Reforming Juvenile Delinquency Treatment to Enhance Rehabilitation, Personal Accountability and Public Safety

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Reforming Juvenile Delinquency Treatment to Enhance Rehabilitation, Personal Accountability, and Public Safety

Shortly before eight on the morning of July 21, 1999, fourteen-year-old Gina Score lay dying of heatstroke on a steamy dirt road in South Dakota's Plankinton girls boot camp. Guards laughed, ignored her pleas, and left her semiconscious in the hot sun for three more hours after she collapsed during the morning's 2.6-mile mandatory run, a daily ordeal that often saw girls forced to jog shackled and handcuffed until blood soaked through their shoes.\(^1\)

In Florida juvenile detention facilities, at least six boys have died from injuries since 1994, including a thirteen-year-old who hanged himself, a sixty-five-pound mentally ill twelve-year-old who was suffocated and crushed to death by a three-hundred-pound staff member, and a seventeen-year-old who died of a burst appendix after guards ignored his moans for three days because they thought he was faking.\(^2\) Youths at a California juve-
nile prison have been handcuffed and slammed into walls by guards, forcibly injected with antipsychotic drugs, shot point-blank with potentially lethal riot guns, and set up to fight gang rivals in bloody brawls that guards derisively called the "Friday Night Fights."3 Dozens of youths in Louisiana's juvenile prisons have suffered broken jaws, fractured eye sockets, and cut faces as guards enlisted youths to beat up one another, and assaulted children themselves, sometimes while the children were sleeping.4 Mississippi juvenile prison guards have stripped suicidal teenage girls naked and hog-tied them in solitary confinement.5 In Georgia juvenile prisons, teenagers who refused to remove their clothes have been forcibly stripped, and male staff have sometimes helped strip female inmates.6

"Juvenile justice facilities across the nation," U.S. News & World Report found in July of 2004, "are in a dangerously advanced state of disarray, with violence an almost everyday occurrence and rehabilitation the exception rather than the rule. Abuse of juvenile inmates by staff is routine."7 In 2005, the U.S. Justice Department found that sexual violence is reported in juvenile prisons at rates ten times higher than in adult lockups.8 Neither finding surprised juvenile justice professionals who have watched the nation's juvenile corrections facilities spiral downward for decades. "Conditions in many American juvenile detention centers are awful," one commentator wrote in 1998, "and

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4 See infra Part I.B.2.
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they have been for years."  

The Justice Department has assumed a central role in efforts to reform state systems that confine delinquents: youths who have committed acts that would be crimes if committed by an adult. Primary authority comes from the Civil Rights of Institutionalized Persons Act (CRIPA), enacted in 1980 after Congress found nationwide conditions of juvenile confinement "barbaric."  

CRIPA authorizes the Justice Department to sue state and local governments to remedy "egregious or flagrant" conditions that deny constitutional or federal statutory rights to persons residing or confined in public institutions, including juvenile correctional facilities. The federal courts may order remedies that "insure the minimum corrective measures necessary to insure the full enjoyment" of these rights. The Department may also sue under the Violent Crime Control and Law Enforcement Act of 1994, which prohibits a "pattern or practice" of civil rights abuses by law enforcement officers.

After learning of alleged constitutional or statutory violations

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9 Michael J. Dale, Lawsuits and Public Policy: The Role of Litigation in Correcting Conditions in Juvenile Detention Centers, 32 U.S.F. L. REV. 675, 675 (1998); see also Fox Butterfield, Profits at a Juvenile Prison Come with a Chilling Cost, N.Y. TIMES, July 15, 1998, at A1. "The issues of violence against offenders, lack of adequate education and mental health, of crowding and of poorly paid and poorly trained staff are the norm rather than the exception." Id. (quoting the President of the National Juvenile Detention Association, which represents the heads of the nation's juvenile prisons).


Four Senators (Strom Thurmond of South Carolina, Paul Laxalt of Nevada, Thad Cochran of Mississippi, and Alan Simpson of Wyoming) dissented from the Senate Judiciary Committee report that recommended passage of CRIPA. See S. REP. No. 96-416, at 44-45 (1980) as reprinted in 1980 U.S.C.C.A.N. at 825. The dissenters argued that States were willing and capable of protecting their institutionalized citizens, that "most Americans feel that the Federal bureaucracy is already too powerful," and that Congress should not "increase the power of one of the most criticized bureaucracies, the Justice Department, to interfere with State efforts." Id. at 44, as reprinted in 1980 U.S.C.C.A.N. at 826.


12 Id. § 1997a(a).

13 Id. § 14141.
from any source, Justice Department personnel inspect a juvenile facility with expert consultants in a variety of fields, including juvenile justice administration, mental health care, medicine, psychology, and education. The Department's report detailing constitutional and statutory violations opens negotiations with the state for corrective action, with the prospect of a federal enforcement lawsuit for violations left unremedied.

Beginning in the 1980s, the Justice Department has inspected more than 100 juvenile correctional facilities nationwide, leading to CRIPA agreements or consent decrees covering more than thirty facilities where conditions had fallen below minimum constitutional standards. Under Democratic and Republican administrations alike, the Department has quickened the pace since 1994.

Using the Justice Department's detailed reports concerning juvenile facilities that the Agency has inspected in the past decade, Part I of this Article shows the abuse, neglect, and barbarity that pass for delinquency treatment in too many states today. More than a century after the creation of the nation's first juvenile court grounded in rehabilitative impulses, many states still maintain inhumane, thoroughly ineffective juvenile prisons that neither rehabilitate children nor protect public safety. States lock up status offenders and nonviolent youths who could be treated more effectively in less expensive community-based alternative settings. Mentally ill and otherwise fragile children are beaten by guards, physically and sexually assaulted by more vicious youths while guards turn their backs, and left in fear for their lives. Children are denied needed mental health and medical treatment, and deprived of education guaranteed to them by state and federal law. Overcrowded prison cells are often little more than roach-infested cages reeking of sewage and urine. Recidivism rates frequently exceed fifty percent, compromising public safety because most repeat juvenile offenders do not turn to white collar crime. Instead they commit new violent crimes against innocent victims whom a lower rate would spare.

One state—Missouri—maintains a juvenile corrections system that has emerged as a national model of excellence against which

other state systems are measured. After nine decades of frustration with large statewide juvenile reformatories, Missouri a quarter century ago turned its back on the failed juvenile incarceration model grounded in violence. Part II of this Article describes Missouri’s innovative juvenile corrections system, which employs highly trained professionals who provide youths constant therapy and supervision in small community-based facilities near their homes and other sources of community support. With treatment rather than incarceration as the goal, Missouri stresses individual accountability in “the least restrictive environment possible without compromising public safety.” The result is a statewide juvenile recidivism rate among the lowest in the nation, and at a cost per youth considerably lower than the amounts spent by most other states. According to Paul DeMuro, Pennsylvania’s former Chief of Youth Prisons, Missouri is “the best model we have” for the correctional phases of juvenile justice.

In 2001, the American Youth Policy Forum called Missouri a “guiding light for reform,” and found that the state’s “unconventional approach”—with its “emphasis on treatment and on least-

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restrictive care, rather than incarceration and punishment”—is “far more successful and cost-effective” than the systems prevailing in most other states.18 The report concluded that Missouri’s approach “should be a model for the nation” because “[i]t success offers definitive proof that states can protect the public, re-habilitate youth, and safeguard taxpayers far better if they abandon incarceration as the core of their juvenile corrections systems.”19

Other respected juvenile justice organizations and foundations echo this praise,20 and troubled states seeking a juvenile justice compass regularly send delegations to Missouri to study its blueprint for long overdue reform. “Missouri is a model we would all love to replicate,” says the Director of the Maryland Juvenile Justice Coalition as that state’s broken juvenile corrections system gropes for solutions after years of unrestrained violence.21 “I could talk for half a day,” adds a Juvenile Justice

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18 MENDEL, LESS COST, MORE SAFETY, supra note 16, at 11.
19 See id. at 14. Massachusetts and Utah have also won attention for closing their large training schools and moving to smaller facilities. See, e.g., JAMES C. HOWELL, JUVENILE JUSTICE & YOUTH VIOLENCE 19 (1997); BARRY KRISBERG & JAMES F. AUSTIN, REINVENTING JUVENILE JUSTICE 146-47 (1993); IRA M. SCHWARTZ, (IN)JUSTICE FOR JUVENILES: RETHINKING THE BEST INTERESTS OF THE CHILD 51-55 (1989); Andrew Rutherford, The Dissolution of the Training Schools In Massachusetts, in THE CHILDREN OF ISMAEL: CRITICAL PERSPECTIVES ON JUVENILE JUSTICE 515 (Barry Krisberg & James Austin eds., 1978).
20 See CTR. ON JUVENILE & CRIMINAL JUSTICE, REFORMING THE JUVENILE JUSTICE SYSTEM, available at http://www.cjic.org/jjic/reforming.php (last visited Feb. 24, 2006) (calling Missouri a “model state” for its “well-developed system of community-based residential and non-residential programs” of delinquency care and treat- ment); Regina Akers, State Juvenile Agency Cited by National Group, KAN. CITY STAR, Sept. 22, 1994, at C3 (discussing National Council on Crime and Delinquency statement that Missouri “has become a national leader in juvenile corrections and provides an excellent model for other states who desire to provide services based upon the individual needs of the juvenile offender”); Douglas W. Nelson, Moving Youth from Risk to Opportunity, KIDS COUNT (Annie E. Casey Foundation, Balt., Md.), June 2004, at 19, available at /databook/pdfs_e/essay_e.pdf (calling Missouri “a national model in juvenile corrections,” and announcing a grant to enable the state to demonstrate its program to other states).
21 See Dan Fesperman, Bill Would Downsize Juvenile Facilities, BALT. SUN, Mar. 4, 2004, at 5B (quoting Heather Ford, Director of the MJJC); see also Franck, supra note 17, (Missouri’s confined youths “still have some light in their eyes . . . as opposed to our system, where the lights have been dimmed.” (quoting a Louisiana state legislator who toured Missouri’s juvenile justice facilities)); Laura Maggi, Rehabilitating Juvenile Justice, TIMES-PICAYUNE (New Orleans), Oct. 3, 2004, at 1 (“The piece of Missouri that was so striking to me was the level of discourse between the kids and the staff . . . . While certainly the staff were adult authorities, there was such an ease of interaction.” (quoting Simon Gonsoulin, head of the Louisiana Office of Youth Services)); Dick Mendel, Missouri’s Division of Youth Services
Project of Louisiana leader, "and not convey how important it is that we have a place like Missouri that we can look to." 22

The time may be ripe for meaningful reform after the spate of "get tough" legislation that drove juvenile justice policy in the 1990s. The nation's violent juvenile crime rate has fallen steadily since 1994, evidently diminishing immediate public pressure for harsh punishment at the expense of rehabilitation. At the same time, Justice Department activism under CRIPA has exposed the infected underbelly of juvenile corrections and spurred calls for reform. Part III of this Article provides a blueprint for reform by drawing lessons from the states recently inspected by the Justice Department, and also from Missouri's experience in the past generation.

I

THE JUSTICE DEPARTMENT'S REPORTS ON THE CONDITIONS OF DELINQUENCY CONFINEMENT

A. Private Lawsuits Challenging Conditions of Juvenile Confinement

In 1967, the Supreme Court conferred due process rights on accused delinquents for the first time in In re Gault. 23 The celebrated decision, which Solicitor General Rex E. Lee later called "the charter of juvenile justice," was grounded in recognition that a reformatory or training school was "in all but name a penitentiary or jail." 24 These juvenile facilities were "institution[s] of confinement in which the child is incarcerated for a greater or lesser time," wrote Justice Abe Fortas for the Court. 25

22 See Franck, supra note 17 (quoting David Utter, Juvenile Justice Project of Louisiana).
24 In Memoriam, Honorable Abe Fortas, 102 S. Ct. 17, 45 (1982); In re Gault, 387 U.S. at 61 (Black, J., concurring).
25 In re Gault, 387 U.S. at 27 (majority opinion) (The child's "world becomes 'a building with whitewashed walls, regimented routine and institutional hours . . .' Instead of mother and father and sisters and friends and classmates, his world is peopled by guards, custodians, state employees, and 'delinquents' confined
Gault energized children’s advocates in the 1970s to challenge the squalid conditions of confinement prevalent in many of the nation’s secure juvenile correctional institutions. Courts ordered relief for conditions so harsh that they violated the Eighth Amendment’s ban on cruel and unusual punishment.

In 1974, for example, a Texas federal district court ordered remedial measures at juvenile institutions rife with “widespread physical and psychological brutality . . . so severe as to degrade human dignity” and “be unacceptable to contemporary society.”26 Brutality was “a regular occurrence . . . encouraged, by those in authority.”27 The court pinpointed:

[T]he widespread practice of beating, slapping, kicking, and otherwise physically abusing juveniles in the absence of any exigent circumstances; . . . the placing of juveniles in solitary confinement or other secured facilities, in the absence of any . . . limitation on the duration and intensity of the confinement . . . the performance of repetitive, nonfunctional, degrading and unnecessary tasks [and] [c]onfinement under circumstances giving rise to a high probability of physical injury to inmates.28

The Texas federal court decried the “use of tear gas and other chemical crowd-control devices in situations not posing an imminent threat to human life or an imminent and substantial threat to property.”29 One youth was sprayed with tear gas while confined to a cell, another while being held by two guards, and a third while attempting to flee a beating.30

An Indiana federal district court described a juvenile institution where youths suffered supervised beatings with a thick board for violating institutional rules; where the nurse injected excited youths with tranquilizing drugs in the absence of medical staff to monitor potentially serious medical side effects; and where youths were placed in solitary confinement in nine-by-twelve-foot locked cells on any staff member’s request for as much as half a year, without education or recreation and with

27 Id. at 73.
28 Id. at 77.
29 Id.
30 Id. at 74.
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only sporadic contact with treatment staff.31

A Rhode Island federal district court described a juvenile corrections institution that maintained a dark, cold solitary confinement room where boys were held for as long as a week, wearing only their underwear, and without toilet paper, sheets, blankets, or changes of clothes.32 Another suit successfully challenged Louisiana's practice of sending hundreds of retarded, disturbed, neglected, abandoned, and otherwise dependent children to out-of-state residential facilities, where they were physically abused, handcuffed, beaten, chained, tied up, held in cages, and overmedicated with psychotropic drugs.33

Lawsuits successfully challenging the abusive conditions of juvenile confinement continued into the 1990s.34 In 1995, a South Carolina federal district court held that conditions in the state's juvenile corrections facilities violated the youths' substantive due process rights to reasonably safe conditions of confinement.35 Staff indiscriminately used potent tear gas on the youths "on a fairly regular basis," even when no danger existed to staff or others.36 Food frequently was infested with cockroaches and other foreign matter.37 The State had not adequately identified youths who needed special education and in some instances had not formulated individual education plans for identified youths.38 Medical resources at the juvenile prisons were "stretched to the limit," plagued by shortages that risked the youths' health.39 The State's Division of Youth Services Commissioner admitted that the Agency was "the dumping ground. The kids come here after society has given up on them."40

34 See, e.g., SCHWARTZ, supra note 19, at 11-15; Barry Krisberg et al., The Watershed of Juvenile Justice Reform, 32 CRIME & DELINQ. 5, 31 (1986).
36 Id. at 785-86.
37 Id. at 787.
38 Id. at 788.
39 Id. at 788-89.
40 See Editorial, S.C. Youth Facilities Plagued by Violence, HERALD (Rock Hill, S.C.), Mar. 22, 1992, at 7A. Problems continued to plague South Carolina Depart-
B. Justice Department Challenges Under the Civil Rights of Institutionalized Persons Act

Private lawsuits continue, but the Justice Department’s CRIPA inspections have assumed center stage in the past decade. The Department’s reports concerning inspected juvenile prisons are in the nature of allegations before trial or settlement, but the Department’s findings have usually recited conditions that the media and children’s advocates had widely reported, and that authorities had knowingly ignored, for years. In some states, federal courts had ordered corrective action as much as a quarter

ment of Juvenile Justice facilities for several years. In 2001, the three-member panel overseeing implementation of the court order concluded that many confined youths were still living in dangerous conditions. See Rick Brundrett, Juvenile Prisons Not Safe, Panel Says, The State (Columbia, S.C.), Dec. 13, 2001, at A1. Other reports surfaced stating that the State paid $1.1 million between 2000 and 2002 to settle nine claims and lawsuits alleging that children as young as ten had been sexually assaulted by other youths in state confinement, DJJ was underreporting assaults, and DJJ had not tracked its recidivism rate for more than seven years. See Op-Ed, More Criticism Leveled at DJJ, Greenville News (S.C.), Apr. 29, 2002, at 4A. A ten-year-old boy was raped by two male cellmates after he was incarcerated for refusing to allow a teacher to search his bookbag for another student’s money. See Bob McAlister, Role Models, New Ideas Can Help Kids At Risk, The State (Columbia, S.C.), Apr. 17, 2002, at A17; Assaults on Juveniles Cost State $1 Million, The State (Columbia, S.C.), Mar. 1, 2002, at B3. In 2002, eleven youths sued the state prison system for nearly $27 million, alleging that prison officials negligently failed to protect them from physical or sexual assault by guards and other youths. See Rick Brundrett, Suit Targets Juvenile Prison System, The State (Columbia, S.C.), June 19, 2002, at B1. In May of 2002, the federal judge overseeing the state juvenile prison system declined to lift the 1995 order, citing improvements but stating that DJJ appeared to be “stagnant and perhaps backsliding” in its efforts to stop assaults in the prisons. Id.

In late 2003, the federal district court lifted its 1995 order and ended judicial oversight of South Carolina juvenile detention facilities, citing significant improvements made by DJJ that year and the parties’ agreement on future reforms in security, programming, and treatment standards. See Rick Brundrett, Juvenile Justice Reforms Satisfy Court, The State (Columbia, S.C.), Dec. 11, 2003, at A1.

41 See, e.g., K.L.W. v. James, No. 2:04-CV-149BN (S.D. Miss., filed Apr. 13, 2004); Complaint, James, supra; Plaintiffs’ Memorandum of Law In Support of Motion For Immediate Preliminary Injunction, James, supra (involving a suit filed on behalf of a developmentally disabled fourteen-year-old incarcerated in Mississippi’s Columbia Training School—reportedly after a youth court hearing that lasted approximately five minutes—for stealing a cell phone belonging to his school; suit alleges that the State unconstitutionally denies access to counsel to youths seeking redress for beatings, violence, and other constitutional violations). All of these documents can be viewed at http://www.splcenter.org/legal/docket/files.jsp?cdrID=46. See also Sewell Chan, Judge Holds D.C. in Contempt Over Care of Juvenile Offenders, Wash. Post, June 20, 2003, at B4 (describing class action suit filed in 1985 and settled a year later in which court held D.C. government in contempt and imposed daily fines for failing to improve services at youth detention center).
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century earlier, only to have the governor and legislature turn deaf ears. Most of the inspected states have acknowledged the accuracy of the Department's findings.

The Justice Department’s CRIPA inspections doubtlessly focus on states the Agency deems most troubling, but the sheer volume of states inspected so recently in such a short period suggests that the Department has only scratched the surface. Reinforcing this impression are documented reports of wretched conditions of juvenile confinement in states not yet inspected. Florida and California are two of these states.

In early 2004, the Orlando Sentinel found 661 confirmed cases of abuse or neglect since 1994 in Florida juvenile lockups operated by the State or by private contractors.42 Records showed that guards hit confined youths, threw them against walls, and twisted their arms until they snapped.43 At least six boys had died from abuse or neglect by guards at Florida juvenile detention facilities, including a seventeen-year-old who died in 2003 from a ruptured appendix after crying in pain for three days and begging for care.44 An angry legislator charged that "dogs are treated better than" the boy, who was in detention while awaiting a bed at a school for troubled teens.45

Eighty youths attempted suicide in Florida juvenile detention facilities in the first six months of 2004 alone, leading some children's advocates to worry that the facilities overmedicated teens with antidepressants and other mental health drugs that the federal Food and Drug Administration warns might induce suicidal tendencies if administered to children without monitoring.46 One Florida juvenile court judge reported that some youths who appeared in his courtroom after being drugged in confinement

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42 Rene Stutzman, 661 Kids Abused in Juvenile Centers, SUN-SENTINEL (Fort Lauderdale, Fla.), Apr. 13, 2004, at 1A.
44 See Marc Caputo, State Fires Officer in Rape Case, MIAMI HERALD, Oct. 21, 2005, at A1; Editorial, Keep Them Safe, supra note 2; Carol Marbin Miller, Cameras Don't Record Boy's Death, MIAMI HERALD, Dec. 1, 2003, at 1B; Stutzman, Abuse of Young Offenders, supra note 2; see also supra text accompanying note 2.
45 See Caputo, supra note 44; Carol Marbin Miller, Juvenile's Death Ends Hospital's Contract, MIAMI HERALD, June 28, 2003, at 1B.
appeared "sort of in a semicoma."  

