The Honorable Mike Huckabee
Governor of Arkansas
State Capitol
Little Rock, Arkansas 72201

Re: CRIPA Investigation of
Alexander Youth Services Center
Alexander, Arkansas

Dear Governor Huckabee:

We are writing to report the findings of our investigation of the conditions at the Alexander Youth Services Center (herein referred to as "Alexander" or "the facility"). On May 8, 2002, we notified you of our intent to investigate Alexander pursuant to the Civil Rights of Institutional Persons Act ("CRIPA"), 42 U.S.C. § 1997, and the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141").

On June 3-5 and 19-21 2002, we conducted on-site inspections of the facility with expert consultants in juvenile justice management, mental health care, fire safety, and education. While at Alexander, we interviewed residents, and direct care, program, and administrative staff. Before, during, and after our visit, we reviewed documents including policies and procedures, incident reports, investigations, and mental health, medical, and education records.

We would like to thank the staff at Alexander and State officials for the level of cooperation we received during our investigation. We also appreciated the candor and openness of the facility's staff and administration. Moreover, State and facility staff and administration reacted positively and constructively to the observations and recommendations for improvement made by our consultants during the site visits.

Consistent with the statutory requirements of CRIPA, we write to advise you of the results of the investigation. As described more fully below, we conclude that certain conditions at Alexander violate the constitutional and statutory rights of residents at the facility. We find that children confined at Alexander suffer harm or the risk of harm from deficiencies in the facility's mental health care and fire safety protections. In addition, the facility fails to provide required education services. Finally, we find that Alexander violates the First Amendment rights of its juvenile residents by forcing them to engage in religious activities. While we have some recommendations regarding the facility's overall juvenile justice management, we found no constitutional or statutory violations in that area.

I. BACKGROUND

A. FACILITY DESCRIPTION

Alexander is a 140-bed facility that serves as the central intake center for the Arkansas juvenile justice system. It houses only children who have been adjudicated as juvenile offenders and committed to State custody. Youth housed at Alexander range in age from 10 to 17. On September 1, 2001, a private corporation, Cornell Companies, Inc. ("Cornell"), assumed operation of Alexander. The State employees who had staffed the facility prior to that date were required to reapply for employment, and there has been considerable staff turnover since Cornell assumed the management of the facility. While State employees still provide some intake services at the facility, all of the facility administration, counselors, security staff, and direct care workers are now Cornell employees.

There is a boys' and a girls' intake unit at Alexander.(1)> Alexander also houses the State's sex offender unit for juveniles and a separate unit for children who have either committed the most serious types of offenses or caused problems while housed in another part of Alexander or elsewhere in the State system (this unit is called the "JUMP" unit). There are two additional units that house boys, one for 10-15 year-olds (called "MAC"), the other for 16-17 year-olds (called "HOPE"). The children in these two units are housed by age, rather than any other form of classification, and are generally waiting for space to open up in some other placement, whether it be the JUMP unit at Alexander or another program within the State juvenile system. Alexander cannot refuse to accept juveniles from other State facilities, nor can it transfer juveniles to another State facility unless that facility agrees to house them.

While most of the buildings on the campus are more than twenty years old, two new buildings were built recently. The first is an education building in which classes were already taking place during our first visit to the facility. The second is a dormitory housing unit that was not occupied as of the time of our second visit to the facility, but that we understand is now housing some residents.

Children in the JUMP unit go to school, eat, are given medication, and receive recreation all within the JUMP unit building and the attached outdoor recreation area. Thus, youth in the JUMP unit can go long periods of time without ever leaving the JUMP unit complex. Children in the other units attend school in a separate school building, go to the cafeteria for lunch and dinner, receive medicine at the infirmary, and have access to a gymnasium and outside recreation fields.

B. LEGAL BACKGROUND

Both CRIPA and Section 14141 give the Department of Justice the authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of children in juvenile justice institutions. 42 U.S.C. § 1997; 42 U.S.C. § 14141. As a general matter, the State must provide confined adjudicated juveniles with reasonably safe conditions of confinement. See Youngberg v. Romeo, 457 U.S. 307, 315-16, 24 (1982) (recognizing that a person with mental retardation in state custody has substantive due process rights under the Fourteenth Amendment); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979) (applying the Fourteenth Amendment standard to facility for adult pre-trial detainees); Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9th Cir. 1987) (applying Fourteenth Amendment standard to facility for adjudicated juveniles).

Adjudicated juveniles have a right to adequate education instruction. See Alexander S. v. Boyd, 876 F. Supp. 773, 798 (D.S.C. 1995). They also possess federal statutory rights to education under the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400, et seq. Moreover, the Equal Protection Clause can bar discrimination based on gender in the provision of education services. See United States v. Virginia, 518 U.S. 515 (1996).

The First Amendment both prohibits states from coercing individuals to support or participate in religion and guarantees their right to exercise freely their religious beliefs. U.S. Const. Amend. I ("Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof").

