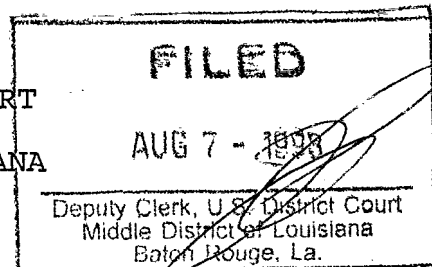


IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF LOUISIANA



HAYES WILLIAMS, et al,

Plaintiffs,

v.

JOHN MCKEITHEN, et al,

Defendants,

UNITED STATES OF AMERICA,

Amicus Curiae.

Civil No. 71-98-B

IN RE: TALLULAH CORRECTIONAL
CENTER FOR YOUTH

Civil No. CH 97-0665-B-M1

IN RE: JETSON CORRECTIONAL
CENTER FOR YOUTH

Civil No. CH 97-0666-B-M1

IN RE: SWANSON CORRECTIONAL
CENTER FOR YOUTH

Civil No. CH 97-0667-B-M1

IN RE: LOUISIANA TRAINING
INSTITUTE - BRIDGE CITY

Civil No. CH 97-0668-B-M1

RESPONSE OF THE UNITED STATES TO
THE COURT'S MARCH 10, 1998 ORDER



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RESPONSE OF THE UNITED STATES TO
THE COURT'S MARCH 10, 1998 ORDER

I. INTRODUCTION

On March 10, 1998, this Court ordered the United States and its expert consultants to inspect the State's secure juvenile facilities — the Louisiana Training Institute at Bridge City (Bridge City), the Jetson Correctional Center for Youth (Jetson), the Swanson Correction Center for Youth (Swanson), and the Tallulah Correctional Center for Youth (Tallulah) — and report on the conditions found. During April and May of this year, attorneys for the United States conducted tours of each facility with experts in education, medical and mental health, and protection from harm. The Court Expert, Warden John Whitley, accompanied the United States' attorneys and experts on all but one tour. Each expert provided a detailed debriefing to persons identified by the State of Louisiana: facility administrators, and, in most cases, to counsel for the Department of Public Safety and Corrections on the last day of each tour.

On June 17, 1998, the United States filed its expert reports on conditions at Tallulah, and on July 9, 1998, the Court ordered a status conference to discuss conditions at Tallulah for August 10, 1998. We submit our expert reports regarding conditions at the other three facilities before the August 10 status conference because the attached reports make clear that although conditions vary to some degree from one institution to another, many of the

problems identified in the reports exist at all three facilities and Tallulah, and many others are caused by systemic deficiencies that affect all the institutions.

Attached are reports from Dr. Nancy Ray (protection from harm)¹, Sheri Meisel (education)², and Drs. Pam McPherson³ and Bernard Hudson⁴ (mental health, medical and dental care). We summarize below key findings in the reports and highlight the systemic issues they raise.

The reports show that the State has made some systemic progress since our tours of the facilities more than a year ago. Incidents involving excessive use of force by correctional staff resulting in serious injuries to youth have been reduced due to the State's Project Zero Tolerance ("PZT") initiative. The use of pepper spray has decreased because the facilities have limited access to this intervention to only certain correctional staff. The State has lengthened the school day in all three facilities. Opportunities for family visitation have increased. And there have been several facility-specific improvements since our last tours. For instance, at Jetson, a series of incentive programs reward youth for positive accomplishments. With the assistance

¹ Dr. Ray toured Jetson on March 31 - April 2, 1998; Swanson on April 28-30, 1998; and Bridge City on May 11-13, 1998.

² Dr. Meisel toured Bridge City on April 22-23, 1998; Jetson on May 4-6, 1998; and Swanson on May 20-22, 1998.

³ Dr. McPherson toured Jetson on May 5-8, 1998, and Bridge City on May 11-13, 1998.

⁴ Dr. Hudson toured Swanson on April 28 - May 1, 1998.

of a federal grant, Swanson has implemented a limited after care program which assists youth on discharge to obtain special residential and vocational support. Bridge City has hired an extremely well-credentialed lead special investigator, who, assisted by a junior investigator, conducts high quality investigations which meet professional standards.

Despite this progress, major deficiencies remain in the areas of protection from harm, education, and medical and mental health treatment. With respect to protection from harm issues, all three facilities remain violent places, where youth continue to suffer serious injuries on a daily basis; the facilities face staffing shortages and high turnover; abuse investigations continue to be deficient; and staff continue to use excessive force to break up fights, escalating these situations into dangerous incidents. There are continuing deficiencies with both medical and mental health care, causing preventable suffering, undue restraint, and life-threatening risks of harm. Initial mental health assessments are grossly deficient; there are a substantial number of juveniles with severe mental illness or mental retardation who do not receive adequate care in the facilities; psychiatric treatment is inadequate, due in part to insufficient psychiatric coverage and inadequate oversight by the State; isolation is often used as a substitute for adequate mental health treatment; and suicide prevention measures are inadequate. Medical care is inadequate; at Jetson, our expert concluded that medical services were in a state of emergency.

Educational services continue to be inadequate. The State continues to fail to provide sufficient numbers of adequately qualified teachers, fails to provide the necessary supports for the teachers employed, and fails to comply with federal mandates for special educational services for qualified youth.

II. PROTECTION FROM HARM

The State has made some progress in the reduction of obvious staff abuse resulting in serious injuries to youth in the facilities. Still, all three State facilities remain violent, where youth are not often adequately protected from preventable harm. See, e.g., Ray Jetson Protection from Harm Report (hereinafter "JCCY PH") at 7-8, 11, 15-17 (attached as Exhibit A); Ray Swanson Protection from Harm Report (hereinafter "SCCY PH") at 5-8 (attached as Exhibit B); Ray Bridge City Protection from Harm Report (hereinafter "BC PH") at 7-10 (attached as Exhibit C). Serious injuries are common occurrences and injuries of suspicious cause are daily events. Serious problems recruiting and retaining qualified staff, and continuing problems in the quality of abuse investigations, contribute to the problem. Inadequacies in mental health treatment, discussed separately below, contribute to a high risk of harm to youth with mental health problems.

A. Youth-on-Youth Violence

There continue to be many serious injuries at the facilities, predominantly due to juvenile-on-juvenile violence. During the first three months of this year, 190 juveniles at

Bridge City reported to the infirmary after fights, and seven required emergency room treatment for traumatic eye injuries. BC PH at 7. During the four days prior to our tour at Jetson, 60 juveniles were sent to the infirmary to be evaluated after fights. JCCY PH at 16. The statistics on serious injuries at Swanson are particularly troubling. In a six-week period in February and March 1998, 24 juveniles were confined overnight in the infirmary for traumatic injuries (most of which occurred in fights) including broken jaws, injured eyes, and fractured noses. This rate of injuries continued during the time of our tours — in April, 32 youth were on bedrest in the infirmary for traumatic injuries, including eight for facial fractures. SCCY PH at 6.

Juveniles who are young, or have mental health problems, are particularly vulnerable to such violence and suffer disproportionately. BC PH at 11-12; SCCY PH at 12. For example:

- Nursing staff at Bridge City found that L.H., a 92-pound thirteen-year-old with a low IQ, had bruises over most of his body in April of this year. He reported that he had been held down and beaten by a number of other youths. He has also reported being raped by other youth on at least two occasions. BC PH at 8.
- G.V., another small thirteen-year-old at Bridge City with low intelligence, has been seen in the infirmary at least 15 times for fights this year. Id. at 9.
- V.J., a twelve-year-old at Bridge City, was taken to the emergency room at the end of March 1998 after a reported rape by three other youths. Id.
- L.H., a fifteen-year-old at Bridge City who is mentally retarded and under psychiatric care, has been involved in fights on almost a daily basis since being placed at Bridge City. Five sutures were recently required to close a head wound inflicted by another juvenile's crutch; the day after he was sutured, L.H. barricaded himself in a room and threatened to kill himself. When

we met L.H., he had a badly bruised and swollen left eye with a large blood spot, suffered from a fight. Id. at 7.

- B.C., a thirteen-year-old with psychiatric problems at Jetson, was involved in at least ten fights in eight weeks between January and March 1998, resulting in bruises to his neck, a swollen eye, and fractured ribs. JCCY PH at 15.

There are also large numbers of injuries attributed to sports or accidents. Some youth admitted that injuries are sometimes reported as accidental to avoid punishment for fighting. SCCY PH at 6. This is consistent with the suspicious nature of many of the injuries, the surprisingly large numbers of such "accidents," and the youths' often incredible explanations for them. For example, during two weeks in April, 40 different youth were seen for allegedly accidental or sports-related injuries at Swanson, including a youth who attributed a fractured jaw from "walking into a door"; one who claimed his broken hand was from a fall in the bathroom; and another who claimed to have broken his jaw by falling against a bathroom sink. SCCY PH at 6. Similarly, a youth at Jetson attributed a broken jaw to falling out of his chair. JCCY PH at 15. Too often, staff accept these seemingly implausible explanations and do not investigate the true source of the injury. Id.

There are a number of reasons for the alarming rate of injuries among youth in these facilities. Often, officers either fail to intervene promptly to stop fights between juveniles or never become aware of them due to inadequate staffing and supervision. SCCY PH at 6-7; BC PH at 10. And, as discussed in

more detail below, there remain significant problems in staffing, staff training and investigations in the facilities.

B. Staff Abuse and Excessive Force

In each of the facilities, the number of incidents of blatant and obvious physical abuse by staff resulting in serious injuries has fallen from the high levels documented by the United States' first tours of these facilities two years ago. But the reduction in incidents of brazen, easily detected abuse does not mean that excessive force against juveniles has been eliminated. Staff abuse continues to occur regularly. Even at Bridge City, where Dr. Ray found the greatest reduction in the excessive use of force by correctional staff since her earlier tours of the facility, there were 23 confirmed incidents of staff abuse over an 8-month period. BC PH at 5. Moreover, Dr. Ray found that staff at Swanson and Bridge City routinely use excessive force in breaking up fights, escalating these situations into more violent and dangerous incidents. SCCY PH at 6-7; BC PH at 10. She also found that officers at Swanson use excessive force in response to juveniles' acts of defiance or disobedience. SCCY PH at 7-8.

It appears that many officers now understand that flagrant and obvious abuse resulting in serious injury to youth will likely be detected and punished. The challenge now is to assure that officers will not engage in abuse that is less easily detected or more easily covered up.

For example, at Bridge City, even though the vast majority of the juveniles interviewed denied witnessing or experiencing

abuse by officers, just days after our tour, an officer brutally assaulted juveniles J.M. and J.C. for talking. The officer threw shoes at J.M.'s head, punched both youth in the face, broke a chair over J.M.'s head, and hit J.C. on the arm with the broken chair. Shortly thereafter, the officer assaulted two other youths. BC PH at 4. The officer told the youth not to report the abuse and threatened them with more harm. The officer allowed only J.M. to go to the infirmary for medical attention for his injuries, and told him to lie about the cause of his injuries. The cover-up was successfully carried out by all involved for a time. There was no PZT report and no investigation. The incident came to light only when J.M.'s family arrived for visitation and complained about his injuries. Bridge City's investigation ultimately confirmed the abuse, which had been witnessed by another Bridge City officer who had only worked at the facility for a few weeks and remained silent until confronted by investigators. Id.

This incident emphasizes the need for effective abuse reporting and investigative procedures. However, as discussed more fully below, the State's PZT program and the safety of the youth in the facilities is jeopardized by a failure to ensure competent, trained abuse investigators and to assure the adequacy of abuse investigations.

C. Detection and Investigation of Abuse

While there have been substantial improvements in the quality of investigations at Bridge City, Dr. Ray continues to

identify serious deficiencies that draw into question the comprehensiveness and accuracy of the State's investigations of allegations of abuse in the other facilities.

A dramatic improvement in investigation quality resulted at Bridge City when the Warden hired competent, trained investigators. BC PH at 3, 5. However, at the same time, improvements in the quality of investigations at Swanson were undermined when the Warden recently replaced a trained investigator whose work had been improving with an investigator with no training or experience who had been dismissed from Tallulah for reasons that had not been adequately investigated. SCCY PH at 12-13 & n.2. When this employee failed to perform well, the Warden replaced him with an employee with a recent criminal record⁵, at least three recent disciplinary actions related to use of force incidents⁶, and also no prior experience or training as an investigator. *Id.* at 13. The change of personnel is particularly troubling in that an improving and trained investigator was replaced by a less qualified staff person within weeks of a dispute between the investigator and the

⁵ Criminal background and other reference checks at Swanson were often deficient, leading to the hiring of a number of staff who had been terminated at other juvenile facilities (without exploring why) or who had significant criminal histories. SCCY PH at 14. There have also been questionable hirings and promotions of staff with histories of abusing offenders or obstructing abuse investigations. *Id.* at 16.

⁶ The discipline was for: (1) failure to follow procedures relating to initiating a confrontation with a youth; (2) falsifying an escape charge against an offender arising out of a use of force incident; and (3) filing a false use of force report in an abuse investigation. SCCY PH at 13.

Warden over the results of one of her investigations. See id. at 12-13, 15. In any event, investigations at Swanson continue to be significantly flawed, because investigators fail to interview all relevant witnesses or take adequate steps to resolve conflicting testimony. Id. at 12.

At Jetson, half of recent investigations failed to shed light on what had actually happened, due in large part to investigators' routine failure to re-interview witnesses to resolve conflicting testimony or take other basic steps to uncover untruthful statements. JCCY PH at 13-14. Medical records reveal numerous instances in which medical staff documented allegations of sexual assault without making any referral for investigation or other appropriate action. Id. at 11. Most troubling, Jetson's protocol for handling abuse allegations allows some allegations to be "screened out" prior to investigation based upon an initial cursory review of the complaint by the facility's executive team, in violation of the State's PZT policy. Id.

D. Staffing

A significant factor in the continuing protection from harm problems in these facilities is the inability to recruit, train and maintain an adequate work force of qualified security personnel. At Swanson, for instance, on the closed campus where youth who are very difficult to manage are housed, in each of four dorms one officer oversees 36 youth on the day and night shifts. SCCY PH at 17. At Bridge City, where most dorms house

between 40 and 50 children and only two officers (usually one sergeant and one cadet) are assigned, officers are simply not able to contain the level of juvenile violence. BC PH at 10.

The dangerous staffing pattern is, in part, the result of ongoing staffing shortages and high turnover. For example, at Bridge City, nearly one in five security positions was vacant when we toured and turnover was high. BC PH at 17; see also SCCY PH at 16-17 (ongoing staffing shortages coupled with nearly a 50% turnover rate for security staff).

III. MEDICAL AND MENTAL HEALTH CARE

Two years after our initial tours of the three State-run secure juveniles facilities, there were continuing deficiencies with both medical and mental health services. In some areas, services have worsened. See generally Hudson Swanson Medical and Mental Health Report (hereinafter "SCCY MD") (attached as Exhibit D); McPherson Jetson Medical and Mental Health Report (hereinafter "JCCY MD") (attached as Exhibit E); McPherson Bridge City Medical and Mental Health Report (hereinafter "BC MD") (attached as Exhibit F). Below we describe the many failures of the mental health system.

The consequence of these failures is the imposition and tolerance of severe, preventable suffering, undue restraint, and life-threatening risks of harm. In addition, as discussed below, numerous youth are subject to punishment and prolonged isolation as a result of behaviors arising from untreated mental illness or unaccommodated mental retardation.

A. The Reception and Diagnostic Center

1. *Mental Health Screening and Assessment*

The Reception and Diagnostic Center at Jetson is the gateway through which juveniles must enter prior to placement in any of the four secure care facilities in Louisiana. At the Center, youth are given evaluations and assessments that are intended to identify medical, mental health and educational needs for treatment and facility placement decisions. Thus, the quality of these assessments is critical for assuring youth adequate medical and mental health care, as well as proper educational services.

A minimally adequate psychiatric assessment includes a review of documents, an evaluation of psychiatric history, face-to-face interview with the juvenile, a complete mental status evaluation, a diagnosis with symptoms listed, and treatment recommendations. JCCY MD at 15. Jetson employs a single psychiatrist for eight hours per week to conduct these evaluations for the intake unit and to provide general psychiatric care for the other 550 youth at the facility. As a result, he concedes that he only spends four to eight minutes on each psychiatric evaluation, a period that results in grossly inadequate evaluations. Id. at 16. The psychiatrist frankly stated, "[Y]ou realize you can't do a complete mental status when you have only a few minutes to see patients." Id.

As a result, most of the psychiatric assessments at Jetson do not meet minimal professional standards — they do not include a complete mental status examination, do not list symptoms

meeting the criteria for a given diagnosis, and often lack any definitive diagnosis at all.⁷ JCCY MD at 16. A valid diagnosis is the basis of adequate psychiatric treatment, determining the course of treatment to follow and criteria for determining whether the treatment is having an effect. Louisiana juveniles are often started on a course of medication treatment based on the unsupported and potentially inaccurate diagnosis provided at Jetson. These prescriptions are then continued at other facilities when the youth is transferred, based upon an ill-founded reliance on the Jetson diagnosis, perpetuating substandard care throughout the system. Moreover, mental illness or mental retardation not diagnosed at Jetson is generally also not detected at the other facilities, for the same reason of inadequate psychiatric care, and can lead to situations which pose a danger to the juvenile and the staff. *Id.* at 5.

For example, A.P. arrived at Jetson with a history of receiving services from the Office of Citizens with Developmental Disabilities for his mild mental retardation. He was not, however, identified as mentally retarded at Jetson. In fact, he was not even given individual psychological testing ("individual psychological not indicated" is written in his file). As a result, he has received no treatment or modifications to the facility's programming to accommodate his disability, and has adjusted extremely poorly, even to the point of banging his head

⁷ Instead, many state that the patient "probably" or "might have" a given diagnosis. JCCY MD at 33.

on the wall hard enough to create abrasions. JCCY MD at 20.

The inadequacies of mental health assessments at Jetson are well-known in the other facilities. JCCY MD at 6. The psychologist at Bridge City described the psychological assessments from Jetson as "lacking" and stated that they must be repeated. *Id.* at 16. At Swanson, the Program Manager stated that he does not believe the IQ scores from Jetson are accurate, but he does not retest. SCCY MD at 12-13.

2. Placement

Both of our mental health experts, and two consultants for the State, found that there are a substantial number of juveniles with severe mental illness and mental retardation who do not receive adequate care in the State's secure facilities. JCCY MD at 4; SCCY MD at 4; Childress & Cook, "Report to Mr. Richard Stalder, Secretary Louisiana Department of Public Safety and Corrections" (undated) (Attachment 1 to Exhibit G, Meisel Report on Education) ("Offenders with mental health problems should be housed in a location where proper treatment can take place. They should not be placed at either of the four (4) current training facilities under current existing conditions.").

Although the State has written policies requiring the identification and placement of youth with severe mental illness or mental retardation in more appropriate settings, this almost never actually takes place. Part of the reason is the inadequate screening and assessments at Jetson and the other facilities. JCCY MD at 4. And even where mental health staff recognize that

juveniles are not appropriately placed, our expert found that the State provides no programs to treat the juveniles in the facilities. *Id.* at 6; see also Barry Glick, "Louisiana Department of Public Safety and Corrections: A Preliminary Report of the Juvenile Justice Systems" (May 1998) (hereinafter "Glick Report") at 23.⁸ As a result, these youth languish in secure facilities that cannot provide for their basic mental health care needs. For example:

- S.A. has remained at Jetson many months despite a referral to a setting for persons with developmental disabilities. A Quarterly Education Assessment of S.A. states she has "[v]ery few basic skills abilities and will not acquire them in this setting." JCCY MD at 6.
- L.Lu. remains at Jetson despite the psychiatrist's order that she be placed in a facility for persons with developmental disabilities. *Id.*
- M.E., who has a history of six psychiatric hospitalizations, mild mental retardation, and a psychotic thought disorder, remains at Jetson despite a recommendation by the program manager of the intake unit that he be transferred to a more appropriate facility. *Id.* at 6-7.

B. Mental Health Care

1. *Psychiatric Treatment and Medication Management*

Adequate psychiatric care for serious mental illness requires an accurate diagnosis, professionally acceptable treatment methods, and on-going monitoring of the youth to determine the efficacy of the treatment and possible adverse side effects. If the psychiatrist prescribes medication, many drugs

⁸ Dr. Glick's report is in the record, attached as Exhibit A to Defendants' Response to Reports regarding Conditions at Tallulah Correctional Center for Youth (July 7, 1998).

require pre-administration laboratory testing to assure that using the medication will be safe for the particular patient, and periodic lab work to monitor efficacy and side effects. In all cases, to monitor treatment efficacy and respond to potentially life threatening side effects, the psychiatrist must function as part of a treatment team of medical and other professionals who have knowledge of the youth's progress and behavior in the facility. These basic professional standards are seriously compromised in every facility, to varying degrees, due in part to the insufficient psychiatric coverage and quality assurance supervision provided by the State.

At Swanson, the sole psychiatrist failed to diagnose or treat a broad range of common psychiatric disorders and other mental health conditions, even when such diagnoses were well-documented by previous professionals. SCCY MD at 6. For example, he failed to diagnose or treat many cases of mood disorders (such as major depression and bipolar disorder), any form of developmental disability (such as mental retardation), and any cases of sexual predatory behavior even though many youth at the facility are placed at Swanson for sexual offenses. *Id.* at 6-10. Moreover, when youth arrive at the facility with such diagnosis and prescriptions for medications to treat those disorders, the psychiatrist routinely discontinues the treatment over the telephone without seeing the youth, even when abrupt discontinuation of the medicines is dangerous. *Id.* at 6. At Jetson, diagnoses for youth permanently assigned to the facility

are also inadequate. JCCY MD at 16. For example, the psychiatrist often fails to chart target symptoms for which he is prescribing medications and sometimes prescribes medications not indicated by the patient's diagnosis. JCCY MD at 19.

At all three facilities, staff routinely fail to monitor necessary pre-prescription lab work and routine lab tests while the juvenile is taking the medication to ensure that the medication is being used at therapeutic levels or to conduct testing for side-effects. SCCY MD at 11, 22; JCCY MD at 19-23; BC MD at 12-13. For example, youth receiving medication which can cause abnormal heart functioning do not receive cardiac monitoring. JCCY MD at 20. Also, there was no monitoring for tardive dyskinesia — a potentially irreversible movement disorder — which may be a side effect of medications used to treat psychosis. JCCY MD at 20; SCCY MD at 11; BC MD at 13. Labs required to determine whether the medication is being used at a therapeutic level, or causing serious side effects (such as liver or kidney damage, seizures or heart conditions), are often either not ordered, not conducted, significantly delayed, or not reviewed. Id.

Continuing the risk of medication side effects is only justified if the treatment shows promise of actually addressing target symptoms. Thus, adequate psychiatric care requires monitoring not only of side effects, but also of drug efficacy. Because each facility's contract psychiatrist has limited contact with the patient, he or she must rely upon other staff to convey

critical information about the youth's reaction to, and behavior under, the treatment regime. However, none of the facilities employs the sort of treatment teams necessary to provide this information adequately. SCCY MD at 13; JCCY MD at 19-23; BC MD at 12-24.

These deficiencies often compound to result in inadequate care. For example, A.P. arrived at Jetson with prior diagnoses of attention deficit-hyperactivity disorder (ADHD), conduct disorder, and mild mental retardation made after extensive evaluation by the Jefferson Parish Mental Health Authority. JCCY MD at 20. His file also indicated that he had been receiving services from the Office of Citizens with Developmental Disabilities. However, after a brief examination with Jetson's psychiatrist, A.P. was given the sole diagnosis of major depression with psychotic features, with no mention of his mental retardation or ADHD. Id. Even the treatment for depression, however, was inadequate. He was prescribed valproic acid (an uncommon prescription for depression), a choice that was not justified in psychiatric notes in the file as professional practice requires. Id. Moreover, according to laboratory results, the amount of medication he was receiving was not enough to have any effect (i.e., the medication was at subtherapeutic levels in his blood). Thus, A.P.'s psychiatric care at Jeston exposed him to the risks of the medication (serious side effects, such as impaired liver function) without providing any benefits. Id. In the meantime, A.P. continued to suffer, including making

suicidal gestures, documented repeatedly in his record. Id. And he received no accommodations for his mental retardation that might be necessary for him to derive any benefit from facility programming or to avoid being punished for behaviors (such as not following complex orders) that are caused by his mental disabilities - not willful disobedience. Id.

Finally, at Bridge City and Jetson, the psychiatrists have issued standing orders for psychotropic medications in violation of professional standards. JCCY MD at 19; BC MD at 12. A standing order permits nursing staff to administer medications without consultation with the doctor, and without the doctor evaluating the patient beforehand. At Bridge City, for example, the psychiatrist has written standing orders for the use of Thorazine for "agitation." BC MD at 12. These standing orders amount to uses of drugs for behavioral control and create an unacceptable risk that the medications will be used for the convenience of staff rather than based on medical needs determined by a medically qualified professional. Id.

2. Other Mental Health Treatment

Non-medicinal treatment for mental health problems is also inadequate. As discussed in the staffing section below, psychiatrists and psychologists at the facilities provide very little, if any, psychotherapy or counseling to youth with serious mental health needs. JCCY MD at 23-25, BC MD at 4-8, SCCY MD at 13. To the extent any non-medicinal treatment is provided, it is through ordinary staff counselors who generally are not qualified

to treat serious mental illness. Counseling notes reflected that the counselors do not understand the mental health or mental retardation needs of the juveniles whom they are counseling. In many cases, the possibility of serious mental illness is not recognized by the counselors. "Counseling" services that are provided are generally not linked to the mental illness. JCCY MD at 23; SCCY MD at 14, 17-19; BC MD at 4, 11-12. The lack of mental health treatment for girls on the Delta Structured Treatment Unit at Jetson was particularly egregious because this unit was created for girls with the greatest mental health needs. See JCCY MD at 23.

There are also insufficient and inadequate programs for youth in need of specialized treatment to address developmental disabilities, drug abuse, or sexual perpetration. There is often a waiting list for sexual offender or therapeutic drug treatment groups. See SCCY MD at 18 (waiting list of approximately 20 youth for sexual perpetrators treatment). What treatment is available is generally inadequate. SCCY MD at 12, 16-20; BC MD at 4-8, 11-12; JCCY MD at 4-8, 11-12; see also Glick Report at 24. And there are generally no accommodations that would permit youth with mental retardation or other cognitive disabilities to benefit from what programming is available. JCCY MD at 24.

3. Supervision and Quality Assurance

State administration of mental health care in all the facilities is inadequate. The State has no central mental health authority, provides little or no mental health programming

guidance or resources to the facilities, and engages in insufficient oversight of the quality of care provided. The psychiatrists in all three State facilities provide little or no supervision of or training for mental health staff and engage in no quality assurance activities. SCCY MD at 13-15, 21, 22; BC MD at 13-14; JCCY MD at 8, 32. At Jetson, the mental health authority (a psychologist) expressed confusion about his role as a mental health authority. JCCY MD at 31. At Bridge City, the mental health authority (a social worker) was unfamiliar with current mental health treatment interventions or literature regarding seriously disturbed youth. BC MD at 13. Moreover, none of the facilities have any formal quality assurance mechanisms in place. JCCY MD at 31; BC MD at 13; SCCY MD at 22.

4. Staffing

Our experts found that mental health staffing in all three State facilities was insufficient to render adequate services. With respect to psychiatric staffing, at Swanson the psychiatrist is contracted for only 12 hours per month. SCCY MD at 6. At Bridge City, the psychiatrist is only contracted for 4 to 6 hours per week. BC MD at 14. Jetson only employs a psychiatrist for 8 hours per week which is grossly insufficient in light of the responsibilities of the psychiatrist to assess the mental health needs of all juveniles entering the system through the reception and diagnostic process as well to treat the mental health problems of the more than 500 juveniles placed in Jetson's long-term program. JCCY MD at 16, 31-32.

5. Isolation, Discipline and Behavior Management

Systemic use of excessively prolonged isolation as a punitive measure continues to cause harm to juveniles in most of the facilities. Our experts also found that isolation is often used as a substitute for adequate mental health treatment. JCCY MD at 31; SCCY MD 15, 19-22.

As explained by our mental health experts, and the State's own juvenile corrections consultant, the prolonged use of isolation is generally counterproductive (making youth more angry and volatile, not less) and psychologically harmful (creating a heightened risk of depression, self-mutilation and suicide). JCCY MD at 26; SCCY MD at 19-21; BC MD at 9; Glick Report at 16-20. These risks are particularly profound for youth with mental illness. JCCY MD at 26; SCCY MD at 19-21; BC MD at 9.

In the State's facilities, isolation is used variously as a long-term punishment, a misguided attempt at behavioral control, suicide watch, protective custody, or as a place where a juvenile can recuperate from serious injuries. For instance, for a seven-day period in May 1998, almost one-fifth of the youth at Swanson spent time in isolation. SCCY PH at 8. These periods of isolation are often prolonged, sometimes lasting weeks or even months. SCCY PH at 9; JCCY PH at 17.

The State's failure to develop adequate behavior management systems in the facilities contributes to the excessive use of isolation. While Jetson and Swanson have taken some steps to reward youth who avoid disciplinary tickets (such as instituting

honor dorms and special privileges), more intensive behavior management practices are required to address the behavior of youth who are unlikely to respond to such incentives and who are likely, otherwise, to be consigned to prolonged and harmful isolation units. JCCY MD at 23; see Glick Report at 14-15.

This includes youth with mental illness and cognitive impairments, who make up a disproportionate share of the youth subject to isolation. SCCY PH at 9; BC PH at 10-11; Glick Report at 23. To illustrate, on May 1, 1998, Swanson held in isolation only five youth with IQs above 90, compared to eleven youth with IQs of 70 or below. SCCY PH at 9. These youth often have other mental health problems as well. For example, our expert met P.C. in Swanson's segregation unit. P.C. is mentally retarded and had been in isolation on protective custody for two weeks at the time, leaving his cell for only 30 minutes per day for recreation. P.C.'s voice was hoarse because, he said, he "screamed a lot" while in isolation. SCCY MD at 20.

At all the State-run facilities, correctional staff are inadequately trained to understand and interact with adolescents, especially those with mental illness or mental retardation. JCCY MD at 32, BC MD at 14, SCCY MD at 14-15. Generally, correctional staff did not even know which juveniles under their care were mentally ill or mentally retarded. SCCY MD at 14; JCCY MD at 32. The lack of training of correctional staff routinely results in juveniles being subject to inappropriate disciplinary measures instead of therapeutic interventions. For instance, at Jetson,

Dr. McPherson found that the facility continues to isolate juveniles for behaviors that its staff does not recognize as mental illness and does not treat adequately. JCCY MD at 31.

6. Suicide Prevention and Suicide Hazards

In every one of the facilities, suicide prevention measures are inadequate. SCCY MD at 15; BC MD at 8-10; JCCY MD at 25-31. The facilities continue to expose youth on suicide watch to serious suicide hazards, despite warnings about these hazards in the United States' letters and consultant reports sent to the Governor more than a year ago. Because youth are not often monitored adequately while on suicide watch, youth can and, in fact, do engage in self-harming activities presented by their unsafe environments. For example, at Jetson, the isolation cells (where youth on suicide watch are housed) have sharp metal plates and glass windows which have repeatedly been used by youth as weapons to harm themselves. JCCY MD at 28. At Bridge City, there were many safety hazards in the infirmary, where juveniles on suicide watch are held (e.g. exposed light bulbs, exposed electrical sockets, bathrooms with locks on the inside), and numerous other hazards in the facility, including time-out rooms with hanging hazards and sharp metal window frames and vents. BC PH at 12-15.

C. Medical and Dental Care

We did not undertake a full review of all aspects of the medical and dental services on these most recent tours; however, our experts' review of critical areas uncovered a number of

significant problems.

1. Assessment and Referral of Medical Problems

The foundation of an adequate medical system is the ability of medical staff⁹ to become aware of, and properly respond to, medical problems. Youth entering the system receive physical examinations at Jetson, including laboratory work, that can identify youth at risk for diabetes, seizures, heart conditions, and other serious medical conditions. It is critical that initial assessments and laboratory results are reviewed, problems identified, and appropriate treatment or monitoring is undertaken. It is also critical that when youth report medical problems, they are evaluated promptly by qualified medical personnel who take appropriate action, including referral to a physician when needed. Our experts found problems, to varying degrees, in all of these areas at all of the institutions.

In every facility, staff fail to review laboratory results adequately and, as a result, miss indicators of potentially serious medical conditions, such as anemia and diabetes. JCCY MD at 9; SCCY MD at 22; BC MD at 16. Even when such chronic conditions are diagnosed, staff at Bridge City and Jetson fail to monitor those chronic conditions adequately. BC MD at 18; JCCY MD at 9. Dr. McPherson noted particularly deficient monitoring

⁹ It is important that medical, not correctional, staff be the gatekeepers to medical services. At the time of our tours, correctional staff at Bridge City controlled access to medical care, although our expert was told a sick call slip system monitored by medical staff was under development. BC MD at 16.

and care for seizure disorders, a potentially life-threatening problem. BC MD at 18-19; JCCY MD at 11-12.

When medical problems are presented, nursing staff must adequately document the treatment provided and appropriately traige cases for referral to the physician. These basic features of adequate care were so dangerously substandard at Jetson that our expert concluded that medical services at Jetson were in a state of emergency.¹⁰ The nursing staff routinely failed to diagnose serious medical conditions, failed to make any nursing notes that might give the physician the information needed to make the diagnoses, and failed to refer very serious medical problems to the doctor.

To illustrate, F.B. suffered a "diabetic emergency" on April 16. If she was seen by nurses, they made no notations in her chart and no referral to the physician. There was a notation by nurses three days later, but again no referral to the physician. On April 20, F.B. suffered another diabetic emergency. The incident report describes her condition as "arm trembling, crying and grunting, eyes rolling back in head." Yet, again, there is no indication in her chart that she was seen by the nursing staff and, again, no referral to the physician. She was not seen by the doctor until more than a week later, whereupon he immediately referred her for treatment at a hospital endocrinology clinic.

¹⁰ We immediately informed the State of this finding and provided recommendations for immediate action to address the situation. The State implemented some of our recommendations. JCCY MD at 2.

JCCY MD at 9. Examples of such serious, potentially life-threatening failures to provide adequate medical care abound at Jetson and Bridge City. JCCY MD at 9-11; BC MD at 16-19.

2. Quality Assurance

Problems such as the ones discussed above should have been identified and addressed by each facility's medical quality assurance program and by State oversight of the medical services offered in its facilities. They were not, quite simply, because the State's oversight is insufficient and the facilities lack even rudimentary quality assurance processes. The State has no medical director, issues no system-wide medical regulations, and engages in no quality assurance activities to monitor the quality of medical care in the facilities. Nor do the individual facilities engage in standard quality assurance practices to detect and respond to problems before youth are seriously at risk of harm. SCCY MD at 22; BC MD at 20; JCCY MD at 13.

3. Staffing, Staff Training, and Administration

Swanson does not have 24-hour nursing, even though its infirmary often houses many juveniles overnight (watched by emergency medical technicians) and serves a population of 440 youth. SCCY MD at 21. Jetson's and Bridge City's physicians are employed for too few hours, given the population and needs of the juveniles, and both facilities provide insufficient nursing coverage. JCCY MD at 14; BC MD at 20.

4. Infirmaries

The infirmaries at all three facilities were also deficient

in varying degrees. All three are too small for the current populations and contained many safety hazards, generally due to deterioration of the physical plants. JCCY MD at 13; BC MD at 19. Fights often break out in the overcrowded Jetson waiting room; water leaks into the clinic at Swanson from the "condemned" and abandoned second floor above the infirmary; and patients who may be on suicide watch in the Bridge City infirmary have access to exposed wires. JCCY MD at 13; SCCY MD at 22; BC MD at 19. At Swanson, staff lock juveniles recuperating in the infirmary in cells that are identical to (and formerly served as) isolation cells. These convalescents spend 23 hours a day locked in their cells, sometimes for weeks, as they recover from injuries. SCCY MD at 22; SCCY PH at 5.

5. Dental Care

The extent of available dental care varied from facility to facility. Periodic dental examinations are not provided at Swanson (except in the rare event where a youth takes the initiative to put himself on sick call for a dental examination), even though juveniles may be in the system for a number of years and may develop dental problems that could have been detected by such exams before extractions become necessary or other permanent damage occurs. SCCY MD at 22-23. The dentist at Jetson reports that his contract of eight hours per week for more than 600 youth would be sufficient if he had a dental assistant. Jetson does not have one. JCCY MD at 14. Dental care at Bridge City is sometimes delayed or postponed indefinitely pending the youth's

release in cases where the delay may cause permanent damage or unnecessary loss of teeth. BC MD at 20-21.

IV. EDUCATION

Meeting the educational needs of youth in juvenile facilities is critical to reducing recidivism and fulfilling the purpose for which youth are committed to these facilities. See, e.g., Meisel Education Report (hereinafter "ED") (attached as Exhibit G) at 2;¹¹ Consultants' Report at 1-2. As we and our experts were repeatedly told by teachers in the facilities, academic instruction of youth in juvenile institutions is a significant challenge — many youth function at elementary levels of academic achievement or are functionally illiterate¹², many have learning disabilities, and many have behavioral problems that can interfere with their own learning and the instruction of their classmates. Overcoming these challenges requires skilled, well-trained, and well-supported teachers who can give youth

¹¹ Attached to Dr. Meisel's report are four reports prepared for the State by outside education consultants and DPSC employees: "Report to Mr. Richard Stalder, Secretary Louisiana Department of Public Safety and Corrections" by consultants Childress and Cook (undated) (Attachment 1 to ED) (hereinafter "Consultants' Report"); Committee on Physical Space and School Maintenance Report (January 30, 1998) (Attachment 2 to ED) (hereinafter "Physical Space Report"); Education Reform Team Report (February 2, 1998) (Attachment 3 to ED) (hereinafter "Ed. Reform Report"); Education Committee Report on Vocational Plan (May 28, 1998) (attached as Attachment 4 to ED) (hereinafter "Voc. Ed. Report").

¹² One principal estimated, for example, that 70% of the students were three or more years below grade level in reading and mathematics. ED at 5. Numerous youth test in the elementary reading and math levels. See, e.g., id. at 14-17 (case studies).

individualized attention within the context of a curriculum that addresses the specific academic needs of youth in such institutions.

Moreover, the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1401 et seq., imposes additional obligations upon the State to identify and provide special education services to youth with qualifying disabilities in order to assure that these youth are able to obtain an education despite the additional challenge posed by their disabilities.¹³

While there have been some improvements in education in the State facilities — the most significant of which is a commitment to extend the school day for most youth in the facilities — our investigation found that the State continues to fail to provide sufficient numbers of adequately qualified teachers, fails to provide the necessary support for the teachers employed, and fails to comply with the mandates of the IDEA.

A. Regular and Vocational Education

1. *Staffing*

As has been pointed out by the State's own consultants and administrators, the facilities' ability to hire and retain sufficient numbers of qualified teachers is hampered by uncompetitive salaries. See Consultants' Report at 3; Voc. Ed. Report at 3. Regular education teachers earn \$5,000 - \$10,000

¹³ Approximately 25% of youth in the State facilities have been determined to qualify for special education services. ED at 13. As explained below, this figure is an underestimate of the number of youth in the facilities who qualify for such services.

per year less than they could in the surrounding community schools¹⁴. Moreover, staffing shortages are exacerbated by the State's failure to provide for substitute teachers, a problem the State's consultants and administrators have also acknowledged. ED at 6; Consultants' Report at 5; Ed. Reform Report at 1, 3, 4.

The insufficient number of teachers contributes to overcrowded classrooms. For example, the State's internal reports indicate that the student-to-teacher ratios at Bridge City is 22:1 and recommended a maximum of 15:1. Physical Space Report at 3; Consultants' Report at 5. This crowding is particularly troublesome in a correctional setting where youth have significantly greater educational needs than in a public school classroom; where the classes contain significant numbers of special education students who must receive individualized accommodations from the teacher; and where the school system often fails to place youth in classes according to academic ability, resulting in large classes containing students with widely varying degrees of academic achievement.

2. *Classroom Space*

The overcrowding is also caused by a shortage of classroom space, which imposes an impediment to implementing a full school day of instruction, as the State's own personnel and consultants

¹⁴ Special Education teachers employed by the State's Special School District Number 1 (SSD#1) are paid according to the rates in the surrounding community and can earn \$15,000 - \$20,000 more than their regular education colleagues. ED at 6 n.15. The State's own consultants were "appalled" that DPSC instructors received so much less. Consultants' Report at 3.

have acknowledged. See Consultants' Report at 5; Physical Space Report. The State's Physical Space Committee concluded that additional space is needed at all the schools, and that in the long term, four new modern school buildings should be constructed to replace the current facilities. Physical Space Report at 3, 5, 7, 9.

3. *Amount of Instruction*

In a positive development, the State recently revised its policies to require State facilities to provide at least 330 minutes of instruction per day for most students. As discussed in Dr. Meisel's report, significant numbers of students are still excluded from or given reduced instruction on a regular basis, including youth in higher security units (such as the closed campus at Swanson), youth in administrative segregation, and youth on protective custody or suicide watch. ED at 7. For example, there are youth in protective custody at Swanson who have not received educational services in months. Id.

The amount of instruction is reduced at all facilities, for all youth, by numerous logistical problems in coordination between education and security staff; youth being placed on work details when they are scheduled for school; and teachers who end instruction significantly before the end of the class period on a regular basis. For example, we conducted a random audit of class attendance during one period at Bridge City and found that 43 youth were absent from class, most of whom were out working on job details for the facility. ED at 8.

4. *Class Placement*

Even if students are placed in less crowded classrooms with better qualified teachers for more time, they would be unlikely to benefit from education if the instruction is at a level significantly above or below their academic abilities. Our expert found that educational testing, conducted at the Jetson intake unit, often yields unreliable results that lead to inappropriate class assignments which are corrected only after long and unnecessary delays. ED at 9.

5. *Curriculum and Instruction*

Although we met a number of teachers who provided quality instruction in the face of formidable systemic obstacles, far more commonly, teachers are unable to provide even minimally adequate instruction to youth due to lack of adequate training, curricula, and teaching materials. ED at 10. The State's education consultants concluded that the system needs "a totally new and updated curriculum." Consultants' Report at 6. In general, youth are given worksheets and asked to work on their own at assignments at their desks, with little instruction or assistance from the teachers. ED at 10. Our expert found that this mode of instruction is particularly unproductive with students in a correctional setting who have often shown themselves to be unlikely to know when they need assistance, have a hard time keeping on task, or fail to learn independently. Moreover, the boredom and frustration created by this mode of instruction often leads to classroom disruptions. Moreover, the

schools often lack appropriate instructional materials in sufficient quantities to provide adequate education. *Id.* at 10.

6. *Behavior Management*

Teachers throughout the system complained to us about difficulties they were having maintaining order in their classrooms. Dr. Meisel found that the schools have not developed programs to address behavior management productively in the classroom, even though a wide range of effective strategies are available to reduce disruptive behavior, de-escalate conflicts, and encourage active learning. ED at 11. The State's failure to address behavior management in the classrooms is particularly significant for youth who have been identified as in need of such classroom accommodations under the IDEA.

7. *Vocational Education*

As the State's own consultants and staff have emphasized, vocational education is a critical component of any program that seeks to reduce recidivism and accomplish the rehabilitative purposes of commitment. *See* ED at 25; Voc. Ed. Report at 3; Consultants' Report at 4. Yet, as shown below, vocational training is severely limited in the State facilities:

Facility	Number of Youth Served in Vocational Program	Number of Youth Housed at Facility	Percentage of Youth Receiving Vocational Education
Bridge City	0	180	0%
Jetson	180	660	27%
Swanson	70	440	16%

Source: ED at 23.

The small number of youth who are enrolled in vocational classes often derive only minimal benefits from these classes due to a severe shortage of space, equipment and materials, and quality instruction.¹⁵ ED at 23-24; see also Voc. Ed. Report at 2-3.

Furthermore, the rationing of the limited services available is discriminatory. Girls are not permitted to attend classes in the vocational shops (where the equipment is kept) at Jetson and, as a result, their classes often resemble more "arts and crafts" (as one instructor put it) than vocational education. ED at 24. Moreover, Swanson limits enrollment to youth who have tested at the seventh grade level in reading, thereby excluding the majority of students at the facility, including the vast majority of youth who qualify as disabled under the IDEA. This requirement is not related to any legitimate prerequisite for taking advantage of vocational education — as Dr. Meisel points out, youth who read below the seventh grade level, including learning disabled and mentally retarded students, routinely participate in and benefit from vocational education in other correctional facilities and public school settings. ED at 24.

B. Special Education

Youth in juvenile facilities are also guaranteed rights

¹⁵ As with other teachers, vocational instructors' salaries are not competitive. One program coordinator told Dr. Meisel: "I can't hire certified qualified instructors — they take a tremendous cut in pay to come here as compared to the community." ED at 23 n.44.

under the Individuals with Disabilities Education Act. The Act requires the State to screen, identify, and evaluate youth who may be eligible for services under the Act; create and implement Individualized Education Plans (IEPs) for each eligible youth; and provide related services (such as individualized and family counseling) and transition services.¹⁶ Throughout the State system, these requirements are routinely violated.

1. Screening, Identification and Evaluation

Under the IDEA, the State must make adequate attempts to identify youth qualifying for special education services. The procedures employed by SSD#1 to identify special education-qualified youth are seriously flawed, succeeding in identifying some students (usually those with active IEPs in the community), but failing to identify or evaluate many whose records and diagnostic evaluations from Jetson, or performance in the facilities' schools, clearly identify them as potentially eligible. As Dr. Meisel demonstrates in her report, there are youth in every facility who were identified at Jetson as potentially eligible for special education (in fact, "refer to SSD#1" is often written on the case file cover) who are either never evaluated or who are given delayed and grossly inadequate evaluations. ED at 12.

¹⁶ See 20 U.S.C. § 1401 *et seq.*; 35 CFR Part 300. The responsibility for administration of special education services is delegated to the Special School District Number 1 (SSD#1), which employs its own cadre of special education teachers and operates semi-independently. ED at 3.

For example, G.S., who is visually impaired (he is blind in one eye and significantly impaired in the other) attended school in the State's facilities for almost a year before he was scheduled for an evaluation for special education eligibility. In the meantime, he spent 11 months squinting at chalk boards and holding books centimeters from his one functioning eye in a valiant attempt to receive at least some benefit from school. ED at 14-15.

Numerous other students are identified at intake as likely to be mentally retarded, with low educational achievement scores and reporting a history of special education, yet wait months (sometimes almost their entire period of incarceration) before they are even evaluated. For example, Z.R. received an estimated IQ of 55 (in the mildly mentally retarded range) at Jetson; scored in the kindergarten reading level and second grade math level at age 15; reported that he had been enrolled in special education classes in the community; and was referred to SSD#1 by the Jetson intake unit in December 1997. ED at 15. At the time of our tours, four months later, he had still not been evaluated. Id.

Not surprisingly, the proportion of youth receiving special education services in the States' facilities is lower than even very conservative estimates of the national prevalence rates. See ED at 13 (finding an identification rate of about 25% in Louisiana facilities, compared to estimates in the professional literature of prevalence rates of 30 - 70% in juvenile

facilities).

2. *Individualized Education Programs*

The foundation of the special education process is the development and implementation of an Individualized Education Program (IEP) for each qualified youth. The IEP must identify the services to be provided to the youth. Importantly, those services must be tailored to the individualized needs of the student, not to the resource constraints of the institution.

Facilities in Louisiana routinely fail to comply with most of the statutory and regulatory requirements. Most glaring is the limited and uniform nature of services offered, under which all youth receive essentially the same level of services based on the resource constraints of the facility, rather than the individual needs of the youth. ED at 20. Thus, youth who had been receiving widely varying levels of special education services in the community, all receive essentially the same level of services in State facilities, usually a level that is significantly less than they were receiving in the public schools. Thus, for instance, youth whom professionals in the community had determined required 330 minutes of special education per day routinely receive no more than 120 minutes (or, more often, 60 minutes) in the juvenile facilities. Id.

As a result, special education students spend most of their time in the general education program with one or two periods of special education resource class time. The IEPs generally state that the youth is to receive special accommodations in the

general class. However, we found that youth uniformly did not receive such accommodations and that, in fact, all too often, the general education teacher did not even know which students in the class had IEPs, much less what those IEPs required. ED at 10. Moreover, the general education teachers have little, if any, training in the provision of such accommodations. *Id.*

Other IDEA requirements are routinely violated. When IEP meetings are held, few efforts are made to comply with the requirement to include parents or obtain parent surrogates. ED at 21. The IEPs also frequently fail to specify measurable short-term objectives and tend to be generic.

3. *Staffing and Resources*

The reduced level of special educational services is undoubtedly related to the lack of sufficient numbers of qualified special education teachers. At Swanson, a State committee found that three special education teachers serve 81 students in the closed program. Physical Space Report at 7. One special education teacher at the facility told Dr. Meisel that she was not able to provide even the limited 60-minutes-per-day of services required under the reduced IEPs created at the facility (she was providing 30-40 minutes), given her large caseload. ED at 18. The facilities also lack sufficient staff to provide special education services to youth in administrative segregation, protective custody, and on suicide watch.

Thus, the State fails to provide all of the very limited services promised in the IEPs of the students it actually

identifies as eligible for special education. If the screening and identification processes were improved, and if IEPs provided for the full range of services required to meet students' individualized needs, the need for additional special education staff would be even greater.

4. *Related and Transition Services*

Among other things, the IEP must include "related services," such as individual or family counseling, that are required to assist a child with a disability to benefit from special education. For children sixteen years-old or older (and younger children when appropriate), the IEP must also provide for services to aid the child in the transition from school to post-school activities, such as vocational training or instruction in independent living. ED at 22.

Despite the obvious need for related services — such as, for example, psychological counseling for youth whose learning disabilities cause behavioral problems that result in frequent removal from the classrooms — such services generally are not considered in the IEP process or are not provided to the students as part of the special education process. Some youth in the facilities with obvious impairments that interfere with their education (such as speech impediments) are not given appropriate related services. ED at 20-21. Moreover, individual counseling for behavior problems in school is generally not provided at all, even though the State has identified a large percentage of the youth in special education as having behavior problems and even

though teachers identify maintaining classroom order as a primary challenge. Instead, when counseling is mentioned at all in an IEP, it is listed as a related service in the amount offered to every youth at the facility by the general counseling staff. Yet, the counselors are not a part of the IEP team meetings and are generally unaware of the contents of the IEP, much less the counseling-related goals in the IEP. ED at 20. Such services do not constitute "related services" within the meaning of the IDEA. This failure has real and serious consequences — without adequate related services for behavior problems, many disabled youth spend substantial periods in isolation or administrative segregation units where they generally receive little, if any, education or special education services. ED at 21.

Finally, while IEPs formally contain a check-off list of transition services, in reality, there is no evidence that these are provided. ED at 22.¹⁷

In sum, special education services at the State's secure juvenile facilities fail to comply with federal requirements and do not provide students with the benefits of the free, appropriate public education to which they are entitled.

V. CONCLUSION

Based upon our recent tours of the three State-run secure juvenile facilities, as well as our recent tour of Tallulah, the

¹⁷ SSD#1 does not employ transition teachers, although public schools in the State employ such teachers to implement IDEA requirements. ED at 22.

United States has identified continuing serious systemic deficiencies throughout the system. We look forward to discussions concerning remedial measures to address these systemic deficiencies at the status conference on August 10, 1998.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF LOUISIANA

HAYES WILLIAMS, <u>et al</u> ,	)	
	)	
Plaintiffs,	)	Civil No. 71-98-B
	)	
v.	)	
	)	
JOHN MCKEITHEN, <u>et al</u> ,	)	
	)	
Defendants,	)	
	)	
UNITED STATES OF AMERICA,	)	
	)	
<i>Amicus Curiae.</i>	)	
	)	
	)	
IN RE: TALLULAH CORRECTIONAL	)	Civil No. CH 97-0665-B-M1
CENTER FOR YOUTH	)	
	)	
IN RE: JETSON CORRECTIONAL	)	Civil No. CH 97-0666-B-M1
CENTER FOR YOUTH	)	
	)	
IN RE: SWANSON CORRECTIONAL	)	Civil No. CH 97-0667-B-M1
CENTER FOR YOUTH	)	
	)	
IN RE: LOUISIANA TRAINING	)	Civil No. CH 97-0668-B-M1
INSTITUTE - BRIDGE CITY	)	
	)	

CERTIFICATE

I hereby certify that copies of the foregoing have this day
been mailed by first class mail, postage prepaid, to the
following:

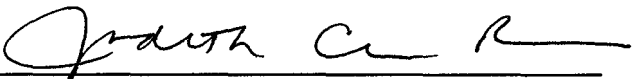
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Washington, D.C., this 6th day of August 1998.



JUDITH C. PRESTON
Trial Attorney

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

NOTICE OF DOCUMENTS NOT FILED IN RECORD

CIVIL/CRIMINAL NO. 97-665

TPRE: TCCY
VERSUS

ATTACHMENTS TO Response of the U.S. to 3/4/98 order
FILED ON 8/7/98 IN THE ABOVE CAPTIONED CASE HAVE BEEN
PLACED BEHIND THE RECORD.

Heldine Johnson
DEPUTY CLERK



3:97-cv-00665 326 - 1

DATE: 08/07/98

DEPUTY CLERK: HJ

**A Review of Jetson Correctional Center for Youth
Baton Rouge, Louisiana
March 31 - April 2, 1998**

**Prepared by
Nancy K. Ray, Ed.D.**

**For the Civil Rights Division
of the United States Department of Justice**

EXHIBIT A

Jetson CCY Review
March 1998

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Jetson CCY Review
March 1998

Executive Summary

This review of the Jetson Correctional Center for Youth (CCY) was conducted at the request of the Civil Rights Division of the United States Department of Justice. I was asked to assess the facility's ability to provide a safe and secure environment for youthful offenders, with special attention to protections from injuries due to offender-to-offender violence and officer-to-offender abuse, mistreatment, and neglect. Of note, this was my third review of Jetson CCY. I had conducted prior reviews of the facility in June and December 1996.

