U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

February 13, 1998

U.S. v. Georgia

DJ-GA-002-002

The Honorable Zell Miller
Governor of Georgia
203 State Capitol
Atlanta, GA 30334

Re: Findings of Investigation of State Juvenile Justice Facilities

Dear Governor Miller:

On March 3, 1997, we notified you of our investigation of juvenile facilities in the State of Georgia under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997a et seq., and the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141. I am writing to report our findings.

We conducted our investigation through inspection of documents provided by the State, interviews with Department of Juvenile Justice (DJJ) leadership and staff, discussions with other juvenile justice officials and youth advocates, and through a series of tours of nine DJJ facilities. During the tours, we inspected physical conditions and various documentation (including incident and use of force reports; unit log books; youths' institutional, medical and educational records; DJJ and Department of Family and Children Services (DFCS) abuse reports and investigations; policy and procedure manuals, etc.), and interviewed staff and residents. We were assisted in the process by ten expert consultants in the fields of juvenile justice administration, psychology, psychiatry, medicine and education. Over a six-month period from April to October, 1997, we spent more than 35 days on-site at the facilities.

During the tours and throughout this investigation, we have received the complete cooperation of the staff at the facilities, the leadership of the DJJ, and the Attorney General's office. At the close of many of the on-site inspections, our experts provided some initial comments on their preliminary observations arising from the tours. In light of the State's cooperation in this matter, and State officials' expressed desire to improve

conditions in these facilities, we will be sending you reports from these experts which provide their more detailed findings and their recommendations for steps to address the inadequacies they found and improve operations in the facilities. The purpose of our letter is to inform you of the Department of Justice's findings.

I. FINDINGS

The Georgia Department of Juvenile Justice operates two types of secure juvenile facilities in the State: Regional Youth Detention Centers (RYDCs), which primarily house youths pending their hearings in juvenile court, and Youth Development Campuses (YDCs), which serve as longer-term treatment facilities.

The State operates twenty-two RYDCs throughout the State. Each RYDC serves one or more counties in facilities generally designed to accommodate between thirty and forty youths. While the average stay in an RYDC is approximately 30 days, some youths are released within a matter of hours and many stay for months or even as long as a year. Each year, more than 20,000 youths are processed through the RYDCs. Most are fifteen years-old or younger.

DJJ also administers short- and long-term treatment programs at eight YDCs which range in size between about 150 and 500 beds. Youths who have been adjudicated delinquent spend between one and five years in the long-term programs at the YDCs. About 1,000 youths are committed to long-term programs each year. The average age of the youths is fifteen. More than three-quarters of these youths are committed to long-term programs for non-violent offenses.

Since the passage of Senate Bill 440 (SB440) in 1994, juvenile courts also have been authorized to order youths to attend 90-day programs administered at the YDCs, primarily in the form of paramilitary boot camps. Some of these programs are run at YDCs with long-term programs, while other YDCs serve solely as boot camps. These boot camp programs range in size from as few as twenty-five beds to more than 300. About 4,000 youths are sent to these short-term programs each year. The average age is fifteen and, according to DJJ statistics, ninety percent of these youths have committed non-violent offenses.

Finally, a small number of youths, ages thirteen to sixteen, who are tried and convicted as adults are housed in the Lee-Arendale Correctional Institute in Alto, Georgia.

Our investigation identified a pattern of egregious conditions violating the federal rights of youths in the Georgia

juvenile facilities we toured.[1] These violations include the failure to provide adequate mental health care to mentally disturbed youths throughout the system; overcrowded and unsafe conditions in the Regional Youth Detention Centers; abusive disciplinary practices, particularly in the boot camps, including physical abuse by staff and the abusive use of mechanical and chemical restraints on mentally ill youths; inadequate education and rehabilitative services; and inadequate medical care in certain areas. Because of these conditions, many youths have suffered grievous harm, such as being injured or hospitalized due to fights with other youths or physical abuse by staff; mentally ill youths have degenerated in the State's care; youths have suffered needless pain and continued illness from undiagnosed or inadequately treated medical conditions; and youths' educations have been damaged by grossly substandard DJJ educational programs.

Moreover, our review of State documents and interviews with State administrators indicate that many of the problems identified in the facilities we visited were caused in large part by lack of resources and other inadequacies that are prevalent throughout the DJJ system and affect facilities beyond those toured by our experts and investigators.

Below we discuss our findings regarding the RYDCs we toured (pp. 3-19), followed by our findings relating to the YDCs and boot camps we inspected (pp. 19-32). We also discuss the systemic patterns that pervade the entire DJJ system (pp. 32-33). Finally, we discuss the Lee-Arendale Correctional Institute (p. 33).

A. Regional Youth Detention Centers

The juvenile justice system in Georgia detains youths prior to adjudication in one of twenty-two State-run Regional Youth Detention Centers (RYDCs) or in the Fulton County Juvenile Detention Center (which Fulton County administers for the State pursuant to a contract, and which is to be closed when a new State-run facility is completed). Our investigation included on-site tours at five RYDCs — the DeKalb, Gainesville, Griffin, Gwinnett and Rome RYDCs — and the Fulton County Juvenile Detention Center.

1. Punitive Conditions. Youths may not be subject to punishment in pre-adjudication facilities, including imposition of restrictive conditions or practices that are excessive in relation to the legitimate governmental objectives of safety,

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[1] We discuss the conditions in the Lee-Arendale Correctional Institute separately, see p. 33.

order and security. See, e.g., Schall v. Martin, 467 U.S. 253, 269 (1984); Hill v. DeKalb RYDC, 40 F.3d 1176, 1187 n.19 (11th Cir. 1994); H.C. v. Jarrard, 786 F.2d 1080, 1085 (11th Cir. 1986). See also Lynch v. Baxley, 744 F.2d 1452 (11th Cir. 1984).

a. Conditions in the RYDCs

Georgia's RYDCs house youths awaiting adjudication on charges ranging from running away from home and truancy to murder. According to DJJ statistics, almost three-quarters are charged with non-violent offenses and about one-third are charged with status offenses or probation violations.[2] Even so, the RYDCs are in most respects similar to many adult jails. They were constructed to accommodate thirty youths in locked cells with one bunk and a toilet. Each cell is approximately eight feet by ten feet. The facilities were built with a common area designed for indoor recreation and dining, and have an outdoor recreation yard. They generally were constructed with a single classroom, built to accommodate approximately fifteen youths. The DeKalb RYDC, built more recently, has a slightly different design, with a capacity of forty, a larger multipurpose area, and four classrooms. The facilities employ jail-like security — they are surrounded by razor wire fences, and employ uniformed guards who have access to shackles and (in many facilities) pepper spray, place youths in correctional jumpsuits and use handcuffs when transporting youths to and from the building.

These facilities are also grossly overcrowded. Since the passage of SB440, authorizing boot camp placements, the number of youths housed in the RYDCs each year increased by approximately one-third. During our initial series of tours last spring and summer, the population of most of the RYDCs in the system ranged from 150 percent to almost 300 percent of design capacity, with more than half the facilities operating at or above double their capacity. As a result, between two and five youths share the eight-by-ten-foot cells designed for one youth, with several youths having to sleep shoulder-to-shoulder on thin mattresses on the floor (often with their heads inches away from the cell toilet). The facilities lack adequate space for functional classrooms and little room to accommodate youths' spending time outside of their cells. Prolonged periods of lock-down are especially common on weekends when there are no classes and the facilities lack sufficient staff to supervise activities out of the cells. As one facility director candidly pointed out to DJJ administrators in a monthly report:

> We are staffed to manage 19 boys and 11 girls. When we try to manage 53 boys and 23 girls our staff becomes

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[2] This amounts to more than 1,200 status offenders and more than 5,000 probation violators.

> overwhelmed. All of our systems become overwhelmed. There is not enough room for the residents to sit in a common area. There is not enough room for residents to attend class. There is not enough room for residents to have either indoor or outdoor recreation . . .

Conditions during lock-down are especially punitive. Many of the facilities take the youths' mattresses away during the day, leaving the youths with no choice but to lie on the cold, hard metal bed frames and concrete floors. In many of the RYDCs we visited, youths may not even have reading materials in their rooms (other than a Bible). And, as discussed below, the prolonged unsupervised idleness leads to fights and sexual assaults, resulting in numerous injuries and hospitalizations in all the facilities.

These conditions are particularly harmful to the large number of young detainees charged with status offenses or similar less serious offenses. One of our experts' strongest impressions of the RYDCs we visited was the large number of small and young youths who would not be held in such jail-like, high security facilities in other jurisdictions. For example, we encountered a very small eleven-year-old boy who was being detained for threatening his fifth grade teacher; a twelve-year-old boy with a seizure disorder incarcerated for making a harassing phone call; a fourteen-year-old girl in secure detention for painting graffiti on a wall; numerous youths detained after relatively minor fights at school; a sixteen-year-old girl detained for "failing to abide by her father's rules" (throwing objects in her room and skipping school); a thirteen-year-old girl who had stolen $127 from her mother's purse; and numerous children who had run away from troubled homes. Many young children were held on charges of "terroristic threat," which often amounted to nothing more than "cussing out" a teacher or group home staff member.

