Dear Mr. Kilberg:

This letter sets forth our assessment of the VisionQuest program in Franklin, Pennsylvania. We have identified several significant areas of concern relating to how VisionQuest treats its charges, which we believe violate their constitutional and/or federal statutory rights. Notwithstanding these serious concerns, we also believe that there are several positive aspects to the care and treatment of residents at the VisionQuest Franklin facilities, including the significant effort to assist these juveniles with difficult psychological problems, exposing the juveniles to varied environments, and viewing the residents as youth with problems, not just intrinsically bad and deserving of punishment.

We invite you to meet with us to discuss our evaluation of VisionQuest and the remedial measures we believe would cure the problems identified. We intend to revisit the Franklin site early next year to assess whether the deficiencies outlined here continue.

I. LEGAL FRAMEWORK

A. CRIPA.

The Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq., gives the Department of Justice standing to bring actions against facilities such as VisionQuest over "rights, privileges, or immunities protected by the Constitution or laws of the United States ..." CRIPA § 3, 42 U.S.C. § 1997a (emphasis added). Hence, CRIPA authorizes suit for violation of federal statutes and regulations as well as for constitutional violations.
B. Juvenile Detainee Constitutional Rights.


2. Equal Protection. Incarcerated juveniles do not lose their rights to equal protection under the law guaranteed by the 14th Amendment simply by virtue of their incarceration. Any disparity in treatment with non-incarcerated juveniles -- such as provision of educational services -- must be rationally related to a legitimate penological interest. *Donnell C. v. Illinois State Board of Education*, 829 F. Supp. 1016 (N.D. Ill. 1993).


1. IDEA. The Individuals with Disabilities Education Act ("IDEA") (formerly, the Education of the Handicapped Act), 20 U.S.C. § 1400 et seq., was enacted to ensure that children with disabilities receive a free appropriate public education which "consists of educational instruction specially designed to meet the unique needs of the handicapped child, supported by such services as are necessary to permit the child 'to benefit' from the instruction." *Board of Education v. Rowley*, 458 U.S. 176, 188-89 (1982). The Third Circuit has interpreted *Rowley* to require that "children with disabilities [be offered] individualized education programs that provide more than a

*/ Even under the more restrictive Eighth Amendment, the constitutionality of conditions of confinement are not assessed on an item by item basis, rather, courts assess the totality of circumstances present at an institution to determine whether those conditions as a whole violate the constitution. See *Tillery v. Owans*, 907 F.2d 415, 426-27 (3d Cir. 1990) ("in determining whether conditions of confinement violate the Eighth Amendment we must look at the totality of conditions within the institution .... factors to be considered includ[ing] food, medical care, sanitation ... ventilation, bedding, furniture, education and rehabilitation programs, safety and security and staffing."); *Young v. Quinlan*, 950 F.2d 351, 359, n.20 (3d Cir. 1992) (same). /*


II. FACTUAL SUMMARY

The following factual summary was derived from the accompanying reports of our four experts, our inspections of VisionQuest, and the documents provided by VisionQuest.

A. Physical and Mental Abuse.

Since its inception 20 years ago, VisionQuest has been plagued by credible allegations of physical and mental abuse of residents. The fact that these allegations have occurred over many years at different VisionQuest facilities seems to preclude any claim that all the allegations are false or are a result of prejudice, disgruntled employees, or misunderstood policies. Unfortunately, we see evidence of a serious abuse problem at VisionQuest’s Franklin facilities.

1. Physical Abuse. According to VisionQuest’s records, at the Franklin facilities alone it has fired 13 staff for "known or suspected abuse or physical harm" in the past two years. VisionQuest conducted 147 investigations regarding alleged staff abuse, neglect or misconduct in 1992 and 1993. Some of the incidents animating these 147 abuse investigations

were allegedly severe, including, grabbing a youth's groin (alleged twice), frequent punching and hitting juveniles in the face, rendering a youth unconscious which caused him to urinate on himself and spit blood, use of chicken wing holds, and frequent use of headlocks, headbutts, and choking restraints.