In late 2005, a seventeen-year-old convicted male sex offender confined in a Tallahassee juvenile detention center was charged with raping a severely retarded fifteen-year-old inmate who had an IQ of thirty-two and the mental capacity of a toddler. According to reports from local police and the State Department of Juvenile Justice, guards had assigned the sex offender to bathe the victim and change his diaper.  

The core question was not the propriety of assigning a convicted sex offender to bathe a severely disabled inmate, but the reason why the State had put the victim in lockup in the first place. The victim's crime? "Battery on an elderly person" because, after his mother died and left him an orphan, he had been violent toward his elderly grandmother who was too frail to care for him.  

A frustrated judge had ordered the disabled victim detained only after the State Department of Children and Families and the Agency for Persons with Disabilities each said that they had no room for him in a group home.  

On January 6, 2006, a fourteen-year-old boy died less than a day after suffering a savage half-hour beating inflicted by guards at Florida’s Bay County boot camp. The guards had found the boy “uncooperative” barely three hours after he was admitted for taking his grandmother’s car for a joyride. After running several laps on the boot camp track under the guards’ instructions, he fell to the ground complaining of shortness of breath. A video camera captured seven to nine guards kneeling, choking, 

47 See O'Matz, supra note 43.  
48 See Brendan Farrington, Rape Charges Filed Against Teen, BRADENTON HERALD (Fla.), Oct. 21, 2005, at 8.  
49 Id.  
50 Id.; Caputo, supra note 44; Editorial, Detention Center Inmate Is Victim of Callous System, MIAMI HERALD, Oct. 21, 2005, at A22; Carol Marbin Miller, State Put Disabled Boy In Sex Offender’s Care, MIAMI HERALD, Oct. 20, 2005, at 1A.  
punching and slamming the limp, nonresistant boy to the ground while applying painful "pressure points" to his neck and head.\(^{53}\) Unable to fend off the blows, the boy tried rising to his feet at least thirteen times—sometimes with the guards' help—but each time he fell back to the ground.\(^ {54}\) Several times the guards appeared to shove ammonia in the boy's face in attempts to revive him.\(^ {55}\) A boot camp nurse stationed just a few feet away watched the beating before the boy's nearly lifeless body was removed to the hospital on a gurney.\(^ {56}\)

One state legislator called the videotaped beating "the most heinous treatment of a human being he'd ever seen."\(^ {57}\) Two legislators charged that the boy had been "flung around like a rag doll."\(^ {58}\) Other legislators likened the beating to "torture"\(^ {59}\) at a "death camp."\(^ {60}\) "[A] mugging couched in euphemisms," concurred a retired Miami juvenile court judge.\(^ {61}\) The \textit{Miami Herald} called the beating "cold-blooded violence."\(^ {62}\) "There can be no good reason," the \textit{Herald} continued, "why a healthy, athletic 14-year-old boy should enter a state-sponsored boot camp and end up on a stretcher fighting for his life three hours later."\(^ {63}\)

Charges of cover-up immediately clouded the aftermath of the fatal Bay County boot camp beating.\(^ {64}\) For one thing, the State refused to release the videotape of the beating until the \textit{Miami}
Herald and CNN sued the Florida Department of Law Enforcement for its release. The dead boy’s body was removed from the hospital in one county and delivered to the boot camp’s county for autopsy, a step that even the latter county’s medical examiner found “highly unusual.” The medical examiner in the boot camp’s county conducted an autopsy without watching the videotape of the beating. He determined that the boy had died of “natural causes” from a previously undiagnosed sickle cell trait, and not from the beating, a conclusion that numerous medical experts called unlikely. The medical examiner had reportedly mishandled earlier autopsies, including one in which he described the condition of organs that surgeons had previously removed from the examinee’s body, and another in which he described the condition of a nonexistent prostate gland and testicles on a female.

A second autopsy of the boy beaten at the Bay County boot camp, performed at the insistence of his family and civil rights groups, was conducted on March 13, 2006. The autopsy determined that the boy indeed had not died of a sickle cell trait or other natural cause. Dr. Michael Baden, the nationally known former medical examiner, was present at the second autopsy and said afterwards that the boy died “‘of what you see in the videotape,’ . . . calling the youth ‘almost a ragdoll’ as guards beat him.” As this Article is prepared for press, federal authorities are investigating whether the relentless beating violated the boy’s civil rights.

A state legislator and former juvenile court prosecutor charged that the fatal Bay County boot camp beating stemmed from “un-

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66 See, e.g., Hiassen, supra note 53; Marc Caputo, Autopsy Finding on Boy ‘Surprises’ State Doctor, MIAMI HERALD, Feb. 24, 2006, at 1B; Too Many Questions Still Cloud Boot-Camp Death, supra note 65 (noting that the medical examiner later denied making the statement).
67 See, e.g., Hiassen, supra note 53.
68 See, e.g., Carol Marbin Miller & Marc Caputo, Troubled Boot Camp to Close, MIAMI HERALD, Feb. 22, 2006, at 1A; Hiassen, supra note 53.
71 Id.
supervised guards who are poorly trained." The problem is not limited to Florida's boot camps. About ninety percent of the state's juvenile detention facilities are run by private contractors, which pay guards and counselors an average of only $8.36 per hour or $17,398 a year, barely above the federal poverty level if the guard or counselor has a family. Some fully employed guards and counselors qualify for public assistance for themselves and their families. This stingy pay scale has staffed the private facilities with inexperienced, poorly trained staff members ready to quit at the first offer of a more livable wage. Residential direct care staff in Florida juvenile facilities turns over at a statewide rate of about fifty-five percent annually. The resumes of staff members recently hired by private juvenile justice contractors showed "training" that included jobs at a donut shop, a turnpike toll booth, and a grocery store.

In 2003, the Miami Herald reported that Florida Department of Juvenile Justice workers and supervisors included about 350 ex-felons and persons with arrest records, including four superintendents and four assistant superintendents of juvenile detention facilities. The offenses ranged from child abuse and burglary to assault and weapons violations. For years, the State and private contractors have also hired juvenile prison guards previously fired for punching, choking, tackling, head-butting, or having sex with teens under their care in other juvenile facilities. The private providers assert that low salaries stem from the State's unwillingness to pay the providers more adequate per diems.
hit the mark: "[I]t's hard to rehabilitate boys and girls using people who need rehabilitation themselves."\textsuperscript{81}

Also still beyond Justice Department inspection and report is the California Division of Juvenile Justice, which until 2005 was known as the California Youth Authority (CYA). The newly renamed Division, which is overseen by the State Department of Corrections and Rehabilitation,\textsuperscript{82} operates large prisons for youths between thirteen and twenty-five who as juveniles committed the most serious felonies, such as rape or murder.\textsuperscript{83} A federal judge has threatened to place California's juvenile prisons under federal receivership.\textsuperscript{84} The Los Angeles Times calls these prisons "irredeemable rathole[s],"\textsuperscript{85} "modern-day Bedlams,"\textsuperscript{86} and "junkyard[s] for young lives."\textsuperscript{87} The San Jose Mercury News says that if the purpose of California's system "were to take teenage troublemakers and turn them into career

\textsuperscript{81} Update Juvenile Justice with Scrutiny of Hiring, supra note 77.


\textsuperscript{83} California organizes delinquency services at both the state and local levels. See Nat'l Ctr. for Juvenile Justice, State Juvenile Justice Profiles: California (2004), available at http://www.ncjrs.org/stateprofiles/CA06.asp?state+CA.06asp&topic=. County probation departments administer detention, delinquency intake screening, predisposition investigation, and probation supervision. See id. The California Youth Authority administers the state's delinquency institutions and parole supervision. See id. On April 9, 2003, the Justice Department reported on the three juvenile halls operated by Los Angeles County. Letter from Ralph F. Boyd, Jr., Assistant Att'y Gen., to Yvonne B. Burke, Chair, L.A. County Bd. of Supervisors (Apr. 9, 2003), available at http://www.usdoj.gov/crt/split/documents/la_county_juvenile_findlet.pdf. The Department found that youths confined in the juvenile halls suffered harm or the risk of serious harm from deficiencies in the facilities' medical and mental health care, sanitation, use of chemical spray, and insufficient protective measures. Id. The Department also found failure to provide proper rehabilitation, education, opportunities to use the telephone and participate in religious programming, insufficient provision of translation services for Limited English Proficient (LEP) youths, and an ineffective grievance system. See id.; Cal. Legislative Analyst's Office, A Review of the California Youth Authority's Infrastructure (2004), available at http://www.lao.ca.gov/2004/cya/052504_cya.htm. See generally Edward Humes, No Matter How Loud I Shout: A Year in the Life of Juvenile Court (1996).


\textsuperscript{86} Id.

\textsuperscript{87} State Prisons' Revolving Door; Judge's Last-Chance Demand, supra note 84; Editorial, A Junkyard for Young Lives, L.A. TIMES, Feb. 4, 2004, at B12.
criminals, it would be a national model."88 "Kids are treated like animals."89

In 2000, California’s Inspector General admitted that “it would be impossible to overstate the problem” of brutality, sexual misconduct, and other abuses in the state’s juvenile prisons.90 He found that many mentally ill youths were held in lockup units because the CYA lacked more appropriate treatment and housing alternatives.91 About ten percent of youths in some juvenile prisons, including mentally ill or suicidal youths, were confined to their rooms twenty-three hours a day for months, sometimes spending the other hour locked in wrist or leg shackles.92 Some of these youths spent the final hour each day locked in steel-mesh cages too small to permit standing up or turning around.93

A few years after a public report forced CYA guards to use chemicals rather than rubber bullets against confined youths,94 California’s Inspector General documented guards’ dangerous and potentially fatal use of high-powered weapons that delivered chemical agents.95 These weapons and chemicals were designed to quell riots in large prison yards, but guards risked asphyxiating youths by spraying them in living quarters and other confined but secure areas.96 The Inspector General also found that youths sometimes suffered severe skin burns and other chemical-induced injuries because they were denied timely access to first aid or showers after being sprayed.97

Between 1996 and 2004, fifteen youths committed suicide in

89 Editorial, More Than New Name, CONTRA COSTA TIMES (Walnut Creek, Cal.), Aug. 1, 2005, at F4.
92 Id.
93 Id. at 51, 59. In 2004, the CYA Director announced that the Agency would end the practice of twenty-three-hour-a-day isolation. See, e.g., Jenifer Warren, Youth Prisons to Stop Use of Extended Isolation, L.A. TIMES, Aug. 5, 2004, at B1.
94 See A Junkyard For Young Lives, supra note 87.
95 KRISBERG, supra note 91, at 30.
96 Id.
97 Id. at 30, 50.
California Youth Authority institutions. Between 2000 and 2004, another 165 attempted suicide. The most recent suicides occurred in early 2004, when two teens hanged themselves with bed sheets in their isolation cell. In early 2003, a CYA guard was videotaped allowing his police dog to attack a youth who was lying on the floor, following orders, and not resisting. In an unrelated incident, two CYA guards were videotaped beating one youth in the head after the youth lay face down on the floor, and then repeatedly kicking another youth and punching him twenty-eight times in the head. A third guard sprayed the two prone youths with a chemical agent, and another fired rounds from a gun that shot balls of pepper spray.

A few weeks after the 2003 suicides, national experts commissioned by the State underscored the deplorable conditions already revealed by the Inspector General and the media in California youth prisons. Echoing findings of another study completed nearly two decades earlier, National Council on Crime and Delinquency President Barry Krisberg called California’s youth prison system “a very dangerous place” marked by “an intense climate of fear.” Some incarcerated youths were so scared for their lives that they feigned mental illness so that they would be placed in special housing away from the general population. “[T]he effort to survive,” the Los Angeles Times concluded, “overshadows hope for rehabilitation.”

98 See Warren, supra note 17.
101 See CYA Wants Charges Filed in Dog Attack, MONTEREY COUNTY HERALD (Cal.), May 8, 2004; Warren, supra note 100.
102 See Kim Vo, Protesters Confront Attorney General in CYA Case, SAN JOSE MERCURY NEWS, May 13, 2004, at 1B.
103 See id.; Jenifer Warren & Tim Reiterman, No Charges In Videotaped Beating Case, L.A. TIMES, Apr. 24, 2004, at B6. The state Attorney General acknowledged that the two guards used excessive force but refused to prosecute because he said it would be “damn near impossible” to get a conviction for beating inmates who had criminal records, started the fight, and suffered no discernible injuries. See Editorial, Just Look the Other Way, S.F. CHRON., Apr. 29, 2004, at B8. The CYA later fired the guards. See Brandon Bailey, 6 Guards Fired In Inmate Beatings, SAN JOSE MERCURY NEWS, Sept. 24, 2004, at 1A.
104 See KRISBERG, supra note 91, at 18, 23.
105 See id. at 28.
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In 2004, the CYA’s new Director called the scathing independent report “substantially correct,” and the Corrections Independent Review Panel appointed by the Governor cited recent incidents of “unjustifiable use of force.” By that time, the unstemmed violence had led some California counties to stop committing young offenders to the state’s juvenile prisons altogether.

The CYA’s systemic problems have transcended unrestrained violence and a recidivism rate that hovers around seventy-five percent. In 1997, the CYA permitted Stanford University to test a powerful psychiatric drug for two months on sixty-one youths between the ages of fourteen and eighteen, an experiment that the Agency later believed violated state law. The 2003 expert report found that despite some progress in improving


109 See Lee Romney, S.F. to Seek Alternative to State’s Youth Prisons, L.A. TIMES, Oct. 23, 2004, at B6 (reporting San Francisco mayor’s desire to stop sending youths to CYA facilities within two years because the CYA “is no place to send our children”).

110 See Bailey & Palmer, supra note 108.

mental health services, the CYA still overmedicated or ignored youths who needed mental health treatment and medical care.\textsuperscript{112} CYA mental health programs were in complete disarray, and “[t]he vast majority of youths who have mental health needs are made worse instead of improved by the correctional environment.”\textsuperscript{113} Mentally ill youths in solitary confinement were often fed “blender meals,” consisting of a pulverized bologna sandwich, apple, and milk fed by straw through a slit in the cell door.\textsuperscript{114}

In 2004, California settled a class action lawsuit brought by a woman who alleged that her mentally ill nephew had been locked in a filthy CYA isolation cell twenty-three hours a day for seven months.\textsuperscript{115} The consent decree anticipated reforms in living conditions, medical and mental health care, education and rehabilitation programs, and in use-of-force policies at CYA facilities.\textsuperscript{116} The decree, however, did not guarantee funding or require the State to take the expensive step of replacing the existing huge juvenile prisons with smaller regional facilities based on the Missouri model, even though leading juvenile justice experts deem such facilities essential to any meaningful reform.\textsuperscript{117} A post-decree agreement provided for confining youths in smaller groups with more counseling, a measure a smaller statewide juvenile inmate population makes possible without closing any existing large congregate prisons.\textsuperscript{118}

The \textit{Los Angeles Times} presciently warned of storm clouds ahead, saying that the class action settlement “uses all the right words. It calls for noble-sounding reforms . . . . That might generate more excitement if not for the long history in California of


\textsuperscript{113} See Trupin & Patterson, \textit{supra} note 112, at 17.

\textsuperscript{114} See Broder, \textit{supra} note 107.

\textsuperscript{115} Editorial, Needed Reforms; Suit Forces Youth Authority to Change, SAN DIEGO UNION-TRIB., Nov. 20, 2004, at B8.


\textsuperscript{118} See Brandon Bailey & Karen de Sa, Juvenile Prison Plan Made Public Legal Settlement, SAN JOSE MERCURY NEWS, May 16, 2005, at 3A.
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passionate entreaties to reform the CYA and promises of action, with no follow-up." On January 26, 2006, the head of the State's Department of Corrections and Rehabilitation abruptly resigned because he no longer saw "will and commitment" from State authorities to produce the reforms he had been hired to effectuate two years earlier. Amid fierce opposition from the powerful state prison guards union and other groups, the San Jose Mercury News says that "[r]eform, once promising, then faltering, is all but dead" in California.

Florida and California, statewide juvenile prison systems not yet inspected by the Justice Department, serve as preludes to the state systems the Department has inspected in recent years, most of which paint portraits as bad or worse. The remainder of this Part describes the Department's reports on these systems.

1. Puerto Rico and Kentucky

"Rats, insects and other vermin crawl[ed] over the juveniles in the night." In 1994, a federal court in Puerto Rico entered a CRIPA consent decree in litigation brought by the Justice Department to correct conditions at the Commonwealth's overcrowded juvenile correctional facilities. The Department found that youths were forced to share filthy mattresses in hot, unventilated, overcrowded cells in which "[r]ats, insects and other vermin crawl[ed] over [them] in the night." Defective plumbing forced youths to drink from toilet bowls. Staff failed to intervene when youths attempted or committed suicide, and failed to provide needed psychiatric treatment.

was allowed to walk around the facility with a sheet around his neck.¹²⁷ Youths at nearly all the facilities received little or no education.¹²⁸

In 1995, a Kentucky federal court entered a CRIPA consent decree to remedy serious deficiencies the Justice Department found in that State’s thirteen juvenile treatment facilities.¹²⁹ The decree required the State to protect confined youths from abuse, mistreatment, and injury; to insure adequate medical and mental health care; and to provide adequate educational, vocational, and aftercare services.¹³⁰

2. Louisiana

“We don’t deliver services for kids. We just play like we deliver services for kids.” ¹³¹

By the time the Justice Department inspected Louisiana’s four juvenile prisons in 1996, the prisons had already been under federal district court oversight for fifteen years. The court had found three of the four juvenile prisons—Bridge City, Jetson and Swanson—infected with violence, abuse, and neglect in 1981.¹³² The court assumed jurisdiction of the fourth prison, the Tallulah Correctional Center for Youth, in 1994 when that facility opened under private management.¹³³

¹²⁷ Id.
¹²⁸ Id. at 2-3.
¹³⁰ Id.
¹³² See HUMAN RIGHTS WATCH, CHILDREN IN CONFINEMENT IN LOUISIANA 10 (1995), available at http://www.hrw.org/reports/1995/us3.htm. The full names of the three facilities were the Louisiana Training Institute—Bridge City, the Jetson Correctional Center For Youth, and the Swanson Correctional Center For Youth (formerly known as the Louisiana Training Institute—Monroe). Id. Bridge City, Jetson, and Swanson were state owned and operated. See, e.g., State ex rel. S.D., 2002-0672 (La. App. 4th Cir. 2002), 832 So. 2d 415, 416 (calling Bridge City “the juvenile equivalent of jail”).
¹³³ Tallulah was privately owned and operated until the State assumed its operation in 1999. Riots led the court to declare a state of emergency at Tallulah in December of 1994. See HUMAN RIGHTS WATCH, supra note 132, at 3-7, 10, 14, 15, 21-22 (finding that children at all four secure facilities were suffering “pervasive” physi-
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a. The Justice Department Reports

(i) The First Interim Emergency Letter

The Justice Department found conditions at Louisiana’s four juvenile prisons so “life-threatening or dangerous” that it sent the Governor two interim emergency letters requesting immediate corrective action.\textsuperscript{134} The first letter, concerning Bridge City and Jetson, reported beatings and other assaults that staff members confirmed and neither facility’s superintendent denied.\textsuperscript{135} Officers at both facilities arranged for children to beat up other children, usually “paying” the aggressor with cigarettes, special protection, soap, or food.\textsuperscript{136}

At Bridge City, officers themselves assaulted children, sometimes even while the children slept.\textsuperscript{137} Youths also repeatedly suffered physical and sexual assaults at the hands of other youths, especially at night.\textsuperscript{138} Younger children and children with significant cognitive limitations (IQs less than sixty-five) were often targeted.\textsuperscript{139} Under a practice called “Take Five,” Bridge City guards agreed not to intervene when one child beat another.\textsuperscript{140} Bridge City held only 178 youths, but infirmary logs indicated that during a five-month period, youths on forty occasions suffered orthopedic injuries or serious lacerations, including dislocated fingers, broken and sprained ankles, split lips, and broken noses and jaws.\textsuperscript{141}

Violence was also rampant at Jetson, where a boy reported that a guard repeatedly punched him in the face when the guard suspected him of making a noise; two days after the beating the boy underwent surgery for crushed bones and placement of a metal plate in his face.\textsuperscript{142} The Justice Department confirmed that

\textsuperscript{134} Letter from Deval L. Patrick, Assistant Att'y Gen., Civ. Rights Div., U.S. Dep't of Justice, to the Hon. Mike Foster, Governor of La. (July 15, 1996), \textit{available at} (regarding investigation of secure correctional facilities for children in Louisiana).

