



**Overcrowding in  
Department of Juvenile Services  
Detention Facilities**

**Report of the  
Juvenile Justice Monitoring Unit  
August, 2010**



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

August 9, 2010

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

Members of the State Advisory Board on Juvenile Services  
c/o Department of Juvenile Services, One Center Plaza, 120 West Fayette Street  
Baltimore, Maryland 21201

Dear Mr. President, Mr. Speaker, Sec. DeVore, Ms. Johnston, and State Advisory  
Board Members:

Enclosed please find the most recent Quarterly Report from the Juvenile Justice  
Monitoring Unit (JJMU) of the Office of the Attorney General. This report covers the  
Second Quarter of 2010, from April 1 – June 30, 2010. The Department of Juvenile  
Services (DJS) Response is also included.

I would be pleased to answer any questions you may have about this report. I can be reached by email at [mvaldez@oag.state.md.us](mailto:mvaldez@oag.state.md.us) and by phone at 410-576-6953 (o) or 301-257-5399 (c). All reports of the Juvenile Justice Monitoring Unit are also available on our website at [www.oag.state.md.us/jjmu](http://www.oag.state.md.us/jjmu).

I look forward to continuing to work with you to enhance programs and services provided to the youth of Maryland.

Respectfully submitted,

*Marlana Valdez*

Marlana R. Valdez  
Director  
Juvenile Justice Monitoring Unit

Cc: The Honorable James Brochin, Maryland State Senate  
The Honorable Joan Carter Conway, Maryland State Senate  
The Honorable Brian Frosh, Maryland State Senate  
The Honorable Nancy Jacobs, Maryland State Senate  
The Honorable Edward Kasemeyer, Maryland State Senate  
The Honorable Delores Kelly, Maryland State Senate  
The Honorable Nancy King, Maryland State Senate  
The Honorable C. Anthony Muse, Maryland State Senate  
The Honorable Robert A. Zirkin, Maryland State Senate  
The Honorable Kathleen Dumais, Maryland House of Delegates  
The Honorable Adelaide Eckardt, Maryland House of Delegates  
The Honorable Ana Sol Gutierrez, Maryland House of Delegates  
The Honorable Susan Lee, Maryland House of Delegates  
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The Honorable Anthony J. O'Donnell, Maryland House of Delegates  
The Honorable Victor Ramirez, Maryland House of Delegates  
The Honorable Luiz R.S. Simmons, Maryland House of Delegates  
The Honorable Nancy Stocksdale, Maryland House of Delegates  
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# Juvenile Justice Monitoring Unit 2nd Quarter, 2010 Report

## EXECUTIVE SUMMARY

In this quarter, the Juvenile Justice Monitoring Unit Report focuses on overcrowding in Department of Juvenile Services (DJS) secure detention facilities. The Department of Juvenile Services operates eight secure detention centers in the state. This report highlights the four largest facilities because their overcrowding issues tend to be chronic and severe:

1. Alfred D. Noyes Center – Montgomery County
2. Baltimore City Juvenile Justice Center – Baltimore City
3. Charles H. Hickey School – Baltimore County
4. Cheltenham Youth Facility – Prince Georges County

Overcrowding at DJS detention centers has been an issue for the past several summers and continues this year. This increase in detention center population is cyclic and predictable.

Overcrowding is harmful to both youth and staff in the facilities. Research shows that crowded conditions in correctional facilities increases stress and violence and strains efforts to maintain sanitation, ventilation, and basic facility operations. When DJS detention centers become overcrowded, staff must be recruited to work overtime and are forced to manage too many youth. Stress and resulting fatigue make staff less capable of dealing with emergency situations and leads to high turnover.

Serious overcrowding violates both state and national standards. State standards guarantee youth:

- An appropriate physical environment (ventilation, food, sufficient bathrooms)
- A sanitary living area
- A safe environment
- Sufficient services and basic needs (clothing, medical care, recreation)
- Sufficient staffing<sup>1</sup>

The Noyes Detention Center was above its population capacity for boys on 90% of the days of the 2<sup>nd</sup> Quarter. At its height 18 boys were forced to sleep on “boats” on the floor<sup>2</sup> in two units.

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<sup>1</sup> Maryland Standards for Juvenile Detention Facilities 5.1.5.

<sup>2</sup> A “boat” is a molded plastic form into which a mattress is inserted.

Hickey housed as many as 99 youth on one day during the quarter (capacity of 86). On one night, 12 boys slept on boats. The facility was over capacity 41% of the quarter.

Cheltenham is the most seriously overcrowded facility. With only 85 beds, its population rose to as high as 131 during the second quarter. Overflow youth were primarily assigned to two cottages and double or triple-bunked in rooms designed to hold only one youth. Two group disturbances in late June resulted, one of which sent a youth and staff member to the hospital.

On most days this quarter, the Baltimore City Juvenile Justice Center population did not exceed its rated capacity of 120 youth. However, 40 Baltimore City youth were housed in detention centers around the state and contributed to overcrowding problems at *other* facilities.

In response to overcrowding, in late June and early July, DJS successfully implemented strategies on several fronts to reduce population at the three most crowded facilities.

In Montgomery (Noyes), Baltimore (Hickey) and Prince Georges (Cheltenham) Counties, DJS Headquarters staff executed similar plans:

1. All stakeholders were contacted and were informed of concerns about overpopulation.
2. DJS worked collaboratively with stakeholders to implement strategies to reduce population, including ensuring that lower-risk youth were not detained.
3. In weekly detention review meetings (which are ongoing), greater focus was placed on youth in pending placement status, and staff developed strategies to contact vendors when waiting for an admission decision.

In addition, at Noyes, one of the two girls' units was turned over to boys. The remaining girls' unit at Noyes (with 16 beds) has been redecorated. Now there are 41 beds for boys, and boys no longer sleep on the floor. On July 14, Noyes' population was 47 – 11 girls and 36 boys, down from an average of 59 in June.

At Hickey, population was reduced from an average of 85 youth in June to 66 youth on July 14.

At Cheltenham, the Area Director led a case review for all youth held at Cheltenham, and low-risk youth were identified for alternatives to secure detention. The population there was reduced from an average of 115 youth in June to 105 youth on July 14. With an actual capacity of 85, Cheltenham remains significantly overcrowded, but the population decrease has improved staffing shortages.<sup>3</sup>

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<sup>3</sup> DJS Daily Population Reports, June, July, 2010.

The Department has also announced its intention to create a Juvenile Detention Alternatives (JDAI) structure in Prince George's County. DJS will work with the judiciary, State's Attorney, Office of the Public Defender, and others to reduce Cheltenham's population and increase the use of community-based alternatives. The initiative will build on DJS' JDAI work in Baltimore City, which is a formally-designated JDAI site.

These actions required tireless work by DJS staff who were already facing extensive challenges, including budget cutbacks. The steps taken are the right ones, and they have significantly reduced overcrowding, at least at Noyes and Hickey.

However, the Department must *anticipate* summer crowding each year, and begin implementing population reduction strategies in the late spring. Better yet, these strategies should be used year-round to ensure that no youth is held in detention who could be supervised in a less restrictive environment and that youth get to treatment placements quickly following adjudication.