II. FINDINGS

A. MENTAL HEALTH

The Constitution requires that confined juveniles receive adequate medical treatment, including mental health treatment and suicide prevention measures. Hott v. Hennepin County, 260 F.3d 901, 905

(8th Cir. 2001) (citing Williams v. Kelso, 201 F.3d 1060, 1065 (8th Cir. 2000)); Young v. City of Augusta, 59 F.3d 1160, 1169 (11th Cir. 1995); Horn v. Madison County Fiscal Court, 22 F.3d 653, 660 (6th Cir. 1994); Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977).

i. Suicide Prevention

Alexander fails to employ sufficient suicide prevention measures. Two juveniles at Alexander have committed suicide by hanging themselves since May 2001. Both cases illustrate deficiencies in the suicide prevention measures utilized by Alexander. Since those cases, the State has taken some measures to attempt to address these deficiencies. However, there are still unremedied deficiencies in the facility's suicide prevention procedures.

On May 13, 2001, a juvenile who was housed in Alexander's JUMP unit hanged himself. Although the juvenile had a long history of self-harm and self-mutilation, and a member of the treatment staff placed him on suicide watch on May 5, 2001, the log book on the JUMP unit covering the period from May 1st until the juvenile's death did not indicate that suicide watch procedures were utilized. Thus, it was not communicated to direct care staff that he was on suicide watch or that he should be under constant observation. In addition, the juvenile was given sheets for his bed, even after a May 5, 2001 search of his room indicated that he had torn his sheet in strips and was braiding the strips together to make a rope. The investigation of the incident showed that direct care workers were sleeping on the job, had failed to conduct required ten minute checks, and may have falsified log book entries.

On September 16, 2001, another juvenile housed in Alexander's JUMP unit hanged himself. After an August incident in which this juvenile placed a sheet around his neck, he was put on suicide precautions. Later, the facility psychiatrist discontinued the suicide precautions, but ordered that the juvenile be put on close observation. However, there was no description of what close observation required in the suicide prevention policy in effect at the facility at that time. Moreover, once again there was no documentation of this order to provide close observation provided to the staff on the JUMP unit. As a result, only one check of the juvenile was made during a three-hour period ending in the discovery of his body. During the evening of his death, the juvenile repeatedly threatened to kill himself, and covered the window to his room to prevent being observed. Despite these threats, and his covering of his window, the juvenile was not constantly observed and was allowed to continue to have his sheets. The investigation of this incident found that direct care staff had failed to conduct required checks on the juvenile, had falsified records, and failed to ensure his safety and security.

Since the first of these suicides, the State has adopted a revised suicide policy and has taken disciplinary action against several employees whose conduct during these incidents violated facility policy. However, serious deficiencies in the facility's suicide prevention measures remain. The facility continues to lack an effective method of communicating vital information about juveniles to direct care staff. Even though we were told that the facility relies on the unit log books to provide direct care staff with necessary information about the children under their care, we reviewed numerous log books that failed to provide sufficient information about the incidents that led youth to be placed on suicide watch, close observation, or room restriction. In other cases, log books failed to provide sufficient information for staff to carry out properly orders for suicide watch (i.e., what material children should be allowed in their rooms while on watch).

For example, during our most recent visit to the facility, we observed a juvenile in the JUMP unit who had threatened to commit suicide by fashioning a noose from his sheets. Not only was there no information available on the unit regarding what led to the suicide precautions, but the juvenile was allowed to keep his sheets. During our first visit to the facility, we met a child who appeared very sullen

and depressed. We later learned that he had told officials at another facility that we would kill himself if he were returned to Alexander. However, this information had not been communicated to direct staff, and this child was not placed on any kind of precautions until we expressed our concerns to the facility staff about his condition.

While the State has adopted a revised suicide policy which provides for strong suicide prevention measures, there was considerable confusion among the staff we interviewed about the particulars of the policy. Different staff members provided different explanations of what level of scrutiny was required by the various levels of observation (i.e., the differences between "Close Supervision" and "Continuous Observation"). We also received varying answers about what type of staff members could place juveniles on suicide observation or remove them from such designation. Finally, even though the policy states that juveniles on suicide precautions should not have bed sheets and regular blankets, as discussed above, we observed a juvenile who was on suicide precautions for threatening to hang himself in possession of bed sheets and a regular blanket. Thus, additional training needs to be provided to employees about the suicide prevention policy. Further, it is critical that the facility develop quality assessment mechanisms to ensure that staff are properly implementing these suicide prevention policies. Moreover, the policy should be revised to provide clearer guidance on who can put a juvenile on suicide precaution (the policy provides that any staff member can refer a juvenile to the treatment staff for evaluation, but does not specify who can actually put the juvenile on suicide watch), and on whose authority the juvenile can be removed from such precautions.

ii. Treatment

Alexander fails to provide the juveniles in its care with sufficient individual mental health treatment and counseling -- particularly residents with serious mental illnesses. The facility recently hired a qualified mental health professional, a social worker, to serve as a counselor to children on the JUMP unit. However, as described below, more qualified mental health professionals, and additional remedial measures, are required to provide adequate individual mental health treatment at the facility.