\textsuperscript{135} Id.

\textsuperscript{136} Id.

\textsuperscript{137} Id.

\textsuperscript{138} Id.

\textsuperscript{139} Id.

\textsuperscript{140} Id.

\textsuperscript{141} Id.

\textsuperscript{142} Id.
a girl suffered a bloody eyeball when a guard hit her with keys. The Department also expressed concerns about sexual abuse by female officers at Jetson.

(ii) The Second Interim Emergency Letter

In its second 1996 interim emergency letter to the Governor, the Justice Department documented a high rate of injuries caused by similar patterns of physical, sexual, and emotional abuse at Louisiana’s other two juvenile prisons, Monroe (later known as the Swanson training institute) and Tallulah.

The Justice Department found that officials at both facilities misused and overused chemical and mechanical restraints and isolation. Youths were isolated in solitary confinement for extended periods after minor disciplinary infractions or even suicide attempts. Guards reportedly allowed youths to fight other youths without intervening, or even ordered youths to fight each other, threatening beatings for failure to follow the order. Many staff disclosed that youths at both institutions often misrepresented the causes of injuries from staff abuse for fear that telling the truth would only bring more abuse.

During a six-week period, twenty-four Swanson juveniles were held at least one night in the infirmary for serious injuries from assaults by other youths or staff members. Ten youths were injured so severely that they required stays of seven days or longer. Ten suffered fractures to the jaw, eye socket, nose, hand, or ankle. Five suffered serious eye injuries, and one was placed in the infirmary for injuries attributed to anal rape.

Several Swanson juveniles reported that guards sometimes gave youths chips or cigarettes to complete a “hit” by injuring a youth.

143 Id.
144 Id.
146 Id.
147 Id.
148 Id.
149 Id.
150 Id.
151 Id.
152 Id.
badly enough to require hospitalization.\textsuperscript{153}

The Justice Department found three juveniles in Tallulah’s infirmary with broken jaws and two with broken noses.\textsuperscript{154} In the first twenty days after the State announced a zero tolerance policy against violence in the four juvenile prisons, twenty-eight Tallulah youths were hospitalized for evaluation or treatment of serious injuries, including fractures or suspected fractures and serious lacerations requiring sutures.\textsuperscript{155} Tallulah’s medical personnel reported that they treated a juvenile with a perforated eardrum about once every two weeks, and that the physician once treated eight ruptured eardrums in one day.\textsuperscript{156} Almost all these injuries were attributed to staff assaults or youth-on-youth violence.\textsuperscript{157} Several Tallulah juveniles described how a guard would crush their testicles with his outstretched arms during routine spread-eagle searches.\textsuperscript{158}

The Justice Department’s second interim emergency letter also cited medical and mental health deficiencies that posed serious risks of harm to confined juveniles. Tallulah, for example, lacked adequate suicide prevention measures and plans.\textsuperscript{159} Both facilities failed to respond to juveniles’ requests for HIV testing, despite documented rapes.\textsuperscript{160} Tallulah staff routinely denied asthmatic juveniles—including those in the physically demanding boot camp—access to immediate medical care.\textsuperscript{161}

\textit{(iii) The Final Report}

The Justice Department’s final report found an “unacceptable level of violence” at all four Louisiana juvenile prisons, and said that “little attention has been paid to sexual activity between juveniles and between officers and juveniles.”\textsuperscript{162} “[S]taff routinely continue to kick, hit, slap, stomp, choke [and] scratch”

\begin{footnotes}
\footnotetext{153}{Id.}
\footnotetext{154}{Id.}
\footnotetext{155}{Id.}
\footnotetext{156}{Id.}
\footnotetext{157}{Id.}
\footnotetext{158}{Id.}
\footnotetext{159}{Id.}
\footnotetext{160}{Id.}
\footnotetext{161}{Id.}
\footnotetext{162}{Letter from Isabelle Katz Pinzler, Acting Assistant Att’y Gen., Civ. Rights Div., U.S. Dep’t of Justice, to the Hon. Mike Foster, Governor of La., at A, \textit{available at} \url{heinonline.org} (last visited Feb. 25, 2006) (third letter regarding the investigation of secure correctional facilities for juveniles in Louisiana).}
youths. A Bridge City lieutenant punched a child in the eye and threw him through a screen door while a teacher watched. Videotapes recorded separate incidents of a Swanson guard karate kicking a juvenile in the head and another guard punching a juvenile. A captain discovered Tallulah guards macing youths while they were held by other guards, and beating up youths, including one who bled heavily from the mouth with his hands cuffed behind his back. A Jetson guard repeatedly whipped two females with a belt—one girl was whipped allegedly because it was her birthday and the guard had a practice of whipping juveniles on their birthdays, and the other girl was whipped allegedly because she was going to be discharged shortly.

The Justice Department found all four secure detention facilities plagued by inadequate medical and mental health care. Moreover, educational programs at all four facilities operated "completely outside the bounds of acceptable educational practice," and fell below applicable state regulations, federal statutes, or professional standards concerning special education, vocational education, and life skills training.

b. Aftermath

Alleging that Louisiana had "failed or refused" to address its findings for more than two years, the Justice Department filed suit in November of 1998. The State settled these suits, but in a private suit brought in 2001 the Louisiana Court of Appeals found Tallulah still marked by a "culture of violence." While confined in Tallulah that year, the plaintiff youth suffered a broken jaw when a guard punched him in the face while another guard had his arm around the boy's neck in a choke hold.

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163 Id. at A1.
164 Id.
165 Id.
166 Id.
167 Id.
168 Id. at C.
170 State ex rel. S.D., 2002-0672 (La. App. 4th Cir. 2002), 832 So. 2d 415, 437.
171 Id. at 428.
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ter receiving testimony and other evidence—including guards' uncontradicted testimony—the court found that authorities "maintained order through fear, force and violence." Fights happened regularly, often with guards turning their backs or refusing to intervene; "vulgarity, incendiary profanity, and the expression of aggressively hostile feelings constitute[d] the normal tone of interactions between guards and youth"; and between twenty and twenty-five percent of confined youths suffered injuries each month, including broken jaws and other bones, inflicted by guards or other youths.

In 2003, at the invitation of Louisiana's Joint Legislative Juvenile Justice Commission, the Annie E. Casey Foundation conducted a comprehensive study that recommended fundamental structural reforms and specifically urged the state to replicate Missouri's juvenile corrections system. "Despite some reform measures," the Lafayette Daily Advertiser editorialized at the time, the juvenile corrections system "remains underfunded, lacks effective treatment options, and puts children guilty of property crimes or minor drug offenses in the company of those who are violent and dangerous." The State has closed Tallulah, but rapes and other violence continue at the other facilities. With top Missouri juvenile justice officials helping Louisiana pursue reform at the behest of a Governor actively advocating positive change, the State has unveiled a blueprint for reform, including a pilot project at Bridge City that, according to one juvenile court judge, "looks just like Missouri."

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172 Id. at 437.
173 Id. at 430-32.
175 Editorial, PRISONS FOR JUVENILES SHOULD BE OPERATED BY SEPARATE AGENCY, DAILY ADVERTISER (Lafayette, La.), Jan. 22, 2004, at 8A.
179 Laura Maggi, JUVENILE JAIL'S NEW DORM UNVEILED, TIMES-PICAYUNE (New Orleans), July 15, 2005, at 3; see also Op-Ed, GAINS IN REFORMING JUVENILE JUSTICE SYS-
3. Georgia

“Some incidents and conditions . . . amount to state-sanctioned child abuse.”

In 1994, the Atlanta Journal and Constitution described Georgia’s juvenile prisons as “[d]ark, dungeonlike fortresses where roaches roam freely and heaters and toilets don’t work. Children sleeping two and three to a cell. Youngsters without access to teachers or doctors.” Two years later, the newspaper was more blunt, calling these prisons “an abomination to humanity.”

The Constitution was speaking of both types of facilities operated by the State’s Department of Juvenile Justice (DJJ). Twenty-two Regional Youth Detention Centers (RYDCs)—which primarily housed youths held pending their hearings on charges ranging from running away from home to murder—maintained locked eight-by-ten-foot cells with a bunk and a toilet that were generally similar to cells in many adult jails. Nine Youth Development Campuses (YDCs) were longer-term treatment facilities with regular programs for boys and girls and boot camps for boys.

Two youths committed suicide in DJJ facilities in 1991. In 1993, Atlanta Legal Aid filed a federal class action suit challenging conditions at the Marietta RYDC, where grand jury reports since the late 1980s had described children living in filth, sleeping on thin foam pads on concrete floors, and shivering in the winter in unheated cells with rotting walls and broken toilets. The lawsuit alleged that youths were confined in cramped cells dank
with the stench of raw sewage seeping onto the floor, and were sometimes forced to drink from toilets because sinks in their locked cells had no running water.\textsuperscript{187} Youths sometimes urinated into heating vents because the locked cells provided no ready access to functioning toilets.\textsuperscript{188} Guards frequently “hog-tied” children, forcing the child to lie face-down on the floor while the guard tied the child’s arms and legs together behind the back with rope, chains, or shackles.\textsuperscript{189}

When a high school film class toured Marietta to make a video of the juvenile prison shortly before suit was filed, the students left with more than footage of exposed wires, peeling paint, broken bathroom sinks, and rotted moldy showers. “People say that these kids are criminals and don’t deserve to stay in the Hilton,” said one of the high school seniors, “but this was disgusting.”\textsuperscript{190}

Two more federal lawsuits followed in 1996. The first suit alleged that overcrowding at the Gwinnett RYDC had led several youths to attempt suicide, and had encouraged older youths to commit physical abuse, rape, and sodomy on younger ones.\textsuperscript{191} The second suit charged that the Dalton RYDC was unsanitary, dilapidated, and so overcrowded that some youths slept with their heads near toilets.\textsuperscript{192} The Dalton plaintiffs alleged, among other things, that overcrowding (1402 youths confined in a facility built for 669) led authorities to house nine- and ten-year-old runaways in cramped cells with violent older gang members.\textsuperscript{193} The State settled the Dalton suit under pressure from U.S. Dis-
strict Judge Harold Murphy, who warned that his order after trial would embarrass the State by detailing the facility’s operation.\footnote{See Ron Martz, Juvenile Authority Settles Suit, ATLANTA J.-CONST., Dec. 22, 1998, at E1.} The State promised upgrades at the facility, and the settlement gave the federal court continuing jurisdiction over its operation.\footnote{Id.}

While the Gwinnett and Dalton suits were pending, officials acknowledged that Georgia’s overcrowded youth prisons failed to meet national standards, but they said the State was trying its best “to sustain a humane environment” amid budget constraints and persistent pressure from lawmakers to incarcerate more juvenile offenders.\footnote{See Mark Silk, Official Disputes Report on Hanged Teen, Says Staff Not at Fault, ATLANTA J.-CONST., Apr. 29, 1995, at C10; Mark Silk, Youth’s Suicide Highlights Problems at DeKalb Facility, ATLANTA J.-CONST., May 9, 1995, at C4 (quoting the commissioner of the Georgia Department of Children and Youth Services).} With the DJJ “adding prison beds as quickly as they can be built, borrowed or rented”\footnote{Silk, supra note 192.} to meet the demands of new anticrime legislation, the Atlanta Journal-Constitution despaired in 1996 that “more lawsuits . . . are the last hope for young people.”\footnote{Kids’ Futures Back in Courts, supra note 182.} Soon afterwards, the Justice Department announced its investigation, implicit with the threat of enforcement in federal court.

\textit{a. The Justice Department Report}

\textit{(i) The Regional Youth Detention Centers}

The Justice Department’s 1998 report found chronic abuse at some or all RYDCs, including (1) “hitting or slamming youths onto the ground and into walls, or otherwise injuring” them; (2) routine use of mechanical restraints as punishment for behavior that did not threaten the safety of the youth or others; and (3) sometimes stripping youths of their clothes and taking their mattresses, forcing them to sit naked on the cold concrete floor or the metal bed, often for days without education or exercise.\footnote{See Letter from Bill Lann Lee to the Hon. Zell Miller, supra note 6, § I(A)(4)-(5).} Youths who refused to undress were forcibly stripped, and male staff sometimes helped strip female inmates.\footnote{Id. § I(A)(4).}

The Justice Department also found Georgia’s RYDCs under-
staffed and “grossly overcrowded,” with populations generally ranging from 150% to 300% of design capacity, and with more than half the facilities operating at or above double their capacity.\(^\text{201}\) “[B]etween 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).”\(^\text{202}\) “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,” without reading materials other than a Bible.\(^\text{203}\) At one RYDC, understaffing kept youths from ever going outdoors; the facilities smelled of urine because cells had no toilets and inmates locked up without access to hall toilets sometimes had to urinate in cups.\(^\text{204}\) Prolonged lockdown was common on weekends when classes were not held and the facilities lacked sufficient staff to supervise activities outside the cells.\(^\text{205}\)

The RYDCs systematically denied adequate mental health care to mentally disturbed youths, who comprised a large percentage of the population at most of the facilities and a majority at some.\(^\text{206}\) Inadequately trained staff handled suicide screening and supervision, and the condition of suicidal, depressed youths deteriorated from isolation in demeaning conditions for hours (and sometimes days) without proper treatment.\(^\text{207}\)

The Justice Department found that overcrowding and lack of resources compromised every aspect of education at the RYDCs. Most youths were six or more grade levels behind in their studies, but the RYDCs had insufficient classroom space, an insufficient number of teachers for the growing inmate population, and a lack of books and other teaching materials.\(^\text{208}\) State and federal law entitled many of the youths to special education, but the Justice Department found noncompliance with the Individuals with Disabilities Education Act (IDEA) and section 504 of the

\(^{201}\) Id. § I(A)(1)(a).
\(^{202}\) Id.
\(^{203}\) Id.
\(^{204}\) Id. § I(A)(1)(b).
\(^{205}\) Id. § I(A)(1)(a).
\(^{206}\) Id. § I(A)(3).
\(^{207}\) Id. § I(A)(3)(b).
\(^{208}\) Id. § I(A)(6)(a).
(ii) Youth Development Campuses and Boot Camps

The Justice Department found that chronic understaffing left Georgia’s YDCs unable to prevent physical and sexual assaults by youths on one another.\(^{210}\) Children received inadequate educational and rehabilitative services and inadequate medical care.\(^{211}\) Mentally ill youths locked in isolation units were restrained, hit, shackled to beds and even toilets, put in restraint chairs for hours, and sprayed with oleoresin capsicum (OC) spray, or pepper spray, by staff who lacked training and resources to respond appropriately to the manifestations of mental illness.\(^{212}\)

Researchers have warned that OC sprays “should be regarded as poisons or weapons and kept away from children and teenagers” because spraying risks “serious adverse health effects, even death” in children.\(^{213}\) “When OC spray is used, officers must de-


\(^{210}\) See Letter from Bill Lann Lee to the Hon. Zell Miller, supra note 6, § I(B)(5)-(6).

\(^{211}\) Id. § I(A)(6)-(7); see also Edwards v. Dep’t of Children & Youth Servs., 525 S.E.2d 83 (Ga. 2000) (reversing order granting summary judgment in favor of Department in suit brought under state tort claims act by parents of youth who died from a subdural hematoma at a YDC, allegedly because the institution’s employees negligently failed to provide proper medical care).

\(^{212}\) See Letter from Bill Lann Lee to the Hon. Zell Miller, supra note 6, § I(B)(1)(a).

\(^{213}\) C. Gregory Smith & Woodhall Stopford, Health Hazards of Pepper Spray, available at http://www.geocities.com/CapitolHill/6416/smith-ok.html (last visited Feb. 28, 2006). The researchers specified that “laryngospasm, laryngeal and pulmonary edema, chemical pneumonitis and respiratory arrest have occurred after intentional and accidental OC spray inhalation by children.” Id. In adults and children alike, exposure to OC spray can also cause “tingling, intense burning pain, swelling, redness, and, occasionally, blistering” of the skin; “burning of the throat, wheezing, dry cough, shortness of breath, gagging, gasping, inability to breath or speak...and, rarely, cyanosis, apnea and respiratory arrest”; “acute hypertension...which in turn can cause headache and increase the risk of stroke or heat attack”, “bronchoconstriction, which could manifest as acute asthma”; and “redness, swelling, severe
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contaminate those sprayed as soon as possible, continuously monitor them for evidence of serious adverse effects, and seek medical attention immediately if potentially life-threatening symptoms develop.” 9214 Incarcerated children, many or most of whom are medically or mentally impaired, remain at particular risk because showers and first aid are often withheld in juvenile corrections facilities, where youths are sometimes fortunate to see a physician or other health professional from one month to the next.

Georgia staff used excessive force and abusive discipline against youths at both the YDCs and the state-maintained paramilitary boot camps, or “shock incarceration” programs. Boot camp staff routinely inflicted beatings on “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.” 9215

One boot camp staff supervisor, for example, broke a youth’s arm after restraining him for collapsing during punitive exercises, and broke another youth’s eardrum when he hit the youth in the head for talking in line. 9216 At another boot camp, staff regularly took youths out of range of the camp’s cameras and beat them, put them in choke holds, or slammed them into walls. 9217 One youth collapsed while doing push-ups and needed facial sutures after a staff member began lifting him and dropping him to the floor. 9218 Youths at one boot camp had been deprived of water and forced to do push-ups in heat exceeding ninety-five degrees on black asphalt that burned their hands. 9219 Other youths had been forced to run laps in the heat while carrying a heavy tire. 9220

burning pain and stinging [of the eyes], conjunctival inflammation, . . . and involuntary or reflex closing of the eyelids. *Id.* In almost all deaths from exposure to OC spray, contributing factors included conditions prevalent in juvenile detention facilities: “positional asphyxia (usually associated with hog-tying the sprayed person), drug intoxication, . . . preexisting cardiovascular or respiratory disease, [and] obesity.” *Id.*

The U.S. Consumer Products Safety Commission requires OC spray labeling as a hazardous substance under the Federal Hazardous Substance Act. *Id.*

9214 *Id.*
9215 Letter from Bill Lann Lee to the Hon. Zell Miller, *supra* note 6, § I(B)(3)(c).
9216 *Id.* § I(B)(2).
9217 *Id.*
9218 *Id.* § I(B)(3)(c).
9219 *Id.*
9220 *Id.*
b. Aftermath

Georgia swiftly reached an agreement with the Justice Department to improve juvenile confinement conditions, including an immediate $10.8 million appropriation to hire more teachers, guards and medical personnel at the state's juvenile detention facilities.221 Commentators and juvenile justice professionals have continued to implore Georgia to save money by incarcerating fewer children and by funding less expensive community-based treatment programs.222 Meanwhile, the State continues to imprison not only juvenile murderers, but also children found guilty of offenses as relatively minor as unruly behavior.223

In 2000, the Special Monitor appointed under Georgia's agreement with the Justice Department found the state's secure detention facilities still overcrowded, lacking necessary educational and mental health services, and suffering a severe shortage of well-trained, experienced staff.224 Seven youths committed suicide in Georgia juvenile justice facilities between 1995 and 2002, and suicide attempts and assaults have continued.225 In 2003, the Georgia Bureau of Investigation reported that Augusta YDC

employees provided youths with marijuana, drugs, and pornography; took money for allowing youths to fight one another; and had sex with some of the youths.\textsuperscript{226} In late 2005, Georgia authorities revealed that they were investigating allegations that State Department of Juvenile Justice personnel had falsified documents to help juvenile detention centers pass the federal inspections required by the 1998 CRIPA settlement.\textsuperscript{227}

The \textit{Atlanta Journal-Constitution} has charged that Georgia’s juvenile justice system is still “a scrap heap for the things that go wrong in society that no one cares about enough to fix.”\textsuperscript{228} Children who skip school or break curfew are still being locked up with armed robbers and other violent offenders.\textsuperscript{229} Years after the Justice Department report chronicled an unstemmed culture of violence, “[t]he state’s juvenile detention centers overflow with mentally ill kids who need therapy and neglected kids who need community support.”\textsuperscript{230} “Only a fraction of the kids jailed in Georgia are dangerous criminals,” the newspaper continued.\textsuperscript{231} “Most are hapless adolescents from frayed families without the resources or the stability to get their children back on track,” but Georgia “hasn’t got the money or the political will to provide the children in its jails with even the basic education required by law, never mind the counseling necessary to straighten out their muddled lives.”\textsuperscript{232}

4. \textit{Arkansas}

“(N)one person should take the fall for a state that decided


\textsuperscript{229} See Jill Young Miller, \textit{Kids’ Penalties Criticized; Minor Offenders Often Locked Up}, \textit{Atlanta J.-Const.}, Nov. 27, 2004, at B1. Some improvements in Georgia juvenile prison conditions had been noted. See Jill Young Miller, \textit{Juvenile Justice System on Mend}, \textit{Atlanta J.-Const.}, Oct. 24, 2004, at El.