*Reacting to* overcrowding that is predictable comes too late to avoid the many strains it places on staff and youth.

Detailed recommendations appear at the end of the report. They include:

1. Implement a plan to maintain population at safe levels during the summer. Use experts to set a population cap and close admissions when population reaches unsafe levels.
2. Purchase temporary housing to expand detention capacity when necessary.
3. Expand capacity by reopening Ford Hall at Hickey and moving the committed program for girls out of Waxter. Follow through on posting the RFP for a treatment program for girls.
4. Cease transferring Baltimore City youth to detention centers in other parts of the state except in special cases.
5. Reduce the time youth spend in pending placement status by implementing the intensive detention review process used successfully this summer throughout the year.
6. Significantly increase the number of community-based alternatives to detention, including evening, day, and weekend reporting centers. Focus on jurisdictions with an overcrowded detention center, including Baltimore City and Prince Georges County. Open a weekend reporting center at Cheltenham outside the security fence.

7. Reopen shelters and group homes that provided alternatives to detention and residential treatment and send more youth to small treatment programs and group homes that currently provide quality services.
8. Provide judges with alternatives to detention that will stop the use of weekend and consequence bed detention.
9. Increase treatment capacity by fully staffing Savage Mountain Youth Center and William Donald Schaefer House.
10. Increase base staff base pay and begin professionalizing workforce to decrease overtime and its effect on safety, staff morale and retention.

## OVERVIEW

### I. Why is Overcrowding a Problem?,

Overcrowding can have serious psychological consequences for incarcerated persons. “Crowding is an ecological and psychological aspect of population density which produces a significant impact upon the behavior and physiology both of the individuals and of social groups.”<sup>4</sup> Overcrowding has particularly harsh consequences for young incarcerated populations, and researchers have studied the damaging effects of crowding for decades.

As early as 1931 Professor W.C. Allee of the University of Chicago demonstrated that most animals have optimal levels of crowding, above and below which biological and behavioral functions are impaired.<sup>5</sup> His studies of wild house mice are illustrative:

*Crowding is often accompanied by a breakdown of normal territorial behavior and an upset of dominance hierarchies which were formerly stable. These changes in turn lead to increased social contact and irritation. Aggressive behavior becomes more frequent and more intense, and it often changes from threat display to injurious fighting and violence...The physical consequences of crowding and of social stress are often profound and widespread. They clearly affect physical health and well being....*<sup>6</sup>

The effects of overcrowding on incarcerated populations were documented in a number of studies done in response to the mid-twentieth century expansion of prison populations.<sup>7</sup> Research to date concludes that crowding – along with the environmental factors that generally accompany crowding, such as diminished sanitation, poor ventilation, uncomfortable temperatures, lack of privacy, lack of access to necessary services, and increased encounters with strangers – is harmful to incarcerated people.

*In conclusion, the studies that have examined the relationship between overcrowding and disruptive behavior suggest that overcrowding elevates the rate of disciplinary infractions. Assaults by all inmates and infractions by younger inmates show the most pronounced rate increases....As the amount of living space per inmate declines, especially when the institution as a whole is operating above capacity, the rate of rule infractions tends to increase....In general, inmates residing in more crowded living*

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<sup>4</sup> Southwick, Charles H., *The Biology and Psychology of Crowding in Man and Animals*, The Ohio Journal of Science, Vol. 71, No. 2, March 1971.

Southwick, Charles H., *The Biology and Psychology of Crowding in Man and Animals*, The Ohio Journal of Science, Vol. 71, No. 2, March 1971.

<sup>5</sup> Allee, W.C., *Animal Aggregations, a Study in General Sociology*, University of Chicago Press 1931.

<sup>6</sup> Southwick, *supra* note 5, at pp. 67-68.

<sup>7</sup> See, e.g. Megargee, *Population Density and Disruptive Behavior in a Prison Setting*, in *Experimental Behavior: A Basis for the Study of Mental Disturbance* 135 (J.Cullen ed. 1974); Nacci, Teitelbaum & Prather, *Population Density and Inmate Misconduct Rates in the Federal Prison System*, 41 Fed. Probation, June 1977; Walker & Gordon, *Health and High Density Confinement in Jails and Prisons*, 44 Fed. Probation 1980.



*arrangements, especially when the institution is itself overcrowded, experience higher rates of illness complaints than inmates living in less crowded arrangements.....<sup>8</sup>*

In the past several years, studies have confirmed that overcrowding is particularly difficult for young people:

*Overcrowding appears to have especially adverse effects on the institutional behavior of younger inmates....Younger inmates may be more susceptible to the problems and control structures in large prisons than older inmates. Researchers found that the relationship between crowding and violence was strongest in the institutions housing young offenders.*

*Age-related crowding effects are not surprising. Younger prisoners tend to be more volatile, sensitive to their surroundings and, in general, more likely to react aggressively to the tensions and conflicts that crowded conditions of confinement generate.<sup>9</sup>*

Overcrowding also has a negative impact on the people who work in the facilities. Increased overtime, working multiple consecutive shifts, inability to take breaks and failure to participate in required training are all consequences of the relentless effort to maintain staff to youth ratios.<sup>10</sup> The physiological and psychological effects of crowding of youth affect the staff as well as the youth. Exposure to contagious illnesses is increased. Stress is increased.<sup>11</sup>

Crowded facilities are difficult to manage. "From directly impacted areas such as inmate housing and classification/segregation to more indirectly impacted areas such as visitation and inmate programs, virtually all administrative and operational dimensions of jails are affected by overcrowding."<sup>12</sup> Because staff, are stretched to the limit, danger is increased.

Facility infrastructure breaks down when forced to support a population beyond the number for which it was designed. Plumbing and sewage capacity meant to support the needs of 30 people cannot support sixty. Ventilation, climate control, electrical,

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<sup>8</sup> Thornberry & Call, *Constitutional Challenges to Prison Overcrowding: The Scientific Evidence of Harmful Effects*, 35 *Hastings Law Journal* p. 313 (1983).

<sup>9</sup> Haney, C. *The Wages of Prison Overcrowding: Harmful Psychological Consequences and Dysfunctional Correctional Reactions* 22 *Wash.U. Journal of Law and Policy*, 265 (2006), citing Sheldon Ekland-Olson et al., *Prison Overcrowding and Disciplinary Problems: An Analysis of the Texas Prison System*, 19 *J. Applied Behav. Sci.*, 163, 174 (1983)

<sup>10</sup> The ratios required by the Department in its detention facilities are 1:8 during daytime hours and 1:16 during sleeping hours. Because of its unique architecture, Baltimore City Juvenile Justice Center operates under a self-imposed ratio requirement of 1:6 during the daytime and 1:12 at night.

<sup>11</sup> Overcrowding is noted as a primary factor in increased stress among correctional officers. Finn, Peter, *Addressing Correctional Officer Stress: Programs and Strategies*, Issues and Practices in Criminal Justice, National Institute of Justice, December 2000.

