



**OFFICE OF THE ATTORNEY GENERAL
JUVENILE JUSTICE MONITORING UNIT**

2007 ANNUAL REPORT

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

ANNUAL REPORT 2007

Introduction

The Juvenile Justice Monitoring Unit (JJMU) respectfully submits this report to the Governor, members of the General Assembly, the Secretary of Juvenile Services, and members of the State Advisory Board on Juvenile Services as required by Md. State Govt. Code Ann. §6-401 et seq. (Supp. 2007). This year marks the seventh anniversary of the creation of the Monitor's Office and its sixth annual report.

This report discusses:

1. JJMU's activities and achievements during the reporting period;
2. Major systemic issues affecting the safety and treatment of youth in Department of Juvenile Services residential facilities;
3. Corrective actions taken by the Department to remedy problems and other progress during the year.

Readers are referred to our website at www.oag.state.md.us/jjmu for copies of all other reports of the Juvenile Justice Monitor from 2002 – present.

This report was produced by the staff of the Juvenile Justice Monitoring Unit – Philip (Jeff) Merson, Tim Snyder, Tanya Suggs, Marlana Valdez, and Claudia Wright.

The Monitor's Function

The Juvenile Justice Monitoring Unit (JJMU) evaluates Department of Juvenile Services (DJS) residential facilities, including detention centers, committed

placement programs, group homes, and shelters. The Unit monitors 20 facilities – those operated by DJS or operated by private vendors on State-owned property. Reports of its evaluations are issued on a quarterly basis and address the following issues:

1. Treatment of and services to youth;
2. Adequacy of staffing
3. Physical conditions of facilities;
4. The child advocacy grievance process; and
5. DJS' internal monitoring process.

Md. State Govt. Code Ann. §6-404 (Supp. 2007).

Monitors make unannounced visits to facilities, visiting between one and four times per month, depending on current challenges at the facility. During these visits they inspect the physical plant, interview youth and staff, observe school classes, and review documents including seclusion reports, activity logs, medical records, school records, and staffing charts.

Monitors also review the DJS Incident Reporting and ASSIST Databases to follow up on incidents in facilities, particularly those involving alleged staff on youth violence, youth on youth violence, group disturbances or injuries. They review DJS Investigative Reports for incidents that prompt formal investigations and review all grievances filed by youth. Monitors participate in multi-agency meetings called to discuss reports of alleged child abuse or neglect in facilities.

Each quarter Monitors incorporate their findings into Individual Facility Reports. When a serious and immediate threat to youth and/or staff safety is identified (e.g., fire safety code violations, escapes, or serious staffing or operational issues), the Juvenile Justice Monitoring Unit may issue a Special Report.

Monitors attend Facility Advisory Board meetings, which include community leaders and advocates, and report their findings to the Boards. JJMU also attends meetings of the State Advisory Board on Juvenile Justice and reports to its membership.

Activities and Accomplishments in 2007

To date in 2007, the Juvenile Justice Monitoring Unit has issued approximately 60 Individual Facility Reports and 3 Quarterly Reports. These include a pictorial report issued for the 2nd Quarter that highlighted critical facility needs.

The Unit also issued Special Reports relating to:

- Waxter Children's Center (multiple physical plant and safety issues)
- Charles Hickey School (escape)

- Charles Hickey School (escape)
- Carter Center (overcrowding, youth safety, and lack of supervision)

In addition to statutorily-required duties, JJMU staff members participate in a number of task forces and work groups on juvenile justice issues. This year our external work included:

- Task Force to Study Group Home Education and Placement Practices
- Governor's Office for Children, Workgroup on Core Regulations
- Annie E. Casey Foundation Juvenile Detention Alternatives Initiative, Baltimore City Juvenile Justice Center Self-Assessment
- Task Force on Juvenile Prevention and Diversion Services
- Maryland Juvenile Justice Coalition
- Montgomery County Commission on Juvenile Justice
- Child Welfare League of America
- Maryland Child Action Network
- Maryland Disability Law Center
- Maryland Office of the Public Defender
- Department of Juvenile Services Transition Working Group
- Department of Human Resources Transition Working Group

Senate Bill 360, passed in the 2007 legislative session, expands JJMU's monitoring responsibilities to include all facilities licensed by DJS. This expansion of responsibility, which adds 14 new facilities to JJMU's inspecting and reporting authority, becomes effective on January 1, 2008. At that time, the Unit will also add new staff members to assist with the increased workload – two Monitors and one Information Specialist. We have devoted significant attention to developing appropriate procedures and work plans to successfully incorporate these new facilities into our monitoring program.

One of JJMU's goals for 2007 was to write more reader friendly reports that clearly articulate issues in Maryland's juvenile facilities and accurately depict conditions. We added a quarterly overview on systemic issues and developed a consistent format for all Individual Facility Reports.

A second goal was to produce more data-driven reports and improve the consistency of reporting across institutions, enhancing our ability to measure progress. To that end, JJMU is working collaboratively with the Department of Juvenile Services and the Governor's Office for Children to develop a monitoring tool which we will implement in 2008.

Challenges

a. Access to Information

While this Annual Report is as data-based as possible, we acquired much of the statistical data supporting its conclusions from sources outside DJS. The major challenge the Unit encountered this year was the Department's repeated failure to provide access to records that this Office is legally authorized to inspect and needs to fulfill its legal reporting responsibilities.

In mid-September, the Monitor's Office issued a formal letter to the DJS Secretary requesting that a standardized and reliable information sharing system be developed. The letter listed specific data required for completion of our reports.

Nearly two months later, DJS released a limited number of documents and made others available for on-site inspection but refused to provide **ongoing access** to information without a complete re-negotiation of the agencies' Standard Operating Procedure, a complex contractual negotiation that will undoubtedly take many months.

In the meantime, the Department will release data to the Monitor's Office only upon written request specifying the precise documents requested, somewhat equivalent to a Public Information Act (PIA) request.

Information that should be shared on a regular on-going basis includes:

- a. Staffing data, including overtime hours worked, number of vacancies, and employee training records;
- b. Timely population data, including Daily Population Sheets that DJS widely distributes outside state government, average lengths of stay in detention, and number of youth placed outside the state;
- c. Facility renovation, replacement, or repair plans, including project requests submitted to the Department of General Services.

The Department already produces most, if not all, of these reports for the Governor's StateStat Program, the Department of Budget and Management, or the General Assembly. Statistics and reports produced by DJS would enhance both the accuracy and quality of the Monitor's reports.

The only regular information source available to JJMU is its access to the DJS Incident and ASSIST databases which document incidents in facilities and include individual youth records. While these information sources are quite valuable, they do not provide the full range of data needed to produce our reports.

The current DJS administration has also discontinued the historical practice of informally notifying the Monitor about critical and emergency incidents in facilities, a practice followed since the inception of the Monitor's office. These events include serious injury to or death of a youth, escapes, allegations of child abuse, and mass lockdowns.

In the past month alone, DJS' Office of Investigations and Audits declined to notify JJMU about a large group disturbance involving Cheltenham and BCJJC youth that sent five youth to the hospital and a staff member's arrest for child abuse. JJMU learned of these events from local media reports.

The Department is legally obligated to provide JJMU with access to "any information that is readily accessible on site at a DJS facility or office..." and to notify JJMU "as soon as practicable...of all imminent or material threats to the health, life, and safety of youth, staff, or the public..."¹

Establishing a free-flowing exchange of information is not just a legal issue, however. It is good public policy. Transparency is particularly critical in this State where employees, families, youth, child advocates, and the general public have suffered so many false starts at reform.

b. Corrective Action Planning

JJMU's enabling legislation envisions a collaborative corrective action planning process – one in which DJS and JJMU work together to develop corrective actions to address facility problems. The agencies' Standard Operating Procedure *requires* them to "engage in discussions concerning DJS' proposed Corrective Action Plan."²

For most of this year, JJMU and DJS did not engage in a meaningful corrective action planning process, and collaborative corrective action planning has been rare, if not non-existent. Most responses to JJMU reports and corrective action plans have sorely lacked detail, and many issues raised in monitoring reports are never addressed at all. For example, in the 1st Quarter 2007 Report, we discussed the issue of weekend detention, a legally questionable practice followed in several counties. Judges in these jurisdictions delegate blanket authority to Case Managers to send youth to weekend detention for violating probation conditions. These short-term detentions occur without due process hearings and exacerbate facility overcrowding.

