JUVENILE JUSTICE MONITORING UNIT

OFFICE OF THE ATTORNEY GENERAL

SECOND QUARTER REPORT AND FACILITY UPDATES

APRIL 1 – JUNE 30, 2009

Juvenile Justice Monitoring Unit
2nd Quarter, 2009 Report

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Overview

Most reports of the Juvenile Justice Monitoring Unit address facility-wide or systemic issues affecting youth in Department of Juvenile Services (DJS) custody. But the individual young people who live in these facilities are faceless and anonymous – signified in reports by a reference to "youth," to population counts, or to incident reports.

This report gives a human face to DJS-involved youth by profiling three youth with long-term involvement in the Maryland juvenile justice system. Their names and other identifying information have been changed and the profiles combine parts of the stories of several youth to protect their confidentiality. But these youths' stories represent those of many other youth in the system.

All of these youth have complex treatment needs, but they are very much like the youth JJMU Monitors meet every day in DJS facilities. These young people are "deep-end" youth – those who cycle in and out of juvenile detention centers and other locked institutions. They come disproportionately from poor single parent homes and have high rates of learning disabilities, mental health, and substance abuse problems.[1]

In the current environment, the outlook for these children is poor. Many will graduate to the adult criminal system. Many will continue to suffer from mental illness and substance abuse. And few will complete their educations and go on to lead productive lives.

Following the presentation of their stories, the report discusses current research-based treatment approaches for deep-end youth and makes recommendations. The goal of this report is to encourage dialogue about deep-end youth, particularly those who "cross over" the child welfare, mental health, education, and delinquency systems. We hope future conversation will lead to the development of innovative approaches to treating deep-end and cross-over youth.

Readers may also be interested in a recent New York Times article on youth with mental illness in the juvenile delinquency system, "Mentally Ill Offenders Strain Juvenile System,"(Aug.10,2009)
http://www.nytimes.com/2009/08/10/us/10juvenile.html?_r=1&scp=4&sq=delinquency&st=cse

[1] Annie E. Casey Foundation, KIDS COUNT Data Book, Essay and Data Brief (2008)

Anne

Anne[2] has been in and out of foster homes and shelters since the age of three. Her mother and father were alcohol and drug abusers, and her father physically abused her. At the age of 11, when her mother died, it was Anne who discovered her body.

Following her mother's death, Anne was again placed in foster care. Within weeks she was hospitalized for suicidal thoughts and threatening to harm her foster parents. For the last 7 years Anne has been placed in multiple group homes, hospitals, detention facilities and she has attended special schools.

Anne has been diagnosed as suffering from bipolar disorder, post-traumatic stress disorder, borderline personality disorder, and conduct disorder. Anne has also been diagnosed with attention deficit hyperactivity disorder (ADHD). Anne has an IEP and has qualified for level V schools since 2007.

Anne has been charged on at least 20 occasions since her first contact with DJS. She was found responsible on 6 of the resulting complaint petitions. Two of those complaints, for second degree assault, were based on incidents inside DJS facilities.

Throughout the past 7 years Anne has exhibited suicidal and homicidal behavior, including cutting herself, ingesting foreign objects (she tried to eat a hairbrush and pencils), and threatening to harm others. She was been expelled from several rehabilitative placements because of aggressive behavior.

Anne spent much of her time in detention. During her time in detention multiple staff reported that Anne was a serious safety risk to staff and other youth because of her unprovoked rage and the need for several staff to manage her at one time, which often left other youth unattended. Anne often needed one-on-one staff support and could not attend school or shower with other youth because of her aggressive unpredictable behavior.

She tried to alert staff when she became angry, but had difficulty controlling impulses and anger. Positive incentives did not seem to help Anne control her behavior even though staff gave her privileges such as extra time to play games and McDonald's food for lunch. She was placed on a behavior agreement plan and included in group sessions, and the psychiatrist prescribed medication to manage her anger. However, clinical services at the detention center were not intensive enough to meet her needs and she sometimes refused medication.

[2] Names and other identifying information have been changed to protect confidentiality, but this youth's story represents those of many other youth in the Maryland delinquency system.

One clinician reported that every day she spent at least half an hour one-on-one with Anne. Other girls often asked what they had to do to get the same amount of attention as Anne. Some staff reported that several code blues[3] were called each week while Anne was a resident. The numerous incidents, critical enough to call a code blue, did not include the daily struggle staff had with Anne to get her to walk down the hall, return to her living unit, or participate in activities.

Many of the incidents involved the need to restrain Anne. During restraints staff were injured. Injuries ranged from a broken arm to a broken wrist, and one staff received a black eye after being kicked in the face.

Generally Anne was remorseful following outbursts, and she did make some strides with anger management. Her improved behavior may have been influenced by increased family involvement and visits.

An Intervention Strategy Team was created to address Anne's needs. The team was made up of DJS staff and workers from other state agencies. Unfortunately, a lack of leadership compounded by miscommunication between team members led to a slow dismantling of the team. According to staff, Anne's behavior began to worsen without a plan or support from DJS.

This year Anne was waived into the adult correctional system. During her time in the adult system she exhibited similar behaviors including eating her own feces. Anne used her phone privileges to call the detention center to speak with staff. Staff indicate that the center was like a "home" to her. She is on a waiting list to be admitted to the Patuxent Mental Health Correctional Facility.

[3] A code blue occurs when staff feel the situation is unmanageable and need assistance from additional staff.

Mary

Mary[4] is a seventeen year old girl. She is tall and attractive, intelligent, and articulate. She has a sophisticated understanding of the systems with which she has been involved since she was a young child. Her documentary history indicates underlying emotional and mental health issues that appear to be the basis for her continued involvement with the juvenile delinquency courts and agencies.

Mary's mother died when Mary was eight years old. Some records indicate that her mother died of HIV,[5] and that Mary was exposed to both drugs and alcohol *in utero*. Following her mother's death, Mary was placed in the custody of a family friend. She was sexually abused beginning at the age of 9 and raped when she was 11.

Mary started to run away, drink alcohol and smoke marijuana. Mary first became involved with the juvenile justice system shortly after the death of the man Mary believed to be her father. She was arrested following an emotional outburst at school during which she time she began throwing desks, destroying school equipment, and threatening her teacher with a hammer. At the time Mary reported that she was very upset and just started breaking things up.[6]

At DJS intake, Mary was released on community detention. She violated the terms of her release by failing to abide by the curfew requirements of community detention. In March, 2006, she was placed in secure detention for the first time. Mary was found to have committed a 2nd degree assault by threatening her teacher with the hammer. This remains the only offense for which Mary was found to be responsible.

Since 2006, Mary has spent 400 days in secure detention and one year in a psychiatric residential treatment center. Her behavior has deteriorated over the three years she has been under the supervision of the Department of Juvenile Services (DJS). Since entering DJS custody, Mary has been arrested 21 times. She has been charged with assault 13 times; malicious destruction 6 times and escape twice. She has not been found guilty of these charges.

Mary has made many suicide attempts since her first incarceration period. DJS records reveal that she tried to poison herself, cut herself with broken light bulbs, and tried to hang herself several times. She has gone AWOL from every placement that

[4] Names and other identifying information have been changed to protect confidentiality, but this youth's story represents those of many other youth in the Maryland delinquency system.

[5] Documents are primarily the result of self-report and interview. There are no definitive records available regarding the cause of the mother's death.

[6] A review of the documentary history reveals that over time this incident came to be described as an assault on a teacher with a hammer as well as destruction of property. There is no evidence in the original documents that Mary ever struck or attempted to strike the teacher with a hammer. It should also be noted that this incident happened shortly after the death of Mary's assumed father.

was not locked down. Recently Mary disclosed to her case manager that she "never really wanted to kill herself, she just wanted to go home."

Over the last few years Mary has been diagnosed with mood disorder, bipolar disorder, conduct disorder, personality disorder, post traumatic stress disorder, depression, attachment disorder, and bereavement. She has been prescribed, at various times, Geodon, Depakote, Seroquel, Zoloft, Prozac, Risperadol, Sertraline, Haldol, and Thorazine.

During one stay in detention, Mary threatened staff and fought with little or no provocation. She frequently required one-on-one staff supervision. She placed a sheet around her neck and told a staffer she was going to kill herself. Mary was sent to a psychiatric residential treatment center.

Mary was at the RTC for almost a year. She never stabilized there and ran away while on a home pass. Mary said she ran away because she was sad all the time and had been there for too long. She also said she ran away because she was overmedicated and felt "doped up" while she was at the RTC.

DJS tried to get her back into the RTC or find another placement for her, possibly out-of-state. Meanwhile, Mary tried to scale the fence at the detention center.

Following her attempted escape, DJS recommended out-of-state placement. Mary was eventually accepted into a residential treatment program in Phoenix, Arizona. She left Maryland but she didn't make it all the way to her placement.

During an overnight stay at an airport hotel in Dallas, Mary escaped from DJS custody. Eleven days later, she was arrested and charged as an adult with providing a false identity. A Texas court sentenced Mary to time served. She was admitted to placement in Arizona on May 12, 2009. It is not known when she may be released from placement.

Trevor

Trevor[7] is a 16 year old male. His teenage parents never married. His mother has been involved in numerous abusive relationships with male partners, frequently moving with Trevor in tow. Substance abuse and mental illness are pervasive in Trevor's biological family. Trevor's life has been characterized by chaos, abuse, and abandonment.

Trevor's full scale IQ is 72. He has been assessed with borderline intellectual functioning, and attention-deficit hyperactivity disorder (ADHD), bipolar disorder, conduct disorder (adolescent onset type), and poly-substance abuse.

Mental illness is common in Trevor's family. His sister was diagnosed with bipolar disorder; other close relatives have been diagnosed with ADHD and psychosis. Trevor's behavior was problematic even as a younger child, but escalated when he was 10 years old. He came and went from home at will. He also began getting into trouble for fighting at the various schools he attended. He started using alcohol and marijuana by age 11. Later he explored prescription drugs and cocaine. Trevor has a history of lighting small fires at home and running away from home.

By age 14, Trevor was smoking marijuana daily and reportedly drinking up to six beers a day. He was experiencing blackouts. Following one arrest, Trevor was referred and voluntarily admitted to a residential program focused on alcohol and drug abuse treatment. He was discharged unsuccessfully due to his non-compliance and unwillingness to participate in treatment. He returned home but did not return to school.

Over the next two years, Trevor was charged with robbery, burglary, possession of a deadly weapon on school property, numerous assaults, and illegal possession and distribution of drugs. During that time Trevor spent 250 days in community detention, 40 days in shelter care, and 275 in a secure detention center. He participated in and failed several intensive outpatient programs.

Following another arrest for robbery, Trevor was committed to DJS for residential placement. Trevor was denied readmission to the alcohol and drug treatment center due to his previous behavior but was accepted into a DJS residential program.

While seeming to make an initial adjustment, Trevor soon became a threat to safety and security. He had conflicts with other youth and was moved to another residential program. At his second residential placement, he was non-compliant with taking his medications. He admitted that he had been "cheeking" medication, saving

[7] Names and other identifying information have been changed to protect confidentiality, but this youth's story represents those of many other youth in the Maryland delinquency system.

them to take all at one time to get high, and seeking meds from other youth. Trevor was taken off all medications.

Trevor ran away from the program and then was moved to a secure committed program where he continued to fight with other youth.

