

MARYLAND HEALTH CARE COMMISSION

Certificate of Need Application Seasons Residential Treatment Program, LLC Prince George's County



RECEIVED

SEP 03 2015

MARYLAND HEALTH
CARE COMMISSION

VIA Email & U.S. MAIL

July 24, 2015

Tyeaesis Johnson, CEO
Seasons Residential Treatment Program, LLC
1101 30th Street, NW, 4th Floor
Washington, Dc 20007

Re: Seasons Residential Treatment Program Establishment of an 72-bed RTC, Matter No. 14-16-2357

Dear Ms. Johnson:

Commission staff has reviewed the application of Seasons Residential Treatment Program, LLC (“Seasons RTP”, “Seasons” or “the Applicant”) for Certificate of Need (“CON”) approval to establish a 72-bed residential treatment center (“RTC”) on a 16.01-acre site in Fort Washington, Prince George’s County, Maryland. The total project costs are estimated to be \$16,218,312. Staff found the application incomplete, and, accordingly, requests that you provide responses to the following questions:

PART I – Project Identification and General Information

1. Please clarify whether Seasons will construct a 55,000 sq. ft. building as indicated on p. 8 or a 52,263 sq. ft. facility as in Chart 1, p. 17.
A: The total square footage for the proposed site is 52,263 sq. ft +/-, as indicated in Chart 1, p. 17.

2. Regarding Question #11, Project Location and Site Control, please describe what information is conveyed in Exhibit 1, and its implications for the project’s feasibility.
A: Regarding Question #11, Project Location and Site Control, the information conveyed in Exhibit 1 is meant to support the selection of this site and project feasibility in the following ways:
 - *To show the Commission the County ordinance repealed the special exception requirement for Group Residential Facilities;*

- *The project meets the standard for intended use; Seasons Residential Treatment Program will not need a “special exception” ruling to use this site as proposed;*
- *Implies County support for the type of program allowed in the O-S zone designation;*
- *Reflects consistency with the proposed timeline, if the site required “special exception” ruling, our timeline for completion and service delivery would have been significantly impacted;*
- *The CN-2012 legislation was proposed and sponsored by Mr. Obie Patterson (and co-sponsored by Council members: Davis, Franklin, Lehman). The Allentown Road site sits in District 8 – Mr. Patterson’s council district. While this fact does not indicate general support of the proposed project, or application, Mr. Patterson has gone on the legislative record as supporting this type of facility in the O-S designation.*

3. Please provide a copy of the final agreement signed by both parties that includes the terms and the relationship of Seasons Residential Treatment Program, LLC with Strategic Behavioral Health, LLC.

A: Please see information attached to this Letter.

4. The application describes plans to have a multi-disciplinary team that includes a staff psychiatrist, pediatrician, therapist, social workers and a behavioral support team; are all of those positions included in Table 4 – Revenue and Expense Statement, and in Table 5 – Manpower Information (e.g., we find a .5 FTE internist, but not a pediatrician), and if not, please include these costs in these two tables.

A: Please see corrections to Table 4 and Table 5.

Part II – Project Budget

5. The construction budget discussed at the bottom of p. 15 is stated to be \$12,366,000; this number does not agree with the Project Budget on p. 20-21 of the modified CON application. Please reconcile this difference.

A: The “Total Budget” listed under Project Description (question 15 and page 15) does not capture all of the capital costs listed in Part II: Project Budget on page 20-21 of the modified application. The “total budget” of \$12,366,000, listed in question 15, page 15 under Project Description captures costs for the building and site preparation only. The total construction budget is correctly stated in the Project Budget on page(s) 20-21.

6. Please discuss the basis for the \$1,143,662 set aside for Working Capital Startup Costs.

A: Working Capital Startup Costs represent the total amount of operating losses from the time operations begin until the time that the facility breaks even. It is forecasted that there will be a total of \$1,143,662 in operating losses. From the date that the facility hits the breakeven point up until 12/31/18 there will be net operating income of \$201,774. In Table 4: Revenues and Expenses you will notice a Net Operating Income (Loss) of

(\$941,888) in FYE 12/31/18. This figure represents the sum of the net operating losses (\$1,143,662) and the net operating income \$201,774.

Part III – Consistency with General Review Criteria at COMAR 10.24.01.08G(3)

State Health Plan Chapter for Psychiatric Services: Interim Residential Treatment Center Capacity at COMAR 10.24.07G

Need

7. The recommendations in Exhibit 6, the Services Gap Analysis (p. 37-41), states on p. 40 that DJS' Capital Improvement Plan includes the establishment of two male secure treatment centers, the Baltimore Regional Treatment Center (48 beds) and the Cheltenham Treatment Center (48 beds). Please discuss why there is a need for Seasons' 72 bed RTC if there exists one 14-bed facility for girls (J. DeWeese Carter Youth Facility) and one 48-bed RTC for boys (Victor Cullen Center), and that two 48-bed facilities for boys will come into service soon.

A: Please see attached.

8. Please provide a copy of the article on p. 32 titled Out of State, Out of Mind: The Hidden Lives of D.C. Youth in Residential Treatment Center, and the 2009 report filed with the City Administrator that you mention.

A: Please see Attached

Age and Sex Specific Programs

9. The application states (p. 37 – 39) that the proposed facility will have 20 beds for Diagnostic and Assessment Unit; 36 beds for PRTF/RTC unit; and 20 beds for the adult male program for a total of 76 beds. Please clarify the discrepancy between the 76 beds identified in this response versus the 72 beds reported on Question #10, p. 9 for the proposed facility.

A: The discrepancy is an typographical error, please resolve as follows:

Boys Diagnostic and assessment = 10

Girls, Diagnostic and Assessment = 10

Girls, RTC = 18

Boys, RTC=18

Adult Male Beds = CORRECTION/TYPO: 16, not 20 as stated in the application

Need

10. You did not provide a response to COMAR 10.24.01.08G(3)(b). Staff assumes that omission is due to applicant's addressing the NEED in standard 3(a). Please confirm your intent, or provide a response to this criterion.

A: Yes, the NEED standard in COMAR 10.24.01.08G(3)(b) is addressed in standard 3(a). It is the intent of the applicant to address the NEED standard in the response in 3(a). The applicant apologizes for any confusion to the Commission. During the pre-application meeting the applicant understood to use the standards in COMAR 10.24.07G and thus, listed the NEED response under (3)(a).

11. Please provide some detail regarding the source of the projected volumes in Table 2, statistical projections. Estimate the number of referrals that Seasons anticipates from each referral source identified in your response to standard 10.24.07 G(3)(a) Need.

A: Please see attached table for projected percentage of annual placements by payer/funding source identified in response to standard 10.24.07 G(3)(a) Need.

Viability of the Proposal

12. Please provide the audited financial statements for Strategic Behavioral Health, LLC for the year ending December 31, 2014.

A: Please see attached

13. Regarding Table 2, please provide a breakdown of the proposed PRTF/RTC by the three proposed units separately (Diagnostic & Assessment, PRTF/RTC, and for older male teens). Please include the number of patients admitted to the diagnostic and assessment unit included in this table. All of the patients have an ALOS of 180 days, which is supposedly the utilization for the two residential programs. Please clarify and show the utilization for the Diagnostic & Assessment unit as well.

A: Please see attached table with breakdown of admissions, (admits), by unit. Please note there are some fractional admits (most notably on the Diagnostic and Assessment Unit), the fractional days reflect admissions carried over from the previous year.

14. Regarding Table 5, the total for Salary & Benefits does not agree with the totals given in Table 4 for either FYE 12/31/20 or FYE 12/31/2021 for Salaries, Wages, and Professional or Contractual Services. Please provide revised Tables that are consistent with each other.

A: Table 5 Total Salary and Benefits is \$4,310,873 and agrees with total Salary and Benefits listed in Table 4 -- \$4,310,873. Annual Salaries, Wages and Professional Fees are driven by census projections and internal standards for therapeutic/clinical staff to patient ratio.

Part IV – Applicant History, Statement of Responsibility, Authorization and Signature

15. Please include Strategic Behavioral Health, LLC in the response to this affidavit.

See Attached

Tyeaesis Johnson

July 24, 2015

Page 5

Please submit six copies of the responses to the additional information (one set of drawings and one set of requested exhibits is sufficient) requested in this letter within ten working days of receipt. Also submit the response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov).

All information supplementing the application must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Should you have any questions regarding this matter, feel free to contact me at (410) 764-5982.

Sincerely,

Kevin McDonald, Chief
Certificate of Need

cc: Pamela B. Creekmur, Prince George's County Health Department
(internal distribution)

Question 3:

Please provide a copy of the final agreement signed by both parties that includes the terms and the relationship of Seasons Residential Treatment Program, LLC with Strategic Behavioral Health, LLC.

ASSIGNMENT OF MEMBERSHIP INTEREST

THIS ASSIGNMENT OF MEMBERSHIP INTEREST (this "*Instrument*"), is entered into as of April 7, 2015, by and between Tyeaesis Johnson, a resident of the District of Columbia ("*Assignor*") and Strategic Behavioral Health, LLC, a Delaware limited liability company ("*Assignee*").

WHEREAS, this Instrument is delivered pursuant to Section 5.01 of that certain Membership Interest Purchase Agreement by and between Assignor and Assignee dated April 7, 2015 (the "*Purchase Agreement*").

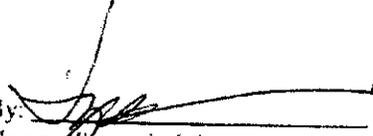
NOW, THEREFORE, in consideration of the mutual promises set forth herein and in the Purchase Agreement, the parties agree as follows:

1. Definition of Terms. Except as otherwise defined herein, all capitalized terms used herein shall have the respective meanings set forth in the Purchase Agreement.
2. Representation. This Instrument is being executed in connection with, and is subject to, all representations, warranties and covenants set forth in the Purchase Agreement. This Instrument shall neither add to nor detract from such representations, warranties and covenants.
3. Transfer of Interest. Pursuant to the delivery of the Initial Payment, the receipt and sufficiency of which is hereby acknowledged, Assignor does hereby sell, assign, transfer, and deliver the Membership Interest of the Company to Assignee, and Assignor shall forever warrant and defend Assignee's title thereto. Assignee hereby accepts the Membership Interest of the Company from the Assignor. Assignor further irrevocably constitutes and appoints Assignee as attorney to transfer the Membership Interest of the Company, with full power of substitution.
4. Governing Law. This Instrument shall be governed by and shall be construed in accordance with the laws of the State of Delaware without application of principles of conflicts of laws.
5. Counterparts. This Instrument may be executed in counterparts (including by means of facsimile or other electronic transmission) and such facsimile or electronic transmissions will be considered to be an original signature.

[Remainder of this page intentionally blank; signatures appear on following page.]

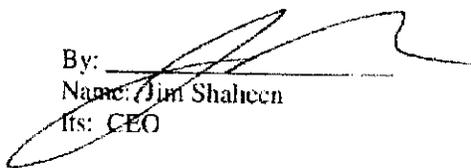
IN WITNESS WHEREOF, Assignor and Assignee have caused this Instrument to be executed as of the Effective Date.

ASSIGNOR:

By: 
Name: Yvacaasis Johnson

ASSIGNEE:

STRATEGIC BEHAVIORAL
HEALTH, LLC

By: 
Name: Jim Shaheen
Its: CEO

**UNANIMOUS WRITTEN CONSENT ACTION
OF THE MANAGERS OF
STRATEGIC BEHAVIORAL HEALTH, LLC**

The following actions are taken and the following business is transacted by the unanimous written consent of the managers (the "Managers") of Strategic Behavioral Health (the "Company"), as of the April 6, 2015 pursuant to the Limited Liability Company Agreement of the Company and the Delaware Limited Liability Company Act.

WHEREAS, the Managers are aware of that certain Membership Interest Purchase Agreement (the "Purchase Agreement"), by and among Tyeaesis Johnson ("Seller") and the Company, in substantially the form attached hereto as Exhibit A, which Purchase Agreement contemplates the Company's purchase of the membership interest of Seasons Residential Treatment Program, LLC, as more particularly described in the Purchase Agreement (the "Purchase");

WHEREAS, the Managers have determined that the Purchase and the other transactions contemplated by the Purchase Agreement are in the best interest of the Company; and

WHEREAS, the Managers deem it advisable, desirable, and in the best interest of the Company to approve and authorize the Purchase Agreement and all other instruments and documents necessary or desirable in effecting the Purchase and the other transactions contemplated by the Purchase Agreement.

NOW THEREFORE, BE IT RESOLVED, that the Managers hereby approve and authorize the Purchase and in connection therewith, approve and authorize the execution of the Purchase Agreement on behalf of the Company, as well as any other instruments and documents necessary or desirable in effecting the Purchase;

FURTHER RESOLVED, that the Managers hereby approve and authorize the execution and delivery by any Authorized Officer (as hereinafter defined) of the Purchase Agreement with such additional changes as such Authorized Officer reasonably believes are in the best interest of the Company, and any other instruments and documents necessary or desirable in effecting the other transactions contemplated by the Purchase Agreement;

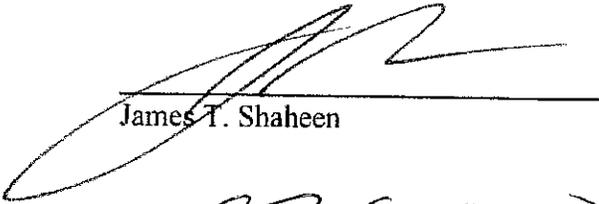
FURTHER RESOLVED, that James T. Shaheen, Jr., President and Michael A. Orians, Assistant Secretary (each an "Authorized Officer") be, and each of them hereby is, authorized and directed, from time to time and in the name and on behalf of the Company, to do and perform all acts, to make, execute, deliver, certify, or file all such agreements, certificates, instruments, deeds, leases, assignments, notices, and other documents as may be required by, or as such officer or officers deem necessary, proper, or desirable in connection with, the performance by the Company of the foregoing resolutions, to pay such fees required by or in furtherance of the foregoing resolutions, and to take all such other steps as they may deem necessary, advisable, or convenient and proper to carry out the intent of this and the foregoing resolutions, all such actions to be performed in such forms as such officer or officers shall approve and the performance or execution thereof by such officer or officers shall be conclusive evidence of the approval thereof by such officer or officers and by these Managers;

FURTHER RESOLVED, that any and all lawful actions previously taken by any Authorized Officer of the Company in connection with the transactions contemplated by the foregoing resolutions are hereby adopted, ratified, confirmed and approved in all respects as the acts and deeds of the Company.

[Signatures contained on the following page]

IN WITNESS WHEREOF, the undersigned, being all of the Managers of the Company, have executed this written consent, which may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, each of which counterpart originals may be executed by signatures transmitted by facsimile transfers, and such facsimile transfers will be considered to be original signatures, effective as of the date first above written.

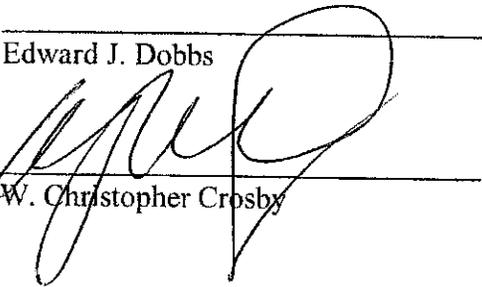
MANAGERS:



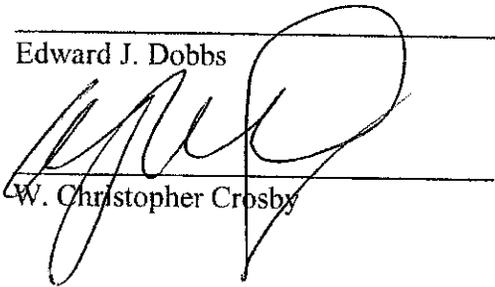
James T. Shaheen



Michael A. Orians



Edward J. Dobbs

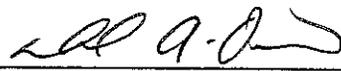


W. Christopher Crosby

IN WITNESS WHEREOF, the undersigned, being all of the Managers of the Company, have executed this written consent, which may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, each of which counterpart originals may be executed by signatures transmitted by facsimile transfers, and such facsimile transfers will be considered to be original signatures, effective as of the date first above written.

MANAGERS:

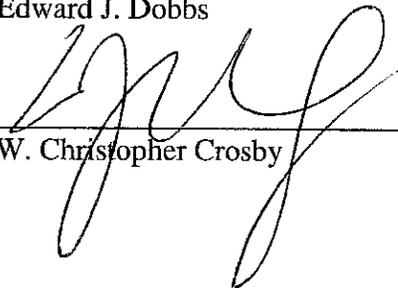
James T. Shaheen



Michael A. Orians



Edward J. Dobbs



W. Christopher Crosby

Exhibit A

Purchase Agreement

(see attached)

STRATEGIC BEHAVIORAL HEALTH, LLC

SECRETARY'S CERTIFICATE

I, the undersigned Michael A. Orians, Assistant Secretary of **STRATEGIC BEHAVIORAL HEALTH, LLC**, a Delaware limited liability company (the "Company") hereby certify as follows:

1. I am the duly elected, qualified and acting Assistant Secretary of the Company as of the date hereof, and in such capacity I have the authority to execute and deliver this Certificate.

2. The below named person is a duly elected, qualified and acting officer of the Company as of the date hereof, holding the indicated office, and the signature set forth opposite his name is his genuine signature:

<u>Name</u>	<u>Title</u>	<u>Signature</u>
James T. Shaheen, Jr.	President	

3. Attached hereto as Exhibit A is a true, correct and complete copy of the Resolutions adopted by the Managers of the Company (the "Resolutions") by action taken on written consent in accordance with the Company Agreement and applicable law. The Resolutions are in full force and effect and have not been repealed, modified and/or rescinded as of the date hereof.

[Signature Page Follows]

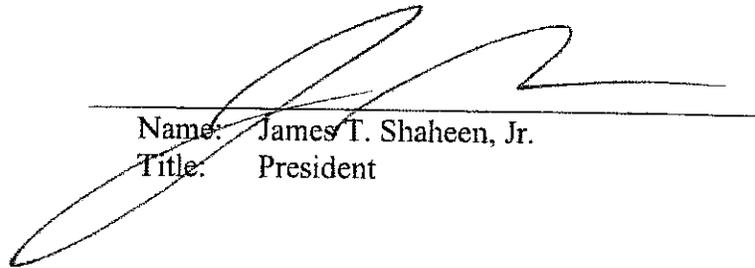
IN WITNESS WHEREOF, the undersigned has executed this certificate effective as of April 7, 2015.



Name: Michael A. Orians
Title: Asst. Secretary

I, James T. Shaheen, Jr., the President of the Company, hereby certify that Michael A. Orians is the duly elected, qualified and acting Assistant Secretary of the Company as of the date hereof and that the signature set forth above is his genuine signature.

Dated: As of April 7, 2015.



Name: James T. Shaheen, Jr.
Title: President

[Signature Page to Secretary's Certificate]

Question 4:

The application describes plans to have a multi-disciplinary team that includes a staff psychiatrist, pediatrician, therapist, social workers and a behavioral support team; are all of those positions included in *Table 4 – Revenue and Expense Statement*, and in *Table 5 – Manpower Information* (e.g., we find a .5 FTE internist, but not a pediatrician), and if not, please include these costs in these two tables.

SEASONS RESIDENTIAL TREATMENT

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

CY or FY (Circle)	Project Years (Ending with first full year at utilization)				
	FYE 12/31/18	FYE 12/31/19	FYE 12/31/20	FYE 12/31/21	
1. Revenues					
a. Inpatient Services	10,08,04	18,126,000	24,042,000	25,550,000	
b. Outpatient Services (Day School)	1,080,000	1,200,000	1,200,000	1,200,000	
c. Gross Patient Services Revenue	10,088,000	19,326,000	25,242,000	26,750,000	
d. Allowance for Bad Debt	(100,880)	(193,260)	(252,420)	(267,500)	
e. Contractual Allowance	(4,956,307)	(9,284,627)	(11,815,666)	(12,176,014)	
f. Charity Care	-	-	-	-	
g. Net Patient Care Service Revenues	5,030,813	9,848,113	13,173,914	14,306,486	
h. Total Net Operating Revenue	5,030,813	9,848,113	13,173,914	14,306,486	
2. Expenses					
a. Salaries, Wages, and Professional Fees					
(including fringe benefits)	4,310,873	5,935,554	6,942,783	7,185,596	
b. Contractual Services	84,032	120,336	144,168	150,200	
c. Interest on Current Debt	-	-	-	-	
d. Interest on Project Debt	290,334	275,413	260,493	245,572	
e. Current Depreciation	20,000	40,000	60,000	80,000	
f. Project Depreciation	489,286	489,286	489,286	489,286	
g. Current Amortization	-	-	-	-	
h. Project Amortization	-	-	-	-	
i. Supplies	189,168	379,764	504,882	536,550	
j. Other Expenses (specify)					
Advertising	18,000	18,000	18,000	18,000	
Recruitment	36,000	36,000	36,000	36,000	
Travel	96,000	72,000	72,000	72,000	
Repairs	9,008	18,084	24,042	25,550	
Rent	36,000	36,000	36,000	36,000	
Insurance	48,000	48,000	48,000	48,000	
Utilities	132,000	132,000	132,000	132,000	
Property Taxes	202,000	202,000	202,000	202,000	
Other Expenses	12,000	12,000	12,000	12,000	
k. Total Operating Expenses	5,972,701	7,814,437	8,981,654	9,268,754	
3. Income					
a. Income from Operation	(941,888)	2,033,676	4,192,260	5,037,732	
b. Non-Operating Income	-	-	-	-	
c. Subtotal	(941,888)	2,033,676	4,192,260	5,037,732	
d. Income Taxes	-	-	-	-	
e. Net Income (Loss)	(941,888)	2,033,676	4,192,260	5,037,732	
4. Patient Mix:					
A. Percent of Total Revenue					
1. Medicare	0%		0%	0%	0%
2. Medicaid	50%		50%	55%	55%
3. Blue Cross	0%		0%	0%	0%
4. Commercial Insurance	2%		2%	4%	4%
5. Self-Pay	3%		3%	3%	3%
6. Other (specify) - SEA/LEA	5%		5%	3%	3%
6a. Other (specify) - Direct Pay Agency	40%		40%	35%	35%
7. Total	100%		100%	100%	100%

SEASONS RESIDENTIAL TREATMENT PROGRAM

CERTIFICATE OF NEED: TABLE 5

TABLE 5: MANPOWER INFORMATION

Position Title	Proposed/ New FTE	Changes in FTE's (+/-)	Average Salary	Employee/ Contractual	Annual Salary Cost	Part time total	Total payroll included in benefits	
Admin								
Executive Director	1.00	-	136,500	E	\$136,500	0	\$136,500	
Director of Finance	1.00	-	85,063	E	\$85,063	0	\$85,063	
Dir of Academics/Principa	1.00	-	90,000	E	\$90,000	0	\$90,000	
Clinical Director	1.00	-	90,000	E	\$90,000	0	\$90,000	
Director of Admissions	1.00	-	75,000	E	\$75,000	0	\$75,000	
Director of Human Resour	1.00	-	77,000	E	\$77,000	0	\$77,000	
Milieu Mgr/Program Mgr	1.00	-	55,000	E	\$55,000	0	\$55,000	
Director of Nursing	1.00	-	92,000	E	\$92,000	0	\$92,000	
Psychiatrist	2.00	-	165,000	E	\$330,000	0	\$330,000	Dept coverage is 24/7/365. Meets PRTF standards/certification
Direct Care								Direct care Dept coverage is 24/7/365; exceeds staff/resident ratio requirements
Direct Care Staff - AM	6.00	-	45,000	E	\$270,000	45,000	\$225,000	assumes 2 PT staff
Direct Care Staff - PM	6.50	-	45,000	E	\$292,500	67,500	\$225,000	assumes 3 PT staff
Direct Care Staff - Midnigh	6.00	-	45,120	E	\$270,719	0	\$270,719	
Education								
Special Education Teacher	3.00	-	85,000	E	\$255,000	0	\$255,000	
General Education Teache	3.00	-	75,000	E	\$225,000	0	\$225,000	
Teacher Assistant	1.50	-	47,850	E	\$71,775	23,925	\$47,850	Assumes .5 FTE/1 PT staff
IEP Coordinator	1.50	-	55,204	E	\$82,806	27,602	\$55,204	Assumes .5 FTE/1 PT staff
Therap am								RN coverage is 24/7/365; meets PRTF standards and certification
Nursing - RN	4.00	-	78,250	E	\$313,000	78,250	\$234,750	
Nursing - LPN	2.50	-	55,200	E	\$138,000	82,800	\$55,200	
Therapist	4.50	-	75,000	E	\$337,500	75,000	\$262,500	
Discharge Planner	1.00	-	55,100	E	\$55,100	55,100	\$0	
Food Services								
Food Service Manager	1.00	-	55,050	E	\$55,050	0	\$55,050	
Line Cook/Food Prep	3.00	-	36,100	E	\$108,299	36,100	\$72,199	
Support								
Clinical Dept Secry	1.00	-	50,400	E	\$50,400	0	\$50,400	
Marketing/Business Dev C	1.00	-	50,000	E	\$50,000	0	\$50,000	
UR/Credentialing/Ins Veri	1.00	-	50,000	E	\$50,000	0	\$50,000	
Finance Ops/Admin Asst	1.00	-	44,001	E	\$44,001	0	\$44,001	
Receptionist/General	1.00	-	38,000	E	\$38,000	0	\$38,000	
Accounts Payable	1.00	-	55,150	E	\$55,150	0	\$55,150	
Accounts Receivable	1.00	-	55,000	E	\$55,000	0	\$55,000	
Admissions Coordinator	1.00	-	50,000	E	\$50,000	0	\$50,000	
Maintenance/ Housekeeping								
Maintenance Mgr	1.00	-	48,000	E	\$48,000	0	\$48,000	
Maintenance	2.00	-	36,000	E	\$72,000	36,000	\$36,000	
Housekeeping	1.50	-	32,000	E	\$48,000	48,000	\$0	
							\$3,490,585	
							\$820,287	
							\$4,310,872	
Contract Staff								
Security Staff	1.50		30,972	C	\$46,458			
Pediatrician	0.50		38,051	C	\$37,575	Benefits (0)	\$84,033	This position is for wellness care and any physicals that cannot be billed to private insurance or Medicaid
							\$84,033	

**Part III – Consistency with General Review Criteria at COMAR 10.24.01.08G(3)
 State Health Plan Chapter for Psychiatric Services: Interim Residential Treatment
 Center Capacity at COMAR 10.24.07G**

Need

Question 7.

The recommendations in Exhibit 6, the Services Gap Analysis (p. 37-41), states on p. 40 that DJS' Capital Improvement Plan includes the establishment of two male secure treatment centers, the Baltimore Regional Treatment Center (48 beds) and the Cheltenham Treatment Center (48 beds). Please discuss why there is a need for Seasons' 72 bed RTC if there exists one 14-bed facility for girls (J. DeWeese Carter Youth Facility) and one 48-bed RTC for boys (Victor Cullen Center), and that two 48-bed facilities for boys will come into service soon.

A: While we cannot speak to the specific philosophy, programming, milieu or mission of the proposed facilities under DJS' Capital Improvement Plan, Seasons Residential Treatment Program will address program differentiation and need based on the facilities listed in Question 7 of the Completeness Letter.

The graph below provides a general comparison of MD DJS and DHMH programs to Seasons Residential Treatment Program.

Name of Program	License/Certification	Primary Funding Source	Population Served
Seasons Residential Treatment Program	RTC (proposed) and Psychiatric Residential Treatment Facility (proposed CMS certification)	Various federal, state and local funders. State funding will include payers from MD, WV, VA, DC. Program will also accept private pay, commercial insurance providers and TriCare (military insurance plan).	Male and female adolescents and young adults ages 13-21 y.o
Cheltenham Youth Facility	Secure Detention Facility	Maryland Dept of Juvenile Svcs. Maryland court-involved youth	Males, 12-18 y.o
Victor Cullen Center	Committed Placement Center	Maryland Department of Juvenile Services; Maryland youth only	Males, 14-18 y.o.
J. DeWeese Carter Center	Committed Placement Center	Maryland Dept of Juvenile Services; Maryland youth only	Girls, 13 - 18 y.o.
Baltimore Regional Treatment Center (RICA) Baltimore	RTC	MD DHMH; Medicaid funds. Maryland youth only	Boys and Girls, 12-18 y.o.