Following issuance of the report, DJS said it would discuss the issue with judges. Those discussions may have occurred and some agreement on the issue

¹ Department of Juvenile Services and Juvenile Justice Monitoring Unit Standard Operating Procedure, §§5.3.1, 5.6.

² Department of Juvenile Services and Juvenile Justice Monitoring Unit Standard Operating Procedure, §6.6

may have been reached, but JJMU has been unable to learn what, if any, progress has been made on this issue.

In September we expressed concern about the treatment of pregnant girls in detention facilities after a girl detained at Noyes gave birth at a local hospital and was then returned to Noyes. With no access to her baby or appropriate post-natal care, she became seriously depressed. We asked the Department to designate a specific facility for detention of pregnant girls and to develop appropriate programming that takes into account the special medical, psychological, and familial needs of this population. We understand Noyes staff has completed the gender-specific training the Department developed for those who work with girls, but have observed no new system-wide policies or programming pertaining to pregnant girls and have received no follow-up on our inquiry.

In December, DJS appointed its Deputy Secretary for Operations as the primary point of contact for JJMU. As mentioned in the report, a new DJS staff member began coordinating responses and corrective action planning in October. A first meeting to renegotiate the agencies' Standard Operating Procedure has been scheduled for mid-January. We hope that these changes may signal a willingness to engage in true discussion and negotiation with JJMU on issues raised in its reports.

c. Conclusion

The Juvenile Justice Monitoring Unit fulfills a critical role for Maryland youth, families, communities, and State leadership, and the information collected and reported by Monitors should be welcomed by the Department. Monitors' reports provide crucial information to assist the Department in protecting and providing services for youth in its care.

We urge the Department to work toward a more transparent and collaborative relationship with JJMU as well as with other organizations seeking improvements for youth. Maryland's juvenile justice system has been mired in crisis and dysfunction for decades. Reform of the system will require the hard work of all who have a stake in these issues, and all willing participants should be invited to the table.

Progress on DJS' Strategic Goals

In July, DJS issued its Fiscal Year 2008 Strategic Plan. The Plan set out four major goals:

1. Reduce reliance on out-of-state placements;
2. Eliminate federal oversight – CRIPA;
3. Keep our children, staff and communities safe;
4. Organization development.

This section of the report evaluates progress toward achievement of these strategic goals. Although the Strategic Plan itself does not include metrics by which progress can be measured, the Department evaluates progress via metrics established in its Managing for Results report. Evaluation of progress toward strategic goals is complicated, however, because:

1. The most recent posted update to the Managing for Results document is dated January, 2007. This report does not include actual data from fiscal years 2007 or 2008 – only projected data.³ A new Managing for Results report will be published in early, 2008 including data through June, 2007.
2. Managing for Results does not include data on some strategic goals – for example, reducing the number of youth placed out-of-state or ending CRIPA involvement. Managing for Results does include indicators to measure progress toward DJS' 3rd strategic goal – “keep(ing) our children, staff, and communities safe.” Presumably, indicators such as the number of injuries from youth injuries in state-operated programs would be one such measurement (MFR, p. 8). Again, however, progress toward this goal is difficult to assess, because the report is outdated:

Actual FY 2005	1330
Actual FY 2006	1709
Estimated FY 2007	1538
Estimated FY 2008	1384 ⁴

DJS has also spearheaded an interagency strategic planning process to include the Department of Human Resources, Department of Health and Mental Hygiene, Governor's Office for Children, and Maryland Department of Education. The University of Maryland's Innovation Institute is facilitating the plan's development and has moved quickly to schedule meetings and complete the plan by June, 2008. The goal of the strategic planning process is to develop and implement “a

³ Managing for Results, p. 8 <http://djs.state.md.us/pdf/djsfy2008mfr.pdf>

⁴ Managing for Results, p. 8. <http://djs.state.md.us/pdf/djsfy2008mfr.pdf>

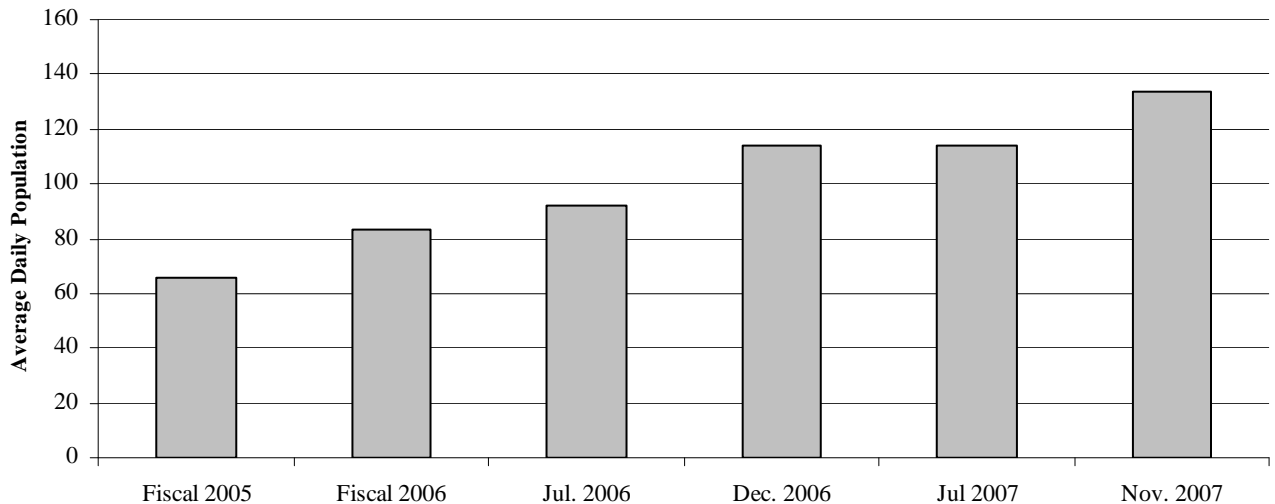
coordinated interagency effort to develop a youth service system that can better meet the needs of youth and their families and target children who are at-risk.”⁵

While implementation of the strategic plan will no doubt improve delivery of services to children in DJS care, it will not address issues such as facility replacement and renovation, youth and staff safety in facilities, improvement of staffing, and enhancement of facility programming and educational opportunities. DJS needs a concrete approach to these issues that are peculiar to its responsibilities and population. The Department plans to issue a Strategic Plan update in February, 2008 to address these and other issues.

1. Reduce reliance on out-of-state placements

The Department has not made progress on this goal in 2007. Out-of-state placements have risen in 2007, from 117 in January to 134 as of the writing of this report, a 14% increase. The chart below illustrates the continued rise in the number of out-of-state placements over the past four years.

Out-of-state Committed Residential Populations Average Daily Population
Fiscal Year, 2005 – 2008 (to date)



Source: Department of Legislative Services, FY 2008 Executive Budget Analysis

⁵ DJS Interagency Youth Services Strategic Plan Fact Sheet.

**Number of Youth in Out-Of-State Placements
January, 2007 – November, 2007**

January	117
February	113
March	113
April	no data
May	119
June	114
July	114
Aug	121
Sept.	126
Oct.	134
Nov. 18 ⁶	134

One major strategy the new DJS Secretary developed to reduce out-of-state placements was the renovation and reopening of the Victor Cullen Academy in western Maryland. The facility underwent an expensive fast-track renovation this year, opening 48 new beds for committed placement youth. At the time of writing of this report, 27 youth are housed at Victor Cullen, and 30 are expected by the end of the year. Although the General Assembly appropriated \$6.8 million for Victor Cullen's renovation, total FY2008 costs to date are approximately \$10 million. In June, 2007, DJS estimated that by the end of fiscal year 2008 (June, 2008) reopening and operating costs for Victor Cullen would total \$19 million.