Although the facility has a psychiatrist and a psychologist, they respectively only prescribe medication and conduct intake analysis. They do not provide any individual treatment to the children. Alexander employs counselors to provide direct services to its residents. However, these counselors are only required to have a Bachelor's Degree and need not be qualified mental health professionals. Moreover, many of the counselors we interviewed during our visit stated that they did not believe they had the knowledge or experience to provide individual mental health treatment to residents. A substantively identical individual mental health treatment program for incarcerated juveniles was found constitutionally deficient in Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974).

The counselors at Alexander also have many competing demands on their time. They are primarily responsible for a number of tasks that while important, take time away from their ability to provide individual mental health treatment. For example, they are charged with case management for the juveniles, which requires interacting with other State and local agencies, keeping the children and their families informed about their status, and fulfilling a wide variety of record-keeping requirements. The counselors also conduct group treatment classes that can have as many as 20-30 children. Counselors also told us of being asked to aid the direct care staff in basic custodial functions. Because of these time pressures, most counselors told us they were unable to meet with the juveniles for the amount of time regularly scheduled for such sessions. Even the fact that a child was under suicide watch did not ensure that they received individual attention from a counselor.

The counselors' level of education and experience do not allow for the provision of what could

properly be characterized as individualized mental health treatment. The need for such treatment is especially pronounced at Alexander because the facility manages children with serious mental illnesses, rather than sending them to other facilities. During our visit we met several children with serious mental illnesses, including psychosis and bi-polar disorder, who were receiving medication, but no other mental health services. These children with serious mental illnesses require individual mental health treatment from a qualified mental health professional. They would also greatly benefit from smaller group therapy sessions conducted by such professionals. These services are currently unavailable at Alexander.(2) The hiring of additional qualified mental health professionals would also allow the counselors to focus on their case management responsibilities and spend more time interacting with the children. This increased interaction will provide more support for the children and reduce anxiety, which can help reduce the need for more formal mental health treatment.

Alexander generally does a good job in conducting mental health screenings and employs a highly qualified and experienced psychiatrist to prescribe medication. Still, there are deficiencies in these areas that contribute to the overall deficiencies in mental health treatment. First, there is no regular and institutional means of obtaining from outside sources (i.e., mental health facilities, other detention centers, etc.) medical and mental health records about children entering the facility. We were told by facility staff that such records are not obtained as a matter of course, but instead must be tracked down by the nursing staff, the psychiatrist, or the psychologist. Of the files of juvenile residents we reviewed, while some had such outside medical and mental health records, others for whom such records clearly existed did not. We understand that there are even difficulties in getting medical and mental health information that was generated during previous admissions of the juvenile to Alexander. Such records are not centralized, but are kept in multiple files throughout the facility, and in some cases cannot be retrieved if they date to before Cornell assumed operation of the facility only a year ago.

Second, there are problems in the development and implementation of treatment plans -- problems that adversely effect the overall treatment provided to juveniles at Alexander.(3) First, the psychiatrist often does not document his diagnosis or the basis for the diagnosis. This fails to meet the standard of proper care. Second, the psychiatrist does not appear to have access to information from direct care staff that may be essential to him in prescribing appropriate medication - for example, direct care staff who may be able to inform the psychiatrist of a youth's reaction to medication or recent changes in a youth's behavior. Finally, Alexander should develop written protocols for reviewing the appropriateness of prescribed medicine at required intervals and ensuring that all necessary tests and screenings are conducted before and while children are prescribed pyschotropic medication. Currently there are no such formal protocols.

B. FIRE SAFETY

Alexander violates the constitutional rights of its residents by failing to provide adequate fire safety protection. See Estelle v. Gamble, 429 U.S. 97, 103 (1976). This failure results from deficiencies in sprinkler coverage of the facility; the absence of smoke detectors in dormitory rooms; inadequate fire separation of cells and hallways (which allows the flow of smoke and fire from one room or corridor into another); the lack of proper ventilation in dormitory cells; and the facility's failure to have remote unlocking devices to automatically release juveniles from their cells in the event of an emergency. See Cody v. Hillard, 599 F. Supp. 1025, 1025 (S.D.S.D. 1984) (in determining whether the constitutional requirement of adequate fire safety is met, courts look at the totality of the circumstances, rather than measuring compliance simply by checking the conditions against any one fire code or set of national standards). These deficiencies exist in Alexander's housing units and in other buildings in which residents spend significant amounts of time.

i. Housing Units

The older housing units (which include the boys' and the girls' intake, MAC, HOPE, JUMP, and the sex offender unit) are inadequate to meet constitutional standards for fire safety. None of these housing units have adequate safeguards to control the spread of smoke, nor do they have sufficient smoke detection equipment. There is no smoke management system to ventilate the cells and hallways in the event of a fire emergency. See Coniglio v. Thomas, 657 F. Supp. 409, 414 (S.D.N.Y. 1987) (finding that the Due Process Clause requires facilities to develop effective smoke management systems and smoke barriers).