Earlier this year, Trevor participated in a large group disturbance, allegedly assaulted staff members and escaped from the facility. Trevor is now in secure detention awaiting another placement.

DISCUSSION

The stories of Anne, Mary, and Trevor illustrate a number of truths about youth in the deep end of the juvenile justice system:

1. Many youth deeply involved in the juvenile system are "cross-over" children.

Most literature defines "cross-over" youth as those involved in both the delinquency and child welfare (abuse and neglect) systems. Research has consistently linked childhood abuse and neglect with delinquency – delinquency rates are approximately 47% greater for youth associated with at least one substantiated report of child maltreatment.[8] Abused or neglected children have higher rates of juvenile arrest and detention, higher recidivism, and poorer long-term outcomes than other delinquent youth.[9]

Anne is a cross-over youth. She entered the social services system at the age of three. Sadly, her trajectory from neglected child to adult criminal, with no appropriate treatment, could have been predicted. Mary and Trevor also come from backgrounds characterized by instability, abandonment, abuse, and tragedy.

Girls are of particular concern because it is estimated that 80-90% of girls in the juvenile delinquency system have been victims of physical, sexual, and emotional abuse. They tend to come from homes "characterized by extreme stress and chaos, (and) an alarming percentage suffer mental health conditions ranging from depression to post-traumatic stress disorder."[10]

2. Deep-end delinquent youth have disproportionate rates of mental illness and substance abuse disorders.

Anne, Mary, and Trevor have long histories of mental illness. Anne first expressed suicidal thoughts at the age of 11, and she has since been diagnosed with multiple mental health disorders. Mary has been diagnosed with eight mental health disorders. Mental illness is common in Trevor's family, and he has been diagnosed with bipolar disorder and conduct disorder in addition to ADHD.

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[8] Ryan, J. and Denise Herz, "Cross-over Youth and Juvenile Justice Processing in Los Angeles County," Administrative Office of the Courts, Center for Families, Children & the Courts, Research Update, (2008); Ryan J. and M.F. Test, "Child Maltreatment and Juvenile Delinquency: Investigating the Role of Placement and Placement Instability," 27 Children and Youth Services Review, pp. 227-249 (2005).

[9] Ibid., citing Mossis & Freundlich (2004); Halemba & Lord (2005); Ryan, in press; Wiig, Widom& Tuell (2004).

[10] Sherman, F.T., "Detention Reform and Girls: Challenges and Solutions," Pathways to Juvenile Detention Reform, Vol.13, Annie E. Casey Foundation (2005).

Anne and Mary were held for extended periods in secure juvenile detention centers because no appropriate treatment options could be found. Anne has spent in excess of a full year in secure detention, an inappropriate place for a girl with her level of serious mental illness. Her presence in the detention center placed excessive stress on staff and on a system that was not equipped to manage her needs. Staff's and youths' physical safety was threatened by her unpredictably aggressive behavior.

Recent studies find that 65-70% of youths in juvenile facilities have a diagnosable mental health disorder, and 31-45% have a substance use disorder.[11] Among girls, the rate of diagnosis of at least one mental health disorder is 81%.[12]

3. Youth with complex treatment issues cycle in and out of the same facilities and programs, often with little to no improvement.

The course of Trevor's involvement in the juvenile system is not surprising. Substance abuse and mental illness are pervasive in Trevor's biological family, and he has a history of neglect, abandonment, and substance abuse. Delinquent youth with psychiatric disorders and with histories of abuse or neglect are at an increased risk for recidivating.[13]

Trevor has been placed in numerous community-based and residential programs, including secure detention, residential drug treatment, and a secure commitment facility. So far, he has not succeeded in any program.

Over the past three years, Mary has been incarcerated in secure juvenile or psychiatric facilities more than 700 days when her only adjudicated offense is a single 2nd degree assault. She moves from one failed treatment option to detention and back again. Some of these youth, like Anne, begin to see a secure detention center as home and the staff as their only friends.

[11] Robertson, AA, Dill, Husain et al, "Prevalence of Mental Illness and Substance Abuse Disorders among Incarcerated Juvenile Offenders in Mississippi," Child Psychiatry 59:1133-1143 (2004); McClelland, GM, Elkington, Teplin et al, "Multiple Substance Use Disorders in Juvenile Detainees," Journal of the American Academy of Child and Adolescent Psychiatry, 45:1215-1224 (2004). Wasserman, Ko and McReynolds, (2004).

[12] Kowyra, Kathleen and Joseph Cocozza, National Center for Mental Health and Juvenile Justice, "Blueprint for Change: A Comprehensive Model for the identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System" (2007).

[13] Vermeiren, R., Schwab-Stone, Ruchkin et al, "Predicting Recidivism in Delinquent Adolescents from Psychological and Psychiatric Assessment," Comprehensive Psychiatry 43:142-149 (2002).

CONCLUSION

The problems faced by the children described here and their families are exceedingly difficult to treat. Few programs have been successful. Recently, however, some jurisdictions have begun to experience success with innovative programs for deep-end youth.

We know what does not work with deep-end youth. "Pushing cross-over youth deeper into the secure facilities within the juvenile justice system is unnecessary and unlikely to resolve the complex needs associated with maltreatment and juvenile offending."[14]

For example, no significant research has demonstrated the efficacy of Positive Peer Culture (PPC), which remains the programming model for all DJS-operated committed care programs for boys in the state.[15] No evidence supports the use of this program for youth with mental health or substance abuse issues or backgrounds of abuse or neglect. JJMU's 2nd Quarter, 2008 Report highlights research findings on Positive Peer Culture. http://www.oag.state.md.us/JJMU/reports/CMR_08_Q2.pdf (pp. 17-19).

In his book, Changing Lives, Delinquency Prevention as Crime Control, Peter Greenwood explains the reasons why programs that do not work continue to flourish:

> "Our…budgets are loaded with programs supported by particular constituencies for which there is little or no evidence that they accomplish their purported goals….Another factor that helps ensure replication of…programs, in spite of evidence finding limited…impacts, is that the science producing evidence of program effectiveness often goes unchallenged."[16]

The National Center for Mental Health and Juvenile Justice's recent report, "Blueprint for Change," examined ways the juvenile justice and mental health systems could work together to produce better outcomes for youth with mental illness.

The report described a number of programs across the country that are either evidence-based or employ strategies consistent with the comprehensive model proposed in the report.[17] Among the 29 programs featured were:

Boston Juvenile Court Clinic. At intake, a needs assessment is conducted for all youth. Judges then refer appropriate youth to the Juvenile Court Clinic. At the clinic

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[14] Ryan, J. and Denise Herz, supra at 7.
[15] The exception is the 20-bed William Donald Schaefer House substance abuse treatment program in Baltimore City.
[16] Greenwood, Peter W., Changing Lives: Delinquency Prevention as Crime-Control Policy (2006).
[17] For a full listing of programs, see Ibid at p. 65 et seq.

a comprehensive evaluation is performed that includes interviews with the child, parents, teachers, social workers, and therapists. Services are then provided by a multi-disciplinary team from the Clinic, to the youth wherever he may be placed, including detention, a residential facility, foster care, or at home.

Cayuga Home for Children's Multi-Dimensional Treatment Foster Care (MTFC) Program, Auburn, New York. MTFC is an alternative to group home or residential placement. Youth in the custody of the department of social services are eligible. Youth appropriate for the program include:

- Serious and chronic juvenile offenders
- Seriously emotionally disturbed youth
- Youth with an IQ in the borderline range who do not do well in congregate settings
- Youth who have been unsuccessful in other placements
- Youth who need highly structured, Individualized treatment.

MTFC host families serve as foster families for youth. Host families undergo intensive training that emphasizes behavior management methods which provide a structured and therapeutic setting. A behavior modification program is implemented within the home. Family therapy is simultaneously provided to the youth's biological family with the goal of returning the youth back home. Parents are taught to use the same structured system that is in place in the MTFC home.

Prime Time Project, King County, Washington State. This program is for high-risk youth with mental illness who are repeatedly involved in the juvenile justice system. Youth eligible for the program have at least two prior admissions to detention, must be in detention for a relatively serious offense or have a diagnosed mental health disorder. Youth in detention are referred to the program by judges, detention staff, family members, or probation staff.

Services begin in detention and follow youth as they return to the community. Service interventions usually last a year. They are based largely on multi-systemic therapy, dialectic behavior therapy and motivational enhancement therapy (MET). Case management is provided by experienced, cross-trained therapists and case managers with mental health, substance abuse, and juvenile justice backgrounds.

Maryland is beginning to develop community based programs for deep-end youth. But addressing the needs of Maryland's most challenged children should not be solely DJS' responsibility. State agencies such as the Department of Health and Mental Hygiene (DHMH), Department of Human Resources (DHR), and the Maryland State Department of Education (MSDE) should share information and resources to help ensure that appropriate thoughtful decisions are made concerning each child.

The National Center for Mental Health and Juvenile Justice "Blueprint" report commented on the difficulty of collaborating across agencies to provide effective intervention for cross-over youth:

> "Despite the large numbers of youth with mental health needs in the juvenile justice system, the current landscape of service delivery for these youth is often fragmented, inconsistent, and operating without the benefit of a clear set of guidelines specifying responsibility for the population….(N)o one system bears sole responsibility for caring for these youth." [18]

A small number of pilot programs for Maryland's deep-end youth are in place, and if they continue to show positive results, they should be rapidly expanded. Despite poor economic conditions, programs that work are solid investments. It costs approximately $200/day to care for a youth in residential placement. The youth profiled in this report have cost the state $200,000 or more with no apparent improvement.

"Wraparound" programs exist in Baltimore City, and Montgomery, St. Mary's and Wicomico Counties. These programs serve families with youth at risk of out-of-home placement and focus on preventing youth from reoffending.

The wraparound process is collaborative. Teams of individuals, including the caregiver, service providers and an agency representative, develop an individualized treatment plan for the youth and her family. They implement the plan over a set period of time. A facilitator oversees the team. Fidelity of the services to the wraparound model is measured. Seventy youth statewide are currently receiving wraparound services.[19]

Multisystemic Treatment Foster Care (MTFC) targets chronic offenders with severe risk of residential placement in psychiatric institutions or committed care programs. Although the Department intends to use MTFC as one of its evidence-based programs, no programs are operational yet. Maryland does offer Treatment Foster Care, like MTFC but a traditional foster care-based model. The Department of Human Resources licenses a number of Treatment Foster Care programs, but it is unknown yet clear whether or how many DJS youth may be placed in these programs.

Preliminary efforts to enhance collaboration have been made through the year-long Georgetown University Center for Juvenile Justice Reform's Breakthrough Series. This program brings together judges, child welfare workers, and agency personnel to develop ways to enhance collaboration and information sharing. This program focuses on bringing together top level personnel and managers.

But it is also essential that DJS, DHR and DHMH work from the ground up with community providers to develop capacity to address challenging, vulnerable youth in

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[18] Kowyra, Kathleen, supra at p. 15.

[19] Department of Juvenile Services Gap Analysis Addendum, http://djs.state.md.us/pdf/gap/gap_analysis2009.pdf (2009).

specialized settings that offer expert, individualized care. Such facilities should be established and funded and outcomes should be measured.

Mount Clare House group home in Baltimore City was a model for such an approach. Unfortunately, it was closed on March 31, 2009 because the building in which the program was housed needed expensive repairs.