During the review, I visited many residential dormitories of the facility, reviewed use-of-force, accident, and special investigation reports, observed offenders in the on-campus school and interviewed youth, program and security staff, and most key administrators and clinical/program supervisors at the facility. Mr. John Whitley, the Court's Monitor, also accompanied me on my entire review of the facility. [See Report pp.1 for more detail on the review's methods.]

As during my previous visits to Jetson CCY -- I was impressed by the commitment and energy of its administrative team and the discipline and sense of purpose of its security and program staff. These personnel had a clear sense of mission, a planned short- and long-term strategy to achieve it, and an executive leadership capacity which was evident not only to outside observers, but also to youth and staff. The many accomplishments which the Jetson CCY team had achieved since my visit to the facility only 15 months earlier were concrete testimony to these attributes. These accomplishments are briefly listed here. Readers are directed to Report pp. 2-6 for a more extensive discussion.

- **Lengthened School Program:** Jetson CCY has implemented a lengthened school program for most children
- **High School Equivalency Diplomas:** Jetson's renewed emphasis on academic achievement has also reaped concrete rewards for offenders in terms of the increasing numbers of children receiving their high school equivalency diplomas. During 1998, the facility expects to award more than 100 diplomas, which reflects a 40% increase over the number awarded in 1996.
- **On-Campus College Courses:** Jetson has further rewarded older children who have achieved their high school equivalency diploma by offering on-campus college level math and English courses two evenings a week. Presently, 18 youth are participating in these programs.
- **Enhancing Family Support:** Jetson's administration has also recognized that for most of its offenders, renewing and strengthening family ties will be critical to their successful discharge. Family visiting has been increased from monthly to weekly -- and attractive gazebos have been built in the courtyards to promote comfortable and private visiting areas.
- **Work Opportunities:** All 59 of Jetson's youth who have earned their high school equivalency diplomas now participate in full-day work programs.

Jetson CCY Review
March 1998

- ❑ **Reforms in Segregated Isolation:** Jetson has revised its policy for the use of segregated isolation. This policy now directs that this intervention is only to be used as a last resort and for the briefest period possible.
 - ❑ **Rewards for Positive Accomplishments, including No Violence:** Jetson CCY's administration also recognized early that youth would respond more quickly to positive incentives for good behavior than punishment as a deterrent for bad behaviors and violence. Thus, in the past 15-months, a series of incentive programs, meaningful to incarcerated youth, have been instituted. These have included, among others: honor dormitories for girls and boys, a special on-campus bicycle riding program for offenders who go without disciplinary tickets for a full month, barbecue privileges with visiting families, and increased canteen privileges.
 - ❑ **Program Reforms in Services to Adolescent Girls:** A new director had been hired to oversee the girls' section of the facility. This mature woman has a strong background in services to young girls -- and fully appreciates that need to balance fair and predictable standards for behavior and accomplishments with an appreciation that the traumatic histories of many of the girls can spur acting-out and attention-seeking behaviors which require a carefully measured and disciplined response by both security and program staff. Girls residing in the facility's special dorms for children with mental disabilities now also attend a lengthened school day.
 - ❑ **Project Zero Tolerance Initiatives:** Jetson had also instituted a number of specific PZT reforms which have had a direct impact on the children's safety and protection. These include enhanced PZT rounds by case managers and administrators; a comprehensive tracking report of all PZT investigations, and a fencing program which has allowed youth to spend more time outside in constructive sports programs and other leisure activities. The Warden has also greatly restricted the use of pepper spray and handcuffs at the facility.
 - ❑ **Additional Infirmary Staffing :** The facility has provided increased physician staffing, as well as four additional nurses, and two additional medical records clerks. Despite these additions, and as confirmed by the Department of Justice's medical expert, medical staffing remains inadequate.
- Despite this impressive list of accomplishments -- this review also revealed several problem areas at Jetson CCY which require administrative attention and correction.
- ❑ **Problems in the Campus Infirmary**
- Clearly the most serious of these problem areas were in the management and direction of the facility's Infirmary. These problems included substantial departures from professional standards in the delivery of basic medical care services, serious problems in medication administration and accountability of prescription drug inventories, critical deficiencies in the maintenance of medical records, and other specific management issues which seriously compromised the facility's Project Zero Tolerance initiatives. [See Report pp. 7- 12 for more detail]

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□ **Limitations of Project Zero Tolerance (PZT) Activities**

Although Jetson CCY administrators had achieved full compliance with many PZT activities, some areas of significant non-compliance were also noted. Most seriously, the large proportion of special investigations which result in no clear determination of what actually occurred is troubling and reflects a pattern of both some youth and some staff regularly being less than fully truthful in their testimony to special investigators. It will be important for facility administrators to immediately take steps, including those offered in this report, to address this problem. If left unaddressed, this pattern of both youth and staff not being fully truthful will have a profound adverse effect on the integrity of the facility's special investigations. Problems were also noted in the facility's procedures for ensuring that all reported allegations of youth abuse are referred for special investigations. [See Report pp. 13-15 for more detail.]

Record reviews surfaced a number of other serious adverse incidents, including sexual assaults on offenders by other offenders, serious offender injuries (e.g. fractured jaws, noses, serious lacerations), and other serious injuries of suspicious reported cause (i.e. an offender who reported that he had fractured his jaw falling out of a chair) which warranted more thorough investigations than they had received.

□ **Needed Improvements in the Treatment of Mentally Disabled Youth**

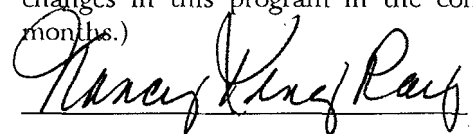
Jetson CCY had made several improvements in its services and programs for mentally disabled youth, but in several key areas these services substantially departed from accepted professional

standards. [See Report pp. 17 for more detail.]

❖ The allowance of only four hours weekly of a psychiatrist services is plainly not adequate to provide all of the assessment services for Jetson's Reception and Diagnostic Center and the over 100 long-term youth placed at Jetson with serious mental health problems.

❖ The ongoing practice of co-treating youth on suicidal/self-injury precautions with youth being disciplined for willful disobedience also substantially departs from accepted clinical standards. Equally unacceptable was the practice of providing all supervision of these children by security officers who had little, if any, formal psychiatric training. As a result, suicidal and self injurious youth were left alone, in cells with suicide hazards to inflict harm on themselves.

❖ Current mental health services and programming for girls confined to the Delta A and B also substantially departs from accepted professional standards for the treatment of children with serious mental disabilities. In particular the continued long-term confinement of these girls in locked isolated segregation cells much of the late afternoons, evenings, and all nights without recent assessments of their dangerousness and in the absence of significant less restrictive treatment is problematic. (Of note, Jetson CCY administrators have already targeted this problem and plan to make significant changes in this program in the coming months.)



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Introduction

This review of the Jetson Correctional Center for Youth (CCY) was conducted at the request of the Civil Rights Division of the United States Department of Justice. I was asked to assess the facility's ability to provide a safe and secure environment for youthful offenders, with special attention to protections from injuries due to offender-to-offender violence and officer-to-offender abuse, mistreatment, and neglect. Mr. John Whitley, the Court Monitor, accompanied me on my entire tour of Jetson CCY. His assistance was much appreciated -- as he was able to offer valuable commentary on our observations.

I conducted this review by visiting the facility (March 31 - April 2, 1998), interviewing staff and offenders, and reviewing numerous documents. In total, I visited seven residential dormitories, including Alpha, Delta A, Delta B, Delta C, Pinecrest, and Evergreen, as well as the on-campus school. I also spent considerable time in the facility's Infirmary observing the routine delivery of medical services to children and reviewing sick call logs, emergency medical requests, and medication administration records. I also carefully reviewed the medical records of more than one dozen children who had recently been seriously injured. I also reviewed 19 special investigations of allegations of officer abuse completed in February/March 1998. In addition, I also reviewed security logs and segregation orders in the segregation areas for the boys and girls.

In addition to informal interviews with offenders and program, security, and nursing staff, I conducted more in-depth structured interviews with a number of facility administrators and program staff. I interviewed Warden Elijah Lewis, the Assistant Warden for Security, the Assistant Warden for Program Services, the Director of Nursing, the Personnel Director, the lead special investigator, and the Director of the CCY's Reception Center. In addition, I interviewed key program staff including the Principal of the facility's school, the Pharmacist, the Director of Psychology Services, and the Major responsible for services for the girls units of the facility.

It is also relevant to note that this was not my first visit to Jetson CCY for the U.S. Department of Justice. I had made prior visits to Jetson CCY in June 1996 and in December 1996. The focus of the December visit was to assess Jetson CCY's progress in implementing the Louisiana's Department of Corrections' Project Zero Tolerance (PZT) initiative. My observations during both of these prior visits indicated that the then 'new' administration of the facility headed by Warden Lewis was energized and determined to turn the facility around, ridding it of abuse and neglect of offenders and creating a rehabilitative setting for its youthful offenders. As reflected in this report, during my recent third visit, I noted that many of the planned initiatives of the administration had been translated into positive accomplishments and the changed atmosphere at the facility -- despite some ongoing areas of continued problems -- was remarkable.

Positive Observations

During this visit, I noted continuing improvements at Jetson CCY. Indeed, it was striking that so many of the ambitious plans articulated by the Jetson administration at the time of my prior visit (December 1996) had now been accomplished. Staff at all levels -- from administrators to case managers to front-line security staff -- all spoke with pride at the facility's many accomplishments in the past 15 months. Equally noteworthy were the children's many positive comments. Most important, however, in the three days of touring Jetson CCY, I was impressed by the overall sense of purposefulness in the conduct of both children and staff. Like all large institutional settings, Jetson CCY continues to experience periodic episodes of violence and situations where children and staff did not demonstrate optimal performance, but the overall atmosphere of orderliness and purpose was unmistakable.

The listing of programmatic and protective accomplishments at Jetson CCY since my prior visit speaks most clearly of the infrastructure which has allowed this transformation.

- ❑ **Lengthened School Day:** Jetson CCY has implemented an all-day school program for most children. Additionally, improvements have been in the school program, which proceeded in an orderly manner on the day of my observation.
- ❑ **High School Equivalency Diplomas:** Jetson's renewed emphasis on academic achievement has also reaped concrete rewards for offenders in terms of the increasing numbers of children receiving their high school equivalency diplomas. In 1996, the facility awarded approximately 60 youth equivalency diplomas; in 1997 the number increased to 92 youth. This year (1998), Jetson set the goal of awarding 100 youth high school equivalency diplomas and it expects to surpass it.
- ❑ **On-Campus College Courses:** Jetson has further rewarded older children who have achieved their high school equivalency diploma by offering on-campus college level math and English courses two evenings a week. Presently, 18 youth are participating in these programs.
- ❑ **Enhancing Family Support:** Jetson's administration has also recognized that for most of its offenders, renewing and strengthening family ties will be critical to their successful discharge. Thus, the family visitation schedule has been increased to four times a month (from once a month) --- and attractive gazebo-like pavilions have been built on both the boys' and girls' sections of the campus to promote comfortable visiting settings.

The facility has also attempted to capitalize on visiting days -- by offering some specific informational and parenting skills sessions for visiting parents.

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Additionally, virtually all members of the administrative team of Jetson make it a point to be on campus during visiting hours to meet with parents. (Case managers are required to participate in every visiting day.)

- ❑ **Work Opportunities:** Although Jetson administrators are the first to point out that the facility badly needs enhanced vocational programs for its youth where they can learn work skills which will help them earn jobs in the community, it is noteworthy that Jetson has established on-campus jobs for all 59 of its youth who have earned their high school equivalency diplomas.
- ❑ **Reforms in Segregated Isolation:** Disciplinary procedures at Jetson CCY have also moved toward compliance with accepted professional standards. Most impressively, the facility now actively fosters the release of children from segregated isolation as soon as they have been able to demonstrate that they are no longer dangerous. This practice was most evident in the segregated isolation area for boys -- where most boys spend fewer than two hours in isolation, and it is common policy to release after an hour of 'cooling off' and calm behavior. More recently, this policy has been extended to the girls' segregated isolation area on Delta C. However, at the time of my visit, the policy was not yet being implemented in the girl's isolation cells. Records continued to indicate that most girls remained in segregation for at least 24 hours and some for much longer. Yet, I was told that the administration had urged a concerted effort to bring the segregated isolation practices for girls into compliance with the facility's recently issued new policy.
- ❑ **Rewards for Positive Accomplishments, including No Violence:** Jetson CCY's administration also recognized early that youth would respond more quickly to positive incentives for good behavior than punishment as a deterrent for bad behaviors and violence. Thus, in the past 15-months, a series of incentive programs meaningful to incarcerated youth have been instituted. These have included, among others:
 - ❖ **Honor Dorms:** Honor dormitories have been established on both the boys (40 beds) and the girls (50 beds) sections of the campus. These dormitories, which are reserved for offenders who both receive few 'tickets' and who participate successfully in academic, vocational, and counseling programs, allow youth a variety of privileges, including freedom of movement about the campus during identified hours, freedom to have barbecues with family members on visiting days (families provide the food), and extra canteen privileges. Honor Dorm youth are also afforded family visits on the fifth Sunday of a month, if there is one, and they wear a special 'gold' shirt which signifies their special status.

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- ❖ **Bicycle Riding:** Youth who receive no disciplinary tickets for 30 days are allowed to ride bicycles (on-the-campus) on designated weekends. This program, which was made possible with only a relatively small expenditure for 100 bicycles, has been immensely popular with Jetson youth, some of whom had never before ridden a bicycle. During the most recent bicycle ride prior to my visit, 221 youth were qualified to participate.
 - ❖ **Other Incentives:** Youth at Jetson can also earn other rewards ranging from time outside to increased canteen privileges. These privileges provide incentives to youth who have not yet achieved the higher level privileges of Honor Dorms residence or the bicycle riding program to continue striving for better residential, school and program performance.
- **Program Reforms in Services to Adolescent Girls:** Jetson CCY is the only secure detention facility in Louisiana serving girls -- and as such it provides services to a very diverse population of girls -- many of whom have extensive histories of problems in school, their communities, and their families. A large percentage of these girls also have histories of prior psychiatric treatment and out-of-home placements. Reflective of their histories, the girls at Jetson CCY have long presented more difficult management issues. At the time of both of my prior visits, administrators and line security and program staff acknowledged that substantial reform of the facility's girls' program was needed. Thus, it was noteworthy that in the past year several important improvements have been accomplished.
- ❖ **New Director of the Girls' Program:** A new director had been hired to oversee the girls' section of the facility. This mature woman has a strong background in services to young girls and fully appreciates the need to balance fair and predictable standards for behavior and accomplishments with an appreciation that the traumatic histories of many of the girls can spur acting-out and attention-seeking behaviors which require a carefully measured and disciplined response by both security and program staff. Most critically, the new director has fostered a renewed spirit of cooperation between the security and program staff members serving the girls' campus.

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- ❖ **Lengthened School Day for Girls with Mental Disabilities/ Behavioral Problems:** Jetson CCY has two special dorm areas, Delta A and Delta B, which are reserved for the girls whose mental and behavioral disabilities have created serious disruption on the general population girls dormitories. In a recent reform, the Jetson administration has afforded these girls a lengthened school program off their dorm area in the much larger and brighter day room areas of the Alpha Dormitory. (During these hours, the girls who live in Alpha are attending the on-campus school or participating in work programs.)
- ❑ **Project Zero Tolerance Initiatives:** Jetson had also instituted a number of specific PZT reforms which have had a direct impact on the children's safety and protection.
- ❖ **Enhanced PZT Rounds:** Jetson administrators have exceeded the Department's requirements for PZT rounds. Jetson case managers are required to make PZT afternoon and early evening rounds weekly. In addition, all administrators are required to make at least two unannounced PZT rounds monthly on the night shift. During the brief period, March 2 - March 9, 1998, for example, four different Jetson administrators, the school principal, the school assistant principal, and two chaplains made and documented night-time rounds between 10:30 pm and 3:30 am. The frequency of these unannounced night rounds has allowed the Jetson administration considerably more accountability for staff performance, as well as the expected activities of children during the night shift.
- ❖ **Tracking of PZT Investigations:** On his own initiative, the Warden has established a tracking system for all PZT investigations. Indexed by the name of the staff person involved, this system allows the Warden to determine at a glance the number and nature of PZT complaints against a staff person, the determination of the investigation, and the issued disciplinary actions. This tracking log is a valuable tool for the Warden in his reviews of special investigations of PZT complaints. It is also a helpful record for the facility's special investigators.
- ❖ **Reduced Use of Chemical and Physical Restraints:** By limiting access to these interventions to Majors, their use has been greatly reduced.

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- ❖ **Fencing Program:** An ambitious dormitory fencing program is approximately 80% completed at the facility. This program has allowed Jetson CCY to ensure adequate security for youth, while simultaneously allowing youth to spend time in outside dormitory courtyards -- equipped with basketball courts, picnic tables etc. This program has responded to the need for the youth at Jetson to participate in regular physical exercise. It has also relieved tension/stress inside the dormitories as youth are able to spend time in a secure outdoor setting in the late afternoon, early evenings, and weekends.
- ❑ **Additional Infirmary Staffing :** As noted below, limitations in the management and direction of Jetson CCY's Infirmary remain outstanding serious concerns. The facility's accomplishments in the past year in increasing medical services staffing were noteworthy, although as found by the Department of Justice's medical expert, medical staffing at Jetson CCY remains inadequate..
- ❖ **New Physician:** In response to prior criticisms by external parties and its own investigation, the facility's long-time very part-time physician has been replaced with a physician with corrections experience who works 75% time at the facility. Although I only briefly met this physician, I was impressed by the detail, thoroughness, and sensitivity of his medical assessment notes in the children's records. Notably, this physician has also brought other reforms, including scheduled appointments for sick call and diligent attention to the children's receipt of specialized outside medical consults.
- ❖ **Nursing Staff:** The facility has also hired four additional nurses -- and it plans to hire at least one more nurse.
- ❖ **Medical Records Clerks:** Two additional medical records clerks have also recently been hired. With proper direction and supervision, it should now be possible for the facility to maintain professional standards of medical records maintenance.

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Problems in the Campus Infirmary

Despite this impressive list of accomplishments, this review also revealed several problem areas at Jetson CCY which require administrative attention and correction. Clearly the most serious of these problem areas were in the management and direction of the facility's Infirmary. As noted below these problems included substantial departures from professional standards in the delivery of basic medical care services, serious problems in medication administration practices, critical deficiencies in the maintenance of medical records, and other specific management issues which seriously compromised the facility's Project Zero Tolerance initiatives.

❑ Deficiencies in Emergency Medical Care

Review of the records of children with serious injuries surfaced a number of instances of apparent problems in emergency medical care for youth with potentially serious injuries. Of note, in all cases, the problems noted had their roots in poor nursing assessments/follow-up. The following four cases (all of which occurred in February/March 1998) are illustrative of the problems noted.

- ❖ B.C., a 13-year-old boy with mental health problems (on suicide precautions as of 2/4/98) completed an emergency treatment request form on 2/9/98 complaining of chest pain. There was a note from the physician dated 2/12/98 (no explanation for the delay) stating that he believed B.C.'s ribs were fractured. For unexplained reasons, B.C. was not sent for x-rays until 2/18/98 when his fractured ribs were formally diagnosed.
- ❖ S.J., a very troubled 13-year-old girl, with a long psychiatric history, had required emergency room treatment at a local hospital three times in February and early March 1998 for self-injurious behavior -- including drinking a toxic substance and breaking pencil lead in her ears. On March 13, 1998, she filed a sick call request stating that she had placed broken glass in her ear and that it was bleeding. She was seen by the nurse and sent back to her cell in Delta B. When I met S.J. on 3/30/98, she complained that her ear and now her neck were very painful, but she was not allowed to go the Infirmary. On 3/30/98, S.J. was seen (at my request) by the facility physician who noted that her right ear drum was opaque and retracted and that movement of her right auricle caused pain. He requested that she be sent to the local hospital to be seen by a specialist. The next morning, S.J. had not yet been sent to the hospital, and she was again seen by the facility physician. His note of this second examination indicated that he could visualize a foreign object deep in her ear canal. Later that day, S.J. was sent to the local hospital for treatment.

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- ◆ T.B. reported to the infirmary on 3/23/98 after a fight with an offender. The nurse who initially examined him sent him back to his dorm with no treatment other than Motrin. Several days later he was still complaining of pain and was seen by the facility's physician, who diagnosed a probable fractured jaw and referred T.B. to the local hospital for treatment. However, this referral did not take place (reportedly the doctor's order was misplaced), and T.B. was again sent back to his dorm without treatment (or any special diet). Several days later, the order was found, and T.B. was sent to the emergency room and diagnosed with a fractured jaw.
- ◆ C.G. was involved in an offender fight on 3/21/98 and reported to the infirmary. The nurse noted that his nose was swollen, with a slight deviation to the left. The injury was tentatively diagnosed as a probable fracture to the nose. The nose was 'packed,' and the offender was prescribed Motrin for 14-days. He was not sent to the emergency room to see an ear, nose and throat (ENT) specialist. C.G. was not afforded any orthopedic or ENT assessment of his fractured nose until ten days later on 3/30/98, when C.G. reported to the Infirmary noting that he was not breathing well.

❑ **Serious Oversights in Medication Administration and Inventory Control**

Routine review of recent medication refusal forms indicated that a number of children, especially girls, fairly regularly refused their prescribed medications. Although the Nursing Director appreciated that she should have a system for tracking children's medication refusals, she reported that she did not yet have an effective one in place. When I questioned her specifically, about a young girl (L.L.) who had been periodically refusing her anti-convulsant medications and who had had several recent seizures (1/30/98, 2/3/98, 2/20/98, 3/5/98), she indicated that she knew that L.L. sometimes refused her medications, but she did not know that L.L. had been having seizures. L.L. had also not been referred to a physician.

More seriously, when I attempted to match medication refusal forms (reportedly completed by the nurse administering the medications) with the children's official medication administration records (also reportedly completed by the nurse administering the medications), there were marked inconsistencies in four of the first five children's records reviewed. Nurses were noting on the child's medication administration record that the medications were given and taken by the child, but medication refusal forms (signed by the child/nurse) in the child's chart indicated that the child had refused their medications. When I showed these to the Nursing Director and noted that I had only reviewed five records, she stated that I would likely find similar errors if I reviewed more records. She appeared to know that medication administration documentation errors were common, but she did not seem to appreciate the seriousness of these errors.

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Concerned about this matter, I inquired about the Infirmary's practices for ensuring accountability for medication inventories. The facility's Pharmacist explained that no inventory checks were conducted to ascertain correct medication counts in the medication administration cart. She noted that she inventoried the medication closet (in the Infirmary) -- but she had no staff or procedures for checking unit dose packets or medication bottles for individual children to ascertain that their supplies matched the amount of medications they had reportedly taken/not taken as documented on official medication administration forms/medication refusal forms.

❑ **Badly Managed Clinical Records**

The children's medical records and the Infirmary's medical record room were in a state of serious disarray.

- ❖ Piles of unsorted and sorted documents lay on various counters and tables in the Infirmary awaiting filing in the children's records. There appeared to be no organized system for storing and promptly filing accident forms, laboratory reports, MD notes, hospital emergency room reports, etc.
- ❖ Upon initial request, at least one-third of the children's medical records could not be found. Some of the missing records had reportedly been pulled for pending appointments with the psychiatrist or physician, but staff had not completed or inserted the designated file card noting when the file had been taken, who had taken it, and why it had been taken. More often, however, missing records had simply been misfiled in the record room -- or were misplaced under a pile of documents.
- ❖ In almost all records reviewed, documents were placed out of chronological order. 'White-outs' and cross-outs were also noted on many records with no initials.¹ In others, documents were also filed in the wrong section of the record.

The Jetson CCY Infirmary is a busy and crowded place -- providing both admission physicals for all youth coming through the state secure juvenile system's Reception and Diagnostic Center (located at Jetson CCY), as well as routine medical and mental health care for the facility's approximately 500 more long-term youth. More space and/or better utilization of the existing space would clearly make organizing records/documents in the Infirmary more efficient. At the same time, the extent of the problems, as well as the facility's provision of three full-time record clerks for the Infirmary, suggested other management and supervision issues.

¹ It is standard nursing practice to forbid the use of 'white-out' in medical records.

❑ Inattention to Children's Privacy and Protection Concerns

Observations also indicated that Infirmary nursing staff needed additional training, clearer performance expectations, and more accountable supervision. In the meantime, the protection from harm and privacy rights of children were being violated. As detailed below, many of these issues had a direct adverse impact both on the medical care for youth and the facility's capacity to gain accurate information about injuries that had incurred.

- ❖ Most egregiously, children continued to be questioned about their complaints and their experiences in the open waiting room in full view of many other children and security officers, often including the child and/or officer who was involved in the conflict/fight with the child being questioned.
- ❖ Even when children were taken to the back area of the Infirmary -- they were often examined or questioned in an open area, rather than in a treatment room. Assessments for injuries subsequent to use of force reports were extremely variable. In a number of instances, children were simply asked if they had been injured and there was no physical exam whatsoever. The Nursing Director confirmed that there no explicit standards for the conduct of injury assessments. There also appeared to be no quality assurance review which would detect these problems. Thus, critical issues of where exams should occur, the extent of hands-on visual exams of youth, and how exam findings should be documented were left to the discretion of individual nurses. This absence of any articulated standards even extended to exams of children subsequent to use of force reports and filed abuse allegations.
- ❖ The confidentiality of the children's medical records was also routinely compromised by the sloppy storage of piles of clinical documents throughout the Infirmary.
- ❖ Although there are many children at Jetson CCY who have long-standing mental health conditions which include repeated self-injurious behaviors, neither the nursing staff nor the security staff responsible for mental health units had adequate knowledge about these disorders or how to respond to these children's complaints and acts of self-injury. In several cases, it was apparent that staff were frustrated with what they perceived to be these children's 'attention-seeking' requests --- and they responded by ignoring complaints without first obtaining a psychiatric consultation.

In the 30 days prior to my visit, I saw evidence of such disinterest in the records of at least two children (S.J. and D.M.). As would be reasonably clinically predicted

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-- both of these children responded to the disinterested response of staff by resorting to more serious acts of self-abuse to gain the staff's attention. Additionally, I witnessed nursing and security staff interacting with these children by teasing or joking with them about their self-injurious behaviors.

- ◆ Nursing staff also did not properly respond in instances of children's complaints of sexual assaults by other offenders. During my brief review, I noted a number of such 'documented' complaints in different children's records -- but I could find no facility follow-up or response to any of these complaints. While facility administrators indicated that such incidents should be reported to them (for discussion at morning Executive Team meetings) -- the Nursing Director did not appear to be aware of this expectation. Several examples of these references are listed below.²

- J.G. was treated for pain to his nose and shoulder, a swollen nose and lip subsequent to a fight with another offender. Nursing notes stated that he complained 'another kid was pushing a peneus [sic] in his face.' [12/24/97] A month later, he filed another complaint indicating the boys in the dorm were touching his buttocks. [1/24/98]
- B.M. wrote a note to the Director of the Reception Center which was found in the Infirmary. (The Reception Center Director reported never receiving the note.) B.M. wrote about being continually beaten by other boys and having his food stolen. The last statement read, "People kept [sic] on asking me can they rape me. "I say no" and tell the guard. They [other kids] say I'm lying."
- T.W. was brought to the Infirmary after a fight with another offender. He had bruises to both sides of his neck. He reported that another offender (Tom) had his hands on T.W.'s buttocks and that this started the fight. [2/18/98]
- T.F. reported to the nurse that he saw another offender put his penis in J.D.'s face. [11/1/97]

² Two of these complaints were immediately shared with the Warden so that he could take appropriate protective actions for the children involved. He acknowledged that he had not been informed of these reports.

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❑ **Inconsistent Nursing Progress Notes**

Nursing progress notes were inconsistently documented. Although it appeared that some nurses were charting notes every time they saw a child for an assessment or medical treatment, others were not. The Nursing Director confirmed that nurses who 'treated' children should enter a progress note, but she reported that there was some confusion as to whether nurses who only 'assessed' children due to a 'use of force' or 'accident/injury' reports were required to chart a progress note. The Nursing Director also reported that she had not counseled any of the nursing staff for failing to write progress notes or in instances where it appeared based on subsequent medical findings (usually of fractures) that their initial assessments had not been competently done.

❑ **No Follow-Up on Missed Sick Calls**

On the second day of my visit, I learned that all of the youth scheduled for sick call with the physician from two dormitories had not shown up for sick call. I was told that it was not unusual for some children to ask to come to sick call in the evening -- but then to decide not come the next morning. The Nursing Director did acknowledge that it was unusual for so many youngsters not to report for sick call -- but she indicated that she did not usually follow-up with youngsters who did not show for sick call and that she did not plan to follow-up on this situation.

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Limitations of Project Zero Tolerance (PZT) Activities

As noted in the forward section of this report, in many areas, Jetson CCY administrators had complied with the Department's PZT directives -- and in some important areas, like required PZT administrative rounds, it had exceeded the requirements of these directives. Yet, in other areas, there was a need for improvement/reform in the facility's PZT activities.

❑ Inconclusive Investigations

The most serious outstanding problem was that nearly half of the recent special investigations of allegations of staff abuse and/or neglect resulted in final findings which did not clarify with any degree of certainty what had actually occurred. Often, youth and officers offered strikingly different accounts of what had happened.

Careful study of the witness statements attached to the 19 February/March 1998 Jetson CCY investigations further clarified that *untruthful statements from both youth and security staff members* was a recurring problem in these investigations. In many instances, the accounts of both the youth and the officers appeared unlikely to be fully truthful. In other cases, reports by children or officers that they had not seen or heard anything were simply not credible given their proximity to the incident.

Investigation reports usually did not acknowledge the apparent likelihood that at least some, if not all, witnesses had not been fully forthcoming in their testimony. Reports also usually contained no documentation that investigators had taken any steps to resolve witnesses' conflicting testimony.

Interviews and observations further revealed that standing practices at Jetson CCY tend to encourage collusion and falsification of statements by both youth and staff. Staff members are allowed to prepare their statements well in advance of being interviewed and in collaboration with their colleagues. Similarly, children often complete their statement forms in the open waiting room of the Infirmary and in discussion with other youth. Not infrequently, the security officer from the child's (children's) dormitory is also present, and sometimes he/she helps the child/children complete his/her (their) statements.

If left unaddressed, this pattern of both youth and staff not being fully truthful will have a profound adverse effect on the integrity of the facility's special investigations. Each time children and/or staff are untruthful in an investigation that particular investigation is compromised. More critically, however, each time this occurs, the 'habit' of youth and staff being untruthful is reinforced. This 'habit', in turn, sets the stage for youth and staff -- with little fear of adverse

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consequences -- to encourage and/or coerce their peers/colleagues to be untruthful during investigations. Indeed, if this habit of offering untruthful (or only partially truthful) statements persists, over time there may come to be more incentives for children and staff to be untruthful versus truthful in their statements to investigators.

Although it is not always possible for institutional administrators to 'break' codes of silence or untruths, whenever investigation testimony suggests fabrication by children or staff, it is critical that the situation is addressed in a forthright manner. Re-interviews of involved parties which focus carefully on the points of conflicting testimony are essential. As warranted, senior administrators should be present to reinforce the importance of the situation. It is also advisable for the facility to keep records of inconclusive investigations and the witnesses involved to determine any patterns across staff members, youth, and dormitories.

The most helpful actions in promoting more truthful fact-finding in institutional investigations, however, are steps which best guarantee initially obtaining truthful and accurate accounts.

- ❖ Initiating investigations and interviews within hours of an allegation being reported is an important first step. [This requires prompt availability of special investigators, 24-hours a day, 7 days a week.]
- ❖ Witnesses (staff and youth) should also be directly alerted at the beginning of all interviews that intentionally lying during an investigation is a performance offense and is subject to discipline.
- ❖ Investigators should also be cautious about relying so extensively on written statements of youth and staff in lieu of direct interviews. It is much preferable to interview witnesses first and then to ask them to prepare a written statement confirming their oral testimony.
- ❖ Staff members and youth should also always prepare written statements in private -- with as little time as possible to collude with others regarding their accounts.
- ❖ During interviews, investigators should also carefully follow and critique witness' accounts. Points of apparent confusion and conflict should be readdressed with the witness. Similarly, investigators should always evaluate if the witness' professed observations were likely given his/her location vis a` vis the alleged event. Although investigators should always be polite and disciplined in their interviews with witnesses, they should also clearly communicate that they will not "buy" apparently false accounts.

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❑ **Failure to Refer All Abuse Allegations for Investigation**

Another serious PZT concern is that the facility's protocol for handling children's allegations allows that some allegations will NOT be referred for a special investigation. According to facility administrators, the Jetson CCY protocol assures daily morning meetings of the Executive Team to review use of force reports, serious offender injuries, and allegations of abuse. The Director of Jetson's Reception Center Program initially collects these reports from the Infirmary and summarizes them in a memo. At the morning meeting, this individual presents the relevant cases. If, upon this review, the Executive Team believes that the PZT complaint was 'spurious' and unsupported by the immediate facts -- it may not be referred for investigation.

This practice is in violation of the Department of Correction's PZT policy which requires special investigations of all allegations of abuse, neglect, and mistreatment of youth. Additionally, it exposes Jetson's youth, administrators, and staff to unnecessary risks of overlooking potentially serious occurrences which may be masked by the reports of the front-line staff members. There was also evidence that the above-noted problems in the management/direction of the Infirmary may lead to the loss or oversight of PZT allegation reports. In reviewing the packets prepared for only three meetings of the Executive Committee, I discovered at least one offender allegation which had apparently been overlooked in the Reception Center's Director's review of Infirmary documents.

❑ **Failure to Investigate Other Untoward Events/Occurrences**

In addition to failing to investigate all allegations of abuse, Jetson CCY also did not have sufficient safeguards to ensure that other serious incidents, especially offender-to-offender assaults received accountable investigations. Such serious incidents included sexual assaults (as referenced above), serious offender injuries suffered in offender fights, and other serious injuries where the offender's self report of the cause of the injury was apparently untrue. One such case involved V.N. who suffered a fractured jaw on 12/15/97. There was no documentation that V.N.'s claim that he had fractured his jaw by falling out of a chair was investigated further.

There was also no investigation of the apparent victimization of a number of youth who were repeatedly harmed in offender fights. One such offender was B.C., a 13-year-old youngster with a psychiatric condition. He was seen in the Infirmary for involvement in at least 10 offender fights in the eight week-period 1/21/98 - 3/14/98. Over this time, he suffered many injuries, including fractured ribs, bruises to his neck, a swollen eye, and a swollen thumb, but there was no documentation that B.C.'s repeated victimization had been referred for investigation.

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Overall, Infirmary logs indicated that the most serious injuries to youth at Jetson CCY were due to offender fights -- including what appeared to be an increase in 'snookings' or surprise attacks on offenders. In the four-day period proximate with my visit (3/26-3/29/98) Infirmary logs documented more than 60 youth were sent to the Infirmary to be checked for injuries after offender fights. Although youth reportedly did receive disciplinary tickets for fights --- in-depth reviews were not conducted of these incidents. Rather a brief report was usually filed by the on-duty officers. Critical issues to aid the facility in preventing such altercations, including an investigation of the cause of the fight, security's ability to detect and respond to the escalating situation, and the likelihood of a recurrence of altercations between the offenders involved are usually not addressed.

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Needed Improvements in the Treatment of Mentally Disabled Youth

As mentioned above, Jetson CCY has taken a number of steps to begin to address the behavioral problems and conduct disorders of youth with limited formal programs of incentives. The facility has also revised its segregated isolation policy. Improvements had also been made in the special programs on Delta A and B for girls with mental disabilities who were unable to live successfully in general population. Facility administrators also reported ambitious plans to develop a much more comprehensive behavioral treatment program for the girls living on Delta A and B.

As discussed below, however, until such plans are implemented, conditions on Delta A and B continue to place the youth placed there at risk of substantial harm. In several basic areas Jetson CCY did not meet accepted professional standards in its treatment of youth with mental disabilities.

- ❑ The Nursing Director reported that psychiatry services at the facility are limited to four hours weekly of a local psychiatrist. This psychiatrist is expected to provide psychiatric assessments of selective children passing through Jetson CCY's Reception Center, as well as ongoing psychiatric services, including medication management, to the more than 100 youth placed at Jetson CCY with identified psychiatric conditions. It is clearly unreasonable that a psychiatrist working only 10% of a regular work week can meet all of these obligations.
- ❑ Jetson CCY continues to provide protective custody of suicidal and seriously self-injurious children in the same segregated isolation cells used for addressing youth's serious disciplinary infractions. There are apparent clinical contraindications of this co-location which suggests to youth (and staff) that psychiatric conditions/symptoms are not differentiated from disobedient, willful behavior. These issues are especially important for many of the children who resist acknowledgment and treatment (including physician-prescribed medications) of their mental health conditions. The co-location also results in suicidal and self-injurious children being 'guarded' by security staff who had little training or skill in addressing their mental health needs. There continues to be no regular nursing coverage of these units -- even when they are housing seriously mentally ill children. These children are also not routinely seen on a daily basis by a psychiatrist or other qualified mental health professional.
- ❑ Pending the establishment of the formal program on Delta A and B, the girls with mental disabilities served here continue to spend most of their waking hours locked in their cells, especially on weekends. They are also routinely locked in their cells all nights. Maintaining these self-injurious/suicidal girls in locked seclusion for so many hours, week after week, substantially departs from accepted professional mental health treatment standards.

**A Review of Swanson Correctional Center for Youth
Monroe, Louisiana
April 28-30, 1998**

**Prepared by
Nancy K. Ray, Ed.D.**

**For the Civil Rights Division
of the United States Department of Justice**

EXHIBIT B

Swanson CCY Review
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Executive Summary

This review of the Swanson Correctional Center for Youth (CCY) was conducted at the request of the Civil Rights Division of the United States Department of Justice. I was asked to assess the facility's ability to provide a safe and secure environment for youthful offenders, with special attention to protections from injuries due to offender-to-offender violence and officer-to-offender abuse, mistreatment, and neglect. Of note, this was my third review of Swanson CCY. I had conducted prior reviews of the facility in August 1996 and January 1997.

I conducted this review by visiting the facility (April 28-30, 1998), interviewing staff and offenders, and reviewing numerous documents. Page 1 of this report provides a more complete description of the review methods.

Swanson CCY Accomplishments

Since my last visit, Swanson CCY had made several programmatic improvements. These changes have served to provide offenders with more constructive activities and more incentives for performing well in school, vocational settings, and their dormitories. As aptly summarized by the new Warden, "[The new programs] are set up for a young man to have something to work to."

These accomplishments, which are discussed in more detail on pages 2-4 of the report, include:

- ❖ a lengthened school day for most youth;
- ❖ an increase in the number of high school equivalency diplomas awarded in 1997-98;
- ❖ creation of an honor dorm system to provide incentives for good behavior and program performance;

- ❖ other youth reward programs for no violence;
- ❖ an increase in recreational activities for youth;
- ❖ an after care program for some discharged youth; and
- ❖ more frequent family visitation days.

Areas In Need of Improvement

Despite these efforts, the State has failed to take basic steps to stem the violence in the facility. Swanson CCY remains a violent campus where youth are often not adequately protected from preventable harm. Serious offender injuries are common occurrences and offender injuries of suspicious cause are daily events.

❑ Serious Offender Injuries

The most apparent outstanding problem at Swanson CCY is its ongoing high incidence of serious offender injuries, including fractured jaws and noses. Although fewer serious offender injuries are attributed to officer abuse, there continue to be many serious injuries due offender-on-offender assaults. These incidence of these injuries indicates the facility's failure to supervise youth adequately to ensure their health and safety.

In April 1998, 32 offenders were confined to the infirmary due to traumatic injuries. Almost all were confined for several days. The eight youth with facial fractures were confined to the infirmary for several weeks. [See Report pp. 5-6.]

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The review also indicated that some youth suffered two or more injuries/assaults in a brief period of time. Almost all of these youth were in repeated fights with other offenders which were not promptly stopped and/or apparently noticed by security officers.

In addition, many youth at the facility suffered injuries reportedly due to accidents or sports injuries. For example, in the two-week period, April 12 - 25, 1998, 40 youth reported to the infirmary for treatment of accidental and sports injuries. The number of these accidental injury reports, as well as the nature of the injuries (i.e., a fractured jaw attributed to walking into a door; a swollen jaw and left eye attributed to playing basketball; a fractured hand to a fall in the bathroom; a swollen jaw from falling on a bathroom sink) suggested that many of these injuries were more likely to have occurred in fights with other offenders and/or in altercations with a staff person. Several youth acknowledged that they would sometimes falsely report the cause of injuries to avoid a ticket for fighting. [See Box, p. 7].

☐ **Excessive Use of Force in the Management of Offender Disobedience and Disorderly Conduct**

Use of force reports, special investigations of offenders' allegations of abuse, as well as staff interviews clarified that a major factor contributing to the offenders' serious traumatic injuries was the subsequent force used by security officers in interrupting offender fights and/or in addressing acts of offender defiance and/or disobedience. Officers routinely intervened with excessive force, including taking youth to the ground, pushing youth up against walls, or kicking youth, in responding to relatively minor situations ranging from youth refusing haircuts to youth begging for new shoes. This use of force not only substantially departs from accepted professional standards, but it also contributed substantially to the escalation of these situations into more violent and dangerous incidents.

One-third of the 35 special investigations reviewed (2/1-3/15/98) included acknowledged reports of officers that they had intervened in offender fights by taking offenders to the ground, or by kicking or pushing offenders backwards or up against a wall.

There were also many reported cases of officers' using significant force to address relatively innocuous acts of alleged offender disobedience. For example, there was a report of four officers physically restraining (holding down) an offender during a haircut which he was resisting. There was another report of an officer's pushing an offender down (backwards) when he would not stop begging for another pair of shoes. In another case, an officer admitted forcefully pulling two youth out of the dining hall after they had broken rank to run into the dining hall to elude the rain. Although the officers' accounts of all of these incidents cited acts of offender defiance or disobedience, none appeared to require officer use of force to attain an appropriate resolution. [See Report pp. 7-8]

☐ **High Use of Administrative Segregation**

Swanson CCY, like Tallulah CCY, also uses administrative segregation excessively in managing its youth. For the seven-day period 5/11-5/17/98, approximately one-fifth of the youth in the facility (82 youth) spent some time in segregation. Twenty-three of these youth spent more than two days in administrative segregation.

There was also substantial evidence that youth with borderline and more severe mental retardation were disproportionately subjected to administrative segregation. These youth represented well over half (58%) of the children placed in administrative segregation during the 7-day review period, although they comprise only 48% of the census of Swanson CCY. There were also data that indicated that these disabled youth were more likely than other youth to be subjected to frequent recurring episodes of segregation. [See Report pp.8-10]

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□ **Special Risks for Youth with Mental Disabilities**

Like the other three secure juvenile correctional facilities in Louisiana, Swanson CCY has inadequate services and staff to meet the needs of its increasing number of high risk, mentally disabled youth. In some respects, however, this problem manifests itself more poignantly at Swanson -- as all of the youth confined here are long-term offenders.

The facility does not offer any regular counseling or cognitive and behavioral therapies even for its troubled youth with extended periods of confinement. Many of these youngsters have had extremely traumatic childhoods strained by parental alcohol and substance abuse, recurring sexual and physical abuse, the violent deaths of one or more close family members, and long early histories of parental neglect of their custodial and protection needs.

The adverse impact of Swanson CCY's inattention to children's mental disabilities was most apparent among the number of children suffering from depression, suicidal ideation/attempts, and histories of sexual victimization. In the first four weeks of April 1998 alone, 15 such children required medical attention in the facility's infirmary.

The Warden also acknowledged that few of the children suffering from significant mental disabilities achieve 'honor dorm' privileges -- and that the majority live in the most restrictive campus dormitories. The most seriously impaired and/or disruptive of these children spend most of their confinement on the locked (closed) campus in one of the institution's 30 segregated isolation cells. [See Report pp. 8-10.]

Another large contingent of these youth live in one of the four Holly Dormitories on the locked campus and in the Pecan Dormitory on the

open campus -- which is designated for weak and frail offenders --- many of whom have histories of sexual victimization and/or sexual offending. The frequent reports of sexual and physical assaults in the Pecan Dormitory caused this expert to question the reality of this 'protective' setting. Although the Warden stated that he attempted to pay more attention to the Pecan Dormitory, he admitted that this 'special setting' was not afforded any different staffing or programs than the other dormitories on the campus. The Nursing Director and the Special Investigator also agreed that from a youth management perspective, the Pecan Dormitory, is the most difficult of all the campus dormitories and, with only two sergeants on duty at any one time, it was simply not possible to prevent the physical and sexual assaults between offenders before they happened. The continued failure of the State to ensure that its juvenile correctional facilities have sufficient and competently trained staff to protect confined high risk youth from harm is egregious. [See Report pp.10-12.]

□ **Questionable Dismissals/Hires of PZT Special Investigators**

Swanson's special investigations of abuse and neglect had improved since my prior visit in January 1997, and it was apparent that the facility's former special investigator (Ms. Ensley) had benefitted greatly from the special training and supervision provided by the Department and Major Pepper. Despite these improvements, many Swanson CCY investigations were deficient in several areas. The most common ongoing problems in Swanson's special investigations were the investigators failure :(1) to interview all offender witnesses, and (2) to ensure reasonable follow-up efforts to resolve conflicting testimony.

Generally, however, there had been improvement in Swanson CCY's special investigations since my prior visit, and thus, it was of concern that the new Warden had very recently removed the special investigator and replaced her with a captain who not only had no special

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investigator training or experience, but who had also been recently dismissed from Tallulah CCY reportedly because of misconduct.

When this officer failed to perform well in the investigator job (reportedly, he could not complete investigations in a timely manner), the Warden made another questionable appointment. In this case, the employee selected had a recent criminal record, at least three recent disciplinary actions related to abuse situations, and also no prior experience or training as an investigator. The Warden justified these decisions by stating that he did not trust performance reports by others and that he made the decisions based on his own observations of the officers.

Although the Warden may have personal reasons for wanting to appoint his own special investigator, both the nature of his choices of replacements and the timing of these decisions more than six months after he was appointed and soon after he disagreed with former special investigator's (Ms. Ensley's) substantiation finding in a particularly serious allegation appeared improper. [See boxed insert Report p.15.]

There was also no evidence that any Department official had reviewed or participated in any of the above decisions regarding dismissals and hires of special investigators at Swanson CCY. For obvious reasons, central office independent oversight of these decisions is critical to an accountable investigation process. [See Report pp. 10-13.] The failure of the State to ensure competent, trained investigators in its secure juvenile facilities continues to jeopardize the safety of juveniles in the facilities.

❑ Questionable Personnel Decisions

Anonymous allegations reported by Swanson CCY staff caused this expert to review the personnel records of approximately 10 current employees of the facility. These reviews surfaced a number of questionable personnel decisions, whereby individuals were hired or promoted who had recent problematic performance and/or

criminal records.

For example, there were other instances where employees had been hired after their termination from Tallulah CCY with no documentation that a reference check with Tallulah officials. In other instances, employees had been promoted despite recent serious criminal records. There were also instances where criminal record checks of employees were not in their records, in spite of representations that a criminal background check is completed on all staff who work with youth. Finally, there were additional cases where employees with recent histories of sustained performance offenses and discipline related to excessive use of force and/or offender abuse or neglect had been promoted. [See Report 12-15.]

❑ Staffing Shortages and High Turnover

Ongoing staffing shortages, as well as high staff turnover are also critical barriers to ensuring needed improvements in the supervision and discipline of youth and officers at Swanson CCY. As of April 28, 1998, 20 of the 177 authorized security positions were vacant. Since all authorized positions are required to meet minimum staffing, the facility was compelled to rely on costly overtime staff daily just to meet daily staffing minimums.

Facility data further showed that in the five months, 11/2/97 - 4/19/98, 45 employees (almost all security staff) had resigned, retired or been terminated. If this turnover rate continues, the facility will hire/terminate an estimated 90 security staff this year --- or about 50% of its entire complement of security staff items.

The Warden reported that despite all of his efforts, he had not been able to overcome these problems. He stated that unless there was some wage relief allowing the institution to more competitively recruit personnel in the local community, as well as better and more tailored training for new recruits for the secure youth facilities, he would never be able to fill all of his vacant security positions or curtail the high

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turnover rate of security officers.

The Warden, as well as this expert also noted that the staffing allocation of only a single officer in each of the dormitory areas of the closed campus Holly Dormitory was inadequate and dangerous. Each of these dorms serve 36 offenders, identified as being particularly difficult to manage. By contrast, most dorms on the open campus, which are designated for less difficult offenders are assigned two staff members for 30-44 offenders. [See boxed insert p. 16.]

❑ No Accountability in Video Monitoring Practices

In prior reports regarding Swanson CCY, this expert had noted that the facility's limited video monitoring capacity was often compromised by 'broken' cameras, cameras which ran out of video tape, and cameras that had inexplicably been turned off. This follow-up review indicated that little had been done to address these problems and that, in fact, the pervasiveness of the problems in the accountability of video monitoring may have worsened.

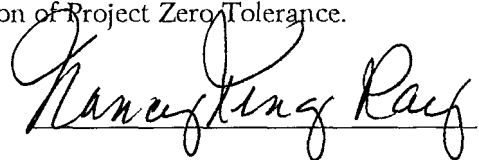
Of the 28 special investigations initially sent to this expert for review, 10 occurred in areas where the facility had video monitoring capacity. In only half of these cases, however, were videos actually available to verify what had occurred. A variety of problems were found with the faulty video monitoring, ranging from cameras which had been broken for months and not reported or repaired to cameras which inexplicably had been turned off at the time of the alleged abusive incident. I was told that no officer has been disciplined for his/her complicity and/or inattention to duty which contributed to the video monitoring problems in the above cases.

The Warden reported that he planned to purchase a more state of the art system in the near future, but he could provide no time frames for when an effective video monitoring system would

be in place. [See Report p. 17-18.]

As suggested by the above summary, this review indicated many ongoing protection from harm problems at Swanson CCY. Despite efforts by the new administration to initiate program improvements during its short eight-month tenure, serious ongoing problems in offender injuries and in officers' using excessive force to intervene in fights and other acts of offender disobedience and defiance continue at the facility. Most fundamentally, correctional staff at Swanson CCY have not been adequately trained to properly supervise and intervene with physically aggressive youth.

There is also evidence that the facility's continued failure to provide services for mentally disabled and frail and vulnerable youth has placed these youth at especially high risk for suffering recurring preventable harm and restrictive placement in the facility's locked compound. Additionally, recent questionable appointments of inexperienced personnel with troubled performance backgrounds to serve as PZT investigators, as well as the facility's failure to ensure the more accountable operation of its existing video monitoring system have compromised offender and officer perception of facility management's commitment to the mission of Project Zero Tolerance.



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Expert Consultant

Swanson CCY Review
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Introduction

This review of the Swanson Correctional Center for Youth (CCY) was conducted at the request of the Civil Rights Division of the United States Department of Justice. I was asked to assess the facility's ability to provide a safe and secure environment for youthful offenders, with special attention to protections from injuries due to offender-to-offender violence and officer-to-offender abuse, mistreatment, and neglect. Mr. John Whitley, the Court Monitor, accompanied me on my tour of Swanson CCY, and his assistance and commentary were valuable.

I conducted this review by visiting the facility (April 28-30, 1998), interviewing staff and offenders, and reviewing numerous documents. In total, I visited five residential dormitories, including Cypress B, Holly A/C, Pecan, and Rose Bud, as well as the on-campus school. I also spent considerable time in the facility's Infirmary observing the routine delivery of medical services to children and reviewing sick call logs, emergency medical requests, and medication administration records. I also carefully reviewed the the medical records of more than one dozen children who had recently been seriously injured. In addition to informal interviews with offenders and program and security staff, I conducted more structured interviews with a number of facility administrators and program staff. I interviewed Warden Travis, the Director of Nursing, the Personnel Director, the Principal of the campus school, and the facility's former lead special investigator, who had just been replaced by the Warden.

My review of PZT documents included:

- (1) all 35 special investigation reports of allegations of officer abuse completed in February/March 1998;
- (2) security logs and segregation orders in the segregation areas;
- (3) various personnel, staffing, and overtime records; and
- (4) a video tape of the closed compound Holly dormitory related to a specific allegation of abuse which had been substantiated by the facility's former PZT investigator, but unsubstantiated by the Warden.

It is also relevant to note that this was not my first visit to Swanson CCY for the U.S. Department of Justice. I had made prior visits to Swanson CCY on August 19-20, 1996 and on January 21-22, 1997. The focus of the January 1997 visit was to assess Swanson CCY's progress in implementing the Louisiana's Department of Corrections' Project Zero Tolerance (PZT) initiative. Since my last visit to Swanson CCY, the former and longstanding warden had retired (October 1997), and there had been many changes in the senior management personnel at the facility.

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Swanson CCY Accomplishments

During this visit, I noted several programmatic improvements at Swanson CCY. These changes have served to provide offenders with more constructive activities and more incentives for performing well in school, vocational settings, and their dormitories. As aptly summarized by the new Warden, "[The new programs] are set up for a young man to have something to work to."

As indicated in this report, despite these accomplishments, Swanson CCY remains a violent campus where serious offender injuries are common occurrences and less serious offender injuries of suspicious cause are daily events. At the same time, it is important to emphasize that the new administration has had only eight months to engineer basic changes in the daily activities, programs and operation of the facility and that many other improvements are reportedly scheduled for implementation in the coming months. The high motivation and expressed objective of the new Warden to establish Swanson CCY as the best youth facility in Louisiana is also notable.