\textsuperscript{230} \textit{Clouds Envelop Juvenile Justice}, supra note 228.

\textsuperscript{231} \textit{Id.}

\textsuperscript{232} \textit{Id.}; see also Editorial, \textit{Sorry State of Child Care}, \textit{Atlanta J.-Const.}, Nov. 29, 2004, at A10 (“As a political matter, the General Assembly can afford to ignore children’s issues. The children themselves have no voice and no vote. So the agencies that deal with children in Georgia remain chronically underfunded and impervious to improvement.”).
long ago that it was easier and cheaper to warehouse juvenile delinquents than rehabilitate them."\textsuperscript{233}

In 2002, the Justice Department inspected the Alexander Youth Services Center, Arkansas' largest juvenile lockup. By that time, children committed to the custody of the Arkansas Division of Youth Services (DYS) had already suffered years of physical, sexual, and emotional violence widely publicized in the media.\textsuperscript{234} In 1998, four years before the Justice Department inspection, the Arkansas Democrat-Gazette's acclaimed investigative reporter Mary Hargrove wrote an award-winning six-part series exposing brutality at Alexander and the state's other juvenile prisons.\textsuperscript{235} "The abuses I was uncovering," she confided a few months later, "were so bad that I became concerned that I could not write the series fast enough to prevent more children from being hurt."\textsuperscript{236}

The 1990s, Hargrove recounted, had been rocky for the DYS. In 1995, the State opened the Central Arkansas Observation and Assessment Center in an old, rundown North Little Rock jailhouse that had been built decades earlier to hold eighty-four adults but now held more than 130 children.\textsuperscript{237} Children who hunted deer out of season were mixed with juvenile murderers; children sometimes went weeks without seeing daylight in the windowless institution; raw sewage spewed from the shower drains when the toilets were flushed; and poor ventilation and malfunctioning air conditioning guaranteed a persistent stench.\textsuperscript{238} Overcrowded cells meant that "[g]irls were sleeping in


\textsuperscript{235} See Hargrove, supra note 234.

\textsuperscript{236} \textit{Id.}


\textsuperscript{238} \textit{Id.}
showers."

Daily verbal and physical attacks by teens and staff members led the North Little Rock staff to lash out. "Some employees ordered rougher teen-agers to scare those who were discipline problems, which usually resulted in some kind of physical attack," Hargrove wrote. "[A] thinly veiled underground sprang up among the boys. The more vulnerable children were forced to barter food to ward off beatings or attacks by sexual predators in the crowded cells. Toothbrushes and pencils were sharpened into lethal weapons to be used on staff members or opposing gang members."

Hargrove described these acts of violence committed at North Little Rock in 1997 against David G., an emotionally disturbed fourteen-year-old boy who had been treated at five psychiatric centers before being found delinquent for third-degree battery:

David was taken upstairs to a Quiet Room, a "timeout" cell for troublemakers. His brown jumpsuit was taken away. He wore only underwear. Two older, bigger boys in green jumpsuits were already in the 11-by-11-foot cell. "Beat him up and do him good. Don't leave any marks," the staff member ordered, according to the two older boys. During the next 30 minutes, numerous staff members and other teen-agers heard David repeatedly screaming and crying for help. He was beaten, spat on, slapped and taunted. He said the older boys twisted a sheet into knots and beat him with it, according to a state police report. Then, he said, he was held down while one of the boys stuck a broom handle into his rectum. He was removed from the area for a few hours. And then, despite his desperate pleas to be left alone, the sobbing boy was taken back to the Quiet Cell where two other boys slapped him, threw water on him and hit him in the head with combs and brushes while cursing him.

Later, a staff member allegedly hog-tied David and left the screaming boy face down on the concrete floor in his underwear.

Later in 1997, a sixteen-year-old boy committed to North Little Rock tied a bed sheet to a bunk bed and hanged himself.

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239 Id.
240 Id.
241 Id.
242 Id.
243 Id.
244 See Boy, 16; Hangs Self; Autopsy is Pending, ARK. DEMOCRAT-GAZETTE (Little Rock), Oct. 22, 1997, at 10B.
Conditions were no better in Alexander and Arkansas’ other juvenile detention facilities, where Hargrove verified physical, sexual, and emotional abuse of youths eleven to seventeen years old by untrained workers, some of whom had criminal records.245 Some boys were hog-tied, forced to sleep outside on the ground in freezing weather, slugged in the face and denied medical attention despite gaping, bloody wounds.246 Other boys were stripped of their clothes and placed in cells after the air conditioning was turned down, and threatened with death if they reported the abuse.247 A 1998 DYS investigation verified that Alexander staff members would line up boys and slug, slap, or hit them with wooden sticks, and then sometimes deny them medical attention when they bled.248

When the Hargrove series appeared in the Democrat-Gazette, the DYS Director immediately resigned and the Governor closed the North Little Rock center, but violence at other DYS detention facilities continued. In three follow-up articles in 2000, Hargrove reported that DYS remained “a giant holding cell, a warehouse for children with every imaginable background.”249 Some of the children belonged in secure detention, others appeared mentally ill and belonged in a state hospital, and others were low risk and belonged in community-based nonsecure care. DYS records indicated that only nine percent of the boys and forty percent of the girls at Alexander had been placed in treatment programs recommended for them by a clinical psychologist.250

Calls for educational reform at Alexander fell on deaf ears. Hargrove’s 1998 series reported that classes were held only “spo-

245 Hargrove, supra note 237.
246 Id.
247 Id.; see, e.g., Tribble v. Ark. Dep’t of Human Servs., 77 F.3d 268 (8th Cir. 1996) (holding that Alexander authorities’ failure to notify youth’s teachers that a classmate had previously sexually assaulted him did not constitute deliberate indifference to the youth’s safety in suit filed after the classmate later physically assaulted the youth); Ashby v. State, No. CA CR 94-1016, 1995 WL 529596, at *1 (Ark. Ct. App. Sept. 6, 1995) (defendant convicted of raping his fourteen-year-old roommate at Alexander).
radically." A 1998 DYS study found that Alexander fell short of federal and state education requirements in twenty-four areas. In 2001, Alexander was found to be out of compliance with federal and state regulations in eight of nine education-related areas. A few months before the Justice Department inspection, the State's Education Department warned that DYS risked losing federal and state education funding because conditions at Alexander had "steadily declined" in the four years since the State had contracted with a private firm to provide educational services there. When the Education Department toured Alexander, it found "children not in classes, no textbooks and limited numbers of teachers."

In 2001, two sixteen-year-old boys committed suicide by hanging themselves in their Alexander cells. In August of 2002, a DYS guard was convicted of third-degree battery for trying to hurl a youth into the ground. By that time, DYS' reputation for unrestrained physical and emotional abuse had led some juvenile court judges to resist placing children in the Agency's custody at all, preferring instead to rely on local placements near the delinquent's home when such placements were available.

a. The Justice Department Report

The Department's 2002 report found no constitutional or statutory violations in the facility's overall management. The re-

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255 Id.
port did find, however, that youths confined there suffered harm or the risk of harm from deficient mental health care, and were denied required educational services.\(^{260}\)

The Justice Department found that Alexander failed to provide sufficient individual mental health treatment and care. The facility’s psychiatrist and psychologist prescribed medication and conducted intake analysis, but youths with serious mental illnesses, including psychosis and bipolar disorder, received no treatment from qualified mental health professionals.\(^{261}\) The Justice Department also cited Alexander’s insufficient suicide prevention measures, a sore point following the two suicides there in 2001.\(^{262}\)

Concerning educational services, the Justice Department found that children at Alexander routinely remained in the intake units without attending school for weeks.\(^{263}\) The facility lacked vocational training, lacked a school counselor, failed to maintain a systematic process for evaluating children to determine whether they required special educational services, and failed to provide adequate special education services.\(^{264}\) The facility also failed to provide adequate access to reading materials, failed to assign homework, retained some inadequate or ineffective teachers, and suffered from a critical shortage of textbooks and other educational resources.\(^{265}\)

\(\text{b. Aftermath}\)

When the Justice Department issued its report in 2002, the Arkansas DYS Director was the Agency’s eighth since 1997.\(^{266}\) Years of underfunding and hollow promises of reform left the State Public Defender Commission’s Ombudsman Coordinator skeptical that the report would produce meaningful change because “nothing changes very quickly” at Alexander.\(^{267}\) The Democrat-Gazette shared this skepticism because the problems “have been there for decades.”\(^{268}\) Alluding to the two recent sui-

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\(^{260}\) Id.
\(^{261}\) Id. § II(A)(ii).
\(^{262}\) Id. § II(A)(i).
\(^{263}\) Id. § II(C)(i).
\(^{264}\) Id. § II(C)(ii).
\(^{265}\) Id.

\(^{266}\) See Shurley, supra note 256.

\(^{267}\) Meredith Oakley, So Much Need, So Little Time, ARK. DEMOCRAT-GAZETTE (Little Rock), Nov. 15, 2002, at 23.

\(^{268}\) Id.
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...cides, the newspaper lamented that "through the years [the problems] have been studied to death, but unfortunately the only death that is ever visited upon Alexander is the human variety."269

After reaching a settlement with the State in March of 2003, the Justice Department announced in late October of 2003 that DYS had made "significant progress" in improving education and mental health services at Alexander.270 Death and deterioration, however, remained. In November of 2003, a twelve-year-old girl locked up at the Jack Jones Juvenile Justice Center in Pine Bluff tied a bed sheet to steel mesh covering a light fixture and hanged herself in her cell.271 In April of 2005, a seventeen-year-old girl died of blood clots in her lungs after nurses at Alexander disbelieved her persistent complaints of chest pains, dizziness, and shortness of breath, even though the girl had lost color in her lips and fingernails.272 Two months later, the Democrat Gazette reported that the private contractor operating Alexander had hired a guard that the State had fired in 2002 for having sex with an adult inmate at a maximum security prison.273

5. South Dakota

"I couldn't believe what was going on."274

On December 29, 1999, the Justice Department formally notified South Dakota's Governor of plans to inspect the Juvenile Prison and Training School at Plankinton and the Youth Correctional Center at Custer.275 Then the waiting game began. The

269 Id.
275 See Letter from Ralph F. Boyd, Jr., Assistant Att’y Gen., U.S. Dep’t of Justice, to the Hon. William J. Janklow, Governor of South Dakota, available at  (last visited
State refused to permit the Department access to either juvenile corrections facility for more than two years, citing pending litigation arising from the heatstroke death of fourteen-year-old Gina Score on July 21, 1999, at the Plankinton girls boot camp. On March 18, 2002—more than a year after the litigation was settled and two months after the State closed Plankinton amid public criticism of abusive conditions—the State again denied the Department access to Custer. Permission to tour Custer was not granted until June 12, 2002.

Plankinton's boot camp staff had often forced girls to run shackled and handcuffed until blood soaked their shoes. Only five days after she arrived at Plankinton for shoplifting, the severely overweight Score and other girls were taken on a mandatory 2.6-mile jog at about 6:30 in the morning with the temperature and humidity about seventy and rising. Score quickly fell behind the others, and two staff members repeatedly shouted at her to catch up, sometimes holding her up to keep her moving. When she staggered and collapsed 500 feet from the finish, girls circled around her to provide shade but counselors ordered them to back away. Score collapsed again on the way back to her quarters.

With Score left on the ground in the hot sun three hours later, two physicians arrived and ordered an ambulance. Paramedics administered oxygen, but the girl's heart stopped before she reached the hospital. "In the emergency room, they sent chilled IV fluids through Gina's rigid body and packed her in ice, but a rectal thermometer peaked at 108—the highest it would go. Internally, she had literally begun to cook." Her organs shut down and she was declared dead shortly after noon. An emergency room physician called it "the worst case of heatstroke I've ever seen."

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276 Id.
277 Id.
278 Id.
280 See Teen's Death at Camp Fuels Debate, Inquiry, supra note 279.
281 Selcraig, supra note 274.
282 Id.
283 Id.
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Gina Score’s death exposed what one South Dakota legislator called a “culture of violence” in the state’s juvenile corrections facilities. The lawmaker, a former State Corrections Commission Chairman and once a prison guard himself, began receiving anonymous calls about boys being molested at Custer. “[W]hen I started checking into things,” he said, “I couldn’t believe what was going on.” Sexual abuse, physical and emotional violence, and suicide attempts by traumatized juveniles marked life in South Dakota’s juvenile corrections facilities:

[K]ids in the boot camps who were considered discipline problems were shackled by their wrists and ankles to beds or concrete floors—a restraint called “four-pointing”—sometimes for 24 hours a day. Male guards often took part in cutting off the clothes of girls who were four-pointed, ostensibly to prevent suicide. Male guards also patrolled the showers, a particularly traumatizing practice for the 75 percent of Plankinton girls who reported to counselors that they had been sexually abused as children. Some kids were pepper-sprayed naked in their cells and denied medication. Children considered violent were kept in total isolation, more than 23 hours a day in small cells, for as long as two weeks.

Because South Dakota was not in compliance with the 1974 federal mandate prohibiting secure detention of status offenders, many children charged with only truancy or running away from home found themselves behind bars. Even after the State settled a class action suit challenging conditions at Plankinton in late 2000, Gina Score’s death reportedly left some judges reluc-

284 Id.
285 Id. (“I saw one induction, and that was enough. I thought it was barbaric.” (quoting a former Plankinton group counselor)).
tant to send troubled children to the state’s juvenile corrections programs at all.Governor William J. Janklow, however, resis-ted reform. When four teens instigated a melee at Plankinton three months after Gina Score’s death, the Governor publicly called the four inmates “scum” (a characterization for which he later apologized).

a. The Justice Department Report

In the two-and-a-half years before South Dakota permitted the Justice Department to inspect Custer, state authorities had plenty of time to stem the violence there. The Department’s 2003 report found “no systemic constitutional or statutory violations in the areas of overall juvenile justice management, excessive force, or provision of medical care.”

The Justice Department report found, however, that Custer failed to provide required educational services, including sufficient educational time for youths in the intake center, adequate instruction to youths held in isolation cells, and vocational training for girls commensurate with that offered to boys. The staff lacked certified teachers in some areas of mandatory instruction, including special education. The report also found that youths confined at Custer suffered deficiencies in mental health care, such as failure to provide psychiatric care or support to youths awaiting transfer to other facilities.


290 See Letter from Ralph F. Boyd, Jr. to the Hon. William J. Janklow, supra note 275.

291 Id. § II(A).

292 Id.

293 Id. § II(B).
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b. Aftermath

In 2003, the Sioux City Argus Leader called South Dakota's juvenile corrections record "nothing short of terrible" because "we've resisted [reform] for so long."294 At the same time, the Argus Leader offered measured praise for the state's announced pledge to heed the Justice Department's recommendations and rectify the deficiencies that the Agency found. "[T]his sudden change of heart comes as we're being forced to comply with federal law—rather than from a real sense of caring," the newspaper said, "but the end result will be good for our youths, and that's important."295

6. Mississippi

The Justice Department report "means the Legislature can't treat the youth training centers as zoos."296

In 2002, the Justice Department inspected two aging Mississippi training schools, the Oakley Training School in Raymond and the Columbia Training School in Columbia. The New York Times was not wide of the mark a year later, when it called them "debilitating dumping grounds for troubled children . . . [w]oefully underfinanced, understaffed, and ill-equipped."297

At the time of the Justice Department's inspection, Oakley was still subject to a 1977 federal district court order mandating corrective action.298 For more than a quarter century, the order had been largely ignored by the Governor's Office, the legislature, and the State Division of Youth Services. Not only had the State failed to rectify most of the constitutional and statutory violations the court had found;299 if anything, conditions at Oakley were growing worse. So too were conditions at Columbia.

In 1977, most children held at Oakley were incarcerated for

294 Editorial Comment, Youths Now a Priority, ARGUS LEADER (Sioux Falls, S.D.), Sept. 9, 2003, at 5B.
295 Id.; see also Editorial Comment, Fixing Juvenile Justice, ARGUS LEADER (Sioux Falls, S.D.), Feb. 24, 2003, at 5B; Lee Williams, Corrections Report Released, ARGUS LEADER (Sioux Falls, S.D.), Feb. 18, 2003, at 1B.
296 Eric Stringfellow, Musgrove Must Also Fix Deficiencies for Juveniles, CLARION-LEDGER (Jackson, Miss.), July 24, 2003, at 1B.
299 Id. at 1159; see, e.g., Halbfinger, supra note 297 ("Perhaps most alarming about the Justice Department's conclusions . . . is how loudly they echo those of a federal judge in a landmark 1977 court ruling on conditions at Oakley.").
running away, fighting, or attempted suicide. The federal court found that the institution "completely undermine[d] the remedial purposes of juvenile corrections" by (1) confining children around the clock in isolation units in dark, cold cells, some bare except for a hole in the floor for an unflushable toilet; (2) maintaining understaffed medical and mental health facilities that denied needed treatment; (3) maintaining overcrowded living units that denied basic privacy; and (4) providing little or no general or vocational education, and virtually no special education programs for the "extremely high percentage" of juveniles who were mentally disabled or otherwise required these services.

