September 9, 2005

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

Re: Investigation of the Plainfield Juvenile Correctional Facility, Indiana

Dear Governor Daniels:

I am writing to report the findings of the Civil Rights Division's investigation of conditions at the Plainfield Juvenile Correctional Facility ("Plainfield"), Plainfield, Indiana. On February 10, 2004, we notified you of our intent to conduct investigations of Plainfield and two other juvenile correctional facilities, the Logansport Juvenile Diagnostic/Intake Facility ("Logansport"), and the South Bend Juvenile Correctional Facility ("South Bend") 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] As we noted, both CRIPA and Section 14141 give the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of children in juvenile justice institutions.

On June 8-11 and June 30-July 2, 2004, we conducted on-site inspections of Plainfield. We were accompanied by expert consultants in mental health care, juvenile justice, sanitation, and education. We interviewed staff, youth residents, mental health care providers, teachers, and administrators. Before, during, and after our visits, we reviewed an extensive number of 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. Consistent with our commitment to

[1] Our findings regarding South Bend and Logansport are provided separately, but are referenced in this letter.

provide technical assistance and conduct a transparent investigation, at the conclusion of each tour, we conducted exit conferences with facility and Indiana Department of Correction ("IDOC") officials, during which our consultants described their initial impressions and concerns.

At the outset, we commend the staff of Plainfield for their helpful, courteous, and professional conduct throughout the course of the investigation. We also wish to express our appreciation for the cooperation of IDOC officials.

Consistent with our statutory obligation under CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. As described more fully below, and in the findings letters also issued today in regard to Logansport and South Bend, we conclude that certain deficiencies at Plainfield violate the constitutional and federal statutory rights of the youth residents.

I. BACKGROUND

Plainfield is a facility for male juveniles. It primarily houses juveniles between the ages of 12 and 18 years who are committed to IDOC's Juvenile Services Division, although juveniles can be held until age 21. During the time of our visits, the population was approximately 300 juveniles. The average length of stay at Plainfield is 17 months.

Originally built in the 1800's, the campus includes 12 housing units as well as a school, health unit, central dining hall, vocational building, and chapel. The residential units consist of duplex cottages with either single cells or dormitories. The campus also includes "Cottage 13," which is a maximum security, self-contained building used to house residents who need to be separated from the general population on a short- or long-term basis.

Most male juveniles in the IDOC who have committed sexual offenses are sent to Plainfield. Generally, these youths are housed together in specific units. In most of these sex offender units, residents sleep on bunk beds in large dormitories.

Plainfield utilizes a level program that is mandated by the IDOC as part of its comprehensive case management system. The program consists of several levels that a youth is required to complete in order to qualify for release. A youth's progress

through the levels is measured against his "Individual Growth Plan," which is a set of long-term and short-term cognitive and behavioral goals specifically designed for the youth by his interdisciplinary treatment team, as well as interventions to be utilized to achieve those goals. The youth's treatment team, which includes custody, mental health, and educational professionals, decides when a youth has successfully completed a level; unanimous approval by the team is required for a youth to move to the next level.

All male juveniles entering the IDOC, including those who ultimately are committed to Plainfield, are initially sent to Logansport for a 13-day intake period. According to Logansport officials, during this intake period each youth undergoes a physical examination; dental, vision and hearing screenings; an intellectual and educational assessment; a risk and needs assessment; a substance use assessment; a crimino-psychosocial history; and, if deemed necessary, is referred to a psychiatrist and/or psychologist. See Logansport Findings Letter at 2. At the conclusion of the 13-day intake process, juveniles are classified and transferred to one of seven IDOC operated juvenile treatment facilities (which include Plainfield), or to one of four privately-operated facilities.

II. FINDINGS

We find that Plainfield fails to adequately protect the juveniles in its care from harm. We also find constitutional deficiencies in the facility's mental health care. Finally, Plainfield fails to provide juveniles with disabilities the education services required by the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1401.

A. PROTECTION FROM HARM

As a general matter, the State must provide confined juveniles with reasonably safe conditions of confinement. Youngberg v. Romeo, 457 U.S. 307 (1982); Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974). Such constitutionally mandated conditions include the right to be free from undue restraint and the use of excessive force by staff. Youngberg, 457 U.S. at 315-16; Nelson, 491 F.2d at 356. Juveniles in state custody also have a constitutional right to be reasonably protected from harm inflicted by third parties. K.H. v. Morgan, 914 F.2d 846, 851

(7th Cir. 1990). Neither the Supreme Court[2] nor the Seventh Circuit[3] has determined definitively whether the Eighth Amendment or the Fourteenth Amendment provides the governing constitutional standard for conditions in juvenile facilities. For purposes of this letter, we need not resolve which standard governs because we find that the conditions at Plainfield violate even the more stringent Eighth Amendment standard.