Summary of Important Accomplishments

- ❖ A Lengthened School Day for Most Youth
- ❖ An Increase Number of Youth Awarded High School Equivalency Diplomas
- ❖ Honor Dorms
- ❖ Other Reward Programs for No Violence
- ❖ More Recreational Activities
- ❖ The Initiation of an After Care Program for Discharged Youth
- ❖ More Frequent Visitation Days

Some of the improvements which have already been accomplished are highlighted below.

- ❑ **Lengthened School Day:** Swanson CCY has implemented a lengthened school day program for children on the open and closed campuses. The school program has also been upgraded, with more computer-assisted instruction. During my observations classrooms on the open campus were orderly, and most offenders were engaged with their work assignments. [The school program at Swanson CCY will be discussed in a separate report by another Department of Justice consultant.]

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- **High School Equivalency Diplomas:** Swanson's renewed emphasis on academic achievement has contributed to an increasing number of children receiving high school equivalency diplomas. Warden Travis reported that in 1996-97 academic year, only 17 youth at Swanson CCY had received high school equivalency diplomas. Thus far in the 1997-98 academic year, 45 youth have received their equivalency diplomas -- and the school principal stated that he anticipates that a total of at least 65 youth will have received their diplomas by the end of the academic year.

School officials also reported improvements in the academic achievements of youth enrolled in basic education programs, as well as an increasing number of youth taking ACT tests for later college admission.

- **After Care Program:** With the assistance of a federal grant, Swanson CCY has implemented a limited after care program which assists youth on discharge to obtain special residential and vocational support. Due to this program, several recently discharged/paroled Swanson youth have transitioned to special residential treatment, work, and school programs.
 - ◆ Eight discharged youth have transitioned directly into specialized residential programs with rehabilitative treatment components.
 - ◆ Four discharged youth are attending various community college and vocational programs where they continue to work on their high school equivalency diploma half-day and receive vocational training half day.

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- ❑ **Enhancing Family Support:** Swanson's administration has also recognized that for most of its offenders, renewing and strengthening family ties will be important to their successful discharge. Thus, the family visitation schedule has been increased to two times a month (from once a month). Visiting days have also been made more pleasant with canteen options where families can purchase hotdogs and other refreshments. The Warden also reported that he is considering further expansion of visiting days to four times monthly, as is the current practice at Jetson and Tallulah CCYs. He also has plans to build picnic pavilions/barbecues for family visiting days similar to those on the Jetson CCY campus.
- ❑ **Rewards for Positive Accomplishments, including No Violence:** Swanson CCY's new administration has recognized that its youth need more concrete incentives for good behavior and school and vocational program performance. To this end, the new administration has established a progressive residential program whereby offenders can earn their way from placement on the closed residential campus¹ to a regular dormitory on the open campus to a semi-honor dormitory to the honor dormitory.

Although not as formally structured as the honor dormitory system at Jetson CCY, I was told that youth at Swanson CCY could be recommended for upgraded residential dormitory placement by their counselors and security staff and that recommendations were based both on their disciplinary and academic/work progress reports. Full honor dorm privilege at Swanson CCY entitles youth to come and go on their own (on the campus) during daylight hours as long as they are on-time for school, work assignments, line-ups etc.

- ❑ **Improved Recreation Program:** The new administration has also made many improvements in the recreation program, including the creation of a Boys' Club where youth who have gone without tickets for the week may spend one early evening weekly playing ping pong and other games, using exercise equipment, watching a large screen television, and purchasing small snacks from the canteen. Boys residing in the honor dorm are able to attend the Boys' Club two times weekly. Additionally, the facility now has an organized sports program which occurs daily from 12:00 - 1:00 pm and on weekends. Recently, the facility has also formed a basketball team which plays other teams from other local facilities.

¹ Reportedly, some offenders are initially placed on the open campus upon admission. It appeared, however, that the vast majority of newly admitted youth spent at least some time initially on the closed campus.

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Areas In Need of Improvement

Despite its accomplishments, Swanson CCY has not achieved many important Project Zero Tolerance initiatives and it remains a facility plagued by serious offender injuries and many complaints of excessive officer use of force.

☐ Serious Offender Injuries

The most apparent outstanding problem at Swanson CCY is its ongoing high incidence of serious offender injuries. Most serious injuries are attributed to offender-on-offender assaults, while many less serious injuries are attributed to accidents, often in the bathroom or while playing basketball. The most frequent serious injuries were fractured jaws and noses.

The inpatient infirmary log (i.e., 'bed rest' log) identified a litany of offender injuries due to violence at the facility. In the six-week period, 2/16/98 - 3/30/98, 24 different offenders were confined to the infirmary due to traumatic injuries.

Almost all were confined for several days. Youth with facial fractures were usually confined to the infirmary for several weeks. [See boxed insert on this page.]

Offenders Confined to the Swanson CCY Infirmary Due To Traumatic Injuries 2/16/98 - 3/30/98

●	2/16/98	D.D.	confined for a fractured jaw
		W.H.	confined for a fractured hand
		R.S.	confined for a serious laceration
●	2/18/98	R.A.	confined for a laceration (upper lip)
●	2/19/98	J. S.	confined for a left ankle injury
●	2/21/98	R.H.	confined for a right eye injury
●	2/23/98	D.E.	confined for a right ankle injury
		D.G.	confined for a fractured jaw
●	2/24/98	K.M.	confined for a right thumb injury
●	2/26/98	B.A.	confined for a swollen right testicle
		T.B.	confined after having #8 tooth replaced
●	3/5/98	A.R.	confined for a fractured nose
		T.W.	confined for a left ankle injury
●	3/10/98	O.B.	confined for a left ankle injury
●	3/11/98	A.L.	confined for a left ankle injury
●	3/14/98	G.N.	confined for a right ankle injury
●	3/15/98	F.G.	confined for a fractured nose
●	3/16/98	T.T.	confined for a left hand injury
		J.H.	confined for fractured jaw
●	3/17/98	D.D.	confined for a nasal fracture
●	3/18/98	S.O'H	confined for orthopedic injuries to both hands
●	3/22/98	J.S.	confined for a fractured nose
●	3/23/98	T.D.	confined for observation of left jaw and left orbital injury
		Y.H.	confined for serious laceration to upper lip
●	3/24/98	R.S.	confined due to orthopedic injury to fingers of right hand
●	3/25/98	R.S.	confined due to orthopedic injury to fingers of right hand
●	3/26/98	S.O'H	confined for a fractured right hand
●	3/28/98	K.J.	confined due to serious laceration and fracture to left hand
		H.N.	confined for a serious laceration to the left side of his head
		B.H.	confined for a laceration to his upper left lip

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Subsequent review of the Infirmary bed rest log for April 1998 suggested that the rate of violent injuries at the facility was increasing. In the four weeks of April, 32 different youth, including eight youth with facial fractures, were confined to the infirmary due to traumatic injuries.

Further review of facility incident reports indicated that some youth suffered two or more injuries/assaults in a brief period of time. Almost all of these youth were in repeated fights with other offenders which were not promptly stopped and/or apparently noticed by security officers.

- ❖ T.A., a 16-year-old youth, alleged that he was sexually assaulted on 2/9/98. On 2/19/98, he was sent to the local hospital for an x-ray of a right hand injury. On 3/20/98, he reported to the infirmary with a contusion to his left molar area. On 3/24/98, he reported to the infirmary stating that he had been punched twice in the left hemothorax. On 4/25/98, T.A. alleged that he was again sexually assaulted, when another offender stuck his fingers up his [T.A.'s] rectum.
- ❖ C.L., a 16-year-old youth, suffered a serious nose injury and a chipped tooth on 2/5/98. On 2/9/98, he reportedly re-injured his nose. On 2/13/98 he suffered a laceration to his left cheek and contusions and abrasions to his face. On 4/6/98 he reported to the infirmary with serious lip laceration which required sutures. On 4/16/98, he suffered a fractured nose.
- ❖ W.H., an 18-year-old youth, dislocated his shoulder on 12/29/97. On 2/17/98, he fractured his hand. On 4/21/98, he reportedly re-injured his right hand.
- ❖ J.L., a 16-year-old youth, reported to the infirmary on 12/25/97 complaining of an injury to his left hand which had occurred during basketball. On 12/27/97, two days later, he again reported to the infirmary, this time complaining of pain to the right side of his nose. On 3/23/98, he again reported to the infirmary. This time, x-rays confirmed that his nose was broken.
- ❖ D.D., an 18-year-old youth, fractured his collarbone on 2/18/98. On 3/17/98, he reported to the infirmary (after a fight) with a bloody and swollen nose. The next day, local hospital physicians determined that his nose was fractured.

For the two-week period, April 12 - 25, 1998, 40 different youth also reported to the infirmary for treatment of accidental and sports injuries. The number of these accidental injury reports, as well as the nature of the injuries themselves (i.e., a fractured jaw attributed to walking into a door; a swollen jaw and left eye attributed to playing basketball; a fractured hand to a fall in the bathroom; a swollen jaw from falling on a bathroom sink) suggested that many of these injuries were more likely to have occurred in fights with other offenders and/or in altercations with a staff person. Several youth acknowledged that they would sometimes falsely report the cause of injuries to avoid a ticket for fighting. [See boxed insert on the next page].

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☐ **Excessive Use of Force in the Management of Offender Disobedience and Disorderly Conduct**

Use of force reports, special investigations of offenders' allegations of abuse, and staff interviews clarified that a major factor contributing to offenders' serious traumatic injuries was the subsequent force used by security officers in interrupting offender fights and/or in addressing acts of offender defiance and/or disobedience. Logs for April 1998 revealed that such events were daily occurrences in many dormitories.

One-third of the 35 special investigations reviewed (2/1-3/15/98) included acknowledged reports of officers that they had intervened in offender fights by taking offenders to the ground, or by kicking or pushing offenders backwards or up against a wall. There were also many reported cases of officers' using excessive force to address relatively innocuous acts of alleged offender disobedience. Although the officers' accounts of all of these incidents cited acts of offender defiance or disobedience --- in none of the cases was the use of force reasonable in light of the facts reported.

Several examples are illustrative:

- ◆ *In response to an offender's refusing a haircut:* Four officers admitted holding down an offender in the facility's Barber Shop as he resisted getting his hair cut. According to the officers, the offender was held by his arms and legs throughout the haircut, but he continued to resist causing minor scratches to one of the officers. [#S0398045]

**Suspicious Offender Injuries
Attributed to Sport Events or Other
Accidents**

- ☐ D.G. reported that he fractured his jaw by walking into a door. [4/24/98]
- ☐ W.H. reported that he fractured his hand when he fell in the bathroom and hit his hand on the locker. [2/15/98]
- ☐ T.D. reported to the infirmary with a swollen jaw and left eye. He stated that he was accidentally injured by another youth playing basketball. [3/23/98]
- ☐ B.C. reported that he had injured his swollen jaw by falling on a sink. [3/21/98]

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- ❖ *In response to an offender's begging for a new pair of shoes:* One officer admitted pushing an offender backwards (at which point the offender fell to the floor) because the offender had gotten in his face asking for a new pair of shoes. [#S0298043]
- ❖ *In response to 'feeling someone' touch his buttocks:* One officer admitted that he turned around quickly and kicked the nearest offender to him when he felt someone touch his buttocks. The 'kicked' offender had a large welt on his abdomen. [#S0398044]
- ❖ *In response to an offender's refusing to leave the dining hall:* One officer admitted grabbing an offender by his shirt and dragging him out of the dining hall. Reportedly, the offender had refused the Sergeant's order to exit the dining room. [#S0398057]
- ❖ *In response to an offender's repeated attempts to retrieve his deodorant [contrary to orders]:* A cadet admitted grabbing an offender with both arms when the offender tried to retrieve his deodorant which had been confiscated in a dorm search. The video showed that in short period of time the officer had actually physically intervened three times with the offender over the deodorant. There is no clarification why the cadet did not wait for a more senior officer to deal with the situation. [#S0298030]
- ❖ *In response to two offenders' breaking line formation to run ahead to elude the rain:* A cadet admitted becoming angry with two offenders who had run into the dining hall to avoid the rain contrary to a direct order. The cadet admitted pulling the two offenders out of the dining hall, and with the Sergeant, placing both in handcuff restraints. [#S0298035]

Of note, investigations did not substantiate officer abuse in any of the above cases, and in one case (#S0398044) did the investigation making a finding of officer use of excessive force. In five of the cases, investigations did not even consider whether the officers' methods of physically intervening were appropriate. Youth who were witnessing the incidents were also almost invariably not interviewed as a part of the investigations of these cases.

❑ Unusually High Use of Administrative Segregation

Swanson CCY, like Tallulah CCY, also relies extensively on the placement of children in isolated segregation. Analysis of the administration segregation log for the one-week period, 5/11-5/17/98 indicated that 83 of the approximately 420 youth at the facility or almost 20% spent at least some time in administrative segregation. Twenty-three (23) of these youth spent more than two days in this week in administrative segregation.

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There was also substantial evidence that some cognitively impaired/mentally retarded youth at Swanson CCY were repeatedly subjected to isolated segregation. The repeated segregation of mentally retarded and cognitively-impaired youth is uniformly recognized as inappropriate and potentially harmful. The recurring use of segregation with the following seven children with IQs of 70 or less well illustrates that most of these children did not respond well to being segregated. For these youth, as well as many other mentally retarded youth at the facility, the most predictable outcome of extended segregation was simply another closely timed readmission to segregation.

- ❑ P.C., who has an IQ of 66, spent at least 13 days in isolated segregation between 4/28/98 and 5/13/98.
- ❑ T.D., who has an IQ of 64, was admitted to segregation on 5/1/98, 5/13/98, and 5/16/98. It appeared (because T.D. was not listed on the next day's segregation log) that he was released each time within 24 hours, although this was not always properly documented on the log.

**Over Representation of Children with
Cognitive Impairments/Mental Retardation
in Administrative Segregation Cells
Swanson CCY, May 1, 1998**

- ❑ A Swanson CCY listing of children's intelligence quotients (IQs), as assessed at Jetson CCY, provided scores for 433 children.
- ❑ Approximately, one-fourth (24%) of these children had IQ scores of more than 90, and approximately one-fourth (26%) of these children had IQ scores of 70 or below.
- ❑ Yet, the Swanson Administration Segregation Log indicated that twice as many children with IQs of 70 or below (11) than children with IQs more than 90 (5) were in segregation cells on May 1, 1998.

- ❑ A.P., who has an IQ of 70, was admitted to segregation on 4/30/98, released on 5/1/98, and admitted again on 5/3/98. He was admitted to segregation for the fourth time just eight days later on 5/11/98.
- ❑ J.S., who has an IQ of 70, was admitted to segregation on 4/29/98, and according to one log listing, he was released on 5/3/98 and readmitted sometime afterward. According to a second listing, however, he remained in segregation continuously from 4/29/98 through 5/12/98 (15 days) when he was transferred to the Holly Dorm.

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- ❑ L.G., who has an IQ of 61, was admitted to segregation on 5/14/98, 5/15/98, and 5/17/98. He remained in segregation as of 5/18/98.
- ❑ T.W., who has an IQ of 68, was admitted to segregation on 4/30/98 and released on 5/1/98. He was again admitted to segregation on 5/12/98 and released on 5/13/98.
- ❑ C.T., who has an IQ of 80, was admitted to segregation on 5/1/98 and released on 5/2/98. He was again admitted on 5/10/98 and 5/15/98. As of 5/18/98, he remained in segregation.

Well over half of the children (58%) placed in administrative segregation during the 7-day period studied were children with borderline or more severe mental retardation. These cognitively-impaired children also represented more than half of the children (52%) who were placed in segregation for more than two days of the 7-day period.

The data also clearly indicated that low IQ youth were disproportionately represented in segregation cells relative to the numbers of these youth at Swanson CCY.

- ❑ Although children with IQs over 80 represented more than half of the census (52%) -- they represented only 42% of the children placed in segregation during the 7-day period.
- ❑ By contrast, children with IQs of 80 or less represented 58% of the children placed in segregation during the 7-day period, while they represented only 48% of the children in residence.

❑ Special Risks for Youth with Mental Disabilities

Like the other three secure juvenile correctional facilities, Swanson CCY has inadequate services and staff to meet the needs of its increasing number of high risk, mentally disabled youth. In some respects, however, this problem manifests itself more poignantly at Swanson -- as all of the youth confined here are long-term offenders. As discussed below, the absence of any substantive mental health treatment to youth at Swanson CCY has resulted in many of these children being harmed and in almost all of these children being confined to the most restrictive living units (often segregated isolation) for all or almost all of their incarceration. Thus, Swanson continues to fail to protect many youth with mental disabilities from harm.

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The facility does not offer any regular counseling or cognitive and behavioral therapies even for its troubled youth with extended periods of confinement of three or more years. Many of these youngsters have had extremely traumatic childhoods marked by parental alcohol and substance abuse, recurring sexual and physical abuse, the violent deaths of one or more close family members, and long early histories of parental neglect of their protection needs.

The adverse impact of this inattention to the children's mental disabilities was most apparent among the number of children suffering from depression, suicidal ideation/attempts, and histories of sexual victimization. In the first four weeks of April 1998 -- 15 such children required medical attention in the facility's infirmary.

- ❖ Two youth (J.P., 4/11 and M.I., 4/23) were seen in the Infirmary for suicide attempts;
- ❖ Seven youth, in addition to those above, spent at least several days in the Infirmary for suicide watch in April 1998 (T.A., 4/9; T.W., 4/10; T.D., 4/15; A.L., 4/22; D.S., 4/22, J.B., 4/23; R.H., 4/27)
- ❖ One youth (T.W., 4/9) was seen in the Infirmary for 'self-destructive' behavior;
- ❖ One youth (B.C., 4/2/98) was so disturbed that he was placed in a straight-jacket and leg irons;
- ❖ One youth (G.F., 4/24) was seen in the Infirmary for an alleged rape;
- ❖ One youth (C.T., 4/23) was seen in the Infirmary with complaints that his buttocks hurt from having sex;
- ❖ One youth (J.P., 4/5) was seen and placed on protective custody for flashbacks;
- ❖ One youth (K.C., 4/6) was seen for sex offense examination; and
- ❖ Three youth were seen for testicle pain of undisclosed cause (M.D., 4/3; B.A., 4/3; K.S., 4/11).

The Warden also acknowledged that few of the children suffering from significant mental disabilities achieve 'honor dorm' privileges -- and that the majority live in the most restrictive campus dormitories. The most seriously impaired and/or disruptive of these children spend most of their confinement on the locked (closed) campus in one of the institution's 30 segregated isolation cells. Here, youth spend the vast majority of their days in stark cells, by themselves, with little or nothing to do. As noted above, cognitively-impaired and mentally

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retarded youth represent well over half of the children at the facility who are subjected to segregation.

Another large contingent of these youth live in one of the four Holly Dorms on the locked campus and in the Pecan Dormitory on the open campus -- which is designated for weak and frail offenders --- many of whom have histories of sexual victimization and/or sexual offending. The frequent reports of sexual and physical assaults in the Pecan Dormitory caused this expert to question the reality of this 'protective' setting. The Warden admitted that although he personally tried to pay more attention to the Pecan Dormitory, this 'special setting' was not afforded any different staffing or programming than the other open campus dorms. The Nursing Director and the Special Investigator agreed that from a youth management perspective, the Pecan Dormitory, is the most difficult of all the campus dormitories -- and that with only two sergeants on duty at any one time, it was simply not possible to prevent all physical and sexual assaults among offenders before they happened. This continued failure of the State to ensure that its juvenile correctional facilities have sufficient staff to protect confined high risk juveniles from harm is an egregious departure from accepted professional standards.

❑ Questionable Dismissal/Hirings of PZT Special Investigators

Swanson's special investigations of abuse and neglect had improved since my prior visit in January 1997. Many investigation reports reflected attention to basic investigatory standards and techniques, and it was apparent that the facility's former special investigator (Ms. E.) had benefitted greatly from the special training and supervision provided by the Department and Major Pepper. Documentation in investigation records, including many offenders' statements, also clearly indicated that offenders believed Ms. E. to be fair and responsive to their complaints -- even when her investigations did not substantiate their allegations.

Despite these improvements, there remained some deficiencies in Ms. E.'s reports. The most common ongoing problems in Swanson's special investigations were the failure (1) to ensure reasonable follow-up efforts to resolve conflicting testimony, and (2) to interview all offender witnesses. There were also a number of apparent typographical errors involving dates in reports. In a number of cases, for example, dates of interviews supposedly conducted in the course of investigations were after the date of the report. In a few cases, the investigator had also referenced interviews in the conclusion section of reports that had not been summarized in the interview findings.

Generally, however, there was improvement in Swanson CCY's special investigations since my prior visit, and thus, it was of concern that the new Warden had recently removed Ms. E. and replaced her with a captain (Capt. F.) who not only had no special investigator training or experience, but who had also been recently dismissed from Tallulah CCY --

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reportedly because of misconduct.² Unfortunately, Captain F.'s troubled past at Tallulah CCY was also well-known among officers and some offenders on the campus. The Warden could provide no reasonable explanation for his decision to replace Ms. E. With Capt. F. -- but he did acknowledge that Capt. F. had not performed well in his investigator duties and that he now planned to appoint a lieutenant (Lt. L.) to these duties.

This second choice also seemed questionable as Lt. L. (who had only recently been promoted from sergeant provisionally) also had no special investigatory experience or training. The Warden reported that he hoped to compensate for this limitation by having the previous special investigator (Ms. E.) supervise Mr. L.. Ms. E., however, had been assigned many new duties, and she reported that she would have little time to perform this supervision.

The Warden's choice of Lt. L. was also questionable in view of Lt. L.'s past criminal and performance record. This Lieutenant had several criminal convictions since 1990, including convictions for driving while intoxicated [twice], disturbing the peace [while intoxicated], failure to yield to a stop sign, driving left of center, speeding, and driving with a suspended license [all while intoxicated]. He had also been disciplined in 1994 for failing to follow procedures 'with regard to initiating a confrontation between an officer and an offender' and again in 1995 for hitting an offender and then falsifying an escape charge against the offender. As recently as February 1997, he had again been found guilty of failing to file a use of force report in an abuse investigation. The Warden justified his decision to appoint an officer with such a troubled performance history to be his special investigator by stating that he did not trust the prior disciplinary reports.

Although the Warden may have personal reasons for wanting to appoint his own special investigator, both the nature of his choices of replacements and the timing of these decisions more than six months after he was appointed and soon after he disagreed with the former special investigator's (Ms. E.'s) substantiation finding in a particularly serious allegation appeared improper. [See boxed insert on page 12.]

It is only reasonable to predict that the Warden's chain of decisions from his removal of Ms. E. to his initial appointment of Capt. F. and his subsequent appointment of Lt. L. would likely be perceived by both officers and offenders as weakening the integrity of Swanson's special investigation process. When I spoke with the Warden about this likely adverse outcome of his actions, he was staunchly defensive of his commitment to the Department's PZT initiative, and he stated that he did not care about gossip or perceptions of others.

² It should be noted that Capt. F. had been rehired by Swanson CCY in July 1997, prior to the appointment of the current Warden. He was, however, promoted by the Warden since his arrival. Additionally, there is no indication in the Captain's file that at the time of his hiring, any reference checks were conducted of his work history or his performance at Tallulah CCY.

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Notwithstanding his affirmations, the Warden's decisions did not appear to be based on reasoned deliberations of their likely 'chilling' effects on both offender and officer confidence in the special investigation process.

In short, nearly two years after my initial review of Swanson CCY and my repeated recommendations that abuse allegations be adequately investigated, the facility still lacks adequately trained and competent investigators. The Warden's apparent interference in the selection of special investigators, allegedly under the direct supervision of the Department, is an indisputable problem. Especially given the recent history of these facilities, the State must provide more assurances and oversight that special investigators will not be dismissed arbitrarily when the Warden disagrees with their investigation conclusions. For obvious reasons, such central office independent oversight of these decisions is critical to an accountable investigation process.

❑ Other Questionable Personnel Decisions

Anonymous allegations reported by Swanson CCY staff caused this expert to review the personnel records of approximately 10 current employees of the facility. These reviews surfaced a number of questionable personnel decisions in recent months whereby individuals were hired or promoted who had recent problematic performance and/or criminal records.

For example, there were other instances (in addition to Capt. F.) where employees had been hired after their termination from Tallulah CCY with no documentation of reference checks with Tallulah officials. In other instances, employees had been promoted despite recent serious criminal records. There were also instances where criminal record checks of employees were not in their records. Finally, there were cases, in addition to Capt. F. and Lt. L., where employees with recent histories of sustained performance offenses and discipline related to undue use of force and/or offender abuse or neglect had been promoted.

The examples below are illustrative:

- ❖ L.G.'s criminal record check, dated March 1990, listed three criminal convictions for illegal drug possession, one conviction for negligent driving, and one conviction for extortion, from 1984 - 1990. He was recently promoted to be the director of the facility's recreation program without any updated criminal record check.
- ❖ S.H. was hired at Swanson CCY on 1/16/98. Although it was known that he had worked the previous year at Tallulah CCY, there is no documentation that any reference checks were conducted. [In fact, S.H. had been terminated from Tallulah CCY subsequent to an abuse investigation.] There was also no criminal record check in S.H.'s personnel file.

The Warden's Questionable Reversal of a PZT Investigator's Findings of Officer Neglect

On 3/14/98, an offender (G.F.) fractured his nose at Swanson CCY. According to G.F., his nose was broken in a fight with another offender in a dorm bathroom where there are no cameras. G.F. further alleged that the fight had been sanctioned by the Sergeant (W.H.), who was supervising the dormitory. G.F. added that when the Sergeant noticed his injury, he sent another offender in to clean up the blood, but that he (G.F.) was not immediately given medical attention.

Upon interview, the Sergeant denied the allegation that he had sanctioned or permitted the fight to occur. The investigator (Ms. E.), however, did not find this account credible. Her viewing the video tape (which have no audio) indicated that the boys had been in the bathroom for 45 minutes -- during which time they should have been checked by the Sergeant. The video also showed the Sergeant entering the bathroom or at least going to the entrance on several occasions. The video also showed a youth entering the bathroom area with a mop and pail (assumedly to clean up the blood). There were also a number of offenders who presented convincing corroborating testimony to G.F.

Based on her analysis of the evidence, Ms. E. substantiated neglect against the Sergeant. This decision was, however, reversed by the Warden, and he sent a letter to Major Pepper criticizing the special investigator's investigation. The Warden stated that the investigator had overstated the situation and had implied that the Sergeant had simply sat at his desk and done nothing over the entire time -- neglecting his duties and attention to the offenders. [This observation was, however, not stated in Ms. E.'s report.]

Due to the unusualness of this situation and the apparently serious charges leveled against the former special investigator -- this expert reviewed the critical video tape. After several viewings of the video tape, I was able to confirm that the offenders were in the bathroom area for at least 45 minutes, that the Sergeant had walked to the entrance of this area several times, that the Sergeant witnessed a youth enter the bathroom area with a pail and mop, and that the Sergeant witnessed the offender G.F. exit the bathroom area with a towel to his face -- but did not offer him medical assistance or transport. Segments of the tape also clearly indicated that the Sergeant had difficulty maintaining order in the dormitory and that on at least one occasion he had struck an offender. In short, my viewing of the video tape led me to determine that a preponderance of the evidence sustained the offender's allegation.

When confronted with our opinion, the Warden reported that he had only viewed a small segment of the video tape, and based on this, he had come to another opinion. The Court's Expert urged the Warden to re-review the video tape.

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- ❖ T.W., one of only two sergeants who have been promoted by the new Warden to lieutenant (the other was Lt. L. mentioned above), had just months before (8/97) been found guilty of obstructing a special investigation of abuse and neglect at the facility.
- ❖ T.K. was terminated from Tallulah CCY due to abuse. He had admitted taking an offender to a Burger King for about an hour and a half to have a beer with some of the officer's his fraternity brothers. Shortly, thereafter, he was hired at Swanson CCY -- with no documentation of a reference check of his performance history at Tallulah. Within months of his hiring (12/10/97), T.K. was found guilty of striking an offender. For this offense, he was demoted to cadet rank for ten months, but allowed to stay employed at Swanson CCY.
- ❖ K.M., who served as the 'coach' at Swanson CCY, had been employed at the facility at least since 1987. There was, however, no criminal record check in his record. [K.M.'s record was selected for review because other staff members had alleged that he had recent criminal charges related to alcohol/substance abuse.]

There are evident unreasonable risks of harm associated with the State's continued hiring of individuals with criminal records. Additionally, the State has yet to develop reasonable safeguards for updated criminal checks on employees already working in its juvenile facilities to ensure that they are notified of recent criminal charges/convictions against members of its standing workforce.

☐ **Staffing Shortages and High Turnover**

Ongoing staffing shortages, as well as high staff turnover are also critical barriers to ensuring needed improvements in the supervision and discipline of youth and officers at Swanson CCY. As of April 28, 1998, 20 of the 177 authorized security positions were vacant. Since all authorized positions are required to meet minimum staffing, the facility was compelled to rely on overtime staff daily just to meet daily staffing minimums.

Facility data also showed that in the five months, 11/2/97 - 4/19/98, 45 employees (almost all security staff) had resigned, retired or been terminated. If this turnover rate continues, the facility will hire/terminate an estimated 90 security staff this year --- or about 50% of its entire complement of security staff.

The Warden reported that despite all of his efforts he had not been able to overcome these problems. He stated that unless there was some wage relief allowing the institution to more competitively recruit personnel in the local community, as well as better and more

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tailored training for new recruits for the secure youth facilities, he would never be able to fill all of his vacant security positions or curtail the high turnover rate of security officers.

The Warden, as well as this expert also noted that the staffing allocation of only a single officer in all four dormitory areas of the closed campus Holly Dormitory was inadequate and dangerous. Each of these dorms serve 36 offenders, identified as being particularly difficult to manage. By contrast, most dorms on the open campus, which are designated for less difficult offenders are assigned two staff members for 30-44 offenders. [See boxed insert p. 16.]

☐ **No Accountability in Video Monitoring Practices**

In prior reports regarding Swanson CCY, this expert had noted that the facility's limited video monitoring capacity was often compromised by 'broken' cameras, cameras which ran out of video tape, and cameras that had inexplicably been turned off. In addition, in many cases, reviewed tapes have abrupt jumps over critical segments, which were not readily explainable. These problems were identified as very serious, not only because they compromised the thoroughness of many special investigations of allegations of officer abuse, but also because officer complicity in the frequent video monitoring defaults appeared to be highly likely. This follow-up review indicated that little had been done to address these problems and that, in fact, the pervasiveness of the problems in the accountability of video monitoring may have worsened.

Disparate Security Staffing for Youth Who Require the Most Secure Custody

	Authorized Staff Per Shift	Number of Offenders
Closed/Secure Campus		
Holly A	1	36
Holly B	1	36
Holly C	1	36
Holly D	1	36
Cypress A	1	15
Cypress B	1	16
Open Campus Dorms		
Pecan	2	38
Pine	2	42
Red Bud	2	34
Mimosa *	2	44
Willow *	2	38
McKoin **	2	40
All Purpose	2	30

(* - Honor Dorms; ** - Semi-Honor Dorms)

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Of the 28 special investigations initially sent to this expert for review, 10 occurred in areas where the facility had video monitoring capacity.³ In only half of these cases (50%), however, were videos actually available to verify what had occurred. A variety of problems were found with the faulty video monitoring.

- ❖ In one case, the video camera had been inexplicably turned off at the time of alleged abusive incident. [#S0298034]
- ❖ In one February 1998 case, the two video cameras in the dormitory had reportedly not worked for months (one had been broken since 12/8/97, and the other since 10/6/97). The Special Investigator reported to this expert that there was no reasonable explanation for why the broken cameras had not been reported earlier. [#S0298036]
- ❖ In one case, the video tape in the video camera was 'coincidentally' being changed just at the time that the offender had alleged that the Sergeant assaulted him. [#S0398051]
- ❖ In two cases, the evidence of the tape was compromised because the 'time' on the video camera had been incorrectly set. [#S0298030; #S0398048]

Swanson CCY's former special investigator confirmed that there continued to be many problems with the accountability of video monitoring in the dormitories which had this capacity. She also reported that to her knowledge no officer had been disciplined for complicity and/or inattention to duty contributing to the video monitoring problems in the above cases.

Warden Travis acknowledged problems with video cameras and reported that he planned to purchase a more state of the art system in the near future. He also agreed that it would be important to establish firm protocols for staff conduct and responsibility with regard to the videos. Notwithstanding these commitments, Swanson's administration's failure to lax response to apparent officer interference in the institution's video monitoring capacity long-term has sent a message fundamentally in conflict with the mission of the Department's Project Zero Tolerance Campaign.

³ Many areas of the Swanson CCY campus are not under video surveillance, including several dormitories on the open campus, all outside areas, the dining room, all shower areas, the Barber Shop etc. Additionally, in two cases, videos reportedly taken of the scene had been intentionally erased in the two-week intervening period between the date of alleged abuse and the date when the offender initially reported his complaint.

**A Review of Louisiana Training Institute at Bridge City
Bridge City, Louisiana
May 11 - 13, 1998**

**Prepared by
Nancy K. Ray, Ed.D.**

**For the Civil Rights Division
of the United States Department of Justice**

EXHIBIT C

LTI at Bridge City
May 1998

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☐ Protection of Weak and Fragile Youth, Including Youth with Mental Disabilities	
☐ Environmental Conditions	
☐ Illegal Drug Use	
☐ Staffing Shortages	
☐ No Video Monitoring	

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Executive Summary

This review of the Louisiana Training Institute at Bridge City was conducted at the request of the Civil Rights Division of the United States Department of Justice. I was asked to assess the facility's ability to provide a safe and secure environment for youthful offenders, with special attention to protections from injuries due to offender-to-offender violence and officer-to-offender abuse, mistreatment, and neglect. Of note, this was my third review of Bridge City. I had conducted prior reviews of the facility in June and December 1996.

My review was conducted over the three-day period May 11-13, 1998. During this review, I visited most areas on the campus, interviewed staff and offenders, and reviewed numerous documents. The specific review activities are listed on page 1 of the narrative report.

As reflected in this report, during my most recent visit, I noted several areas of improvement at Bridge City. These included markedly fewer offender complaints of officer abuse and mistreatment. Indeed, the vast majority of the offenders interviewed stated that officers treated them fairly and only intervened physically when offenders were fighting with one another. [See Report pp. 3.]

The veracity of the offenders' accounts of much diminished officer abuse of youth at the facility was, however, called into question by an exceptionally brutal officer assault on four youth just several days after my on-site tour. As confirmed in a Bridge City investigation, on May 17, 1998, a sergeant attacked four youth for talking -- throwing

shoes at their heads and faces, punching them in the face, and slamming them with a plastic chair. Two of the youth suffered significant injuries. [See Report p. 4.]

Bridge City had also hired an extremely well-qualified and competent lead investigator, who was assisted by a junior investigator. This investigative team conducts high quality investigations which meet professional standards for child abuse and neglect investigations. The improved quality of special investigation led to an increased substantiation rate from 9% to 32%. The close collaboration and support of the Superintendent and the facility's Personnel Director has also ensured timely disciplinary action in most sustained investigations. [See Report pp. 3-5]

The Superintendent also presented an impressive listing of new and planned programs to promote youth involvement in constructive activities and to encourage good youth behavior and academic performance. Already implemented programs include: an open honor dorm for offenders with no tickets, a facility choir, a facility welcoming committee, and weekly dormitory competitions with rewards for youth in winning dormitories. Other planned initiatives include upgraded visitation facilities and programs, an on-site 'home-theater program, a color guard program, and an etiquette educational program. [See Report pp. 5] Bridge City has also recently implemented a lengthened school program. [See Report pp. 6]

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Despite these accomplishments, offender and staff safety and protection from harm at Bridge City remain imperiled in many respects. As detailed in the narrative of this report, environmental maintenance and safety problems, illegal drug use on the campus, and a high incidence of offender-to-offender violence persist at the facility. These problems are compounded by other on-going deficiencies -- including serious staffing shortages and fundamental inadequacies in Bridge City's weak and fragile offender program and its services to mentally disabled youth.

Several of the most serious deficiencies noted during the review are listed below:

■ Although the reports of serious/moderate injuries from officer violence have decreased in 1997/98, the incidence of serious/moderate injuries from offender-on-offender assault have not. Since January 1998, 20 offenders required treatment in hospital emergency rooms for traumatic injuries (usually fights), and 21 offenders had scheduled appointments in orthopedic and ENT clinics at local hospitals for the follow-up care of traumatic injuries. [See Report pp. 7-10]

■ Segregation cells at Bridge City are dangerous, poorly maintained and odorous cells with no bathroom facilities. In the period February 1-May 9, 1998 at least 46 different offenders were placed in these cells at least one time. Thirteen (13) offenders were placed in segregation cells more than one time during this period. Many features in these rooms present dangers

to self-injurious and suicidal youth. [See Report pp. 10-11]

■ Although all youth at Bridge City were potentially unprotected from preventable harm, there was objective evidence that youth specially placed at Bridge City due to their classification as "weak and fragile" and/or due to their having mental/physical disabilities, were especially vulnerable to these harms. Facility documents confirmed that these children were much more likely than other children at the facility:

- (i) to have been victimized by sexual and physical assaults by other offenders;
- (ii) to have been seriously injured requiring hospital treatment; and
- (iii) to have been placed in isolated segregation.

Although Bridge City officials attempted to segregate offenders classified as weak and fragile in its Brown Dormitory, no special program or staffing accommodations were made for their specific physical limitations and/or mental disabilities. [See Report 11-12]

■ Environmental problems were observed in virtually all areas of the facility visited. Many of these problems presented immediate potential suicide hazards, and others presented ready opportunities for youth to craft

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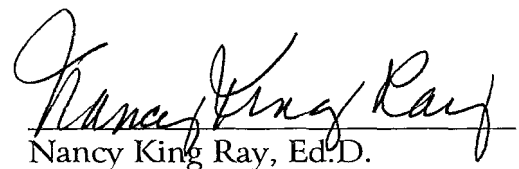
weapons which could be used to harm other youth or officers. Additionally, long-term maintenance neglect (as well as poorly done repairs) has resulted in massive underlying problems in roofing integrity, the electrical service, and the plumbing infrastructure throughout the facility.

Correction of the pervasiveness of the safety hazards and capital plant maintenance problems will require a long-term, comprehensive capital renovation plan. In the short-term, however, certain problems must be corrected immediately both because of the danger that they present to youth and because of their apparent security risks to both youth and facility staff. [See Report pp. 12-15]

- During the tour I, as well as several other members of the review team, witnessed direct evidence of marijuana use in several different areas of the campus. I also received credible reports and obtained direct evidence that the facility assured poor accountability of its large stock supply of prescription medications used to treat anxiety, depression, and mood disorders. [See Report pp. 15-16]

- Serious staffing shortages and a very high annual staff turnover rate are major contributing factors to the facility's problems. As of May 9, 1998, almost 20% of the facility's line security positions and more than 50% of its maintenance positions were vacant. Data for the first four months of 1998 regarding staff resignations, retirements, and terminations suggest that unless staff turnover abates, the facility will have more than a 100% turnover in security staff by the end of the year. [See Report p. 17]

- The facility has no capacity for video monitoring. This capacity would allow the facility an important resource in the conduct of special investigations. It may also aid the facility in addressing the apparent problems with illegal drug use on the campus. [See Report p. 18]


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I. Introduction

This review of the Louisiana Training Institute at Bridge City was conducted at the request of the Civil Rights Division of the United States Department of Justice. I was asked to assess the facility's ability to provide a safe and secure environment for youthful offenders, with special attention to protections from injuries due to offender-to-offender violence and officer-to-offender abuse, mistreatment, and neglect. Mr. John Whitley, the Court Monitor, accompanied me on my tour of Bridge City.

My review was conducted over the three-day period May 11-13, 1998. During this review, I visited most areas on the campus, interviewed staff and offenders, and reviewed numerous documents. My specific review activities are listed below.

- ☐ Tours of three of the five residential dormitories (Kennedy, Brown, and the Open [Honor] Dorm), the on-campus school, the recreational building, the gym, segregation rooms, and the Infirmary (including its small inpatient unit and on-site 'pharmacy')
- ☐ Observations of children and staff in the campus school, in the Infirmary, and on the campus during youth drills and movement to the dining room
- ☐ Interviews with the Superintendent, the Special Investigator for PZT, the Director of Personnel, the Nursing Director, the facility's part-time psychiatrist, physician, and dentist, as well as the dormitory counselors for the Brown Dormitory designated for weak and fragile youth
- ☐ Review of PZT special investigation reports completed by the facility from March 15 - May 10, 1998 (24 reports)
- ☐ Review of the complete records of 12 children who were seriously and/or frequently injured at the facility in recent months
- ☐ Interviews with 10 children who were seriously and/or frequently injured at the facility in recent months
- ☐ Review of infirmary logs recording hospital emergency room visits, outside hospital clinic appointments, and infirmary inpatient stays for the period 9/1/97 - 5/10/98
- ☐ Review of the facility's 'time-out' (room segregation) log for the period 2/1/98 - 5/9/98

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It is also relevant to note that this was not my first visit to the Louisiana Training Institute at Bridge City for the U.S. Department of Justice. I had made prior visits to Bridge City on June 2-3, 1996 and December 16, 1996. The focus of the December 1996 visit was to assess Bridge City's progress in implementing the Louisiana's Department of Corrections' Project Zero Tolerance (PZT) initiative.

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II. LTI at Bridge City's Accomplishments

Since my last visit to Bridge City in December 1996, some improvements were especially notable.

☐ Fewer Offender Complaints

Perhaps the most striking difference in this tour and my previous visits to Bridge City was the content of the offender interviews. Offenders reported that officer violence on offenders was infrequent and that it usually occurred only when offenders fought. Upon direct questioning, all of the 10 offenders interviewed reported that officers usually treated the youth fairly. Most acknowledged that officers' physical intervention was triggered by offender violence and direct disobedience of reasonable orders. Notably, these positive reports were received from both long-term and short-term [STOP] offenders.

The veracity of these accounts of much diminished officer abuse of youth at the facility was, however, called into question by an exceptionally brutal officer assault on four youth just several days after my on-site tour. As confirmed in a Bridge City investigation, on May 17, 1998, a sergeant attacked four youth for talking -- throwing shoes at their heads and faces, punching them in the face, and slamming them with a plastic chair. Two of the youth suffered significant injuries. While the facility's response to this incident of abuse affirmed its ability to swiftly and capably investigate and respond to such incidents --- that such a brutal act could occur with initial officer cover-up and multiple false reports is a signal that Bridge City CCY has clearly not yet attained the goals of the Department's Project Zero Tolerance. [See Report p. 4]

☐ Quality PZT Special Investigations

Previously, Bridge City officials had handled offender complaints of abuse and mistreatment 'informally.' No formal investigation reports or findings were prepared. As of October 1997, however, Bridge City hired an extremely well-credentialed lead special investigator, with prior State Police and District Attorney investigator experience. This investigator works in tandem with a sergeant on the facility's security force in conducting special investigations.

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**A Brutal Officer Assault, An Orchestrated Cover-Up, and Denial of Medical Care
Followed By Courageous Family and Youth Reporting and a Timely, Thorough
Investigation Result in an Officer's Termination**

On May 17, 1998, at about 2:30 pm, J.M.'s mother and two sisters made the drive from Baton Rouge to visit their son and brother, who was enrolled in the Short-Term Offender Program (STOP) at Bridge City CCY. They met J.M. coming up the walkway crying and holding an ice bag to his head, which was disfigured by a large hematoma. J.M. told his mother that he had been beaten by a guard for talking. According to J.M. and later confirmed in Bridge City CCY's investigation, the officer had thrown shoes at the youth, punched him in the face, and broken a chair over his head. The infirmary report indicated that J.M. suffered a hematoma on his head and a scratch to his elbow.

The investigation further discovered that the officer had also attacked the youth (J.C.) who was talking with J.M., punching him in the face and hitting him in the arm with the now broken chair. J.C. suffered a large hematoma to his left arm. The investigator also learned that shortly after assaulting J.C., this same officer assaulted two other youth who lived in the Kennedy Dormitory. One of these youth (V.S.) suffered bruises on the right side of his chest and on his arm; the other (T.T.) suffered a hematoma on his arm.

The investigator further confirmed that the officer had told the youth not to report the abuse and threatened them with more harm. He also encouraged the youth to prepare false statements of the incident. While the sergeant allowed J.M. to go to the Infirmary for medical care -- this did not occur until almost two hours after the assault, and J.M. was told to report that he had injured himself falling down the stairs. None of the other offenders were allowed by the officer to report to the Infirmary. (These youth received medical care only after J.M.'s family reported the complaint.)

Records showed that J.M. and the other youth were initially compliant with the officer's request to cover-up. The youth came forward only after J.M.'s family's complaint and the initiation of a formal investigation by Bridge City CCY officials. The investigation also confirmed that the other officer in the dormitory at the time, a cadet who had worked in the dorm only about one week, had initially colluded with the more senior sergeant in covering up the abuse. This cadet continued to report that he had seen nothing when first interviewed by Bridge City CCY's special investigator. He came forward only after the special investigator refreshed his memory that lying during an investigation was a punishable disciplinary offense.

This case is a poignant reminder that brutal assaults on youth by officers do still occur at Bridge City CCY -- even on family visiting days -- and that the full objectives of Project Zero Tolerance have not yet been achieved. At the same time, it is a warning of the ease with which officer violence can be covered up by officers --- due to the power they hold over youth, as well as the collaboration of very junior colleagues, who due to the high staff turnover at the facility, may have worked there less than two weeks. Simultaneously, this case also speaks to the value of two important PZT initiatives, the establishment of a competent special investigator team at Bridge City CCY and the valuable outside watchdog benefits of providing more frequent opportunities for family members to visit and observe conditions at the facility. It seems apparent that this case of brutal officer abuse may never have come to light except for the fortuitous appearance of J.M.'s mother and two sisters on the campus, just a few hours after it had occurred.

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I reviewed 24 special investigation reports prepared by this team. Almost all of the investigations had been completed in a timely manner (within 14-21 days of the date of the allegation) and they consistently demonstrated attention to critical standards, including:

- ❖ photographs of offenders' injuries;
- ❖ interviews with all key officer and youth witnesses;
- ❖ explicit assessments of the credibility of witnesses' testimony;
- ❖ re-interviews of witnesses providing conflicting testimony;
- ❖ completion of well-prepared written witness statements; and
- ❖ explicit reliance on the preponderance of evidence in making determinations of the substantiation/nonsubstantiation of offender allegations.

Bridge City's investigations also stood out in their attention to small details -- including the time of particular alleged events and the location of witnesses at the time of the allegation. The investigators also often asked witnesses to 're-enact' their observations at the scene to verify their accounts. The Superintendent's attentive review of PZT investigations was also evident in his periodic requests that the investigation team conduct additional steps before he would approve the investigation report.

The Bridge City investigators, as well as the Superintendent, were also attentive in their final determinations of the officers' full compliance with the PZT guidelines and requirements. Thus, it was not uncommon for PZT investigations at Bridge City not to sustain the offender's allegation of abuse -- but to nonetheless confirm the officer's misconduct in failing to file a use of force report, to call for help from a superior, or to make a fully truthful account of the incident.

The improved diligence of the new investigative team was plainly evident in the outcomes of its investigations. The facility's PZT log indicated that only 6 of the 55 investigations (9%) completed in the first nine months of 1997, prior to the hiring of the new lead investigator were sustained. By contrast, 23 of the 72 allegations (32%) of officer abuse on offenders investigated by the new investigative team over the period 10/97 - 4/97 were sustained.

☐ **New Programs Under Development**

Bridge City officials are also moving ahead in the implementation of many programs designed to promote good offender behavior and school performance. The Superintendent was strongly supportive of these new programs. He reported that many of these incentive programs had been in place at the facility

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several years ago and that they had worked well.¹

The Superintendent provided a list of already implemented and proposed programs . He reported that all programs under development would be in place within weeks of my visit. Several of the programs listed included:

- ❖ an honor dorm program (already in place);
- ❖ upgraded visiting privileges (access to barbecues, private visiting pavilions etc.) for offenders with good performance;
- ❖ weekly dormitory competitions for drill performance, cleanliness, and discipline (partially implemented);
- ❖ a color guard program;
- ❖ a facility choir (already in place);
- ❖ an on-site 'home theater' program;
- ❖ an etiquette program; and
- ❖ a welcome group program (already in place).

The Superintendent also reported that a range of different rewards were available through the above programs, including: use of the facility's swimming pool, increased access to the facility library, late night TV time, birthday parties, bus rides to 'no-where', on-dorm movies, and talent shows. Although these initiatives were a definite improvement and good for morale, it should be stressed that they were no substitute for the comprehensive behavioral programming required by many Bridge City's mentally disabled youth.

☐ Lengthened School Day

Bridge City had recently implemented a lengthened school day. Although security and program staff alike spoke of the benefits to the children and to the discipline on the campus of having the children attend a longer school day --- it was apparent that Bridge City's school program still had many problems. While there did appear to be reasonable discipline in classrooms, even my brief observations in the classrooms indicated that many of the children were not assertively addressing academic goals or objectives.

¹ He explained that when the facility shifted several years ago to become the system's short-term 'boot camp' program, many of the incentive programs were canceled.

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III. Areas In Need of Improvement

Despite these accomplishments, offender and staff safety and protection from harm at Bridge City remain imperiled in many respects. As detailed in this section of the report, environmental maintenance and safety problems, security oversights, and a high incidence of offender-to-offender violence persist at the facility. These problems are both compounded and aggravated by other on-going problems -- including serious staffing shortages, limitations in personnel practices and procedures, and fundamental inadequacies in Bridge City's weak and fragile offender program and its services to mentally disabled youth.

❑ Offender-on-Offender Violence

Bridge City continues to have a high incidence of offender-on-offender assaults, both physical and sexual. There was no indication of any declining trend in offender violence at Bridge City .

- Data maintained in monthly reports prepared by the Infirmary indicated that there were more than 190 sick call visits for the period 1/1/98 - 3/31/98 due to offender-on-offender violence. This number compared to 167 offender fight-related sick call visits for the period 7/1/97 - 9/30/97 and 213 offender fight-related sick call visits in the quarter, 10/1/97 - 12/31/97.

L.H., a mentally retarded offender under psychiatric care

L.H. is 15 years old, mentally retarded, and under psychiatric care. Since his placement at Bridge City he has been involved in fights on an almost daily basis. His medical record documented his treatment in the Infirmary following at least 15 fights with other offenders since January 1, 1998. In the visits, he was treated for numerous scratches, lacerations, abrasions, and bruises -- often to his face.

- On 3/9/98 while in a fight with another offender he was hit in the head with the other offender's crutch and required emergency room treatment and five sutures to treat the head wound. The day after, he barricaded himself in a room and threatened to kill himself.
- On 4/1/98, his ear was injured in a fight; on 4/4/98, he suffered a laceration to his left eye in a fight; on 4/21/98, he self-reported that his chin laceration and scratches on his neck were due to falling out of bed.
- On 5/12/98, when I met with L.H. he had a badly bruised and swollen left eye with a large blood spot. He reported (and his record confirmed) that he had been in a fight on 5/7/98.

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***L.H., a small 13-year-old offender,
with mental disabilities***

L.H. is 13 years old. He weighs 92 pounds and stands 4 feet and 11 inches. He has a history of physical and sexual abuse, documented low intelligence, and a long history of psychiatric treatment.

Officers and Infirmary staff confirm that the past two months have been especially traumatic to this vulnerable offender.

- On 3/15/98, he alleged that he had been sexually assaulted by five other offenders in Brown Dormitory. The Infirmary report quoted L.H., "This happened yesterday and made me ejaculate on them and told me if I didn't, they would beat me up or get someone else to beat me up. This happened before with S.M. and C.D. [two of the five named offenders in this assault.]"
- On 4/2/98, L.H. suffered bruises to his neck and arm from an offender fight.
- On 4/24/98, L.H. was examined at the Infirmary and noted to have bruises and abrasions over most of his body. He reported that he had been pulled out of bed by several offenders who had covered his mouth with a towel, held his legs and arms, and beat him up.
- On 4/28/98, L.H. was reportedly hiding under an air conditioner in the gym. When pulled from this position by officers he suffered abrasions to his back. The next day he told a nurse in the Infirmary that he had been raped in the gym. The nurse described the youth as fearful, shaking, and crouched in a rocking position as he recounted his allegation.
- On 5/1/98 and 5/2/98 L.H. continued to be very disturbed and on at least two occasions he was examined at the Infirmary for self-abuse, including banging his head on walls.

■ According to the Infirmary log, 15 different offenders had regularly scheduled orthopedic appointments to treat traumatic bone injuries for the period 11/97 - 4/98. Another six (6) offenders had Ear, Nose, and Throat Clinic appointments, usually for documented eye injuries and nasal fractures due to fights.

■ The Infirmary's Hospital Emergency Room Visit Log for 1/1/98 - 5/11/98 listed more than 20 offenders who required emergency room treatment for traumatic injuries (almost always due to offender fights). A partial listing of these injuries is illustrative.

- Seven (7) offenders were treated at an emergency room for traumatic injuries to their eyes. Several of these offenders suffered corneal abrasions and at least two required sutures/steri-strips to treat eye lacerations. [L.W. (1/10/98), J.C. (1/21/98), D.H. (2/2/98), J.H. (2/2/98), C.M. (2/17/98), S.L.P. (3/2/98), W.L. (3/26/98)]

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- V.J., a 12-year-old offender was sent to the local emergency room after reporting that he had been raped in his dormitory [Brown] by three other offenders. (3/26/98)
- R.P. was 'snuck' (hit in a sneak attack) and required emergency room treatment for a ear injury and blood in his ear canal. (2/17/98)
- C.L. received a head injury which required emergency room treatment, including staples to close the wound. (2/26/98)
- J. LeB. received emergency room treatment for multiple injuries after he was reportedly beaten by officers. The emergency room physician's treatment orders included that the youth be seen daily by the Bridge City physician for 3-5 days, that he be placed on bed rest for two days, and that he be given Motrin 800 mg. three times a day as needed for pain. (3/5/98)
- D.A. required emergency room treatment for a fractured jaw (allegedly occurred playing basketball). (3/17/98)
- T.McG. required emergency room treatment after an offender fight where he lost a tooth and suffered a laceration to his lip which required sutures to close. (3/24/98).
- D. H. required emergency room treatment for a fractured nose. (5/11/98)

G.V., a 13-year-old mentally retarded youth, weighing only 83 pounds

G.V. is 13 years old, and self-reported that he is the smallest youth at Bridge City . He is apparently of borderline intelligence. Officers confirm that he is involved in fights almost daily in the Brown Dormitory.