Seasons differs from the MD DJS programs listed above, in the following key areas:

Type of Program

Seasons Residential Treatment Program proposes to deliver a separate, stand-alone entity licensed to provide a range of comprehensive services to treat the psychiatric condition and related behavioral health challenges of residents on an inpatient basis under the direction of a physician. The **purpose** of the service is to improve the resident's condition or prevent further regression so that services are no longer necessary. We will partner closely with

community-based programs, lower level of care providers, state and local agencies and other resources to support successful community, academic and social reintegration. The average length of stay for our residential unit is 6 months and less than 30 days on our diagnostic and assessment unit.

The type of youth we propose to serve have a DSM-V diagnosis, refractory behaviors and comorbid substance abuse. We will admit adolescents and youth ages 13 to 21 from various regional referral sources including parents and guardians with private (commercial) insurance, social service agencies, education authorities and juvenile/court services agencies.

As detailed in several areas of our CON application, we also plan to admit appropriate youth from agencies, guardians and community partners outside of the State of Maryland, with preference given to youth from Maryland, that meet our admissions criteria. Our application details our philosophy of care, treatment approach and the diagnostic tools we plan to use to support positive youth development and community/family reintegration.

Seasons Residential Treatment Program (Seasons) is not a detention center or a committed placement program. Youth admitted to our program will likely have refractory behaviors that may be aggressive and assaultive in nature, however, unlike youth in MD DJS committed placement or detention centers, not all youth in our care will be court-involved or court-ordered to treatment and *all admitted youth will have a mental health diagnosis and a clinical history of behavioral challenges due to mental illness.*

Age and Gender

Seasons will admit male and female adolescents and young adults between the ages of 13 and 21 years old. Our adult male program will serve young men ages 18-21 years old with specific academic and therapeutic programming including credit recovery, GED programming, vocational and technical training and certification.

Currently, none of the MD DJS detention or treatment programs admit youth over the age of 18 and legally cannot supervise a youth beyond the age of 18 unless so ordered by the court. It is very unlikely, given our admissions criteria (that) we will admit a youth alleged to have committed a criminal act that is excluded from the jurisdiction of the juvenile court, or if the juvenile court waives its jurisdiction to the adult court.

According to information on the Department of Health and Mental Hygiene website, none of the Regional Institute for Children and Adolescents programs support youth above the age of 18 years old. According to agency data, mental health, education and therapeutic services and resources end at the age the youth becomes an adult.

Demographic data collected and detailed in the Seasons CON application indicates there is a need for an in state residential treatment program that can admit youth above the age of 18. Data indicates there is a service gap for youth between the ages of 18 and 24 – after they become adults, but before they understand how to negotiate adult mental health services.

In Maryland, youth between the ages of 17 and 21 are more likely to be sent to out of state programs because so few MD RTC's can admit above the age of 18 *and* offer appropriate programs for this population. National data suggests older youth are generally harder to place in community based programs, have low family involvement in treatment and are tougher to treat because of the longer history of refractory behaviors and truancy.

Therapeutic Approach and Treatment Resources

After several attempts to contact the facilities, we were unable to qualify either the clinical philosophy or treatment modalities used by any of the programs listed on the MD DJS directory or list of DHMH facilities.

Our program model and treatment approach is very different from the type of care being provided in the detention centers and treatment programs operated and licensed by MD DJS. This conclusion is drawn based on the data provided in the **2014 Annual Report of the Maryland Juvenile Justice Monitoring Unit (JJMU)**.

The **2014 Annual Report of the Maryland Juvenile Justice Monitoring Unit (JJMU)**, is on file with the State of Maryland Office of the Attorney General and provides data and analysis concerning treatment of and services provided to youth in Department of Juvenile Services, (DJS/the Department) directly run and licensed facilities throughout Maryland. This report incorporates findings through the end of the fourth quarter of 2014. **We have attached a copy of the report to this letter for your review.**

According to the attached JJMU, report, "there were 336 incidents involving suicide ideation and 60 incidents of self-injurious behavior at Department of Juvenile Services-operated facilities. Facilities operated by DJS are not appropriate settings for children with serious mental health issues." (*JJMU 2014 Annual Report, Facility Incidents and Population Trends, page 7*)

On page 9 of the annual report, the report states, "Currently, DJS' committed placement centers do not provide sufficient treatment services. Therapies to manage anger or aggression are not available in DJS-operated committed placement centers. Most youth in the juvenile justice system have experienced trauma. However, DJS staff are not trained in the effects that trauma has on children, or how to identify and best respond to behavioral manifestations of a child's traumatization."

The report continues, "The Department should implement evidence-based treatment models in order to promote a therapeutic culture in which children receive individualized services. Staff and administrators should be trained "to give priority to continuous intensive treatment in how they respond to disruptive and aggressive behavior." (*JJMU 2014 Annual Report, Page 9*)

Family Engagement:

According to the Juvenile Justice Monitoring Unit report, "Family engagement is limited at DJS committed placement centers while, according to DJS data, 90% of girls and 79% of boys have a moderate to high family related need. Research links increased family visitation to improved behavior among incarcerated youth and indicates family engagement is key in establishing trauma-informed programs. (*JJMU 2014 Annual Report, page 10*).

Unlike MD DJS programs, families are *required* to participate in treatment and family therapy. We are committed to improving family and youth experiences and long-term outcomes through family-driven and youth guided approaches. We are committed to understanding and treating the past trauma of the adolescent and young adult in our care in order to better understand present behaviors. This philosophy is embedded in our programs and reflected in our outcomes data.

Staff to Resident Ratio:

The population we intend to treat requires well-trained and qualified staff. Without regard to profit margins and "bottom line," Seasons/Strategic Behavioral Health is committed to growing the program very slowly over the first few years in order to make sure we have the right staff and resources available to support the youth in our care. The senior management team is committed to a high staff to resident ratio on all three shifts. Over the first 24 months of the program, we project our staff to resident ratio to be 1:3. As census increases, the staff to resident ratio will never fall below 1:6 on any of our three (3) shifts.

While researching the use of seclusions and restraints, we requested information regarding the staff to resident ratio at Maryland Department of Juvenile Services detention and treatment programs to compare to the proposed program. We did not receive the information at the time of this submission. However, the JJMU 2014 Annual Report states: "Committed placement centers should engage families and be equipped with a higher ratio of clinical staff to residents to allow youth to have several individual counseling sessions per week with a psychologist, psychiatrist or social worker." (*JJMU 2014 Annual Report, Page 9*)

Staff and Training

We will hire and train mental health technicians/direct care staff to work in tandem with our clinical staff. Our nurses, therapists, social workers, and psychiatrist will work together to support youth in our care. It is our goal to promote a culture of clinical collaboration and communication with internal and external stakeholders. Most staff will have a background and/or experience working in an inpatient unit or clinical setting with children, adolescents or youth adults suffering from mental health challenges.

We will not hire staff (at any level) that cannot embrace our therapeutic approach to this level of care. All staff will go through rigorous annual training outlining core strategies to prevent conflict and violence and reducing the use of seclusions and restraints. According to data in the JJMU report, the authors recommended "Staff and administrators should be trained "to give priority to continuous intensive treatment in how they respond to disruptive and aggressive behavior." (*JJMU 2014 Annual Report, page 9*). The staff training requirements and curriculum is outlined in the CON application.

According to the Juvenile Justice Monitoring Unit, report, the use of seclusions and restraints increased year over year for all DJS committed programs. At the J. DeWeese Carter Center, "physical restraints increased by 40% and seclusions increased by 67% in 2014 compared to 2013." (*JJMU 2014 Annual Report, page 17*).

Post RTC licensure, Seasons will petition CMS to certify as a Psychiatric Residential Treatment Facility and Joint Commission accreditation. Our funders, accrediting bodies and certification standards are very rigorous in the area of seclusions and restraints. Strategic Behavioral Health has an impressive history of reducing restraints across all populations served (children, adolescents and adults) and program intensity (acute and RTC programs) in all of our hospitals.

Education

According to findings from the JJMU report, there is no GED track available in DJS committed programs. The report states: "Options for post-secondary and vocational education are limited in DJS committed placement centers." Seasons Residential Treatment Program plans to have a robust educational program licensed by the Maryland State Department of Education. The program will support general and special education curriculum, vocational/technical students and students in need of credit recovery to qualify for high

school graduation. All of our teachers will be content certified and qualified in the areas of special education according to state standards. Details of our proposed education program are outlined in the CON application.

Physical Plant

According to recent article in the Capital News Services written on November 13, 2013, by Natalie Komicks (see attached) "The Victor Cullen Center relies mostly on locks, bars and fences to restrict freedom instead of staff supervision." The data in the Juvenile Justice Monitoring Unit, 2014 Annual Report, states, "Security measures should not preclude, counteract, or overwhelm the promotion of a therapeutic environment." (*JJMU 2014 Annual Report, page 10*).

Seasons Residential Treatment will be housed in a 53,000 sq foot, one story building. The proposed physical plant is designed to support a therapeutic, home-like environment. While the building will be secure and is designed to keep our residents, staff and community safe, we will not have bars or fences around our perimeter or interior outdoor space. The building will have state of the art technology including electronic locks and cameras as required by federal regulations for the level of care we propose. More than cameras and equipment, we will also have a high staff to resident ratio which will help deescalate and redirect youth when needed.

System of Care and Discharge Planning:

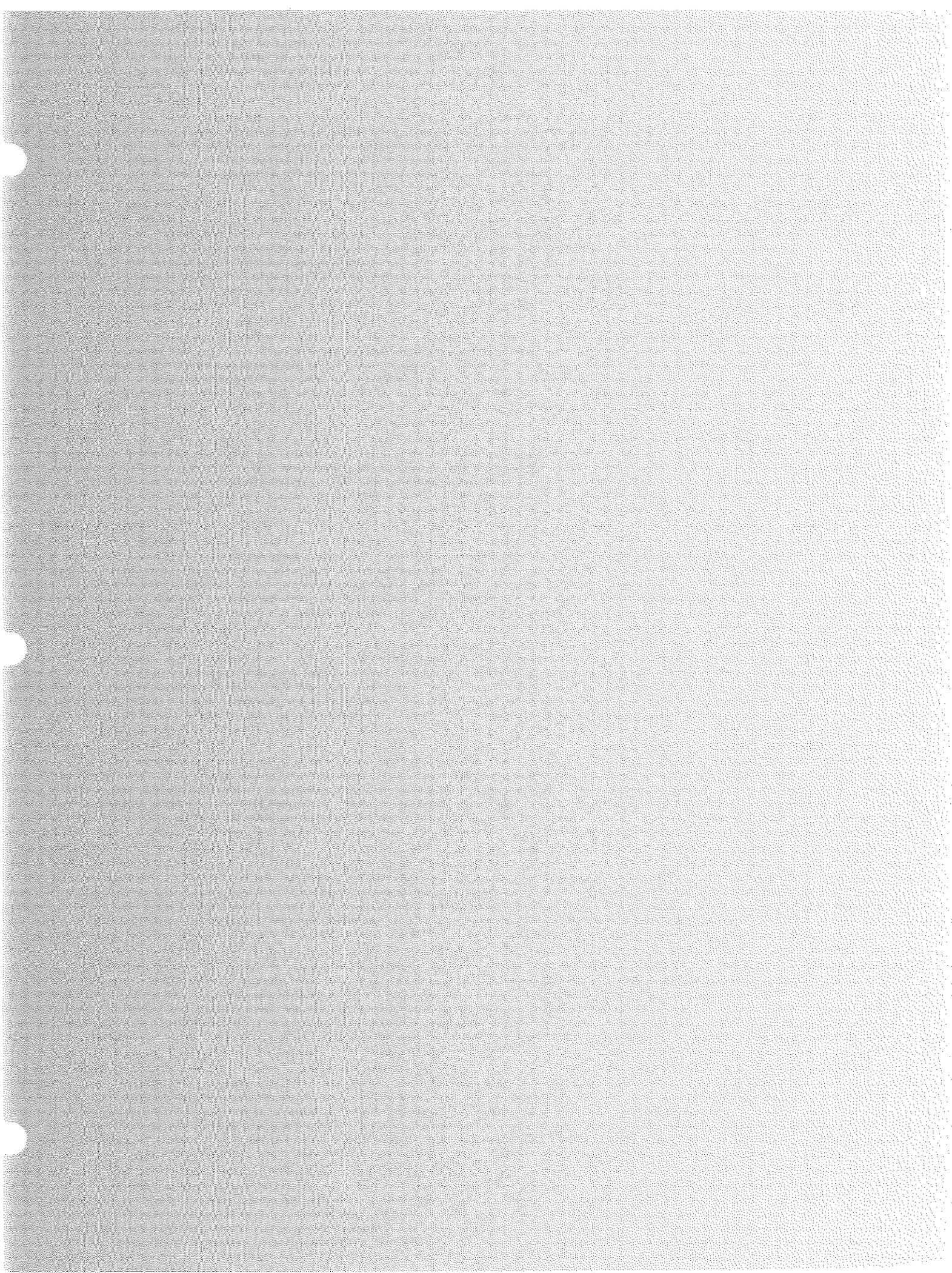
Residential Treatment Programs should be the last resort for children, adolescents and young adults suffering from mental health challenges. Placement should be recommended only after every community based program has been exhausted and true need has been established. Our philosophy of care is predicated on supporting youth who are appropriately placed. We will work with referral sources through our diagnostic and assessment and residential program to make sure level of care is established prior to care coordination and treatment planning.

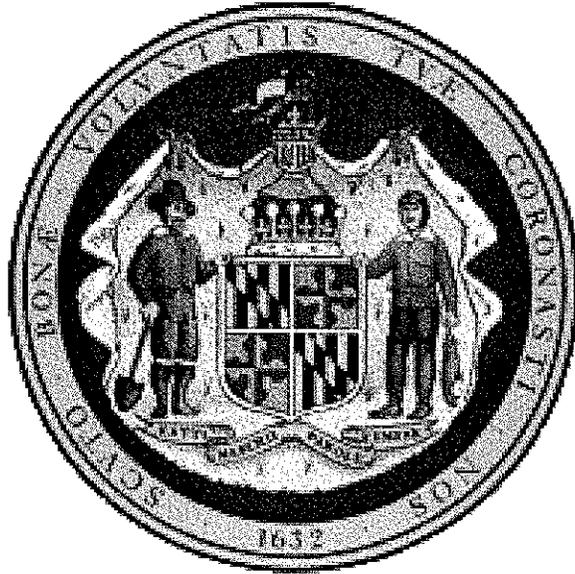
For the youth and families who meet the level of care for RTC placement, we will support agencies, programs, and services that reflect the cultural, racial, ethnic and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports. This commitment to partner with local resources to establish and support a system of care sets Seasons apart from state and local programs and other providers at this level of care.

An integral part of our service delivery and model is our discharge planning process. Our goal is to support strategies that take place in the most inclusive, most responsive, most accessible and least restrictive setting possible. By consistently working closely with state and local agencies and community-based programs and partners, we plan to implement service and support strategies that seamlessly, quickly and safely reintegrate the youth in to home, school and community life. We have identified several community partners that have complementary programming. We will partner with programs and agencies that promote quality aftercare and reintegration efforts focused on reducing recidivism rates, improving behavioral health and overall outcomes.

Youth and family-centered discharge planning will start during the admissions process and will continue post-discharge. Our staff will support admitted youth and families for three (3) years post discharge and will have dedicated staff trained to identify natural resources,

formal and informal supports and interventions. All stakeholders will have access to our unbiased outcomes data.





**JUVENILE JUSTICE MONITORING UNIT
OFFICE OF THE ATTORNEY GENERAL**

2014 ANNUAL REPORT



NICK MORONEY
Director

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
JUVENILE JUSTICE MONITORING UNIT

February 2015

The Honorable Lawrence J. Hogan, Jr., Governor
State of Maryland

The Honorable Thomas V. Mike Miller, Jr., President of the Senate
Maryland General Assembly

The Honorable Michael E. Busch, Speaker of the House of Delegates
Maryland General Assembly

Members of the General Assembly

The Honorable Sam J. Abed, Secretary
Department of Juvenile Services

The Honorable Arlene F. Lee, Executive Director
Governor's Office for Children

Members of the State Advisory Board on Juvenile Services
c/o Department of Juvenile Services

Dear Governor Hogan, Senate President Miller, Speaker of the House Busch, Members of the General Assembly, Sec. Abed, Ms. Lee, and State Advisory Board Members:

Enclosed please find the 2014 Annual Report of the Maryland Juvenile Justice Monitoring Unit (JJMU). The annual report provides data and analysis concerning treatment of and services provided to youth in Department of Juvenile Services (DJS/the Department) directly run and licensed facilities throughout Maryland. This report incorporates findings through the end of the fourth quarter of 2014. The Departments' response and a response from the Maryland State Department of Education are included, as indicated on the contents page.

The "Juvenile Justice Reform In Maryland" section details DJS spending on the operation

of secure detention and committed placement facilities during the past fiscal year. Overuse of secure detention and committed residential placement is taking place while research indicates community-based options are more beneficial to youth and more cost efficient. Plans to build more committed placement facilities, at an estimated cost of \$179 million, should not go forward. Instead, the Department should increase funding for community-based resources (see pages 5-6).

The JJMU Annual Report was produced by Margi Joshi, Nick Moroney, Tim Snyder and Eliza Steele. Thanks to Taran Henley, Fritz Schantz and Maria Welker for technical assistance.

All current and prior reports of the Juvenile Justice Monitoring Unit and related responses are available through our website at www.oag.state.md.us/jjmu.

We respectfully submit this report to the Governor, members of the General Assembly, the Secretary of Juvenile Services, and members of the State Advisory Board on Juvenile Services as required under Maryland law.

I am pleased to answer any questions you may have about this report. I can be reached at nmoroney@oag.state.md.us. My three colleagues and I look forward to continuing to work with all interested parties to guard against abuse and ensure appropriate treatment and services are provided for youth in Maryland.

Respectfully submitted,

Nick Moroney

Nick Moroney
Director
Maryland Juvenile Justice Monitoring Unit

Cc: Attorney General Brian Frosh
Chief Deputy Attorney General Elizabeth Harris
Deputy Attorney General Thiruvendran Vignarajah
Ms. Susanne Brogan, Treasurer's Office
Deputy Secretary Linda McWilliams, Mr. Karl Pothier and Mr. Jay Cleary, DJS
Margi Joshi, Tim Snyder and Eliza Steele, JJMU

JUVENILE JUSTICE MONITORING UNIT 2014 ANNUAL REPORT

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JUVENILE JUSTICE REFORM IN MARYLAND

During fiscal year 2014, the Maryland Department of Juvenile Services (DJS/the Department) spent \$111,659,988 to operate fourteen detention and committed placement facilities.¹

The average daily cost per youth in DJS detention facilities in FY 2014 was \$670. In recent years, the DJS administration has successfully worked to reduce the number of youth unnecessarily placed in secure detention. Between FY 2012 and FY 2014, the average daily population (ADP) of youth in secure detention centers statewide decreased by 36%.²

The reduction can be attributed to DJS efforts to decrease the number of youth in detention awaiting placement and to the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI) which promotes the appropriate use of alternatives to secure detention. The result is that the average daily population at the secure juvenile detention center in Baltimore City decreased 22% between 2011 and 2014. Hundreds of thousands of dollars were saved without compromising public safety.³ The JDAI effort should be expanded statewide.

In DJS operated committed placement centers, the average per diem cost during FY 2014 was \$470 per child.⁴ Although the detention population has declined in recent years, there is evidence that committed placement to residential facilities is overused. According to DJS data, only 28% of committed residential placements in FY 2014 were for crimes of violence or other felonies while 68% of committed placements to out-of-home facilities were for misdemeanor offenses.⁵

Overuse of residential placement is taking place even as research indicates community-based options are more beneficial to youth and more cost efficient. According to a report from the Justice Policy Institute, "options that keep youth at home and engaged in school and family life are documented to produce better outcomes both for youth and public safety."⁶ The report notes "community-based programming that can provide individualized, wraparound services based on the unique needs of each youth and that engage family and connect the youth to neighborhood resources can cost much less – about \$75 per day."⁷

Committing youth to residential facilities "imposes heavy burdens on family members, leaves confined youth vulnerable to assaults, exposes our communities to higher rates of recidivism, and impedes young people's transition to adulthood."⁸ Given the potential harm to

¹ DJS FY 2014 Data Resource Guide, p. 191 http://www.djs.state.md.us/drg/Full_2014_DRG.pdf

² Ibid, 96.

³ GOCCP, Crime Statistics. <http://www.goccp.maryland.gov/msac/crime-statistics.php>

⁴ DJS FY 2014 Data Resource Guide, p. 191 http://www.djs.state.md.us/drg/Full_2014_DRG.pdf

⁵ Ibid, 129.

⁶ Justice Policy Institute, "Sticker Shock: The Price We Pay for Youth Incarceration." December 2014, p. 6

http://www.justicepolicy.org/uploads/justicepolicy/documents/sticker_shock_final_v2.pdf

⁷ Justice Policy Institute, "Sticker Shock: The Price We Pay for Youth Incarceration," Executive Summary. December 2014, p.1

http://www.justicepolicy.org/uploads/justicepolicy/documents/executive_summary_-_sticker_shock_final.pdf

⁸ Justice Policy Institute, "Sticker Shock: The Price We Pay for Youth Incarceration." December 2014, p. 3

http://www.justicepolicy.org/uploads/justicepolicy/documents/sticker_shock_final_v2.pdf

youth, out-of-home placement should not be ordered by the courts except as a last resort and only in situations when a child poses a serious risk and when community-based options have been exhausted.

Given this background and the need to reduce overreliance on committed placements, the Department should focus on engaging individualized and intensive service resources within the communities of the youth being served. However, DJS (and Maryland state government) currently plans to spend \$179 million to construct three new state-operated committed placement centers which would create 120 more committed placement beds. Such facilities interrupt “normal adolescent development and can contribute to recidivism when a young person might have naturally aged out of delinquency.”⁹

The Department (and Maryland state government) should scrap plans to construct costly and likely ineffective new committed placement centers and instead commit to long term investment in community based treatment options offering individualized and intensive services as needed. Such an approach is less expensive for the state and would increase Maryland’s ability to effectively meet the needs of youth and their families.

⁹ Ibid, 5.

Facility Incident and Population Trends

Incident and population trends in 2014 compared with 2013:

- ✓ Average combined daily population (ADP) in DJS detention facilities decreased by 9%.
- ✓ Combined ADP in DJS committed placement facilities decreased by 13%.
- ✓ Incidents involving aggression decreased at the Charles H. Hickey, Jr., School (Hickey), Cheltenham Youth Facility (CYF) and the Thomas J.S. Waxter (Waxter) detention centers and in committed placement at the four youth centers in western Maryland.
- ✓ Use of physical restraints in committed placement centers decreased at Victor Cullen and the four youth centers, and in detention at Hickey, Waxter, Lower Eastern Shore Children's Center (LESCC) and CYF.
- ✓ Utilization of mechanical restraints (handcuffs and/or shackles) decreased by 29% at Hickey and by 90% at the J. DeWeese Carter (Carter) committed placement center for girls.
- ✓ Seclusion of youth declined at the Baltimore City Juvenile Justice Center (BCJJC) and CYF detention centers.
- Incidents involving aggression increased in detention at BCJJC, LESCC and Noyes and in committed placement at Carter, Victor Cullen, and Silver Oak Academy (SOA).
- Use of physical restraints increased at BCJJC, Noyes, and the Western Maryland Children's Center (WMCC) detention centers. Physical restraint of children in committed facilities significantly increased at Carter and at SOA.
- Utilization of mechanical restraints increased at Victor Cullen and BCJJC, CYF, Noyes, WMCC, and Waxter.
- Seclusion of youth increased at Hickey, Noyes, and WMCC detention centers and at Carter and Victor Cullen committed placement centers.
- There were 336 incidents involving suicide ideation and 60 incidents of self-injurious behavior at Department of Juvenile Services-operated facilities. Facilities operated by DJS are not appropriate settings for children with serious mental health issues.

Snapshot Of Ongoing Concerns:

- DJS plans to spend \$179 million on three new committed placement centers. This money would be better spent on intensive services for youth (including high risk youth) within their own communities (see page 5). See the JJMU Third Quarter 2014 report for more details: http://www.oag.state.md.us/JJMU/reports/14_Quarter3.pdf
- DJS policy requires all youth to be transported to and from medical and educational appointments in shackles and handcuffs fastened to belly chains and black boxes. Policy also requires youth be strip searched after visits with families and lawyers, and after earned outings in the community. The Department should end the practice of strip searching and shackling children without individualized determination of risk (see page 33).
- Under current Maryland law, CPS investigates allegations of abuse and neglect involving kids under 18 who have sustained an injury. Maryland law should be changed to empower CPS to investigate all allegations of abuse or neglect involving youth in the custody or under the supervision of DJS, whether or not the child has a visible injury or is over 18. See the JJMU Second Quarter 2014 report for more details: http://www.oag.state.md.us/JJMU/reports/14_Quarter2.pdf
- Changes to telephone access in DJS facilities subject youth to diminished privacy and decreased protections. During the third quarter, DJS installed telephones in common areas of the living units in its facilities. The Department now requires youth to use the recently installed telephones for calls to family, lawyers and case managers. Calls made from these phones may be recorded and DJS has access to the recorded calls. Recordings may be released to outside entities, including law enforcement. The Department should ensure that no phone calls are recorded and that kids are able to make phone calls in private settings. Kids should be able to make phone calls to lawyers, family members and community case managers using a staff phone in an office with a case manager present, as was previous practice. See the JJMU Third Quarter 2014 report for more details: http://www.oag.state.md.us/JJMU/reports/14_Quarter3.pdf

COMMITTED PLACEMENT CENTERS

In fiscal year 2014, the Maryland Department of Juvenile Services spent \$33,725,103 to operate its committed placement centers.¹⁰ Out-of-home or committed placement should not be used except as a last resort in situations when a child cannot be served at home or in the local community. According to the National Juvenile Justice Network, a growing body of evidence shows that “post-adjudication incarceration for youth can have extremely negative ramifications for the youth’s ability to get back on the right track.”¹¹

In DJS operated committed placement centers, the average per diem cost during FY 2014 was \$470 per child.¹² “By contrast [with committed placement], community-based programming that can provide individualized, wraparound services based on the unique needs of each youth and that engage the family and connect the youth to neighborhood resources can cost much less – as little as \$75 per day.”¹³

In 2014, the average daily population of youth in DJS-operated committed placement centers decreased by 13% compared to 2013. This trend should continue in an effort to ensure that only youth who cannot be served in the community are in out-of-home placements. As it works to reduce the inappropriate use of out-of-home placements, the Department should also focus on developing a treatment culture in its committed placement facilities that administrative and direct care staff are trained to implement and model.

Need for Treatment Resources in Committed Placement Centers

Currently, DJS’ committed placement centers do not provide sufficient treatment services. Therapies to manage anger or aggression are not available in DJS-operated committed placement centers. Most youth in the juvenile justice system have experienced trauma.¹⁴ However, DJS staff are not trained in the effects that trauma has on children, or how to identify and best respond to behavioral manifestations of a child’s traumatization.