Throughout our tours, youth residents repeatedly informed us that they are not safe at Plainfield. Our investigation confirmed that juveniles in Plainfield live in a violent culture where physical assaults between youths occur regularly, overt sexual behavior among youths is commonplace, and corrections staff often use excessive physical force when restraining youths.

1. Youth Violence and Inadequate Supervision

Juveniles in institutions have a constitutional right to be reasonably safe from harm inflicted by other juveniles in the facility. In order for juveniles to be reasonably safe from such harm, it is essential that a facility provide adequate supervision to youths in its care. Our investigation revealed that there are inadequate numbers of staff to meaningfully supervise the youth residents.

At Plainfield, physical assaults among the youth residents are commonplace. Moreover, these assaults frequently occur without intervention – or even awareness – by staff. The following are examples from facility incident reports:

- On or about June 25, 2004, a Plainfield youth attacked another youth in the recreation area and broke his victim's jaw. No officers reported observing this assault. Three days after the assault, the victim came forward to seek medical attention for his sore jaw. The victim was

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[2] See Ingraham v. Wright, 430 U.S. 651, 669 n.37 (1977) (Although holding that the Eighth Amendment is inapplicable to the paddling of schoolchildren, the Court declines to consider whether the Eighth Amendment applies to conditions in juvenile institutions).

[3] In Nelson, the Seventh Circuit held that the State violated the Eighth Amendment rights of confined juveniles by administering abusive corporal punishment and forced tranquilizing medication, but violated their Fourteenth Amendment rights by failing to provide them with minimally acceptable rehabilitative treatment. 491 F.2d at 357; 360.

transported to the local emergency room, where it was confirmed that his jaw was broken and would have to be wired shut.

- On June 12, 2004, three youths attacked another youth while he was sitting in a staff member's chair in the unit dormitory. The three youths beat their victim in the head and face, ultimately breaking his jaw. No officers reported observing this assault. The following day, the victim came forward to seek medical attention for a sore jaw. The injury report indicates that the youth could open his mouth only partially and that there was blood in his mouth. He was referred to a dentist on the following day, June 14. The dentist then referred the youth to the local emergency room, where it was confirmed that the youth's jaw was broken and would have to be wired shut.

- On March 27, 2004, one youth attacked another youth, ultimately fracturing the victim's jaw. The victim did not receive medical attention for his injury until four days later. At that time, his jaw was x-rayed and the fracture diagnosed.

- On November 11, 2003, a youth was assaulted by another youth. As a result of this assault, the victim's mouth was bleeding and two of his teeth were broken. On December 1, 2003, the same youth was again assaulted. He received bruises and facial lacerations and was unable to move his jaw without pain. A dental x-ray on December 4 revealed several jaw fractures and, therefore, the youth's jaw was wired shut.

The examples above reflect a consistent and disturbing pattern of unchecked violence among Plainfield's youths resulting from a lack of adequate supervision of residents. In many cases, the victims suffer serious injuries as a result of assaults that are not detected by staff or reported by other residents. In many of the incidents described above, staff did not learn of the assault until the victims sought medical attention several days afterward. Moreover, the actual number of youth assaults is likely much higher than what is reflected in the incident reports. During our tour, residents consistently reported that there are numerous incidents of youth-on-youth violence about which staff are unaware, resulting in an environment where youth assaults can and, in fact, often do occur without detection or prevention.

Another consequence of the inadequate supervision of youths at Plainfield is an unacceptably high rate of sexual activity.

Because Plainfield houses many of the IDOC's juvenile sex offenders, the risk of sexual abuse and molestation among the residents is particularly high. Constitutional standards require that Plainfield take reasonable measures to protect more vulnerable residents from abuse and exploitation by more sophisticated, sexually predatory youths. J.H. and J.D. v. Johnson, 346 F.3d 788, 791-92 (7th Cir. 2003). The Constitution also obligates Plainfield to provide a rehabilitative environment for all young sex offenders. Nelson, 491 F.2d at 360. Unfortunately, we found that Plainfield fails to provide supervision adequate to accomplish either of these legally required objectives.

Sexual activity among youth residents, referred to at Plainfield as "overt sexual behavior," or "OSB," is rampant at Plainfield. We reviewed numerous reports involving scores of incidents of OSB among youths at Plainfield. These incidents are not limited to a particular area within the facility. Rather, OSB occurs throughout the campus, for example, in the dormitories, day rooms, bathrooms and shower areas, and even in the campus security van. An April 2004 critical incident report, submitted by the facility's acting superintendent to IDOC's Deputy Commissioner of Juvenile Services, describes a series of incidents of OSB involving over 20 youths on the same unit over the course of several months. The OSB among these youths was so pervasive and elaborate that the report includes a flow chart identifying each youth involved and the specific sexual acts each youth performed with each other youth. A March 2004 critical incident report to the Deputy Commissioner describes a similar series of OSB incidents involving eight youths from the same unit. In an October 2003 critical incident report to the Deputy Commissioner, over 14 different youths on the same unit are reported to have engaged in a variety of sexual acts occurring throughout the facility, including in the movement lines, the day room, restroom, recreation area, and storage closet.