Victor Cullen's admission criteria raise questions about the program's ability to help stem the tide of out-of-state placements. Generally, youth are placed out of state because their problems are complex (e.g., significant mental health issues or violent history) and because no appropriate treatment programs exist within the state. Originally, Victor Cullen was planned as a facility for treatment of these difficult to place youth, particularly those who required placement in a secure facility.

Neighboring community members, however, did not favor reopening the facility if "dangerous" youth would be placed there, and as a result, few youth with histories of serious violence or mental health issues are placed at Victor Cullen. Out-of-state placement numbers will continue to rise until appropriate treatment programs for these populations are developed in-state.

2. Eliminate Federal Oversight – CRIPA

The Civil Rights of Institutionalized Persons Act (CRIPA) authorizes the U.S. Department of Justice to conduct investigations and litigation relating to conditions of confinement in government operated residential facilities to enforce the constitutional rights of residents.

⁶ Last date for which this office has data.

In 2004, the U.S. Department of Justice concluded that certain longstanding conditions at Cheltenham and Hickey violated the constitutional and federal statutory rights of juveniles confined there. In 2005, the State of Maryland entered into a settlement agreement to implement key reforms to strengthen services for youths at Cheltenham and Hickey.

This year, the Baltimore City Juvenile Justice Center (BCJJC) was added to the agreement, and the State promised to improve conditions there as well. A federal monitoring team evaluates the State's progress in approximately 50 areas, issuing reports every six months. DJS hopes to be in compliance in all areas by July, 2008 and to be released from federal oversight at that time.

No progress reports on BCJJC have been issued yet, but DJS has made significant progress in remedying deficits at both Cheltenham and Hickey and appears to be on track to satisfy its strategic goal of eliminating federal CRIPA oversight, at least at these two facilities, by next year.

The chart on the following page summarizes findings of the most recent federal monitoring report, covering January 1 – June 30, 2007. All CRIPA monitoring reports may be found on the DJS website at www.djs.state.md.us.

**Settlement Agreement between the State of Maryland and the United States
Department of Justice**

4th Monitoring Report, January – June, 2007

<u>Substantive Area</u>	<u>Total Provisions</u>	<u>Substantial Compliance</u>		<u>Partial Compliance</u>		<u>Non-compliance</u>	
		<u>Hickey</u>	<u>CYF⁷</u>	<u>Hickey</u>	<u>CYF</u>	<u>Hickey</u>	<u>CYF</u>
Protection from Harm	17	7	6	10	11	0	0
Suicide Prevention	9	7	6	2	3	0	0
Mental Health	10	7	5	3	5	0	0
Medical	5	1	2	4	3	0	0
Special Education	8	6	6	2	2	0	0
Fire Safety	1	0	0	1	1	0	0
Total Facility – Level	50	28	25	22	25	0%	0%
		56%	50%	44%	50%		
Mental Health	1	1		0		0	
Medical	1	1		0		0	
Quality Assurance	4	1		2		1	
Total Agency – Level	6	3		2		1	
		50%		33%		17%	

Unanticipated Consequences of Strategic Goals #1 and #2

An unanticipated consequence of the first two strategic goals – reducing out-of-state placements and ending CRIPA oversight – is that precious departmental financial and staff resources have been diverted from other important priorities while attention is focused on these.

For example, renovating Victor Cullen within a three month period diverted millions of dollars that might have been used for desperately needed repairs at other facilities. Large contingents of Headquarters staff were also detailed on nearly a daily basis to the Victor Cullen construction site in western Maryland. While Victor Cullen was built, other facilities and programs suffered, and as discussed above, the

⁷ Cheltenham Youth Facility

facility may or may not be successful in diverting youth from out-of-state placements in the long run.

Likewise, the CRIPA monitoring process taxes limited staff resources. Correcting conditions cited by the CRIPA Monitors must be a critical priority for the Department because these conditions involve civil rights violations. However, the focus should be on repairing the conditions correctly, no matter how long that takes, rather than quick fixes aimed at releasing the state from federal oversight at some arbitrary point in the future. For example, \$700,000 has been invested in installing fire sprinklers in buildings at Cheltenham – buildings that the Department admits should be demolished – and an additional \$750,000 is being spent on building renovation at Hickey.

An alternative might have been to focus on building two facilities – one for detention and one for committed care - on the Cheltenham site this year. The property is beautiful, historic, and in a portion of the State that lacks committed placement beds. New construction on the Cheltenham (or Hickey) site would have addressed many federal monitoring concerns while providing additional committed placement beds.

3. Keep Our Children, Staff, and Communities Safe

The Department's strategies under this goal include:

- Reducing recidivism
- Enhancing services for reduction of gangs

The effect of any new programs or strategies to reduce recidivism will not be known for some time in the future – at a minimum, two years.

The Department has funded several anti-gang programs focusing on conflict resolution, anger management, and alternatives to gang membership. We hope these programs will be significantly expanded, taking advantage of the State's skilled cadre of gang mediators and conflict resolution experts.

4. Organizational Development

a. Recruitment and retention of personnel

Progress toward this goal is discussed in the section on staffing (p. 19).

b. Implementation of regionalization

Recent legislation required DJS to regionalize service delivery via the development of multiple service regions throughout the state. The Western Region (Region 3) was established as a pilot program and a final plan for regionalization was

to be submitted to the General Assembly by November 1, 2007. As of the writing of this report, the regionalization plan, to include the number of regions to be established and residential and non-residential services to be provided in each region, has not been submitted. Reportedly, it is forthcoming.

c. **Improve inter- and intra-agency planning**

DJS participates in numerous inter-agency task forces and groups in all branches of government. In October, it contracted with the University of Maryland's Innovation Institute to develop an inter-agency strategic plan to improve coordination of services among DJS, the Department of Health and Mental Hygiene, and the Department of Human Resources.

The strategic planning team is actively organizing the planning process and scheduling stakeholder meetings around the state. A final inter-agency plan is expected by July, 2007 (see discussion above, p. 9).

d. **Improve fiscal planning and management**

The strategic plan does not provide metrics by which to gauge progress on this goal.

Major Systemic Issues in 2007

Population

1. Overcrowding

Among detention facilities, the Baltimore City Juvenile Justice Center and Carter Center in eastern Maryland have experienced chronic overcrowding this year. Western Maryland Children's Center has experienced periodic overcrowding. When a facility's beds are full, youth sleep in "boats" (fiberglass sleeping containers into which a mattress is inserted). These youth frequently sleep in hallways or other common areas and have no private space or space for personal belongings. Overcrowded facilities threaten youth safety and tax already overworked staff.

The detention facilities at Cheltenham, Hickey, Lower Eastern Shore Children's Center and Noyes generally have not housed youth beyond their capacity.

The typical departmental response to facility overcrowding, particularly when it results in a group disturbance, is to move problem youth to another detention facility. This practice does not solve the problem – it only shifts it to another location. Reviews of Incident Reports show that the same few youth are often responsible for disturbances at multiple detention facilities, causing new problems with each shift in placement.

The Department operates a number of detention alternative programs, including Community Detention (CM), Electronic Monitoring (EM). Baltimore City has two evening reporting centers, and the PACT Center (also in Baltimore City) collaborates with youth and their families to develop intervention plans to address underlying issues. The Choice Program provides community-based supervision and services in education, employment, advocacy, family support, community service and resource linkage at five sites in and around Baltimore City.

The Detention Diversion Advocacy Program (DRAP) is part of the larger Annie Casey Foundation's Juvenile Detention Alternatives Initiative (see below) and provides increased community supervision with daily monitoring and weekly therapeutic interventions. It is also only available in Baltimore City.

