in which rehabilitation can occur. Juvenile direct care staff should receive additional pre-service and annual in-service competency-based training in adolescent development and effective strategies for working with this challenging population. Additionally, the Facility should provide remedial training or appropriate corrective action to staff found to have engaged in inappropriate or abusive communications with youth.

The State should ensure that youth who are discharged from DOC's facilities are provided the supports and services necessary to ensure their successful rehabilitation and reintegration back into their homes, schools and communities. Funding disincentives should be removed, and the State should strive to create inter-agency collaboration to ensure that youth discharged from the juvenile justice system are provided the supports and services necessary to successfully re-enter their communities and avoid re-offending.

C. Providing Youth With Adequate Mental Health Care Services

To provide youth with adequate mental health care services, Pendleton should provide adequate screening and assessment, treatment planning, mental health treatment, and transition planning. Pendleton also should provide adequate staffing, use adequate quality assurance practices, and eliminate the Facility's traumatizing environment.

Pendleton should provide adequate, comprehensive, and reliable screening and assessment services to identify youth with serious mental health needs, both at intake and throughout the youth's time at Pendleton. At intake, a qualified mental health professional should complete an initial mental health assessment form that summarizes the youth's prior mental health history and includes a current mental status examination, suicide risk inquiry, provisional diagnosis, and treatment plan, if applicable. The intake process should foster trust between the youth and mental health staff.

The Facility should refer youth for mental health services where such services are indicated as a result of the mental health screening and assessment process, or where a youth demonstrates symptoms of mental illness that significantly interfere with the youth's ability to complete the Facility's treatment program. Mental health assessments, where indicated, should begin during the youth's time in the intake unit. Assessments should include pursuit and review of prior behavioral health records; contact with the youth's family; consultation with Facility staff; interviews with the youth; and, where indicated, specialized testing using standardized tools, as well as medical consultation. Assessments should be documented accurately and accurate diagnoses should be reached. Pendleton further should have routine methods for recognizing emerging mental health issues that may not have been present upon intake. The Facility also should refer to mental health staff youth whose physical complaints may be expressions of mental health distress.

Mental health treatment plans should be individualized and should be reviewed and revised as appropriate. They should articulate the youth's problems, strengths, progress and/or deterioration, planned frequency of treatment, range of treatment methods, information about family interventions, plans for counseling, and specific planned behavioral interventions. If

medication will be part of a youth's treatment, the treatment plan should specify the medication, its target symptoms, and the basis for using it.

Psychiatric medications should be prescribed appropriately after a thorough and adequately documented psychiatric assessment. The prescribing professional should adequately monitor youth on psychiatric medications by conducting and adequately documenting medication monitoring visits at least monthly, or more frequently as indicated, including one-week follow-up for youth who are severely ill or who have begun new medications.

The Facility should ensure that the formulary includes medications appropriate for the types and prevalence of mental health disorders found at Pendleton, and excludes dangerous medications that are outside the standard of care for treating psychiatric disorders. The Facility further should obtain appropriate consent prior to starting a youth on medication, including providing the youth with a consent form that contains information about the specific side effects of the relevant medication in easy-to-understand language.

Pendleton should provide mental health contacts for youth with mental health needs as clinically indicated, and at least weekly for youth with severe needs. Qualified mental health professionals should provide and adequately document individual counseling sessions, which should be predictable, reliable, and structured.

Pendleton should provide timely and adequate transition planning, including, at a minimum, ensuring that mental health staff provide an accurate written summary of the youth's mental health treatment and response to treatment, and a recommendation regarding further care, upon the youth's discharge.

The Facility should maintain sufficient qualified mental health staff to provide adequate mental health care services to all youth requiring such services. The Facility's pediatrician also should work closely with the mental health team on a weekly basis.

Pendleton further should implement an adequate quality assurance process to track the effectiveness of its mental health services. This process should include interviews with youth.

Finally, as noted above, Pendleton should strive to create a therapeutic, rather than traumatic, environment.

D. Providing Youth With Adequate Special Education Services

To provide adequate special education services to youth with disabilities, the State should ensure that all youth with disabilities who are in need of special education and related services are identified, located, and evaluated, in accordance with Child Find. At intake, youth should be asked, in a private setting, about previously offered special education, and academic interventions for youth who are struggling should be documented. Additionally, the Facility should document academic interventions for struggling general education students.

Pendleton should implement and maintain adequate general education interventions. Prior to the evaluation of a youth for special education, the Facility should consider whether the youth

is being provided appropriate instruction by a highly qualified teacher and should review data-based documentation of the youth's progress. The Facility further should adequately document youth's behavior in their learning environment, including in the regular classroom setting.

Pendleton should develop, implement, and maintain an adequate IEP for each youth who qualifies for an IEP and should provide necessary related services. IEPs should be updated and/or completed as quickly as possible upon intake. Services provided to youth who have IEPs should be comparable to those described in the youth's IEP from his previous agency, and the Facility should provide adequate justification for any changes in services. Parents and/or guardians should be included in IEP meetings to the extent possible. Pendleton should adequately individualize and implement IEPs, including by collecting and reporting data on youth progress and annual goals and by making individual accommodations for youth requiring such accommodations.

Pendleton should provide youth with disabilities adequate access to special education services by: enrolling youth in school within two days of intake; providing youth access to the Core 40 and general education curriculum; providing adequate special education staffing; providing youth with disabilities the same number of instructional minutes as other youth in the State's schools; and providing adequate direct instruction using research-based instructional approaches for youth with, and at risk for, disabilities.

Pendleton should ensure that youth with disabilities receive adequate behavioral supports by training school staff on, implementing, and maintaining a systemic behavior plan; ceasing the use of segregation and exclusionary settings as a behavior plan; providing adequate individualized interventions for youth with disabilities; and implementing and collecting relevant data regarding individual progress toward goals and objectives in behavior plans.

Finally, Pendleton should provide results-oriented, individualized, coordinated transition services for youth with disabilities who are 16 years old or older to facilitate the youth's movement from school to post-school activities.

IV. CONCLUSION

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division.

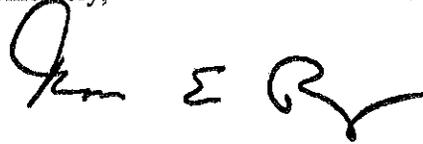
We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. See 42 U.S.C. §§ 1997b(a)(1); see also 42 U.S.C. § 14141.

We hope, however, to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns with respect to the services the State provides to youth confined at Pendleton. Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. These reports are not public

documents. Although their reports are the work of each expert consultant and do not necessarily represent the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the relevant concerns and offer practical, technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at prompt remediation.

It remains our desire to address juvenile detention conditions throughout the State of Indiana at one time instead of continuing with the piecemeal approach thus far undertaken. We believe that such an approach would best protect the constitutional and legal rights of all of Indiana's detained youth and would result in decreased recidivism/increased public safety. If you have any questions regarding this letter, please call Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393. Regardless, we will be in touch soon about next steps.

Sincerely,



Thomas E. Perez
Assistant Attorney General

cc: Greg Zoeller
Attorney General
State of Indiana

Thomas Quigley
Deputy Attorney General
Special Counsel to the Commissioner
Indiana Department of Correction

Bruce Lemmon
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Michael Dempsey
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