A significant number of residents interviewed alleged they had been physically abused. Some said they had difficulty breathing during one or more restraints. Obviously, proper restraint technique should never result in a cut off of air. Some residents alleged they had been physically abused at times other than during a restraint, including being slammed or thrown into a wall, hit in the chest, punched in the head, elbowed in the throat, choked, head-butted in the face, and having had their hair pulled. Residents were allegedly made to stand in the cold as punishment. While we understand that juveniles can fabricate stories, we feel the allegations raised in resident interviews are essentially corroborated by VisionQuest's own documents and records.

The residents who alleged physical and mental abuse attributed a significant portion of the incidents to two staff, Cathy Clay (hair pulling, harsh restraints, choking, slamming into walls, verbal abuse and vulgarity) and Steve Powell (elbows to throat, hitting in chest, harsh restraints, punching in head, verbal abuse and vulgarity). Two other staff, Frank Fedisson and Walt Seals, were the targets of several complaints.

2. Restraints. According to VisionQuest's records, at the Franklin facilities alone 63 restraints during 1992 and 1993 resulted in physical harm, including an unconscious youth, lacerations requiring 8 and 11 sutures, a fractured ankle, a cervical spasm, two fractured noses, a dislocated arm, a fractured finger, a resident unable to move his legs, a dislocated patella, and several chipped teeth.

Resident interviews seem to corroborate the documentary record. A large number of residents said that they had difficulty breathing during one or more restraints. Several said they had almost passed out during a restraint from lack of air, and one said she had an elbow placed in her throat during a restraint. Several residents said they, or someone else, had been injured during restraints. These injuries included a seizure, a cut mouth, a cut cheek, and a bruised neck.

3. Confrontation and Mental Abuse. Despite the intent of VisionQuest leadership, the implementation of VisionQuest's explicit policy of engaging youth in intense verbal confrontations has resulted in some extremely pernicious results. Juveniles described many abuses of the confrontation process, including out of control staff using confrontation as a way of exercising their bad temper, staff egging juveniles on to provoke
a confrontation, staff using abusive and profane language before, during and after confrontations, confrontation and restraint being used over minor incidents, staff yelling for the sake of yelling, staff trying to hurt residents during restraints, and the escalation of verbal confrontations into physical encounters. Most residents reported that face-to-face screaming confrontations were daily occurrences.

VisionQuest's confrontation techniques as currently implemented can be counterproductive, and actually harm, not help, youth. Some juveniles are provoked by confrontation. Confrontations lead residents to blame those confronting them rather than teaching them to take responsibility for their own actions. If a youth has been mistreated in his or her past, repetition of that abuse may backfire. A juvenile's fragile sense of worth may be easily damaged by VisionQuest's confrontational process. Youth learn in part through modeling behavior of adults; watching staff lose self control during confrontations may teach juveniles the opposite message to that which is intended.

VisionQuest's own psychologists candidly acknowledge that (a) face-to-face confrontation is unacceptable for many residents, (b) it is acceptable only for juveniles for whom it has been determined that it will not harm them, and that no other technique will work, (c) only highly trained staff are competent to use this technique, and (d) the technique should never occur with only a single staff.

B. Environmental Issues.

1. Sleeping Arrangements. Tipis are crowded, uncomfortable, and have unhygienic conditions in which people cough and breath on each other in a very confined space. Residents sleep on wooden floors in sleeping bags without padding, in violation of VisionQuest's own policies. Air temperatures vary widely depending on where they are measured. VisionQuest's 22 foot diameter tipis have a floor space of about 380 square feet of encumbered space.