While some diversion programs have been highly successful in reducing recidivism, they are still only available in a few areas of the state – primarily in and around Baltimore City. Enrollment in some of these programs, such as DRAP and PACT continues to be very low. Shelter use is up in the last months of the year – a positive sign because youth who do not pose a safety risk should be housed in a less restrictive environment than secure detention.

**Youth Enrolled in Detention Alternative Programs
(State-Wide)
August – November, 2007**

	Aug.	Sept.	Nov.	Dec.
Shelter ADP*	68	61	71	87
Evening Reporting ADP	29	29	32	36
CD/EM ADP**	502	512	525	575
PACT	7	8	8	9
Other Detention Alternatives (DRAP)	4	4	0	0

*Alternative to Detention Placement

**Community Detention/Electronic Monitoring

Alternatives to Detention should be expanded, particularly those that are evidence-based,⁸ Additional solutions to overcrowding should be developed to keep youth out of secure detention unless absolutely necessary. Facility staff should also be given authority to turn away youth when the facility has reached capacity.

Despite community programs, new risk assessment tools, and improved casework practices, the numbers of youth held in secure detention increased in 2007 and remained stable throughout the year - but the number of youth in secure detention decreased by 25 between October and November.

2. Detention Population

The number of youth held in secure detention remained stable throughout the year. Although the Department implemented new assessment tools and case management practices to decrease the number of youth in secure detention, to date these measures have not reduced detention population numbers.

For the past five years, the Department has participated in the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI). The Baltimore City Juvenile Justice Center (BCJJC) has been the pilot site, and the Department hopes to expand the program to other areas of the State. JDAI focuses on eight core strategies that analyze the conditions of confinement, collaboration between systems, controlling the front gates of detention centers, case processing, and reducing racial and ethnic disparities.

Although DJS implemented a variety of strategies to reduce the detention population at BCJJC, the detention population was fairly flat through the first months of the year and increased in September, October, and November.

⁸ Proven by rigorous studies to be successful in reducing recidivism, increasing graduation rates, and improving other indicators of success for juveniles.

**Baltimore City Juvenile Justice Center
Detention Population
January – November, 2007**

January	78
Feb.	77
March	85
April	84
May	82
June	77
July	76
Aug.	83
Sept.	96
Oct.	95
Nov.	91

Secure Detention – Pre-Adjudication

In FY2005, an average of 253 youth were held in secure detention – in FY2008 (to date), that number has increased to 285.

**Number of Youth in Pre-Adjudication Secure Detention
Fiscal Year Average 2005 – 2008**

FY 2005	253
FY 2006	290
FY 2007	288
FY 2008 (to date)	285

**Average Number of Youth in Pre-Adjudication Secure Detention
January, 2007 – November, 2007**

January	303
Feb.	297
March	289
April	272
May	282
June	271
July	272
Aug.	283
Sept.	300
Oct.	299
Nov.	274

Source: DJS Monthly Population Report, November 2007.

Secure Detention – Post-Adjudication (Pending Placement)

The number of youth in Pending Placement status has increased since January of this year and is virtually identical to the averages for FY 2007.

The numbers of youth in pending placement have declined, however, since June (from an average of 160 to 140). New case management practices and frequent meetings to discuss difficult to place youth (“stuck kids”) may continue this downward trend.

Number of Youth in Post-Adjudication Secure Detention (Pending Placement) Fiscal Year Average 2005 – 2008

FY 2005	130
FY 2006	167
FY 2007	144
FY 2008 (to date)	145

Average Number of Youth in Post-Adjudication Secure Detention (Pending Placement) January, 2007 – November, 2007

January 3	130
Feb.	137
March	153
April	151
May	153
June	159
July	155
Aug.	149
Sept.	136
Oct.	136
Nov.	137

Source: DJS Monthly Population Report, November, 2007

Although the total number of youth in pending placement status has not declined this year, these youth remained in pending placement for a much shorter period of time than was the case even one year ago. The following charts show the average length of stay for youth in pending placement status as measured in a one-day count on the first day of each month.

**Number of Youth in Pending Placement Status for 90 Days or More in 2007
(System-wide)**

<u>Month</u>	<u>Percentage</u>	<u>Details</u>
April	33%	(64 of 192 total pending placement)
May	16%	(25 of 155)
June	12%	(20 of 163)
July	13%	(21 of 158)
August	17%	(27 of 160)
September	21%	(29 of 140)
October	13.5%	(20 of 1480)
November	18%	(27 of 153)
December	8%	(11 of 144)

As part of its JDAI effort, the Department’s FY2008 Strategic Plan set a goal to “decrease the number of youth pending placement (at BCJJC) by 50% by June 30, 2008.”⁹ Numbers of Youth in Post-Adjudication Secure Detention (Pending Placement) at BCJJC for the for calendar year 2007 are:

**Average Number of Youth in Post-Adjudication Secure Detention
(Pending Placement) at
Baltimore City Juvenile Justice Center
January, 2007 – November, 2007**

January	25
Feb.	29
March	40
April	40
May	50
June	52
July	48
Aug.	48
Sept.	46
Oct.	39
Nov.	36

⁹ DJS Strategic Plan FY2008.

Although the total number of youth in pending placement status at BCJJC has grown through the year, dropping off in October and November, the length of stay in pending placement has dropped dramatically as the chart below indicates:

Number of Youth in Pending Placement Status for 90 Days or More in 2007 (BCJJC)

April	52%	(24 of 46)
May	24%	(13 of 54)
June	22%	(12 of 55)
July	12%	(6 of 50)
Aug.	18%	(9 of 49)
Sept.	23%	(11 of 47)
Oct.	16%	(7 of 43)
Nov.	19%	(8 of 43)
Dec.	5%	(2 of 43)

Source: DJS Response to JJMU Annual Report, charts, p. 29.

3. Alternatives to Detention

The Department is funding several community-based programs that reduce the number of youth in secure detention or committed care. These include Functional Family Therapy (FFT), Multi-systemic Therapy (MST), and Multidimensional Treatment Foster Care (MDTFC), all evidence-based practices that support youth in the community through intensive intervention for them and their families. These programs have been proven to significantly reduce recidivism, enhance clinical functioning and improve school performance, at considerable cost savings compared with confinement in juvenile facilities.

Currently DJS is funding FFT in Baltimore City, Charles County and the Eastern Shore. In September, the Department entered into a four-year compact agreement to implement MST in Baltimore County.

Again, while these are positive steps, evidence-based programs remain unavailable to the vast majority of Maryland youth. The Department has discussed establishing additional evidence-based practice programs in Anne Arundel, Prince Georges and Montgomery Counties, but no time frames have been provided, and the pace so far – one county per year – is exceedingly slow.

4. Recommendations

A real and long-term solution to overcrowding must be developed – not just a system of shuffling youth among detention facilities. Some options that should be explored include:

- Intensive case management to ensure that all youth in detention are, in fact, “a danger to themselves, others, or the community or pose a flight risk.” Monitors routinely observe youth in secure detention facilities who do not meet the criteria for secure detention. In some cases, no family member is available to take the child. In others, the child has mental illness or mental retardation but no other short-term care facility has been identified.

The Baltimore City Juvenile Justice Center's Community and Family Resource Center offers a promising model – its focus is on providing an array of services to families to enable them to successfully care for a youth who might otherwise be detained. The Department should provide additional support for this program and consider replicating this model in other areas.

- Shelter care alternatives should be more aggressively pursued. Ironically, a number of shelters in the State operate under capacity and would be more appropriate settings for many detained youth.
- Development of more community-based alternatives to secure detention. In many cases, youth released on community detention or electronic monitoring have no programming options available to them. In some jurisdictions, such as Baltimore City, multiple community-based detention alternatives exist, but decision-makers under-utilize them. These programs must be evidence-based – shown by research to reduce recidivism and improve long-term outcomes for youth.