His medical record indicated that he had been seen at the Infirmary for at least 15 fights with other offenders since January 1, 1998. Although G.V.'s injuries did not require emergency room treatment, he repeatedly suffered bruises to his face and neck and abrasions and scratches to his neck.

G.V.'s medical record documented that the facility psychiatrist had discontinued his medications (for depression and impulse control) on 4/4/98 noting that he had not been involved in fights. When asked, the psychiatrist reported that he often did not have access to this information formally, and thus he relied on self-reports by youth in making these decisions.

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- As detailed in the boxed case vignettes, there was also evidence that some weak and fragile offenders, specifically placed at Bridge City for their protection, were particularly vulnerable to repeated harm at the hands of other offenders.

Although some staff members and a few children reported that offender fights were sometimes tacitly permitted by officers who either turned the 'other way,' delayed their intervention, or simply slept while on-duty -- there was more evidence that available officers were simply not able to contain the level of offender violence especially in the dormitories.

Most dormitories at the facility housed 40-50 offenders, and usually only two officers (often one sergeant and one cadet) were assigned for coverage. One officer was required to roam the dorm, and the other was required to sit at his desk, leaving many opportunities for offender fights to begin and proceed for some time without officer intervention. Officers' limited ability to control offender violence was especially prevalent in the Brown Dormitory which served offenders classified as "weak and fragile" and the King Dormitory which also served a large number of younger offenders (ages 12-13).

□ Segregation Room Practices

Segregation rooms at Bridge City are dangerous, poorly maintained, and odorous cells with no bathroom facilities. There are multiple features of these three rooms which present dangers to self-injurious and suicidal children, and there are even more features which could allow youth to fashion weapons to harm others. The walls and ceilings are in poor repair; one room's window has no screens, exposing a breakable glass window; another room's light fixture has no cover. The rooms themselves are barren cement rooms, with absolutely no furnishings. Children are compelled to rest on dirty floors, with no sheet or mattress. The strong urine stench in some of the rooms indicated that floors had also been urinated upon.

The hallway bathroom for use by offenders in segregation rooms was filthy and in extremely poor repair. The bath tub was littered with dirt and debris -- including many cigarette butts. The bathroom ceiling was mold covered and damaged. Sink faucets leaked and were extremely corroded. A bathroom window was held shut with a rusty, twisted wire.

Even if these rooms were used very seldom, they would present a harsh violation to the humane treatment and safety of youth at Bridge City. In fact, however, children are placed in these rooms frequently. From February 1 - May 9, 1998, the segregation log recorded 70 segregation episodes, involving 46 different youth, including 13 youth who

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were segregated two or more times during the period. The listing of children subjected to segregation further suggested a pattern of segregation use with the facility's youngest youth and youth who are mentally retarded. One young, mentally disabled youth (G.M.) was segregated eight times during this period.

Other information gleaned from the log indicated that room segregation of mentally disabled youth was often the first, not last resort of officers to calm these children. Most often, segregation was the 'punishment' for fighting -- yet there was no evidence that the children were offered time to calm down in a quiet area of their dormitory or the Infirmary before being placed in segregation. Indeed, the segregation log's documentation often suggested that the children were calm prior to being placed in segregation.² In addition, the facility's psychiatrist and counselors confirmed that there were no special officer training programs to address the impulsive disorders of many of these mentally disabled youth. Officers had also not received any special training for less restrictive interventions for handling altercations involving mentally retarded and mentally ill youth.

Review of the segregation log also indicated that contrary to the facility's policy, youth were often kept in segregation rooms for longer than one hour. Log entries from February 1 - May 9, 1998 showed that 14 of the 70 recorded segregation episodes were longer than one hour, including at least 6 episodes which were longer than two hours (G.V., 3/2/98; G.M., 3/18/98; J. L.'B., 4/13/98; T.A., 4/13/98; J.H., 4/13/98; and J.W., 4/13/98). Three of these offenders (G.V., G.M., and J.LeB., all mentally disabled) reportedly spent more than six hours in segregation rooms. The log also documented many instances when more than one offender was placed in a single segregation cell -- which appeared to both violate the intent of the youths' placement in segregation and present serious potential protection issues for the youth who (according to facility policy) ostensibly were isolated because they were of danger to themselves and/or others.

□ Protection of Weak and Fragile Youth, Including Youth with Mental Disabilities

Although all youth at Bridge City were potentially at risk of preventable harm, there was objective evidence that youth specially placed at Bridge City due to their classification as "weak and fragile" and/or due to their having mental/physical disabilities, were especially vulnerable to these harms. The facility's Superintendent,

² It was standing practice to first transport these children to the Infirmary where they were examined and treated for injuries from the fight. After this examination, they were then transported to the segregation area. Infirmary records almost *never* indicated that youth were violent or dangerous during their pre-segregation exam.

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Social Services Director, and Nursing Director, as well as several counselors, and security officers confirmed the special vulnerability of these youth. Facility infirmary and segregation logs further confirmed that these children were much more likely than other children at the facility:

- to have been victimized by other offender sexual assaults;
- to have been seriously injured requiring hospital treatment; and
- to have been placed in isolated segregation.

Bridge City officials reported that the Brown Dormitory had been set aside specifically for the segregated housing of its "weak and fragile" youth. This arrangement, however, only served to segregate and stigmatize these youth identified in the Jetson Reception and Diagnostic Center. No special program or staffing accommodations were made for their specific physical limitations and/or mental disabilities.

- The Brown Dormitory was not offered any additional security or program staff -- and security and program staff assigned to this dormitory were also not afforded any additional training in addressing the needs of mentally disabled youth.
- Bridge City had also not made any program or scheduling accommodations for these youth who were predominantly very young (11-13) and/or mentally retarded.
- Reasonable accommodations were also not made for physically handicapped youth, who were potentially at greater risk of harm. For example, inadequate accommodations had been made for the visual handicap of a blind youth.

☐ Environmental Maintenance and Safety Problems

In my earlier reviews of Bridge City, I commented on the widespread problems affecting its physical environment. On this tour, I noted few improvements -- and additional signs of environmental deterioration. These problems presented themselves in virtually all areas of the facility visited. As noted below, many of these problems presented immediate potential suicide hazards, and others provided ready opportunities for youth to craft weapons which could be used to harm other youth or officers. Additionally, long-term maintenance neglect (as well as poorly done repairs) has resulted in massive underlying problems in roofing integrity, the electrical service, and plumbing infrastructure throughout the facility.

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The pervasiveness of the problems indicated that if the facility is to continue to be used as a juvenile facility, a long-term capital plant renovation plan will be required to ensure timely and cost-efficient repairs and renovation. In the short-term, however, certain problems must be corrected immediately because of the danger that they present and their apparent security risks.

■ Suicide Hazards

In all dormitories visited, segregation rooms, and infirmary areas, there were many hazards for youth inclined to harm or kill themselves. This concern is of special importance, as record reviews indicated at many points in time in recent months, there have been at least a half dozen youth at the facility with recent histories of potentially lethal attempts at self-harm. In the past several months alone, two youth have attempted to kill themselves by strangulation (with belts) and one youth has overdosed on medications.

Although the listing of specific suicide hazards would be too lengthy to include in this report, some of the more outstanding and common hazards included:

- exposed overhead pipes;
- window screens with broken and sharp pieces of heavy wire accessible to youth;
- bathrooms with exposed overhead pipes and other weight-sustaining fixtures which could be readily used as 'hanging' vehicles by youth;
- segregation rooms with unprotected glass windows;
- segregation rooms with unprotected, open light fixtures with exposed glass bulbs;
- closets in the open dormitory with weight-sustaining, non-breakaway hanging bars, which locked (with bolt locks) from the inside of the door; and
- exposed bed springs which could readily be used by youth to harm themselves.

■ Hazards Which Could Be Readily Converted to Weapons

Other environmental hazards could easily be converted to lethal weapons and they presented safety risks to offenders and staff.

- In almost all campus buildings, there were heavy wire-mesh screens with torn loose pieces which could be manipulated into a weapon.

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- On a number of walls throughout the campus, nail heads protruded $\frac{1}{2}$ to 1 inch out of cement block walls presenting a particular danger to anyone who might be thrown up against the wall.
- Wall heat/air conditioning vents had been partially pulled off walls and could be fully loosened to provide particularly lethal weapons.
- Bathrooms were particularly dangerous sites. Many bathrooms had loosened wall-mounted towel racks, soap and toilet paper dispensers which could be easily pulled from walls and used as weapons.
- In one dormitory, I found a heavy hinged caster (about the size of a baseball) left casually unattended on a table.

■ Bathrooms

Throughout the campus, bathrooms were in a state of disrepair. Faucets leaked and were badly corroded; ceilings were in horrible repair and often covered in mold and mildew; and sinks were sometimes partially pulled from walls. Caulking in almost all areas was failing, and there was much evidence of poorly done partial caulking repairs in the past. I was told that there was a bid out for a bathroom renovation project for the facility, but it was unclear exactly what would be repaired, if all bathrooms would be a part of the project, or when the project would actually get underway or be completed.

■ Electrical Hazards

In every dormitory visited, there were numerous electrical switch plates which were loose or poorly mounted so that part of the electrical switch box was exposed. In other areas, electrical sockets appeared burned. I was told that this was due to offenders (and/or officers) sticking pencils into the sockets to create a flame to light cigarettes (cigarettes are contraband for offenders and officer smoking is restricted in all youth areas of the facility).

Throughout the facility there were also numerous problems with overhead lighting fixtures. Some did not work. More were missing their protective covers exposing light bulbs and electrical light sockets.

The numerous roof leaks throughout the facility also posed likely electrical problems.

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■ Roof, Ceiling, Wall, and Door Repairs

In many buildings, including most dormitories, the Infirmary, and the gymnasium, there was evidence of longstanding roof leaks and resulting ceiling damage. In several areas of almost all buildings visited, ceilings had deteriorated and fallen due to roof leaks. Although the Superintendent reported that the large leak in the gymnasium roof which had resulted in a gaping ceiling hole several feet in diameter noted on my previous visit had been repaired, the ceiling remained in disrepair.

Many areas of the facility also required repainting. The amount of old peeling paint in the facility's Infirmary was especially egregious, but problems with wall maintenance and needed re-painting pervaded the entire facility.

□ Illegal Drug/Medication Use

During my tours of the facility, I detected strong odors of marijuana in several areas (the Kennedy Dormitory, the Segregation Area, outside the Infirmary). In the Kennedy Dormitory, I came upon direct physical evidence of apparent marijuana use. [See boxed insert on next page.] Other members of the review team, touring at other times made similar observations. The Nursing Director also reported that she, like myself, had detected what she thought were marijuana odors outside of the Infirmary.

The many areas of the campus with signs of recent marijuana use suggested that there may be widespread illegal drug use at the facility. Although the Superintendent reported that he planned to take immediate action to address this problem, the obvious evidence of illegal drug use on the campus during the review team's brief tour begged the question of why it had not already been vigorously addressed.

Some youth also reported that it was common practice to "check" or secretly "pocket" their prescribed psychotropic medications and later to sell these to other offenders in exchange for extra snacks or other small items.

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I was also concerned about the security of prescription medications were in the facility's 'pharmacy.' The 'pharmacy' was a small room in the Infirmary -- where literally thousands of dollars of 'stock' prescription medications were stored in ordinary metal wardrobes cabinets with simple, readily 'tamperable' locks. On the one hand, it appeared that the stockpile of medications maintained by the facility was excessive. And, on the

other hand, it seemed given the drug problem in New Orleans, that this cabinet and area should be made more secure. I was also told that although the pharmacist (who visited the facility weekly) counted the medications in these wardrobes -- *no inventory checks* of the counts of medications in bottles for individual children were done.

There was also widespread indication of cigarette smoking in youth areas, formally designated as no smoking areas. Cigarette butts littered the grounds and window sills in several areas. They were also found in large numbers in unused bathtubs in one dormitory (Brown) and the locked segregation area.

The pervasiveness of the problems with illegal drug use, contraband, and smoking in restricted areas presented immediate and critical dangers to offenders, as well as the overall security integrity of the facility. Similarly, the facility's lax security and accountability over its large stockpile of prescription drugs for anxiety, depression, and mood disorders requires immediate attention.

In a small back room of the first floor of the Kennedy Dormitory, I discovered a pile of ashes and cigarette butts on the floor. The entire area had the strong stench of marijuana. I showed this area to the Court's Expert, John Whitley, as well as the facility's lead PZT Investigator. The PZT Investigator, formerly a narcotics agent for the State Police, confirmed my suspicion of evidence of illegal drug use. Later the PZT Investigator reported that he had notified the head of security, as well as the maintenance chief at the facility of our observations.

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❑ Staffing Shortages, High Staff Turnover

Severe staffing shortages and very high security staff turnover for new employees contributed to many of the above problems. Review of basic personnel statistics strongly suggested that substantive improvements in protection may be beyond the facility's reach until it is able to markedly reduce staff turnover and recruit successfully to fill its vacant positions.

- Facility data showed that nearly one of every five (19%) authorized line security positions (12 of 65) were vacant as of May 9, 1998. This vacancy rate resulted in some security posts going unmanned weekly -- as well as more than 6,000 overtime hours worked by security staff in the first eight two-week payroll periods in 1998 (or an average of 768 overtime hours each payroll period).
- More than half of the authorized maintenance positions at the facility (6 of 11) were vacant at the time of my visit. Although I was told that one of these positions would be filled shortly, it was notable that three of the six currently vacant positions had been vacant for at least five months.
- The facility reported that 31 security staff had resigned, retired, or been terminated in the period January 1 - May 9, 1998. During this same period, the facility hired only 26 officers, five of whom reportedly had resigned or been terminated as of May 6, 1998.

The Personnel Director reported that the facility could not recruit more candidates to fill its vacant positions due to the low salaries and low status of work at Bridge City relative to the cost of living and other available employment in the New Orleans area. She explained that the current starting salary for security cadets is \$15,300 (or approximately \$8.00/hour) and \$17,000 for security sergeants (or approximately \$8.75/hour). She added that there is no pay differential for the New Orleans area -- where the cost of living is markedly higher than in other regions of the state. The Superintendent further explained that salaries at Bridge City were considerably lower than those offered by the New Orleans Police Department which was also recruiting new employees.

- Assuming the same rate of staff separations for the entire year, 74 officers, approximately the same number as the facility's entire force of line cadet, sergeant, and lieutenant positions, will be hired and terminated during the current year. Given this turnover rate, the piles of papers and backlogged workload of the facility's one-person Personnel Department were understandable. It was also understandable that she usually did not take time to document her reference checks on employment candidates, but this practice is unacceptable and does not comport with community standards for employment screening in child care facilities.

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☐ **No Video Monitoring**

Bridge City has no capacity for video monitoring of any area of the facility. This deficiency capacity has apparent adverse implications for the administration's ability to oversee conditions in the dormitories and dining hall. It also takes away a viable investigative resource in incidents of alleged employee abuse or neglect or other misconduct. Video monitoring may also be of assistance to the facility in addressing the ongoing problem with illegal drug use on the campus. The latter is most likely to be achieved if some video cameras are clandestinely stationed (and periodically moved) to capture segments of the facility's relatively small grounds.

EXHIBIT D

August 4, 1998

Kevin Russell
United States Department of Justice
Civil Rights Division
Special Litigation Section
P.O. Box 66400
Washington, D.C. 20035-6400

Re: Swanson Correctional Center for Youth
(formerly, Louisiana Training Institute - Monroe)
Consultation for Louisiana Juvenile Facilities Investigation

Dear Mr. Russell:

This report will document my participation and findings during the Swanson Correctional Center for Youth tour April 28, 29, 30, and 31, 1998.

INTRODUCTION

In April of 1998, I was asked to assist in your investigation of medical, dental, and mental health care at Swanson Correctional Center for Youth (SCCY). Below is a description of my activities and my findings.

METHODOLOGY

In April of 1998, I toured the Swanson Correctional Center for Youth in Monroe, Louisiana. At the time of my tour there were listed 426 adolescents with an age range of 13 to 20.

The following is a list of clinical methods utilized during the course of this investigation:

- Actual structure of the facility was examined, especially as it related to the mental health needs of residents. This included viewing the rooms to which they were assigned, indoor and outdoor recreation facilities, and the dining area.
- Administrative, supervisory and front line staff were interviewed as needed (see below).

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- All medical personnel associated with SCCY were interviewed as needed (see below).
- General medical, dental, and psychiatric records of juveniles at SCCY were examined randomly, as well as the charts of virtually all residents on psychotropic medications. This included 29 randomly chosen medical charts, 33 psychiatric charts, and 10 counseling charts.
- I interviewed selected residents as needed. Occasionally I would do a full psychiatric interview with a complete mental status examination and differential diagnosis.
- Serious incident reports were examined.
- Policy and procedure manuals for SCCY were examined and reviewed. Additional documents that were examined and reviewed are listed below.

The following individuals were interviewed during my tour at SCCY:

B.R. Travis, Warden SCCY, 4/28/98
Humphrey C. Townsley, M.D., Consulting Psychiatrist, 4/28/98
Pat Hernandez, B.S.N., Director of Nursing, 4/28/98
Jose Singson, M.D., Acting Medical Director, 4/28/98
E. Gayle Dean, Protestant Chaplain, 4/29/98
William Caldwell, M.S.W., B.C.S.W., Program Manager II, 4/29& 5/1/98
Katheryn A. Crawford, Ph.D., Staff Psychologist, 4/29/98
Sandy Dietle, M.S. (Psychology), 4/30/98
Jeff Hooton, D.D.S., Consulting SCCY Dentist, 4/30/98
Selected SCCY Youth
Selected Front Line Staff

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The following documents were reviewed at the time of the tour and/or prior to finalizing this report:

Letter to The Honorable Mike Foster,
Governor of Louisiana from the
Department of Justice (July 15, 1996).

List of offenders with IQ's below 70,
compiled by SCCY (April 21, 1998).

Letter to The Honorable Mike Foster,
Governor of Louisiana from the
Department of Justice (October 3, 1996).

List of youth sent to outside facilities for
medical treatment, compiled by SCCY
(undated).

Letter to The Honorable Mike Foster,
Governor of Louisiana from the
Department of Justice (June 18, 1997).

List of youth placed in medical isolation
through April 20, 1998, compiled by
SCCY.

"Report to the Department of Justice on
Louisiana Training Institute, Monroe"
from Pamela McPherson, M.D. (January
16, 1997).

Medical Alert Roster (undated).

List of youth seen for emergency medical
treatment from February 15, 1998 to
April 20, 1998, compiled by SCCY.

"Department of Public Safety and
Corrections, Disciplinary Rules and
Procedures for Juvenile Offenders," First
Edition (1993).

List of individuals with psychiatric
diagnoses, compiled by SCCY (undated).

"Louisiana Training Institute, Monroe
Louisiana Security Manual," (July 1,
1996).

Department of Public Safety and
Corrections, Swanson Correctional
Center for Youth, "Policies and
Procedures Manual."

SCCY "Treatment Guideline Manual."

"Louisiana Department of Public Safety
and Corrections Health Care Manual."

Schedule of Groups, compiled by SCCY.

Compilation of accident or incident
reports for the previous 60 days prior to
my tour, compiled by SCCY.

Copies of contracts between SCCY and
Armand Dental (June 12, 1997); Dr.
Humphrey C. Townsley (June 13, 1997);
and Dr. Jose T. Singson (June 19, 1997).

"Daily Log Administrative Segregation"
(March 19 - May 17, 1998)

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SUMMARY

PSYCHIATRIC CARE FOR JUVENILES WITH MENTAL ILLNESS AND/OR MENTAL RETARDATION AT SCCY IS GROSSLY INADEQUATE.

The facility psychiatrist fails to diagnose or treat broad categories of common psychiatric disorders and other mental conditions, including mental retardation, major depression, bipolar disorder, and attention deficit-hyperactivity disorder. As a result, individual medications and entire classes of medications are rarely, or if ever, prescribed. Potentially dangerous abrupt discontinuation of medications despite documentation of medical necessity takes place on a regular basis. Pre- and post-laboratory work-ups are rarely done. Medications that are utilized are often times utilized at potentially subtherapeutic dosages. Virtually all adolescents are seen every three months, with little discretion as to the possible necessity for them being seen earlier. This may be due in part to the grossly inadequate number of hours and days of psychiatric coverage provided.

OTHER MENTAL HEALTH TREATMENT OF JUVENILES WITH MENTAL ILLNESS AND/OR MENTAL RETARDATION AT SCCY IS INADEQUATE.

The clinical approach to adolescents at SCCY is disorganized, limited in scope, not well implemented, severely compromised at the outset by poor mental health and mental retardation screening from Jetson Correctional Center for Youth, and is utilizing clinically outdated and therapeutically questionable approaches with mentally ill and/or mentally retarded youth. A component of this inadequacy is a direct result of the lack of leadership and quality assurance from the State.

A SUBSTANTIAL NUMBER OF JUVENILES WITH MENTAL HEALTH NEEDS ARE BEING PLACED AT SCCY INAPPROPRIATELY.

Provision for mental health services for those who are severely mentally ill and/or mentally retarded does not take place at SCCY. Severely mentally ill and/or mentally retarded youths are not treated for their mental illness and mental retardation while at SCCY and are rarely transferred to any facility to meet their mental health and/or mental retardation needs. Again, disorganized and at times incompetent mental health screenings from Jetson Correctional Center for Youth and a lack of leadership and assistance from the State contribute to the growing number of adolescents at SCCY who are in desperate need of mental health services which cannot be attained in their current placement.

REHABILITATIVE TREATMENT SERVICES FOR JUVENILES AT SCCY ARE INADEQUATE.

These services at SCCY are limited, shortsighted, ineffective, in many cases outdated, and would appear to have little impact on the youths for whom they are provided.

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Adequate treatment team meetings with all relevant personnel involved do not to take place. Most youth with mental illness and/or mental retardation appeared isolated, uncomfortable, helpless, lacking appropriate stimulation, and fearful of constant aggression.

Front line staff have little therapeutic knowledge, and virtually no information on the clinical needs of any particular youth under their guard.

Leadership, quality assurance, and implementation of a uniform rehabilitative process from the State level appears to be grossly lacking.

It is my clinical opinion that many youth who leave SCCY will do so angry, ignorant, suspicious, defiant, and unprepared to function in society. SCCY has a high percentage of youths with multiple mental illnesses; serious family dysfunction without any kind of family supportive therapy or counseling; and limited to nonexistent vocational opportunities. Individuals appear to be part of a "massive herd."

**A PRELIMINARY ASSESSMENT OF MEDICAL AND DENTAL SERVICES
PROVIDED TO JUVENILES AT SCCY INDICATES SEVERAL AREAS OF
CONCERN.**

A preliminary review of medical and dental services raised several issues of concern.

The facility's antiquated infirmary is insufficient for the medical needs of the youth. Youth confined to the infirmary are housed in punitive conditions. The facility also lacks adequate quality assurance processes and procedures for the review of laboratory results. Arrangements are needed for periodic dental exams.

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FINDINGS

PSYCHIATRIC CARE FOR JUVENILES WITH MENTAL ILLNESS AND/OR MENTAL RETARDATION AT SCCY IS GROSSLY INADEQUATE.

Staffing

SCCY contracts with a Board-certified adult psychiatrist in Texas, who visits the facility once each month for two days, for a total of twelve hours per month. While he is available by telephone, he is only contacted zero to four times each month, usually about new transfers, or occasionally about medication issues. He has been providing psychiatric services to SCCY for approximately three years. Given the population of adolescents currently served at SCCY, a minimum of 22 hours of psychiatric services per week are required to provide adequate treatment.

The facility also employs a part-time (30 hours per week) psychologist who has been at SCCY approximately 10 years. Her duties are extensive and include evaluating all youth considered for early release, placement outside the home upon release, assignment to alternative placement settings, or admission to a sexual or violent offenders group; co-facilitating the sexual offender group; participating in orientation of new staff; consulting with counselors; and providing limited court-ordered individual counseling. She was also recently asked to begin seeing youth on the psychiatrist's patient list during the months the psychiatrist is unable to see them, although she does not know how she will find the time to do this. She reports that her first priority is to conduct court-ordered evaluations. Individual counseling represents approximately 5-10% of her time. She also states that she has very little input into the program for sexual perpetrators because she lacks sufficient time to do so.

The Program Manager II has been at SCCY for more than 15 years. He oversees the provision of religious, medical and counseling services. Although he supervises the facility's counselors and is designated as the supervisor of the medical program, he does not supervise the psychologist.

Use of Psychotropic Medication

The use of psychotropic medications for adolescents at SCCY is grossly below acceptable professional standards. The consulting psychiatrist fails to recognize, diagnose or treat a broad range of psychiatric conditions — such as major depression, mental retardation, bipolar disorder and attention deficit-hyperactivity disorder (ADHD) — even when such diagnoses are well documented by previous professional contacts. When youth arrive at the facility with such diagnoses and prescriptions for medications to treat those illnesses, the psychiatrist generally discontinues the medications over the telephone without seeing the patient, even when the patient is receiving medications the abrupt discontinuation of which can be dangerous. When

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the psychiatrist does prescribe psychotropic medications, he often fails to conduct necessary laboratory tests to determine whether the medication is safe for the youth and generally fails to undertake adequate monitoring to determine the safety and efficacy of the prescription once it has been started.

A. Diagnoses and Medication

Psychiatric services in any capacity involve diagnosis and treatment. The importance of diagnosis is that it determines the kind of treatment that is going to be available for any particular individual. Accurate diagnosis, therefore, is required for effective treatment. This is particularly important when psychotropic medication is involved. At SCCY, the psychiatrist's failure, almost as a matter of policy, to make or accept other psychiatrists' diagnoses of a range of mental illnesses, results in a failure to provide adequate treatment for those conditions.

1. *Mental Retardation*

The psychiatrist at Swanson does not diagnose mental retardation and has not diagnosed fetal alcohol syndrome, pervasive developmental disorder NOS, fragile X, etc., which are common conditions that result in diminished cognitive capacity. With a sizeable population of mentally retarded youth at SCCY, and increasing clinical knowledge that mental retardation is actually the result of a variety of causes, it is important that the consulting psychiatrist be aware of the advances in diagnostic schemes regarding mental retardation. For example, fragile X is now the number one inherited cause for mental retardation, while fetal alcohol syndrome is the number one cause of acquired mental retardation. Additionally, many of these youths come from family backgrounds that are heavily involved in alcohol and are at high risk for fetal alcohol syndrome. Accurate diagnosis of the patient's particular type of developmental delays is important to ensure proper treatment and accommodations for the youth in the facility's programming. At Swanson, the facility psychiatrist not only fails to distinguish among different forms of developmental delays, but fails to diagnose any form of developmental disability at all.

2. *Paraphilias*

The psychiatrist has never diagnosed a youth with a paraphilia (abnormal sexual behavior, *e.g.*, exhibitionism, sadism, masochism, pedophilia, etc.), even though many youth at Swanson were placed there for sexual offenses (*e.g.*, T.A., W.I., J.H., and J.P.). As a result, he has not been involved in any treatment for such conditions.

3. *Attention Deficit-Hyperactivity Disorder (ADHD)*

Despite the fact that Ritalin (Methylphenidate) is the most widely prescribed medication used in the treatment of ADHD and has substantial numbers of studies indicating its efficacy in ameliorating the target symptoms of ADHD — reducing gross

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motor overactivity, decreasing off-task behavior, increasing compliance with adult requests, and decreasing aggressiveness — the facility's psychiatrist, as a matter of policy, refuses to prescribe Ritalin (or any of similar stimulant). Moreover, he discontinues these medications on patients who have been taking them prior to coming to SCCY (including those prescribed such medications upon intake to the system at JCCY). There are multiple examples in patients' charts of their being abruptly discontinued on Ritalin despite a previous history of Attention-Deficit/Hyperactivity Disorder and positive responses to that medication (*e.g.* **D.S.**, **R.H.**, **J.R.**, **M.B.**)

For example, **D.S.** arrived at Swanson taking Ritalin. He had seen a child and adolescent psychiatrist fairly regularly prior to coming to SCCY and had been diagnosed as having ADHD, for which he was prescribed Ritalin. However, as soon as he arrived at Swanson, the Ritalin was discontinued by telephone order. When he was later seen by the psychiatrist, he was started on Zyprexa, a drug which is used for psychosis and can be used for aggressive/violent behaviors. As a result, **D.S.**'s ADHD remains essentially untreated. During my interview with the youth, he exhibited markedly poor concentration; was frequently agitated, hyperactive, looking through drawers, placing his hands on the desk, playing with objects, bringing his head up and head down. He also continued to complain of auditory hallucinations as he had done in the past.

R.H. was admitted in late October to SCCY. Documentation in his chart from DePaul Hospital in New Orleans indicates a fairly thorough work-up for ADHD for which he was being treated with Ritalin. That medication had been continued when he was at the Baton Rouge facility. However, when he arrived at SCCY, the psychiatrist discontinued the Ritalin and started **R.H.** on Wellbutrin via telephone order without actually having seen the patient.

J.R. was admitted April 9, 1997 from JCCY, where he had been prescribed Ritalin for ADHD. He had been diagnosed with Attention-Deficit/Hyperactivity Disorder since the age of 9 and had been taking Ritalin since that time. On April 23, 1997, Swanson's psychiatrist examined the youth and made objective findings of impulsivity, poor anger management, and hyperactivity. In his evaluation, the psychiatrist acknowledged the history of ADHD but stated that "today he evidences no findings of ADHD." It should be noted, however, that on the day he was seen he had been taking Ritalin, which might account for the lack of symptoms. As a result, the psychiatrist discontinued the Ritalin and placed the youth on Wellbutrin, a drug that can be used for ADHD although carries with it additional risk of constipation, sleep-wake cycle disturbance, tremor and, at higher dosages or in susceptible individuals, seizures. Since that time the youth has done extremely poorly. His file indicates that he has had 15 disciplinary reports recorded for the last quarter and that he continues to receive disciplinary reports. He was placed in maximum custody level in March and no motivation to improve his behavior is noted. Counselor reports note that he is grumpy, unpleasant, negative in counseling sessions, etc. School reports indicate he is disruptive and disrespectful to his teacher. These reports come one quarter after he was started on

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Wellbutrin as a substitute for Ritalin, which apparently had worked well in other settings. This patient will never be considered for a trial of Ritalin, Dexedrine, or Cylert because the policy of the Swanson psychiatrist is to never use stimulants for the treatment of ADHD, even though these drugs may be the only effective treatment for this individual.

4. *Mood Disorders*

The psychiatrist fails to diagnose or treat many cases of mood disorders. For example, when asked how often he had diagnosed youth with bipolar disorder, he stated that he has "not seen a single one." Moreover, he states that he has never seen a youth suffering from major depression, phobia, obsessive-compulsive disorder, and has only seen one case of panic disorder. These statements are implausible. Mood disorders are common in adolescents, especially those that come from impoverished backgrounds, violent family history backgrounds or backgrounds where the family history is loaded for genetic predisposition towards mood disorders. One would expect to find numerous youth suffering from these conditions in a facility as large as Swanson. Nonetheless, the psychiatrist reports that he does not use the most common drugs employed to treat these disorders and the charts indicate that he routinely discontinues such medications for youth arriving at the facility. For example, he states that he does not prescribe Lithium; rarely, if ever, uses Depakote; and rarely uses Tegretol. There is an overwhelming abundance of psychiatric literature, over the past ten years in particular, that demonstrates the efficacy of mood stabilizing agents in the treatment of adolescents. The psychiatrist's policy of not prescribing mood stabilizers and procedure of discontinuing the medication when a patient is taking that medication upon admission, results in a failure to treat numerous youth with significant mental illnesses (*e.g.* C.W., M.B., T.C., R.C., D.S.).

Although he states he has never seen a youth with major depression, the psychiatrist does sometimes use antidepressant medication, but in a clinically inadequate manner. First, he continues to use the older antidepressants that, while certainly efficacious, have considerable side effects which can be debilitating for an adolescent in a maximum-security facility or boot camp setting. Newer medication (such as Prozac, Zoloft, and Paxil) that do not have these side effects are less often prescribed. Additionally, he never prescribes Trazadone for fear that it may cause priapism (a condition resulting in painful erections) in some patients, although the incidence of that side effect is extraordinarily low. Second, the medications he does prescribe are regularly used in a dosage range that will predictably be too low for many adolescents, without undertaking adequate monitoring that would allow him to increase dosages to therapeutic levels when necessary. Third, as discussed below, he fails to adequately monitor the use of these medications through required pre- and post-prescription laboratory tests.

For example C.W. was admitted October 1, 1997 from JCCY on several medications used to treat a variety of psychiatric disorders, including Depakote (1,000 mg per

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day). The psychiatrist noted that he found absolutely no justification for the use of Depakote at such a "large dose," discontinued it along with the other medications, and placed him on Clonadine, a drug used to treat ADHD or disruptive behavior. However, had the psychiatrist reviewed the medical file before discontinuing the medication, he would have seen the clinical reason for choosing Depakote was to treat a mood disorder. A discharge summary from Crossroads Regional Hospital, dated September 8, 1997, indicates that staff were able to obtain a history that "the patient had a manic-like episode for three days prior to admission with excess energy and needing little or no sleep for three days," indicating a bipolar disorder. Depakote is commonly used to treat such a disorder, and 1,000 mg of Depakote each day is not necessarily a high or low dosage. It depends on the patient's response, side-effect profile and blood level, none of which was checked by the psychiatrist before he decided to discontinue the medication. In any event, given the psychiatrist's practice of not prescribing medications to treat mood disorders, such as bipolar disorder, he would not have continued the Depakote in any event.

4. *Psychosis*

The psychiatrist's uses of antipsychotic medications are quite limited. He rarely uses Thorazine or Mellaril, two commonly used medications. Many youth entering the facility on such medications have their prescription abruptly discontinued or switched (e.g. C.W., A.L., C.O., M.B.). Additionally, the psychiatrist rarely prescribes antidyskinetic medications like Cogentin, Artane or Benadryl, which may be necessary to treat or reduce serious side effects from these medications (such as muscle stiffness or spasms, restlessness, drooling, etc.).

B. Use of Outdated Diagnoses

Psychiatric intervention with children and adolescents requires knowledge of current, acceptable, and valid psychiatric diagnoses. The professionally-recognized criteria for psychiatric diagnosis is the American Psychiatric Association's Diagnostic and Statistical Manual (DSM), and its most current version is DSM IV, which has been the current standard since 1994. As reflected throughout the charts, Swanson's psychiatrist tends to use a combination of DSM III and III-R diagnoses, occasionally including a DSM IV diagnosis.

C. Abrupt Discontinuation of Medication without Examination

As discussed above, the psychiatrist at Swanson routinely issues telephone orders from Texas directing staff to discontinue medications youths are taking when they enter the facility. This practice is a substantial departure from professional standards, especially with regards to treatment of children and adolescents. Psychiatrists must exercise caution in discontinuing medications until they have sufficient information to determine that the medication is contraindicated, or they have had time to actually interview the individual and review the relevant clinical notes to determine that another course of

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treatment is appropriate. As a wealth of clinical literature now indicates, abrupt discontinuation of medications imposes significant risk of harmful withdrawal side effects or the re-emergence of psychiatric symptoms. For example, discontinuing antipsychotic medications abruptly in an adolescent population exposes them to withdrawal dyskinesia (muscle spasms or abnormal movements) which can be extremely painful and can last several months. Ordinarily, when medications are discontinued, they are withdrawn slowly by progressively decreasing the dosage to avoid these dangers.

D. Inadequate Lab Work and Monitoring

Psychotropic medications are not benign. They have physiological effects that can cause positive benefits and negative side-effects. For example, antipsychotics medications can have severe side effects such as potentially irreversible tremors and unusual tic disorders. Mood stabilizing drugs can cause liver and renal function problems, seizures, tremors, spasms, etc. Antidepressant medications can cause gastrointestinal complaints such as nausea, vomiting, diarrhea, constipation, bloating, etc. Stimulant medications may result in unusual tics, difficulty with sleep-wake cycle, appetite disturbance, etc. Many medications in psychiatry cause blood pressure changes and can be dangerous for youth engaging in strenuous exercise or who are subject to long exposure to the sun.

As a result, it is critical that before certain medications are used, required laboratory tests are run and their results analyzed. Also, certain medications require periodic laboratory or other tests to determine whether an effective dosage level has been achieved and to detect potentially dangerous side effects (such as liver damage or the development of involuntary tics or tremors).

The psychiatrist at Swanson routinely fails to order required pre-prescription labwork, routine lab tests while the youth is taking the medication, or to conduct other necessary tests for side effects. For example, there are no Abnormal Involuntary Movement Scale tests (or any other substitute monitoring mechanisms) to be found in any charts.

Continuing Education, Supervision and Quality Assurance

The psychiatrist at Swanson is an adult, rather than a child and adolescent psychiatrist. Child and adolescent psychiatrists undergo training, usually in a two year fellowship, which requires them to diagnose and treat children and adolescents as part of their subspecialty in medicine. Adult psychiatrists do not undergo this kind of training, although they may have occasional exposure in their residency to older adolescents and children. By and large, adult and/or general psychiatrists lack the necessary clinical and motivational requirements to work with an adolescent population psychiatrically. Additionally, child and adolescent psychiatrists understand the need for evaluation, diagnosis, treatment, and treatment planning; coordination amongst

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different mental health providers; and adequate premedical and postmedical work up when starting an adolescent on psychotropic medication. They can provide a variety of individuated and group services such as counseling, individual therapy, group therapy, treatment plan review, consultation with the facility physician, etc.

Swanson's psychiatrist admits that he is not involved in any ongoing continuing medical education in the psychiatric treatment of adolescents, whether in the general population or the correctional population. Moreover, he receives no supervision from the State or any other entity to assure the appropriateness of his treatment.

OTHER MENTAL HEALTH TREATMENT OF JUVENILES WITH MENTAL ILLNESS AND/OR MENTAL RETARDATION AT SCCY IS INADEQUATE.

Providing mental health treatment at SCCY should include the ability to reduce disabling effects of serious mental illness in order to allow each youth to maximally participate in correctional programs, to decrease the needless suffering that takes place because of mental illness, and to enable the facility to remain safe for staff, youths, volunteers, and visitors.

In January of 1997, an expert for the Department of Justice issued medical findings regarding mental health services of juveniles with mental illness and/or mental retardation at Swanson Correctional Center for Youth. Problems were found in general screening and general assessment of individuals who may have mental illness or have mental retardation. There were also problems with counseling records not documenting psychiatric diagnosis and symptoms of that diagnosis and measurable plans to "ameliorate the manifest symptoms." Deficiencies were also noted in the provision of adequate youth development programs and adequate documentation in treatment planning. To a large extent, these problems continue to exist today.

Screening and Evaluation

SCCY has a difficult problem in attempting to determine and implement treatment programs because of the difficulty in obtaining reliable information from Jetson Correctional Center for Youth. Consequently, counseling staff must rescreen the transfers to SCCY. However, the Program Manager stated that psychiatric reports from JCCY and outside facilities oftentimes do not arrive at SCCY to help in screening and diagnosis, and he is not aware of any mechanisms to correct this problem. At screening, youth who come to the facility on psychotropic medications are automatically referred to the psychiatrist, but few others are given psychiatric referrals. Of the ten counseling charts I reviewed, all showed deficiencies with regard to screening new admissions for mental illness and/or mental retardation and ongoing screening for the occurrence of mental illness while at SCCY.

The identification of individuals with mental retardation is of particular note. IQ scores come from JCCY, but the Program Manager does not believe them to be

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accurate. However, these youths are not retested, nor is adaptive behavior testing done to confirm a diagnosis of mental retardation. An IQ listing of those individuals with IQ scores from JCCY, dated April 21, 1998, indicated that there were 74 individuals at SCCY identified with IQ scores in the range of mild to moderate mental retardation (roughly 20% of which were in the moderate retardation range). Although there is no adaptive behavioral scale used, it appears that approximately 17 to 18% of individuals at SCCY likely have mental retardation.

Treatment by Professional Staff

The psychiatrist does not provide individual treatment or therapy for any of the youth under his care. He generally sees each youth once every three months and focuses on adjusting medications. He does not participate in any treatment team meetings with the counselors or the medical staff.

The psychologist also provides little individual counseling for youth with mental health problems. She was recently asked to see each of the psychiatrist's patients during the months between their appointments with him, but does not believe she has the time to do so.

Thus, as the Program Manager admits, there are no treatment team plans for individual mentally ill youth at SCCY. The treatment team should consist of the psychiatrist, the counselor, a front line staff member who is familiar with the resident, nursing staff, and any other member of the facility that has clinical information about the resident. The treatment team should meet on a regular basis for those residents who require psychiatric intervention. The lack of adequate treatment teams results in, among other things, a lack of adequate monitoring of the efficacy and side effects of medications prescribed by the psychiatrist, who must rely on information from facility staff to adequately monitor the course of treatment.

For example, J.W. was on Wellbutrin and Clonidine for an extended period of time. On March 18, 1998, he was examined by the medical director and found to have thrombosed external hemorrhoids. Constipation is a common side effect of Wellbutrin and could have caused or exacerbated the hemorrhoids. The charts indicates no consultation between the physician and psychiatrist, and no steps are documented to address the potential aggravation of the condition by the psychotropic medication (for instance, the youth was not placed on any stool softener).

Instead of employing a treatment team, counseling and treatment for youths with psychological conditions is left to the general counseling staff. The Program Manager is in charge of implementing treatment programs at SCCY for all youth (including youth with significant mental health needs). He has been there for a number of years, knows the programs well, understands the limitations of his authority with respect to a correctional setting, and has been attempting to begin development of specific programs and youth development protocols with little help from the State of Louisiana

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Department of Corrections and Public Safety. The State does not provide mental health professionals working within the detention facilities any kind of mission statement, goal or supervision. Consequently, SCCY has been attempting to develop its own mission statement, goals and protocols with regard to the care and treatment of the mentally ill and mentally retarded. The protocols that have been developed are often impractical, cumbersome, and do not appear to be translated into individuals' charts in the form of some kind of counseling or therapy.

The protocol for mental retardation, for example, is outdated and of little value. The psychiatric section entitled Mental Retardation (Chapter 34, p. 1758) is copied from a psychiatric volume that is ten years old. There have been enormous strides in the treatment of individuals with mental retardation and mental illness since that time, and nothing in the mental retardation protocol indicates an awareness of those advances.

Treatment by Line Staff

The training of front line staff to work in a correctional setting with those individuals who have mental illness and/or mental retardation is of utmost importance. The Program Manager pointed out during my tour that there is no specific State requirement for training in detention facilities. He apparently trains front line staff for suicide prevention and abuse and/or neglect but points out that security receives little training in dealing with treatment issues with the mentally ill and/or mentally retarded. The staff psychologist apparently provides basic orientation four to five times each year as needed and is also involved in approximately six to eight sessions, three to four hours each, with behavior management skills with regards to Zero Tolerance. The facility psychiatrist is not involved in any manner with ongoing training of front line staff.

During my tour of SCCY and in discussions with front line staff, it was apparent that many front line staff were relatively new and knew little with regard to treatment approaches with particular adolescents. Of the dozens of front line staff that I communicated with, none could tell me what the treatment plan was for a particular adolescent, or even whether the adolescent was mentally retarded or mentally ill. Front line staff unanimously stated that they were rarely involved in training in treatment issues for adolescents. Generally staff appeared unable and unqualified to interact with seriously disturbed adolescents other than through their correctional policies and procedures.

Many studies have shown that staff-offender interaction is vital for their rehabilitation. Staff characteristics of being friendly, getting to the point of an issue, explaining why certain behaviors are important, providing descriptions of alternative behaviors in a well-controlled and thoughtful manner, providing positive feedback, smiling, and generally offering to help are more meaningful to adolescents than derogatory or profane comments directed at them. Although I did not directly hear staff using

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derogatory or profane comments towards SCCY adolescents, a number of adolescents informed me that this routinely took place.

Lack of training of front line staff places those individuals with mental illness and/or mental retardation at risk of inappropriate disciplinary measures as opposed to therapeutic interventions. Mentally ill and/or mentally retarded individuals have difficulties with processing auditory information, have high rates of vision and hearing problems, high rates of expressive and receptive language disorders, and these limitations may cause individuals to behave in a manner that can easily be mistaken by the untrained observer for uncooperative, oppositional, or defiant behavior. The front line staff then would apply inappropriate disciplinary procedures for behavior they see as intentionally disobedient when in fact it is behavior brought on by the limitations that accompany mental illness and/or mental retardation.

Crisis Management

Crisis management of psychiatric emergencies, including the management of suicidal youth, does not meet professional standards. Behavior management at SCCY is more reactive than proactive. It lacks adequate screening and assessment of youth who are potentially at risk of attempted suicide. Currently, the program manager obtains copies of all serious incident reports and reviews them each morning. He places all youth he believes to be suicidal on suicide watch, either at the Cypress dormitory or the infirmary, so that he can observe them more closely. The psychiatrist, however, is not called for psychiatric emergencies, nor is he made aware of such incidents after they occur--the psychiatrist believes that, "these [psychiatric emergencies] don't occur." The program manager stated that he would only refer to the psychiatrist if a suicidal youth had to be transferred out of the facility for care. There must be a coordinated effort in the form of a treatment team consisting of a psychiatrist, psychologist, program manager, and frontline staff to care for a particular youth in a case of psychiatric emergency. This does not exist at SCCY. Moreover, juveniles appear to be isolated for suicide watch for staff convenience rather than for meeting the mental health needs of the juveniles. Moreover, juveniles on suicide watch are often isolated in areas which are not suitable for the treatment of suicidal juveniles, due to the presence of suicide hazards in the environment.

The case of juvenile R.H. exemplifies substandard crisis management. R.H. had a history of sexual perpetration, multiple psychiatric hospitalizations, and a diagnosis of Attention Deficit/Hyperactivity Disorder. On April 26, 1998 he reported suicidal ideation and was placed on suicide watch; however, he was not referred to the psychiatrist.

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**A SUBSTANTIAL NUMBER OF JUVENILES WITH MENTAL HEALTH NEEDS
ARE BEING PLACED AT SCCY INAPPROPRIATELY.**

General staff consensus is that there are a number of individuals at SCCY who are mentally ill and/or mentally retarded who are not being adequately treated because of their placement. A number of inappropriate placements occur on a regular basis and estimates from staff indicate that around 10% of those individuals at SCCY are inappropriately placed and require an alternate treatment settings. The Program Manager, for instance, estimated that 30-40 youths in the facility could be placed in more appropriate settings, such as a forensic facility. This likely undercounts the number of youth requiring such alternate placements given the facility's inadequate mental health screening process.

Individuals like **W.I., T.A., R.H., J.P., R.N., A.L., and G.F.** appear to need a different treatment setting, preferably a state hospital or a forensic setting. Although there are policies that permit transfer of those who are mentally retarded to a more appropriate setting, no staff member could tell me of any youth who had been placed in another state agency or private facility in accordance with these State policies.

**REHABILITATIVE TREATMENT SERVICES FOR JUVENILES AT SCCY ARE
INADEQUATE.**

Findings by an expert for the Department of Justice in January of 1997 indicated that youth development programs were deficient. During my tour of the facilities at SCCY it was my clinical conclusion that many programs that were being described were not actually being implemented. Counseling services are inadequate and understaffed. Programs for substance abusers were reported as unsuccessful.

To begin providing these services, there needs to be a general understanding by the facility's administration, supervisory personnel, and front line staff, of adolescent developmental issues. Adolescents struggle with a number of psychosocial and biological issues as they move through their adolescent years. The following is an incomplete, although illuminating, listing of some of the changes that adolescents experience during adolescence:

- A. Identity, discovery, consolidation, and integration.**
- B. Relationship with parents and/or caregivers.**
- C. Constructive organization of moral development and emotional development.**
- D. The importance of their peer group in their development.**
- E. The continual movement toward independent living.**

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- F. **The relationship between the sexes.**
- G. **Changing developmental lines occurring during different stages of adolescence.**
- H. **Gender identity.**
- I. **Growing capability, willingness, and competence in their functioning as an independent individual who is able to work.**
- J. **Increasing intellectual ability in the form of cognitive improvement in formal operations (e.g., the ability to abstract, anticipate, plan, symbolize, etc.).**
- K. **Their role in society and the meaning of that role.**
- L. **Their growing understanding and acceptance of authority.**

Child and adolescent developmental lines are complicated and at times difficult to understand even in the best of circumstances. Add into this mix mental illness and/or mental retardation and the task becomes even more difficult. Ongoing inservice training with staff at the facility regarding adolescent development — not only biologically, but also emotionally, psychologically, and socially — is vital to their day-to-day living and interacting with these troubled youth.

Counseling Services

The Program Manager stated that there are no treatment team meetings with security, education and counseling staff, although there apparently used to be such meetings until a more "adult model" was imposed on the facility.

Counseling notes indicate a lack of adequate treatment team meetings to organize treatment approaches for each individual being counseled. Notes do not adequately address treatment objectives, treatment goals or an understanding of the mental health and/or mental retardation needs of the youth for which the note is written.

Sexual Offender Treatment

SCCY has a number of individuals with sexual perpetration problems. There are two groups of 8 to 12 youth that meet an hour to an hour and a half at a time for approximately 12 weeks. The groups are run by two counselors, who are under the supervision of the Program Manager, and the psychologist. The psychologist was officially designated as a co-facilitator in December of 1997, but has little input into the development of the program. One of the counselors has attended approximately

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one conference a year in sexual perpetration treatment, the other is reportedly still receiving training.

According to the psychologist and the Program Manager, there is a waiting list of approximately 20 youth to participate in the program.

It was the psychologist's opinion that few individuals successfully complete the program, and a review of the program indicates that it is more educational than therapeutic. There is no attempt to diagnose specific paraphilias within the sexual perpetrators' groups, and there is little documentation in any of the charts to indicate how they are progressing through the groups. Additionally, the sexual perpetrators' sexual abuse protocol does not take into allowance cognitive impairment, which might prevent a number of sexual perpetrators from deriving any benefit from the program.

Examples of the lack of adequate sexual perpetration programming include the case of J.H., who was placed in the custody of the Department of Public Safety and Corrections on January 10, 1997 after being adjudicated delinquent for the offense of aggravated oral sexual battery. It appears from his records that he has never received treatment for sexual perpetration. Instead, an August 30, 1997 letter to the Court indicated that "treatment here will utilize the cognitive therapy model. It will focus on sex education and emotional stability (depression)." A progress note in this individual's file indicates that he apparently committed an aggravated sexual assault while at SCCY.

T.A. reported during an interview that he had been raped on two separate occasions and was actually placed into detention facilities because of sexual battery on a six- or seven year-old boy. A note in his file states "rule-out pedophilia." However, he was not involved in any sexual perpetrators group at the time we interviewed him, and he had arrived at SCCY in November of 1997.

Substance Abuse Treatment

Substance abuse is a particular problem among juvenile detention residents. Estimates in the literature range from 60 to 90% of those individuals who are adjudicated into detention facilities have or have had substance abuse problems.

The type of substance abuse treatment youth receive at Swanson depends on a classification decision made upon admission. Youths are placed in Category 1 based on an intake screening or by virtue of a court order for substance abuse treatment. A Category 1 individual receives group drug abuse counseling. Although one of the drug counselors we met, Ms. Dietle, was knowledgeable, she reported that no one ever transferred for more intensive in-patient substance abuse treatment, although there have been individuals in need of that. (We had met with this substance abuse facilitator so that we could observe a group, but gave up after waiting one hour for security to bring the youth for the session).

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A Category 2 individual would receive some counseling about drugs from his ordinary counselor in the course of general counseling sessions, but this counseling appears to be educational and not therapeutic.

Due to lack of resources, very few youth who require intensive drug treatment receive it. For example, chart review indicates that **R.J.** indicated that he had used marijuana and alcohol on a daily basis, however he was placed in Category 2 and not Category 1. Additionally, **L.G.**, at the time of initial substance abuse assessment, stated that he was using marijuana and alcohol on a daily basis, and he was placed in Category 2. **A.L.**, at the time of his substance abuse assessment, indicated that he was regularly using marijuana, although he was placed in Category 2.

Behavior Management

The Program Manager noted that behavior management is "pretty much the same" for all the youths in the facility and is administered by the security staff.

Currently, SCCY operates an open campus of seven dorms (including two full honor dorms), and a closed campus which consists of four more restrictive compounds, including the Cypress Unit, which is used for short- and long-term administrative segregation, as well as for protective custody and suicide watch. Youths in these units spend prolonged periods locked in their rooms. During our tour, the rooms were noted to be extremely warm with poor ventilation. The Warden informed us that he had deliberately set the temperature high, to reduce the likelihood that youth would want to be in segregation for the air conditioning. However, front line staff in the unit and youth in administrative segregation report that the air conditioning is never used and there have been times when the ventilation is so poor that some youth "act up" simply to get out of their rooms for a period of time. These conditions potentially place youths' health at risk (*e.g.*, youths with asthma, youths on certain medications) and may create situations where the youths become self injurious.

While isolation of youth in detention facilities for a period is sometimes necessary for the safety of the youths and/or staff, the use of prolonged isolation is extremely harmful to adolescents. As I wrote in my report on Tallulah, adolescents respond to isolation in a way that is dramatically different from adults. Many adolescents respond to isolation with increased hostility, not less. Prolonged isolation poses increased risks of mental illness, particularly for those youths with histories of psychiatric disorder, substance abuse and socialization problems related to fragmented families. As I also explained in my report on Tallulah, prolonged isolation is particularly harmful to youth with mental retardation and/or mental illness. For both types of youth, isolation should end when it is determined that the youth no longer poses an imminent danger, a process that generally at most takes a few hours and which should involve mental health professionals.