Moreover, the age and size disparity between many of the youths involved in these incidents is alarming. For example, the incidents described above involved many 13-year-old youths engaged in sexual acts with youths as old as 16 years. Likewise, we found significant weight disparities between involved youths, for example, youths weighing under 70 pounds who engaged in sexual acts with youths who weighed as much as 100 pounds more than them. When older, bigger, and/or more sophisticated youths

have access to younger and/or smaller youths, the risk of abuse and exploitation is particularly high.[4]

Two particularly disturbing incident reports we reviewed involved 12-year-old boys with significantly older youths. An incident report dated February 8, 2004, describes an incident in which a 16-year-old youth gave a 12-year-old youth articles of clothing as enticement to perform sexual acts with the 16-year-old while in the unit day room. A report dated July 31, 2003, describes two separate incidents in which an 18-year-old youth attempted to force a 12-year-old youth to perform sexual acts on the older youth in the bathroom area. It is not appropriate for 12-year-old boys to be housed with older, more sophisticated juveniles, nor is it appropriate that these older youths have such apparently easy access to the younger residents. Moreover, for both the victims and the aggressors, these experiences are likely to inhibit whatever rehabilitative efforts have been made in the past or that will occur in the future.

The most obvious and glaring reason for the frequency of physical assaults and OSB among juveniles at Plainfield is that there are not enough staff to supervise the residents adequately. Constitutional standards require that juvenile facilities staff every shift with a number of qualified staff members sufficient to ensure the safety and security of its youth residents. Without an adequate number of officers on duty, existing staff cannot respond in a safe and timely manner when assaults occur. Moreover, without adequate numbers of staff on duty, correctional officers do not have the time to establish relationships with the youth residents that would enable staff to identify when tensions are rising between youths and to prevent violent incidents from occurring.

At Plainfield, the staffing ratio varies among the units, from one staff to between 30 to 48 youths. One adult simply cannot provide supervision to 30-48 delinquent juveniles sufficient to keep them safe, much less establish relationships with and provide a rehabilitative environment for the youths.

The physical design of the cottages in which most of the sex offenders are housed exacerbates the inadequacy of nighttime staffing ratios. Typically, in facilities that house sex

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[4] In fact, the incidents involving juveniles under the age of 14 years implicate Indiana's child molestation law. See IN. CODE § 35-42-4-3 (defining criminal molestation to include sexual acts committed by any person with children under the age of 14 years).

offenders, residents sleep in individual rooms in order to prevent sexual activity among the residents. In contrast, most of Plainfield's sex offenders sleep in large dormitories in bunk beds. Housing sex offenders in dormitories with bunk beds is a questionable practice regardless of staffing ratios. Doing so when staffing ratios are significantly deficient places youth residents at clear risk of serious harm and is particularly inappropriate.

2. Use of Physical Force

Juveniles at Plainfield have a right to be free from unnecessary restraint and the use of excessive force. Youngberg, 457 U.S. at 315-16; Nelson, 491 F.2d at 356. See also H.C. v. Jarrad, 786 F.2d 1080, 1089 (11th Cir. 1986); Milonas v. Williams, 691 F.2d 931, 942 (10th Cir. 1982). We were pleased to learn that, for the most part, Plainfield takes strong disciplinary action, including termination of employment, against employees when an inappropriate use of force is identified. Additionally, some youths identified specific members of the corrections staff who they felt were fair and conscientious in executing their duties.

Nevertheless, we found a disturbing consistency in the youths' accounts of the use of unnecessary physical restraint and excessive force by many staff at Plainfield. For example, a number of youths reported incidents where staff "slammed" a youth into a wall or onto the floor for a minor rule infraction, sometimes after the youth was already in handcuffs. Many other youths described incidents in which corrections staff provoked a youth in order to justify use of force on him.

Use of force reports at Plainfield support the accounts we received from youths and reveal a pattern of youth injuries resulting from physical restraints by staff. In many of these incidents, the use of physical force, or the amount of force used, was not warranted by the situation. For example, in one incident in January 2004, an officer grabbed a youth by his face and pushed him into a wall after the youth was "verbally disrespectful and threatening" to the officer. The officer involved ignored a direct order by his sergeant to let the youth go, and the sergeant ultimately had to physically remove the officer from the youth and help the youth up. The youth was treated in the health care unit, which reported that the youth sustained bruises and cuts across his neck and shoulder.[5]

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[5] The sergeant appropriately reported this incident to (continued...)