Mount Clare served youth with complex treatment needs who had been unsuccessful in other residential programs. The program was well known for taking the most difficult "cross-over" youth in the system. Mount Clare was a 12-bed facility with four beds for DHR, four beds for DHMH and four beds for DJS. Caseworkers worked with each other and the providers to be sure that the most appropriate youngsters were placed in each of the beds regardless of label. The downtown location made it possible to work closely with families. The program was a vital last opportunity to avoid placing youth in more restrictive settings. Mount Clare offered expert intervention in a homelike environment in downtown Baltimore City. Youth stayed in the program from nine months to one year. Some youth stayed until they were 21 years old.

Throughout its 20-year history, Mount Clare was a model of interagency collaboration and service integration. Staff members averaged almost 20 years of experience working with challenged youth. In 2008, four Mount Clare residents completed high school and two went on to college. Another youth successfully transitioned into independent living.

The Maryland Model for juvenile services purports to develop small home-like facilities, like Mount Clare, with highly trained staff located close to youths' homes and communities. It is hard to understand why, in the past 2 ½ years, the only new programs opened or licensed by DJS are Victor Cullen, a 48-bed institution in a rural setting in western Maryland, far from most youth's communities, and the newly-licensed Rite of Passage/Silver Oak in Carroll County, another institutional program in a rural setting. Rite of Passage has been granted an initial license for 48 beds, but the physical plant has 175 beds, and the company has repeatedly said it plans to grow.

Despite the many millions of dollars spent to open these programs and to continue to operate them, there is no evidence that either of these programs will be successful in the rehabilitation of delinquent youth.

Mount Clare was one example of what the Maryland Model envisions, particularly for deep-end youth – a small home with experienced staff within youths' communities. Decision-makers should re-examine the closing of Mt. Clare. Perhaps the program could be re-opened at another site and the model expanded to other sites. Even more important, decision-makers must re-examine continued financial support for placement of youth in institutional settings for "treatment" without evidence of the success of the model.

Juvenile Justice Monitoring Unit
2nd Quarter, 2009 Report

FACILITY UPDATES

Because this Quarterly Report focused on systemic issues, individual facility updates are brief. Only issues of imminent concern are reported. The 3rd Quarter Report will include full reports on each of the 25 facilities that JJMU monitors.

No updates are included for some facilities monitored by the Unit. This means that no critical reporting issues were identified for this Quarter.

ALFRED D. NOYES CHILDREN'S CENTER

According to Department of Juvenile Services' (DJS) State Stat information, Noyes can accommodate up to 57 youth. Overpopulation is an area of concern at Noyes during the 2nd quarter. Girls are now housed in two Units at Noyes because of the extraordinarily high population. This has led to overcrowding in the two remaining Units in which the boys are housed. All of the boy's rooms must sleep at least two youths, and youths sleep on the floor in the common area of the Units in "boats"[20] every night.

	June 30 2008	March 31 2009	June 30 2009[21]
Total Population	60	50	62
Girls	10	16	23
Boys	50	34	39

Over the last year, the Administration at Noyes has confronted a variety of fire safety issues.[22] At the end of the 2nd quarter, all issues have been addressed. All alarm systems have been tested and found to be in compliance. Still awaiting correction are the issues of the installation of a fire alarm in the boiler room and placement of access keys in appropriate locations for Fire Department entry in case of an emergency. Efforts are underway to make these corrections.

The Administration must also comply with requirements for fire drills, including fire drills on the third shift.

[20] "Boats" are molded plastic shells that hold a bunk size mattress.
[21] DJS Assist Data Base population statistics.
[22] See DJS Office of Quality Assurance and Accountability Comprehensive Quality Review Report November 12, 2008.

BALTIMORE CITY JUVENILE JUSTICE CENTER

The BCJJC population exceeded the facility's capacity of 120 beds on 25 of the 91 days in the 2nd quarter.

2nd Quarter 2009

Population Summary April 1- June 30, 2009

	Capacity	High	Low	Average	# of Days Exceeding Capacity
2nd Quarter, 2009	120	136	94	115	25
April	120	136	98	114	5
May	120	128	112	117	8
June	120	126	94	115	12

BCJJC continues to be plagued with a variety of security concerns. Video review reveals that youth often roam freely on the pods without staff supervision. They can be seen entering and leaving case manager's offices at will. Staff leaves their posts without permission. For example, during the quarter one youth was left alone in a case manager's office for thirteen minutes without supervision before an officer realized he was attempting suicide within the office.[23]

Contraband is also a problem. On May 4, an unsupervised youth took a pair of scissors from a medical exam room. The youth hid the scissors in his waistband and used them in an altercation the next day. Fortunately only minor injuries resulted from this altercation.[24]

Use of restraints is high and often includes the use of mechanical restraints. When a youth is restrained, insufficient attention is paid to controlling the other youth who are present. Video reveals that some youth have been placed in locked cells while in handcuffs and not properly supervised.

Utility closets are left unlocked giving youth access to cleaning materials and supplies including mops and brooms. On May 4, a youth was placed on suicide Watch Level III after entering a utility closet and threatening to drink cleaning solution.[25]

The last fire safety inspection was performed by the Fire Marshal in March, 2009 and no critical findings were noted.

[23] DJS Incident Report 74001
[24] DJS Incident Report 73385
[25] DJS Incident Report 73290

Fire alarm system inspections are also required on a quarterly and annual basis and are performed by a contractor. When the Monitor requested documentation of the 2008 annual fire alarm inspection, it was discovered that no inspection had occurred. An annual fire alarm inspection was then completed on July 8 (for 2009), and no major findings were noted.

Quarterly inspections include spot checks of the alarm system such as smoke detectors, heat detectors, or sprinklers. A review of the last two years' records showed that there were system failures, primarily smoke detectors, in the August, 2007 quarterly test. No records of subsequent repairs or of a January, 2008 quarterly test were provided to the Monitor's Office, but DJS said that the repairs had been completed and that the system was retested at that time.

In April, 2008, a quarterly test was conducted and the systems tested were in good working order. It does not appear that any quarterly inspections were performed by the contractor between April, 2008 and the annual inspection in July, 2009.

In late June, the DJS Medical Director reported that there were three confirmed cases of youth who contracted the swine flu virus. There were also eighteen "symptomatic" cases that were not confirmed. These youth were treated with anti-viral medication and were not sent out to the hospital.

The Baltimore City Health Department epidemiologist said the 18 youths who were considered "symptomatic" likely also had the swine flu based on their symptoms. It was only necessary to test a sample of the youths for the H1N1 virus in order to determine the organism and treat it. The epidemiologist also said some staff members had H1N1 symptoms, but that a meeting was held to create for internal monitoring of staff members' illness to ensure appropriate measures were taken.

The DJS Medical Director said that the Department has a pandemic flu plan, and that the following measures were taken to control the outbreak:

1. New youth were not admitted to the facility; they were sent to Hickey.
2. Gloves, masks, and hand sanitizers were distributed throughout the facility.
3. Anti-viral medications were provided to all symptomatic youth and staff.
4. Anti-viral medications were offered on a prophylactic basis to staff, teachers, and youth.

The last case of likely H1N1 flu occurred on June 26, approximately 10 days after the initial outbreak, when a student became ill. He was placed in the infirmary.

CHARLES H. HICKEY SCHOOL

The current capacity for Charles Hickey Jr. School is 109. The facility has expanded from three 24 bed units to 4 units capable of sleeping 26, 25, 35 and 23 youth respectively in single bed rooms. Included in those numbers are the 23 beds in the intake/orientation unit and the 8 beds in the infirmary. Population has increased approximately 20% at the facility from a quarterly average of 70 youth in the first quarter to 86 this quarter.

The facility has also seen a relative increase in aggressive incidents. Youth on youth assaults rose 20% from 41 to 52. Physical restraints rose 20% from 44 to 55. Allegations of physical abuse tripled, from 2 during last quarter to 6 this quarter.

The Maryland State Department of Education School is located in modular trailers on the facility grounds. The school's resources and staffing were established based on a maximum of 72 youth and an average of 12 youth in each of the six classes held throughout the day. The school population has reached 15 youth in each class. These numbers will become unmanageable without added personnel and resources.

In June, the facility's superintendent was transferred to the Baltimore City Juvenile Justice Center and Mark Hamlett, the former superintendent from the Waxter Children's Center was transferred to Hickey.

In the Second Quarter, the Monitor's Office sent a Special Notification Letter to DJS expressing concerns about an investigation into alleged physical child abuse at Hickey. Child Protective Services did not interview the alleged victim until one week after the incident occurred, the victim and one witness's statements were partially corroborated by physical evidence of injuries, and the police did not interview the victim in the case.[26] In response to the letter, DJS and Child Protective Services re-examined the investigation but ultimately found there was insufficient evidence to sustain the allegation.

On July 5, a youth escaped from the facility[27]. He was watching a basketball game in the west campus gym and left when the lone staff was distracted with a fight between other youth. The youth exited through a poorly secured side gate (locked but still room to get through the gates) and left the facility grounds. The youth was apprehended several days later by Baltimore City Police after he broke into a building

In 2007 two youth escaped from same gym and exited through a poorly secured gate. This office continues to recommend video surveillance of the facility and improved fencing at vulnerable points.

[26] DJS Investigation Report Number 09-73929 and JJMU Special Notification Letter dated July 9, 2009.
[27] DJS Investigation Report Number 09-75044

CHELTENHAM YOUTH FACILITY

Overpopulation at Cheltenham Youth Facility (CYF) has been a mounting problem since the last quarter of 2008. It continued to be a cause of great concern during both the first and second quarters of 2009.

DJS rates the population capacity at CYF at 115 youth. The population went as high as 151 between April 1 and June 30 of this year. The average daily population over the same period was 132 youth. The facility was above DJS' own rated capacity figure for approximately 97% of the second quarter.

CYF was already considerably over capacity during the first quarter, but the second quarter figures represent the highest youth population at the facility in recent years. When the population reached 151 in June, there was nowhere left for youth to sleep, even with the use of plastic sleeping "boats" in addition to all available fixed beds. Facility administrators had to contact DJS headquarters and request a temporary halt to youth admissions to CYF.

January	February	March	April	May	June
125	134	135	139	146	151

This table shows the highest population figure reached each month from January through June of 2009. Every month the population was above the rated capacity. The population increased steadily each month.

The increase in population was not caused by importation of youth from other jurisdictions. The increase was from the region traditionally served by the facility. Factors which appear to have contributed to the increase in population include active pursuit of old warrants by the Prince George's County Police, and a rise in the number of youth detained for minor parole violations.

DJS administrators at the facility, regional and headquarters level have been involved in a number of efforts to tackle the issue of increasing population. Alternatives to detention are being actively pursued for those youth who qualify. Documentation delays for youth waiting to leave CYF are being addressed. Contact has been made with parents and guardians reluctant to come and pick up children who can be released. A few youth have been transferred to other state facilities. The Re-Direct commitment program, which is located outside the fenced detention area at CYF, has been expanded to take additional youth and the nearby CYF shelter has also been utilized more frequently.

These measures have provided some level of relief from the surge in admissions. But the number of youth arriving at CYF continues to pose a definite challenge and the population inside the fence continues to be well above the rated capacity for the facility.