<sup>12</sup> *Jail Overcrowding Management Handbook*, State of California Board of Corrections, January 1988.

sanitation, laundry, food service equipment and every other aspect of the physical environment of a closed facility is quickly degraded by overuse.

The classic red flag indicator of intolerable overcrowding is the presence of residents sleeping on the floor on makeshift cots. Sleeping on the floor is in itself unsanitary and unacceptable. Trash and debris, along with dust mites, mold and mildew collect on the floor and contaminate items that come in contact with them. Any personal items – cup of water, toothbrush, Kleenex – that need to be close to the bed must sit on the floor. Further, the youth who must sleep on the floor has no personal space for belongings such as books, pictures, underwear, extra clothing, or shoes. He has no personal space to read or do homework. What might be allowed for children for a sleep-over or on a camping trip is not acceptable in an institutional living setting.

But the reason the practice is a warning of dangers to come is because if there are not enough beds in the building design to accommodate all the residents, then there is not enough of anything else required to meet minimum standards of decency.<sup>13</sup>

## **II. What Standards Determine Whether a Facility Is Overcrowded?**

Maryland Standards for Detention Facilities require that each resident “be afforded (1) a clean, dry room of moderate temperature, equipped with light sufficient for reading during regular waking hours; and (2) access to adequate toilet and bathing facilities.”<sup>14</sup> The Standards also state that youths’ basic needs must be satisfied, regardless of the total number of youth in the facility. Youth have the right to:

- An appropriate physical environment (lighting, heating, plumbing, etc.)
- A sanitary living area
- A safe environment
- Sufficient services and basic needs (clothing, medical care, recreation)
- Sufficient staffing<sup>15</sup>

To ensure that facilities satisfy youths’ basic needs, the Department has established a rated capacity for each facility - the number of youth that can be safely housed there. Rated capacity is also determined by the number of individual cells and beds although some of the larger facilities can handle overflow by using their infirmaries. Standards permit the rated capacity limit to be exceeded, but only if basic needs continue to be successfully met.

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<sup>13</sup> See, e.g. *D.W., by and through Devonsha Fairley v. Harrison County, Mississippi*, Case. No. 1:09 cv 267 LG-RHN, Memorandum of Agreement June 24, 2009.

<sup>14</sup> Maryland Standards for Juvenile Detention Facilities 6.5.2.

<sup>15</sup> Maryland Standards for Juvenile Detention Facilities 5.1.5.

## **Applicable Standards**

**Maryland Standards for Juvenile Detention Facilities 5.1.5.** *The population of each juvenile detention center shall generally be limited to the budgeted operating capacity. However, the facility shall not be considered crowded as long as the Department can safely and humanely maintain critical aspects of the facility, to include the following:*

### **5.1.5.1 The condition of the physical plant**

*The provision of lighting, heat, plumbing, ventilation, living space, noise levels and recreational space shall be sufficient to adequately meet the needs of the detained youth.*

### **5.1.5.2 Sanitation**

*Proper sanitation within the facility shall be maintained to include the control of vermin and insects, clean food preparation areas, medical facilities, lavatories, showers, and places to eat, sleep, and work.*

### **5.1.5.3 Safety**

*Youth shall be protected from violent, emotionally disturbed, contagious or ill youth. Provisions shall also be made for fire and/or other emergency evacuations.*

### **5.1.5.4 Youth needs and treatment services**

*Clothing, proper nutrition, bedding, medical, dental, and mental health care, visitation time, exercise and recreation, and educational and programming services shall be maintained at a sufficient level to accommodate the number of youth in the facility.*

### **5.1.5.5 Staffing**

*Staffing levels shall ensure the proper supervision and safety of the residents.*

## OVERCROWDING AT INDIVIDUAL DETENTION CENTERS

### ALFRED D. NOYES CENTER

#### I. Rated Capacity and Population Data

The Department of Juvenile Services has established a rated capacity of 57 youth at Noyes. However, Noyes cannot safely house 57 youth, and the rated capacity ignores a number of important factors that contribute to unacceptable crowding.

First, Noyes is the only juvenile detention center in Maryland that allows two youths to sleep in every room.<sup>16</sup> Every sleeping room has at least two beds, and two slightly larger rooms have as many as four. The generally accepted Standards of the American Correctional Association state, in the standard on the housing of juveniles, “Living units are primarily designed for single occupancy sleeping rooms; multiple occupancy rooms do not exceed 20 percent of the bed capacity of the unit.”<sup>17</sup> If Noyes was limited to single occupancy the rated capacity would be 32.

The Superintendent at Noyes explains that some boys must sleep outside the individual rooms in the common area on plastic “boats” almost every night, even when there may be a bed available in a double room. Some youngsters simply cannot be allowed to share a room for a variety of reasons including safety or medical conditions.

Second, Noyes is only one of two detention centers that houses boys and girls.<sup>18</sup> Until June 27, two of the four housing units at Noyes were dedicated to girls even though they were never full. Each unit houses approximately 16 youth. For the past two years, the population breakdown was typically about 30 – 35 boys and fewer than 20 girls. Thus, the boys’ units were overcrowded with boys sleeping in boats while the girls’ units had empty beds.

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<sup>16</sup> Waxter and Cheltenham have some dormitory-style rooms that sleep multiple youth.

<sup>17</sup> American Correctional Association Standards for Juvenile Detention Facilities 3-JDF-2C-01.

<sup>18</sup> Lower Eastern Shore Children’s Center houses girls and boys.

## Noyes Children's Center Population<sup>19</sup>

Reporting Period	Rated Capacity	High Population	Low Population	Average Daily Population	Average Monthly Population	Number of Days Over Capacity
<b>2<sup>nd</sup> Quarter, 2009</b>	57 (32 boys; 25 girls)	63	52	56	April 53 May 56 June 59	40
<b>2<sup>nd</sup> Quarter, 2010</b>	57 (32 boys; 25 girls)	70	46	56	April 52 May 56 June 59	38

Despite the facility's total rated capacity of 57, during the 2<sup>nd</sup> Quarter, there were only 32 beds for boys, even when boys were doubled-bunked. When this data is factored in, the facility was over capacity for boys on 82 out of the 91 days of the 2<sup>nd</sup> Quarter or 90% of the quarter. On June 15, 2010, the boys' population reached a high of 50. On that date, 18 boys slept in boats in the two small dayrooms of the boys' units.

## II. Violations of Standards

### A. Condition of the physical plant

*The provision of lighting, heat, plumbing, ventilation, living space, noise levels and recreational space shall be sufficient to adequately meet the needs of the detained youth.*

On June 15 and 17, 25 teenage boys were housed in each unit with only 2 toilets, 2 sinks and 2 showers. Youth are locked in their rooms during the extended showering process required to provide each youth with one shower per day. There is no dining area at Noyes. Residents must eat all their meals in their living units. During the week of June 13, not only was there no table available for each youth to eat, there were not enough chairs to go around. Youth walk around carrying their chairs so they won't lose them. Youth who eat their meals with no tables place their trays on the floor. Youth who are assigned to sleep in the day room in boats have no personal space, no access to a window, and no storage space.

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<sup>19</sup> DJS Daily Population Reports.