The housing of such youths in the secure RYDCs, rather than in alternate placement facilities such as shelter care or group homes, contributes significantly to the overcrowding in the facilities. Although State law requires that intake workers attempt to place such youths in the least restrictive environment possible, see O.C.G.A. § 15-11-18.1(d), our interviews with State and facility administrators and juvenile judges indicate that this requirement cannot be adequately implemented due to the lack of alternative placement options.[3] As a result, more than half the detainees at the Bob Richards RYDC were listed as detained

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[3] While more than 24,000 youths were detained in secure facilities in FY1996, the State provided only 2,734 placements in non-secure settings such as group homes or in-home supervision with electronic monitoring.

for status offenses, violation of probation, or violation of the rules of an alternative placement at the time of our tours. The same was true of almost half of the youths at the Gainesville RYDC, approximately one-third of the youths at the Griffin and DeKalb RYDCs, and one-quarter of the youths at the Gwinnett RYDC. Many of these youths spend significant periods of time in these facilities, often awaiting placement in non-secure programs (such as a group home). One RYDC director stated that while not all youths accused of violating probation or committing less serious offenses are appropriate for less secure placements, he estimated that thirty percent of the youths in his facility could be adequately supervised in a less jail-like setting.

Such youths suffer disproportionately from the harms associated with the facilities' punitive conditions and other deficiencies (like lack of adequate mental health care, discussed below). For example, in the DeKalb RYDC, we met a 13-year-old girl with a history of running away from home because her mother's boyfriend sexually molested her. She was being held in the RYDC after charges were filed against her for breaking a window screen in a group home and attempting to kick a staff member. She had been held in the RYDC for almost a month when we met her, the legal justification for which was the lack of a suitable parent or other custodian to supervise her pending her hearing.[4] While incarcerated, she suffered from serious depression and had nearly succeeded in committing suicide the morning of the day we met her. Such consequences are not uncommon. In another case, for example, we met a 16-year-old girl being held as an accessory to an aggravated assault. The court ordered her held in the Griffin RYDC because she had an unstable family situation (a history of running away and poor parental supervision) pending trial. At the time of our visit, she had already been in secure detention for eight months and had attempted suicide on four occasions.

Subjecting youths to such punitive conditions violates their constitutional rights. See Gary H. v. Hegstrom, 831 F.2d 1430, 1434-36 (9th Cir. 1987); Morgan v. Sproat, 432 F. Supp. 1130 (S.D. Miss. 1977). See also Lynch v. Baxley, 744 F.2d 1452 (11th Cir. 1984).

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[4] This girl was one of many youths detained solely because she had "no parent, guardian or custodian or other person able to provide supervision and care for [her] and return [her] to court when required." See DJJ Policy #8.5 (VII)(D)(1)(c) (DJJ intake policies). See also O.C.G.A. § 15-11-18 (permitting, but not requiring, secure detention for such youths). Absent an allegation of delinquency, such a child would likely be considered "deprived" and subject to the care of the DFCS in a non-secure foster home or shelter. See O.C.G.A. § 15-11-20(f); 42 U.S.C. § 5633(a)(12)(A).

b. Fulton County Juvenile Detention Center

The Fulton County facility, which is run by Fulton County under a contract with the State, is much older, designed as a multi-floor detention center for approximately 160 youths. Because of massive disrepair, however, twenty or more of these rooms are uninhabitable at any given time. It has a large, enclosed outdoor recreation area and is attached to the juvenile court building. This facility subjects youths to long periods of lock-down in a dilapidated, unsafe building.

Youths often live doubled up in decaying, ill-ventilated rooms built for one. They spend inordinate amounts of time in their rooms, in part because the school lacks sufficient space for all youths to attend — on the day of our site visit more than twenty-five percent of the youths were locked in their rooms throughout the school day. Even though the facility has a large, enclosed outdoor recreation area, youths never go outdoors because of insufficient staffing. While locked in their rooms, youths must rely on staff to take them from their cells to the bathroom, since the cells have no toilets. The severe understaffing at the facility — sometimes one staff must supervise an entire wing, consisting of twenty or more youths housed in a long, twisting hallway — often means that staff are unavailable to respond to requests to use the bathroom (or simply refuse to respond). As a result, youths urinate in cups or out the window — the smell of urine was present throughout the facility (even though substantial efforts had been undertaken to clean the facility prior to our visit). Moreover, the bathrooms themselves are in disrepair, many with broken fixtures, mold and mildew.

2. Protection from Harm. The State has a constitutional obligation to assure the reasonable health and safety of the youths in its custody in the RYDCs. See Youngberg v. Romeo, 457 U.S. 307 (1982); Alexander S. v. Boyd, 876 F. Supp. 733, 787 (D.S.C. 1995); D.B. v. Tewksbury, 545 F. Supp. 896 (D. Or. 1982). This duty includes the obligation to protect residents from other youths and fire safety hazards. See Thomas S. ex rel. Brooks v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990); Alexander S. v. Boyd, 876 F. Supp. at 786. Overcrowding and understaffing of the RYDCs we visited has prevented the State from complying with this constitutional mandate.

a. Physical and Sexual Assaults

The lack of space in the RYDCs prevents implementation of an adequate classification system to separate younger, more vulnerable youths from older, potentially predatory detainees. Directors at the facilities admitted that they are unable to comply with even the very minimal classification criteria

promulgated by DJJ. And, as pointed out by one facility director in a report to DJJ officials, "[w]hen four boys are housed in a room designed for one, it leads to horseplay which leads to injuries and fights. There is also an increased risk of sexual assaults." For example, in one incident, a youth held for violation of probation at the Gwinnett RYDC was housed with three youths accused of armed robbery and aggravated assault and was beaten and sexually assaulted without intervention by staff. A Georgia Department of Family and Children Services (DFCS) child abuse investigation concluded that the youths were not being adequately monitored or classified, due in large part to the overcrowded conditions in the facility.

Staff do not — and given the staffing levels, often are simply not able to — provide visual checks on the rooms with sufficient frequency to prevent fights or intervene to prevent harm when fights do occur. Staffing levels at every facility were dangerously low. At the DeKalb RYDC, for instance, five line staff commonly supervise 100 youths or more as they rotate through school, showering, recreation, etc., while also conducting regular checks on youths in disciplinary lock-down or suicide watch. On the third shift, three staff members commonly monitor the entire DeKalb facility. In the smaller RYDCs, two or three staff are often patrolling the living units (with one additional staff in the control room) to supervise between fifty and ninety youths during the day. At night, as few as two staff (one in the control room) monitor the entire building. The design of the buildings, in which cells along multiple connected hallways cannot be observed simultaneously from any given point, makes observation especially difficult when staffing is low. Only the DeKalb RYDC has video monitors, and the audio monitoring systems in the other facilities function poorly. On numerous occasions, staff in these facilities only became aware of injuries when the youths were let out of their rooms the next morning.

Thin staffing patterns also present a danger of staff abuse during periods when only one or two staff members are on duty in the building. For example, on one occasion, a male staff member at the Gwinnett RYDC convinced the only other staff member on the third shift to take a nap and then sexually assaulted a 14-year-old female resident (for which he was dismissed and eventually criminally prosecuted).

b. Fire Safety

The thin staffing in all the RYDCs not only prevents adequate monitoring of youths, but also presents a real danger of loss of life in the event of a fire, given that each cell must be manually unlocked. On the third shift, this task would often fall to two or three staff, responsible for releasing up to 100 youths. This dangerous situation creates a constitutionally

unacceptable safety risk to the youths. See Alexander S. v. Boyd, 876 F. Supp at 786.

3. Inadequate Mental Health Care. RYDC residents have significant mental health care needs. A 1996 study conducted by Emory University for DJJ found that sixty-one percent of RYDC residents had psychiatric disorders and that thirty percent had substance abuse problems. These youths are systemically denied access to adequate mental health care in the RYDCs.

a. Mental Health Treatment

The RYDCs and the Fulton County facility do not have access to sufficient resources to meet the serious mental health needs of their most troubled residents. The State's medical contractor provides a very limited amount of psychiatric consultation. These psychiatric subcontractors are paid $75 per hour to provide up to two hours of services per week at some of the RYDCs. However, we found little evidence that these services were being used even to that limited extent at the facilities we toured. Recently, the contractor has begun paying psychologist consultants $300 per month to provide services "as needed." Again, we saw little evidence of their use in these facilities.

To supplement the meager mental health resources provided by the DJJ, individual facilities' directors attempt, with varying degrees of success, to obtain help from outside agencies in the local communities. Thus, Local Community Health Boards provide fairly minimal services to some RYDCs, in the form of evaluation services to permit referrals for hospitalization and, at a few of the RYDCs, behavioral staff to provide one-on-one suicide watch monitoring in the facility in severe cases. Although some outside groups volunteer to conduct drug education programs in the facilities, there are very few drug and alcohol treatment services provided.