In 2002, a state legislative committee found medical care, dental care, and treatment and programming for special-needs children still deficient at both Oakley and Columbia. The Justice Department's 2003 report confirmed these findings and also focused on a matter untouched by the 1977 federal court order—the serious injuries children routinely suffered at both institutions from assaults and other physical violence that staff routinely perpetrated "with impunity."

a. The Justice Department Report

Oakley and Columbia operated on a paramilitary model—Oakley for 336 boys, and Columbia for 92 girls and 104 boys. Some of the confined youths were as young as ten, and most were nonviolent offenders. Many of the confined youths suffered from mental illness or mental retardation, even though state law required courts to commit such youths to rehabilitation facilities operated by the State Department of Mental Health

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300 Morgan, 432 F. Supp. at 1143.
301 Id. at 1138-40.
302 Id. at 1143-46.
303 Id. at 1148-49.
304 Id. at 1151-53.
307 Id. at 2-4.
308 Id. at 2-3.
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rather than to prison-like facilities.\textsuperscript{309}

The Justice Department found that children at Oakley and Columbia were hog-tied, pole-shackled, locked in mechanical restraints and isolation units, and routinely assaulted by staff.\textsuperscript{310} A Columbia staff member confirmed incidents of hog-tying, which youths reported occurred while they were on suicide watch or when they failed to follow orders.\textsuperscript{311} Pole-shackled children had their hands and legs handcuffed around a utility pole for hours while other youths performed military drills around them.\textsuperscript{312}

Oakley and Columbia staff also regularly sprayed children with potentially lethal oleoresin capiscum (OC) pepper spray as punishment for minor infractions when no safety risks existed.\textsuperscript{313} At Columbia, suicidal youths were sprayed for their suicidal behavior and gestures, and youths locked in isolation rooms were sprayed for banging on their cell doors.\textsuperscript{314} One suicidal girl was sprayed because she failed to remove her clothes before being placed in solitary confinement.\textsuperscript{315} Also sprayed were youths who failed to perform military exercises, including youths physically unable to keep up with others.\textsuperscript{316}

The Justice Department found that guards sometimes stripped suicidal girls naked and hog-tied them in Columbia’s “dark room,” where they were held for three days to a week.\textsuperscript{317} The room was a locked, windowless isolation cell with nothing but a drain in the floor through which the girls urinated and defecated but which they could not flush.\textsuperscript{318} Of the fourteen girls confined in Columbia’s isolation unit when the Justice Department arrived, nine had been locked up in extremely hot, poorly ventilated cells for more than a week, and one had been locked up for 114 days.\textsuperscript{319} Staff sometimes used restraint chairs for punishment, sometimes hog-tied the girls, and sometimes used OC

\textsuperscript{309} See id. at 2.
\textsuperscript{310} Id. at 5-7.
\textsuperscript{311} Id. at 6.
\textsuperscript{312} Id.
\textsuperscript{313} Id. at 11-12.
\textsuperscript{314} Id. at 11.
\textsuperscript{315} Id.
\textsuperscript{316} Id. Concerning OC spray generally, see supra text accompanying notes 213-14.
\textsuperscript{317} Id. at 7.
\textsuperscript{318} Id. at 8.
\textsuperscript{319} Id.
spray on them for minor misbehavior.\textsuperscript{320} The girls were often denied water, personal hygiene items, bathroom facilities, and sufficient mental health care, even though many of the girls suffered from forms of mental disorders, particularly separation anxiety disorder.\textsuperscript{321}

Girls reported being forced to eat their own vomit if they threw up while exercising in the hot sun.\textsuperscript{322} Youths recommitted to Oakley were taken to an isolation room and punched and slapped by staff as punishment.\textsuperscript{323} Staff confirmed that one counselor choked a boy, and another boy reported that a staff member had shoved his head into a toilet.\textsuperscript{324} Girls as young as ten in Columbia’s isolation unit also reported being hit, choked, and slapped.\textsuperscript{325}

At both institutions, youths with mental health conditions received only “haphazard and cursory” treatment, and many youths were denied the psychiatric medications they had previously taken.\textsuperscript{326} Rather than receiving counseling, rehabilitative treatment, and education, suicidal youths were kept, sometimes naked, on the concrete floor of bare isolation cells with no mattresses during the day.\textsuperscript{327} Justice Department consultants observed a thirteen-year-old boy sitting in the restraint chair near the control room at Oakley, reportedly to prevent self-mutilation.\textsuperscript{328} Family members had severely sexually abused the boy, who had been in several psychiatric hospitals.\textsuperscript{329} As described in the report:

\begin{quote}
No staff approached him, and he was not allowed to attend school or receive programming, counseling, or medication. . . . Just before our arrival, he had been locked naked in his empty cell. His cell smelled of urine, and we observed torn pieces of toilet paper on the concrete floor that he had been using as a pillow.\textsuperscript{330}
\end{quote}

The Justice Department found Oakley and Columbia's
paramilitary programs particularly unsuitable for four groups of children forced to participate in them: (1) younger boys, (2) girls, (3) youths with developmental disabilities, and (4) physically or emotionally fragile youths.331 “Many staff perceived that [younger boys were] non-compliant and anti-authority, when in reality, many of the boys are merely active third, fourth and fifth graders with short attention spans,”332 or boys with Attention Deficit Hyperactivity Disorder (ADHD) who were denied their medication.333 “Harsh disciplinary practices . . . characterized as training” were meted out to girls, including one who was required to sleep one hour and walk one hour for two successive nights before she was forced to eat every meal standing for the next week.334 A staff member told the Justice Department that youths with learning or developmental disabilities “can’t make it” in the military program, but that these youths nonetheless served longer commitments because of their failures.335

Twenty-five years after the federal district court ordered improvements at Oakley, the institution’s kitchen still had rodent and insect infestation, including mouse droppings in the food storage areas and live and dead cockroaches in the kitchen. Staff said they had to cover food while cooking because cockroaches would otherwise fall in from the hood above the stove, and youths found roaches in their food.337

Medical and dental care at Oakley and Columbia still relied on equipment that was old, rusty, and dirty. Oakley’s medical clinic, located in a decrepit building damaged by water leaks, had no sterilization facilities to clean medical equipment.338 Supplies were not properly stored to maintain any kind of sterilization.339 “The dental clinic had not been cleaned in many months,” the Justice Department found, “because we observed dirt, spider webs, mouse droppings, and dead roaches everywhere. It was apparent that the clinic has a major insect and rodent infestation.”340

331 Id. at 20.
332 Id.
333 See id.
334 Id. at 20-21.
335 Id. at 21.
336 Id. at 35.
337 Id.
338 Id. at 23, 34.
339 Id. at 34.
340 Id.
Medical care also suffered from professional staff shortages, incomplete health assessments, and routine failures to continue medication and other medical regimens children followed before they were admitted. In 1997, a fifteen-year-old Oakley youth died of meningococcal meningitis—a bacterial disease that essentially causes a spinal infection—after staff reportedly ignored his complaints for two days because they thought he was faking until he was found breathing abnormally and bleeding from the mouth.

Youths at Oakley and Columbia still did not attend school for several weeks after admission, and then generally did not receive state-mandated class time, appropriate placements, or special education that met the requirements of the IDEA and the Rehabilitation Act. Staff regularly removed children from class for work detail.

b. Aftermath

In December of 2003, the Justice Department sued Mississippi when the Agency was unable to negotiate a settlement concerning conditions at Oakley and Columbia. Because many of Mississippi’s poorest counties have no juvenile group homes or treatment centers, the counties have continued using Oakley and Columbia “as a catch basin for all the child and youth problems in the state.” The member of Congress who first asked the Justice Department to inspect the two institutions remained skeptical that the State had the will to reform its juvenile justice system: “Mississippi had plenty of time to get its act together and didn’t. You’re asking people to trust an entity that has not demonstrated any care or concern about children.”

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341 Id. at 22-24.
342 See Sylvain Metz, Musgrove Tours Training School, Clarion-Ledger (Jackson, Miss.), Jan. 4, 2002, at 1B; Disease Kills Youth At Training Center, Com. Appeal (Memphis, Tenn.), Jan. 1, 1997, at 2B.
343 See Letter from Ralph F. Boyd, Jr. to the Hon. Ronnie Musgrove, supra note 5, at 26-32.
344 Id. at 28.
346 Halbfinger, supra note 297 (quoting Jeffrey A. Butts, Director of the Urban Institute’s Program on Youth Justice).
347 Pamela Berry, State Seeks Help in U.S. Suit, Clarion-Ledger (Jackson, Miss.), Mar. 12, 2004, at 1B (quoting Congressman Bennie Thompson).
7. Arizona

"I would not have committed this kid to the Department of Juvenile Corrections at this time if I had read the Justice Department report."348

In 2002, the Justice Department inspected three Arizona secure juvenile correctional facilities, the Adobe Mountain School for boys and the Black Canyon School for girls in Phoenix, and the Catalina Mountain School for boys in Tucson.349 In the year before the report appeared, three boys had committed suicide by hanging themselves at Adobe Mountain.350 The Department’s 2003 report found that all three institutions failed to protect youths from sexual and physical abuse, tolerated unsafe and un sanitary living conditions, denied adequate special education to children with disabilities, maintained grossly deficient medical and mental health care, and followed inadequate suicide prevention measures.351

The Arizona federal district court had wrestled for years with degrading conditions in the State’s juvenile corrections system. In 1986, a federal suit challenged the constitutionality of conditions at the Catalina Mountain School.352 The Johnson v. Upchurch complaint was soon amended to include all long-term juvenile facilities in the state, and the court certified the suit as a class action.353 After considerable resistance, the State settled in 1993 and agreed to reform the facilities.354

Before the 1993 settlement, Arizona juvenile prisons emphasized harsh punishment, even though few incarcerated youths had threatened public safety and two-thirds were confined for parole violations, often for such reasons as failing to appear for periodic drug testing.355 To fulfill the legislature’s mandate that incarcerated juveniles do twenty hours of hard labor weekly,

350 Id. at 4.
351 Id. at 2, 4-5, 11, 20-21, 25-26.
353 Id. at 2-4.
354 Id. at 1.
355 David Lambert, Juvenile Institution as Prison: The Legacy of Sam Lewis,
some confined youths worked as “shine boys,” shining staff members’ shoes.\textsuperscript{356} Most youths, however, were assigned to work crews that “raked rocks,” continually smoothing out desert sand in the hot sun.\textsuperscript{357} Youths who refused work duty, the Johnson plaintiffs’ lead counsel reported, were shackled and handcuffed to a fence in the outdoor heat.\textsuperscript{358}

The qualifications, job descriptions, responsibilities, job training, and uniforms of the juvenile institutions’ security staff were identical to those of guards in the state’s adult prisons.\textsuperscript{359} In his deposition in the Johnson proceedings, the State Department of Corrections Director testified that he could not identify any significant differences between cells in Catalina Mountain’s isolation unit and cells on death row.\textsuperscript{360}

The pre-1993 culture of violence and resentment at Arizona’s juvenile institutions was accompanied by suicidal behavior and program decline.\textsuperscript{361} Treatment and education suffered cuts, and some youths were held in isolation for days with their wrists handcuffed to their ankles, or with their handcuffed and shackled bodies four-pointed to bed frames.\textsuperscript{362} Some youths were stripped naked and handcuffed for days.\textsuperscript{363}

After evident improvement at the juvenile prisons during five years of federal district court oversight beginning in 1993, the court excoriated the State in 1998 for proposing to ease persistent overcrowding by locking up some youths in an adult prison. “Who dreamed that one up? That’s a real winner,” the judge asked in open court.\textsuperscript{364} “They’ve got to be smoking marijuana to do things like that—putting the youngest kids in a peniten-

\textsuperscript{356} Lambert, \textit{supra} note 352, at 1-2.
\textsuperscript{357} Id. at 2.
\textsuperscript{358} Id.
\textsuperscript{359} Lambert, \textit{supra} note 355, at 2.
\textsuperscript{360} Id.
\textsuperscript{361} See Allen Breed et al., \textit{Opportunity Is Here For State To Fix Juvenile Mess}, \textit{ARIZ. REPUBLIC} (Phoenix), Feb. 16, 2004, at B9 (article by the three court-appointed Independent Monitors who supervised implementation of the Johnson agreement); Lambert, \textit{supra} note 352, at 1.
\textsuperscript{362} Lambert, \textit{supra} note 355, at 3.
\textsuperscript{363} Id.
\textsuperscript{364} Kristen Cook, \textit{Juvenile Plan Awful, Judge Says}, \textit{ARIZ. DAILY STAR} (Tucson), Apr. 29, 1998, at 1B.
The Monitors' report on the Adobe Mountain School, the judge added, "makes me ashamed to be born and raised in this state."  

### a. The Justice Department Report

The Justice Department found that boys at Adobe Mountain were sexually abused by staff and other youths "with incredibly disturbing frequency." Staff also acknowledged that many Adobe Mountain staff members physically abused boys by hitting them or slamming them to the ground. Boys were exposed to unnecessary risks of physical injury by other staff members, including one who required youths to crawl on their stomachs through a drainage ditch to receive their free time. Staff members also permitted and even encouraged boys to fight each other. An Internal Affairs investigation determined that one boy received a serious eye injury in a youth-on-youth fight set up by a staff member.

Most Adobe Mountain and Catalina Mountain rooms lacked toilets, forcing boys to urinate and defecate in plastic bottles and laundry bins at night because understaffing kept them from leaving their rooms to relieve themselves. The three schools did not adequately screen and identify students for special education services, and failed to provide special education required by the IDEA and the Rehabilitation Act.

Mental health treatment at all three institutions "exposure[d] youth to significant risks of harm." One boy had threatened to kill himself for months, but a staff member said he did not take the threats seriously because the boy had not yet made any attempt. "Another staff member stated that if a youth was serious about killing himself, he should get a knife or a rope and 'just

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365 See id.; Editorial, Mishandling Juveniles, ARIZ. DAILY STAR (TUCSON), May 3, 1998, at 2F.
366 See Cook, supra note 364.
368 Id. at 13.
369 Id.
370 Id.
371 Id. at 13-14.
372 Id. at 19.
373 Id. at 20-24.
374 Id. at 25-26.
375 Id. at 34.
do it.' ”\(^{376}\) Even after the three boys hanged themselves at Adobe Mountain in 2002, suicide prevention procedures at all three schools remained “grossly inconsistent” with generally accepted professional standards.\(^{377}\)

b. Aftermath

In September of 2004, the Justice Department filed a federal CRIPA enforcement action against Arizona, and the parties reached a settlement on the same day.\(^{378}\) The agreement provides for Independent Monitors who will report regularly to the Department about the state’s progress in eliminating constitutional and statutory violations, and a gubernatorial task force will also continue to review department policy.\(^{379}\) The Monitors’ first report pointed to partial compliance with the Justice Department agreement, but also found that confined youths still feared that staff members would not keep them safe and that only one in thirty confined youths knew how to report abuse.\(^{380}\)

8. Maryland

“If you were sort of a mad scientist who was sent to Maryland to deliberately make kids into criminals, you could hardly do any better than what’s going on in Maryland’s juvenile facilities . . . . You’d have to work hard to cripple kids worse than they’re being crippled now.” \(^{381}\)

The Justice Department’s 2004 report on two Maryland juvenile detention facilities—the Cheltenham Youth Facility and the Charles H. Hickey, Jr. School—was not the first time a federal agency urged the state to reform its juvenile detention system. In 1967, the U.S. Department of Health, Education, and Welfare (HEW)—which is now the Department of Health and Human Services—found Maryland’s system “too large” and marked by

\(^{376}\) Id.

\(^{377}\) Id. at 4-5.


\(^{379}\) Kornman, supra note 378.

\(^{380}\) See id.

\(^{381}\) Todd Richissin, Lt. Gov. Is Urged to Close Teen Jail, BALT. SUN, Nov. 27, 2001, at 1A (quoting Vincent Schiraldi, Executive Director of the Center on Juvenile and Criminal Justice).
an overuse of institutionalization. To no avail, HEW recommended that Maryland "establish[ ] community-based programs for delinquent youth capable of being treated in the community." In 1991, private consultants warned that mistreatment by guards left Hickey's "warehoused" youths "at imminent risk of physical and emotional damage." A study of 947 youths released from Maryland correctional facilities in 1994 revealed that eighty-two percent were referred to juvenile or criminal courts within two-and-a-half years after release. Maryland responded by fencing in Hickey and contracting with a private firm to operate it—and by creating three boys boot camps in 1996 as a much touted "tough on crime" measure.

The rise and fall of Maryland's juvenile boot camps was swift and bloody. In late 1999, within days after the Baltimore Sun published a four-part series exposing savage beatings routinely inflicted by boot camp guards, the embarrassed Governor hastily summoned the National Guard to protect the youths and closed the three-year-old camps.

The Baltimore Sun reported that boot camp guards routinely slammed, punched, choked, dragged, and kicked the boys, sometimes while the youths were handcuffed, shackled, and unable to

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383 Id. In 1973, the NAACP Legal Defense and Educational Fund similarly concluded that Maryland's secure training schools confined too many children who did not belong in secure detention, and recommended that the large training schools "be phased out and replaced by a variety of community-based facilities." Id. at 8-9.

384 See Editorial, Hickey on the Rebound?, BALTIMORE SUN, Sept. 28, 1992, at 10A; Scott Shane, A Rough Road Up from Delinquency: At Hickey School, Young Offenders Make Progress, But Will it Matter?, BALTIMORE SUN, Oct. 11, 1992, at 1A.


protect themselves.\textsuperscript{387} Boys suffered shattered teeth and broken bones. According to the class action complaint filed by the injured youths, one guard stepped on a youth's head with his boot until the youth passed out.\textsuperscript{388} Another guard broke a youth's arm and then forced him to do push-ups and chin-ups every day for a week before receiving medical care.\textsuperscript{389} Another youth was slammed into a chalkboard with such force that he cut his head and broke the board.\textsuperscript{390} Yet another youth suffered a broken left arm when he was on the ground and guards twisted it until it snapped.\textsuperscript{391}

A hastily appointed gubernatorial task force confirmed the brutality and found that top juvenile justice agency officials had known about it for months but did almost nothing to protect the youths.\textsuperscript{392} The task force told of a boot camp guard who threw a teen to the ground and banged the boy's face into the dirt until he could not breathe, producing chest and neck compression and hemorrhaging in both eyes that a physician said was the worst case of hemorrhaging she had ever seen.\textsuperscript{393} The task force described punches from guards that left one juvenile "bleeding profusely";\textsuperscript{394} a circle of guards who pushed a boy around with a hood pulled over his head;\textsuperscript{395} guards who forced a boy to stand in formation outdoors in January until he suffered frostbite;\textsuperscript{396} and guards who, whenever a boy left food on his plate, would push the boy's face into the food and gouge his eyes with their thumbs.\textsuperscript{397}

Some Cheltenham and Hickey staff members had felony

\textsuperscript{387} See Todd Richissin, \textit{Boot Camp Deal Is Struck}, \textit{BALT. SUN}, Mar. 29, 2002, at 1A.
\textsuperscript{388} Id.
\textsuperscript{389} Id.
\textsuperscript{390} Id.
\textsuperscript{391} See Kate Shatzkin, \textit{Guarding Against Abuse of Authority: Boot Camp Case Has Roots in Civil Rights Law}, \textit{BALT. SUN}, Dec. 29, 1999, at 1B.
\textsuperscript{392} See Richissin, \textit{Glendening Suspends}, \textit{supra} note 386.
\textsuperscript{394} See Todd Richissin, \textit{Another Casualty at a State Boot Camp}, \textit{BALT. SUN}, Dec. 10, 1999, at 1A.
\textsuperscript{395} See Richissin, \textit{Graduation Day}, \textit{supra} note 386.
\textsuperscript{396} See Richissin & Shatzkin, \textit{supra} note 393.
records of their own. Staff routinely perpetrated or encouraged beatings of youths, according to the state’s Independent Juvenile Justice Monitor, an office created by statute and charged with monitoring conditions in all Department of Juvenile Justice (DJJ) facilities and reporting its findings to the Governor, legislature, and the DJJ Secretary. The Independent Monitor intimated that the steady stream of reported abuse and neglect at the two institutions was only the tip of the iceberg because “many other cases . . . go unreported by staff and youth for fear of retaliation.”

Internal incident reports contained dozens of allegations that Cheltenham staff members punched or slapped children as young as eleven. The Independent Monitor reported that Hickey staff members pulled a youth from his room for setting off a sprinkler system, slammed him against the wall, and allowed older youths to beat him. A staff member was dismissed for using a fire extinguisher and a club to threaten youths. State police found that guards at a third Maryland juvenile institution, the Victor Cullen Center, forced teens to settle scores with their fists as the guards stood by and watched, spectacles the Baltimore Sun likened to dog fights.