GUIDE CATONSVILLE STRUCTURED SHELTER FOR BOYS

In June 2009, GUIDE Shelter for Boys closed. According to the Department of Juvenile Services, the operating contract for the shelter was expiring, and when bids were requested, all bids received exceeded available DJS funding to meet program operating costs.

Youths who require emergency shelter are being sent to per diem residential programs, such as Aunt CC Harbor House Shelter for Boys.

KENT YOUTH GIRLS GROUP HOME - LARRABEE HOUSE

Larrabee House ceased operations on May 14, 2009. The group home for girls was located in Queen Anne's County near Chestertown. The facility was operated by Kent Youth, Inc. which also operates a group home for boys on the outskirts of Chestertown.

Larrabee House offered a comfortable, home-like environment where staff members supported, mentored and nurtured the talents of residents until the youths were ready to rejoin their communities.

The decision to close Larrabee was made by the Kent Youth Board of Directors. The Board cited budgetary necessity as the basis for the decision. The girl's home was financially subsidized by the boy's home throughout its 3 1/2 years of operation. According to Kent Youth administrators, Larrabee required 6 to 7 youth in residence to continue operating. The home would have had to consistently maintain the maximum population capacity of eight youth to become an independent going concern. These goals were not reached due to a dearth in referrals. The decision was difficult because of the success Larrabee staff demonstrated with vulnerable youth and also because of the lack of facilities on the Eastern Shore and throughout the state for girls on the brink of acute involvement with the juvenile justice system.

It is hard to understand why DJS and DHR did not offer more support to Larrabee. The program succeeded in helping challenged girls become functional members of their communities. The closing leaves both DJS and DHR without a valuable resource to help intervene for young women who may otherwise fall deeper into the state juvenile justice or welfare systems.

SYKESVILLE SHELTER

On June 30, 2009, the DJS-licensed Sykesville Shelter for Girls closed. According to the shelter's parent company, the North American Family Institute, the facility's census was low and the facility needed a lot of repairs.

According to the Department of Juvenile Services, the decision was based on the need for funding to complete necessary repairs and renovations of the facility and the implementation of Evidence Based Services (EBS) that could effectively serve youth at a lower cost.

Girls who require emergency shelter are being sent to Allegany Children's Home in Cumberland or the Graff Shelter in Hagerstown.

THOMAS J. S. WAXTER CHILDREN'S CENTER

Throughout the quarter Waxter was overpopulated and understaffed. This situation threatens the safety of both youth and staff. Waxter personnel have worked valiantly with severely limited resources to provide needed services to girls. Waxter administrators report that they have recently been given 5 additional PINS to help alleviate the staff shortage.

For a detailed summary of concerns, please refer to the attached Special Report, Appendix B.

VICTOR CULLEN CENTER

On May 27, 2009, a large group disturbance occurred at the Victor Cullen Center in which youth took control of two buildings, attacked and injured staff, and escaped from the facility. The Juvenile Justice Monitoring Unit issued a Special Report on the disturbance and escape, attached as Appendix A (including the Department of Juvenile Services Response).

The conditions surrounding this dangerous security breach raise questions about whether Victor Cullen can successfully provide programming and security for the youth housed there.

Twenty Victor Cullen staff members were interviewed following this incident. Direct care staff consistently reported that Victor Cullen has not been able to establish a safe and positive therapeutic culture in the two years since it opened. Many factors, including multiple leadership changes, an inability to hire a full complement a staff, and staff failure to understand and implement the rehabilitative model, have contributed to the difficulties.

Staff reported that many staff are inexperienced and lack clarity and expertise in crisis intervention methods, including de-escalation and physical restraint techniques. Because of this, many staff are afraid of youth and reluctant to confront negative behaviors, inappropriately giving control to youth.

On May 25, two days prior to the escape, a youth refused to open a door to allow passage and then slammed a door on a staff person's hand, amputating the end of his finger."[28] As the staff member left for the hospital, the DJS Incident Report noted that the youth "celebrated along with some of his peers."[29] The videotape of the incident showed several youth walking by the amputated finger on the floor and joking. In interviews following the incident, none of the involved youth expressed remorse.

Maryland State Police were not notified until the following day, and when a trooper took an initial report, he said no one told him the staff member's finger was actually amputated. On interviewing the injured staff member, MSP learned of the severity of the injury. The youth was charged with reckless endangerment and 2nd degree assault.

Staff interviewed said that there were no initial consequences for any of the youth involved, only serving to embolden more aggressive youth. They believed the incident exacerbated an already unstable environment, contributing to the escape two days later.

Other findings of the Special Report may be found in Appendix A. Following the escape, Victor Cullen's population was lowered from 48 to 36 and has remained at that level.

WESTERN MARYLAND CHILDREN'S CENTER

In interviews this quarter, WMCC staff continued to express confusion about policies regarding use of force. Staff said that DJS emphasizes de-escalation techniques and discourages use of force, but the guidelines for physical intervention are unclear. Staff said they had been warned their jobs could be in jeopardy if they overreact in using force, but they are unsure what behavior constitutes "overreacting."

DJS trains its staff in crisis prevention management using a curriculum provided by Jireh Consulting and Training. The Children's Cabinet has rejected Jireh training for use in privately-operated residential child care facilities, citing .substantive concerns such as the lack of trauma informed care approach in the training materials, limited material on working with youth with special needs, and limited "promotion of individualized interventions…includ(ing) the identification of triggers…"[30]

COMAR regulations do not apply to the Department of Juvenile Services – only to privately-operated programs it licenses - so the Department's choice to use the program does not violate a specific written standard. However, it does beg the question of whether the Department should use a training provider and curriculum that the Children's Cabinet has found inappropriate for use with children and youth in the State.

[28] DJS Incident Report 73777.
[29] DJS Incident Report 73777.
[30] Letter to Jireh Consulting and Training from Governor's Office for Children, May 5, 2009

Staff and administrators at WMCC also say that current training does not prepare staff to effectively control bigger and more aggressive youth, particularly if the youth is against a wall, or advancing toward another, and staff cannot get behind the youth. The training also does not address the use of handcuffs and leg shackles which are used at times with particularly aggressive youth. The lack of appropriate training has been implicated many times in restraints that resulted in injury to youth and/or staff.

Fencing inadequacy remains a concern. DJS staff and the Monitor's Office have emphasized inadequacy of fencing at WMCC for the past three years. The Department has not completed fencing upgrades, and the project was removed from the DJS budget. In its May meeting, the WMCC Advisory Board expressed concern about the fencing problem and requested a response from the DJS Secretary. According to the DJS 2nd Quarter, 2009 WMCC Monthly Report the fencing upgrade is now included in the budget.

YOUTH CENTERS

The combined population capacity of the Youth Centers has been reduced by 24 to a total of 140. In early May Savage Mountain Youth Center sent youth and staff to the Victor Cullen Academy.

As the Department focuses on keeping youth in state, the Youth Centers have been required to enroll increasing numbers of youth with histories of violence. Chief DJS staff report to the Monitor's Office that the Youth Centers accept essentially the same youth who are committed to the Victor Cullen Academy, a hardware secure facility, except those with repeated AWOL histories generally go to Victor Cullen.

Staff at the Youth Centers also raised concerns about the adequacy of crisis prevention and intervention training (see Western Maryland Children's Center update above).

APPENDIX A

MARLANA R. VALDEZ
Director

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
JUVENILE JUSTICE MONITORING UNIT

SPECIAL REPORT
VICTOR CULLEN CENTER
JULY 20, 2009

Facility: Victor Cullen Center
6000 Cullen Road
Sabillasville, MD 21780
Administrator: Mark Bishop

Reported by: Philip J. Merson, Senior Monitor
Tim Snyder, Monitor

Issue Monitored: Group Disturbance, Assaults on Staff and Escape

Persons Interviewed: Youth, Staff, Administration, Community Members, Washington County Township Police, Maryland State Police

Date of Report: July 2009

EVIDENCE

DJS Incident Report 09-73905
MSP Report 09-51-017828
Washington Township Police Report 09-1866
Video Review 6/1/09
Youth Interviews 7
Staff Interviews 20 (Including 4 administrators and 3 professional staff)
Community Interviews 14
Police Interviews 4

EXECUTIVE SUMMARY

This Special Report documents a large group disturbance at the Victor Cullen Center in which youth took control of two buildings, attacked and injured staff, and escaped from the facility. The youth were captured quickly, but staff suffered serious injuries. Several injured staff are still on medical leave more than one month after the incident.

Victor Cullen is the State's only hardware secure commitment facility for juveniles, and it should be able to provide the highest level of security for youth. However, this marks the third escape from the facility since July 2007.[31]

Our investigation raises questions about whether the facility can successfully provide programming for the broad range of youth housed there. The rehabilitative program is designed for youth who can comprehend a complex peer-oriented treatment program and who are amenable to participating in the treatment program. Yet many of the youth admitted to Victor Cullen have histories of violent crime, lack empathetic skills, or have cognitive difficulties that make them inappropriate for this type of program.

Staff interviewed following the event consistently remarked that they do not have the tools to do their jobs. They said the program continues to be short-staffed, and that too many staff lack experience working with youth. Staff also said that training in de-escalation and physical restraint techniques continues to be inadequate, and that the Victor Cullen campus is a non-therapeutic environment.

As in past escapes, many neighbors did not receive notice until youth had been returned to custody. Some information provided to the public by the Department of Juvenile Services was inaccurate, prompting staff and at least one elected official to suggest that the Department had downplayed the seriousness of the incident.[32]

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[31] Escapes of two youth on November 19, 2007 (DJS Incident Report 07-59812) and an escape of two youth
on June 16, 2008, (DJS Incident Report 08-64717).
[32] Frederick News-Post, June 9, 2009.

The Victor Cullen program continues to struggle two years after its opening. Staff and leadership change frequently, and problems tend to be addressed by disciplining or dismissing individual staff members. Six staff members were disciplined following this event.

The Department of Juvenile Services should examine systemic issues afflicting this program and engage all staff, including those on the front lines, in developing and implementing changes that will make Victor Cullen a viable and safe program.

The investigation of this event was hampered by some DJS staff who made it difficult for Monitors to gain access to evidence and to interview youth on the campus.

STATEMENT OF FACTS

On May 27 at 6:45 PM staff in Rutledge Cottage confronted a youth for staying on the telephone too long. Twenty minutes later the youth still refused to cooperate so staff disconnected the phone. The youth carried the phone from the office and assaulted a staff by elbowing him in the face.

Staff from other units responded to this assault. Their response left two cottages with only one staff each and one cottage with no staff. A video review showed that staff tried to talk with the youth but he continued to refuse to cooperate. Staff eventually attempted to physically restrain the youth in the hallway. The attempted restraint moved to the common area of the cottage and other youth observed staff trying to gain control of the youth.

Staff attempted to place mechanical restraints on the defiant youth but were unsuccessful. Other youth took the mechanical restraints and threw them down the hall. The restrained youth broke free. One staff continued to try to deal with him while the Shift Commander, staff and other youth looked on. The youth was throwing chairs and tables while staff tried to talk with him for nearly 10 minutes.

Raine Cottage is located next to Rutledge Cottage. While one of the two staff on Raine Cottage left the building to assist on Rutledge Cottage, eleven youth and one staff remained on Raine Cottage watching the incident. Several minutes later, a Raine Cottage youth attacked the lone unsuspecting staff by punching him in the side of the face, knocking him down and then hitting and stomping him. The staff was able to crawl to safety. As a result of the assault, the staff member received a broken nose, a black eye, and a head contusion. Six stitches were needed to close cuts above his eye and inside his mouth. [33]

[33] Maryland State Police Report 09-51-017828.