There are no smoke detectors in any of the individual cells in the housing units. There are also no smoke detectors in the JUMP unit's classrooms. Such detectors are needed to provide facility staff with sufficient warning that a fire has started to facilitate the safe evacuation of residents. While there are smoke detectors in the corridors of the JUMP unit, these detectors are battery operated. Not only can such battery operated detectors be compromised by the failure to replace the batteries or to regularly check that they are still functioning, but they create additional risk to the safety of both residents and staff. Currently, if a battery operated detector is activated, a staff member is required to go investigate where the smoke or fire is coming from, and inform the appropriate fire prevention officials. This system not only increases response time, and therefore puts juveniles at greater risk, but by requiring staff members to go towards the fire, it jeopardizes staff safety as well. Alexander should replace its battery operated smoke detectors with a "hard-wired" monitoring system that would automatically trigger a fire alarm when smoke is detected and would provide central monitoring of the entire system to inform staff exactly where the fire is coming from without human investigation.

There are additional deficiencies in the housing units that contribute to the failure to provide constitutionally adequate fire safety protection. In all of the dormitories except the JUMP unit, there are currently no sprinklers.[(4)] Sprinkler systems are critical to suppressing the spread of fire. Even in the JUMP unit, only one of the three sections of the unit has sprinkler heads. The sprinkler heads in that area, at the time of our visit to the facility, had not been tested or inspected since 1994 and lacked sufficient water pressure for the sprinkler heads to be effective when activated. The cabinets containing the fire extinguishers on the unit are locked, adding to the failure to provide adequate fire suppression.

Each of the housing units also has a gas furnace supported by a plywood surface. This is a fire hazard that can not only cause a fire to start, but can provide additional combustible material to spread a fire. Also, the utility closets on the housing units that contain the gas furnaces are not sufficiently separated from the rest of the building to provide adequate protection against a fire spreading to the rest of the building. The JUMP unit also has an unused kitchen that has a live gas line. This incendiary device poses unnecessary risk to the youth living in the JUMP unit.

The locking system used for cells on the housing units also poses a hazard in the event of a fire. There is no automatic unlocking system for the cells; each cell must be unlocked manually by a staff member. See Alexander S., 876 F. Supp. 773 (finding that the requirement to provide adequate fire safety is violated by housing juveniles in cells that need to be unlocked one by one with a key, rather than a remote unlocking device); Coniglio, 657 F. Supp. 409 (noting the absence of remote unlocking devices as one factor in finding inadequate fire safety protections).[(5)] This is especially dangerous given the absence of adequate fire suppression and smoke detection equipment described above.

Alexander's emergency generator system is insufficient to provide power in the event of a fire. While some of the housing units have emergency generators, none of them are automatic, but instead require manual operation. Thus, for the emergency generator to operate during a fire, a staff person who knows

how to run the generator must be able to reach the generator quickly. This is an unreasonable safety risk. Generators that automatically provide power in the event of a power failure during a fire should be installed to service all of the housing units.

There are also deficiencies in Alexander's preparedness to evacuate youth in the event of a fire emergency. We found that several staff members in the housing units were unfamiliar with the facility's fire safety procedures. The staff member we asked to demonstrate the proper use of a fire extinguisher was unable to do so. We also received conflicting reports from staff and children regarding the frequency with which fire drills are conducted. Moreover, the facility has no written training materials for instructing staff in fire safety procedures.

Finally, there are currently no oxygen breathing apparatuses in any of the dormitory units. Such equipment can be utilized by staff members if they are required to go through a housing unit to unlock the cells or go through the buildings to make sure all of the children have been evacuated. This type of apparatus should be available in each housing unit.

ii. New Dormitory

A new dormitory building was recently constructed on the Alexander campus. While it was not being used when we toured the facility, we understand that youth have recently been moved into this new building. This building suffers from serious fire deficiencies. Although the new dormitory building has an alarm system, that system is not centrally monitored. Instead, the fire alarm control panel, which has a light that indicates when the alarm is not functioning, is in a closet adjacent to the front entrance of the building. Thus, unless someone happens to enter the closet, no one will know if the alarm is not functioning.

While the new dormitory does have a sprinkler system, a check of the pressure on the sprinkler revealed that it was very low. This low pressure renders the sprinkler system useless in the event it is needed in a fire emergency. This deficiency must be remedied.

The new dormitory has delayed locking devices and key locks installed on the exterior doors. In the event of an emergency, it is likely to take too long to locate a staff person to unlock the exterior lock and engage the delayed locking device.[(6)] This creates an unreasonable delay in the facility's ability to evaluate residents.

