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FINAL REPORT
OF THE
COMMISSION INVESTIGATING THE DEATH
OF TROY CHAPMAN
AT MONTROSE SCHOOL

April 7, 1986

Juvenile Services Administration

Department of Health and Mental Hygiene

State of Maryland

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DHMH

Richard Hamilton, Acting Director,
JSA

Mary Ann Willin, Chairperson,
Montrose Commission

Montrose Commission

Members

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Introduction

Troy Chapman, a thirteen year old resident of the Montrose School in Baltimore, Maryland, killed himself while in an isolation cell at Montrose on Friday, January 31, 1986. On February 18, Mr. Richard Hamilton, Acting Director of the Maryland Juvenile Services Administration, convened an investigative commission to study Troy's suicide. The Commission was chaired by Ms. Mary Ann Willin, Director of the Mayor's Coordinating Council on Criminal Justice, and included Sergeant Harold Harbold of the Maryland State Police, Ms. Lynn Klair, Psychiatric Clinical Nurse Specialist at Springfield Hospital, Mr. T.B. Jones, counselor at the Charles H. Hickey School, and Mr. Harry Langmead, administrator in the Department of Health and Mental Hygiene. Ms. Martha Pedroni of the Mayor's Coordinating Council on Criminal Justice was staff to the Commission.

Mr. Hamilton charged the Commission with the tasks of investigating the circumstances surrounding Troy's suicide, and recommending improvements in the areas of hiring, staffing, training, programming, policy and procedures, to prevent suicides at Montrose School in the future.

During the five-week life of the Commission, its members met eleven times. Two site visits were made to Montrose School by the entire Commission to interview staff on duty, to view Williams Cottage, where Troy lived, and to view the isolation unit where he committed suicide. Individual members of the Commission also visited Montrose several times and informed the Commission of any new insights at the regular meetings.

School, Medical, and Court History of Troy Chapman

Troy Chapman, born on December 9, 1972, was one of twin boys. He was raised by his mother and maternal grandmother; his father did not live with the family and visited his sons infrequently. Troy's developmental history up to age six was reported to be normal by his mother.

School history for Troy was erratic from the beginning. He was held back in first and fourth grades, and switched schools several times during the six year period 1978-1984. He was suspended frequently for fighting, and many teachers noted his disruptiveness and "hyperactivity" in class.

In July and August, 1981, Troy was evaluated at the John F. Kennedy Institute for Children at The Johns Hopkins University. Doctors there found neurological dysfunction, hyperactivity and difficulty in behavior control, and the need for specialized educational placement, probably in a Level IV classroom.

In 1983, Troy was charged with assaulting a young girl. A Juvenile Services intake officer referred Troy for informal supervision by a private program, which he completed successfully. Still, his problems in school and with his peers continued.

The next evaluation Troy had was in February of 1984, at which time the doctor noted in his report, "Of utmost concern is the fact that Troy is not in a Level IV classroom." The doctor diagnosed learning disabilities, attention deficit with hyperactivity, and started Troy again on medication which had been started and discontinued earlier.

Troy began a special education placement, Level IV, in March of 1984 at Windsor Mills Elementary. Unfortunately, over two years had elapsed between the first recommendation that Troy be placed in a Level IV classroom and the actual placement.

Evaluations were continued at JFK Institute during early 1984. Ms. Chapman, Troy's mother, also brought Troy to see a psychiatrist from the Sinai Outpatient Psychiatry Department, who stated at this time, "Characteristics of attention deficit disorder with hyperactivity and learning disability are evident through-

out the history and evaluation." He stressed the need for appropriate school placement. He also recommended stimulant drug therapy and family counseling.

Throughout 1984, Troy continued to be evaluated by the clinical staff at JFK Institute. During this time his behavior worsened. He was fighting frequently, stealing and lying, and maintaining an aggressive, defiant attitude. He was suspended from school and had to be placed in another Level IV classroom in another school. However, his teachers at the second Level IV class reported that Troy was unable to function at that level. Efforts began to find a Level V placement for Troy.