Staffing

Introduction

DJS facilities have suffered for many years from inadequate staffing. Staffing problems appear to be slowly improving as the General Assembly approves more permanent positions. One notable exception to the issue of understaffing is the Victor Cullen Academy. The Department expended great effort to advertise, interview, and hire staff to enable the opening of Victor Cullen in a record 4 months. All of the positions at Victor Cullen are permanent PIN positions carrying full benefits.

While the target direct care staff/youth ratio system-wide is 1 to 8¹⁰, the target staff/youth ratio at Victor Cullen is 1 to 4, and 1 to 10 at the Youth Centers. As of the date of this report, all but four facilities were meeting their targeted staff/youth ratios, but were using significant overtime hours to meet the target.

1. Staff vacancies

As of October 1, DJS reported a total of 1,118.7 permanent (PIN) staff positions for the programs monitored by JJMU.. Eighty nine percent, or 988.5 of the total permanent positions, are reported as filled, and 130.2 positions are reported as vacant, representing an 11% vacancy rate overall.¹¹ Individual facility staff vacancy rates are as follows:

Facility	Total Permanent Positions	Vacant Positions	Vacancy Percentage
Cheltenham	168	16	9.5%
Hickey	144	22	15.3%
Carter	22	1	4.5%
BCJJC	171.2	9.2	5.4%
MYRC	41	3	7.3%
LESCC	48	3	6.3%
Noyes	70	10	14.3%
Schaefer House	25	1	4%
Victor Cullen	90	36 ¹²	40%
Waxter	78	3.5	4.5%
Western Md. CC	60	11	18%
Youth Centers	201.5	14.5	7.2%

Excluding all vacancies at Victor Cullen, the overall staff vacancy rate is 8.75%.

¹⁰ 1 to 16 during sleeping hours.

¹¹ DJS StateStat Report, October 1, 2007

¹² Victor Cullen's vacancy rate is unusually high because the facility has only been open a few months and does not have a full complement of staff or youth on site yet.

In 2007, the General Assembly required DJS to submit a plan to improve its recruitment and retention of staff. That plan included the following provisions:

- increasing base salaries for initial hires;
- hiring and referral bonuses for certain key job categories, e.g., nurses, social workers, teachers, and school psychologists;
- tuition assistance/student loan repayment programs;
- attendance and retention bonuses for all direct care staff, including bonus for completing 12 months of employment with continued good attendance; and
- geographically based recruitment and retention bonuses.

Some of these strategies have been implemented, but others have not. The FY 2008 Executive Budget Analysis commented:

*For the most part, these strategies were not new. Indeed, the plan noted that some have been available to DJS for some years (for example, hiring and referral bonuses for nurses and social workers and tuition reimbursement) but have not been funded.*¹³

Staffing has improved this year, and in some facilities nearly all positions are filled at this time. Nevertheless, staff members continue to work enormous overtime hours, making it clear that facilities need even more positions than are currently allocated to them.

2. Staff Turnover

The Maryland Legislative Information Service FY 2008 Executive Budget Analysis reports that the percent of “new direct care hires (regular and contractual) leaving within 12 months, while still high at one third, is certainly much better than in fiscal 2003 when only one-third were staying for 12 months.”¹⁴

JJMU does not have access to more recent turnover data, but DJS records show the following:

	2006	2007
Direct Care Permanent	16%	12%

¹³ Source: Department of Legislative Services, FY 2008 Executive Budget Analysis

¹⁴ Source: Department of Legislative Services, FY 2008 Executive Budget Analysis

Other Permanent	17%	19%
Direct Care Contractual	61%	39%
Other Contractual	30%	37%
All Direct Care	22%	14%
Total	21%	16%

Source: DJS Office of Human Resources

DJS supervisory staff reports that it often takes two years for new hires to become very effective. In the mean time, another third of the staff may have left, leaving the facility in the hands of a few experienced personnel and even more new staff – a revolving door system that affects safety and security, programming, and staff morale.

Facility leadership also changes at an extraordinary rate – numerous Facility Superintendents and Directors resigned, were transferred to other facilities, or were terminated during 2007. Frequent leadership turnover affects facility stability and services for youth and has a strong negative impact on staff morale.

Facilities monitored by JJMU had the following number of Superintendents or Directors this year:

Hickey	3
Carter	3
Noyes	3
O'Farrell	3
BCJJC	2
Waxter	2
MYRC	2 (before closing in October)
LESCC	2
WMCC	2
GUIDE	2
Victor Cullen	1
Youth Centers	One transfer among 4 Centers but no other changes
Allegany	1
Mt. Clare	1
WDSH	1
Cheltenham	1
Sykesville	1

3. Staff/Youth ratios

The 4th federal CRIPA Monitors' Report said:

“The Department’s standard staffing ratios are 1:8 during waking hours and 1:16 during sleeping hours. These are within the range of those accepted in

the field as necessary to protect youth from harm, *However, these ratios should be considered minimal staffing ratios – they are sufficient only to the extent that the population congregates in only a few locations* (emphasis added) (e.g., dining hall, housing units).

Given the convoluted physical design of the housing at both facilities (Cheltenham and Hickey) and the range of activities in which youth can be engaged, additional staff may be needed to adequately supervise youth. For example, if three staff are assigned to supervise 24 youth, and one staff is working with four who are writing letters, the ratios fall out of compliance by leaving 2 staff with 20 youth playing basketball. Rather than looking at staffing numbers in terms of simple ratio, they must also be examined throughout the day to ensure proper deployment.”¹⁵

The Report found that staffing levels at Hickey were met 98% of the time. However at CYF, “the facility met its targeted staffing ratios for only 69 percent of all shifts. The failure to meet targeted ratios was particularly pronounced during the latter half of the monitoring period when the facility’s population was higher.”¹⁶

4. Overtime

The Department continues to report extremely high overtime hours among staff. Excessive overtime leads to exhaustion, inattention, burnout, and resulting threats to safety and security .

According to the October 1, 2007 StateStat Report, between July 1 and September 25 (87days) DJS employees worked a total of 64,579 overtime hours.

Overtime Hours By Facility July 1 – September 25, 2007

Cheltenham	19,327 hours
BCJJC	15,827 hours
Hickey	10,354 hours
Noyes	6,235 hours
WMCC	2,607 hours
Waxter	2,266 hours
Carter	2,083 hours
Youth Centers	1,771 hours
LESCC	1,731 hours
Victor Cullen	1,193 hours
WDSH	605 hours

¹⁵ Federal CRIPA Monitors’ Report, 4th Report, January 1 – June 30, 2007. www.djs.state.md.us

¹⁶ Federal CRIPA Monitors’ Report, 4th Report, January 1 – June 30, 2007. www.djs.state.md.us

MYRC	580 hours
Total	64,579 overtime hours

The Department would have needed over 90 additional staff working 40 hour weeks during this 3-month period to avoid assigning staff to overtime hours.

Excessive overtime also results in significant costs to the State. According to the Oct 1, 2007 StateStat Report, between July 1 and September 25 (87 days), DJS spent \$1,685,951 in overtime pay for the following facilities monitored by DJS – annualized, this would be approximately \$7 million per year in overtime pay.

**Overtime Costs By Facility
July 1 – September 25, 2007**

Cheltenham	\$541,235
BCJJC	\$388,215
Hickey	\$261,636
Noyes	\$168,737
WMCC	\$63,615
Carter	\$60,786
Waxter	\$56,034
LESCC	\$47,699
Youth Centers	\$37,049
Victor Cullen	\$27,061
WDSH	\$17,442
MYRC	\$16,442
Total	\$1,685,951

The Department of Budget and Management required that DJS reduce its overtime hours by 25% by August, 2007 (DJS FY 2008 Strategic Plan, p. 42). JJMU does not have information sufficient to evaluate progress toward this goal.

5. Training Issues

The federal CRIPA Monitors' Report to DJS for of January 1 – June 30, 2007 discussed staff training issues:

“Although staff are not permitted to work independently with youth prior to completing ELT (Entry Level Training), some evidence suggests that at times, multiple provisionally certified staff (ie, those who have not completed ELT) are assigned to cottages with only one fully-certified staff person.”