The Department should implement evidence-based treatment models in order to promote a therapeutic culture in which children receive individualized services. Staff and administrators should be trained “to give priority to continuous intensive treatment in how they respond to disruptive and aggressive behavior.”¹⁵ Committed placement centers should engage families and be equipped with a higher ratio of clinical staff to residents to allow youth to have several individual counseling sessions per week with a psychologist, psychiatrist or

¹⁰ DJS FY 2014 Data Resource Guide, p. 191 http://www.djs.state.md.us/drg/Full_2014_DRG.pdf

¹¹ National Juvenile Justice Network. “Community-Based Supervision: Increased Public Safety, Decreased Expenditures.” November 2014. p. 1 http://www.njjn.org/uploads/digital-library/NJJN-YAP_CBA-costs_Nov2014_FINAL2.pdf

¹² DJS FY 2014 Data Resource Guide, p. 191 http://www.djs.state.md.us/drg/Full_2014_DRG.pdf

¹³ Justice Policy Institute, “Sticker Shock: The Price We Pay for Youth Incarceration,” Executive Summary. December 2014, p. 1 http://www.justicepolicy.org/uploads/justicepolicy/documents/executive_summary_-_sticker_shock_final.pdf

¹⁴ Mental Health and Juvenile Justice Collaborative for Change, “Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System.” 2014, p. 2 <http://cfc.ncmhji.com/wp-content/uploads/2014/01/Whitepaper-Mental-Health-FINAL.pdf>

¹⁵ SAHMSA National Registry of Evidence-based Programs and Practices, “Mendota Juvenile Treatment Center Program.” <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=38>

social worker.¹⁶ The DJS behavior management system should complement principles of the treatment program and adolescent development (see page 35). Security measures should not preclude, counteract or overwhelm the promotion of a therapeutic environment.

Strip Searching and Shackling

Youth in DJS committed placement centers are routinely strip searched and shackled, and physical restraints and seclusion may be used although there is evidence that “any situation in which [trauma survivors] have no control over what happens to them can be retraumatizing,” including “very blatant examples like strip searches, restraint or...seclusion.”¹⁷ The Department should end the practice of indiscriminate shackling and strip searching (see page 33). Administrators and staff should continue to receive ongoing training on effective communication and de-escalation techniques to counter the use of restraints and seclusion.

Family Engagement in Committed Placement Centers

Family engagement is limited at DJS committed placement centers while, according to DJS data, 90% of girls and 79% of boys have a moderate to high family related need.¹⁸ Research links increased family visitation to improved behavior among incarcerated youth¹⁹ and indicates family engagement is key in establishing trauma-informed programs.²⁰

Family visitation is usually limited to certain hours on two days per week while the location of most DJS committed placement centers makes them difficult to reach for many families. Regular telephone contact with family members is limited to two ten minute calls per week, the same amount allotted to youth in detention. Depending on their level in the DJS behavior management program, youth can buy more phone calls with earned points. Youth in the advanced stages of the behavior program may participate in two home passes. The Department should increase weekly phone calls, visitation hours and home passes for youth in treatment to foster as much family engagement as possible.

Education in Committed Placement Centers

Options for post-secondary and vocational education are limited in DJS committed placement centers. All students who are eligible should have access to higher education at local colleges and universities, and through online courses. There should be a dedicated vocational education instructor at each committed placement center. Students should be able to participate in internships and employment opportunities onsite and in the community to acquire new skills and build self-esteem. The chance to earn and be awarded a high school diploma should be available to students while in DJS committed placement centers.

¹⁶ Ibid

¹⁷ Penney, D., National Center for Trauma Informed Care, “Creating a Place of Healing and Forgiveness: The Trauma-Informed Care Initiative at the Women’s Community Correctional Center of Hawaii.” 2013, p. 3
http://www.nasmhpd.org/docs/NCTIC/7014_hawaiian_trauma_brief_2013.pdf

¹⁸ DJS Report on Female Offenders, February 2012, p. 11 <http://www.djs.state.md.us/docs/Girls.Feb.2012.Report.pdf>

¹⁹ Vera Institute, “The Impact of Family Visitation of Incarcerated Youth’s Behavior and School Performance,” April 2013.
<http://www.vera.org/sites/default/files/resources/downloads/family-visitation-and-youth-behavior-brief.pdf>

²⁰ National Childhood Traumatic Stress Network, “The Role of Family Engagement in Creating Trauma-Informed Juvenile Justice Systems.” August 2013. http://www.njcn.org/uploads/digital-library/NCTSN_family-engagement-trauma-informed-systems_Liane-Rozzell_September-2013.pdf

Victor Cullen Center

The Victor Cullen Center is a hardware secure (fenced and locked) committed placement facility operated by the Department of Juvenile Services (DJS/the Department). The facility is located in Frederick County and has a DJS-rated housing capacity of 48 boys. African American youth represented 89% of total youth entries in 2014 compared to 88% in 2013.

Victor Cullen – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	45	46	43
1. Youth on Youth Assault/Fight	69	85	104
2. Alleged Youth on Staff Assault	33	30	20
3. Physical Restraint	287	283	265
4. Use of Handcuffs and/or Shackles	195	171	178
5. Seclusion	86	97	106
6. Contraband	13	17	6
7. Suicide Ideation/Attempt	9	7	13

The average daily population at Cullen during 2014 decreased by 7% compared to 2013. Fights and assaults increased by 22%. Incidents involving the use of seclusion and mechanical restraints also increased.

The hiring of four mental health clinicians during 2014 was a positive addition to the staffing at Cullen. However, the facility is still lacking in therapeutic resources that could contribute to the establishment of a treatment culture.

Victor Cullen is the only hardware secure committed placement center for boys in the state and youth placed there are likely to be facing serious challenges involving anger or aggression. Also, youth are frequently moved to Victor Cullen in response to alleged disruptive or aggressive behavior at other, less restrictive facilities. However, therapies to develop youth skills in anger management or aggression replacement are not available at Cullen.

Administrators and direct care staff at Victor Cullen are not trained in any evidence-based treatment model. Given that most youth in the juvenile justice system have experienced traumatic victimization,²¹ all staff – direct care and administrative – should be trained to implement trauma-informed therapeutic programming that enables them to “give priority to continuous intensive treatment in how they respond to disruptive and aggressive behavior.”²²

The Department’s data shows that 79% of boys in out-of-home placement have a moderate-to-high family related need.²³ However, opportunities for family engagement are limited due to Cullen’s location and DJS policy regarding phone calls, visitation and home passes (see page 10). The Department should expand opportunities for family engagement at Victor Cullen.

Development of a safe learning environment will also support efforts to establish a treatment culture at Cullen. There were significant safety concerns in the school during 2014. On-site mental health clinicians, DJS staff and administrators, and Maryland State Department of Education Juvenile Services Education (MSDE-JSE) personnel should collaborate to address behavioral issues on an individual basis using a clearly defined therapeutic approach that incorporates closely aligned treatment and education goals and services.

Currently, there is no GED or post-secondary school track available to students. There should be an opportunity for students with a high school diploma or GED to enroll in college courses (online and on campus). All youth, especially those already in possession of a high school diploma or GED, should be able to gain employment (on grounds and in the community), and participate in formal vocational education programs that lead to certification in a variety of fields.

There is a need for increased and varied team- and confidence-building recreational programming at Cullen. Plans to install an outdoor and indoor ropes course (high and low elements) should go forward without delay.

Research suggests that facilities should adopt “programs that take a therapeutic approach to changing behavior by focusing on constructive personal development,” and include programs that are matched to address the specific needs and challenges of the youth being served.²⁴ The Department should invest in treatment resources and devote considerable attention to the establishment of a safe and therapeutically oriented culture at Victor Cullen.

²¹ Mental Health and Juvenile Justice Collaborative for Change, “Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System.” 2014, p. 2 <http://cfc.ncmhji.com/wp-content/uploads/2014/01/Whitepaper-Mental-Health-FINAL.pdf>

²² SAHMSA National Registry of Evidence-based Programs and Practices, “Mendota Juvenile Treatment Center Program.” <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=38>

²³ DJS Report on Female Offenders, Feb 2012, p. 16 <http://www.djs.state.md.us/docs/Girls.Feb.2012.Report.pdf>

²⁴ Lipsey, M., Howell, J., Kelly, M., Chapman, G., Carver, D. “Improving the Effectiveness of Juvenile Justice Programs.” December, 2010, p. 28 <http://cjjr.georgetown.edu/pdfs/ebp/ebppaper.pdf>

Youth Centers x4

The youth centers consist of four separate staff secure (not fenced) facilities for boys owned and operated by the Maryland Department of Juvenile Services (DJS/the Department): Green Ridge (40 beds), Savage Mountain (36 beds), Meadow Mountain (40 beds) and Backbone Mountain (48 beds) youth centers. African American youth represented 73% of totally youth entries in 2014, compared to 76% in 2013.

Security cameras have not been installed as planned at any of the four youth centers.

Combined Youth Centers (x4) – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	162	146	124
1. Youth on Youth Assault/Fight	174	181	140
2. Alleged Youth on Staff Assault	19	44	30
3. Physical Restraint	253	381	284
4. Use of Handcuffs and/or Shackles	52	91	92
5. Seclusion	0	0	0
6. Contraband	50	45	29
7. Suicide Ideation/Attempt	15	21	18

The combined average daily population at the four youth centers during 2014 was 124, a 15% decline compared to 2013. Incidents involving aggression decreased 23% and the use of physical restraints decreased 25%, however the use of mechanical restraints remained high.

Youth may be moved between youth centers, or ultimately to a higher security facility (Victor Cullen or an out-of-state facility), in response to disruptive or aggressive behavior. However, there are no specific programs to address anger or aggression issues at any of the four youth centers (or Victor Cullen). Evidence-based therapies to support kids in their ability to manage aggression and anger should be available to all youth in committed placement.

Given that most youth in the juvenile justice system have experienced traumatic victimization,²⁵ all staff – direct care and administrative – should be trained to implement an evidence-based, trauma-informed therapeutic program (or programs) that enables them to “give priority to continuous intensive treatment in how they respond to disruptive and aggressive behavior.”²⁶

The Maryland State Department of Education Juvenile Services Education division (MSDE-JSE) operates the schools at each of the youth centers (see page 40). There is a need for increased vocational education options at the youth centers especially for youth who have already earned their high school diploma or GED. Community based options for employment and vocational training should also be available. Currently, students do not have access to the internet for educational purposes.

²⁵ Mental Health and Juvenile Justice Collaborative for Change, “Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System.” 2014, p. 2 <http://cfc.ncmhjj.com/wp-content/uploads/2014/01/Whitepaper-Mental-Health-FINAL.pdf>

²⁶ SAHMSA National Registry of Evidence-based Programs and Practices, “Mendota Juvenile Treatment Center Program.” <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=38>

Silver Oak Academy

Silver Oak Academy (SOA/Silver Oak) is a privately operated staff secure (not locked and fenced) committed care center located in Carroll County and licensed by the Maryland Department of Juvenile Services (DJS/the Department). In June 2013, the license was expanded to allow Silver Oak to house up to 96 boys. African American youth represented 90% of total youth entries in 2014, compared to 88% of entries in 2013.

SOA – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	47	54	62
1. Youth on Youth Assault/Fight	19	24	39
2. Alleged Youth on Staff Assault	4	3	2
3. Physical Restraint	18	17	59
4. Use of Handcuffs and/or Shackles	0	0	0
5. Seclusion	0	0	0
6. Contraband	15	24	64
7. Suicide Ideation/Attempt	1	2	1

The average daily population during 2014 increased by 15% compared to 2013 while incidents involving aggression and physical restraint increased at a higher rate. As the population at Silver Oak continues to increase following the expansion of their license, staff and administrators should devote significant attention towards minimizing the use of physical restraints as their utilization can be harmful to individuals, particularly those who have experienced trauma.²⁷

The increase in restraints may, in some instances, be related to youth placed at SOA following ejections from other committed placement centers. Mental health staff should work especially closely with these youth to help facilitate a safe transition into their placement at

²⁷ Penney, D., National Center for Trauma Informed Care, "Creating a Place of Healing and Forgiveness: The Trauma-Informed Care Initiative at the Women's Community Correctional Center of Hawaii." 2013, p. 3
http://www.nasmhpd.org/docs/NCTIC/7014_hawaiian_trauma_brief_2013.pdf

SOA. Additionally, security cameras should be installed without delay to facilitate accuracy in reviewing incidents and to enhance staff training.

While there was an increase in incidents involving aggression, Silver Oak continued to provide valuable treatment services in a nonrestrictive, therapeutic, school-like environment during 2014. All staffers at Silver Oak are trained in a treatment model based on the principles of cognitive-behavioral therapy and a comprehensive therapeutic approach incorporating trauma-informed care.

Students at Silver Oak can graduate from high school or choose to pursue a GED. They also participate in interscholastic sports teams and a variety of vocational education programs, including a Certified Nursing Assistant course that was added during the third quarter. During 2014, Silver Oak added a transitional living unit for students who wish to remain on campus after graduation while they work in the community and attend college. Twenty seven students at Silver Oak earned and received a high school diploma during 2014.

The J. DeWeese Carter Center

The J. DeWeese Carter Center is a DJS-operated, 14-bed hardware secure (locked and fenced) committed placement center for girls located on the eastern shore of Maryland. African American youth represented 74% of total entries to Carter in 2014 compared to 78% in 2013.

There are a significant number of staffing vacancies as of the end of 2014 and beginning of 2015. These positions should be filled as soon as possible as staffing impacts safety and security, facility-based activities including recreation as well as community outings which can be used as a meaningful reward.

Carter – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	11	11	11
1. Youth on Youth Assault/Fight	6	6	9
2. Alleged Youth on Staff Assault	11	2	4
3. Physical Restraint	44	43	60
4. Use of Handcuffs and/or Shackles	1	10	1
5. Seclusion	12	9	15
6. Contraband	4	0	2
7. Suicide Ideation/Attempt	18	15	15

The average daily population at Carter during 2014 remained the same as in the two previous years, however, fights and assaults increased by one-third. While Carter is the only hardware secure committed placement center for girls in the state, therapies to support management of aggression or anger are not available.

Physical restraints increased by 40% and seclusions increased by 67% in 2014 compared to 2013. Research indicates that “[m]ost youth detained in juvenile justice facilities have extensive histories of exposure to psychological trauma.”²⁸ Seclusion and restraint “are

²⁸ Ford, J., Blaustein, M. (October, 2013). Systemic Self-Regulation: A Framework for Trauma-Informed Services in Residential Juvenile Justice Programs. *Journal of Family Violence*, 28 (7).

likely to re-traumatize women who are trauma survivors and to cause trauma responses in women who had not previously experienced trauma.”²⁹

Exposure to trauma can undermine the ability of youth to manage behavior and emotions. All staff and administrators at Carter should receive comprehensive and ongoing training in trauma-informed treatment models and therapies that promote self-regulation among youth.³⁰

Department of Juvenile Services’ data indicates that 90% of girls in out-of-home placements have a moderate to high family need.³¹ Girls from various parts of Maryland are placed at Carter, however, opportunities for family engagement are limited due to Carter’s remote location and DJS policy regarding phone calls, visitation and home passes (see page 10). The Department should expand opportunities for family engagement to promote comprehensive treatment at Carter.

The Department is obliged to provide for at least one hour per day of large muscle exercise, however, the outdoor recreation space at Carter cannot be used during the winter. The recreation specialist works to create indoor activities but space is extremely limited. Youth should have routine access to a local community recreation center to ensure they have enough space and equipment to allow opportunities for regular exercise.

The Maryland State Department of Education Juvenile Services Education division (MSDE-JSE) provides school related services at Carter. During 2014, there was a girl at Carter who had remained there for nearly a year. The youth had already earned her GED while in detention (prior to coming to Carter) yet she was not afforded any opportunities for higher education while she was in placement at Carter. The MSDE-JSE program should have an established track for post-secondary school students that includes access to a nearby college and to online courses.

The Department of Juvenile Services and MSDE-JSE should work together to implement a community-based program of employment and internship opportunities. Currently, vocational education programs are not offered on a daily basis at Carter and are limited to a basic food hygiene course and four modules in network cabling. Plans to add a course leading to certification in customer service should go forward.

Girls at Carter continue to be transported to medical and educational appointments in handcuffs and shackles fastened to belly chains with black boxes (see page 33). Plans to have girls placed at Carter take the GED test at a nearby community college should be implemented without requiring girls to be mechanically restrained during transport.

http://www.traumacenter.org/products/pdf_files/Trauma%20Services%20in%20Residential%20Juvenile%20Justice%20Settings_Ford_Blaustein.pdf

²⁹ Penney, D., National Center for Trauma Informed Care, “Creating a Place of Healing and Forgiveness: The Trauma-Informed Care Initiative at the Women’s Community Correctional Center of Hawaii.” 2013, p. 3

http://www.nasmhpd.org/docs/NCTIC/7014_hawaiian_trauma_brief_2013.pdf

³⁰ Ibid.

³¹ DJS Report on Female Offenders, Feb 2012, p. 11 <http://www.djs.state.md.us/docs/Girls.Feb.2012.Report.pdf>

DETENTION CENTERS

In fiscal year 2014, the Maryland Department of Juvenile Services (DJS/the Department) spent \$70,750,077 to operate its seven detention centers.³²

Sending a child to a detention facility (secure detention) while awaiting a court hearing or committed placement should not happen except as a last resort and only when there has been an objective and individual determination of risk that indicates a youth cannot stay or wait in the community. According to the National Juvenile Justice Network, research has shown that diversion and community supervision programs are more cost-effective than incarceration, decrease recidivism, provide more appropriate treatment for youth, reduce stigma associated with formal juvenile justice system involvement, and increase family participation.³³

In recent years, the Department of Juvenile Services has worked to reduce the inappropriate use of secure detention. In 2014, the average daily population of youth in DJS detention centers statewide decreased 23% compared to 2012. This reduction is partially attributable to DJS' work with the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI) in Baltimore City. The JDAI project is a coordinated effort between DJS, the courts and other stakeholders to promote appropriate alternatives to secure detention.

The Department should expand JDAI across Maryland to minimize the inappropriate use of secure detention. (A recent spike in the statewide secure detention population underscores the need to continue and expand the appropriate use of alternatives to secure detention in Maryland.³⁴)

In recent years, the Department has notably improved operations in detention centers to enhance safety for youth and staff. During 2014, incidents of aggression, physical restraint, seclusion and mechanical restraint decreased in most detention centers. An exception was the Alfred D. Noyes Children's Center. Although there was a 22% reduction in average daily population at Noyes in 2014 (compared with 2013), incidents of aggression, restraints and seclusions increased substantially.

Secure detention is a particularly inappropriate environment for kids with mental health needs and yet many youth with such needs are sent to and admitted into detention centers. Incidents of suicide ideation in DJS detention centers increased 16% between 2012 and 2014. The Department should bolster therapeutic services available to kids in detention. Additional therapeutic resources would also benefit youth in need of additional support as they enter DJS detention centers following ejection from committed placement.

³² DJS FY 2014 Data Resource Guide, p. 191 http://www.djs.state.md.us/drg/Full_2014_DRG.pdf

³³ National Juvenile Justice Network. "Community-Based Supervision: Increased Public Safety, Decreased Expenditures." November 2014. p. 2 http://www.njnn.org/uploads/digital-library/NJNN-YAP_CBA-costs_Nov2014_FINAL2.pdf

³⁴ The average daily population of DJS youth in secure detention statewide increased by 19% during the fourth quarter of 2014 compared to the same time in 2013. These figures do not include youth being charged as adults who may be held in DJS detention centers.

Baltimore City Juvenile Justice Center

The Baltimore City Juvenile Justice Center (BCJJC) is a secure detention center for boys operated by the Department of Juvenile Services (DJS/the Department) which rates housing capacity at 120. African American youth represented 94% of total youth entries during 2014 compared with 97% in 2013.

In Baltimore City, DJS partnered with the courts and other stakeholders to participate in the Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative (JDAI) which promotes the appropriate use of alternatives to secure detention. Continuous and diligent participation in JDAI should receive added emphasis given that the population of DJS youth at BCJJC increased 23% during the fourth quarter of 2014 compared to the same time last year.

The recent population increase does not include youth facing adult charges held at BCJJC as a result of an agreement between DJS and the Maryland Department of Public Safety and Correctional Services (DPSCS, the adult corrections agency). Housing certain youth charged as adults at BCJJC is a positive development that has protected a substantial number of youth from being held at the adult detention center in Baltimore.

BCJJC – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	98	81	90
1. Youth on Youth Assault/Fight	264	209	270
2. Alleged Youth on Staff Assault	28	13	34
3. Physical Restraint	428	347	395
4. Use of Handcuffs and/or Shackles	136	114	171
5. Seclusion	394	246	199
6. Contraband	42	26	25
7. Suicide Ideation/Attempt	34	17	28

The chart above shows that, comparing 2014 with 2013, there was an 11% increase in average daily population at BCJJC. Over the same period, fights and assaults increased by 29%; physical restraints increased by 14%; and the use of mechanical restraints increased by 50%. Administrators, managers and direct care staff at BCJJC should model and promote the

use of verbal de-escalation techniques and request pre-emptive assistance from mental health and case management staff to help prevent incidents involving aggression and restraints.

During the last quarter of 2014, administrators and staff at BCJJC focused on addressing the increase in incidents. This initiative has begun to show success, especially in reducing seclusions. While there was a slight decrease in ADP (approx. 2%), there was a far larger decrease in some incident categories during the fourth quarter of 2014 compared with the third quarter.

	<u>Q3 2014</u>	<u>Q4 2014</u>
Average Daily Population	88	86
Assaults/fights	68	65
Physical Restraint	103	86
Use of Handcuffs/Shackles	51	32
Seclusions	48	9

The chart above tabulates a decrease in physical restraints of 17%; a 37% dip in the use of handcuffs and shackles; and a steep decline of 81% in seclusion of youth (in the fourth quarter of 2014 in comparison to the prior quarter).

The effort to reduce incidents should continue and include a particular focus on reducing the number of fights and assaults.

Cheltenham Youth Facility

Cheltenham Youth Facility (CYF) is a secure detention center for boys owned and operated by the Department of Juvenile Services (DJS/the Department) and located in Prince George's County. The Department has determined a facility housing capacity of 115 youth at CYF. African American youth represented 79% of total youth entries in both 2014 and 2013.

The average daily population at CYF during 2014 decreased by 10% compared to 2013. This reduction is mainly attributable to the Department's success in reducing the number of youth stuck in detention for long periods of time before being transferred to a long term committed placement center.³⁵

Conversely, Department of Juvenile Services' data indicates that secure detention continues to be overused in Prince George's County. While the rate of juvenile complaints received by DJS in fiscal year 2014 reflected a drop of 43% in Prince George's County since fiscal year 2005, the rate of Prince George's County youth in secure detention increased by 115% during the same period. The data further indicates that large numbers of Prince George's County youth were detained in response to violations of court orders as opposed to for serious offenses.³⁶

In order to guard against the inappropriate use of secure detention, the Department re-launched the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI) in Prince George's County at the end of 2014. The JDAI project brings together DJS, the courts and other stakeholders to reduce the overuse of secure detention by promoting the appropriate utilization of alternatives. All involved stakeholders, including the courts, should participate actively in JDAI as research shows that "pre-trial detention and post-adjudication incarceration for youth can have extremely negative ramifications for the youth's ability to get on the right track."³⁷

During 2014 there were significant reductions in incidents of aggression, physical restraint and seclusion at CYF in comparison with the previous year. Fights and assaults declined 29% while incidents involving physical restraint and seclusion decreased by 54% and by 88%, respectively.

However, incidents involving the use of mechanical restraints increased by 41%. Mechanical restraints should not be used except as a last resort in situations when a child presents an imminent threat to himself or others.

The chart on the following page offers a comparison of average daily population and incident rate data at Cheltenham for the past three years.

³⁵ Compared to fiscal year 2012, the pending placement population in FY 2014 decreased by 43% while the pre-disposition detention population remained relatively steady. DJS Long Term Trends in Prince George's County, December 2014. p. 6 http://www.djs.maryland.gov/docs/PGCo_Region_Trends_FY2014.pdf

³⁶ Ibid. 4, 10.

³⁷ National Juvenile Justice Network. "Community-Based Supervision: Increased Public Safety, Decreased Expenditures." November 2014. p. 1 http://www.njjn.org/uploads/digital-library/NJJN-YAP_CBA-costs_Nov2014_FINAL2.pdf

CYF – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	104	88	79
1. Youth on Youth Assault/Fight	259	187	135
2. Alleged Youth on Staff Assault	36	22	9
3. Physical Restraint	454	299	139
4. Use of Handcuffs and/or Shackles	36	17	24
5. Seclusion	61	7	1
6. Contraband	21	21	12
7. Suicide Ideation/Attempt	48	22	16

Youth at CYF who struggle with issues of aggression may be placed on the Intensive Services Unit (ISU). These youth have been identified as being in need of increased supports. However, during 2014, they were not receiving education services equal to those of youth on regular housing units. Plans for the Maryland State Department of Education Juvenile Services Education division to implement a full education schedule (including six hours of teacher instruction) on the ISU should go forward.

Incident reports at CYF are not uploaded to the incident report database until several weeks after the incident occurs. The Department should permanently correct issues with the database software that prevent staff at CYF from logging into the system, approving incidents for submission to the database, and editing incidents that have been posted. To the extent possible, facility administrators should ensure that incidents are uploaded to the database without delay.

Charles H. Hickey, Jr., School

The Charles H. Hickey, Jr., School (Hickey School/Hickey) in Baltimore County is a 72-bed secure detention center for boys, operated by the Department of Juvenile Services (DJS/the Department). The average daily population decreased 23% in 2014 compared with 2013. African American youth accounted for 69% of entries in 2014, up from 65% in 2013.

The overall decrease in Hickey School population is a positive trend and should continue. According to juvenile justice experts, “punitive responses to juvenile crime (e.g., the incarceration of juvenile offenders in correctional facilities) are far more expensive and often less effective than less harsh alternatives (e.g., providing juvenile offenders rehabilitative services in community settings).”³⁸ In order to ensure that appropriate alternatives to secure detention are widely available, the Department should focus on a statewide plan to expand the Juvenile Detention Alternatives Initiative (JDAI) of the Annie E. Casey Foundation.

The chart below indicates that average daily population (ADP), incidents involving aggression and the use of physical restraints all decreased at Hickey in 2014. While ADP fell 23%, physical restraints decreased 39% and the use of mechanical restraints decreased 29% compared with the previous year. However, seclusions increased 15% in 2014 versus 2013.

Hickey – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	60	52	40
1. Youth on Youth Assault/Fight	153	130	97
2. Alleged Youth on Staff Assault	22	12	6
3. Physical Restraint	249	303	186
4. Use of Handcuffs and/or Shackles	18	31	22
5. Seclusion	53	72	83
6. Contraband	6	7	10
7. Suicide Ideation/Attempt	49	36	26

³⁸ Piquero, A., Steinberg, L. *Rehabilitation Versus Incarceration of Juvenile Offenders: Public Preferences in Four Models for Change States*. http://www.macfound.org/media/article_pdfs/WILLINGNESSTOPAYFINAL.PDF p.1.

In 2013, Hickey management implemented additional incident review procedures and enhanced staff training in an attempt to decrease the use of restraints. The effort has been successful and should continue and be expanded to include work to decrease seclusions.

Staff at Hickey developed a mentoring program (Boys 2 Men) and a fitness program (Residents Making a Change) to foster youth growth and development. The Department should facilitate the development of similar programs at all DJS facilities.

Participation in the Hickey fitness program is contingent on youth demonstrating positive behavior throughout each week. Youth placed on the Intensive Services Unit (ISU) at Hickey (who are sent there to be provided additional supports) are not allowed to participate in either the mentoring or the fitness program. Meaningful activities and incentives should be available for all youth in DJS facilities.

The Maryland State Department of Education Juvenile Services Education division (MSDE-JSE) is responsible for providing educational services at Hickey. Youth placed on the ISU do not receive the required six hours of educational instruction on a consistent basis. Teacher instruction for kids in the ISU should be for the full length of the school day at Hickey.

Thomas J.S. Waxter Children's Center

The Thomas J.S. Waxter Children's Center (Waxter) is the only all-girls detention center in the state. Waxter is owned and operated by the Department of Juvenile Services (DJS/the Department) and located in Anne Arundel County. Waxter has a DJS rated capacity of 42 beds. African American youth represented 80% of total youth entries during 2014, compared to 74% in 2013.

