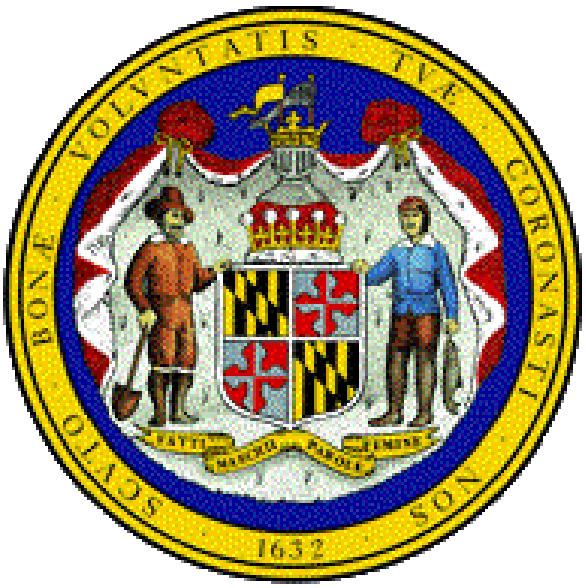

JUVENILE JUSTICE MONITORING UNIT

OFFICE OF THE ATTORNEY GENERAL

3rd QUARTER 2010 REPORTS

NICK MORONEY
Acting Director

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

December 13, 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 Reports from the Juvenile Justice Monitoring Unit (JJMU) at the Office of the Attorney General. This report covers the Third Quarter of 2010, from July 1 – September 30, 2010. The Department of Juvenile Services (DJS) Response is also included.

I would be pleased to answer any questions you may have about these reports. I can be reached by email at nmoroney@oag.state.md.us and by phone at 410-576-6599 (o) or 410-952-1986 (c). All reports of the Juvenile Justice Monitoring Unit are also available on our website at 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,

Nick Moroney

Nick Moroney
Acting 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
The Honorable Gerron Levi, Maryland House of Delegates
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
The Honorable Joseph Vallario, Maryland House of Delegates
The Honorable Jeff Waldstreicher, Maryland House of Delegates
The Honorable Nancy Kopp, Treasurer's Office
Katherine Winfree, Chief Deputy Attorney General, Office of the Attorney General

Electronic Copies: Howard Freedlander, Treasurer's Office
Ronojoy Sen, Governor's StateStat Office
Sheri Meisel, Karl Pothier, and Wendy Estano, DJS

TABLE OF CONTENTS

1. Allegany County Girls Group Home 5
2. Aunt CC's Harbor House Shelter 10
3. Baltimore City Juvenile Justice Center 14
4. J. DeWeese Carter Children's Center 27
5. Cheltenham Youth Facility 36
6. Graff Center for Girls 49
7. Haddon Group Home for Boys 53
8. Charles H. Hickey School for Boys 55
9. Karma Academy – Randallstown 67
10. Kent Youth Boys' Group Home 72
11. Lower Eastern Shore Children's Center 79
12. Morningstar Youth Academy 88
13. Alfred D. Noyes Children's Center 98
14. Silver Oak Academy - Rite of Passage 108
15. The Way Home – Mountain Manor 118
16. Victor Cullen Center 124
17. Thomas J. S. Waxter Children's Center 133
18. Western Maryland Children's Center 145
19. William Donald Schaefer House 156
20. Youth Centers 159

NICK MORONEY
Acting Director

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

FACILITY REPORT
ALLEGANY COUNTY GIRLS GROUP HOME
JULY - SEPTEMBER, 2010

Facility:	Allegany County Girls Group Home 10700 Leslie Lane Cumberland, Maryland 21502 Administrator: Jennifer Younker
Dates of Visits:	August 10 and September 9
Reported by:	José D. Saavedra Monitor
Persons Interviewed	Program Director, Direct Care Staff, and Youth
Date of Report:	November 2010

INTRODUCTION

The Allegany County Girls Group Home (ACGGH) is a community-based residential program for young girls. The Department of Juvenile Services (DJS) owns the facility, but the Cumberland, Maryland YMCA manages services to the youth. DJS licenses the group home to serve up to nine female residents ages 13 to 18. Residents stay (on average) from seven months to a year. The program mission is to "provide a safe, healthy, home environment" for girls that emphasizes skills and values necessary to "ensure a successful transition [back] into the community."[1] The administrator is a licensed and certified social worker. Throughout the quarter, ACGGH staff have kept their promise to the young women they serve.

SUMMARY

The facility is in good physical condition, with the exception of windows in the sunroom that need immediate repair. Programmatic services and staff support provide a solid structure for girls to individually progress toward personal goals. However, referral shortages challenge the potential to maintain the quality of services provided to the girls. Fire and health safety inspections indicate no need for corrective action. Fire drill logs indicate ongoing rapid evacuation practices. Overall, the facility is in good shape, provides great care for its residents, and maintains a safe home.

Critical issues observed:

1. *Number of referrals continue to be precariously low*
2. *Windows in the sunroom need to be repaired without delay (before the start of the winter season)*

FINDINGS

1. Population

Throughout the quarter, an average of six to seven girls resided in the facility (six in July and August; eight in September). All were DJS-referred youth from six different counties (Baltimore, Prince George's, Baltimore City, Montgomery, Anne Arundel and Washington).

2. Safety and Security

Staff utilizes a Level System accountability structure to manage behavior. Girls earn privileges through positive behavior and lose them for misbehavior. Youth clearly understand the system expectations and processes, benefits and consequences.

[1] Source: http://www.acggh.org/content/mission

Applicable Standard

COMAR 14.31.06.15.A (1)(a)(b)(c)(f) – *The licensee shall establish and follow written policies and procedures that are communicated to the child, the child's parent, employees, and the placing agency; identify all approved forms of discipline; specify the approved procedures for the administration of each form of discipline; and periodically review the forms of discipline used for effectiveness and safety.*

3. Physical Plant and Basic Services

a. Fire Safety

On May 20, a Maryland State Fire Marshal Inspector found the ACGGH free of fire code violations.

Fire drill logs indicate that staff routinely practices effective and timely facility evacuation procedures.[2] However, staff performed only eight of nine required fire drills this quarter.

b. Physical Plant

Overall, the facility is in good condition. The interior is clean. The exterior is free of debris and environmental hazards. However, windows require significant repairs. Duct tape currently seals the windows in the sunroom to prevent cold air and bugs from entering (see next page for pictures of sunroom windows). One of the windows was screwed shut because it no longer locks properly. In August 2009, the facility Director submitted quotes for window repair to DJS. At time of writing (November 2010), DJS had yet to have the windows repaired.

[2] Two in the morning, three during evening and graveyard shifts.

c. Basic Services

On September 27, 2010, an Allegany County Health Department Inspector conducted an Environmental Health Survey at the facility. The Health Department assessed the facility's water supply, physical plant, waste handling, safety, and sewage disposal. The Inspector found no public health or environmental concerns.

Applicable Standards

COMAR 14.31.07.5(a)(b) – *The licensee shall hold emergency drills at least monthly, and on each shift, at least quarterly.*

COMAR 14.31.06.07 (A)(4) – *The licensee shall ensure compliance with the local fire and health requirements by submitting annually to the licensing agency, reports of all fire and health inspections conducted by the local jurisdiction.*

COMAR 14.31.06.07.2 – *The licensee shall supply on all exterior windows that can be opened and doors that may [be] left open, screens that are in good repair and removable in emergencies.*

4. Youth Advocacy, Internal Monitoring and Investigation

No youth-generated grievance forms were submitted this quarter.

DJS performed two unannounced inspections at ACGGH this quarter. The department found the facility in Full Compliance with department standards - no deficiencies or areas requiring improvement.

RECOMMENDATIONS

1. Windows should be repaired before the winter season.

2. DJS should maintain the maximum population of nine at the program to ensure long-term sustainability.

3. Staff must perform all required fire drills.

NICK MORONEY
Acting Director

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

FACILITY REPORT
AUNT CC's HARBOR HOUSE
JULY – SEPTEMBER, 2010

Facility: Aunt CC's Harbor House
1031 East Monument Street
Baltimore, Md. 21202
Administrator: Donald Barrett

Dates of Visits: July 29
September 1 and 29, 2010

Reported by: Tanya Suggs
Monitor

Persons Interviewed: Administrator, Supervisor, Clinical Staff, Nurse, and Youth

Date of Report: November 2010

INTRODUCTION

Aunt CC's Harbor House (Aunt CC's) is operated by the North American Family Institute (NAFI) and licensed by the Department of Juvenile Services (DJS/the Department). The facility is an emergency shelter and functions as an alternative to detention - a placement for youth who require temporary care.

Male youth at low risk of offending and between the ages of 11 and 17 are referred by both DJS and the Department of Social Services (DSS). The average length of stay is 30 days. Residents are provided with food, clothing, group and individual clinical services, life skills education, and post release clinical services.

FINDINGS

- Annual fire safety, fire alarm, and health inspections are past due.
- Two youth did not receive required asthma medication.

1. Population

Aunt CC's houses lower risk youth who do not require detention but who, without available shelter care, might end up in a detention center anyway. The program is performing as an essential resource helping to redirect children who might otherwise become more deeply involved with the juvenile justice system.

2. Safety and Security

The number of critical or aggressive incidents at Aunt CC's continued to remain low during the third quarter of 2010 and the facility continued to be a safe environment for youth in residence.

There were two AWOLs during the quarter, considerably less than during the same time period in 2009.

3. Physical Plant and Basic Services

The living room is beautifully furnished and painted. The youth continue to report that they have experienced a comfortable stay and staff treats them well.

The home last received a Baltimore City Fire Department fire safety inspection in November of 2009. The home should have its annual fire safety inspection (for 2010) scheduled and completed as soon as possible.

The last fire alarm inspection at Aunt CC's was conducted by a private contractor in October of 2009 - another inspection needs to be arranged and conducted without delay.

Annual fire safety inspections are a minimal but essential factor in ensuring that the physical plant is safe for the housing of youth; that fire safety equipment is in working order; and that there are no other fire safety- related issues needing remediation.

The Baltimore City Health Department last completed a health inspection at Aunt CC's in March 2009 – a health inspection is long overdue and should be undertaken as soon as possible. Regular health inspections are essential in order to safeguard the wellbeing of youth and staff at the facility.

Applicable Standards

COMAR 14.31.06.07. (A)(4) *The licensee shall ensure compliance with the local fire and health requirements by submitting annually to the licensing agency, reports of all fire and health inspections conducted by the local jurisdiction.*

COMAR 14.31.06.07. (C)(1) *The licensee shall maintain all structures and grounds in good condition, free from health or safety hazards.*

4. Medical

The Monitor reviewed four randomly chosen medical files. Two of the four files were not in compliance with Maryland regulations (COMAR). Two youths did not receive required asthma medication. Clinical staff did not communicate with a physician within the three day period required by COMAR. Aunt CC's staff must communicate effectively with youth and youth parents or guardians concerning any medication needs. Home management must also communicate with a physician regarding administration of medications and other youth medical needs as they arise.

Applicable Standard

COMAR 14.31.06.13.C.2 (a) (b) *The licensee shall continue any current medications that the child is receiving at the time of admission to the program, and within 3 days of admission, consult with the licensee's medical care provider or the child's physician concerning the continuation of a current medication.*

5. Youth Advocacy, Internal Monitoring, and Investigation

Youth at Aunt CC's did not seen familiar with the protocols DJS youth grievance process. The DJS grievance policy states that youth should receive instruction on how to use the grievance process. Youth should be required to sign

grievance procedure instructions as an indicator that they have read and understood the procedure and as proof that staff has reviewed the procedure with youth. A signed copy of the grievance procedure instructions should be included in each youth's file.

Applicable Standard

COMAR 14.31.06.09.E.2 (a)(b)(c) *The licensee shall provide the child and the child's parents, as appropriate, a description of how to file a grievance, including any formal grievance forms or other requirements for the format and content of the complaint.*

RECOMMENDATIONS

1. The home should have fire safety, fire alarm, and health inspections completed as soon as possible.

2. Staff should ensure that COMAR medication management policy is followed as required.

3. Staff should ensure all youth are familiar with the DJS grievance policy. Youth signatures should be included on procedure forms and a signed procedure form should be placed in each youth file.

NICK MORONEY
Acting Director

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

FACILITY REPORT
BALTIMORE CITY JUVENILE JUSTICE CENTER
JULY – SEPTEMBER, 2010

Facility:	Baltimore City Juvenile Justice Center 300 North Gay Street Baltimore, MD 21202 Superintendent: Mr. Anthony Wynn
Dates of Visits:	July 10 (off-site), 15, 27 and 31 August 6, 12 (offsite), 13 and 24 (offsite) September 7, 16 (offsite), and 21
Reported by:	Nick Moroney Senior Monitor
Persons Interviewed:	Administrators, Staff, Youth, Director of Detention, Area Director and Public Defenders
Date of Report:	November 2010

INTRODUCTION

The Baltimore City Juvenile Justice Center (BCJJC) houses a detention facility for male youth on the ground floor of a building complex that includes juvenile courts and other youth-related services. The detention center is operated by the Maryland Department of Juvenile Services (DJS/the Department), which currently rates the youth population capacity at 120.

When it opened in October 2003, BCJJC was intended to serve youth for short stays awaiting court dates. It was not designed to house youth for waiting periods of more than 30 days. Currently, forty to fifty percent of youth at BCJJC are waiting to move to a treatment placement. Some remain at the facility for many months

SUMMARY OF CRITICAL FINDINGS

- The design of the detention center remains unsuitable for housing youth for extended periods.
- A large number of youths wait for months for a treatment placement. Other youths remain in detention status at BCJJC for significant periods of time.
- The population at BCJJC is consistently over the rated capacity.
- BCJJC has not been able to provide full staffing for all shifts.
- Youth in the orientation units do not receive appropriate education.
- BCJJC was released from Federal CRIPA monitoring.
- The number of serious Group Disturbances decreased by almost 80% during the third quarter of 2010.
- Youth-on-youth assaults with injury are down 55% over the same period last year.
- The creation and implementation of the Intensive Services and Transition units continues to contribute to a reduction in the number of aggressive incidents.

FINDINGS

1. Population

a. General

Facility Capacity	High Population	Low Population	Average Population	Days Over Capacity
120	126	99	**July** 119 **Aug** 117 **Sep** 122	45 (49%)

During the third quarter of 2010, BCJJC successfully exited Federal monitoring having been found to be in compliance with requirements of the Civil Rights of Institutionalized Persons Act (CRIPA).

While basic functions and services at BCJJC have significantly improved, the overall number of youth at the facility and especially the number of youth in "pending placement" (awaiting treatment beds) continues to be a cause for serious concern.

There were 793 recorded youth entries during the third quarter of 2010.this is a slight decrease from the 811 for the third quarter of 2009. Some youth had more than one stint at BCJJC between July and September 2010 while others were at the facility for a single day or less. Youth held during the third quarter included five twelve-year-olds; 22 thirteen-year-olds; and 63 fourteen-year-olds.

The slight decline in youth entries has not mitigated crowding on the orientation unit or on other units. Once the population reaches 123, regular beds for youth are not available and youth have to sleep in plastic beds which are covered with a mattress and placed on the floor. Youth are sometimes moved into vacant cells on the Intensive Services Unit. Both practices raise security and health concerns. The Department must keep BCJJC population within the rated capacity of 120.

If youth waiting for placement were promptly transferred, there would be approximately 60 youth at the facility. The result could be a welcome end to the mixing of detained and adjudicated youth.

Youth entering BCJJC spend 3 days to a week on an orientation unit. Orientation is often overcrowded. Youth on orientation are not classified for security. Youth in the orientation unit receive minimal education services.

b. Detention and Pending Placement (on September 30, 2010)

	Number of Youth in Status 60 Days or more (on September 30)	Number of Youth in Status 90 Days or more (on September 30)
Pending Placement Status	13 (83, 83, 80, 78, 78, 76, 73, 72, 72, 70, 70, 69, and 66 days)	8 (208, 140, 133, 125, 114, 111, 106, and 102 days)
Detention Status	0	0

Average length of stay for youth at BCJJC during the third quarter was 18 days. Youth in pending placement stay longer.

(i) Extended length of stay for youth at BCJJC any time during the 3rd quarter of 2010

July to September 2010	30 days and over	60 days and over	90 days and over
Pending Placement	62 youths (59, 59, 58, 57, 57, 56, 56, 56, 55, 54, 54, 53, 52, 52, 50, 50, 49, 49, 48, 48, 47, 47, 46, 46, 46, 46, 45, 45, 45, 45, 44, 44, 44, 44, 43, 43, 42, 42, 41, 39, 38, 38, 36, 36, 36, 36, 35, 35, 35, 34, 34, 34, 34, 33, 32, 32, 32, 32, 32, 31, 30, and 30 days.)	42 youths (84, 84, 83, 83, 80, 78, 78, 78, 78, 77, 76, 76, 76, 76, 73, 72, 72, 70, 71, 71, 71, 70, 70, 69, 70, 70, 69, 68, 68, 67, 67, 67, 66, 66, 66, 64, 64, 62, 61, 61, 61, and 60 days.)	27 youths (210, 208, 204, 202, 176, 166, 147, 145, 140, 133, 130, 127, 126, 125, 114, 111, 108, 108, 106, 103, 102, 98, 96, 94, 94, 92, and 91 days)
Detention	34 youths (59, 57, 57, 56, 56, 55, 51, 49, 49, 48, 48, 47, 47, 46, 46, 45, 44, 44, 44, 42, 42, 41, 41, 41, 40, 38, 38, 38, 38, 37, 37, 36, 36, and 35 days.)	5 youths (77, 72, 64, 62 and 61 days.)	1 youth (98 days.)

The Department holds too many youths for too long in a physical plant that is inappropriate in such circumstances. The time spent in BCJJC is dead time. It does not count toward treatment time. During the third quarter of 2010, between 40% and 50% of the youth in BCJJC were awaiting placement. Pending placement youth would be in treatment centers if slots were available.

(ii) Shortage of In-State Resources

The problem of long stays for youth awaiting placement has not been effectively addressed and therefore many youth are stuck in BCJJC because of a resource shortage. On a typical day, there are approximately 150 or more youth from Baltimore City in detention centers throughout Maryland. Alternatives to detention have not significantly altered this number.

There is an ongoing treatment placement shortage in Maryland and so there is a need to prioritize and develop a number of small and specialized in-state treatment sources. As a stopgap measure, pending placement youth at BCJJC could be moved to the Hickey School in Baltimore County. Resources, especially outdoor recreation, are available at Hickey.

(iii) The Treatment Orientation Program (TOP) Initiative vs. Dead Time

The Department will attempt to mitigate dead time through a new program called the Treatment Orientation Program (TOP). The initiative will initially be aimed at youth waiting to go a DJS facility treatment program. The Department plans to include all youth awaiting placement in the TOP program eventually.

Youth enrolled in TOP will gain comprehensive knowledge about programs and expectations at treatment placements. Successful completion of the TOP program while in a detention center will result in a reduction in length of stay at DJS placements.

The TOP program may help address the length of time some youth spend in dead time/pending placement status. However, the development and utilization of a number of small and specialized community-based and residential treatment resources are needed to comprehensively address the issue.

c. Population Breakdown by Race/Ethnicity

	3rd Quarter 2009	3rd Quarter 2010
Total Recorded Youth Entries	812	786
African American	787	759
White/Caucasian	16	21
Other	9	6

There has been a 3% decline in admissions to BCJJC compared with the third quarter of 2009. The number of African American youth decreased by 3.5%, while White/Caucasian admissions increased slightly. However, African American youth at BCJJC continue to form over 90% of the population at the facility.

Applicable Standards

Maryland Rules, Rule 11-112. Detention or shelter care. *Maximum period of detention or shelter care – continued detention or shelter care pending the adjudicatory or waiver hearing may not be ordered for a period of more than thirty days.*

JDAI Standards I (D) Population Management *1. Written policies, procedures and actual practices (shall) ensure that when the institutional population approaches or reaches its rated capacity, appropriate youth are released or "stepped down" to non-secure settings. 2. Written policies, procedures and actual practices (shall) ensure that staff review the institutional population on a daily basis to make sure that youth who no longer need secure confinement are promptly released, are "stepped down" to less restrictive settings, or transferred to other settings.*

Md. Standards for Juvenile Detention Facilities 5.1.5.1 *The provision of … living space shall be sufficient to adequately meet the needs of the detained youth.*

Md. Dept. of Juvenile Services Policy and Procedure RF-01-08 Classification of Youth in Detention Facilities. *The Department of Juvenile Services (DJS) shall ensure a safe, secure and stable environment for detention facilities. Each facility shall implement an objective internal classification system to assess youths' potential vulnerability and supervision needs, and shall utilize the results of the classification assessment to guide appropriate housing decisions.*

2. Staffing

The provision of full staffing for all shifts continues to be a challenge. The Department must follow through on plans to hire 16 additional direct care staff and should expedite the recruiting process. BCJJC also needs an additional facility case manager and an additional nurse to make up for resignations and retirements.

On July 18, "six youth from Unit 23 were placed on seclusion due to staff shortage" and remained in their cells "until another staff arrived for duty" (DJS Incident Report 83861). Neither the length of time youth spent locked in their cells or the arrival time of other staffers to facilitate youth movement from cells was included on the incident report.

When adequate staff coverage is available, operational effectiveness improves. On July 16, staff were able to conduct "a better search of the youths room due to more staff being in the building…we were able to locate a cell phone behind youth –'s bed" (DJS Incident Report 83810).

The Department has attempted to alleviate shift coverage problems through both the hiring of new staff and by transferring DJS personnel from the William Donald Schaefer House (Schaefer House).

In addition to regularly scheduled bi-weekly staff training sessions by a Department employee, the behavioral health provider also offers on-site bi-weekly training sessions for BCJJC staff.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.1.5.5 Staffing *Staffing levels shall ensure the proper supervision and safety of the residents.*

Md. Standards for Juvenile Detention Facilities 5.1.3 Staffing *Staffing arrangements shall aim to provide a safe, humane, and caring environment.*

3. Safety and Security

a. Aggregate Incidents

Incident Categories	3rd Quarter 2009	3rd Quarter 2010
1. Youth on Youth Assault	176	97
2. Youth on Youth Assault with Injury	108	49
3. Alleged Youth on Staff Assault	24	14
4. Alleged Youth on Staff Assault with Injury	8	3
5. Group Disturbances (injury/property destruction)	31	6
6. Group Disturbances (without injury/destruction)	3	3
7. Restraints	290	141
8. Restraints with Injury	123	58
9. Seclusions over eight hours	9	9
10. Physical Child Abuse Allegations (DJS Custody)	1	0
11. Suicide Ideation, Gesture, Attempt or Behavior	10	3
12. Alleged Inappropriate Staff Conduct/Comments	7	4

A nearly 80% reduction in serious group disturbances is noteworthy. Serious (with injury) youth on youth assaults are down 55%. The decline in serious group disturbances and other incidents involving aggression is a credit to staff and administrators at BCJJC. Positive changes over the past year include more programming for youth, and the creation, implementation and fine-tuning of the ISU and Transition units.

The changes made to basic operations at BCJJC, especially over the course of the last year, have positively benefitted youth and staff and helped the facility in meeting requirements to successfully exit Federal monitoring during the third quarter.

The successful exit of BCJJC from Federal monitoring means the facility has been found to be in compliance with requirements under the Civil Rights of Institutionalized Persons Act (CRIPA).

The administration and staff at BCJJC deserve high praise and credit for all the positive things they have done at BCJJC and the contributions they have made to ensure a substantially improved environment for youth and employees at the facility.

b. Videotaping of Incidents

Digital footage from the camera system at BCJJC is automatically taped over after 30 days. All filmed incidents involving aggression or any critical issue should be archived and held for at least a year.

c. Intensive Services and Transition Units

During the third and fourth quarters of 2009, an Intensive Services Unit (ISU) was planned and implemented. The ISU began as a pilot program for youth involved in aggressive incidents at BCJJC. The ISU was later augmented by a Transition Unit for youth in the process of moving from the ISU back into the regular youth population.

The program was deemed successful and credited with helping to bring down the number of group disturbances. The program positively affects the atmosphere and group dynamic among youth at BCJJC. The ISU model includes individualized behavioral health assessments and differentiated guarded care plans, on-unit education with MSDE-certified teachers and a Special Education instructor, and specialized training and behavioral health needs instruction for ISU staffers.

The Department should expand the ISU and Transition programs to Cheltenham.

d. Security Equipment and Practices

The Department initiated a comprehensive review and upgrading of the BCJJC key control system.

One of the classrooms at BCJJC does not have camera coverage.

BCJJC does not have personal distress or man down alarms for teachers or direct care staff. Personal distress alarms should be issued to staff.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.1.1 Security and Control *Security in a detention facility shall recognize and balance the legitimate need for security and safety felt by staff and society with the residents' need for a setting that provides them with safety and a reasonable quality of life.*

Md. Department of Juvenile Services Policy and Procedure RF-02-07 Use of Crisis Management (CPM) Techniques Policy *Employees of the Department of Juvenile Services (DJS) … shall establish and maintain a safe and orderly environment within each facility.*

4. Fire Safety and Physical Plant

BCJJC is up-to-date and in full compliance regarding state fire prevention inspection requirements and food handling inspection requirements.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 5.2.1 *All detention facilities shall conform to State fire safety requirements.*

5. Education

Youth on the Orientation unit do not attend school but are given education-related packets.

The woodshop class has been replaced by an art class.

Educators at BCJJC report that they have been consistently supported by DJS staff concerning safety and security. Long-standing shortcomings in Special Education program assessment, placement and documentation at BCJJC have been comprehensively addressed by MSDE and DJS in consultation with the CRIPA education consultant.

There are vacancies for a science teacher and a records clerk in the BCJJC education department.

Class observations at the school found youth engaged and on task. Textbooks and materials used were grade appropriate and in good condition. During a well-planned Language Arts class, the instructor and assistant instructor demonstrated significant classroom management skills and elicited constructive contributions from youth. However, classes lasting 90 minutes seemed overly long for youth.

The education component in the ISU is properly serviced and implemented. The school principal was teaching on the ISU unit during a monitoring visit.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.1 Educational Services *The Department shall ensure that educational services provided within the detention facility are consistent with state requirements and that they meet the individual needs of the youth.*

6. Rehabilitative and Recreational Programming

Programming has increased throughout the facility. Administrators and line staffers are attempting to implement comprehensive programming for the orientation units.

Although there is a gym and two concrete enclosed outdoor pads for basketball, there is insufficient indoor and outdoor recreation space at BCJJC. The facility is not designed to house youth for extended periods of time.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.1.5.4 *… (E)xercise and recreation … services shall be maintained at a sufficient level to accommodate the number of youth at the facility.*

Md. Standards for Juvenile Detention Facilities 4.5 Recreational activities *A well-defined and structured recreation program shall be provided for each resident.*

Md. Dept. of Juvenile Services Policy and Procedure RF-08-07 Recreational Activities Policy *The Department of Juvenile Services (DJS) shall provide recreation and leisure activities to youth in DJS residential facilities and programs to promote skill development and prevent idleness. Recreation shall be available to all youth each day. Leisure activities shall be provided to alleviate boredom, provide positive reinforcement and develop skills of cooperation, teamwork and sportsmanship.*

7. Medical and Behavioral Health

The medical unit lost two nurses and hired one during the quarter. Another nurse should be hired. Medical staffers report that the medical suite does not have enough examination rooms to meet the needs of youth.

Behavioral Health services are provided onsite by Hope Health Systems, Inc.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 4.3 health Care Services *Health care services shall be in accordance with established Departmental policy and procedures.*

Md. Standards of Juvenile Detention Facilities 4.3.2 Mental Health Services *The Department shall be responsible for acquiring, either directly or by agreement or contract with a public or private mental health agency, necessary mental health care and services for youth within facilities operated by the Department and its vendors. All mental health services shall be provided in accordance with guidance from the Department of Health and Mental Hygiene.*

8. Youth Advocacy, Internal Monitoring and Investigation

Community Case Managers (often called P.O.s) visiting youth at BCJJC are required to fill out a contact form. This form includes the type of visit and a space for remarks. The youth visited signs the form. The form provides documents community case manager visits.

The DJS Quality Improvement (QI) Unit issued its most recent report on BCJJC in March of 2009. The facility achieved Superior or Satisfactory Performance in 40% of the 45 standards evaluated.[3] The results represented an improvement compared to a prior evaluation in 2008, which yielded a result of 18% Superior or Satisfactory Performance regarding 45 standards evaluated.

[3] http://www.djs.state.md.us/quality-assurance/qir-bcjjc.pdf

RECOMMENDATIONS

1. The Department should continue to seek treatment resources in Maryland to alleviate high numbers of youth in pending placement.

2. The Department must follow through on the hiring of at least 16 direct care staff. The hiring and training of direct care staff should be expedited.

3. Another nurse should be hired for the BCJJC medical unit.

4. A facility case manager position should be filled.

5. The Department must keep BCJJC population within the rated capacity of 120.

UNABATED CONDITIONS

1. BCJJC remains unsuitable for housing youth for extended periods.

2. The Department continues to hold youth in pending placement status for long periods at BCJJC.

3. The orientation units remain overcrowded.

4. Youth in orientation do not receive appropriate education services.

5. All filmed incidents involving alleged abuse, assault and/or physical restraint should be archived and held for at least a year.