2. Sewage and Water. The Big Lodge sewage system has ongoing serious problems, jeopardizing resident and staff health. There is a lack of handwashing facilities near the unacceptably dirty portable toilets. The Pennsylvania Department of Environmental Resources ("DER") December 1992 inspection of the Silver Valley sanitation system noted several operational problems. Although VisionQuest management stated that the Silver Valley sewage problems had been cured, an inspection of the site revealed serious problems, including a significant leak from one septic tank.
3. **Food Service.** VisionQuest's food services are deficient. Food temperatures are dangerously low. There is no cough or sneeze protection for food. Food containers violate health codes. Evidence of rodent infestation was found in food storage area for Old Elk Lodge. Silver Valley food service fails far short of food service standards for a variety of reasons. Despite VisionQuest’s assertion that it would produce DER food service inspection reports, evidently none were provided. The lack of supervision and oversight of VisionQuest’s food services, and the lack of adequate food service policies and procedures puts residents and staff at risk of food borne illness.

C. **Treatment Plans.**

In general, VisionQuest’s treatment plans for residents are rote and boilerplate. Treatment plans tied rigidly into VisionQuest’s typical “issues” ignore specific, individual needs. Many residents fail to understand their treatment plan goals. Nevertheless, one of VisionQuest’s strengths is its practice of constantly reminding residents of their goals and the behaviors they have agreed to change. This practice should replace confrontations.

Quests are not sufficiently needs-based and individualized, and quest goals are not sufficiently meaningful. The steps necessary to achieve a quest are not adequately defined. Several of the female residents believe that they receive fewer quest opportunities than do the males.

D. **Education.**

1. **Special Education.** We received contradictory information about the extent of VisionQuest’s special educational services. Supervisory staff said him that about 10% of residents receive such services. However, VisionQuest’s lone special education teacher reported that at any one time an average of three students are enrolled in special education programs, and that at the time of our visit not a single resident was receiving special education assistance. Several students who had received special education services prior to incarceration said they wanted to, but did not, receive such services at VisionQuest.

Contrary to the assertions of a VisionQuest consultant, a sample of educational files showed that VisionQuest admits juveniles who are mentally retarded. In our review of records, we observed IQ scores of 65, 59/69, 73, 74, and 70. Through record reviews and interviews, we identified a number of residents whose achievement levels were extremely minimal, sometimes as low as second grade. In sum, there can be no dispute that many VisionQuest residents are academically deficient, some seriously so, and that they are receiving
Inadequate special educational services. In sum, VisionQuest's special educational services are inadequate and do not meet IDEA or Section 504 requirements.

2. General Education. Several serious deficiencies exist in VisionQuest's general educational program. Students' education goals set forth in their individualized plan are totally inadequate. VisionQuest's supervisory staff are too inexperienced, and there is no on-site expertise for instructional programming for residents with academic and behavioral problems.

E. Miscellaneous Issues.

1. Short v. Long Term Program. We conclude in an observation relevant to some aspects of our evaluation of VisionQuest, that VisionQuest is more like a long term residential treatment program than like a short term 'Outward Bound' type program, particularly for girls. For instance, during one of our visits, 14 girls has been at VisionQuest more that 6 months, 5 had been there more than a year, and one had been there 768 days for "non-school attendance." On another visit, six girls had been at VisionQuest more than seven months, two had been there almost 300 days, three boys had been at VisionQuest more than one year, two had been there more than nine months, and half had been at VisionQuest more than four months.

2. Medical Care. Several complaints about medical services came to our attention. One resident stated that he had been complaining for a month of blood in his urine, but had not seen a nurse or doctor. Another youth said that he could not get appropriate soap for African American skin. One resident reported that he could get deodorant only if he worked in the kitchen, and another said that the nurse would walk away from him when approached with a complaint.

The Department of Justice understands from conversations with its expert consultants that in a population like VisionQuest's, typically 30-40% of residents require some special educational services.

The professional standards to assess conditions of confinement vary depending on whether the facility provides short or long term care and treatment.

Statistical information VisionQuest provided the Department of Justice confirms that VisionQuest is more like a long-term treatment center than like an Outward Bound program: the average length of stay in the impact camps alone is 4.8 months.
3. COA. Several problems exist with the operation of the COA. There is no clear set of rules for what behaviors will result in placement into the COA, and there are no rules governing length of stay when youths are assigned to the COA. Several girls said that if a person in the Center of Attention asked how long she was going to be there, that staff imposed extra days simply for asking.