Waxter – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	31	26	25
1. Youth on Youth Assault/Fight	93	106	66
2. Alleged Youth on Staff Assault	24	15	10
3. Physical Restraint	226	172	147
4. Use of Handcuffs and/or Shackles	9	8	24
5. Seclusion	29	26	27
6. Contraband	10	18	6
7. Suicide Ideation/Attempt	75	117	130

While there was a slight decrease (4%) in average daily population in 2014 compared with 2013, fights and assaults decreased by 38% and incidents involving physical restraints decreased by 15%. While physical restraints decreased, the use of mechanical restraints increased by 20%. Administrators at Waxter attribute the rise in the use of mechanical restraints to an increasing number of girls detained at Waxter following ejection from mental health facilities (Residential Treatment Centers [also called RTCs]).

Secure detention is a particularly inappropriate environment for youth with mental health needs. However, girls with serious mental health needs continue to be sent to and admitted into detention. Incidents of suicide ideation increased by 11% at Waxter in 2014 compared with 2013. And, in addition to the 130 incidents of suicide ideation during 2014, there were also 18 incidents of self-injurious behavior. The Department should therefore increase mental health

services at Waxter. Additionally, plans to train all direct care staff in Youth Mental Health First Aid should go forward.

Waxter faced significant challenges in maintaining full staffing during 2014. At the end of the year, there were 16 vacancies. As a stopgap measure, four staff have been temporarily reassigned to Waxter from another DJS detention center for a period of several months. Vacancies should be filled as soon as possible and Waxter (and DJS human resources) should attempt to maintain a pool of qualified job candidates on an ongoing basis.

The Maryland State Department of Education, Juvenile Services Education division provides school related services at Waxter. Currently, vocational education programming is limited to a course offering certification in basic food safety training that is offered once per marking period. Plans to add a course leading to certifications in customer service and medical coding and billing should be implemented.

Alfred D. Noyes Children's Center

The Alfred D. Noyes Children's Center, located in Montgomery County, is a Department of Juvenile Services (DJS/the Department) owned and operated maximum security detention center for boys and girls with a DJS-rated capacity of 57. Most cells at Noyes are double (or higher) occupancy. Housing two or more youth per cell is a risk to institutional and resident safety and is contrary to the best practice of placing residents in individual rooms. African Americans represented 76% of youth entries in 2014, up 6% over 2013.

While the overall average daily population decreased by 22% in 2014 compared with 2013, mechanical restraint usage and seclusions both increased by 136%. Fights and staff utilization of physical restraints also increased significantly in 2014 (compared to 2013).

Noyes – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	49	37	29
1. Youth on Youth Assault/Fight	84	53	71
2. Alleged Youth on Staff Assault	14	9	5
3. Physical Restraint	139	103	132
4. Use of Handcuffs and/or Shackles	6	11	26
5. Seclusion	19	11	26
6. Contraband	8	15	7
7. Suicide Ideation/Attempt	21	22	37

Noyes administrators attribute the increase in incidents to a rising number of youth with mental health needs and to an increased population of youth who are placed in detention following ejection from committed placement.

Although secure detention is an inappropriate environment for kids with mental health needs, many youth with such needs are sent to and admitted into detention centers. A 68% rise in suicidal ideation at Noyes underscores the need for expanded mental health services. Youth entering detention following ejection from placement are also in need of additional

support. The Department should bolster and enhance mental health services and interventions to meet the needs of all of these children.

The Department should also ensure that Noyes administrators, management and direct care staff are further or more intensively trained to utilize and model verbal de-escalation techniques and that staffers are encouraged to seek assistance from mental health professionals and case manager workers onsite before resorting to restraints and seclusion.

The Department has completed renovations to the outdoor educational trailer at Noyes. The trailer had been in a dilapidated state and in need of many repairs. New floors and doors were installed, walls were freshly painted, and structural deficits were corrected.



A renovated classroom at Noyes.

The Department plans to install additional cameras for monitoring of high traffic areas in the facility, including the areas outside the education trailer and outside the education resource room. These plans should be expedited. The installation of security cameras in these locations will enhance safety for both staff and residents. Camera footage can be used as a staff training tool and its availability prompts assiduousness in written incident reporting.

Lower Eastern Shore Children's Center

The Lower Eastern Shore Children's Center (LESCC) in Salisbury is a secure detention center owned and operated by the Maryland Department of Juvenile Services (DJS/the Department), with 18 cells for boys and six cells for girls. Overall average daily population was down by 10% during 2014 compared with the previous year. African American youth represented 67% of total youth entries in 2014, an increase of 6% (compared to 61% in 2013).

LESCC – Selected Incident Categories	2012	2013	2014
Average Daily Population (ADP)	19	20	18
1. Youth on Youth Assault/Fight	41	27	32
2. Alleged Youth on Staff Assault	11	2	15
3. Physical Restraint	91	160	138
4. Use of Handcuffs and/or Shackles	13	6	5
5. Seclusion	19	8	8
6. Contraband	7	10	1
7. Suicide Ideation/Attempt	13	26	43

Incidents involving fighting were more common and instances of suicide ideation increased substantially at LESCC in 2014 compared with 2013 even though there was a 10% decrease in average daily population.

A longstanding vacancy for an addictions counselor throughout 2014 remains unfilled at time of writing (January 2015). The Department should fill this position as soon as possible as substance abuse-related groups are needed and are not being held.

Western Maryland Children's Center

The Western Maryland Children's Center (WMCC), located in Washington County, is a 24-bed secure detention center for boys owned and operated by the Maryland Department of Juvenile Services (DJS/the Department). African Americans comprised 59% of youth entries in 2014, a 10% increase compared with 2013.

The overall average daily population decreased by 14% percent in 2014 compared with 2013. However, as the chart below indicates, staff utilization of physical restraints, mechanical restraints, and seclusion all increased in 2014 compared with the previous year.

WMCC – Selected Incident Categories	2012	2013	2014
Average Daily Population	22	21	18
1. Youth on Youth Assault/Fight	20	40	40
2. Alleged Youth on Staff Assault	9	0	3
3. Physical Restraint	72	87	96
4. Use of Handcuffs and/or Shackles	17	11	16
5. Seclusion	12	8	12
6. Contraband	5	4	2
7. Suicide Ideation/Attempt	9	14	9

Facility management at WMCC attribute the increase in incidents to an increasing influx of youth with mental health needs and also of youth who placed in detention following ejection from a committed placement. Although secure detention is an inappropriate environment for kids with mental health needs, many youth with such needs continue to be sent and admitted into detention centers. Mental health services and interventions should be enhanced at WMCC to meet the needs of these children and to provide additional support to youth entering detention following ejection from a committed residential placement.

In addition to bolstering mental health services, staff should utilize verbal de-escalation techniques and seek pre-emptive assistance from mental health professionals and case managers before resorting to the use of restraints and seclusion.

There are currently seven vacancies for resident advisor (direct care) positions at WMCC. The Department should facilitate the expeditious hiring of qualified staff to meet facility staffing requirements. Improving staff to resident ratios results in enhanced youth supervision and can lead to fewer incidents. It also allows staff to provide individualized attention to residents who could benefit from extra support.

The Maryland State Department of Education Juvenile Services Education division (MSDE-JSE) is responsible for educational and vocational instruction at WMCC. Opportunities for post-secondary educational, vocational, and work experience is currently limited. Students who have already obtained their high school diploma are forced to attend high school level classes.

Youth who qualify should have access to higher education and the option of gaining job-related skills during their time in detention. The Maryland State Department of Education should include WMCC in its plan to introduce career technical education courses such as business administration and certification courses in internet and computing and in green systems technology to DJS facilities.

STRIP SEARCHES AND SHACKLING

“Seventy five percent of youth in the juvenile justice system have experienced traumatic victimization.”³⁹ For survivors of trauma, “any situation in which they have no control over what happens to them can be retraumatizing,” including “very blatant examples like strip searches, restraint or...seclusion.”⁴⁰

Strip Searches

Current DJS policy requires all youth in DJS facilities to be strip searched following all visits and trips off grounds, including outings earned as a reward for good behavior. Youth are required to remove all of their clothes, squat and cough while observed by staff. All youth are subject to this practice whether or not there is reasonable suspicion that they are hiding something potentially harmful.

As noted above, the majority of youth in the juvenile justice system have experienced traumatic victimization. Strip searches “can trigger flashbacks and exacerbate a traumatized child’s stress and mental-health problems.”⁴¹ Their utilization “undermines, rather than helps, the child’s well-being.”⁴²

Research on adolescent development indicates that strip searches are particularly harmful to youth, “in fact, ‘a child may well experience a strip search as a form of sexual abuse.’”⁴³

The Department should end the practice of conducting strip searches without individualized determination of risk or reasonable suspicion that a child is hiding something potentially harmful.

Shackling

Current DJS policy requires all youth to be restrained in handcuffs, shackles, waist chains and a black box with a padlock when they are transported to and from court, medical and educational appointments. Children remain restrained in public waiting rooms and during receipt of medical services.

³⁹ Mental Health and Juvenile Justice Collaborative for Change, “Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System.” 2014, p. 2 <http://cfc.ncmhjj.com/wp-content/uploads/2014/01/Whitepaper-Mental-Health-FINAL.pdf>

⁴⁰ Penney, D., National Center for Trauma Informed Care, “Creating a Place of Healing and Forgiveness: The Trauma-Informed Care Initiative at the Women’s Community Correctional Center of Hawaii.” 2013, p. 3 http://www.nasmhpd.org/docs/NCTIC/7014_hawaiian_trauma_brief_2013.pdf

⁴¹ Brief for the Juvenile Law Center as Amicus Curiae, Joe Smook v. Minnehaha County, SD. <http://www.jlc.org/blog/juvenile-law-centers-findings-strip-searches-youth-detention-cited-international-report>

⁴² Ibid.

⁴³ Jessica R. Feierman & Riya S. Shah, *Protecting Personhood: Legal Strategies to Combat the Use of Strip Searches on Youth in Detention*. 60 Rutgers L. Rev. 67 (2007) <http://www.scotusblog.com/movabletype/archives/06-1034Amicus.pdf>

This policy is in place at all DJS-operated facilities including committed placement centers, where the Department is mandated to provide a program of rehabilitation. It applies uniformly to all youth, including those in committed placement who are permitted to participate in community outings and/or home passes as rewards for good behavior.

Children should not be transported “in conditions that in any way subject [them] to hardship or indignity.”⁴⁴ Experts in child psychology, adolescent development and trauma have testified on the harmful and damaging effects that shackling has on young people, particularly those who have experienced traumatic victimization.⁴⁵ As mentioned above, the majority of youth in the juvenile justice system have experienced some form of trauma.

The Maryland Department of Juvenile Services should end the practice of shackling children without individualized determination of risk and instead develop policies - such as those of New York State - which do not permit the use of mechanical restraints during transportation except if necessary for public safety.⁴⁶

⁴⁴ Human Rights Watch. Custody and Control: Conditions of Confinement in New York’s Juvenile Prisons for Girls 2006 by Human Rights Watch. <http://www.hrw.org/reports/2006/us0906/7.htm>

⁴⁵ Affidavit of Dr. Marty Beyer <http://njdc.info/wp-content/uploads/2014/09/Beyer-Affidavit-w-CV-Jan-2015-Final.pdf>; Affidavit of Dr. Julian Ford <http://njdc.info/wp-content/uploads/2014/09/Ford-Affidavit-Final-Dec-2014.pdf>; Affidavit of Dr. Donald Rosenblitt <http://njdc.info/wp-content/uploads/2014/09/Rosenblitt-Affidavit-Notarized-CV-Final-1-6-15.pdf>

⁴⁶ 9 NYCRR §168.3(a) “Permissible physical restraints, consisting solely of handcuffs and footcuffs, shall be used only in cases where a child is uncontrollable and constitutes a serious and evident danger to himself or others. . . . Use of physical restraints shall be prohibited beyond one-half hour unless a child is being transported by vehicle and physical restraint is necessary for public safety.”

BEHAVIOR MANAGEMENT PROGRAM

The Department of Juvenile Services (DJS) has implemented a behavior management program called Challenge in all DJS operated facilities.

Challenge is a points and levels system. Youth receive points daily based on their ability to follow staff directions, maintain personal appearance requirements, demonstrate verbally and socially appropriate behavior, and stay on-task.

Points can be redeemed for designated reinforcer items and/or activities at the end of the week. Reinforcers include items such as name brand hygiene products, stationary, and snacks (fruit, chips, and cookies) as well as activities such as being able to watch a movie or play video games for a designated period of time.⁴⁷ Children are eligible for a greater variety of weekly reinforcers as they progress through the levels.⁴⁸

Kids committed to placement sites must progress through five levels of Challenge before DJS will recommend them for release. Promotion from level to level is contingent on a minimum length of stay for each level and on the child completing a checklist of level-specific assignments and tasks. Examples of tasks and assignments include:

- earning a certain percentage of points each week
- attending orientation and therapy sessions
- reciting youth rules from the handbook (referred to as the “youth creed”)
- writing and reading aloud several writing assignments such as a goodbye letter to your past life and criminal activity and your challenges to personal change
- keeping a journal
- [and] requesting feedback from staff about one’s progress.

While Challenge intends to establish structure and foster personal growth for participants, the lack of uniform applicability, limited opportunities for youth to receive meaningful and timely rewards, and overly rigid adherence to checklists and mandates consistently undermine its aims. The Challenge program can be improved and better equipped to meet its stated objectives by taking the following into account and adjusting the program as needed:

- *Children who are identified as needing individualized and intensive services are housed in a separate unit, the Intensive Services Unit (ISU), in detention. Children placed on the ISU are not allowed to participate in the Challenge program. Additionally, children in predisposition status cannot move through the levels of the Challenge program. They are limited to redeeming their points for hygiene products.*
- ✓ **Recommendation:** All children in detention should be afforded equal opportunity to participate in the program.

⁴⁷ Challenge Program Manual for Youth, pages 14-17.

⁴⁸ *Ibid.*

- *Research on adolescent development shows that adolescents are particularly attuned to rewards and that immediate incentives can positively shape adolescent behavior.*⁴⁹
- ✓ **Recommendation:** Challenge should include more timely incentives for good behavior, including providing daily rewards rather than the current practice of reserving reinforcers for the end of the week.
- ✓ **Recommendation:** Recognition and rewards for youth accomplishments should be expanded beyond the limited list of weekly reinforcers currently available. Examples of meaningful rewards include community outings, certificates given to kids to acknowledge level promotions and public recognition of their promotion during facility community meetings.
- ✓ **Recommendation:** Children who receive a certain percentage of points at the end of the week could be rewarded with a pizza party or other organized social event, which can serve as a form of social reinforcement that promotes positive behavior since all participants earned their place in the event for each having accomplished a positive goal. Studies show that “healthy adolescent development is promoted by inclusion in a peer group that values and models prosocial behavior”.⁵⁰
- The Challenge program emphasizes compliance and adherence to uniform behavior. **Recommendation:** Emphasis should be shifted toward providing individualized services and interventions in a supportive and therapeutic environment that help foster positive youth development. This approach allows for individualization and recognizes that making mistakes and learning from them is a normal part of adolescent development.⁵¹ Programs which are therapeutically oriented are more effective than those focused on maintaining external control and discipline.⁵²
- ✓ **Recommendation:** Staff should be trained in therapeutic techniques which show them how to develop and maintain healthy and constructive relationships with residents and how to model self-regulation, social, and decision making skills for the youth under their care. As researchers have recognized, “positive modeling and connection between staff members and residents are usually considered to be critical components of effective institutional environments.”⁵³

⁴⁹ Bonnie, R. J., Johnson, R.L., Chemers, B.M., & Schuck, J.A. (2013) *Reforming juvenile justice: A developmental approach*. Washington DC: National Research Council. p.94

⁵⁰ *Ibid* p.102

⁵¹ *Ibid* p.38

⁵² Lipsey, M., Howell, J., Kelly, M., Chapman, G., Carver, D. “Improving the Effectiveness of Juvenile Justice Programs.” December, 2010, p. 23 <http://cjjr.georgetown.edu/pdfs/ebp/ebppaper.pdf>

⁵³ <http://www.pathwaysstudy.pitt.edu/documents/RPD%20Residential%20Confinement%20Knowledge%20Brief.pdf> (p.5)

SMALLER FACILITY UPDATES

Karma Academy (NOTICE OF CLOSURE)

Karma Academy closed at the end of October of 2014. The facility provided residential treatment for low level sex offenders in a nonrestrictive and homelike setting. Kids adjudicated for sex offenses are often unable to remain in their homes. The Department of Juvenile Services needs to ensure that, with the closing of Karma, youth are not inappropriately placed in a more restrictive setting.

Kent Youth Boys' Group Home (NOTICE OF CLOSURE)

Kent Youth group home closed during the third quarter of 2014. Kent Youth provided treatment services to boys in a safe, non-restrictive and homelike environment.

Liberty House Shelter

Liberty House is a DJS-licensed shelter care facility in Baltimore City operated by Youth Enterprise Services, Inc., that offers a less restrictive alternative to secure detention for boys 13 to 18 years old. Boys reside in a home-like environment and are under 24-hour care with a staff to resident ratio of 1 to 4. They attend school and recreational activities in the community and have access to community-based tutoring and behavioral health services. Incidents were low in 2014 and the shelter continues to be an appropriate alternative to secure detention.

One Love Group Home

One Love is an 8-bed group home located in Baltimore City. The home is licensed by and receives referrals from DJS. The program, operated by Building Communities Today for Tomorrow, Inc., focuses on providing adjudicated youth between the ages of 17 and 20 with the skills and services they need to facilitate their transition to the community.

Youth reside in a comfortable, home-like environment and attend school, work, and engage in recreational and volunteer activities in the community. One Love has a structured points and level system which allows youth to earn meaningful rewards (walks in the community, allowance money, food from nearby community restaurants) on a daily and weekly basis.

In addition, youth receive individual and group therapy (including trauma therapy if indicated), life-skills training, and substance abuse counseling. Family therapy is not available at this time. Services are provided within the context of a supportive, caring environment. Incidents remained rare in 2014, and One Love continued to offer youth effective, individualized services in a less restrictive, safe, and nurturing environment.

Morning Star Youth Academy (NOTICE OF CLOSURE)

Morning Star Youth Academy closed during the third quarter of 2014.

The Way Home (temporarily closed)

The Way Home, located in west Baltimore, is a privately operated group home licensed by the Department of Juvenile Services to serve up to 12 girls. The Way Home is temporarily closed while the facility undergoes renovations.

William Donald Schaefer House

William Donald Schaefer House is a staff secure (not locked and fenced) substance abuse treatment program for adjudicated male youth between the ages of 13 and 17. The program has the capacity to serve 19 youth and is located in a converted home in Baltimore city. Program duration is approximately 120 days.

In addition to educational services provided by the Maryland State Department of Education and individual and group substance abuse counseling, Schaefer House partners with multiple community organizations to provide youth with enrichment programs and activities.

In 2014, youth received mentoring services and health education from local organizations. In addition, they had the opportunity to participate in a service learning program offered in partnership with the American Visionary Art Museum. Incidents were low in 2014 and Schaefer House continued to provide valuable services to youth under safe and comfortable conditions.

THE MARYLAND STATE DEPARTMENT OF EDUCATION IN DJS FACILITIES

The Maryland State Department of Education Juvenile Services Education program (MSDE-JSE) is responsible for providing educational services to students in detention and placement centers operated by the Maryland Department of Juvenile Services (DJS). During its tenure, MSDE-JSE has brought educational resources and expertise to DJS-operated facilities. According to MSDE-JSE data, the MSDE-JSE made a 3% increase in math gains in FY 2014 compared to FY 2013. However, a reported 4% decrease in reading scores and 7% decrease in the General Educational Development (GED) test pass rate suggests that more work needs to be done to ensure that children leaving detention and placement have achieved academic progress that will prepare them for future success.⁵⁴

Investing resources to improve educational services and outcomes for MSDE-JSE students should be a priority. For juveniles who are incarcerated, “access to a high-quality education during their confinement is a vitally important and cost-effective strategy for ensuring they become productive members of communities”.⁵⁵ Youth who participate in some form of higher education are half as likely to be recommitted, even when compared to peers with similar histories.⁵⁶

Recognizing the need to strengthen educational services for incarcerated youth, the federal government recently disseminated a set of guiding principles for providing high quality education in juvenile justice facilities.⁵⁷ Consistent with the federal guidelines summarized and distilled below, MSDE-JSE should make several improvements in its delivery of educational services.

- Federal Guideline 1: Provide a facility climate that prioritizes education, provides conditions for learning, and includes behavioral and social support services that address the individual needs of all youth, including those with disabilities.
 - At MSDE-JSE schools, Individualized Education Program(s) [IEPs] are modified to reflect resource availability rather than a student’s current needs. Special education staff have both administrative and teaching roles, making it difficult for them to fulfill IEP instructional mandates. MSDE-JSE should enhance resources

⁵⁴ Educational Coordinating Council for Juvenile Services Educational Programs Annual Report FY2014 p.8

⁵⁵ U.S. Departments of Education and Justice, *Fact Sheet on Correctional Education Guidance Package*, Washington, D.C., 2014, available at <http://www2.ed.gov/policy/gen/guid/correctional-education/fact-sheet.pdf>

⁵⁶ U.S. Departments of Education and Justice, *Fact Sheet on Correctional Education Guidance Package*, Washington, D.C., 2014, available at <http://www2.ed.gov/policy/gen/guid/correctional-education/fact-sheet.pdf>

⁵⁷ U.S. Departments of Education and Justice, *Guiding Principles for Providing High-Quality Education in Juvenile Justice Secure Care Settings*, Washington, D.C., 2014, p. iv. <http://www2.ed.gov/policy/gen/guid/correctional-education/guiding-principles.pdf>

and support services at its schools, including hiring additional staff, to meet the educational needs of its students.

- Federal Guideline 2: Secure necessary funding to support educational opportunities for all youths comparable to opportunities for peers who are not system-involved.
 - With the exception of one small program at a boys' facility, MSDE-JSE students do not have access to post-secondary education, and options for vocational education are limited. All youth should have access to higher education at local colleges and universities, and through online courses. Youth should also be able to participate in internships and employment opportunities in the community. A variety of hands-on vocational education courses that are of particular interest to the individual youth being served should be available either on grounds or in the community.
 - Girls at MSDE-JSE schools do not have opportunities to pursue higher education. This year two girls at Carter who had earned their GEDs were not afforded access to university, community college, or formal employment. Institutions are required by law to have equal educational opportunities for female and males.⁵⁸ MSDE-JSE should offer post-secondary educational opportunities for girls at MSDE-JSE schools. Vocational education programs that are available in boys' facilities, such as basic construction and job safety courses, should be equally available in those serving girls.
- Federal Guideline 3: Actively recruit, employ, and retain qualified education staff with skills relevant to juvenile justice settings who can impact student outcomes by creating and sustaining effective learning environments.
 - MSDE-JSE continues to face significant challenges recruiting and retaining qualified teachers as positions in public school pay better and include school year and summer holidays. Because of the shortage of qualified teachers, some MSDE-JSE teachers have to teach outside of their area of certification. Teacher absences or shortages can also result in students completing worksheets on their own instead of receiving formal instruction. The MSDE leadership should prioritize the MSDE-JSE program and work to secure increased funding and positions to add teachers and support staff.

⁵⁸ U.S. Departments of Education and Justice, *Letter on the Civil Rights of Students in Juvenile Justice Facilities*, Washington, D.C., 2014, p.4, available at <http://www2.ed.gov/policy/gen/guid/correctional-education/cr-letter.pdf>

- Federal Guideline 4: Ensure rigorous and relevant curricula aligned with state academic and career and technical education standards that use methods, tools, materials, and practices that promote college and career readiness.
 - All MSDE-JSE schools should have computers with internet access for educational purposes
 - Current practice is to conduct classroom instruction by living unit rather than grade level at most DJS facilities. Teachers are expected to provide instruction in multiple grade levels in a single class period. Classes should be differentiated by grade level as is common practice in the community.

- Federal Guideline 5: Develop policies and procedures to ensure successful re-entry into communities.
 - MSDE-JSE does not ensure that high school credits earned while in detention or placement are being transferred to a student's community school. Students cannot earn a high school diploma while enrolled in a MSDE-JSE school. MSDE-JSE should coordinate with community schools before and after a student is released to ensure that credits are appropriately applied toward a student's diploma. Students should have the option of earning a high school diploma while enrolled in a MSDE-JSE school.
 - MSDE-JSE should collaborate with DJS to form after care plans for students nearing program completion so that students who leave placement are enrolled in an educational program or have employment options upon release.

Appendix

The Juvenile Justice Monitoring Unit

The mission of the Juvenile Justice Monitoring Unit (JJMU) is to promote the positive transformation of the juvenile justice system to meet the needs of Maryland's youth, families and communities. This mission is accomplished by collaborating with all who are involved with the juvenile justice system. The JJMU is responsible for reporting on Department of Juvenile Services (DJS) operated and DJS licensed programs across Maryland.

The Unit was established in 2000, codified in 2002, and originally housed in the Governor's Office of Children, Youth, and Families. In 2006, the monitor's office was moved to the Office of the Maryland Attorney General and renamed the Juvenile Justice Monitoring Unit.

1. The Monitor's Function

Public reports of the JJMU's evaluations are issued on a quarterly basis and address the following issues:

- Treatment of and services to youth, including:
 - whether their needs are being met in compliance with State law;
 - whether their rights are being upheld;
 - whether they are being abused;
- Physical conditions of the facility;
- Adequacy of staffing; and
- Effectiveness of the child advocacy grievance process and DJS monitoring process.

Monitors make unannounced visits to facilities with frequency determined by challenges and progress at each facility. Monitors review the DJS population and case note databases and follow up on incidents in facilities, particularly those involving alleged staff on youth violence, youth on youth violence, and other incidents involving injury or an allegation of abuse or neglect. They also review DJS internal investigative reports and grievances filed by youth in facilities. Monitors participate in multi-agency meetings convened to discuss reports of alleged child abuse or neglect in facilities.

In calendar year 2014, JJMU staff conducted dozens of facility monitoring visits (and attended facility related meetings) that resulted in monitoring reports available at www.oag.state.md.us/jjmu. The Unit worked diligently with the Maryland Department of Juvenile Services and a variety of state and local agencies and youth-serving organizations to improve the quality of services for Maryland youth. The agencies and organizations included the Juvenile Detention Alternatives Initiative of the Annie E. Casey Foundation; the Maryland State Advisory Board for Juvenile Services and various facility advisory boards; Advocates for Children and Youth (ACY); the Female Youth Workgroup; Maryland State's Attorneys' Offices; the Maryland Office of the Public Defender including the Juvenile Protection Division; the

Maryland Disability Law Center; the American Civil Liberties Union of Maryland; Child Protective Services units; and the Montgomery County Commission on Juvenile Justice.

2. Current Issues

During 2014, the JJMU continued to work with DJS and other stakeholders to address particular concerns including overuse of secure detention facilities and of out-of-home commitment. As of early 2015, the population of juvenile services-involved youth at DJS detention centers continues to decline while utilization of appropriate alternatives to secure detention have increased. More work needs to be done to ensure youth are not unnecessarily or inappropriately committed to out-of-home placement.

3. Personnel

The Maryland Juvenile Justice Monitoring Unit (JJMU) consists of four staff members including the director (and not including unfilled vacancies). Staff members utilize knowledge of detention and committed care program operations and management, civil rights law, treatment modalities, social work, education, advocacy and counseling.

Nick Moroney was appointed director in April of 2011. He joined as a monitor in February of 2008, was promoted to senior monitor in early 2010 and became acting director in October of the same year. Before he joined the JJMU, Mr. Moroney taught in an alternative public school for troubled youth. Prior to teaching, he worked as an editor and writer on issues affecting vulnerable populations in Maryland and Washington, D.C. Mr. Moroney holds a Master's Degree from Georgetown University and a B.Sc. from Towson University.

Margi Joshi joined the JJMU as a monitor in August of 2014. Prior to joining the JJMU, Ms. Joshi worked as a social worker for youthful offenders at a treatment-oriented maximum security prison where she coordinated a mentorship and art program and led re-entry modules. Before becoming a social worker, Ms. Joshi worked as a regulatory compliance specialist for a large research university. She holds a Juris Doctor and a Master's Degree in Social Work from Tulane University and a B.A. degree from Georgetown University.