Not only is this a dangerous practice in terms of protecting youth from harm if a fight were to occur, but it also places these provisionally certified staff in an

untenable situation – either to intervene without proper certification, or to stand by without supporting their colleagues.

It is not uncommon for Monitors to observed uncertified staff working with youth. At Noyes, on several occasions this year, uncertified staff who had received neither the background clearance nor Entry level Training were working alone with youth with no other supervision.

From the information provided to JJMU, it is difficult to determine how many staff are completing required training hours. In response to a request from JJMU, DJS said that its records “indicate that during calendar year 2006, the In-Service Training compliance rate for existing employees was 93%. The information is not broken out by facility.”

However, the federal Monitors’ Report for January 1 - July 30, 2007 assessed staff training compliance at Hickey and Cheltenham and found that “(f)or those staff hired prior to January 1, 2006..., of 106 staff at Hickey, 23% did *not* (meet the annual in-service training) requirement...Of (57) staff at CYF, 55% did *not* meet this requirement.” (CRIPA Monitors’ Report, January 1, - July 30, 2007, p. 34.)

Inexperience of staff (due to high turnover) is also a problem. For example, in April 2007 Noyes reported that only half of the 42 direct care staff have served for more than a year, and that approximately 18 of the 42 had been hired in the past six months.

The number of ELT classes increased this year, and the Department is recruiting an additional full-time trainer.

6. Staff Culture

Staff culture varies from facility to facility. Many staff demonstrate tireless dedication to youth in their charge. Nevertheless, some staff do not model appropriate behavior for youth. Reviews of Incident Reports and Youth Grievances include staff using excessive use, inappropriate language and disrespectful behavior in interactions with youth.

While the Department disciplines staff demonstrating these behaviors, because of severe staff shortages, staff are only terminated for the most egregious behaviors. Strong leaders in some facilities are working to improve staff professionalism – to be successful in the long term, these efforts must include increasing required credentials of incoming staff and providing significant pay upgrades.

Some longer term staff have intimidated newer staff as reported in the Noyes report July, 2007. “Interviews with staff during this quarter revealed that some staff

permit behavior that should result in an incident report and discourage other staff from initiating a report.”

Factors Contributing to Staffing Issues

1. Salaries

Low salaries for direct care workers present an obstacle in the attraction and retention of staff at DJS facilities. Most entry level staff at DJS facilities begin at a starting salary between \$27,000 and \$29,000. At Noyes, salaries were adjusted so that an entry level employee with a bachelor’s degree could begin as high as \$34,000.

Salaries were adjusted upwards significantly to attract staff at Victor Cullen. At Victor Cullen, a Residential Advisor 1 with a bachelor’s degree begins at an annual salary of \$38,000.

By comparison entry level direct care staff at the Fairfax County Detention Center in Virginia earn a starting salary of \$40,000.

2. Permanent Positions v. Contractual Positions

The provision of Position Identification Numbers (PINs) which entitles the employee to benefits is an important incentive for attraction and retention of staff.

The facilities with the lowest number of PINs are BCJJC at 71%, (135 PIN, 54 Contractual), Cheltenham with 72% PIN positions (115 PIN and 43 Contractual) and Noyes with 78% PIN positions (47 PIN and 13 Contractual).

In contrast MYRC (now closed) reports 100% PIN positions. At Victor Cullen 99% of its positions have a PIN, and the Youth Centers reported that 96% of the positions have a PIN.

Percentage of PIN and Contractual Positions by Facility

This data includes facility administration, and for Noyes, Victor Cullen, WMCC and all of the Youth Centers it also includes dietary and health employees.

BCJJC	135 Pin (71%)	54 Contractual (29%)	189 total
Cheltenham	115 PIN (72%)	43 Contractual (28%)	158 total
Noyes	47 PIN (78%)	13 Contractual (22%)	60 total
Hickey	128 PIN (87%)	19 Contractual (13%)	147 total
Carter	20 PIN (90%)	2 Contractual (10%)	22 total
LESCC	34 PIN (92%)	3 Contractual (8%)	37 total
Waxter	51 PIN (93%)	4 Contractual (7%)	55 total
WMCC	39 PIN (93%)	4 Contractual (7%)	43 total

Green Ridge	30 PIN (94%)	2 Contractual (6%)	32 total
WDSH	16 PIN (95%)	1 Contractual (5%)	17 total
Youth Ctr.	98 PIN (96%)	4 Contractual (4%)	102 total
<i>Savage Mt.</i>			
<i>Meadow Mt.</i>			
<i>Backbone Mt.</i>			
Victor Cullen	89.5 PIN (99%)	1 Contractual (1%)	90.5 total
MYRC	29 PIN (100%)	0 Contractual (0%)	29 total

3. Length of time to fill vacant positions

It takes many months to fill vacant positions – a major contributing factor to staffing shortages and the excessive use of overtime. After advertising, interviewing, and offering an applicant a position it has usually taken the Department several months to offer the new hire a start date. On occasion it has taken up to a year or even longer to fill vacated positions.

For example, at Savage Mountain Youth Center where there are three Case Managers, one left in November, 2006, but permission to fill the vacancy was not given until February of 2007. The new Case Manager was hired and was on site on April 25th.

However, the staff could only observe because his background check was not completed until October of 2007. After the background check was completed, the staff member began Entry Level Training (5.5 weeks). At the time of writing this report, no fully certified staff has been in the position for over a year.

In the Spring of 2007 the other two Case Managers left, and only one of those positions has been filled. The other Case Manager position remains open.

Some hiring initiatives implemented this year to reduce the time it takes to fill positions include conducting drug screening, fingerprinting and mental health interviews at the time of the applicant interview. Reference checks and background checks are completed later. This appears to have taken several days off the application/screening process.

The Department has not yet conducted a full evaluation of the new hiring practices and how much they may have reduced the lag time for filling positions. An ad-hoc, manual analysis of hiring records for Hickey, Victor Cullen and BCJJC for June – November, 2007 determined that time to hire had been reduced for those facilities on average to 1.4 months

Recommendations

1. Staff Vacancies

- A. Salaries should be increased to be competitive.
 - 1. Entry level staff with a bachelor's degree should start at no less than \$34,000, and regionally salaries should be adjusted upwards to \$40,000.
 - 2. PIN positions should be increased to attract and retain staff.
 - 3. Staff who refer other candidates who become employees and who stay for a year should receive a bonus.
 - 4. Staff who maintain good attendance records and remain beyond a year, and for each year afterward should receive a bonus.
- B. School loan repayment programs should be considered.
- C. DJS should develop working relationships with Maryland and neighboring state colleges and universities to enhance recruiting.
- D. DJS should expand internship opportunities.
- E. DJS should attend job fairs not only in Maryland, but in neighboring states.
- F. DJS should develop a staff mentoring capability to attract new direct care staff and should follow up after employment.
- G. DJS should develop a cadre of personnel to fill anticipated vacancies. With an 11% vacancy rate and an annual 1/3 drop out rate an ongoing effort to maintain the cadre should ensure that candidates do not have to wait long to be called up for employment.
- H. DJS Human Resources must shorten the time it takes to approve hiring for a vacancy. Many vacancies can be anticipated, and permission to hire should be given in advance.

2. Staff Turnover

Many of the recommendations above will help reduce staff turnover.

3. Staff/Youth Ratios

As exemplified at Victor Cullen, a 1 to 4 staff ratio should be maintained.

4. Overtime

Overtime should be reduced by implementing the above recommendations to decrease staff shortages. In addition, overtime should be limited to 16 hours a week to reduce the incidence of fatigue and burnout.

5. Training

- A. ELT training should be scheduled more frequently and locally.
- B. More trainers are needed to offer both ELT and 40 hour annual refresher courses.

