

Panel 3: Transparency and Access of Independent Experts to All Places of Detention

Oversight Practices of U.S. Juvenile Facilities

Presentation by Judge Ted H. Rubin (RET)*

THE SPATE OF INSTITUTIONAL CARE DEFICIENCIES AND MALTREATMENT OF YOUTH IN STATE AND LOCAL FACILITIES, CHARTERED TO MEND JUVENILES, IS WIDELY REPORTED – AFTER THE FACT.

This past week, it was the pretrial juvenile detention center in Hinds County (Jackson), Mississippi, where it was found that countless detained juveniles did not receive judicial review within the 48 hours of admission required by the statute, that nearly 300 status offenders had been held (almost all in violation of federal restrictions,) and that the judge had sentenced at least one adult to spend time in this juvenile facility (another federal violation). This center held approximately 72% of detentions in the state, although the county’s population approximated just 10% of the state’s population.

In 1993, deficiencies in care in this same facility had led to a federal court consent decree, following a U.S. Department of Justice (DOJ) investigation of conditions. The court issued “findings” that concerned such apparent unconstitutional conditions as: inadequate on-site material and medical health care; inadequate suicide prevention measures; inadequate supervision and staff training (the findings noted that a private law suit had been filed alleging juveniles had been sexually abused and raped by guards at the center); and deficient lighting, bedding, and opportunities for exercise. The center was directed to remedy these conditions based on a DOJ outline stating the minimum procedures necessary.

Just two weeks ago, two corrupt Pennsylvania judges pleaded guilty to receiving \$2,600,000 in kickbacks from the builders and owners of private for profit juvenile centers, having dispatched up to 2,000 juveniles, the great bulk of then unnecessarily, to these facilities (most without having defense attorney representation.) Public institutions often fail to provide safe and constructive care, while private for profit juvenile facilities all too often care more about their profits and maintenance of political connections than furnishing quality care to those in their temporary custody.

Of course, institutional care provision is not all bleak. Yet all too many communities and states fail to effectively monitor the care, the absence of care, and sometimes maltreatment in their facilities on an ongoing and early corrective basis. Juvenile court judges often overly trust detention and institutional facilities and are seduced into using facilities unnecessarily, rather than stimulating more effective community-based non-institutional interventions, retaining a juvenile in his own home and working with and around parental and neighborhood deficiencies.

Among the states, Rhode Island appears to be a superior example of both proactive and reactive monitoring. The office of child advocate, enacted by statute, maintains an office at the training school, makes unannounced visits to the different units and programs, has been meeting monthly with the girls unit (and seeking better housing and a more gender specific program there). Its officials meet regularly with top level institutional officials seeking to obtain remedies for concerns such as perceived insufficient staff training to better handle juvenile behaviors, and several confirmed institutional abuse cases where abusive staff members had not been discharged. It initiates court action when necessary, such as those litigating the practice of placing institutionalized youth on a waiting list for special education services, search practices with residents in a group home, and conditions at the training school. This state has the longest standing federal consent decree (1973 Affleck case whose requirements are still overseen by a federal master). The office is active on the legislative front, has the official responsibility to review child fatalities that occur in the state, and plays a very active role monitoring the care of dependent and abused children in foster care facilities.

Among the failures of U.S. monitoring of cases are:

- too little takes place
- that which takes place is superficial
- monitoring is most often pre-scheduled
- monitors too often are fellow governmental professionals who are low key in pushing improvements and reforms. Informed citizen and medical/mental health specialists/lawyers are not often part of state or local level monitoring
- employees who are aware of institutional abuse or gross insufficiencies do not blow the whistle or wait too long to blow it
- prosecutors are not very interested in inspecting juvenile facilities until a death or very serious institutional abuse receives headlines
- defense counsel all too often know of program deficiencies but do too little about it
- juvenile court judges do insufficient follow ups with institutional placements they order

Two weeks ago, in providing technical assistance to a juvenile court in a Pacific Coast state, I was informed, jointly by the seemingly very competent Chief Probation Officer and Detention Director, that the center had a wonderful program (it probably did as it was small, and had just 20 beds) and that locking up errant juveniles, even for a few days, enabled so many to straighten out their lives and turn their lives around. They admitted that many of these youths had committed minor offenses, but all or virtually all were admitted to detention who had

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been brought there by law enforcement. (There is a widespread though far from universal silent conspiracy: do not unsettle police department beliefs that lock ups are good for juveniles' souls and do maintain good relationships with law enforcement). Many were released within several days by a judge who saw no value in continuing secure care. (However, the judge did not get ahead of the curve to direct higher standards for detention admission in the first place). Lead officials here failed to recognize that once locked up, and when followed by a reoffense and another lock up, one had become a prime candidate for commitment, directed or on hold, to a state institution or a private residential placement, either at great cost to the parents, as well as to the youth's sense of well being.