The ceilings in the new dormitory are made of combustible plywood. There is also a gas furnace located in a utility closet resting on a combustible plywood platform. As stated above, the combustible combination of gas and plywood creates a dangerous environment.

iii. Administrative Buildings

a. Old Education Building

The older education building, which also houses some administrative offices, poses the same type of fire safety dangers to the juveniles who use this building as are found in the housing units. It does not have a sprinkler system or a hard-wired smoke detection system that is integrated into the fire alarm system. While Alexander has placed smoke detectors in corridors and classrooms, there are no smoke detection devices in any of the administrative offices or in the utility room that houses the gas furnace for the building. Like the housing units, the gas furnace for this building sits on top of a plywood surface. There is also not adequate compartmentalization of the utility room to prevent fire and smoke

from spreading to the rest of the building. Moreover, there is no ventilation system in the building. Finally, the building has no automatic back-up generator in the event of a power failure during a fire emergency.

b. New Education Building

Like the new dormitory building, the fire alarm control panel in this building was placed in a closet. The building does not have sprinklers. Also, like the new dormitory, the ceilings are made of combustible plywood, and there is a gas furnace located in a utility closet that sits atop a plywood platform. The cumulative effect of these conditions unreasonably places juveniles at risk of harm.

c. Chapel, Kitchen, Dining Hall, and Storage Facilities

The chapel, kitchen, dining hall, and storage facilities have adequate fire safety protections. We did notice, however, cigarette butts on the floor in the storage area indicating that some smoking may be occurring. This is a situation that should be monitored closely by Alexander staff.

C. EDUCATION

Alexander violates the constitutional and statutory rights of its residents by failing to provide adequate education services. These education deficiencies include the failure to provide education services within a reasonable amount of time upon a resident's entering the facility and the lack of adequate overall education and special education instruction and resources.

i. Delay in Providing Education Services

Children at Alexander routinely remain in the intake units without attending school for weeks. This leads to unreasonably long delays in providing education service. For example, we reviewed the records of a special education student who arrived at the school on March 21, 2002. This student waited in the intake unit for a month before being placed in school. During one of our visits to the facility, we met two boys who were in the intake unit waiting to be placed in school. One had been in facility for a month and the other for more than two weeks without being enrolled in school.

Alexander's current practice of having children remain in intake units without attending school for weeks at a time has serious negative consequences not only for the educational progress of the children, but for their overall rehabilitation. Moreover, the long delay in providing education services is unreasonable and unnecessary. Alexander can, without much hardship or disruption to its education program, provide education services much sooner than is its current practice.[(7)] The failure of Alexander to take reasonable steps that would prevent harmful delays in its provision of education services deprives children of their constitutional right to adequate education.

ii. General Education Services

The general education program at Alexander is inadequate. This deficiency is caused by the failure to provide all students with adequate instruction; the absence of vocational training; the failure to employ a school counselor; inadequate access to reading materials; and the failure to assign homework. The failure to provide some of these education services not only contributes to Alexander's overall violation of its residents' Due Process Clause right to adequate education, but also violates the rights of the children under the Equal Protection Clause. The Arkansas State Standards for Accreditation of Arkansas Public Schools (SAAPS) require schools to provide guidance counseling, adequate vocational education,

homework, and the opportunity to obtain a diploma. The failure to provide these services to students at Alexander is not justified by legitimate correctional concerns and therefore violates the Equal Protection Clause.

There is a wide range of competency and effectiveness among the teachers at Alexander. With respect to the students of those teachers that are not competent or effective, Alexander fails to provide adequate instruction, because it lacks sufficient mechanisms to monitor the quality of teaching and to provide effective staff development and mentoring to those teachers who need it. This requires instruction and correction directed at the particular weaknesses of individual teachers.

There is also a critical shortage of resources available to both teachers and students at Alexander. A February 2002 State education report found a shortage of textbooks and other education materials at the facility. During our visit to the facility, the library in the JUMP unit was in disarray and had few reading materials. Although the library serving the general population appears to have a sufficient number of books, many of the books we examined had never been checked out, suggesting that the library is not regularly used by students. There is also a critical shortage of reading materials available in living areas.

The education program at Alexander also suffers from the failure of students to be given homework on a regular basis. Despite there being "quiet time" periods on housing units' schedules, students report being given little or no homework. Homework materials would also supplement the meager reading materials available in the housing units. SAAPS requires each Arkansas school district to adopt a policy for appropriate and meaningful homework to "promote the development of students' independent study skills . . . [to] reinforce and strengthen academic skills, broaden the education experiences of the students, and relate those experiences to the real life of the community."[(8)] The failure to provide children at Alexander with homework not only interferes with their overall education, but it deprives them of the resources that are available to children in Arkansas public schools.

SAAPS requires schools to provide a developmentally appropriate guidance program to aid students in education, personal, social, and career development.[(9)] As stated above, Alexander does not even have a guidance counselor. Thus, the facility fails, without any justification, to provide equivalent education counseling services to those enjoyed by public school students. The failure of the facility to have a guidance counselor also contributes to overall education deficiencies at the facility. As discussed below, it also contributes to shortcomings in the special education evaluation process. In addition, a guidance counselor would aid the facility in ensuring that the instruction that students receive at Alexander is compatible with the program of study at the public school from which they came and to which they will return. Such a counselor could also improve documentation regarding the education students receive, thereby helping to ensure that other schools accept credits from Alexander.