Tim Snyder is a senior monitor who joined the Unit in 2001. Before becoming a monitor, Mr. Snyder spent eleven years serving as Director of the New Dominion School in Maryland, an adventure-based residential treatment program for troubled youth. He also worked in direct care and family services at New Dominion School in Virginia. As a private practitioner, Mr. Snyder consulted with numerous families experiencing difficulties with their children. He holds an M.A. in Pastoral Counseling (special emphasis in marriage and family counseling) from LaSalle University and a B.A. degree from Guilford College (Sociology).

Eliza Steele is a senior monitor who joined the JJMU in 2012. Prior to accepting a permanent position, Ms. Steele worked as an intern for the JJMU during 2011 when she visited facilities and contributed to the 2011 Pictorial Report. Ms. Steele has also studied with a judge in juvenile court in Pennsylvania where she attended court proceedings and shadowed a school based probation officer. She holds a B.A. degree from Dickinson College and is pursuing a Master's Degree in Social Work at the University of Maryland.



MARYLAND Department of Juvenile Services

Successful Youth • Strong Leaders • Safer Communities

February 18, 2015

DJS Response to the Juvenile Justice Monitoring Unit's 2014 Annual Report

The Department of Juvenile Services (DJS) appreciates the time and effort that JJMU has taken to provide the 2014 Annual Report. We have thoughtfully considered all findings and recommendations provided. We are appreciative of the JJMU's recognition of our accomplishments during the past year.

The Department has and continues to work to implement reform efforts designed to keep low risk youth out of secure confinement. This includes detention reforms achieved through the Juvenile Detention Alternatives Initiative (JDAI), an Annie E. Casey Foundation program as well as legislative reforms such as SB 122 which requires an intake officer who authorizes detention of a child for a violation of community detention to immediately file a petition to authorize the continued detention of a child. The juvenile court must hold a hearing on the petition no later than the next court day unless extended for no more than five days by the court on good cause shown. We will continue our efforts to expand JDAI collaborations statewide.

The Department supports that where appropriate, intensive, community based services are preferable to out of home placements. The department has invested \$25 million to stand up and support evidence based community located services like Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST). We also maintain slots for the statewide Care Management Entity (CME) which uses a community based wrap-around service model, and the Department contracts with Youth Advocate Programs, Inc. in Baltimore City, a nationally recognized non-residential program that provides community based programs for high risk youth as an alternative to residential placement. Additionally, DJS has expanded its use of community based programming in Prince George's County by restoring funding for the Choice program to serve youth in Prince George's County. DJS has also contracted with Community Conferencing to prioritize its use as an alternative to court action.

The Department continues to evaluate the population of youth that must be served in out of home placements. Currently, the Department is working with the Annie E. Casey Foundation to analyze decisions and processes that drive juvenile commitments.

Despite the success evidenced by falling crime rates and Department reforms in driving down detention populations, a population of committed youth still remains in committed programs out of state due to not having appropriate programming space in Maryland to accommodate them. The Department is obligated to serve these youth committed by the court in a setting determined by the court. In order to meet the security level and treatment needs of these youth, the Department must contract for out of state services.

Our view is that it is far better for those youth to be treated in Maryland rather than an out of state program and therefore, we will continue to explore ways to meet that need with services located in Maryland.

DJS Response to JJMU Snapshot of Ongoing Concerns

- **JJMU Capital Plan**

The Department will make adjustments to the capital construction plan to address the needs of the committed population. See above paragraph regarding the committed population.

- **JJMU Use of Mechanical Restraints, Strip Searches**

The Department's policies must address public safety, and safety concerns for youth and staff. Current procedures require the use of mechanical restraints routinely for all youth placed in *hardware secure facilities*, to include detention and two committed facilities. Youth placed in staff secure facilities are transported in mechanical restraints if it is determined that they present as a security risk. Youth are strip searched after visits to reduce and eliminate the introduction of contraband in the facility.

- **JJMU Current law for CPS investigations**

DJS abides by current law in reporting allegations of abuse. In addition to notifying Child Protective Services, all allegations are reported to the State Police for investigation. Additionally, DJS's internal Inspector General's office conducts investigations into allegations of abuse independent of Child Protective Services and the State Police.

- **JJMU Youth Phone System**

The federal Prison Rape Elimination Act, Standards for Juvenile Facilities require that youth are provided at least one way to report abuse or harassment to a public or private entity, or office that is not part of the agency and is able to receive and immediately forward youth reports. The Department has installed a youth phone in the dayroom of each living unit to give youth direct access while enabling ongoing supervision by direct care staff. The Department has contracted with Maryland 211 to provide a 24/7 hotline to receive youth complaints of sexual abuse or harassment. Reports are forwarded to Child Protective Services and the DJS Office of the Inspector General for investigation. Utilization of the phone system gives youth the ability to make reports of abuse immediately while remaining anonymous if they choose to, which is a requirement of the Prison Rape Elimination Act. Having a phone for the sole purpose of making PREA complaints would not afford the youth anonymity. The phone system is also used by youth to make calls to family members. Sensitive calls that require a level of privacy are made under the supervision of the case manager in the case manager's office. Calls to youth attorneys are not recorded. All other recorded calls are made available to the Inspector General as needed for investigative purposes.

Need for Treatment Resources in Committed Placement Centers

Beginning in July 2013, the Department established a comprehensive evaluation initiative known as MAST, Multi-Disciplinary Assessment Staffing Team. The MAST initiative standardized evaluations that are completed when youth are in detention. These evaluations include completion of a psychological, psycho-

social, educational testing, trauma screening, substance abuse and medical screening. Therapists in residential facilities use the MAST evaluations, in addition to their own assessments, to develop an individualized treatment plan for each youth. Therapists provide individual counseling and cognitive-behavioral therapy to youth, both of which have been shown to be effective in addressing the mental health issues of juvenile justice youth. Issues of anger management and trauma are addressed individually. In groups, anger management is addressed through the use of psycho-educational materials in Forward Thinking, an evidence-based journaling series that focuses on the development of appropriate coping strategies. Youth participating in the 7 Challenges Substance Abuse Program also receive anger management counseling. Additionally, the Department has conducted extensive research to determine best practices and evidence-based approaches to providing trauma informed care and anger management. The Department is in the process of developing a request for bids to expand staff training and services to youth in these areas.

The type of programming and frequency of youth contact with a therapist is based on the individual needs of the youth. The JJMU report references the Wisconsin “Mendota Juvenile Treatment Center Program” which describes a specialized program that offers intensive mental health treatment to the most violent male adolescents held in a correctional facility. In Maryland, the state operated program that serves this population is located at Victor Cullen Academy. Like the Mendota Juvenile Treatment Center Program, the ratio of behavioral health staff is twice that assigned to other committed programs. The ratio of therapists to youth at Victor Cullen is one therapist for every 12 youth, which meets and exceeds therapist generally assigned in residential treatment centers.

Family Engagement in Committed Placement Centers

Therapists determine the need and schedule family counseling and therapy sessions. Visitation is offered at each facility two times each week. Upon request, the DJS community case managers assist families with transportation to the facilities. Youth are afforded home visits as a therapeutic intervention to help prepare them to transition back to the community. The Department is currently developing a re-entry strategic plan with a goal of increasing family engagement.

Education in Committed Placement Centers

The Maryland Department of Education is responsible for providing education services to DJS youth. We support the need for GED, post-secondary education and expanded vocational education for youth. Youth housed at the four Youth Centers are eligible to participate in the college program at Garrett College.

FACILITY RESPONSES

Victor Cullen

Victor Cullen is the only state run hardware secure treatment facility which serves youth with the most serious committing offenses and aggressive histories. Given the impulsivity and needs of this population incidents of aggression fluctuate. The facility management and treatment staff have been responsive in addressing the individual needs of youth. DJS and education staff work collaboratively to address behaviors of youth occurring in school. The Department is developing an intensive services unit to provide an additional alternative to addressing the needs of the most aggressive youth. Behavior health resources at Victor Cullen are adequate to meet the needs of the population. There are six mental health clinicians assigned to the facility, four therapists, a clinical supervisor, and a half time licensed psychologist who provides programmatic and clinical supervision. The Department is seeking to procure additional programming and training for all staff in the areas of trauma informed care and anger management.

Family therapy is provided by clinical staff. Youth are afforded home visits as a therapeutic tool to assist with re-integration with their families. Youth also maintain contact with their families via facility visits, letter writing, video conferencing and phone calls. Transportation assistance is also provided to families. The Department funds two postage stamps and two phone calls weekly for each youth.

Comprehensive services to youth also include daily recreation and participation in the C.H.A.M.P.S. (Changing Habits and Making Progressive Strides) Program, an intramural sports, arts, and academic challenge program. Activities include competitions in basketball, baseball, soccer, tennis, and bowling; art, poetry and creative writing contest; and academic bowl competitions. Intramural activities are scheduled with other DJS facilities, and with Job Corps youth. Youth at Victor Cullen are also afforded opportunities to participate in the Reflections Camping Program, a year round camping program located at Meadow Mountain Youth Center. Camping activities are varied, and include confidence and team building events. The Reflections Program has a full ropes course. The Department is considering establishing some of the components of the ropes course at Victor Cullen.

Youth Centers

Programming to address anger management and trauma is described in the Need for Treatment Resources in Committed Placement Centers section of this report.

Youth located at the four Youth Centers have the opportunity to earn college credits through participation in the Garrett Community College Program. During the past year 20 eligible youth participated.

J. DeWeese Carter Children's Center

At admission all youth are screened for trauma exposure using the Trauma Symptom Checklist for Children (TSCC). Each youth receives an individualized treatment plan to address their specific treatment needs, along with weekly individual therapy and bi-weekly family therapy. Programming to address anger management is provided through CHALLENGE, the Department's behavior management program, individual counseling and therapy, and psycho-educational material utilizing Forward Thinking, a cognitive behavioral journaling series that uses evidence-based strategies to assist youth in making positive changes to their thoughts, feelings, and behaviors. Additionally, the Department has conducted extensive research of best practices and evidence-based approaches to expand anger management programming and trauma informed care. The Department is in the process of developing a request for bids to expand staff training and services to youth in these areas.

JJMU cites research indicating that "restraint and seclusion is likely to re-traumatize women who are trauma survivors...." Department policy and procedures uses seclusion only as therapeutic intervention to allow youth an opportunity for "time-out" to regain self-control. Seclusion is not used as punishment, and is limited to situations where youth present an imminent threat of physical harm to themselves or others, they have not responded to less restrictive methods of control or for whom less restrictive measures cannot reasonably be tried; or when youth have escaped or are attempting to escape. Youth are not placed in seclusion for a pre-determined amount of time. When seclusion is used, staff observes youth every 10 minutes and counsel with the youth to return him/her to the treatment milieu as soon as possible. Staff that meet with the youth may be case managers, behavioral health, and/or supervisors. The Department provides extensive de-escalation training to all staff to minimize the use of restraints and seclusion. There were 15 incidents of seclusion used at Carter during 2014, that averaged one hour per incident. All

incidents of restraint and seclusion are reviewed by facility administrators to ensure compliance with Departmental policy and procedures.

As noted by JJMU, the Carter Center has limited indoor recreation space. The Department contracts with the Kent County Parks and Recreation Center to augment the need for indoor space during inclement weather. Youth are transported to the recreation center where there is a large indoor gym.

Detention Centers

The Department's efforts to support alternatives to detention are discussed in the opening remarks of this response.

In July 2014, the Department completed the roll out and implementation of CHALLENGE, the behavior management program. CHALLENGE is now operational in all DJS detention and residential facilities. This enables single focused and directed training resources for staff. Outcomes are showing improved consistency of managing youth behavior. The Department appreciates JJMU's recognition of the improved structure and reduction of aggressive behavior in detention.

The JJMU reported a concern for youth with mental health needs being placed in detention. Recognizing that placement in detention can be an emotionally stressful event, the Department screens **all** youth at admission utilizing the Massachusetts Youth Screening Instrument (MAYSI) to identify youth who may require immediate mental health care. A more extensive evaluation is completed by mental health staff as part of the Multi-Disciplinary Assessment Staffing Team (MAST) process. Throughout a youth's stay in detention behavioral health staff are available and responsive to the needs of youth. When behavioral health staff determine a youth has intensive mental health needs that cannot be met at the facility, the youth is referred for hospitalization and/or placement in an intensive mental health services facility.

All DJS direct care staff are trained to refer youth in crisis to mental health staff for an assessment. Beginning June 2014, the Department began utilizing Youth Mental Health First Aid, USA for Adults Assisting Young People, an evidence based model to train all direct care staff. Youth Mental Health First Aid is designed to teach staff how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. The course introduces common mental health challenges for youth, reviews typical adolescent development and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. As required by the Department's Suicide Prevention Policy and Procedures staff are trained to respond to all verbalizations, self-injurious behaviors and suicide gestures by providing one on one direct supervision until the youth can be assessed by mental health staff.

Baltimore City Juvenile Justice Center

Facility administrators and behavioral health staff have been responsive to the increase in acts of aggression. During the 4th quarter of 2014 implemented strategies resulted in a decrease of incidents.

Cheltenham Youth Facility

The Department in partnership with the Annie E. Casey Foundation continues to work with the stakeholders in Prince Georges County to launch the Juvenile Detention Alternative Initiative. The Department's IT unit has corrected the database problem reported by JJMU. All incidents occurring at Cheltenham have been entered in the database.

Charles H. Hickey, Jr. School

The Department appreciates JJMU's recognition of the efforts of facility staff to more effectively manage youth behavior. JJMU reports that youth in the Intensive Services Program (ISU) are not permitted to participate in special activities. The youth placed in the ISU program are youth who have engaged in assaultive behaviors with their peers and staff and therefore are restricted from participating in rewarding extracurricular activities.

Alfred D. Noyes Children's Center

The increase in restraints can be attributed to staff managing the behavior of several youth with chronic mental health and maladaptive behaviors. Seven youth accounted for an 80% increase in incidents during the 4th quarter. Consistent with protocols these youth were evaluated by mental health professionals and referred for psychiatric hospitalization as needed. Long term specialized placements were secured to meet the needs of the youth. Behavioral health staff, administrators and direct care staff work collaboratively to manage the behaviors of youth. All incidents of restraint and aggression are reviewed by the facility administrator and monitored by the executive director. Use of restraints is required to prevent youth from harming themselves or others. All direct care staff complete crisis prevention management, verbal de-escalation, and mental health first-aid training annually.

Lower Eastern Shore Children's Center

The slight increase in incidents of youth on youth assaults, 32 in 2014 compared to 27 in 2013, were due to incidents occurring in the last two months of the year. These behaviors were attributed to a younger, more impulsive age group ranging from 12 to 14 years of age. These youth were provided additional behavioral health services.

Incidents of suicidal ideations/verbalizations increased during 2014 compared to 2013 at LESCC. As reported, the Department screens **all** youth at admission utilizing the Massachusetts Youth Screening Instrument (MAYSI) to identify youth who may require immediate mental health care. Twenty six percent of the reported ideations were reported during this screening. The facility is staffed with trained behavioral health staff to address the mental health needs of youth.

A more extensive evaluation is completed by mental health staff as part of the Multi-Disciplinary Assessment Staffing Team (MAST) process. Throughout a youth's stay in detention behavioral health staff are available and responsive to the needs of youth. When behavioral health staff determine a youth has intensive mental health needs that cannot be met at the facility, the youth is referred for hospitalization and/or placement in an intensive mental health services facility.

The Department continues to actively recruit to fill the vacant addictions counselor position at LESCC. In the interim, substance abuse assessments have been re-assigned to staff from headquarters.

Thomas J.S. Waxter Children's Center

The Department appreciates JJMU's recognition of the decrease in incidents of aggression and physical restraints. Mechanical restraints are applied as a last resort to safely move youth to appropriate locations for de-escalation. Two youth accounted for 66% of the mechanical restraint usage in 2014. Youth are evaluated by behavioral health staff following the use of restraints. Staff training in de-escalation, Youth Mental Health First Aid, USA for Adults Assisting Young People, and the Department's Suicide Prevention Policy and Procedures is ongoing. All incidents of physical and mechanical restraint use are reviewed by facility administrators to ensure adherence to Departmental policy and procedures.

The following positions are assigned to the facility to provide mental health services: a licensed clinical professional counselor, a clinical social worker, licensed psychologist, two substance abuse counselors, and a half time licensed social worker. The social worker and the psychologist also conduct Multi-Disciplinary Assessment Staffing Team (MAST) evaluations for the youth at the facility. Clinical hours have been expanded to provide coverage evenings and weekends.

The Waxter facility experienced a significant number of vacancies. Resident advisors were voluntarily re-assigned from two facilities to support staffing during recruitment to fill the vacancies. Recruitment interviews are held every two weeks. At present two resident advisor positions are vacant.

Western Maryland Children's Center

The slight increase in the use of restraints and seclusion were required interventions to address the behaviors of extremely aggressive youth. The facility has adequate behavioral health staff assigned consisting of a full time social worker, an addictions professional counselor, and a half-time psychologist.

Three of the seven vacant resident advisor positions have been filled. Recruitment is underway to fill the remaining positions.

William Donald Schaefer House

The Department appreciates the JJMU's recognition of the community enrichment opportunities afforded to youth participating in the substance abuse program at the Schaefer House.

BEHAVIOR MANAGEMENT PROGRAM

In July 2014, the Department completed implementation of the CHALLENGE Program in all detention centers. The CHALLENGE Program is now implemented in all DJS detention and committed facilities. This enables the Department to focus training and supervisory resources, and the youth learn one set of expectations which better prepares them to adjust to a change of environment when they move from detention to a DJS committed facility. CHALLENGE is a behavior management program which incorporates evidence-based behavioral principles. Behavior management is grounded in the principles of *positive reinforcement* and *modeling* and is intended to encourage pro-social behavior. Behavior management strategies are designed to elicit *positive* behavior. Reinforcing positive behavior means providing a stimulus or reward that strengthens the behavior and increases the future probability of the desired behavior. The program uses social reinforcement, a point and level system, and tangible reinforcers to strengthen desired pro-social behaviors. Research supports the use of behavior management strategies for maintaining order, minimizing disruption, improving climate and reducing problem behavior. The Department has achieved positive outcomes as evidenced by improved interactions between staff and youth and a reduction in acts of aggression.

All programs require ongoing training and monitoring to support consistent application. Staff receives CHALLENGE training in entry level training, annual in-service training, and interim updates as needed at each facility. Program oversight and modifications are approved by the Central Program Committee, chaired by the Director of Behavioral Health; implementation is monitored by two behavior health clinical supervisors (one assigned to detention and one to committed programs), in addition to administrators and behavior health staff at each facility. Program evaluations are conducted by the Department's research and evaluation unit.

The CHALLENGE Program clearly establishes behavioral expectations for youth and staff responses for youth accountability. These expectations create a structured and safe environment in which treatment services can be provided. It establishes an environment of respect and fairness that places the responsibility for compliance and behavioral change on the youth. The program uses checklists that guide behavioral and treatment service expectations through each level. Contrary to the JJMU report, these checklists do not prohibit individualized services for youth; in fact Treatment Teams are expected to amend the checklist to address each youth's target behaviors and treatment services. In committed programs an Individualized Treatment Plan is established for each youth. The plan is monitored monthly by the Treatment Team to assess each youth's progress towards earning release.

JJMU reports a concern that youth who are placed in Intensive Service Units (ISU) are not permitted to participate in the CHALLENGE Program. The behavior of youth placed in ISU continues to be managed using the CHALLENGE Program. Youth placed in ISU are placed there because they have been assaultive to peers and/or staff in the general population. Aggressive behaviors are not behaviors that should be reinforced and therefore these youth do not earn levels or privileges while removed from the general population. JJMU cited a second group of youth who do not progress through the CHALLENGE levels. These are youth placed in detention pending adjudication. Youth in pre-adjudication are placed on level I and they earn level I privileges. If committed, they begin to earn levels towards eligibility for release as do all other youth. JJMU suggests that youth should receive daily reinforcers. Staff is trained to socially reinforce youth by giving verbal praise. Youth also receive immediate reinforcement by the awarding of points and written positive comments on their point cards. Each youth's percentage of points earned daily and level promotion is posted on a Challenge board in the living unit. Recognition of youth accomplishments are addressed in daily community meetings held on the unit. On a weekly basis, youth earn an opportunity to go to the reinforcer (games) room where they can spend points for items such as snacks, stationary, brand name hygiene products, and video games. Providing this level of reinforcer each day would significantly reduce the incentive for youth to meet behavioral expectations. In addition to weekly reinforcers, youth have opportunities to earn special privileges, such as participation in pizza parties, movie events, and off campus trips, as appropriate.

The majority of the JJMU recommendations regarding CHALLENGE Program implementation are already being implemented. Contradictions to the principles of behavior management were noted above.

Private Providers

Silver Oak Academy

Silver Oak Academy (SOA) is a privately operated staff secure group home licensed by the Department. In 2014 there was a noted increase in incidents of aggression requiring the use physical restraints. Program changes impacting the increase in incidents include a 15% increase in population, management of significant behavior problems, and re-training of staff in new programming. SOA continues to provide valuable programming for DJS youth.

Smaller Facility Updates

As reported by JJMU, a number of smaller programs closed during 2014, however, the Department continues to contract for programs to meet the needs of the current population.

Maryland State Department of Education
Juvenile Services Education

Response to JJMU 2014 Annual Report

Page 12

JJMU Statement: "Currently, there is no GED or post-secondary track available to students."

MSDE Response: Juvenile Services Education (JSE) has a GED curriculum that is imbedded in the core courses taught in the facilities. Students receive instruction in the content area which allows them to earn credit as well as develop the skills necessary to succeed on the GED.

Students with high school diplomas/GED first take the Accuplacer which is a placement test used by community colleges to determine if a student needs to take non-credit courses in mathematics or English prior to enrolling in credit-bearing postsecondary coursework. JSE provides the remediation to students who are not successful on the Accuplacer. The experience to date is that most students require remedial course work prior to postsecondary enrollment.

Page 14

JJMU Statement: "There is a need for increased vocational education options at the youth centers especially for youth who may have already earned their high school diploma or GED. Community based options for employment and vocational training should also be available. Currently, students do not have access to the internet for educational purposes."

MSDE Response: JSE provides a variety of career technology education (CTE) options for youth including those who have already earned their high school diplomas and continues to explore additional CTE opportunities that can benefit its students. JSE is supportive of developing options for community based employment experiences for youth through collaboration with the Department of Juvenile Services.

JSE is currently in the process of upgrading technology resources within all school sites. As this process continues JSE in concert with DJS will be exploring options for access to designated internet based learning opportunities.

Page 18

JJMU Statement: "The MSDE-JSE program should have an established track for post-secondary school students that include access to a nearby college and to online courses."

The Department of Juvenile Services and MSDE-JSE should work together to implement a community-based program of employment and internship opportunities. Currently, vocational education programs are not offered on a daily basis at Carter and are limited to a basic food hygiene course and four modules in network cabling. Plans to add a course leading to certification in customer service should go forward.

Girls at Carter continue to be transported to medical and educational appointments in handcuffs and shackles fastened to belly chains with black boxes (see page 33). Plans to have girls placed at Carter take the GED test at a nearby community college should be implemented without requiring girls to be mechanically restrained during transport.”

MSDE Response: JSE currently has an established post-secondary program through Garrett College. This program is housed at Backbone Youth Facility. Over the past year, the number of youth qualifying for this program has been steadily decreasing. JSE is exploring options for providing online post-secondary options for implementation as JSE’s current technology initiative is completed.

JSE is supportive of collaborating with DJS to provide youth opportunities to participant in community based employment/internship options. JSE provides a variety of career technology educational courses/classes for the students at Carter. An additional class culminating in a retail customer services certification is scheduled for deployment in the near future.

Measures taken for safety and security reasons are not within the purview of MSDE.

Page 23

JJMU Statement: “Youth at CYF who struggle with issues of aggression may be placed on the Intensive Services Unit (ISU). These youth have been identified as being in need of increased supports. However, during 2014, they were not receiving education services equal to those of youth on regular housing units. Plans for the Maryland State Department of Education Juvenile Services Education division to implement a full education schedule (including six hours of teacher instruction) on the ISU should go forward.”

MSDE Response: JSE has collaborated with DJS to ensure youth residing on CYF’s ISU unit are provided with six hours of teacher-led instruction per day.

Page 25

JJMU Statement: “The Maryland State Department of Education Juvenile Services Education division (MSDE-JSE) is responsible for providing educational services at Hickey. Youth placed on the ISU do not receive the required six hours of educational instruction on a consistent basis. Teacher instruction for kids in the ISU should be for the full length of the school day at Hickey.”

MSDE Response: JSE has collaborated with DJS to ensure youth residing on Hickey's ISU unit are provided with six hours of teacher-led instruction per day.

Page 27

JJMU Statement "The Maryland State Department of Education Juvenile Services Education division provides school related services at Waxter. Currently, vocational education programming is limited to a course offering certification in basic food safety training that is offered once per marking period. Plans to add a course leading to certifications in customer service and medical coding and billing should be implemented."

MSDE Response: JSE provides a variety of career technology educational courses/classes for the students at Waxter including: ServSafe, office systems management, and C-Tech. An additional class culminating in a retail customer services certification and medical billing and coding are scheduled for deployment in the near future.

Page 32

JJMU Statement "The Maryland State Department of Education Juvenile Services Education division (MSDE-JSE) is responsible for educational and vocational instruction at WMCC. Opportunities for post-secondary educational, vocational, and work experience are currently limited. Students who have already obtained their high school diploma are forced to attend high school level classes.

Youth who qualify should have access to higher education and the option of gaining job related skills during their time in detention. The Maryland State Department of Education should include WMCC in its plan to introduce career technical education courses such as business administration and certification courses in internet and computing and in green systems technology to DJS facilities.

MSDE Response: The short length of stay within detention facilities affects the types of career technology educational courses which can be offered. Currently, JSE provides opportunities at detention sites for youth to receive instruction in office systems management and courses such as ServSafe which either provide youth with the opportunity to develop basic computer skills and or/earn industry certifications and do not require a large number of direct instructional hours. At WMCC JSE offers ServSafe and OSHA 10 in addition to Office Systems Management. JSE will explore options for implementing Green Systems at WMCC.

JMU Statement: “At MSDE-JSE schools, Individualized Education Program(s) [IEPs] are modified to reflect resource availability rather than a student's current needs. Special education staff have both administrative and teaching roles, making it difficult for them to fulfill IEP instructional mandates. MSDE-JSE should enhance resources and support services at its schools, including hiring additional staff, to meet the educational needs of its students.”

MSDE Response:

JSE does not support amending or developing student IEPs to reflect resource availability. IEPs implemented at JSE schools –whether amended or initially developed- must be individually appropriate for students with disabilities to receive special education and related services in the least restrictive environment and progress in the general curriculum. JSE implemented a process to monitor and verify that IEPs are reviewed and drafted consistent with the procedural requirements of IDEA and State law.

JSE has a comprehensive monitoring system both at the program and school level. The Special Education Coordinator’s program monitoring team regularly schedules monitoring visits to the program’s school sites throughout the year. The program monitoring team provides feedback to each school principal which includes specific information on IEP revisions/changes. Principals are required to conduct regular school-based monitoring of records and practices to ensure adherence to special education policies and procedures, including IEP revisions.

JMU Statement: “With the exception of one small program at a boys’ facility, MSDE-JSE students do not have access to post-secondary education, and options for vocational education are limited.”

MSDE Response:

JSE currently has an established post-secondary program through Garrett College. This program is housed at Backbone Youth Facility. Over the past year, the number of youth qualifying for this program has been steadily decreasing. JSE is exploring options for providing online post-secondary options for implementation as JSE’s current technology initiative is completed.

During the past year JSE completed a significant expansion and update of the Career and Technology Education (CTE) offerings in its schools in both committed and detention facilities across the state. CTE coursework is now aligned to the programs of study being offered in the Local School Systems so that students can return to their community schools with credit towards CTE graduation requirements in Business Administrative Services, Construction, and Career Research and Development. JSE also offers specific coursework to prepare youth for direct entry into the telecommunication and hospitality industries. Students can leave with the following industry certifications: ServSafe, OSHA 10, C-Tech, NCCER Construction and Office Systems Management. The Program continues to explore other career-focused options for its students.