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Isolation is used excessively and inappropriately at SCCY. A review of the daily log for administrative segregation at SCCY for the month of April indicates an average daily census of 28, with a range of 22 to 34 youths in administrative segregation. During the week of April 8 - 14, approximately 20% of the total population at SCCY were, at some point, placed in administrative segregation. This includes large numbers of youth with mental retardation or mental illness. For example, during a one-week period in April, fully one-third of the youths in administrative segregation were suffering from mental illness or mental retardation. During my tour of the unit, there were a number of youths with serious mental health problems.

For example, **W.I.** had been on Cypress Unit for four months when I interviewed him. He had a history of multiple psychiatric hospitalizations, had been sexually abused by a cousin when he was 8, and had been committed on charges of forcible rape and sexual battery. While in the Cypress Unit, he was taking psychiatric medications, having difficulty sleeping, and refusing to participate in the sexual perpetrator's group. However, there had been no involvement with the Swanson psychiatrist.

J.H. had been in the Cypress Unit for many weeks, having been admitted to SCCY on two occasions for oral sexual battery. He also had a history of alcohol abuse. While at the facility, he jaw was broken in a fight. At the time of my tour, he had been in the Cypress Unit for several weeks on suicide watch. He was taking antidepressant medication but continued to complain of depression with suicidal ideation and intent.

P.C., a youth with an IQ of 65, had been in the Cypress Unit for two weeks. At the time of the interview he was in protective custody and was not, therefore, permitted to attend school. As a result, he spent his days locked in his room except for a 30-minute period of recreation each day. He states that he "scream a lot" when he doesn't receive enough attention. He had been transferred from one of the other closed units dorms after being pepper sprayed for banging on a door. He states that he sees the psychiatrist "once in a blue moon."

R.H., has a history of multiple psychiatric hospitalizations and a prior suicide attempt. Upon arriving at the facility, the psychiatrist discontinued his antipsychotic medication. At the time of my tour, he had been in the Cypress Unit for 30 days and had been on suicide watch. During the day, he sits on the concrete slab without his mattress (which is taken away during the day).

T.A., who has a past history of attempted suicide by hanging and cutting himself, had not been seen by the psychiatrist since his arrival, but had been held in the Cypress Unit for three months when I toured the unit. Although he has a history of sexual offenses, he has not been involved in any sexual offender treatment. He also stated that he had been raped at the facility on two occasions by other youth.

It would appear that SCCY is using administrative segregation as a substitute for an adequate overall behavioral management program at the facility, and as a result of a

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lack of mental health services for mentally ill or mentally retarded youth, particularly psychiatric services. There is a lack of mental health professionals' involvement in behavior management, particularly by the psychiatrist. SCCY lacks sufficient alternatives to such isolation for controlling the behavior of its youth generally, and for dealing with the behavior of mentally ill or mentally retarded youth especially. The facility lacks a continuum of care model for the mentally ill and/or mentally retarded that would allow staff to address behavior in less restrictive settings with adequate access to mental health professionals.

A PRELIMINARY ASSESSMENT OF MEDICAL AND DENTAL SERVICES PROVIDED TO JUVENILES AT SCCY INDICATES SEVERAL AREAS OF CONCERN.

While I did not undertake a comprehensive review of the medical program, my preliminary assessment revealed a number of areas of concern.

Staffing and Staff Training

The facility physician has been involved with SCCY since 1982. He is intimately associated with the nearby local hospital where he practices. The day-to-day operations of the medical program are overseen by an RN who has been at the facility for ten years. The facility employs 4 RNS, 4 LPNs and a part-time LPN, as well additional Emergency Medical Technicians who provide coverage at night and on the weekends.

The facility physician expressed concern that there is not 24-hour nursing, which is especially troubling when there are youth in the infirmary recovering from surgery.

The physician is currently not involved in any ongoing education of the staff. He does not attend any medical staff meetings. He is interested in having the medical staff be involved in obtaining continuing medical education regarding juveniles in detention facilities, although he is apparently not willing to take the leadership role in that area.

Infirmary

Both the physician and the head nurse expressed concern that the infirmary is inadequate. The top floor of the building is reportedly condemned and has leaked significant amounts of water into the waiting room in the past. The physician expressed concern that because the building is extremely small and difficult to work in, he is at times unable to perform minor surgeries (*e.g.*, suturing, etc.). Because of the proximity of youths and other staff, it is sometimes difficult to insure privacy of medical information and consultations.

Youths who require bed rest or are recuperating from injuries sustained in fights, are confined to a cell block in the infirmary that is more or less identical to an

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administrative segregation unit. Youth in these cells are locked in their rooms for 20 or more hours per day, as if they were being punished in a segregation unit, largely due to lack of adequate staff to supervise them in a less restrictive environment. Medical staff expressed concern that security staff often even forbid convalescing youth from having radios or Walkmans, even though SCCY's Policies and Procedures Manual permit such items. (The Warden represented to us that this practice would be stopped).

Staff stated that there has been talk for years about replacing the infirmary building (we were informed that such changes were about to take place, too) but nothing seems to happen.

Medical Records

The medical staff reported a number of difficulties in obtaining records from Jetson Correctional Center for Youth, and in determining whether or not adolescents have been properly immunized.

Quality Assurance

The facility lacks an adequate quality assurance process, involving the physician and other medical staff members. Nor is any such review or monitoring undertaken by the State.

Review of Laboratory Results

The facility lacks an adequate policy and procedure for reviewing laboratory results in youths medical charts and undertaking adequate follow up. This has resulted in staff missing potentially significant lab results in a number of cases. For example, a number of youth had labs indicating potential anemia (*e.g.*, E.T., D.L.), low white blood cell count (*e.g.*, T.S., W.T.,) or possible diabetes (*e.g.*, T.S., C.W.,) without any indication that these results had been noted or appropriately responded to by the Swanson medial staff.

Dental Care

The dentist has been employed for the past three years and has worked in the Monroe area since 1984. He is there approximately 2-1/2 days each week (Monday, Friday, and half day Saturday), conducting screenings and seeing youth placed on sick call for dental care. He does a number of different dental procedures including cleaning, extractions, partials, false teeth, root canals, etc.

The facility does not provide annual screenings or routine dental care unless a youth specifically requests to see the dentist. The dentist believes that such routine examinations should be undertaken and noted that in the past, the facility had begun to

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make arrangements with the Northeast Louisiana University school of dental hygiene to have hygiene students provide this service, although these plans never came to fruition.

Respectfully submitted,

Bernard O. Hudson, M.D.

BOH:lh

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Respectfully submitted,

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Bernard O. Hudson, M.D.

BOH:lh

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Bernard O. Hudson, M.D.

BOH:lh

**A Review of Medical, Dental and Mental Health Care at
Jetson Correctional Center for Youth
Baton Rouge, Louisiana
May 5-8, 1998**

**Prepared by
Pamela McPherson, M.D.**

**For the Civil Rights Division
of the United States Department of Justice
July 27, 1998**

EXHIBIT E

July 27, 1998

Ms. Iris Goldschmidt
U.S. Department of Justice
Special Litigation Division
P.O. Box 66400
Washington, D.C. 20035-6400

Re: Jetson Correctional Center for Youth
CRIPA Investigation, May 5th - 8th, 1998

Dear Ms. Goldschmidt:

This letter documents my participation and findings during my tour of the Jetson Correctional Center for Youth on May 5 - 8, 1998 with my associates Dr. Marc Colon and Dr. Bill Richie.

The sources of information for this report include:

Interviews:

Dr. Alejandro Penzo, M.D., Medical Director, 5/5/98
Dr. Winfield, Jr., M.D., Gynecologist, 5/5/98
Dr. Gutierrez, M.D., Psychiatrist, 5/6/98
Dr. Melvin Jones, D.D.S., Dentist, 5/6/98
Perla Steele, A.C.S.W., B.C.S.W., Program Manager Team A, (Reception and Diagnostic Center/Intake Unit), 5/6/98
Barbara Gagneaux, R.N., Medical Authority and Nursing Director, 5/5/98
Dr. Howard Hughes, Ph.D., Director Psychological Services, 5/7/98
Dr. Friedt, Ph.D., Psychologist, 5/7/98
Dr. Solieaux, M.A., Psychologist, 5/7/98
Mr. Rivet, B.C.S.W., Assistant Warden, 5/7/98
Jean Roan, M.S.W., Female Unit Manager, 5/7/98
Joe Lott, M.S.W., L.P.C., Program Manager Team D, 5/6/98
Stephanie White, M.S.M., Substance Abuse Program, 5/8/98
Emily Wagner, M.A., Program Manager Area I, Team A, Sex Offender Treatment, 5/8/98

Documents:

Louisiana Department of Public Safety and Corrections Health Care Manual (B-06-001)
Monthly Report for JCCY(C-05-001), February 1998 and March 1998
Quality Control Procedures for Monitoring Suicide Watch Cases, dated 4/6/98
Health Care Services Workload Indicators, January through March, 1998
Selected Policies and Procedures and Departmental Regulations
Selected Counseling and Medical Records
Transportation Log (documenting hospital visits) for March and April
Employee Roster/Schedule
Juvenile Roster
Dental Log
Staff Training Activities
Special Programs/Counseling Groups and Youth Attending Those Groups
Delta Structured Treatment Unit Program
Behavioral Skills Development Program (draft outline), dated 4/30/98

Lists:

Juveniles referred to outside facilities for mental health treatment
Juveniles with chronic illnesses
Juveniles with mental health problems
Juveniles who have been prescribed or have received psychoactive medication
Juveniles who have committed/attempted suicide or were placed on watch
Juveniles placed in restraints in the last sixty days
Juveniles with an IQ less than 70 (DSM IV criteria for mental retardation)
Juveniles eleven years of age or younger
Juveniles who are pregnant

It was shocking to find that in the two years since my initial visit to Jetson Correctional Center for Youth (JCCY), medical and mental health services have not improved, and, in some areas, they have worsened. The facility continues to substantially depart from currently accepted professional standards in supplying medical and mental health services to the youth entrusted to their care. In fact, at the exit interview I declared the medical services to be in a state of emergency. I recommended that a physician be hired full-time and be made the medical authority with 25% administrative time. This would require the hiring of an additional part-time physician. Mr. Lewis, JCCY's director, indicated his intention to hire Dr. Penzo as acting medical authority effective immediately. I recommended weekly meetings between the medical authority and Mr. Lewis until the medical care at JCCY meets minimum acceptable standards.

While the inadequate medical services were identified as my most pressing concern at JCCY, I found the mental health services at JCCY to be far below acceptable

professional standards. I recommended that a full-time psychiatrist be employed by JCCY. This recommendation is necessary because of the high number of seriously emotionally disturbed youth within the LTI system. The psychiatrist hired should spend thirty percent of his or her time assisting in raising the mental health service delivery system at JCCY to minimally acceptable standards. This requires a psychiatrist with knowledge of service delivery systems and corrections in addition to adolescent psychiatry.

Problems with the current delivery system are pervasive. The use of medical restraints should be halted until a psychiatrist familiar with their appropriate use is employed by JCCY. The inadequate care to youth at risk for suicide was identified as an outstanding issue to be addressed by the mental health authority. The lack of minimally acceptable treatment, including medication management and counseling, remains a serious deficiency at JCCY.

I found that recommendations in my initial report of January 1997, as well as those of other experts, had not been implemented. Those staff who were familiar with my initial report complained that only selected portions were made available to them. The staff were not familiar with current juvenile corrections literature, nor had they made use of local resources such as the State's Hunt Correctional Center.

The Louisiana Department of Public Safety and Corrections Health Care Manual addresses the care of incarcerated individuals. Some sections cite separate policies for adults and juveniles with the care outlined for juveniles falling below the care offered adults. This indicates that the Department of Public Safety and Corrections (DPS&C) is aware of acceptable standards of care but fails to provide this care to youth. In fact, the DPS&C has cited the lack of mental health services as a reason for transferring juveniles to adult institutions. This indicates indifference to the mental health needs of Louisiana's youth.

The continued failure to meet the medical and mental health needs of incarcerated youth represents indifference to these Louisiana youth by the Louisiana DPS&C.

A detailed discussion of my concerns follows.

I. THE RECEPTION AND DIAGNOSTIC PROCESS AT JETSON IS DEFICIENT.

The Reception and Diagnostic Center at JCCY is the gateway to the secure care facilities in Louisiana. During the Reception and Diagnostic Center's process, JCCY

screens and assesses the juveniles and makes a placement decision for each juvenile. The process includes a psycho-social interview and mental status exam by a social worker, a request for past school and facility records, identification of high risk juveniles, medical assessment, dental screening and a group educational/psychological test. The social workers refer juveniles to the psychologist and/or psychiatrist for further mental health assessment when they deem it necessary.

Summary of Standards: The screening that occurs at the reception and diagnostic center is the first step in the overall medical and mental health service delivery system. The identification of previously diagnosed or potential mental or physical disorders is the goal of the screening and assessment process. This process must be conducted in a manner which comports with currently accepted professional standards. The screening and assessment process should identify youth with severe mental retardation and/or severe mental illness whose needs cannot be met in the secure care system. Youth with mental retardation or mental illness should receive treatment in the most appropriate setting to meet their needs. The State must ensure that these juveniles are placed in a facility that can provide them with adequate treatment.

Summary of Findings: The reception and diagnostic center process at JCCY substantially departs from currently accepted professional standards. The State of Louisiana continues to place juveniles with mental illness and mental retardation in the secure facilities where it does not provide them with adequate treatment. The State has also failed to develop appropriate settings for the treatment of special needs juveniles.

Discussion: While the reception and diagnostic program has succeeded in reducing the time required for the initial assessment process to two weeks, serious deficiencies remain. Serious deficiencies include: the lack of a structured evaluation to identify all possible psychiatric diagnoses; the inadequacy of specialized mental health assessments; the lack of confidentiality during screenings and medical assessments; and the failure of medical staff to identify serious problems with juveniles prior to placement in JCCY or the State's other secure juvenile facilities. In addition, there is no systemic approach to the care of special needs youth that would allow for the identification of youth inappropriately placed at JCCY and the other secure care settings. With the current lack of appropriate services for special needs youth in Louisiana's secure care settings, a substantial number of youth with serious mental illness and mental retardation are inappropriately placed in these facilities. Moreover, youth with mental retardation or mental illness should receive treatment in the most appropriate setting to meet their needs. The State has failed to develop appropriate settings for the treatment of special needs juveniles.

While the brief initial screening for mental health problems (a thirty-minute to one-hour interview with a social worker designed to identify serious acute mental health

needs) is adequate to identify immediate concerns, the reception and diagnostic program must have a more thorough, structured evaluation to identify all possible psychiatric diagnoses. A structured evaluation does not currently exist at JCCY. Youth in juvenile justice settings commonly suffer more than one illness. JCCY should utilize one of the many computerized assessments designed to screen for all possible mental illnesses.

The reception and diagnostic process at JCCY relies heavily on the psychiatric evaluations conducted by the facility's psychiatrist, Dr. Gutierrez, to identify all youth with psychiatric illness. The State's reliance on Dr. Gutierrez's evaluations is unrealistic because he only sees youth for four to eight minutes. This unrealistic expectation leads to the State's failure to identify significant mental health problems in the youth under the State's care. Youth within juvenile justice facilities have been shown to have a greater incidence of mental health problems than their non-adjudicated peers. The importance of identifying all youth with mental illness and mental retardation cannot be overstressed. The symptoms of undiagnosed mental illness and mental retardation lead to behavioral difficulties which create situations which pose a danger to the youth as well as staff. For example, post traumatic stress disorder is common especially among females within juvenile justice settings. Not one of the thirty-two records, that I reviewed included this diagnosis. Numerous records did not list a final diagnosis.

The program manager of the intake unit, Ms. Steele, stated that an inadequate flow of information from the medical unit leads to a failure to place medical information in the final reception and diagnostic center problem list. This results in an inadequate problem list. Because symptoms of medical illness may easily be mistaken for mental illness, the reception and diagnostic team must fully understand all medical issues faced by each youth. The lack of information coordination is further illustrated by Dr. Gutierrez's admission that he generally does not have juveniles' social history of at the time he evaluates the juveniles. This information is critical to an adequate psychiatric assessment.

In all settings, the lack of privacy was a major deficiency in the initial assessment process. The program manager of the intake unit indicated that partitions have been erected in the intake social workers' offices to partially alleviate this problem. The partitions do not provide an adequate sound barrier. Medical staff indicated that they sometimes conduct evaluations with doors open because the lack of staff does not allow for two staff to be present during all examinations. Youth are unlikely to disclose symptoms fully when peers may overhear them.

Mental health staff at the Swanson Correctional Center for Youth and the Tallulah Correctional Center for Youth reported to Dr. Hudson, the United States medical/mental health consultant who recently toured those facilities, that information received from

JCCY was incomplete and unreliable and that assessments had to be repeated. Similarly, at LTI-Bridge City, Dr. Dowling and Dr. Fontenelle indicated to me that they spend their limited contract time repeating JCCY assessments because they find them inadequate. Furthermore, Dr. Dowling stated that he frequently disagrees with the diagnosis and medication selections made by Dr. Gutierrez. No juvenile should be transferred from JCCY without an adequate assessment.

Psychological testing reveals a high number of youth in the State's secure juvenile system with mild or moderate mental retardation. At the time of our tour, twenty-one youth at JCCY were identified as mentally retarded. One hundred and twenty-eight had IQ's less than seventy (One hundred is average; below seventy indicates possible mental retardation or learning difficulties. The diagnosis of mental retardation requires an IQ less than 70 and impairment of day-to-day functioning.). The program manager of the intake unit, and the psychologist for the intake unit, reported the average IQ of youth at Jetson as 78 or 79 (low average, with below 70 indicating possible mental retardation). JCCY's psychiatrist explained "facilities [specializing in developmental disabilities] won't take them [adjudicated youth with mild to moderate mental retardation]".

The State has no programs within the secure care system to prepare mentally retarded, learning disabled, and mentally ill youth to function upon return to their communities. This fails to meet currently accepted professional standards. The majority of youth with an IQ less than 70 will not be successful at JCCY or the other secure facilities, given the facilities' current conditions, nor upon their return to Louisiana's communities without special programs. A small percentage will not master the challenges of adolescent development without intensive individualized programs.

Even when the facility recognizes that juveniles are not appropriately placed in the secure care system, the State fails to provide appropriate placements for these juveniles. For example, at the time of the tour, the following four youth (S.A., L.La., L.Lu. and M.E.) were awaiting placement in a facility for the developmentally disabled:

- S.A. has remained at JCCY many months despite a referral to a setting for the developmentally disabled. A Quarterly Education Assessment of S.A. states that she has "[v]ery few basic skills abilities and will not acquire them in this setting."
- Juvenile L.La. remains at JCCY despite the Dr. Gutierrez's recommendation that she be placed in a facility for the developmentally disabled.
- Juvenile L.Lu. suffers seizures, substance abuse, moderate mental retardation, and receptive and expressive language delays (i.e., her language skills are less than would be expected of a person with moderate mental retardation). She had

experienced multiple psychiatric placements prior to her placement at JCCY. Dr. Gutierrez sought help for L.Lu. within the State's mental health system. After a brief hospitalization L.Lu. was returned to JCCY without significant improvement.

- The program manager of the intake unit had recommended that M.E. (JIRMS #1389) be transferred to a more appropriate facility on 4/14/98. M.E. has a history of six psychiatric hospitalizations, mild mental retardation and a psychotic thought disorder. At the time of the tour, M.E. was still at JCCY.

Mental health staff at Swanson and Tallulah also reported to Dr. Hudson that they had a significant number of mentally ill and/or mentally retarded youth who needed alternative treatment settings. My record review at JCCY and LTI-Bridge City indicated a tendency to transfer seriously emotionally disturbed youth from one secure facility to another, thus preventing the continuity of care which is necessary for adequate treatment.

II. CRITICAL MEDICAL PRACTICES AT JCCY ARE GROSSLY INADEQUATE.

My findings represent a selected review of certain critical medical practices at JCCY rather than a comprehensive evaluation of all aspects of medical care.

Summary of Standards: Youth confined to JCCY have a right to unimpeded access to medical care. Their medical needs must be evaluated only by medical staff. The quality of medical care given to youths must comport with currently accepted professional standards. The medical care given to juveniles must be fully and accurately documented in the youth's medical record in accordance with professional standards. The infirmary must be adequately equipped and provide for patient safety and privacy.

Adequate administration of medical services and quality assurance is essential. Specifically, the medical authority of JCCY must understand the unique challenges of correctional medicine, accept responsibility for the medical care of the youth at JCCY, and provide an adequate quality assurance review of medical services. In addition, there must be sufficient adequately trained and qualified medical staff to ensure adequate care.

Summary of Findings: Critical aspects of medical care at JCCY substantially depart from currently accepted professional standards and are in a state of emergency. The serious deficiencies in the delivery of medical care are creating life-threatening situations. JCCY fails to provide adequate access to medical care. The quality of medical care at JCCY provided to all juveniles, and especially to those with serious medical needs, is not minimally adequate. JCCY substantially departs from professional standards in medical record keeping, including the documentation of care and the

tracking of laboratory results. The physical plant of the infirmary departs substantially from accepted professional standards with regard to patient privacy, safety, and equipment availability.

With respect to the administration of medical care, the medical authority at JCCY lacks sufficient understanding of correctional medicine to ensure the delivery of adequate health care to youth at JCCY. There is inadequate physician supervision of nursing care and the number of physician hours is inadequate to provide for the oversight of medical care. The medical director stated that he has no administrative duties. Nursing staffing is insufficient to ensure adequate care for juveniles. I noted numerous examples of nursing staff judgement in the delivery of care which departs substantially from currently accepted professional standards. The facility has not implemented quality assurance mechanisms.

Given that JCCY is the reception and diagnostic center for the entire secure juvenile correctional system, the facility's failure to provide adequate medical care services to juveniles places youth throughout the system at risk.

Discussion:

Access to Medical Care: Direct access to medical care is a basic tenet of correctional medicine. Correctional officers and other non-medical personnel should not decide who receives medical care. Youth must have direct access to medical staff. This is typically accomplished through the use of sick call slips that are picked up and reviewed by medical staff on each shift. Youth should have direct access to sick call slips. Correctional staff should not decide who fills out slips.

Nurse Gagneux, the nursing director, indicated that sick call slips are obtained from direct care staff on the units or in the cafeteria. Nurses collect the slips and schedule sick call appointments. Numerous charts contained sick call requests that were not completed by nurses. (Youth fill out the top half of the request, there is a space at the bottom for the nursing assessment.) This indicates that youth complaints were not adequately addressed. Moreover, Nurse Gagneux acknowledged that youth have complained about correctional staff not communicating medical needs to the medical staff in a timely fashion. She reported "frequent" complaints regarding access to care from the girls and "10-12 per month" from boys. When youth require emergency medical care they must ask staff to contact the medical department. Nurse Gagneux stated that "direct care staff may not recognize medical needs" resulting in interference with direct access to medical care. Correctional officers and other non-medical personnel decide who receives medical care at JCCY. This does not comport with currently accepted professional standards.

Quality of Medical Treatment: Juveniles' medical needs must be adequately identified and treated by the appropriate medical staff. Timely and adequate communication among health care staff is essential in medical triaging. Medical staff must ensure that juveniles receive appropriate follow-up care, if necessary. Patients with chronic illnesses require ongoing monitoring and tracking of symptoms of the illness and response to treatment. It is a professional practice for medical staff to record all contacts with patients in the medical chart.

At JCCY, nursing staff routinely fail to fully evaluate the medical needs of juveniles. They also fail to refer serious problems to the physician when it is necessary. Although the nursing director stated that all labs are reviewed by the physician, the facility's physician stated that there is no system for reviewing lab results. It is standard practice for nursing staff to review labs and identify all abnormal results for physician review. JCCY does not follow this practice. In many instances, when the physician orders labs or refers juveniles for care outside of the facility, the records do not indicate that nursing staff follow these orders. Nurses routinely send juveniles with serious medical conditions to the hospital without later informing Dr. Penzo that they had done so. They also start medications ordered by physicians other than Dr. Penzo and Dr. Gutierrez without notifying the facility's physicians. This is a dangerous practice because emergency room physicians are not aware of all pertinent medical history. Dr. Penzo and Dr. Gutierrez are responsible for integrating all medical needs; therefore, they must be made aware of all medical treatment rendered. Medical staff do not routinely monitor the symptoms of persons with serious and chronic illnesses. The lack of sufficient notes in the medical records makes it impossible to adequately track the medical condition of juveniles and the progression of illness. This is particularly egregious in the cases of youth with chronic illnesses.

The following case studies exemplify medical care at JCCY which substantially departs from currently accepted professional standards and many of which create potentially life-threatening situations.

- Juvenile F.B. (JRMS # 53764) suffered a "diabetic emergency" on 4/16/98. This was noted on an unusual occurrence form. There was no note in the nursing notes section of the chart. F.B. was not referred to a physician. Her condition was not followed-up by nurses until 4/19/98. On 4/20/98, she suffered a second "diabetic emergency." The unusual occurrence form states "arm trembling, crying and grunting, eyes rolling back in head". There was no documentation of followed up of this incident until Dr. Penzo saw F.B. on 4/28/98. He immediately referred her to the EKL Hospital endocrinology clinic. The failure to communicate critical information to Dr. Penzo represents substandard medical triaging. Poor medical triaging in the care of a diabetic patient leads to poorly controlled blood sugar levels and an increased risk of complications including blindness, kidney failure,

and death. When I reviewed this case with the physician, he agreed that the lack of timely referral to him by nursing was "inappropriate." Nurse Gagneux's response to the delayed referral was that communication was not going well between shifts.

- Juvenile R.R. (JRMS # 032714) also suffers from diabetes. Dr. Penzo noted that his condition is "brittle," meaning difficult to control. R.R. has his blood sugar checked before meals. At times, the blood sugar was noted to be "HI". This means it was too high for the machine to register (i.e., >450). Coma can occur with blood sugars above 500. There is no documentation that a physician was notified of the high blood sugar levels. R.R. also failed his vision screening 1/22/97. Blindness is a common complication of diabetes. JCCY did not follow-up on the failed vision screening. A 9/97 note from EKL Hospital states "keep ophthalmology clinic appointment." There is no documentation that this appointment was kept, thus placing R.R. at risk of vision loss.
- Juvenile K.F. suffers from a potentially life-threatening heart condition called paroxysmal supraventricular tachycardia. He is treated with two heart medications for this abnormally fast heart beat which can result in heart failure if not properly monitored and treated. On 2/10/98 he was placed on emergency sick call when he complained of his heart beating too fast. The staff observation portion of the form was not completed and there was no documentation of any evaluation or treatment offered to K.F. There was no monitoring of his blood pressure or pulse and no EKG on his chart. He was seen at EKL Hospital on 2/17/98 but a note documenting that hospital visit was not on his chart. A note on 4/26/98 states: "referral to AM sick call." There is no indication on his chart that this follow-up occurred. During my interview with Dr. Penzo, he stated that he had not been made aware of K.F.'s medical condition. The failure to communicate critical information to Dr. Penzo represents nursing judgment and medical triaging which substantially depart from currently accepted professional standards.
- Juvenile A.H. (JRMS # 33986) fainted in March 1998 and was evaluated by an L.P.N. There are many reasons for fainting. A.H.'s medication may have been responsible. There is no indication that this possibility was considered by JCCY's nursing staff. There is no indication in her medical record that a physician was notified. The failure to communicate critical information to the physician represents nursing judgement and medical triaging which substantially depart from currently accepted professional standards.
- Juvenile J.D. suffers from sickle cell anemia. Pain is frequently experienced during a sickle cell crisis. J.D. required a blood transfusion in 1/98 for

complications of his sickle cell anemia. When he complained of prolonged pain in February 1998, the L.P.N. evaluating him gave him Tylenol with no further follow-up. J.D. was not referred to Dr. Penzo for evaluation of a possible sickle cell crisis. Poor medical triaging of a patient with sickle cell anemia could lead to a child suffering unnecessary pain and risking complications of sickle cell crisis, including death. In addition, Dr. Gutierrez treated J.D. with Tofranil (an antidepressant that has been implicated in several cases of sudden death due to heart failure) without appropriate heart monitoring. This is particularly egregious given the fact that J.D. has tricuspid regurgitation (a heart valve defect) which has required monitoring by a cardiologist.

- Juvenile S.J. (JRMS # 48918) was sent to the infirmary on 2/16/98 for hemoptosis (coughing up blood). There is no note documenting how this complaint was evaluated. An L.P.N. is not qualified to fully evaluate hemoptosis and should consult with a physician in assessing such potentially life threatening conditions. S.J. was not evaluated by JCCY's physician until 2/18/98. He referred her to EKL Hospital at that time. The failure to communicate critical information to the physician represents nursing judgment and medical triaging which substantially depart from currently accepted professional standards.
- Juvenile E.G. (JRMS # 53502), an eleven year old at JCCY, had an abnormal EKG which was not referred to the physician before his transfer to LTI-Bridge City. The significance of his abnormal EEG is uncertain. It may represent a normal variant or a life threatening condition. A physician must make this determination. The failure to communicate critical information to the physician represents substandard nursing judgement and medical triaging.

Moreover, JCCY's substandard treatment of juveniles with seizure disorders is appalling. Dr. Penzo, the facility's physician and medical director, stated that he was not aware of any juveniles at the facility experiencing seizures and that JCCY was not equipped to handle seizure activity. The nursing director reported that youth with seizure disorders are referred to Dr. Gutierrez, the facility's psychiatrist, rather than to Dr. Penzo. JCCY needs to have a protocol for seizure management, including staff training to recognize seizure activity (While it is hard to mistake a grand mal seizure, there are types of seizures that require special training to recognize.). Failure to recognize and appropriately treat seizures may lead to increased frequency of seizures and make a seizure disorder more difficult to control. Poorly controlled seizures carry a risk of brain damage and death. Many youth at JCCY suffer from seizure disorders. The following case studies exemplify JCCY's failure to provide adequate medical care for youth with seizure disorders:

- Juvenile L.L. suffers a seizure disorder. She is treated with Tegretol, a medication that requires monitoring by blood tests. Although Dr. Gutierrez ordered these tests, there is no indication in L.L.'s record that they were done. Her last blood count result was from March 1997. At that time her white blood count was low. This could indicate that her body has stopped making white blood cells, a potentially life-threatening condition. Moreover, her institutional file indicates five possible seizures during the first three months of 1998. There is no evidence in the medical record that she ever received medical attention for any of these seizures. Her institutional record also indicates "complaints of incontinence". Loss of bladder control is common with seizures and may be the only indication of seizure activity during sleep. There is no indication that anyone considered L.L. was experiencing seizures when she experienced incontinence.
- Juvenile J.W. (JRMS # 025238) has not had the required blood tests for her seizure medication since 11/97. At that time, the level was subtherapeutic, indicating that the dosage was too low to be effective. JCCY placed her at increased risk of experiencing seizures.
- Juvenile K.W. (JRMS # 49872) has not received adequate treatment for her seizure disorder. In the March 1998 Monthly Report submitted to Mr. Stalder an unusual occurrence report (listed as an assault on staff) indicates: "...K.W. fell to the floor shaking and foaming at the mouth. ... K.W. was checked by medical for seizures." The medical record entry for the same date indicates that K.W. was involved in a gang fight, but does not indicate that nursing staff considered the possibility of a seizure or that her seizure disorder was followed up with appropriate medical care.
- Juvenile C.W. (JRMS# 35520) has a subtherapeutic level of his seizure medication placing him at risk for seizures. The possibility that his bed-wetting could be due to seizure activity was not considered. Dr. Gutierrez had ordered medication levels, but there was no indication on C.W.'s chart that they were done.

Follow-up of Vision and Hearing Screenings: Youth entering JCCY undergo vision and hearing screening. The initial vision and hearing screenings were completed in most cases; however, in numerous cases no follow-up was done when juveniles failed the screening. We were told by Nurse Gagneux that juveniles are referred to the school for hearing testing, but that there is no feedback from the school.

Medical Record-keeping: The standard of care is to document all patient contacts. Medical record keeping is grossly deficient at the facility. In my review of 32 medical records, I did not find one record which adequately documented care received by a

juvenile. The records were disorganized and incomplete. Dr. Penzo stated that records were not always prepared for his visits and that records were often misplaced. The majority of the records reviewed had no nursing notes. Because I selected records of youth with chronic illnesses, all records should have contained regular nurses notes. It appears that regular nurses' notes are only made when youth are housed in the infirmary. The laboratory results were not initialed and dated. In numerous cases, labs requested by physicians were not in the records.

Adequacy of the Infirmary and Equipment: The infirmary is crowded with little privacy and many blind spots. Patient care areas have exposed wires, electrical outlets and knobs which provide potential for self harm. The emergency button in Dr. Penzo's examination room does not work. His examination room doubles as an office; however, it does not have a telephone. Youth are often crowded in the hallways awaiting appointments. Dr. Penzo has asked that no more than ten youth be waiting in the infirmary at any time because fights have broken out in the infirmary. This order was not being honored during our tour. Basic equipment, such as an ophthalmoscope to examine eyes and a high quality stethoscope and blood pressure cuff were not available. In addition, there were eight pregnant juveniles in the facility at the time of our tour and the facility did not have a Doppler to monitor the fetal heart beat.

Administration of Medical Care and Quality Assurance: The responsibility of the medical authority at JCCY is indeed great. The medical authority must synthesize medical and correctional/legal knowledge with administrative skills. The medical authority is responsible for ensuring unimpeded access to health care, developing a service delivery system, and monitoring the quality of care. These responsibilities are not being met at JCCY; indeed, no one seemed to recognize these needs. The medical authority at the time of our tour was Nurse Gagneux. She stated: "I'm overwhelmed," and "I can't make decisions about staff numbers and competency." She explained that she had recently returned to the facility after a six-month absence. The lack of adequate medical administration is exemplified by the lack of effective communication of information regarding juveniles among medical staff and between medical staff and other professionals in the facility whom are also caring for the juveniles. There are no quality assurance mechanisms in place at JCCY to identify and correct problems with medical record keeping, patient triaging, and medical care. JCCY's lack of quality assurance results in the failure to correct substandard patient care practices and places all youth at JCCY at risk.

Medical Staffing and Supervision: Medical staffing (physician and nursing) is inadequate to meet the needs of youth at JCCY. Dr. Penzo is responsible for 600 youth, and is available for only 30- 35 hours onsite per week. He has no administrative or supervisory duties and does not take call (i.e., does provide coverage when he is off-site). The medical director's responsibilities should be expanded to include supervision

of the medical services and staff. Physician staffing should be one full-time physician per five-hundred youth.

With respect to nursing staff, JCCY currently has positions for three registered nurses (R.N.), seven licensed practical nurses (L.P.N.), and five emergency medical technicians (E.M.T.s) (three full-time and two part-time). On weekdays the nursing director, an R.N., is available 8:30 am to 4:30 p.m. A second R.N. is scheduled 6:00 am to 2:00 p.m. Three L.P.N.'s are scheduled 6:00 am to 2:00 p.m. and three are scheduled 2:00 p.m. to 10:00 p.m. One E.M.T. is scheduled 12 p.m. to 8:00 p.m. and 6:00 p.m. to 6:00 a.m. E.M.T.s are the only medical professionals available on weekends. On weekdays, an R.N. provides telephone back-up coverage and on weekends a L.P.N. provides telephone back-up coverage. Although this level of coverage is scheduled, staff turnover, vacations, and sick leave do not allow this coverage to be routinely achieved. Nurse Gagneux indicated that the facility does not have a supervisory R.N. on all shifts and that she needed two additional registered nurses in order to provide adequate supervision of nursing staff on all shifts. In addition, she indicated a need for eight full-time L.P.N.'s and five full-time E.M.T.s. Because of the failure to meet professional standards in staffing the nursing department, medical staff indicated that they sometimes conduct evaluations with doors open because the lack of staff does not allow for a nurse to be present during all examinations. This undermines the examination, because youth are unlikely to disclose symptoms when their peers can overhear them; moreover, this lack of confidentiality during examination deviates from standard medical care.

It is well documented that youth in juvenile detention facilities have greater medical needs than the general population, yet according to JCCY staff, the DPS&C provides even less medical staffing in their juveniles facilities than in their adult facilities. Moreover, the Louisiana DPS&C Health Care Manual documents that adults in Louisiana's prisons are afforded a higher standard of care than youth at JCCY.

Dental Care: I did not conduct a comprehensive evaluation of dental care; my findings represent a selected review. The following observations are derived from my interview with the facilities dentist, Dr. Melvin Jones, DDS. Dr. Jones indicated that he holds two four-hour weekly dental clinics at JCCY. He stated that eight hours per week would be sufficient if he had a dental assistant. Moreover, he stated that there is no dental x-ray equipment at JCCY and that youth must be sent to EKLH for dental x-rays. Dr. Jones stated that he provides oral hygiene instruction and dental examinations as well as restorative and periodontal treatments. Dr. Melvin's hours per week should be expanded or a dental assistant should be hired.

III. MENTAL HEALTH CARE SERVICES DEPART SUBSTANTIALLY FROM CURRENTLY ACCEPTED PROFESSIONAL STANDARDS.

Summary of Standards: Youth at JCCY have a right to receive adequate mental health care. This needed continuum of services includes specialized mental health assessments, treatment planning and case management, management of psychotropic medications, rehabilitative treatment programs, and crisis management which comport with current professional standards. The provision of care requires adequate administration of mental health services in the facility as well a sufficient number of adequately trained and supervised staff who can recognize mental illness and mental retardation and who can provide youth with the appropriate level of care. Adequate quality assurance measures are essential.

Summary of Findings: Despite my previous report finding serious deficiencies in the delivery of mental health care to youth at JCCY, JCCY has failed to improve the quality of mental health services to juveniles in the facility. Specialized mental health assessments, management of psychotropic medications, treatment planning and case management, rehabilitative treatment programs, and crisis management substantially depart from currently accepted professional standards. Often, juveniles are exposed to life-threatening situations because of the failure of JCCY to provide them with appropriate treatment and a safe living environment. The mental health staff, counselors, and correctional staff are not dealing appropriately with mentally ill and developmentally disabled juveniles and many lack appropriate training to do so.

Specialized Mental Health Assessments: Specialized mental health assessments include psychiatric evaluations and psychological assessments. All youth must receive an assessment for possible mental illness beyond the screening now conducted at JCCY. Youth with psychiatric symptoms should receive a complete psychiatric assessment. A complete psychiatric assessment should include a review of documents, face-to-face interviews with the youth, documentation of psychiatric history, a complete mental status evaluation, a diagnosis with symptoms listed, and treatment recommendations, including any additional data collection (i.e., calling parents for more details, obtaining past records, medical tests, additional psychological testing). A minimum of one hour is necessary to conduct an adequate psychiatric assessment. Juveniles with extensive psychiatric histories may require an hour just for record review. Psychological testing times vary depending on the tests administered.

Psychiatric evaluations are conducted by Dr. Gutierrez. He generally evaluates between 20 to 30 youth during his four hour visit to the facility. He stated that he sees youth for only four to eight minutes. It is impossible given this time constraint to conduct an evaluation which comports with currently accepted medical standards. Dr. Gutierrez stated: "You realize you can't do a complete mental status when you have only a few

minutes to see patients.” Dr. Gutierrez has requested that his hours per week be doubled. Even eight hours would be grossly insufficient given that an hour to review available records and conduct a psychiatric evaluation is a minimum. Moreover, many of the youth at JCCY have extensive psychiatric histories which would require even more time. Numerous staff reported that additional psychiatric time was necessary.

The psychiatric assessments at JCCY do not approach minimal professional standards. They do not document a complete mental status evaluation or symptoms meeting the criteria for a given diagnosis. Most of Dr. Gutierrez's evaluations lacked a definitive diagnosis and many included diagnosis listed as “probably” or “might have.” A thorough evaluation allows a physician to reach a diagnosis which provides a sound scientific basis for all treatment offered. The failure to provide a rational basis for mental health treatment to youth at JCCY places youth throughout the secure care system at risk. Because youth are often started on medication before their transfer to another secure care facility in Louisiana, the lack of rationale for medication orders, as well as the absence of a description of the functioning of the juvenile, perpetuates the substandard care received by juveniles throughout Louisiana’s secure care system.

With respect to psychological assessments at JCCY, Dr. Fontenelle, the psychologist at Bridge City, stated that the psychological assessments he has received from JCCY are “lacking” and must be repeated. The following case examples illustrate inadequate psychological assessments at JCCY:

- In the case of A.P., a youth with a history of receiving services from the Office of Citizens with Developmental Disabilities for his mild mental retardation, the institutional record read: “individual psychologicals not indicated”. While at JCCY, A.P. has demonstrated poor skills for coping with frustration, such as banging his head on the wall to the point of abrading his forehead. The psychologists at JCCY were aware that this type of behavior should be addressed with an individual behavioral plan but have not offered A.P. individualized psychological testing nor an individual behavioral plan. This does not comport with currently accepted professional standards and shows indifference to the plight of A.P.
- Juvenile M.P. (JRMS # 51220) has had part of his brain removed. He has a history of a brain tumor in the temporo-parietal area. Injuries to this part of the brain are frequently associated with behavioral difficulties. His case plan does not reflect that counseling staff are aware that M.P. had undergone brain surgery. He has not received special testing to determine the extent of deficits caused by the tumor.

- A psychological evaluation of Juvenile K.B. (JRMS # 19414) indicates a long history of mental illness with at least three psychiatric hospitalizations. Dr. Lemoine, a JCCY psychologist, notes: “[s]he has participated in no groups since she has been at JCCY it is recommended that she be involved in as many as possible... A group for rape survivors is especially recommended.” K.B. did not receive the care recommended by Dr. Lemoine. KB’s borderline intellectual function (IQ 71) is not listed as a diagnosis in the evaluation. This history of mental illness and Dr. Lemoine’s note indicate that KB is a youth with serious emotional disturbance. JCCY substantially departs from standards in the provision of care to KB. Without acceptable care, K.B. will not be able to function at JCCY or in the community upon her release from JCCY and will most likely graduate into the adult correctional system.

As discussed in Section I of this report, the mental health staff in the other secure juvenile facilities in Louisiana have expressed dissatisfaction with mental health screenings and assessments from Jetson.

Treatment planning and case management: Individual treatment planning is necessary to ensure that goals for each youth are identified and fully addressed. Medical, counseling, educational, and correctional staff, as well as the youth and his/her family members, should contribute to the overall plan for each child. Counseling records must document psychiatric diagnosis, symptoms of that diagnosis manifested by the individual, and a clear, measurable plan to ameliorate the manifested symptoms. When a psychiatric diagnosis is not present, the youth’s needs (medical, educational, social skills, life skills, etc.) should be clearly documented along with a plan to ameliorate those needs and promote healthy adolescent development. Youth with special medical needs should have those needs addressed in the case plan (Note: “Treatment plan” is used in this report to describe an individualized written plan for each youth to address problems while at JCCY.). The treatment plan developed by JCCY, called a case plan at JCCY, is likely to provide a model for treatment plans developed at the other secure juvenile facilities; therefore, the identification of problem areas at JCCY is critical. All of Louisiana’s secure care facilities should use the same format for the treatment record.

Case management is the process of implementing the treatment plan. The case manager links the youth to needed services. Case management ensures that treatment planning follows each youth from facility to facility and into the community. Case managers link the youth and his/her family to needed services. Effective case management coordinates a continuum of services of varying intensity. Case management must look toward a youth’s future. Community supports, including the family when available, must be included. When difficulties upon returning home are anticipated, and the family is amenable, intensive in-home crisis services should be considered. JCCY must provide case management as a link to the other secure juvenile facilities as well as

to the community. Youth with mental illness and mental retardation should receive treatment in the most appropriate setting that can provide the protection necessary for the youth and his or her community. Community-based treatments are often appropriate because family involvement is critical. Youth with mental illness and mental retardation are at increased risk for victimization. They must be cared for by staff trained to recognize and meet their special needs. Highly structured programs are necessary if special needs youth are to meet the challenges of adolescent development and avoid incarceration as adults. Youth identified as sexual offenders must be categorized as to offender types (where possible), each youth's dangerousness must be assessed (within the limitations of mental health professionals), and follow-up and monitoring beyond secure treatment must be offered.

JCCY substantially departs from currently accepted professional standards for treatment planning. The result of the reception and diagnostic function at JCCY is a problem list. This problem list is incorporated into a treatment plan. A review of twenty treatment plans revealed inadequate documentation of goals and youth progress toward goals. The plans did not appear to be individualized because the same phrases were listed on all the plans. The symptoms of mental and medical illness were not addressed in the majority of the plans. I did not identify one plan that met currently accepted professional standards. It should be noted that inadequate psychiatric assessments result in deficient treatment planning. The State has not developed a system-wide mechanism for documenting treatment plans. JCCY has not developed quality assurance measures to ensure that all treatment plans are up to date and that all salient issues are addressed in them.

JCCY substantially departs from currently accepted professional standards for case management. While it is substandard for all youth, the case management provided to special needs youth is particularly deficient. There are no skills or training programs (outside of the school program) for youth with mental retardation and no therapy beyond support for mentally ill youth. At JCCY, case management refers to counseling as well as to case management services (i.e., liaison with the court and family, assisting the youth in obtaining necessary services at JCCY and upon return to their communities, and providing emotional support). I found no example of a youth with mental illness or mental retardation receiving adequate counseling/case management services at JCCY.

The sexual offender program falls below professional standards in providing case management services to youth. The DPS&C's case management of youth who have committed sexual offenses endangers the general population within the secure care system, particularly special needs youth who are more likely to be victimized. The case management is deficient because monitoring and treatment of the sexual offender population ends with a youth's completion of the six-month sexual offender program. Sexual offenders require long-term monitoring and therapeutic intervention to reduce

their risk of re-offending.

Management of Psychotropic Medications: Management of psychotropic medications must be conducted by a psychiatrist on a regular basis. Psychotropic medication management includes the careful selection of a medication based on diagnosis and patient history, listing of the symptoms the medication might ameliorate, explanation of risks and benefits of the medication to the patient and regular monitoring for efficacy and side effects. The psychiatrist must work closely with nursing staff and counselors to carefully monitor medication after consent for treatment is obtained and possible side effects are discussed. Medication monitoring is a formal process which requires observation and direct questioning regarding side effects and benefits. Medication monitoring should be carefully documented in the patient's record with a side effect checklist and standardized target symptom questionnaires. Treatment providers should review the side effects with the juveniles regularly in order that youth learn to recognize possible medication side effects. Nursing staff are responsible for coordinating the medication monitoring efforts. Standardized rating scales should be completed quarterly to monitor for movement disorders in youth receiving antipsychotic medications. Management of psychotropic medications must be conducted on a regular basis with the same format throughout the secure juvenile correctional system.

At JCCY, the management of psychotropic medications does not meet minimally accepted professional standards. As discussed above, the psychiatric assessments at JCCY, which serve as the foundation for all treatment, including the use of medication, are unacceptable. Because youth are often started on medication before their transfer to another secure juvenile facility, it is critical to document the reasons for the medication and a baseline description of functioning. Because youth are not adequately assessed, they receive inappropriate treatment.

Dr. Gutierrez prescribes psychotropic medications inappropriately. He saw nothing wrong with issuing standing orders for psychotropic medications to be used for behavioral control. This violates established patient care standards. The National Commission on Correctional Health Care standards, which are endorsed by the American Medical Association, American Psychiatric Association, and the National Counsel of Juvenile and Family Court Judges along with over thirty other professional organizations, specifically prohibits the use of standing orders in juvenile facilities. Dr. Gutierrez often does not chart the target symptoms for which he is prescribing medications and sometimes prescribes medications which are not indicated for the patient's diagnosis. Dr. Gutierrez's assessments include many diagnoses listed as "probably" or "might have." In spite of such inaccurate diagnoses, and in some cases the lack of a diagnosis, he prescribes psychotropic medications to youth.

In addition, no one at JCCY conducts regular monitoring for medication efficacy or side effects. This deficiency, which JCCY recognizes, is having a detrimental effect on the mental health of youth throughout the secure care system. Dr. Gutierrez stated that he tries not to use certain medications because monitoring by nursing staff is inadequate. He indicated that some juveniles needed these medications. Dr. Gutierrez also stated that he requests labs and does not get them for months. The twenty-one records reviewed for medication management and monitoring all contained serious deficiencies. None were in compliance with currently accepted professional standards. Side effects were not monitored in a standardized fashion. Youth receiving tricyclic antidepressants (which can cause abnormal heart functioning) did not receive cardiac monitoring. There was no regular monitoring for tardive dyskinesia (a potentially irreversible movement disorder which may be a side effect of medications used in the treatment of psychosis). Furthermore, neither consent nor assent for psychiatric treatment were documented in the patient records. JCCY's policy indicates that consent or a physician's emergency certificate is necessary for psychiatric treatment.

The following case studies exemplify mental health treatment of juveniles at JCCY which substantially departs from currently accepted professional standards and which are in some cases potentially life-threatening:

- Dr. Gutierrez failed to document a clear diagnosis which would establish the need for starting juvenile C.M. on an antidepressant and lithium. Furthermore, Dr. Gutierrez's order to give C.M. Haldol Decanoate (a long acting antipsychotic medication) IM (meaning intramuscular injection of medication) if oral antidepressant and Lithium are refused and as long as she refuses oral medication, does not comport with accepted psychiatric practice. Haldol Decanoate should not be prescribed without a trial of the short acting form first because of the severe complications (including death) that may result. Moreover, C.M. was sixteen years and three months old when Dr. Gutierrez ordered Haldol Decanoate. JCCY did not follow their policy for refusal of care, nor did they secure a PEC (physician's emergency certificate) as their policy indicates. There should have been a review of the need for medication before forcing the medication on C.M. This wanton use of psychotropic medications substantially departs from currently accepted professional standards.
- Juvenile A.P. has a diagnosis of major depression with psychotic features. There is no indication that Dr. Gutierrez was aware of A.P.'s diagnoses of attention deficit hyperactivity disorder, conduct disorder, and mild mental retardation made after extensive evaluation by the Jefferson Parish Mental Health Authority, or that he knew A.P. was receiving services from the Office of Citizens with Developmental Disabilities. Dr. Gutierrez prescribed valproic acid for A.P. Valproic acid is not a first line choice for A.P.'s symptoms. Dr. Gutierrez did not

document his reason for choosing valproic acid. Physicians typically document their reasons for choosing non-standard therapies. A.P.'s subtherapeutic valproic acid level places him at risk for continued depressive symptoms, including the suicidal gestures which are documented repeatedly in his record, and at risk for medication side effects, including impaired liver function, without receiving the benefits of the medication. In A.P.'s case, JCCY's failure to provide proper mental health care has led to repeated suicidal gestures, which have resulted in serious restrictions in his access to the programs available at JCCY and may result in his prolonged incarceration due to continued behavioral difficulties.

- Dr. Gutierrez started juvenile H.C. (JRMS# 38829) on multiple psychotropic medications without a clear diagnosis. His use of Depakote (a mood stabilizer), Risperdal (an antipsychotic) and Luvox (an antidepressant) is unusual. His note states: "...almost sure she has a psychotic depression." The New Orleans Adolescent Hospital diagnosed H.C. with conduct disorder and a personality disorder, and did not recommend medication for H.C. Basic principles of medical practice require reviewing previous diagnoses, establishing a diagnosis before offering treatment and offering one treatment at a time in order to be able to fully evaluate the efficacy of each treatment. Nursing and Dr. Guitierrez failed to manage and monitor H.C.'s medications appropriately. H.C.'s Depakote level was subtherapeutic. Depakote must be at a therapeutic level to be effective. Subtherapeutic levels expose youth to potential side effects without the potential for benefit. No Depakote level was on her chart and no initial lab was on her chart to indicate that it was safe to begin Depakote. There were no target symptoms identified and no side effect monitoring.
- Juveniles R.R. (JRMS # 032714), M.R. (JRMS #41726) and J.D. received the antidepressant medication Tofranil. Dr. Guitierrez and nursing staff failed to monitor the medication appropriately and as a result these youth were placed at risk for life-threatening side effects, including heart failure.
- Juvenile T.W. often refuses his medication, Tenex. Tenex is a blood pressure medication that is used to treat Attention Deficit Hyperactivity Disorder. There is no evidence in the medical record that T.W. was told of the potentially serious consequences of refusing his medication. Stopping the medication abruptly may lead to increases in blood pressure that may result in a stroke.
- Dr. Guitierrez kept juvenile K.M. on Stelazine (an antipsychotic medication) even though he diagnosed her as "malingering." Antipsychotic medications should only be used to treat serious psychiatric illness. No medication should be prescribed without a medical indication. Serious risks are associated with antipsychotic medications including tardive dyskinesia, a sometimes irreversible involuntary

movement disorder, and, in very rare cases, death.

- Dr. Gutierrez and nursing staff failed to appropriately manage and monitor juvenile M.E.'s (JRMS #1389) medication. M.E. receives Clonidine, a blood pressure medication used in the treatment of Attention Deficit Hyperactivity Disorder, with no blood pressure monitoring. Clonidine may lower blood pressure. Blood pressure must be monitored because low blood pressure may result in increased sedation due to a limited amount of oxygen to the brain. The failure of nursing staff to monitor M.E.'s blood pressure exposed him to medication side effects such as sedation and dizziness which might be mistaken for behavioral problems by direct care staff. He was also administered tegretol (an anticonvulsant used as a mood stabilizer) without adequate blood level monitoring. This exposed him to the risk of side effects such as the inability to fight infections without offering him the benefits of the Tegretol. There was no monitoring for tardive dyskinesia (a potentially irreversible movement disorder) or other potential side effects of Thorazine (an antipsychotic medication).
- Juvenile M.R.(JRMS# 41726) reported multiple complaints of constipation. His record reflects that none of the health care staff considered that his medication (Tofranil, an antidepressant) was the cause of his constipation. M.R. failed the initial hearing screening. He has a history of ear surgery. His failed hearing screening received no follow-up.
- Dr. Gutierrez failed to regularly manage J.W.'s (JRMS # 025238) lithium and valproic acid. J.W. has had a subtherapeutic level of both since 11/97, the last time a level was ordered. This placed her at risk for manic and psychotic symptoms such as impaired judgement and delusions.
- Juvenile L.L.'s (JRMS # 50166) lithium level is subtherapeutic and her CBC (complete blood count) is abnormal. Her medication was last ordered in January 1998 by Dr. Gutierrez. At that time, the order indicated that medications should be given for eight weeks. JCCY nursing staff has continued to administer the medication to L.L. without a current physician's order. Nursing staff should have called the subtherapeutic levels and the need for a new medication order to Dr. Gutierrez's attention.
- No Depakote level was on juvenile T.A.'s (JRMS # 44463) chart even though more than one was ordered by Dr. Gutierrez. Dr. Gutierrez made numerous medication changes without establishing a diagnosis.
- Juvenile J.T.'s (JRMS # 48307) dosage of antipsychotic medication was too low for youth with command hallucinations for two years. JCCY's failure to provide

her with an appropriate level of medication caused her to suffer psychotic symptoms needlessly.