Two Hickey staff members were charged with holding a youth in his room and repeatedly punching him in the face, leaving his face swollen and his body cut for three hours before he was taken to a nurse. One of the staff members reportedly offered the victim’s roommate, who witnessed the beating, free telephone calls and a CD player in return for his promise not to report what

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398 See Editorial, Maryland’s Shame, BALT. SUN, Apr. 19, 2004, at 10A.
399 See Dan Fesperman, Hickey Turns a Violent Page, BALT. SUN, Mar. 30, 2004, at 1A.
400 Id.
401 See Greg Garland, Abuses Reported at Hickey School, BALT. SUN, June 12, 2003, at 1A.
402 Id.
403 Id.
404 See Todd Richissin, Abuse of Teens Persists Despite State’s Promises, BALT. SUN, Nov. 25, 2001, at 1A; see also Tara Andrews, State Must Address Festering Juvenile Justice Problems, BALT. SUN, Nov. 1, 2001, at 23A.
he saw.\textsuperscript{406} Legislators heard testimony about frequent drug use at Cheltenham and Hickey by youths and staff members.\textsuperscript{407} The Independent Monitor reported that Hickey staff brought in alcohol and pornography and had sex with youths.\textsuperscript{408} A youth reported missing from Hickey was found driving the car of a female staff member, who was dismissed for having had sex with him.\textsuperscript{409} In 1999, a staff member impregnated a girl confined at Cheltenham.\textsuperscript{410}

Youth-on-youth violence also continued unchecked. At Cheltenham, youths repeatedly raped a thirteen-year-old boy and staff members were accused of arranging fights between boys.\textsuperscript{411} Youths with idle time on their hands at Hickey stashed scissors and pens for use as weapons.\textsuperscript{412} One sixteen-year-old boy confined at Hickey wrote his grandmother, "I'm so afraid. All the locks are broken, and there is no safe place to be."\textsuperscript{413} His grandmother said the boy "never felt safe for one minute. He was terrified. He sat with his back to the wall in the day room. . . . [T]here were fights all the time."\textsuperscript{414}

State officials and the Independent Monitor acknowledged that suicide threats and attempts were common among youths confined at Cheltenham and Hickey. In 2000 alone, staff members at Cheltenham, Hickey, and the Victor Cullen Center recorded 122 incidents of teens threatening or attempting suicide.\textsuperscript{415} In August of 2003, the State finally announced that it

\textsuperscript{406} See Barker, \textit{Two Staff Members Accused}, supra note 405.
\textsuperscript{407} Jeff Barker, \textit{Youth Facility Beset by Troubles}, \textit{Balt. Sun}, Sept. 8, 2003, at 1B; Fesperman, supra note 405.
\textsuperscript{409} See Garland, supra note 401.
\textsuperscript{410} See Kate Shatzkin, \textit{Monitors Begin Their Watch at Youth Facilities}, \textit{Balt. Sun}, Dec. 15, 1999, at 1A.
\textsuperscript{412} See Barker, \textit{Conditions at Hickey}, supra note 405.
\textsuperscript{413} Id.
\textsuperscript{414} See Fesperman, supra note 399.
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would stop placing children twelve and under in Cheltenham because of concerns for their safety among tougher boys, who included seventeen-year-olds charged with attempted murder, armed robbery, and assault.\textsuperscript{416}

\textbf{a. The Justice Department Reports}

\textit{(i) The 2002 Report on the Baltimore City Detention Center}

Before the Justice Department focused on Cheltenham or Hickey, the Agency inspected the Baltimore City Detention Center, a 200-year-old adult jail that held about 125 juveniles between fifteen and seventeen who were charged or sentenced as adults.\textsuperscript{417} Most of the youths who comprised the Center’s general population were confined in small cells for more than twenty-two hours a day, without sufficient opportunities for exercise.\textsuperscript{418} The Justice Department found the Center infested with roaches, rodents, and insects that spoiled the food supply.\textsuperscript{419}

The Department also found that the Center provided inmates insufficient medical screening and assessment, inadequate acute and emergent care, and only sporadic chronic care.\textsuperscript{420} Many confined juveniles faced serious risk of harm because they were not separated from adult inmates.\textsuperscript{421} Other juveniles were kept isolated in segregation cells for as much as twenty-three hours a day, sometimes for several months.\textsuperscript{422}

\textit{(ii) The 2004 Report on Cheltenham and Hickey}

The Justice Department’s 2004 report on the Cheltenham Youth Facility and the Charles H. Hickey, Jr. School described

\textsuperscript{418} Id. § II(E).
\textsuperscript{419} Id. § II(D)(1); see also \textbf{Human Rights Watch, No Minor Matter: Children in Maryland’s Jails} (1999), available at http://www.hrw.org/reports/1999/maryland (“Children in [the Baltimore City Detention Center] spend their days in grim cells lacking direct natural lighting and crawling with cockroaches, rodents, and other vermin. Ineffective heating and poor ventilation offer little relief from the heat of the summer months and the chill of the winter.”).
\textsuperscript{420} See Letter from Ralph F. Boyd, Jr. to the Hon. Parris N. Glendening, \textit{supra} note 417, § II(B).
\textsuperscript{421} Id. § II(F)(1).
\textsuperscript{422} Id. § II(F)(2).
two institutions beset by beatings routinely perpetrated against youths by staff members, some of whom were hired despite felony conviction records and histories of using excessive force against juveniles. The Hickey staff, for example, used unsafe restraint practices that sometimes landed children in the hospital. One such practice was the "lock and drop," in which staff would take a youth to the ground and force the youth into a prone position (lying on stomach) while placing weight on the youth's upper torso, a position that could cause asphyxiation. The Justice Department also documented cases of a restrained youth who vomited and lost consciousness when he inhaled some of the vomitus, a restrained youth who suffered a seizure and required hospitalization, and a youth sat on by a 300-pound staff member who mocked the boy when he complained that he could not breathe.

At both Cheltenham and Hickey, the Justice Department also found "unacceptably high levels of youth-on-youth violence" that frequently left youths bloodied, bruised, and nursing broken bones. The Department found root causes in understaffing, inadequately trained staff, and lack of an effective classification system to separate violent and mentally ill youths from others. Because unsupervised youths tampered with cell locks at Hickey, many cells remained unlocked, enabling violent youths to enter and commit assaults.

About a quarter of the juveniles locked up in Maryland have severe mental problems, including clinical depression, bipolar disorder, and schizophrenia; another fifty percent or so have drug or alcohol problems. The Justice Department found that neither Cheltenham nor Hickey provided adequate mental health screening, clinical assessment, case management, or counseling. Youths were not placed in appropriate treatment set-

423 See Letter from R. Alexander Acosta, Assistant Att'y Gen., U.S. Dep't of Justice, to the Hon. Robert L. Ehrlich, Jr., Governor of Md. 4-7 (Apr. 9, 2005), available at (regarding investigation of the Cheltenham Youth Facility in Cheltenham, Maryland and the Charles H. Hickey, Jr. School in Baltimore, Maryland).
424 Id. at 7.
425 Id.
426 Id. at 8.
427 Id. at 9-11.
428 Id. at 11.
429 See Richissin, supra note 404.
tings even when ordered by a court. Both institutions improperly medicated some youths with ineffective or dangerous drugs, often without informed consent or demonstrated concern for potential side effects.\textsuperscript{431} Neither institution adequately assessed suicidal youths or provided sufficient supervision or mental health services to youths on suicide precautions.\textsuperscript{432}

The Justice Department also found that youths at Cheltenham and Hickey were denied timely access to medical care, adequate health assessments, treatment for chronic conditions and physical injuries, and needed dental care.\textsuperscript{433} Youths with disabilities, who comprised substantial percentages of the populations at both facilities, did not receive the vocational or special education to which the IDEA entitled them.\textsuperscript{434}

b. Aftermath

Frustrated with its inability to manage Hickey, in 1991 the State contracted with a private firm to operate the facility.\textsuperscript{435} Even after the State changed contractors in 1993,\textsuperscript{436} it became clear that privatization would produce little or no improvement. By the time the State resumed control of Hickey on April 1, 2004, the institution was described as "an out-of-control wreck . . . where housing units reeked of urine, graffiti covered walls, and locks didn't work on the doors of the rooms of dozens of potentially dangerous offenders."\textsuperscript{437}

Even after the state takeover, the independent monitor reported that incidents of abuse and neglect at Hickey still took place about once a week, and that 2.5 violent incidents were reported daily, a number that had remained constant for years.\textsuperscript{438} In April of 2004, a fifteen-year-old entered a seventeen-year-old's room at Hickey, put a pillow over his face, and sexually

\textsuperscript{431} \textit{Id.} at 28-29.
\textsuperscript{432} \textit{Id.} at 13-18.
\textsuperscript{433} \textit{Id.} at 34-41.
\textsuperscript{434} \textit{Id.} at 41-47.
\textsuperscript{435} See Barker, \textit{Conditions at Hickey, supra} note 405.
\textsuperscript{436} \textit{Id.}
\textsuperscript{437} \textit{Id.; see also} Letter from R. Alexander Acosta to the Hon. Robert L. Ehrlich, Jr., \textit{supra} note 423, at 13 (describing that several cells at both facilities smelled of urine because youths locked up were often denied access to toilets outside their cells and sometimes urinated on window sills or into bed linens).
\textsuperscript{438} See Jeff Barker, \textit{Hickey Teen Is Attacked in His Room, BALT. SUN, Apr. 28,} 2004, at 1B.
assaulted him.439 Another fifteen-year-old at Hickey was assaulted and had to be transported by helicopter to the hospital.440 A fourteen-year-old boy awaiting a trip to court was attacked by another youth who tried to set his clothes on fire.441

The new sixty-million-dollar Baltimore City Juvenile Justice Center, which opened in early 2004 after two years of construction delays,442 has worsened the culture of violence in Maryland’s secure juvenile detention facilities. In the Center’s first six months of operation, the press reported that six youths assaulted a fifteen-year-old and fractured his jaw.443 Five youths at the Center severely beat a sixteen-year-old, who suffered severe head and torso injuries and broken legs when, according to police reports, the attackers continued kicking him in the head and face after he fell to the ground defenseless.444 One section of the new facility was vandalized so badly that authorities temporarily closed it.445

In September of 2004, the independent monitor cited the Baltimore City Juvenile Justice Center for “threats to the life, health and safety” of the juveniles confined there.446 The Monitor reported two recent suicide attempts and a revolt by youths who barricaded themselves inside the housing unit and set fire to it.447 One resident tied a bedsheets to a railing, knotted the sheet around his neck, and climbed over the railing.448 The youth, hanging by his neck and left hand, was rescued by a staff member and other youths.449 Another youth battered himself with pieces of a desk, leaving his cell “smeared with blood.”450 Conditions at the Center were so dangerous that public defenders and clergy refused to enter the building to visit the confined youths.451

439 Id.
440 Editorial, For Jailed Kids, Service as Usual, BALT. SUN, May 18, 2004, at 16A.
441 See Fesperman, supra note 405.
443 For Jailed Kids, Service as Usual, supra note 440.
444 Jeff Barker & Stephanie Desmon, New Violence at Youth Jails Causes Alarm, BALT. SUN, Feb. 18, 2004, at 1A.
445 See For Jailed Kids, Service as Usual, supra note 440.
446 See Schiraldi & Soler, supra note 286.
447 Mosk, supra note 442.
448 Id.
449 Id.
450 Id.
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In its report on the Center for the first quarter of 2005, the independent monitor found that “youth on youth assaults and use of force incidents” have sharply increased, seclusion is still used illegally as punishment, nurses still do not report suspected child abuse, and “[p]rogramming and education are still insufficient.” In July of 2005, the Justice Department announced plans to inspect the Center under CRIPA.

Maryland’s journey continues. In 2004, the state legislature enacted a reform measure modeled on Missouri’s juvenile justice system. Many observers considered the measure weak, partly because it gave DJS almost two more years to complete a master plan and provided that Hickey would continue operating under private management until the State assumes permanent control in 2007. In June of 2005, the State and the Justice Department settled the Department’s lawsuit concerning Cheltenham and Hickey by agreeing to needed reforms. The Governor also announced that he would close some confinement sections of Hickey by the end of the year, though the Baltimore Sun editorialized that the state has “few, if any, facilities . . . that can offer the access to schooling, counseling, medical and personal care and continuous oversight that would keep [Hickey’s ex-inmates] and the surrounding community safe.”

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452 Greg Garland, *Justice Department Launches Investigation into City’s Juvenile Jail*, BALT. SUN, July 30, 2005, at 1A.
453 See id.
454 E.g., Kate Shatzkin, *Advocates Hope for Accelerated Reform of Juvenile Centers*, BALT. SUN, Apr. 18, 2004, at 1B.
455 See id.; Cannon, *supra* note 7, at 28.
457 See Editorial, *At Last*, BALT. SUN, July 1, 2005, at 12A.

In addition to the states profiled in Part I of this Article, the Justice Department has recently found serious violations in the juvenile corrections systems of Nevada and Michigan.

The Justice Department’s CRIPA reports and the reactions they have provoked demonstrate the difficult policy choices facing states as they contemplate whether to move from incarceration-based juvenile corrections systems to a treatment-oriented approach. In some states, governors and lawmakers have resisted fundamental reform for years. In the coming years, political considerations will figure prominently in the calculus. Acknowledging past failures is one thing; making commitments necessary to future success may be quite another.

A. The Missouri Program

Missouri began making the necessary commitments in the 1970s, when judges and prominent lawmakers urged the State to reject nine decades of frustration with violent incarceration-based youth prisons, and to stake out a new direction. The State began replacing its failed training schools with small regional, community-based facilities that enable highly trained staff to treat delinquent children with constant therapy in small-group settings. Most Division of Youth Services (DYS) staff today are college-educated “youth specialists,” not guards or corrections officers. No DYS facility contains more than eighty-five beds, and all but three contain thirty-three beds or fewer. Unlike

Among other things, current and former staff members acknowledged that staff frequently punched youths in the chest, kicked their legs, grabbed shirts and shoved youths against lockers and walls, threw youths to the floor, slapped them in the face, smashed their heads into doors, and pulled youths from their beds to the floor. Id. Nevada reached a settlement agreement with the Justice Department in early 2004. See Press Release, U.S. Dep’t of Justice, Justice Department Reaches Settlement Agreement Regarding Conditions at Nevada Juvenile Facility (Feb. 26, 2004), available at http://www.usdoj.gov/opa/pr/2004/February/04_crt_119.htm.


Id. at 13. For a history of Missouri’s juvenile justice system, see DOUGLAS E.
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their counterparts in many other states, DYS facilities have seen little violence or gang activity and no suicides. And Missouri does not maintain boot camps.

Missouri DYS has divided the state into five regions, with thirty-one residential facilities that house the more than 1300 delinquents committed to the Agency each year. Decentralization enables the Agency to treat most youths within thirty to fifty miles of their homes, allowing their families and community to support their treatment. DYS deems family involvement so important to successful rehabilitation that when parents, guardians, or other family members lack their own transportation, Agency staff drive them to and from residential facilities to make visits and participate in family therapy sessions.

Each of Missouri’s five juvenile justice regions has a diverse range of residential facilities that separate violent offenders from other youths. Each incoming youth receives a comprehensive needs and risk assessment. DYS then fashions an Individual Treatment Plan (ITP) for each youth and provides treatment in the region’s residential care facility that provides “the least restrictive environment possible without compromising public safety.” Each youth is immediately assigned an individual case manager whose supervision and support continue throughout the youth’s stay and release into the community. Diverse programming seeks to meet the needs of youths from metropolitan and rural areas alike in an ethnically sensitive environment designed to help youths “develop self-esteem and make positive behavioral changes in their lives.”

For youths who have committed status offenses or misdemeanors, DYS maintains six nonsecure group homes (each with ten to twelve beds) under responsible twenty-four-hour adult supervision, and proctor homes where youths live with college student

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461 ABRAMS, supra note 460, at 205.

462 Id.

463 MENDEL, LESS COST, MORE SAFETY, supra note 16, at 11.

464 ABRAMS, supra note 460, at 205.


466 See SCHWARTZ & VAN VLEET, supra note 15, at 6.

467 See MENDEL, LESS COST, MORE SAFETY, supra note 16, at 10.

468 Mo. DEPT’F OF SOC. SERVS., supra note 465, at 1.
mentor/role models in settings that offer structure, support, and supervision. One such group home for eleven girls is located on a university campus, and the girls eat in the university dining hall and attend university activities. Youths in group homes generally spend time in schools, jobs, group projects, community service, and group, individual, and family counseling.

For youths who have committed more serious crimes and need more supervision, DYS maintains eighteen moderately secure group homes (each with twenty to thirty beds) throughout the state in residential neighborhoods, state parks, and two college campuses. These youths also spend time in the community on service projects, and youths who demonstrate trustworthiness may get jobs at local nonprofit or government agencies. Contrast this recent description of a Missouri DYS residential facility with the stark, sometimes roach-infested juvenile prisons described in the recent Justice Department reports:

Dorm rooms overflow with homey touches—a piano and scented candle here, a fish tank and flowered shower curtain there. The correctional officers look different too. Dressed in their own clothes, Missouri’s staff members carry no Mace, no batons, no handcuffs—only walkie-talkies. . . . “Most of us come in with a fight mentality,” said Eric White, 16, of Kansas City, a lanky youth who is doing time for burglary and was recently named student of the month at the Northwest [Regional Youth] Center [in Kansas City], “But pretty soon you see there’s no reason for that here.”

DYS maintains secure care facilities that provide violent offenders and chronic repeaters education, counseling, and vocational guidance in groups of ten to twelve. The facilities are enclosed and locked with a perimeter fence, but nonetheless seek to maintain an atmosphere conducive to treatment. The Los Angeles Times recently described the maximum-security lockup in St. Joseph, Missouri, where “two cats, Midnight and Tigger, curl up on laps as the state’s toughest teenage offenders explore the roots of their anger, weep over the acts of abusive parents

469 Id. at 5-6.
470 MENDEL, LESS COST, MORE SAFETY, supra note 16, at 14.
471 See Warren, supra note 17; see also Maggi, supra note 17 (describing this facility).
472 Mo. DEP’T OF SOC. SERVS., supra note 465, at 5; see also Warren, supra note 17 (describing the group counseling sessions).
473 Mo. DEP’T OF SOC. SERVS., supra note 465, at 5.
and swap strategies for breaking free of gangs."\textsuperscript{474}

DYS day treatment facilities provide youths a minimum of six hours of daily education, counseling, tutoring, and community service activities before they return home to their families in the evening.\textsuperscript{475} These year-round facilities are the first stop for some younger teens who are relatively minor offenders. For youths previously confined in residential treatment, a period of day treatment provides a transition back to life in the community. Day treatment enables staff to provide supervision and support, and enables youths to continue their education without the interruption that might occur as they await the start of the new semester.\textsuperscript{476}

Some DYS youths participate in local community service activities, including working at hospitals, senior centers, homeless shelters, and children's mental health facilities; other DYS youths join scout troops and other local organizations.\textsuperscript{477} When a youth graduates from the DYS program, the Agency's comprehensive aftercare program has the individual case manager continue to supervise the youth's return to the community, and sometimes even help the youth find employment or admission to GED (high school equivalency) programs or college.\textsuperscript{478} The DYS Job Readiness/Work Experience Program provides a variety of employment experiences in cooperation with not-for-profit enterprises.\textsuperscript{479} College students studying social work and similar disciplines serve as "trackers" who monitor the daily activities and behavior of youths released into the community.\textsuperscript{480} Beginning during the period of confinement and continuing after release, the aim of aftercare is to provide youths a smooth transition that keeps them from drifting back to the unwholesome habits and local peer influences that contributed to criminal behavior in the first place.\textsuperscript{481}

\textsuperscript{474} Warren, supra note 17.


\textsuperscript{476} See generally Am. Correctional Ass'n, Standards for Juvenile Day Treatment Programs (1993).

\textsuperscript{477} Mo. Dep't of Soc. Servs., supra note 465, at 7.

\textsuperscript{478} Id. at 3, 6.

\textsuperscript{479} Id. at 3.

\textsuperscript{480} Mendel, Less Cost, More Safety, supra note 16, at 10.

\textsuperscript{481}See, e.g., Elizabeth Piper Deschenes & Peter W. Greenwood, Alternative Placements for Juvenile Offenders: Results from the Evaluation of the Nokomis
Prevention also receives careful attention. DYS annually provides the state’s juvenile courts nearly seven million dollars in Juvenile Court Diversion funds to help avoid commitment of less serious offenders to the Agency’s custody. This grant-in-aid program enables courts to develop local school programs, intensive probation, educational tutoring, community group counseling, and other early intervention and prevention programs. Diversion funding has permitted some courts to reduce the number of children they commit to DYS by as much as forty percent.

All the while, DYS has been guided by a fifteen-member, bipartisan advisory board comprised of judges, former legislators, civic officials, and concerned citizens from all walks of life and all areas of the state. The board provides expertise concerning juvenile corrections policy and helps develop political support for the Agency’s innovations. Local community liaison councils also help maintain relationships between the Agency and the localities it serves. Missouri DYS has enjoyed bipartisan support from governors and the legislature, and a budget that has quadrupled from about fifteen million dollars to sixty million dollars in fifteen years.

B. The Missouri Record

Missouri has become the national leader in juvenile justice reform by combining low recidivism rates with financial efficiency. According to one national expert, Missouri’s DYS “gives children a way to redeem themselves, and most of the kids do it.” “The Missouri model deals with young people who have demonstrated their willingness to break the law by exposing them to positive, caring relationships,” says University of Chicago juvenile justice


\footnotesize{482} Abrams, supra note 460, at 205.
\footnotesize{483} Id. at 206.
\footnotesize{484} Id. at 205.
\footnotesize{485} Id.
\footnotesize{486} Id.
\footnotesize{487} Id.
\footnotesize{488} Id. at 207 (quoting Barry Krisberg, President of the National Council on Crime and Delinquency).}
reformer Jeffrey Butts.  “It prepares them for the world.”

The Annie E. Casey Foundation, which addresses the needs of vulnerable children and families, calls Missouri’s low juvenile recidivism rates “exceptional.” A 2003 report showed that seventy percent of youths released from Missouri DYS custody in 1999 avoided recommitment to a correctional program within three years:

Of 1,386 teens released from DYS custody in 1999, just 111 (8 percent) were sentenced to state prison or a state-run 120-day adult incarceration program within 36 months of release, and 266 (19 percent) were sentenced to adult probation. . . . [Also] 94 youth were recommitted to DYS for new offenses following release. . . .  
. . . [A] 2000 recidivism study in Maryland found that 30 percent of youth released from juvenile corrections facilities in 1997 were incarcerated as adults within three years. In Louisiana, 45% of youth released from residential programs in 1999 returned to juvenile custody or were sentenced to adult prison or probation by mid-2002.