What also bothered me here was the probation department's early-on use of a risk instrument. The probation director listened to my question: "Do you mean to tell me that if two first time offenders are investigated and one shows high and the other low risk of a second offense that you would formally petition one and not the other?" "Yes," said the director. I next asked: "What happens to equal justice before the law?" "Well," he answered, "our interest is in reducing risks to the community by working more intensively with juveniles at greater risk of offending."

Still, the juvenile justice system is considerably better than its criminal justice system counterpart. In my opinion, it is no contest. The juvenile system had hundreds/thousands of personnel who do care about the youth they work with and humanely and beneficially apply this care along with numerous intervention approaches that do benefit our young people.

The time span, roughly 1987-94, unfortunately witnessed dreadfully large numbers of juveniles violently killing and maiming other juveniles, and not only juveniles, and prompted state after state to legislate that juveniles above a certain age, such as 15 years, should be criminalized. As often happens, the political reaction was excessive, and far too many juveniles under 18 years became the province of criminal courts and criminal jails and prisons. As one example, currently, at least 2,250 persons are serving sentences of life in prison without parole for offenses committed prior to their 18th birthdays!

There is widespread holding of these juveniles in adult jails during the lengthy criminal court timeline until their sentence, without education or rehabilitative interventions, unlike their care in a juvenile pre-trial center. Moreover, there is, as yet, no federal ban on mixing criminalized juveniles with adult offenders in adult jails, a serious shortcoming. No one knows how many juveniles are abused if not badly influenced by adult offenders while residing in these jails, and, for many, in adult prisons.

The Federal Delinquency Act does require that all states receiving funds under the Act (all except Wyoming) make inspections of local secure detention facilities to ensure that 1) status offenders (conduct illegal only for children) are not in care, or not in care for more than 24 hours, except for a subsequent failure to adhere to conditions of a valid court order, and 2) local adult jails provide sight and sound separation of juvenile offenders (not juveniles in criminal court) from adult offenders. But Mississippi funds have not yet been withheld for its violations, and undoubtedly other states have failed these

requirements. Federal officials prefer to keep funding going while seeking to encourage compliance.

Colleagues in a western state recently sent me their report of the February 2008 review of the juvenile detention center in its largest jurisdiction (population approximating 350,000 persons). These officials told me they go beyond the federal requirement in their review. Their review purposes with an annual visitation are to examine juvenile files, the shift logs, and staff work schedules, and to interview juveniles, staff, and facility administrators to determine compliance with state detention standards. So far, so good.

What problems were found? During the past year, there were 8 incidents of staff restraints upon juveniles, although no records or logs were provided by the detention director whose statement was accepted that there were no injuries to staff or juveniles, and no departure from policy or procedures. One attempted suicide was reported, an attempt by a boy to cut his wrists. He was taken to a hospital, treated and returned that evening to the facility. This report was provided to the panel.

Two juveniles were interviewed. Juvenile #1 stated he received medical screening on admission, was not on medication, that his feet hurt, but the nurse was "helpful and nice." He had been sentenced to the facility (i.e., not on a pre-trial hold) for repeated offenses, most recently malicious injury to property, resisting arrest, and a warrant, possibly for not appearing at a court hearing or at probation officer appointments. He said he felt safe here, felt staff were fair, and although he had been disciplined, he said that "90% of staff do not want to discipline." Juvenile #2, a girl, in detention for the 10th time, will be attending drug court, is visited by her family, is in the center's school five hours a day, finds the food "fine," had seen some contraband but did not describe it, and was positive as to the care and program.

The panel found the facility (just 40% occupied that day) was "very clean and impressive," was appropriately staffed at all times, and was faulted only on a data finding that two status offenders had been held more than 24 hours.

The inspecting staff were all juvenile justice professionals, several with particular detention or institutional experience. The inspection team had pre-arranged with the facility the date and time of the visitation.

I have reviewed (off-site) an Ohio inspection report by a mandated inspection committee (legislators are members; findings are to be reported to the state legislature, required every two years) of a juvenile institution that found significant safety and security problems, recommended separation of younger youth (13-15 years) from the oldest (18-20 years), and urged employment of a "full-time security threat group coordinator." Another Ohio institution's assessment found myriad grievances "under investigation," filed by juveniles for such things as staff getting youth to fight a particular youth whom a correctional officer disliked, and staff making racial remarks, verbally abusing youth, and using force against youth.

But a law suit in an Ohio federal court entered findings well beyond what state inspectors had found in those several facilities mentioned here. A 201 page settlement agreement (S.H. V. Stickrath, No. 2:04-CV-1206 (U.S.D.C., S.D. Ohio, 4/9/08))

proscribed major deficiencies in the array of state facilities, and prescribed critical and expansive revisions to be implemented covering non-safe environments; the use of force and isolation; mental health, medical and dental care; assessment and programming for sexual offenders; educational programming; curbing of overcrowded and understaffed facilities; provisions for staff training; and the need to reduce delays in institutional releases and to improve grievance procedures.