The psychiatrist from Sinai say Troy again in 1985, and noted her many concerns in his evaluation report:

- she described Troy as "sad and angry" and "perceiving rejection from everyone."
- the severity and chronicity of his behavioral problems led the doctor to predict "serious consequences" if appropriate multi-level interventions were not implemented immediately.
- she saw no evidence of psychosis, but did diagnose "dysthymic disorder," the essential feature of which is " a chronic disturbance of mood involving either depressed mood or a loss of interest or pleasure in all, or almost all, usual activities and pastimes, and associated symptoms, but not of sufficient severity or duration to meet the criteria for a major depressive episode (full affective syndrome)."
- she recommended group home placement and continued psychiatric treatment for Troy. She also recommended psychiatric treatment for Ms. Chapman.

Despite her recommendations, the family did not see anyone for treatment at Sinai and JFK Institute.

In July, 1985, Troy and his twin brother Todd Chapman were taken to a Baltimore City police station for making prank calls to the 911 emergency line and the Fire Department. Ms. Chapman refused to pick her sons up from the police station when called, so her mother agreed to take the boys.

Several incidents occurred in August and September. A DSS Protective Services worker was assigned to the family because a complaint of abuse and neglect was

made against Ms. Chapman. At about the same time, Troy stole a bicycle and ran away from home. Since his mother refused to pick him up when the police found him, he was placed in a shelter care foster home.

Although abuse was not substantiated in the Chapman home, the DSS worker suspected neglect of Troy, his brother and their younger sister. Discussions between DSS, JSA, and Ms. Chapman led to her agreement to use day-care services for her younger child, and to try another treatment program for herself. DSS agreed to expedite day-care and to monitor the attempts to get Troy into a Level V educational placement.

The Department of Education's Divisional Admission, Review, and Dismissal (DARD) Committee, on September 24, 1985, issued their decision on a process begun months earlier. Troy's placement in a Level IV program was inappropriate, and a Level V placement would be available in October, 1985. Unfortunately, before the decision was made, Troy had run away from his foster home, stolen several bicycles, and was found delinquent and committed to the Juvenile Services Administration by the juvenile court on September 20, 1985. On that day, Troy was placed at Montrose School in Williams Cottage.

On or about October 30, 1985, which was 40 days after placement at Montrose, Troy was seen by the consulting psychiatrist at the School. The evaluation revealed that Troy denied suicide attempts or ideation, but also that he had "some feelings of depression" and a "pervasive feeling of sadness..." The doctor prescribed Tofranil, an anti-depressant drug, because of the "somewhat depressed picture" Troy presented.

Troy was on the Tofranil for 27 days. However, on or about November 26, Troy and his Cottage staff reported to the doctor that the Tofranil had not affected Troy's behavior for the better. Troy also complained of side effects, so the doctor switched his medication to Cylert. Troy had severe headaches as a result of Cylert,so use of Cylert was discontinued 6 days after it was prescribed, on December 2, 1985. The doctor did not see Troy again. Therefore, Troy was on two different medications for a total of 33 days, during his 133-day confinement at Montrose.

Meanwhile, during late October, Troy's aftercare worker sent referrals for Troy to several community-based treatment programs: Regional Institute for Children and Adolescents (RICA), Woodbourne Center, Maryland Youth Residence Center, Bethany House, and Facets, Inc. Troy was not accepted at any of them, for a variety of reasons, including the fact that he was an AWOL (Absent Without Leave) risk and not compliant with rules. His caseworker then was promoted, and Troy was without a worker until shortly before his death.

Troy's situation in Williams Cottage was problematic. His counselor described Troy's behavior as "active, verbal, demanding...complained about his peers and the staff...angry and extremely defensive." She said Troy disrupted the Cottage program daily, threatened peers, and had constant confrontations with peers or staff.

Troy's counselor attempted once again to place Troy at RICA, but the program would not accept him. She then asked, three days before Troy's suicide, that Troy be transferred to another cottage. An interview with that cottage counselor and Troy was arranged for February 3, 1986.

Troy hanged himself on January 31, 1986, and died early on February 1, 1986.