We found that the quality of mental health care provided in the RYDCs we visited was also deficient. The administration of psychotropic medications is seriously deficient in almost every area. Important tests to monitor drug effects on youths' heart, blood and liver are not ordered. Documentation and medical charting is very poor. The use of medication is not part of any coordinated mental health treatment strategy. Almost no psychotherapy or skilled mental health counseling services are provided at any of the RYDCs. There is little interaction between psychiatric consultants and facility staff (including medical staff), contributing to the inadequate monitoring of the psychotropic medication's efficacy and side effects.

Instead, youths are generally monitored and counseled by overworked, bachelor-degree-level counselors at the facility

unless the youth's level of distress reaches a point where hospitalization is required. Even then, the State has almost no capacity to provide hospital treatment to youths who need it. DJJ contracts with the State psychiatric hospitals to provide only five long-term treatment beds for youths throughout the DJJ system (including the YDCs and boot camps). Thus, hospitalization is limited to a short period of evaluation, medication and stabilization, after which youths are returned to the facility. We frequently encountered severely troubled youths in the RYDCs who had long histories of self-mutilation, psychotic episodes, or suicide attempts followed by hospitalization, medication, and return to the RYDC where the cycle repeated. For example, one youth at the Griffin RYDC was hospitalized and returned multiple times for head-banging behavior that resulted in severe bloody ulcers on his forehead. Often, release papers from the hospital recommend treatments — such as individual and family therapy — which are not provided by the RYDCs upon return.

b. Suicide Prevention

The RYDCs lack the resources and training to satisfy their constitutional obligation to respond adequately to the risk of suicide and to suicidal or other self-injurious behavior. See, e.g., Myers v. County of Lake, 30 F.3d 847 (7th Cir. 1994).

Although the facilities attempt to identify youths at risk for suicide through a questionnaire at intake, both the content of the intake and the setting in which it is administered (by inadequately trained line staff as part of a "booking" procedure) are insufficient to identify at-risk youths. For instance, youths at the Gwinnett RYDC are questioned through a hole in the plexiglass separating the intake area from the control room. The intake instrument itself is cursory and fails to identify many suicide risks, particularly when administered by untrained personnel in these circumstances. Often it is not completed at all.

At most RYDCs, once a youth has been identified as being at immediate risk for suicidal behavior, staff lock the youth alone in a cell, removing the youth's sheets, clothing and personal effects, leaving the depressed youth alone in a paper gown, sometimes for days. Suicidal youth are then monitored more closely, but they are not permitted to leave their rooms to eat with the other youths, attend school or (often) even to obtain exercise or recreation. This practice of isolating depressed youths in demeaning conditions for hours (and sometimes days) usually exacerbates the youth's depression.

Mental health responses to suicidal youths' underlying emotional or psychiatric problems are inadequate. All too often, line staff and supervisors without any mental health background

or training are left to determine whether the behavior indicates a need for skilled mental health intervention or is simply non-serious, attention-seeking behavior. Some facilities (the DeKalb and Bob Richards RYDCs, for example) have implemented a program to create in-house "Crisis Response Teams" to respond to suicide risks. But while this program is certainly beneficial (and includes training that should be provided to all staff) it is not an adequate replacement for skilled mental health care, including hospitalization, when appropriate.

Moreover, even the attempts to prevent actual self-harm are inadequate. On more than one occasion, we observed suicidal youths locked in their rooms, alone on the living unit hall without any supervision while the only available staff supervised the other detainees in school or at recreation. These staff admitted that they were unable to conduct even fifteen-minute checks on the suicidal youths back in their rooms. In November, a youth on suicide watch at the Augusta YDC hanged himself after staff failed to conduct fifteen-minute checks.

4. Abusive Disciplinary Practices. With the exception of the Gwinnett facility, the RYDCs we toured do not have any functioning system of positive incentives to manage youth behavior, and instead rely almost solely on discipline (generally, room confinement) and force to manage the facility. This sometimes leads to unconstitutionally abusive disciplinary practices. See, e.g., H.C. v. Jarrard, 786 F.2d at 1089.

Staff in some of the facilities routinely use mechanical restraints as a form of punishment for behavior that does not represent a threat to the safety of the youth or others. These violations of DJJ's own policies are particularly pervasive at the Gainesville RYDC, but also have occurred in the Gwinnett and Bob Richards RYDCs. Most commonly, we found that staff used the restraint chair — a plastic chair into which a youth can be shackled and strapped — to punish youths for making noise, kicking their doors or flooding their toilets.

In the Fulton County facility and at the Gainesville, Griffin and Gwinnett RYDCs, staff sometimes strip detainees who are kicking their doors or being disruptive and remove the youths' mattress from the cell, forcing them to sit in their underwear on the cold concrete floor or metal bed. On one occasion, a staff member at the Gainesville RYDC stripped a mentally ill youth and left him naked in his room for half an hour because he believed the youth might attempt to flood his toilet.

In Fulton County, staff routinely place youths on high level suicide watch as punishment, stripping them of their clothes (sometimes providing paper gowns, sometimes leaving the youths

naked), removing their mattresses and confining them alone in their rooms for days without access to education or exercise. Youths who refuse to remove their clothes are forcibly stripped, and male staff are sometimes involved in stripping female residents. Staff often put youths in disciplinary suicide watch on Friday evening, knowing that no mental health staff will be available to evaluate and release the youth until Monday, and then release the youth on Monday morning before a mental health referral can be made.

Staff at many of the facilities also impose significant periods of isolation in room confinement for very minor offenses. For instance, isolation for three days for cursing at staff is common at the DeKalb RYDC. Youths in Fulton County can also receive three days of lock-down for talking during meals. At this same facility, youths who scraped their names in the walls freshly painted just prior to our inspection tour were placed in disciplinary confinement indefinitely (and had been confined for almost two weeks at the time of our tour). While on isolation, youths do not attend school, generally eat meals in their rooms, and often are not let out of their cells even for recreation or exercise.

5. Staff Abuse. Use of excessive force against juveniles is unconstitutional. See, e.g., H.C. v. Jarrard, 786 F.2d at 1084-85. Patterns of excessive force were present (although to varying degrees) in all the RYDC facilities we toured. With the exception of the Griffin RYDC, our investigation found that staff persistently used excessive physical force against youths, in the form of hitting or slamming youths onto the ground and into walls, or otherwise injuring the youths. For example, a staff member at Fulton County bit a youth during one incident and three staff members from the Gainesville RYDC were criminally indicted for child abuse. Staff at the DeKalb RYDC have used OC spray (pepper spray) to punish youths for non-compliant or otherwise annoying, but non-dangerous, behavior.

This problem is created, in part, by lax supervision of line staff (for example, much of the misuse of restraints and excessive force occurs during the lightly-staffed third shifts); poor documentation of use of force; poor quality investigations of abuse allegations; exceedingly limited risk management by the central office; poor training of staff to de-escalate situations and control their own emotions; and by overcrowded and understaffed conditions that place great strain on the line staff.

We note, in particular, that although state law requires reporting of allegations of child abuse — including excessive force in juvenile institutions — to DFCS for investigation, many allegations of abuse are not reported. For example, our

investigation found a number of written grievances regarding staff abuse at the Fulton County facility, most of which had not been forwarded to DFCS. Moreover, DFCS generally will not conclude that abuse has occurred unless it has resulted in physical injury. Finally, the quality of DFCS investigations is generally quite poor. For instance, investigators routinely fail to question the accused officers or any witnesses other than the complainant, relying instead on the officers' incident report.

6. Inadequate Education. Youths in the RYDCs are entitled to an adequate education while held in the facilities not only by state law, but also by the federal constitution. See, e.g., Gary H. v. Hegstrom, 831 F.2d at 1433; Morgan v. Sproat, 432 F. Supp. at 1140-41. The State also is obligated to provide a free and appropriate education to disabled students pursuant to the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400 et seq., and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. See also, e.g., Alexander S. v. Boyd, 876 F. Supp. at 800.

a. General Education

Every aspect of education in the RYDCs is compromised by crowding and lack of resources. There is not enough space in the classrooms to accommodate the youth; as a result, the multipurpose rooms are used as noisy class space. There are not enough teachers given the population levels. Each facility has one special education and one regular education teacher to serve between fifty and 100 children ranging in age from nine to sixteen and having an even wider range of academic levels. To help with these massive demands on the certified teachers, the facilities use an uncertified teacher's aide and a Juvenile Corrections Officer to teach classes like "Values Education," "Health," and physical education. During our education tours, facilities were attempting to provide four hours of education per day pursuant to the terms of a waiver the DJJ school system had received from the State Department of Education's general requirement of five and one half hours per day for all other schools. However, more than half of the students' time is spent with uncertified teacher aides or line staff. Much of this time often consists of writing letters, reading magazines, or watching videos.