JMU Statement: “MSDE-JSE should offer post-secondary educational opportunities for girls at MSDE-JSE schools. Vocational education programs that are available in boys' facilities, such as basic construction and job safety courses should be equally available in those serving girls.”

MSDE Response: At present, post-secondary opportunities are made available for girls on a case by case basis. JSE plans on deploying OSHA 10 at additional sites including Waxter and Carter based upon completion of training of additional teachers.

JMU Statement: “Some MSDE-JSE teachers have to teach outside of their area of certification. Teacher absences or shortages can also result in students completing worksheets on their own instead of receiving formal instruction.”

MSDE Response: JSE schools, like those in the local school systems, sometimes require teachers to provide instruction in content areas for which they do not hold an endorsement. In these instances, these teachers are provided with support from designated Highly Qualified (HQ) Lead Content Teachers. These HQ Lead Content Teachers also provide support for staff covering classes in situations of long-term absences and vacancies.

Page 41

JMU Statement: “All MSDE-JSE schools should have computers with internet access for educational purposes. Current practice is to conduct classroom instruction by living unit rather than grade level at most DJS facilities. Teachers are expected to provide instruction in multiple grade levels in a single class period. Classes should be differentiated by grade level as is common practice in the community.

MSDE Response:

JSE is currently working to install technology in all of its facilities. Smart Boards along with laptops have been installed at all sites.

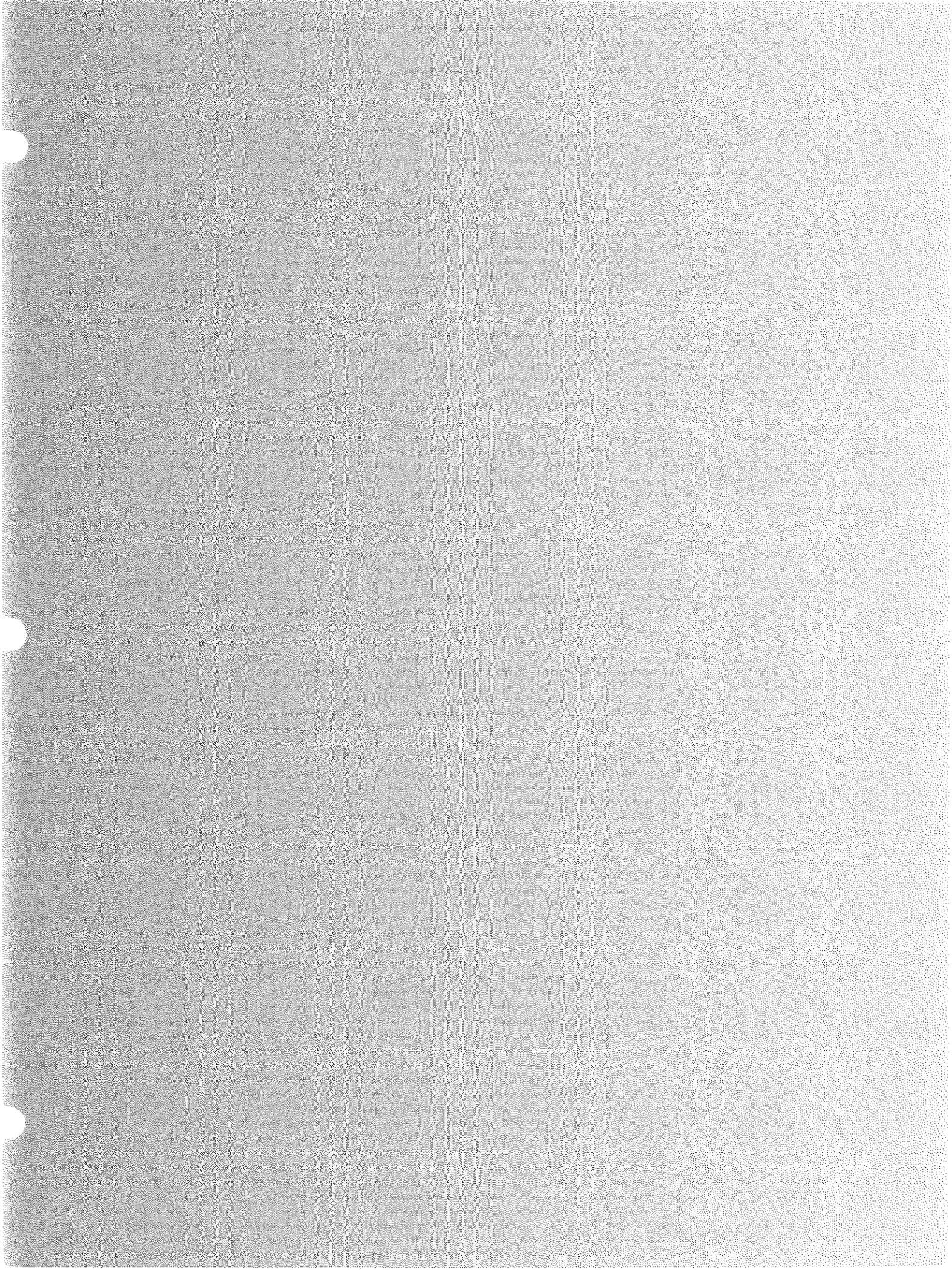
MSDE and DJS are exploring the feasibility of grouping students based upon their achievement levels. A pilot program at Victor Cullen began in January 2015.

JMU statement: “MSDE-JSE does not ensure that high school credits earned while in detention or placement are being transferred to a student's community school. Students cannot earn a high school diploma while enrolled in a MSDE-JSE school. MSDE- JSE should coordinate with community schools before and after a student is released to ensure that credits are appropriately applied toward a student's diploma. Students should have the option of earning a high school diploma while enrolled in a MSDE-JSE school.

MSDE Response:

As previously shared in MSDE's response to the JJMU's First Quarter 2014 Reports, MSDE has taken actions to promote the acceptance of credits being applied towards students' graduation requirements. Course names and content for academic and required classes have been revised to be consistent with the core subjects in the local school systems. These include: English (9-12), History (United States, Government, and World History), Math (Concepts of Algebra, Algebra I/II, Geometry, and Pre-Calculus), and Science (Biology, Physical Science, Concepts of Chemistry, and Environmental Science). Credits earned during a youth's enrollment in JSE are documented on the standardized State Record Transfer Forms. Pursuant to MSDE/DJS Transition Procedures, the reports are forwarded to the receiving school system when the youth is released from DJS custody. The receiving school is responsible for applying the credits earned in the JSE programs towards the student's graduation requirements.

The LSS is able to contact the JSE school or the Program's Coordinator for Guidance and Student Records in the event that there are questions regarding a student's credits. The JSE Coordinator for Guidance and Student Records completes quarterly audits of students' records and contacts the LSS regarding credits earned. The last audit indicated that credits earned by students enrolled in JSE were being accepted by LSSs.



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TV ACTOR HILL HARPER TRIES TO HELP BOYS IN MARYLAND JUVENILE TREATMENT

Education • Justice • Social • Top News — 13 November 2013

By **Natalie Kornicks**
Capital News Service

13 38

SABILLASVILLE — Some of the teens were there for narcotics possession, some were there for theft or assault—but all were there to hear television actor Hill Harper challenge them to become an “active architect of your own life.”

The Victor Cullen Center, the highest-security treatment center for male delinquents in Maryland, is the first juvenile center in the country that the star visited as part of a publicity tour for his fifth book, “Letters to an Incarcerated Brother: Encouragement, Hope and Healing for Inmates and Their Loved Ones.”



After Hill Harper spoke, he shook the hand of every boy, looked them in the eye and told them there are better choices to make. *Capital News Service* photo by Natalie Kornicks.

“You guys might not be able to understand what I’m talking about, but see, I expect more from you all because I can tell that you’re magnificent and that you’re brilliant.”

Harper told the teens that the first stage in the metaphor is ‘blueprinting,’ or making a plan for your life. The second stage is having a solid foundation, made up of elements like motivation, education, money and a career. The next stage is the framework, or the choices that people make, and the last and most important stage is the door, Harper said.

“Doors open and many of us have to let new people, new ideas and new information into our lives...if we’re going to be able to make the choices we need to make to go into the direction we need to go,” he said. “Doors also let people out, and I would suggest to you that the vast majority of us have people in our lives that we need to let out.”



Television star Hill Harper engaged the youth at the Victor Cullen Center by having them write down notes and asking them questions. *Capital News Service* photo by Natalie Kornicks.

Harper, who is best known for his roles as investigator Sheldon Hawkes on *CSI: NY*, and as CIA station chief Calder Michaels in the series *Covert Affairs*, is also an Ivy League graduate of Brown University and Harvard Law School.

Harper spoke to the youth about how to achieve goals and dreams by designing your life like an architect.

“This concept of being active architects of our own life is kind of an elevated concept that I want you to wrap your head around,” he said to boys between the ages of 15 and 18, sitting in plastic grey stackable chairs. “People told me coming here that

they need help.

“Most of you would rather tune me out, most of you don’t want to hear what I have to say,” Harper said.

“But there’s one of you here that’s going to do the work.”

The youth at Victor Cullen are sent to the treatment center by court order for behavioral or substance abuse issues, and all are given a specific treatment plan that typically lasts from six to nine months,

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ABOUT CAPITAL NEWS SERVICE

Capital News Service is a student-powered news organization run by the **Philip Merrill College of Journalism**. For two decades, we have provided deeply reported, award-winning coverage of important issues in Maryland. Our bureaus are

according to Eric Solomon, a spokesman for the Maryland Department of Juvenile Services.

"The treatment plan really depends on the specific issue," Solomon said. "They are all there for different reasons... and we want to find out why they are there in the first place, to figure out how to change their way of thinking."

Solomon added, "Kids that needed the most help are going to this facility. This is essentially their last stop in the state, and if they can't make it in there they are sent out of state for specific services."

Victor Cullen relies mostly on locks, bars and fences to restrict freedom instead of staff supervision. During Harper's November visit, 48 boys lived at the center.

Youths at the other 13 Maryland juvenile services facilities watched Harper via videoconference.

According to Harper, many of these young men are growing up without a positive male role model in their home.

"They desperately are looking for male role models and affection and you could see it out there," Harper said in an interview. "It's like they all want affection and role modeling and all that, but they don't have it in their house and they go and seek it out in the wrong place, in the wrong way, with the wrong people."



CSI actor Hill Harper challenged the delinquent youth to become active architects of their own lives as part of publicity tour for his newest book. Capital News Service photo by Natalie Kornicks.

Harper, whose four previous books are all best sellers, said he wrote his first book, "Letters to a Young Brother: Manifest Your Destiny" in 2006 as a response to letters he received after giving motivational talks at schools, and to provide mentorship for young men and women.

From there he wrote "Letters to a Young Sister: DEFINE Your Destiny."

His latest book was pre-released to the Victor Cullen library in mid-October so that the youth could read it before Harper's visit. After Harper spoke, each boy received a signed copy of the book, which addresses issues specific to inmates

and their families.

"I think young people gravitate to what they need, however subconscious or unarticulated, and sometimes misguided, as seen by the young population that is currently incarcerated," said Lori Kebetz, library media coordinator for Juvenile Services Education under the state's education department. "I think it is interesting that [Harper] intuited those needs... he seemed like a perfect fit in terms of message."

According to Harper, who also speaks at adult prisons, his message to juveniles is about making a plan.

Yet he said the juveniles are less receptive because "when you're still young, you think you know everything," whereas adult inmates are often more reflective about their lives.

"There's one of you here that I'm going to bump into 10, 15 years from now, you're going to walk up to me and look me in the eye, shake my hand... and tell me you made it," Harper said to the boys. "But one of you will be in [prison] blues or oranges... [and will say], 'I got your book, and I got a lot of time to read it.' It's going to be one of you, don't make it you."

based in Annapolis, College Park and Washington, D.C.

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Question 8:

Please provide a copy of the article on p. 32 titled Out of State, Out of Mind: The Hidden Lives of D.C. Youth in Residential Treatment Center, and the 2009 report filed with the City Administrator that you mention.

Out of State, Out of Mind:

The Hidden Lives of D.C. Youth in Residential Treatment Centers

*Published on June 22, 2009 on the 10th Anniversary of the U.S. Supreme
Court Decision in Olmstead v. L.C.*

(Updated August 10, 2009)

*University Legal Services, Inc.
The Protection and Advocacy Program for the District of Columbia
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Washington, D.C. 20002*

UNIVERSITY LEGAL SERVICES, INC.

Since 1996, University Legal Services, Inc. (ULS), a private, non-profit organization, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. Congress vested the P&As with the authority and responsibility to investigate allegations of abuse and neglect of individuals with disabilities. Accordingly, ULS provides administrative and legal advocacy to protect the civil rights of District residents with disabilities.

ULS staff directly serves hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach and education and group advocacy efforts. ULS staff addresses client issues relating to, among other things, abuse and neglect, community integration, accessible housing, financial exploitation, access to health care services, discharge planning, special education, and the improper use of seclusion, restraint and medication.

For more information about this report or to request additional copies, please contact:
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I. Introduction

Ten years ago, in the landmark decision Olmstead v. L.C.,¹ the Supreme Court held that unnecessary institutionalization of individuals with disabilities constitutes a form of discrimination. Despite this, at any given time, the District of Columbia pays for approximately 300 to 550 children who have been diagnosed with a mental illness to attend institutions called Residential Treatment Centers (“RTCs”), congregate institutions that tend to be far from the District, expensive, abusive, and most importantly, generally ineffective. Recently, the District published a report stating that 515 individuals under age 22 were in 96 different RTCs.² Approximately 35% of these youth were more than 300 miles from the District of Columbia.³ The District of Columbia has the second highest percentage of students age 6 to 21 in residential facilities. The only state with a higher percentage of students in RTCs is South Dakota.⁴

There is a professional and legal consensus that youth need and are entitled to treatment in the least restrictive environment appropriate for their needs, and that policies that promote unnecessary institutionalization are both illegal and detrimental to youth. As Justice Ruth Bader Ginsburg explained in Olmstead v. L.C., unnecessary institutionalization is harmful in two ways:

“First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. . . . Second, confinement in an institution severely diminishes the everyday life activities of

¹ 527 U.S. 581 (1999).

² February 2009 report from City Administrator’s Office. On file with author.

³ June 2008 report from City Administrator’s Office. On file with author.

⁴ Based on the number of youth served under the Individuals with Disabilities Act in residential treatment centers. U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), OMB #1820-0517: Part B, Individuals with Disabilities Education Act, Implementation of FAPE Requirements, 2007. Data updated as of July 15, 2008. Available at <https://www.ideadata.org/default.asp>.

individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.⁵

In light of this, the trend in most states has been to reduce or eliminate the use of RTCs.

However, in the District, the population of youth in these RTCs has stayed relatively steady for years.

On the tenth anniversary of Olmstead, children, youth, and families in the District deserve an open and frank discussion about the District's use of RTCs, their benefits and risks, their efficacy, and their cost. There is little public discourse, however, about who the children in RTCs are, how they ended up in RTCs, what life is like in an RTC, and what they need to return home. This information is not readily available for a number of reasons. First, these children are scattered across the country, out of the public's eye. Second, at least five different District of Columbia agencies have some sort of jurisdiction over these placements, making the regulatory scheme fragmented and the oversight poor. Last, the individuals and agencies that control the placement decisions often have financial, institutional, and personal incentives to promote RTC placements, externalizing the true cost of these placements.

In November 2007 and April 2008, University Legal Services (ULS) requested information, via the District of Columbia Freedom of Information Act (FOIA), from agencies that send youth to RTCs, monitor the well-being and treatment of youth in RTCs, and fund RTC placements. ULS requested copies of censuses, monitoring reports, investigations, and spending related to RTCs from the Department of Youth Rehabilitation Services, the Department of Mental Health, the Department of Health Care Finance (then part of the Department of Health), the District of Columbia Public Schools, and the Child and Family Services Agency. While ULS

⁵ Olmstead v. L.C., 527 U.S. 581, 600 (1999).

sought this information, the District of Columbia Office of the City Administrator began tracking placements in RTCs, and publishing monthly analysis. The FOIA responses, the City Administrator's reports, testimony provided at City Council Oversight hearings, and ULS' experience from years of representing youth in RTCs, form the basis of this report.

The report is divided into five sections:

- Section I: Introduction
- Section II: Life in an RTC
- Section III: The Cost of an RTC
- Section IV: The Path to an RTC
- Section V: Alternatives and Recommendations
- Sections VI: Conclusion

The intent of the report is not to give a complete statistical or fiscal analysis of youth in RTCs. At this point that is not possible, due the paucity of information on certain subjects, and conflicting information regarding others.⁶ The hope is that by highlighting what we do and do not know, we can encourage a real dialogue in this city about the District's overreliance on institutions, and offer some recommendations that may help the District start to reform its institutional bias.

II. Life in an RTC

RTCs isolate youth from their families and homes, place youth at risk of abuse, subject youth to dangerous restraint and seclusion practices, and often fail to improve long term outcomes. Because most RTCs the District uses are geographically isolated, unannounced or frequent visits are almost impossible. Youth at RTCs often lack privacy to make telephone calls

⁶ This lack of data is not unique to the District. A recent report by the Government Accountability Office (GAO) noted that most states have serious gaps in their oversight of youth in residential programs, making it difficult to report on abuse and neglect accurately: "Youth in some government and private residential facilities have experienced maltreatment including physical abuse, neglect or deprivation of necessities, and sexual abuse that sometimes resulted in death or hospitalization, but data limitations hinder efforts to quantify the problem." GAO, Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges, May 2008, GAO-08-346, at 3.

or write letters, and therefore communication with these children is additionally limited, particularly if the youth is afraid of retaliation. Although gathering information can be challenging, and the 96 different RTCs the District uses vary, some generalizations may be made.

A. Basic Demographics of District Youth at RTCs

The vast majority of youth in RTCs are between the ages of 15 to 18, accounting for 71% of the total RTC population. There are approximately 150 youth in RTCs that are committed to the District's juvenile justice system, the Department of Youth Rehabilitation Services (DYRS).⁷ Another 135 or so are in the state's custody through the child welfare system, the Child and Family Services Agency (CFSA). More than 70% are receiving special education services.⁸

The District places youth in a total of 96 different RTCs.⁹ Most of these placements are extremely far from home – approximately 35% of these youth are more than 300 miles from the District of Columbia, and more than 50% of the total youth in RTCs are more than 100 miles from D.C.¹⁰ Not only are the RTCs far away, but they tend to be long term placements. At the

⁷ According to the June 2008 report by the Office of the City Administrator, there were approximately 160 youth in residential treatment. According to the March 11, 2009 DYRS performance oversight written testimony, as of that date, there were 110 youth in RTCs. Most recently, DYRS provided data that states that as currently there are 153 youth in RTCs. All of these were "point in time" measurements—that is, a count of the number of children in RTCs on a particular day. DYRS data on file with author.

⁸ February 2009 report from City Administrator's Office. On file with author.

⁹ Id.

¹⁰ See June 2008 Report from City Administrator's Office. On file with author. The City Administrator does not count distance from the District, but rather whether the RTC is in Maryland, Virginia, or D.C. It may be more appropriate to measure distance from D.C., or whether the RTC is accessible through public transit. Many areas of Virginia and Maryland are more than a 100 miles away. For example, the Pines, which had 21 youth from D.C. in February 2009, is located in Virginia, but is almost 200 miles from the District.

beginning of FY 2006, the majority of District youth in RTCs had been in their current RTC for more than eight months. Some had been in RTCs for up to eight years.¹¹

B. Residential Treatment Centers are Isolating, Abusive, and Dangerous.

RTCs tend to isolate youth, even when they are in the midst of a city, because their structure inherently separates children from their natural support systems, including parents, extended family, friends, schools, religious institutions, and community-based case workers. The child spends most of his or her day around paid staff and other children with disabilities. School is often part of the RTC. Visiting hours and telephone calls are usually limited. Many times, parents and other caretakers are not included in the child's day-to-day life, making meaningful family involvement during a child's stay all but impossible.

This isolation severely impedes youths' clinical treatment and their quality of life. The isolation that comes from being in an institution cannot be overstated. As the Supreme Court explained, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."¹²

For obvious reasons, isolation can be counter-productive. For example, if a youth with behavior issues interacts only with other youth with behavior problems, the children will lack positive role models. Isolation can also lead to a lack of "generalization." That is, the skills learned in an RTC often do not transfer to life outside of an RTC because the environments are so different. Isolation also makes children, particularly ones with mental health and other cognitive issues, extremely vulnerable to abuse.

¹¹ FOIA'd documents from CFSA, DMH, DYRS, HSCSN and DCPS, requested April 2007. On file with author.

¹² Olmstead v. L.C., 527 U.S. 581, 601 (1999).

Abuse at RTCs is a serious concern. As the protection and advocacy program for individuals with disabilities for the District of Columbia, ULS has received complaints of beatings and choking, isolation in seclusion rooms for days at a time, excessive and dangerous use of physical and chemical restraints, overmedication with serious psychotropic medications that cause many side-effects, denial of the opportunities to go outdoors for months at a time, unsanitary conditions, insufficient heating and cooling, and denial of access to lawyers and outside advocates. Such abuses are counter-therapeutic and, at worst, lethal: deaths due to restraint have occurred at some of the same facilities where District children either currently reside or have resided in the last five years.¹³

RTCs may also overuse restraint and seclusion. For example, in September 2007, the Pennsylvania Department of Public Welfare sent a letter to CFSA stating its concerns about youth sustaining serious injuries from restraints at an RTC called Kidspace. CFSA interviewed seven of the eight CFSA youth at the program and found that the records show that for these eight youth, Kidspace used 214 physical restraints and 37 chemical restraints in one year.

RTCs use restraint and seclusion as a form of punishment or a threat. Youth often complain about this, but may have difficulty proving it because usually the only evidence that restraint or seclusion was misused is the youth's own statement. On one occasion, however,

¹³ Editorial, Unanswered Questions, Baltimore Sun., March 7, 2007 (restraint-related death of 17 year-old at Bowling Brook); Barbara White Stock, In Harm's Way: Use of Physical Force on Troublesome Kids Unchecked," Pittsburgh Post-Gazette, September 20, 2005 (In 1998, "14-year-old Mark Draheim died after being restrained by three workers at KidsPeace, a residential treatment facility. Held down on his stomach, his hands behind his back, the 125-pound boy protested that he couldn't breathe. "); Terry Bitman, Bidding Ending at Bancroft, Philadelphia Inquirer, August 22, 2005 (2002 restraint related death of 14 year old child at NJ facility); Una Marshall and Russell Lieux, individually and as co-personal representatives of the estate of Michael Lieux, deceased v. Florida Institute for Neurologic Rehabilitation, Inc., Fla. Jury Verdict Rep. No. 05:10-23 (October 2005) (describing \$5,000,000 jury verdict against Florida Institute for Neurologic Rehabilitation (FINR) for a 1998 homicide through positional asphyxiation. Michael Lieux was restrained eight times in four hours on the day before his death. FINR is an institution where 10 District of Columbia youth in CFSA's custody were placed as of October 2006.).

ULS received a recording of an RTC employee threatening a child with seclusion in order to make him or her behave. The staff person said:

Let me tell you something, man. After I'm done doing medication [inaudible] ... and you act out, you're going to end up on seclusion, man. . . . Because you testing limits with me, you're not following no directions, you're just running around like you want to. But I'm just letting you do what you want to do so they can see on camera that you not following no rules in here. None. Then I can justify putting you in that seclusion room.¹⁴

The staff used seclusion as a threat and a form of punishment, instead of de-escalation techniques or interventions to get the child to stop doing what he or she was doing, thereby encouraging the youth to continue acting out so the staff could “justify” seclusion. See Joint Commission, Standards for Behavioral Healthcare PC.12.60 (“The organization does not permit restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.”).

Furthermore, no matter how well the use of restraint is regulated, and even when all staff are following protocol, restraints still carry inherent risks.¹⁵ While RTCs are permitted to use restraints in certain circumstances, the use of restraints could be eliminated if the District set this as a priority. Public state hospitals, such as the Allentown State Hospital, now operate restraint and seclusion free.¹⁶

¹⁴ On Friday, November 3, 2006, at approximately 6:10 p.m., a voicemail recording was left for a ULS staff member where apparently someone left the phone off of the hook on one of the units at Riverside Residential Treatment Center, a District of Columbia RTC that closed around January 2008. Transcription on file with author.

¹⁵ See generally Weiss EM, et al. Deadly restraint: A Five Part Series. Hartford Courant 1998; October 11 – 15; Protection and Advocacy Inc., The Lethal Hazards of Prone Restraint: Positional Asphyxiation, April 2002, available at <http://www.pai-ca.org/pubs/701801.pdf>.

¹⁵ New York State Commission on Quality of Care, In the Matter of Neil Larkin: A Case Study on Restraint, Traumatic Asphyxia and Investigations, available at http://www.cqc.state.ny.us/could_this_happen/caseneillarkin.htm.

¹⁶ <http://www.dpw.state.pa.us/PartnersProviders/MentalHealthSubstanceAbuse/StateHospitals/003670147.htm>.

C. Residential Treatment Centers are not an Evidence-Based Practice

Research does not support the efficacy of RTCs. According to the Surgeon General, theories justifying admissions to RTCs are often based on faulty presumptions: “In the past, admission to an RTC has been justified on the basis of community protection, child protection, and benefits of residential treatment per se. However, none of these justifications have stood up to research scrutiny.”¹⁷ The Surgeon General has noted that “there is only weak evidence for their effectiveness,” as much of the evidence regarding outcomes comes from research published in the 1970s and 1980s, and most of these were uncontrolled studies.¹⁸

III. The Cost of RTCs

RTCs are one of the most costly mental health services provided to District youth. RTCs cost \$250 a day per child (not including the cost of the school, which is often paid for separately by DCPS and completely out of local funds). Recently, the District proposed a rule to increase the rate of RTC reimbursement to \$300 a day.¹⁹ Because Medicaid funds such placements, the District is responsible for approximately 30% of this cost, and receives federal funding for the remaining costs. For RTCs that are not funded by Medicaid, the cost can be considerably more, and the District is responsible for 100% of this funding.²⁰

¹⁷ United States Department of Health & Human Services, *Mental Health: A Report of the Surgeon General*, 1999, Chapter 3, available at: www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter3.

¹⁸ In contrast, evidence supports the efficacy of certain community based interventions, such as Multi-systemic therapy. See generally Ashli J. Sheidow, et al., Treatment Costs for Youths Receiving Multisystemic Therapy or Hospitalization After Psychiatric Crisis 55 *Psychiatric Services* 548 (May 2004).

¹⁹ D.C.R. vol. 55, no. 47 at 012049. November 21, 2008.

²⁰ Calculating the true financial cost of RTC placements is extremely difficult. According to the City Administrator, the District spends approximately \$61 million per year on RTCs in local and federal funds. It is unclear exactly how these costs are divided between local funds and federal funds. Psychiatric Residential Treatment Facilities (PRTFs) are a type of RTC, and they are the only type of RTC that Medicaid will pay for. To further complicate matters, only approximately 60% of the 96 RTCs that the District uses are PRTFs, and so 40% are paid completely with local funds. Finally, many RTCs bill separately for school, which is paid for directly out of DCPS’ budget, using local

The District's overreliance on RTC placements also indirectly costs money. For example, at least two class action lawsuits govern RTC placements, and the District's continued noncompliance with the court orders in these cases is costly. While the current administration has publicly stated that it wants to bring both cases to their conclusions, litigation is likely to continue as long as the District's overreliance on institutional placements remains unaddressed.