In Florida, 29 percent of youth released from a juvenile commitment program in 2000-2001 were returned to juvenile custody or sentenced to adult prison or probation within 12 months; the comparable figure in Missouri is just 9 percent.

But how much does Missouri’s low recidivism rate cost? The American Youth Policy Forum (AYPF) found that Missouri enjoys a recidivism rate one-half to two-thirds below that of most of these states and spends one-third less on juvenile corrections than the eight surrounding states. Missouri spends about $103 per day for each youth in the DYS program, considerably less than the amounts spent per day by other states with significantly higher recidivism rates, such as Florida (approximately $271) and Maryland ($192 per youth ages ten to seventeen).

Missouri’s record of cost-efficient juvenile rehabilitation holds promise elsewhere. In 2001, the Georgia Alliance For Children

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490 Id.
491 See Mendel, Small is Beautiful, supra note 16, at 35.
492 Id. Approximately seventy percent of youths released from secure care in Louisiana since 1994 have committed another crime. See COALITION FOR EFFECTIVE JUVENILE JUSTICE REFORM, BLUEPRINT FOR JUVENILE JUSTICE REFORM: A LEGISLATOR’S BRIEFING BOOK 6, 11 (2003).
estimated that Georgia spent $60,000 a year to "rehabilitate" and incarcerate a child, while community-based programs cost only one-third of that amount.495 In a 2003 report, the Annie E. Casey Foundation found that juvenile incarceration in Louisiana consumed $89 million in state general revenue funds, more local tax dollars than the State spent on mental health, child welfare, public health, and addictive disorders combined.496 Louisiana spent $157 a day to incarcerate a youth, but residential and day treatment programs cost only $85 and $60 a day respectively, and intensive "tracker" supervision costs only $15 a day.497

III

NATIONAL LESSONS FOR JUVENILE JUSTICE REFORM

Discussion of juvenile justice reform must recognize frankly that managing delinquent youths is no easy chore. Delinquents are not angels. They have committed crimes, sometimes serious and even vicious crimes. Many delinquents have left victims with disrupted lives or worse. Many come from broken and sometimes violent homes lacking the core family supports that most Americans take for granted. Many delinquents suffer from mental, physical, or emotional disabilities that leave their behavior sometimes erratic during confinement.

Statewide juvenile justice systems, such as Missouri's Division of Youth Services and the broken systems inspected by the Justice Department, frequently assume custody of the most incorrigible youths deemed not amenable to treatment in county and other local delinquency programs. Administrators and staff may be hamstrung by substandard facilities and inadequate funding beyond their control. States have made it easier than ever before to transfer youths (particularly older violent youths) to criminal court for trial and sentencing as adults, but transfer still leaves statewide juvenile justice systems with troubled and sometimes resistant youths.

The Justice Department has lamented that "the juvenile corrections field has compiled a dismal record in its effort to reduce the repeat offender rate of juveniles released from secure con-

496 See CASEY STRATEGIC CONSULTING GROUP, supra note 174, at 4.
497 Id.
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498 Without turning a blind eye toward personal accountability or public safety, however, Missouri’s consistently low statewide recidivism rates demonstrate that many, indeed most, troubled delinquents can indeed be rehabilitated. For states struggling today with the same legacy of frustration that Missouri overcame a generation ago, Missouri provides a roadmap toward a new direction in the basic structure of juvenile delinquency treatment programs.

A. Political Will

The roadmap to juvenile justice reform begins with the capacity of decisionmakers in all three branches of state government to make the difficult choices necessary to recalibrate the delicate balance between rehabilitation and incarceration. In appropriate cases, police and prosecutors must accept nonsecure programming for “juvenile criminals.” The governor and legislature must fund and advocate for an array of alternative community-based programs, which judges must embrace as integral components of the continuum of delinquency sanctions.

States weighing new treatment-based juvenile justice initiatives today may find a receptive public mood. The 1990s saw a public agitated by a number of criminologists who, examining increases in violent juvenile crime for much of the prior decade, warned of a “ticking time bomb in juvenile crime.”499 One criminologist warned that the nation was “in the lull before the crime storm” because the number of males in the crime-prone fourteen-to-seventeen-year-old cohort would grow twenty-three percent by 2005.500 Some juvenile justice experts predicted the emergence of even greater numbers of violent juvenile “superpredators,” who would be lawless, without remorse, and beyond rehabilitation.501 Reacting to pressure from a fearful and angry public, lawmakers spent much of the 1990s enacting harsher penalties for juvenile offenders.

The experts were wrong. The juvenile violent crime arrest rate

500 Id.
has fallen steadily since 1994,\textsuperscript{502} and generally at an even faster rate than the declining adult violent crime arrest rate.\textsuperscript{503} When fears of a generation of "superpredators" proved unfounded by 2001, the criminologist who coined the phrase a few years earlier admitted: "If I knew then what I know now, I would have shouted for prevention of crimes."\textsuperscript{504}

Public pressure for harsh juvenile punishment may have been overstated even in the years when visions of bloodbaths and ticking time bombs dominated the public discourse. In a 1988 California poll, for example, seventy-one percent of respondents endorsed rehabilitation as the juvenile court's primary goal, and ninety-two percent believed that incarcerated juveniles should have access to job training, education, and counseling before their release.\textsuperscript{505} In a 1997 poll of American adults, respondents "strongly supported setting aside funds . . . specifically for juvenile crime prevention programs."\textsuperscript{506}

Calls for juvenile justice reform inevitably meet resistance, and the step from polling data to meaningful executive and legislative action may be a giant one. In a 2002 national survey, however, eighty-five percent of respondents stated that rather than prison, they supported placement of more youthful offenders in community prevention programs that teach job skills, moral values, and

\textsuperscript{502} In 1989, the juvenile violent crime arrest rate reached its highest level since the 1960s, the earliest period for which comparable data are available. The rate continued to climb each year until it reached a peak in 1994. The rate rose sixty-two percent between 1988 and 1994, a period when the violent crime arrest rate increased for all age groups, including adults. \textit{See} \textbf{DOUGLAS E. ABRAMS \& SARAH H. RAMSEY, CHILDREN AND THE LAW: DOCTRINE, POLICY AND PRACTICE} 1033 (2d ed. 2003).


\textsuperscript{504} \textit{See} Elizabeth Becker, \textit{As Ex-Theorist on Young 'Superpredators,' Bush Aide has Regrets}, \textit{N.Y. TIMES}, Feb. 9, 2001, at A19 (quoting John J. Dilulio, Jr.).

\textsuperscript{505} \textit{See} KRISBERG \& AUSTIN, \textit{supra} note 19, at 2-3.

\textsuperscript{506} \textit{See} Vincent Schiraldi \& Mark Soler, \textit{The Will of the People? The Public's Opinion of the Violent Crime and Repeat Juvenile Offender Act of 1997}, \textit{44 CRIME \& DELINO.} 590, 599-600 (1998). Respondents also "overwhelmingly opposed housing juveniles in adult jails, jailing status offenders with adults, . . . and granting prosecutors exclusive discretion over whether juveniles should be tried as adults." \textit{Id.} at 599.
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self esteem. A 2002 statewide poll in Georgia likewise showed substantial public support for juvenile justice reform. Sixty percent of respondents said the purpose of Georgia's juvenile justice system should be to rehabilitate offenders, while only fifteen percent said punishment should be the purpose. Eighty-one percent of respondents preferred giving judges flexibility when sentencing minors rather than handing down the same mandatory sentences that apply to adult offenders; only twelve percent of respondents favored the same mandatory sentences. Respondents would have allocated an average of forty-seven percent of Georgia's juvenile justice budget to addressing the root causes of juvenile crime, and forty percent of the budget for more effective law enforcement and prisons.

A 2003 poll conducted by the Louisiana State University Public Policy Research Laboratory showed considerable public support among Louisiana residents for rehabilitative juvenile justice programs. Fifty-one percent of respondents believed incarceration costs more than rehabilitation, and fifty-four percent believed youthful offenders rehabilitated outside of prison are less likely to commit crimes later. Seventy-eight percent said the juvenile justice system should focus on rehabilitation, seventy-six percent believed it is less expensive in the long run to rehabilitate youths than to jail them, and fifty-seven percent said prison is less likely than rehabilitation to make a juvenile offender a productive member of society. Seventy-seven percent said that substance abuse is better handled with counseling and treatment rather than incarceration, and seventy-eight percent believed prison should be reserved for violent juvenile offenders.

In June of 2004, the California Corrections Independent Re-


509 Carl Vinson Inst. of Gov't, supra note 508, at 1.

510 Id. at 4.

511 See Editorial, The Times (Shreveport, La.), May 24, 2003, at 9A.

512 Id.

513 Id.

514 Id.
view Panel, appointed by Governor Schwarzenegger, reported the state "under increasing challenge from the public, from lawmakers, and from the courts for failing to provide humane and constitutionally adequate conditions of confinement for incarcerated youths and for not providing adequate education and treatment services." Recent nationwide polling data indicate that the public holds much more positive and optimistic attitudes about children than the attitudes held just a few years ago.

How can decisionmakers translate positive polling data into constructive action? At the threshold, a juvenile justice advisory board comprised of judges, legislators, civic officials, and concerned citizens from all political persuasions can help sustain political will. Missouri has shown that these boards not only generate valuable ideas, but can also help make juvenile justice reform appear respectable to the public.

Initial funding is essential to alleviate overcrowding, which incubates escalating cycles of violence in juvenile facilities, and to stem swift turnover rates, which sap the vitality of experienced staff. Funding is also central to the ongoing provision of medical, mental health, and educational services that not only satisfy minimum federal and state constitutional and statutory standards, but also offer genuine foundations for rehabilitation and reduced recidivism. States must improve staff salaries that, hovering scarcely above the minimum wage, attract applicants unsuited for work with children, including some applicants barely able to hold employment elsewhere. Some states have "found" necessary funding only after fending off, and typically settling, private lawsuits with thousands or millions of dollars that could have been better spent on systemic improvement in the first instance.

"[I]t's far easier to talk tough than it is to talk sensibly about what ultimately is going to turn a young person around." In states traditionally reliant on juvenile incarceration, greater em-

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517 See Cannon, supra note 7, at 28 (stating that in recent years about one-quarter of Arizona’s staff has turned over annually because of low salaries and trying working conditions).
518 See Todd Richissin, Broken Justice System Can’t Fix Maryland’s Troubled Teen-agers; Closing Boot Camps Won’t Do it Unless After-Care is Bolstered, BALT.
phasis on alternative programming may expose judges, legislators, and the governor to charges of “coddling juvenile criminals” or being “soft on crime.” Even with a wary eye toward the next election campaign, leaders must deliver the message that a balanced statewide program like Missouri’s, which holds juveniles accountable in structured court-ordered programs while stemming recidivism, is neither coddling nor soft.

The Justice Department’s recent activism under CRIPA may provide “political cover” for leaders who wish to advocate for reform that, according to recent polls, would attract public support. In August of 2005, for example, soon after the Justice Department reportedly began eyeing Connecticut’s juvenile prison system for a possible CRIPA inspection, that state’s Governor announced plans to close the state’s juvenile training school and replace it with smaller regional facilities.519

Developing the necessary political capital, however, depends on sustained public education because, unlike bricks and mortar, treatment and rehabilitation are not tangible. The Chairman of Georgia’s Department of Juvenile Justice, for example, explained that it is “much easier to get new facilities from the Legislature than to get more programs.”520 One writer has described the dilemma this way:

Changing the system’s course now would cost money, lots of it, without any immediate results. Ten years down the line, juvenile crime may recede . . . but it would call for political and economic commitments no one wants to make. On the other hand, if you build a prison cell today, then fill it, the results appear immediate, even if crime continues unabated.521

Despite clear evidence that alternative delinquency programs are indeed considerably less expensive in the long run than operating large juvenile prisons, initial outlays for these programs may rankle voters squeezed by already tight state budgets. Fiscal

521 HUMES, supra note 83, at 178.
restraint may nonetheless also offer a reservoir of political support for reform. "Leaders in juvenile justice and political leadership," the Executive Director of the National Juvenile Detention Association says, "are finally beginning to discover that the costs continue to rise for secure detention and, in many cases, there is little return on the investment."522

Political will also depends on the capacity of states to confront and overcome the glaring racial disparities that mark juvenile confinement in the United States. Nearly all states hold a disproportionate number of minority youths in residential placements. In 1999 (the latest year for which figures are available), minority youths accounted for thirty-four percent of the United States juvenile population, but sixty-two percent of the juveniles in custody.523 Of this sixty-two percent minority figure, thirty-nine percent were black, eighteen percent were Hispanic, two percent were Native American, and two percent were Asian.524 Minorities accounted for sixty-six percent of juveniles committed to public facilities nationwide, a proportion nearly twice their proportion of the juvenile population (thirty-four percent).525


524 Id.

525 Id. The juvenile population is the number of juveniles ages ten through the upper age of original juvenile court jurisdiction in each state. Id. The term "minority" includes African-Americans, Hispanics, Native Americans, Asians/Pacific Islanders, and youths identified as "other race." See id. An asterisk indicates that there were too few juveniles in the category to calculate a reliable percentage. Id. For these figures and the full chart, with juvenile residential placement statistics for all states and the District of Columbia, see id.; see also Building Blocks for Youth Initiative, No Turning Back: Promising Approaches to Reducing Racial and Ethnic Disparities Affecting Youth of Color in the Justice System (2005), available at http://www.buildingblocksforyouth.org/noturningback/ntb_fullreport.pdf (discussing the issue of, and solutions to, disparate treatment of youth of color in the justice system); Heidi M. Hsia et al., Office of Juvenile Justice & Delinquency Prevention, Disproportionate Minority Confinement: 2002 Update (2004), available at http://www.ncjrs.org/pdf files/ojjdp/201240.pdf.
One can speculate about whether many states have neglected their turbulent juvenile prisons for decades because of a general “tough on crime” impulse, because of a general unwillingness to devote tax dollars to social welfare programs, or because these institutions serve a clearly disproportionate number of minority children. Whatever the reason for the perennial neglect, racial disparities will be relevant to the willingness of government and taxpayers to fund reforms that deemphasize incarceration in favor of treatment. These disparities will also be relevant to the willingness of guards and other juvenile corrections staff to abandon the culture of violence now prevalent in some facilities where whites comprise a majority of the staff and African Americans and other minority youths comprise a majority of the inmate population.

B. Prevention Programs

With the daily cost of confining one youth reaching as high as $270 per day in some states, many juvenile justice professionals stress that prevention programs are a cost-effective response to delinquency. Prevention programs can be likened to accelerated diversion because avoidance of criminal conduct can keep youths out of the juvenile justice system altogether. Missouri’s Juvenile Court Diversion funds, which have permitted some juvenile courts to reduce the number of children they commit to

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526 See supra note 493 and accompanying text.

In \textit{Alexander S. v. Boyd}, the four-year class action suit that successfully challenged conditions in South Carolina's juvenile detention facilities, the court questioned each expert witness about the causes underlying violent juvenile crime.\footnote{528 Id. (footnote omitted).} The causes most commonly advanced were "a significant increase in the number of single-parent families, involvement with alcohol and other drugs, involvement in gangs and other anti-social groups, exposure to violence in entertainment and in the mass media, and access to firearms."\footnote{529 Id. at 783 (quoting \textit{AM. PSYCHOLOGICAL ASS’N, VIOLENCE AND YOUTH: PSYCHOLOGY’S RESPONSE} 21 (1993)).} The court concluded that "[m]ost juveniles who are at greatest risk of becoming extremely aggressive and violent tend to share some of these common experiences or characteristics that appear to place them on what one organization has termed a ‘trajectory toward violence.’"\footnote{530 Id. at 783 (quoting AM. PSYCHOLOGICAL ASS’N, VIOLENCE AND YOUTH: PSYCHOLOGY’S RESPONSE} 21 (1993)).

To neutralize the sort of underlying causes found in \textit{Alexander S.}, Marian Wright Edelman advocates "[p]ositive youth development programs, both recreational and educational (such as mentoring, tutoring, job training, ‘midnight basketball’ leagues, and community service), [which] can provide young people with positive supports, particularly connections to committed, caring adults."\footnote{531 Marian Wright Edelman & Hattie Ruttenberg, \textit{Legislating for Other People’s Children: Failing to Protect America’s Youth}, 7 \textit{STAN. L. & POL’Y REV.} 11, 15 (1995-96).} She explains:

These initiatives . . . seek to provide the life-skills and supports that enable children . . . to cope with the risk factors, and to emphasize the protective factors, in their lives. And these pro-
grams help young people build personal resilience through enhanced social competence, problem-solving skills, autonomy, a sense of purpose, and a belief in their future.\textsuperscript{532}

A 2002 survey reported that a substantial number of Americans favored a role for prevention programs in a state's overall response to delinquency.\textsuperscript{533} The survey found that thirty-seven percent of Americans believed that prevention should be the highest priority in dealing with crime, ahead of punishment (twenty percent), enforcement (nineteen percent), and rehabilitation (seventeen percent).\textsuperscript{534} Rather than prison, eighty-five percent of Americans supported placement of more youthful offenders in community prevention programs that teach job skills, moral values, and self-esteem.\textsuperscript{535} The survey also reported strong support for various preventive measures, including after-school activities to keep young people off the streets.\textsuperscript{536}

\textbf{C. Small Regional Facilities}

Juvenile justice professionals have achieved consensus that small regional facilities offer the best prospects for rehabilitating most delinquents and lowering recidivism rates.\textsuperscript{537} Facilities can range from nonsecure programs for nonviolent youths to intensive serious offender programs for the most violent youths. Whether or not a confined youth is emotionally or physically disturbed, personal attention from the staff is essential to positive treatment and can best be achieved in small settings that emphasize clear and consistent consequences for misconduct. The youth must be more than a number or an anonymous face; staff must know the youths and their family histories.

Regional facilities enable the state to treat most children within driving distance from their homes, thus enhancing the prospect that parents and other community supports can partici-

\textsuperscript{532} Id.
\textsuperscript{533} See PETER D. HART RESEARCH ASSOCIATES, INC., supra note 507, at 3.
\textsuperscript{534} Id.
\textsuperscript{535} Id. at 11.
\textsuperscript{536} Id. at 14-15.
pate in the rehabilitation effort and ease the youth's reentry into the community after release. Access to family by telephone and mail communication during confinement is essential, but cannot substitute for face-to-face visits and involvement.

States must squarely confront the political costs that fundamental change may impose. Guards accustomed to taking and dishing out assaults in violent juvenile institutions may be ill-suited for employment in programs grounded in therapy rather than incarceration. Some guards may lack the educational background and experience to serve as youth counselors in more therapeutic programs. Some guards might be reassigned to other positions in the corrections system, but statewide shifts to therapeutic programs may produce layoffs and stiffen resistance from guards unions. Closing large congregate institutions in favor of smaller regional facilities may affect the local economy in towns that have grown reliant on the large institutions. Opening small regional facilities in or near residential areas may arouse resistance from local residents, particularly those with young children.

D. Therapeutic Attitudes

Decentralization and smaller regional facilities, while central to Missouri's juvenile justice formula, are not the sole antidotes for incarceration-based systems. Georgia, for example, maintains decentralized regional facilities (twenty-two regional youth detention centers and eight youth development campuses).538 Kentucky has long maintained relatively small juvenile corrections facilities. The Justice Department's reports on these two states, however, hardly described models of sound practice.539

Meaningful juvenile justice reform requires commitment to therapeutic attitudes from top to bottom—from the governor and legislature providing leadership and funding to the corridors of the juvenile facilities themselves where staff members interact with juveniles daily. For confined youths who have never met the governor or a legislator, the corridor staff may be the most important nonfamily members in their lives during confinement. With some juvenile prisons mistreating children in ways local humane societies would not tolerate in kennels, one Florida educator warns that "if you treat a dog cruelly and don't feed it and be kind to it, you're going to have a vicious animal. That's what

538 See supra notes 183-84 and accompanying text.
you're going to have with kids."\textsuperscript{540}

At every level, decisionmakers and agency personnel must commit to greater emphasis on treatment, and to nationally recognized standards of sound juvenile justice practices that accompany it.\textsuperscript{541} For staff members accustomed to a culture of violence stoked by the sometimes irritating behavior of juveniles in prison environments, this commitment may require retraining and changed sensibilities. The Director of the Maryland Juvenile Justice Coalition put it well: “Missouri . . . isn’t a model you can replicate with legislation. . . . What is unique about Missouri is the attitude and approach of the staff and the management.”\textsuperscript{542}

\textbf{E. Educational and Vocational Training}

A recurring theme in the Justice Department’s recent CRIPA reports is the failure of many states to satisfy the minimum general, special, and vocational education standards established by the IDEA, the Rehabilitation Act, and state constitutional guarantees of a free public education. Because studies have shown that confined youths who participate in educational and vocational training programs have lower risks of recidivism, educational programming belongs at the forefront of delinquency.