Chronology of Events January 30, 1986 - February 1, 1986, for Troy Chapman

The Commission has reconstructed Troy's activities for the two days prior to his death. The chronology is presented here in outline form:

THURSDAY, JANUARY 30, 1986

5:30 am	Williams Cottage students awakened, routine cleanup
7:25 am	Students to breakfast in dining room
7:45 am	Students returned to Cottage in good order
8:55 am	Students to Gill School
10:30 am	Troy Chapman removed from Gill School for refusing to follow directions and swearing
11:30 am	Troy has lunch in isolation
2:00 pm	Troy released from isolation; returned to Williams Cottage
3:00 pm	Troy counseled for fighting and spitting on fellow students
4:55 pm	Students to dinner in dining room
5:15 pm	Students return to Cottage
5:20 pm	Troy Chapman out of control, removed to isolation. Troy demonstrating assaultive, threatening behavior
9:00 pm	Troy returned to Cottage from isolation
9:15 pm	Students showered and to bed

FRIDAY, JANUARY 31, 1986

5:30 am	Students awakened, routine cleanup
7:25 am	Students to breakfast in dining room
7:45 am	Students returned from breakfast in good order
8:55 am	Students to Gill School
11:30 am	Students returned to Cottage from school
11:45 am	Students to lunch in dining room
12:20 pm	Students returned to Cottage
1:00 pm	Students to Gill School
2:55 pm	Troy removed from Gill School to isolation for disruptive behavior, swearing and punching assistant principal
3:55 pm	Troy found hanging from cell door
4:06 pm	Baltimore County Rescue responds and transports Troy to Carroll County General Hospital
8:30 pm	Troy transferred to University Hospital Shock Trauma

SATURDAY, FEBRUARY 1, 1986

3:08 am	Troy Chapman pronounced dead

Description of Events on the Afternoon of January 31, 1986

Troy's last few hours are chronicled here in detail.

On January 31, after lunch, Troy was in his classroom at Gill School. His counselor says she saw him through the window of the classroom door and was surprised to see him working, "happy" and apparently at ease. She did not enter the classroom.

According to reports from security officers and the teacher and vice-principal, Troy left the classroom voluntarily at some point after his counselor saw him. Another counselor found him in the hall of the school and escorted him back to class, where he became angry and disruptive. A youth supervisor removed him to the vice-principal's office. He became violent, threw the vice-principal's possessions around, and punched her in the mouth. The security guard who responded to the emergency call says he found Troy on top of the vice-principal, choking her; he removed Troy and brought him to isolation.

The State Police criminal investigation report details the hour in isolation, according to many witnesses. The accounts differ, and several of the staff were contradictory in their versions. Also, at least one staff person admitted to falsifying isolation log books and records with regard to Troy Chapman and his girlfriend, who was in isolation at the same time.

Several students, including Troy's girlfriend, who were in or near isolation cells when Troy was brought in, say they heard Troy shout "I'm going to kill myself," and heard him choking. They also say that Troy was complaining that the vice-principal assaulted him and that no one would take his report of abuse, which particularly upset him. (The Commission could find no evidence that an incident report of any kind regarding Troy's complaint was ever made). Troy's girlfriend says she heard Troy shout "You better take my sheet from me!" and heard staff persons in the processing area laugh when they heard him.

Troy then tied a sheet to his cell door and around his neck, and hanged himself.

Findings of Commission

Commission members arrived at several conclusions regarding Troy Chapman, his placement and suicide at Montrose School, and the School and juvenile services system themselves. Each finding is listed in this section of the report individually, but overall, Commission members were shocked and extremely disturbed about the quality of service at Montrose School. The findings of the Commission will demonstrate that placing certain needy youths at Montrose School is warehousing in the worst sense, and absolutely contradictory to any philosophy of a humane juvenile justice system. Rehabilitating delinquent and troubled youths while effectively protecting the public from acts of juvenile delinquency may be considered the dual mandate of any juvenile justice system; Montrose School in its current state fulfills no part of that mandate.

Troy Chapman Findings

The specific findings of the Commission are:

1) Troy Chapman should never have been placed at Montrose School.
Troy's emotional problems had been documented since the age of six (6). He was only committed to Juvenile Services, according to the Master who heard his case, because Troy's mother insisted that she could not take care of him. Although Montrose has virtually no intensive therapeutic services for someone like Troy, he was placed at Montrose technically "awaiting placement" in a community-based setting; however, it is clear to the Commission that the JSA network of services did not include any program appropriate for Troy's severe psychiatric and emotional needs. Therefore, his "temporary" but inappropriate placement at Montrose stretched into nearly five (5) months, because no effective treatment alternative was available.