Part of the reason Alexander has such an urgent need to employ a guidance counselor is that it is unaccredited by the State. For this reason, other public schools may not be required to accept the credits students earn at Alexander. This lack of accreditation has additional negative consequences for students at Alexander. Because it is unaccredited, Alexander is unable to confer high school diplomas based on the completion of course work.[(10)]

Given the population at Alexander, and the tendency for children to fall behind educationally while in a juvenile justice system, vocational training is an essential part of an adequate education system. Moreover, SAAPS requires that Arkansas high schools provide career and technical education to students for whom such instruction is appropriate.[(11)] Alexander fails to have an adequate vocational program. Instead, it has only one teacher who gives one class on career experience. The facility also provides a very limited number of students the opportunity to assist the maintenance staff. This "work-

detail" largely consists of observing staff doing their jobs and does not include instruction in specific vocational skills or other career skills.

iii. Special Education

a. Evaluation

The IDEA requires Alexander to evaluate children to determine whether they require special education services. Alexander lacks a systematic process for conducting this evaluation effectively. Generally, juvenile justice facilities evaluate children for special education needs by both conducting in-depth screening upon admission and by acquiring records from schools they previously attended. While Alexander does have an intake process, and requests education records, there are deficiencies in both processes that render its education evaluation system inadequate.

The intake interview at a facility like Alexander should include questions that test the student's substantive knowledge to determine whether the child needs special services. Instead of performing an in-depth intake interview, Alexander simply has children, as part of its general intake process, self-report where they last attended school and provide other administrative information. No in-depth intake evaluation is performed to determine the level of a child's substantive academic knowledge.

Because of the insufficiency of its intake interview process, Alexander uses a student's prior education records as its primary screening tool to determine eligibility for special education services. Staff informed us, however, that they were frequently unsuccessful in obtaining education records promptly from the school district where the youth previously attended school. One facility administrator reported that Alexander receives relevant education records for only half of its students during their time in intake. This difficulty in obtaining records may be caused, at least in part, by the request form used at the facility. Not only has this form been duplicated so many times that it is hard to read, but it bears the signature of someone who no longer works at the facility. This failure to obtain records contributes to the overall failure to conduct adequate special education evaluations.

b. Services

Alexander provides inadequate special education services to children housed at the facility who qualify for such services. The February 2002 State education report, cited above, notes that a girl who was entitled to receive special education services failed to receive them despite being at the facility for eight months. Staff reported that none of the girls at Alexander who are eligible for special education regularly receive such instruction. This failure to provide special education services to eligible girls apparently results from a shortage of special education teachers and the decision to utilize the available teachers only for special education classes taken by boys. This failure violates both the IDEA and the Fourteenth Amendment.

The special education program for boys is also inadequate. Most boys requiring special education instruction only spend a small portion of their school day receiving such instruction. The rest of the day they are in regular education classes that do not meet their special needs. Some boys in the JUMP unit receive special education instruction all day, but the instruction provided does not meet the intensive special education needs of this population. Moreover, there is insufficient special education staff to work with children who can appropriately be placed in general education classes (and have been placed by Alexander in such classes) but have some needs that require special education instruction.

D. RELIGIOUS FREEDOM

There is no question that religious activities can further a juvenile facility's rehabilitative mission. Moreover, Alexander must allow youth to engage in voluntary religious activities when such activities do not interfere with the operations of the facility. See Religious Land Use and Institutionalized Persons Act of 2000,42 U.S.C. § 2000cc. Alexander's interest in affording juveniles with the benefits of religious activities has led, however, Alexander to "establish" religion in violation of the First Amendment by coercing youth to engage in specific religious activities.

During our second visit to the facility, we witnessed a juvenile being asked to lead an entire unit in prayer during a mandatory unit activity. Staff we interviewed stated that this was a common occurrence and told us that all children were required to stand during the group prayer. Moreover, in many units staff had posted religious prayers such as the "Lord's Prayer," the "Serenity Prayer," and "St. Francis' Prayer" on the walls for the children to read. Mandatory prayer and the posting of religious literature in the common areas of state facilities for children violates the Establishment Clause. See Engel v. Vitale, 370 U.S. 421 (1962) (classroom prayer at beginning of each school day violates Establishment Clause); Stone v. Graham, 449 U.S. 39, 39 (1981) (finding that posting the Ten Commandments on the walls of classrooms violates the Establishment Clause).

We also witnessed a mandatory group therapy class in which children were required to read and discuss biblical quotations that were not presented as part of a secular education program. Instead, the quotations were utilized to foster the "lesson" that participant's confinement was "God's will" and therefore out of their control.[(12)]

Alexander staff informed us that the children on one unit were required to attend a religious revival during the weekend of June 16, 2002. Religious figures, such as pastors, were brought to the facility specifically to lead this event. Due to lack of staff, all children were required to attend for safety reasons. The revival lasted throughout the weekend.

In each of these cases, children were required to engage in specific religious activities and were subject to disciplinary action if they did not participate. As discussed above, these are the same types of activities (required prayers, displaying of religious material, etc.) that the Supreme Court has found to amount to State sponsorship of particular religious beliefs. Moreover, none of these activities are required to maintain facility security or for any other operational purpose. Thus, these activities violate the Establishment Clause.

