MISSISSIPPI **YOUTH JUSTICE** PROJECT

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June 11, 2007

VIA FACSIMILE
AND FIRST CLASS MAIL

Cyndi Eubank, Esq.
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Re: Columbia Training School

Dear Cyndi:

On June 4, I sent Ms. Kathy Pittman a letter documenting our concerns with conditions at the Columbia Training School. I am writing to supplement that letter with information gathered during our recent legal visits and file reviews. I would like to reiterate that we are encouraged by the Division of Youth Service's recent actions to address the deficiencies at Columbia. But we remain gravely concerned about both the safety of our clients who are currently at Columbia and the trauma suffered by our clients who have been released. As you know, individual girls and their guardians have retained us to represent them in this matter. Additionally, we are investigating this matter pursuant to our Protection and Advocacy authority. *See* 42 U.S.C. §§ 10801 *et. seq* ; *See also* 45 C.F.R. 1386.22. We are submitting this letter on behalf of our individual clients and pursuant to 42 U.S.C § 10807, in an attempt to exhaust administrative remedies and reach a cooperative, mutually agreeable resolution of the matters discussed more fully below.

I. Unnecessary use of restraints

Eight girls committed to Columbia, all of whom are young girls living with mental illness, and most of whom are victims of past physical or sexual abuse, were shackled for about twelve hours a day for time periods ranging from one month to one week. Most girls were shackled from May 17 until May 31, but at least one girl was shacked from May 3 until May 31. The girls were not required to sleep or shower in their shackles, but had to eat, attend school and use the bathroom while shackled. Apparently, staff shackled the girls in response to allegations that they planned to escape from Columbia Training School.

One youth, C[redacted]C[redacted] was shackled shortly after she returned to the Columbia Training School following a successful escape attempt on May 3. She lived in shackles for twelve hours a day from May 3 until May 31. C[redacted] has a tumultuous family background and a documented history of physical abuse. She also has a history of emotional disabilities. She reports that after her escape attempt she was told she would be in shackled indefinitely.

Our clients, including S[redacted] W[redacted] J[redacted] A[redacted], H[redacted] D[redacted], E[redacted] S[redacted], and S[redacted] G[redacted] were also shacked for about twelve hours a day during the time period between May 17 and May 31. The girls report that their shackles were removed briefly on May 24, but then staff forced the girls to wear the shackles again on May 25.

The girls went to school and saw the nurse in shackles and report that innumerable staff members observed them going about their daily activities during this entire time period.[1] On May 31, the girls were called into a meeting attended by M[redacted] A[redacted], D[redacted] and J[redacted] and informed that the shackles would be removed, but if they so much as mentioned the word "run," they would be shackled again. Each of these girls also took psychotropic medications. Given their mental illnesses and past histories of physical and sexual abuse, these girls are particularly vulnerable to trauma.

Our clients were sent to Columbia to be rehabilitated—not to receive punitive treatment. Indeed, the Constitution demands that youth confined in Mississippi's training schools receive treatment that is reasonably related to treatment and rehabilitation. *Morgan v. Sproat*, 432 F. Supp, 1130, 135 ("juveniles who are committed to . . . training school have a constitutional right to individualized care and treatment to enable them to become productive members of society.") Federal courts refer to this right as the "right to treatment," which includes the right to reasonably safe conditions of confinement, rehabilitative training, *reasonably non-restrictive confinement conditions and freedom from unreasonable bodily restraint*. *See* Alexander S. v. Boyd, 876 F. Supp. 773, 797-798 (D.S.C. 1995) citing *Youngberg v. Romeo,* 457 U.S. 307 (1982). The right to treatment has developed in the context of individuals who have been involuntarily committed for mental health treatment, but courts apply this right with full force to delinquent juveniles. *See Santana v. Collazo*, 714 F.2d 1172, 1179 (1st Cir. 1983) (relying on *Youngberg* to hold that because the state has no legitimate interest to punishment, the conditions of juvenile confinement are subject to more exacting scrutiny than conditions imposed on convicted criminals.) *See also* B.H. v. Johnson, 715 F. Supp. 1387, 1394 (D. Ill. 1989); *Jackson v. Johnson*, 118 F. Supp. 2d 278, 289 (D.N.Y. 2000).