In another incident in November 2003, an officer restrained a youth for not following the officer's directions to return to the day room. The report identifies a number of injuries the youth received during this physical restraint, including several cuts on and around his ear, back and lips, a contusion on his forehead, and scrapes and bruises across his chest and back. Although the officer involved reported that these injuries occurred when he "wrapped his arms around [the youth] and took him to the ground," several youth residents who were present at the time reported that the officer grabbed the youth and "hit his head into the wall, kicked him, and used his knee on the student's back to hold him down."

Interviews with Plainfield staff indicate that poor staffing ratios likely contribute to the use of more force than necessary in many incidents of physical restraint. Virtually every correctional officer that we interviewed expressed his/her concern about maintaining control of the facility. Moreover, several youths told us that the "residents control the facility," indicating that staff were outnumbered and not consistently able to maintain order in the facility. When staff feel outnumbered and stretched too thin, they are more likely to apply extra force during a restraint to emphasize to the youth that non-compliant behavior will not be tolerated. This is not an acceptable practice.

Also troubling is the IDOC's inclusion of a provision regarding "Lethal Physical Intervention" in its use of force policy. The provision appears in a section entitled, "Juvenile Facilities Step Definitions," and appears to be the final measure in a series of graduated steps to be taken by staff in the event of an incident that might result in the use of force on a youth. "Lethal Physical Intervention" is not defined in this policy, although a separate definition section of the policy includes "deadly force," which is defined as "any force which creates a substantial risk of serious bodily injury or death or which the person using the force reasonably believes creates a substantial risk of causing serious bodily harm or death." In any case, the policy includes no guidelines or limits as to when the use of lethal force is permissible. A policy that permits the use of lethal force, in any setting but particularly in a juvenile facility, without clear limits and guidelines is not appropriate, places youth residents at significant and obvious risk of serious harm or death.

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[5](...continued)
the administration and child protection services. We are unaware of the outcome of this investigation.

3. Grievances

The dysfunctional grievance system at Plainfield contributes to the State's failure to ensure a reasonably safe environment. An adequately functioning grievance system ensures that youth residents have an avenue for bringing serious allegations of abuse and other complaints to the attention of the administration. It also provides an important tool in evaluating the culture at the facility, and alerting the administration about dangers and other problems in the facility's operations. Plainfield's grievance system is inadequate and our investigation revealed that very few youths bother to utilize the grievance process. Almost every youth we interviewed stated that they have no confidence in the grievance system and see little point in using it.[6]

Several factors contribute to the inadequacy of Plainfield's grievance process. First, physical access is unnecessarily restricted. Grievance boxes, where residents can submit their written grievance forms, are available only in the school and the cafeteria, and not in any of the regular living units. Thus, access to initiate the grievance process is not readily available.

When youths do attempt to initiate the grievance process, their substantive complaints are often not addressed, even when the grievance contains serious allegations of staff misconduct. For example, in a May 15, 2004 grievance, a youth alleged that a staff member hit him with a basketball. The youth further alleged that when he questioned the staff's actions, the staff member handcuffed him. The May 26 response to this grievance states only, "Rejected. A complaint step 1 was not submitted."[7]

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[6] In an interview, Plainfield's grievance coordinator informed us that she believes that youths do not use the grievance system because the youths have access to a campus mail system that enables them to communicate with staff members in writing. While it is commendable that residents at Plainfield are able to use the campus mail to communicate with staff, this cannot replace a formal grievance system that includes a coordinator who is authorized to resolve identified problems, a response memorialized in writing, a process for appealing the resolution of a grievance, established time frames for responding to grievances, and a mechanism for tracking the substance and resolution of grievances.

[7] "Complaint Step 1" refers to a specific form that

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In another example, a youth filed a grievance on May 16, 2004, alleging that an officer had informed him that two other corrections staff had successfully "set up" another youth in order to extend the youth's time at Plainfield. The May 26 response said only "Rejected. A student may not file a complaint on another student's behalf."

Plainfield's grievance process policy also provides that a youth's access to the grievance process may be denied if it is determined that the youth is "attempting to flood the procedure with frivolous complaints." See Section XX of Plainfield's "Offender Grievance Process." Plainfield's grievance coordinator informed us that it was within her discretion to suspend a youth's access to the grievance process, and to lift the suspension.

Access to the mechanism through which youth residents can communicate serious allegations and concerns to the administration is a critical element of ensuring that youths' rights are protected and suspension of this access is inconsistent with generally accepted standards. The experience of one Plainfield youth illustrates the potential problems in permitting suspension of access. This particular youth filed 13 grievances within a three-week period in 2004, eight of them filed on one day. Plainfield's grievance coordinator determined that the youth's grievances were excessive and, therefore, suspended the youth's access to the system. The youth's grievances included the following allegations:

- He witnessed an officer strike another youth in the face and improperly restrain the youth;
- An officer verbally abused him and yanked his arm fiercely;
- He heard an officer threaten to "beat the s— [expletive deleted]" out of another youth;
- He requested to go to the health care unit and was refused;
- He witnessed an officer strike another youth with a notepad;
- He requested a grievance form from an officer and the officer told him to "leave him the f--- alone [expletive deleted];"

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[7](...continued)
youths must first submit, notifying the Grievance Specialist of his desire to file a Grievance, which is defined in IDOC's policy as "a legible, formalized version of a complaint...that has been signed and dated by a student and the Grievance Specialist."