2) Troy should not have been in Williams Cottage at Montrose School.
Troy was initially placed in Williams Cottage, where he remained until his death. This cottage is for younger boys, who are smaller than other youths at Montrose, and who are usually slightly less aggressive. Troy, who weighed 101 lbs. when he entered Montrose, but who was 5'4" and 127 lbs. at the time of his death, was larger than most of his peers in this cottage. His documented aggressive, impulsive, and sometimes violent behavior was also more pronounced than his cottage mates. Much of his violence and aggressiveness was directed toward his smaller peers, which made his presence in Williams Cottage extremely disruptive.

3) Troy was wrongly placed in isolation.

Troy Chapman was clearly a child in need of special care and therapeutic attention. His behavior and his evaluations for years had identified him as emotionally disturbed. Yet, daily, whenever Troy was disruptive or caused a problem, he was placed in isolation and left there until his counselor came to pick him up or the isolation staff decided to send him back to his cottage. Isolation was not used effectively in connection with on-going group or individual therapy, but rather only as a means to quell Troy's disruption of the controlled life at the school. The help that Troy truly needed was not going to be given to him through isolation.

The Commission heard different accounts as to whether or not Troy could have been identified as suicidal. Although he never spoke of suicide before the afternoon he hanged himself, the suicide prevention expert at the school stated that Troy's angry behavior may have been a manifestation of suicidal tendencies. On the other hand, Troy's impulse control was so limited that the suicide may have been spontaneous.

Regardless of Troy's reasons for committing suicide, there is substantial evidence that on the afternoon of his suicide, from his cell, he told staff that that he planned to kill himself. His threats were ignored, and he was left completely unmonitored.

Therefore, the Commission found that Troy's history and needs were such that isolating him for every infraction was neither appropriate nor effective; furthermore, he should not have been left isolated after he threatened to kill himself.

4) While Troy was in isolation on January 31, 1986, he was not seen by a nurse as the policy requires; he was not checked every fifteen minutes as policy requires; his sheets were left in the isolation cell, and no staff person took note of his complaint that the vice-principal had assaulted him.

A memorandum was issued to staff at the isolation unit by the Acting Superintendent of Montrose School on January 30, 1986, reiterating the policy: All students brought into isolation must be examined first by a nurse. Troy was not examined at all.

Isolation policy also requires that outer clothes with items with which a student could harm himself, and any other item which a student could use to hurt himself,be removed from the cell. Troy had a sheet in the room, and according to one account, told the staff he would kill himself if they didn't take his sheet away. But the sheet remained in the room and Troy used it to hang himself.

Every student in isolation is supposed to be checked every 15 minutes. Troy was not, and the staff person on duty admittedly falsified the monitoring records to show that cellls were checked during that afternoon. To begin to remedy this particular problem, time clocks have been installed where the cells are. Staff persons must punch in monitoring cards every 15 minutes, which means they must get up and walk past the cells. Time clocks are not ideal, but will improve the monitoring of cells.

5) More effort should have been made to place Troy out of Montrose as soon as possible.

Although the Commission believes the most appropriate placement for Troy did not exist in the JSA system, the least appropriate placement was an institution. Therefore, much more time and effort should have been put forth by all staff who worked with Troy to find him alternative placements. When letters of referral were sent to programs on Troy's behalf, and those programs did not respond, the workers involved should have followed up the referrals more aggressively. Troy's case was exceptional enough to warrant special attention.

6) The Baltimore City School system was not responsive enough in placing Troy in an appropriate educational level class.

Troy was diagnosed at age 8 by a psychologist as needing a Level IV educational program. A Level IV program is a special class in public school, made up of fewer students, with at least 15 hours of remedial and special instruction. The youths receive more attention and instruction individually geared to their level. Students in Level IV may attend other classes in public school as well.

Troy was not actually placed in Level IV until 2½ years after the recommendation was made. During those years, his problems worsened, and one psychologist who saw Troy during that time period attributed his difficulties in part to his frustrations at school in a regular classroom.

When he finally was placed in Level IV, he needed Level V, which is a more restrictive classroom environment. 9-12 students is the maximum Level V public school class size, and each student receives all instruction within that class. A Level V placement was not available until after Troy was sent to Montrose.

The school system is faced with numerous problems, especially a lack of resources for special education. Unfortunately, Troy's case and the delay of 2½ years is not unique. Furthermore, Troy's mother missed some key meetings which may otherwise have facilitated Troy's placement in Level V. Nonetheless, the system did not respond quickly enough, and Troy suffered for it.