A juvenile delinquent's right to treatment is violated "when the decision by the professional is such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible did not base the decision on such a judgment." *Youngberg* at 323. *See also Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1245-46 (2d Cir. 1984). According to the National Association of State Mental Health Directors:

Restraint should never be used for the purposes of discipline, coercion, or staff convenience, or as a replacement for adequate levels of staff or active treatment.

The use of seclusion and restraint creates significant risks for people with psychiatric disabilities. These risks include serious injury or death, re-traumatization of people who have a history of trauma, and loss of dignity and other psychological harm. In light of these potential serious consequences, seclusion and restraint should be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible.[2]

The American Psychiatric Association's Resource Document on the Use of Restraint and Seclusion in Mental Health Care advises that "restraint for protective reasons . . . does not take the place of efforts to understand and address the cause of the aberrant behavior. In most uses of . . . restraint the staff should have considered or tried less restrictive means of control such as verbal, environmental, or pharmacological interventions."[3] Similarly, the National Center for Mental Health and Juvenile Justice cautions that "[T]he juvenile justice experience itself can be traumatic event and can trigger memories and reactions to previous traumatic experiences. This is especially true for girls, where traditional methods of juvenile justice management and control (such as seclusion, restraint and other physically confrontational approaches) can exacerbate feelings for loss of control and result in re-traumatization." The Council of Juvenile Correctional Administrators states that "Use of physical interventions or restraints is

1 Miss Code § 43-21-353 provides "Any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, child care giver, minister, law enforcement officer, public or private school employee or any other person having reasonable cause to suspect that a child is a neglected child or an abused child, shall cause an oral report to be made immediately by telephone or otherwise and followed as soon thereafter as possible by a report in writing to the Department of Human Services, and immediately a referral shall be made by the Department of Human Services to the intake unit and where appropriate to the youth court prosecutor."

2 National Association of State Mental Health Program Directors Medical Directors Council, *Reducing the Use of Seclusion and Restraint*, March 2001, available at http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Seclusion_Restraint_2.pdf (last visited on June 11, 2007).

3 American Psychiatric Association, *The Use of Restraint and Seclusion in Correctional Mental Health Care*, December 2006, available at http://www.psych.org/edu/other_res/lib_archives/archives/200605.pdf (last visited on June 11, 2007).

a last resort and should always follow prudent preventative use of screening, classification and programmatic interventions… Use of physical or other intrusive intervention methods should only continue as long as the youth prevents a danger to self, other or property."

The 12 hour-a-day shackling clearly violated the professional standards for the treatment of mentally ill, non-violent female juvenile offenders who suffer trauma from past physical and sexual abuse, and thus violated our clients' constitutional rights.

II. Inadequate mental health treatment and suicide prevention

Columbia staff allowed several of our mentally ill clients to harm themselves, despite clear indications that these girls struggled with depression, bi-polar disorder and suicidal ideation. Other girls living with mental illness have repeatedly completed clinic passes requesting mental health care, but their requests have been ignored.

Specifically, S W attempted suicide by slicing her wrist against the edge of her concrete bunk in the OMU. E S attempted suicide by cutting her wrists with glass she found lying on the ground outside OMU. While already on suicide watch, H D was able to carve the words "HATE ME" across her forearm. E W has been diagnosed with major depressive disorder, psychosis, schizophrenia, and bipolar disorder yet has been allowed to participate in the military program. E reports that she has repeatedly requested mental health care, but her requests have been ignored. Similarly, L J and M S requested treatment for their previously diagnosed depression and did not receive consistent treatment at Columbia.[4]

Each girl's file clearly indicates her mental illness, and instead of providing them clinically indicated care, Columbia held the girls in conditions that not only failed to address their conditions, but often exacerbated their illnesses. Unsurprisingly, a review of the Monitor's Reports in *U.S. v. Mississippi* proves that Columbia's protection from harm and suicide prevention procedures have been continually inadequate. [5] *Youngberg* requires that mentally ill juvenile delinquents receive care in line with professional standards. Columbia denied our clients the care to which they are entitled under federal law.