\textsuperscript{540} See Marego Athans, \textit{The War Zone; Shootings, Stabbings, Beatings Are Unwelcome Additions to Schools' Curriculum}, SUN-SENTINEL (Flt. Lauderdale, Fla.), Nov. 14, 1993, at 1G.


\textsuperscript{542} See Fesperman, \textit{supra} note 21 (quoting Heather Ford, Director of the MJJC).
treatment and rehabilitation. Sound programming requires qualified instructors, adequate books and other supplies, a student-faculty ratio that permits individual attention, and clean classroom space conducive to the educational enterprise. The task may be daunting because so many delinquents enter state custody far behind in their studies and prone to "act out." As in Missouri, educational programming should exceed the bare constitutional and statutory minima by implementing individual assessments completed when the youth is admitted to the facility.

F. Classification

Ira Schwartz, former Director of the Justice Department's Office of Juvenile Justice and Delinquency Prevention, points to "strong evidence that community programs work and they do not compromise public safety and they reduce recidivism. The number of kids that need to be under lock and key is very, very small." For lack of community-based alternative treatment programs, however, too many states lock up status offenders (such as truants, runaways, and curfew violators); mentally ill youths; and nonviolent youths who could respond positively to treatment in structured facilities without bars or razor wire. Some states then compound the problem by failing to separate younger, more vulnerable youths from older, violent ones in the facilities themselves.

The Justice Department's recent reports confirm that thousands of youths incarcerated nationwide do not belong locked up because they are better suited for less expensive community-based juvenile justice programs. In 1989, for example, the Director of Georgia's Division of Youth Services said that up to eighty percent of incarcerated juveniles should be in alternative programs, not jails. A 1990 report issued by the Georgia

543 See CAL. PERFORMANCE REVIEW, supra note 108.
544 See Vincent Schiraldi, Detention Homes Aren't the Answer, FULTON COUNTY DAILY REP. (Ga.), Dec. 13, 2001 (on file with author), available at http://www.dailyreportonline.com; see also Shelly Zavlek, Planning Community-Based Facilities for Violent Juvenile Offenders as Part of a System of Graduated Sanctions, JUV. JUST. BULL. (Office of Juvenile Justice & Delinquency Prevention, Wash., D.C.), Aug. 2005, at 2 ("A promising strategy for responding to juvenile crime is one in which secure confinement is an integral part of a continuum of options that also includes prevention, comprehensive services, graduated sanctions, and, for confined youth, aftercare programming to ensure successful reentry into the community.").
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Risk Assessment Task Force, which the state Division of Youth Services had assembled, concluded that nearly half (forty-eight percent) of the youths held in Georgia's juvenile jails on March 1 of that year should have been placed in alternative rehabilitation programs instead. Critics said the task force underestimated the percentage, which they asserted was actually about sixty percent.

When the Justice Department reported in 1998, Georgia still incarcerated many small and young children, charged only with status offenses or other less serious offenses, in high security facilities rather than in alternative shelters or group homes. The Department found:

[A] very small eleven-year-old boy . . . 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 . . . throwing objects in her room and skipping school . . . and numerous children who had run away from troubled homes.

"Many young children were held on charges of 'terroristic threat,'" which the Justice Department determined "often amounted to nothing more than 'cussing out' a teacher or group home staff member." Vulnerable youths spent weeks or months in Georgia's RYDCs, often on waiting lists for placement in one of the state's scarce nonsecure facilities, and sometimes attempting suicide during the wait. Thanks to inadequate classification procedures that overlooked safety concerns, these youths were often mixed with older, potentially predatory detainees. The Justice Department also found that Louisiana was:

[F]ailing to protect a substantial number of the children confined in its secure facilities from harm by placing them in these facilities in the first place. The state's own post-adjudication
screenings identified a number of juveniles, many of whom have special needs, including mental or physical disabilities, who were appropriate for nonsecure placements upon commitment.552

The Department found that these youths were placed in secure facilities because chronic underfunding left the state with few community-based residential and day treatment centers.553

In 2003, the Annie E. Casey Foundation confirmed the Justice Department’s Louisiana findings.554 A hefty seventy-seven percent of youths incarcerated in Louisiana had committed nonviolent offenses, including misdemeanors.555 Most incarcerated youths were low-level offenders who did not pose a public safety risk (with simple battery and simple burglary the most common offenses), or youths with behavioral, mental health, and substance needs.556 Judges with few disposition options, however, were often forced to choose between probation and incarceration in facilities557 where, as the Justice Department found, youths received beatings and frequent sexual abuse, but little semblance of treatment.558 The Foundation concluded that by greatly expanding alternatives to incarceration, Louisiana would enhance rehabilitation and public safety while saving taxpayer dollars.559

Overreliance on incarceration can contribute to chronic overcrowding in juvenile facilities, or in some parts of these facilities. Some of the nation’s juvenile facilities operate at 200%–300% of design capacity.560 Overcrowding is associated with higher rates of institutional violence and suicidal or self-destructive behavior, disruption of programs and services, deterioration of conditions of confinement, and greater reliance by authorities on punitive isolation.561 Overcrowding, and its attendant understaffing, may also limit juveniles’ time outside their cells, and thus their access

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552 See Letter from Isabelle Katz Pinzler to the Hon. Mike Foster, supra note 162, § I(A)(6).
553 Id.
554 See CASEY STRATEGIC CONSULTING GROUP, supra note 174.
555 Id. at 3, 17.
556 Id. at 3, 4.
557 Id. at 13-14.
558 See Letter from Isabelle Katz Pinzler to the Hon. Mike Foster, supra note 162, § I(A).
559 CASEY STRATEGIC CONSULTING GROUP, supra note 174, at 39.
560 See Mark Soler, Juvenile Justice in the Next Century: Programs or Politics?, 10 CRIM. JUST. 27, 27 (1996).
to constructive programming. In crowded cells and other close quarters, guards may tacitly encourage youths to release energy by assaulting one another, or may feel powerless to stem such violence. Frustrated youths may turn around and assault or taunt guards, who develop an “us-against-them” mentality and return the violence in their own frustration.

States would better serve the articulated goals of sound juvenile corrections policy by reserving the most secure detention for truly violent youths unable to respond positively to less restrictive alternatives. Status offenders and nonviolent youths may be assigned to less restrictive community-based facilities under a classification system that, during a youth’s admission or as soon thereafter as possible, assesses such factors as offense history, gender, maturity and age level, propensity for violence, vulnerability to victimization, medical status, gang membership, and capacity to respond to treatment.

Sound classification also requires each juvenile corrections facility to separate confined children according to their age, size, background, and temperament. In close quarters, indiscriminate mixing invites violence and impedes programming goals that can best be achieved by tailoring resources to individual needs. Education, vocational training, and other delinquency treatment hold the greatest chance for success when nonviolent youths are spared constant fear of assault.

G. Mental Health Treatment

Juvenile justice reform means removing mentally ill children from prisons that inevitably worsen their condition and compromise therapy that could be accomplished more effectively in a controlled environment outside prison walls. Removal would need to be coupled with a commitment to provide adequate mental health care for these children under the auspices of other agencies. In turn, this commitment would require collaboration among the juvenile justice system, mental health and other social services agencies, the public schools, and other community providers. Depending on the severity of the mental illness, an incarcerated child could be better treated in an inpatient hospital, a group home or other residential placement, in the family home with intensive community-based services, or in foster care.562

562 See Special Investigations Div., Minority Staff of H. Comm. on Gov’t Reform, 108th Cong., Incarceration of Youth Who Are Waiting for
Rather than confront the pediatric mental health crisis with positive measures, however, many states have been moving in the opposite direction. State and federal budget cuts have closed or drastically reduced access to local mental health facilities since the 1980s. As a result, several thousand mentally ill children are incarcerated each year because the juvenile corrections system provides their only access to treatment, frequently in facilities that offer little semblance of meaningful therapy.\footnote{See generally Cornelia M. Ashby, Dir., Educ., Workforce, and Income Security Issues, U.S. Gen. Accounting Office, Child Welfare and Juvenile Justice: Several Factors Influence the Placement of Children Solely to Obtain Mental Health Services, Statement Before the Senate Committee on Governmental Affairs (July 17, 2003), available at http://www.gao.gov/new.items/d03865t.pdf. See generally Lois A. Weithorn, Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates, 40 Stan. L. Rev. 773 (1988); Fran Lexcen & Richard E. Redding, Mental Health Needs of Juvenile Offenders, Juv. Correctional Mental Health Rep. (Civic Research Inst., Kingston, N.J.), 2002, available at http://www.civicresearchinstitute.com/ch4.html.}

As described in 2004 by the administrator of a Washington state juvenile detention facility, “We are receiving juveniles that 5 years ago would have been in an inpatient mental health facility. . . . [W]e have had a number of juveniles who should no more be in our institution than I should be able to fly.”\footnote{Id. at 5, 8 (“[A] majority of the youth held here are warehoused awaiting placement.” (quoting a Montana juvenile justice administrator)).}

Among juvenile justice professionals, the word "warehousing" has become almost a term of art to describe conditions of confinement for mentally disturbed children.\footnote{Id. at 5.} When asked why a mentally ill child was held in his juvenile detention facility without charges, a Georgia administrator frankly told a congressional committee that "[n]o other place would accept the child."\footnote{See, e.g., Joseph J. Cocozza & Kathleen Skowyra, Youth With Mental Health Disorders: Issues and Emerging Responses, 7 Juv. Just. 3, 6 (2000); Gail A. Wasser- man et al., Assessing the Mental Health Needs of Youth in Juvenile Justice Settings, Juv. Just. Bull. (Office of Juvenile Justice & Delinquency Prevention, Wash., D.C.), Aug. 2004, available at http://www.ncjrs.org/pdffiles1/ojjdp/ 202713.pdf.}


In 2000, the Coalition for Juvenile Justice estimated that fifty to seventy percent of incarcerated youths nationwide have a diagnosable mental health disorder, at least fifty
percent have substance abuse problems, and nine to thirteen percent suffer from serious emotional disturbances. In 2004, the National Mental Health Association estimated that as many as sixty percent of youths in the juvenile justice system have mental health disorders, one-quarter to one-third of incarcerated youths have anxiety or mood disorders, up to nineteen percent of incarcerated youths may be suicidal, and nearly one-half of incarcerated girls meet criteria for posttraumatic stress disorder.

In 2004, a U.S. House Committee surveyed every juvenile detention facility in the nation, seventy-five percent of which responded. During the first half of 2003, nearly 15,000 children (almost eight percent of children incarcerated nationwide) were incarcerated while awaiting mental health services. Two-thirds of the nation's juvenile detention facilities held youths who did not need to be in secure detention but were awaiting community mental health treatment, including children as young as seven. These youths suffered from such mental disorders as depression, substance abuse, attention deficit hyperactivity disorder, retardation and learning disorders, schizophrenia, anorexia nervosa, autism, and posttraumatic stress disorder. Some mentally ill


569 See NAT'L MENTAL HEALTH ASS'N., MENTAL HEALTH TREATMENT FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM 1 (2004); see also Nieves, supra note 90 (quoting California Youth Authority spokesman who said that ninety percent of boys and girls in CYA custody have an "identifiable mental health disorder"); Linda A. Teplin et al., Psychiatric Disorders in Youth in Juvenile Detention, 59 ARCHIVES GEN. PSYCHIATRY 1133, 1135 (2002) (discussing 2002 federally funded study finding that at the Cook County (Illinois) Juvenile Detention Center almost two-thirds of boys between ten and eighteen, and more than two-thirds of girls, had diagnosable psychiatric disorders); Letter from Ralph F. Boyd, Jr. to the Hon. Ronnie Musgrove, supra note 5, at 15 (discussing 2001 study funded by two Mississippi state agencies finding that between sixty-six and eighty-five percent of youths incarcerated in that state "met . . . diagnostic criteria for a mental disorder"); that "multiple, co-occurring mental health and substance abuse diagnoses were evident"; and that nine percent of the incarcerated juveniles had "suicidal thoughts and plans"); Mark Silk, Study: Kids In Jail Often Suffer Psychological Disorders; Addiction, Anxiety, Depression Rampant, ATLANTA J.-CONST., Feb. 28, 1996, at 3B (discussing 1996 Emory University study finding that more than half of the juveniles jailed in Georgia suffered from one or more behavior-altering psychological disorders, ranging from serious depression to anxiety disorders to substance abuse).

570 See SPECIAL INVESTIGATIONS DIV., supra note 562, at ii.

571 Id. at i.

572 Id. at 9. Concerning disturbing rates of PTSD in the juvenile justice system due to youths—particularly violent offenders and girls—having witnessed or been a victim of a violent event, see NAT'L CHILD TRAUMATIC STRESS NETWORK (NCTSN), ASSESSING EXPOSURE TO PSYCHOLOGICAL TRAUMA AND POST-TRAU-
youths were confined without charges, and others charged with crimes were locked up for extended periods solely because no inpatient or outpatient mental health treatment was available. Some of these youths had attempted suicide or attacked others.

In 2005, the House Committee reported that the mental health crisis is particularly acute in California's juvenile detention facilities. Most of these facilities hold youths awaiting community mental health treatment, including children as young as eight with no charges pending against them. One administrator told the Committee that the state's juvenile detention facilities have become "the depository of last resort for all acting out, behaviorally challenged, developmentally disabled [youths] when others don't know how to handle [them]."

The juvenile justice system was not designed to provide de facto psychiatric hospitals, and many state administrators acknowledge that their juvenile justice facilities are ill-equipped to care for children needing mental health treatment. Even well-meaning guards untrained in mental health care can misinterpret a mentally disturbed youth's behavior as insolence, disobedience, or insubordination. "Many detention facility staff are never trained to recognize and respond appropriately to symptoms of mental health distress. Some young inmates, consequently, have been overmedicated, too frequently isolated, beaten or killed when 'acting out.'"

The juvenile justice system has also become the mental health care provider of last resort for desperately ill youths whose families cannot afford private care, have no health insurance, have health insurance that provides little more than nominal services

matic Stress in the Juvenile Justice Population (2004); NCTSN, Trauma Among Girls in the Juvenile Justice System (2004); NCTSN, Trauma-Focused Interventions for Youths in the Juvenile Justice System (2004); NCTSN, Victimization and Juvenile Offending (2004). These are all available at http://www.NCTSNNet.org.
573 See Special Investigations Div., supra note 562, at i.
574 Id.
576 Special Investigations Div., supra note 562, at 9-10; see, e.g., Lisa Melanie Boesky, Juvenile Offenders with Mental Health Disorders: Who Are They and What Do We Do with Them? 7-10 (2002).
577 See Coal. for Juvenile Justice, supra note 568.
for mental illness, or have had their insurance claims denied altogether. Not all children covered by Medicaid receive needed services due to lack of funding or an overburdened health care system. Managed care plans reportedly often resist approving mental health treatment for children. Desperate parents (perhaps facing child protective authorities' threats to remove siblings from the home unless the violent child is removed) sometimes seek to have the child taken into custody for delinquency or a status offense.

In 1999, the National Alliance for the Mentally Ill commissioned and helped conduct a survey of families with children suffering from a serious brain disorder. Sixty-six percent of responding parents reported a lack of health insurance parity, with forty-nine percent saying lack of parity impeded needed care. Forty-nine percent of parents indicated that managed care organizations limited or denied access to needed treatment for their children to the detriment of their children's health. Thirty-six percent of parents reported that their children were placed in the juvenile justice system because needed services were otherwise unavailable.

"It's tragic," says a Dallas County (Texas) juvenile court judge. "If you are a young person and mentally ill, you have to get arrested to receive treatment." "I had a 15-year-old girl who was hallucinating and psychotic," said a supervisor at the Letot Center for runaway children in Dallas. "And a staff member from Mental Health and Mental Retardation agreed she needed hospitalization. But then she said they were over budget.


580 See, e.g., Ashby, supra note 563, at 15.


582 Id.

583 Id.


585 Id.

586 Id.
for the year, so couldn’t I find an offense that would get her arrested, like an assault?"  

The ultimate indignities, as demonstrated in the Justice Department’s recent CRIPA reports, are that mental health treatment in juvenile detention facilities is often inadequate, substandard, or virtually nonexistent, and that guards sometimes inflict physical punishment on mentally ill youths. According to one Texas judge:

It’s not as if you get Cadillac services when you get into the juvenile justice system . . . There is a tremendous shortage of services and a tremendous shortage of quality. You can wind up going [the juvenile justice system] route and not getting much more help than you would if you hadn’t gone this route to begin with.  

The 2004 House Committee survey led Congress to enact the Mentally Ill Offender Treatment and Crime Reduction Act, which made available $50 million in block grants to states for the next fiscal year to support programs to divert some mentally ill adults and youths from incarceration, and to provide mental health treatment for persons confined for crimes.  

The legislation appears to be a step in the right direction, though its funding (reduced from $100 million before passage) remains less than adequate to meet the needs of confined mentally ill youths.  

When incarceration squanders chances for effective treatment, the state fails the mentally ill youth whose condition inevitably worsens during confinement. The state also fails other confined youths who are exposed to unnecessary levels of institutional violence because, as the director of a Detroit juvenile detention facility explains, mentally ill children are “more difficult to manage, more explosive and more easily agitated,” and “[m]ost juvenile detention centers . . . do not have the luxury of separating youth with mental health problems from the general population.”  

Finally, the state fails the public, which remains at risk
when the disturbed youth is released without effective mental health intervention.

H. Aftercare (Reintegration and Reentry)

Positive behavioral change achieved during confinement can unravel quickly when a youth returns without effective supervision and support to the neighborhood that bred the criminal conduct in the first place. Aftercare, a loose analogue of criminal law probation, is an essential part of the continuum of juvenile justice services and sanctions because it helps youths achieve a smoother transition from confinement to life in the community.\(^{592}\)

Coherent, well-managed aftercare programs begin during confinement and continue afterwards, with the youth perhaps being assigned to a day treatment facility as an intermediate step toward release and supervised by a counselor for a period after release.\(^{593}\) Research has consistently shown that enriched aftercare services can enhance rehabilitation and public safety by reducing recidivism rates.\(^{594}\) Particularly central to positive outcomes are life skills training and gainful employment.\(^{595}\)


Conclusion

In most of the states inspected by the Justice Department, the scenario is familiar. A newspaper exposes brutal conditions of juvenile confinement, a private lawsuit challenges these conditions, an official report criticizes these conditions, or a confined youth commits suicide. Headlines hold public attention for a few weeks or months, but promises of lasting reform soon fade because delinquents are an unsympathetic constituency with little political muscle.

The Justice Department’s recent forceful nationwide use of CRIPA holds promise because federal involvement can command public attention. Most of the inspected states have agreed to raise their juvenile corrections systems above minimum constitutional and statutory standards, but challenges remain because the road to juvenile justice reform has been strewn with broken promises for years.

Regardless of which political party controls the governor’s mansion or the state legislature, the Justice Department must act without fear or favor. The Department’s virtual clearance of Arkansas—after at least a generation of documented savagery at the Alexander Youth Services Center, and before continued deterioration—raises the disturbing prospect that politics may sometimes intrude on CRIPA enforcement. The Department’s threat to sue noncomplying states will carry real teeth only if the Department inspects with a close eye and then holds states to stern post-inspection bargains. Because troubled youths and public safety are the ultimate beneficiaries of the Department’s recent initiatives, the Agency must remain resolute, filing suit where necessary to prod states that drag their feet. Courts too must put teeth into their orders, because civil settlements hold meaning only when the prevailing party actually secures promised relief.

When all the dust settles, juvenile and family courts do not impose life sentences. Delinquent youths confined in juvenile corrections facilities today will be released within a few months or years. In the public interest, the Justice Department’s recent CRIPA initiatives are catalysts for states—ones inspected and ones not yet inspected—to move beyond time-worn juvenile correctional systems that fail year after year to rehabilitate children, advance personal accountability, or protect public safety.