We stress that we are not suggesting that all religious practices at Alexander must stop. In fact, the Free Exercise Clause of the First Amendment protects the juveniles' rights to engage in voluntary religious activity. Moreover, because of the unique nature of the correctional setting, we recognize that facilitating the juveniles' religious exercise may require a degree of State involvement in religious activities that would not be appropriate in other settings. For example, courts have held that it is permissible for the State to pay for chaplains in order to accommodate the religious exercise of those under State custody or control. See Katcoff v. Marsh, 755 F.2d 223 (2d Cir. 1985) (upholding military chaplaincy program); Carter v. Broadlawns Medical Center, 857 F.2d 448 (8th Cir. 1988), cert. denied, 489 U.S. 1096 (1989) (county hospital's hiring of chaplain did not violate the Establishment Clause). Likewise, while having a chapel in a public school would clearly violate the Constitution, chapels are present in most large correctional facilities. Similarly, substance abuse programs that incorporate faith, such as Alcoholics Anonymous, are used by correctional facilities and probation departments throughout the country. Such programs are permissible under the Establishment Clause, though those objecting to the religious elements must be given a secular alternative if participation is mandatory. See Warner v. Orange County Dep't of Probation, 115 F.3d 1068 (2d Cir. 1997).

To comply with the Constitution, in sum, Alexander need not excise religion from the facility and its programs. However, it must ensure that it does not coerce the youth to engage in religious activities by making all such activities voluntary. Also, the exhibition of religious posters in common areas should be limited to areas where the juveniles are present voluntarily, such as a room where a religious service or religious instruction is being held.

E. JUVENILE JUSTICE MANAGEMENT

As part of our investigation, we reviewed the overall management of the facility. Our review revealed some concerns regarding the classification of juveniles (specifically that juveniles who are housed at the facility for more than just intake, with the exception of the sex offenders and the most serious offenders, are grouped solely by age rather than any other basis). In addition, some staff and juveniles provided anecdotal evidence suggesting a concern regarding the level of juvenile-on-juvenile violence in these unclassified units. However, we found, based on our tour of the facility and our review of relevant records, no evidence of a pattern or practice of harm resulting from this classification system. Nor do we believe this classification system is so flawed that it subjects juveniles to an unconstitutional level of risk of harm. Still, we recommend expanding the facility's classification system in order to ensure that any potential for juvenile-on-juvenile violence is minimized.

III. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional and statutory rights of the youth confined at Alexander, the facility should implement, at a minimum, the following measures:

A. MENTAL HEALTH CARE

1. Develop an effective method of ensuring that direct care staff have all mental health information about the children on their unit the staff needs to ensure the children's health and safety, including instructions regarding any required suicide precautions and information about critical incidents in which the children were involved.

2. Provide staff with additional training on the facility's suicide prevention policy, including the different levels of observation and the types of precautions that should be taken. Develop a quality assurance system regarding the facility's suicide prevention policy.

3. Revise the suicide prevention policy to clarify what type of staff can place juveniles on suicide precautions and what type of staff can remove a juvenile from such precautions.

4. Ensure that a qualified mental health professional has sufficient daily interaction with children on suicide precautions and sufficient weekly interaction with any child who needs such treatment.[(13)]

5. Develop and implement a procedure to obtain mental health and medical information on a routine and systemic basis from outside sources and keep all such information in one centralized location available to all appropriate facility employees.

6. Develop and implement a procedure to ensure that the facility psychiatrist documents the diagnosis and the basis for that diagnosis for each juvenile patient.

7. Develop and implement a protocol for reviewing, at required intervals, the appropriateness of prescribed medication.

8. Develop and implement a protocol for ensuring that all children receive any necessary medical screening or tests before and during prescription of medication.

9. Ensure that when the facility psychiatrist meets with a child, he has appropriate access to relevant information from the direct care staff regarding the juvenile.

B. FIRE SAFETY

1. Provide adequate smoke detection and fire alarm systems in all housing and education buildings. (14)

2. Provide adequate sprinkler coverage in all housing and education buildings. (15)

3. Provide adequate automatic ventilation or smoke management systems in all housing and education buildings.

4. Ensure that staff can release juveniles from their rooms without having to approach each room and use a key on each door.

5. Remedy the danger posed by the unused gas line in the kitchen of the JUMP unit.

6. Remedy the danger posed by gas generators atop combustible materials such as plywood platforms.

7. Remedy the danger posed by the plywood ceilings in the new dormitory and education buildings.

8. Ensure sufficient separation between rooms in all housing and education buildings to adequately limit the spread of fire and smoke.

9. Provide adequate back-up power generation for all housing and education buildings.

10. Formalize fire safety and emergency procedures and provide staff with adequate training on these procedures.

11. Provide staff with breathing equipment to allow them to assist juveniles in the case of a fire, and train them in their use.