Even the time spent with certified teachers is of very limited value due to the lack of educational materials, the extraordinary range of academic abilities within each class, and the teaching methods employed. Most facilities have no budget to purchase educational materials and must use outdated text books discarded by local schools (although the RYDCs have a small number of computers through special funding from the State Lottery). While the RYDCs do perform some academic testing upon

admission, class assignments are determined by room assignment, rather than academic level. Thus, we encountered both youths who could not read and high school honors students in the same classes, receiving identical assignments which were uninstructive to either student. Most classroom instruction takes the form of xeroxed worksheets to be completed by the student with little instruction or assistance from the teacher. Our experts concluded that given the educational deficits of most of the students and the high prevalence of learning and emotional disabilities among the students, this is the least effective mode of instruction possible for these students.

The youths incarcerated in the RYDCs are especially in need of adequate education. According to DJJ's own estimates, over half of the youths admitted to the RYDCs are six or more grade levels behind in reading, and more than a third are six or more grade levels behind in mathematics. The failure to provide adequate educational services in the RYDCs has serious consequences for the youths incarcerated there. Although many youths' stay at the facility is quite short, a substantial number are detained for many weeks or even months. For those destined for boot camps, the combination of time spent in the RYDC and time spent in boot camp can amount to the better part of a semester at school. And many troubled youths, through multiple admissions to the local RYDC, spend a substantial portion of each school year in the facilities. Finally, the RYDCs make no effort to transfer records or grades to the child's home school or to ensure the student receives academic credit for work performed at the facility, except on the rare occasions where the student's family requests a transcript.

As a result, detention at the RYDC results in serious disruptions to children's educations, including causing children to repeat grades in school. The infliction of such consequences — often in violation of State law and regulations and even upon those ultimately found not guilty for their charged offenses — serves no legitimate State purpose.

b. Special Education

Our education experts found non-compliance with most of the requirements of the Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act in all of the facilities we investigated.

i. Screening, Identification and Evaluation.

Under the IDEA, the State must make adequate attempts to identify youths qualifying for special education services. 20 U.S.C. § 1412(2)(C); 34 C.F.R. § 300.128 (IDEA); 34 C.F.R. § 104.32 (Section 504); Alexander S. v. Boyd, 876 F. Supp. at 788. The RYDCs' attempts to identify youths who qualify for

special education services are inadequate. The RYDCs' primary method for identification is requesting educational records from the youth's home school district. Some of the facilities (e.g., the Gainesville and Bob Richards RYDCS) have employed a part-time records clerk to assist in this process. However, high turnover rates for residents and delays in receiving such records often result in the child leaving the RYDC before records are received. Attempts to retrieve such records are usually abandoned when the child leaves the facility, even when the youth has transferred to another DJJ facility and even though many youths will return to the RYDC at some point in the future. The facilities often ignore other indications of special education qualification elsewhere in the children's institutional and medical files. For instance, we found children whose probation reports indicated a history of special education but who were not receiving such services in the RYDC. There were even children who had active special education plans in their institutional files, but who were not identified as eligible for special education by the facility. Moreover, referrals for special education evaluation are rare even when the youths display obvious signs of special education need.

Implementing such identification procedures is especially important for youths who will be going to boot camps; delays in implementing special education services at the RYDC, in addition to delays at the boot camps often results in youths spending as much as six months in the DJJ educational system without ever receiving the services they need, and federal law requires, in order to benefit from education.

ii. Individualized Education Program

The foundation of the special education process is the development and implementation of an Individualized Education Program (IEP) for each qualified child. Honig v. Doe, 484 U.S. 305, 311 (1988). See also 34 C.F.R. § 300.341(a). Compare 34 C.F.R. § 104.33(b)(2) (Section 504). If a youth is brought into the facility with an active IEP, the RYDC may implement it in the facility, so long as the facility provides the services required (or closely approximate to those required) in the IEP, and so long as the youth's stay in the RYDC is short. See Alexander S. v. Boyd, 876 F. Supp. at 802. However, significant deviations from the existing IEP can only be made to accommodate the interests of the youth, not the resource constraints of the facility. See 34 C.F.R. § 300.17. If no current IEP exists or is otherwise unavailable, the RYDC must develop one through team meetings, as described in the regulations. See 34 C.F.R. § 300.344(a)-(b), 300.345 (IDEA). See also 34 C.F.R. § 140.35 (Section 504).

Among other things, the IEP must include "related services," such as individual or family counseling, that are "required to

assist a child with a disability to benefit from special education." 34 C.F.R. §§ 300.347(a)(3), 300.16. For children sixteen years-old or older (and younger children when appropriate), the IEP must also provide for services to aid the child in the transition from school to post-school activities, such as vocational training or instruction in independent living. 34 C.F.R. §§ 300.347(b), 300.18.

Our investigation found consistent failure to comply with most of the statutory and regulatory requirements. When IEP meetings are held, few efforts are made to comply with the requirement to include parents or obtain parent surrogates. See 34 C.F.R. §§ 300.344(a)-(b), 300.345. The IEPs frequently fail to specify measurable short-term objectives. See 34 C.F.R. § 300.47. Despite the obvious need for related services — such as, for example, psychological counseling for youths whose behavioral problems result in frequent expulsion from the classrooms — such services are not considered in the IEP process or provided to the students. There was little evidence of transition planning.

Rather than designing IEPs to meet the students' individual needs, IEPs in the RYDCs uniformly are altered to designate that the child will attend class with general education students, not because this is the most integrated setting consistent with the child's needs, but because the RYDCs offer no other educational options. We found little evidence that the individual attention and special modifications promised in the IEPs are received in practice.

Students entitled to special education are also routinely excluded from education altogether. Students on suicide watch or in disciplinary isolation are excluded from class and no substitute educational opportunities are provided. Some disabled students are consistently excluded from class for repeated periods of "time out" in their rooms, often for reasons directly related to their disability, indicating an unfulfilled need for related services or the inappropriateness of placing the disabled youth in a general class room. See also 20 U.S.C. § 1412(a)(1)(A).

7. Medical Care. Youths in DJJ's facilities have a constitutional right to adequate medical care. Estelle v. Gamble, 429 U.S. 97 (1976); H.C. v. Jarrard, 786 F.2d at 1086. While the State has begun to address the need for adequate medical care in the RYDCs in recent years — hiring a private contractor to provide a basic level of services, including a facility nurse — our investigation found that medical care was still inadequate in some areas.

a. Admission Health Appraisals

The starting point of an adequate medical system is identification of health problems upon admission to the facility. See, e.g., H.C. v. Jarrard, 786 F.2d at 1086; Patterson v. Hopkins, 481 F.2d 640 (5th Cir. 1973). While the RYDCs conduct a medical screening interview immediately upon admission, and attempt to assure prompt physical examinations, the scope, quality, and timeliness of these examinations varied considerably. We found long delays in conducting physicals at the DeKalb RYDC and Fulton County facility. Exams often are incomplete. For example, the facilities often do not give gynecological exams to girls or conduct tests for sexually transmitted diseases, even though more thorough testing at the girl's YDC in Macon frequently identifies such diseases and other medical problems that could have been identified and treated months earlier in the RYDCs.

Adequate screening is particularly important because high turnover rates in these facilities bring large numbers of youths through the RYDCs every year, many with serious medical problems — such as seizure disorders, diabetes, asthma, pregnancy and mental illnesses — that require careful monitoring to prevent serious health emergencies.

b. Dental Care

The RYDCs do not conduct any dental screening on youths and provide dental care only in extreme emergencies (usually requiring tooth extraction). Dental care is not covered under the State's contract with the private health care provider, even though a significant number of youths in the RYDCs may be held there for many months in need of dental care to ameliorate pain and prevent further damage to their teeth.

c. Quality of Care

Each RYDC is staffed with one nurse, who is on-site eight hours each weekday, and on-call on nights and weekends. The nurse must conduct sick call, manage and distribute medication, review intake medical screenings, arrange outside appointments and consultations, and respond to emergencies, in addition to performing the required physical examinations on new intakes. Each RYDC contracts with a private physician to provide two hours per week of medical service. This level of staffing is inadequate, given the population of the RYDCs and the rapid population turnover, leading to dangerous lapses in medical care. Often, screening forms are not completed by the line staff or sufficiently reviewed by the medical staff; physicals are not completed in a timely manner or are only partially completed; medical conditions requiring treatment or monitoring are missed; response to sick call requests can be delayed for days; and

medical records are incomplete and often not sent with youths when they are transferred to another DJJ facility. These predictable consequences of an overburdened medical staff are exacerbated by inadequate training and supervision of the medical personnel — for most practical purposes, the facility nurse runs an autonomous health care program without any significant oversight or quality assurance from the State Medical Director's office or the contractor.