7) Services to Troy while he was at Montrose were fragmented and inadequate. The Commission found that Troy did not receive any comprehensive attention and services from one individual or a team of individuals. The consulting psychiatrist and psychologist saw Troy for evaluation and medication, but did not observe his behavior, treat him, or work in depth with others who did. The counselors and staff in Williams Cottage observed Troy's behavior in the cottage, and had brief conversations with him, but generally used isolation to handle confrontations with Troy. They did not work closely with the Gill School staff, who also observed behavior and used isolation as punishment. Nurses responded to somatic complaints only, even though at least one nurse felt she could contribute to the overall treatment for children at Montrose.

Troy's behavior was unusual enough to make him noticeable in every part of an institution full of difficult and troubled children. But because the different factions of the school did not work closely together, the Commission believes a pattern of Troy's problems did not emerge for any of them. If services were not so fragmented, perhaps Troy would have received the special care he so desperately needed.

Isolation Unit Findings

The Commission had one overall opinion of the isolation unit at Montrose: It should be razed, rebuilt with the assistance of experts in the field of institutional seclusion, and the new unit should not be used for all infractions of institutional policy. The unit as it exists now is poorly designed, with many dangerous features. Staff use it as the simplest method of handling all problems, major or minor, which arise.

Specific findings about the isolation unit include:

1) The isolation unit should not be combined with the Tour Office.
This finding was brought to the attention of the Commission by both the Acting Superintendent of Montrose and the Secretary of the Department of Health and Mental Hygiene. During the time Troy was at Montrose School, and undoubtedly before that time, one staff person was responsible for the duties of the isolation unit and the tour office. The duties entailed answering the switchboard after 4:30 p.m., monitoring the radio, doing paperwork on every youth coming in or leaving the School, and processing and monitoring every youth in isolation. The task was virtually impossible. The problems have since been somewhat alleviated. There is now supposed to be one staff person responsible only for the isolation unit, and another staff person working in the tour office.

2) The grates on the windows of the isolation cell doors were dangerous.
These grates had large enough holes so that a youth could fashion a noose to fit through them. The grates have since been removed; however, the security mesh screens which were installed are apparently not effective. Recently, a youth kicked out the screen, wriggled through the small window, and seriously assaulted a nurse in the infirmary.

3) The doors into the cells in the isolation unit are not placed correctly for visual monitoring.
The doors into the cells are placed near a corner, so that one corner is not visible from outside the door looking in. A suicidal youth could be harming himself in that corner, and a careless staff person who simply glanced in would never know. All parts of an isolation cell should be visible to the monitoring staff at all times.

4) The bunk in the isolation cell has holes from which a youth could hang himself. It also has bolts which protrude 2½" from the wall and could be dangerous.

The design of the bunk is dangerous, especially if youths who are potential suicide risks are placed into isolation. Although a mattress on the floor evokes images of the training schools of the 50's and 60's, it is infinitely safer when suicidal youths are being placed in these cells.

5) Sheets and blankets which can be used as nooses are dangerous and should be removed from cells.

Sheets and certain blankets which can be torn or knotted fairly easily have been in the cells, even after Troy's death. This is against policy. Again, if youths at risk of suicide are going to be placed in the cells, all harmful or potentially harmful objects should be removed.

6. The convex light fixture and sharp-edged heat duct in each isolation cell are dangerous.

Both fixtures have sharp edges; and a suicidal student could hang himself from the light fixture. These flaws should be corrected immediately.

The Commission notes here that most of the findings regarding the isolation unit relate to the potential suicide risk. The Commission cannot state strongly enough that any youth who is even vaguely considered at risk for suicide SHOULD NOT BE ISOLATED. The unit needs re-designing because suicide risks will not always be identified; but even having a "perfect" isolation unit will not stop suicides if suicidal youths are isolated.

Program Findings

Programming for youths at Montrose School appeared minimal at best. The specific programmatic findings of this Commission may not always be related to suicides, or to Troy Chapman; however, the Commission believes they should be included in this report because they describe the nature of the institution. Understanding Montrose School is critical if we are to understand Troy's death and to prevent others from committing suicide at Montrose.

Specific findings regarding programming at Montrose:

1) Staff are underqualified, untrained, and with no accountability.