6. One of the classrooms at BCJJC still does not have camera coverage. Cameras should be installed in every room or office frequented by youth.

7. The medical suite does not have enough examination rooms.

8. Community case manager contact forms should be mandatory at all DJS facilities.

9. The Department should supply personal distress alarms for teachers and direct care staff at all DJS facilities.

10. The Department should expand the ISU and Transition programs to Cheltenham.

NICK MORONEY
Acting Director

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

FACILITY REPORT
J. DEWEESE CARTER CHILDREN'S CENTER
JULY – SEPTEMBER, 2010

Facility: J. DeWeese Carter Children's Center
300 Scheeler Road
Chestertown, MD 21620
Superintendent: Derrick Witherspoon

Dates of Visits: July 19
August 3 and 19
September 10 and 16, 2010

Reported by: Nick Moroney
Senior Monitor

Persons Interviewed: Superintendent, Assistant Superintendent, Facility Case Managers, Resident Advisors, Group Life Staff, Child Advocate, DJS-OIG Investigator, Medical Staff, Office Administrator, Maintenance Staff, Education Staff, State Law Enforcement, Youth

Date of Report: November 2010

INTRODUCTION

The J. DeWeese Carter Youth Facility (Carter) is a 15-bed detention center for boys on Maryland's Eastern Shore. It is located in one wing of what was an adult residential psychiatric facility in Chestertown, Kent County. It is operated by the Maryland Department of Juvenile Services (DJS/the Department).

SUMMARY OF CRITICAL FINDINGS

- The Carter facility continued to remain a safe and secure environment for youth during the third quarter of 2010.
- Youth population remained at or below the cap of 15 throughout the third quarter.

FINDINGS

1. Population

a. General (for the third quarter of 2010)

(DJS-set) Rated Capacity	High Population	Low Population	Average Monthly Population	Number of Days Over Capacity
15*	15	7	**Jul** 14 **Aug** 12 **Sep** 11	0

*Often incorrectly stated as 27 on DJS facility population-related documents

There were no more than 15 youth at the Carter Center during the third quarter. The Department should be commended for continuing to honor an appropriate rated population capacity.

The cap on population for the past couple of years at this once troubled center has helped to produce a facility now often referred to as the "Miracle of Chestertown." The transformation occurred with considerable effort from invested DJS staff and youth at Carter and with the help of both community and professional advocates.

b. Pending Placement

The average length of stay for all youth at Carter during the third quarter of 2010 was 24 days. All youth left Carter within 60 days of entrance.

The Department is implementing a pre-placement orientation program called Treatment Placement Orientation (TOP) at DJS detention centers including Carter. The program includes the opportunity to receive credit towards placement time. This could help lessen extended periods of "dead" time spent waiting for treatment placement. The Department deserves praise for designing and implementing this long-needed program.

c. Population Breakdown by Race/Ethnicity at Carter

	3rd Quarter 2009	3rd Quarter 2010
Total Youth Entries	86	68
African American	40	41
White/Caucasian	43	22
Latino	3	3
Other/Unknown	0	2

Overall youth entries have dipped approximately 20% at Carter compared with the third quarter of 2009. The number of African American admissions has marginally increased while White/Caucasian admissions have declined by almost 50%.

Applicable Standard

Maryland Rules, Rule 11-112. Detention or shelter care. *Maximum period of detention or shelter care – continued detention or shelter care pending the adjudicatory or waiver hearing may not be ordered for a period of more than thirty days.*

2. Staffing

A long-standing staff coverage shortage at Carter has been addressed through the hiring of new staff.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 5.1.5.5 Staffing *Staffing levels shall ensure the proper supervision and safety of the residents.*

3. Safety and Security

a. Aggregate Incidents

Incident Categories	3rd Quarter 2009	3rd Quarter 2010
1. Youth on Youth Assault	4	9
2. Youth on Youth Assault with Injury	1	1
3. Alleged Youth on Staff Assault	0	0
4. Alleged Youth on Staff Assault with Injury	0	0
5. Group Disturbances (injury/property destruction)	1	0
6. Group Disturbances (without injury/destruction)	0	0
7. Restraints	6	11
8. Restraints with Injury	2	1
9. Seclusions over eight hours	1	0
10. Physical Child Abuse Allegations (DJS Custody)	1	0
11. Suicide Ideation, Gesture, Attempt or Behavior	4	6
12. Alleged Inappropriate Staff Conduct/Comments	0	1

Compared to the third quarter of 2009, there was a rise in the number of youth on youth assaults and of instances where physical restraint was used, despite a 20% decline in overall youth admissions. However, the overall number of aggressive incidents resulting in injury remained low during the third quarter of 2010 and the Carter facility continued to be a safe and secure environment for youth held there.

b. Safety and Security Related Upgrades

At Carter, DJS direct care staff work in both the hallway and the classrooms of the school during school hours. There are plans to extend camera coverage at Carter to the school. Security camera coverage should extend to all areas frequented by youth within the entire facility, including the school.

Priority should be given to the implementation of camera installation in every room or office frequented by youth (including counseling offices) throughout every DJS facility, including Carter.

Holes for windows have been cut in doors to counseling offices to allow for ease of visual security checks on youth and staff from outside the door. An attempt to use security mirrors to allow visual coverage inside offices where youth and staff interact proved technically unworkable. However, residential advisors are posted to keep watch when youth are with teaching or counseling staff. Such security upgrades will be effective as long as direct care staff are present in the immediate vicinity and are systematically checking inside offices. There should also be security camera coverage in offices used by the facility case managers.

Carter does not have personal distress alarms for teachers or direct care staff. There are 25 emergency man-down alarms for school and counseling staff at the Lower Eastern Shore Children's' Center (LESCC), DJS' other detention center on the Eastern Shore. School staff, counselors, social workers and direct care staff at all DJS facilities (including Carter) should also be given man-down distress alarms. The tool is pressed by a staffer in an emergency causing a "code blue" signal at Master Control. The alarm can only be disabled off-scene.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 5.1.1 Supportive Security
Security in a detention facility shall recognize and balance the legitimate need for security and safety felt by staff and society with the residents' need for a setting that provides them with safety and a reasonable quality of life.

4. Physical Plant and Basic Services

a. Fire Safety

Carter complies with fire safety requirements and is up-to-date on inspections.

b. Physical Plant

The condition of the physical plant improved in tandem with the population cap. The staff includes a full time maintenance man who tends to maintenance needs in a timely manner. Beds are suicide-resistant and each youth has his own room. The exterior and interior of the facility are clean and well kept.

c. Basic Services

The Food Service Manager for Carter and the Lower Eastern Shore Children's Center (LESCC) works assiduously to insure the supply of appropriate types and

quantities of basic foodstuffs and healthy snacks for youth. Headquarters nutrition personnel also monitor the food service provider.

Administrators and staff continue to hold an ongoing series of Town Hall meetings between staff and youth at which suggestions and concerns about food and other issues are aired. Administrators at Carter make a conscientious effort to address concerns and act on suggestions.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.2.1 Conformity with Codes *All detention facilities shall conform to state fire safety requirements.*

Md. Standards for Juvenile Detention Facilities 5.5.1 Food Service Management *A full time staff member experienced in food service management shall supervise the food service operation within a detention facility.*

5. Education

The Maryland State Department of Education (MSDE) provides education services at Carter. The building is clean, spacious and aids in the provision of a constructive learning environment. The school dedicated a new library room during the third quarter.

Youth at Carter enter school upon arrival and education records are requested and usually received in a timely manner. Special education requirements continue to be consistently met at Carter. Youth are in class for six hours each day, however, there are no security cameras in the school buildings. The Department needs to prioritize the installation of cameras in classrooms and the school hallway.

Classroom visits indicate youth are academically engaged. The classrooms are roomy and the staff to youth population allows individual attention to youth education needs. Youth and instructors utilize appropriate, up-to-date textbooks and computer equipment. Students needing GED programs are assisted on an individual basis. Career planning is incorporated into the education component at Carter.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.1 Educational Services *The Department shall ensure that educational services provided within the detention facility are consistent with state requirements and that they meet the individual needs of the youth.*

6. Rehabilitative and Recreational Programming

a. Therapeutic Program

Staff and administration continue to provide a wide variety of programs to youth, including alcohol and drug abuse groups, focus groups and Town Hall meetings with the Superintendent. Behavioral health and social work staff provide ART (Aggression Replacement Therapy) twice per week. Speakers from Narcotics Anonymous and Alcoholics Anonymous visit the facility to meet with youth.

Youth continue to work regularly with a local children's author. She directs readings and journaling. This author has a significant positive impact on the youth at Carter as a teacher and role model through her "World of Books" program.

At the beginning of the summer, youth were involved in youth service projects through MSDE in which they learned some gardening skills. Summer happenings included a family day and a carnival day.

b. Recreational Programming

Youth receive one hour of large muscle exercise per day. An interior room includes a climbing wall and exercising equipment. There was a table tennis tournament for youth at Carter during the summer. In the outside recreation area, the basketball court has been resurfaced, however, a cover is still needed to facilitate outdoor activities during inclement weather.

Funds for materials used in recreational programming at DJS facilities are limited. Some members of advisory boards at DJS facilities (including Carter, Lower Eastern Shore Children's Center and Cheltenham Youth Facility) are contemplating the creation of a non-profit [501 (c)] mechanism to facilitate charitable contributions.

c. Parental Involvement

Parents or guardians can visit twice per week, and youth receive at least two phone calls per week. Parents and guardians are encouraged to attend treatment and education-related meetings for youth.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.5 Recreational activities *A well-defined and structured recreation program shall be provided for each resident.*

7. Medical and Behavioral Health

Youth who come to Carter receive prompt physical exams and screenings regarding mental health issues, proclivity to substance abuse and suicide risk. The physician conducting the physical exam also does the dental screening. Youth are not seen by a dentist unless referred by the physician or for emergencies.

Medical services are provided on-call on the third shift and on some weekends. A physician is present one day per week and a psychiatrist is available one day per week for medication management. Dental services are provided in nearby Chestertown by appointment.

Another nurse needs to be contracted or hired (part-time) to facilitate in-house rather than on-call weekend medical coverage. This would also allow for more shift flexibility among the current small number of staffers who may need time off.

Carter staff includes two Licensed Clinical Social Workers (LCSW's), two case managers, and an addictions counselor to provide screening and counseling for youth. A behavioral health staffer is on-call after normal business hours. The Department should ensure a mental health care professional is available to meet and counsel youth and staff 24/7.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.3 health Care Services *Health care services shall be in accordance with established Departmental policy and procedures.*

8. Youth Advocacy, Internal Monitoring and Investigation

The DJS Child Advocate retrieves and processes youth grievances in a timely and effective manner. The DJS Quality Improvement Unit issued a report on Carter in July of 2010.[4] The facility achieved Superior or Satisfactory Performance in 69% of the 36 standards evaluated. The results represented an improvement in performance compared to a prior evaluation in 2008 that yielded a result of 64% Superior or Satisfactory Performance regarding 44 standards evaluated.

Applicable Standard

Md. Department of Juvenile Services Policy and Procedure MGMT-01-07 Youth Grievance Policy *The Department of Juvenile Services (DJS) shall permit youth and individuals on behalf of DJS youth to file a grievance for a circumstance or action related to behavior of other youth, behavior of employees, or conditions of confinement.*

[4] http://www.djs.state.md.us/quality-assurance/qir-carter.pdf

RECOMMENDATIONS

1. Population should remain capped at no more than 15 youth.

UNABATED CONDITIONS

1. Camera coverage should extend to all areas in the facility frequented by youth (including classrooms, hallways and case management offices).

2. Staff should be supplied with emergency man-down alarms.

3. A part-time nurse should be added to the medical staff.

4. A behavioral health staffer should be available to meet with youth and staff on a 24/7 basis.

5. A cover should be provided for the basketball court.

6. To reflect the actual DJS rated capacity of the Carter facility, DJS-HQ should correct the reported rated capacity at Carter from 27 to 15 youth on all facility related documentation, including DJS population reports.

NICK MORONEY
Acting Director

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

FACILITY REPORT
CHELTENHAM YOUTH FACILITY
JULY – SEPTEMBER, 2010

Facility: Cheltenham Youth Facility
11001 Frank Tippett Road
Cheltenham, MD 20623
Interim Administrator: Reginald Garnett
Superintendent: William Wilson

Dates of Visits: July 7, 13 (offsite), 21 and 22 (offsite)
August 10, 17, and 26 (offsite)
September 9, 20 (offsite), 23 and 27 (offsite), 2010

Reported by: Nick Moroney
Senior Monitor

Persons Interviewed: Superintendent, Assistant Superintendents, Interim Administrator, Regional Director, DJS-OIG Investigators, Head Nurse, Shift Commanders, School Staff, Special Education Needs Assessment Staff, Residential Staff, Youth, Public Defenders, Glass Mental Health Staff, Facility Case Managers, Child Advocate, Office Administration Staff

Date of Report: November 2010

INTRODUCTION

Cheltenham Youth Facility (CYF) is operated by the Maryland Department of Juvenile Services (DJS/the Department) and is located in Prince George's County. CYF serves young men from 12 to 18 years old. The facility includes three separate components. The detention component at CYF consists of youth awaiting trial, adjudication or committed placement. The ReDirect program, a short-term program for committed youth that is housed in Murphy Cottage, remains closed following the death of a staff member in February 2010. The third component at CYF is a small group home shelter program for youth under court supervision who do not require secure confinement. The shelter has also been closed since February. The Shelter and ReDirect units are located outside the security fence on the CYF campus.

SUMMARY OF CRITICAL FINDINGS

- A JJMU Special Report addressing safety and security concerns and the death of a staff member in February 2010 at Cheltenham Youth Facility (CYF) was published in October 2010. The report can be accessed at:

  http://www.oag.state.md.us/JJMU/reports/100610_Cheltenham_Special_Report.pdf

  The DJS response to the Special Report on CYF can be accessed at:

  http://www.oag.state.md.us/JJMU/reports/100610_DJS_Response_Cheltenham_Special_Report.pdf

- The residential cottages at CYF continue to be severely overcrowded.
- The DJS rated capacity for CYF remains 115. The number should be lowered to 86 youth to reflect the loss of 29 youth slots with the closure of the Murphy and Shelter cottages.
- Youth are held for longer than permitted periods in social separation (de facto seclusion).
- The dilapidated residential cottages at Cheltenham should be replaced as soon as possible
- Staff coverage for direct care shifts is inadequate.
- The CYF Shelter should be fitted with a sprinkler system and re-opened as soon as possible.

FINDINGS

1. Population

a. CYF Population figures for Third Quarter, 2010

DJS-Set Facility Capacity	High Population	Low Population	Average Monthly Population	Number of Days Over Capacity
115	131	90	**Jul** 106 **Aug** 98 **Sep** 111	17 (18%)

The chart above does not indicate the level of overcrowding of the residential cottages at CYF. The rated population capacity of 115 youth for Cheltenham was not lowered after the closing of the cottages housing the ReDirect and Shelter programs. These closures resulted in a loss of 29 youth beds. The rated capacity for CYF should be lowered from 115 to 86 youth to reflect the loss.

The more realistic capacity figure of 86 was exceeded every day (100%) during the quarter. On one day, Rennie cottage housed 47 youth, almost 100% over the cottage capacity of 24. The cottage was so jammed that four youth were moved to the infirmary to sleep due to lack of space.

Staff call-outs and coverage issues complicate the overcrowding situation. Youth legal and security status along with other security considerations also exacerbate the overcrowding problem.

The aged and decrepit cottages at Cheltenham are unfit for youth residency even when below capacity. Cheltenham has been in operation since 1872 and is first in line for DJS facility replacement. Although plans for a 72-bed detention facility on Cheltenham grounds are underway, the new purpose-built Cheltenham detention center will take three years to complete - if design and construction go ahead on schedule.

Initial construction plans also included an urgently needed 48-bed treatment center at Cheltenham. This plan has been postponed due to budget constraints.

The Department closed the shelter program when it closed Murphy Cottage. The shelter program should be re-opened as soon as possible. The CYF Shelter offered a home-like and well-managed environment for youth. The Department should install

sprinklers in the shelter so that the home can accept 12 youth (instead of the earlier maximum of 5). Re-opening plans should include the assignment of school staff (with direct care staff support) to instruct the youth who will be housed in the shelter.

b. Pending Placement and Detention at CYF

	Youth in Status 60 Days or more (on 9/30/10)	Youth in Status 90 Days or more (on 9/30/10)
Pending Placement	3 (89, 70 and 62 days)	2 (101 and 93 days)
Detention	0	0

The average length of stay for all youth at CYF during the third quarter was 21 days. However, large numbers of youth spent much longer at the facility awaiting a treatment bed ("pending placement") or in detention status. Pending placement time is "dead time" – time not counted towards completion of a treatment program.

The chart below illustrates the magnitude of upper-end stay time among all youth who spent time at Cheltenham at any time during the third quarter of 2010.

Pending Placement and Detention data concerning youth who were at CYF at any time during the third quarter of 2010

July to September 2010 – in detail	30 days and over	60 days and over	90 days and over
Pending Placement	49 youths (58, 58, 58, 57, 56, 55, 51, 49, 49, 48, 48, 48, 45, 45, 44, 44, 43, 42, 42, 42, 42, 42, 40, 37, 37, 37, 36, 37, 36, 36, 35, 35, 35, 34, 33, 33, 33, 32, 32, 32, 31, 31, 31, 31, 30, 30, 30, 30, and 30 days.)	22 youths (89, 82, 82, 81, 81, 78, 76, 72, 72, 72, 72, 70, 70, 68, 67, 67, 65, 65, 65, 65, 62, and 62 days.)	13 youths (209, 157, 148, 145, 139, 131, 110, 107, 101, 101, 97, 93, and 91 days)
Detention	44 youths (59, 57, 55, 52, 52, 50, 48, 45, 43, 43, 42, 42, 42, 41, 41, 40, 40, 40, 39, 39, 39, 38, 37, 37, 37, 36, 35, 35, 35, 35, 34, 34, 33, 32, 32, 32, 32, 32, 31, 31, 31, 30, 30, and 30 days.)	7 youths (80, 79, 76, 71, 65, 60, and 60 days.)	1 youth (91 days.)

(i) The Treatment Orientation Program (TOP) Initiative vs. Dead Time

The Department is attempting to mitigate dead time through a new program called the Treatment Orientation Program (TOP). The initiative will initially be aimed at youth waiting to go a DJS facility for treatment. The Department plans to include all youth awaiting placement in the TOP program.

Those youth eligible to enroll in TOP will be given the chance to gain comprehensive knowledge about programs and expectations at treatment placements. Successful completion of the TOP program while in a detention center will result in a reduction in length of stay at DJS-run placements.

The Department should carefully measure the program's efficacy. If subsequent data indicate the TOP program is succeeding in addressing the dead time/pending placement issue, DJS should ensure the program is expanded to include all youth waiting for treatment beds in all DJS detention centers.

c. Population Breakdown by Race/Ethnicity at CYF

	3rd Quarter 2009	3rd Quarter 2010
Total Youth Entries	848	635
African American	706	531
White/Caucasian	100	73
Hispanic/Latino	36	27
Other/Unknown	6	4

Overall youth admissions have decreased approximately 25% at Cheltenham compared with the third quarter of 2009. The number of African American , White/Caucasian and Hispanic/Latino admissions have also declined by 25%.

Applicable Standards

Maryland Rules, Rule 11-112. Detention or shelter care. *Maximum period of detention or shelter care – continued detention or shelter care pending the adjudicatory or waiver hearing may not be ordered for a period of more than thirty days.*

JDAI Standards I (D) Population Management *1. Written policies, procedures and actual practices (shall) ensure that when the institutional population approaches or reaches its rated capacity, appropriate youth are released or "stepped down" to non-secure settings. 2. Written policies, procedures and actual practices (shall) ensure that staff review the institutional population on a daily basis to make sure that youth who no longer need secure confinement are promptly released, are "stepped down" to less restrictive settings, or transferred to other settings.*

Md. Standards for Juvenile Detention Facilities 5.1.5.1 *The provision of … living space shall be sufficient to adequately meet the needs of the detained youth.*

2. Staffing

William E. Wilson was named as the new Superintendent at CYF during the third quarter. He has instituted tighter security protocols for entry and exit at Cheltenham. He is in the process of implementing needed operational changes concerning various issues at the facility including staffing patterns.

Cheltenham continued to have a shortage of direct care staff. This is due, in part, to staff on sick leave and staff calling to say they will not be able to come to work (call-outs).

Applicable Standard

Md. Standards for Juvenile Detention Facilities 5.1.5.5 Staffing *Staffing levels shall ensure the proper supervision and safety of the residents.*

3. Safety and Security

a. Aggregate Incidents (third quarter 2009 and third quarter 2010)

Incident Categories	3rd Quarter 2009	3rd Quarter 2010
1. Youth on Youth Assault	54	35
2. Youth on Youth Assault with Injury	34	14
3. Alleged Youth on Staff Assault	5	1
4. Alleged Youth on Staff Assault with Injury	2	0
5. Group Disturbances (injury/property destruction)	3	0
6. Group Disturbances (without injury/destruction)	1	1
7. Restraints	64	46
8. Restraints with Injury	33	17
9. Seclusions over eight hours	1	0
10. Physical Child Abuse Allegations (DJS Custody)	2	5
11. Suicide Ideation, Gesture, Attempt or Behavior	22	7
12. Alleged Inappropriate Staff Conduct/Comments	1	2

A decrease of approximately 25% occurred in overall youth admissions. The number of reported youth on youth assaults is down by 35%, and those with injury down almost 60%.[5] Dips in aggressive events indicate positive operational improvements.

Factors driving reduction of aggressive incidents at CYF might include (1) an increasing involvement by Glass Mental Health (onsite behavioral health provider) staff with youth in the cottages and school; (2) an emphasis by the new superintendent on programming and on more intensive case manager involvement with youth; (3) a

[5] The Aggregate Incident chart data is compiled from and dependent upon the completeness and accuracy of DJS incident reporting data. If incident documentation or reporting provided by CYF to DJS headquarters is shown to be incomplete or inaccurate, then conclusions regarding increases or decreases in aggressive incidents will have to be revisited.

stronger emphasis on the need to utilize case management and behavioral health staff in prevention and early intervention stages of youth unrest; and (4) an insistence that direct care staff utilize de-escalation training whenever possible.

According to reported data, events such as youth on youth assaults and physical restraints involving injury (down by close to 50%) have decreased significantly, however, the number of reported physical abuse allegations has more than doubled during the third quarter of 2010.

b. Physical Abuse

There were five reported physical abuse allegations during the third quarter.

At least three CYF staff members have been terminated and a number of others were disciplined after investigations stemming from alleged abuse incidents.

In one incident, IR 85644, a staff member dragged a youth on his back across a hallway floor and into the youth's cell. The youth was handcuffed at the time. Apparently, the youth had refused to go into his cell.

c. Unlocked Door Seclusion called "Social Separation" at CYF

Social Separation is a time-out mechanism in which a youth may go to his room "*for a non-punitive 'cooling—off' period of no more than 60 minutes, which provides an opportunity for a youth to calm down and the situation to defuse,"* according to DJS standards and procedures.[6]

At Cheltenham, staff and supervisors confine youth to their cells with doors unlocked for hours and sometimes for days. This is de facto seclusion, but without the protections detailed in the DJS policy for seclusion.

These unlocked door seclusions go unreported. CYF ostensibly had zero seclusions over 8 hours during the third quarter and only one for the same period last year. However, a social separation logbook shows that this practice is widely used. Some entries cover a six-hour plus period and do not mention any aggressive behavior by youth and yet the youths continued to be held in so-called "social separation."

The practice of putting a youth into his cell for long periods locked or unlocked and failing to report the event as a seclusion has been going on for some time at CYF. During the first quarter of this year, an internal DJS investigation sustained an allegation of physical abuse of a youth by a staff member which occurred on March 27, 2010 (DJS Incident 09378). The youth told the DJS Office of Inspector General (DJS-OIG) investigator that he (the youth) had been on seclusion for almost 24 hours and that he knotted sheets and banged on the cell door because "staff was not trying to let me out."

[6] Reference the Maryland DJS Crisis Prevention Management Techniques Policy at RF-02-07 (3) (p).

The youth said that, during the time he was in seclusion, staff never tried to talk with him to give him an opportunity to process out of seclusion. According to the investigator, the youth "stated the door was locked the entire time," and staff "did not give him any options to come out of seclusion." And yet there were no recorded incidents on the DJS Incident database of locked door seclusions lasting over 8 hours at CYF during the first quarter of 2010 (or indeed for the last quarter of 2009).

Rather than misusing social separation at CYF, the Department should expand on the success of the ISU and Transition model at BCJJC by bringing the model to Cheltenham. The ISU and Transition unit at BCJJC offer a well-designed and implemented alternative facility program to address the needs of youth needing intensive individualized services. Administrators at the Cheltenham facility should work with mental health professionals to adopt a similar approach to the ISU system at BCJJC in order to properly address youth who need intensive individualized services.

In addition, the Department should designate social separation as a reportable incident for inclusion on the DJS Incident database.

d. Security Equipment and Practices

There is a shortage of radios for direct care staff to use while working with youth. Sometimes as many as five staffers share one or two radios. If an incident occurs in such circumstances, communication between staffers could be difficult or impossible. The shortage of radios is a serious safety and security issue for youth and staff.

The Department recently supplied radios enough for all staff on each shift. The radios have arrived and will be distributed when new shelving is constructed to house the radios and chargers in the gatehouse.

Cheltenham does not have personal distress alarms for teachers or direct care staff.

The Department should insure a clear and effective key control system for each DJS facility including CYF. A key control expert should be charged with the implementation of facility specific key control systems at CYF. Lock barrels need to be replaced at CYF to guard against the use of unauthorized keys.

Security camera coverage should extend to all areas frequented by youth within the entire facility.

Applicable Standards

Md. Dept. of Juvenile Services Policy and Procedure RF-01-07 Seclusion Policy *The Department of Juvenile Services (DJS) shall maintain a safe, secure area to isolate or seclude youth who present an imminent threat of physical harm to themselves or other individuals, have not responded to less restrictive methods of control or for whom less restrictive measures cannot reasonably be tried, or have escaped or are attempting to escape. The duration of seclusion shall be determined by the youth's level of risk, as indicated by his or her behavior and statements.*

Md. Dept. of Juvenile Services Policy and Procedure RF-01-07 (3) (c) *Seclusion means the placement of a youth in a locked room where a youth is kept for a period of time during waking hours.*

Md. Dept. of Juvenile Services Policy and Procedure RF-01-07 (4) (a) (7) *Seclusion shall not be used as punishment and is limited to youth who: (i) Present an imminent threat of physical harm to themselves or other individuals; (ii) Have not responded to less restrictive methods of control or for whom less restrictive measures cannot reasonably be tried; or (iii) Have escaped or are attempting to escape.*

Md. Dept. of Juvenile Services Policy and Procedure RF-01-07 (4) (a) (8) *The length of seclusion shall not be a pre-determined time frame and shall be based on the criteria identified in section 4 (a) (7) of this policy. When these conditions are no longer present, youth shall be released from seclusion.*

Md. Dept. of Juvenile Services Policy and Procedure RF-01-07 (4) (a) (24) (vii) *In instances where an incident of seclusion lasts longer than 8 hours, the Facility Administrator or designee shall…ensure that the youth is removed from seclusion after 48 hours unless a written declared emergency is issued by the Facility Administrator and approved by the Assistant Secretary for Residential Services.*

Md. Dept. of Juvenile Services Policy and Procedure RF-02-07 (3) (p) *Social Separation means the supervised placement of a youth in his/her room for a non-punitive "cooling-off" period of no more than 60 minutes, which provides an opportunity for a youth to calm down and the situation to defuse. The door of the room shall remain opened and unlocked.*

COMAR 14.31.06.15 D. Use of Time Out. *(4) Each period of time out shall be appropriate to the developmental level of the resident and the degree of severity of the behavior, and may not exceed 30 minutes.*

4. Physical Plant

The physical plant at CYF is aged and unsuited to housing youth.

CYF is up-to-date and in compliance with fire safety regulations and mandatory inspections. Cheltenham is also in compliance with health and food preparation standards and inspections.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 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.*

Md. Standards for Juvenile Detention Facilities 5.2.1 *All detention facilities shall conform to State fire safety requirements.*

5. Education

A large number of students benefit from Special Education services. Youth are professionally assessed upon entry. There is a system in place to assure youth school records are speedily requested. Glass Mental Health has personnel assigned to the school.

The Department should work with the school principal to hire personnel to be trained in crisis prevention. These staff members would then be available to supervise one-on-one learning and for other school area duties as assigned. These new employees should be hired to work exclusively at the school. At the end of the quarter, there are tentative plans to hire five additional direct care staffers to work exclusively in the school.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.1 *The Department shall ensure that educational services provided within the detention facility are consistent with state requirements and that they meet the individual needs of the youth.*

6. Rehabilitative and Recreational Programming

Community Case Managers were present as required during Treatment Service Plan meetings attended by the Monitor this quarter.

Administrators at CYF are attempting to improve planning and expand types of recreational activities available to youth.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 5.1.5.4 *… (E)xercise and recreation … services shall be maintained at a sufficient level to accommodate the number of youth at the facility.*

7. Medical and Behavioral Health

Glass Mental Health Services (Glass) manages CYF behavioral health services for both youth and staff. Glass behavioral health therapists have also been involved in training staff and have been available throughout the year to help youth and staffers address issues of concern.

