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Civil Rights Division

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Special Litigation Section - PHB
950 Pennsylvania Ave, NW
Washington DC 20530

October 17, 2017

Via E-mail and U.S. Mail

Robert D. Bugher
Chief Counsel
Indiana Department of Correction
Indiana Government Center – South
302 West Washington Street
Indianapolis, IN 46204

Re: Pendleton Juvenile Correctional Facility

Dear Mr. Bugher:

We write to notify you that the Department of Justice is closing its investigation of the Pendleton Juvenile Correctional Facility ("Pendleton"), which we conducted pursuant to Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, and the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, 34 U.S.C. § 12601 (formerly codified at 42 U.S.C. § 14141).

We appreciate the State's cooperation throughout our investigation. We recognize that the State has made many improvements at Pendleton and at other juvenile correctional facilities over the course of our involvement. Most broadly, the State has made system-wide efforts to minimize incarceration of youth; to move toward a rehabilitative juvenile justice model; to increase youth's access to community-based alternatives to incarceration; and to reduce the use of isolation. We understand that the State has reduced its juvenile facility population by more than 70%[1] since the beginning of our involvement with the State's juvenile justice system in 2004.

Since we issued the findings of our investigation ("Findings Letter"), which identified deficiencies in Pendleton's protection of youth from harm, suicide prevention, mental health, and

[1] When we opened our investigations of the South Bend Juvenile Correctional Facility ("South Bend"), Plainfield Juvenile Correctional Facility ("Plainfield"), and Logansport Juvenile Intake/Diagnostic Facility ("Logansport") in 2004, the State incarcerated more than 1,400 youth in its juvenile facilities and contract beds. Indiana Department of Correction, *2005 Annual Report* 97-98, http://www.in.gov/idoc/files/2005DOCAnnualReport-Stats.pdf; Indiana Department of Correction, *Fact Card*, http://www.in.gov/idoc/files/FACT_CARD_JANUARY_2004.pdf. As of May 1, 2017, the State's juvenile facilities housed 420 youth. Indiana Department of Correction, *Offender Population Statistical Report* (b) (Apr. 2017), http://www.in.gov/idoc/files/0417%20OffenderPopulation.pdf.

special education practices, we have been engaged in on-site inspections, document review, conversations with State and Pendleton officials, and interviews of numerous Pendleton youth, staff, and administrators. Based on these activities, the United States has determined that Pendleton has implemented sufficient reforms to address the deficiencies identified in the Findings Letter, and that continuation of our investigation is no longer warranted.

Recently, in particular, the State has made strides to improve practices in three areas: (1) isolation of youth on Level 1 of the Making a Change Unit, (2) implementation of suicide precautions, and (3) use of the restraint chair. We appreciate the information the State has continued to provide to us, including in its July 1, 2017 letter and accompanying documents, detailing the State's continued efforts to address these areas.

First, with respect to isolation, the State has become a national leader in reducing isolation systemically throughout its juvenile facilities. For example, Stop Solitary for Kids, a partnership of national juvenile justice organizations that has received broad support for its efforts to end solitary confinement of youth, has lauded Indiana's efforts in reducing isolation while improving safety and decreasing violence in its juvenile facilities.[2] On numerous occasions, officials from the Department of Correction, particularly Christine Blessinger, Executive Director of the Division of Youth Services, have presented to national audiences regarding the State's efforts to reduce isolation and have provided recommendations to other jurisdictions that are working to accomplish the same.

Second, Pendleton has made two important improvements with respect to housing and additional precautions for youth at risk for suicide. The facility has added to its Suicide Prevention Plan ("Plan"), provided to us on July 1, 2017, provisions that allow for the shadowing of youth on suicide precautions. This option of shadowing is in lieu of the facility's prior practice of automatically sending youth on suicide precautions to the MAC Unit. In addition, the Plan specifies that orders from mental health staff will denote the appropriate items, including kimonos and bedding, for youth on suicide precautions.

Finally, we appreciate the State's providing to us its current policy on restraint chair use, as well as prior recent documentation regarding use of the chair. As of our May 30, 2017 call, we understand that the chair had not been used since August 2016. For this issue, and other issues, we offer some additional technical assistance from our consultants in the attached appendix.

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[2] Stop Solitary For Kids Home Page, http://www.stopsolitaryforkids.org/ (last visited Oct. 16, 2017) (identifying Indiana as one of four states that have worked successfully to accomplish this goal).

In sum, we recognize the State's many improvements at Pendleton and we are closing our investigation. If you have any questions, please contact Marina Mazor at (202) 305-3347.

Sincerely,

Steven H. Rosenbaum
Chief
Special Litigation Section

Enclosure

Appendix

As technical assistance, our consultants offer the following recommendations in the areas of isolation of youth on Level 1 of the Making a Change ("MAC") Unit and implementation of suicide precautions.