This report is not the document in which to detail the innumerable problems the Commission found with the staff at the institution. But, in brief, members learned that employees were hired with no background checks; little or no orientation was given to new employees; no training was offered within the institution on various issues, such as suicide prevention or violent behavior management; employees who violated rules time and time again were either not disciplined or disciplined very lightly; and in general, staff distanced themselves from the responsibility of caring for the students. Many who may have genuinely tried to help youths were fatigued by the rigors of the job, and others simply lost morale when they saw policy infractions with no sanctions.

One consultant at the school said staff were untrained and unresponsive to youths' needs. He saw them as reacting to their students' behavior instead of acting to help or control them.

2) Policies of the school, particularly of the isolation unit, are too vague to be used effectively by trained staff, much less by untrained staff.

The policies contained in the Montrose Policy Manual are generalized and vague. They do not tell staff specifically what to do in what situations, but instead generally instruct them, as in the suicide risk policy:

> Staff shall constantly be aware of the threat or danger of suicide. Constant and regular supervision is a necessity. Any change in mood or behavior of the youth shall be rapidly observed and brought to the attention of the appropriate clinical or medical personnel... consideration for transfer to a hospital or other appropriate facility should be given.

This "policy" is thoroughly inadequate for such a serious situation. In the case of suicide, a special procedure should be spelled out, listing each step in how to handle a youth at risk. This "mechanism" should be learned and memorized by every staff member and should be triggered automatically when suicide risks are identified.

3) On the Behavior Modification Campus at Montrose, only negative reinforcement is used. Youths have no hope and no incentive. There is a serious lack of recreation.

Behavior Modification is a specific treatment model which requires trained staff and negative and positive reinforcement strategies. "Contracts" are often used, in which youths state their behavior goals and promise that they will abide by certain rules and attempt to achieve those goals. The Commission members saw no contracts, nor did they see any sign of positive reinforcement for youths who complied with rules. On the other hand, negative reinforcement is all too evident: isolation, denying visits from parents, denying participation in special events.

Youths at Montrose have no clear understanding of what is expected of them. They have no role models. Furthermore, they have nothing to look forward to; as one volunteer put it, hope is taken away from the youths. Recreation is virtually non-existent, such as organized sports and other special events. What is done is ad hoc at best, and one volunteer in particular is responsible for most of the enjoyable activities which occur for Williams Cottage students.

The lack of exercise for the young boys particularly concerned the Commission members. Young boys have an abundance of energy, which at Montrose is almost never released. The results of no exercise for these youngsters must be mental and physical trauma, and undoubtedly the pent-up energy is the cause of many confrontations in the cottages.

4) There is a critical need for more clinical services at Montrose.

The availability of clinical help at Montrose is so limited as to be non-existent for most youths. On the Behavior Modification Campus, no individual or group therapy is done. A psychologist visits the school for eight (8) hours

per week. Nurses tend only to somatic troubles, and cottage counselors are not clinically trained, for the most part.

Montrose School has an average daily population of 270 students, and several staff members estimated the number of psychiatrically ill students at 50-60 at any one time. Yet no consistent and available help exists for them at Montrose, just as it did not exist for Troy Chapman.

In general, the lack of programming for youths, combined with a dearth of clinical services, translates into warehousing, not rehabilitation and treatment.

Recommendations to Prevent Suicide at Montrose

Throughout the five weeks the Commission met, members continually suggested methods to improve services and the overall situation at Montrose, so that more suicides do not occur. The Commission has learned that up to 24 youths attempt or threaten suicide every month at Montrose; and several recent attempts have been very serious and could have succeeded. Therefore, we believe our recommendations and those of past committees on suicide prevention at Montrose should be reviewed carefully by DHMH and JSA and implemented as soon as possible. The situation is critical; children's lives are at stake.

1) The Commission recommends that the isolation unit at Montrose be torn down and re-designed immediately.
(See isolation unit findings). The unit should be made as suicide-proof as possible, which includes having one wall of each cell a see-through grate so that the entire cell and student are visible at all times. Builders of seclusion units at other State institutions should be asked to provide consultation.

2) The Commission recommends that JSA institute a Classification System based on the Massachusetts Classification Panel, to assess which youths are appropriate for placement in secure institutions.
The system must include a post-adjudication pre-disposition assessment process. Youths should be placed always in the least restrictive environment appropriate for their needs, as JSA policy dictates. Emotionally disturbed youths should be placed in an appropriate clinical setting. (See Recommendation 4).