All but one of the responses to these grievances stated, "Complaint rejected. Student continues to flood the grievance system," or similar language.

Clearly, this youth's use of the grievance system presents challenges to Plainfield's staff. And to be sure, there are appropriate limitations that may be placed on repetitive and frivolous filers. Nevertheless, many of his grievances contain allegations of serious misconduct that should have prompted further investigation. Suspending this youth's access to the grievance process altogether leaves him without an avenue through which to communicate potentially serious allegations and complaints in the future. Disregarding his concerns and fears also ignores an opportunity to evaluate how to meet the treatment needs of this youth and to possibly address systemic harm to other youths. Moreover, the mere existence of a provision permitting the denial of access to the grievance system, without any guidance for staff, may inhibit the filing of grievances and, therefore, undermines the purpose and effectiveness of the process.

B. MENTAL HEALTH CARE

The Constitution requires that youths in juvenile justice institutions receive adequate mental health care. Youngberg, 457 U.S. at 323, n.30.; Nelson, 491 F.2d at 360; see also K.H., 914 F.2d at 851; A.M., 372 F.3d at 585 n.3. We find that certain aspects of the mental health care at Plainfield are constitutionally inadequate. Specifically, we find that Plainfield fails to provide adequate (1) mental health screening and assessment services, and (2) psychopharmacological services.

1. Screening and Assessment Services

We were pleased to learn that all juveniles entering Plainfield are assessed by a psychologist upon arrival. Thus, the framework exists for identifying youths with serious mental health issues. Unfortunately, we found that the mental health assessments conducted at Plainfield are not sensitive enough to identify serious mental illnesses where the youths' symptoms are internalized, as can be the case with depression, post-traumatic stress disorder, and psychosis. For example, one youth we interviewed described a variety of hallucinations that he was experiencing, but his hallucinations had not been identified or treated by Plainfield's mental health staff. Another youth we interviewed exhibited clear signs of depression, however, this had not been detected through screening and assessment at Plainfield. In fact, approximately half of the youths

interviewed by our mental health consultant during our visit to Plainfield exhibited clear symptoms of depression and/or psychosis which had not been identified or treated by Plainfield's mental health staff.

2. Psychopharmacological Services

As stated above, juveniles placed at Plainfield first spend 13 days at Logansport, purportedly for evaluation and assessment. And, as we explain in our letter issued today regarding mental health services at Logansport, when a youth is admitted to Logansport and reports that he is currently receiving psychopharmacological treatment,[8] he is typically permitted to finish whatever medication he has with him at the time of intake. If the youth reports that he is currently receiving psychopharmacological treatment but does not have any medication with him, then Logansport's intake nurse will refer him to the psychiatrist, who will meet with the youth within seven days. In either scenario, however, unless the youth is overtly exhibiting the symptoms the medication purports to treat, medication is automatically discontinued once the youth's personal supply has been exhausted.[9] Logansport's psychiatrist reports that the purpose of this discontinuation practice is to institute a "wash-out" period. A wash-out period is a medication-free time during which, in theory, the mental health professional will monitor the youth's behavior and assess whether any psychopharmacological treatment is appropriate.

A wash-out period, if implemented appropriately, can be a useful diagnostic tool for ensuring the appropriate use of psychotropic medications. However, in order to meet generally accepted professional standards of care,[10] a youth who undergoes

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[8] Psychopharmacological treatment refers to the use of psychotropic medications to control symptoms of mental illness.

[9] In interviews during our visit, Logansport's psychiatrist stated that it was his understanding that the discontinuation of psychotropic medications once a youth exhausts his personal supply is mandated by IDOC policy. IDOC's medical director, however, stated that no such policy exists. Thus, the origin of this practice remains unclear.

[10] In assessing the constitutional adequacy of mental health care practices at Plainfield, we must consider whether professional decisions substantially depart from accepted professional judgment. See Youngberg, 457 U.S. at 323; Estate

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a wash-out period must be carefully monitored and assessed by a qualified mental health clinician before, during, and after discontinuation of the medication in order to determine whether a return to medication is warranted. Without adequate monitoring and assessment throughout this time, juveniles are exposed to a number of potential harms. Most obviously, youths whose mental health needs are not adequately identified and treated may suffer mental distress and anguish, as well as an increased risk of suicidality. Additionally, such youths are less likely to be able to successfully complete the rehabilitation program, a requirement for release from the treatment facility. Moreover, juveniles with unmet mental health needs are more likely to demonstrate unacceptable behaviors that elicit punitive responses from staff.