Glass personnel are involved in violence prevention. They counsel staff and youth and advise on constructive interaction among youth and between staff and youth. Glass personnel are not authorized to intervene when youth are involved in an aggressive incident.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 4.3 health Care Services *Health care services shall be in accordance with established Departmental policy and procedures.*

Md. Standards of Juvenile Detention Facilities 4.3.2 Mental Health Services *The Department shall be responsible for acquiring, either directly or by agreement or contract with a public or private mental health agency, necessary mental health care and services for youth within facilities operated by the Department and its vendors. All mental health services shall be provided in accordance with guidance from the Department of Health and Mental Hygiene.*

8. Youth Advocacy, Internal Monitoring and Investigation

The child advocate at CYF is conscientious in responding promptly to youth grievances.

The DJS Quality Improvement Unit issued its most recent report about CYF on May 1, 2009.[7] The facility achieved Superior or Satisfactory Performance in 42% of the 38 standards evaluated. The results represented a decline in performance compared to a prior evaluation in 2008 that yielded a result of 62.5% Superior or Satisfactory Performance regarding 40 standards evaluated.

[7] http://djs.state.md.us/quality-assurance/qir-cheltenham.pdf

RECOMMENDATIONS

1. Cheltenham's youth population should not exceed 86.

2. The Department should ensure enough direct care staffers are available to cover every shift and youth should never be confined to cells because of coverage problems.

3. Staff on each shift should be supplied with radios and man down alarms.

4. Camera coverage should be extended to all areas in the facility (interior and exterior) frequented by youth.

5. Each youth at Cheltenham should have his own individual cell.

6. No youth at Cheltenham should have to sleep in a plastic bed placed on the floor.

7. New personnel should be hired to supervise one-on-one learning and for other school area duties. These new employees should be hired to work exclusively at the school.

8. The Department should expand on the success of the ISU and Transition model at BCJJC by bringing the model to Cheltenham.

UNABATED CONDITIONS

1. The cottages at Cheltenham continue to be severely overcrowded.

2. The DJS rated capacity for CYF should be lowered to 86 youth to reflect the loss of 29 youth slots with the closure of the Murphy and Shelter cottages.

3. The CYF Shelter should be re-opened with a sprinkler system so that it can be expanded to serve more youth.

4. Social Separation should be a reportable incident.

5. Lock barrels need to be replaced at CYF to guard against the use of unauthorized keys.

NICK MORONEY
Acting Director

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

FACILITY REPORT
THE GRAFF SHELTER FOR GIRLS
JULY – SEPTEMBER 2010

Facility:	Dr. Henry F. and Florence Hill Graff Shelter for Girls 8504 Maplesville Road Boonsboro, MD 21713 Chief Administrator: Bruce Anderson
Date(s) of Visit(s):	June 30 and September 9, 2010
Reported by:	José D. Saavedra Monitor
Persons Interviewed	Direct Care Staff, Program Staff, and Youth
Date of Report:	November 2010

INTRODUCTION

The Graff Shelter for Girls (Graff) is operated by San Mar Children's Home, Inc. (San Mar), and is a 12-bed facility serving young girls. It is located in rural Washington County, Maryland. San Mar also provides a therapeutic group home for girls and treatment foster care program for boys. The Department of Health and Mental Hygiene licenses San Mar to treat youth with psychiatric diagnoses. The Department of Juvenile Services (DJS/the Department) licenses Graff to serve youth referred for treatment by either DJS or the Department of Social Services (DSS). Residents may stay at the facility for up to 90 days.

SUMMARY

The Graff facility is in excellent physical condition. The programs and services provide a positive, well structured, and consistent environment to residents. Food, recreational, health, education, case management, and other services operate at a high standard. Fire drill logs indicate ongoing effective rapid evacuation practices. The facility, overall, is in excellent condition and provides a healthy and therapeutic environment to its girls.

FINDINGS

1. Population

The staff to youth ratio, set at one staffer to four youth, is adhered to consistently.

Applicable Standard

COMAR 14.31.06.05.D. (4) – [The licensee shall] *Maintain adequate staff coverage at all times based on the time of day, the size, and nature of the program, and layout of the physical plant.*

2. Safety and Security

No critical issues observed this quarter.

3. Physical Plant and Basic Services

Bedrooms, bathrooms, and shared living areas are neat and clean. Each girl resides in an individual bedroom and is assigned shower space in the bathroom.

Staff routinely practices effective and timely facility evacuation procedures. However, staff performed only eight of nine required fire drills this quarter. [8]

Applicable Standard

COMAR 14.31.07.5(a) (b) – *The licensee shall hold emergency drills at least monthly, and on each shift, at least quarterly.*

4. Rehabilitative and Recreational Programming

a. Therapeutic Program

Four randomly selected youth files were reviewed. Treatment/Individual Service Plans were complete for all four files.

b. Recreational Programming

Youth exercise at least one hour daily. Girls rotate their activities daily. Four girls go to the gym while the remaining girls play volleyball, swim, play fitness-related games on a Nintendo Wii game console (e.g., "Wii fit" or "Just Dance"), or walk. Every Wednesday youth residents travel to restaurants or on field trips to historical sites or other destinations. Youth also regularly visit the local library.

Applicable Standards

COMAR 14.31.06.17.2.F – *Within 30 days after admission, develop for each child an individual service plan that identifies documentation indicating that the child, child's advocates, guardian, and family, when appropriate, have been involved in, informed of, and agree with the plan.*

COMAR 14.31.06.17.2 – *Within 30 days after admission, develop for each child an individual service plan.*

COMAR 14.31.06.12.B.1 – *The licensee shall provide the children with a range of indoor and outdoor recreation and leisure activities both in the program and in the community.*

5. Medical

File review indicates that medical and dental visits are current.

[8] Two during the morning, three during evening and graveyard shifts.

Applicable Standards

COMAR 14.31.06.13.G.1 *The licensee shall secure for each child a physical examination and a copy thereof within 30 days of admission or earlier if indicated by the child's health status.*

COMAR 14.31.06.13.E.3 – *Have each child examined by a dentist at least every 12 months or more frequently as prescribed by the dentist.*

6. Youth Advocacy, Internal Monitoring and Investigation

DJS performed two evaluations this quarter. The evaluator concluded that the facility is in Full Compliance with all standards reviewed by the inspector.

CONCLUSION

Graff is a clean and well-maintained facility. Staff provide a caring, home-like and nurturing environment for female youth residents and youth claim their experience at the facility is positive. The shelter is in compliance with standards and provides appropriate services to the residents.

RECOMMENDATION

The Graff Shelter should be fully utilized as it is an essential resource for vulnerable youth in Maryland.

NICK MORONEY
Acting Director

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

FACILITY REPORT - NOTICE OF CLOSURE
HADDON GROUP HOME

Facility: Haddon Group Home for Boys
4802 Haddon Avenue
Baltimore, MD 21207
Program Administrator: Ebony Vaughan

Reported by: Tanya Suggs
Monitor

Date of Report: November 2010

NOTICE OF FACILITY CLOSURE

Haddon Group Home (Haddon) closed in August of 2010.

At the time of closure, case managers had transitioned all but one youth from the home directly into foster care. At time of writing, the last youth at the home had also been transferred into foster care.

Administrators at Mentor Maryland, the provider at Haddon, cited an inability to continue to provide adequate services to youth at the rate of funding offered by the Department of Juvenile Services.

Further inquiries about the Haddon Group Home may be addressed to:

Mentor Maryland
State Office
5720 Executive Drive
Baltimore, Maryland 21228
Tel: 443-543-2100
Email: md-mentor.com

NICK MORONEY
Acting Director

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

FACILITY REPORT
THE CHARLES H. HICKEY, Jr., SCHOOL
JULY – SEPTEMBER, 2010

Facility: Charles Hickey School for Boys
2400 Cub Hill Road
Baltimore, Md. 21234
Administrator: Mark Hamlett

Dates of Visits: July 9
August 5, 6 and 10
September 10, 24 and 27

Reported by: Tanya Suggs and Jamaal Stafford

Persons Interviewed: Administrators, MSDE Administrators and Staff, Shift Commanders, Unit Managers, Direct Care Staff, Maintenance, DJS Investigators, and Youth

Date of Report: November 2010

INTRODUCTION

The Charles H. Hickey, Jr., School (Hickey) is a Department of Juvenile Services (DJS) owned and operated detention facility for male youth between the ages of 12 and 18. The facility is located in east Baltimore County. The facility can house 109 youth in four residential cottages, including 23 in the orientation unit and 8 in the infirmary. All residential buildings are located behind two electronically alarmed fences topped with razor wire. The Maryland State Department of Education (MSDE) utilizes modular buildings at Hickey to provide educational services to resident youths.

SUMMARY OF CRITICAL FINDINGS

- Facility staff violated several safety and security policies and procedures and two youth escaped from the facility in a food service truck during the third quarter.
- A psychiatrist was left alone with a youth in a confined space with the door closed.
- Youth movement is not recorded consistently.
- The MSDE Correctional Education section at hickey was investigated by the DJS Field Director of Education Services and subsequently cited for several violations.
- There were three escapes during the last year and a half.

FINDINGS

1. Population

a. General

Facility Capacity	High Population	Low Population	Average Daily Population	Average Monthly Population	Days Over Capacity
109[9]	89	43	73	**Jul** - 70 **Aug** - 80 **Sep** - 69	42

Currently the rated capacity for Hickey is 72 because of the closing of Ford Hall. The facility can house 109 youth when all four cottages and the infirmary on Douglas Hall are used. The facility closed several cottages in the past due to renovations and staff shortages. When Roosevelt, Clinton, and Mandela Halls reach maximum capacity, overflow youth "sleep-out" at the infirmary, if bed space is available there. "Sleep-out"

[9] Ford Hall orientation (23-bed unit) was closed this quarter - 86 beds were actually available.

youth return to their assigned units the next morning. The high population this quarter was 89 although only 86 beds were available.[10]

Ford Hall, the orientation unit, remains closed despite the increase in population and the lack of space in the three remaining cottages. Re-opening Ford Hall might alleviate the population problem. According to facility administrators, Ford Hall was closed in order to cut overtime. However, staffers actually worked more overtime hours while Ford Hall was closed (3,129 additional hours) when compared with the figures from the second quarter of 2009 when all four cottages were open[11].

The Monitor observed a large number of youth cramped in a small dining room size space in the rear of Roosevelt Hall. The youth had nothing to do to occupy their time. Staffers said that they were trying to prevent direct contact between youth from two different cottages. Youth in orientation were therefore being required to stay in the rear of the cottage while Roosevelt Hall youth occupied the front of the cottage. Staff were unable to provide sufficient programming for youth as they sat in a small space for several hours.

b. Detention and Pending Placement

	Number of Youth in Status 60+ Days	Number of Youth in Status 90+ Days	Average Length of Stay
Pending Placement	8 (64, 74, 76, 77, 79, 82, 82 and 87 days)	5 (95, 99, 106, 107 and 208 days)	27 days
Detention	7 (60, 60, 62, 64, 67, 70 and 77 days)	2 (109 and 145 days)	22 days

Seven youth remained in detention at Hickey for over 60 days this quarter. Eight youth were in pending placement status for more than 60 days. Five youth were held in pending placement for more than 90 days.

[10] Youth sleep in the day room in boats when the facility runs out of bed space. Hickey does not double bunk.

[11] 15,788 overtime hours were worked during second quarter 2010, an increase compared to the 12,659 overtime hours worked during the second quarter of 2009.

c. Population Breakdown by Race/Ethnicity

	Third Quarter, 2009	First Quarter, 2010	Third Quarter, 2010
Total number of Youth Detained	368	301	277
White/Caucasian	66	64	69
African American	289	224	197
Hispanic/Latino	9	10	3
Other	4	3	8

2. Safety and Security

a. Aggregate Incidents

Incident Categories	3rd Qtr (2009)	3rd Qtr (2010)
1. Youth on Youth Assault	47	43
2. Alleged Youth on Staff Assault	7	6
3. Restraints	39	49
4. Seclusion	20	9
5. Physical Restraint Where Injury Was Sustained	17	26
6. Allegation of Child Abuse (DJS Custody)	3	5
7. Suicide, Ideation, Gesture, Attempt, or behavior	22	31
8. Escape/AWOL	1	1
9. Alleged Sexual Contact/Abuse	1	0
10. Alleged Youth on Staff Sexual Assault	0	1
11. Youth Requiring On-Grounds Medical Care (Sports or Non-Incident Related Injury)	47	57

According to the DJS Incident database, there were 225 total reported incidents during the third quarter of 2010 compared to 219 during the third quarter of 2010. The number of suicide-related events increased significantly this quarter as did the number of restraints (from 39 to 49) and restraints with injury (17 to 26). However, seclusions decreased by half.

b. Escape

On September 7, two youth escaped the facility in a food service truck.

The two youth who subsequently escaped had been left to help clean the dining hall after dinner was over. After finishing cleaning the dining hall, the youth were transported in a food service truck driven by a dining hall staffer. The youths overpowered the staffer, commandeered the truck and drove it through a large security fence. The youths then drove around a neighboring community where they hit and damaged several cars and mailboxes. The youths were later captured by police. One of the youths, a seventeen-year-old, was transferred to an adult facility and will be charged as an adult. The other escapee, a fifteen-year-old, will be charged as a juvenile.[12]

c. Supervision of Youth

During a visit, the Monitor observed a psychiatrist alone with a youth in a confined space with the door closed. The psychiatrist did not have a radio or distress alarm. No direct care staffer was present. The Department must ensure that direct care staff are present to supervise when youth meet with counselors or visitors.

On another visit, the Monitor observed a youth using a metal bat during a softball game. A metal bat is not a safe choice as it can be used a weapon without difficulty. Hickey staff and the Monitor have asked the Hickey administration to re-think the needless risk the use of a metal bat engenders – the administration does not agree that youth using a metal bat is a problem.

d. Security Equipment and Practices

The residence halls at Hickey and the school building do not have internal video surveillance. The absence of video cameras remains an unabated issue. Video cameras are invaluable to ensure the safety and security of staff and youth. Video review is also useful as a training tool for staff.

Teachers do not have radios or distress alarms. The facility should purchase distress alarms and radios to ensure the safety of all staff and youth.

Staff does not record youth movement consistently, as required. Roosevelt Hall and Ford Hall orientation units were sharing a logbook. The logbook included scratch-overs and fill-ins. Neither unit was able to record all movement as required by DJS policy. Each unit should be in possession of a discrete logbook.

[12] As of the writing of this report, a JJMU Special Report is forthcoming with complete details.

e. Restraints and Seclusion

According to the DJS incident database, there were no seclusions that lasted over 8 hours. However, the Public Defender's Office submitted a letter of concern to DJS noting that a youth was placed in seclusion for a day, allegedly after a staffer slammed the youth on a table in the dining area. The DJS Office of the Inspector General is deciding on whether to launch an investigation.[13]

Applicable Standards

Maryland Department of Juvenile Services Policy and Procedure RF-05-06-4 C (10) *Under no circumstances shall any entry in the logbook be eliminated. There shall be no erasures or crossed-out sections, which cannot be read as a result of being crossed-out. Whiteout shall not be used. When a mistake is made, a single line shall be used to cross out the mistake and the employee making the entry shall initial the mistake.*

Maryland Department of Juvenile Services Policy and Procedure 4.e.2 (Section i through vii). *Employees are responsible for making log book entries relevant to, but not limited to, the following events all sanctions that are imposed on the unit (e.g. time out, cool off, etc.)…*

Md. Standards for Juvenile Detention Facilities 6.9 *The facility shall be controlled by appropriate means to ensure that the youth remain within the perimeter and to prevent access by the general public without proper authorization. Perimeter surveillance shall be maintained through mechanical surveillance devices (e.g., electronic, pressure, or sound detection system, mobile patrols, or a combination of these systems).*

4. Physical Plant and Basic Services

a. Physical Plant

The wiring on the fences near the cottages is inadequate – shortcomings should be addressed. A youth was able to crawl through a small hole in a gate on the side of the infirmary during an attempted escape.

Additionally, a van has been placed near the main entrance gate to the cottages in an attempt to cover broken sections of the gate until they can be repaired so that they can be closed during the times that the youth are on the units. Repairs must be prioritized and expedited.

[13] Office of the Public Defender, letter dated October 5, 2010 and DJS Incident Report 85107.

b. Basic Services

Youth at Hickey require appropriate space and materials to practice religion. These are not always provided although some local organizations have donated some items. During a visit to one of the units, the Monitor observed a Muslim youth praying in the middle of a noisy unit while his peers were engaged in recreational time. The youth, who needs to pray a number of times each day, had neither a Qur'an nor a prayer mat to kneel as he went about his devotions.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.6 *Space and time shall be provided that may be used for religious purposes. Youth desiring to participate in such services may do so on a voluntary basis or may be taken to places of worship in the community, if doing so presents no risk to security.*

5. Education

a. Special Education

Last quarter MSDE hired two special education teachers. However, the educational needs of youth housed in the infirmary remain unaddressed.

During the second quarter, the Maryland State Department of Education - Division of Special Education and Early Intervention Services conducted an investigation into allegations concerning education services at Hickey and found that youth housed on the infirmary at Douglas Hall had not been provided special educational services. MSDE noted the following violations:[14]

- There is no documentation or information to demonstrate that steps are taken to determine whether students are well enough to receive instruction in the infirmary, and if they are, there is no documentation to ensure that they are provided with special education instruction required by the IEP.

- There is no documentation to determine whether there is verification that students are unable to attend school due to a physical or emotional condition and to ensure that home and hospice procedures are followed.

- Although a special education teacher provided two hours per day of instruction to the youth in the infirmary, there is no information or documentation that these services are consistent with each student's IEP.

[14] MSDE letter dated April 29, 2010: "Re: Charles H. Hickey School Reference # 10-076."

b. Classes

The math teacher reported that they are reviewing the implementation of an IC3 program to decide how it will be used with each student. The IC3 program is designed to teach individuals digital literacy skills associated with basic computer programs and the internet. The IC3 project is pending.

The computer lab is furnished with new computers.

c. Vocational Education

The facility does not have a vocational program. There is a vacancy for a Life Skills teacher – the position has remained vacant for over one year.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 4.1 *The Department should ensure that educational services within the detention facility are consistent with state requirements and that they meet the educational needs of the youth.*

COMAR 13A.03.05.04.A (1) *Initial service need is determined by verification of the physical condition, including drug and alcohol dependency, by a licensed physician, or verification of emotional condition by a certified school, or licensed psychologist or licensed psychiatrist.*

COMAR 13A.03.05.04.A (2) *Initial service need is determined by a statement by the physician or psychologist verifying that the current physical or emotional condition prevents the student from participating in the student's school of enrollment.* (2) A statement by the physician or psychologist verifying that the current physical or emotional condition prevents the student from participating in the student's school of enrollment.

COMAR 13A.03.05.03D (4) *The instructional service shall begin as soon as possible, but not later than 10 school calendar days.*

COMAR 13A.03.05.04B (1) *Service need is subject to review 60 calendar days after the initial determination of eligibility; or sooner at the request of either the parent, guardian, or local school system.*

6. Rehabilitative and Recreational Programming

Therapeutic Program

Youth receive clinical services from a private provider, Glass Mental Health Services.

7. Youth Advocacy, Internal Monitoring and Investigation

a. Internal Monitoring

The DJS Quality Improvement Unit (DJS-QI) conducted an audit at Hickey during the third quarter.[15] The facility achieved Superior or Satisfactory Performance in 42% of the 36 standards evaluated. The results represented a decline in performance compared to a prior evaluation in 2009 which yielded a result of 81.5% Superior or Satisfactory Performance regarding 38 standards evaluated.

Some areas of concern identified in the 2010 DJS-QI report:

- **Senior Management Review** - September and October 2009 incident reports [IRs] were audited by a senior manager, within 72 hours as required in almost every case. However, DJS conducted a review of 15 IRs and found that the audits were completed at an average over two weeks later. Five additional review audits were completed over fifty-five days later.

- **Tools and Weapons** - Prior to the new Key Control Facility Operating Procedure dated 4/30/10, the facility did not routinely control and account for keys as required by DJS policy. Between 11/09 and 5/10, there were 3 incidents involving stolen keys; one incident involving a youth obtaining a key from the facility. The key was recovered after the youth had escaped the facility.

  Kitchen staff still does not maintain an inventory list of knives and utensils. A tour of the East campus gym revealed that two youth (kitchen helpers) were going in and out of a room containing several metal utensils.

- **Youth Movement** - DJS's policy requires that the facility count youth movement every 30 minutes. The facility has been reporting youth counts to Master Control every 2 hours.

  During a tour of the facility, a QI member observed a youth left unattended in the gym's restroom while his unit was outside preparing to move to another location. Another youth was observed wandering the school halls.

b. Incident and Child Abuse Reporting and Investigation

There were eight investigations concerning Hickey conducted by the Office of Inspector General during the quarter. DJS and Baltimore County Child Protective Services (CPS) conducted three investigations of alleged physical child abuse.

[15] DJS Office of Quality Improvement report on Hickey: http://www.djs.state.md.us/quality-assurance/qir-chhs.pdf

A number of investigations related to alleged child abuse resulted in a finding of "Not Sustained". A DJS Incident Report concerned an allegation that a staffer slammed a youth against a wall and hit him in the right side of his neck. The DJS-Office of the Inspector General (DJS-OIG) ruled the allegation not sustained due to insufficient evidence to prove a violation of DJS Standards of Conduct. The allegation was also ruled out by Child Protective Services (CPS).

DJS Incident Report 100428 concerns an allegation that a youth was inappropriately restrained by staff after an incident occurred at the Peabody School. The youth said that the staffer elbowed him in the back of his head. DJS-OIG ruled the allegation "Not Sustained" due to insufficient evidence available to prove a violation of DJS Standards of Conduct. This allegation was also ruled out by CPS.

The administrator received an anonymous letter stating that a named staffer had been sexually involved with a youth. The allegation was investigated and ruled "Not Sustained" due to insufficient evidence to prove or disprove misconduct on the part of the staffer. CPS did not accept the anonymous letter complaint for investigation.

An investigation was conducted into alleged negligence by two staffers in failing to supervise youth (DJS Incident 11435). According to documentation, a youth alleged he warned staffers that he was being picked on by two youth but his complaints were ignored. The two youth allegedly targeting the complainant were able to enter the shoe room and allegedly hit the youth on his head and in his stomach. The alleged victim ran out of the room and informed the two staffers, who allegedly did nothing. The staffers also allegedly failed to report events as required by DJS Incident Reporting Policy. The DJS-OIG ruled the allegation "Sustained," citing staffers for several violations of the DJS Standards of Conduct. Maryland State Police charged the two students who targeted the victim with second-degree assault. CPS screened out the complaint.

OIG ruled an allegation concerning attempted escape as "Sustained" (DJS-OIG Investigation 10-0415). During a one-to-one supervision of a youth in the outside area of Douglas Hall infirmary, a staffer failed to be attentive to the movements of the youth. The youth was able to sneak through a hole in the fence on the side of the infirmary, sustaining injuries as he attempted to escape. The staffer who was supposed to be supervising the youth did not have a radio. After the attempted escape, the youth alleged that he received his injuries from a physical restraint when he was caught by a male staffer.

The allegation concerning use of force was rendered "Not Sustained" by the DJS-OIG, however, staff was found to be in violation of DJS Security Policy because he was not attending to the youth in his charge. DJS-OIG recommended that staff be provided with adequate training and with a radio. It was also recommended that a policy be developed requiring staff to search youth under one-to-one supervision. DJS-OIG further advised that surveillance cameras be installed on all units.

A DJS-OIG report (following Incident Report 84795) detailed an allegation that a nurse made inappropriate comments to a youth – the allegation was sustained. The narrative described a situation where a youth became agitated with a nurse and the nurse stated, "I'm not afraid of you. The only person afraid of you is your mother." Upon the nurse's comment, the youth became upset, punched the wall and was then physically restrained.

A DJS-OIG investigation (Report 10-0494) of an allegation that a youth inappropriately touched two female MSDE teachers was sustained. A student allegedly cupped the buttocks of two MSDE teachers and touched them on their arms, legs, and thighs on separate occasions. According to the DJS-OIG report, the incidents occurred one month apart.

Charges related to an escape from Hickey by two youth on September 7 were ruled "Not Sustained" by DJS-OIG due to insufficient evidence to prove or disprove any act of misconduct on the part of the staff.[16] The youths involved in the escape were charged by police with first and second degree assault, malicious destruction, carjacking, reckless endangerment and escape.

Applicable Standards

Md. Department of Juvenile Services Standards of Conduct 2.10
Examples of unsatisfactory performance include but are not limited to lack of knowledge, unwillingness or inability to perform assigned tasks, failure to conform to work standards established for the employee's classification or position, or failure to take appropriate action to ensure compliance with the Department's regulations.

Md. Department of Juvenile Services Standards of Conduct 2.13.2
An employee may not take any action or fail to take action when the action or failure to act causes a breach of security or a potential breach of security by jeopardizing the safety or security of an employee, delinquent youth, offender, client, visitor or member of the public.

Maryland Department of Juvenile Services Policy and Procedure 03-07 (1) (a) *The employee involved or having knowledge of a critical incident shall immediately report the incident to their Supervisor, or to their Area or Regional Director if their supervisor is not available.*

Maryland Department of Juvenile Services Policy and Procedure 03-07 (1) (c) *The employee involved in or having knowledge of the incident shall complete and submit a DJS Incident reporting form to their supervisor, or to their Area or Regional Director…for review and approval, prior to the end of the employees work day.*

[16] As of the writing of this report, a JJMU Special Report is forthcoming with detailed information.

RECOMMENDATIONS

1. The facility should conduct youth movement counts and record it in the logbook as required by DJS policy.

2. The facility should ensure that each unit has its own youth movement logbook, and prohibit the use of units sharing logbooks.

3. The facility should check all areas of the fencing and have faulty wiring repaired as soon as possible.

4. The Department should provide youth with appropriate space for religious practice.

UNABATED CONDITIONS

1. The facility should re-open Ford Hall to house orientation youth.

2. Staffers should ensure youth are not left unsupervised.

3. The Department should install video cameras throughout the facility and in MSDE trailers.

4. Teachers should be provided with radios and distress alarms should be installed in classrooms and on units.

5. MSDE should ensure that youth in the infirmary receive structured lessons in accordance with lesson plans and special education requirements.

6. MSDE should ensure substitute teachers are provided with lesson plans and are aware of the specific educational needs of youth with special education requirements.

7. Visitors should not meet with youth without the supervision of a direct care staffer.

NICK MORONEY
Acting Director

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

FACILITY REPORT
KARMA ACADEMY FOR BOYS - RANDALLSTOWN
JULY – SEPTEMBER, 2010

Facility:	Karma Academy for Boys - Randallstown KHI Services, Inc. 4202 Holbrook Road Randallstown, Md. 21133 Facility Administrator: Kay-Meagan Washington
Dates of Visits:	July 27 and September 30
Reported by:	Tanya Suggs Monitor
Persons Interviewed:	Direct care staff, Youth, Therapist, and Director
Date of Report:	November 2010

INTRODUCTION

The Karma Academy for Boys at Randallstown is an 8-bed unlocked privately managed residential program for boys. The home is located in a suburban community that sits on the Baltimore and Carroll County lines. Karma is licensed by the Maryland Department of Juvenile Services (DJS), and operated by KHI Services, Inc. The program serves low-level offenders and youth who need sex-offender treatment and services. On average, the program takes 6 to9 months to complete successfully.

FINDINGS

1. Population

The population has remained consistent with eight youth in the home throughout the quarter.

2. Staffing

a. General

There are vacancies for a full-time youth care worker and an Education Coordinator. Due to budgetary constraints, KHI is unlikely to fill the Education Coordinator vacancy anytime soon. The director, the lead counselor, and the part-time therapist have been sharing the Education Coordinator and the Program Coordinator duties.

b. Staff Training

The Center for Sex Offender Management (CSOM) facilitated a sex offender treatment training for direct care and all non-clinical staff and will hold the trainings annually.

Administrators at Karma should ensure that youth and staff are trained on the Prison Rape Elimination Act (PREA). The incorporation of PREA could highlight important relationship boundaries (physical and verbal); help to define healthy and unhealthy relationships; show how to report sexual misconduct and assault; offer advice on what to do in the event of a potential or actual sexual assault; and attempt to explain the importance of not making a false allegation.

3. Safety and Security

Most youth complete the program successfully however, there was one AWOL during the third quarter and Karma unsuccessfully terminated two youth after an allegation concerning sexual activity.

According to DJS Incident Report 85024, a youth stated that he and another youth in the home were involved in sexual contact on several occasions during times direct care staff left them alone. The Monitor followed-up on the allegation to ascertain whether the DJS-Office of the Inspector General (DJS-OIG) would be investigating. The Department did not initiate an investigation until approximately one month after the initial allegation surfaced.

The DJS-OIG investigation about the sexual contact allegation included a statement by a youth who said that, on one occasion, a staff fell asleep on a couch while the rest of the youth went on an outing with another staff. Staff is responsible for ensuring the safety and security of all youth by consistently providing sight and sound supervision of all youth. Based on the information provided, staff failed to follow proper supervision procedures. There is no indication that staff responsible for supervising the youth during the time these incidents allegedly occurred were reprimanded or counseled.