Pursuant to the LaShawn A. v. Fenty Amended Implementation Plan, a judicially enforceable plan governing the implementation of child welfare reform in the District, "no more than 82 children shall be placed more than 100 miles from the District of Columbia."²¹ From the information CFSA provided, it is not possible to determine exactly how many of the 137 children in placements were more than 100 miles from the District, but it is clear that CFSA was at least near the maximum number of children allowed at LaShawn A. More importantly, LaShawn A. guarantees children the right to be placed in the least restrictive, most family-like setting appropriate to his or her needs.²² The District's continued use of residential treatment centers makes it impossible for the District to meet this mandate, thus prolonging the LaShawn A. litigation and its attendant costs.

Similarly, under the exit criteria in Dixon v. Fenty, the class action lawsuit governing the delivery of mental health services, 85% of children and youth served must be in their own home or a family-like setting.²³ Furthermore, the entire mental health system for children must be

funding. Therefore, while it is safe to say that a tremendous amount of money is spent on RTCs, at this point there is no existing analysis stating exactly how much local tax dollars are spent on RTCs.

²¹ Available at

http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/Dixon_Criteria_4/Dixon_2008_Report.pdf.

²² Id.

²³ According to the Dixon Court Monitor's January 2009 report, approximately 94% of the children and youth served are served in their own home or a surrogate's home, but the penetration rate is only 1.74%. The penetration

found to be at an 80% acceptability rating for youth reviewed through the Community Service Review process. In last year's report, the District earned only a 36% acceptability rating. This general failure of the local children's mental health system is a driving force behind RTC placements. As the 2008 Community Service Review report noted, areas that stakeholders found were "in critical need of addressing" included delays in being able to timely access community-based services such as Multi-systemic Treatment, and that CFSA reported that "they frequently cannot get the right services for their kids when they need the services and with the quality that is necessary to be effective." Until the District fixes these problems, RTCs will continue to be used as a stop-gap solution in a system where youth cannot obtain high quality services in a timely manner.

IV. The Path to an RTC Placement

Given that RTCs are expensive and difficult to regulate, and there is relatively little evidence that they are effective, why does the District continue to rely on them so heavily? Unfortunately, there is not one simple answer. Almost all youth at RTCs are deeply involved with one or more public agency. Most children pass through one of four cabinet-level departments: the Department of Youth Services, the Child and Family Services Agency, the District of Columbia Public Schools, and the Department of Health Care Finance, which in turn subcontracts to Managed Care organizations. The ways in which each of these agencies fund and facilitate RTC placements is discussed below.

A. Department of Youth Rehabilitation Services

Of the 720 youth committed to DYRS' custody,²⁴ DYRS sends approximately 150 at any time to RTCs.²⁵ That is, approximately 20% of DYRS-committed youth are sent to RTCs, or two to three times the population of youth committed to New Beginnings (the District's new secure facility for youth committed to DYRS custody). While advocates, courts, and the media have rightly focused on conditions at Oak Hill (the predecessor of New Beginnings) for more than 20 years,²⁶ youth who are committed to DYRS are more likely to be sent to an RTC than they are to go to New Beginnings.

Youth committed to DYRS are placed in RTCs at DYRS' discretion. A judge commits youth to the care of DYRS, and in turn, the agency determines the most appropriate placement. Judges exert indirect pressure on placement. For example, DYRS must submit a proposed plan of care describing what will happen to a youth if committed, and a judge can stretch out the commitment process if he or she does not agree with the plan. Furthermore, even though the majority of youth involved with DYRS are not a danger to the public, when small numbers of youth commit serious, violent crimes – or worse yet, are hurt or killed – public, politicians, and the Attorney General's office often exert intense pressure for more secure settings for all youth.²⁷

Additionally, once a decision has been made to send a youth to a secure setting, DYRS has a financial incentive to use RTCs instead of their own juvenile correctional facilities. A placement at an RTC costs about the same as a placement at a long-term juvenile correctional facility, but Medicaid generally pays 70% of the placement at a RTC. Therefore, during times of

²⁴ As of March 2009, written responses provided by DYRS to FY 2009 Performance oversight hearing, March 11, 2009. On file with author.

²⁵ As of February 2009, *supra*, n. 6.

²⁶ See generally *District of Columbia v. Jerry M.*, 571 A.2d 178 (D.C. Feb 12, 1990), describing history of case.

²⁷ Colby King, *Hidden Details in a Teen's Death*, Washington Post, May 9, 2009 at A15.

financial constraint, trans-institutionalization becomes a real danger, as it becomes increasingly tempting to divert youth who may have been the type of youth sent to a correctional facility in the past, and place those youth in RTCs.

B. Child and Family Services Agency

The District's Child and Family Services Agency (CFSA) sends almost as many youth to RTCs as DYRS. Youth in CFSA's care have been taken away from their families and are in the District's custody. Their parent's rights may or may not have been terminated, and the family may be working towards reunification or the child may be awaiting adoption. As of April 2007, CFSA had 137 children in RTCs. This comports with the data from the City Administrator's Office, reporting that as of February 2009, approximately 135 youth in CFSA's custody were in RTCs.

Children in foster care enter RTCs three ways. CFSA may decide to place them directly, through the Office of Clinical Practice. Until approximately five years ago, all CFSA youth entered RTCs this way. Once the Department of Mental Health became a cabinet-level department, however, the system changed. Now, if the RTC is a Medicaid-funded facility, youth generally enter through a "system of care" meeting that is held in conjunction with DMH. Ideally, this is a meeting where the youth and his or her relatives, service providers, and agency employees meet and decide whether the youth should go to an RTC or whether other interventions should be tried. Last, at times the judge involved in the youth abuse and neglect proceeding will order a residential placement, either on his or her own initiative or based on the urging of a party.

C. District of Columbia Public Schools

Youth that end up in an RTC through the school system generally do so through the special education system. Either a team of individuals that is responsible for determining what environment is least restrictive²⁸ determines that a residential placement is necessary in order for that child to make adequate educational progress, or a hearing officer decides that an RTC is necessary in order to provide the child with a Free and Appropriate Public Education (or to compensate for a previous failure to provide a Free and Appropriate Public Education). Under either scenario, these placements are voluntary, to the extent that the child stays in the family's custody, and the parents maintain the authority to withdraw the child from the RTC.

It is often assumed that Hearing Officer orders fuel RTC placements, and therefore placement decisions are not in DCPS' discretion. In fact, it appears that a rather small percent are ordered to RTCs by hearing officers. In June 2008, the City Administrator found that approximately 70 youth (or 14% of the total RTC population) were sent to RTCs through DCPS, without the involvement of any other agency. Strikingly, only approximately 5% of the total RTC population was ordered there from a Hearing Officer decision.

This does not mean that advocates and attorneys are not the driving force behind RTC placements, but if the data the City Administrator based his report on is correct, this suggests that the school system, through the special education process, is consenting to a majority of the placements. One of the District's basic requirements under the Individuals with Disabilities Act requirement is to ensure "to the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with

²⁸ 20 U.S.C. § 1412(a)(5) (Individuals with Disabilities Education Act).

children who are not disabled.”²⁹ The District cannot meet this requirement while consenting to such large numbers of RTC placements.

D. Medicaid Managed Care

In the District, youth remaining out of state custody tend to be enrolled in a Medicaid managed care program (in contrast to fee-for-service Medicaid, which is most often used for youth in CFSA or DYRS custody). Managed care can be roughly divided into two categories: regular managed care and health services for children with special needs. As many have already discussed, the organization of the District’s Medicaid managed care system has created serious fragmentation and impeded quality service delivery.³⁰ Similarly, this fragmentation makes it particularly difficult to track and assess the status of youth in RTCs.

1. Regular Managed Care

Information regarding how many District youth were sent to RTCs through a managed care organization (MCO) is not available. MCOs are required to pay for one full month (up to 60 days) of RTC treatment. After that, MCOs may switch residents to fee-for-service Medicaid. This means that the MCO is no longer responsible for funding the placement, and bills are processed directly through the Department of Health Care Finance (DHCF) (the District’s Medicaid Agency). Prior to January 2009, no single government agency tracked the admission or discharge of these youth to RTCs. Starting January 2009, the Department of Mental Health

²⁹ Id.

³⁰ See generally Towards a True System of Care by District of Columbia Behavioral Health Association Part 1 of 2 February 2009, on file with author; Human Systems and Outcomes, Inc., 2008 Report on Children and Youth Served by the District of Columbia Department of Mental Health, May 2008, available at http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/Dixon_Criteria_4/Dixon_2008_Report.pdf

(DMH) and DHCF agreed to require MCOs to produce information about RTC placements, and DMH agreed to begin tracking and monitoring these placements.³¹

2. Health Services for Children with Special Needs (HSCSN)

HSCSN is a Medicaid-funded managed care organization for D.C. residents under age 24 who are receiving Supplemental Security Income (SSI) disability benefits or have an SSI-related disability as defined by the D.C. Department of Health Care Finance. This means that HSCSN tends to serve the youth with the greatest medical needs in the District. To compensate for this, instead of receiving a capitated rate for services, HSCSN is able to bill directly for what youth use.

Children and youth enrolled in HSCSN enter RTCs differently than any other children in the District. HSCSN, like other managed care organizations, makes the initial determination of whether or not it will fund the RTC. Unlike the other MCOs, HSCSN retains responsibility for funding the placement throughout the youth's stay at the RTC; entering an RTC does not cause a child to switch to fee-for-service Medicaid. Compared to other funding and/or sending agencies, HSCSN only accounts for a small number of youth in RTCs at any one time. According to information from the FOIA requests, HSCSN funded only approximately 10 youth in RTCs in April 2007.

E. Multiple Agency Involved Youth

Last, youth may have funding from multiple agencies. For example, the school system may be responsible for sending the child, but if the child is eligible for Medicaid, the school system may only pay for the educational portion and room and board for the child, and Medicaid

³¹ Memorandum of Understanding Between the undersigned District of Columbia Agencies: The Department of Health Care Finance (DHCF) and the Department of Mental Health (DMH) For Implementation of DHCF's Solicitation Number DCHC-2007-R-5050. On file with author.

may pay for treatment. This creates a system rife with miscommunication and confusion. As the D.C. Behavioral Health Association recently commented: “The District’s current model of delivering behavioral health services to children adds up to a fragmented system, with duplication of services and efforts. It is a model that is simultaneously costly and difficult to access.”³² Fragmented funding leads to a lack of coordination among agencies, delays in discharge, gaps in monitoring, and a general lack of accountability. “There is currently no interagency system in place for the communication of patient records and evolving needs to case managers.”³³

V. Alternatives and Recommendations

There is little evidence that RTCs work. Furthermore, unnecessary use of RTCs constitutes a form of segregation. RTCs isolate youth from their families and place them at risk of abuse. Despite this, the District still has approximately 500 youth in RTCs across the nation, and the number does not appear to be decreasing. In light of this, ULS offers the following suggestions to help the District fulfill the mandate and promise of Olmstead:

A. Reinvest in Community-Based Services

To erase the institutional bias youth face when seeking mental health services are, the District must commit to investing in quality local services on more than a pilot or trial basis. Some have suggested solving the problem of distant RTC placements by building a local RTC in the District. A local RTC would not, however, remedy the problem. A local RTC would have many of the same issues as a distant one: it would still be a model of treatment that is not

³² Towards a True System of Care by District of Columbia Behavioral Health Association Part 1 of 2 February 2009, pg. 13.

³³ Id. at 12.

evidence based, it would still subject youth to seclusion and restraint and put them at risk for abuse, and it would still be costly. Investing in evidence-based community services is a long-term solution.

1. Provide Therapeutic Foster Care

Therapeutic foster care is an intensive intervention designed to let a foster parent be the primary agent for interventions with the child, but also gives the foster parent intensive, 24-hour support, training and guidance. It is usually paired with an array of therapeutic services from traditional mental health providers, and is marked by frequent contact with the therapeutic foster care provider. A therapeutic foster parent is paid more than a regular foster parent, and in turn a greater time commitment and skill level is expected.

The District of Columbia lacks true therapeutic foster care. The District has a Medicaid billing code called “therapeutic foster care,” which allows the District to reimburse therapeutic foster parents a per diem rate (approximately \$60 per day) in addition to what they are paid by the child welfare system. However, families do not receive the extensive pre-service training and in-service supervision and support that are a hallmark of successful therapeutic foster care programs.³⁴ Many families acting as therapeutic foster parents quickly find themselves overwhelmed when they need to provide support to a child with significant needs. Furthermore, this service is only available to youth in the foster care system and the juvenile justice system, while it is a service that any child experiencing a disruption in his or her home could benefit from. This creates a perverse incentive for youth to be placed in state custody in order to receive

³⁴ For a description of characteristics of therapeutic foster care, see generally Surgeon General report, available at http://mentalhealth.samhsa.gov/features/SurgeonGeneralReport/chapter3/sec7__1.asp

services. Parents may be faced with the choice of sending their child to a distant RTC that District Medicaid is willing to fund, or relinquishing their child to CFSA so that he or she can get funding to go to a local therapeutic foster home placement. Such choices are unconscionable, but are the real and direct result of the District's failure to fund sufficient high-quality community-based services.

2. Create Flexible Funding for Wrap Initiatives

Jurisdictions that have successfully transitioned youth from RTCs to the community have done so by creating funding mechanisms for mental health care that allow youth to access mental health care in their community. Jurisdictions must plan creatively and carefully for this because there is no simple federal mechanism to divert money that would be spent in RTCs back into the community. For example, federal Medicaid law does not include RTCs as one of the types of institutions that a state can create a 1915(c) (home and community based) waiver for. That is, under Medicaid law, no mechanism would allow the District to create a program exactly like the programs we have for adults with developmental disabilities, or for adults who have a nursing home level of care.³⁵ However, the District could make changes that would increase flexibility in funding and provide more services to youth in the community.

The District could designate a flexible funding pool, much like the District currently does through the D.C. City Wide Wrap Pilot, a program that currently has an enrollment of approximately 15 youth deemed to be at risk of RTC placement. With this program, each agency

³⁵ As part of the Deficit Reduction Act of 2005, the federal government created a demonstration grant program for Community-based Alternatives to Psychiatric Residential Treatment Facilities, allowing 10 states to divert money that would have been spent in RTCs to the community. However, the District did not apply for this grant. For more information, see generally National Evaluation of Medicaid Demonstration: Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities: Implementation Status Report as of October 1, 2008. Available at http://www.cms.hhs.gov/DeficitReductionAct/20_PRTF.asp.

dedicates a certain lump sum per child, and those funds are blended together to make a pool of local dollars to support the youth in the program. The project is designed to utilize Medicaid funds first, but also empowers frontline employees to use flexible local funding, when necessary, to purchase services or items that the child needs but are not covered by Medicaid. For example, if a child is very motivated by taking boxing lessons, and this helps him or her concentrate in school and reduces the traditional therapeutic interventions he or she needs, the fund could pay for that. This allows the individuals who know the child best to control the purse strings, and allows for non-traditional services to be purchased, in much the same way that a waiver might, without delay.

B. Vest Control and Oversight Responsibility for RTCs with a Single Agency

Too many government agencies currently fund and monitor RTC placements. Admission standards are haphazard and oversight is fragmented. Four different agencies control placement decisions. Each agency responds to its own financial and political incentives and pressures when making placement decisions. However, RTCs are extremely restrictive mental health placements. They should never be used unless absolutely medically necessary. They should not be used because a child needs a place to live, because an agency wants to draw down federal Medicaid dollars, because a social worker is overworked and poorly supported, or because the District has failed to invest in alternative services that would be more appropriate.

The Department of Mental Health should be the only department that has the authority to authorize residential treatment, should be the single entity responsible for monitoring youth in RTCs, and should be responsible for ensuring appropriate discharge.³⁶ Under District law, the

³⁶ DMH is already doing some of this, and there is currently a proposal to the Subcommittee on Residential Placements of the Mayor's Interagency Collaboration and Services Integration Commission (ICSIC) to have DMH

Department of Mental Health has the authority to “[a]rrange for all authorized, publicly funded mental health services and mental health supports for the residents of the District, whether operated directly by, or through contract with, the Department except that DYRS shall be responsible for the provision of mental health services for youth in custody in DYRS secure facilities.”³⁷ The only two DYRS secure facilities are New Beginnings and Youth Services Center. Outside of this, all arrangements for mental health services should go through DMH and be provided by a DMH contractor or directly by DMH.

Vesting control of RTC placements and RTC oversight with DMH would comply with District law, would streamline guidelines to ensure that all placements are medically necessary, and help guard against unnecessary placements. It would also add accountability to the system, especially for youth placed in RTCs through the school system or by their parents, and would help prevent unreasonably long lengths of stay.

VI. Conclusion

On this tenth anniversary of Olmstead, the District should reflect on its unfulfilled promises and obligations to its youth, and take a moment to assess the cost of this failure, both in dollars and in children’s and families’ lives. The District can no longer afford to invest in non-evidence based, isolated, and costly institutions. More importantly, the residents of this city deserve better—they deserve a community where youth have access to services near their homes so that their children are not sent away to distant institutions. They deserve a frank discussion about the type of mental health programs that the District is investing in, whether those programs

review all PRTF placements and to implement standardized admission criteria. However, as the publication of the report, this remains a proposal and standardized admission criteria have not been implemented.

³⁷ D.C. Code § 7-1131.04

are what youth actually need and what families want, and the alternatives they are entitled to under the law.

Question 11.

Please provide some detail regarding the source of the projected volumes in Table 2, statistical projections. Estimate the number of referrals that Seasons anticipates from each referral source identified in your response to standard 10.24.07 G(3)(a) Need.

Diagnostic and Assessment Unit				
Referral Source/Funder	2018	2019	2020	2021
MD MHA	15%	16%	16%	15%
MD DJS	17%	18%	15%	15%
MD DHR	0	0	0	0%
MD DOE	0	0	1%	0%
DC Dept of Behavioral Health	20%	18%	15%	16%
DC Dept of Youth Rehabilitative Svcs	25%	21%	19%	19%
DC Child and Family Services	10%	12%	15%	15%
WV DHHR	5%	5%	8%	8%
Virginia DJS	5%	5%	5%	5%
TriCare (Military dependents)	2%	3%	3%	4%
Self Pay/Third Party/Commercial Insurance	1%	2%	3%	3%
Total	100%	100%	100%	100%
PRTF: Males Adolescents				

Diagnostic and Assessment Unit				
Referral Source/Funder	2018	2019	2020	2021
Referral Source/Funder	2018	2019	2020	2021
MD MHA	15%	18%	18%	16%
MD DJS	17%	19%	20%	16%
MD DHR	0	0	0	0%
MD DOE	0	0	1%	1%
DC Dept of Behavioral Health	20%	16%	16%	18%
DC Dept of Youth Rehabilitative Svcs	25%	20%	18%	18%
DC Child and Family Services	10%	12%	8%	9%
WV DHHR	5%	5%	8%	8%
Virginia DJS	5%	5%	5%	5%
TriCare (Military dependents)	2%	3%	3%	4%
Self Pay/Third Party/Commercial Insurance	1%	2%	3%	5%
Total	100%	100%	100%	100%
PRTE: Female Adolescent				
Referral Source/Funder	2018	2019	2020	2021
MD MHA	12%	11%	11%	14%
MD DJS	9%	11%	12%	11%
MD DHR	0	0	0	0%
MD DOE	0	0	1%	1%
DC Dept of Behavioral Health	12%	18%	16%	18%
DC Dept of Youth Rehabilitative Svcs	25%	20%	18%	18%
DC Child and Family Services	12%	12%	12%	9%
WV DHHR	12%	7%	10%	10%
Virginia DJS	8%	9%	9%	9%
TriCare (Military dependents)	5%	6%	6%	5%
Self Pay/Third Party/Commercial Insurance	5%	6%	5%	5%
Total	100%	100%	100%	100%
Adult Male Unit				

Diagnostic and Assessment Unit				
Referral Source/Funder	2018	2019	2020	2021
Referral Source/Funder	2018	2019	2020	2021
MD MHA	10%	12%	15%	16%
MD DJS	15%	17%	19%	22%
MD DHR	0	0	0	0%
MD DOE	0	0	0%	0%
DC Dept of Behavioral Health	15%	18%	16%	14%
DC Dept of Youth Rehabilitative Svcs	18%	19%	19%	17%
DC Child and Family Services	10%	8%	8%	8%
WV DHHR	8%	7%	6%	5%
Virginia DJS	8%	9%	8%	9%
TriCare (Military dependents)	5%	6%	4%	4%
Self Pay/Third Party/Commercial Insurance	5%	4%	5%	5%
Total	94%	100%	100%	100%
Day School				
Referral Source/Funder	2018	2019	2020	2021
MD DOE	65%	65%	68%	79%
DC DOE	25%	25%	25%	25%
VA DOE	10%	10%	10%	10%

Question 12:

Please provide the audited financial statements for Strategic Behavioral Health, LLC for the year ending December 31, 2014.

**STRATEGIC BEHAVIORAL HEALTH, LLC
AND SUBSIDIARIES**

Memphis, Tennessee

**Consolidated Financial Statements –
Modified Cash Basis**
Years Ended December 31, 2014 and 2013

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INDEPENDENT AUDITOR'S REPORT

Members
Strategic Behavioral Health, LLC
Memphis, Tennessee

Report on the Consolidated Financial Statements – Modified Cash Basis

We have audited the accompanying consolidated financial statements of Strategic Behavioral Health, LLC and Subsidiaries (the "Company"), which comprise the consolidated statements of assets, liabilities and members' equity on a modified cash basis as of December 31, 2014 and 2013, and the consolidated statements of revenues and expenses, changes in members' equity and cash flows on a modified cash basis for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements – Modified Cash Basis

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with the modified cash basis of accounting described in Note 1; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the consolidated financial statements in the circumstances. Management is also responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of the consolidated financial statements on a modified cash basis that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk

assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

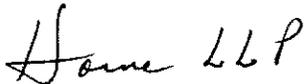
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the assets, liabilities and members' equity of the Company as of December 31, 2014 and 2013, and its revenues and expenses, changes in members' equity and cash flows for the years then ended in accordance with the modified cash basis of accounting described in Note 1.

Basis of Accounting

We draw attention to Note 1 of the consolidated financial statements, which describes the basis of accounting. The consolidated financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinions are not modified with respect to this matter.

A handwritten signature in cursive script that reads "Home LLP".

Memphis, Tennessee
May 8, 2015

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Assets, Liabilities and Members' Equity -
Modified Cash Basis
December 31, 2014 and 2013

	2014	2013
ASSETS		
Current assets		
Cash and cash equivalents	\$ -	\$ 2,271,076
Patient accounts receivable, net of allowance for doubtful accounts of \$908,652 at 2014 and \$2,544,167 at 2013	14,677,544	13,593,272
Due from third-party payors	776,604	215,868
Inventories	102,971	86,741
Prepaid expenses	1,376,727	1,221,325
Total current assets	<u>16,933,846</u>	<u>17,388,282</u>
Property and equipment	94,518,057	73,426,065
Less accumulated depreciation	(7,555,502)	(4,331,553)
Property and equipment, net	<u>86,962,555</u>	<u>69,094,512</u>
Goodwill	45,326,774	45,326,774
Other assets, net	1,813,441	1,470,620
Total other assets	<u>47,140,215</u>	<u>46,797,394</u>
Total assets	<u>\$ 151,036,616</u>	<u>\$ 133,280,188</u>
LIABILITIES AND MEMBERS' EQUITY		
Current liabilities		
Book overdraft	\$ 864,940	\$ -
Current maturities of long-term debt	4,666,667	3,072,422
Accounts payable	4,130,616	3,294,809
Accrued expenses	6,046,970	4,694,081
Accrued distributions to members	1,026,371	155,942
Total current liabilities	<u>16,735,564</u>	<u>11,217,254</u>
Long-term debt, less current maturities	69,053,333	65,527,959
Total liabilities	<u>85,788,897</u>	<u>76,745,213</u>
Members equity		
Members contributions	45,915,034	45,915,034
Note receivable for members contributions	(63,255)	(161,878)
Retained earnings	19,395,940	10,781,819
Total members' equity	<u>65,247,719</u>	<u>56,534,975</u>
Total liabilities and members' equity	<u>\$ 151,036,616</u>	<u>\$ 133,280,188</u>

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Consolidated Statements of Revenues and Expenses -

Modified Cash Basis

Years Ended December 31, 2014 and 2013

	2014	2013
Revenues		
Patient service revenue (net of contractual allowances and discounts)	\$ 106,680,067	\$ 84,341,797
Provision for bad debts	(2,100,378)	(3,849,410)
Net patient service revenue, less provisions for bad debts	<u>104,579,689</u>	<u>80,492,387</u>
Expenses		
Salaries and benefits	60,619,766	47,276,225
Professional fees	8,870,831	6,129,697
Supplies	6,016,083	4,668,386
Management and incentive fees	1,034,914	754,517
Depreciation and amortization	3,242,843	2,169,598
Rent	1,085,786	967,683
Utilities	1,713,589	1,264,783
Insurance	801,419	618,143
Interest	3,202,997	2,693,906
Property tax	480,990	547,467
Travel	1,387,043	1,304,452
Acquisition costs	110,847	619,877
Other expenses	3,412,473	2,512,386
Total expenses	<u>91,979,581</u>	<u>71,527,120</u>
Excess of revenues over expenses - modified cash basis	<u>\$ 12,600,108</u>	<u>\$ 8,965,267</u>

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Consolidated Statements of Changes in Members' Equity -

Modified Cash Basis

Years Ended December 31, 2014 and 2013

	Members Contributions	Note Receivable for Members Contributions	Retained Earnings (Deficits)	Total
Balance, January 1, 2013	\$ 36,915,034	\$ (71,616)	\$ 4,262,617	\$ 41,106,035
Excess of revenues over expenses - modified cash basis			8,965,268	8,965,268
Contributions	9,000,000	-	-	9,000,000
Note receivable from members	-	(103,185)	-	(103,185)
Payment on note receivable from members	-	12,923	-	12,923
Distributions to members	-	-	(2,446,066)	(2,446,066)
Balance, December 31, 2013	45,915,034	(161,878)	10,781,819	56,534,975
Excess of revenues over expenses - modified cash basis	-	-	12,600,108	12,600,108
Contributions	1,000,000	-	-	1,000,000
Redemption of equity	(1,000,000)	-	-	(1,000,000)
Payment on note receivable from members	-	98,623	-	98,623
Distributions to members	-	-	(3,985,987)	(3,985,987)
Balance, December 31, 2014	<u>\$ 45,915,034</u>	<u>\$ (63,255)</u>	<u>\$ 19,395,940</u>	<u>\$ 65,247,719</u>

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Consolidated Statements of Cash Flows -

Modified Cash Basis

Years Ended December 31, 2014 and 2013

	<u>2014</u>	<u>2013</u>
Cash flows from operating activities		
Excess of revenues over expenses - modified cash basis	\$ 12,600,108	\$ 8,965,268
Adjustments to reconcile excess of revenues over expenses (modified cash basis) to net cash provided by operating activities		
Depreciation and amortization	3,242,843	2,169,598
Amortization of debt issue costs	231,754	203,496
Provision for bad debts	2,100,378	3,849,410
Change in assets and liabilities		
Patient accounts receivable	(3,184,650)	(6,857,732)
Due from third-party payors	(560,736)	(524,786)
Inventories	(16,230)	1,859
Prepaid expenses	(155,402)	(455,713)
Other assets	(192,667)	(109,971)
Accounts payable	835,807	2,286,127
Book overdraft	864,940	-
Accrued expenses	1,352,889	1,442,932
Net cash provided by operating activities	<u>17,119,034</u>	<u>10,970,488</u>
Cash flows from investing activities		
Acquisitions of property and equipment	(21,110,886)	(18,613,606)
Acquisition of SBH-EI Paso, LLC	-	(24,764,177)
Net cash used by investing activities	<u>(21,110,886)</u>	<u>(43,377,783)</u>
Cash flows from financing activities		
Debt proceeds received	73,720,000	77,030,626
Repayment of long-term debt	(68,600,381)	(50,872,843)
Cash contributions from members	1,000,000	8,896,815
Payments of debt issuance costs	(381,908)	(482,874)
Proceeds received on members note receivable for contributions	98,623	12,923
Redemption of members equity	(1,000,000)	-
Cash distributions to members	(3,115,558)	(2,726,784)
Net cash provided by financing activities	<u>1,720,776</u>	<u>31,857,863</u>
Net decrease in cash and cash equivalents	(2,271,076)	(549,432)
Cash and cash equivalents, beginning of year	<u>2,271,076</u>	<u>2,820,508</u>
Cash and cash equivalents, end of year	<u>\$ -</u>	<u>\$ 2,271,076</u>
Supplemental disclosure of cash flow information		
Cash paid during the year for interest	<u>\$ 3,060,969</u>	<u>\$ 2,706,591</u>
Supplemental disclosure of non-cash investing and financing activities		
Accrued distributions to members	<u>\$ 1,026,371</u>	<u>\$ 155,942</u>
Purchase of members contribution by issuance of note receivable	<u>\$ -</u>	<u>\$ 103,185</u>

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Nature of Business and Significant Accounting Policies

Nature of Business

Strategic Behavioral Health and its subsidiaries (collectively "SBH" or the "Company") provide a variety of services for individuals with psychiatric disorders, including emotional and behavioral disorders. Services provided include but are not limited to therapy, education, nursing and medical services, treatment planning, social skills training and substance abuse counseling. At December 31, 2014, SBH operated 8 behavioral healthcare facilities, with over 600 beds, located in the states of Colorado, Nevada, New Mexico, North Carolina, and Texas.