The staff who left Raine Cottage to assist returned to Raine to check on the injured staff. When she opened the door, several youth pushed out of the unit, ran to Rutledge Cottage and pounded on the door to get in.

While youth from Raine Cottage were gathered outside of Rutledge Cottage, the Shift Commander went into the Supervisor's office with another staff and locked the door. The mob of youth was screaming to be let in. The staff member standing at the door inside Rutledge Cottage said she feared that youth would take her keys or physically attack her and felt she had no choice but to let the youth inside. She unlocked the entrance door and allowed the Raine Cottage youth into Rutledge Cottage.

The same youth who had assaulted the staff on Raine Cottage immediately assaulted a staff member who was standing next to the door. The youth punched the staff member in the face, knocked him to the floor, and continued punching him while two other youth joined in punching other staff, stomping on staff with their feet, and hitting staff with mop handles and chairs. On Rutledge Cottage, one staff received a black eye and later required stitches to repair the eye injury. A second staff received a black eye, lacerations on his hand, and bruises. A third staff received cuts and contusions.[34]

Staff were able to leave the cottages and close the security gate to the upper campus. Staff said they feared for their lives as youth violently shook the fence, partially climbed up the fence and screamed at them. Staff went to the administration building area and when they heard that youth had breached the outer fence, they went to the entrance to the facility. They were then transported to the hospital.

At approximately 7:30 PM fourteen youth ran across the campus to the new Apprenticeship Program building. They broke into the building and removed hammers and wire cutters from the locked tool cabinet. Then they cut through the interior fence and ran across the football field to the exterior fence. The youth broke through the exterior fence and then broke into the maintenance building. Ten youth remained in the maintenance building destroying property and trying to steal several vehicles before being confronted by police at approximately 7:45 PM.

Four youth went to the railroad tracks near the facility and proceeded along the tracks for approximately 2 miles. Police from Pennsylvania observed them and a chase ensued. Police from several jurisdictions responded and apprehended the youth at approximately 8:15 PM.

Ambulance Units responded to Victor Cullen from Pennsylvania and Maryland. Six staff were taken by ambulance or drove themselves to area hospitals for treatment.

[34] Maryland State Police Report 09-51-017828.

A large number of law enforcement and rescue personnel responded to this incident, including approximately 50 police units from surrounding jurisdictions in Pennsylvania and Maryland, and five K-9 units from local and State Police in Maryland. Numerous off-duty staff from Victor Cullen and other DJS administrators responded to the facility to assist in the apprehension efforts.

Thirteen of the fourteen involved youth were transferred to juvenile detention facilities. One 18-year-old was placed in adult detention.

FINDINGS

1. Youth Admitted to Victor Cullen Are Inappropriate for the Facility's Treatment Program.

A Positive Peer Culture (PPC) rehabilitative program is used at Victor Cullen. PPC is a complex peer-oriented treatment program. Youth who participate in PPC must be able to comprehend the nuances of the program and must be amenable to treatment.

The Department has stated that youth with violent histories or adjudications for the most serious crimes would not be sent to Victor Cullen. But many of the youth admitted to Victor Cullen do have histories of violent crime.

The 14 youth who escaped had juvenile records for a variety of crimes including arson, carjacking, robbery, first and second-degree assault, assault on police officers, sex offenses, possession of controlled substance with intent to distribute, burglary, motor vehicle theft, and escape**.**

Many youth at Victor Cullen do not have the cognitive ability to successfully participate in PPC. During the investigation of this incident, the Monitor's Office examined a random sample of 15 of 32 files of youth enrolled in the program. One-third of the youth in the sample had IQ's in the range of Borderline Intellectual Functioning or Mental Retardation.[35] Youth with poor cognitive processing abilities have difficulty with the abstract nature of the Positive Peer Culture program.

It is not clear whether specific admission criteria for Victor Cullen exist. For the past six months, the Monitor's Office has requested copies of Victor Cullen admission criteria from DJS without success. The Department has not responded to JJMU's most recent written request to the Region 3 (Western Maryland) Director on June 16, 2009.

Two of the youth who behaved most violently during this incident had violent histories. The youth who began the disturbance has been involved in 25 serious

[35] Four youth had IQ's in the range of Borderline Intellectual Functioning (between 70 and 86) and one was in the Mental Retardation range (IQ below 70).

incidents since being in DJS custody. From January 1 through March 9 of 2009, he was involved in five (5) group disturbances while in detention at the Baltimore City Juvenile Justice Center. In the March 9 incident, he choked another youth while staff struggled with him.[36]

After admission to Victor Cullen, he was charged with assault on a staff member on April 9.[37]

The youth who instigated subsequent violence on Raine Cottage is a known gang member with a history of violence in DJS facilities. He broke another youth's nose in an unprovoked fight at Victor Cullen on February 6.[38]

Interviewed staff said the youth was "fronting" his way through the program waiting for an opportunity such as this to perpetuate more violence. Several weeks before the escape, approximately 30 staff signed a petition asking that administrators sanction the youth for his previous behavior. Nevertheless, he received a 72-hour home pass three days before the incident occurred.

2. Victor Cullen Has Not Established a Safe Therapeutic "Culture."

In institutional settings, culture is defined as the "values, assumptions, and beliefs that leadership and staff hold in common and ultimately define the way the institution functions." [39] In the two years since its opening, Victor Cullen has been unable to establish a positive therapeutic culture. Many factors, including multiple leadership changes, staff shortages, lack of clinical staff, and staff failure to understand the rehabilitative model, have contributed to the difficulties.

Staff interviewed following this incident said the Victor Cullen culture inappropriately gives control over to youth and actively undermines safety, security and the treatment process. Statements made to investigators by staff include:

- Staff do not have control over youth at the facility. Youth call other staff foul names and no action is taken.
- Some youth fail to comply with facility norms and do not face consequences. Some youth repeatedly fail to follow through with programming expectations but are allowed to remain in the facility.
- Staff are inconsistent in their interactions with youth because the program culture is not well-established.
- Youth are supplied with inappropriately violent and sexualized music, movies, and other media. Many inappropriate music CD's have been provided to youth by a staff member.

[36] DJS ASSIST Database; DJS Incident Reporting Database, Incident Report 71696.
[37] DJS Incident Report 72539.
[38] DJS Incident Report 70854.
[39] Corcoran, Randy, Changing Prison Culture, Corrections Today (April, 2005).

- Sometimes youth turn up inappropriate music with profanity so loud staff that cannot hear their radios. Staff do not address this because the youth will get upset.
- Staff feel unsafe because the guidelines on de-escalation and restraint are unclear.
- More structured programming is needed, particularly on the weekends. Youth spend too much time playing cards and gambling.

Youth on Youth Assaults nearly doubled between January – May, 2008 and January – May, 2009 - another indication that staff does not have the tools to create a safe environment at Victor Cullen. The population increased from an average of 34 to 44 between these time periods, an increase of 29%. Yet Youth on Youth Assaults increased from 14 to 27 (an increase of 93%).

3. Staffing Issues Continue.

In interviews, staff continue to complain about lack of training, staff shortages, and excessive overtime hours. Statements to investigators include:

- Staff need more training. Crisis Intervention Techniques and Behavior Management Plans are not taught consistently enough to ensure staff have a thorough understanding of how to deal with inappropriate behavior.
- More staff are needed, particularly during evening hours. At the time of this incident, two staff persons were trying to supervise youth in showers, monitor youth outside of showers, and provide telephone calls.
- Staff must work significant overtime both after their shift is over and before their shift begins just to transition from and to work assignments.[40]
- DJS has not dealt with the traumatic effects of this event on both staff and youth. Even the ambulance drivers were so afraid that they fled the facility. Continued debriefings in which staff are required to watch video of the incident is not helping.
- The Department minimized the extent of injuries to staff by making public statements that injuries were limited to bruises and cuts when they were more serious.
- Punishment of individual staff members (six staff members were disciplined) has worsened staff morale. The Department should examine the bigger picture at Victor Cullen and determine why these problems persist.

Youth Witnesses

Seven youth from Raine and Rutledge Cottages who did not participate in the violence and escape were interviewed. Most of the youth hid in closets or other rooms

[40] The AFSCME staff union is reportedly in negotiations with DJS to have the schedules prepared in compliance with the collective bargaining process.

during the melee. They said they felt afraid for their own lives if they tried to intervene. While some youth said they were generally fearful of some of the youth involved, they all said they felt safe with the population of youth and staff once those youth were removed from the facility.

In interviews, youth on Raine Cottage said that gang issues played some role in the disturbance. They said that the youth who assaulted staff on Raine Cottage saw what was happening to his "crew members" on Rutledge Cottage and blurted out, "I'm going to hit somebody" right before punching staff in the face. Youth said the assaulting youth grabbed the injured staff's radio and shouted into it, "You got our youth and we got your staff!"

Youth stated they needed more structured activities after school and on weekends. They said all they normally do is sit around and play cards.

4. Communication with the Public Continues to Be Inadequate.

According to the DJS website:

> *"The CityWatch Community Alert Notification System is a comprehensive solution designed to enhance communication efforts between the Department, local law enforcement, emergency management offices and targeted groups of residents, businesses, and internal staff. The purpose of the system is to quickly and reliably disseminate critical information…. In the event that there is an emergency at a facility, you will receive an automated telephone call…."*

In interviews, residents of the surrounding community said they were not notified of the escape or were notified after the youth were already in custody. According to the DJS Assistant Secretary, the Facility Administrator is the only person who can activate the community notification system. When he arrived on the scene, police would not allow him inside the administration building for safety reasons. At 8:15 PM, the Assistant Secretary contacted DJS Headquarters to activate the alert system, but by that time the escaped youth had been apprehended. The Monitor's Office received notice of a possible escape at 8:32 PM; almost twenty minutes after the last youth had been taken into custody.

One Monitor spoke to 12 local residents and business owners from the area just north of the facility. None of those interviewed heard the siren. Three of the 12 were on the CityWatch Notification System and said they were notified of the possible escape between 8:45 PM and 9:00 PM. A resident south of the facility also complained that he was not notified of the escape until the following day.[41] Most community members said they were notified through word of mouth after the incident was over.

One of those notified at 8:45 PM was the Chief of the Washington Township Police Department. He said that he contacted his station when he received the alert at

[41] Frederick News-Post, May 29, 2009.

his residence and his officers advised him they had already made apprehension and cleared the scene.

DJS Secretary Devore called a community meeting for June 8. Administrators apologized for the incident, thanked police for their quick response and promised to learn from their mistakes. DJS staff discussed steps being taken to correct problems:

- All tools were removed from the facility,
- The fence was repaired and perimeter security tightened,
- Staff would receive additional training.

The Frederick County Sheriff said that the police response went well, but he was concerned by what he saw on the video of the incident and the type of youth who were being committed to the facility. The Sheriff said he felt DJS had downplayed the seriousness of the incident.[42]

When asked to elaborate, the Sheriff said he was part of the initial meetings about reopening Victor Cullen and there was a promise that violent youth would not be committed there. He said that was not what he saw in the video. He saw violent youth who should not have been placed there.

Numerous citizens reported not hearing the alert siren.