## B. Sanitation

*Proper sanitation within the facility shall be maintained to include the control of vermin and insects, clean food preparation areas, medical facilities, lavatories, showers, and places to eat, sleep, and work.*

Cleaning of the bathrooms is done by the residents and is not sufficient to meet sanitation requirements. Laundry is done by staff at night. Laundry equipment is not adequate to meet the needs of 70 residents. Youth complain that they wear the same clothes every day, and they do not always get their own clothes back when they send them to be cleaned.

It is not sanitary for youths to sleep in boats at night. Bedding is continuously contaminated by contact with the floor. Boats with bedding inside are stacked on top of each other during the day, allowing the contaminated bottom of one boat to rest on the clean bedding of the boat beneath. **American Correctional Association Standards for Juvenile Detention Facilities 3-JDF-2C-03** states in the comment accompanying the standard, “[T]he bed should be elevated from the floor and have a clean, covered mattress with blankets provided as needed.”

Because Noyes has no kitchen or dining facilities, food is brought in plastic trays. These trays are transported on metal carts that are layered with grunge. When the food arrives in the units, the trays are placed on the floor. The trays are also filthy from years of use.

## C. Safety

*Youth shall be protected from violent, emotionally disturbed, contagious or ill youth. Provisions shall also be made for fire and/or other emergency evacuations.*

It is not possible to classify youth for safety at the present level of crowding. In the May 10, 2010 Comprehensive Quality Review Report of the DJS Office of Quality Improvement, the facility received a rating of Non-Performance on classification.<sup>20</sup> The facility simply does not implement the Department’s classification policy. For example, during the week of June 13, Unit Two included an 11 year old, 80 pound boy and a fully grown youth with adult charges who both slept in the dayroom in boats.

The Department has consistently refused to allow fire drills on the third shift after the youths are locked in their rooms. The danger of this deficiency is increased when there are 25 youths in one unit with only one staff person.

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<sup>20</sup> DJS Office of Quality Improvement, Comprehensive Quality Review Report, Noyes, May 10, 2010

#### **D. Youth Needs and Services**

*Clothing, proper nutrition, bedding, medical, dental, and mental health care, visitation time, exercise and recreation, and educational and programming services shall be maintained at a sufficient level to accommodate the number of youth in the facility.*

At Noyes, basic needs cannot be met at current population levels. Doctors' appointments are missed because transportation cannot keep up with the demand. Youth constantly complain that they do not get enough to eat, especially fresh fruits and juice. Staff struggle to meet the education, exercise and recreation program requirements.

#### **E. Staffing**

*Staffing levels shall ensure the proper supervision and safety of the residents.*

The recent DJS Quality Improvement Report for Noyes rated staffing as another area of non-performance.<sup>21</sup> During the week of June 13, the ratio of staff to youth on Units One and Two was 1:25. The required ratio during sleeping hours is 1:16 Youth do not get to go outside for recreation because there are not enough staff to supervise them. Phone calls are not allowed, even for youth who have achieved the highest levels, because staff are not available to supervise them. Supervisory staff work overtime on cleaning and laundry duty. Youth are left without supervision by residential staff while in the medical department or the school.

### **III. Departmental Actions to Ease Overcrowding**

On June 27, 15 girls were moved into the largest of the four housing units, and the boys were divided among the remaining three units. In this configuration, at least every child has a bed, unless there is a security or medical reason for someone to sleep in the dayroom on a boat.

Staff from Waxter assisted in moving the girls, and redecorated the new girls unit in accord with principles of gender specific programming. This is a big step toward a more appropriate environment for girls at the Noyes facility, and is a significant move forward for the Department. Further, this move increases the housing space available for boys by 50%. Along with these important changes, large flat screen TV's were installed in all four units. This much needed equipment can be used for both programming and recreation.

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<sup>21</sup> Ibid.



Photo of Alfred D. Noyes Girls Unit, June 30, 2010, Department of Juvenile Services.



## BALTIMORE CITY JUVENILE JUSTICE CENTER

### I. Rated Capacity and Population Data

#### **Baltimore City Juvenile Justice Center Population<sup>22</sup>**

Reporting Period	Rated Capacity	High Population	Low Population	Average Daily Population	Average Monthly Population	Number of Days Over Capacity
2 <sup>nd</sup> Quarter, 2009	120	136	94	115	April 114 May 117 June 110	April 5 May 8 June 12
2 <sup>nd</sup> Quarter, 2010	120	127	110	119	April 120 May 123 June 115	April 17 May 25 June 15

### II. Violations of Standards

Generally, the Baltimore City Juvenile Justice Center has not been overcrowded this quarter. The average monthly population has been as high as 3 youth over capacity, but overcrowding at BCJJC is minor compared to other detention facilities.

This office has consistently recommended that BCJJC permanently downsize because the physical plant was not designed to hold youth for long periods of time. The facility lacks both outdoor recreation and classroom space. However, it is currently rated to hold 120 youth and has 120 beds plus additional beds in the infirmary.

Safety and security related incidents have decreased since Summer, 2009.. This is a positive indicator that recent reforms are working. Changes at BCJJC include the creation of an Intensive Services Unit for the most challenging youth and a nearly full staffing complement.

The hiring of staff, which continues as of this writing, has improved staff coverage which was inadequate during the first quarter of this year.

Maintaining staffing and a relatively uncrowded environment at BCJJC has come at a high cost to other facilities throughout the state. The Department has alleviated the staffing problems at BCJJC, in part, by pulling personnel from the William Donald Schaefer House (Schaefer House), a Baltimore City treatment center for youth with substance abuse issues. The Schaefer House has been downsized from 20 beds to 6 since December, 2009, so that staff could be transferred to BCJJC. The Schaefer

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<sup>22</sup> DJS Daily Population Reports.

House is one of the best physical plant resources in the state, but it sits virtually unused because of a lack of staffing. Re-staffing Schaefer House should be a priority. This would provide at least 14 additional treatment beds which are sorely needed, and would reduce the time some youth spend in pending placement status.

Overcrowding has been avoided at BCJJC by transferring many Baltimore City youth to other detention centers. On July 8, in addition to the 114 youth held at BCJJC, 40 Baltimore City youth were being held at other DJS facilities throughout the state.

On that date, there were 5 youth at Cheltenham Youth Facility (CYF) who fell under Baltimore City jurisdiction – this number reached 27 in mid-June. On June 21, when 12 Baltimore City youth were held at CYF, there was a group disturbance at Cheltenham between youth from Baltimore City and Prince George’s County in which both a youth and a female staffer were injured.

The Hickey School population on July 8 was 68 youth with 23 youth falling under Baltimore City jurisdiction. On July 13, out of 62 total youth, 29 were from Baltimore City. On the same date, the Western Maryland Children’s Center (WMCC) - which has a rated capacity of 24 - was housing 27 youth including 3 from Baltimore City.