The Company's significant accounting policies are summarized below:

Basis of Presentation

The Company's policy is to prepare its consolidated financial statements on a modified cash basis of accounting. Except as described below, the Company records amounts due from patients and third-party payors at the time services are rendered and costs and expenses associated with providing services as they are incurred. If an expenditure results in the acquisition of an asset having an estimated useful life which extends substantially beyond the year of acquisition, the expenditure is capitalized and depreciated or amortized over the estimated useful life of the asset. Due to the uncertainty regarding the realization of certain enhanced revenue payments received from governmental payors, these payments are recorded as revenues when the cash is received without considering the potential uncertainties pertaining to any subsequent review by the governmental payors. Additionally, the Company has entered into interest rate swap agreements (see Note 3) with a third party, which are recorded on an accrual basis whereby cash flows are included in interest expense during the period. However, the interest swap agreement is not recorded at fair value at the end of each period as required by accounting principles generally accepted in the United States of America.

Principles of Consolidation

The accompanying consolidated financial statements include SBH and its wholly-owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in the consolidation.

Use of Estimates

The preparation of consolidated financial statements in accordance with the modified cash basis of accounting requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reporting period.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Actual results could differ from those estimates. The amounts recorded as revenues from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

Cash and Cash Equivalents

For purposes of reporting cash flows, SBH considers all cash accounts and all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents.

Accounts Receivable, Net

SBH reports patient accounts receivable at net realizable value after deduction of allowances for doubtful accounts. Management determines the allowance for doubtful accounts based on historical losses, aging of accounts and current economic and regulatory conditions. On a continuing basis, management analyzes delinquent receivables and, once these receivables are determined to be uncollectible, they are written off through a charge against an existing allowance account or against earnings. For receivables associated with services provided to patients who have third-party coverage, SBH analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts predominately based on the aging of accounts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurances and patients with deductible and copayment balances due for which third-party coverage exists for the part of the bill), SBH records a provision for bad debts based on the age of the accounts. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Company's allowance for doubtful accounts was 6 percent and 16 percent of patient accounts receivable at December 31, 2014 and 2013, respectively. The Company has not changed its charity care policies related to discounts for certain uninsured patients during fiscal years 2014 or 2013.

Inventories

Inventories consist primarily of pharmaceutical supplies and are stated at the lower of cost using the first-in, first-out method, or market.

Prepaid Expenses

Prepaid expenses are amortized over the period of benefit using the straight-line method.

Property and Equipment

Property and equipment is stated at cost. Depreciation is computed using the straight-line method over the useful lives of the assets. Assets under capital leases are recorded at the present

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

value of the future minimum rentals at the lease inception and are amortized over the shorter of the lease term or the useful life of the related asset. Amortization of assets under capital lease obligations is included in depreciation and amortization expense.

Debt Issue Costs

Debt issue costs, which include underwriting, legal and other direct costs related to the issuance of debt, are capitalized and amortized to interest expense over the contractual term of the debt using the effective interest method.

Long-Lived Assets

Long-lived assets, such as property and equipment, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable from the estimated future cash flows expected. The Company will recognize an impairment loss when the carrying amount of a long-lived asset is not expected to be recoverable from its undiscounted cash flows. Such a charge is measured by the amount by which the carrying amount exceeds the estimated fair value of the asset. No such impairment losses have been recognized during 2014 or 2013.

Goodwill

The Company's goodwill was recorded as a result of the Company's business combinations. The Company has recorded these business combinations using the acquisition method of accounting. In 2013, the Company recorded the purchase of SBH-El Paso, which resulted in an addition of \$16,710,662 to previously existing goodwill. During 2012, the Company recorded the acquisitions of SBH-Red Rock and SBH-Montevista which resulted in \$ 28,616,112 of goodwill. There were no business combinations that occurred in 2014. The Company tests its recorded goodwill for impairment on an annual basis, or more often if indicators of potential impairment exist. The Company first assesses qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If, after assessing the totality of events or circumstances, the Company determines it is not more-likely-than-not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. Because it was determined that it was not more-likely-than-not that impairment existed, the two-step impairment test was not performed and no impairment loss was recognized during the years ended December 31, 2014 and 2013. Changes to goodwill for 2014 and 2013 are outlined below.

	Balance at 1/1	Additions to Goodwill	Balance at 12/31
2014	\$ 45,326,744	-	\$ 45,326,774
2013	\$ 28,616,112	\$ 16,710,662	\$ 45,326,774

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Compensated Absences

SBH employees are granted both vacation and sick leave. Accumulated time off is accrued at the balance sheet date because the employees' right to receive the compensation for the future absences is vested.

Net Revenues

Other than certain enhanced revenue payments received from governmental payors, net revenues are reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered. A summary of the basis of reimbursement with major third-party payors follows:

Medicare

Medicare reimbursement generally is based on the Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS"). Under this methodology, the facility is paid on the basis of a Federal per diem base rate, limited by a specific target amount per discharge, and adjusted annually for such factors as wage index, DRG assignment, rural location and other facility-level adjustments. These annual adjustments are subject to frequent changes and could impact future reimbursement. In addition to the per diem rate, the IPF PPS provides additional payment policies for outlier cases, stop-loss protection, Electroconvulsive Therapy ("ECT") treatments and interrupted stays.

Medicaid

Services rendered to Medicaid beneficiaries are generally reimbursed on a per-diem rate set by each state's division of Medicaid.

Other

SBH has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to SBH under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

The laws and regulations under which the Medicare and Medicaid programs operate are complex and subject to interpretation and frequent changes. As a part of operating under these programs, there is a possibility that government authorities may review SBH's compliance under these laws and regulations. Such reviews may result in adjustments to program reimbursement previously received and subject SBH to fines and penalties. Although no assurance can be given, management believes that it has complied with the requirements of these programs. Due to the uncertainty regarding the realization of certain enhanced payments received from governmental payors, these payments are recorded as revenues when the cash is received. As of December 31, 2014, cost reports for fiscal years 2011 and forward have not been settled.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Charity Care

SBH provides medical care without charge or at a reduced charge to patients that meet certain criteria. Because SBH does not pursue collection of amounts determined to qualify as charity, these charges are not reported as revenue.

Advertising Costs

Advertising costs are charged to operations as incurred. For the years ended December 31, 2014 and 2013, advertising costs totaled approximately \$327,000 and \$305,000, respectively.

Income Taxes

SBH files a consolidated federal income tax return with its subsidiaries. SBH is structured as a limited liability company and therefore does not incur federal income taxes. The federal taxable earnings are reported by and taxed to the members of SBH individually. SBH also files composite tax returns in several states and makes payments for state income taxes to each of those states on behalf of its members. The state payments are reflected as distributions to members on the accompanying consolidated financial statements. The Company is subject to excise taxes on earnings allocated to the State of Tennessee. The amount of Tennessee excise tax is not considered material and accordingly no deferred or current income taxes are reflected in the accompanying consolidated financial statements.

Reclassifications

Certain reclassifications have been made in the 2013 consolidated financial statements to conform with the 2014 presentation. There was no impact in members' equity or changes in members' equity, as previously reported.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 2. Long-Term Debt

Long-term debt consists of the following at December 31:

	2014	2013
Credit Facility (See below)		
Term Loan	\$ 70,000,000	\$ 55,670,000
Construction Loan	-	6,126,709
Revolver Loan	3,720,000	6,800,000
Total Credit Facility	<u>73,720,000</u>	<u>68,596,709</u>
Other Debt		
Capital lease obligation	-	3,672
Total long-term debt	73,720,000	68,600,381
Less current maturities	4,666,667	3,072,422
Long-term debt, less current maturities	<u>\$ 69,053,333</u>	<u>65,527,959</u>

In December 2014, SBH entered into a \$130 million Credit Facility (the "Credit Facility") with a syndicated group of lenders with a maturity date of December 2019. The Credit Facility consists of an initial Term Loan of \$70 million, a Development Loan (the "Development Loan") of up to \$50 million and a Revolving Line of Credit (the "Revolver Loan") of up to \$10 million. The Revolver Loan provides for a sublimit of \$2 million for standby letters of credit, of which \$245,000 was outstanding at December 31, 2014. The Credit Facility also has an accordion option in which borrowing limits can be increased by up to \$20 million. The purpose of the Credit Facility was to increase funds available for growth, as well as refinance substantially all existing debt. There is also a commitment fee charged on all unused borrowing capacity equal to a range of .25% up to .5% dependent upon amounts of total indebtedness less cash on hand in excess of \$2.5 million (not to exceed \$10 million) factored by adjusted EBITDA ("net leverage ratio").

Provisions of the Development Loan require monthly interest payments on advances. Advances taken during the year must be aggregated each December 31 (commencing December 31, 2016) and converted to term loans in tranches. The term loans will begin amortization on the last day of the first quarter following the anniversary of the closing date. Each term loan will be payable in quarterly installments of 1.25% of the respective tranche amount. There were no amounts outstanding on the Development Loan as of December 31, 2014.

The Revolver Loan requires monthly interest only payments through maturity with all principal due at the maturity date of December 31, 2019.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 2. Continued

The interest rates on all the loans under the Credit Facility are based on the net leverage ratio as follows:

Net Leverage Ratio	Spread
Less than 2.50	30-Day LIBOR + 250 basis points
Greater than or equal to 2.50 but less 3.00	30-Day LIBOR + 275 basis points
Greater than or equal to 3.00 but less 3.50	30-Day LIBOR + 300 basis points
Greater than or equal to 3.50	30-Day LIBOR + 350 basis points

The interest rate at December 31, 2014 was at 3.67 percent.

The previous debt outstanding at December 31, 2013 required interest on the loans at a variable rate equal to the 30-Day LIBOR plus a certain amount of basis points beginning at 350 (3.75 percent at December 31, 2013).

The Credit Facility is secured by substantially all of the assets of the Company.

The terms of the Credit Facility described above requires certain affirmative and negative debt covenants including the maintenance of a minimum fixed charge coverage ratio and a maximum net leverage ratio. At December 31, 2014 and 2013, SBH was in compliance with all required covenants.

The maturities of long-term debt are as follows:

Year Ending December 31,	Amount
2015	\$ 4,666,667
2016	4,666,667
2017	4,666,667
2018	4,666,667
2019	55,053,332
Total	<u>\$ 73,720,000</u>

Note 3. Interest Rate Swaps

The Company has entered into various interest rate swap agreements to manage interest costs and risks associated with changes in interest rates. These agreements effectively convert underlying variable-rate debt based on the 30-Day LIBOR to fixed-rate debt through the exchange of fixed and floating interest payment obligations without the exchange of underlying principal amounts.

At December 1, 2014 and 2013, the following interest rate swap agreements were in effect:

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 3. Continued

	Description	Notional Value	Maturity	Pay Index	Receive Index	Fair Value
<u>Swap 1</u>						
December 31, 2014	Fixed payer	\$ 4,768,166	June 2017	4.29%	30-Day LIBOR	\$ (367,155)
December 31, 2013	Fixed payer	5,069,966	June 2017	4.29%	30-Day LIBOR	(530,785)
<u>Swap 2</u>						
December 31, 2014	Fixed payer	19,188,000	June 2017	1.06%	30-Day LIBOR	(51,348)
December 31, 2013	Fixed payer	20,340,000	June 2017	1.06%	30-Day LIBOR	(67,942)
<u>Swap 3</u>						
December 31, 2014	Fixed payer	\$ 6,080,000	June 2017	.87%	30-Day LIBOR	\$ 11,601
December 31, 2013	Fixed payer	6,362,000	June 2017	.87%	30-Day LIBOR	19,585
<u>Swap 4</u>						
December 31, 2014	Fixed payer	5,337,000	June 2017	.87%	30-Day LIBOR	10,161
December 31, 2013	Fixed payer	5,581,500	June 2017	.87%	30-Day LIBOR	17,162
<u>Swap 5</u>						
December 31, 2014	Fixed payer	18,911,565	June 2017	.90%	30-Day LIBOR	250
December 31, 2013	Fixed payer	19,931,973	June 2017	.90%	30-Day LIBOR	7,790
<u>Swap 6</u>						
December 31, 2014	Fixed payer	45,410,000	May 2018	2.96%	30-Day LIBOR	(309,020)
December 31, 2013	Fixed payer	45,410,000	May 2018	2.96%	30-Day LIBOR	59,507
					Fair value	
					2014	<u>\$ (705,511)</u>
					Fair value	
					2013	<u>\$ (494,683)</u>

Swap 6 is a forward interest rate swap that becomes effective on July 1, 2017.

As a result of the interest rate swap agreements, interest expense increased by \$590,560 and \$343,003 in relation to the required debt service for the years ended December 31, 2014 and 2013, respectively.

Note 4. Property and Equipment

A summary of property and equipment follows:

	December 31,	
	2014	2013
Land and improvements	\$ 11,753,592	\$ 8,739,753
Building and improvements	67,254,093	45,839,068
Fixed and major moveable equipment	9,050,777	7,124,183
	<u>88,058,462</u>	<u>61,703,004</u>

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 4. Continued

Less accumulated depreciation and amortization	(7,555,502)	(4,331,553)
	80,502,960	57,371,451
Construction in progress	6,459,595	11,723,061
Property and equipment, net	\$ 86,962,555	\$ 69,094,512

Depreciation expense related to these assets for the years ended December 31, 2014 and 2013 amounted to \$3,242,843 and \$2,169,598, respectively. The amount of interest capitalized by the Company was \$89,726 and \$223,277 for the years ended December 31, 2014 and 2013, respectively.

At December 31, 2014, the Company had outstanding construction commitments related to construction in progress of \$8,156,569.

Note 5. Other Assets

Other assets at December 31, 2014 and 2013 consisted of the following:

	2014	2013
Debt issue costs, net of accumulated amortization of \$545,431 and \$313,677 at December 31, 2014 and 2013, respectively	\$ 1,389,672	\$ 1,229,820
Other	423,769	240,800
	\$ 1,813,441	\$ 1,470,620

Note 6. Leases

SBH leases certain property and equipment from third parties and related parties under long-term operating leases. Total rental expense for all operating leases for the years ended December 31, 2014 and 2013 was \$1,085,786 and \$967,683, respectively. Minimum future rental payments under non-cancelable operating leases having remaining terms in excess of one year as of December 31, 2014 are as follows:

Year Ending December 31,	Amount
2015	\$ 659,147
2016	531,872
2017	305,215
2018	358,015
Thereafter	308,861
Total	\$ 2,163,110

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 7. Patient Accounts Receivable and Net Patient Service Revenue

Patient Accounts Receivable, Net

SBH grants credit without collateral to its patients. The percentage mix of receivables from patients and third-party payors is as follows:

	December 31,	
	2014	2013
Medicare	15%	20%
Medicaid	30	39
Commercial	47	35
Self Pay	8	6
Total	<u>100%</u>	<u>100%</u>

A summary of the activity in the allowance for doubtful accounts for 2014 and 2013 is as follows:

	Balance at Beginning of Year	Additions to Allowance	Accounts Written Off, Net of Recoveries	Balance End of Year
Allowance for doubtful accounts year ended December 31, 2014	\$ 2,544,167	\$ 2,100,378	\$ (3,735,893)	\$ 908,652

	Balance at Beginning of Year	Additions to Allowance	Accounts Written Off, Net of Recoveries	Balance End of Year
Allowance for doubtful accounts year ended December 31, 2013	\$ 915,540	\$ 3,849,410	\$ (2,220,783)	\$ 2,544,167

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 7. Continued

A summary of net revenue, net of the provision for bad debts, for patient services rendered for the years ended December 31, 2014 and 2013 is as follows:

	2014		2013	
	Amount	Percentage	Amount	Percentage
Medicare	\$ 20,754,781	20%	\$ 15,839,812	20%
Medicaid	41,051,140	39%	29,150,783	36%
Commercial	41,920,355	40%	34,713,653	43%
Self Pay	853,413	1%	788,139	1%
	<u>\$ 104,579,689</u>	<u>100%</u>	<u>\$ 80,492,387</u>	<u>100%</u>

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Year Ended December 31, 2014		
	Third-Party Payors	Self-pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	\$ 105,809,514	\$ 870,553	<u>\$ 106,680,067</u>

	Year Ended December 31, 2013		
	Third-Party Payors	Self-pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	\$ 83,515,967	\$ 825,830	<u>\$ 84,341,797</u>

Note 8. Charity Care

The Company maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The direct and indirect cost, which includes all operating expenses excluding the provision for bad debts, associated with these services cannot be identified to specific charity care patients. Therefore, management estimated the costs of these services by calculating a ratio of cost to gross charges and multiplying that ratio by the gross charges associated with providing care to charity patients. The estimated direct and indirect cost incurred is approximately \$491,000 and \$485,000 for the years ended December 31, 2014 and 2013, respectively.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 9. Insurance Programs

SBH purchases professional and general liability insurance to cover medical malpractice claims. Management believes that any claims would be substantially covered under its insurance program and would not have a significant effect on the consolidated financial statements. Nevertheless, the future assertion of claims for occurrences prior to year-end is possible and may occur, although not anticipated.

Note 10. Related Party Transactions

Dobbs Management Service, LLC ("Dobbs") is a related party entity due to common ownership by certain members of SBH. SBH's business formation agreement requires a base management fee to Dobbs in an amount not to exceed \$5,000 per month. Management fees incurred to Dobbs \$60,000 for each of the years ended December 31, 2014 and 2013.

The business formation agreement also requires that guaranteed payments be made to certain SBH's members. For the years ended December 31, 2014 and 2013, the amounts of guaranteed payments totaled \$447,510 and \$418,636, respectively, and are included in salaries and benefits on the accompanying consolidated financial statements.

Additionally, the business formation agreement requires that an incentive fee based on a percentage of net income be paid to certain members of SBH and Dobbs, respectively. The incentive fees for the years ended December 31, 2014 and 2013 were \$974,670 and \$754,517, respectively. Accrued incentive fees at December 31, 2014 and 2013 were \$95,175 and \$58,868, respectively.

SBH has declared certain distributions payable to its members as of December 31, 2014 and 2013 related to income tax distributions. Total accrued distributions to members as of December 31, 2014 and 2013 were \$1,026,371 and \$155,942, respectively.

The Company allows members from time to time to transact equity transactions in the form of secured promissory notes. At December 31, 2014 and 2013 outstanding amounts receivable from members were \$63,255 and \$161,878, respectively. Interest is charged at a variable rate with the principal to be paid in full in May 2015. The Company received \$98,623 and \$12,923 of principal payments related to the notes receivable during 2014 and 2013, respectively. Note receivable balances due from members are presented as a component of members' equity on the accompanying consolidated financial statements.

The Company purchases property, casualty, and malpractice insurance coverage from a company which is owned by Dobbs. During 2014 and 2013, the Company paid insurance premiums of approximately \$1,800,000 and \$1,500,000, respectively to this party.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 11. Employee Benefits

SBH participates in a multi-employer defined contribution 401(k) plan sponsored by Dobbs for its eligible employees. Contributions by the Company to the plan for the years ended December 31, 2014 and 2013 were \$325,859 and \$249,221, respectively.

SBH also provides health insurance benefits to its eligible employees. Health insurance benefits provided were \$3,635,125 and \$2,972,148 for the years ended December 31, 2014 and 2013, respectively.

Note 12. Risks and Uncertainties

SBH is involved in litigation in the normal course of business. Management is of the opinion that likelihood of any financial impact to SBH would be minimal and would be covered by insurance.

The amounts of certain enhanced revenues received from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

SBH maintains cash deposits that are at times in excess of FDIC insurance limits. The Company has not experienced any losses as a result of this concentration.

Note 13. Acquisition

On May 19, 2013, the Company entered into an asset purchase agreement with Universal Health Services, Inc. ("UHS") for the purchase of substantially all of the net assets and assumption of certain liabilities of Peak Behavioral Hospital. The Company's acquisition was based on management's belief that the Santa Teresa, New Mexico location is complementary to the Company's existing business and provides a base for further growth. The total original purchase price was \$24,000,000.

The Company's acquisition was recorded by allocating the cost of the acquisition to the assets acquired, including intangible assets and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the cost of the acquisitions over the net amounts assigned to the fair value of the assets acquired, net of liabilities assumed, was recorded as goodwill. The following table summarizes the valuation:

Assets	
Accounts receivable	\$ 2,389,688
Inventory	20,669
Prepaid expenses and other assets	24,927
Property and equipment	5,988,588
Goodwill	16,710,662
Assets acquired	<u>25,134,534</u>

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2014 and 2013

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 13. Continued

Liabilities

Accounts payable	\$ 85,309
Accrued expenses	<u>285,048</u>
Total liabilities	<u>370,357</u>
Net assets acquired	<u>\$ 24,764,177</u>

The difference between the original consideration paid of \$24,000,000 and assets acquired of \$24,764,177 was \$764,177 and represented a subsequent working capital adjustment paid to UHS.

During 2014 and 2013, the Company recorded expenses of approximately \$111,000 and \$620,000, respectively, related to costs incurred in this and other potential acquisitions. The acquisition costs were primarily related to legal and professional fees and other costs incurred in performing due diligence.

Note 14. Subsequent Events

SBH has evaluated, for consideration of recognition or disclosure, subsequent events that have occurred through May 8, 2015, the date the consolidated financial statements were available to be issued and has determined that no significant events have occurred subsequent to December 31, 2014 but prior to May 8, 2015, that would have a material impact on its consolidated financial statements.

Question 13:

Regarding Table 2, please provide a breakdown of the proposed PRTF/RTC by the three proposed units separately (Diagnostic & Assessment, PRTF/RTC, and for older male teens). Please include the number of patients admitted to the diagnostic and assessment unit included in this table. All of the patients have an ALOS of 180 days, which is supposedly the utilization for the two residential programs. Please clarify and show the utilization for the Diagnostic & Assessment unit as well.

	2018				2019				2020				2021				
	Beds	Admits	Patient Days	ALOS	ADC	Admits	Patient Days	ALOS	ADC	Admits	Patient Days	ALOS	ADC	Admits	Patient Days	ALOS	ADC
D&A Unit	20	48.17	2,168	45	5.94	98.8	4,446	45	12.2	130.26	5,862	45	16.1	155.8	7,010	45	19.2
PRTF	36	29.0	5,220	180	14.30	57.0	10,260	180	28.1	70.0	12,600	180	34.5	72.0	12,960	180	35.5
Adult Male	16	9.0	1,620	180	4.44	19.0	3,420	180	9.4	31.0	5,580	180	15.3	31.0	5,580	180	15.3
Total	72	86	9,008		24.7	175	18,126		49.7	231	24,042		65.9	259	25,550		70.0

Question 15

Part IV – Applicant History, Statement of Responsibility, Authorization and Signature

Please include Strategic Behavioral Health, LLC in the response to this affidavit.

Part IV – Applicant History, Statement of Responsibility, Authorization and Signature

Strategic Behavioral Health Answers

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identify and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

	<u>Address</u>
John Hull Dobbs, Jr.	1000 Ridgeway Loop Road Suite 203 Memphis, TN 38120 1985 Trust (17.74% interest)
John Hull Dobbs, Jr.	1000 Ridgeway Loop Road Suite 203 Memphis, TN 38120 Grantor Trust (5.9% interest)
Edward J. Dobbs, Jr.	1000 Ridgeway Loop Road Suite 203 Memphis, TN 38120 Grantor Trust (22.375% interest)
Edward J. Dobbs, Jr.	1000 Ridgeway Loop Road Suite 203 Memphis, TN 38120 2009 Trust (5.37% interest)
Caroline Kirby Dobbs	1000 Ridgeway Loop Road Suite 203 Memphis, TN 38120 1985 Trust (18.64% interest)
Caroline Kirby Dobbs Floyd	1000 Ridgeway Loop Road Suite 203 Memphis, TN 38120 2012 Trust (5% interest)
Juliette C. Dobbs	1000 Ridgeway Loop Road Suite 203 Memphis, TN 38120 1985 Trust (17.64% interest)
Jackson Dobbs Allen	1000 Ridgeway Loop Road Suite 203 Memphis, TN 38120 2012 Trust (6% interest)

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each facility, including facility name, address, and dates of involvement. (Please note: The corporation was founded in 2006. by virtue of ownership in Strategic Behavioral Health, LLC, a Memphis Corporation, all owners with greater than 5% interest, as listed above in Part IV, Question 1, have ownership in the following Strategic Behavioral Health facilities.)

Strategic Behavioral Center
1715 Sharon Road West
Charlotte, NC 28210
<http://www.sbccharlotte.com/>

Strategic Behavioral Center
3200 Waterfield Drive
Garner, NC 27529
www.sbcraleigh.com/

Strategic Behavioral Center
2050 Mercantile Drive
Leland, NC 28451
www.sbcwilmington.com

Rock Prairie Behavioral Health
3550 Normand Drive
College Station, TX 77845
www.rockprairiebh.com/

Peak Behavioral Health- El Paso
5045 McNutt Road
Santa Teresa, NM 88008
<http://www.peakbehavioral.com/>

Montevista Hospital-Las Vegas NV
5900 West Rochelle Avenue
Las Vegas, NV 89103
www.montevistahospital.com/

Red Rock Behavioral Health, Las Vegas, NV
5975 Twain Avenue
Las Vegas, NV 89103
www.redrockhospital.com/

Peak View Behavioral Health, Colorado, Springs
7353 Sisters Grove
Colorado Springs, CO 80923
www.peakviewbh.com/

Clear View Behavioral Health
4770 Larimer Parkway
Johnstown, CO 80534
Opening Nov 2015
www.clearviewbh.com/

Willow Creek Behavioral Health
1351 Ontario Road
Green Bay, WI 54311
Opening 2015
www.willowcreekbh.com/

Palms Behavioral Health
613 Victoria Lane
Harlingen, TX 78550
Opening 2015
www.palmsbh.com/

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner or other person responsible for implementation of the Project was not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

As stated previously: "No," the Maryland license or certification of the applicant facility, has never been suspended or revoked, or been subject to any disciplinary action (such as ban on admissions) in the last 5 years.

No. The Maryland license or certification of the facilities listed in Questions 1 and 2, have never been suspended or revoked, or been subject to any disciplinary action (such as ban on admissions) in the last 5 years.

All Strategic Behavioral Health facilities are in currently in full compliance with all federal, state and local licensing and accreditation boards, including the Commission on Accreditation for Rehabilitation Facilities (CARF) and The Joint Commission.

4. Is any facility with which the applicant is involved, or has any facility with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition reached by the applicable governmental authority.

No

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

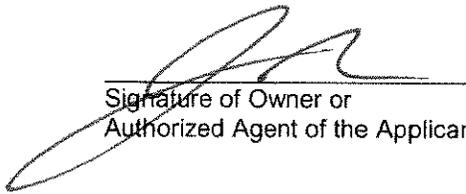
No

ATTESTATION

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project, which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed or existing facility.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

8-10-15
Date


Signature of Owner or
Authorized Agent of the Applicant *Jim Shaheen, President*