4. Other. Several residents said that group punishment was imposed for infractions by an individual. Several Muslims claimed they were not allowed group prayer, or prayer over their food. A couple of residents reported that they were allowed to have pillows from home, but that others were denied the opportunity to have pillows.

III. REMEDIAL MEASURES

We recommend that VisionQuest implement the following changes to its care and treatment of residents, and to the environment in which they reside.

A. Changes to Eliminate Physical and Mental Abuse.

While firing 13 staff since January 1992 for child abuse is commendable, it would be preferable to address the root cause of the problem, which in our opinion is the officially sanctioned culture of verbal and physical violence endemic to in-your-face screaming and resulting restraints. It seems relatively apparent that direct care staff become inculcated with the VisionQuest values of screaming and confrontation, and come to believe (rightly or wrongly) that their physical and mental abuse of residents is a part of that value system. To eliminate this culture of violence, we ask that VisionQuest make the following changes to its program.

1. Confrontation. Intense verbal confrontation must become the rare exception, not the rule. Residents must be presumed unfit for such techniques, unless a qualified psychologist assesses a resident’s fitness and finds both that no less intrusive method is feasible, and that the youth will not be harmed by intense verbal confrontation. Only highly trained staff should perform the technique, and it should only be used with three or more staff present. Staff use of profanity and insults must cease. Ground or floor restraints must be

\* According to VisionQuest’s own COA records, it is quite frequent for children to stay in the COA for more than two weeks, and some children stay there longer than a month.
2. **Restraints.** Use of restraint techniques which cause juveniles to choke or to suffer from lack of air must cease. Staff must be trained in proper restraint technique.

3. **Physical Abuse.** VisionQuest must create a truly independent youth advocate (the current "youth advocate" is perceived by most residents as untrustworthy, since he or she also serves as the "staff advocate"). We have attached a job description for a youth advocate used by a juvenile facility in New Jersey. VisionQuest should create one such position for its Franklin facilities, with the job duties and responsibilities as set forth in the attached description. The youth advocate should report directly to corporate headquarters, not to anyone at the Franklin site.

VisionQuest staff should receive additional training in crisis resolution other than face-to-face screaming. A quick tracking system should be developed to enable the facility to monitor effectively staff and residents who are involved in an unusual number of incidents. Identified staff should be counseled, trained or fired, and identified residents should be given appropriate treatment. VisionQuest should continue to fire staff who abuse juveniles. As to those current staff explicitly named above as possibly guilty of child abuse, VisionQuest must take immediate action to address those allegations.

VisionQuest must not impose group punishment for acts of an individual, and must not use the elements as punishment (making residents stand in the cold weather).

4. **COA.** VisionQuest must adopt ACA or other extant standards for confinement in the COA. Length of stay must be articulated in advance and youth should not be given added time for asking about their status. Youth should have their COA.

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1/ VisionQuest has already agreed to eliminate ground or floor restraints in California. See Rand Report at page 8, n.3 ("a youth who tried to back away from his confronters would be taken to the ground and held in prone restraint. The technique has been modified and only standing restraint is now used."). and at page 17 ("In the past [during a verbal confrontation], a youth who resisted or struck out at the staff would be taken to the ground and held in prone restraint. However, in response to numerous criticisms of this practice, VisionQuest revised their policy to permit only standing restraints rather than wrestling the youth to the ground.") It makes no sense for VisionQuest to agree not to use ground restraints in California, but to continue to use them in Pennsylvania.
atus regularly reviewed by the youth advocate and psychologist or other professionals at least once every three days.