Also on July 8, 2010, the J. DeWeese Carter Center on the Eastern Shore had 2 Baltimore City youth out of a population of 15. The Lower Eastern Shore Children’s Center (LESCC) had 2 Baltimore City youth. LESCC has a rated capacity of 18 male youth and was at 20 on July 8. On the same date the Alfred D. Noyes Children’s Center had 5 Baltimore City youth.<sup>23</sup>

Occasionally a youth must be transferred out of his home region due to special circumstances such as medical issues, age, size, or other special needs. But the movement of this large number of youth violates the Maryland statute that requires services to be provided via a regional service system.<sup>24</sup> DJS has established six regions; one of the six regions is Baltimore City.

Much of the overcrowding at other detention centers statewide results from the transfer of Baltimore City youth.

The Department should develop a plan to detain Baltimore City youth in their jurisdiction near their homes rather than dispersing them to distant facilities throughout the State. The solution to this problem may be developing more community-based alternatives to detention in Baltimore City that would allow youth to be supervised in their homes while awaiting adjudication or placement.

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<sup>23</sup> DJS ASSIST Database.

<sup>24</sup> Md. Human Services Article 9-238.1

## CHARLES H. HICKEY SCHOOL

### I. Rated Capacity and Population Data

Although the official rated capacity of Hickey is 72, the campus can actually house 109 youth when all dorms and the infirmary are open.<sup>25</sup> For the past few years, the capacity has fluctuated, as DJS closed various dorms due to renovation or staff shortages. The current actual capacity of Hickey is 86 youth (including infirmary beds).<sup>26</sup>

#### Charles H. Hickey School Population<sup>27</sup>

Reporting Period	Rated Capacity	High Population	Low Population	Average Daily Population	Average Monthly Population	Number of Days Over Capacity
2nd Quarter, 2009	109/82 <sup>28</sup>	102	70	81	April 79 May 75 June 90	32
2nd Quarter, 2010	109/86 <sup>29</sup>	99	75	82	April 79 May 75 June 85	41

In June, population averaged 85 youth, and on one night, the facility held 99 youth in only 86 beds. The facility was over capacity 41 of the 91 days in the quarter.

When a unit reaches its full capacity, staff send youth to other units to sleep out. Those youth are returned to their assigned units the following morning. During the daytime hours, units may house significantly more youth than they are rated to hold.

Hickey does not double-bunk youth so overflow youth also sleep in the dayrooms in boats. According to the logbook and staff interviews, on June 1, twelve youth slept in boats in the dayroom of Clinton Hall.

<sup>25</sup> One hundred and one (101) youth in the four dormitories and 8 in the infirmary.

<sup>26</sup> A 24-bed unit has been closed since early in the year.

<sup>27</sup> DJS Daily Population Reports.

<sup>28</sup> A 27-bed unit was closed during the 2<sup>nd</sup> Quarter, 2009 so 82 beds were actually available.

<sup>29</sup> A 24-bed unit was closed during the 2<sup>nd</sup> Quarter, 2010 so 86 beds were actually available.

## II. Violations of Standards

### A. Sanitation

*Proper sanitation within the facility shall be maintained to include the control of vermin and insects, clean food preparation areas, medical facilities, lavatories, showers, and places to eat, sleep, and work.*

Youth sleep in boats that are not always clean. According to youth and staff, sheets are often kept in the boats when they are piled on top of other boats during the day. The bottoms of the boats have been on the floor, and youth are not issued new sheets each night. This practice is unsanitary. Additionally, youth said that they are provided with a boat at random at night – so they may be sleeping in a bed another youth occupied the night before.

### B. Safety

*Youth shall be protected from violent, emotionally disturbed, contagious or ill youth. Provisions shall also be made for fire and/or other emergency evacuations.*

Hickey has always had a strong classification system in place to ensure that youth are placed in housing according to age, size, offense history, severity of current charge, and other risk factors. An intake officer processes youth in the Intake Unit, and the youth remains on the orientation unit for three days. The intake officer then places the youth on a dorm based on the outcome of the initial assessment and observations of the youth during orientation.

Overcrowding and staff shortages, however, have hampered staff ability to keep the classification system fully operational this quarter, heightening safety and security risks.

According to the master control logbooks, on several afternoon and evening shifts during the quarter neither an intake officer nor a transportation officer were available due to call-outs.<sup>30</sup> A staffer placed youth on dorms without classifying them until an intake officer was available to process the youth. The failure to classify youth property poses a danger because, youth at higher risk of violence may be mixed with youth at lower risk, rival gang members could unknowingly be placed together, and the like.

Review of several room charts showed that high and medium level risk youth were placed in lower-level rooms and low risk youth were placed in high-level rooms. The facility placed an AWOL risk youth in a medium level room. When a high-level youth is placed in a low-level room, he is not in close proximity to or in view of direct care staff.

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<sup>30</sup> June 5 and 6.

## C. Staffing

*Staffing levels shall ensure the proper supervision and safety of the residents.*

In light of the serious overcrowding problem, it is difficult to understand why one 24-bed dormitory (Ford Hall) sits vacant. The facility administrator said that Ford Hall was closed to cut down on overtime hours. The facility was already severely understaffed this quarter due to the resignation of some new hires, the termination of several staff, and staff call-outs. Keep a fourth dormitory open would exacerbate the overtime problem.

In the months of April and May, staff worked 15,788 overtime hours, compared to 12,659.7 overtime hours during the same period last year. With 99 Residential Advisor staff at Hickey, this averages to approximately 20 hours of overtime work per week and an extra 40 hours in each two-week pay period.

According to the master control logbook and staff interviews, almost all direct care staff worked at least one double shift (16 continuous hours) during the quarter. Documents show that nearly all direct care staff worked double shifts (16 hours) in the last week of May. During a late night monitoring visit in May, at least half the staff members on the campus were on their second shift of the day.

A supervisor reported that one of his staff worked 20 hours, took a break of several hours and returned to work another shift. Another staff member reported that at the end of the quarter, one employee was working at least 30 hours of overtime per week on top of his regular 40 hour workweek. The facility administration did not respond to a request for documents regarding staff schedules.

Overpopulation and understaffing causes increased stress and staff burnout. Exhausted staff are unable to provide adequate one-on-one supervision to youth who need it, to respond to emergencies, or to ensure the safety of youth. Staff interviewed said that many staff are not sick when they call out; they call out in order to avoid being drafted into working an extra shift once they arrive at the facility. DJS StateStat data shows that between the beginning of April and the middle of June, the facility accumulated 1,904 call-out hours, the equivalent of 47 full work weeks.<sup>31</sup>

Due to staff shortages, non-direct care staff, such as Case Managers and Office/Clerical Staff, must fill in for direct care staff on occasion. Direct care staffers are required to be present outside of rooms during youth interviews and to escort youth to various appointments. On several visits, the Monitor observed case managers supervising group or individual youth interviews without the presence of a direct care staffer. Many non-direct care staffers, such as case managers and administrative staff, are not trained in Crisis Prevention Management, which teaches how to deescalate aggressive situations.

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<sup>31</sup> StatStat Reports, 2010.

## CHELTENHAM YOUTH FACILITY

### I. Rated Capacity and Population Data

Cheltenham has a rated capacity of 115, but that capacity includes the ReDirect and Shelter programs with 24 and 5 beds, respectively. Both of these programs have been closed since February so the actual capacity of the facility is 86 youth.