Rehabilitative treatment: JCCY fails to provide adequate counseling to juveniles. The individual and group counseling which are provided deviate from currently accepted standards. The counseling notes which I reviewed reflect that the counselors at JCCY do not understand the mental health or mental retardation needs of the juveniles whom they are supposed to be counseling. The records reflect a lack of care for youth with serious mental health and/or mental retardation needs. Counseling goals and case plans were not complete in the majority of charts reviewed and counseling notes do not agree with quarterly progress notes. Psychiatric diagnosis and important medical information were not integrated into the counseling goals and case plans in most of the charts. In many cases, the possibility of a serious mental illness goes unrecognized by the counselor. As a result, counseling is given without any understanding of the condition and needs of the juvenile being counseled. None of the counseling records reviewed reflected that appropriate counseling was taking place.

I was told the Delta Structured Treatment Unit has been established at JCCY because of the high number of young women with serious emotional disturbances; however, the written description of the program describes a disciplinary unit where young women are placed for the inability to function within the general population and must "work their way out". The therapy, as described in the written description, is not adequate to allow the young women to achieve this goal. Ms. Roan, director of the Delta Unit, indicated that the treatment program for Delta was being "revamped" and that a behavior modification program "is in development." It is especially egregious that the unit which specifically houses the juveniles with the greatest mental health needs does not have a behavior modification program. Ms. Wagner, the supervisor of this structured program, stated that the counselors assigned to this unit are supposed to have a lesser case load, however staffing shortages do not permit this. She stated that girls on this unit received 30 minutes of individual counseling bi-monthly. Records did not indicate that counseling beyond support was taking place. The mental health treatment offered to the young women of Delta Unit does not comport with currently accepted professional standards. Moreover, the girls on this unit do not have access to therapeutic groups available to some of the other juveniles on in the facility; instead, they are offered "at least one therapeutic group per week." The Delta Unit is not a "treatment" unit.

The case studies of juvenile M.P. (JRMS#51220) and juvenile K.B. (JRMS#19414), set forth on page 16 of this report, exemplify the lack of appropriate care for youth with serious, chronic mental illness. The following case study further exemplifies the lack of appropriate mental health care:

- Juvenile L.Lu. was placed at JCCY for driving a car without permission. She has an extensive psychiatric history, a seizure disorder, and a limited ability to understand language and express herself. She is not receiving the minimum care needed to allow her to function outside of an institution. Services do not currently exist at JCCY that could prepare her for her future. Her treatment plan is not individualized to her needs. Her individual service plan goals are not specific. This case is not an isolated example. This lack of care for youth with serious mental illness is typical of the charts I reviewed.

Group therapy provides an integral part of the stimuli necessary for healthy youth development in institutional settings. Access to group therapy at JCCY is inadequate because it is limited to too few youth. All youth should be involved in youth development groups on a daily basis.

Dr. Gutierrez identified group therapy as a top priority if mental health services at JCCY are to improve. The anger management group which I observed during my tour did not comport with currently accepted professional standards for a therapeutic process group. The group leader focused the discussion on how to avoid tickets and deal with correctional staff by the "look, listen, follow commands" method. This method does not teach skills that could be easily related to life in the community and the leader failed to offer any examples of situations that could occur in the community. Although the group leader had described the group to us as a process group (a group where members interact with each other with guidance from the leader), he conducted it in a didactic (classroom teaching) fashion. The group leader knew the youth by name, interacted with the youth easily, and held the boys' attention. As a safety issue, the pencils were not counted when collected. Detention facilities often number pencils and dispense them from a numbered wooden block to prevent stealing and later use as a weapon.

My discussion with Ms. Wagner, program manager of Area I, Team A, revealed some serious problems with the sex offender group at JCCY. Ms. Wagner is frequently denied arrest records and investigation reports of the youth in her program. Such information is critical for the assessment, treatment, and monitoring of youth ordered to receive treatment in the sex offender program by the courts. The program is not designed for youth with mental retardation and does not make accommodations for them, although judges order youth with mental retardation to the program. There is no follow-up after the six-month program is completed. Sex offender programs must identify offender types (where possible), assess dangerousness (within the limitations of mental health professionals), and offer follow-up and monitoring beyond secure treatment. JCCY did not offer any of these services at the time of the tour. Louisiana judges should not consider referral to the JCCY sex offender program a solution to the problem of youth who commit sexual offenses.

JCCY continues to fail to meet the rehabilitative needs of all juveniles because of failure to implement a structured hour-to-hour daily program that includes a behavioral management program. With an estimated 80-90% of the youth at Jetson qualifying for the psychiatric diagnosis of oppositional defiant disorder or conduct disorder, a facility-wide behavioral management program is mandatory. A behavioral management program teaches youth to set and achieve goals and anticipate consequences. A behavioral management program provides staff with a tool to encourage appropriate behavior.

The youth at JCCY require an hour-to-hour structured program designed to promote healthy development and prepare the youth for success upon return to their communities. Youth development programs are necessary for seriously emotionally disturbed youth as well as the typical JCCY youth. Incarceration is a crisis point in the life of a teenager. Crisis points offer unique opportunities for learning and change. JCCY must take advantage of this opportunity to teach life and communication skills. Substance abuse education, and where appropriate counseling, must be offered to all youth. Conflict resolution and life skills (i.e., managing finances, finding housing, securing a job, negotiating relationships, navigating assistance programs, etc.) are critical. The goal of youth development programs are to educate youth in the skills necessary for success upon release. The needs of youth with mental retardation must be met. Youth with special needs require modifications of the general program.

Youth development programs at JCCY do not comport with currently accepted professional standards. During my tour, I observed that youth spend hours with little or no structure. Not all youth at JCCY receive substance abuse education. The Intensive Substance Abuse Group, which according to facility policy is supposed to meet three times per week for two months, met only once in three settings the week of the tour. Groups and activities are available to a limited number of youth. Numerous staff at JCCY commented on the need for youth development programs, some have even written proposals for such programs. The schedule titled "Educational Counseling Session Schedule" for January through December 1998 indicates that one group topic is addressed per month in a one-hour session three times per week. Approximately ten to fifteen youth participate in each group. This means that only sixty youth receive group therapy in any given month and, depending on the month a youth enters JCCY, he/she may never receive certain groups. This does not comport with currently accepted professional standards for youth development programs in juvenile correction settings.

Crisis Management: JCCY fails to adequately handle medical and mental health emergencies which arise in the facility. The management of youth who make suicidal gestures or threats substantially departs from current professional standards and exposes juveniles to life threatening situations. The facility continues to expose juveniles to a large number of suicide hazards. Also, the level of violence at JCCY continues to constitute a medical and mental health crisis. The overwhelming violence which is

rampant throughout the secure correctional facilities visited is not fully described in this report as it is being addressed by an expert in protection from harm. JCCY staff do not meet professional standards in use of force and restraints of youth who act out. JCCY has failed to implement, as I recommended two years ago, a facility-wide behavioral management program, with individualized plans when needed, that is necessary to reduce behavioral difficulties among youth and to address behavioral crisis without resorting to violence.

JCCY's management of youth who make suicidal threats or gestures does not meet acceptable professional standards. In order to prevent suicidal gestures and suicides, JCCY must constantly monitor youth for risk signs. Every employee of JCCY must be trained to recognize risk factors for suicide. Risk factors should be listed on a youth's case plan. Youth must undergo periodic reassessment for evidence of mental illness through staff observation, direct questioning and screening for mental illness. Reassessment should occur whenever symptoms appear and at least every six months in the absence of symptoms. This is mandatory because youth at JCCY are at high risk of developing mental illness, may respond to the stress of incarceration by developing a mental illness, and fall into an age group for which the onset of mental illness is common. It is not uncommon for youth, as they develop a trusting relationship with a counselor, to report symptoms at reassessment that were not reported originally.

Youth identified at risk for self harm should be assessed by a licensed mental health professional or nurse as indicated by currently accepted professional standards. The assessment should include a thoroughly documented mental status evaluation, listing of all risk factors and protective factors, notation of any symptoms of depression or other mental illness, and an action plan to provide for the youth's protection. The action plan should include daily reassessment and an environment free of opportunities for self harm. Youth at risk of self harm should not be isolated. Isolation often increases hopelessness, disorganized thinking, and rage leading to behavioral difficulties, as well as a heightened risk of self-harm. An individual behavioral plan should be implemented for any youth who chronically engages in threats of self harm or self-harming behaviors. JCCY's policy should clearly identify who is responsible for evaluating and monitoring youth at risk for self harm. Quality assurance must be implemented for this mental health service as well as all others.

Dr. Hughes, the mental health authority, acknowledged the need for quality control procedures in order to improve the monitoring of suicide watch cases. He supplied me with the protocol which is being piloted to provide improved suicide watch monitoring by mental health professionals. JCCY does not conduct periodic reassessments for the onset of mental illness and the majority of records do not contain monitoring of psychiatric symptoms by counselors. Both are necessary to minimize suicide risk. When youth are identified as at risk for self harm, the assessments

conducted do not comport with currently accepted professional standards or JCCY's own policy. Daily reassessments do not occur in many of the cases and when a counselor does meet with the youth, an adequate assessment is rarely documented. Youth identified as at risk for self harm at JCCY were often isolated in unsafe environments, and in some cases, they have harmed themselves while on suicide watch. JCCY's own policy indicates that suicide precautions are to be carried out in the least restrictive setting possible to maintain safety. The two cases in which the new protocol was implemented (H.C. and T.D.) do not meet current professional standards and did not even meet the facility's own protocol because youth were not evaluated daily while on suicide watch and weekly staffings were not documented. In addition, JCCY's "Suicide Precaution" policy and procedure does not comport with currently accepted professional standards. The policy does not comport with the guidelines for the monitoring of youth on suicide watches, assessment of current suicide risk, high risk behaviors that should be observed, and the use of restraints.

The following case studies exemplify JCCY's failure to take adequate suicide precaution measures:

- Juvenile H.C. made a suicide attempt while she was on suicide watch. She was on the watch for one month. H.C. has borderline intellectual function. She is receiving three psychotropic medications without documentation of a diagnosis. On 4/15/98, Dr. Gutierrez wrote: "... almost sure she has a psychotic depression." Her medications were not properly monitored, perhaps increasing the time she required a suicide watch. Many of the counselor's notes during that time did not address H.C.'s mental status (i.e., symptoms of depression, psychosis or other mental disorders, thoughts of suicide, etc.). Regular reviews did not take place as detailed in the protocol being piloted.
- Juvenile T.D. (JRMS #044654) was on suicide watch from 4/15/98 through 5/4/98. She has a past diagnosis of mild mental retardation and is classified as having borderline mental retardation by JCCY. She was referred to the psychiatrist for an evaluation for possible depression on 11/26/97 but a complete evaluation was not done. She was not seen daily by a counselor while on suicide watch and many of the assessments that were done did not comport with professional standards. There was no case plan on her chart. The behaviors that led to her suicide watch resulted in disciplinary action. In effect, JCCY failed to provide adequate treatment and then punished T.D. when her illness worsened.
- Juvenile A.P. has a diagnosis of major depression with psychotic features and mild mental retardation. He was on suicide watch on 2/23/98 through 3/2/98. The monitoring of A.P. while on suicide watch did not comport with acceptable professional standards because counselors failed to conduct a full suicide initial

assessment after A.P. made a suicide gesture and the daily evaluations by counselors did not include questioning about depressive or psychotic symptoms.

- An unusual occurrence report dated 3/29/98 indicates that T.W. "opened stitches to her wound" while on suicide watch, indicating that the observation provided by direct care staff to a youth on suicide watch was not sufficient to prevent self-harm and that the environment was unsafe.

During the tour we found that no staff member on one of the boys' units had a emergency cut-down tool to be used in case of a hanging incident. Also, in the Delta girls unit, the emergency cut-down tool was in a sealed box, which was locked in another box, in the locked control center. The placement of this tool made the rendering of immediate assistance in case of a hanging difficult.

JCCY also exposes juveniles to harm by failing to remove obvious suicide hazards from the facility. There are many unsafe areas in the JCCY physical plant. The confinement or administrative segregation rooms (single cells) have sharp metal plates and glass windows which have been used repeatedly by youth as weapons to harm themselves or others. For example:

- A 2-5-98 unusual occurrence report notes: "[j]uvenile J.P. said he was trying to kill himself by running his wrist along side of a piece of metal from the door." J.P.'s bloody wrist required medical attention. J.P. was placed in physical restraints to prevent further harm in the unsafe administrative segregation room. JCCY resorted to physical restraints because they could not provide a safe environment for J.P.
- Juvenile L.J. has broken the glass in her cell door three times and removed the metal speaker cover from the wall. She has also successfully barricaded herself in her cell. She was treated in the infirmary for cutting and scratching herself and attempting to swallow glass.

The administrative segregation rooms are unsafe, particularly for suicidal youth. In the Delta Structured Treatment Unit, which houses many girls who are mentally ill and/or mentally retarded, there were many blind spots in the cells where girls could engage in self-harming activities, many places in the cell on which girls could tie a cord to hang by, and in the main area, there was a fixed shower curtain rod. Dr. Penzo reported many girls have succeeded in engaging in self-mutilating acts in this unit (e.g., repeated incidents of glass placed in ears). During the tour, I informed the officer who was assigned to tour with me of the many suicide hazards present on the units as I observed them.

The administrative segregation cards at the facility contain a space for mental health concerns. This section was filed with "none," "N/A," or left blank for ten youth under psychiatric care. When completed, the most common notation was "suicide watch." Staff must be aware of the mental health status of youth under their care. Staff at JCCY were not aware of the special needs of youth for whom they have responsibility.

The contraband reports for February and March 1998 were reviewed. Contraband is confiscated daily. Numerous confiscated items held potential for serious self-harm. These included: a shampoo bottle filled with bleach, scissors, a putty knife, correction fluid, pencils and pens, a razor, rope, liquid paper, and metal and glass pieces. Typically facilities number pens, pencils, scissors and tools regularly used by youth and count them. Moreover, while no facility can be contraband free, it is of particular concern that cigarettes, often entire packages, are confiscated daily. This suggests that correctional officers have implemented their own "behavior program" with cigarettes as the reward. Marijuana was found on one occasion during the two-month period.

Unusual occurrence reports included in the February and March 1998 Monthly Reports were reviewed. The methods of restraint or "holds" used by correctional officers substantially depart from current accepted professional standards. For example, on a 3/25/98 use of force report the reporting officer writes: "I grasped Offender Mott behind the head and neck area with my right hand holding her head so she could not move." This is not a hold taught in prevention and management of aggressive behavior courses. Officers should approach out of control youth as a team. This "show of force" approach may require a group of officers with a team leader and specific assignments. For example, prior to approaching the youth, each officer should have an assignment to stabilize an arm or leg, carry the torso, protect the head, open doors, etc. The team leader should direct the operation and not engage in the physical aspect of the procedure. Proper use of force would reduce the number of youth and staff injuries. A show of force often leads to immediate de-escalation of the situation. Many facilities assign specially trained officers to the team on a daily basis. Unusual occurrence reports also indicate that freeze or pepper spray at JCCY is used to subdue youth when less restrictive measures have not been tried. A behavior management program with meaningful rewards is the first tool that should be employed to modify behavior. A show of force should be employed when verbal interventions have been exhausted.

Recent examples of inappropriate use of pepper spray include:

- On 3/4/98 T.Y. was sprayed with two bursts of pepper spray when trying to leave her cell when staff told her not to leave and to allow the mechanical door to close. A mattress might have been held in front of the door to prevent T.W. from leaving while the door was closing. Records indicate that T.W. requires frequent interventions to prevent harm to herself, others and property. Individual behavior

management programs are indicated for such youth and should be in regular use on the "Delta Special Unit." T.W.'s care at JCCY does not comport with currently accepted professional standards. The lack of treatment at JCCY leads to increased use of punishment.

- On 2/19/98 juvenile C.B. was sprayed with pepper spray because she was uncooperative in putting on a jumpsuit after being carried to administrative segregation. Officers might have physically held C.B. until she was calm, possibly avoiding the chemical spray.

Mechanical restraints should only be used to prevent harm to self or others after all other measures have failed. Restraints should be ordered by a physician. When restraints are used, a youth should be restrained for the briefest time possible. A nurse should evaluate the youth after the restraints are placed; a direct care staff should then provide continuous monitoring. A counselor should evaluate the youth within an hour. Two to three hours are the maximum time for restraints. A psychiatrist should evaluate a patient within twenty-four hours of placement in restraints. Many of the youth at JCCY have been victims of physical and sexual abuse. The process of restraining a youth may cause flashbacks to early abuse creating a more dangerous situation for all involved and complicating the youth's treatment and recovery from mental illness. Hospital standards require the identification of patients with a history of abuse and many states are requiring that this information be used to create a crisis plan for managing out of control behavior in the most therapeutic and humane way possible.

JCCY's use of mechanical restraints is a gross departure from currently accepted professional standards and is inhumane and detrimental to the health of juveniles. JCCY records indicate that the facility uses mechanical restraints, four point restraints, and straight jackets when less restrictive measures would have been adequate. They also reflect that they are not appropriately prescribed, are not adequately monitored, and are used for inappropriate durations of time. Examples of JCCY's substantial departure from currently accepted professional standards in the use of restraints include:

- In the case of juvenile D.J. (JRMS # 50223) Dr. Gutierrez left a verbal order "give Vistaril 50mg IM q 4-6 hours as needed, place on standard suicide watch for every fifteen minutes until tomorrow 9-06-97 (sic) if this doesn't work place in 4 point restraints with a diaper and helmet." This is an inappropriate order. Dr. Gutierrez should have had staff contact him if the Vistaril was ineffective (which would have been very likely given the choice of medication and dosage). Only after reviewing the situation with staff present at the scene should a restraint order have been issued. The order should have included the maximum time limitation for the restraint. The restraint log for D.J. from 3/23/98 indicates she was released from restraints to use the restroom, shower and for breaks multiple times over a

twenty-four hour period. If D.J. could be released without incident the restraints were not necessary. Dr. Gutierrez did not evaluate D.J. until 3/25, two and one-half days after the order to restrain D.J.

- Juvenile L.L. (JRMS # 50166), a youth with moderate mental retardation (IQ 50) referred to a facility for the developmentally disabled by Dr. Gutierrez, was placed in four point restraints on multiple occasions. Dr. Gutierrez did not evaluate L.L. within the twenty-four hours following the use of the restraints. Delays in psychiatric assessment of up to twenty days after placement in restraints were noted.
- Juvenile J.H. (JRMS # 52794) was in four point restraints for six hours before a doctor's order could be obtained for the procedure. This delay in obtaining a physician's order does not comport with currently accepted professional standards. The appropriateness of J.H.'s placement at JCCY is questionable. A letter dated 1/27/98 to Ms. Bell from Ms. Clark, a local probation officer, and Ms. Dowe, an Office of Youth Development placement officer, states: "We are requesting that a psychiatric evaluation be done. If the evaluation yields that the juvenile is inappropriate for the facility, please contact our office." Youth should not be placed at JCCY for psychiatric evaluations. A psychiatric evaluation of a minor requires parental involvement. It should be done in the youth's own community.

Moreover, it is egregious that JCCY continues to isolate youth for behavior that its' staff does not recognize as mental illness and does not treat in accordance with professional standards.

Administration of Mental Health Care and Quality Assurance: While Mr. Lewis and Mr. Rivet did acknowledge their responsibility for the mental health care of youth at JCCY, the identified mental health authority (a psychologist) expressed some confusion about his role as the mental health authority. The JCCY administration and psychology department do not have the support of the DPS&C in implementing the necessary programs. Communication between disciplines is poor and quality assurance measures which would assist in identifying poor communication and substandard treatment practices are not in place.

Mental Health Staffing, Supervision of Mental Health Staff, and Training of Correctional Officers: JCCY currently employs one part-time psychiatrist (eight hours per week), two full-time psychologists, three masters level psychologists, one B.S. level psychologist and thirty-three counselors (including masters level and B.A. level counselors). Current mental health staffing is inadequate to provide adequate assessment in the Reception and Diagnostic process and to provide adequate mental health treatment to juveniles placed at JCCY after the reception and diagnostic process. Hiring more

mental health professionals is only one part of the adequate solution to JCCY's problems. The problem must be approached by identifying the range or continuum of necessary mental health services, ranking youth according to need, and identifying the mental health professionals required to meet those needs. The exact number of professionals will depend on the service delivery system selected by the Department of Public Safety Corrections and the needs of the juveniles in the facility. At the exit interview, I recommended that the facility employ at least one full-time psychiatrist.

Supervision of mental health staff does not comport with currently accepted professional standards. Supervision at JCCY is offered on an "as needed basis." Final responsibility for treatment should lie with a psychiatrist or Ph.D. level psychologist. Cases should be staffed with an M.D. or Ph.D. regularly to allow for ongoing supervision. There are currently no such staffings at JCCY.

Correctional staff require training to recognize and treat youth with mental retardation and mental illness. JCCY has failed to provide the necessary training. I toured the Oakwood dormitory which houses many youth with mental retardation and mental illness and asked the correctional officer on the unit if any of the youth in his care were mentally retarded or mentally ill. He responded that there were none to his knowledge. During the anger management group that I observed, the counselor stated: "All my disciplinary reports come out of Oakwood." This is not surprising since officers at JCCY have no idea that they are dealing with seriously disturbed youth and have had no training to manage them.

Summary

It is shocking and disappointing that medical and mental health care of youth at JCCY has deteriorated since my 1996 tour. Despite being on notice of the significant problems in medical and mental health care, the DPS&C continues to be indifferent to the basic health needs of juveniles in their care. The DPS&C has implemented numerous reforms in their adult correctional facilities which have not been supported within the juvenile facilities. The fact that there is no organized system of care for special needs youth within the juvenile secure care system reflects a basic lack of awareness regarding how to construct such a system and that the mental health personnel do not feel the authority to undertake this task.

JCCY departs substantially from professional standards in providing medical and mental health care to youth. The lack of an organized medical program led me to declare a state of emergency at the exit interview. JCCY requires immediate assistance from the State to initiate appropriate medical and mental health care delivery systems.

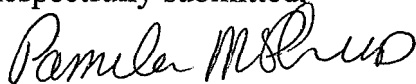
A glaring concern is basic safety. Crisis management must be brought up to currently accepted professional standards. The pervasive culture of violence at JCCY makes it an unsafe environment. The violence must stop for the physical and mental well-being of youth at JCCY. The physical plant must be made safe. Youth development programs, including a facility wide behavioral management program, are critical to stabilize the facility and promote safety. As such programs are developed, staff training in their implementation will be critical.

The Office of Youth Development should expand community placements and family supports so youth might be maintained in the least restrictive settings possible. Large, overcrowded facilities increase the risk that youth will be harmed and are recognized by authorities in corrections as outdated.

Psychiatric evaluations must be more thorough. The psychiatric evaluation at JCCY is a critical tool for understanding a youth's needs and developing a plan to meet those needs. Inadequate JCCY evaluations result in inappropriate placement, provide an unsound basis for all treatment (including medication management), and require physicians in the other secure facilities to conduct additional assessments.

Quality assurance measures must be implemented. This will require improved medical record keeping. Record keeping should be standardized throughout the medical and mental health services of the secure juvenile correctional system. Monitoring quality throughout JCCY is critical in promoting an environment which is safe and encourages the healthy development of adolescents.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Pamela McPherson". The signature is fluid and cursive, with the first name "Pamela" written in a larger, more prominent script than the last name "McPherson".

Pamela McPherson, MD

**A Review of Medical, Dental and Mental Health Care at
Bridge City Correctional Center for Youth
Bridge City, Louisiana
May 11-13, 1998**

**Prepared by
Pamela McPherson, M.D.**

**For the Civil Rights Division
of the United States Department of Justice
July 27, 1998**

EXHIBIT F

July 27, 1998

Ms. Iris Goldschmidt
U.S. Department of Justice
Special Litigation Division
P.O. Box 66400
Washington, D.C. 20035-6400

Re: Louisiana Training Institute at Bridge City (LTI-BC)
CRIPA Investigation, May 11 - 13, 1998

Dear Ms. Goldschmidt:

This report documents my participation and findings during the Louisiana Training Institute at Bridge City tour on May 11 - 13, 1998 with my associates Dr. Gandle and Dr. Holloway. This report addresses my comprehensive review of mental health services for detained youth, including management of psychotropic medications, mental health counseling, crisis management, treatment planning, case management, and youth development programs. This report also addresses certain critical medical and dental practices at LTI-BC.

The sources of information for this report include:

Interviews:

Dr. Felix Bopp, M.D., Medical Director, 5/13/98
Dr. Patrick Dowling, Psychiatrist, 5/13/98
Dr. Gibson, D.D.S., Dentist, 5/13/98 (telephone)
Dr. Fontenelle III, Ph.D., Psychologist, 5/13/98
Victoria Lewis, Mental Health Authority, 5/11/98
Jeanie Zoll, RN, Head Nurse, 5/11/98

Documents:

Overview of Louisiana Training Institute/LTI-BC
Louisiana Department of Public Safety and Corrections Health Care Manual
ACA visiting committee report, dated 4/28/97
Policies and Procedures of LTI-BC
Employee roster
Training Offered Employees at/through LTI-BC, 1996-1998

C-05-001 Monthly Report for March 1998

Medical Doctor's Standing Orders

Psychiatrist's Standing Orders

List of youth with chronic illnesses

List of youth making suicide attempts or gestures

List of all youth sent outside LTI-BC for medical or mental health treatment

List of youth receiving emergency care in the 60 days before the tour

List of Youth Receiving Psychotropic Medication & Those Whose Medication has been Discontinued

List of youth with IQ <70

List of youth with psychiatric disorder or developmental disability

Incident Reports of Juveniles Receiving Psychotropic Medications

Description of Medical Services

Recreation Schedule Summer 1998

Documents describing group therapies

Memo to D. Bunin from V. Lewis Re: Work Assignment, dated 3/9/98

Memo to Thomas Kuester from B.G. Harris Re: Monitoring of time out area, dated 5/13/98

Memo to Dr. Dowling from Mr. Harris dated 5/13/98

Memo to Dr. Fontenelle from Mr. Harris dated 5-13-98

Document describing duties of correctional clinical social workers and counselors, undated

Youth records: JP(048565), JJ(49093), GS(49114), LH(45489), RN(52941), CM(41161), JV(50691), EG(50130), MJ(52960), MG(44461), ZR(38090), EM(29189), RP(34605), JD(46398), NS(37496), TB, TF(17011), GM(37702), LH(32593), TM(52672), KD(47054), JH(46983), TS(47811), DJ(47825), WC, GV(48057), RT(53050), JS(51949), ME(29189), MJ(52960)

Group Observation:

Substance Abuse Group in Brown Dorm led by Mr. Buck, 5/13/98, 2:00- 2:35 p.m.

In the two years since my July 1996 visit to LTI-BC, I found no improvement in the mental health, medical and dental care of youth at the facility and numerous examples of services which substantially depart from currently accepted professional standards. The lack of appropriate mental health care services is especially egregious. Seriously emotionally disturbed and mentally retarded youth are very likely to deteriorate in the stark environment of LTI-BC. Even youth without serious emotional disturbances suffer due to the lack of programs necessary to promote normal adolescent development. Of greatest concern is the lack of an organized system of care for providing medical and mental health services. During the tour, the medical and mental health consultants to LTI-BC readily acknowledged that they provide a lower standard of care to the youth at

LTI-BC than to patients in their other practice settings. As I found at the Jetson Correctional Center for Youth (JCCY), staff at LTI-BC had not had the opportunity to review my full report regarding my findings during my July 1996 tour of the facility and they were not familiar with current juvenile corrections literature regarding medical and mental health care.

As with JCCY, the delivery of health care at LTI-BC is outlined in the Louisiana Department of Public Safety and Corrections Health Care Manual. This Manual addresses the care of incarcerated adults and juveniles in the State of Louisiana. The Manual documents a higher standard of care for adults than for juveniles. In addition, the State of Louisiana provides services for medically fragile and mentally ill adults in a setting separate from the general adult population. Juveniles are not afforded this same level of care. The fact that the Louisiana Department of Public Safety and Corrections has demonstrated an awareness that special services are necessary within correctional settings, yet still fails to provide such services to juveniles, represents indifference to the medical and mental health care of Louisiana's confined youth.

A detailed discussion of my concerns follows.

I. MENTAL HEALTH CARE SERVICES ARE GROSSLY INADEQUATE.

Summary of Standards: Youth at LTI-BC have a right to receive adequate mental health care. Adequate mental health care includes a continuum of services organized within a health care delivery system. The needed continuum of services includes specialized mental health assessments, management of psychotropic medications, treatment planning and case management, rehabilitative treatment programs, and crisis management which must comport with currently accepted professional standards. The provision of adequate care requires adequate administration of mental health services, adequately trained and supervised staff who can recognize mental illness and mental retardation and who can provide youth with an appropriate level of care. Appropriate quality assurance mechanisms are needed to ensure the adequate delivery of mental health services.

Summary of Findings: Despite my previous report finding serious deficiencies in the delivery of mental health care to youth at LTI-BC, LTI-BC has failed to improve the quality of mental health services to juveniles in the facility. In fact, LTI-BC does not even follow their own policy titled "Availability of Staff Members to Counsel Offenders"(93-M-10-05-49) in providing treatment to the youth under their care. Treatment planning and case management, rehabilitative treatment programs, and crisis management substantially depart from currently accepted professional standards. In addition, there are discrete areas where psychotropic medication management does not

comport with currently accepted professional standards. Often, juveniles are exposed to life-threatening situations because of the failure of LTI-BC to provide them with appropriate treatment and a safe living environment. The mental health staff, counselors, and correctional staff are not dealing appropriately with mentally ill and developmentally disabled juveniles and many lack the appropriate training to do so. The administration of mental health services, staffing, staff supervision, and quality assurance mechanisms are inadequate to ensure adequate provision of mental health care services at LTI-BC.

- Rehabilitative Treatment: Ms. Lewis, MSW, was identified as the mental health authority at LTI-BC. She reported that she supervises all treatment programs in the facility, as well the counseling staff, medical staff, and chaplain. Ms. Lewis indicated that there are no special treatment programs at LTI-BC for youth with mental illness or mental retardation. The failure of LTI-BC to provide treatment to youth with mental illness and mental retardation does not comport with currently accepted professional standards.

LTI-BC fails to provide adequate counseling to juveniles. Individual and group counseling that is provided deviates from currently accepted professional standards. Counseling notes did not meet currently accepted professional standards. Because I could not find examples of adequate mental health treatment by counselors or social work staff documented in any of the twenty institutional records that I reviewed, I requested that Ms. Lewis choose two institutional records which contained good treatment examples for me to review. I was provided the records of M.E. (JRMS#29189) and M.J. (JRMS#52960). M.E.'s record contained no counseling notes. It indicated that he suffered moderate mental retardation with an IQ of 49. M.J.'s chart contained no regular counseling notes. M.J. has a well-documented history of psychiatric hospitalization and referral to Dr. Dowling, the LTI-BC psychiatrist. M.J. was seen by the psychiatrist on 4/24/98; however, there were no psychiatric notes in his chart when I reviewed it on 5/12/98. Both boys require specialized treatment to successfully master the developmental tasks of adolescence. Because I found no evidence that any treatment was provided, I again approached Ms. Lewis asking her to point out the treatment examples to me. She replied, "We just document the session, not the specifics." Documentation in M.E.'s and M.J.'s charts did not indicate that counseling sessions occurred on a regular basis. When asked about this, Ms. Lewis stated "I don't document. We just keep the information in our office." No documentation of treatment received by M.E. or M.J. was ever provided to me. Thorough documentation is critical to monitor symptoms and behavior patterns that would indicate the success of treatment or the need for a new therapeutic approach. The lack of any documented, adequate rehabilitative treatment reflects a lack of care for youth with serious mental health and/or mental retardation needs. In many cases, the possibility of a serious illness is not recognized by the counselors. Further examples of the lack of rehabilitative treatment at LTI-BC were

found in the following records:

- On 2/27/98 Dr. Dowling evaluated J.S. (JRMS#51949) and noted “rule out schizophrenia.” This indicates that Dr. Dowling was concerned that J.S. was developing abnormal thinking patterns causing him to lose contact with reality. The appropriate counseling response to such a note by a psychiatrist would be to monitor J.S. for abnormal behaviors. LTI-BC did not monitor J.S. for abnormal behavior. The following incident indicates that LTI-BC’s staff did not even recognize bizarre behavior as a possible symptom of schizophrenia. An incident report on 2/28/98 indicates that J.S. engaged in behavior such as “sitting in the day room slapping himself.” This strange behavior was not reported to Dr. Dowling. There are no further notes by anyone in J.S.’s record indicating follow-up of the possibility that J.S. was developing schizophrenia. Failure to monitor and recognize J.S.’s mental illness is typical of the lack of mental health counseling at LTI-BC.
- Dr. Fontenelle has conducted two psychological evaluations of juvenile D.J. (JRMS#47825). Psychological testing indicated borderline to mild mental retardation. Dr. Fontenelle referred D.J. to a group home on both occasions. LTI-BC has not followed this recommendation. Counseling notes did not address Dr. Fontenelle’s recommendations. The counselors should document why the consultant’s recommendation was not followed. Furthermore, a progress report by D.J.’s counselor dated 7/28/97 indicates: “recommended D.J. remain in the STOP program until his behavior improves.” D.J. is not receiving the services that would assist him in understanding the demands being placed upon him and promote the appropriate development which would allow for improved behavior. In effect, the recommendation that he remain at LTI-BC until his behavior improves is a juvenile life sentence. LTI-BC failed to acknowledge D.J.’s special needs even when these needs were noted twice by their own psychologist.
- Records indicate that T.F. (JRMS#17011) suffers from major depression with psychotic features and borderline intellectual functioning. Dr. Dowling is treating T.F.’s mental illness with the antidepressants Elavil and Wellbutrin and the antipsychotic medication Risperdol. A common side effect of T.F.’s medications is sedation. On 6/4/97, Dr. Dowling wrote, “he should not be disciplined for this sleeping.” Dr. Dowling’s 2/3/98 note indicates, “he has been written up for sleeping and is concerned that he is being forced to stay at LTI longer because of his sleeping secondary to his medication. He should not be disciplined for sleeping which is a side effect of the medication.” Once again, LTI-BC does not follow the recommendation of their own consultant and punishes a youth for mental illness.

- M.G.'s (JRMS# 44461) chart did not contain a social summary from JCCY. There were no counseling contacts documented in his institutional chart. The failure of LTI-BC to provide counselor contacts for M.G. does not meet currently accepted professional standards, nor does it meet the policies of LTI-BC and the DPS&C.
- C.M.'s (JRMS#41161) institutional record includes a counselor's notes containing the photocopied statement "[c]ounselor made self available to answer questions and provide information. This offender expressed no unusual concerns naed [sic] noted." A brief hand written note follows and is initialed by the counselor. The use of photocopied notes is totally unacceptable. C.M. suffers mental retardation and has a long history of psychiatric illness. LTI-BC did not provide C.M. with care approaching appropriate mental health treatment for a seriously emotionally disturbed youth.
- E.G.(JRMS#50130) had a motor vehicle accident in 1996. Records indicate that he was hospitalized two to three weeks after the accident for a broken arm, brain damage, and a punctured liver. E.G.'s chart had no therapy notes, nor was there any indication that he has received psychological testing or psychological treatment. The report of brain damage should have resulted in a referral to the psychologist in order for the effect of brain damage on thinking and behavior to be fully evaluated.

The above case examples also illustrate Dr. Dowling's comment " [There is a] tendency to deal with mentally ill youth as bad and needing punishment." The indifference of LTI-BC to the needs of seriously disturbed youth is appalling.

In addition to the lack of adequate individual treatment, the limited group therapies offered at LTI-BC do not comport with currently accepted professional standards. One group offered at LTI-BC is "Sexuality." When I asked if this was a group for sexual offenders court-ordered to receive treatment, Ms. Lewis replied that it was an educational group, not a treatment group, because "I have looked and I cannot find any literature on juvenile sexual offenders." There is extensive professional literature on juvenile sexual offenders.

Another group is "Play Therapy." Ms. Lewis stated that she conducts this group to give the younger boys a chance to play. She stated: "I take the kids with low IQ's out of school to do finger painting, drawing, and dance." She could not explain the therapeutic content of this group and there were no group notes describing the therapeutic benefits of this group. The "kids with low IQ's" should not be deprived of the educational services they need in order to play. As described by Ms. Lewis, this "group"

does not comport with currently accepted professional standards.

A third group described by Ms. Lewis is the "Chaotic Adolescents in Need Group" for youth with severe emotional disturbances. This group does not meet regularly and had not met in the three weeks prior to our tour. Other groups offered at LTI-BC are "Victim Awareness," "Grief Management," "Anger Management," and "Multidisciplinary Group." I did not observe these groups.

In addition to therapeutic groups, the youth at LTI-BC require an hour-to-hour structured program designed to promote healthy development and prepare the youth for success upon return to their communities. Youth development programs are necessary for a seriously emotionally disturbed youth, just as they are for the typical LTI-BC youth. Incarceration is a crisis point in the life of a teenager. Crisis points offer unique opportunities for learning and change. LTI-BC must take advantage of this opportunity to teach life and communication skills. Substance abuse education and counseling, where appropriate, must be offered to youth. Conflict resolution and life skills (e.g., managing finances, finding housing, securing a job, negotiating relationships, navigating assistance programs, etc.) are critical. The goal of youth development programs is to educate youth in the skills necessary for success upon release. The needs of youth with mental retardation must be met. Youth with special needs require modifications of the general program.

Youth development programs at LTI-BC do not comport with currently accepted professional standards. I could identify no organized approach to the provision of counseling services at LTI-BC. There is no clear distinction between therapeutic groups and youth development groups. I observed the Substance Abuse Group led by Mr. Buck on 5/13/98. This group did not comport with currently accepted professional standards because there was no identifiable goal and no appropriate peer-peer or leader-participant interactions. The group was held in the day room of the Kennedy dormitory. Just off the day room was a small room with the distinct odor of marijuana, numerous cigarette butts, burnt toilet paper, and scorched areas near an electrical socket. Mr. Buck reported that transportation of the youth to groups by correctional officers "varies widely." Eight of the nine youth scheduled to attend the group were present. There was no explanation for the one absence. Mr. Buck did not know all the boys' names nor did he have a good rapport with them. The majority of the youth denied any experience with drugs then later laughed and joked as they traded stories of selling drugs. There were no audio-visual materials. The session was conducted in a question-answer format with the youth clearly dominating the session. During the group, one of the newer members, R.S., did not seem to be functioning appropriately for group participation. He mumbled to himself and dozed off numerous times, possibly indicating mental illness or a response to his medication. Youth must be screened before entering a group to assess their ability to

participate in a meaningful way.

I found that the day room areas of the dorms, where the youth spend long hours, offered little recreation. In those day rooms that contained recreational equipment, the equipment was poorly maintained and insufficient to provide activities for all youth contained in the area. In some areas, the clocks did not function. Because juveniles at LTI-BC do not wear watches, the dormitory clocks are their only means of orienting themselves to time. When daily schedules were posted, they were incomplete. Appropriate use of leisure time and keeping schedules are two critical skills for adolescents to learn if they are to be successful in the free world.

Crisis Management: LTI-BC fails to adequately handle medical and mental health emergencies that arise in the facility. The management of youth who make suicidal gestures or threats substantially departs from current professional standards and exposes juveniles to life-threatening situations. The facility continues to expose juveniles to a large number of suicide hazards, delineated on page 10. Also, the level of violence at LTI-BC, as indicated by monthly reports and injury reports, continues to constitute a medical and mental health crisis (Note: the overwhelming violence which is rampant throughout the secure correctional facilities visited is not fully described in this report as it is being addressed by an expert in protection from harm.). LTI-BC has failed to implement (as I recommended after my previous visit to the facility) a facility-wide behavioral management program, with individualized plans as needed. This kind of program is necessary to reduce behavioral difficulties among youth and to address behavioral crises without resorting to violence.

LTI-BC's management of youth who make suicidal threats or gestures does not meet acceptable professional standards. In order to prevent suicidal gestures and suicides, LTI-BC must constantly monitor youth for risk signs. Every employee of LTI-BC must be trained to recognize risk factors for suicide. Risk factors should be listed on a youth's case plan. Youth must undergo periodic reassessments for evidence of mental illness through staff observation, direct questioning, and screening for mental illness. Reassessment should occur whenever symptoms appear and at least every six months in the absence of symptoms. This is mandatory because youth at LTI-BC are at high risk of developing mental illness, may respond to the stress of incarceration by developing a mental illness, and fall into an age group for which the onset of mental illness is common. It is not uncommon for youth to report symptoms at reassessment that were not reported originally because they have developed a trusting relationship with a counselor. Youth identified at risk for self-harm should be assessed by a licensed mental health professional or nurse in a timely manner, in accordance with currently accepted professional standards. The assessment should include a thoroughly documented mental status evaluation, listing of all risk factors and protective factors, notation of any

symptoms of depression or other mental illness, and an action plan to provide for the youth's protection. The action plan should include daily reassessment and an environment free of opportunities for self-harm. Youth at risk of self-harm should not be isolated. Isolation often increases hopelessness, disorganized thinking, and rage which leads to behavioral difficulties and a heightened risk of self-harm. An individual behavioral plan should be implemented for any youth who chronically engages in threats of self-harm or self-harming behavior. LTI-BC's policy should clearly identify who is responsible for evaluating and monitoring youth at risk for self harm. Quality assurance must be implemented for this mental health service as well as all others. The facility staff must be aware of the location of, and methods for using, emergency suicide prevention equipment.

Ms. Lewis' description of LTI-BC's care to suicidal youth does not meet currently accepted professional standards, nor the Louisiana DPS&C's policy and procedure (LTI-BC supplied me with the Louisiana DPS&C policy for suicide prevention and post-suicide management, but not with a facility-specific policy.). Ms. Lewis indicated that all suicide watches are initiated by a mental health professional who refers the youth to the psychiatrist, who in turn sees the youth weekly and is available for telephone consultation daily. She explained that all youth on suicide watch are seen daily by a mental health professional until the psychiatrist discontinues the suicide watch.

At LTI-BC "extreme watch" for suicide prevention refers to observation in the infirmary, not physical restraints as stated in the DPS&C Manual. LTI-BC's practices for suicide prevention deviate from currently accepted professional standards because any staff member identifying a youth with suicide risk factors should begin a watch. The facility cannot currently rely on mental health professionals to do this because they are not on site twenty-four hours per day. The lack of mental health staff on-site at all times increases the importance of minimally acceptable documentation, including the listing of all diagnoses and risk/protective factors in the case plan, as well as thorough mental status evaluations. LTI-BC does not comport with currently accepted professional standards in the assessment of suicidal youth by mental health professionals. Weekly psychiatric evaluations of youth on extreme watch is a much lower standard of care than Dr. Dowling offers to his patients in other settings. Dr. Dowling stated that he would see patients on suicide watch daily in his other practice settings. Dr. Dowling noted an increase in the number of youth placed on suicide watches in the past two years. This indicates a growing need for skilled mental health professionals at LTI-BC. He indicated that one nurse punishes youth on extreme suicide watch by not allowing them writing materials, even though Dr. Dowling has encouraged the youth to keep a journal as part of his treatment. Of course, staff must exercise professional judgement in allowing suicidal youth to have pens or pencils. Although the cut down tool in LTI-BC's infirmary is kept in the medical control room, the room is kept locked at night because there is no nurse on

duty. The cut down tool must be readily accessible to the officer conducting the suicide watch. No cut down tool was available in the Brown Hall dormitory. The DPS&C Manual indicates a cut down tool should be available. As with the other LTI facilities, there is no periodic reassessment of youth for mental illness which may not have been identified upon admission.

The following case studies exemplify the failure of LTI-BC to take adequate suicide prevention measures:

- On 3/10/98 Dr. Dowling placed L.H. (JRMS#32593) on suicide precautions after he barricaded himself in his room and threatened to kill himself. Although L.H. was not on suicide precautions at the time of the May tour, there was no order to discontinue LH's suicide precautions. Dr. Dowling did not see L.H. weekly. There are no follow-up notes by Dr. Dowling. This does not comport with currently accepted professional standards, nor with LTI-BC's own policies and procedures regarding suicide watches.
- J.P. (JRMS#48565) has been on extreme suicide watch since 3/12/98. No individualized mental health plan has been developed to assist with J.P.'s chronic suicidal gestures. During my tour, the officer conducting J.P.'s suicide watch in the infirmary did not know where the cut down tool was located (It was his first day at LTI-BC.).

A walk through the LTI-BC physical plant revealed numerous suicide hazards which were pointed out to the security officer accompanying me. Because extreme suicide watches are conducted in the infirmary, safety is critical. Safety hazards in the infirmary included exposed glass light bulbs (which might be used by youth to harm themselves or others), active electrical sockets in rooms where extreme watches are conducted, regular hospital beds (which are a hanging risk), and bathrooms with locks on the inside (so that suicidal youth might easily lock themselves inside). In other areas of the facility, hazards included exposed glass light bulbs, numerous blind spots in bathrooms and day areas, some unlocked storage areas (which provide places to hide or harm oneself unnoticed), and exposed rusty wires and sharp metal plates in the time out room. Some of the dormitory rooms had closets with locks on the inside and fixed metal bars inside of the closets. The time out/isolations rooms have hanging hazards and sharp metal window frames and vents. On 3/18/98 G.M. (JRMS#37702) was placed in time out. During his confinement he stated, "I'm going to kill myself," then scratched his arm on the sharp window frame. LTI-BC must provide youth with an environment free of suicide hazards and should not isolate youth who are at risk of harming themselves.

Treatment Planning and Case Management: Individual treatment planning is necessary to ensure that goals for each youth are identified and fully addressed. Medical, counseling, educational, and correctional staff, as well as the youth and his/her family members, should contribute to the overall plan for each child. Counseling records must document psychiatric diagnosis, symptoms of that diagnosis manifested by the individual, and a clear, measurable plan to ameliorate the manifest symptoms. When a psychiatric diagnosis is not present, the youth's needs (medical, educational, social skills, life skills, etc.) should be clearly documented with a plan to ameliorate those needs and to promote healthy adolescent development. Youth with special medical needs should have those needs addressed in the case plan.

Case management is the process of implementing the treatment plan. The case manager links the youth to needed services. Case management ensures that treatment planning follows each youth from facility to facility and into the community. Case managers link the youth and his/her family to needed services. Effective case management coordinates a continuum of services of varying intensity. Case management must look toward a youth's future. Community support, including the family when available, must be included. When the family is amenable, and the difficulties upon a youth's return home are anticipated, intensive in-home crisis services should be considered. LTI-BC must provide case management as a link to the other secure juvenile facilities as well as to the community. Youth with mental illness and mental retardation should receive treatment in the most appropriate setting to meet their needs. Youth with mental illness and mental retardation are at increased risk of victimization. They must be cared for by staff trained to recognize and meet their special needs. Highly structured programs are necessary if special needs youth are to meet the challenges of adolescent development and avoid incarceration as adults. Youth identified as sexual offenders must be categorized as to offender types (where possible), each youth's dangerousness must be assessed (within the limitations of mental health professionals), and follow-up and monitoring beyond secure treatment must be offered.

Poor record keeping at LTI-BC made it very difficult to evaluate treatment planning and case management. Numerous charts had no documentation of the semi-monthly counselor-juvenile contact required by LTI-BC. LTI-BC substantially departs from currently accepted professional standards for treatment planning and case management. None of the twenty institutional records that I reviewed was in compliance with currently accepted professional standards. The plans were not individualized, psychiatric diagnoses were not routinely listed or addressed in the plan, and goals were not measurable. While case management is substandard for all youth, the case management provided to special needs youth is particularly deficient. There are no skills or training programs (outside of the school program) for youth with mental retardation and no therapy beyond support for mentally ill youth. At LTI-BC, case management

refers to counseling as well as to case management services (e.g., liaison with the court and family, assisting the youth in obtaining necessary services at LTI-BC and upon return to their communities, and providing emotional support). I found no example of a youth with mental illness or mental retardation receiving adequate counseling/case management services.

Management of Psychotropic Medication: Management of psychotropic medications must be conducted by a psychiatrist on a regular basis. Psychotropic medication management includes the careful selection of a medication based on diagnosis and patient history, listing of the symptoms the medication might ameliorate, explanation of risks and benefits of the medication to the patient, and regular monitoring for efficacy and side effects. The psychiatrist must work closely with nursing staff and counselors to carefully monitor medication after consent for treatment is obtained and possible side effects are discussed. Medication monitoring is a formal process that requires observation and direct questioning regarding side effects and benefits. Medication monitoring should be carefully documented in the patient's record with a side effect checklist and standardized target symptom questionnaires. Treatment providers should review the side effects with juveniles regularly in order that youth learn to recognize possible medication side effects. Nursing staff are responsible for coordinating the medication monitoring efforts. Standardized rating scales should be completed quarterly to monitor for movement disorders in youth receiving antipsychotic medications. Management of psychotropic medications must be conducted on a regular basis with the same format throughout the secure juvenile correctional system. Monitoring for side effects must be coordinated by nursing staff and take place regularly.

Psychotropic medication management at LTI-BC does not comport with currently accepted professional standards. The National Commission on Correctional Health Care standards, which are endorsed by the American Medical Association, American Psychiatric Association, and the National Counsel of Juvenile and Family Court Judges along with over thirty other professional organizations, specifically prohibits the use of standing orders in juvenile facilities. Dr. Dowling's standing orders (generic physician's orders that nursing staff may implement at their discretion) contain psychotropic medication orders that do not comport with currently accepted professional standards. The standing orders for psychotropic medications indicates that Thorazine (an antipsychotic medication) may be used for agitation. Because "agitation" is not well defined, this order amounts to the use of thorazine for behavioral control. This violates established patient care standards. The standing order for Cogentin (given for the side effects of antipsychotic medications) requires that nursing staff recognize "EPS" (extrapyramidal side effects of antipsychotic medication). Nurse Zoll reported that the nursing staff has not received training to recognize extrapyramidal side effects.

Nurses and counselors do not assist Dr. Dowling in his monitoring of medication. In fact, the head nurse stated that her staff has had no training to recognize medication side effects. Also, nursing staff sometimes fail to refer abnormal lab results to the psychiatrist for review. Dr. Dowling's time at LTI-BC is very limited, less than four hours per week, and, therefore, he cannot provide adequate medication monitoring alone. His notes do not contain full documentation of medication efficacy and side effects.

In addition, the following case example illustrates the LTI-BC's failure to follow currently accepted medication refusal practices:

- On 3/11/98 G.M.(JRMS#37702) was given a ticket for aggravated disobedience and placed in time out for refusing to take his medication. Youth should not be punished for refusal to take medication.

Administration of Mental Health Care and Quality Assurance: Mental health care administration at LTI-BC does not comport with currently accepted professional standards. Communication between disciplines is poor and quality assurance measures, which would assist in identifying poor communication and substandard treatment practices, are not in place. There is no regular communication between mental health care providers. Drs. Dowling and Fontenelle do not have any administrative duties. As the mental health authority, Ms. Lewis is responsible for the administration of mental health services. She was not familiar with current treatment interventions or literature regarding seriously disturbed youth such as behavioral modification programs. She was unable to define the term or give examples of a behavior modification program. In addition, the state does not provide adequate materials for Ms. Lewis and her staff to develop and implement adequate programs. Ms. Lewis indicated that because of a lack of funds for treatment materials she often purchases them herself.

Quality assurance measures do not comport with currently accepted professional standards. There is no quality assurance by nursing with regard to mental health or general medical and dental practices. There is only informal quality assurance of counseling services. Ms. Lewis reported that she conducts informal chart reviews and sends notes to the counselors indicating deficiencies. However, there is no record keeping or follow up of this process. Record keeping and follow up are critical in order to identify ongoing problems and approach solutions in an organized fashion. The record reviews conducted by Ms. Lewis do not comport with acceptable quality assurance practices.

Mental Health Staffing, Supervision of Mental Health Staff, and Staff Training: LTI-BC currently employs one part time psychiatrist, one part time psychologist, four M.S.W. level counselors and four B.A. level counselors. Current mental health staffing is

inadequate to provide adequate mental health treatment to juveniles placed at LTI-BC. The psychiatrist, Dr. Dowling, is available only four hours per week, including travel and dictation time. Dr. Dowling indicated that eight hours of psychiatric coverage is necessary for direct patient care with additional time required for supervisory activities. The psychologist, Dr. Fontenelle, is available four to six hours per week. He indicated that he has requested an increase in consultation hours. He stated that while the severity of mental health problems among offenders has increased dramatically, his contract time has not been increased in ten years. In addition to increased time for psychological testing, Dr. Fontenelle should be contracted to assist LTI-BC in establishing group and individual programs for mentally retarded youth, as this is one of his areas of interest and expertise. Mr. Harris was very enthusiastic about these suggestions in the exit interview and indicated he would seek support from the state to pursue additional hours for Drs. Dowling and Fontenelle.