B. Chances to Sleeping Arrangements.

22 foot tipis should house no more than seven persons, and 25 foot tipis no more than nine persons. All juveniles should be provided with pillows. If sleeping bags are to be used, bags must be of sufficient width at the bottom to allow all juveniles, regardless of size, to spread their legs comfortably (two bags zipped together might accomplish this). Residents should not sleep directly on the floor; they should be provided mattresses, cots, futons, or other means of elevation. VisionQuest should give serious consideration to creating barracks type housing with bunk beds, indoor toilets and showers for those residents at the Franklin facilities for more than four months. VisionQuest should regularly monitor air flow and temperature in the tipis.

C. Increased Hygienic Protection.

1. Water and Sewage. Toilets must be clean at all times. Handwashing facilities must be near the toilets. VisionQuest's sewage problems must be solved, and the public water supply at Big Lodge should be expanded and used at all sites, especially given the documented evidence of contamination of certain wells used at the facility. The Big Lodge sewer project must be completed. The malfunctioning Silver Valley septic tank must be repaired. If septic tanks are used, they must be adequately monitored and maintained by outside agency oversight. Old Elk Lodge should be relocated so that it can be connected to the proposed sewage treatment plant, rather than using septic tanks. VisionQuest must retain an outside auditor to monitor periodically sewage, waste disposal, water, and other sanitation issues.

2. Food Service. VisionQuest's food services should be monitored at least quarterly by qualified independent auditors. Using qualified help, VisionQuest's policies and procedures relating to food services must be updated, expanded, and fully implemented. Food service facilities should be renovated to include smooth and easily cleanable surfaces, adequate storage, and fixtures such as handwash basins as required by food service codes.

D. Programming and Treatment.

VisionQuest's treatment plans should be individualized to each youth's specific needs and interests, and should be written so that the youth can understand them. Communication between VisionQuest psychologists and staff must be improved. Quests should be needs-based and individualized, and quest goals should be meaningful to the resident. The steps necessary to achieve a
quest should be explicitly articulated. To conform to the policies animating the Juvenile Justice and Delinquency Prevention Act, VisionQuest should seriously consider either refusing to admit status offenders or using a classification system in which status offenders are separated from other juveniles. Services provided males and females should be equal. VisionQuest should undertake a more thorough screening process of prospective staff to weed out those with anger management problems, and should require a year’s commitment from residential staff. If a resident cannot achieve a quest within four months, the services provided that youth should be redesigned as a long-term, not a short-term program.

E. Education.

VisionQuest must acknowledge its legal obligations under the IDEA, Pennsylvania law incorporated into the IDEA, and Section 504 to provide quality special educational services to those who need them, and it must also acknowledge that many of its charges are in need of special education services. Juveniles with educational deficits should not be penalized or left out of the educational process simply to avoid being labeled as needing special attention. VisionQuest must determine the educational needs of all residents, and provide special educational services to all juveniles who need them. VisionQuest must hire a second special education teacher, a special education aide, necessary clerical support, and provide them with adequate space to work with small groups of residents. Small group remedial classes for part of the school day would better serve residents in need of special help than constant heterogeneous large group instruction.

VisionQuest should seriously consider hiring someone with the expertise and experience necessary to running a full time educational program for a school of 150-200 students, many of whom have significant behavioral and learning disabilities, in order to establish education services as a high rather than low VisionQuest priority. Meaningful and specific educational goals and objectives must be devised and implemented for each resident. VisionQuest might consider implementing a vocational program to enable students to be exposed to a range of different, realistic occupations.

F. Miscellaneous.

VisionQuest might review its policies regarding Muslim prayer at meals and in groups. African-American residents should be provided with soap that is appropriate for their skin. All juveniles should be provided deodorant as needed. Medical complaints should receive prompt attention and must never be screened by anyone other than a trained professional. VisionQuest should contemplate implementing all of the
Recommendations of the experts who assisted the Department of Justice, even if not mentioned in this summary letter.

We look forward to your response to this letter. We are available to discuss this letter, the expert reports, or any other matter at your convenience.

Sincerely,

Mark Masling
Trial Attorney
Special Litigation Section
(202) 514-6252

Enclosures