The DJS-OIG investigation resulted in a finding of "not sustained" on any violations of DJS standards of conduct.

4. Physical Plant and Basic Services

a. Fire Safety

The Baltimore County Fire Department (BCFD) completed an annual fire safety inspection on January 19, 2010 and did not note any violations.

b. Physical Plant

The home is spacious, clean, and well maintained by the youth and staff. The backyard is large and perfect for outdoor recreation, seasonal festivities, and group activities. The youth enjoy the scenic view from the rear of the home, where deer and a neighbor's horses can sometimes be seen.

c. Basic Services

The Baltimore County Department of Health (BCDH) completed an annual Health Safety Inspection on September 23, 2010, and did not note any serious violations.

5. Education

Youth in the home attend high school in Catonsville or Arbutus, Maryland. If a resident requires level V placement, he will be enrolled in the Florence Burtell Youth Academy. A level V school is for the most behaviorally challenged youth. The school provides academic, therapeutic, and behavioral services to youth with learning disabilities. If the youth has a behavior problem, he will be enrolled in the Catonsville Center for Alternative Studies.

One youth attends school on Saturdays so that he can obtain an academic credit needed to graduate.

6. Rehabilitative and Recreational Programming

a. Therapeutic Program

The therapeutic model utilized at the home is EQUIP, consisting of Positive Peer Culture and Aggression Replacement Therapy. The youth meet with their counselor weekly, and they participate in independent life skills sessions (peer support), sex-offender rehabilitation, and narcotics anonymous meetings.

b. Recreational Programming

The youth have partaken in a number of activities this quarter including an International Festival at high school, community service at a farm, various sports activities, and a wilderness challenge activity.

c. Parental Involvement

The therapist at the home holds monthly family group therapy sessions to provide parents and guardians an opportunity to participate in therapy with youth.

7. Medical

A doctor based in west Baltimore City provides medical care for the youth. The home is mandated by Maryland law (COMAR) to schedule check-ups and as-needed medical appointments for youth. If a youth becomes seriously ill and the medical office is closed, a staffer transports the youth to a nearby hospital emergency room.

8. Youth Advocacy, Internal Monitoring and Investigation

The Monitor did not receive any grievances this quarter. The Child Advocate visits the home on a weekly basis. Most youth concerns are minor and rarely reach a level that would prompt youth to complete a DJS grievance form.

Audits were completed by the DJS Program Evaluation Unit on July 26 and August 25. For the August evaluation, the home received a rating of partial compliance in the areas of Basic Life Needs and Youth Rights and Health Care and Medication Administration. For July's evaluation, the home was in full compliance regarding Emergency Planning, General Safety and Transportation but partial compliance in Physical Plant, Sanitation, and Health Inspection.

According to the DJS audits at Karma, some areas in need of improvement are:

- Medical and dental exams: the home is completing medical and dental exams but not within the 30-day period specified by COMAR.

- The files should have notes stating the reason why exams are not completed in accordance with COMAR.

- Staff should not express their personal opinions about controversial matters in front of the youth and they should be more cognizant of what they say in front of the youth.

c. Youth Concerns

Youth did not express any concerns to the Monitor this quarter. The youth reported that they enjoy their stay in the home and they feel safe under the care of the Karma staff.

RECOMMENDATIONS

1. Staff should provide consistent sight and sound supervision of all youth.

2. Karma should implement PREA policies into the program and provide training on PREA to youth and staff.

3. The administrators should reprimand or verbally counsel staff who do not follow safety and security policies.

NICK MORONEY
Acting Director

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

FACILITY REPORT
KENT YOUTH BOYS GROUP HOME
JULY – SEPTEMBER, 2010

Facility: Kent Youth Boys Group Home
7582 Quaker Neck Road
Chestertown, MD 21620
Administrator: Jillyn Coleman

Dates of Visits: July 27
August 19
September 16, 2010

Reported by: Nick Moroney
Senior Monitor

Persons Interviewed: Administrator, Case Manager Supervisor, Child Advocate, Social Worker, Direct Care Staff, Office Staff, Youth and Facility Board Members

Date of Report: November 2010

INTRODUCTION

Kent Youth Boys Group Home (Kent Youth) is located in Chestertown, on the Eastern Shore of Maryland. It is operated by Kent Youth, Inc., and provides a comfortable, home-like environment for 10 adjudicated boys aged 14 to 18. The residential group home was founded in 1971 as a local alternative to institutional or out-of-state placement of Eastern Shore youth. The group home is licensed by the Maryland Department of Juvenile Services (DJS/the Department).

SUMMARY OF CRITICAL FINDINGS

The program is stable and is performing as an essential resource helping to redirect children who might otherwise become more deeply involved with the juvenile justice system. The home provides personal attention and mentoring within a less restrictive setting than youth would experience in an institution.

FINDINGS

1. Population

With a ten-youth capacity, Kent Youth was close to but not fully utilized during the third quarter of 2010, with 8 to 10 youth in residence at any given time. DJS seems to recognize the importance of the home, its staff and programming in helping vulnerable youth stay on track and in preparing youth for constructive re-integration into their communities.

All 11 youth served at Kent Youth during the third quarter hailed from Eastern Shore counties. Six of the youth served were African American and five were white.

2. Staffing

The program director is a certified Child Care Program Administrator who previously worked as program manager at Kent Youth. The program is fully staffed.

Applicable Standard

COMAR 14.31.06.06.3 *The program administrator shall be certified as required by Health occupations Article, Title 20, and Annotated Code of Maryland.*

3. Safety and Security

The number of critical or aggressive incidents at Kent Youth continued to remain low during the third quarter of 2010 and the facility continued to be a safe environment for youth in residence.

There was one allegation of child abuse concerning a youth who said he was shoved by a staff member (DJS Incident Report 85323). The allegation is under investigation by the DJS Office of the Inspector General.

There were five instances of aggression between youth reported during the third quarter. One involved a relatively minor altercation between two youths (DJS Incident Report 83997). A youth threw sand and dirt at another youth (DJS Incident Report 84571); the youth who threw the sand subsequently apologized to the other youth involved. Another instance concerned youth briefly pushing each other (DJS Incident Report 85118). A youth also allegedly hit another youth with a belt (DJS Incident Report 85239). On September 30, a youth threw a mop after a verbal argument with another youth. The mop hit a third youth who was not involved in the verbal exchange (DJS Incident Report 85605). The youth hit by the mop did not require medical attention.

While the number of aggressive incidents at Kent Youth remains low and staff usually react quickly and appropriately, JJMU supports the facility board and administrator in their wish to install security cameras in order to further safeguard youth and staff.

Cameras can act as a deterrent to aggression and footage from cameras can be used for investigatory and re-training purposes. The facility planned to pay for the camera system leaving no cost to the State. However, citing possible infringement of youth privacy, a manager at DJS HQ has not given permission for the installation.

4. Physical Plant and Basic Services

The physical plant consists of home-like environment which is fastidiously maintained by staff and youth.

Kent Youth is up-to-date and in full compliance regarding state fire prevention, nutrition, food preparation, sanitation and well-water inspections. A Fire Marshall performed an annual inspection and noted “no violations.”

A State of Maryland Sanitary Inspection conducted on May 5, 2010, also resulted in a clean report and included a note that “the facility is very clean and organized.” The Kent County Health Department tested the well just before the beginning of the quarter and documented in a letter dated June 30, 2010, that the well was “free from bacteriological contamination.”

Applicable Standard

COMAR 14.31.06.07. A.1(a)(b) *The licensee shall establish a written plan of action describing how the licensee will respond in the event of natural or man-made emergency conditions which is approved by the licensing agency; and includes detailed plans for fire prevention and emergency evacuation of the physical plant.*

5. Education

Residents at Kent Youth attend Kent County public schools. The facility ensures each youth is represented at school-based meetings concerning the educational needs and academic progress of Kent Youth residents.

A well-equipped computer room is available to residents for research and homework. Some members of the evening shift direct care staff have college degrees and assist youth during a period set aside daily for supervised study and tutoring.

The facility ran a summer school program twice weekly from 9am to noon during summer vacation.

Applicable Standard

COMAR 14.31.06.12.2(C) *The placing agency and licensee shall work cooperatively with the local school system to participate as appropriate in the child's educational activities.*

6. Rehabilitative and Recreational Programming

a. Therapeutic Program

Kent Youth residents participate in the Passage program that includes a level system. Youngsters work their way up to higher levels with good behavior and participation in the program. Youth may be released 30 days after reaching the highest level. Each higher level increases privileges such as extra phone calls.

Youth also receive individual and group counseling four times a week with a licensed clinical social worker (LCSW). Drug and alcohol education programs are offered once to twice a week while a therapist provides weekly anger management sessions. Numerous life skills programs and activities, including cooking and cleaning, occur throughout the week including a weekly formal life skills program. Family therapeutic meetings are scheduled monthly to every 6 weeks or more frequently depending on a counselor's assessment of youth and family therapeutic needs.

b. Recreational Programming

Youth play basketball and use the gym-cum-weight room daily with staff guiding youth on physical fitness related issues. There is a recreation room in the basement where youths can watch TV and DVDs, read, and play games.

Staff post a weekly schedule of activities in the facility. In addition to goal setting and life skills sessions, Kent Youth offers drug and alcohol awareness sessions and a public service volunteer program that counts toward public school service learning hours. Youth made jewelry items in aid of charity during the third quarter.

Youth also visit local libraries and parks, swim at community pools, attend high school basketball games and go fishing and to the movies. Youth also went on special outings during the quarter including a visit to the Baltimore Zoo, a boat trip on the Cape May-Lewes ferry and a visit to a water park.

In addition, guest speakers, including Kent Youth, Inc. Board Members, came to the house to make presentations, share skills and chat with youth.

c. Parental Involvement

Parents participate in the orientation process when youth first come to the facility. Ongoing visiting takes place on Sunday afternoons. Phone calls are allowed in the evening, with details worked out in accordance with the facility behavior level system (Passage). Parents are included in the preparation of Individual Service Plans and discharge plans. Youths can earn weekend home passes through the Passage system.

Applicable Standards

COMAR 14.31.06.17.2.F *Within 30 days after admission, develop for each child an individual service plan that identifies documentation indicating that the child, child's advocates, guardian, and family, when appropriate, have been involved in, informed of, and agree with the plan.*

COMAR 14.31.06.12.B.1 *The licensee shall provide the children with a range of indoor and outdoor recreation and leisure activities both in the program and in the community.*

COMAR 14.31.06.12.C.1 *The licensee shall have a written plan of normal daily routines which shall be made available to the children and employees.*

7. Medical

The residents at Kent Youth see a local family doctor upon entry to the program and for routine medical needs. The doctor is available as needed. Regular visits to a dentist are also scheduled for each youth.

Applicable Standards

COMAR 14.31.06.13.G.1 *The licensee shall secure for each child a physical examination and a copy thereof within 30 days of admission or earlier if indicated by the child's health status.*

COMAR 14.31.06.13.E.2 *The licensee shall unless a child has been examined and treated as necessary during the 12 months before the child's admission to the program, have each child examined by a dentist within 30 days after admission.*

COMAR 14.31.06.13.E.3 *Have each child examined by a dentist at least every 12 months or more frequently as prescribed by the dentist.*

8. Youth Advocacy, Internal Monitoring and Investigation

The DJS Youth Advocate visits Kent Youth regularly and responds promptly to any grievances.

A youth complained about lack of understanding concerning behavioral consequences after not being allowed to partake in a special reward trip to Six Flags (DJS Grievance 8830). The administrator and management staff met with the youth and agreed that, in future, management "will sit down with the youth before the activity and explain the reasoning behind their decision."

A newly hired staffer went into an office to call for advice about a youth who seemed to be upset. During the phone call, the youth were out of the staffer's sightline (DJS Grievance 8785). The staffer was subsequently counseled by the program manager about the necessity of keeping eyes "on the youth at all times" and to make use of an available cordless phone if needed in the future.

The DJS Program Evaluator also visited Kent Youth during the quarter and corrective action has been taken to address issues relating to physical plant (roof repair needed), food services (some out-of-date food items) and incident reporting (off-site allegation of shoplifting not reported to DJS). The roof was repaired. Food items were re-checked and a system implemented to ensure disposal of out-of-date food items.

The administrator explained to DJS and the Monitor that the shoplifting-related event was not reported because the shoplifting allegation stemmed from a situation where the youth allegedly concerned did not leave the store and the store management declined to prosecute or even call the police. This version of events is verified by a documented complaint by the youth (DJS Grievance 8768) after he was given in–house consequences for attempted shoplifting under the facility behavior management plan. Notwithstanding the explanation, the administrator stated that all such allegations (without exception) will be reported to DJS in the future.

RECOMMENDATION

Youth should continue to be referred to Kent Youth which is an essential resource helping to redirect children who might otherwise become more deeply involved with the juvenile justice system.

NICK MORONEY
Acting Director

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

FACILITY REPORT
LOWER EASTERN SHORE CHILDREN'S CENTER
JULY – SEPTEMBER, 2010

Facility: Lower Eastern Shore Children's Center
405 Naylor Mill Road
Salisbury, Md. 21801
Superintendent: Derrick Witherspoon

Dates of Visits: July 29
August 13
September 15, 2010

Reported by: Tim Snyder
Monitor

Persons Interviewed: Superintendent, Group Life Supervisors, Resident Advisors, Dietary Staff, Maintenance Staff, and Youth

Date of Report: November 2010

INTRODUCTION

The Lower Easter Shore Children's Center (LESCC) in Salisbury is a 24-bed maximum-security detention facility owned and operated by the Maryland Department of Juvenile Services (DJS/the Department). The facility opened in 2003 and is designed to house male and female youth awaiting adjudication or placement. Youth are separated into three housing pods according to gender and security considerations. Pod A houses a maximum of 6 girls; Pod B accommodates 6 boys; and Pod C houses 12 boys.

SUMMARY OF CRITICAL FINDINGS

- DJS should increase staffing levels to provide adequate coverage of youth.
- DJS should provide more comprehensive and effective crisis intervention, de-escalation, and physical restraint training.
- Population should not rise above 27

FINDINGS

1. Population

a. General

Facility Capacity	High Population	Low Population	Average Daily Population	Average Monthly Population	Number of Days Over Capacity
24	29	16	22	**July** 25 **August** 21 **September** 19	20

Although DJS-rated capacity is 24 youth, sometimes the population is over 27 and youth must either be housed in the infirmary; double bunked with another youth; or kept in the pod day room overnight sleeping in a boat (a fiberglass container with a mattress). The facility should not house more than 24 youth (18 male youth maximum and 6 female youth maximum).

b. Detention and Pending Placement

The average length of stay for all youth at LESCC during the third quarter of 2010 was 20 days. All youth left LESCC within 60 days of entrance.

The Department is implementing a pre-placement orientation program called Treatment Placement Orientation (TOP) at DJS detention centers including LESCC. The program includes the opportunity to receive credit towards placement time. This could help lessen extended periods of "dead" time spent waiting for treatment placement. The Department deserves praise for designing and implementing this long-needed program.

c. Population Breakdown by Race/Ethnicity at LESCC

	3rd Quarter 2009	3rd Quarter 2010
Total Youth Entries	143	138
African American	103 (72%)	99 (72%)
White/Caucasian	39 (27%)	31 (22%)
Hispanic/Latino	1	7
Other/Unknown	0	1

Applicable Standard

Maryland Rules, Rule 11-112. Detention or shelter care. *Maximum period of detention or shelter care – continued detention or shelter care pending the adjudicatory or waiver hearing may not be ordered for a period of more than thirty days.*

2. Staffing

a. General

DJS has permitted LESCC to fill staff vacancies. This is a great improvement over past years. At time of writing, LESCC has three staff vacancies, two Resident Advisor positions and one Group Life Manager position. Pre-screening has taken place to fill these vacancies. Additionally, a vacancy for a cook has been filled after a delay.

In spite of filled vacancies, DJS staffing levels still result in shortages. Staff shortage compromises safety, security and the ability to provide one-on-one supervision as needed. Training requirements, vacations, sickness, and unforeseen call outs all contribute to staffing shortage.

The staff culture at LESCC is very positive. Most staff demonstrate significant sense of ownership and responsibility. Supervisors and Group Life Managers at LESCC come in at least 30 minutes early to ensure they are briefed on concerns before beginning their shift. Most staff members at LESCC participate in extra activities in association with their work - activities that greatly enhance program opportunities for youth.

LESCC recognizes staff that go the extra mile. The "You Have Been Spotted" procedure allows staff members to recommend other staff for the honor. Administration has a special certificate made and posts the award on the bulletin board for all to see.

b. Staff Training

DJS staff training in crisis intervention and restraint is inadequate.

The Department uses the JIREH curriculum for Crisis Management training. The JIREH curriculum is lacking in comprehensive and practical training in de-escalation. Additionally, the training is inadequate in that it requires a staff to be capable of physically dominating an aggressive youth. Direct care staff members need training in techniques that all can use regardless of size or strength to protect themselves and youth from injury while effectively controlling aggressive behavior.

DJS requires that staff use only JIREH - CPM techniques. Because the required techniques are inadequate, staff are often uncertain as to proceed in handling situations. A lack of tools, clarity and confidence fosters a safety and security problem for youth and staff.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.1.3 *Staffing arrangements shall aim to provide a safe, humane, and caring environment.*

COMAR 14.31.06.05 F (3) The training of employees who may provide direct care to children shall include: (f) approved forms of discipline and behavior management techniques including crisis management and the use of isolation and restraints.

Md. Standards for Juvenile Detention Facilities 2.2.1 *The Department shall ensure that designated classes of departmental and vendor employees are trained according to the standards established by the Maryland Correctional Training Commission.*

3. Safety and Security

b. Aggregate Incidents

Incident Categories	3rd Quarter 2009	3rd Quarter 2010
1. Youth on Youth Assault	3	14
2. Youth on Youth Assault with Injury	1	8
3. Alleged Youth on Staff Assault	1	5
4. Alleged Youth on Staff Assault with Injury	1	2
5. Group Disturbances (injury/property destruction)	0	1
7. Restraints	10	28
8. Restraints with Injury	2	12
9. Seclusions over eight hours	0	4
10. Physical Child Abuse Allegations (DJS Custody)	0	3
11. Suicide Ideation, Gesture, Attempt or Behavior	0	11
12. Alleged Inappropriate Staff Conduct/Comments	1	1

Staff members sometimes injure youth, or are injured themselves, during a restraint. DJS should provide effective and comprehensive training to staff. Injury should be a rare occurrence. Additionally, the Department should increase staffing levels during shifts to enhance safety and security. During this Quarter, 12 of the 28 restraints resulted in injury.

The Department has upgraded the antiquated and inadequate surveillance system at LESCC, adding six cameras and installing a state of the art digital recording system.

b. Alleged Inappropriate Staff Conduct

Three incidents of alleged physical child abuse were referred to Child Protective Services. CPS screened out two of the incidents and did not accept the third for investigation. DJS internal investigation found no evidence of physical child abuse in

any of the incidents, but did cite several staff members for violations of DJS Standards of Conduct. One of the violations of conduct was for not using the approved CPM techniques in a restraint. In another case, staff members failed to notify Child Protective Services directly after a youth alleged a staff member pushed the youth into a wall.

c. Behavior Management Plan

The program utilizes a four-level system built on earning points and levels with increasing privileges as youth progress. LESCC provides each youth with a Youth Handbook that describes the expectations, responsibilities, rewards, and consequences of youth behavior. Youth generally describe the system as being fair, but the point system is not always implemented in the same way by all staff members. LESCC is addressing this issue through staff training and teambuilding.

4. Physical Plant and Basic Services

The food and food service at LESCC is very good. The Maryland Department of Health and Mental Hygiene conducted an inspection of the food service at LESCC in January of 2010. The cafeteria is decorated with colorful posters advocating good nutrition.

The Maryland State Fire Marshall's Office conducted a Fire Safety Inspection in May of 2009, at which time no violations were noted. A private contractor checked the fire alarm systems in September of 2010.

DJS has approved an LESCC request to replace carpeting in the housing units.

A local artist is involving youth in the creation of a decorative mural on the wall of the outdoor recreation area.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.2.1 Conformity with Codes *All detention facilities shall conform to state fire safety requirements.*

Md. Standards for Juvenile Detention Facilities 5.5.1 Food Service Management *A full time staff member experienced in food service management shall supervise the food service operation within a detention facility.*

5. Education

Youths attend 6 hours of instruction each school day. Maryland State Department of Education teachers provide classes that include math, language arts, social studies, science, computer technology, career development, life skills, and library media. LESCC requests youth school records and staff report that the information is usually received in a timely manner. Upon admission to LESCC, teachers assess youth

in order to design a curriculum that meets the youth's individual educational needs. Teachers also administer a career interest inventory. Generally, one-third to one-half of the youth at any given time require special education services. These services are provided as needed. Youth may also prepare to take the GED test.

Youth at LESCC can earn a Certificate of Achievement in school. Youth earning this award have their picture taken and the picture is posted.

LESCC offers limited vocational programming including the opportunity for youth to earn a "Safe Serve" certificate. Youth who have earned the Safe Serve certificate will more easily obtain employment in the food industry. LESCC also provides a work opportunity for youth within the facility. Youth can earn the privilege of helping with housekeeping duties. In return for effort, youth receive minimum wage and can use the experience as part of developing a work resume complete with references from supervising staff.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.1 Educational Services *The Department shall ensure that educational services provided within the detention facility are consistent with state requirements and that they meet the individual needs of the youth.*

6. Rehabilitative and Recreational Programming

Counselors and therapists at LESCC see youth individually as needed. Staff report that approximately 85% of the youth are experiencing substance abuse problems. A number of youth are dually diagnosed, having both substance abuse and mental health issues. A psychiatrist also comes to LESCC weekly to see youth as needed. Additionally, the therapeutic staff team members provide a number of services including psycho-educational groups and substance abuse groups. Youth also participate in Aggression Replacement Therapy (ART).

The Department is implementing a pre-placement orientation program called Treatment Placement Orientation (TOP) at DJS detention centers including LESCC. The program includes the opportunity to receive credit towards placement time. This could help lessen extended periods of "dead" time spent waiting for treatment placement. The Department deserves praise for designing and implementing this long-needed program.

LESCC staff are implementing TOP - a case manager supervisor acts as the TOP coordinator and contact at LESCC. Western Region staff developed the TOP program in conjunction with other DJS staff from across the State. DJS designed TOP for youth who area waiting enrollment at the Youth Centers or at Victor Cullen. Youth complete a workbook and maintain contact with designated staff in the receiving facility. Staff at the detention centers track progress as youth begin learning and adopting

cognitive and behavioral changes that will facilitate completion of the program in the Youth Centers.

LESCC staff members provide many other programming activities such as Kidz Roc – Open Mic Night, and LESCC After Dark, in which youth who earn enough points are awarded a special evening of refreshments, games and movies. LESCC also offers Gender Responsive Activities, such as the Girl's Ice Cream Social which was held on July 29th. LESCC holds a monthly Youth Advisory Meeting, and bi-weekly Town Hall meetings. Youth on each unit at LESCC are encouraged to participate in housekeeping. Administrators award a special prize to the cleanest unit of the week.

At the end of July, LESCC held an Enrichment Empowerment Day which featured a number of inspirational speakers.

Youth at LESCC receive at least one hour of large muscle exercise per day, typically in the gymnasium. The broken ping pong table has been replaced and the new table provides an additional skill expression and development activity.

c. Parental Involvement

LESCC permits parents or guardians to visit twice per week. DJS policy permits youth at least two phone calls per week. LESCC also encourages parents/guardians to attend treatment and education-related meetings for youth. Staff at the facility provide families and youth a "fun box" which includes puzzles and card games for youth and visitors to use during visitation hours. The intention is to help facilitate positive social interaction by broadening the focus to more than conversation.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.5 Recreational Activities *A well-defined and structured recreation program shall be provided for each resident.*

7. Medical and Behavioral Health

Youth at LESCC receive timely physical exams and screenings for mental health issues, substance abuse and suicide behavior and/or ideation. Staff manage medication appropriately within the facility. There have been instances where youth miss their medication because DJS Transportation does not transport medications when transporting youth - this results in a serious situation that the Department must remedy.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.3 health Care Services *Health care services shall be in accordance with established Departmental policy and procedures.*

8. Youth Advocacy, Internal Monitoring and Investigation

The DJS Child Advocate retrieves and processes grievances with youth and DJS employees in a timely and effective manner.

The DJS Quality Improvement Unit published a review of the Lower Eastern Shore Children's Center in September of 2010.

Applicable Standard

Md. Department of Juvenile Services Policy and Procedure MGMT-01-07 Youth Grievance Policy *The Department of Juvenile Services (DJS) shall permit youth and individuals on behalf of DJS youth to file a grievance for a circumstance or action related to behavior of other youth, behavior of employees, or conditions of confinement.*

RECOMMENDATIONS

1. DJS should increase staffing levels in order to provide adequate supervision of youth.

2. Staff training should be improved to provide all necessary skills.

3. DJS should insure comprehensive crisis prevention training is provided for restraint and incident intervention.

4. DJS should maintain a maximum population of 18 male and 6 female youth.

NICK MORONEY
Acting Director

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

FACILITY REPORT
MORNING STAR YOUTH ACADEMY
JULY – SEPTEMBER, 2010

Facility: Morning Star Youth Academy
1441 Taylors Island Road
Woolford, Md. 21677
Program Administrators: Gerry Fox and Dave Boyle

Dates of Visits: July 30
August 16
September 14, 2010

Reported by: Tim Snyder
Monitor

Persons Interviewed: Administrators, Supervisors, Direct Care Staff, Therapists, Teachers, and Youth

Date of Report: November 2010

INTRODUCTION

Vision Quest Inc. operates Morning Star Youth Academy (Morning Star). The residential facility is near Cambridge, in rural Dorchester County, on Maryland's Eastern Shore. The Maryland Department of Juvenile Services (DJS/the Department) licenses Morning Star to serve up to 40 boys.

The program focus is on helping 14 to 18 years old youth with substance abuse problems in addition to behavioral, relational, self-esteem, and mental health concerns. Youth generally require 6 to 9 months to complete the program. Morning Star utilizes a cognitive behavioral approach to helping youth make positive changes. The facility partners with Eastern Shore Psychological Services to provide behavioral health therapy. Morning Star also offers Equine Assisted Therapy.

Vision Quest/Morning Star also contracts with DJS to provide Functional Family Therapy (FFT) to youth (and their families) enrolled in the program. The FFT program runs for four months.

SUMMARY OF CRITICAL FINDINGS

- DJS utilization of the program has been low with youth population continuously under-capacity.
- Staff teambuilding is needed.
- Some DJS Community Case Managers do not visit youth as required.
- Standing water in the center of the campus
- Bathrooms not thoroughly cleaned.

FINDINGS

1. Population

The population has increased slowly over the past Quarter. Morning Star is working with DJS in screening referrals more thoroughly and is admitting youth in a more measured fashion. The population has become somewhat more diverse as youth referred and admitted are coming from broader areas within the State.

According to the initial license granted by DJS, Morning Star can serve up to 40 residents, however, the facility remains under-utilized. The census remained in the lower 20's for months during 2010. By mid-September, the census was 26. Under-utilization makes it difficult to achieve financial viability. Additionally, low population limits resources that would enable the residents to participate in a wider range of programming activities. Morning Star hopes to increase population so that they will be able to open a fourth cottage unit.

2. Staffing

a. General

Leadership is in transition at Morning Star for the second time in as many years. Gerry Fox has stepped back and is acting as a resource for David Boyle, the new Chief Administrator. Mr. Boyle is in training. He has worked with Vision Quest (Morningstar parent company) for seven years. He comes to Maryland from Arizona where he worked in direct care, supervision, training, and in various other capacities within the organization.

Morning Star administrators have been mandated to work fewer hours and receive less pay to help the facility meet financial debts. The facility maintained appropriate direct care staff-to-youth ratios throughout the quarter. Morning Star has a minimum of one direct care staff overnight on each unit, a roving supervisor, and a contract night watchman. Morning Star will hire and train additional staff members, as census levels rise, in order to maintain appropriate supervision and delivery of services.

b. Staff Training

Morning Star utilizes Safe Crisis Management training developed by JKM, Inc. The training emphasizes prevention, de-escalation, and use of positive reinforcement. The Maryland Governor's Office for Children has approved JKM training for use by Maryland childcare providers.

Staff members receive all required State of Maryland training for direct care responsibilities regarding youth at the facility.

Morning Star leadership is currently honing staff training and teambuilding. This step is crucial since issues have arisen concerning staff consistency from shift to shift and regarding the need to implement a comprehensive system to help resolve staff disputes. Trust and teambuilding are critical to developing and maintaining high quality treatment within the facility. Youth need to see all staff members demonstrating positive attitudes and behavior within a culture of personal growth and problem resolution.

Applicable Standards

COMAR 14.31.06.05. F (1) *The licensee shall ensure that each employee who provides direct care to children shall receive a minimum of 40 hours of initial and annual training.*

COMAR 14.31.06.05 F (3) *The training of employees who may provide direct care to children shall include: (a) Emergency preparedness and general safety practices; (b) Cardiopulmonary resuscitation leading to certification; (c) Annual first-aid training.*

3. Safety and Security

a. Aggregate Incidents

Morning Star experiences few youth incidents involving aggression. During the third Quarter, there were a total of nine incidents posted by the facility on the DJS Incident Database. Four of the incidents involved youth on youth assaults. – one of which resulted in youth injury. Three incidents resulted in youth requiring medical treatment: two resulted from sports related injuries; and one involved a youth verbalizing suicidal thoughts. A youth also requested emergency medical care when several mosquitoes bit him and he feared an allergic reaction.