According to the U.S. Department of Justice's National Criminal Justice Resource Reference Service (NCJRS), which publishes a series of reference materials for correctional administrators, "rooms designed to house suicidal youth should be suicide-resistant, free of significant protrusions, and provide full visibility."[6] In an abstract specifically on suicide prevention in juvenile facilities, NCJRS stated that "staff should observe [suicidal] youth at staggered intervals not to exceed 15 minutes. Constant observation is reserved for youth who are actively suicidal—either threatening or engaging in suicidal behavior." [7] Our clients, each of whom had been on suicide watch, were able to harm themselves on protrusions in their cells or with stray glass found on the Columbia campus. H who was on the highest level of suicide watch at the time, was left unmonitored long enough to carve up her entire forearm. Columbia clearly subjected these young girls to an unacceptable level of risk. In addition to suicidal ideation, our clients had a variety of other mental health needs that went addressed at Columbia including treatment for substance abuse addiction and post-traumatic stress disorder.

4 Compounding her lack of mental health treatment, M was victimized by two sexual assaults while committed to Columbia: one committed by other youth and another committed by "Mr. " a staff member. We understand that these incidents are under investigation, and we look forward to receiving the full results of the investigation. In addition, A B reports that Security 21 maced her and touched her inappropriately when he was attempting to break up a disagreement in the shower area. We understand that this incident is also under investigation.

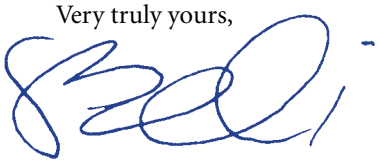
5 In the most recent monitor's report concerning Columbia, Joyce Burrell, court monitor, found that, a year after entering into a consent decree with the federal government, Columbia was only in partial compliance for suicide prevention, including mental health response to suicidal youth, supervision of youth at risk of self harm, and housing for youth at risk of self harm. *See* Fourth Quarter Monitor's Report, *United States v. Mississippi*, 3:03-cv-01354-HTW-JCS, pages 64-68.

6 *Critical Components of a Suicide Prevention Policy: Suicide Prevention in Juvenile Facilities*, Juvenile Justice - Youth With Mental Health Disorders: Issues and Emerging Responses, April 2000, Vol. VII, No. 1, available at http://www.ncjrs.gov/html/ojjdp/jjjnl_2000_4/sui_4.html (last visited on June 11, 2007).

7 *Id. See also* Lindsay M. Hayes, Juvenile Suicide in Confinement: A National Survey, National Center on Institutions and Alternatives, Feb. 2004.

On behalf of our clients and MS Protection and Advocacy Systems, we hope that we can resolve these matters informally, without resorting to legal action. We understand that you are developing a strategic plan to address these issues, and we hope that the plan will allow us to avoid litigation. To that end, request that the plan include actions to make our clients whole—including a formal apology, ongoing assistance accessing community-based counseling/ mental health services, and compensation for pain and suffering. It is also critically important that the plan include concrete measures to ensure the safety and care of girls in the Department Human Services' custody. Please let me know on or before June 18, 2007, if the Department of Human Services is willing to work cooperatively with us to resolve these complaints and ensure the safety of the girls in its custody.

Very truly yours,



Sheila A. Bedi
Kristen Levins

Cc: Tammi Simpson, Esq.
George Flaggs, Jr.(redacted)
Joyce Burrell
Rebecca Floyd (redacted)