The Maryland State Police Commander of the Frederick Barrack stated that State Troopers are highly trained with their firearms and they keep them on when they enter the facility. This is not a sound policy. Youth can assault troopers the same way they assaulted staff – then they would have access to a handgun. Police should unload and store weapons when they enter juvenile residential facilities, just as they do in adult correctional facilities.

AFTERWORD

The investigation of this event was hampered by some DJS staff. Throughout this investigation, DJS made it difficult for Monitors to gain access to evidence and to interview youth on the campus. The Monitor's Office is required by law to report on youth safety and security in DJS facilities and should not be impeded in fulfilling its statutory duties.

[42] Ibid.

RECOMMENDATIONS

Admissions

1. DJS assessment professionals should assess youth and then work with facility administrators before accepting them into the Victor Cullen program to ensure adaptability to the Positive Peer Culture program and amenability to treatment.

Programming and Culture

1. Victor Cullen's population should be reduced to youth who are amenable to the treatment program. Emphasis should be placed on creating a stable staffing complement, training staff, developing teamwork, providing consistency for youth, and improving communication.

2. PPC groups should ideally not be larger than 10 and preferably 8, especially with more difficult youth, to achieve fidelity to the PPC model.

3. Youth who repeatedly fail to follow through appropriately with the programming at the facility should be removed for the benefit of the other youth and staff.

4. Staff must be in control of the facility. Staffing numbers and quality should be appropriate for the type of youth on the cottage. More violent and aggressive youth need strong staff who have good relationships with the youth they are supervising.

5. The Department should consider designating cottages for youth with special treatment needs, including low intellectual functioning, and providing specially trained staff and programming for these cottages as it has by designating one cottage for youth with substance abuse treatment needs.

6. Youth should not have access to violent or sexualized music, movies, or reading materials or media which includes inappropriate language.

7. The use of the telephone by youth should be consistent and closely monitored.

8. The facility has the capability to simulcast movies to all cottages from the technical control building. Movies with appropriate content should be simulcast throughout the facility for youth who achieve special privileges such as "movie night."

Staffing

1. The Department must provide additional training for staff. Staff should be well-versed in proper crisis intervention techniques.

2. Staff should know when restraint of youth is appropriate. Appropriate restraint should be taught and consistently practiced.

3. Two staff are needed during shower time. If youth make phone calls at the same time as showers, a third staff is needed to monitor the calls or youth need to stay in their rooms.

4. A single staff member should never be left alone on a cottage with youth.

Safety and Security Measures

1. DJS must develop a reliable system of community notification to meet the safety needs of the public surrounding the facility.

2. Staff should have panic alarms.

3. Bedroom doors should have both manual and electronic locking devices for the safety and security of staff and youth.

4. Shoes should be collected and stored when not in use. Youth should not have access to their shoes at night or when they are a threat for escape.

Other

1. DJS should instruct law enforcement personnel to leave their firearms in their cars or provide a safe weapon lockbox outside the facility to prevent any possibility of youth gaining access to firearms inside the facility.

Maryland Department of Juvenile Services
Treating • Supporting • Protecting

July 17, 2009

DJS Response to Victor Cullen Special Report of July 2, 2009

Following an escape from Victor Cullen on May 27, all youth were safely apprehended within one hour and without further incident through the prompt response and efforts of law enforcement in coordination with Victor Cullen staff.

This response clarifies or corrects certain information in the JJMU Special Report. The response also provides information concerning how DJS maintains a high priority focus on ensuring a safe and effective treatment program for youth and a safe environment for our dedicated staff at Victor Cullen Center (VCC).

As is always the case, we are happy to discuss these and any other concerns of the JJMU and we appreciate the opportunity to respond.

Special Report: Executive Summary at pages 2-3

The JJMU asserts that their investigation was hampered by some DJS staff.[43] This assertion is absolutely incorrect. To the contrary, DJS ensures that JJMU monitors are consistently afforded very broad access to our facilities, youth and staff. The JJMU monitors had access to Victor Cullen on every day that they arrived at the facility to examine this incident, including May 28, June 1, June 2, June 9, June 11 and June 25. DJS provided JJMU with access to all of the materials that they requested, including the videotape of the incident and the written incident report. The JJMU also conducted interviews with youth and staff at Victor Cullen.

DJS cooperated with law enforcement to ensure the youth involved in the incident were first interviewed by the police as part of their investigation. A criminal case may be hampered by witnesses who have been interviewed multiple times before police speak to them. The JJMU were informed that the Maryland State Police wished to have first access to youth for investigative purposes and it was noted that the JJMU respected this request.

[43] The statutory authority of the JJMU identifies their role and function as monitors, not investigators.

The JJMU recommends that DJS examine systemic issues concerning Victor Cullen. DJS regional and central office administrators have been actively involved with Victor Cullen staff in examining the escape incident itself as well as underlying, system issues. All Victor Cullen staff are participating in regular forums to address and contribute to resolution of issues.

Special Report: Statement of Facts at page 4

According to medical documentation received by DJS and contrary to the JJMU report, no staff suffered a broken nose as a result of this incident.

The youth traveled about one mile from the facility before their apprehension by law enforcement, not two miles as reported by the JJMU.

Special Report: Findings at page 5

The JJMU indicates that youth involved in the incident had histories of "violent" offenses and provides as evidence a listing of offenses. Some of the offenses identified by the JJMU are alleged offenses, not adjudicated offenses. As the JJMU is aware, youth may be charged with offenses but are not found facts sustained (guilty) of those charges. For example, the JJMU identifies "arson" as a charge, but that charge was dismissed; the charge of "assault on police" was adjudicated as "resisting arrest" (Assault on Police is a separate and more serious offense altogether); and a "carjacking" charge was not sustained in court. A youth's juvenile record is that for which he has been found facts sustained.

Special Report: Safe Therapeutic Culture at page 6

The JJMU assert that some youth repeatedly fail to follow through with programming expectations but are allowed to remain in the facility.

Youth may struggle to comply and cooperate with program expectations as part of the process of adjustment to a new, structured placement that requires accountability and responsibility for behavior, such as Victor Cullen. As part of the therapeutic process, VCC continues to work with and provide treatment for difficult youth. These youth can demonstrate progress in the program and accomplish the goals established by the treatment team. Victor Cullen has at times determined that the program is not appropriate for a youth and has removed him from the facility. With all due consideration for the safety of youth, staff and the public, Victor Cullen does make every effort to intervene and facilitate youths' successful completion of the program.

The JJMU identifies that a youth involved in the escape was charged with staff assault after his admission to Victor Cullen. This youth was charged with staff assault – the facility focuses on youth accountability for behavior – but for clarification of the assault charge, he had thrown milk on a staff member.

The JJMU asserts that staff had signed a petition seeking sanctions for another youth involved in the escape "several weeks" before the incident. This is misleading. What actually occurred

several *months* before the escape is that staff did advocate that the youth not be advanced to a higher level in the positive peer culture program. The home pass that this youth received was not then an issue. However, a committee at Victor Cullen, including line staff, meets regularly to recommend whether youth should receive home passes, and this staff committee recommended that the youth involved in the incident *should* receive a home pass.

As to the availability and volume of music and movies at the facility, all movies are rated PG-13 or G. VCC continues to conduct random searches and confiscates any CD that is not approved for viewing by youth.

JJMU indicates that staff should receive restraint training. Victor Cullen staff is required to participate in Crisis Prevention and Management (CPM) training at least two times per year.

We agree that more structured programming would be beneficial. The facility has reduced the time students play cards and are continuing to offer creative programming including gang awareness/prevention and arts activities. A Victor Cullen staff committee is currently examining additional programming options.

The JJMU assert that the population at the facility increased from an average of 34 to 44 youth between January and May 2008 and 2009, an increase of 29% and that Youth on Youth Assaults increased from 14 to 27. DJS data indicate that the number of students in the facility at the end of each month in 2008 was as follows: January 08 - 27 youth, February 08 – 29 youth, March 08 – 30 youth, April 08- 28 youth, May 08 – 31 youth. This is an average of 29 youth in 2008 not 34.

Special Report: Staffing Issues Continue at page 7

The assertion that DJS has not addressed the traumatic effects of this incident on staff is simply incorrect. DJS arranged for an opportunity for staff to meet with a DJS staff psychologist as well as with a private mental health provider with significant juvenile detention experience, soon after this incident. Staff was also provided with an opportunity to seek assistance from the DJS Employee Assistance Program.

The JJMU asserts that discipline of staff worsens morale. Through a thorough investigative process, DJS concluded that some staff violated the DJS Standards of Conduct. DJS cannot ignore individual staff actions when security is violated and does take appropriate action, including disciplinary action as warranted. DJS also recognized staff for their excellent performance involving this incident. At the same time, the facility is working diligently with our Professional Development and Training Unit to ensure that staff needing further safety and security training receive that training.

Re: Communication with the Public at page 8

The JJMU assertion that DJS did not notify community members about the escape is erroneous.

The JJMU reports that 14 community members were interviewed about whether they were notified of the escape, and states that “residents of the surrounding community said they were not

notified of the escape or were notified after the youth were already in custody." However, the JJMU later writes that 12 persons were interviewed and later discloses that only 3 of those 12 community members were on the DJS CitiWatch Community Notification System.

DJS established and maintains a Community Notification System and broadly advertises the option for residents to complete a brief registration process to receive alerts. A total of 430 people were registered on the Victor Cullen Community Notification System at the time of the May 27 escape.

It is fortunate that law enforcement and DJS response led to quick recovery of the youth, and DJS will review the alert system to improve in any way possible the promptness of the alerts. DJS also alerts the community through sounding of a siren. At the community meeting chaired by Secretary DeVore shortly after the escape, only one community member indicated they could not hear the siren, but the strong consensus of the individuals in attendance at the meeting was that the siren was clearly audible.

The community meeting chaired by the Secretary was well attended and was an open discussion about the event and DJS' multi-layered responses to it. This open communication by the agency exactly reflects the transparency approach consistently taken by DJS.

Re: Recommendations at page 10

Admissions: Two DJS assessment professionals do assess youth and they interact regularly with VCC administrators. The Clinical Director and Superintendent have been involved on numerous occasions for appeals and special cases when applicable.

Staffing: Staff is never left alone unless an emergency situation arises. There are two staff per cottage (a 1:6 ratio), a campus supervisor, a rover staff and master control staff who monitor video surveillance; this is sufficient staff to successfully provide treatment in a safe and secure environment.

APPENDIX B

MARLANA R. VALDEZ
Director

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
JUVENILE JUSTICE MONITORING UNIT

SPECIAL REPORT
THOMAS J.S. WAXTER CHILDREN'S CENTER
JULY 20, 2009

Facility:	Thomas J.S. Waxter Children's Center 375 Red Clay Road, S.W. Laurel, MD 20724 Administrator: Johnitha McNair
Reported by:	Moira Lee, Monitor Marlana Valdez, Director
Issues Monitored:	Continuing Staff Shortages, Comingling of Committed and Detained Youth
Date of Report:	July 2009

SPECIAL REPORT

This Special Report is issued as a follow up to our Special Notification Letters on Waxter Children's Center (March 1 and June 5, 2009) and the Department's response to those letters.[44] The JJMU Monitor has continued to visit the facility regularly, and the Director visited Waxter on June 18, 2009. Conditions have not improved in the 3 ½ months since our first letter. Based on these observations, the Monitor's Office finds it necessary to issue a Special Report amplifying our concerns and renewing our recommendations as follows:

- Additional staff must be hired to provide a safe environment for youth.
- Population should be lowered.
- Co-mingling of detention and committed girls should cease.