8. Delayed Probable Cause Hearings. Ordinarily, youths believed to be delinquent or believed to have committed a status offense are first evaluated by a juvenile intake officer who determines whether the youth should be detained in an RYDC pending adjudication, placed elsewhere, or returned home. If the intake officer detains the youth, a probable cause hearing before a juvenile judge is held within three days (exclusive of weekends and holidays) to determine if there is probable cause to believe that the offense was committed and whether the youth should continue to be detained in the RYDC prior to an adjudication on the offense. See O.C.G.A. § 51-11-21(c). Youths detained on a Thursday often do not receive probable cause hearings until the next Monday.

The Due Process Clause of the Fourteenth Amendment requires that probable cause hearings be held within two days (including weekends and holidays) absent exigent circumstances. See A.M. v. Martin, No. 1:96-CV-2316-JEC (N.D. Ga. Jan. 26, 1998); see also County of Riverside v. McLaughlin, 500 U.S. 44 (1991); Moss v. Weaver, 525 F.2d 1258, 1261 (5th Cir. 1976). Youths in Georgia are consistently denied their right to prompt probable cause hearings.

9. Discipline without Due Process. Youths may be isolated and locked in their rooms as an immediate response to out-of-control behavior that endangers the youth, other youths, or staff. However, once the youth has regained control, further isolation for punitive purposes may only be imposed if the youth is afforded notice of the charges and an informal hearing before a staff member not involved in the incident. Cf. H.C. v. Jarrard, 786 F.2d at 1089; Gary H. v. Hegstrom, 831 F.2d 1430, 1443 (9th Cir. 1987); Patterson v. Hopkins, 481 F.2d 640 (5th Cir. 1973). With the exception of youths at the Griffin and Bob Richards RYDCs, detainees in the facilities we toured are consistently punished without such due process procedures.

10. Grievance Process. Detained youths have a constitutional right to file grievances with facility administrators regarding their treatment in the RYDCs. See Bradely v. Hall, 64 F.3d 1276 (9th Cir. 1995). Such grievances also provide an important quality-control mechanism by which DJJ administrators could be monitoring whether facilities are

adhering to State policies. Although DJJ policy requires a grievance procedure be available in each facility, this policy has been only partially implemented in most RYDCs we toured. Often, youths are not made aware of their right to file a grievance (they are not given handbooks explaining their rights, also in violation of DJJ policy), no forms are available, or line staff refuse to give youths the forms. A number of the facilities apparently interpret DJJ policy to require the youth to file the grievance with the employee against whom the youth is complaining, creating an obvious deterrent to the filing of such complaints and an unreasonable impediment to access to DJJ administrators.

B. Youth Development Campuses and Boot Camp Programs

We conducted our investigation of the YDC short- and long-term programs through document review, staff and resident interviews, and on-site tours with our experts of three short-term and two long-term programs. This included inspection of the Bill E. Ireland YDC, which houses about 500 youths and conducts both a long-term "regular" program and a boot camp for boys on a large campus in Milledgeville, Georgia. Here, youths are housed in small cottages built for twenty youths, or in a large temporary dormitory created from a former gymnasium. We also visited the Macon YDC for girls, which also conducts long- and short-term programming for about 160 girls in cottages built for about 25 youths. Finally, we inspected the Irwin YDC, which is run solely as a boot camp by a private contractor for the State. It houses about 300 boys in a single building originally designed as an adult prison. The boys sleep in open dormitory units containing about fifty boys.

Youths in these facilities have basic constitutional rights to adequate medical and mental health care, protection from harm (including staff abuse), and to adequate education and rehabilitative treatment. See, e.g., Gary H. v. Hegstrom, 831 F.2d at 1432; Nelson v. Heyne, 491 F.2d 352, 359-60 (7th Cir. 1974); Alexander S. v. Boyd, 876 F. Supp. at 790; Morgan v. Sproat, 432 F. Supp. at 1135; Pena v. New York Div. for Youth, 419 F. Supp. 203, 206-207 (S.D.N.Y. 1976); Martella v. Kelley, 349 F. Supp. 575, 585 (S.D.N.Y. 1972).

Our investigation uncovered systemic violations of the federal rights of the residents at these facilities.

1. Inadequate Mental Health Care and Suicide Prevention. There are significant numbers of mentally ill youths in Georgia's YDCs, many of whom are not receiving adequate mental health care. As mentioned above, more than sixty percent of youths entering the DJJ system have diagnosable psychiatric disorders.

a. Mental Health Care

Our investigation found many youths whose mental illnesses were left untreated even when they suffered from prolonged acute distress. Our experts found that mental illness is almost solely addressed through correctional responses (e.g., discipline, isolation and restraints) and through medication that is not part of an integrated mental health treatment strategy.

The results of this mode of treatment are dramatic. For example, on one occasion, a youth with a history of psychiatric hospitalizations and self-injury (such as placing staples in his eyes) was placed in shackles for two and a half hours as punishment for misbehavior in the security unit at the Bill E. Ireland YDC. When he managed to escape from the cuffs, staff physically subdued him and put the handcuffs back on. He then threatened to kill himself. Staff called the nurse to administer a shot of Thorazine. When the youth resisted the shot, three officers engaged him in a struggle and held him down while the shot was given. When released, he began hitting his head against the wall and was restrained. Shortly thereafter, he began kicking his cell door. Staff placed him in handcuffs and shackles. When he began to kick the door again, staff opened the door and sprayed him with OC spray. He was then showered and put in the isolation room, where he continued to beat his head against the wall until staff placed him in a straight jacket and helmet. Although he was checked for physical injury by the nursing staff, he was not seen by any mental health professional as a result of this incident.

This incident typifies the conditions in which many mentally ill youths are housed and treated. Many end up locked in security units where they spend large portions of their days isolated in small rooms with few activities. In these units, and elsewhere, they are often restrained, hit, shackled, put in restraint chairs for hours, and sprayed with OC spray by staff who lack the training and resources to respond appropriately to the manifestations of mental illness.[5] Instead of properly de-

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[5] Until recently, staff were also authorized to use medication — in the form of involuntary injections of psychotropic drugs — to restrain youths deemed out-of-control, on the authority of a "PRN" (as needed) prescription by a psychiatrist and administered by the facility nursing staff. Such a practice is subject to dangerous abuses in a correctional setting and we found significant evidence that on at least some occasions, youths at both the Bill E. Ireland and Macon YDCs were subject to forced injections as punishment for angering staff (particularly the nursing staff) rather than as an appropriately monitored medical treatment to prevent injury to the youths or others. See Nelson v. Heyne, 491 F.2d at 356-47. This situation

escalating situations or seeking aid from mental health resources, staff respond with force that ordinarily escalates the crisis. For instance, while in the security unit at the Bill E. Ireland YDC, one of our experts witnessed staff respond to a mentally ill youth's refusal to leave his cell when ordered. Rather than attempt to de-escalate the situation, three line staff engaged him in a physical confrontation, dragged him from his room, threw him in another and slammed the door (whereupon he immediately responded by unsuccessfully attempting to hang himself from the fire sprinkler head with his pants as staff looked on laughing). Other youths have been shackled to their beds or even to toilets. Staff have used OC spray on suicidal youths who resist having their clothes taken from them. Often these responses have little effect on controlling the youth's behavior (for instance, many OC spray reports note that the spray had no effect).

Such youths receive very little treatment from mental health professionals and the treatment they do receive is often substandard. Mental health resources in the YDCs we toured were very limited. At the 500-bed Bill E. Ireland YDC, one full-time psychologist provides a minimal amount of individual counseling for a few youths in addition to his other duties. The facility contracts with the local state hospital for approximately four hours of psychiatric consultation each week. The present psychiatrist, who specializes in adult treatment, spends this time solely monitoring psychotropic medications, meeting with youths on medications for brief (five- to fifteen-minute) interviews once a month and seeing additional referrals when emergencies arise.

Mental health resources at the Irwin YDC are even more limited. A contract psychologist visits the facility once every two weeks or so, for half a day, but spends most of that time involved in the special education process. A psychiatrist is on contract, but only visits the facility a few times each year (the facility's contract physician monitors psychotropic medications).

Mental health care resources at the Macon YDC are greater, but still inadequate. At the time of our mental health tour, the facility was contracting for up to six hours per week of psychiatric consultation, and a few hours per week of psychologist time. However, we were informed that new contracts for the provision of mental health services would soon reduce the number of hours provided by the psychologists and psychiatrists.

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should be resolved by appropriate implementation of guidelines recently issued by DJJ's medical director.

Even at present staffing levels, mental health contractors do not have time to consult with cottage staff about youth's behavior or reaction to medications, participate in treatment planning, or train line staff regarding treatment of mentally ill youths.