Hiring more mental health professionals is only one part of the adequate solution to LTI-BC's problems. The staffing problem must be approached by identifying the range or continuum of necessary mental health services, ranking youth according to need, and identifying the mental health professionals required to meet those needs. The exact number of professionals will depend on the service delivery system selected by the DPS&C and the needs of the juveniles in the facility.

Supervision of mental health staff does not comport with currently accepted professional standards. Inadequate mental health assessments at JCCY, where juveniles are assessed prior to being transferred to LTI-BC, require LTI-BC's psychiatrist, Dr. Dowling, and psychologist, Dr. Fontenelle, to spend much of their limited time reevaluating inadequately evaluated youth. Because of these time constraints, they are not active in supervising LTI-BC medical or counseling staff, nor in the development of therapeutic programs. Supervision at LTI-BC is offered on an "as needed basis" at daily morning meetings with Ms. Lewis. Final responsibility for treatment should lie with a psychiatrist or Ph.D. level psychologist. Cases should be staffed with an M.D. or Ph.D. regularly to allow for ongoing supervision. There are currently no such staffings at LTI-BC.

Staff's ability to recognize and treat youth with mental retardation and mental illness does not comport with currently accepted professional standards. All staff require training to recognize and treat youth with mental retardation and mental illness. LTI-BC has failed to provide the necessary training. Drs. Dowling and Fontenelle do not provide training. When asked about training, Ms. Lewis stated "I go out and get what ever we need." Medical and counseling staff have not been trained to recognize medication side effects.

II. CRITICAL MEDICAL AND DENTAL PRACTICES AT LTI-BC ARE SUBSTANDARD.

My findings represent a selected review of certain critical medical and dental practices at LTI-BC rather than a comprehensive evaluation of all aspects of medical and dental care.

Summary of Standards: Youth confined to LTI-BC have a right to unimpeded access to medical care. Their medical needs must be evaluated only by medical staff. The quality of medical care given to youths must comport with accepted professional standards. The medical care given to juveniles must be fully and accurately documented in the youth's medical record in accordance with professional standards. The infirmary must be adequately equipped and provide for patient safety and privacy.

Adequate administration of medical services and quality assurance is essential. Specifically, the medical authority of LTI-BC must understand the unique challenges of correctional medicine and must accept responsibility for the medical care of the youth at LTI-BC. There must be an adequate quality assurance review of medical services. In addition, there must be sufficient adequately trained and qualified medical staff to ensure adequate care.

Youth at LTI-BC must have access to dental care including screening, education and restorative work not limited to extractions. Dental care must be delivered in a timely manner and in accordance with currently accepted professional standards.

Summary of Findings: Medical care at LTI-BC substantially departs from currently accepted professional standards. The serious deficiencies in the delivery of medical care are creating life threatening situations. LTI-BC fails to provide adequate access to medical care. The quality of medical care at LTI-BC provided to all juveniles, and especially to those with serious medical needs, is not minimally adequate. LTI-BC substantially departs from professional standards in medical record keeping, including the documentation of care and the tracking of laboratory results. The physical plant of the infirmary departs substantially from professional standards with regard to patient privacy, safety, and equipment availability.

Dental care at LTI-BC substantially departs from currently accepted professional standards. Cases were identified where dental care was not delivered in a timely manner. This caused youth to suffer unnecessary pain and possibly the unnecessary loss of teeth.

Discussion:

Access to Medical care: Direct access to medical care is a basic tenet of correctional medicine. Correctional officers and other non-medical personnel should not decide who receives medical care. Youth must have direct access to medical staff. This is typically accomplished through the use of sick call slips that are picked up and reviewed by medical staff on each shift. Youth should have direct access to sick call slips. Correctional staff should not decide who fills out slips.

Nurse Zoll indicated that LTI-BC is in the process of developing sick call slips. Currently, youth tell an officer when they are in need of medical attention and the officer makes the decision to access medical care. Ms. Zoll reported that she does receive occasional complaints from offenders about this system. Correctional officers and other non-medical personnel decide which juveniles receive medical care at LTI-BC. This does not comport with currently accepted professional standards.

Quality of Medical Treatment: Juveniles' medical needs must be adequately identified and treated by the appropriate medical staff. Timely and adequate communication among health care staff is essential in medical training. Medical staff must ensure that juveniles receive appropriate follow-up care, if necessary. Patients with chronic illnesses require ongoing monitoring and tracking of symptoms of the illness and response to treatment. It is a professional practice for medical staff to record all contacts with patients in the medical chart.

At LTI-BC, nursing staff fail to fully evaluate the medical needs of juveniles. They also fail to refer serious problems to the physician when it is necessary. All labs are not reviewed by the physician. Dr. Bopp stated there is no system for reviewing lab results at LTI-BC. He does have such a system in his other practice settings. It is standard practice for nursing staff to review labs and identify all abnormal results for physician review. LTI-BC does not follow this practice. In many instances, when the physician orders labs or refers juvenile for care outside of the facility, the records do not indicate that nursing staff follow up on these orders. Nurses routinely send juveniles with serious medical conditions to the hospital without later informing the physician that they had done so. Medical staff do not routinely monitor the symptoms of persons with serious and chronic illnesses. The lack of sufficient notes in the medical records makes it impossible to track adequately the medical condition of juveniles and the progression of illness. This is particularly egregious in the cases of youth with chronic illnesses.

The following case studies exemplify medical care at LTI-BC that substantially departs from currently accepted professional standards. Many of the following examples created potentially life-threatening situations:

- J.S. (JRMS#49114) is legally blind. His social history from Jetson indicates “visually impaired left eye.” The fact that GS is blind was not fully noted in his institutional record. In April of 1998, nearly one year after J.S.’s admission into the LTI system, a consultation from the State of Louisiana’s School for the Blind was done. Dr. Bopp indicated that LTI-BC cannot meet the medical needs of blind youth such as J.S. On 7/1/97 and 7/4/97, J.S. complained of eye pain. His repeated complaints eventually resulted in an order for artificial tears on 7/22/97. These delays in care for this juvenile do not comport with currently accepted professional standards. On 7/4/97 J.S., requested treatment for finger pain. Four days later, when his finger was finally examined, he required treatment for an abscessed finger. Because J.S. is blind, he is not able to visually examine painful wounds himself and may experience unnecessary mental and physical pain when his medical needs are not met in a timely fashion. LTI-BC’s care represents inadequate triaging of medical care.
- J.V.’s (JRMS#50691) thyroid functions were abnormal. There is no indication in J.V.’s medical record that this laboratory result has been acknowledged by LTI-BC’s medical staff or that he has received any follow up. Thyroid dysfunction can have many causes and lead to serious dysfunction or death.
- On 2/17/98 R.P. (JRMS#37605) was noted to have blood in his ear canal. This represents a medical emergency; however, he was not referred by nursing staff for further evaluation until 3/28/98 and not seen at Charity Hospital until 4/14/98. This represents inappropriate triaging of R.P.’s medical needs. LTI-BC placed him at risk for permanent damage to his ear and possible hearing loss. Blood in the ear canal may be the only symptom of a life threatening skull fracture. Of course, this was no longer an issue by the time R.P. was finally evaluated on 4/14/98.
- J.D.(JRMS#46398) JCCY materials note that J.D. suffers sickle-cell anemia. The admission assessment notes at LTI-BC do not note his sickle-cell disease. It is critical that nurses review all medical information and document all illnesses on the admission assessment because the physician does not review all records and relies on the admission assessment form for information. A common problem with sickle cell disease is severe pain. If medical staff are not aware that J.D. suffers sickle cell disease, they could very easily misdiagnose his pain. In addition, an unusual occurrence report on 4/30/98 indicates J.D. fell down the stairs. The report notes that J.D. was referred to nursing for an assessment; however, there was no corresponding nursing note indicating that J.D. was assessed.
- N.S.’s (JRMS#37496) medical record indicates complaints of a swollen eyelid on 5/5/98. There are no further notes indicating that this complaint was followed up.

The eye problem appears to be a recurrent problem for N.S. as he made a similar complaint of eye pain on 4/6/98. Failure to adequately treat N.S. has resulted in unnecessary pain and suffering.

- T.M.'s (JRMS#52672) initial lab was not reviewed. It contained a blood sugar level of 45 which is abnormally low. An abnormally low blood sugar may impair consciousness or result in behavioral difficulties. Nursing staff failed to review this lab and failed to present the abnormal result to the physician for his review.
- K.D.(JRMS#47054) suffers a seizure disorder, sickle-cell trait, a heart murmur and is on a Ventolin inhaler. (There is no indication on K.D.'s chart as to why he receives a Ventolin inhaler. This medication is commonly used for asthma.). In July 1997, cardiac abnormalities were noted on an EKG. Follow up cardiac tests were ordered but are not on K.D.'s chart. He is currently waiting for a pediatric cardiology appointment, nearly one year after the problem was first identified. K.D.'s inhaler may increase his heart rate and make his cardiac abnormality even more dangerous. Also, K.D. receives the anti-seizure medication Tegretol. One side effect of Tegretol is a decreased white blood cell count which can impair the body's ability to fight infection and, in rare cases, lead to death. Lab reports indicate that K.D. suffers a decreased white blood cell count. There has been no follow up of his low white blood cell count since it was identified on 5/1/97, one year ago. LTI-BC failure to appropriately monitor K.D.'s white blood cell count has exposed KD to a potentially life threatening medication side effect.
- L.H. (JRMS#45489) alleged that he was raped at LTI-BC. Nursing staff did not follow their own protocol because they did not send L.H. to the emergency room for a rape evaluation. The reason given was L.H. did not want to go. The failure to refer L.H. for a full rape exam does not comport with currently accepted medical practice.

Moreover, LTI-BC's failure to provide care for juveniles with seizure disorders is especially deficient. The LTI system must develop a protocol for the proper medical management of youth with seizure disorders, including staff training to recognize seizure disorders (While it is hard to mistake a grand mal seizure, there are types of seizures that require special training to recognize.). Failure to recognize and appropriately treat seizures may lead to increased frequency of seizures and make a seizure disorder more difficult to control. Poorly controlled seizures carry a risk of brain damage and death. Many youth at LTI-BC suffer from seizure disorders. The following case studies exemplify LTI-BC's failure to provide adequate medical care for youth with seizure disorders:

- J.J.(JRMS#49093) has experienced "a spontaneous loss of consciousness,"

possible seizures, and frequent headaches lasting as long as three days at a time. He did not receive a neurologic evaluation in spite of two medical referrals for such an examination. It is the responsibility of nursing staff to follow up on medical orders. The failure of J.J. to receive a neurological evaluation has placed him at risk of further seizures and possible neurologic impairment. He has received treatment with a seizure medication, Dilantin, without documentation of blood levels on his chart. Dilantin must be maintained in a narrow therapeutic range. Failure to maintain appropriate blood levels places J.J. at risk for medication side effects (if the level is too high) and seizures (if the level is too low). J.J.'s initial nursing assessment, laboratory work-up, and vision test are incomplete.

- G.M.(JRMS#37702) suffers from a seizure disorder. The last Depakote level on his chart dated April 15, 1998 was sub-therapeutic. A subtherapeutic medication level places G.M. at risk for experiencing seizures. G.M. failed his vision screening and there is no indication of any follow up by LTI-BC staff.
- J.H.(JRMS#46983) suffers from a seizure disorder for which he is treated for with depakote. He has been scheduled for a neurology clinic appointment to evaluate his seizures, but there is no note in his chart of the clinic's recommendations. There are no medication levels on J.H.'s chart. Depakote must be maintained in a very narrow range in order to be effective. If the level is too low, J.H. could experience life threatening seizures. If it is too high, he may experience increased side effects. JH is also treated for enuresis (bed-wetting). His chart does not indicate that anyone considered that his bed-wetting could be secondary to seizures. Bed-wetting is a common occurrence when youth experience seizures during their sleep.

Medical record keeping: The standard of care is to document all patient contacts. Medical record keeping is deficient at the facility. Dr. Dowling stated that records were not always prepared for his visits. The laboratory results were not initialed and dated. In numerous cases labs or medical consultations requested by physicians were not in the records.

Adequacy of the Infirmary: The infirmary is crowded and thus offers limited privacy. Patient care areas have exposed wires, electrical outlets, and knobs which provide potential for self-harm.

Administration of Medical Care and Quality Assurance: The responsibility of the medical authority, Nurse Zoll, is indeed great. The medical authority must synthesize medical and correctional/legal knowledge with administrative skills. The medical authority is responsible for ensuring unimpeded access to health care, developing a

service delivery system, and monitoring the quality of care.

The medical authority lacks sufficient understanding of correctional medicine to ensure the delivery of adequate health care to youth at LTI-BC. Nurse Zoll is struggling to meet the medical needs of youth under her care without adequate support. Louisiana DPS&C must offer the medical authority training in correctional medicine. There are no quality assurance mechanisms in place at LTI-BC to identify and correct problems with medical record keeping, patient training, and medical care. LTI-BC's lack of quality assurance results in the failure to correct substandard patient care practices and places all youth at LTI-BC at risk.

Medical Staffing and Medical Supervision: Medical staffing is inadequate to meet the needs of youth at LTI-BC. Dr. Bopp is responsible for the medical care of all of the youth at LTI-BC. He provides constant telephone coverage but is available onsite only one or two days a month for one to four hours each day. Because of his demanding practice, Dr. Bopp is in the process of locating resident physicians to assist him. There is inadequate physician supervision of nursing care and the number of physician hours is inadequate to provide for the oversight of medical care. Dr. Bopp stated that he has no administrative or supervisory duties. Dr. Bopp's responsibilities should be expanded to include supervision of the medical services and staff. Physician staffing should be one full-time physician per five hundred youth.

Nursing staffing is insufficient to ensure adequate care for juveniles. With respect to nursing staff, LTI-BC currently has staffed positions for one registered nurse (RN) (Ms. Zoll), and two full-time and two part-time licenced practical nurses (LPN). Nurse Zoll reported that there is currently one unfilled full-time LPN position and that she is free to employ as many part time LPN's as needed. The infirmary is only staffed from 7:00am until 9:00pm. Nurse Zoll provides telephone coverage when she is not at the facility. There is no RN coverage when Nurse Zoll is not available. LTI-BC should expand nursing coverage to include another registered nurse in order to allow Nurse Zoll adequate time for her duties as medical authority and to provide RN coverage when Nurse Zoll is on vacation.

Dental Care: The following observations are derived from my interview with the facilities dentist, Dr. Guy Gibson, DDS. Dr. Gibson indicated that he conducts dental screenings at LTI-BC and sees youth from LTI-BC at his private office for all other services. He finds this necessary because of the limited dental equipment at LTI-BC and the lack of a dental assistant at LTI-BC. Serious questions were raised regarding the access of youth to dental services beyond extractions as required by currently accepted professional standards. Dr. Gibson stated that he "needs permission" before performing certain dental procedures. He believed this delay in care was necessary in order to verify

medicaid numbers. The availability of medicaid should not influence the dental care rendered to youth. The following case examples illustrate dental care which does not comport with currently accepted professional standards:

- Juvenile W.C.- On 1/24/98 the dentist indicated: "several incipient cavities...advised patient to see dentist when he is released." Given W.C.'s sentence, he could remain at LTI-BC until he is eighteen in the year 2002. Clearly his dental concerns should not wait until he is released.
- Juvenile T.B. complained of dental pain one and one-half months before being placed on the dentist's list. During this time, he required pain medication on more than one occasion for dental pain. When T.B. was seen in February of 1998, the dentist indicated that T.B. was suffering a possible abscess and requested that he return for further care to include extraction of his tooth. It is possible that T.B.'s tooth might have been saved had he been evaluated in a timely fashion.

Summary

Mental health and medical health services at LTI-BC have not improved in the two years since I last toured the facility. The lack of mental health programs for seriously emotionally disturbed and mentally retarded youth is particularly problematic. The level of mental health care does not comport with current professional standards. The Louisiana DPS&C has been on notice of the deficiencies and has been indifferent to these conditions. The State must support the medical and mental health authorities at LTI-BC with the training and funding to implement the necessary reforms.

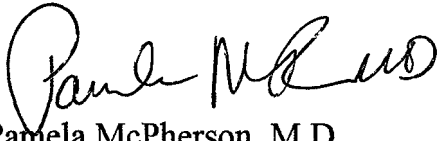
Basic safety remains an overriding concern. Crisis management must be brought up to currently accepted professional standards. The facility must ensure that its staff implement adequate suicide prevention measures and must make the physical plant safe. The pervasive culture of violence at LTI-BC makes it an unsafe environment. The violence must stop for the sake of the physical and mental well-being of youth at LTI-BC. Youth development programs, including a facility-wide behavioral management program, are critical to stabilize the facility and promote safety. As such programs are developed, staff training in their implementation will be critical.

Nursing and counseling staff must monitor youth for symptoms of mental illness and mental retardation, as well as medication side effects, and regularly communicate this information to Dr. Dowling and Dr. Fontenelle. Drs. Dowling and Fontenelle must provide direction for the development of mental health services at LTI-BC and supervision as those mental health services are rendered.

Medical and dental care must be delivered in accordance with currently accepted professional standards. A protocol for the management of seizure disorders is imperative. Dental care must be delivered in a timely fashion independent of a juvenile's Medicaid coverage.

Quality assurance measures must be implemented. This will require improved medical and mental health record keeping. Monitoring quality throughout LTI-BC is critical in promoting an environment which is safe and encourages the healthy development of adolescents.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Pamela McPherson". The signature is fluid and cursive, with the first name "Pamela" being more prominent than the last name "McPherson".

Pamela McPherson, M.D.

Review of Education Programs in Three Secure Juvenile Facilities
Operated by the Louisiana Department of Public Safety and Corrections

Prepared for the Civil Rights Division
of the United States Department of Justice
July 6, 1998

by
Sheri M. Meisel, Ph. D.

Sheri M. Meisel

EXHIBIT 67

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SUMMARY

The education programs in the secure juvenile facilities operated by the Louisiana Department of Public Safety and Corrections (DPSC) do not comply with federal and State statutes, constitutional requirements, professional standards, or applicable policies promulgated by the agency itself. Despite limited progress since my review of the facilities two years ago, the programs do not have the capacity to provide appropriate educational services for incarcerated youth, including the substantial population with illiteracy and learning or emotional disabilities.¹ Major reform is needed to direct sufficient resources, administrative support, and accountability to an education system that is markedly inadequate and neglectful.

The State recently increased the amount of instruction provided for many youth in the juvenile facilities to a full day, in accord with minimum standards. However, significant numbers of youth spend considerable periods of time in the DPSC facilities with no access or extremely limited access to schooling, including those who are isolated on administrative segregation or protective custody units, and those ages 17 and older. In addition, the DPSC initially confines all juveniles to a central diagnostic intake unit, where they receive virtually no education.

The services that are provided are of marginal quality, relying on curriculum models and instructional strategies that are ineffective for engaging troubled adolescents in education. The adequacy of education is further undermined by overcrowded classes, insufficient number of qualified staff, and severe shortage of classroom space and instructional materials. While vocational programs are provided for some youth, their capacity to prepare students for employment in the community is compromised by antiquated equipment and by activities that are focused on the production or maintenance needs of the facilities. Moreover, female students and those with disabilities do not have equal access to the vocational program.

The Louisiana Department of Education (LDOE) fails to identify and provide special education and related services for many youth, despite abundant documentation that they may have mental retardation, specific learning disabilities, or emotional and behavioral disorders. For youth who are identified, individualized education programs are inadequate when services are limited to one or two hours per day, transition services are not implemented, and adequate opportunities for parents or guardians to participate in decisions about special education are not provided. Further, special education services are not implemented on the diagnostic intake unit, or for youth who are segregated from the general population.

There is minimal coordination between special education staff who administratively are part of Special School District Number One (SSD #1) and who are employed by the LDOE, and staff providing academic and vocational education who work for the DPSC. Teachers and principals employed by the DPSC are paid substantially less than their counterparts who work for

¹ For a perspective on the chronic nature of these deficiencies, see P. Leone and S. Meisel, *On the Adequacy of Education Services in the Juvenile Correctional Facilities of the Louisiana Department of Public Safety and Corrections*, provided to the U. S. Department of Justice in December, 1996.

public school systems in the State, or for the LDOE within the same juvenile facility. Principals cannot adequately advocate or plan for the school programs because they do not have sufficient autonomy, including independent budget authority. On a systems level, the education programs lack a strong, centralized administrative structure with sufficient status and expertise.

Education has been repeatedly demonstrated to be a central component of rehabilitation in juvenile correctional settings. The provision of adequate educational services in any setting requires sufficient resources and commitment; in juvenile facilities, it also requires understanding of the unique features of schooling for disadvantaged and disabled youth. The State's failure to provide adequate education programs in the DPSC juvenile facilities has serious consequences for individual youth and for all citizens.

INTRODUCTION

At the request of attorneys with the Civil Rights Division of the United States Department of Justice, I reviewed the adequacy of education programs in the three secure juvenile facilities operated by the Louisiana Department of Public Safety and Corrections (DPSC).² The scope and content of the review were directed to developing a comprehensive assessment of academic programs, special education, and vocational education for incarcerated youth in the State.

To conduct the review, I observed the operation of the school programs at the Louisiana Training Institute in Bridge City ("LTI - Bridge City", April 22 - 23, 1998), Swanson Correctional Center for Youth in Monroe ("SCCY", May 20 - May 22, 1998), and Jetson Correctional Center for Youth in Baton Rouge ("JCCY", May 4 - May 6, 1998). After an initial meeting with the warden and principal at each facility to discuss the review process, I observed classes, interviewed students and staff, and examined school and facility documents. Mr. John Whitley, Court Expert for the United States Middle District Court, observed my review of the education program at LTI - Bridge City and at JCCY. During my visit to JCCY, I discussed the special education programs in the DPSC juvenile facilities with Mr. Lester Klotz, superintendent of SSD #1. I appreciate the courtesy and assistance of many individuals at each of the facilities during the review process.

I presented and discussed preliminary findings concerning each facility during an exit conference that was attended by the warden, principal, special education coordinator, program directors, and other administrative staff. Attorneys from the Department of Justice participated in these meetings, and Mr. Whitley attended the exit conferences at LTI - Bridge City and JCCY. Mr. Richard Thompson, Assistant Secretary of the DPSC, attended the exit conference at JCCY. An attorney for the DPSC attended the exit conferences held at SCCY and JCCY.

² The State also contracts with Trans-American Development Associates, Inc. to confine juveniles at the Tallulah Correctional Center for Youth in Tallulah, Louisiana. See S. Meisel, *On the Adequacy of Education at the Tallulah Correctional Center for Youth*, provided to the DOJ on June 15, 1998.

In preparing this report, I also reviewed federal statutes including the Individuals with Disabilities Education Act (IDEA),³ Section 504 of the Rehabilitation Act of 1973 (Section 504),⁴ and the Americans with Disabilities Act (ADA); State regulations; and professional standards and DPSC policies relevant to the provision of educational services for incarcerated youth. I also examined audits prepared for the DPSC by its employees or consultants on various aspects of the education program.

Each source of data contributes to the overall findings in this report. The report reflects systemic findings across the major education program areas at LTI - Bridge City, JCCY, and SCCY, incorporating examples of inadequacies and positive features unique to the individual facilities.

BACKGROUND

Administration and Standards

Academic and vocational education services in the Louisiana secure juvenile facilities are operated and administered directly by the DPSC; special education services are provided and administered by SSD #1⁵ through an interagency agreement with the Louisiana Department of Education. Collaboration among education, treatment, and security staff is fundamental to the provision of adequate educational services for youth in correctional settings, but the academic, vocational, and special education program components in the DPSC facilities are poorly linked. The lack of coordination impedes the delivery of adequate education programs in critical ways including fragmented planning and service delivery, inadequate identification of juveniles with special needs, competition for resources, and inconsistent application of requirements and standards.

The LDOE has oversight and supervisory responsibility for ensuring that all schools and school districts in the State, including the DPSC and SSD #1, comply with applicable federal and State laws and standards including requirements for youth with disabilities. The State Board of Elementary and Secondary Education (SBESE) establishes policies and minimum standards for public schools in Louisiana, including those operated in the juvenile facilities. These policies and standards are delineated by the SBESE in the Louisiana Handbook for School Administrators (Bulletin 741).

The education programs operated at LTI - Bridge City (Riverside High School), SCCY (Southside High School), and JCCY (Scenic High School) are classified by the SBESE as alternative schools. The DPSC and SSD #1 have specific obligations to assure that education programs in the facilities meet applicable standards. Bulletin 741 specifies that "alternative

³ 20 U. S. C. 1400 et seq.

⁴ 29 U. S. C. 794 et seq.

⁵ SSD #1 is a special school district with responsibility for special education for institutional persons in the State including juveniles in correctional facilities.

schools/programs shall comply with prescribed policies and standards for regular schools except for those deviations granted by the State Board of Elementary and Secondary Education.”^{6 7} Extending the requirements to students with disabilities, Bulletin 741 stipulates that “special education within an alternative school shall comply with all state and federal standards.”⁸

Bulletin 741 reiterates Louisiana compulsory education law requiring every person having control or charge of any child between the ages of 7 and 17 to assure that child attends regularly assigned classes during regular school hours.⁹ The DPSC policies parallel this requirement,¹⁰ and specify that education programs in its juvenile facilities will provide, among other services, competency-based curriculum utilizing adequate resources, flexible scheduling for open entry/exit to classes, adequate classroom space, and library services. With respect to vocational education, Bulletin 741 requires schools to provide modern equipment, and to maintain physical environments that are appropriate for instruction and for the health and safety of students.¹¹ The DPSC policies require vocational programs to be equally accessible to all age-appropriate offenders, and to provide skills related to employment in current or emerging occupations and assessment to develop an individual program plan.¹²

The following sections of the report describe findings based on my examination of the education programs in the DPSC juvenile facilities with regard to their significant lack of compliance with applicable laws, regulations, policies, and standards for the operation of secondary and alternative schools.

FINDINGS

This report provides evidence of serious and pervasive inadequacies that continue to undermine the education programs at LTI - Bridge City, JCCY, and SCCY. The findings in this report are based on my observations in the school and other areas of the juvenile facilities; interviews with youth and staff; review of applicable laws, regulations, constitutional

⁶ Bulletin 741, 2.151.00.

⁷ The DOJ requested, and the State provided, information regarding any deviations from the SBESE standards for the education programs in the DPSC juvenile facilities. The DPSC indicated that the education programs have two approved deviations: (1) For incarcerated students in Carnegie Unit courses, teachers may not be certified in appropriate areas of instruction, however, state curriculum materials will be used and state standards will be adhered to in order to enable the student to continue the program of studies; (2) In March, 1998, SSD #1 received a waiver to defer initiation of IEP notice and development requirements for eligible youth with disabilities who are placed on the intake unit at JCCY for three weeks or less.

⁸ Bulletin 741 2.151.05.

⁹ LA R. S. 17:221; Bulletin 741 1.055.00.

¹⁰ DPSC Policy No. B-07-002.

¹¹ Bulletin 741, 2.176.01, 2.176.02.

¹² DPSC Policy No. B-07-002.

requirements, and professional standards; and examination of educational and institutional records, policies, and procedures. With limited exceptions, explained in the following sections, the deficiencies identified in my prior reports to the DOJ in 1996 continue to exist today.

Academic Program

Profile of Students

Youth admitted to the DPSC juvenile facilities demonstrate a range of academic strengths and needs, but many have troubled school histories and learning deficits.¹³ While their length of stay in the facilities varies, it is not unusual that juveniles are incarcerated for many months, or that they experience multiple admissions, spending a considerable portion of their secondary school years in the DPSC facilities. One principal estimated that 70 percent of students confined to the juvenile facilities are three or more years below grade level in reading and mathematics. Staff in each facility reported that increasing numbers of youth require intensive remediation for multiple problems including illiteracy, mental retardation, emotional disabilities, and behavioral disorders. Juveniles with disabilities in the DPSC facilities are often placed on disciplinary confinement or administrative segregation units (potentially lengthening their incarceration) where they do not attend school, or where they do so infrequently.¹⁴ Youth with behavior problems, including many with disabilities, are often transferred among the three DPSC facilities, and the Tallulah Correctional Center for Youth, with an associated loss of continuity in their access to instruction. Consultants for the DPSC (DPSC Consultant Report, Attachment 1) recently determined that treatment services for many youth in the juvenile facilities are inadequate, and recommended that:

Offenders with mental health problems should be housed in a location where proper treatment can take place. They should not be placed at either of the four (4) current training facilities under existing conditions.

Staffing

A serious problem that limits the capacity of the juvenile facilities to attract and retain sufficient numbers of qualified teachers is the significant lack of parity between the salary schedules and working conditions for staff employed by the DPSC, and the special education staff employed by the LDOE/ SSD #1. The DPSC staff are paid substantially less than their colleagues working for the LDOE within the same facility, and they are required to work one-half

¹³ During my visit, approximately 180 boys were confined at LTI-Bridge City, 440 boys at SCCY, and 660 youth at JCCY (approximately 510 boys and 150 girls).

¹⁴ Youth on administrative segregation and protective custody units are isolated most of the day. At SCCY, for example, a security officer reported that youth on 'permanent housing' in the Cyprus dormitory are isolated except when their behavior is acceptable and they are participating in school, or recreation (about one and one-half hours, and an additional one-half to one hour if the unit has a sufficient number of staff). The officer further stated the facility did not provide him a written policy concerning time in isolation for juveniles at the facility.

hour more per day and more days per year.¹⁵ The DPSC staff also earns substantially less than their counterparts in the neighboring parish school systems.¹⁶ The negative impact of the non-competitive salaries for the DPSC teachers was explained by one principal, who stated that he may be forced to hire “a bunch of people who couldn’t go to any reasonable school to teach”; another principal said that the low salaries are “the biggest obstacle to hiring and keeping qualified teachers.”

Another policy with a negative impact on the education programs is the DPSC’s failure to provide substitutes when teachers are absent (substitutes can be employed for SSD#1 teachers), despite a specific requirement for the employment of substitute teachers contained in Bulletin 741.¹⁷ As a result, in all DPSC juvenile facilities students receive *no* educational services or they are randomly distributed among other classrooms on the frequent occasions when teachers are absent. At SCCY, tutors (teacher aides) may cover classes, or youth may be sent to “catch-all” classes to play basketball under the supervision of a security officer. I was told by security officers at SCCY that school on the Holly dormitory (closed campus) was cancelled because the teacher was attending a meeting (students remained isolated and had no instructional materials during the time they would have attended school). At JCCY, I observed 26 girls in one class, including several who were sitting on the floor because chairs and desks were not available for them. The class was “doubled up”, combining students from two classes because one teacher was absent. An “enrichment lab” was organized at SCCY to provide computer-assisted instruction for students when their teachers are absent. However, teachers reported that this program has never been implemented as intended because the lab does not have any functional computers (six computers are in the lab, but only one is operational), instructional planning is impossible because they never know which students will be assigned to the lab, and a high rate of teacher absences creates overcrowding in the lab on a daily basis.¹⁸

Length of School Day/Amount of Instruction

The DPSC recently revised its policies concerning the length of the school day for the juvenile facilities, increasing the school schedule from 180 minutes to 330 or 360 minutes per day for many youth. This is a positive development with the potential to bring this aspect of the education programs in line with State requirements.

¹⁵ Several staff members stated that these are ongoing concerns that had not been resolved for more than ten years. Staff at JCCY reported that a teacher hired for SSD #1 earns \$15,000 to \$20,000 per year more than a teacher with comparable educational background and experience employed by the DPSC. (The SSD #1 salaries are based on the salary schedule for the neighboring parish school system pro rated for 260 school days per year).

¹⁶ Staff in the juvenile facilities indicated that public school teachers in the community with the same educational background and years of experience are paid on average \$5,000 to \$10,000 more per year.

¹⁷ Bulletin 741, 2.011.06: “Procedures for providing instruction by qualified substitute teachers or other qualified personnel shall be established and used.”

¹⁸ Reports provided to the DPSC by internal workgroups recommended hiring substitute teachers for the juvenile facilities. See Consultant Report (Attachment 1) and “Education Reform Team” (Attachment 2).

However, it is important to note that *instructional time was not increased for all youth*. Many continue to receive instruction that is markedly substandard, including youth housed on the closed side of JCCY and SCCY;¹⁹ on administrative segregation, protective custody, or medical units; and on the diagnostic intake units at JCCY. The consequence of these policies severely restricts access to education and special education for many youth for extended periods of time. During my May, 1998 visit to SCCY, for example, I was told that two juveniles on protective custody *had not attended school for at least six months*. In addition, many youth ages 16 and older at LTI - Bridge City attend school half-day because they are assigned to work details, many youth ages 17 and older throughout the juvenile facilities attend school for one-half day, and a small number of youth at JCCY ages 17 and older receive no schooling.

In an effort to provide instructional services for youth on the intake units at JCCY, one teacher was assigned to provide two hours of school per day for each of the two intake dormitories.²⁰ This means that *one teacher is responsible for as many as 52 youth* (the capacity of each intake dorm is 52 youth) for the two hour period. Although 52 students and one teacher may be physically present in a room, nothing approaching adequate education can take place in this situation. The teacher stated, "I don't usually know the boys' names unless I ask them, I don't know anything about their skill levels, and I don't know if any of them have learning problems."

At JCCY, staff reported that the warden recently scheduled an assembly to announce that youth ages 17 and older can "waive school" (e.g., drop out), and that some youth have stopped attending school.²¹ Youth receiving special education who drop out will also be denied related services including counseling and speech therapy. Several school staff expressed their disagreement with informing youth that they can exercise this option, believing school drop out was the last thing youth needed or that the facility should publicize. The principal, guidance counselor, and others indicated they attempt to dissuade youth from dropping out. Youth who drop out may elect to return to school at the start of a semester, which can mean they will be out of school for several additional months. During my visit to JCCY, I spoke with F. S., a special education student who had not attended school for about two months.²² He said that he wanted to re-enroll, but could not do so until September, 1998. He also said that "my mother cries every time I talk to her because I dropped out." Research has repeatedly demonstrated that remaining in school offers troubled youth a critical chance to acquire basic academic, social, and vocational skills, and to avoid delinquency. In correctional settings, any practice other than active

¹⁹ For example, see SCCY Policy No. JS-04-005: "Offenders fifteen years of age or younger shall attend an education program consisting of six hours of academic classwork, except those offenders classified in the lowest levels of the Treatment Program (Holly A, Holly C, and Cyprus) who will be provided four hours of academic classwork."

²⁰ The intake classes were implemented about March, 1998.

²¹ The warden indicated that 12 youth dropped out from January to May, 1998. JCCY requires written consent from parents, and a student signature, before youth ages 18 and under are allowed to drop out.

²² This youth is identified as mildly mentally retarded.

encouragement of school completion undermines the State's obligation to rehabilitate incarcerated juveniles.

Regardless of the amount of instruction scheduled, routine practices in every juvenile facility compromise the time actually available for education. School typically ends early for "line up" and counting of youth, for example, eliminating one-half hour of instruction per day and two and one-half hours per week. The lack of coordination between the school and other program components results in youth being scheduled for work details during the school day. This was described as a common and on-going problem by the principal and teachers at LTI - Bridge City. When I visited the JSEP class at this facility, five students were not in class because they were on work details, and a special education teacher told me that students frequently are absent from class because they are working. During my May, 1998 visit to the facility, counting of all youth in classes during one period of the day determined that 43 youth were not attending school, and that the majority of these youth were assigned to work details.

Classroom Space

A severe shortage of classroom space and excessive class sizes in the juvenile facilities were cited by an internal DPSC committee as a primary reason for the lack of full-day school programs. On January 30, 1998, the committee issued a report (Attachment 3) citing problems in the specific institutions, including:

- LTI - Bridge City has a severe space problem with a 22:1 pupil/teacher ratio. The school is one small congested building;
- At JCCY, three additional classrooms are needed for the girls. There is not enough space available for the TABE, GED, or ACT testing of the students;
- The closed campus at SCCY has a severe space problem with a 19:1 pupil/teacher ratio. In the closed campus, there is no gym or classrooms for the physical education activities and health classes. There is no space for the SSD #1 teachers to have their own classroom. These three teachers serve 81 students.

The report includes the following overall findings and recommendations for alleviating the space problems in the DPSC juvenile facilities:

*The classrooms should be made more conducive to learning. Therefore, in the near future a capital outlay budget and plan should be presented to the Governor and legislators for the construction of four (4) modern centralized schools.*²³

Class Placement

The DPSC policies provide for placement of students in the juvenile facilities into academic classes based on reading grade equivalent scores as measured by the TABE (Test of Adult Basic Education). Accurate assessment of skill levels on the TABE is critical because, in

²³ This refers to the three DPSC facilities and TCCY.

addition to class placement, the scores contribute to decisions about referral of youth for special education, and at SCCY, they constitute one criteria determining eligibility for vocational education and an aftercare program.²⁴ In practice, the identification of academic skill levels and decisions about appropriate instruction and programming are fundamentally flawed in the juvenile facilities.

The juvenile facilities group students on the basis of reading levels into Basic Skills I (Kindergarten to grade 4), Basic Skills II (grades 4 to 7), pre-GED (General Equivalency Diploma; grades 7 to 9), JSEP (computer-assisted Job Skills Education Program, generally grade 6 and above) and GED or Carnegie Unit (grade 9 and above) classes.²⁵ According to teachers at each of the juvenile facilities, youth are routinely placed in classes that are not appropriate because initial TABE scores, received from the intake unit at JCCY, are not an accurate representation of their skills. Despite teacher observations, appropriate placements are significantly delayed by DPSC policy that establishes a six-month timeframe for re-testing. The DPSC policy suggests that youth may be re-tested more often as needed, but this practice is not consistently implemented.

At LTI - Bridge City, for example, which generally adheres to a six-month re-test schedule, I observed J. T. in his Basic Skills I class. He appeared disinterested in the task he was assigned (computer drill-and-practice exercise for basic addition and subtraction). J. T. told me that he was enrolled in algebra classes before his incarceration and was constantly bored in the Basic Skills class. He anticipated being released before he could re-take the TABE test and transfer to an appropriate class, because he is in the STOP program (generally 90 day confinement). J. T. also explained that he could not access appropriate reading materials in class or in the facility because the librarian refused to allow him to check out books, telling him that "you've only been here a short time, I don't know you well enough", and that except for JSEP and GED books, school materials are considered contraband on his housing unit.

The re-test schedule appears to be more flexibly applied at SCCY; the principal at this facility said that he, "didn't believe in the six-month wait", and a counselor commented that she had referred students for testing when a need is identified because "it's obvious kids are bored and getting in more trouble when classes are repetitious for them." However, teachers at the facility also said that some students remained in their classes for one or two months after TABE scores confirmed their need for different placements because space was not available in an appropriate class.

²⁴ See SCCY Policy No. JS-04-003: Each offender is evaluated every six months through the administration of the Test of Adult Basic Education. The test results are used to promote Offenders to the next level, to determine academic progress in basic skills, to determine the Offender's eligibility for a vocational program, and to qualify Offenders to take the GED.

²⁵ Small numbers of youth may also be enrolled in college colleges on a part-time basis, and the facilities provide GED testing. For example, JCCY reported that 92 youth received the GED in the 1996-97 school year.

Adequacy of Instruction

The DPSC juvenile facilities have not developed adequate curriculum and instructional strategies to engage troubled youth in education and to differentiate instruction for their individual strengths and needs.^{26 27} The education programs do not assign homework and youth have limited access to library books or other instructional materials outside of class. The quality of instruction in the majority of classes I observed was far below minimum professional standards, and teachers did not have adequate supplies of appropriate instructional materials. The education programs rely on instructional methods that foster boredom, frustration, or disruption for students. Typically, teachers distribute worksheets or textbooks, directing students to complete exercises independently, and providing little or no explicit instruction or assistance. For example, when I observed D. G. in a Basic Skills class at SCCY, he had completed *every* math problem on a worksheet incorrectly. He received no feedback or instruction, and after about ten minutes, when he had “finished”, he began drawing on the worksheet and talking to other students.

At LTI - Bridge City, teachers who had worked in the local school system reported that the instructional materials available at the facility were not comparable to those provided for students in the community. An English teacher said she needs “entirely different kinds of literature texts. The type of books we have here are not what the boys will have if they go back to school - we are not preparing them.” One teacher at SCCY who had many years of experience in the local public schools said, “we get nothing like the parish schools here, especially no computers or textbooks geared to special education students.” Many teachers said that they are not provided sufficient funds to purchase computers, audiovisual equipment, and textbooks. In a positive improvement, library procedures at SCCY have been improved to allow youth to check out books. The librarian explained that as a result, “we don’t have as many books stolen - now the kids don’t have to steal to read.” She felt that library materials were “minimal” as compared to the public schools, but that the resources had improved.

Additionally, the adequacy of instruction is further compromised for students with disabilities, who spend the majority of their school day in the general education classroom without appropriate assistance. Many teachers demonstrate a lack of basic information about these students; at SCCY, I interviewed a Basic Skills teacher who told me that he did not have any students with disabilities in his classes. When we compared his class roster with the listing of special education students provided to me by the SSD #1 program, the teacher was surprised to discover that four boys in the class were identified as having learning disabilities, mental retardation, or emotional disabilities. The teacher had received no training or support to assist him in meeting the needs of these youth.

²⁶ See Bulletin 741, 2.087. 07: “The instructional program shall reflect the selection and use of varied types of learning materials and experiences...” and 2.087.09: “Teaching strategies and techniques shall be adjusted to accommodate the types of learners served and their individual styles.”

²⁷ On January 20, 1998, in a report to the DPSC (Attachment 3), an internal workgroup described a grant funded project to develop and pilot an integrated curriculum of life skills, GED preparation, and vocational skills for the juvenile facilities.

Behavior Management and Support

The education programs have not developed or implemented appropriate programs of behavior management and support. Teachers rely on sanctions such as disciplinary “tickets” (the number of tickets received, and the nature of the incidents that generate tickets, may be factors in decisions to retain youth in secure custody). Others may become apathetic, allowing the classroom environment to be disruptive and unsuitable for learning. For example, a teacher at SCCY said that “if the students don’t want to work, there’s nothing I can do.” In general, the education staff appear to have little understanding that a wide range of effective strategies are available to encourage pro-social behavior, reduce oppositional behavior, and de-escalate conflict in school settings. A school psychologist told me that she had volunteered to provide in-service training for the education staff on crisis prevention and intervention, but the facility administration had not responded to the suggestion.

There is an urgent need for professional development in this area. One teacher stated, “every day there is an incident I’m concerned about.” At SCCY, I observed a small part of a serious incident that occurred in a classroom on the closed side of the facility, and I participated in an interview about the incident conducted by a PZT investigative officer. During the interview, the teacher reported that the youth involved in the incident is verbally non-compliant on a routine basis, often leaves his seat without permission, and frequently escalates to more serious behavior. Despite the chronic nature of this student’s problems, the education program had not developed alternative behavioral plans or suggested additional resources to assist him or the teacher.

Further, the IDEA and State regulations require schools to review individualized education programs (IEPs) for students with disabilities who demonstrate behavior problems, to determine their need for additional services, or their teachers’ need for supports such as training in behavior management, but there is no evidence that the education programs in the juvenile facilities implement this requirement.

SPECIAL EDUCATION

The IDEA provides that all eligible children and youth with disabilities, regardless of the nature or severity of their disability, are entitled to appropriate special education and related services designed to meet their individual needs. Special education is specialized instruction that can be provided in a range of settings including juvenile correctional institutions. States receiving federal funds under the IDEA must assure that all eligible youth will receive special education that meets the requirements of the statute.

Louisiana policies corresponding to the IDEA are contained in the Regulations for the Implementation of the Exceptional Children’s Act (Bulletin 1706). Appropriate special education for youth with disabilities is defined in Bulletin 1706 as:

... all special education and related services provided each exceptional student which meet State Board standards, including these Regulations and all applicable bulletins approved by the State Board, and that are provided in conformity with an IEP at public expense.

The SSD #1, an education agency of the LDOE, has responsibility for the administration and operation of special education services in the juvenile facilities. Among other requirements, the juvenile facilities fail to comply with federal and State special education requirements for screening, evaluation, and identification of youth with disabilities; development and implementation of individualized education plans (IEPs); related services; transition services; and participation of parents or guardians.

Screening, Evaluation, and Identification

The implementation of SSD #1 procedures to locate and identify youth with disabilities is significantly flawed in the DPSC facilities. At best, the procedures identify some youth - usually those who received services prior to their incarceration and who have current evaluations and IEPs. At worst, the procedures fail completely. Significant numbers of youth with disabilities in the juvenile facilities are *never* evaluated to determine their need for special education or related services, while others may be evaluated only after significant delays of *one year or more*. In juvenile correctional settings, the need for thorough and aggressive screening is accentuated because many youth have histories of erratic school attendance, drop out, and prior incarceration that complicate the accurate and timely retrieval of disability-related information.

The screening and evaluation process in the DPSC juvenile facilities is inadequate for many reasons, including delay in receiving records from youth's prior schools; ineffective screening procedures at the JCCY diagnostic unit including lack of involvement of SSD #1 staff;²⁸ insufficient review and exchange of information among education, special education, mental health, medical, and other program components; ineffective operation of the School Building Level Committee (SBLC);²⁹ and insufficient knowledge concerning the criteria and protocols for referral by general education teachers, counselors, and other program staff, limiting their ability to recognize and respond to characteristics and behaviors of youth that suggest the need for special education.

²⁸ Reporting of information by the intake unit can be inconsistent. For example, D. J.'s records contain a Master Record Sheet completed at the intake unit in April, 1997 that noted an estimated IQ of 62, and reading and math scores on the second grade level, but the special education indicator was marked "No." Although he has been confined to the custody of the DPSC for more than one year, D. J. has not been evaluated for special education. The SBLC is reported to meet once per month at the juvenile facilities.

²⁹ I spoke with several committee members at the various facilities, who stated they infrequently make initial referrals for special education and they do not consider students' eligibility for accommodations under Section 504.

The following table provides approximate numbers and percentages of youth receiving special education at the DPSC facilities:

DPSC JUVENILE FACILITY	APPROXIMATE NUMBER OF YOUTH RECEIVING SPECIAL EDUCATION ³⁰	YOUTH RECEIVING SPECIAL EDUCATION AS PERCENTAGE OF TOTAL POPULATION
LTI - Bridge City	45	25%
JCCY (excludes intake unit) ³¹	145	25%
SCCY	150	25%

It is important to note that the failure noted above of the screening and evaluation procedures suggests that *the prevalence of eligible youth with disabilities is much higher than the numbers receiving special education in the juvenile facilities.*³² In addition, although estimates of the prevalence of incarcerated youth with disabilities vary, practitioners and researchers agree that youth with learning disabilities, mental retardation, and emotional or behavioral disorders are over-represented in juvenile facilities as compared with the public school population. Widely accepted estimates of youth with disabilities in juvenile correctional settings range from 30 percent to more than 70 percent.

On May 1, 1998, the superintendent of SSD #1 directed the special education staff of the DPSC juvenile facilities to implement procedures to screen youth in the diagnostic unit through interviewing, review of records, and search of an automated database (Louisiana Network of Special Education Records (LANSER)). I discussed these procedures with staff but I was not able to observe their operation directly. The procedures will implement screening and evaluation for the first time for youth on the intake unit, and have potential to reduce the delay in identification and provision of services for youth with disabilities.

G. S.'s experience at LTI - Bridge City provides a particularly explicit example of the State's failure to evaluate youth with disabilities or to provide needed services. He has almost no functional eyesight and attended the Louisiana School for the Blind prior to his incarceration, but he has not received special education or related services at the juvenile facility. When I observed this student, he placed his eyes directly on a worksheet and on the chalkboard attempting to see assigned math problems. His teacher reported that, after he had been in the facility for *nearly one year*, consultants from the Louisiana School for the Blind visited and recommended enlarging the text on instructional materials for him. Because the school does not have a photocopy machine that can enlarge to the size of type recommended, the teacher copies and

³⁰ The majority of youth in the DPSC juvenile facilities who do receive special education are identified as emotionally or behaviorally disordered, learning disabled, or mentally retarded. Youth with speech impairments, traumatic brain injury, visual impairments, hearing impairments, and physical disabilities are incarcerated less frequently.

³¹ The number of identified youth with disabilities on the intake unit at JCCY is not available because the DPSC did not implement IDEA and State requirements to determine eligibility of youth for special education until May 1, 1998.

enlarges every math worksheet in the community. It is important to note that observations of this student in the classroom, and information communicated to me by his teacher, demonstrate that the accommodations provided for G. S. are grossly inadequate. A large variety of specialized equipment, materials, and interventions are routinely available to youth with visual impairments in school settings.

In many cases, required screening and evaluation does not occur despite multiple referrals for special education initiated by DPSC staff and based on documentation that is contained in educational and institutional case records maintained in the juvenile facilities. The case examples that follow illustrate the juvenile facilities' repeated failure to evaluate and identify G. S. and other students.

G. S., age 16, is blind in one eye and visually impaired in the other. <i>He has been in the custody of the DPSC for one year but has not received special education or related services.</i> Eleven months after his admission to LTI-Bridge City, the facility arranged for consultation about his need for classroom accommodations. Teachers began enlarging some print material for his use, but these materials do not provide this student adequate access to the education program.	
Date/ Data Source ³³	Need for Evaluation/Special Education
5/97 JCCY Diagnostic Unit Facesheet	Blind in left eye Last school attended: Louisiana School for the Blind in March, 1997 Special Education Indicator: "Yes"
5/97 JCCY Diagnostic Unit Admission Summary	Educational Status: Special Education in 7 th grade School Attended: Louisiana School for the Blind Precautions: Offender blind in right eye Physical Limitations: Offender blind in left eye
5/97 JCCY Diagnostic Unit Mental Status Checklist	Intellectual Functioning: Special Education/LD G. S. states he received education through Louisiana School for the Blind and special education/ LD program ³⁴ Recommendation: SSD #1
6/97 Medical Record Notes	G. S.: "My left eye is blind and I can't see out of my right eye."
6/97 JCCY Social History	Special Treatment Recommendations: SSD #1 Offender is visually impaired
7/97 LTI Bridge City Educational Assessment	"G. S. needs his glasses and a monocular". The

³³ The table includes selected data; additional information confirming the need for evaluation or special education may be available in educational or institutional records for some youth.

³⁴ "LD" refers to learning disabilities.

(completed by teacher)	School for the Blind refused to lend a monocular ³⁵ to us. We have no large print materials. I can't require G. S. to complete assignments until he gets what he needs to see. He is putting a serious strain on his sighted eye."
ND Note from G. S. to Program Coordinator	"I would like to get on work detail because that way I wouldn't have any risk to my lovely vision."
7/97 Request for Specialized Services	Due to history of receiving services, G. S. is being referred for placement in SSD # 1 program.
7/97 Declaration of Emergency Treatment	G.S.: "My eye hurts all day and night..."
8/97 LTI Bridge City Notification of Special Precautions	Medical Alert: Blind in right eye, Visually Impaired in left eye Referral: SSD #1 and psychiatric assessment for suicidal ideation
3/98 LTI Bridge City Progress Notes	We are in progress of having him evaluated for a Visually Impaired program
4/98 LTI Bridge City Progress Notes	G. S. was recently evaluated by a team from the Louisiana School for the Visually Impaired - made some suggestions as to how to help him in the classroom.

Z. R. , age 15, has an estimated IQ of 55. He has been incarcerated for four months but has not received evaluation to determine his need for special education.	
Date/ Data Source	Need for Evaluation/Special Education
12/97 DPSC Master Record	Special Education indicator: "Yes"
12/97 TABE scores	Reading K.8 (eighth month of Kindergarten) Math 2.0 (second grade)
12/97 JRDC Group Psychological Assessment	Estimated IQ 55; Offender reports history of LD classes; Referral: SSD #1 pupil appraisal
1/97 LTI Bridge City Case Plan (STOP Program)	Educational Assessment: Special Education Referral: SSD #1
1/98 LTI Bridge City Special Precautions	Referral: SSD #1

³⁵ An optical aid which may be recommended for students with visual impairments.

J. J., age 16, has been confined to the custody of DPSC <i>for 18 months</i> . Although testing during intake estimated his IQ to be 54, and his records indicate he received special education in the community, he has not received evaluation or special education while incarcerated.		
Date/	Data Source	Need for Evaluation/Special Education
10/97	DPSC Master Record	Special Education Indicator: "Yes"
10/97	Social History	Offender stated he was enrolled in special education- Behavior and Learning Disordered. Repeated Kindergarten, 4 th , and 5 th grade; Recommendation: SSD #1
11/97	Assessment Summary	Referral: SSD #1
12/97	LTI- Bridge City Case Plan (STOP Program)	Educational Assessment: SSD #1
2/98	LTI- Bridge City Educational Data	'F' grade in math, English, language, science, life skills, and social studies
3/98	Educational Assessment (completed by teacher)	"Extremely lazy and poor student. Does no class work only sits in class and writes filthy and lewd letters to girls. I have been instructed by the principal to ignore this situation until it goes away. To date (4/98) it has not done so."
ND	Educational Assessment (completed by teacher)	"..unable or unwilling to stay on task for long periods of time. Possible screening for ADD?" ³⁶

T. J. is 18 years old, his estimated IQ is 58, and he reads at the second grade level. His need for special education has not been determined while in the custody of DPSC.		
Date/	Data Source	Need for Evaluation/Special Education
3/97	Psychosocial History (completed by a community hospital)	Repeated 3 rd and 5 th grade, and 7 th grade two times; needs evaluation for ADHD, depression, and exploration of school problems by means of a psychological test

³⁶ ADD refers to attention deficit disorder.