1. Serious Staff Shortage

On the morning of our June 18 visit, the staffing shortage was severe, and we are very concerned about how the facility can continue to operate safely, both for youth and for employees, with so few staff.

- The Shift Commander had been there all night and was scheduled for a double shift.

- On the A Unit[45], the Lead RA had been there all night with 13 girls (2 girls from the B Unit slept on the A Unit), and was alone on the unit with 11 girls until a staff member came in at 9 am, a violation of staff:youth ratios. She was finally able to leave at 10:30 am.

- On the B Unit, both staff had already worked the overnight shift and had not been relieved at 10 am. We do not know if or when they may have been relieved that day.

- On the C Unit, one staff member had been alone on the unit overnight with 14 girls (3 girls from the B unit had slept in the C unit). At 9:30 am the next morning, she was still alone on the unit with 11 girls, a violation of staff:youth ratios. At that time, a trainee, who could not be left alone with the youth, arrived to help out.

[44] Attached to this Special Report.

[45] Waxter has three units. The sleeping area in the A unit consists of 14 individual cells. Girls in the committed treatment program sleep here. The B unit is for girls in pre-adjudication status (detention) and consists of 13 individual cells and a dorm sleeping area with 6 beds. The C unit is for girls awaiting placement in a committed care program, the sleeping area consists of one large room with 12 beds.

- At 9:30 am, none of the girls was in school because there were not enough staff members in the facility to transfer them to the school building - at 10:10 am, the last group of girls was finally taken to the school building.

- Girls we interviewed said they rarely get to school on time. In fact, on the day of the recent serious group disturbance, girls were still waiting in the day room at 10:00 am to be taken to school.

The staff we interviewed seemed very dedicated to the youth and to their jobs. The Shift Commander, Mr. Weathersbee, was involved in everything from janitorial work to counseling to youth transportation while we were there, and he performed these functions after already working an overnight shift. But all of the staff members we spoke with were very clearly exhausted.

We appreciate your acknowledgement of the staff shortage and that you have taken steps to transfer experienced staff to Waxter, but adding four staff to the facility is not adequate when the need is clearly much greater.

2. Co-mingling of Girls

As you know, Human Resources Article § 9-238.1(a)(6) requires that DJS serve children with programming that "uses detention and committed facilities that are *operationally separate* from each other and that *do not share common program space*, including dining halls and educational or recreational facilities." (Emphasis added.)
The persistent commingling of detention and committed youth at Waxter is in direct contravention of this statute

- When the detention (B unit) is full (as has been common recently), detention unit girls (B unit) are moved to the committed care unit (A unit) to sleep. On the evening before our visit, 2 detention (B unit) girls had slept on the committed care unit (A unit).

- The detention/pending placement girls (Unit C) must walk through the day room of the committed care unit (A unit) to reach their unit several times a day. Committed care (A unit) girls and staff we interviewed said the practice is extremely disruptive to any programming or recreation in progress. Unfortunately, the physical layout of Waxter does not provide any other access to or from the C unit.

- The committed care girls (A unit) and detention girls (C unit) share the common cafenasium. In fact, they routinely dine at the same time, albeit at separate tables.

- Detained and committed girls in the GED program attend class together.

Therefore, our concerns that youth are being co-mingled is not limited to one adjudicated youth residing with the committed program as stated in your letter of June 12.

We understand that following our June 18 visit, girls from the B unit stopped being moved to the A unit for sleeping and that the A and C units were separated for dining. If this change in procedure has occurred, it is a good start. But the program will continue to be in violation of State law until detained and committed girls are no longer attending school together and until C unit girls are no longer accessing their unit via the A unit.

We see little way this can be accomplished in the Waxter building as currently configured, and we continue to recommend that the Department move the committed girls program out of the Waxter facility altogether.

3. Overcrowding

Waxter's rated capacity is 46 girls. On June 17th there were 11 girls in Unit A, 24 in Unit B (including 5 who slept in other units), and 11 in Unit C, so the facility itself was at capacity.

But, the B/Detention Unit was actually 5 girls over capacity except during sleeping hours. According to staff, the detention unit is the most difficult to manage. A maximum of 19 girls should be admitted to this unit at any time.

To clarify, irrespective of its rated capacity, Waxter is "overpopulated" when any single unit has more girls than it has beds, even if other units have empty beds. The facility is also overcrowded when staffing is not sufficient to meet Departmental staff:youth ratios.

Finally, regardless of whether Departmentally-established staff:youth ratios are being met, we consider Waxter to be overpopulated when, given the special needs of the girls housed there, staff is unable to maintain critical facility functions. These include maintaining an ordered environment, transporting girls to school to school on time, and providing appropriate programming.

CONCLUSION

The staff we observe during our visits are doing the best they can in an exceedingly difficult situation. But the Waxter program for girls is the only program in the state that is required to operate both a detention and a committed care program out of one facility. Programmatically, that has proven nearly impossible, regardless of the talent or dedication of the staff.

Waxter staff should be able to focus on operating one program – the program for detained girls - particularly given the significant mental health needs of many of the girls housed there.

Because the committed program is small, often less than ten youth, the Department could issue a Statement of Need to interested private providers to take over the committed program at another site. There are several private programs in Maryland that would be suitable and already have established programs for girls. Or the Department could purchase a small property – even a private home – to house the committed program.

Maryland Department of Juvenile Services
Treating • Supporting • Protecting

July 17, 2009
DJS Response to Waxter Special Report of July 2, 2009

We are responding to the JJMU Special Report about the Thomas J. S. Waxter Children's Center that we received on July 2, 2009. The Special Report identified three areas of concern, and we provide information about each below. We have scheduled a meeting with you about Waxter regarding the issues that your office has identified so that we can provide and discuss any additional information or clarification that you may require.

1. Additional Staffing

The JJMU Special Report indicates that the facility is in need of additional staffing. Active recruitment for additional direct care staff positions for the Waxter facility is underway. Since January 2009, the Department has allocated nine additional full-time direct care staff positions, a half-time program coordinator position, and an assistant superintendent for the Waxter facility. The Department has also transferred experienced direct care staff to assist with youth supervision at the Waxter facility. When necessary, we do maintain ratios for youth supervision by assigning line staff to work double shifts. You indicate that on June 18, a Shift Commander at Waxter was scheduled to work a double shift. Shift Commanders, like line staff, are sometimes required to work overtime. The new direct care positions, once hired and trained, will reduce the need for staff to work double shifts.

One staff supervising 13 or 14 girls on the overnight shift, as you indicate occurred on June 18, does not mean the facility was understaffed during that shift. To the contrary, the overnight shift was in compliance with staff-to-youth ratios. The staffing ratio for overnight shifts at Waxter is 1:16. Overnight shifts in juvenile facilities nationally have a different staff-to-youth ratio than day shifts because the youth are sleeping. The 1:16 ratio overnight is within nationally accepted standards and as you know is common at many of our facilities statewide. You are correct that the 1:11 ratio that you observed on June 18 at 9:00 a.m. on one housing unit and 9:30 a.m. on another unit did not meet the daytime 1:8 ratio. We will point out that this temporary deviation from the required staffing ratio did not result in any safety or security incident.

2. Reduction of Youth Population

The Special Report recommends reducing the youth population at Waxter. The Department is in full support of maintaining the lowest possible detention and pending placement population in our facilities consistent with public safety and the Department monitors the youth population at

Waxter on a daily basis. However, as the JJMU are aware, the courts' detention orders are not something over which DJS has control. If we are ordered to detain a youth, we must do so, but we do so with procedures in place to identify and vigorously expedite appropriate alternatives to detention for youth made eligible by a judge.

3. Co-mingling of Detention and Committed Youth

As indicated in the JJMU Special Report, co-mingling is no longer an issue during the overnight hours because detained or pending placement youth are no longer sleeping on the committed unit. Preparations are underway to operate separate GED programs for detained and committed girls in the facility as well. The JJMU also reports that due to the design of the facility, pending placement youth must walk through the committed unit on their way to school, meals and other activities. The committed girls are not always on their unit when the pending placement girls are walking through. Pending placement youth are always escorted by staff when they do walk through the committed unit, which takes just a few minutes and occurs a few times each day. While you report that this limited movement through the committed unit can be disruptive, our administrators and staff have not observed disruption. However, we will follow-up and take action as warranted to avoid any disruption to youth, staff or activities.

MARLANA R. VALDEZ
Director

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
JUVENILE JUSTICE MONITORING UNIT

June 5, 2009

The Honorable Thomas V. Miller, Jr., President of the Senate
Maryland General Assembly
H107 State House
Annapolis, MD 21401

The Honorable Michael E. Busch, Speaker of the House
Maryland General Assembly
H101 State House
Annapolis, MD 21401

The Honorable Donald DeVore, Secretary
Department of Juvenile Services
One Center Plaza, 120 West Fayette Street
Baltimore, Maryland 21201

Rosemary King Johnston, Executive Director
Governor's Office for Children, Office of the Governor
301 W. Preston Street, Suite 1502
Baltimore, MD 21201

Special Notification Letter

Dear President Miller, Speaker Busch, Secretary DeVore, and Ms. Johnston:

I am writing to inform you of persistent dangerous conditions at the Thomas J. S. Waxter Children's Center (Waxter). We are obliged to immediately report such conditions under State Government Article §6-406, which requires that the Monitor "report in a timely manner…knowledge of any problem regarding the care, supervision, and treatment of children in facilities."

This is the second letter of notification[46] we have issued regarding serious safety concerns at Waxter in little more than three months. The Department of Juvenile Services did not respond to our letter of March 1, 2009 which discussed overpopulation and insufficient staffing at the facility. Conditions have worsened since that time, and this week, a serious group disturbance disrupted operations and injured staff members.

Waxter is seriously understaffed. Insufficient staffing causes two major problems: (1) staff are not able to provide programming to youth; and (2) staff are not able to maintain a safe environment. In our interviews with Waxter youth and staff, they told us that youth are kept in their rooms for extended periods of time because there are not enough staff available to supervise them. They said (and we have observed) that sometimes school is held on the living unit, or not at all, because there are not enough staff to move the youth to the school. Some youth report they do not receive recreation. In addition to these programming concerns, staff report concerns that they are not able to manage youth behavior.

On Tuesday, June 2, 2009 a group disturbance occurred on the detention unit. There were not enough staff to safely move youth to school, so at 10:30 am, the girls were on their unit waiting, prepared to attend school, for almost two hours. During the delay they were cleaning their unit.

The incident started when a youth with a history of serious mental health issues hit a staff member in the face with a broom. The staff member's nose was broken in two places. Another staff member restrained the youth, but immediately was assaulted by four other youth. These girls then proceeded to tear the staff member's clothes off. The girls then struck her while attempting to prevent her from restraining the youth. Fortunately the situation stabilized quickly and no youth were injured.

But two staff persons were taken to the hospital for treatment, and another staff went home with less serious injuries. Later, staff from Cheltenham Youth Facility were transported to Waxter to assist in coverage.

All five youth involved in this incident are reported to have mental health issues. The youth who started the incident has incited other group disturbances while at Waxter. Staff report that they believe she needs a staff member assigned to shadow her all day to maintain safety, but that they do not have sufficient staff to make that possible.