#### Cheltenham Youth Facility<sup>32</sup>

Reporting Period	Rated Capacity	High Population	Low Population	Average Daily Population	Average Monthly Population	Number of Days Over Capacity
2 <sup>nd</sup> Quarter, 2009	115	151	113	132	April 133 May 132 June 143	88
2 <sup>nd</sup> Quarter, 2010	86 <sup>33</sup>	131	106	116	April 117 May 115 June 115	91

Cheltenham's population reached a high of 131 this quarter, 44 youth and 51% over capacity. The population averaged 116 youth on each day of the quarter, 30 youth and 35% over capacity.

The chart below, which breaks down population by individual cottage, illustrates the severity of Cheltenham's overcrowding.

<sup>32</sup> DJS Daily Population Reports.

<sup>33</sup> In February, 2010, DJS closed both the Shelter and the ReDirect Programs at Cheltenham. This reduced the number of total available beds from 115 to 86 (loss of 24 beds in ReDirect and 5 in the Shelter).

**Cheltenham Population By Individual Cottage  
June, 2010 Average Population<sup>34</sup>**

	<b>Capacity</b>	<b>Actual Population</b>	<b>Number Over Capacity</b>	<b>Percent Over Capacity</b>
Rennie	24	42	18	75%
Henry	24	44	20	83%
Cornish	24	28	4	17%
Infirmary	14	9	-5	n/a

In mid-June, Monitors visited Henry Cottage in the late afternoon before dinner, and the dayroom was packed with youth sitting on every available piece of furniture. Staff members were yelling to be heard, and the environment was chaotic.

**II. Violations of Standards**

**A. Safety**

*Youth shall be protected from violent, emotionally disturbed, contagious or ill youth. Provisions shall also be made for fire and/or other emergency evacuations.*

On June 21 there was a large group disturbance among youth on Rennie. A youth and a staff member were sent to the hospital for treatment of injuries. The altercation took place on the basketball court after an argument between Prince Georges County and Baltimore City youth. The Baltimore City Juvenile Justice Center has been at or near capacity for some time, and many of its overflow youth have been sent to Cheltenham, a facility that is supposed to serve youth from Prince George's and Montgomery Counties and southern Maryland.<sup>35</sup>

On the date of the group disturbance, there were 127 youth at Cheltenham, including 12 youth from Baltimore City. Rennie housed 46 youth – 92% over its capacity of 24 youth.

A week later, on June 28, there was another group disturbance involving Baltimore City and Prince George's County youth.<sup>36</sup>

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<sup>34</sup> DJS Daily Population Reports.

<sup>35</sup> DJS Incident Report 83375.

<sup>36</sup> DJS Incident Report 83550.

## **B. Youth Needs and Services**

*Clothing, proper nutrition, bedding, medical, dental, and mental health care, visitation time, exercise and recreation, and educational and programming services shall be maintained at a sufficient level to accommodate the number of youth in the facility.*

In addition to the increased threat of violence and strain on the facility's physical plant structure, school and psychological services are compromised by Cheltenham's severe overcrowding.

While direct care staff can be called in to work overtime shifts, there are no additional teachers or clinical staff (psychologists, case managers, nurses) to service overflow youth. There are enough teachers and clinical staff to work with a population of approximately 85. It is physically impossible for them to provide sufficient services for an additional 30 youth.

The classrooms at CYF are overcrowded with youth. Teaching staff interviewed said that there are often 22-25 people crowded into a classroom designed for no more than 12-15 youth. The teachers explained that when their classroom is filled with so many youth, it becomes even more challenging to teach. One teacher stated that her class had so many youth in it that s/he could not even walk between the desks to hand out papers to the youth.

In addition to the physical obstacles created by crowding, it creates additional academic hurdles for youth at CYF. Many of the youth at CYF are far behind their peers in terms of their reading and mathematical abilities. The overcrowded classrooms, however, make it even more difficult for these youth to receive the individualized attention or the small class setting that they need to learn effectively.

## **C. Staffing**

*Staffing levels shall ensure the proper supervision and safety of the residents.*

Many direct care staff at Cheltenham say they are exhausted. The vast majority of direct care staff said that they regularly work double shifts (16 hours straight) and log between thirty to over fifty hours of overtime during each two week pay period. Teachers interviewed said they had seen direct care staff fall asleep in class frequently and that they wake them up. They try not to report them because they know they are so overworked. Almost all of the direct care staff that we interviewed admitted to falling asleep or nodding off during a shift, especially if they were on a double shift or had worked long hours earlier in the week.

StateStat data shows that for the four weeks ending June 1, 5737 hours of overtime was worked at Cheltenham. With 154 direct care staff, the average was 37



hours per staff member over four weeks, or 18.5 hours in each two week pay period, less than the number of hours reported in interviews.<sup>37</sup>

Mandatory overtime is often imposed when the person scheduled to relieve a direct care staffer on the next shift calls out. Because CYF is understaffed, the direct care staff member who is on duty is then forced to work another eight-hour shift to keep the unit within ratio. Staff said they are subject to internal discipline if they leave the campus when drafted into overtime, even if they have previously-scheduled appointments or responsibilities. The constant lack of certainty about work schedules has led to low morale and contributed to high turnover.

When CYF is overcrowded, staff must supervise more youth with less safety equipment, including radios. Direct care staff at CYF are not assigned their own radios.

On one of our visits, we observed five staff on duty sharing two radios among them. The 40 youth in the cottage had been split into groups and were in different parts of the cottage. Staff in the front of the cottage did not have visual or audio contact with staff members in the back of the cottage.

Dividing large numbers of youth into smaller groups is a positive strategy to reduce the effects over overcrowding. But it is essential that each staff member be provided with a radio or other means of communication to ensure safety.

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<sup>37</sup> DJS StateStat Report, June 1, 2010

## SOLUTIONS TO OVERCROWDING

### I. Reduce Time Youth Spend in Pending Placement Status

Since 2007, the Department has reduced time youth spend in pending placement.<sup>38</sup> But, as the charts below illustrate, many youth still spend long periods of time in secure detention.

The charts below show the number of days youth were held in the four facilities that are the subject of this report. Any youth admitted to the facility during the quarter is included if s/he stayed in detention or pending placement more than 60 days.

#### **Alfred D. Noyes Children's Center Days in Pending Placement and Detention (Youth Held at Any Time During Quarter)<sup>39</sup>**

<b>2<sup>nd</sup> Quarter, 2010</b>	<b>Number of Youth in Status 60 days and over</b>	<b>Number of Youth in Status 90 days and over</b>
<b>Pending Placement</b>	5 male, 2 female youth (87, 71, 70, 63[f], 62[f], 61, and 61)	2 male, 1 female youth (140, 95[f], and 90)
<b>Detention</b>	6 male, 2 female youth (81, 79, 76, 72, 69, 68[f], 64, and 64[f])	6 male, 1 female youth (421[f], 288, 279, 139, 128, 91, and 90)

<sup>38</sup> Pending Placement is the period of time a youth spends in secure detention after s/he has been adjudicated delinquent and is awaiting a residential treatment placement.