Morning Star policy requires that all personal keys (car keys etc.) brought to the facility by staff members and visitors are turned over to be locked in a secure location during duty and visitation hours.

4. Physical Plant and Basic Services

a. Fire Safety

A Fire Marshal conducted an inspection in April of 2010. Staff members conduct fire drills each month which vary as to location and shift. Youth and staff are aware of fire safety procedures and know where to go in the event of an emergency.

b. Physical Plant

The buildings are modular units that are approximately 50 years old. Morning Star leases the facility, which is in poor to fair condition. Vision Quest, the parent organization of Morning Star, has taken a number of steps to maintain and improve the physical plant including remodeling the three education trailers in December of 2009.

When it rains, there is standing water on the grounds between the buildings. Leaves and pine needles clog the drains where there are drains, but the land is at sea level and the water has no place to go. Standing water draws mosquitoes and can present a health risk.

Standing water at Morning Star

The bathrooms in the youth living units are dirty and in need of a thorough cleaning. Some lights in the living units were not working upon inspection and working lights were left on when there was no-one around.

Shower at Morning Star

c. Basic Services

The Dorchester Health Department conducts regular food service inspections as required. Administrators also inspect the kitchen and dining areas weekly to ensure all cleaning requirements are met.

The DJS Program Evaluation Specialist conducted a visit in July. A subsequent report in August details deficiencies. Almost all of the deficiencies related to physical plant problems - holes in walls, dirty bathrooms and broken furniture. Morning Star has taken some steps to correct problems but much remains to be done to ensure facility-

wide cleanliness and ongoing maintenance. Staff and youth need to take ownership and pride in maintaining a satisfactory living environment at Morning Star - inclusive of basic cleanliness, orderliness, and energy conservation.

Applicable Standards

COMAR 14.31.06.07 (A)(4). *The licensee shall ensure compliance with the local fire and health requirements by submitting annually to the licensing agency, reports of all fire and health inspections conducted by the local jurisdiction.*

COMAR 14.31.06.07.C.1 *The licensee shall maintain all structures and grounds in good condition, free from health or safety hazards.*

5. Education

a. General

Morning Star operates a Type III school which follows Dorchester County School curriculum and meets Maryland State Department of Education (MSDE) standards. Morning Star is in the process of finalizing an agreement with the Dorchester County School System that will allow youth requiring five or fewer hours of special education to be served at the facility. This will increase the referral base for the program and allow more youth to benefit from the Morning Star treatment and education program.

The facility school provides ninth grade level classes, offering remedial help to those who need it. The program provides six hours of classes or hours of study each school day. Recently, Morning Star reduced the length of classes from 90 minutes to 60 minutes. This is a positive change because some students were having difficulty maintaining focus for the longer length of time. Approximately 80% of the residents enter the Morning Star Pre-GED program to prepare for the GED exam.

1. Records

Morning Star requests school records as part of the intake process. Educators work with the Maryland State Department of Education and with local school district offices to help coordinate communication between the facility and the LEA (Local Educational Authority).

2. Educational Plan

Morning Star enrolls new admissions directly into the educational program. The youth receive report cards. Educators update Guardians and therapists on a weekly basis concerning educational progress. Morning Star has a designated computer room which youth use as an integrated part of the education program. The school includes a library that meets MSDE standards.

Staff members at Morning Star are in the process of revising the incentives within the educational program and in the overall program at the facility. Currently, youth may earn a "Student of the Week" designation based on the number of points earned for participation, progress and achievement in school. Typically, one half to two thirds of the youth earn this reward. Youth who receive Student of the Week designation every week for a calendar month earn "Student of the Month" designation.

b. General Educational Development Program (GED)

Approximately 75% of the youth taking the GED test have been successful in passing. Youth who have passed the GED before entering Morning Star (or who are staying after taking the exam) have a 27-hour-per-week work schedule. After a 30-day internship, the youth earn a wage and keep a time sheet.

Although Morning Star does not offer formal vocational education course, youth can use work experience at the facility for reference purposes after completing the treatment program. Post GED studies or pre-college studies are not provided at Morning Star.

c. Vocational Education

There are no plans to introduce formal vocational training at Morning Star. Lack of funding is currently limiting the facility's ability to provide additional programing for youth. A once-mooted plan to create a vocational arts program utilizing the gym area would be a valuable addition to the overall program. Such a program could be implemented if the facility youth population were to be consistently above 30 youth.

Applicable Standard

COMAR 13A.09.10.13.A.1 *A school shall maintain instructional materials and equipment of sufficient variety, quantity, and quality, and, at an appropriate range of reading levels, to implement its educational program in each curricular area for each age, grade, instructional program, or any combination of these, based on the classification of the educational program specified on the approval document of the school.*

6. Rehabilitative and Recreational Programming

a. Therapeutic Program

Morning Star has a four level system in which youth earn progress up through successive levels from admission to discharge. Youth move from cottage to cottage as they progress. Youth begin in the orientation cottage and move to Cottage B, then to Cottage A and finally to the Upper Dorm. Youth who demonstrate significant problems may lose a level. Youth who receive write-ups may have time added to their placement.

Family involvement is crucial for success at Morning star. Youth must complete three successful home visits before release. As a youth prepares for release, he creates and presents a Discharge Board for senior staff to review. The Discharge Board is a large sheet of construction paper on which the youth designs a symbolic representation of achievements while at Morning Star. After a successful presentation, staff post the Discharge Board on a wall of the administration building. Staff and youth also sign off on a Youth Guide, which lists significant steps required and successfully completed by the youth.

The treatment plan includes participation in group therapy and individual therapeutic elements including: Cognitive Behavior Therapy (CBT); Aggression Replacement Therapy (ART); Seven Challenges substance abuse counseling; individual therapeutic sessions; group process intervention; and equestrian-based therapy. A therapist from Eastern Shore Psychological Services works with Morning Star youth for 40 hours each week. A multidisciplinary team meets monthly to review progress and needs for each youth in the program.

b. Recreational Programming

The facility has a partially covered basketball court, a space for volleyball, football, weight lifting and a swimming pool for use from April through October. Youth receive sufficient recreational activity time. During inclement weather, resources are limited.

In September, Morning Star staff and youth participated in an Iron Man event. Eleven teams (most consisting of both staff and youth) competed in three events: a 10-lap swim; a 3.5-mile run; and a 12-mile bike ride.

Youth at Morning Star have opportunities to participate in activities in the local community. More such activities would provide additional normalization and socialization for youth.

c. Parental Involvement

Residents can telephone home once during the week and once on weekends. They earn weekend visits home to maintain family contact and prepare for transition back to communities. Family visits take place once a week. Youth can receive and send mail from approved sources. Morning Star therapists provide Functional Family Therapy for youth and parents to support youth throughout treatment. Family members take part in multidisciplinary meetings.

Applicable Standards

Md. Dept. of Juvenile Services Policy and Procedure CJ-1-05 Case Management for Committed Youth 3 (2) (vi) The Community Justice Case Management Specialist shall: *Meet at least monthly with youth who are in residential care in Maryland to assess treatment progress and plan for community reintegration.*

COMAR 14.31.06.12.B.1 *The licensee shall provide the children with a range of indoor and outdoor recreation and leisure activities both in the program and in the community.*

7. Medical

Morning Star provides full time nursing care with an examination room and infirmary. The RN is on-site duty 40 hours a week and on call 24/7. The nurse responds to sick call slips from 12.30 pm but sees youth immediately as needed. Youth are taken to a doctor's office in Easton for physician services. Choptank Community Dental Service provides for youth dental service needs.

Morning Star staff members administer the Facility Initial Reception/Referral Screening Tool (FIRRST) assessment to youth upon arrival. FIRRST screens for immediate concerns that might preclude admission. The MAYSI youth screening test is administered within two hours of entry. Health and safety screening is completed within 24 hours. The Child and Adolescent Needs and Strengths (CANS) assessment is administered within 20 days, again at 90 days and at discharge.

Sometimes it takes months to receive youth insurance information from DJS Community Case Managers.

8. Youth Advocacy

a. Community Advisory Board

Morning Star hosts quarterly Advisory Board meetings and a meeting on the first Wednesday of each month. There are also periodic "Congress" events that include a cookout, games, and other activities. Members of the Advisory Board along with DJS officials, Community Case Managers, staff members, and youth family members are invited to attend.

b. Youth Advocacy

There is a locked box for youth grievances in the dining hall and youth report the system works well. The DJS child advocate responds to youth concerns in a timely way.

c. DJS Community Case Manager visitation with youth

According to the sign-in sheet at Morningstar, only 8 youth were seen by their Community Case Manager at the facility during the third quarter of 2010. Some DJS Community Case Managers are dedicated - others rarely call or visit. DJS regulations require Community Case Managers to visit youth on a monthly basis.

Applicable Standard

Department of Juvenile Services Policy CJ-1-05.1(2) *Community Case Manager Specialists shall: (vi) Meet at least monthly with youth who are in residential care in Maryland to assess progress and plan for community reintegration.*

RECOMMENDATIONS

1. DJS should fully utilize this program. It is an appropriate placement for many youth in the care of the Department.

2. Morning Star should enhance staff team-building and staff training in order to provide a more consistent and constructive treatment environment for youth.

3. DJS Community Case Managers should visit youth at Morning Star as required.

4. Morning Star should provide post-GED and college preparation courses.

5. Vocational education should be provided to youth as part of the curriculum.

6. Morning Star should implement higher standards of cleanliness and maintenance at the facility.

NICK MORONEY
Acting Director

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

FACILITY REPORT
ALFRED D. NOYES CHILDRENS CENTER
JULY - SEPTEMBER, 2010

Facility: Alfred D. Noyes Children's Center
9925 Blackwell Road
Rockville, MD 20850
Administrator: John Dowdy, Superintendent

Dates of Visits: July 13
August 17 and 30
And September 16, 2010

Reported by: Claudia Wright
Senior Monitor

Persons Interviewed: Superintendent Dowdy, Assistant Superintendent Gaskins, direct care staff, medical staff, youth

Date of Report: November 2010

INTRODUCTION

The Alfred D. Noyes Children's Center (Noyes) is a State owned and operated detention facility located in Montgomery County. Noyes is currently comprised of three units for males and one unit for females. Department of Juvenile Services (DJS/The Department) rated capacity for Noyes is 57.

SUMMARY OF CRITICAL FINDINGS

- Overpopulation is a chronic problem at Noyes.
- Fire drills are not held as required on the third shift, after youth are locked in their rooms.
- No infirmary is available. Medical services are not available 24/7.
- Youth were not allowed to attend school in designated classrooms or to take recreation outdoors for more than six weeks due to a failure of the security fence.

FINDINGS

1. Population

a. General

Rated Capacity	High Population	Low Population	Average Daily Population	Average Monthly Population	Number of Days Over Capacity
57	65 (8/7)	39 (9/2,9/3,9/4,9/7)	49	July 54 August 52 September 42	11

Overpopulation continues to be the major issue of concern at Noyes. The population numbers charted above reflect the DJS daily population reports. These reports are misleading because of the Department's arbitrary definition of "rated capacity." Rated capacity is defined as "the budgeted operating capacity" and the ability of the Department to "safely and humanely maintain critical aspects of the facility…."[17] This flexible definition, and consequent rating of the population capacity of Noyes at 57, 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. Every sleeping room has at least two beds, and two

[17] Md. Standards for Juvenile Detention Facilities 5.1.5 Crowding.

slightly larger rooms have as many as four. Youths are locked in their rooms at night. They cannot leave without the assistance of staff.

The generally accepted Standards of the American Correctional Association (ACA) 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."[18] Safety is the reason single occupancy rooms are important in juvenile detention facilities. Although, for accreditation purposes, the ACA standard applies to newly constructed facilities and not older facilities such as Noyes, the Department should ensure that youth do not have to share rooms because single occupancy rooms are the best practice.

Some youngsters cannot be allowed to share a room with others for their own safety. In some cases, because youth come into the facility directly from the street, there is not enough information about the youth to allow room sharing. In some cases, medical issues may require that an individual have a single room. If Noyes was limited to single occupancy the rated capacity would be 32.

Second, Noyes is only one of two detention centers that houses boys and girls.[19] Noyes houses all girls in detention from the DJS Metro region which includes Prince George and Montgomery Counties. Girls from other counties and Baltimore City are also often placed at Noyes for security reasons. It is difficult to understand why a facility with critical space limitations would be the one selected to house both boys and girls.

In early July, the administration modified the use of the four living units and designated three units for boys and one for girls.[20] This means that now boys rarely have to sleep on plastic "boats", unless a youth needs constant observation or cannot share a room with others. However, with only one unit for girls, if that population goes over 16, then girls have to sleep in boats, which are plastic shells put under a mattress and set on the floor.

Sleeping near the floor in boats with a mattress is an unacceptable practice for a number of reasons. It is unsanitary. 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. Youth complain that when there are overflows in the bathroom, the water floods the dayrooms where the boats are placed. Clothing, sheets and blankets touch the floor and collect dust and dirt.

[18] American Correctional Association Standards for Juvenile Detention Facilities 3-JDF-2C-01.
[19] Lower Eastern Shore Children's Center houses girls and boys.
[20] Previously, two units were designated for boys and two for girls. The boys units were constantly overcrowded, and the girls units were not fully utilized. (For more information, see *Overcrowding in Department of Juvenile Services Detention Facilities*, Report of the Juvenile Justice Monitoring Unit, August, 2010.)

Further, the youth who must sleep in boats set on the floor has no personal space for belongings such as books, pictures, underwear, extra clothing, or shoes. She 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.

Sleeping on plastic boats placed on the floor is not the only negative consequence of overcrowding. When too many people are crowded into an inadequate space, all of the support systems of the facility are stressed. Water, sewage, electrical, climate control and laundry capabilities are stretched beyond the physical limitations of the facility. Crowding also increases stress for the people who live and work in the building. Chronic overcrowding at Noyes is likely to continue at least as long as both boys and girls are assigned to the facility.

Applicable Standards

American Correctional Association Standards for Juvenile Detention Facilities 3-JDF-2C-01 Juvenile Housing *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.*

Md. Standards for Juvenile Detention Facilities 6.5.2 Resident rooms *Each resident shall 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.*

b. Detention and Pending Placement

	Number of Youth in Status 60+ Days[21]	Number of Youth in Status 90+ Days[22]	Average Length of Stay
Detention	2 (62, 80)	5 (91, 133, 142, 377, 507)	17.51
Pending Placement	0	0	22.65

[21] September 30, 2010
[22] September 30, 2010

c. Race/Ethnicity Breakdown

	3rd Quarter, 2009	3rd Quarter, 2010
Total # of Youth Detained	314	266
White	37	46
African American	226	178
Latino	43	32
Other	8	10

2. Staffing

a. General

The DJS Quality Improvement Unit (QI) issued a Comprehensive Quality Review Report on Noyes on May 10, 2010. The QI Unit rated Noyes as "non-performance", the lowest rating, in the area of Staffing.[23] The report cites areas of deficiency that include supervision as consistently out of ratio (failure to provide supervision by at least one staff per eight youth),staff working several double shifts per week, and frequent failure to provide direct care staff supervision when youth are interacting with education or medical personnel.

The staff at Noyes creates an environment that undoubtedly contributes to the relatively low level of violence in the facility, even in the face of unusual challenges – staff shortages, housing boys and girls together, overcrowding, lack of dining and program areas, and double-celling.

b. Training

The DJS/OQI Report issued May 10 rated Noyes as "partial performance" in the area of staff training.[24] According to this report, 28 of 42 staff did not meet training expectations. Areas of deficiency in training include Crisis Prevention and Management, Suicide Prevention, and Recognizing and Reporting Child Abuse and Neglect.

[23] Maryland Department of Juvenile Services Office of Quality Improvement Comprehensive Quality Review Report, Alfred D. Noyes Center, May 10, 2010, page 22. (http://www.djs.state.md.us/quality-assurance/qir-noyes.pdf)
[24] *Supra,* page 32.

3. Safety and Security

a. Aggregate Incidents

Incident Categories	3rd Quarter 2009	3rd Quarter 2010
1. Youth on Youth Assault	38	22
2. Alleged Youth on Staff Assault	4	1
3. Inappropriate conduct by youth/with restraint	-	28
4.Group Disturbances (without bodily harm or property destruction)	2	1
5. Restraints	41	43
6. Seclusions more than 8 hours	1	0
7. Escape	0	0
8. Suicide attempts, ideation, gestures, behavior	10	9

b. Videotaping of Incidents

Stationary cameras have been installed and are in operation in all the living units. Installation of cameras is a major step forward in enhancing security of youth and staff at Noyes.

Applicable Standard

Md. Dept. of Juvenile Services Policy and Procedure RF-05-07 *The Department of Juvenile Services (DJS) employees shall video tape room extractions, escorts to seclusion, use of restraints or other critical incidents that relate to the safety and security of a residential facility. Incidents shall be videotaped unless videotaping of the incident compromises the safety and/or security of youth and/or employees. The Department encourages the videotaping of incidents to de-escalate incidents and to prevent further misbehavior and the use of physical restraint. Videotaping shall be in accordance with the requirements set forth within this Policy and Procedure.*

4. Physical Plant and Basic Services

a. Fire Safety

The administration's conduct of fire drills remains an issue. The facility is conducting three fire drills per month, with one drill taking place on each shift. However, drills are not being conducted as instructed by the Fire Marshal. The Marshal instructed that the 3rd shift drills (midnight shift) should occur at some time after occupants have been locked in their rooms and are asleep. The purpose of this drill is to assure that staff are trained and willing to maintain their posts so that they can release youths from the locked rooms in the event of a fire. Each room at Noyes must be unlocked individually by key, making it even more critical that staff practice removing youth from their rooms during the night.

b. Physical Plant

Noyes is not appropriate for the housing of 57 children. However, significant efforts to improve the environment have begun. New baseboard heating is being installed in the sleeping rooms. New locks and keys, as well as new doors are being installed. Bids are out to replace tile flooring, and the interior is being painted. Some new furniture is in place, and new flat screen TV's have been placed in the living units.

c. Basic Services

Meals for youth at Noyes are prepared at a nearby treatment facility and transported to Noyes. Youth eat in the day rooms of their units, which further contributes to the lack of sanitation in the sleeping areas.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.2.1 Conformity with codes *All detention facilities shall conform to state fire safety requirements.*

Md. Standards for Juvenile Detention Facilities 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. Education

During a thunderstorm in July, a tree fell on the electronic fence that surrounds the Noyes property. For six weeks, students were not allowed to attend classes in the school trailers outside the main building because the fence was not secure. Classes took place in the living unit dayrooms. Teachers and students indicated that it was virtually impossible to provide meaningful education under these circumstances. Finally

in September the fence was repaired and school resumed in the designated classrooms.

6. Recreational Programming

All youth receive large muscle exercise each day. Each unit is allowed to visit the game room four times per week. Boys and girls who reach Level 4 are allowed to participate together in recreational activities, including game room and movie nights. A variety of speakers and other volunteers visit the facility to provide activities for youth.

There were no outside activities during the six week period that the fence was disabled. Youth rarely go outside for recreation. In the DJS/OQI report of May 10, the facility received the lowest rating of "non-performance" in the area of structured rehabilitative programming. Evaluators found that activities do not take place as scheduled, mental health staff do not conduct therapeutic groups, and much time is spent watching TV.[25]

Applicable Standard

Md. Dept. of Juvenile Services Policy and Procedure RF-08-07 Recreational Activities Policy *The Department of Juvenile Services (DJS) shall provide recreation and leisure activities to youth in DJS facilities and programs to promote skill development and prevent idleness. Recreation shall be available to all youth each day. Leisure activities shall be provided to alleviate boredom, provide positive reinforcement and develop skills of cooperation, teamwork and sportsmanship.*

7. Medical and Behavioral Health

a. Basic Medical Services

Noyes administration is hard-pressed to provide adequate medical services with the resources provided. Services are not provided at night. During these times, shift supervisors must determine if a youth is sick enough to call for medical help. There is no infirmary, and no ability to separate youth for medical observation or quarantine.

b. Mental Health Services

A psychiatrist visits Noyes as needed. There is a full-time clinical psychologist, 2 addictions counselors and a licensed social worker who provide mental health services.

[25] *Supra*, note 7, p. 41.

8. Youth Advocacy, Internal Monitoring and Investigation

a. Youth Advocacy

Noyes youth understand and frequently use the DJS grievance system. The Child Advocate responds promptly to youth grievances. Fourteen grievances were filed during the quarter.

b. Internal Monitoring

The DJS Office of Quality Improvement issued its report on May 10, 2010. Of the 43 standards reviewed in this report, the facility was found to be in satisfactory performance in 35%, partial performance in 37% and 28% non-performance. No area was rated as superior performance.[26]

c. Incident and Child Abuse Reporting and Investigation

Child abuse allegations are regularly reported as required by Maryland law and DJS policy. During the quarter there was one allegation of child abuse. The allegation was ruled out by Child Protective Services, and was not sustained by DJS Office of the Inspector General.

Applicable Standard

Md. Dept of Juvenile Services Policy and Procedure Number 01.01.13 Reporting and Investigating Child Abuse and Neglect *The purpose of this policy is to ensure the safety of youth in the care of the Department of Juvenile Justice (DJJ). The policy sets forth the procedures to be followed in reporting and investigating cases of suspected child abuse or neglect. The guiding principles of this policy are as follows:*
A. To insure that youth under the care of the Department of Juvenile Justice are protected from abuse or neglect it is required that every employee report any suspected abuse or neglect, both orally and in writing, to the proper authorities.
B. There shall be a timely investigation by the appropriate authorities of each suspected incident of abuse or neglect.

[26] *Supra*, note 7. The DJS-QI report can be accessed at http://www.djs.state.md.us/quality-assurance/qir-noyes.pdf

RECOMMENDATIONS

1. Individual rooms should be limited to single occupancy. No youth should be required to sleep in a “boat” set on the floor.

2. Fire drills must be held on the third shift after youths are locked in their rooms and asleep.

3. Medical staff should be increased to allow 24/7 coverage.

4. Space should be allotted for an infirmary or youth who must be separated should be transferred to other facilities.

5. Youth should be allowed to participate in outdoor recreation on a regular basis.

UNABATED CONDITIONS

1. Overpopulation is a chronic problem.

2. Fire drills are still not being held on the third shift after youths are locked in their rooms and asleep as required.

NICK MORONEY
Acting Director

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

FACILITY REPORT
RITE OF PASSAGE - SILVER OAK ACADEMY
JULY - SEPTEMBER, 2010

Facility: Silver Oak Academy
999 Crouse Mill Road
Keymar, Md. 21757
Facility Administrator: Kevin McLeod
Executive Director: James Bednark

Dates of Visits: July 7, 9 and 28
August 20 and 24
September 7, 10, 21 and 22, 2010

Reported by: Claudia Wright
Senior Monitor

Persons Interviewed: Facility administrators, staff and youth.

Date of Report: November 2010

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INTRODUCTION

The Silver Oak Academy (SOA) is a 48-bed, staff secure residential program for boys. It is owned and operated by Rite of Passage, Inc. The Maryland Department of Juvenile Services (DJS/the Department) licenses the facility. SOA opened and began admitting youth into the program on July 6, 2009. It is located in northern Carroll County in Keymar, Maryland, on the grounds of the former Bowling Brook Academy.

SUMMARY OF CRITICAL FINDINGS

- Since opening in July 2009, 22 students have successfully completed the program. Thirty-three students have been discharged as unsuccessful, at a cost to taxpayers of $468,375.00.
- The number of staff on duty at night – 3 awake and 2 sleeping - has not proved sufficient to prevent serious incidents.
- There are no fixed security cameras in the facility.
- Incident reports of reportable and critical incidents are not consistently filed as required by DJS policy and COMAR. When incident reports are filed they are often incomplete.
- Twenty-one youth were quarantined for 5 days in June due to an outbreak of *Salmonella enteritidis.*
- The school at SOA was found non-compliant with COMAR regulations, and was placed on intensive monitoring by the Maryland State Department of Education (MSDE) in June 2010.
- Documentation of medical procedures is not adequate.
- SOA does not have access to a psychiatrist.

FINDINGS

1. Population

The population has increased steadily since the program opened in July, 2009. By September 30 of 2010, there were 46 youth participating in the program.

According to the DJS Assist database, on September 30, 2010, 101 youths had been admitted since opening. Twenty-two of these youths successfully completed the program.

Thirty-three youth were discharged without successfully completing the program. These youngsters either went AWOL or were otherwise transferred without completion. A failure rate of 32.7% is high. Youth who do not successfully complete the program

are typically returned to a secure detention center while the Department begins a new search for an appropriate placement. The 33 discharged youth spent a total of 2,498 days in the SOA program. The cost of these wasted days, at $187.50 per day, is $468, 375.00. The Department will pay a heavy price at per-diem rates for large numbers of youth who are returned to DJS, and then must start over in detention and a new treatment program. Youth should be carefully assessed for their appropriateness for the SOA program before being placed there.

Of the 22 youth who successfully completed the program, seven have been re-arrested or warrants issued. These 7 youths spent a total of 1,621 days at Silver Oak Academy, at a cost of $303, 937.00.

2. Staffing

Daytime supervision of youth appears to be sufficient, but night staffing is problematic. Forty-eight youths are divided into two housing units. At night, there is only one direct care worker awake and on duty in each unit. A third staff person is assigned as perimeter security. There is no one in master control and no one in the medical unit. The Director argues that this number at night meets the DJS required ratio of 1:16. However, 1:16 does not insure adequate supervision.

Students at Silver Oak are not locked in their rooms – they sleep in large, open dormitories. On September 18, four students attacked two other students after lights out in Harvard Hall (DJS Incident Report 85230). Both victims received injuries that required medical treatment. One received injuries so severe he had to be taken to the emergency room the next day. Because this event happened on the evening shift, there were two staff on duty. According to the youths, one staff person was downstairs doing laundry when the attack occurred. It is not known what the other staff was doing during the attack because no report of the incident was filed. Logs reveal that the severely injured student was seen in the bathroom trying to put cold water and cream on his face during the midnight shift, but that staff person did not report the incident either. Nothing was reported until the next day when day shift staff noticed the injured students in the breakfast line.

Earlier this year, a student was attacked while sleeping and received a fractured jaw (DJS Incident Report 80237). One of the students injured in the September 18 fight had previously sought medical attention twice under suspicious circumstances, reportedly from falling out of his bed. Failure to provide adequate staff supervision not only allows incidents like this to happen, but staff shortages allow serious incidents to go unreported. The presence of an extra staff person asleep in the unit does not alleviate the problem.

Further, one staff per unit is not adequate coverage for this number of youths at this security level in the event of an emergency. If a youth becomes ill, if there is a fight or group disturbance, or if a group decides to escape, the lone staffer is helpless. There are no cameras, distress alarms or other technical equipment that might allow a call for

assistance. If one staffer leaves the post on his unit to assist on the other unit, 24 youths will be left without supervision. Although there is a second staff person sleeping in each unit, the value of that person in an emergency is questionable. Each living unit should have at least two awake staff at all times, in addition to the perimeter security person, unless staff supervision is supplemented by cameras, alarms or other technology.

A collateral staff shortage problem was revealed during the September 18 incident. It was determined on September 19, a Sunday, that one of the youths would be taken to the emergency room. The nurse, with no back-up, was allowed to drive the youth 25 miles to a hospital in downtown Westminster. No security measures were taken. The Director of Student Services at SOA said that this is "a common practice." It is a practice that is dangerous for youth, staff and the public.

Applicable Standard

COMAR 14.31.06.06.F *The licensee shall ensure(1) Sufficient staffing at each site to carry out the licensee's administrative, business, clerical, dietary, housekeeping, maintenance, secretarial, and supervisory functions; (2) Adequate staff coverage at all times based on the time of day, the size and the nature of the program (3) That one direct care staff member shall remain awake in each building at all times.*

3. Safety and Security

a. Aggregate Incidents and Incident Reporting

	3rd Quarter 2009	3rd Quarter 2010
1. Alleged Inappropriate conduct/comments by youth	8	0
2. Physical assault youth on youth	0	7
3. Attempted Escape	2	0
4. Escapes/AWOL's	0	1
5. Alleged physical child abuse	1	0
6. Sick youth requiring emergency care	0	2

According to the DJS Incident Report database, there were 30 incident reports filed during the quarter. The facility reports that none of the incidents involved the use of physical restraint. However, there are unresolved issues concerning the reliability of the information reported to DJS by the SOA administration. Review of disciplinary

reports, medical records and youth files, and interviews with staff and youth, indicate that there were significantly more reportable incidents than the number reflected in the DJS Incident Reporting Database. Incident reports have also been found to be incomplete or inaccurate.

For example, in DJS Incident Report 84158, August 1, 2010, the narrative that was filed with the report and placed on the DJS database states that, "While in the nurse's station [student] informed the nurse that he was having chest pain on the left side of his body. The nurse immediately notified the EMT." However, the statement of the staff person on duty during the event, which was taken a day *after* the report was filed, tells a different story. The staff person describes a harrowing event in which he repeatedly had to take the youth back to the nurse's station and beg the nurse to call the EMTS, as the youth's symptoms became more and more severe. At the end of his detailed statement, the staff writes, "I feel as though the EMTS should have been called the minute he started to cough and spit up blood and the nurse should have allowed me to get the medication instead of leaving me with a student who I thought was on the brink of death." The youth was later determined to have suffered a reaction to a change in psychotropic medication. The DJS Office of the Inspector General sustained violations of DJS policy against the medical personnel involved in this incident.