This incident occurred while there was a ratio of one staff to five girls. On two earlier daytime visits this Monitor observed a one to ten staff to youth ratio. Staff described this as a common staffing situation. The night before the incident described here there were forty-six youth at Waxter and only five staff on duty. The Department of Juvenile Services sets staff: youth ratios at different levels, depending on the conditions at facilities and needs of youth housed there. Even a ratio of one staff to five girls was obviously insufficient to protect staff in this incident.

[46] See attached letter dated March 1, 2009.

Significant overtime is required to keep even this minimum coverage. While no staff involved in this incident was working overtime that day, several had worked 16 hour days that week. During monitoring visits and interviews, staff appear to be physically exhausted. They repeatedly voice safety concerns because of the high population, insufficient numbers of staff, and excessive overtime. Procedures must be implemented immediately to assure that minimum staffing needs are met.

Recommendations

Waxter's population should be reduced. Committed and detained girls, by law[47], should not be intermingled. The legal prohibition on mixing detained and committed youth was discussed in this Office's letter of March 1. The Department of Juvenile Services did not respond and continues to intermingle the girls.

The committed program at Waxter could be removed from the facility to allow more space for detained girls. Because the committed program is small, often less than ten youth, several options are available. The Department could issue a Statement of Need to interested private providers to take over the program. There are several private programs in Maryland that would be suitable and already have established programs for girls. Or the Department could purchase a small property – even a private home – to house the committed program.

In the interim, the Department must send additional trained staff to Waxter to alleviate the current danger. I would appreciate receiving a response to this letter outlining corrective actions the Department of Juvenile Services is taking to remedy the conditions at Waxter.

Sincerely,

Marlana R. Valdez

Director

cc: The Honorable Brian Frosh, Maryland State Senate
The Honorable Robert A. Zirkin, Maryland State Senate
The Honorable Anthony Muse, Maryland State Senate
The Honorable Joseph Vallario, Maryland House of Delegates
The Honorable Anthony O'Donnell, Maryland House of Delegates
The Honorable Gerron Levi, Maryland House of Delegates
Katherine Winfree, Chief Deputy Attorney General, Office of the Attorney General
Wendy Estano, Department of Juvenile Services
Joan Dudley, Administrative Office of the Courts

[47] Maryland Human Services Article §9-238.1 (a)(6)

Maryland Department of Juvenile Services
Treating • Supporting • Protecting

June 12, 2009
DJS Response

We write in response to your June 5 letter concerning certain conditions at the Waxter Children's Center.

As noted in your letter, a group disturbance took place on June 2 at the Waxter Children's Center that involved five girls on one of the facility's housing units, resulting in injury to two staff members. Youth were not injured in the incident. Also as pointed out in your letter, the staff-to-youth ratio on the housing unit at the time of the incident was within Department guidelines; this staff to youth ratio falls well within staffing ratios in juvenile detention facilities nationally. Despite adequate staffing and preventive measures that the Department has in place, incidents involving youth assaults do sometimes regrettably occur. In those instances, the Department immediately responds and takes appropriate action, as was done in this case.

We will clarify that, contrary to the conclusion in your letter, Waxter is not "overpopulated." Waxter is experiencing a temporary surge in population, which is not uncommon in detention facilities, but the population at the time of the incident and previously has remained below the facility's rated capacity. You recommended that the Department allocate additional staff for Waxter, and we have taken steps to accomplish that through transfer of experienced staff and recruitment of new staff for the facility. On the infrequent occasion that the population exceeds rated capacity, the Department transfers youth to one of our other detention centers. The Department plans for and accommodates temporary population surges through various measures, including the use of overtime to ensure sufficient staffing and supervision of youth. We also coordinate ongoing efforts, with the juvenile courts and community-based service providers, to use alternatives to detention, consistent with public safety, such as shelter care and community detention.

It is not correct, as stated in your letter, that the night before the June 2 incident there were five line staff supervising 46 youth in the facility. There was actually seven line staff supervising a total of 45 youth that evening, which is within established staff ratios. Two additional staff were also working in the facility that evening managing intake and Master Control functions.

Your letters notes that girls at Waxter have mental health problems. The Department employs four qualified mental health clinicians at Waxter, three full-time and one half-time, including two doctoral level clinical psychologists. The Waxter mental health staff provides screening, evaluation, and individual and group counseling sessions for all the youth at the facility as appropriate to their needs.

Detention facilities, including Waxter, do house youth who display behaviors which are challenging to manage. We have had youth at Waxter on one-to-one staff supervision as needed. Decisions to place youth on one-to-one supervision are made by a multidisciplinary staffing team at the facility. The decisions of the staffing teams are appropriate to the needs of each youth and

may include such one-to-one staff supervision as well as other strategies. In addition, the mental health staff coordinate Guarded Care Plans for youth as warranted, which may include a range of individualized strategies to support pro-social youth behavior. We would encourage the JJMU to recommend to the staff who spoke to your Monitor to speak with the facility superintendent or mental health staff, and to contribute to staffing team decisions. The perspectives of all staff are important in making such decisions.
With regard to your concern about "intermingling" of detained and committed youth at Waxter, this was investigated and is limited to one adjudicated youth, who has been housed on the committed/treatment unit. The youth is pending placement to the Waxter treatment program and we expect her transition there is imminent.

In summary, the Department has responded to the temporary population surge that Waxter is experiencing, including through the use of overtime to maintain staffing ratios, and assignment of additional staff to the facility through transfer and recruitment, in order to maintain a safe environment in the facility.
We hope that this responds to your concerns and would be glad to meet with you .

MARLANA R. VALDEZ
Director

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
JUVENILE JUSTICE MONITORING UNIT

March 1, 2009

The Honorable Thomas V. Miller, Jr., President of the Senate
Maryland General Assembly
H107 State House
Annapolis, MD 21401

The Honorable Michael E. Busch, Speaker of the House
Maryland General Assembly
H101 State House
Annapolis, MD 21401

The Honorable Donald DeVore, Secretary
Department of Juvenile Services
One Center Plaza, 120 West Fayette Street
Baltimore, Maryland 21201

Rosemary King Johnston, Executive Director
Governor's Office for Children, Office of the Governor
301 W. Preston Street, Suite 1502
Baltimore, MD 21201

Special Notification Letter

Dear President Miller, Speaker Busch, Secretary DeVore, and Ms. Johnston:

I am writing to inform you of current conditions of confinement at the Thomas J. S. Waxter Children's Center ("Waxter"). We are obligated to immediately report such conditions under State Government Article §6-406, which requires that the Monitor "report in a timely manner…knowledge of any problem regarding the care, supervision, and treatment of children in facilities." The facility is seriously overcrowded. The crowding has resulted in intermingling of committed and detained youth, increased levels of violence, and unsanitary conditions.

In January, sleeping area was limited because dorms were closed[48] while their bathrooms were renovated. Between January 1st and February 24th, there were more youths than beds on 43 of 55 days. Staff reported that through January and February youths slept on the floor in "boats"[49] in the common area of the detention unit. Youths reported that when there were not enough boats to go around, they slept on the floor on mattresses.

Construction on the bathrooms was completed last weekend. The new bathroom facilities are a significant improvement over the old ones. They provide both sufficient area and a measure of privacy for the girls. Even with all dorms reopened, however, the facility continues to be overcrowded. Population will further increase when other detention centers, such as Noyes in Montgomery County and Lower Eastern Shore Children's Center, return girls they have been housing during the construction period.

Overpopulation causes three major problems:

(1) Youth are inappropriately intermingled;
(2) Incidents increase; and
(3) Physical conditions become unsanitary.

Intermingling

Population pressure requires mixing pre-adjudication (detention) and post-disposition (committed) girls for sleeping. This practice violates Maryland Human Services Article §9-238.1 (a)(6), which states in relevant part:

> *The Department shall serve children…with programming that: … uses detention and committed facilities that are operationally separate from each other and that do not share common program space, including dining halls and educational or recreational facilities.*

On February 24, eleven girls slept on the A Unit, reserved for youth in the committed care program. Six of those girls were in detention status and five were in the committed care program. Youth and staff said this practice is common. During the construction period, committed and detention girls slept together in the open dorm room on Unit C.

Increase in Incidents

[48] Waxter has three units. The sleeping area in the A unit consists of 14 individual cells. Girls in the committed treatment program sleep here. The B unit is for girls in pre-adjudication status (detention) and consists of 13 individual cells and a dorm sleeping area with 6 beds. The C unit is for girls awaiting placement in a committed care program, the sleeping area consists of one large room with 12 beds.
[49] Fiberglass sleeping 'shells" into which a mattress is inserted.

Overcrowded conditions result in an increase in incidents. In the first two months of the 4th Quarter, 2008, staff reported 39 incidents. In the same period this year, staff have reported 72 incidents, an almost 85% increase. Since last quarter, restraint use has increased by 36%.

The facility does not have enough space to separate youth to protect them from one another. Youth interviewed in the past week report that fighting occurs "all the time," or "daily." Many are worried about getting "jumped" or beaten up by other youth. While almost all youths report that staff intervene and try to protect them, there are too many to effectively control.

Staff and youth report that committed and detention youth are also intermingled during the day. Girls are locked in their rooms for hours if a fight is imminent. Sometimes youths stay in an administrative office with staff. One youth reported that she resided in an administrative office for 3 weeks and received no education or programming during that time.

Unsanitary Conditions

Finally, overcrowding leads to unsanitary physical conditions. On a visit on Saturday, February 21, the new bathroom facilities were dirty and unhygienic. Two Monitors observed bloody tissues and garbage on the floor and multiple clogged toilets.

Youths consistently report that they do not have enough underwear and no longer receive night clothes. In a recent grievance, a youth complained of being disciplined for refusing to leave her room. She would not leave her room because she had no underwear.

In the first quarter of 2007, this Office reported that youth at Waxter were not receiving underwear. The reemergence of the issue indicates that there still is no effective protocol to ensure that youth receive appropriate clothing.

Recommendations

Waxter's population should be reduced. No youth should have to sleep on the floor. Committed and detained girls should not be intermingled. Facility operating procedures must be implemented to ensure that basic custodial responsibilities are fulfilled. This includes ensuring that girls have underwear and that common areas remain clean.

To create sufficient space for detention housing, the Department should move the committed care program out of the Waxter facility. Unit A, which houses committed girls has 14 rooms, but there are rarely more than five to six girls in that program. The other rooms sit empty while Unit B, the detention Unit, is chronically overcrowded.

It is difficult for staff to manage both a detention and a committed care program in the same facility. This is the only facility in the state that provides both functions, and it is clear that this arrangement, which includes shared cafeteria and recreation space, violates State law.

Because the program is small, several options are available. First, the Department could issue a Statement of Need asking for interested private providers to take over the program. This Office monitors several private programs that would be suitable. Second, the Department could purchase a small property – even a private home – for the committed program. There must be other options that also would better serve the girls in the Department's care.

I would appreciate being updated on any plans for girls' residential programming.

Sincerely,

Marlana R. Valdez

Marlana R. Valdez
Director

Cc: The Honorable Brian Frosh, Maryland State Senate
The Honorable Joseph Vallario, Maryland House of Delegates
The Honorable Robert A. Zirkin, Maryland State Senate
Katherine Winfree, Chief Deputy Attorney General, Office of the Attorney General