<sup>39</sup> DJS ASSST Database.

**Baltimore City Juvenile Justice Center  
Days in Pending Placement and Detention  
(Youth Held at Any Time During Quarter)<sup>40</sup>**

<b>2<sup>nd</sup> Quarter, 2010</b>	<b>Number of Youth in Status 60 days and over</b>	<b>Number of Youth in Status 90 days and over</b>
<b>Pending Placement</b>	26 youths  (89, 85, 85, 80, 80, 79, 78, 78, 76, 75, 74, 73, 72, 71, 70, 70, 70, 69, 68, 67, 64, 63, 62, 62, 62, and 61)	29 youths  (210, 198, 181, 175, 162, 150, 146, 144, 143, 140, 133, 131, 129, 127, 126, 121, 118, 116, 115, 115, 112, 108, 105, 99, 99, 98, 96, 92, and 91)
<b>Detention</b>	5 youths  (79, 78, 76, 72, and 61)	3 youths  (136, 121, and 98)

A significant proportion of the youth at BCJJC during both the first and second quarter of 2010 were waiting at the facility to move to a treatment placement. Some youth wait for many months at BCJJC, months that are not counted in calculating completed Court-mandated treatment time. Youth frustration over “dead time” is a component contributing to incidents involving aggression.

**Detention and Pending Placement Snapshot  
Baltimore City Juvenile Justice Center  
July 8, 2010<sup>41</sup>**

<b>Total Youth Population</b>	<b>Pending Placement Population</b>	<b>Detention Population</b>
114	51 (45%)	63 (55%)

Some youth awaiting treatment placement present during the second quarter of 2010 were still at BCJJC during the third quarter. By July 6, 2010, one had spent 204 days at BCJJC awaiting a treatment bed; one 168 days; another 139; one 132, one 122, another 118 days – all on dead time.<sup>42</sup>

<sup>40</sup> DJS ASSST Database.

<sup>41</sup> DJS ASSST Database.

<sup>42</sup> DJS ASSIST Database.

**Charles Hickey School**  
**Days in Pending Placement and Detention**  
**(Youth Held at Any Time During Quarter)<sup>43</sup>**

<b>2<sup>nd</sup> Quarter, 2010</b>	<b>Number of Youth in Status 60 days and over</b>	<b>Number of Youth in Status 90 days and over</b>
<b>Pending Placement</b>	15 youths (89, 84, 81, 79, 78, 74, 72, 69, 67, 67, 66, 65, 62, 61, and 60)	10 youths (122, 119, 118, 115, 108, 98, 97, 96, 91, and 90)
<b>Detention</b>	8 youths (89, 82, 74, 68, 67, 63, 63, and 61)	6 youths (160, 122, 116, 112, 94, and 91)

**Cheltenham Youth Facility**  
**Days in Pending Placement and Detention**  
**(Youth Held at Any Time During Quarter)<sup>44</sup>**

<b>2<sup>nd</sup> Quarter, 2010 2010</b>	<b>Number of Youth in Status 60 days and over</b>	<b>Number of Youth in Status 90 days and over</b>
<b>Pending Placement</b>	13 youth (72, 70, 68, 67, 66, 65, 64, 64, 64, 62, 62, 62, and 62 days)	16 youth (167, 157, 145, 145, 145, 135, 132, 125, 124, 119, 117, 113, 102, 97, 94, and 91 days)
<b>Detention</b>	5 youth (80, 79, 77, 77, and 66 days)	4 youth (203, 105, 101, and 91 days)

Some long-stay youth present during the first quarter were still waiting for a treatment bed on July 13, 2010. One youth had spent 145 days at CYF, while other pending placement youth had spent 138 days, 132 days, and 75 days, respectively.

<sup>43</sup> DJS ASSST Database.

<sup>44</sup> DJS ASSST Database.

Strategies to reduce time youth spend in detention facilities include expanding community-based alternatives to secure detention and reopening some of the residential treatment programs DJS closed over the past two years. At the time, the state fiscal crisis and need to save money was given as the reason for many closures but according to DJS, detention costs between \$300 and \$400/day per youth. Opening more residential treatment options would be less expensive and better for youth than holding them in pending placement for long periods of time.

## **II. Increase Community-Based Alternatives to Secure Detention**

The Department should develop and offer more community-based alternatives to secure detention for youth who do not need to be securely detained. The Department already funds several community-based programs that reduce the number of youth in secure detention. These programs provide supervision and services to youth in their homes at considerable cost savings compared with detaining them in secure juvenile facilities. But the number of youth enrolled in these alternative supervision programs remains relatively low.

Currently, there are only four evening reporting centers in the entire State - one in Baltimore City, two in Prince Georges County, and the Pre-Adjudication Coordination and Training (PACT) Evening Reporting Center in Baltimore. There are no evening reporting centers for girls.

In its first full year of operation, 100% of youth enrolled in the PACT program returned for their court dates, 95% did not reoffend while enrolled, and 100% received an individualized service plan by the time of their court appearance. In 2009, it was selected as a MacArthur Model for Change.<sup>45</sup>

Shelter use has decreased steadily over the past year as the Department closed a number of privately operated shelters. These shelters were used to house youth who lack appropriate parental supervision and could not return home but did not meet the risk criteria for secure detention. In June, 2008, 86 youth were in shelter care. That total declined to 71 in June, 2009, and by June of this year, only 32 youth were in shelter care statewide.<sup>46</sup>

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<sup>45</sup> MacArthur Models for Change, <http://www.modelsforchange.net/reform-progress/19>

<sup>46</sup> DJS StateStat Reports, 2009, 2010.

<b>Detention Alternatives</b>	<b>June, 2010</b>	<b>June, 2009</b>
Shelter	32	71
Evening Reporting including PACT-Baltimore City	63	72
Community Detention/ Electronic Monitoring	617	645
Other Detention Alternatives (DRAP)	35	34

The lack of alternatives to secure detention contributes to overcrowding. For example, at Cheltenham, on June 21, the date of the large group disturbance, Cheltenham’s population was at 129. Of the total youth housed there, 9 youth were listed in the ASSIST database as “eligible for detention alternatives,” but were still being held in secure detention. The reason for this is not clear.

Most of these nine youth were held in secure detention for long periods of time while eligible for community-based alternatives – 37, 35, 28, 21, 20, 19, 18, 7, and 4 days.

Case folder notes showed that these youth tended to be detained for technical violations<sup>47</sup> and were either eligible for further community detention (possibly with more supervision or electronic monitoring) or for shelter care. In several cases, youth were sent to Cheltenham because parents did not want them returned to the home after a probation violation. Because there are few, if any, shelter beds available in Prince George’s County, the youth remained in Cheltenham until the parent was willing for them to return home. Several other youth were eligible for electronic monitoring, but it took as much as a month to set up the monitoring.