6. Staff Culture

- A. Shifts should overlap so that weekly training and teambuilding can occur at the facility level.
- B. Inappropriate behavior should not be tolerated and staff should be appropriately disciplined and terminated for serious misbehavior.

Safety and Security

The number of incidents in facilities including Youth on Youth Assaults, Physical Restraints, Group Disturbances, and Youth on Staff Assaults have either remained stable or risen during the year. Safety and security of youth, staff, and the public remain an issue of great concern. Among all facilities, DJS reported total incidents as follows:

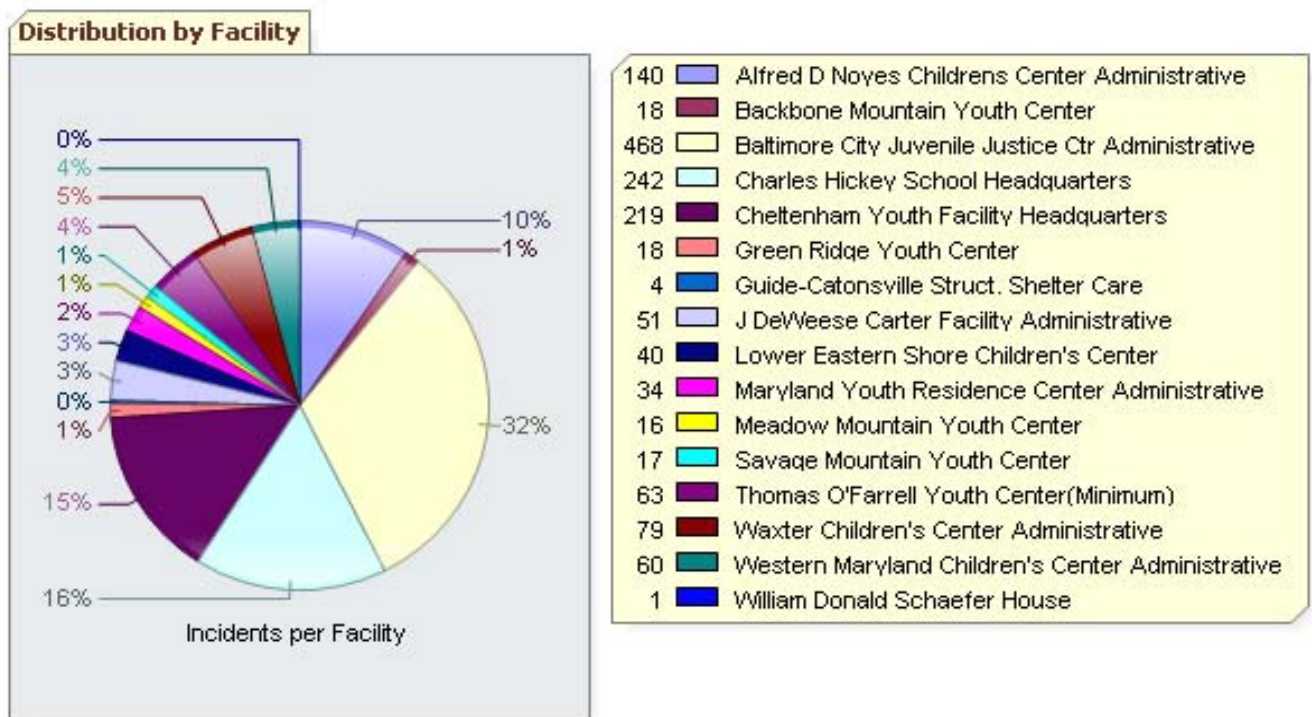
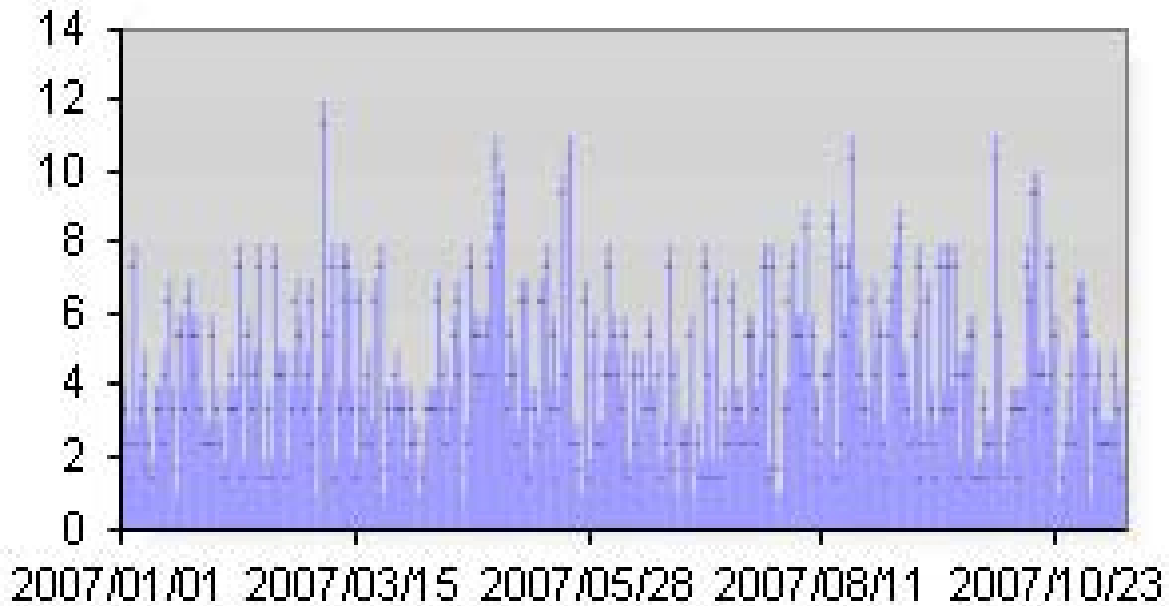
4 th Quarter, 2006	1,108
1 st Quarter, 2007	1,318
2 nd Quarter, 2007	1,157
3 rd Quarter, 2007	1,242

The following pages feature statistical breakdowns of various incidents throughout the year and by facility. Full interpretation of this data is beyond the purview of this report, but several conclusions can be drawn:

1. Over 70% of all youth on youth assaults occur at BCJJC, Hickey, Noyes, and Cheltenham, the system's four large detention centers. Measures to reduce aggressive incidents in these facilities such as implementation of effective behavior management programs, increased staffing, and reductions in population should be a high priority.
2. Over 85% of all group disturbances occur at these same four detention centers.
3. Youth at BCJJC and Hickey are physically restrained with much greater frequency than youth at other facilities. Waxter also shows an unusually high number of physical restraints, given its small population.

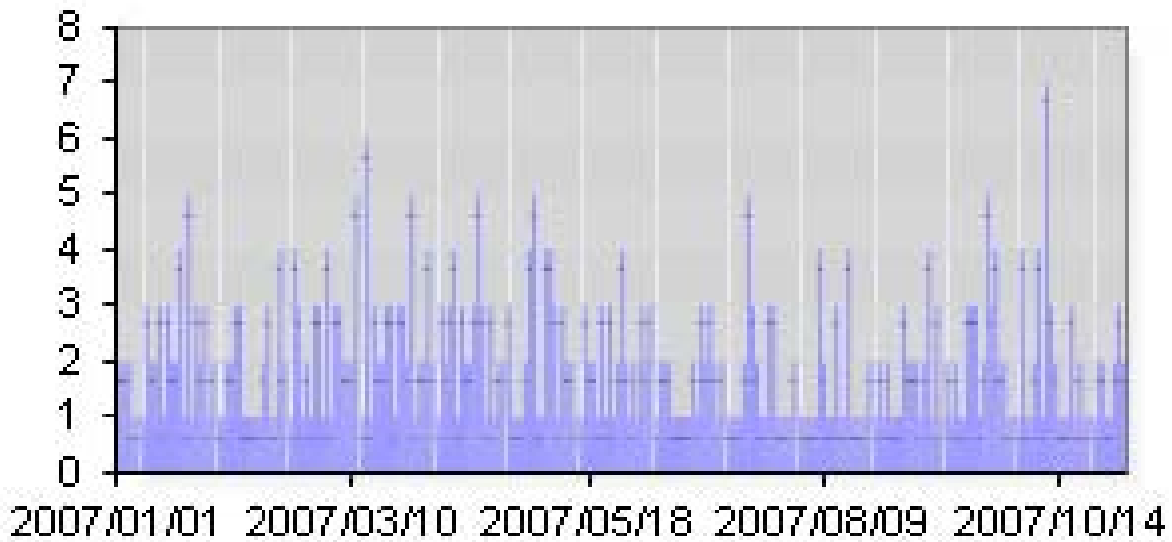
Violent and Aggressive Incidents January 1 - November 15, 2007¹⁷