The result is serious deficiencies in the quality of psychiatric care. DJJ does not conduct adequate mental health evaluations or screenings. None of the facilities we visited undertake adequate, coordinated treatment planning. Very few youths in any of these facilities receive any significant psychotherapy, skilled mental health counseling or behavior management. With the notable exception of the care at the Macon YDC, there are serious deficiencies even within the limited scope of pharmacological responses to mental health care needs. For example, at the Bill E. Ireland YDC, there were no diagnoses or initial psychiatric evaluations prior to beginning medications; no interaction between psychiatrists and medical or direct care staff; insufficient monitoring of the efficacy and side effects of drugs; inadequate follow-up and re-evaluation; and deficient record keeping. The facility's contract psychiatrist has prescribed dangerously high dosages of medications (sometimes beginning youths on dosages five or six times acceptable starting dosages) without adequate evaluation or monitoring for serious side effects, as well as continued youths on non-therapeutic dosages of medications without taking adequate steps to determine their efficacy.

b. Suicide Prevention

As in the RYDCs, suicidal youths are generally isolated, often in secure disciplinary units, and monitored more frequently. At the Bill E. Ireland YDC, suicidal youths are housed in the security unit which, as discussed below, is the most psychologically abusive unit on the campus. Staff in these units do not always conduct required room checks. As mentioned earlier, a youth on suicide watch committed suicide in a security unit at the Augusta YDC last November when staff failed to conduct timely room checks.

Screening of youths for mental health problems generally, and suicide risk in particular, is deficient. And, as discussed above, there are few mental health resources to respond to underlying conditions that lead to suicidal behavior. As in the RYDCs, youths who attempt suicide or engage in self-mutilation are often shuttled back and forth between the facility and the local State Hospital which lacks the capacity to accept youths for longer-term treatment.

2. Excessive Force. Our investigation found that excessive force is employed against youths in all of the YDCs we inspected, often in a misguided, and illegal, attempt to control the

manifestations of mental illness. See Gary H. v. Hegstrom, 831 F.2d at 1436.

Staff at the Bill E. Ireland YDC have hit youths, shackled them to their beds for kicking doors, and shackled them in their cells for using abusive language. Staff sometimes respond to banging on doors or general rowdiness by deploying OC spray. OC spray is also used, at times, as a substitute for adequate staffing, when staff is alone and when the availability of sufficient staff would have obviated the need to resort to OC spray. Insufficient documentation and quality control exists for the use of this chemical agent.

To a lesser, but still significant degree, our investigation found patterns of staff employing excessive physical force against girls at the Macon YDC, generally by security personnel transporting girls to the Detention Unit.

Our investigation also found systemic use of excessive physical force against youths in the boot camps we toured. Under the guise of providing "on-the-spot correction," boot camp staff routinely inflict extreme forms of corporal punishment that have resulted in serious injuries in some cases to youths who are often very young and sometimes mentally ill. At the Bill E. Ireland boot camp, staff routinely punish youths for offenses, ranging from fighting to showing disrespect, by placing them on the ground and twisting the youth's arm behind his back, up to his neck, for up to half an hour or more. Although this practice was officially disavowed just after the announcement of our investigation, and although the facility and local DFCS investigators routinely conclude that allegations of continued use of such restraints are unfounded, the practice continues. In fact, in November, 1997, a staff supervisor broke a youth's arm after restraining him for collapsing during punitive exercises. A month earlier, this same supervisor broke a youth's eardrum when he hit the youth in the head for talking in line. At the Irwin boot camp, staff regularly take problem youths out of range of the facility's cameras and hit them with their fists or plastic slippers, put them in choke holds or slam them into walls.

The pattern of physical abuse of residents persists, in part, due to the inadequacies of the State's supervision of staff and investigations of allegations of abuse. Facilities conduct internal investigations of use of force on an ad-hoc basis, generally only in response to an allegation of abuse. These investigations are generally cursory and inadequate. The State Office of Law Enforcement is also available to conduct investigations upon request of the facility or central office officials, but while the quality of its investigations are better, it is involved in only a small portion of questionable use of force incidents. The absence of viable grievance systems

in almost all of the facilities also contributes to the failure to detect and respond to abuse.

And, as in the RYDCs, allegations of abuse are often not reported to DFCS. Restraints and other abuse that do not leave physical signs of injury are often either "screened out" or considered unfounded, and the quality of investigations in many counties is very poor.

3. Abusive Discipline. Our investigation found that staff often engage in a variety of abusive disciplinary practices that are informally and arbitrarily imposed with little supervision from DJJ administrators and no due process protections for the youth. These practices violate youths' due process right to be free from arbitrary and excessive punishment and are inconsistent with the States' obligation to provide minimally adequate treatment. See, e.g., Youngberg v. Romeo, 457 U.S. at 316-18; H.C. v. Jarrard, 786 F.2d at 1085.

a. Regular Programs

Staff at the Bill E. Ireland facility administer an informal, unregulated and often abusive form of discipline they call "rock time" (sitting on the concrete floor without back support and forbidden to lean on one's arms for hours at a time). Two hours of "rock time" is a common sanction for talking at dinner or in the television area or for showing disrespect. Youths can accumulate twenty hours or more of rock time, and often serve six or more hours at a time. Youths complained of back and hemorrhoidal pain, and of being denied permission to use the bathroom while serving rock time (or being forced to choose between using the bathroom and serving additional rock time). In some units, youths sent to the Detention Unit for discipline are given ten hours of rock time by unit staff in addition to the punishment given at the due process hearing and must serve the rock time even if they are cleared of the charges at the due process hearing. In at least one unit, the Cottage Life Supervisor converted all rock time remaining at the end of the week into additional time to be served beyond the youth's minimum release date, one day for each remaining hour.

Boys in some of the Bill E. Ireland cottages are also punished by being forced to surrender their clothing and bedding and being required to sit in their cold rooms in their underwear. Staff at the Macon YDC consistently shackle and order youths to the Detention Unit cells for the offense of "continued refusal to obey," often in response to very minor infractions that could easily be resolved through less drastic and harmful means.

Staff at Bill E. Ireland YDC also punish youths through a "reclassification" process through which time is added to a

youth's minimum release date. While the decision is approved by a committee, the committee almost always accepts the recommendation of the Cottage Life Supervisor. The youth is not permitted to attend or present any evidence and often does not know the "reclassification" has occurred until after his release date has been pushed back. The lack of procedural protection in this system results in the arbitrary extension of sentences, as demonstrated most clearly by its use to "reclassify" youths who refused or were unable to complete arbitrary "rock time" sentences.

Most of these unconstitutional practices also violate DJJ policies, but persist due to lack of sufficient supervision of staff and quality assurance mechanisms.

b. Security Unit at Bill E. Ireland YDC

Building 14 on the Bill E. Ireland YDC campus has two units. One houses youths being detained pending a disciplinary hearing or on suicide watch. The other is a long-term security unit. Youths are placed in the long-term unit for a minimum of thirty days, after which they are re-evaluated for release to the regular campus periodically. The units look like those in a high security prison, with individual locked cells opening into enclosed day room areas (also locked) arrayed around a central hub control room. The cells are approximately ten by twelve feet and contain two metal bunks and a toilet, with a small window. The units also have isolation cells of bare concrete, with no fixtures except a grated hole in the floor for a toilet (which can only be flushed from outside the cell).

Youths in the long-term unit attend school within the building for two to three hours each morning, and receive an hour of physical education (unless they are on disciplinary restriction). They spend most of the rest of the day (and eat their meals) locked in their cells, except for a few hours during which they are allowed to watch television in the day rooms. While they have some access to the unit counselor, few rehabilitative services are offered. Instead, line staff in this unit curse and belittle youths (many of whom are mentally ill) and impose arbitrary and cruel discipline. Angry youths frequently bang on their doors in frustration (often legitimate, as when their requests for toilet paper are ignored). Staff regularly respond by spraying such youths with OC Spray, shackling them to their beds, or stripping them to their underwear and placing them in the isolation cell. Our medical expert found that youths were being served meals in unsanitary conditions in the isolation cells, their trays sitting on the floor inches from the toilet hole.

This long-term unit is a dangerous, cruel and anti-therapeutic place for youths. Similar units have been found

unconstitutional by several courts. See, e.g., Morgan v. Sproat, 432 F. Supp. at 1138-40; Nelson v. Heyne, 355 F. Supp. 451 (N.D. Ind. 1972), aff'd, 491 F.2d 352 (7th Cir. 1974); Boy's Training School v. Affleck, 346 F. Supp. 1354, 1364 (D.R.I. 1972); Lollis v. New York State Dep. of Social Services, F. Supp. 473 (S.D.N.Y. 1970).

c. Boot Camps

While the use of paramilitary boot camps is not, in itself, unconstitutional, youths in the boot camps we inspected are often subject to unconstitutional excessive discipline that is largely unregulated by DJJ administrators. Youths in the boot camps are forced to engage in excessive exercise — sometimes in crowded, heated quarters — and corporally punished when they fail to complete the punitive exercises. For instance, a youth at the Irwin YDC collapsed while doing push-ups and required stitches to his face after a staff member began lifting him up and dropping him on the floor. And although written policies prohibit excessive exercise at the Bill E. Ireland boot camp, a youth's arm was broken in a restraint after he failed to complete 100 push-ups as ordered. Youths at the Irwin YDC have been forced to exercise in heat exceeding 95 degrees, doing pushups on black asphalt that burns their hands while being deprived of water, and have been forced to run laps in the heat while carrying a tire. In both camps, youths are sometimes forced to finish meals in five minutes and must leave unfinished food on their trays when the time has elapsed. These punishments are largely unregulated by supervisory personnel and inflict arbitrary punishment on youths.