A major strength of a federal court judgment is the appointment of a monitor or master to facilitate implementation of conditions of care stipulated to or judged by findings. For example, the November 25, 2008 six-month report of the Ohio monitor notes “the S.H. stipulation is extraordinary in its breadth and depth and remarkable in its ambition.” Further, “while I do not underestimate the complexity of the undertaking, the performance of the defendants to date has been disappointing in some respects and promising in others.”

The report notes as to use of force: “In August 2007, DYS reported 510 use of force incidents. In July 2008 there were 367. August 2008, 349; and September 2008, 354. This data by itself is not compelling, but it does show some reduction and then a recent leveling off on use of force. With a reduction in use of force, there has been a corresponding increasing in the use of isolation albeit for limited periods of time.”

“Further, in August 2007 there were 1836 youth in DYS custody while in September there were 1463. Thus, there was a population decrease of 21%. While use of force incidents decreased by 31%, our collective aspirations are for a much greater decrease in use of force incidents, but surely this is movement in the right direction.”

The report noted as to mental health the employment of a new contract psychologist, two social workers, a psychiatric nurse, and an occupational therapist, as well as the monitor’s having been “pleasantly surprised to observe a functioning interdisciplinary team in the intensive mental health care unit There was a more relaxed feel to it. Youth were not as agitated as they were during previous visits, carpets and new furniture have appeared, a comfort room (for time out moments) existed, and so on.”

The monitor notes, as to the grievance system, that he has forwarded his drafts that reflect revision of the present system, that he envisions a “good deal of personal assistance for these youth, many of whom are functionally illiterate and inarticulate.” He urged the creation of a new position, a specially trained youth advocate to assist youth with grievances and deal with disciplinary charges.

California is one state that adds in citizen monitors, as a statute requires county officials to appoint a juvenile justice and delinquency prevention commission to examine and oversee juvenile facilities and advocate for improvements. Chief probation officers of a county then need to prepare a report to county government as to how they are addressing concerns highlighted by a commission, as in the following report excerpts from Santa Cruz County (recognized as one of the best juvenile justice systems in that state): “The first phase is underway in upgrading the security/safety systems . . . six computers have been added . . . educational materials (do) address both English speaking and English language learners at all grade and developmental

levels . . . some schooling disruptions are unavoidable as medical services are being delivered that require students to be removed from their studies.” Further, a required biennial inspection by the state’s correctional standards authority found full compliance at this juvenile detention facility in all categories, such as buildings and grounds, its fire and safety plan, staffing qualifications, population compared with approved capacity, its policies and practices regarding use of force and physical restraints, and its grievance procedures.

Let me continue by commenting on an extremely important tool, which often comes after the fact of failures in care, the Civil Rights of Institutionalized Persons Act (CRIPA) enacted by the Congress in 1980, that authorizes the US Attorney General to direct the Civil Rights Division of the Department of Justice to investigate and bring actions against state or local governments for systemic violations of these civil rights, i.e., depriving confined persons of their constitutional rights. Facilities covered by CRIPA include juvenile detention and correctional facilities, psychiatric institutions and institutions for the developmentally disabled, jails and prisons, and nursing homes.

Here is just one example:

A law suit (*United States v. Oklahoma* (06-CV-673-FHM)) was filed in December 2006 by the US Attorney General that alleged that at the state juvenile institution (the Rader Facility) there was a failure to:

- protect residents from staff abuse
- protect residents from abuse by other youth
- protect residents from sexually inappropriate relationships among staff and youth and among youth
- protect residents from self-injurious behavior
- provide adequate management of psychotropic medications

A 30 page consent decree, specifying in detail how these failures would be remedied by the state, was approved on September 30, 2008. (This illustrates that investigations need not always result in law suits. Presumably no court action had to be filed). Most CRIPA investigations, whether or not court actions, result in settlements.

In the last decade or so, CRIPA actions also have changed (dreadfully) delinquent institutional care in Arkansas, Georgia, Hawaii, Indiana, Maryland, Mississippi (its state facility), New Jersey, Texas, Puerto Rico (and the Northern Mariana Islands), Arizona, Ohio, and Louisiana. Other important actions have been initiated by youth law/juvenile law centers (as in South Dakota), American Civil Liberties Union (Philadelphia and Cook County juvenile detention center), prison rights organizations (California) and private lawyers (as in Ohio). Human Rights Watch has actively monitored and reported on juvenile justice failures. Arizona and Utah are among the states whose institutional care failures influenced juvenile deaths. Louisiana and Mississippi are among the several states which have totally closed a juvenile institution.

I have long said: juvenile justice reform is not for the short winded. We should continue to expand laws and professional judgments that reduce institutional placements.

But more expansive and effective monitoring, as well as well targeted investigations and, yes, law suits, will prove beneficial to our young people and to our communities. **HRB**