1. On isolation of youth on Level 1 of the MAC Unit, our consultants recommend that:

    a. The State establish an affirmative expectation that youth on Level 1 of the MAC Unit are to spend all waking hours outside of their rooms, barring a legitimate, imminent safety or security threat that requires their short-term isolation. To help accomplish this, our consultants recommend that the State consider increasing programming on the MAC Unit, with a focus on therapeutic and other structured programming during times that youth currently are not engaged in programming. Our consultants note that this type of programming is particularly important to meet the intensive needs of youth on the MAC Unit.

    b. The State consider the following modifications to its new MAC Level 1 confinement logs:

        1) Clarifying that the confinement logs should capture any time a youth is alone in his room, regardless of the reason. Currently, the updated MAC Unit Guidelines ("Guidelines"), provided to us on July 1, 2017, suggest that the logs are intended to capture isolation of youth on MAC Level 1 for "inappropriate behavior" only. Guidelines at 1. The Guidelines do not indicate that the logs also are intended to track other time a youth may spend alone in his room, *e.g.*, during gaps in programming. Notably, implementing the change recommended in 1.a above, *i.e.*, mandating that youth on Level 1 spend all waking hours outside their rooms barring a legitimate, imminent security threat, would result in the logs capturing only where a youth is sent to his room because of such a threat.

        2) Reflecting in the logs both the date and the time a youth is placed in his room and the date and time the youth is removed from the room. Although the copy of the log provided on July 1, 2017 requires staff to document the time of confinement and release, the log does not require documentation of the date of these events.

        3) Identifying in the log the individual who was notified of, and/or authorized, the placement in confinement. Capturing and analyzing this information will help the facility manage its confinement practices on Level 1 of the MAC Unit.

    c. Pendleton use room check sheets, in addition to confinement logs, any time a youth is confined in his room.[1] Our consultants recommend that these sheets be affixed to the youth's door, and that they track the youth's welfare and safety at frequent intervals, at least every 10 minutes, and at least six times per hour. Our consultants note that, because

[1] Although the facility has kept such documentation in the past, it is unclear whether the facility uses room check sheets currently.

youth in isolation are among those at highest risk of self harm, such monitoring is paramount to maintaining their safety.

d. The facility track additional quality assurance data regarding the MAC Unit, to aid the State in evaluating the effectiveness of the unit. Our consultants recommend that this data include aggregate monthly information on:

1) the number of MAC referrals;
2) reasons for MAC referral;
3) length of stay on each level;
4) total length of stay on the MAC Unit;
5) number of hours of therapeutic programming each youth receives;
6) number of days that recreation was offered;
7) percentage of days on which youth refused recreation;
8) frequency and duration of isolation use, *e.g.*, number of times isolation is used each month, average length of stay in isolation, percentage of instances of isolation lasting: under two hours, two to four hours, four to six hours, etc.;
9) rate of violent misconduct on the MAC Unit; and
10) change in rate of violent misconduct for individual youth before and after their stay on the MAC Unit.

2. On suicide precautions, our consultants recommend that:

a. Youth on suicide precautions be placed in the least restrictive housing assignment, commensurate with their security level. Most specifically, our consultants recommend that youth who are not housed on the MAC Unit not be placed on the MAC Unit for suicide precautions.

b. All cells designated to house suicidal youth be as "suicide-resistant" as is reasonably possible, free of all obvious protrusions, and provide full visibility of the youth.

c. Housing assignments for youth on suicide precautions be based on the ability to maximize staff-youth interaction. Our consultants note that housing assignments should not heighten the depersonalizing aspects of confinement.

d. Each youth continue to receive regular services and privileges, including education, programming, showers, telephone, visiting, recreation, leisure and other out-of-cell time, commensurate with his security level, unless contraindicated with clear clinical justification in the health care chart by a qualified mental health professional each day the youth is on suicide precautions.

e. Removal of a youth's clothing (excluding belts and shoelaces) and the use of safety smocks be avoided whenever possible. Our consultants recommend that such measures be used only as a last resort, at the direction of a qualified mental health professional, when the youth is physically engaging in self-destructive behavior.

f. All youth on suicide precautions always receive a mattress, including a safety mattress as appropriate, during both sleeping and non-sleeping hours, unless the youth uses the

mattress in ways in which it is not intended, *e.g.*, attempting to tamper with/destroy the mattress, using it to obstruct visibility into the cell, using it to attempt to engage in self harm, etc.

g. Each youth who is placed on suicide precautions for longer than 24 hours receive a treatment plan. Our consultants recommend that the plan be discussed with the youth and his parent(s)/guardian(s) and:

    1) Include treatment goals and specific interventions designed to address and reduce suicidal ideation and threats, self-injurious behavior, and/or suicidal threats perceived to be based upon attention-seeking behavior;

    2) Describe signs, symptoms, and circumstances under which the risk for suicide or other self-injurious behavior is likely to recur, how recurrence of suicidal and other self-injurious behavior can be avoided, and actions both the youth and staff can take if the suicidal and/or other self-injurious behavior occurs;

    3) Identify the qualified mental health professional and other staff responsible for developing and implementing the treatment goals and specific interventions; and

    4) Include follow-up services.

3. On the restraint chair, because the use of such chairs is highly unusual and is inconsistent with the practice at most other juvenile facilities, our consultants recommend that the State reexamine and fully eliminate use of the chair at Pendleton.