These disciplinary practices are also particularly harmful to the significant number of youths in the boot camps who are physically, emotionally or psychologically unable to participate in or benefit from the boot camp regimen. The State has no entrance criteria for paramilitary boot camps. As a result, the boot camps have been sent children as young as nine years old, youths with injured legs and feet, youths with serious medical conditions such as anemia and brittle diabetes, and mentally ill or mentally retarded youths who cannot, by virtue of their disabilities, be expected to conform to the rigid expectations of a paramilitary boot camp. Very young children have difficulty understanding and following the sorts of instructions they are expected to obey to avoid punishment. As a result, these youths not only obtain little rehabilitative benefit, but are also psychologically and physically harmed as they are subject to punishment for failing to conform to boot camp rules and staff orders.

For example, we encountered a very small fourteen-year-old at the Irwin YDC boot camp whose medical record indicated he was mentally retarded. During his confinement, he was constantly

disciplined and placed in isolation for failing to follow orders and acting out. Line staff disciplinary reports and counselors' notes constantly note frustration with his inability to perform as expected and the inefficacy of their disciplinary measures, but do not indicate that staff was even aware of his mental retardation.

According to DJJ's own staff, the combination of overly aggressive, untrained staff and mentally ill or very young youths consistently results in confrontations that often escalate to physical abuse. These youths are also at greater risk of victimization by other residents, depression and suicide. It is our experts' opinion — and the opinion of many of the boot camp staff and mental health professionals with whom we spoke — that the paramilitary boot camp model is not only ineffective, but harmful to such youths.

4. Protection from Harm. We found that staffing levels in the regular and boot camp programs we toured were inadequate to provide sufficient supervision to protect youths from harm from other youths or to respond to emergency situations endangering all the youths. Staffing shortages have led to one line staff supervising up to thirty youths in the cottages at Bill E. Ireland, while staff at the Irwin YDC must sometimes supervise up to forty-eight youths by themselves at night. Cottages of twenty-five girls are often supervised by a single staff member at the Macon YDC.

As a result, a significant amount of sexual activity occurs at the Macon YDC, activity that may be particularly damaging to girls with a history of sexual abuse. Double-bunking youths in the Macon Detention Units without adequate supervision has led to fights resulting in serious injuries, while there have been near riots in some of the cottages at the Bill E. Ireland YDC. And youths have been sexually molested and choked unconscious by other residents at the Bill E. Ireland YDC. Fights occur daily in the Irwin YDC boot camp.

5. Inadequate Treatment and Education. The YDCs we toured are unable to provide constitutionally adequate education or rehabilitative services given the limited resources available and the significant increase in commitments in the past several years.

a. Rehabilitative Treatment

Although it is well-known that the delinquency of a substantial portion of committed youths is rooted in alcohol or substance abuse, or in a history of physical or sexual abuse, there is very little programming to address these issues. At the time of our tour of the Bill E. Ireland YDC, the small substance

abuse program that had been in place had been disbanded for lack of funding, leaving drug and alcohol treatment programming available for only thirty boys in the entire DJJ system. In addition, up to forty-one girls receive drug and alcohol treatment at the Macon YDC. The Emory University study concluded that more than 25 percent of the youth in the system suffered from drug or alcohol problems. As one DJJ administrator told us, the level of treatment provided "barely scratches the surface."

There is no treatment directed toward victims of sexual abuse at any of the facilities. And while there is a small program for sexual offenders at one YDC, its capacity is far below that necessary to provide treatment to all those for whom such treatment is indicated.

Counseling staff at both facilities are overburdened to the point where they can provide very little effective individualized treatment. At both the Macon and the Bill E. Ireland YDCs, counselors are expected to supervise the line staff assigned to their units which significantly reduces the amount of time available for actual treatment. In addition, shortages of line staff mean that counselors must often spend a substantial portion of their time simply supervising youths rather than providing any treatment. For instance, at the Macon YDC, counselors often do not satisfy the facility's modest requirement to meet individually with each youth twice each month for an hour. And each counselor who provides individual counseling at the Irwin YDC is assigned forty-eight youths, resulting in very infrequent individual counseling. When created at all, treatment plans for youths are quite standardized — treatment plans in the boot camps tend to be identical. There is little, if any, transition planning to help youths plan for their re-integration into the community.

b. Education

Most of the problems identified with the education programming in the RYDCs were also present in the YDC programs, with certain significant exceptions. Our experts found that the Macon YDC's education program was, with certain important exceptions (noted below), one of the best they had ever encountered in a juvenile setting, indicating that with sufficient resources and leadership the YDCs are capable of providing youths with not only minimally adequate, but high quality education during their confinement.

i. General and Vocational Education

Our experts found that the education programs at the Bill E. Ireland YDC and Irwin boot camp fail to assign youths to classes based on academic level or needs, resulting in classes composed

of students with too broad a range of abilities and academic levels to permit adequate education. Attempts to even assess a youth's education level are hampered by the unavailability of prior educational records (due in part to the failure of the RYDCs to request or forward those records).

At all the facilities, vocational programs are limited (for instance, the Macon YDC provides only cosmetology) and not linked to job opportunities in the employment market.

ii. Special Education

Efforts in all the facilities to identify youths in need of special education services are deficient. Our experts found that "[e]ven the most conservative prevalence estimates suggest that the number of incarcerated youth who can be anticipated to meet the criteria for eligibility in these disability classifications is at least three to five times the number who are identified eligible in the Georgia juvenile facilities." About eight percent of the youths in the YDCs we toured are identified as eligible for special education services. This is lower than prevalence figures for public schools generally and significantly lower than the twenty-five to sixty percent prevalence rates estimated for juvenile facilities nationally. The lack of timely access to educational records contributes to under-identification, along with inadequate testing, referral and screening systems, particularly for the boot camp programs.

As in the RYDCs, the IEP development process, and the IEPs themselves, are deficient in many respects. Little effort is made to secure parent or surrogate parent participation in the IEP process. Except at the Macon YDC, required staff, such as school or clinical psychologists and a school administrator, generally do not attend the IEP meetings, nor are the students invited to participate.

Because of limited special education resources, IEP planning is generally limited to choosing among an inadequate continuum of services. In the Irwin YDC, the only option available is inclusion with general education students with some limited assistance from the facility's special education instructor. As in the RYDCs, IEPs are often modified to suit the needs of the facility, rather than the youth. Often, particularly in the boot camps, the IEPs developed at the facilities are unduly standardized and not sufficiently related to the individualized needs of the youth. There is little provision of related services. To the extent that very limited counseling services are available elsewhere in the program, they are not coordinated as part of the special education program. There is almost no transition planning, which is particularly important in the YDC setting in which many youths, confined for significant periods of time under DJJ supervision, will shortly be required to

transition back into public schools or post-school activities and who have shown themselves to be unlikely to succeed in such transitions without substantial planning and assistance.

There were insufficient numbers of special education teachers in all the facilities we examined except the Macon YDC. At the Irwin YDC, for instance, there is only one special education teacher (who was only provisionally certified at the time of our education tour) in a facility serving more than 300 youths. The Bill E. Ireland YDC had only three special education positions for about 500 youths, one of which was unfilled at the time of our experts' visit. Given even conservative prevalence rates, such staffing is inadequate to provide the individualized education required by federal law.

Disabled youths are often denied all (or almost all) education at times. Youths are often absent from class for reasons unknown to their teachers. Youths in disciplinary confinement receive reduced or no educational services. As in the RYDCs, such absences are often directly related to the youth's disability, indicating a need for further services to enable the youth to remain in class or the need for an alternative educational placement for the youth.

Finally, we found that staff were generally unaware of their obligations under Section 504 of the Rehabilitation Act toward youth's whose disabilities are covered under that provision, but not the IDEA.

6. Inadequate Medical Care. The medical programs at the YDCs are more developed than those in the RYDCs. However, this system has been placed under considerable stress to accommodate the recent influx of youths into the YDCs (particularly into the boot camp programs), resulting in some deficiencies in care.

a. Initial Health Appraisals

There are well-defined procedures for initial health appraisals in the YDCs. But the lack of sufficiently trained nursing staff and sufficient contract physician time contribute to a failure to identify and follow through on indications of serious health problems (such as seizure disorders and anemia). Moreover, certain basic tests — such as pregnancy tests for girls, HIV tests for youths indicating high risk of exposure or for pregnant girls, and complete blood tests — are not always administered.

b. Sick Call

Sick call at the YDCs we toured was deficient. The already-overworked nursing staff functions as the gatekeeper to the very

limited physician time for seeing youths with medical complaints. Sick calls are conducted in an informal fashion, with little documentation that could be used to help assure quality care and access. Review of charts and interviews of youths on site showed that youths with serious medical complaints have been turned away by nursing staff and not seen by a doctor until their health had deteriorated further.

c. Dental Care

While a dental screening is performed on admitted youths, lack of resources has forced facility contract dentists to spend most of their time conducting initial examinations to detect and respond to only the most urgent dental care needs and has prevented them from providing needed restorative work to prevent further damage to decaying teeth. Even in conducting random interviews of youths, our investigation encountered numerous residents with large, visible tooth decay who were not receiving treatment.

d. Quality of Care

Our expert identified lapses in the quality of medical care in some areas. For instance, there are serious deficiencies in the care of chronically ill patients (such as diabetics and asthmatics) due to a failure to monitor systematically the youths' health, order and follow up on required testing, and make appropriate referrals to specialists. Staff fail to follow up on abnormal findings on health screenings and exams. As a result, appropriate treatment for identified health problems is often not obtained.