It is important that providers follow rules and regulations regarding incident reporting so that practices that might result in unacceptable risk to students and staff can be identified and corrected. The Department must insist that incident-reporting rules be followed.

Applicable Standards

COMAR 14.31.06.18.A (1) *The licensee shall submit reports and maintain records as requested by the licensing agency in order to ensure compliance with these regulations and other federal and State laws*.

Md. Dept. of Juvenile Services Policy and Procedure MGMT-03-07 (4)(a)(6) *Each Facility administrator, Area or Regional Director shall ensure all incidents are accurately entered into the DJS Incident Reporting Database.*

Md. Dept of Juvenile Services Policy and Procedure MGMT-03-07 (4)(d)(1)(i)(c) *The Programs management staff shall ensure a DJS Incident Reporting Form is completed, entered into the DJS Incident Reporting Database and electronically forwarded to OIA by 9:00 a.m. the next business day.* ***(ii)*** *After business hours, procedures remain the same as during business hours with the additional requirement to notify the OIA Administrator within one hour of the incident's occurrence.*

b. AWOL

On August 5, a SOA student ran away from his home during a supervised visit with his seriously ill mother (DJS Incident Report 84284). The student was later

apprehended and placed in detention at Hickey. He escaped from Hickey on September 7, 2010.

Applicable Standard

COMAR 14.31.06.16. A. *The licensee shall have and follow a written policy to govern its actions when a child is discovered to be absent without leave.* ***B.*** *If the child has not returned to the program within 2 hours, the licensee shall notify (1) the local law enforcement authority; (2) the placing agency; (3) the licensing agency; (4) Unless inconsistent with the child's individual service plan, the child's parent.* ***C.*** *If an absent child does not return to the program within 24 hours, the licensee shall submit a written report to the licensing agency.*

4. Physical Plant and Basic Services

On June 4, 2010, an outbreak of *Salmonella enteritidis* began at SOA. The outbreak lasted until June 14th, and over that time period resulted in illness of 6 staff persons and 21 youth. The sick youth were confined to Harvard Hall for approximately one week. The outbreak was first reported to the Carroll County Health Department (CCHD) on June 8. DJS was first notified on June 8, by e-mail to the DJS/Office of the Inspector General (DJS/OIG). Parents were not notified until June 8.

CCHD conducted an extensive investigation of the outbreak. A report was issued on July 26. CCHD was not able to determine the exact mode of transmission of the illness. The report states that the findings are "consistent with person to person transmission." However, the report goes on to state that

> It is also possible that transmission could have resulted from a continuous exposure to a source, such as an asymptomatic kitchen employee shedding *S. enteritidis* and contaminating numerous food items over a period of time, ill people contaminating common supplies or equipment, or a contaminated food product served over a period of several days.

The CCHD also found that "[S]low detection of cases, as indicated by the discrepancy between first onset date on the line list (June 4) and first onset date given by interviewees (May 29) may have delayed the implementation of control measures…." The report includes the recommendation that "systems be enhanced in the facility to gather accurate information in a timely manner about the health of students and employees. In the event of a future outbreak, it is recommended that control measures be implemented quickly and compliance with these measures be closely monitored."

This outbreak was first discovered by the JJMU monitor during a routine review of medical files on June 24. JJMU was not notified of this critical incident, and there was no DJS Incident Report filed until July 2, 2010.

Applicable Standard

COMAR 14.31.06.07 A *The licensee shall comply with federal State, and local building, fire, and health codes, and all applicable local zoning laws.*

5. Education

On June 11, SOA was placed on Intensive Monitoring because the school did not demonstrate compliance with COMAR requirements. MSDE conducted an unannounced onsite monitoring visit on June 4, and found that SOA failed to demonstrate compliance with all twenty COMAR 13A.09.10 regulations that were monitored. Among other findings, MSDE noted that

- No criminal background check had been conducted for an employee who had been working at the school since November, 2009;
- The school employed a teacher assistant assigned as a substitute for IT who did not hold a bachelor's degree;
- The school employed a nurse to teach the Health course who did not hold a valid Maryland Certificate;
- A student was enrolled in secondary school even though his IEP indicated he was in the 7th grade;
- Required documentation for a physical restraint was not complete;
- The school was unable to provide an instructional materials and equipment inventory for its culinary arts, construction, instructional technology/computer technology, and cosmetology/barbering courses;
- The school was not able to demonstrate that it had current and complete curricula available for culinary arts, construction, information technology/computer technology, and cosmetology/barbering;
- The school was not in compliance with student-to-staff ratio; and
- The school did not submit the required certification application, official Bachelor's degree transcript, and evidence of fingerprint screening for the Education Director.

On September 2, SOA received notification that it had reached compliance with the applicable COMAR provisions and would not need to supply further documentation. However, the school remains subject to unannounced onsite monitoring visits by MSDE to determine ongoing compliance. MSDE monitoring visits on September 14 and October 7 revealed continuing noncompliance with various COMAR regulations. According to MSDE notices to the school, intensive monitoring will continue until at least January 15, 2011.

Applicable Standard

COMAR 14.31.06.12 *Each licensee shall collaborate with the placing agency to ensure that each child of mandatory school age who has not earned a high school diploma or certificate of completion under COMAR 13A.03.02.02 is receiving an appropriate elementary or secondary school education.*

6. Rehabilitative and Recreational Programming

a. Therapeutic Program

The facility relies strongly on the Positive Peer Culture and mandatory Guided Group Meeting models for treatment. There is one LCSW on staff to provide therapeutic services.

The Refocus behavioral intervention program has been abandoned.

b. Recreational Programming

The program emphasizes participation in various athletic programs. Weightlifting, basketball, wrestling and football are available. There are 2 hours of structured recreational and leisure programming daily, 1 hour of large muscle exercise. Students participate in off campus football games.

Many youth are excited about sports and look forward to participation. Unfortunately, students are not allowed to participate until they reach the higher levels of the program.

c. Parental Involvement

Parents may visit students weekly. A staff person is charged with maintaining contact with parents and the community, and to assist with transition when students complete the program.

7. Medical

Medical records are not adequate. The DJS Program Evaluation Unit found the program to be in partial compliance in health care, largely due to failure to document practices and procedures.[27] For example, the DJS evaluator noted that medications are sometimes stopped upon admission with no documentation to explain why. Sick call is not properly documented, and is described as “less than adequate.” If a youth is seen

[27] Program Evaluation Report, DJS Office of quality Assurance and Accountability, June 30, 2010.

by the nurse at a location outside of the clinic, there is no documentation at all. The evaluator notes, “Youth ask for sleep medications and the MD prescribes high doses of Denadryl, Trazadone and Vistaril with no documentation to justify the prescribing of the medication or when the youth is to be followed up.” There is no off-grounds logbook or lab logbook. Referrals for services are not documented.

There is a registered nurse on duty during the week and a contract nurse on weekends. There is no coverage in the evenings. Both the registered nurse and the contract nurse do not appear to be fully competent in post-restraint examination of youth or the requirements of suspected child abuse reporting. Notes are frequently filed several days after an event and are not thorough or complete. Parents are not timely notified of illness. Pictures of injuries are not included in the files.

SOA does not have a psychiatrist. The MD who visits once per week prescribes and monitors psychotropic medication. The program should contract for the services of a psychiatrist.

8. Youth Advocacy, Internal Monitoring and Investigation

a. Youth Advocacy

DJS has assigned a Child Advocate to the facility and youth are aware of the grievance process.

Youth seem to be reluctant to file grievances. One of the Silver Oak program’s treatment “non-negotiables”, according to the program handbook, is that youth cannot complain about the program or staff. The Youth Handbook explains both the DJS and an internal grievance system, but two of the “non-negotiables” listed for Guided Group Meetings (GGM’s) are complaining about staff and the program. According to staff, those rules only apply to the GGM’s and they do not supersede the youth’s ability to file a grievance. The DJS Child Advocate said she believes the youth understand their right to file grievances. However, no grievances were filed during the quarter.

b. Internal Monitoring

The DJS Office of Program Evaluation monitors the SOA. The most recent evaluation was reported on August 10, 2010.

RECOMMENDATIONS

1. Youth must be carefully and accurately assessed before placement at SOA
2. At least 2 awake staff should be on duty in each unit throughout the night.
3. Security cameras should be installed throughout the facility.
4. Incident reports must be filed on all critical incidents and must be complete and accurate.
5. Medical staff should receive training in proper medical documentation.
6. SOA should arrange for the services of a psychiatrist.

NICK MORONEY
Acting Director

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

FACILITY REPORT
THE WAY HOME-MOUNTAIN MANOR
JULY - SEPTEMBER, 2010

Facility: The Way Home-Mountain Manor
3800 Frederick Avenue
Baltimore, MD 21229
Program Director: Jennifer Posey

Dates of Visits: July 9 and September 28, 2010

Reported by: Claudia Wright
Senior Monitor

Persons Interviewed: Paul Wells, Executive Director Mountain Manor; Barbara Groves, Vice President Mountain Manor; Jennifer Posey, Program Director, The Way Home, direct care staff and youth.

Date of Report: November 2010

INTRODUCTION

The Way Home (TWH) is a non-secure group home for girls who are committed to the Department of Juvenile Services (DJS/the Department). It is located within the Maryland Treatment Center, Inc., Mountain Manor complex of therapeutic programs in West Baltimore. The Way Home can provide services to 12 residents.

SUMMARY OF FINDINGS

The Way Home offers a gender-appropriate, comfortable and therapeutic environment to troubled girls. The program benefits from its location on the grounds of Mountain Manor, which offers a wide variety of inpatient and outpatient mental health services.

FINDINGS

1. Population

The population remained below the rated capacity of 12 throughout the quarter. The Department should endeavor to utilize this facility to its full capacity.

2. Staffing

The DJS Office of Program Evaluation conducted an extensive file review on April 29, 2010, and found the facility in full compliance with COMAR requirements in staff training. The Way Home staff have not participated in the gender responsive training offered by DJS. The Department should encourage staff in all programs for girls to participate in gender responsive training.

Applicable Standard

COMAR 14.31.06.05. F (1) *The licensee shall ensure that each employee who provides direct care to children shall receive a minimum of 40 hours of initial and annual training.*

3. Safety and Security

a. Aggregate Incidents

AWOL of youths	3
Inappropriate conduct or comments by youth	6
Contraband	2
Physical assault youth on youth	11
Non-routine off-grounds medical care/emergency care	2
On grounds medical care	2
Other	1

Twenty-seven incident reports were filed during the quarter. The number of critical or aggressive incidents at The Way Home continued to remain low during the third quarter of 2010 and the facility continued to be a safe environment for youth in residence.

b. Behavior Management Plan

The Way Home girls participate in a six-level behavior management system. Residents may apply for promotion to a higher level every two weeks. Requirements for promotion are based on each resident's treatment goals and therapeutic needs. Girls receive incentive awards such as increased computer time, cash allowance, and "kudos" which girls spend at The Way Home's store. Counselors and youth collaborate to develop individual program tasks and goals. There is a clear set of program rules and consequences for rule violations.

Applicable Standard

COMAR 14.31.06.15.A (1)(a)(b)(c)(f). *The licensee shall establish and follow written policies and procedures that are communicated to the child, the child's parent, employees, and the placing agency; identify all approved forms of discipline; specify the approved procedures for the administration of each form of discipline; and periodically review the forms of discipline used for effectiveness and safety.*

4. Physical Plant and Basic Services

a. Fire Safety

The program complies with all fire safety requirements.

b. Physical Plant

The Way Home group home is on the third floor of the main building of the Mountain Manor complex. It is not fancy, but it appears to be comfortable and appropriate for teenage girls. The structures and grounds are in good condition and comply with all health and safety codes. It is conveniently located for girls who need to use the bus for school or work.

The DJS Office of Program Evaluation conducted an evaluation of the physical plant on June 29, 2010, and found the program to be in full compliance with all applicable COMAR regulations.

c. Basic Services

Basic services including food, clothing and shelter are adequate. Health Department inspections are up to date. The DJS Office of Program Evaluation conducted an evaluation of basic life services on June 29, 2010, and found the program to be in full compliance with all COMAR regulations.

Applicable Standards

COMAR 14.31.06.07 (A)(4). *The licensee shall ensure compliance with the local fire and health requirements by submitting annually to the licensing agency, reports of all fire and health inspections conducted by the local jurisdiction.*

COMAR 14.31.06.07.C.1 *The licensee shall maintain all structures and grounds in good condition, free from health or safety hazards.*

COMAR 14.31.06.10 *The licensee shall have a structured plan of care that is designed to meet the children's physical needs and well-being.*

5. Education

The Way Home residents go off campus for school and work. The director maintains close contact with school authorities.

Applicable Standard

COMAR 14.31.06.12.2(C) *The placing agency and licensee shall work cooperatively with the local school system to participate as appropriate in the child's educational activities.*

6. Rehabilitative and Recreational Programming

a. Therapeutic Program

Girls at The Way Home participate in individual, group and family therapy. Individual and group grief counseling are offered. Outpatient substance abuse services are available within the Mountain Manor complex of programs. Treatment teams meet weekly to determine progress and treatment needs.

b. Recreational Programming

A Program Coordinator has been appointed for the group home. The Program Coordinator works with the residents to develop a monthly schedule of activities that includes community service activities, sports and recreation, cultural enrichment field trips and group games and activities within the home. Recent activities include trips to Fort McHenry, the Hampton Mansion& Farm tour and Gwyn Oak Park. During the week, the residents go to the local library and the YMCA.

c. Parental Involvement

TWH provides family counseling. Hours and availability have been increased to make family therapy sessions more convenient for family members. Therapy sessions can now be scheduled around visitation times.

Applicable Standards

COMAR 14.31.06.17.2.F *Within 30 days after admission, develop for each child an individual service plan that identifies documentation indicating that the child, child's advocates, guardian, and family, when appropriate, have been involved in, informed of, and agree with the plan.*

COMAR 14.31.06.17.2.F.3 (a) *Assure that the individual service plan is reviewed and updated at least every 90 days.*

COMAR 14.31.06.12.B.1 *The licensee shall provide the children with a range of indoor and outdoor recreation and leisure activities both in the program and in the community.*

7. Medical

Youth at The Way Home have access to all medical services available at the Mountain Manor complex. A May 26, 2010 evaluation by the DJS Office of Program Evaluation found the program in partial compliance with Health Care and Medication Administration after a review of files revealed deficiencies in documentation.

Applicable Standard

COMAR 14.31.06.13 (A) *General Health Services. The licensee shall: (1) observe a written plan for the provision of preventive, routine, and emergency medical, dental, and mental health care for the children.*

8. Youth Advocacy, Internal Monitoring and Investigation

a. Youth Advocacy

The DJS youth advocate is very engaged with the girls at The Way Home. She visits there regularly, often several times per week, and conducts regular groups with the girls. Her commitment and participation has been an important component in the success of the program.

No grievances were filed during the quarter.

b. Internal Monitoring

The DJS Office of Program Evaluation regularly monitors the program.

Applicable Standard

COMAR 14.31.06.09.E.2 (a)(b)(c) *The licensee shall provide the child and the child's parents, as appropriate, a description of how to file a grievance, including any formal grievance forms or other requirements for the format and content of the complaint.*

RECOMMENDATIONS

1. The Way Home continues to improve. DJS should maintain the population at the optimum capacity.

2. The Department should make gender responsive training available to staff at The Way Home.

NICK MORONEY
Acting Director

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

FACILITY REPORT
THE VICTOR CULLEN CENTER
JULY – SEPTEMBER, 2010

Facility: The Victor Cullen Center
6000 Cullen Drive
Sabillasville, MD 21780
Acting Superintendent: Bill Pickerel

Dates of Visits: July 21
August 10 and 27
September 28, 2010

Reported by: Tanya Suggs
Monitor

Persons Interviewed: Administrators, Regional Director, Maryland State Department of Education Staff, Group Life Managers, Direct Care Staff, Youth, Social Worker, and Therapists

Date of Report: November 2010

INTRODUCTION

The Victor Cullen Center (Victor Cullen) is a 48-bed, state-owned hardware secure facility operated by the Department of Juvenile Services (DJS/the Department). Victor Cullen houses a 6 to 9 month treatment program for adjudicated males between the ages of 14 and 19. The facility is near Sabillasville, in Frederick County.

SUMMARY OF CRITICAL FINDINGS

- The DJS Office of Inspector General (DJS-OIG) conducted three investigations at Victor Cullen during the third quarter - all had sustained findings, including an alleged child abuse.
- The lack of video surveillance in the school buildings at Victor Cullen is an unabated issue.
- Youth in need of need of intense mental health services continue to be placed at Victor Cullen.
- The DJS Program Evaluation Unit concluded the facility has not been developing concrete treatment plans for youth and that many of the plans are incomplete.

FINDINGS

1. Population

Facility Capacity	High Population	Low Population	Daily Average	Monthly Average	Days Over Capacity
48	44	19	43	**July** 41 **August** 43 **September** 44	0

The facility capacity at Victor Cullen is 48, with 12 youth assigned to each cottage. According to the DJS Assist database, there were 16 youth from Baltimore City; 4 from Prince Georges County; 2 from Montgomery County; 1 from Anne Arundel County; and a youth from out of state at Victor Cullen during the third quarter.

2. Staffing

The facility has 96 staff. During the second quarter, the Department added a Social Worker Supervisor position.

Bill Pickerel is acting superintendent at Victor Cullen. Mr. Pickerel was formerly an administrator at the DJS-operated Meadow Mountain Youth Center.

According to the Assistant Administrator, the Department plans to fill the Superintendent vacancy. There are also vacancies for Group Life Manager II, Social Worker (2), Medical Assistant Manager, and Food Service Worker. It is uncertain when the Department will fill these vacancies.

The facility is required to house a social worker, a group life manager, and two direct care staffers on each cottage. However, because of social worker vacancies, two of the four cottages do not have a dedicated social worker. Two therapists are stretched in trying to provide services to all four cottages, making it difficult for residents to receive sufficient therapy sessions. The Department should hire additional clinical staff.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 5.1.3. *Staffing arrangements shall aim to provide a safe, humane, and caring environment. Youth to staff ratios developed by the Department shall ensure adequate supervision of the youth.*

3. Safety and Security

a. Aggregate Incidents (third quarter 2009 and third quarter 2010)

Incident Categories	3rd Quarter 2009	3rd Quarter 2010
1. Youth on Youth Assault	10	16
2. Alleged Youth on Staff Assault	6	5
3. Restraints	25	36
4. Restraints with Injury	5	0
5. Physical Child Abuse Allegations (DJS Custody)	1	2
6. Youth requiring on-grounds medical care (Sports or Non-incident related injury)	22	7
7. Escape(s)/AWOL(s)	0/4	0/0

According to the DJS Incident database, there were 67 total incidents during third quarter of 2009 compared to 94 this quarter.[28] Nineteen percent of incidents occurred during recreation and seventeen percent in the education area.

b. Mechanical Restraints

The number of restraints where mechanical restraints (handcuffs/leg irons) increased from eight to ten.[29] The facility should only use mechanical restraints during off-grounds transportation or to secure movement of a youth. The unnecessary use of mechanical restraints poses a safety threat of youth. The facility should use soft mechanical restraints when mechanical restraints are necessary.

d. Incident-Related Procedures, Practices, and Reporting

During the third quarter, the DJS-Office of the Inspector General (DJS-OIG) conducted an investigation (Investigation 10-84905) concerning a Victor Cullen staffer and two youth. Although a staffer labeled the incident report as inappropriate conduct by youth, DJS-OIG determined that staff and youth were involved in "horse play" and sustained against staff on false reporting and inappropriate use of force. The DJS-OIG report failed to mention that a physical restraint was used and the report did not include a required nursing report. Youth must be examined by a nurse after any type of physical altercation.

Another incident investigated by DJS-OIG (Investigation 10-83984), staffers allowed a youth to "restrain" another youth. Youth are not permitted to physically restrain each other - such a "restraint" is actually a physical assault. Staff did not follow crisis management prevention procedures by not properly attempting to deescalate an argument and allowing the situation to get out of hand. The DJS-OIG sustained against staff concerning breach of security and performance of duty shortcomings.

[28] The Aggregate Incidents chart does not show all incidents, just those in particular categories.
[29] Ten instances of mechanical restraints used during a physical restraint is an accurate accounting (DJS Incident reports 85451 and 85560 belong in the mechanical restraints count).

e. Video Surveillance

There are no cameras are in the school at Victor Cullen. Security cameras enhance safety and security and serve as a valuable training and investigatory aid.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 6.9 *The facility shall be controlled by appropriate means to ensure that the youth remain within the perimeter and to prevent access by the general public without proper authorization. Perimeter surveillance shall be maintained through mechanical surveillance devices (e.g., electronic, pressure, or sound detection system, mobile patrols, or a combination of these systems).*

Md. Department of Juvenile Services Standards of Conduct 2.19.1.*Reports submitted by employees shall be clear, concise, factual and accurate.*

Md. Standards for Juvenile Detention Facilities 2.25 *Every employee has an affirmative obligation to report any suspected violation of the child abuse or use of force policies of the Department to his or her supervisors or other superiors and to the appropriate law enforcement and child protective services agencies.*

Md. Department of Juvenile Services Policy and Procedure 4.C (3) (i) *An incident report file is maintained on every incident. The incident report file shall include a copy of the DJS Incident Reporting Form (handwritten and electronic) and supporting documentation (videotape, witness statements, Nurses Report of Injury with photograph and other documentation as applicable).*

Md. Department of Juvenile Services Policy and Procedure RF-02-07-4a(2)(ii) *Only an employee who has completed DJS approved initial training on the appropriate use of physical restraint and who can provide evidence of a semi-annual DJS approved refresher training on the appropriate use of physical restraint may use a physical restraint on a youth.*

Md. Department of Juvenile Services Standards of Conduct 2.13 *An employee may not take any action or fail to take any action when the action or failure to act causes a breach of security or a potential breach of security by jeopardizing the physical security or integrity of an institution, or the physical security or integrity of any part or area of an institution or the safety or security of any employee, delinquent youth, offender, client, visitor or member of the public.*

Md. Dept. of Juvenile Services Standards of Conduct 2.10 *An employee of the Department shall be responsible for his or her own actions, as well as the proper performance of his or her duties. In carrying out the functions and objectives of the Department, and employee shall perform all duties in a manner that will maintain the highest standards of efficiency.*

4. Physical Plant and Basic Services

a. Fire Safety

No serious findings regarding fire safety were noted this quarter. The next fire marshal's inspection is due in March of 2011.

b. Basic Services

The Maryland Department of Health and Mental Hygiene did not note any major findings in a February of 2010 health inspection report. The next health inspection is due in February of 2011.

5. Education

a. General Educational Development Program (GED), College Courses

Youth continue to report that education is the best part of the Victor Cullen program. They feel well supported by the teachers and believe the teachers are genuinely concerned about youth education needs.

Administrators at Hagerstown Community College and Victor Cullen worked together to make it possible for youth who have already attained a GED or high school diploma to participate in classes and receive credit towards a college degree. Youth are bussed to the college under supervision and a staffer stays with them as they attend college classes. As of this writing, three youth enrolled in the program with another youth set to enroll upon completion of GED requirements.

b. Vocational Education

Victor Cullen continues to operate a program for youth interested in becoming electricians. Youth working towards a high school diploma can earn service-learning credits through a horticulture program at Victor Cullen – the program is also open to Post-GED youth and those working toward gaining a GED.

Youth who have a GED are taking the Armed Services Vocational Aptitude Battery (ASVAB) pre-test at Victor Cullen.

6. Rehabilitative Programming

Positive Peer Culture (PPC) is the therapeutic model used at Victor Cullen. The purpose of the program is to help youth develop a sense of worth and responsibility by holding their peers accountable for their actions. EQUIP is also utilized as a skills-based component of Positive Peer Culture. The substance abuse treatment component uses the Seven Challenges model.

The Monitor reviewed five (an 11% sample) youth clinical files this quarter. Treatment Service Plans (TSPs) were examined and found to be incomplete. Specifics were not offered to how youth might resolve anger issues; there were no follow-up or modifications noted on Individual Service Plans; and treatment goals were not noted.

A youth with behavioral health issues was treated using PPC, Seven Challenges, and EQUIP, however, the consulting psychiatrist for the facility recommended the youth be evaluated at a psychiatric hospital in order to receive intensive psychiatric treatment. The youth was transferred to the Baltimore City Juvenile Justice Center.

According to results of interviews conducted with staff, approximately seventy percent of the youth at Victor Cullen are on psychotropic medication. After interviewing youth, reviewing TSPs and examining Seven Challenges group lesson content in five youth files, the Monitor concluded there is reason to question the suitability of the three therapeutic components programs as applied to the Victor Cullen youth population. Programs such as PPC, Seven Challenges, and EQUIP are not tailored to address the individual needs of youth with serious behavioral health challenges.

According to some staff notes made about Seven Challenges groups, medicated youth were sometimes too groggy to participate in group sessions. Lesson plans for some Seven Challenges group sessions seem irrelevant to youth experiences and challenges. Youth interviewed said that, in most Seven Challenges group sessions, no materials are used and meetings devolve into random discussion rather than focusing on substance abuse.

The Department has discussed the possible applicability of the Missouri Model at Victor Cullen. The Missouri Model focus is on rehabilitation with State facilities replaced by a network of small group homes providing individualized treatment. The State of Missouri, where the model originated, has seen significant reductions in the juvenile recidivism rate. The Annie E. Casey Foundation facilitated a visit by Missouri Model experts to Victor Cullen. The team gave a presentation and performed an assessment of the Victor Cullen program. The Annie E. Casey Foundation may ultimately fund a Missouri Model project in Maryland.

Applicable Standards

Md. Department of Juvenile Services Policy and Procedure CJ 2-03 (8) *A Case Manager shall modify a TSP for each committed youth every ninety (90) days or whenever a change in status occurs.*

Md. Department of Juvenile Services Policy and Procedure CJ 2-03 (9) *A Case Manager shall list specific needs and services (expected TSP outcomes) of a youth and a youth's family, based on the information listed in 6.b.(3).*

7. Youth Advocacy, Internal Monitoring and Investigation

Two investigations allegations of child abuse at Victor Cullen during the third quarter were sustained by the DJS-Office of the Inspector General (DJS-OIG). One Investigation (10-84009) resulted in a conclusion that a staffer kicked a youth when the youth refused to move out of the staffer's way. A second investigation (10-85389) found that a staffer grabbed a youth around his neck during a physical altercation between the staffer and youth. Both allegations were screened out by Child Protective Services (CPS).

Another DJS-OIG Investigation (10-84905) concerned a situation involving "horse play" between a staff and youth. A staffer pushed a youth after a verbal exchange and then attempted to take a plastic bracelet by "taking the youth by the arm and twisting him to the point he had to spin his body completely around. This youth was then pushed over a chair with arm behind his back." According to the DJS-OIG report, the incident did not need to be reported to CPS or the state police because there were no allegations of abuse and the youth were not injured or harmed in any way.

In DJS-OIG Investigation 10-85389, charges of violations of policy were sustained against two VC staff person after an incident in which a youth became upset when a staffer ended his phone call by unplugging the phone wire. The staffer reported that the youth initiated the altercation. A security video showed the staffer initiating physical contact by grabbing for the youth's neck when the attempted to take the phone back from the staffer. The staffer also reported that she slipped in a puddle of water and the youth fell on top off her. No water puddle is visible on the video which shows the staffer grabbing the youth around his neck and falling to the floor. A second staffer subsequently used an improper restraint on the youth.

RECOMMENDATIONS

1. The Department should fill all job vacancies at Victor Cullen as soon as possible.

2. The facility should utilize mechanical restraints only when a youth is a threat to himself or others. Only soft restraints should be used.

3. Staffers should always follow Crisis Prevention Management protocol during physical altercations.

4. The Department should develop a policy that addresses the religious needs of non-Christian youth.

5. The Department should ensure delivery of clinical services to youth.

6. Treatment service plans should be completed appropriately. The facility should reassess youth progress throughout youth stay; review family involvement; and develop individualized, concrete and substantial transitional and relapse prevention plans.

7. Therapist should present Seven Challenges lesson plans that are informed by youth treatment plan content and recommendations and which attempt to address the real challenges faced by youth.

UNABATED CONDITIONS

1. There are no security cameras in the school buildings at Victor Cullen.

NICK MORONEY
Acting Director

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

FACILITY REPORT
THOMAS J. S. WAXTER CHILDREN'S CENTER
JULY - SEPTEMBER, 2010

Facility:	Thomas J.S. Waxter Children's Center 375 Red Clay Road, SW Laurel, MD 20724 Administrator: Johnitha McNair
Dates of Visits:	July 14, 19, 27 September 8, 17, 21, and 23, 2010
Reported by:	Claudia Wright Senior Monitor
Persons Interviewed:	Superintendent Johnitha McNair, security staff, medical staff and youth
Date of Report:	November 2010

INTRODUCTION

Thomas J. S. Waxter Children's Center is a Department of Juvenile Services (DJS/The Department) owned and operated detention/residential treatment facility in Laurel, Maryland. The facility is comprised of two units for detention and pending placement and an 8-bed secure committed program. The facility capacity is 40.