C. EDUCATION

1. Ensure that all students receive appropriate education instruction within a few school days of their arrival at the facility. (16)

2. Provide all teachers who need such services with effective monitoring, professional development, and mentoring.

3. Ensure that students have access to adequate education materials, including books and other reading materials, and develop a policy to provide students with appropriate homework assignments.

4. Hire a school counselor.

5. Gain appropriate State accreditation of the education program and obtain the ability to issue high school diplomas.

6. Provide an adequate and appropriate vocational program.

7. Provide adequate screening of children for special education needs, including obtaining prior education records from school systems in a timely fashion.

8. Hire sufficient additional special education instructors to enable the facility to provide adequate special education services to both boys and girls.

D. RELIGIOUS FREEDOM

1. Develop and implement a policy and protocol that clarifies the proper role that religious activities can play at the facility.

2. Provide adequate training to all staff on the policy and protocol described above.

3. Monitor facility programs and the decorations on units to ensure that the policy and protocol described above is being followed.

# # #

In making the foregoing findings, and identifying appropriate remedies, we recognize that the facility has made progress over the last year in remedying some of its long-standing deficiencies. This progress can be attributed to the efforts of State and facility officials to address proactively problems they identified. These efforts evidence a commitment to improving the facility.

In light of the State's cooperation in this matter, we will be sending our consultants' evaluations of the facility under separate cover. Although the experts' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them.

Pursuant to CRIPA, the Attorney General may institute a lawsuit to correct deficiencies of the kind identified in this letter forty-nine days after appropriate officials have been notified of them. 42 U.S.C. Section 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. Civil Rights Division lawyers will be contacting your attorney to discuss these remedial measures.

Sincerely,

Ralph F. Boyd, Jr.
Assistant Attorney General

cc: Mark Lunsford Pryor, Esq.
Attorney General
State of Arkansas

Kurt Knickrehm, Director

Arkansas Department of Human Services

Doyle Herndon, Director
Division of Youth Services
Arkansas Department of Human Services

Bob McCracken, Director
Alexander Youth Services Center

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1. The girls' "intake" unit houses all girls at the facility, not just new arrivals.

2. As of our last visit to the facility, Alexander was preparing to hire an additional psychologist. While filling this position is important to the overall quality of the mental health services being provided at the facility, we were told that this psychologist would not be providing any direct treatment to children, but would instead provide much needed supervision for treatment staff. Thus, this new hire will not address the treatment deficiencies discussed above. Moreover, according to newspaper reports published since our tours of Alexander, the applicant hired by the facility for this position was terminated.

3. We understand the facility is currently revising its treatment plan development process to provide for more inter-disciplinary input.

4. We have been informed by the State that it is planning to install sprinkler systems in each of the housing units, but this has not yet been done.

5. Alexander has recognized the need for improving the evacuation of children by recently implementing an unlocking system that enables staff to readily identify keys even without any light. This aids in opening the exit doors of the housing units and the doors to individual cells. This was a significant step in improving the procedures for emergency evacuation. However, given the other fire safety deficiencies in the facility, remote unlocking is still required to assure adequate safety.

6. To the extent that the new dormitory was designed to meet the specifications of the Arkansas Fire Prevention Code ("AFPC"), it does not. The AFPC only allows the use of a delayed locking system where a building has a complete and automatic smoke detection system or a complete and automatic sprinkler system that is adequately monitored. As previously mentioned, the new dormitory's fire alarm system is not effectively monitored because the fire alarm control panel is in a closet, and the sprinkler system is undermined by low water pressure.

7. One way for Alexander to provide these services without unreasonable delay is to set up an "intake" education class. This proposal is explained in more detail in the remedial measures section of this letter.

8. SAAPS at 7.

9. Id. at 12.

10. SAAPS requires that students complete 21 credits from an accredited school to receive a high school diploma. Id. at 9.

11. SAAPS at 5-6. SAAPS also requires Arkansas schools to provide arts instruction. Id. at 5. Alexander

should consider art instruction as part of its vocational training and general education program.

12. We were told that this document was not officially sanctioned by the State. However, it is the responsibility of the State to ensure that its employees and agents do not violate the First Amendment rights of the residents.

13. In addition, to improve the overall operations and mental health and education services provided at the facility, we recommend that the facility institute a case management system that ensures that an Alexander staff person would provide information to the juvenile about his/her status, facilitate the juvenile's entry into specialized treatment programs, and ensure that juveniles generally are not "lost" in the system.

14. Although not constitutionally required, the safety of children at Alexander would be enhanced by the installation of a hard-wired smoke detector system in the chapel and in the kitchen.

15. Although not constitutionally required, the safety of children at Alexander would be enhanced by the installation of a sprinkler system in the kitchen.

16. One way Alexander could provide this remedy would be to set up a special "intake" education class. This classroom could focus on basic education skills like literacy, current events, and math skills. This curriculum would be applicable to children with a broad range of education backgrounds. It would also provide the facility with an opportunity to evaluate the children's education abilities even before all relevant education records had been obtained. After an appropriate period of time in this intake classroom, children would be integrated into the general school population.