Facilities lack sufficient and appropriate medical staff. None of the facilities had a medical director. The facilities do not purchase enough physician time to permit the doctors to review incoming admissions adequately, supervise the care of chronic illnesses, and treat acute illnesses. For example, the Macon YDC contracts with its physician to provide only four hours of care per week for its 160 female residents, the Bill E. Ireland YDC's 500 boys receive only ten hours of physician care per week, and the 300 youths in the Irwin YDC receive two or three hours of physician care each week. The nursing staff at each facility is composed largely of LPNs who have relatively little medical education, are poorly paid, and whose positions are often difficult to fill. They are supervised by registered nurses who, because of the very limited physician time under contract and the lack of a medical director, take on the practical responsibility for supervising the medical program, as well as providing a more skilled level of nursing care in particular cases. The facilities do not employ mid-level practitioners (such as physicians assistants or nurse

practitioners) who could perform some of the more skilled functions (such as conducting physicals or performing triage of sick call requests).

Training and supervision of the nursing staff in their performance of these broad responsibilities is very limited. Some recent steps have been taken to improve this situation — the State Medical Director has issued a clinical manual and instituted a rudimentary quality assurance program — but these beginning steps are insufficient to provide adequate assurance of appropriate medical treatment.

Finally, medical care in the YDCs we toured also suffered from a lack of adequate information systems to track medical records and medication information, both within the facility and as youths transfer among DJJ facilities. For instance, nurses in the YDCs reported that almost half of the time they did not receive medical records from the RYDCs. In another example, line staff in the Bill E. Ireland boot camp reported that they had no way of knowing which youths needed to report to the clinic for medication. As a result, youths sometimes miss dosages of important medications.

7. **Inadequate Grievance System.** None of the YDCs or boot camp programs we inspected had viable grievance systems. Staff at the facilities were often unable to produce grievance forms when asked during our inspections, youths reported staff tearing grievances up, and as a result very few are ever officially received (we were given sixteen grievances covering a six-month period at the 500-bed Bill E. Ireland facility; the Irwin YDC could not produce any and its Director admitted that they had no functional grievance system).

C. Systemic Issues

In addition to touring individual facilities, we and our experts also examined information relating to DJJ facilities throughout the State, including documents from other DJJ facilities, state-wide policies and procedures, and DJJ system-wide statistical and programmatic information. We also discussed systemic issues with relevant DJJ administrators. It is clear from these sources that many of the problems identified in the facilities we visited are common throughout the DJJ system, caused in part by a general lack of resources, certain DJJ policies and practices, and the stress put on the entire DJJ system by a burgeoning population of youths. For example, in the RYDC system, severe overcrowding and understaffing is pervasive; mental health resources are inadequate and haphazard throughout; and there are insufficient numbers of teachers and medical personnel in most of the RYDCs given the population levels. In the YDCs, lack of mental health resources and alternative

placement options for mentally ill youths result in inadequate mental health care throughout the system; there are insufficient programs to address rehabilitative needs relating to drug and alcohol abuse, sexual predation, or physical and sexual abuse; and the lack of entrance criteria results in mentally and physically ill youths being placed inappropriately in boot camps throughout the system. Moreover, lack of adequate quality assurance systems in the central office makes it probable that the problems found in the YDCs and boot camps we visited relating to medical care, disciplinary practices and staff abuse also occur in other facilities as well.

III. Lee-Arendale Correctional Institute

In our letter notifying you of this investigation, we stated our intention to investigate the conditions of confinement of the young offenders, ages thirteen to sixteen, sentenced as adults and housed at the Lee-Arendale Correctional Institute. We conducted initial tours of the facility with our juvenile administration and education experts and found that the facility presently houses only a handful of youths. While our experts were critical of several aspects of the operations of this facility — which will be evident in their reports — the Department of Justice has chosen not to pursue the investigation of this facility any further at this time. Although changes in population levels or conditions may, in the future, warrant renewed investigation, at present we consider the investigation of this facility closed.

IV. MINIMUM REMEDIAL MEASURES

To rectify these illegal conditions and to ensure that Georgia's juvenile facilities comply with federal constitutional and statutory requirements, the following minimum remedial measures must be implemented:

1. Take steps to assure adequate environmental conditions in the Fulton County Detention Center.

2. Ameliorate punitive conditions in the RYDCs and the Fulton County Detention Center. Ensure adequate staffing to permit youths reasonable access to education, recreation, and visitation; to eliminate prolonged periods of lock-down; to ensure safe evacuation in the event of a fire; and to permit sufficient access to toilet facilities in the Fulton County Detention Center.

3. Adequately protect youths from staff abuse and abusive disciplinary practices. Provide sufficient staff training and supervision, including appropriate risk management practices, to detect and respond to incidents of staff abuse and ensure compliance with DJJ use of force and discipline policies.

4. Employ sufficient numbers of trained staff, implement a reasonable classification system, and enforce sufficient supervisory practices to assure that youths are adequately protected from violence by other youths in all facilities.

5. Provide adequate trained staff and resources to assure access to adequate medical care, including dental services. Engage in reasonable quality assurance activities to monitor and assure adequate medical care.

6. Provide adequate mental health services to meet the needs of confined youths, including appropriate treatment in response to suicide risks and self-mutilation. Assure adequate access to skilled mental health providers and hospitalization when necessary.

7. Cease placement of mentally ill youths in programs and units where they cannot receive adequate mental health care or where they face a likelihood of punishment or other harm in response to their mental illness.

8. Cease placement of youths into boot camps when, by reason of mental or physical disability or maturity level, the youth cannot reasonably be expected to obtain any significant benefit or placement will likely result in physical or psychological harm to the youths.

9. Provide adequate general and special education services in all facilities. Provide adequate vocational programs in long-term facilities.

10. Comply with the requirements for provision of special education, as required by the IDEA and Section 504 of the Rehabilitation Act, including related and transition services to special education students.

11. Employ sufficient numbers of qualified personnel and implement appropriate programs in the YDCs and boot camps to provide individualized treatment sufficient to afford each youth a reasonable opportunity for rehabilitation.

12. Ensure that required probable cause hearings are held within two days, except in exigent circumstances.

13. Ensure that youths are given due process hearings prior to significant disciplinary confinement.

14. Provide youths on disciplinary confinement with appropriate access to school and adequate exercise. Provide all RYDC youths reasonable access to reading materials in their rooms.

15. Assure that youths are permitted a reasonable opportunity to file grievances with DJJ officials.

16. Create and implement adequate quality assurance mechanisms and reviews to ensure the efficacy of the above corrective measures.

Under the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, the Attorney General may initiate a lawsuit to correct the deficiencies identified herein. 42 U.S.C. § 14141. Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at these institutions forty-nine days after the date of this letter notifying you of the deficiencies. 42 U.S.C. § 1997b(a)(1). Further, in light of the systemic nature of many of the problems identified, the United States could undertake investigations of other DJJ facilities under CRIPA or initiate litigation to correct systemic patterns or practices that violate youths' federal rights under 42 U.S.C. § 14141.

We would prefer, however, to work with State officials to avoid contested litigation to remedy the violations found in the nine facilities we toured and the systemic issues underlying these problems and affecting facilities throughout the State. We know that DJJ officials already have developed plans that may begin to address some of these issues, if required appropriations are available. In a separate letter, we will identify federal resources that may also be available to assist the State in implementing remedial measures and improving conditions throughout the State's juvenile justice institutions. We look forward to conducting negotiations to resolve the systemic

deficiencies we have identified in a reasonable and expeditious manner.

Sincerely,

Bill Lann Lee
Acting Assistant Attorney General
Civil Rights Division

cc: The Honorable Thurbert Baker
Attorney General
State of Georgia

Mr. Eugene Walker
Commissioner
Department of Children and Youth Services

Mr. Allen L. Ault
Commissioner
Corrections Department

Mr. Robert J. Regus
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Fulton County

Mr. Doug Williams
Warden
Lee-Arendale Correctional Institution

Ms. Jane Wilson
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Mr. Bill Bateman
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Mr. Jesse Andrews
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Ms. Shay Bilchick
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Ms. Linda C. Schrenko
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