3/98 TABE scores	Reading and math scores at second grade level
3/98 Group Psychological Assessment	Referral: SSD #1, at-risk for mental retardation
5/98 LTI - Bridge City Case Plan	Educational Assessment: SSD #1

T. A., 16 years old, was admitted to the JCCY intake unit in October, 1997, and to SCCY in November, 1997. T. A. is often isolated on protective custody, and rarely attends school. During my tour of SCCY in May, 1998, a security officer reported that T.A. had not attended school for six months. The school psychologist said this student "needed hospitalization." Despite extreme emotional and behavioral problems since his confinement to State custody, and numerous indications contained in his institutional and school records that he received special education prior to incarceration, he was not referred for an evaluation until February 1998, the evaluation was not completed until May 1998 and - seven months after his admission - T. A. was still not receiving special education.

I interviewed T. A. during my May 1998 tour. When I asked why he was not in school, he replied, "there is no school on protective custody." He said that one teacher had delivered a math book to him in the last few weeks, and that he can request schoolwork from the security officers. During the same interview, T. A. told me that he attended a "special school" in the community.

Date/ Data Source	Need for Evaluation/Special Education
8/97 Psychological Evaluation	Possible perceptual-motor handicap and attention deficit disorder
11/97 JCCY Assessment Summary	Recommendation: SSD #1
5/98 Social History and Court Report	Recommendation: SSD #1
5/98 Educational Assessment (completed by teacher)	T. A. "hardly ever comes to class. Always on P. C. {protective custody) or suicide watch."
5/98 SCCY Educational Evaluation (completed after referral for special education from the principal 2/98)	"T. A. was in school for only 11 days in March, 3 days in April, and no days to date in May (as of May 15)"

G. B. has been in the State's custody for seven months. His records indicate that he self-identified as needing special education on admission to the juvenile facilities.	
Date/ Data Source	Need for Evaluation/Special Education
ND Diagnostic Unit Parent Information Form	Information from Parent: Youth has LD
6/97 Group Psychological Assessment	Offender reports history of special education/ LD
7/97 Assessment Summary	Referral: SSD #1
7/97 JCCY Social History	"Offender admits to having benefited from special education services from sixth grade"
7/97 DPSC Master Record	Special Education Indicator: "Yes"

Special Education Staffing

The LDOE employs insufficient teachers, teacher assistants, and school psychologists to provide adequate special education services in the juvenile facilities. Staff report that the number of youth with disabilities has increased in the last two years, but the State has not allocated increased positions to keep pace with the growing need for special education services. Caseloads of many special education teachers exceed maximum State pupil/teacher ratios, the facilities do not have a sufficient number of teachers to provide special education services for youth isolated for protective custody, administrative segregation, or medical treatment, or for those on the intake unit at JCCY. No special education transition teachers are employed for the DPSC juvenile facilities, although these positions are provided in public schools in the State. The extent of understaffing is more severe given the restricted range of special education services currently provided in the facilities (one hour per day for the majority of identified students) and the failure to identify and provide special education services for many eligible youth - deficiencies that are discussed in other sections of the report and that will require increased staff to correct.

Teachers who are assigned excessive caseloads or have insufficient classroom space to accommodate their students, may not be able to provide the full amount of special education specified on the IEP. One special education teacher at SCCY explained that she had to reduce the amount of service provided for all students on her caseload from 60 minutes, required on the IEP, to only 30 or 40 minutes daily. This teacher is also constrained by a severe lack of classroom space. Her classroom can accommodate only her desk and four computer stations for students, so she can provide special education for only four youth at one time. This classroom has no room for student desks - the teacher said she had purchased small wooden lap boards so that students would have a writing surface. The teacher stated that an inspector from the fire department had concerns that the room was not adequate to safely accommodate four students.

The superintendent of SSD #1 substantiated the need for three additional special education teachers and four paraeducators, explaining in a memorandum to the LDOE in April, 1998, that “the average pupil/teacher ratio is 29.2 students to 1 teacher [at JCCY]. Four of the five teachers presently employed exceed the limit and are out of compliance”;³⁷ and “the teacher to be employed [for the JCCY intake unit] would be out of compliance today if all eligible special education students in the transition population were assigned today.” The juvenile facilities also have a critical need for additional school psychologists. Two school psychologists are assigned to the three facilities. A school psychologist indicates that he visits LTI - Bridge City “when needed”; although significant numbers of youth in the facility are considered “weak and fragile” by the DPSC, he is usually there only two days per month.

Individualized Education Program (IEP)

All eligible students with disabilities must receive an Individualized Education Program (IEP) to enable them to benefit from education by meeting their unique needs as learners. The IEP must be properly developed and implemented, including annual and short-term objectives to guide instruction in academic and behavioral skills, a description of the specially designed instruction and related services that will assist youth in meeting the goals, and transition objectives and services as required. If the education program does not provide the services specified on the IEP, the program does not constitute appropriate special education.

Regulations establishing SSD #1 emphasize the importance of timely and appropriate delivery of special education:

*The purpose of the SSD #1 is to provide free and appropriate education for eligible students, ages 3 through 21 who have been admitted to the State operated programs for treatment, habilitation, and care or who have been placed by Court order. During this period SSD #1 assumes responsibility for special education on an individual basis for each student and assures that the student receives an uninterrupted program of special education and related services from admission to discharge.*³⁸

The IEP requirements are not implemented for substantial numbers of youth confined to LTI - Bridge City, JCCY, and SCCY. The IEP is not developed or implemented for youth housed on the diagnostic unit at JCCY, regardless of their length of stay on the unit. Plans to provide special education services on the intake unit were in a preliminary stage of development during my visit in May, 1998; the special education coordinator and teachers indicated they were uncertain how these services could be provided, given that only one special education teacher would be assigned to the intake unit.

³⁷ In this context, “out of compliance” means student/teacher ratios in excess of State requirements for special education.

³⁸ Bulletin 1706, Section 603.

The development and implementation of the IEP is also compromised when students are provided the identical level of special education service regardless of their needs. Most students in the DPSC juvenile facilities receive one instructional period per day of special education (55 or 60 minutes), although many of them were determined to need as many as 360 minutes of special education per day by public schools in the State. At SCCY, for example, every student but one receives one period of special education daily.³⁹ This is a highly unusual situation that precludes individualized decision-making and the provision of a continuum of services, and it is not comparable to practices for youth in other public schools in Louisiana. It is highly likely that some students in an education program will require more intensive options than one hour of special education per day, if only for limited periods of time. One teacher with many years experience in the local parish schools told me that she had never encountered a situation where all or nearly all youth with disabilities in that education program received only one period of special education per day.

Related Services

Closely aligned with issues discussed in the preceding sections of the report is the failure of the DPSC juvenile facilities to provide related services for all eligible youth. Students with disabilities are entitled to receive related services to assist them in gaining access to or benefit from special education. Related services are developmental, corrective, and other supportive services including counseling, psychological services, social work services, speech pathology and audiology, physical and occupational therapy, medical services for diagnostic purposes, and parent counseling and training.⁴⁰

Counseling is included on the IEP as a related service, but this simply refers to the counseling services provided to all youth at the facility rather than an individualized special education-related service. When counselors do not contribute or participate in IEP meetings,⁴¹ goals and objectives on the IEP are not linked to activities in the counseling sessions; and the counseling and education programs have minimal communication about the progress or needs of youth with disabilities, counseling is not being provided in accordance with IDEA requirements. The treatment program manager (responsible for supervision of counselors) at LTI - Bridge City emphasized the absence of collaboration when she stated "special education is a separate entity - we [counselors] have no involvement ." At LTI - Bridge City, the special education coordinator indicated that the speech therapist also does not attend IEP meetings for students who receive speech services.

The experiences of the following students provide specific examples of the State's failure to evaluate and provide related services for all eligible youth:

³⁹ The student receiving more than one period of special education receives these services for two periods per day.

⁴⁰ See 34 CFR for definitions of related services.

⁴¹ I attended an IEP meeting during my visit to LTI - Bridge City in April, 1998. Counseling was listed as a related service on the student's IEP but the counselor was not in attendance.

- L. J. , age 14, spoke with an obvious articulation impairment (stuttering) when I observed his classroom at SCCY in May, 1998, but he has not been evaluated to determine his need for speech/language therapy or special education. When I interviewed him, L. J. told me that he had received special education for learning disabilities and speech therapy in a public school in Louisiana before his incarceration.
- M. C. does receive special education at SCCY, and was evaluated for speech therapy by SSD #1 in January, 1998, while he was confined at the facility. Although he was found to be eligible for speech therapy on the basis of impairments in receptive and expressive language, written language, and articulation, as of May, 1998, M. C. was not receiving speech therapy.
- G. S. is a visually impaired youth at LTI - Bridge City. I asked the SSD #1 coordinator at the facility if an evaluation was planned to determine the student's need for related services. He responded "No, I don't know if we (e.g., the educational program) will be able to provide related services. The Louisiana School for the Blind said they would mail a monocular - we weren't aware of that material, I understand they use them all the time." The fact that a related service has not been or is not now provided in a school is not adequate grounds for not providing it.

Parent/Guardian Participation

The IDEA and State regulations recognize the importance of parent participation and provide specific requirements for their involvement in special education. Students under the age of majority or unable to represent their own interests have a right to parent or guardian involvement in decisions made during the IEP meeting including, under certain conditions, the appointment of parent surrogates. The DPSC facilities have failed to implement the requirements for parent participation or have implement these requirements inadequately.

The juvenile facilities appear to recognize that increasing parent participation is critical; Scenic High School's special education "school improvement goal" for the 1997-98 school year was to "increase parent participation in IEPs....JCCY is located far from most families and transportation is often sited as a problem. Usually parents just opt to have IEPs sent to them for review. *During the 96-97 school year, no parents attended any of the more than 250 IEP meetings [emphasis added].*"⁴²

Exclusion from Education

In most cases, students do not receive instruction from special education teachers, and do not have access to school assignments or instructional materials, when they are isolated for administrative segregation, protective custody, or medical treatment. The following examples illustrate the denial of special education services for youth:

⁴² It is relevant to note that program staff at some of the DPSC facilities report a large number of parents travel to the facility for family visitation days. Scheduling IEP meetings for visitation days has been a successful strategy to foster parent involvement in special education in many juvenile correctional settings.

- C. R. - This student has been confined at SCCY *for eight months*. He is identified by many staff as having severe and ongoing behavioral and emotional problems. The school psychologist stated that he needed “a developmental center”. When I observed this student, he was isolated on the closed campus of SCCY and was not receiving education or special education.
- W. I. - This student has been confined to the State’s custody for one year. He has been housed on the closed campus of SCCY since December 1998 on “permanent Cyprus”, and security officers on the unit told me that he *had not attended school except very infrequently for six months*. When I interviewed him, W. I. said that he received special education for reading and math in his community school. He had a folder containing worksheets in his isolation cell, but he stated that he could not do the work because he was not permitted to have a pencil. He said that a teacher does not provide assistance to him while he is isolated.
- J. G. - Staff said that this student was placed on “permanent Cyprus” until his release from the facility scheduled in June, 1998. When I interviewed him, J. G. self-identified as receiving special education in the community. In March, 1998, the SBLC at SCCY decided that “more time (is) needed for referral (for special education).” At age 17, J. G. reads on the Kindergarten level.
- D. S. - Staff identified this student as needing hospitalization for severe mental health needs. While he was confined at JCCY, the evaluations determining his need for special education that were completed by a public school in the community became “out of timeline” (beyond the required three-year re-evaluation timeline); he has not been re-evaluated and does not receive special education at SCCY, where he was transferred in April, 1998.

Transition

Youth with disabilities ages 16 and older - and ages 14 and older as determined necessary by the IEP team - must receive transition planning and services. The IEPs for these youth must contain transition goals and objectives that will assist them with post-school education, employment, and independent living. Transition is a process that should be functionally linked to consistent and coordinated programming within the facility, and to aftercare planning.

For eligible youth in the DPSC facilities, however, transition planning is not generally connected to their needs or to the services they will need on release. The IEPs include a transition component that appears to be a “check-off” procedure to indicate that transition issues were addressed - at best meeting procedural requirements but not the substantive content of the IDEA requirements. Further, SSD #1 does not employ transition teachers, although public schools in the State provide transition teachers to implement IDEA requirements for youth with disabilities.

Vocational Education

Vocational programs in the DPSC juvenile facilities routinely violate minimum professional standards and standards for vocational education promulgated by the LDOE. As currently structured, the vocational programs do not prepare incarcerated youth for productive employment in the community and do not fulfill the State's rehabilitative obligations to these youth. Vocational education programs are provided to a limited number of youth in the DPSC juvenile facilities; approximately 180 students of 660 youth confined to JCCY receive training in Building Trades, Horticulture, or Upholstery; approximately 70 students of 440 youth confined to SCCY 440 receive training in Building Trades/Carpentry, Printing, Upholstery, Printing, or Welding at SCCY. The vocational courses are provided mainly as one-half day programs in morning or afternoon sessions; some are offered for one-hour during the school day. LTI- Bridge City does not provide any vocational courses or training. The three juvenile facilities provide computer-assisted instruction for pre-vocational skill development through JSEP courses.

The capacity of the programs to provide certification in marketable trades, or preparation for continued vocational training and viable employment is severely constrained by antiquated equipment and materials, unsuitable facilities, an insufficient number of qualified instructors, lack of vocational assessment, and lack of transition and aftercare linkages with employers in the community. The vocational curriculum is not comparable to that provided by public schools in Louisiana, and the programs do not meet State standards for vocational instruction.⁴³ Activities within the vocational programs are more often related to the production and maintenance needs of the facility than to the educational needs of students. The vocational teachers employed by the DPSC are paid significantly less than their colleagues working in public schools.⁴⁴ The girls confined to JCCY, and specific populations of youth including those with disabilities, do not have equal access to vocational education.

My discussions with staff and observations at JCCY and SCCY revealed extreme deficiencies in every vocational course provided in the facilities. The nearly complete lack of operational equipment has forced instructors to essentially shut down the operation of some programs. At JCCY, the small engine repair course has not operated since the fall of 1997 because the program did not have any suitable instructional space. The welding shop at SCCY has only one functional, modern machine. While six youth are enrolled in the morning and afternoon welding course, only one student at a time can learn or practice welding skills. The upholstery course at SCCY also enrolls six students in each session, but the program has only two operational sewing machines (another machine has been broken for three months). The upholstery shop at JCCY has only one operational sewing machine. When I observed, one student was using the machine, two others were watching, and the remaining nine students in the

⁴³ The LDOE competency-based secondary curriculum standards for vocational education are contained in Secondary Trade and Industrial Vocational-Technical Program and Course Standards (Bulletin 1916). Describing purposes for the standards, Bulletin 1916 states they, "must be adhered to by schools in planning, implementing, and evaluating courses and programs."

⁴⁴ The coordinator of the vocational program at SCCY told me that, "I can't hire certified qualified instructors - they take a tremendous cut in pay to come here as compared to the community."

class were sitting some distance away, talking or sitting quietly. These students had no instructional materials, and the instructor stated he did not have materials to provide for them. The equipment in the building trades/carpentry program at SCCY is 40 or 50 years old, and while some of the machines are functional, others cannot be repaired because parts are no longer manufactured for them. According to the instructor, the lack of modern equipment in the building trades shop presents a significant safety hazard. He stated that the "air in the shop is not healthy" because the shop does not contain an adequate air cleaning device required for carpentry work.

Several instructors indicated that they could not teach standard portions of the vocational curriculum because they did not have computers. For example, the building trades teacher at SCCY stated that instruction in entry-level job skills requires computer-assisted instruction in reading of blueprints, but his program has no computers. Similarly, the print shop teacher at SCCY stated that desk-top publishing skills comprise a significant portion of the curriculum, but he did not have a sufficient number of computers to provide this instruction.

The criteria for participation in vocational programs in the DPSC juvenile facilities do not comport with non-discrimination provisions in the Americans with Disabilities Act. For example, admission criteria for the vocational program at SCCY were recently revised to include a minimum grade equivalent score of 7.0 (grade seven) in reading as measured by the TABE.⁴⁵ This requirement will *exclude the majority of youth from consideration for vocational training*, as considerable numbers of youth admitted to SCCY and the other DPSC facilities have reading scores below this level; the requirement will *also disproportionately exclude youth with specific learning disabilities, mental retardation, and other disabilities affecting reading achievement*.⁴⁶ Teachers reported they were not consulted in developing the criteria, and they expressed concerns that youth who receive special education will not be eligible for vocational education or training. It is important to note that youth who read below the seventh grade level, including those with disabilities, routinely participate in and benefit from vocational education and training programs in public school and correctional settings.

Girls are enrolled in vocational courses at JCCY (the only secure juvenile facility for girls in the State), but they do not have comparable access to vocational education provided to boys in the facility. The girls are not permitted to attend classes in the vocational shops, and no such shops are located in the girl's compound (a separate area within the facility). The classrooms used for vocational courses for girls do not have any vocational equipment. Instructors use only those tools and materials that can be easily transported from the vocational shops used for boys. One instructor described the type of program he is able to provide for the girls under these circumstances as more similar to "arts and crafts" than vocational training.

⁴⁵ SCCY Policy No. JS-04-005.

⁴⁶ To the extent that the State receives federal funding for the juvenile facilities from the Carl D. Perkins Vocational and Applied Technology Education Act, this appears to violate provisions of the Act that assure equal access to vocational education programs for individuals who are members of disadvantaged and special populations. For the State's implementation of the Perkins Act, see Louisiana Program Plan for the Administration of Vocational Education, Office of Vocational Education, Louisiana Department of Education.

In a positive development, SCCY recently received Challenge Grant funding for an aftercare program (enrolling approximately 30 youth) including a vocational component. In April, 1998, the warden appointed a Vocational Manager to supervise the vocational programs and develop resources for employment when youth are released. When I spoke with the Vocational Manager, he stated the facility expects to receive a separate grant of about \$65,000 for vocational equipment. To place the needs of the vocational program in perspective, the Vocational Manager added that at least 1.8 million dollars would be necessary to develop an adequate vocational program serving the same number of youth as are currently enrolled.

I spoke with numerous school and facility staff who commented on the inadequacies of vocational education provided in the juvenile facilities, and the need for improvements to these programs.⁴⁷ One teacher said that, "here, the boys are out mowing grass, in the parish schools they can prepare for a career." A warden said that "if we don't give these kids an education and vocational training, we might as well make room for them at Angola (an adult prison in Louisiana)." The vocational coordinator at SCCY also emphasized the close connection between rehabilitation efforts and vocational education, stating, "if kids have job skills and find employment, recidivism would plummet."

The DPSC appointed an internal workgroup to examine the vocational programs in its juvenile facilities and to recommend improvements. On May 28, 1998, the workgroup issued a report to the DPSC (Attachment 4) that identified the need for a major overhaul of vocational education for incarcerated youth in the State, and provided specific remedies, including:

- the establishment of a Vocational Department separate from the Education Department within the Office of Youth Development with a vocational director to address vocational programs throughout the juvenile institutions and to monitor these programs on a routine basis;
- funds need to be allocated and the budget needs to reflect and to focus on vocational issues...offenders [should] be allowed to acquire skills to a trade by working in the vocational program and not working for the maintenance department. If offenders are assigned to Carpentry/Building Trade they need to build structures for learning purposes...not to become part of maintaining the campus;
- vocational instructors need to be certified and paid the same salaries as vocational instructors presently working for local vocational centers. We want to ensure that juvenile institutions can compete and acquire good and reliable instructors
- a vocational assessment teacher be assigned to JRDC so that each offender be provided with a vocational assessment test that will determine the vocational aptitude of each offender;
- offenders receive certificates or diplomas certifying the skills acquired or accomplished. We recommend that each institution follow the same guidelines and requirements as are followed by local vocational programs. These offenders need to

⁴⁷ The DPSC Consultants Report (Attachment 1) also addressed the value of vocational education: "It is our belief that the goal of each institution must be to return these offenders to society as productive members. We do not believe this is possible without the training that these vocational courses can provide."

present a certificate to their future employer that demonstrates that they possess or have mastered the skills necessary to accomplish the job;

- a vocational learning center be built in the center of the state and that specialized vocational programs be assigned to it ... offenders who qualify for such trades and who are within several months of discharge be given the opportunity to transfer to this facility.

CONCLUSION

The findings in this report are based on site visits to the education programs operated by the Louisiana Department of Public Safety and Corrections in its secure juvenile facilities, interviews with students and staff, and review of applicable laws, policies, and records. The education programs at LTI - Bridge City, Jetson Correctional Center for Youth, and Swanson Correctional Center for Youth are classified as alternative schools, but with limited exceptions, they substantially depart from SBESE standards for the operation of alternative schools, or federal and State requirements for special education. As a result of serious and pervasive deficiencies, many youth spend significant portions of their secondary school years in the facilities without adequate opportunity to learn basic academic or vocational skills; these inadequacies are exacerbated for disadvantaged and disabled youth.

Although many school staff are well-meaning and conscientious, they receive minimal support and resources; teachers employed by the DPSC are paid considerably less than their colleagues working in the public schools and those employed by the SSD #1 within the same juvenile facilities. The education programs lack a centralized administrative structure with sufficient autonomy and authority, and they are poorly coordinated with security and treatment programs. The programs also do not have the independent oversight and monitoring associated with accreditation by a professional association of secondary schools.

Systemic reform of the education programs in the DPSC juvenile facilities is urgently needed and long overdue. The completion of high school is closely associated with improved life chances for troubled youth; a commitment to providing adequate educational services has benefits for individual youth and for all citizens in Louisiana.

ATTACHMENT 1

**REPORT TO MR. RICHARD STALDER, SECRETARY
LOUISIANA DEPARTMENT OF PUBLIC SAFETY AND
CORRECTIONS**

by
M. B. CHILDRESS, CONSULTANT
and
J. W. COOK, CONSULTANT

The initial phase of our work was centered around obtaining information. From our visits to the institutions, four to five visits to each site, we learned as much about the total operation as possible. This was done through site visits as well as conferences with staff members. Several meetings were held with the wardens and school administrators. We conferred with the entire professional staff at each site and with many of the non-professional staff. Everyone with whom we visited was most cordial, supportive and helpful. A concerted effort was made to visit each classroom and several on more than one occasion.

Ms. Marlene Ritter with the State Department of Education was very helpful. We conferred with her regarding annual reports for the four sites.

It is our sincere belief that Ms. Gail Rambin and Ms. Gail Hargrove have a sincere desire to make a difference in the educational opportunities for these young offenders.

For a different perspective, we conducted interviews with a group of probation officers from the Shreveport office. They were very open and offered much information. Mr. Childress spoke with Judge David Matlock via telephone.

We attended the February and May conferences in Woodworth, Louisiana. Attending these sessions provided us with helpful ideas and suggestions.

We traveled to Montgomery, Alabama with Mr. Richard Thompson to attend a conference with the top official at the youth correctional facility. They appeared to have a good, sound operation, and this visit was very helpful in giving us ideas that may work in our juvenile facilities.

From the knowledge we obtained over the past several months and from our many years in education with the Caddo Parish School System, we do have a number of recommendations for improvement in the education process at these institutions. It is our sincere belief that much needs to be done to improve the quality of education. Improving the quality of education will no doubt increase the number of offenders returning to society with skills and attitudes that will make them more productive.

We all know that more juveniles are being incarcerated today than ever before. We also know that more violent crimes are being committed by juveniles today than ever before. We know the tremendous burden placed on taxpayers to incarcerate offenders. These facts alone tell us that we must do more in our institutions to rehabilitate these offenders. Improving the quality of education may reduce the number returning in later life to adult facilities. It is our belief that the efforts should be put forth at this age level as the chance for change is greatest at this age level.

Older adult inmates cost taxpayers an enormous amount of money. In January of 1995, state and federal inmates above the age of fifty (50) numbered about 55,000. According to some estimates, developed prior to passage of "Three Strikes" laws that mandate 25 years to life for third felonies, that number will exceed 125,000 by the year 2000. A report of the National Criminal Commission reports the annual cost for a state inmate over 55 years of age was, on average, \$69,000 a year, which is more than three (3) times the \$22,000 a year cost to imprison the typical adult inmate. The greatest contributor of that cost is medical cost and care. Prisoners develop medical problems in their fifties, years earlier than people on the outside. Our constitution does not mandate health coverages for regular citizens, but for prisoners we are obligated to provide appropriate medical care, whatever the cost.

RECOMMENDATION #1

The first issue we wish to discuss is that of salary. I might say that we were appalled at the discrepancies in salaries of teachers instructing the same offenders and working the same annual schedule. Many are paid at a much lower pay scale than their counterparts. It is our recommendation that the salaries for the four parishes and the city system of Monroe be averaged, and a salary schedule be developed from these averages. All teachers in the juvenile facilities should be paid according to this schedule, giving credit for degrees and years of experience. This would provide for a uniform salary schedule for all employees. Administrators should be paid on a schedule derived from this teacher salary schedule commensurate with degrees and years of experience. Enrollment would be a factor in computing this salary. A 1.50 ratio added to this salary would guarantee a higher salary for administration than the highest paid teacher.

It is our recommendation that no one receive a reduction in salary. All new employees would come under this salary schedule.

Develop a salary schedule with benefits for the Office of Youth Development school administrative staff equal to that of comparable positions within the State Department of Education or positions within the East Baton Rouge School system, depending on which organization has the most compatible position.

RECOMMENDATION #2

It is our recommendation that the school year be based on a schedule of 220 working days. This would end the school year some time around the last of June depending on the beginning of the year. This would allow teachers to be off the month of July plus time in August. The school calendar would be unique to these school sites. The holiday schedule would differ from that of the public schools. If it is absolutely necessary to have summer school, the months of July and August could be for that purpose.

RECOMMENDATION #3

It is our firm belief that every offender should have a five (5) period day with a full 55 minutes of instruction per period. We are aware that this may require additional space. Space will be discussed in another recommendation.

A minimum of 30 minutes per day in this five (5) period day shall be devoted to social skills topics such as parenting, family life, citizenship, loyalty, honesty, respect for oneself and others, character and moral development, drug awareness, human relationships, self esteem and conflict resolution. These topics plus others that must be covered may re-direct the thinking and habits of many.

Within this five (5) period day the class size (teacher-pupil ratio) must never exceed 1-15.

RECOMMENDATION #4

Vocational courses, facilities for these courses, equipment and materials adequate to met the demands of today's world of work must be established. These courses must utilize today's technology. It is our belief that the goal of each institution must be to return these offenders to society as productive members. We do not believe this is possible without the training that these vocational courses can provide.

RECOMMENDATION #5

Principals must be held accountable for all facets of the school and its operation. They must be given full authority over its operation. It is our belief that security personnel assigned to the school must also work under the supervision of the principal. Principals must be the evaluator of the teaching staff. There must be a program of accountability. First-year teachers must be evaluated each year until tenure is obtained. Tenured teachers must be evaluated every fourth year. Staff must develop yearly goals and objectives as part of the evaluation process. The evaluation will determine the extent to which the goals and objectives have been met.

RECOMMENDATION #6

The best teachers must be recruited and employed. Teachers must be trained to work with at-risk students. We recommend a team comprised of the principal, assistant principal, guidance counselor and a member of the teaching staff from the area where the vacancy exists serve as an interview committee for the employment of new teachers. A committee from the Department of Corrections office comprised of the secretary, assistant secretary, supervisor and the warden should interview and select principals. The selection process is very vital and should be taken very seriously by the staff. Assistant principals and counselors should be interviewed and selected by the principal

and one very select member of the teaching staff, with the principal having the final vote on who is selected. To be in compliance with laws of due process, each candidate for a position must be asked the same questions during the interview. A consistent system for evaluating responses during the interview must be in place.

RECOMMENDATION #7

Compliance with State Department Bulletin #746 is absolutely necessary. In every case possible teachers must hold certification for the subjects taught when teaching for Carnegie units. Degree teachers teaching out of their area of certification must fulfill all requirements of a temporary certificate. Compliance will be much easier when salaries are upgraded to a respectable level.

RECOMMENDATION #8

Adequate classroom space must be added with systematic maintenance to accommodate a five (5) period day with fifty-five (55) minutes of instruction per class period and to maintain a 1-15 teacher-pupil ratio. Classroom equipment, textbooks, materials and supplies must be a priority. A need exists for a timely, systematic program for computer maintenance.

RECOMMENDATION #9

We recommend a trained cadre of substitutes for each site who can take the place of the regular teachers when absent. These substitutes should have a minimum of 40 college hours, or in rural areas, a high school diploma. Substitutes should be paid a minimum of \$35.00 per day. We recommend substitutes holding teaching certificates be paid a minimum of \$45.00 per day.

RECOMMENDATION #10

We are recommending only one (1) assistant principal at each site. However, we strongly recommend that each site have a certified school guidance counselor. We would like to see as many as two (2) certified guidance counselors at each site. Relieve these counselors of so much paperwork, allowing them the time to counsel with offenders. Paperwork should be handled by clerical staff. Group counseling sessions should be a regular part of the counseling program.

RECOMMENDATION #11

We can appreciate what is attempting to be done through the "Zero Tolerance" program. However, it is our belief that such a program be initiated for the offenders, having them sign agreements to honor such a program. Offenders should be schooled on what will or will not be tolerated and the results or punishment for violations of non-compliance with this "Zero Tolerance" program.

RECOMMENDATION #12

Recommendation 12 is vital, in our opinion, to the total success of these school programs and recommendations. It is our recommendation that an independent school district be established within the Department of Corrections for all school programs within its jurisdiction.

We realize there would be no local funding for this school district. Funding for its operation would come from legislative appropriation. Our recommendation is that the schools at these sites be funded separately from that of the correctional center. The education part would have a completely separate budget for all operations.

RECOMMENDATION #13

A curriculum committee needs to be established to write a totally new and updated curriculum. A curriculum, along with curriculum guides, needs to be written for each area of instruction. This committee should consist of teachers, administrators and supervisory staff with representation from each site. When this curriculum is established and adopted, it must be adhered to by all staff members. This committee could accomplish this task during the summer.

RECOMMENDATION #14

Offenders with mental health problems should be housed in a location where proper treatment can take place. They should not be placed at either of the four (4) current training facilities under current existing conditions.

RECOMMENDATION #15

The school facility should be clean, attractive and in good repair at all times. Classrooms should be clean and provide an inviting decor. Maintenance staff must provide for systematic repair and care of the site, buildings and equipment.

ATTACHMENT 2

February 2, 1998

TO: Richard Thompson, Assistant Secretary
Office of Youth Development

FROM: The Educational Reform Team

RE: Substitute Teachers
Training & Staff Development
Accountability

The Educational Reform Team visited all of the targeted juvenile correctional facilities to study procedures or plans in place for the following: Substitute Teachers, Training & Staff Development, and Accountability. The findings and recommendations are listed.

Jetson Correctional Center for Youth (Decemeber 12, 1997)

FINDINGS (Substitute Teachers)

Jetson Correctional Center for Youth do not have substitute teachers. A roving teacher teach class when teachers are absent. Classes may be combined if more than one teacher is absent. Coaches are used sometimes to teach classes. SSD #1 have substitute teachers.

RECOMMENDATIONS

Funds should be appropriated to provide the school with substitute teachers or tutorers when teachers are absent.

FINDINGS (Training & Staff Development)

The staff receive the mandatory forty (40) ACA hours of training yearly. The staff is given an overview every school term with reference to staff development. There are professional quarterly faculty meetings. The staff attend various conferences and workshops throughout the year with reference to staff development. Some teachers are enrolled in college courses for professional development.

RECOMMENDATIONS

Teachers and tutors should be granted a professional leave to continue their education with benefits. Teachers or tutors should be given the opportunity to make up work hours missed for professional development. Half of the forty (40) hours used for ACA training should be geared towards educational development.

ACCOUNTABILITY

JCCY has an approved accountability plan in place approved by BESE with reference to teacher/ personnel evaluations. The plan is on going. There is one formal evaluation and as many informal evaluations as desired. One formal evaluation is required yearly for all 1st, 2nd, & 3rd year teacher per three (3) year cycle. Notification of evaluations are given in writing in advance. The observations should be at least 30 minutes in length.

RECOMMENDATIONS: NONE

LTI Bridgecity (December 13, 1997)

FINDINGS (Substitute Teachers)

There are no substitute teachers at LTI Bridgecity school. The school have WAE tutors. The institution employ these WAE tutors. There are presently three (3) in class with the teachers. The school utilize other teachers such as P.E. and Computer Lab teachers when teachers are absent. Some classes go to the library. Classes often combine during absences. The security staff is used as a last result during absences. Each teacher has a substitute packet on file in the office.

RECOMMENDATIONS

To employ a tutorer to work with each teacher.

FINDING (Training & Staff Development)

LTI Bridgecity has the mandatory forty (40) hours of ACA staff development yearly. Mrs. Ramblin and Mrs. Hargrove provide occassional training. There are faculty meeting twice per week throughout the year. Teachers may leave school to participate in professional development. These teachers have to use their comp time.

RECOMMENDATIONS

Provide time for staff development throughout the year. Provide professional development time without penalty. Provide training on correctional issues in other states with reference to juveniles.

ACCOUNTABILITY

LTI Bridgecity has the same accountability plan in place as JCCY.

RECOMMENDATIONS None

SCCY (January 9, 1998)

FINDING (Substitute Teachers)

OPEN Campus

There are no substitute teachers at Swanson Correctional Center for Youth. Students report to the Enrichment Lab for study when teachers are absent. There are two (2) labs. These labs can accommodate three (3) classrooms. The security staff is contacted if more than three teachers are absent. Students may work with the detail or recreation.

CLOSED CAMPUS

Tutorers are utilized when teachers are out. There are three tutorers (1 Title I and 2 state tutorers). Substitute teachers are used when the SSD #1 teachers are out.

RECOMMENDATIONS

Funds should be appropriated to provide the school with state tutorers when teachers are absent

FINDINGS (Training & Staff Development)

The staff receive the mandatory forty (40) hours of training yearly as required by ACA. Speakers convey information to the teachers during the school year. The staff is involved in any training made available. Professional leave is granted.

RECOMMENDATIONS

Correspondence courses for training (Angola). This is a take home course with an open book test.

ACCOUNTABILITY

SCCY has an approved accountability plan in place approved by BESE with reference to teacher/personnel evaluations. The plan is on going. There is one formal evaluation and as many informal evaluations as desired. One formal evaluation is required yearly for all 1st, 2nd, & 3rd year teacher per three (3) year cycle. Notification of evaluations are given in writing in at least 30 minutes in length.

RECOMMENDATIONS: NONE

TCCY (WESTSIDE HIGH SCHOOL) January 8, 1998

FINDINGS (Substitute Teachers)

Westside Alternative High School use substitute teachers when teachers are absent. The substitute teachers are provided by the Madison Parish School Board. These individuals are paid accordingly. Teachers are given ten (10) sick days per year. Only eight (8) days per year can be accumulated. Teachers are docked a portion of their daily pay when they no longer have sick days. The substitute teachers are provided orientation. Each substitute teacher is given a Substitute Handbook as a guide.

RECOMMENDATIONS

To increase the salary per day for substitute teachers at Westside.

FINDINGS (Training & Staff Development)

The staff receive the mandatory forty (40) hours of required ACA training yearly. The Madison Parish Schools provide training throughout the year. The school participates in the Mentor Training Program. The teachers are involved in the Cadre of Teachers Training on a monthly basis. The parish is providing training on the IOWA test. Staff members are given leave time to attend professional meetings and training. The Madison Parish Schools provide the funding for requested and required training. Teachers are given stipends to encourage participation in various Title I Inservices. The majority of the teachers at Westside Alternative High School are enrolled in course courses on the graduate level.

RECOMMENDATIONS

To research training with reference to teaching children in a correctional setting. To make this training available to the staff.

ACCOUNTABILITY

Westside Alternative High School participates in the Personnel Evaluation

Program set forth by the BESE. New teachers receive training on the evaluation procedures and instrument. These teachers are evaluated twice per year by three assessors. The other teachers are assessed twice per year by an internal and external assessors. The supervisors of various departments evaluate their employees yearly.

RECOMMENDATIONS

NONE

ATTACHMENT 3

DEPARTMENT OF
PUBLIC SAFETY & CORRECTIONS

L.J. "MIKE" FOSTER, JR., GOVERNOR



RICHARD L. STALDER, SECRETARY

January 30, 1996

TO: Richard M. Thompson, Assistant Secretary
Office of Youth Development

FROM: Committee on Physical Space and School Maintenance
Victor Cooper, Chairman *VC*

RE: Contract Agreements for LEARN for the 21st Century
Grant

Attached is a report on the findings of the Committee on Physical Space and School Maintenance.

Members of the Committee are:

Andrew Claxton, Assistant Principal--TCCY
Victor Cooper, Assistant Principal--SCCY
Jesse Taylor, Assistant Principal--JCCY
Charles Wayne, Principal--LTI-Bridge City

VC/bp

Attachments

As a result of Louisiana LEARN for the 21st Century Grant for 1996-1997, changes to the educational services at the correctional centers for youth were recommended. The need for effective change and improved operations was established.

Mr. Cooper, Mr. Claxton, Mr. Taylor, and Mr. Wayne were chosen to work on the committee for Physical Space and School Maintenance. One of the primary reasons cited last year for not having a full-day program is the lack of adequate physical space. Offenders attend school in shifts as there is not adequate physical space to house all students in the classrooms at the same time. In reference to School Maintenance, there is no formal plan for physical (janitorial) maintenance of the classrooms and school buildings. The physical plants as they now exist were viewed and plans recommended for better utilization of existing space; renovations for better utilization of existing space; and construction of new space. Furthermore, a formal School Maintenance Plan and policy for janitorial services for the classrooms will be recommended.

TALLULAH CORRECTIONAL CENTER FOR YOUTH

A site visit to Tallulah Correctional Center for Youth on December 9, 1997, yielded the following observations, results, and recommendations:

Physical Space: TCCY has a severe space problem with a 25:1 pupil/teacher ratio. It has two different school campuses

Phase I: There is approximately 250 students with twelve (12) classrooms. The classrooms are approximately 24' X 18'. There is one student bathroom with three (3) toilets, three (3) urinals, and three (3) sinks

Phase II: There is approximately 81 students with seven (7) classrooms eventually reaching a capacity of 15:1 pupil/teacher ratio. There is also one student bathroom with five (5) toilets, five (5) urinals, and four (4) sinks. There is no Gym or Physical Education and Health instructors for the students. There is one small inadequate library in Phase I and one small inadequate library in Phase II

The Principal's office is very small. Generally speaking the entire school building including the Principal's office, the classrooms, bathrooms, and the libraries are too small to accommodate 250 students at one time

Recommendation. According to Mr. Gary Jones, Coordinator of Physical Space for the Monroe City School Board, the class size should be reduced to a 15:1 pupil/teacher ratio. Boys in age groups from 12 years of age to 20 years of age should be in 25' X 25'/25' X 30' classrooms--equivalent to 50 square feet per student. Presently, TCCY classroom space is 432 square feet, 318 square feet less than the recommendation of 750 square feet.

School Maintenance: At TCCY there is no formal plan for physical (janitorial) maintenance of the classrooms and school buildings.

Recommendations: During the school day and at the end of the school day, there should be student custodial service closely supervised by an employee (Security).

At the end of the work day, teaching staff should be sure that the classroom is clean, paper is picked up, and chalkboard is erased.

LTI--BRIDGE CITY

A site visit to LTI--Bridge City on January 14, 1998 yielded the following observations, results, and recommendations:

Physical Space: LTI--Bridge City has a severe space problem with a 22:1 pupil/teacher ratio. The school is one small congested building. Classrooms range from 14 1/2' X 20' to 20' X 27'. There is a pre-fabricated building, 18' X 53', with two teachers which houses the JSEP Lab.

In addition, the Principal's office, the secretary's office, and the sign-in/out area for the teachers is very small and congested.

The gym is large enough for the physical education activities, but there are no classrooms in the gym for Health classes.

Here again the entire school area is too small to accommodate 180 students. There is no space available for outside recreational activities.

Recommendations: The pupil/teacher ratio should be reduced to 15:1 instead of 22:1. Since LTI--Bridge City have smaller boys, those 20' X 27' classrooms can be used but the pupil/teacher ratio needs to be reduced to 15:1.

There is a huge need to build additional pre-fabricated buildings like the JSEP Lab. It should be approximately 25' X 25' (625 square feet) to accommodate the additional students in order for there to be a 15:1 pupil/teacher ratio. This is a little less than the recommended 750 square feet, but these are smaller students.

There should also be an additional building constructed either connected to or separate from the Principal's and central office.

There is a great need to build classrooms for Health--bearing in mind all the health problems and diseases in today's environment.

School Maintenance: At LTI--Bridge City there is no formal plan for physical (janitorial) maintenance of the classrooms and school buildings.

Recommendations During the school day and at the end of the school day, there should be student custodial service closely supervised by an employee (Security).

At the end of the work day, teaching staff should be sure that the classroom is clean, paper is picked up, and chalkboard is erased.

JETSON CORRECTIONAL CENTER FOR YOUTH

A site visit to Jetson Correctional Center for Youth yielded the following observations, results, and recommendations:

Physical Space: JCCY is divided into two campuses. A campus for the girls and a campus for the boys. It is divided by buildings for the Basic Skills I, Basic Skills II, and Pre-GED/GED classes. The classrooms were adequately spaced for offenders in the age group of 12 years old to 20 years old. The Basic Skills I and II building's class sizes range from 33' X 18' (594 square feet) to 25' X 18' (450 square feet), which is roughly 31' square feet below the suggested 625 square feet for this age group.

For the boys, all the classes were filled to capacity with no room for expansion. All the classrooms for the girls were filled to capacity. Three additional classrooms are needed for the girls.

The gym for the boys at Jetson is large enough for the physical education activities, but there are no rooms available for the Health classes. The gym for the girls is large enough for their physical education activities, but there are no classrooms for Health.

At Jetson, the average size classroom for the Pre-GED/GED classes is 19' X 28' (532 square feet), which is 218 square feet less than the suggested 750 square feet room for this age group of boys.

The library is too small to accommodate 161 girls in the girls' unit. The library on the open campus is too small to accommodate 464 boys.

The Principal's office, the Secretary's office, and the sign-in area for the staff has adequate space. The Assistant Principal's office is large enough to accommodate the staff and the students with disciplinary problems.

There is not enough space available for the TASE, GED, and ACT testing of the students.

The bathrooms for the boys' unit are large enough to accommodate 464 boys. The bathrooms for the girls' unit are large enough to accommodate 161 girls.

Recommendations. With 464 boys on campus and filled to capacity, Jetson is facing the possibility of increasing their pupil/teacher ratio with no extra space available. The construction of pre-fabricated buildings adjacent to the regular school would eliminate this problem. These buildings are put on a concrete slab and cannot be moved.

In reference to the gym and the library, these pre-fabricated buildings can also be used. They will provide additional space for the library and provide classrooms to teach Health. These buildings should be built in the girls' and boys' units.

School Maintenance: At Jetson there is no formal plan for physical (janitorial) maintenance of the classrooms and school buildings.

Recommendations. During the school day and at the end of the school day, there should be an organized student's custodial service closely supervised by an employee (Security). Teaching staff at the end of the work day, should make sure their classroom is clean, paper is picked up, and the chalkboard is erased.

SWANSON CORRECTIONAL CENTER FOR YOUTH

Swanson Correctional Center for Youth has two (2) campuses. An open campus, where the boys go to school all day and a closed campus where the boys go to school half day. On the open campus the room sizes range from 23' X 16' (368 square feet) to 40' X 22' (880 square feet). Overall with the different sizes of boys, there is no significant space problem with the 15:1 pupil/teacher ratio.

The open campus is divided into three (3) separate buildings. The Annex--(Basic Skills I), the Yellow Brick Building--(Assistant Principal's office, Basic Skills II, JSEP, and Special School District #1), and the Red Brick Building--(Principal's office, Secretary's office, Pre-GED/GED, Chapter 1, School Library for open campus and the Security Count Room).

The Principal's office, the Assistant Principal's office, and the Secretary's office are all very small. They are not large enough to accommodate the staff signing in/out or students coming in for counseling or disciplinary reasons.

The bathrooms, one in each building, are large enough to accommodate the boys.

The closed campus at Swanson has a severe space problem with a 18:1 pupil/teacher ratio. The classrooms range in size from 22' X 16' (352 square feet) to 21' X 32' (675 square feet). Some of the rooms range from 548 square feet to 225 square feet below the suggested 900 square feet (50 square feet per student).

In the closed campus, there is no gym or classrooms for the physical education activities and health classes. The only space available is a slab of concrete and a driveway with basketball goals attached.

The boys must go back to their dormitories for restroom breaks.

There is no Principal's or Assistant Principal's office in the closed campus.

There is a small library which is used for TABE testing and the teaching of Health classes.

There is no space available for the SSD#1 teachers to have their own classroom. These three (3) teachers serve 81 students.

There is a proposal to change the Cypress classroom to a capacity of sixteen (16) boys in the morning class. The classroom is 21' X 32' (672 square feet), which is 228 square feet less than the suggested 900 square feet for boys in this peer group. There is no covered physical education area for the boys in Cypress.

Recommendation On the open campus at SCCY, there are no major space available problems. Therefore, the Principal's office, the Assistant Principal's office, the Secretary's office, the two Guidance Counselors' offices, the teachers' lounge, and teachers' sign in/out area should all be consolidated in one area.

On the closed campus, there should be a pre-fabricated building built to house ten classrooms and a gym with rooms for Health. Then the students can go to school in one centralized area conducive to learning

Physical Maintenance: At SCCY there is a formal plan for physical (janitorial) maintenance of the classrooms and school buildings on the open campus. There is a Building Trades, Building Inspector and OJT instructor who accomplishes the physical (cleaning and janitorial) maintenance of the buildings.

However, on the closed campus, this person is not responsible for the cleaning of the classrooms on a daily basis because there is not enough time in the day

Recommendation: For the closed campus school, there should be a person (Security) responsible for the physical maintenance of the classrooms, not the buildings. The classrooms are in the dormitories with the exception of two (2) classrooms.

SUMMARY AND CONCLUSION

Physical Space

Short Range: To alleviate the shortage of space, the small classroom, and overcrowding, pre-fabricated buildings on concrete slabs should be built. These buildings should be at least 25' X 25' (625 square feet) up to 25' X 30' (750 square feet). In essence, the classroom should allow at least 50 square feet to every child in the classroom from ages 12 years to 20 years of age.

Long Range: As a result of visiting the four juvenile correctional centers, it is apparent that all the institutions have some problems (major or minor) with classroom space. The classrooms should be made more conducive to learning. Therefore, in the near future a capital outlay budget and plan should be presented to the Governor and Legislators for the construction of four (4) modern centralized schools.

The schools should be designed to implement full-scale vocational programs in welding, carpentry, auto mechanics, printing, upholstery, and computer technicians.

Physical Maintenance

At all the juvenile institutions during the day and at the end of the school day, there should be an organized students' custodial service. These students should be closely supervised by Security or a regular maintenance individual.

ATTACHMENT 4

DEPARTMENT OF
PUBLIC SAFETY & CORRECTIONS

M. J. "MIKE" FOSTER, JR., GOVERNOR



RICHARD L. STALDER, SECRETARY

May 28, 1998

TO: Richard M. Thompson, Assistant Secretary
Office of Youth Development

FROM: Perla Steele, Director
Diagnostic Services

RE: Educational Committee

Committee Members: Perla Steele, Chairperson, Jack Cole, (JCCY) Alley Williams, Howard Randall (SCCY) Robert Carpenter (LTI Bridge City) M.B. Childers and J.W. Cooks (Educational Consultants).

Sites Visited: Tallulah Correctional Center for Youth, Swanson Correctional Center for Youth, Jetson Correctional Center for Youth, and LTI Bridge City.

Topics: Vocational Plan, Student Movement/Classification Issues

This committee visited the institutions mentioned above to observe the vocational programs presently offered at the different facilities and to make proper recommendations for future vocational programs at the different institutions. This committee also addressed transfer issues and how to move the offenders through the juvenile system with the least amount of disruption.

Tallulah Correctional Center for Youth:

While at the above cited facility the committee members met with the school principal. No vocational programs are presently offered at this facility, but there is a great need for vocational services to be offered to the population presently being housed at this facility. It was noted that no space/building facilities are available to house any vocational programs at this facility; so before any programs can be developed some type of construction or renovations must be implemented.

The staff at this facility voiced an interest in developing three vocational programs appropriate for their area and interest. They mentioned Horticulture, Culinary Arts and Auto Mechanics. These are very reasonable requests as this is a primarily agricultural area.

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Swanson Correctional Center for Youth:

This facility is the only juvenile facility with the space and the vocational instructors/offender' ratio to teach the offenders some job skills. This facility has a offender's staff ratio of six to one and three hours interval of vocational instruction. At the present time SCCY is offering Carpentry/Building Trade, Welding, Printing, Upholstery, JSEP and have two Automotive/Body Shops.

The institutional staff voiced a desire to have body shops rather than an automechanic shops and to have the funds and the budget allocated to these programs as those the educational component of the institution. The offenders at this facility are assigned to the vocational programs based on educational scores so it is done in a methodic manner.

The vocational programs at most institution is like a step child to the educational programs and not its own entity. Focus needs to be placed for the vocational programs throughout the juvenile facility to be independent and autonomous and be able to truly provide the offenders with the skills they truly need in a responsible and expedient manner.

Jetson Correctional Center for Youth:

This institution for years has attempted to provide vocational services to the population assigned to this facility, but this institution is in desperate need of more space and better facilities. The building presently utilized to house the vocational training presently offered at this facility is very old and in need of major renovation. If vocational services are going to be provided to this population and new building is needed on this campus.

Another need of this institution is to hire additional vocational instructors as the offender's staff ratio at this facility is extremely high. Another change that is needed is the time allocated for such services to the offender. An hour placement/or class period is not enough time to provide the offender with the skills needed to accomplish the task in a successful manner. At this time vocational periods are assigned to the offenders as elective periods. Vocational programs need to be designed to provide the offenders with the marketable skills necessary to join the labor market and at this time such services are not being provided.

At the present time this facility offers Upholtery, Small Engine Repair, Automechanics, Horticulture, JSEP.

The staff at this facility voiced a desire to have three or four quality vocational programs to offer the population it presently serves. The staff voiced a desire for Culinary Arts, Body Shop, Small Engine Repair and Carpentry/ Building Trade. The staff also suggested that different trades be developed to address the needs of the female population. Trades mentioned for the female population are: Business Class/Computer and Clerical Training, Nurse's Aid, Seamstress, Culinary Arts.

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LTI-Bridge City:

At this time this facility does not offer any vocational programs to their existing population. This institution places emphasis in the JSEP program. It is this committee's opinion that the services presently offered to this population is sufficient. This committee proposes that the JSEP program be expanded and that no vocational programs be assigned to this facility. The committee is of the opinion that these offenders reach the age when these vocational programs need to be offer to the offender that the offenders be transferred to the facility that offers such services.

RECOMMENDATIONS:

Overall this committee is proposing that vocational programs be offered to offenders at the same level as educational services are being provided to this population. This committee is of the opinion that unless we provide this population with the marketable skills to acquire jobs once they return to the community they will recidivate. In order to accomplish these goals this committee is porposing:

- A) The establishemnt of a Vocational Department separate from the Educational Department within the Office of Youth Development with a vocational director to address vocational programs throughout the juvenile institutions and to monitor these programs on a routine basis.
- B) The assignment of Vocational Coordinators in every site.
- C) Funds need to be allotted and the budget needs to reflect and to focus on vocational issues. This committee is recommending that offenders be allowed to acquire the skills to a trade by working in the vocational program and not working for the maintenance department. If offenders are assigned to Carpentry/Building Trade they need to build structures for learning purposes, to acquire marketable skills and not to become part of maintaining the campus. The job skills needs to be offered according to the needs of the community they will be returning to and not for the benefit of the particualr institution. In order to accomplish this goal funds need to be appropriated to each juvenile facility to make this a reality.
- D) This committee is proposing that each juvenile facility be assigned different vocational programs with the exception of one or two trades duplicated in two different facilities. We want each insitution to be the best they can be with each of the trades assigned to their facilities.
- E) This committee is proposing that offenders be assessed for vocational programs and that the offenders be transferred to the institution that can best meet his vocational need and not necessarily by catchment area or close proximity to relatives.
- F) Vocational Instructors need to be certified and paid the same salaries as vocational instructors presently working for local vocational centers. We want to ensure that juivenile institution can compete and acquire good and reliable instructors.

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G) This committee is requesting that offenders receive certificates or diplomas certifying of the skills acquired or accomplished. We recommend that each juvenile institution follow the same guidelines and requirements as they are followed by local vocational programs. These offenders need to present a certificate to their future employer that demonstrate that they possess or have mastered the skills necessary to accomplish the job.

H) This committee is also proposing that a vocational learning center be built in the center of the state and that specialized vocational programs be assigned to it such as welding, electrical wiring, plumbing to name a few. We are proposing that offenders who qualified for such trades and who are within several months of discharge be given the opportunity to transfer to this facility to gain the skills in these areas. We are proposing that they be offenders who are older and more mature in order to deal with the demands of this training.

I) This committee is proposing that a vocational assessment teacher be assigned to JRDC so that each offender be provided with a vocational assessment test that will determine the vocational aptitude of each offender.

J) Money be designated to build, and to expand vocational programs at the different juvenile facilities.

STUDENT MOVEMENT/CLASSIFICATION ISSUES:

This committee is proposing that offenders educational and vocational needs be looked at little bit closer before transferring the offender to another facility. This committee is sensitive to the issue that offender must transfer due to risk to security, disciplinary concerns and violent behavior but this committee is proposing that a staffing be done on all offenders transferring to other facilities and that an individualized treatment plan be developed addressing the offender's present education and vocational needs as well as future needs for this offender. Another issue that needs to be addressed is where the offender will be transferred once the precipitating problem is addressed and the offender's behavioral issues have been successfully dealt with.

It was a pleasure serving as chairperson of this committee. It was a lot of fun but most of all it was a great experience as this was the dreamer's committee. So much needs to be done to accomplish this task and so many resources are needed to make this a reality that it seems like an impossible task. It was the opinion of all members in this committee that vocational programs throughout the juvenile facilities are desperately needed but in order to make vocational services a reality in all juvenile facilities serious lobbying will need to be done with the Legislature to acquire the necessary funds to develop and to continue to operate such programs.

If I can be of further assistance, please advise.