Because residents are transferred out of Logansport shortly following the discontinuation of medication, the bulk of the requisite monitoring and assessment should occur at the treatment facility to which a youth is transferred, in this case, at Plainfield. In our review of Plainfield's mental health services, however, we found that youths whose medications are discontinued[11] at Logansport are not provided with adequate monitoring and assessment at Plainfield to determine whether there is a need to resume the psychopharmacological treatment. In fact, a significant number of the youths we identified as experiencing symptoms of serious mental illness had been receiving psychopharmacological treatment at the time they entered Logansport. The medication was discontinued while the youths were at Logansport, purportedly to institute a wash-out

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[10](...continued)
of Cole v. Fromm, 94 F.3d 354, 262-63 (7th Cir. 1996) (deriving the standard for assessing the adequacy of mental health care provided to pretrial detainee from Youngberg).

[11] We also find the characterization of IDOC's medication discontinuation policy as a diagnostic wash-out period to be problematic. The fact that youths entering Logansport are permitted to finish whatever quantity of medication they may happen to bring in with them before the prescription is discontinued suggests that the subsequent discontinuation is not driven by medical considerations. Indeed, if the driving force for discontinuing a medication is truly a lack of need for that medication, then it should be discontinued *regardless* of whether the juvenile brought in a supply of his own. And, in fact, when we asked Logansport's psychiatrist what the rationale is for permitting residents to finish medications they have with them, he stated that it was to avoid the medication going to waste.

period. Without adequate monitoring, this is not an acceptable practice.

C. SPECIAL EDUCATION SERVICES

Students with disabilities have federal statutory rights to special education services under the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §1401 et seq.[12] Plainfield violates these rights by failing to provide adequate special education at its school program[13] in violation of the IDEA. At the time of our tour, over half of Plainfield residents had been identified as qualifying for special education services under the IDEA.

At the outset, we note that there are several positive aspects of the educational program at Plainfield. For example, Plainfield's teachers are dedicated and enthusiastic and, for the most part, are licensed in the subject area they teach. Additionally, there is a basic system to address student behavior which, although requiring some modifications, encourages discussion between educators, custody staff, and mental health professionals.

We were also pleased to see that students with disabilities spend most of their school day in general education classes, as envisioned under the IDEA. 34 C.F.R. § 300.550(b)(1)(requiring that "to the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are nondisabled"). Nevertheless, we find that Plainfield fails to provide special education services required under IDEA.

1. IEPs

The IDEA requires that each student with a disability have an Individualized Education Program ("IEP"), and describes the IEP components required to ensure that each student receives adequate special education services. 34 C.F.R. §§ 300.346, 300.347. The IEPs developed at Plainfield do not ensure that

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[12] We note that the IDEA was reauthorized and amended by the Individuals with Disabilities Education Improvement Act of 2004, PUB. L. NO. 108-446, 118 Stat. 2647 (2004), effective July 1, 2005. The IDEA provisions cited herein are substantively the same as those in force at the time of our tour.

[13] Plainfield's school program is called the Charlton Jr./Sr. High School.

students with disabilities receive required special education services.

In particular, the IEPs developed at Plainfield are not sufficiently specific or individualized to meet the needs of each student with a disability. For example, IEPs must identify the specific location, frequency and duration of the special education services that each student requires. 34 C.F.R. § 300.347 (a)(6). Yet, nearly half of the 36 Plainfield IEPs that we randomly reviewed contained only a vague statement that the student would be involved in "a 10-12 month educational program, 4-6 times daily up to five hours with recreation (and treatment)." This statement generally describes the education program at Plainfield but does not reflect an adequately developed individualized education plan as required under the IDEA. Moreover, the repetition of this language in so many IEPs indicates that students are not being evaluated for and provided with services specific to their individual needs. Additionally, it is impossible to identify whether students are actually receiving services noted in their IEPs because the criteria listed are too vague to measure.

The majority of the IEPs we reviewed also contain "boilerplate" language regarding the instructional adaptations and assessment accommodations needed by each student. For example, two-thirds of the IEPs we reviewed stated that the only effect the students' disability will have on his involvement in the general education curriculum is that he will need textbooks at his grade level. Similarly, 14 IEPs listed, "May need extra time to complete assignments and tests," as the only accommodation needed by the student. While not problematic on their face, the repetition of these accommodations in so many IEPs strongly suggests that students are not being provided with special education services specific to their individual needs, as required by the IDEA.

We also found several instances where a youth's individual services were dramatically lower than what he had received in his previous educational setting. For example, in four of the records we reviewed, students' direct special educational services were reduced from 100 percent in their prior educational setting to no direct special education services whatsoever at Plainfield. Drastic reductions in services without adequate justification suggest that Plainfield is tailoring IEPs to what is available, rather than the students' individualized needs.