CRITICAL FINDINGS

- Almost all Waxter staff have participated in the short-course training in gender responsive programming. This training has delivered significant positive results in the operation of the program.

- The Department is not evaluating the Growing Great Girls program to document effectiveness.

- Population steadily increased over the quarter. Girls were required to sleep in "boats" on the floor due to the increase in population.

- Two staff persons were fired due to sustained allegations of child abuse. Both allegations occurred during the use of physical restraints and both incidents were video-taped.

- Several important staff positions remain open. An Assistant Superintendent should be hired as soon as possible.

- Fixed video cameras have been installed throughout the main facility. Cameras should also be installed in the school classrooms.

- The condition of the physical plant is significantly improved in some areas of the facility, but remains unacceptable for the long term.

- Waxter does not have adequate space for medical care of youth.

- Mentally ill youth are inappropriately placed at Waxter.

- The physician who provides ob/gyn services to the girls at Waxter was cited by the DJS Office of the Inspector General for a violation of the personal conduct policy for his use of unacceptable language with a patient.

FINDINGS

1. Population

a. General

Facility Capacity	High Population	Low Population	Average Daily Population	Average Monthly Population	Number of Days Over Capacity
40	50 (9/30)	32 (7/1)	39	**July** 36 **August** 41 **September** 41	35

Population exceeded capacity at Waxter for over 1/3 of the quarter. When population exceeds capacity, girls must sleep in plastic boats with a mattress on top – the boat is placed on the floor of the dayroom of the detention unit. This practice is unacceptable. Sleeping on the floor is unsanitary. Further, it is not possible to classify youth for safety reasons when the population is greater than the number of rooms and beds available.

b. Detention and Pending Placement

	Number of Youth in Status 60+ Days[30]	Number of Youth in Status 90+ Days[31]
Detention	1	4
Pending Placement	2	0

[30] September 30, 2010
[31] September 30, 2010

c. Race/Ethnicity Breakdown

	3rd Quarter, 2009	3rd Quarter, 2010
Total # of Youth	216	211
White	43	50
African American	167	158
Latino	3	2
Other	3	1

2. Staffing

a. General

The Superintendent reports that Waxter now has 41 direct care staff. There are three vacancies. The Assistant Superintendent position, one of the most important positions in the facility, remains unfilled. However, The Department has allocated 10 new positions, two permanent and eight contract, for direct care staff. The administration is working to fill those positions, and hopes to have all vacancies filled by the end of the 4th quarter.

Two direct care staff were fired following indicated findings of child abuse by Child Protective Services and sustained violations of policy as found by the DJS-Office of the Inspector General (DJS Incident Reports 82205 and 83857).

b. Staff Training

The Waxter program is moving slowly, but steadily, towards a fully operational gender responsive program. Gender Responsive training has resulted in obvious, significant benefits to both the girls and the staff. Unfortunately there is no evaluation process in place to document the effectiveness of the program.

Applicable Standard

American Correctional Association Standards for Juvenile Detention Facilities 3-JDF-1C-04 *The staffing requirements for all categories of personnel are determined to ensure that juveniles have access to staff, programs, and services. Comment: Staffing requirements should be determined on more than juvenile population figures and should include review of staffing needs for all programs and services. Workload ratios should reflect such factors as goals, legal requirements, character and needs of the juveniles supervised, and other duties required of staff. Workloads should be sufficiently low to provide access to staff and effective services*

3. Safety and Security

a. Aggregate Incidents

Incident Categories	3rd Quarter 2009	3rd Quarter 2010
1. Youth on Youth Assault	34	25
2. Youth on Staff Assault	12	12
3. Group Disturbances (with bodily harm or injury)	1	2
4. Group Disturbances (without bodily harm or property destruction)	0	1
5. Physical Restraint	56	64
6. Seclusions (more than 8 hours)	1	0
7. Escapes/AWOL's	1	0
8. Suicide Attempts, Ideation, Gestures, Behavior	21	20

b. Security Equipment and Practices

The installation of fixed video cameras is invaluable. Two direct care staff, one a supervisor, were fired after two separate allegations of child abuse were verified by video recordings. It is strongly recommended that the Department install video cameras in the school as well as the living area.

The Superintendent has prohibited the use of handcuffs within the facility.

Applicable Standard

Videotaping of Incidents Policy RF-05-07 *DJS employees shall videotape room extractions, escorts to seclusions, use of restraints, or other critical incidents that relate to the safety and security of a residential facility. Incidents shall be videotaped unless videotaping of the incident compromises the safety and/or security of youth and/or employees.*

c. Restraints and Seclusion

Physical restraint remains a serious problem at Waxter. The use of physical restraint is in contradiction to the principles of gender responsive programming. On the positive side, the use of locked room seclusion has been greatly reduced.

d. Child Abuse

There were two substantiated allegations of child abuse since the last monitor's report.

Applicable Standards

Md. Dept. of Juvenile Services Policy and Procedure RF-02-07 (4) (a) (2) (ii) *Restraints shall be used as a last resort only when a youth displays behavior indicative of imminent injury to self or others, or makes an overt attempt to escape. The goal of a physical restraint should be to ensure safety.*

Md. Dept. of Juvenile Services Policy and Procedure RF-01-07 (4) (a) (7) *Seclusion shall not be used as punishment and is limited to youth who: (i) Present an imminent threat of physical harm to themselves or other individuals; (ii) Have not responded to less restrictive methods of control or for whom less restrictive measures cannot reasonably be tried; or (iii) Have escaped or are attempting to escape.*

4. Physical Plant and Basic Services

a. Fire Safety

Documentation of required fire inspections is in order. However, although fire drills are held on all shifts, no fire drills are held after youth are locked in their rooms for the night.

b. Physical Plant

A health inspection was completed on March 3, 2010, with all areas in order. The facility is generally clean, but problems of old buildings – bugs, difficulty cleaning, and

dust – persist. The physical plant at Waxter is not appropriate for housing teenage girls. The current administration has worked hard to make the facility as livable as possible under the circumstances, but a new building will be essential. Bright, youth-friendly bedspreads, rugs, towels have been introduced into all the units, along with new TVs, board games and decorations. Two bathrooms have been renovated, but the bathroom on the Honor Unit (the old C Unit) remains in unacceptable condition.

The committed program should be moved to a separate facility to prevent co-mingling of committed and detained girls, and to provide adequate room for medical and program services for detention.

c. Basic Services

Adequate food and clothing are provided.

Applicable Standards

American Correctional Association Standards for Juvenile Detention Facilities 3-JDF-2C-03 *Each sleeping room has at a minimum the following facilities and conditions: Sanitation facilities, including access to toilet facilities that are available for use without staff assistance 24 hours a day; A wash basin with hot and cold running water; A bed, desk, hooks or closet space, chair or stool; Natural light; Temperatures that are appropriate to the summer and winter comfort zones.*

Md. Standards for Juvenile Detention Facilities 5.6.5.2 Clothing *Youth shall be provided the opportunity to have three complete sets of clean clothing per week.*

Md. Standards for Juvenile Detention Facilities 5.6.2.5 Clean bedding *The facility shall issue clean bedding and linen, including two sheets, a pillow and pillow case, a mattress, and sufficient blankets to provide comfort under existing temperature controls. Linen shall be exchanged at least weekly, and towels exchanged three times per week.*

5. Education

The Waxter education staff does a good job under less than optimum circumstances. The education trailers received some upgrades, including new floors and painting, but should be replaced. The trailer classrooms are cramped and dark, and do not provide a physical environment conducive to learning.

Special education services are offered and staff strive to be sure that all requirements are met. Sometimes it is difficult to get records from public schools during the short time period that most girls are in the facility. Physical education is offered by the education department. GED services are offered to those girls who qualify to participate.

6. Rehabilitative and Recreational Programming

a. Therapeutic Program

Growing Great Girls is a gender responsive, trauma informed program that is utilized at Waxter. The program is beginning to take hold, especially with the girls in the committed program. Both girls and staff understand the tenets of the program and use them in their daily activities. Holding the population of the committed program at a very low population level (3 or 4 girls) for an extended period of time certainly contributed to the apparent acceptance and understanding of the program. Now, with the move of the committed program to the old B Unit, new girls are being admitted and will have to assimilate into the group. It will be important for the administration to keep a close eye on daily developments as the program is extended.

The outlook for Growing Great Girls is positive, especially in regard to the conditions within the facility. There is no data yet on whether the program has any positive effect on behavior once the girls leave the facility. The Department should endeavor to evaluate and validate the Growing Great Girls program to see if it is in fact beneficial to the target population.

b. Recreational Programming

Organized recreation programs have been unfocused at Waxter. But there has been improvement. Physical education is provided as part of the school day. When the weather allows, the entire population takes a long morning walk along the perimeter of the grounds. The administration has endeavored to provide organized sports activities, indoor and outdoor for the girls. Class Acts offers very popular arts projects. School teachers organized community service activities such as visiting a local nursing home. A yoga class is offered to the committed program, and all the equipment is furnished. Girls may participate in poetry writing.

Volunteer groups provide some program services. The Maryland Women's Bar Association provides educational programs. Residents can participate in Girl Scouts. A variety of religious organizations offer spiritual and motivational activities.

c. Parental Involvement

Supervised visiting and phone calls with family are encouraged. Regular visiting hours are on Saturdays.

Applicable Standard

Md. Dept. of Juvenile Services Policy and Procedure RF-08-07 Recreational Activities Policy (4) (a) (1) *A qualified employee trained in recreation and/or leisure services shall be responsible for planning, organizing and supervising recreational activity programs, including the use of the gym, outdoor areas, arts and crafts programs and special events.*

7. Medical and Behavioral Health

a. Basic Medical Services

Youth have access to medical staff from 7 a.m. to 9:30 p.m. during the week and from 8 a.m. to 8:30 p.m. on weekends. A psychiatrist and a gynecologist are each available one day per week; a pediatrician is available two days per week. A new examination room has been prepared adjacent to the medical suite, but it was not yet available for use at the end of the quarter.

There is no infirmary at Waxter. Youngsters who are sick, or who must be separated from the population for other health or safety reasons, must be housed in holding cells in the Tour Office (the admissions area). The lack of adequate space for medical separation is of particular concern for youth in the long-term secure program, pregnant youth, youth with contagious diseases, and mentally ill youth. If the Enhanced Academy (committed program) were relocated, the C wing at Waxter could be converted into a full-service medical wing for girls.

b. Medical Staff

After an investigation, the DJS Office of the Inspector General (DJS-OIG) found (DJS-OIG Investigation Report 10-83626) that the physician who provides gynecological services to the girls at Waxter violated DJS Standards of Conduct regarding personal conduct. DJS Standard 2.2.3 states:

> *An employee acting in his or her official capacity may not use any coarse, profane, or insolent language, or take action towards other employees, supervisors, delinquent youth, offenders, clients or members of the public that is abusive or otherwise considered offensive to contemporary community standards…*

The Inspector General found specifically that, "On July 9, 2010, [the doctor] made a comparison of size between his finger and a penis. This was during a medical examination of the youth."[32]

[32] Names of employees are confidential under Maryland law. Md. State Gov't Code Ann. §10-616(i).

In her witness statement, the youth who was the subject of the report stated that the doctor said to her, during her examination, “Do you get penis this size? [referring to his finger] Girl you need to get new meat with the body you got.”(DJS-OIG Report 10-83626, July 15, 2010, page 5). The youth reported this incident, immediately following the examination, to the youth advocate, to direct care staff and to the supervisor. The supervisor immediately filed the incident report. After this incident occurred, none of the girls scheduled to see the doctor would agree to be examined. Refusal of ob/gyn examination by this physician is common, and girls often go without care.

A similar complaint was made regarding this physician in March, 2007, but that allegation was not sustained. The physician recently received a new contract, and is still working at Waxter.

In 1989, the United States Supreme Court re-affirmed the constitutional principle that incarcerated persons must be provided with adequate medical care. The Court stated, “We reasoned that, because the prisoner is unable by reason of his deprivation of liberty to care for himself, it is only just that the State be required to care for him.”[33] In the current situation at Waxter, girls undoubtedly need the special services provided by a gynecologist. When girls routinely refuse to be examined by the doctor because of his behavior, and no alternative is available, then these girls are effectively denied necessary medical care.

The administration at Waxter has embarked on an admirable project to provide gender responsive and trauma-informed care to delinquent girls. Gender responsive care is “designed to meet the unique needs of young, delinquent and at-risk girls.”[34] Trauma-informed care is “an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.”[35] Recent statistics indicate that 92% of girls who enter the juvenile justice system have experienced one or more forms of physical, sexual, and/or emotional abuse.[36] Conduct such as that demonstrated by this physician is in direct contradiction of the tenets of gender responsive and trauma-informed care.

There is also evidence that this physician fails to follow best practice guidelines of the American Congress of Obstetricians and Gynecologists (ACOG), as required by the DJS medical department. ACOG practice guidelines recommend that the pap smear, which is an invasive procedure, not be administered to girls under 21 years of age. One of the reasons the pap smear is discouraged for young girls is because of the possible traumatic effect of the procedure on the patient.[37] During Fiscal Year 2010, the doctor at Waxter carried out 90 pap smear procedures on girls at that facility, compared

[33] *DeShaney v. Winnebago County Department of Social Services,* 489 US 189, 199 (1989).
[34] As defined by the Office of Juvenile Justice and Delinquency Prevention, www.nttac.org/index.cfm?event=genderResponsiveProgramming.
[35] National Center for Trauma-informed Care, www.samhsa.gov.
[36] Ravoria, L., Fact Sheet: Girls in Juvenile Justice, National Council on Crime and Delinquency, Oakland CA, 2008.
[37] www.acog.org.

to 10 procedures on girls at Noyes and 3 at Lower Eastern Shore Children's Center over the same period. It is difficult to understand this disparity.

The report from the DJS Office of the Inspector General included a recommendation that disciplinary action be taken against the gynecologist at Waxter. However, it is not known whether any disciplinary action was taken. The Department should consider whether the continued employment of this physician at Waxter is in the best interests of youth at Waxter and of the Department.

Applicable Standard

DJS Standards of conduct and Disciplinary Process 2.2.3 *An employee acting in his or her official capacity may not use any coarse, profane, or insolent language, or take action towards other employees, supervisors, delinquent youth, offenders, clients or members of the public that is abusive or otherwise considered offensive to contemporary community standards, except as required as part of an approved treatment program.*

c. Mental Health Services

The mental health department is now fully staffed with 3 PhD psychologists, a Master's level psychologist and two substance abuse counselors. Many youth with significant mental health issues are held at Waxter, sometimes for long periods of time, awaiting placement in Residential Treatment Centers. The mental health team now working with Waxter girls has helped to alleviate many of the problems inherent in housing mentally ill youngsters.

Applicable Standard

Md. Standards for Juvenile Detention Facilities 4.3.2.2 Transfers to mental health agencies *When a youth demonstrates behavior that is indicative of severe emotional disturbance that indicates a need for more intensive services than can be provided on site, the youth shall be seen by the designated facility health professional. If the health professional determines that a youth's behavior is a risk to himself or others, the health professional shall authorize the youth to be transferred to an area hospital for evaluation.*

8. Youth Advocacy, Internal Monitoring and Investigation

a. Youth Advocacy

There are two advocates assigned to review grievances at Waxter. Both advocates are very conscientious. The girls at Waxter appreciate their efforts to resolve grievances fairly. Youth understand the grievance system, and are not hesitant to file grievances. During the quarter, 5 grievances were filed.

b. Internal Monitoring

The most recent DJS Quality Improvement report on Waxter was filed in December 2008.

RECOMMENDATIONS

1. The long term secure commitment program should be relocated. If that occurs, the medical department should consider moving to the C wing. That wing could provide space for comprehensive medical services to girls from other programs, including an infirmary.

2. All staff who work with youth should complete the gender responsive training.

3. Fire drills should be held once per month on each shift. At least one drill per month should be held during sleeping hours.

4. Mentally ill youth should not be housed at Waxter.

6. Critical staff positions should be filled as soon as possible. An Assistant Superintendent should be hired.

7. Cameras should be installed in school classrooms.

8. The Department should consider alternatives for the provision of gynecological services at Waxter

9. Long terms plans should be developed to close the Waxter facility.

NICK MORONEY
Acting Director

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

FACILITY REPORT
WESTERN MARYLAND CHILDREN'S CENTER
JULY – SEPTEMBER, 2010

Facility:	Western Maryland Children's Center 18420 Roxbury Road Hagerstown, Md. 21740 Facility Administrator: Mark Bishop
Dates of Visits:	July 20 August 3 September 7, 2010
Reported by:	Tanya Suggs and Tim Snyder Monitors
Persons Interviewed:	Facility Administrator, Group Life Supervisors Resident Advisors, and Youth.
Date of Report:	November 2010

INTRODUCTION

The Western Maryland Children's Center (WMCC) is a State owned and operated detention facility located just outside of Hagerstown in Washington County, Maryland. WMCC is designed to accommodate a total of 24 male youth in two 6 bed pods and one 12 bed pod.

SUMMARY OF CRITICAL FINDINGS

- Overpopulation of facility
- Programming is insufficient.

FINDINGS

1. Population

a. General (for the third quarter of 2010)

(DJS-set) Rated Capacity	High Population	Low Population	Average Monthly Population	Number of Days Over Capacity
24	30	18	**Jul** 23 **Aug** 24 **Sep** 26	49

When WMCC is over-populated as it was for more than half the days of the third quarter, overflow youth must sleep in day rooms on the pods. This creates a potentially dangerous situation, especially when staff must respond to a distress call and there are not enough rooms to secure youth under supervision before going to assist.

b. Detention and Pending Placement

Three youth at WMCC at the end of the third quarter had spent over 2 months at the facility awaiting treatment placement (for 61, 77, and 84 days respectively). All youth present at WMCC on September 30 left WMCC within 90 days of entrance. The average length of stay for all youth at WMCC at any time during the third quarter of 2010 was 23 days.

The Department is implementing a pre-placement orientation program called Treatment Placement Orientation (TOP) at DJS detention centers including WMCC.

Western Region staff developed the TOP program for youth that are pending placement in detention centers and awaiting enrollment at the Youth Centers or at Victor Cullen. The program includes the opportunity to receive credit towards placement time. This could help lessen extended periods of "dead" time spent waiting for treatment placement. The Department deserves praise for designing and implementing this long-needed program.

c. Population Breakdown by Race/Ethnicity at WMCC

	3rd Quarter 2009	3rd Quarter 2010
Total Youth Entries	129	122
African American	64 (50%)	50 (41%)
White/Caucasian	60 (46%)	70 (57%)
Hispanic/Latino	5 (4%)	1 (0.8%)
Other/Unknown	0	1

Applicable Standard

Maryland Standards for Juvenile Detention Facilities, Part II, Purposes, Values and Goals of Juvenile Detention Facilities. *Detention is the temporary care of youth who, pending court disposition, require secure custody for the protection of themselves or the community in physically restricting facilities. The major goals of a juvenile detention facility are: the protection of the public, the provision of a safe, humane, caring environment, and access to required services for youth.*

2. Staffing

a. General

Staffing has improved somewhat at WMCC. At the end of the first quarter, there were 26 Resident Advisor positions assigned to WMCC. However, the Department of Juvenile Services (DJS/the Department) moved a staff position from WMCC to the Alfred D. Noyes Children's Center in Montgomery County. As of this writing, there are 25 RA positions at WMCC and one vacancy.

However, there are numerous situations which can and do arise requiring a Resident Advisor to be present outside those allowed for in calculating adequate direct care staffing numbers. Situations such as the requirement that direct care staffers always be present when teachers meet with youth; monitoring of family visits; one-on-one suicide watch duty; and supervising intake of youth. These duties take staff members away from regular group supervisory duties and necessitate that additional available staff are present in the facility to manage predictable extra duties. In addition, many staffers need to be away for training or have earned long periods of vacation time, sick leave and family leave.

The most critical staffers in DJS facilities are the direct care staff. DJS should allocate staffing resources to provide for comprehensive supervision and treatment programming for the youth in its care.

b. Staff Training

DJS staff training in crisis intervention and restraint is inadequate.

The Department uses the JIREH curriculum for Crisis Management training. The JIREH curriculum is lacking in comprehensive and practical training in de-escalation. Additionally, the training is inadequate in that it requires a staff to be capable of physically dominating an aggressive youth. Direct care staff members need training in techniques that all can use regardless of size or strength to protect themselves and youth from injury while effectively controlling aggressive behavior.

DJS requires that staff use only JIREH - CPM techniques. Because the required techniques are inadequate, staff are often uncertain as to proceed in handling situations. A lack of tools, clarity and confidence fosters a safety and security problem for youth and staff.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.1.3. *Staffing arrangements shall aim to provide a safe, humane, and caring environment.*

Md. Standards for Juvenile Detention Facilities 5.1.5.5. *(S)taffing levels (should) ensure the proper supervision and safety of residents.*
COMAR 14.31.06.05 F (3) *The training of employees who may provide direct care to children shall include: (f) approved forms of discipline and behavior management techniques including crisis management and the use of isolation and restraints.*

Md. Standards for Juvenile Detention Facilities 2.2.1. *The Department shall ensure that designated classes of departmental and vendor employees are trained according to the standards established by the Maryland Correctional Training Commission.*

3. Safety and Security

a. Aggregate Incidents

Incident Categories	3rd Quarter 2009	3rd Quarter 2010
1. Youth on Youth Assault	12	10
2. Youth on Youth Assault with Injury	10	7
3. Alleged Youth on Staff Assault	4	1
4. Alleged Youth on Staff Assault with Injury	2	1
5. Restraints	43	30
6. Restraints with Injury	12	17
7. Seclusions over eight hours	0	0
8. Physical Child Abuse Allegations (DJS Custody)	2	3
9. Suicide Ideation, Gesture, Attempt or Behavior	8	3

There were 3 allegations of child abuse at the facility. None of the allegations were sustained upon investigation by the DJS Office of the Inspector general (DJS-OIG), however, the investigations found several instances of staff violation of DJS policy and procedure.

A significant concern is the number of youth and or staff who become injured during the course of a restraint. Over the past two years, almost one in three physical restraints at WMCC resulted in injury - the inadequacy of the training provided by JIREH no doubt contributes to this situation.

b. Security Equipment and Practices

DJS is addressing a long-reported concern about the security fence at WMCC. After numerous consultations, a decision has been made to install razor wire at the roof line around the unfenced section of the outdoor recreation area. Engineers determined that installing no climb mesh fencing could structurally compromise the building because of the added weight of the supports and mesh. The presence of razor wire

always presents a potential serious physical danger to youth who might attempt to escape.

The intercom and duress system is working as of July, 2010 and the facility received 15 new batteries for staff radios.

On August 3, the Monitor was able to enter WMCC by walking through two sets of open front doors. No one checked my credentials or questioned my authority to enter the building. WMCC staff must follow policy and procedure consistently by ensuring doors are locked and checking all visitors before they enter the facility.

c. Behavior Management Plan

Staff members conduct behavior evaluation meetings each evening. Youth report they generally feel safe at WMCC and that the behavior modification level system is fair. Feedback, rewards and consequences are timely and meaningful and youth ascend or descend the level system depending on daily progress.

Applicable Standards

Maryland Standards for Juvenile Detention Facilities 5.1.2.2. *Safety and security refers to the provision of staff and resident safety and to the prevention of escape from the facility. Security shall also include measures to prevent persons from entering the facility or ground illegally. Means to ensure security shall consist of physical features of the building and grounds, policy and procedures and staffing arrangements.*

Maryland Standards for Juvenile Detention Facilities 6.2.4. *(Building design) shall not present an expectation of abusive behavior and vandalism and invite challenge by residents, nor shall it be assumed that every youth behaves in a violent and destructive manner. Security and safety of residents dictate construction materials designed to prevent injury or suicidal conduct.*

4. Physical Plant and Basic Services

a. Fire Safety

WMCC holds fire drills as required. The Fire Marshal conducted an annual inspection in March of 2010. A private contractor conducted an annual sprinkler system check in September of 2010. Another private contractor checked the fire extinguishers in August of 2010. WMCC maintenance staff conduct monthly checks on sprinklers and fire extinguishers.

b. Physical Plant

The paint on some of the sleeping room floors is badly chipped. Maintenance staff have repainted some rooms. The rest will be repainted during the winter months.

There is mold in the bathrooms and showers. Maintenance staff have increased the number of regularly scheduled cleanings to help correct the problem.

The DJS Western Region Emergency Management Committee visited WMCC in August. The committee team conducted a physical plant sanitation and safety review and identified a number of concerns that have since been addressed by WMCC staff. Such internal reviews are a valuable tool to help the facilities maintain a safe and secure environment.

c. Basic Services

A Washington County Health Inspector conducted an inspection of WMCC in May of 2010.

WMCC staff report the facility has sufficient clothing for youth as needed for seasonal wear.

Applicable Standard

Maryland Standards for Juvenile Detention Facilities 5.1.1. *The facility shall recognize and balance the legitimate need for safety of youth and staff and provide an environment that ensures a reasonable quality of living conditions.*

5. Education

a. General

MSDE took over the educational component at WMCC in July. Youth are in classes for 6 hours each day, with two 90-minute periods and three 60-minute periods. WMCC staff report that the transition (from a DJS-operated school to an MSDE-operated school at WMCC) has gone well. The addition of an MSDE-provided guidance counselor is welcome - the counselor is conducting tests for each youth after intake and each 30 days thereafter.

b. Special Education

WMCC has two special education teachers who assist the average of 30% to 50% of youth at WMCC who require some level of special education.

c. General Educational Development Program (GED), College Courses.

WMCC offers a GED program. Youth who have completed high school or the GED complain the school does not offer significant higher educational learning experiences.

d. Vocational Education

WMCC/MSDE does not offer vocational, career or technical education

Applicable Standard

Maryland Standards for Juvenile Detention Facilities 4.1. *The Department shall ensure that educational services provided within detention facilities are consistent with State and Federal requirements and meet the individual needs of the youth. Educational services shall be provided on an individual or small group basis. Personnel shall be deployed on the basis of identified instructional needs. A comprehensive educational program that addresses individual learning styles and special education needs shall be provided to every youth admitted to a detention facility. A continuum of comprehensive, quality educational programs and services shall be multifaceted and with a continuous integrated multi-disciplinary process for educating all youth that reflects diversity and commonality. The educational program shall adhere to all applicable educational regulations as established by the Maryland State Department of Education and the Code of Maryland Regulations (COMAR), 13A, Code of Maryland Annotated, Article 49D, United States Code, Title 20 – Education, IDEA, as well as federal guidelines.*

6. Rehabilitative and Recreational Programming

a. Therapeutic Program

The Substance Abuse Counselor holds one group therapy session per week when she is available. Each pod has a group every third week. The Social Worker on duty holds three to five informal groups per week and meets individually with youth. When the Substance Abuse Counselor or the Social Worker is not available, there is no-one else to provide this programming.

WMCC has only one Social Worker position. A Social Worker has been promoted to Regional Social Worker Supervisor while an Advanced Social Worker at the Victor Cullen facility is in the process of transferring to WMCC. As of this writing, Mondays are not covered by any social worker at WMCC. One worker is present on Tuesdays and Thursdays and another is present on Wednesdays and Fridays. A worker is on call to respond as needed to either facility. DJS reports that a worker will be assigned on a full time basis as of the first week in January 2011.

WMCC multidisciplinary staff members meet each week on Thursday. The team consists of the facility case manager, a social worker, a teacher, a nurse and (when available) a representative of the direct care staff. The team develops a Treatment Service Plan for all residents. Additionally the Team meets regularly to review progress and needs and update the Treatment Plan.

The Confinement Review Unit, Residential Case Managers, and DJS Area III Community Services personnel meet every Tuesday to review each youth's status and develop transition and post-detention placement plans.

b. Programming

Overall, programming activities are still lacking at WMCC. There is considerable down time, especially true on weekends, when youth have nothing to do but watch TV, play cards, or sleep.

c. Recreation

WMCC staff take groups of youth outside for recreation when enough extra staff are present to provide supervision. Even when the razor wire is installed, extra staff will accompany youth outdoors to ensure safety and security.

WMCC celebrated Labor Day with a special picnic buffet, flag football and basketball games.

Applicable Standard

Maryland Standards for Juvenile Detention Facilities 4.5.1.2. *The recreational program shall provide a variety of planned structured large muscle and leisure activities. These activities shall include, but need not be limited to the following: organized sports and games that require large muscle activity and permit equal opportunity for participation, supervised small group leisure activities, creative activities, quiet individual leisure activities, activities adapted for physically and developmentally challenged residents.*

7. Medical and Behavioral Health

a. Basic Medical Health

After WMCC staff admit a youth and initial screening is completed, additional assessment tools for mental health and addictions are administered. Staff members complete these initial assessments within two hours of admittance. If a youth scores significantly high on the mental health assessment the behavioral health clinician is notified and the youth is placed on a one-to-one watch until he is cleared. Physical exams are completed within 72 hours of admission. Sick calls are responded to appropriately and in a timely manner. When an incident occurs, the nurse on duty sees the youth within one to two hours.

b. Mental Health Services

WMCC uses the services of a psychiatrist who sees most of the youth. The WMCC Social Worker meets with youth needing his services as often as feasible.