3) The Commission recommends that JSA continue to develop a full-scale community-based treatment network, to ensure that youths such as Troy do not end up institutionalized for lack of alternatives.
Model systems of community-based treatment should be examined to discover innovative methods of program development, monitoring, and contracting. A needs assessment in each JSA region should be performed to discover what types of programs are needed in each community.

4) The Commission recommends the development of a secure program for emotionally disturbed juvenile offenders.

Youngsters like Troy need on-going daily treatment as well as security, and there are enough of these youngsters to justify the development of such a program. The Department of Mental Health should make funds for such a program available, since these youths also fall within the purview of Mental Health.

5) The Commission recommends that a new system of case management be instituted in the regions immediately: "vertical" casework.

The first worker to whom a youth is assigned when committed to JSA should remain that youth's worker through all future placements, intakes, and repeat offenses, until release from commitment. That worker can be the one person the youth knows in the system; he can be an advocate for the youth and make correct placement decisions with his knowledge of the youth.

The Commission has several recommendations to make regarding Montrose School; they are not in order of priority, but are all of equal importance:

1) A full-time clinical staff must be added to Montrose School.

The staff, to be made up of appropriate medical personnel (as determined by clinical experts), should provide individual and group therapy for youths, crisis intervention, suicide prevention, consultation and assessment, and staff training. Youths who need special treatment will be able to receive it from a full-time clinical staff, and isolation will no longer be the only answer.

Furthermore, a clinical staff can direct interdisciplinary teams on all youths, made up of a clinician, the youth's cottage counselor, caseworker, and teacher. The fragmentation of services already discussed would be greatly reduced.

2) Staffing at Montrose School must change.

Hiring procedures must be improved so that qualified people are employed. JSA and the Department of Personnel will have to ensure that procedures for background checks and hiring are followed, through spot checks, record checks, and regular monitoring.

Staff should only be allowed on units with proper training. They should be fully apprised by their supervisors of administrative and emergency policies and procedures. All staff should have knowledge of security management and violent behavior management. Staff counseling children should receive on-going in-service training on issues such as identification of suicidal tendencies.

Staff who violate policies should be subject to immediate sanctions. The specific sanctions should be worked out as soon as possible between the institution and the Department of Personnel. Sanctions should include the ultimate step of termination for cause, and that step should not be impossibly difficult to make. If a supervisor has documented enough flagrant violations of policy to prove that a worker is incompetent and endangering the youths, he should have the option of termination reasonably available.

The management should provide staff with certain cost-free benefits to improve working conditions. For example, "creative reassignment" of staff is one way to avoid staff "burn-out." Staff could be routinely assigned to new units or positions, and in most cases the youths would also benefit.

Other management techniques, as well as management control, should be outlined in a managers' handbook. JSA should draw up such a handbook in order to make expectations for managers and staff clear, and to give managers a tool for better supervision.

3) The program for youths on the Behavior Modification Campus of Montrose School must be upgraded.

It is crucial that youths receive encouragement and incentive as well as punishment. Special events and regular activities must be scheduled every week as positive reinforcement for achievement and good behavior.

Recreation is critical. Money should be allocated to hire enough recreation staff to provide activities for youths at least several times weekly, if not daily. Exercise should be a part of a daily cottage program.

Conclusion:

In order to prevent future incidents of suicide at Montrose, major changes must be made in staffing, in programming and in the physical plant. Unfortunately, all this has been said many times before, both formally by way of other task force reports on the same subject and informally by child advocates and concerned staff members, but to no avail.

Perhaps even under more improved conditions Troy Chapman's suicide could not have been prevented. However, it is the opinion of this Commission that it was preventable. It is also the belief of this Commission that without immediate action being taken to alleviate the problem areas, there will be other "Troy Chapmans."

There is no single source to which we can point and lay blame for this particular suicide. There are many! Every individual who bore responsibility to address the funding needs, the staffing needs, the training needs, the program design needs, the educational needs and the physical plant needs of Montrose must accept the blame.

It has been said time and again that our children are our most valuable resource. However, in Montrose and places similar to it, we are systematically preventing and destroying that resource. Is it any wonder that these children are becoming more and more violent? That violence can manifest itself in self-destruction or in aggression towards others.

As Will Rogers said, "There is nothing as easy as denouncing. It don't take much to see that something is wrong, but it does take some eyesight to see what will put it right again."

The Commission hopes that this report provides some measure of that "eyesight."