Our review of Plainfield's IEPs also reveals serious deficiencies in services to students with disabilities who need

behavioral supports to succeed in the classroom. For example, of the 21 students with emotional disturbances ("ED") whose IEPs we reviewed, not one included a behavior intervention plan ("BIP") to assist them in accessing the curriculum. One youth was in a private residential facility prior to incarceration, yet he now has no BIP. Another student's previous IEP stressed the need for a BIP, yet his Plainfield IEP does not contain one. Yet another student was sent to Cottage 13 (the segregation unit) for getting into a fight just prior to his IEP meeting, and yet it is noted in the resulting IEP that "behavior is not an issue" for this youth and no BIP was implemented.

2. Instructional Services for Students with Disabilities

a. Individualized Instruction

The IDEA requires that students with disabilities receive specially designed instruction in which the content, method, and/or delivery of instruction is adapted as necessary to meet the unique needs of the student, and to ensure his access to the general curriculum. 34 C.F.R. § 300.26(a)(3). For example, a student with disabilities may require a seating change, more time on written assignments, oral testing, specific instructional cues, etc. The general education teacher typically is responsible for implementing the instructional adaptations identified in the IEP. During our tour, however, we found that several general education teachers at Plainfield were unaware of which students in their classes even required special education services. Not surprisingly then, even where IEPs listed specific instructional adaptations for students, such classroom adaptations were not evident during our tour. In fact, during the course of visiting 24 classrooms and instructional areas, we observed only one teacher providing a single instructional adaptation in all of our classroom observations, despite the fact that over half of the students at Plainfield qualify for special education services.

One factor that likely contributes to the inadequate provision of special education services is the lack of teacher oversight. At the time of our visit to Plainfield, there was no formal mechanism in place to observe and evaluate teachers' practices to ensure that they provide appropriate educational services. Likewise, there is no procedure in place to evaluate the performance of the Plainfield principal regarding teacher compliance with special education or other federal and state educational requirements. Plainfield must develop procedures to hold staff accountable for providing special education services to students.

Plainfield's rate of teacher absences and lack of a policy to obtain substitute teachers also contributes to the inadequate provision of special education services. When a Plainfield teacher is absent, there is no system in place for obtaining a qualified substitute teacher to cover his classes. In a sample six-month period in 2004, Plainfield's teachers were absent for an average of 85 hours per week. This interferes with the teaching staff's ability to provide students with disabilities the individualized instruction required under the IDEA.

b. Curriculum

The IDEA requires that States provide special education and related services which meet the standards of the State education agency. 20 U.S.C. §§ 1401(9)(b); 1412(a)(1)(A). See also 34 C.F.R. § 300.600(a)(2)(ii). At Plainfield, the course offerings are insufficient for students to earn a high school diploma. For example, Plainfield does not offer courses in laboratory sciences (such as biology, chemistry, and physics), foreign languages, physical education, fine arts, consumer/economics, or a sufficient number of electives, all of which are part of Indiana's minimum curriculum.[14]

Furthermore, students with disabilities do not have sufficient access to courses needed to obtain a high school diploma. For example, out of 35 randomly selected course schedules of students with disabilities, 81 percent were not enrolled in any history, geography, or science class; 12 percent were enrolled in a life skills class for the entire day; half of this sample of students were not enrolled in any mathematics course; and 42 percent were not enrolled in a language arts course.

c. Access to Instruction

The IDEA requires that all students with disabilities have access to free and appropriate public education which meets the standard of the State education agency. 20 U.S.C. §§ 1401(9)(b); 1412(a)(1)(A). See also 34 C.F.R. § 300.600(a)(2)(ii). It is critical that students with disabilities receive adequate instructional time in order to access the general education curriculum and achieve academic success. Plainfield unacceptably limits access to instructional time in a number of ways.

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[14] 511 IN. ADMIN. CODE § 6.1-5-4(c) (listing the minimum curriculum for high schools).

First, Plainfield only provides class instruction four days per week. On Wednesdays, certain students attend a multi-disciplinary conference (known as "Team") regarding their progress. Students on units having Team on Wednesday spend the day watching videos as they wait for their meeting. Students not scheduled for Team go to school, but their teachers and classes are different than usual, and little or no instruction takes place. While we appreciate Plainfield's dedication to implementation of its rehabilitation program, this progress review cannot be at the expense of required education services to students with disabilities.

Second, on the four days per week that Plainfield provides class instruction, actual instructional time is limited to three hours per day, half of the daily amount required under Indiana law.[15] The other half of each day is devoted to 90-minute sessions each of recreation and skill groups, neither of which is taught by a certified teacher.