8. Youth Advocacy, Internal Monitoring and Investigation

a. Youth Advocacy

Youth have access to grievance forms and the child advocate generally visits twice weekly.

WMCC permits parents/guardians to visit youth in the facility on Wednesday evenings and on weekends. The facility sometimes uses its video capability for family conferencing.

b. Quality Assurance

The DJS Quality Assurance team conducted an audit at WMCC in September of 2010. The team reviewed thirty-six standards and found WMCC in satisfactory compliance on 20 standards; had superior performance on 4 standards; in partial compliance on 11 standards; and in non-compliance on one standard. The non-compliance relates to the lack of vocational programming for youth.

c. Community Advisory Board

The WMCC Advisory Board meets quarterly and is actively engaged in discussing issues of concern. DJS Administrators extend an open invitation to board members to visit their facility, meet with youth and staff, and report on observations.

RECOMMENDATIONS

1. DJS should fill all staff vacancies.

2. DJS should increase Resident Advisor positions from 25 to approximately 30.

3. WMCC should ensure front doors remain secured at all times and that all visitors are screened for admittance.

4. Sleeping room floors should be painted.

5. Youth should receive career and technical programming.

UNABATED CONDITIONS

WMCC provides only one staff member each for the two 6 bed pods, even when overpopulated. The Department takes the position that a 1:6 or a 1:8 ratio is the industry standard. However, having a single staffer working alone on a locked pod when 8 youth are present presents a risk to youth and staff safety and security. The risk is enhanced when individual sleeping rooms are unavailable and two youths must be maintained together in the day room.

1. Staffing

a. Double staffing should be maintained on all units, with three staff on pod C when the population is over 12.

b. The Recreation Specialist position should be reinstated and filled.

c. Training in crisis intervention should be upgraded.

2. Safety/Security

a. Materials need to be installed on the pods to dampen excessive noise created by the removal of carpeting. Vitreous china fixtures should be replaced with a substance that cannot be broken or used by youth to harm themselves or others.

3. Education

a. A post GED program should be offered.

4. Rehabilitative and Recreational Programming

a. Additional programming should be provided especially during evenings and weekends.

NICK MORONEY
Acting Director

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

FACILITY REPORT
WILLIAM DONALD SCHAEFER HOUSE
JULY – SEPTEMBER 2010

Facility:	The William Donald Schaefer House 907 Druid Park Lake Drive Baltimore, MD 21217 Superintendent: Martin Callum
Dates of Visits:	July 30 August 31 September 17
Reported by:	Tanya Suggs Monitor
Persons Interviewed:	Administrator, Direct Care Staff, Youth, and Counselors
Date of Report:	November 2010

INTRODUCTION

William Donald Schaefer House (WDSH) is a 90-day residential substance abuse treatment program for up to 20 boys aged 14 to 18. The home is located near Druid Hill Park in Northeast Baltimore City. The facility is operated by the Maryland Department of Juvenile Services (DJS/the Department).

FINDINGS

1. Population and Staffing

The maximum capacity has been six since November 2009. There were between four and six youth in the program during the third quarter. The facility reported that three staffers returned to the home from the Baltimore City Juvenile Justice Center, where they had been transferred to augment staffing in the detention component. The rated capacity has remained at six but there is room for 14 additional youth, as the previous capacity was 20. It is unclear why the Department has not accepted more youth for treatment or otherwise optimized utilization of WDSH.

2. Safety and Security

The incident rate of the home is very low. According to the DJS incident database, only one incident occurred this quarter (a sports related injury)[38].

4. Physical Plant and Basic Services

Overall, the physical plant is in good condition yet has been operated under capacity for a year while there is a shortage of committed care programs in the state.

The home last received a fire safety inspection in August of 2009 by a fire marshal from the Baltimore City Office of the Fire Marshal. The home should have its 2010 annual fire safety inspection scheduled and completed without further delay. The last fire alarm inspection at WDSH was in May of 2009 and another inspection is therefore overdue.

Annual fire safety inspections are a minimal but essential factor in ensuring that the physical plant is safe for the housing of youth; that fire safety equipment is in working order; and that there are no other fire safety- related issues needing remediation.

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[38] In the first quarter of 2010, the Monitor noted not all incidents were reported and it is possible that numbers and types of incidents reported from the home remain incomplete or inaccurate. Accurate reporting is essential to facilitate appropriate corrective action plans regarding safety, security and health issues. Worthwhile analysis of incident rates also hinges on data accuracy.

The basement is disheveled, dusty, and smells like mold and mildew. Old and torn exercise equipment, outdated program files, miscellaneous boxes and other items are stored in the basement area. In its current condition, the basement area should not be used as a recreation area. The basement could be renovated and used to facilitate computer courses and technical training.

Applicable Standards

COMAR 14.31.06.07 (A)(4). *The licensee shall ensure compliance with the local fire and health requirements by submitting annually to the licensing agency, reports of all fire and health inspections conducted by the local jurisdiction.*

COMAR 14.31.06.07.C.1 *The licensee shall maintain all structures and grounds in good Condition, free from health or safety hazards.*

6. Rehabilitative, Recreational and Educational Programming

According to staff, youth continue to receive drug and alcohol counseling twice per week and attend alcoholics anonymous and narcotics anonymous meetings. The Seven Challenges program remains the model for the substance abuse treatment program.

Youth must share a small basketball court with youth from a different program.

The program would benefit from the addition of vocational and life skills courses.

RECOMMENDATIONS

1. The Department should utilize available treatment slots at WDSH or come up with a plan for an alternative full utilization of the facility. WDSH could be used to house a vocational program or as a treatment center for female youth.

2. The home must schedule a fire marshal's inspection and a fire safety equipment inspection without delay and should assure scheduling of inspections once every year (at a minimum).

3. The home should move or dispose of broken exercise equipment and outdated facility files stored in the basement.

4. The basement should be cleaned and remodeled.

NICK MORONEY
Acting Director

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

FACILITIES REPORT
DEPARTMENT OF JUVENILE SERVICES YOUTH CENTERS
JULY – SEPTEMBER, 2010

Regional Address: Maryland Department of Juvenile Services (DJS)
Youth Center (YC) Headquarters
1 James Day Drive
Cumberland, Md. 21502
Regional Director: Bob McElvie

Reported by: Tim Snyder and Claudia Wright
Monitors

Persons Interviewed: Regional Director, Youth Center Administrators, Case Managers, Residential Advisors, Support Staff, and Youth

Date of Report: November 2010

Facilities and Dates of Visits:

Green Ridge YC
10700 15 Mile Creek Road NE,
Flintstone, Md. 21530
Administrator: Judy Hodel

Visits: July 20, August 19,
and September 13, 2010

Savage Mountain YC
164 Freedom Lane
Lonaconing, MD 21539
Administrator: Steve Northcraft

Visits: July 22, August 5
and September 9, 2010

Meadow Mountain YC
234 Recovery Rd,
Grantsville, Md. 21536
Administrator: Bill Pickerel

Visits: July 22, August 6
and September 1, 2010

Backbone Mountain YC
24 Camp 4 Road
Swanton, Md. 21562
Administrator: Dick Gero

Visits: July 21, August 10,
and September 10, 2010

INTRODUCTION

The Maryland Department of Juvenile Services (DJS/the Department) Youth Centers provide commitment care services in four separate facilities:

Green Ridge, located in Allegany County near Flintstone, provides 40 beds and serves Western Maryland male youth in three separate programs: Mountain Quest, a 90-day intensive adventure based treatment impact program; Revelations, a substance abuse program lasting a minimum of 120 days; and a therapeutic program averaging six to eight months.

Savage Mountain, located in Garrett County near Lonaconing, was downsized in May 2009 from 36 to 12 beds. By September 2009, facility capacity had been re-adjusted to 24 and, by March of 2010, Savage Mountain was back to full capacity at 36 youth. The facility primarily serves youth from non-Western Maryland counties.

Meadow Mountain provides 40 treatment program beds and specializes in treatment of addictions in a six to nine month program. The facility serves male youth residing primarily in non-Western Maryland counties.

Backbone Mountain provides 48 beds. Thirty-two to thirty-eight beds are dedicated to the six to eight month treatment program, and ten to sixteen beds are dedicated to youth in a college program. Backbone Mountain serves male youth residing primarily in non-Western Maryland counties.

FINDINGS

1. Population

a. General

The combined population capacity of the Youth Centers is 164 youth. Over the past five years the Youth Centers have accepted more challenging youth. DJS describes the Centers as staff secure facilities. In other words, security is dependent on adequate staffing to ensure safety and security and prevent youth from leaving the facility without permission. Three issues are of concern and sometimes present simultaneously. First, youth with histories of repeated acts of violence are placed at the Youth Centers. Second, youth who are functioning at very low IQ levels are admitted. Third, youth are admitted with mental health issues beyond the capacity of the Centers to treat effectively.

The Youth Centers Intake Office carefully reviews applications and sometimes denies a number of referred youth because of one or more of the reasons listed above. If the referring Community Case Manager requests an appeal about the decision to deny entrance, the referral is given a second review by a team of Youth Center treatment staff. According to several sources, there is frequently pressure for the Centers to accept youth that have initially been screened out. Youth who are accepted for admission may be placed in any of the Youth Centers. The decision depends on where a slot opens up rather than a youth's specific needs or the suitability of the group dynamics where a youth might be placed.

It seems clear that the DJS commitment care system is failing to meet the needs of children. The Youth Center's leadership, direct care staff members, and support staff do a credible job of attempting to help the youth that enter the Center's programs. The vast majority of staff members are very dedicated and skilled. In spite of this, and in spite of the great efforts in programming, the success rate of youth leaving the Youth Centers is disappointing. The Department has failed to promulgate commitment care standards that would specifically address the unique culture of a treatment program as opposed to a detention center.

Although calculating recidivism rates is a complicated process - full of variables and criteria differentials – data contained in the reports DJS sends to State government show a disappointingly high recidivism rate among post-treatment youth.

According to the DJS StateStat Report dated October 8, 2010 - and concerning post-commitment recidivism rates - an average of 53% of youth are re-arrested. By three years out, the average re-arrest rate reaches 74%.

b. Population Breakdown by Race/Ethnicity at the Youth Centers

GREEN RIDGE YC	3rd Qtr 2009	3rd Qtr 2010
Total Youth Entries	64	62
African American	36 (56%)	30 (48%)
White/Caucasian	16 (25%)	20 (32%)
Hispanic/Latino	12 (19%)	10 (16%)
Other/Unknown	0	2 (4%)

SAVAGE MOUNTAIN YC	3rd Qtr 2009	3rd Qtr 2010
Total Youth Entries	25	55
African American	21 (84%)	52 (95%)
White/Caucasian	3 (12%)	1 (1.6%)
Hispanic/Latino	1 (4%)	1 (1.6%)
Other/Unknown	0	1 (1.6%)

MEADOW MOUNTAIN YC	3rd Qtr 2009	3rd Qtr 2010
Total Youth Entries	63	62
African American	42 (66%)	53 (85%)
White/Caucasian	19 (30%)	7 (11%)
Hispanic/Latino	2 (3%)	1 (2%)
Other/Unknown	0	1 (2%)

BACKBONE MOUNTAIN YC	3rd Qtr 2009	3rd Qtr 2010
Total Youth Entries	74	69
African American	60 (81%)	56 (81%)
White/Caucasian	12 (16%)	10 (15%)
Hispanic/Latino	2 (3%)	3 (4%)
Other/Unknown	0	0

Minority representation within the overall Youth Center population has increased slightly over the past year. During the third quarter of 2010, minority youth represented 85% of the total population.

Applicable Standards

Md. DJS Youth Centers Procedure Manual - DJS Youth Centers Guidelines For Admission *The nature of the program and the fact that it is staff secure requires that youth be capable of a certain level of reasoning, decision making, and emotional maturity. It is also vital that students who are accepted will not present a threat to other students or to the staff.*

Md. DJS Youth Centers Procedure Manual - DJS Youth Centers Guidelines For Admission *Other issues, which generally should be considered impediments for admission, are severe aggression and/or explosive personality disorder, since staff and student protection are of paramount importance. Students with histories of assaultive/violent behavior who pose a threat to the safety or students and staff or who have a history of absconding from other programs are generally not appropriate.*

2. Staffing

a. General

The Youth Centers operate with a shortage of staff. A staffing formula of 1.7 staff for each position is inadequate. The formula should be 2.0 in order to maintain safety, security, programming, and individualized intervention as needed. Vacations, sick leave, family leave and increased annual training requirements pull staff away from the Centers. Additionally, direct care staff from the Centers often have to help out the DJS Transportation Office which is also short of staff.

When staff feel stretched or even overwhelmed, some take sick time off to recover. From July 28th to September 9th, 2010, 467.1hours of overtime were reported at Backbone Mountain Youth Center. Fifty-five percent of the overtime hours were specifically noted as due to staffing shortage. An additional 131.3 hours or thirty percent were specifically noted as being due to staff being sick**.**

DJS reported that during the 75-day period from June 30 through September 7, 2010, the Youth Centers spent $65,127.21 in overtime pay to direct care staff.

b. Staff Training

DJS staff training in crisis intervention and restraint is inadequate.

The Department uses the JIREH curriculum for Crisis Management training. The JIREH curriculum is lacking in comprehensive and practical training in de-escalation. Additionally, the training is inadequate in that it requires a staff to be capable of physically dominating an aggressive youth. Direct care staff members need training in techniques that all can use regardless of size or strength to protect themselves and youth from injury while effectively controlling aggressive behavior.

DJS requires that staff use only JIREH - CPM techniques. Because the required techniques are inadequate, staff are often uncertain as to proceed in handling situations. A lack of tools, clarity and confidence fosters a safety and security problem for youth and staff.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.1.3 *Staffing arrangements shall aim to provide a safe, humane, and caring environment.*

COMAR 14.31.06.05 F (3) The training of employees who may provide direct care to children shall include: (f) approved forms of discipline and behavior management techniques including crisis management and the use of isolation and restraints.

Md. Standards for Juvenile Detention Facilities 2.2.1 *The Department shall ensure that designated classes of departmental and vendor employees are trained according to the standards established by the Maryland Correctional Training Commission.*

3. Safety and Security

c. Aggregate Incidents

Green Ridge (40 youth)	2009 Incidents Jan/Sept	2009 Injuries Jan/Sept	2010 Incidents Jan/Sept	2010 Injuries Jan/Sept
Youth on Youth Assaults	14	5	20	15
Restraints/Use of Force	30	8	18	8
Total	44	13	38	13

Savage Mountain (36 youth since May 2010 – 12 youth from May 2009 through Jan 2009)	2009 Incidents Jan/Sept	2009 Injuries Jan/Sept	2010 Incidents Jan/Sept	2010 Injuries Jan/Sept
Youth on Youth Assaults	14	8	17	7
Restraints/Use of Force	16	5	37	8
Total	30	13	54	15

Meadow Mountain (40 youth)	2009 Incidents Jan/Sept	2009 Injuries Jan/Sept	2010 Incidents Jan/Sept	2010 Injuries Jan/Sept
Youth on Youth Assaults	6	4	13	6
Restraints/Use of Force	9	3	12	5
Total	15	7	25	11

Backbone Mountain (48 youth)	2009 Incidents Jan/Sept	2009 Injuries Jan/Sept	2010 Incidents Jan/Sept	2010 Injuries Jan/Sept
Youth on Youth Assaults	25	10	29	9
Restraints/Use of Force	43	11	50	12
Total	68	21	79	21

Data Source: DJS Incident reporting database

Aggressive incidents have increased significantly at all four Youth Centers. Youth on youth assaults have increased by 25% in the Youth Centers since 2009. Injury from fighting or from staff restraint is a significant problem. Almost a third (28%) of the restraints in 2009 and 2010 resulted in injury.

The Youth Centers have completed an effective key control policy and procedure at each Center.

b. Incident-Related Procedures, Practices, and Reporting

The YC key control procedure includes the use of double locked boxes, with one key lock and one combination lock, located in several strategic places on campus. Staff

members deposit personal keys and sign out a set of work keys for their shifts. Visitors check in their keys and receive a numbered chit, which is then used to reclaim their keys when they leave the facility.

The Youth Centers do not have stationary security cameras. Each Center has completed a survey of building and grounds and made a recommendation for positioning of cameras. DJS requires direct care staff to use portable video cameras to record incidents. Staff members do not follow this requirement. It is impractical for staff intervening in an incident to remove themselves in order to get a camera and video the event.

This Monitor in cooperation with the Region III Director has discussed possible changes that could be made to enhance safety and security of staff and youth in the Centers. Considerations included the use of stationary cameras, placing windows in office doors, the use of mirrors to help facilitate observation and policy and procedure that maintains third party protection for staff and youth.

The Youth Center's Administration has been very active in following up on suggestions especially in placing windows in doors. Administration has gone further in making physical plant changes to help ensure that staff members including Administrators, Case Managers, counselors, and therapists, are not alone in a building with youth.

The Centers continue to allow female staff to supervise youth during shower time. This means that female staff are present in the dorms where male youth clad only in a towel move about between their sleeping area and the shower room. Youth undress and dress behind an opened narrow locker door. During interviews with female staff it was disclosed that they will and have entered the shower room when an altercation is taking place in the showers. The practice of female staff supervising male youth during shower time is unacceptable.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.1.3 *Staffing arrangements shall aim to provide a safe, humane, and caring environment.*

Maryland Department of Juvenile Services Policy RF-05-07. *The Department of Juvenile Services (DJS) employees shall video tape room extractions, escorts to seclusion, use of restraints or other critical incidents that relate to the safety and security of a residential facility. Incidents shall be videotaped unless videotaping of the incident compromises the safety and/or security of youth and/or employees. The Department encourages the video taping of incidents to de-escalate incidents and to prevent further misbehavior and the use of physical restraint.*

Department of Juvenile Services Detention Standard 3.1.2 Any residential program utilized by the Department as a residential alternative to secure detention must be approved for use by the Department, must be licensed, and must conform to all requirements as articulated in COMAR.

4. Physical Plant and Basic Services

a. Fire Safety

All of the Centers hold current Fire Marshal Inspection Reports. Fire drills are held as required.

b. Physical Plant

At Green Ridge, the department has upgraded the gym and is rebuilding a historic cabin - the shower facility should also be refurbished. The driveways at Backbone Mountain and Savage Mountain need to be resurfaced.

Applicable Standard

COMAR 14.31.06.07.C(1). *The licensee shall maintain all structures and grounds in good condition, free from health or safety hazards.*

c. Medical

Nursing availability at the Centers has been increased so that each Center has a nurse on grounds four days each week. In addition, DJS constructed a dedicated nurses office at each Youth Center. The offices are being outfitted with medical equipment.

DJS provided a much needed 4-day medical certification training for 20 direct care staff in October.

d. Basic Services

All of the Youth Centers have current Health Department inspections. Clothing continues to present a problem. Youth do not consistently have what they need. Shoes, particularly tennis shoes, are in short supply and the quality is very poor. Youth wear them out quickly, especially playing basketball on the paved courts.

Because of efficient forward planning, winter clothing is reportedly in good supply this year.

e. Transportation

Transportation is a problem in the Centers. Direct care staff are frequently called upon to transport youth to the clinic and to other appointments. This often results in the use of overtime hours to provide the needed coverage.

The Department should invest in a 20 passenger activity bus that can be used by direct care and school staff to take groups of 12 off campus. Currently, when groups of 12 youth from Backbone Mountain or Savage Mountain are set to participate in an off-grounds activity, two vehicles and a minimum of 3 staff are needed. For groups of less than ten, one van is used and resources are not wasted.

Applicable Standards

Md. Standards for Juvenile Detention Facilities 5.6.5 *The stored inventory of clothing, bedding, and linens shall exceed that required for the facility's maximum youth population. An inventory system shall be maintained to ensure the consistent availability of clothing, bedding, and linens to replace items that are lost, destroyed, or worn out.*

Md. Standards for Juvenile Detention Facilities 5.6.5.2 *Youth shall be provided the opportunity to have three complete sets of clean clothing per week.*

COMAR 14.31.06.10.D. *The licensee shall ensure that the children have an adequate supply of clean, comfortable, well-fitting clothes, and shoes for indoor and outdoor wear.*

5. Education

The Youth Centers Educational Program provides 4 hours of classroom instruction each school day. Youth typically gain between two and four months towards completion for every month that they would expect to gain in public school. The teaching staff provide engaging classroom instruction, and offer individual help to youth.

Youth also participate in the World of Work experience which involves accompanying staff three times per week to help with grounds work or maintenance and classroom instruction in life skills related to working twice weekly. A certificate is granted to youth for participation. Youth receive a health credit for participation in drug classes and the 7 Challenges program and can also earn a Physical Education credit.

Youth who do not plan to return to school enter the GED or Pre-GED program. Vocational instruction varies from Center to Center but offers little in the way of job training - youth who complete the programs are not prepared to enter the workforce.

Backbone Mountain Youth Center is the home of The Honors Academy, a learning partnership between Garrett County Community College and DJS. A review team selects applicants to participate and the program includes college preparation courses and participation in the treatment program.

DJS schedules teachers to take professional days around the holidays. School is closed for 9-10 days. This is especially problematic during the December holidays when staff need maximum programming to help youth deal with the anxieties, disappointments, and issues that arise with the season.

6. Rehabilitative and Recreational Programming

a. Therapeutic Program

The DJS Youth Centers offer Positive Peer Culture, (PPC), EQUIP, and Seven Challenges. The Seven Challenges approach to treatment encourages honest dialogue with youth about their relationship with drugs and alcohol, and the need to take responsibility for their decisions. Most youth in the Centers meet individually with a mental health therapist at least once weekly.

Group size is a significant factor in ensuring safety of youth and ensuring the success of the treatment modality. Harry H. Vorrath and Larry K. Brendtro, the authors of the standard text on Positive Peer Culture, conclude on the issue of group size as follows: “Experience with groups of differing sizes has led to the general guideline that the ideal size of a PPC group is nine members” (see page 52 of *Positive Peer Culture*, 2nd Edition, 1985).

Green Ridge and Meadow Mountain Youth Centers have groups of 10. Savage Mountain and at Backbone Mountain have a minimum of 12 youth in each group. The Honors Academy may have as many as 16 youth. Larger groups greatly impact the effective implementation of the Positive Peer Process model. Ideally, treatment groups should be limited to 9 youth.

Some youth enrolled at the Youth Centers are at such a low reading level, and at a low level regarding general cognition abilities that they have great difficulty

understanding basic questions presented during intake. Youth Center direct care staff and educators find it very challenging to meet address such needs. The Positive Peer Culture and Equip training that the Youth Centers utilize requires youth be able to process and integrate abstract concepts in the program components. Youth already suffering with low self-esteem find it difficult to achieve success in the environment that asks more than they are able to give. Some youth act out behaviorally rather than appear inadequate.

The youth in the Centers earn their way home primarily through behavioral compliance. Staff members report that many youth act their way through the program. There are generally insufficient resources, and time is too short to effectively address the deeper internal dynamics and conflicts that could lead to fundamental change and long-term success for youth. Behavioral change in itself is not insignificant, and some youth do gain meaningful insight and coping strategies and are able to go on to be successful after discharge.

b. Recreational Programming

Frostburg State University opens its facilities to the Centers for youth to swim and to participate in experiential challenge/learning activities. The Youth Centers provide recreational programming at least one hour daily. Therapeutic recreation also includes organized sports which allow youth to participate in structured team activities.

The Ropes and Reflections program at Meadow Mountain are back in full swing with elements revamped, equipment replaced and trained staff dedicated to this valuable treatment resource. The Reflections program forms the core of the approach and is a diversified, adventure based program which utilizes the Ropes program as part of the overall Reflections curriculum. Staff shortages have limited use of the program but groups of youth have been able to participate in significant trust and team building activities. The program components also include personal challenge and problem solving tasks and typical activities have included high and low ropes course challenges, trail hiking, night hiking, rock climbing and rappelling, as well as swimming, fishing and mountain bike riding.

The Youth Centers incorporate as much off-campus recreation, educational and treatment related activities as possible given current staffing and transportation given current staffing and transportation limitations. The Zip Line at Savage Mountain has been out of commission and is greatly missed as a treatment resource. Administrators at Green Ridge and the Department of Natural Resources coordinated in an attempt to utilize nearby land for a low ropes course but budget constraints have curtailed the project for the foreseeable future. The program would be relatively low cost and with a potentially high gain for youth it is to be hoped that plans will reach fruition as soon as it becomes financially feasible.

Other off-campus activities for youth center residents have included outings to historical sites such as Antietam Battlefield and the Flight 93 site in Pennsylvania. Community service activities include splitting wood and maintaining a cemetery. The entire Green Ridge population went to Camp Potomac, a Boy Scout camp, to participate in 2 ½ days of trust building activities. Groups were also taken to watch local high school football games and to dinner at a Chinese buffet.

c. Parental Involvement

Youth make weekly phone calls to parents and guardians. Some youth have the opportunity to earn a home visit as they near completion of the residential program.

Each Center holds family days which offer family members the chance to visit the Center and participate with youth in special activities. Each Center now has video capability and sometimes video conferences are held with parents and/or community case managers in situations where on-site visitation is difficult. Green Ridge offers more opportunities for family interaction than the other Centers.

7. Youth Advocacy, Case Management and the TOP Initiative

a. Youth Advocacy

Some youth report that the grievance process is useless while others fear being "burnt" by staff if they write a grievance. Some staff maintain that such youth concerns result from feelings when youth do not get their way a result of a filing a grievance. The Child Advocate makes regular rounds to each Center. Grievances reviewed this quarter indicate that the Child Advocate addressed the issues appropriately.

b. Case Management

Many youth lose contact with their Community Case Managers (Probation Officers) when they are in the Youth Centers. At times, one worker is assigned to visit all the youth from a particular county – such courtesy visits are often not meaningful for youth. Some youth do not even receive courtesy visits. It is essential that youth be given opportunities to have a consistent relationship with a dedicated case manager throughout the term of commitment.

DJS regulations require community case managers to visit youth at the center at least once per month. Although community case managers see youth in court and may see them during a home visit, such visits do not meet the requirement that youths be visited at their placement on a monthly basis.

In a sample taken from Savage Mountain Youth Center for the month of July 2010, community case managers visited 23 youth out of a population of 41 (in other words, 56% of youth were visited). Sometimes case managers arrive to see a youth and poor or no planning results in the youth being away from the campus on an appointment when the case manager visits.

c. The TOP Initiative

The Department is implementing a pre-placement orientation program called Treatment Placement Orientation (TOP) at DJS detention centers. The program includes the opportunity to receive credit towards placement time. This could help lessen extended periods of "dead" time spent waiting for treatment placement. The Department deserves praise for designing and implementing this long-needed program.

The DJS Western Region implemented the TOP for youth pending placement in the Youth Centers or Victor Cullen. Youth complete a workbook and maintain contact with designated staff in the receiving Center. Staff at the detention center track progress as youth begin learning and adopting cognitive and behavioral changes that will facilitate completion of the program in the Youth Centers. In this way, youth are not doing dead time – they are able to begin treatment that can shorten length of stay at the Youth Centers.

Although some adjustments may be needed as implementation problems are identified, the TOP initiative is an innovative step. One issue already identified is the amount of time it takes staff at the detention centers as well as at the Youth Centers to coordinate all aspects of the program.

Applicable Standards

Md. Department of Juvenile Services Policy and Procedure MGMT-01-07 Youth Grievance Policy *The Department of Juvenile Services (DJS) shall permit youth and individuals on behalf of DJS youth to file a grievance for a circumstance or action related to behavior of other youth, behavior of employees, or conditions of confinement.*

Md. Department of Juvenile Services Policy and Procedure CJ-1-05. *(1) Youth who are committed to the Department of Juvenile Services (DJS) for placement… shall be assigned a Community Justice Case Management Specialist. DJS operated residential programs shall also assign a Facility Case Management Specialist. The Facility Case Management Specialist shall maintain daily contact with the youth and be responsible for the coordination of all services within the facility. In collaboration with the Community Justice Case Management Specialist and the facility Interdisciplinary Treatment Team, the Facility Case Management Specialist shall develop a Treatment Service Plan (TSP) and ensure that prescribed services are made available and delivered in accordance with the Department's Treatment Service Plan (TSP) Policy.*

(2) The Community Justice Case Management Specialist shall: (vi) Meet at least monthly with youth who are in residential care in Maryland to assess treatment progress and plan for community reintegration.

RECOMMENDATIONS

1. Youth admitted to the Youth Centers should meet the written admissions criteria. Youth with significant juvenile crime histories and youth who do not meet the IQ, behavioral or mental health criteria should not be admitted.

2. DJS should use a staffing ratio of 2.0 persons for each direct care position.

3. Female staff should not supervise male youth during shower time.

4. Appropriate and effective crisis intervention training should be provided.

5. Video cameras should be placed in strategic places in each building and on each Center campus.

6. The Department should finalize Commitment Care Standards for review.

7. The driveways at Savage Mountain and Backbone Mountain should be resurfaced.

8. The shower house at Green Ridge should be remodeled.

9. A 20-passenger activity bus should be provided.

10. Community case managers should visit youth on-site as required.

11. Community Case Managers should follow the same youth throughout youth involvement with the Department of Juvenile Services.

12. Groups should be limited to a maximum of nine youth as prescribed in the PPC model.

13. Vocational training, certification, and job placement should be provided to facilitate entry into the work force.

14. Professional Days should be scheduled so that educators are on campus and participating in activities during the high stress times around the holidays.