On June 21, there were also four youth in Cheltenham in “consequence beds.” This office has written about the use of consequence beds in the past – generally, it is a system in which a judge sentences a youth to stay in a secure detention center for a set period of time for violating a condition of his probation. The youth in consequence beds on that date stayed for 2, 4, 7, and 11 days in the facility.<sup>48</sup>

Judges are understandably frustrated when youth violate probation conditions. But DJS staff report that this practice puts extra strain on an already overwhelmed system. Judges must be provided with substantive graduated sanctions for youth who violate probation or terms of community supervision. Those sanctions must not include

<sup>47</sup> Technical violations of probation or community supervision include being truant, missing curfew, and failing to report in to a Probation Officer as agreed, but not committing a new crime.

<sup>48</sup> DJS ASSIST Database.

placement in secure detention centers unless formal proceedings to revoke probation or community supervision have been filed.

A day or weekend reporting center or weekend alternative school program can provide needed structure and supervision at a much lower cost than the \$300-\$400/day cost of keeping them in detention. Murphy Cottage, located on the Cheltenham campus and closed in February, might provide an appropriate environment for a weekend reporting program for youth who are not adjusting well to community supervision and need more structure.

Successful weekend reporting programs often consist of a mix of discussion of immediate issues leading to violations, skills learning (e.g., anger management, decision making), academics, and community service.<sup>49</sup>

The cost of placing a youth at the PACT Evening Reporting Center is only \$44 per day per youth. In this time of severe budgetary constraints, limited funds would be more wisely directed to opening or expanding evening, day, or weekend reporting centers than to continuing the futile attempt to staff overcrowded detention facilities.

### **III. Professionalization of Staff**

As we have written many times in prior reports, professionalization of DJS facility staff is a foundational requirement for appropriate staffing. The State should provide funding to increase pay for direct care staff and require concomitant qualifications such as a 2-year college degree for new staff. A clear upward career path for direct care staff must be defined. Anyone with a high school degree or GED and 21 years of age can apply to work at DJS facilities.<sup>50</sup> The starting salary for Resident Advisor Trainees is \$28,000.

In 2009, DJS paid over \$8,000,000 in overtime wages to staff.<sup>51</sup> Currently, DJS has approximately 830 direct staff in its residential facilities. Each of those staff could have received a raise of over \$9,000/year with the number of overtime dollars spent in that year.

The current system results in constant personnel churn. Despite many reforms DJS has made in the past three years, the quality and retention rates of front line staff remains challenging. Facilities hire staff at low wages and turnover is high as staff find higher-paying jobs, including in the Maryland adult correctional system. This forces remaining staff to work significant overtime (at 1.5 times their regular wage). Although the overtime lifts their salaries, it results in burnout and more turnover. This cycle repeats.

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<sup>49</sup> See Spokane County, Washington, <http://www.spokanecounty.org/juvenilecourt/content.aspx?c=1058>; Alameda County, California, <http://www.acgov.org/probation/ji.htm>.

<sup>50</sup> Currently DJS has one Resident Advisor statewide under the age of 21.

<sup>51</sup> DJS StateStat Reports, 2009, 2010.

The better solution is to raise base staff pay. This will make recruiting new staff easier and will reduce the need for forced overtime, burnout, and the resulting turnover. The Department's reform plan is unlikely to succeed without a well-trained, stable, and dedicated group of workers. Current conditions and pay are not developing the necessary personnel corps for reform.

DJS has begun a new initiative to alleviate understaffing by hiring "relief/on call staff." Relief staff only complete two weeks of training before beginning work (rather than the four or more weeks regular staff complete). These employees are provisionally certified and become fully certified when they complete the remaining entry level training hours before the end of their first year of employment. The on call employees will be called in to work as needed.

Preliminary training for on call staff includes crisis prevention and management, restraint techniques and other safety and security issues – the most pertinent training that staff need before beginning work in a facility. These provisionally certified staff may not be left alone with youth until they have completed the entire 200 hours of entry level training required for full certification.

Beginning in January, 2011, DJS will train all new employees using this model, frontloading two weeks of training courses that are essential for employees beginning work in a facility. Then employees will have one year from the date of provisional certification to complete all 200 hours of training and become fully certified.

The Maryland Correctional Training Commission (MCTC), which certifies staff for eligibility to work in DJS facilities, has approved this plan, as has the employee union. The plan does not appear to violate any current MCTC regulations or DJS standards. It does, however, conflict with COMAR 16.05.02.02 which requires DJS to minimize the use of short-term employment contracts.

It is to the Department's credit that it is attempting to reduce understaffing through creative means during the state budget crisis. However, shortcuts like these skirt the real issue – the need to develop a professionalized workforce. Successful systems form cohesive teams of well-trained staff who work together over the long term. Staff are paid sufficiently for their work and receive full benefits. Staff understand the upward career path and see their jobs as a profession. This initiative moves the state backward rather than forward toward this goal.

#### **IV. Other Recommendations**

1. The Department should immediately develop and implement a plan to maintain population at safe levels at all secure detention facilities during the summer months. The plan should include procedures to close admissions when unsafe levels of population are reached



2. A panel of objective experts (fire, health, prison overcrowding, security) should be convened to establish an absolute cap on population at these facilities. When the facilities reach the cap, admissions should cease.
3. Overcrowding and the time youth spend in detention should be reduced by developing more community-based alternatives to secure detention. Girls should be admitted to evening reporting centers, and more evening reporting centers based on the PACT model should be opened, particularly in parts of the State where secure detention facilities suffer from overcrowding.
4. More detention alternatives should be developed in Baltimore City, including structured programs (e.g., day reporting centers) for high risk youth. Baltimore City youth should not be transferred to detention facilities in other parts of the state.
5. Additional shelter beds must be sought. Fire prevention sprinklers should be added to the shelter building on the Cheltenham campus, and the shelter should be reopened with a capacity of 10-12 boys.
6. Modular temporary housing should be purchased for overflow detention capacity in the summer months. Both Hickey and Cheltenham are located on large tracts of land and could accommodate an extra building. Modular housing could also be shifted from campus to campus if necessary.
7. Ford Hall at Hickey should be temporarily reopened to provide an additional 24 beds. Staffing at Hickey should be increased concurrently.
8. The committed program at Waxter should be moved out of the facility to allow more space for detention operations. The Department should move forward on posting the Statement of Need/RFP for girls committed care programs as promised during the legislative session.
9. Pregnant girls should be moved out of secure detention centers altogether. The Department should seek arrangements with a private provider to offer pre-detention care for pregnant girls.
10. Savage Mountain should be fully staffed at its capacity of 48 beds (up from 36) and filled to reduce the number of youth in pending placement.
11. William Donald Schaeffer House should be fully staffed and used as a residential treatment program.
12. Mount Clare House and other programs that provided excellent residential treatment services should be reopened.

13. Existing programs that provide excellent residential treatment services, such as Allegany County Girls Group Home and Kent Youth Group Home, should be fully utilized.
13. Staff must be increased through hiring or transfer to bring staff/youth ratios to safe levels, especially on the third shift.
14. Staff base pay and credentials should be increased which would decrease the cost of overtime and its effect on staff morale and retention.
15. Weekend detention and consequence bed programs should cease. Judges must be provided with more meaningful sanctions for youth who violate probation.