Additionally, Plainfield's policy regarding student orientation unnecessarily delays special education students' access to instruction. Upon arrival at Plainfield, all students spend approximately two weeks in "orientation" before they are enrolled in school. During this time, they are given a packet of facility information to review. Once the student is finished with the packet (an exercise that takes no more than a few hours to complete), he essentially sits in study hall with nothing to do for the remainder of the two weeks. Significantly, this two-week delay in school enrollment follows the student's 13-day stay at Logansport, during which time no special education services are provided. Thus, students with disabilities spend their first four weeks in the IDOC without access to any special education services.

Finally, segregated juveniles with disabilities do not have adequate access to special education services. According to Plainfield officials, youths who are sent to the facility's self-contained segregation unit, Cottage 13, for a short-term stay (*e.g.*, a few days for disciplinary reasons) are supposed to attend classes with the general population at the school. However, both correctional officers and the school principal

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[15] See 511 IN. ADMIN. CODE § 6.1-3-1(1) (requiring that schools serving 7-12th grade students provide a minimum of six hours per day of instructional time). See also 20 U.S.C. §§ 1401(9)(b); 1412(a)(1)(A) (requiring that students with disabilities receive free and appropriate education which meets the standards of the state education agency).

acknowledged to us that this does not actually happen and, instead, youths remain on the unit all day with no school work or instruction.

Students with disabilities who are sent to Cottage 13 on a long-term basis, referred to at Plainfield as the "Intensive Treatment Unit (ITU)," likewise do not have access to special education services. Depending on the reason for placement there, a youth can remain in Cottage 13's ITU for the entire length of his stay at Plainfield (which is, on average, 17 months). According to Plainfield officials, a teacher from the school is supposed to come to Cottage 13 to provide services to students who are in the ITU program. Likewise, we reviewed numerous IEPs that stated that "If a student is assigned to Cottage 13 (long term) intensive unit, he will receive educational services daily by a licensed teacher." However, administrators and teachers acknowledged, and we observed, that a certified teacher comes to Cottage 13 extremely infrequently. As a result, classes in Cottage 13 are held erratically or not at all, in violation of IDEA's guarantee of appropriate education for students with disabilities.

III. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional rights of juveniles confined at Plainfield, IDOC should implement, at a minimum, the following remedial measures:

1. Ensure that youths are adequately protected from physical violence from staff and other youths, and sexual abuse and exploitation from other youths;

2. Ensure that there is sufficient, adequately trained staff to safely supervise the residents at all times;

3. Provide safe and appropriate housing for youths, including sex offenders;

4. Develop and implement a use of force policy that provides clear guidelines and appropriate limits on the use of force;

5. Provide adequate training and supervision to correctional staff regarding safe and appropriate use of force and physical restraint;

6. Develop and implement a grievance system that ensures resident access to a functional and responsive grievance process;

7. Provide adequate screening and assessment services to identify juveniles with serious mental health needs; at a minimum, all juveniles should receive a comprehensive mental health screening and assessment, either during their stay at Logansport or immediately after admittance to their treatment facility;

8. Provide adequate psychopharmacological treatment to youths. If a wash-out period is implemented for youths who enter Logansport on psychotropic medication, IDOC should:

    a. Conduct an adequate baseline assessment of the youths and ensure adequate documentation of the baseline;

    b. Provide adequate monitoring during the wash-out period;

    c. Provide timely follow-up assessments to determine whether a return to treatment with medication is warranted; and

    d. Ensure that psychopharmacological treatment is promptly resumed when necessary;

9. Develop and implement adequate IEPs for students with disabilities;

10. Provide individualized instructional services to students with disabilities in accordance with the IDEA;

11. Ensure students with disabilities have sufficient access to an adequate curriculum; and

12. Ensure students with disabilities have sufficient access to instructional services.

* * *

As stated above, we appreciate the cooperation we have received from IDOC officials and facility staff throughout this investigation. We hope to be able to continue working with the State in an amicable and cooperative fashion to resolve the deficiencies found in the operation of this facility. Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. Although these reports are the consultants' work – and do not necessarily

reflect the official conclusions of the Department of Justice – the observations, analyses, and recommendations contained in the reports provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them.

In the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to institute a lawsuit pursuant to CRIPA to correct the deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will be contacting your attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Bradley J. Schlozman

Bradley J. Schlozman
Acting Assistant Attorney General

cc: The Honorable Steve Carter
Office of the Indiana Attorney General

J. David Donahue, Commissioner
Indiana Department of Correction

Dawn Buss, Superintendent
South Bend Juvenile Correctional Facility

Curtis Correll, Superintendent
Plainfield Juvenile Correctional Facility

Kellie Whitcomb, Superintendent
Logansport Juvenile Intake/Diagnostic Facility

The Honorable Joseph S. Van Bokkelen
United States Attorney
Northern District of Indiana

The Honorable Susan W. Brooks

United States Attorney
Southern District of Indiana

John H. Hager
Assistant Secretary
Office of Special Education and Rehabilitative Services
United States Department of Education

Troy Justeson
Acting Director
Office of Special Education Programs
United States Department of Education