Youth on Youth Assaults per Day

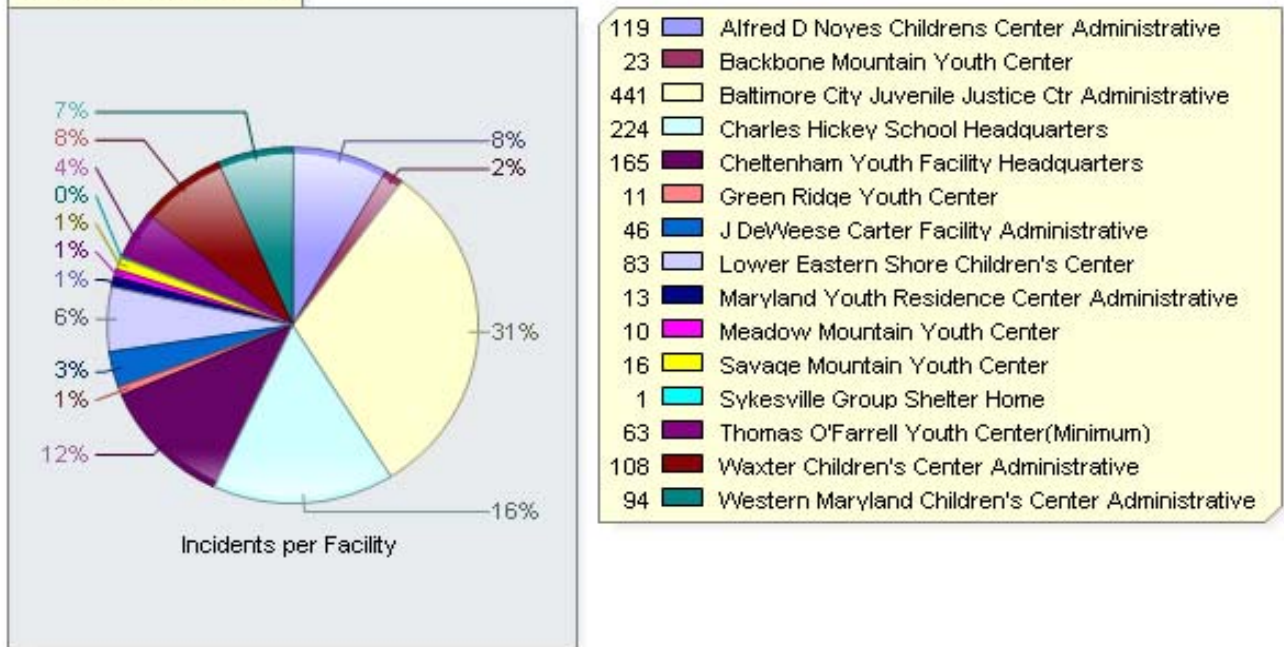


¹⁷ Source: DJS Incident Database; All Facilities Monitored by JJMU

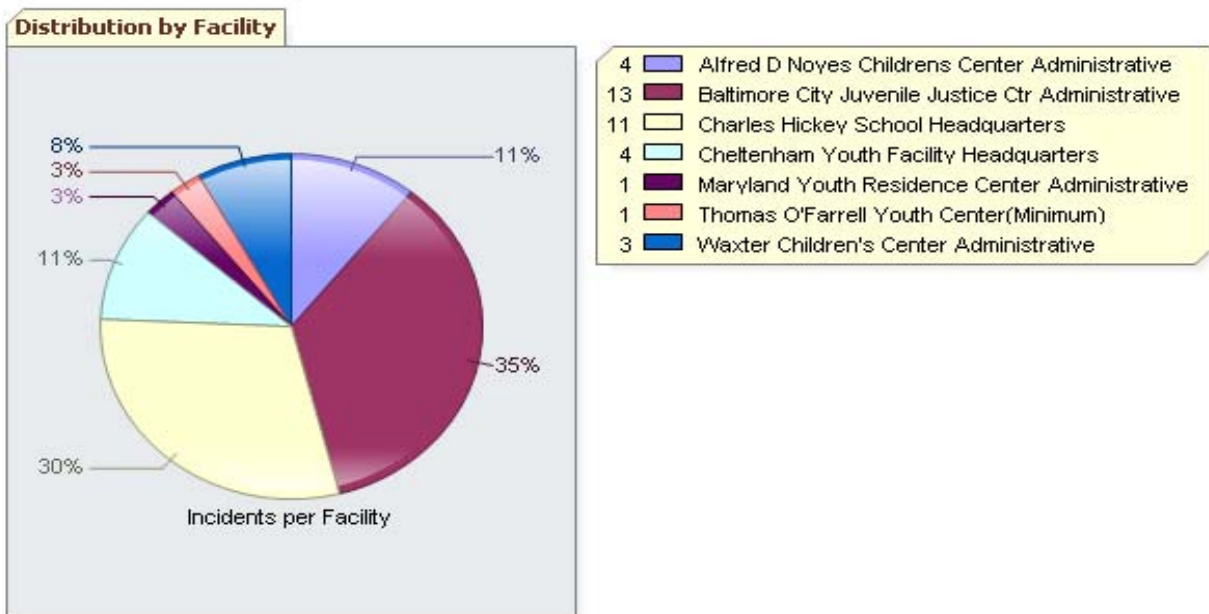
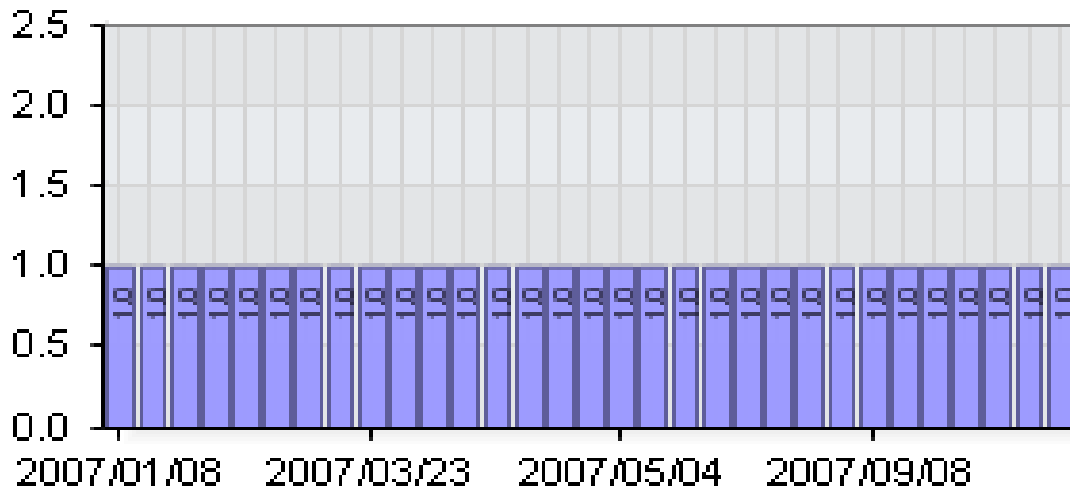
Physical Restraints per Day



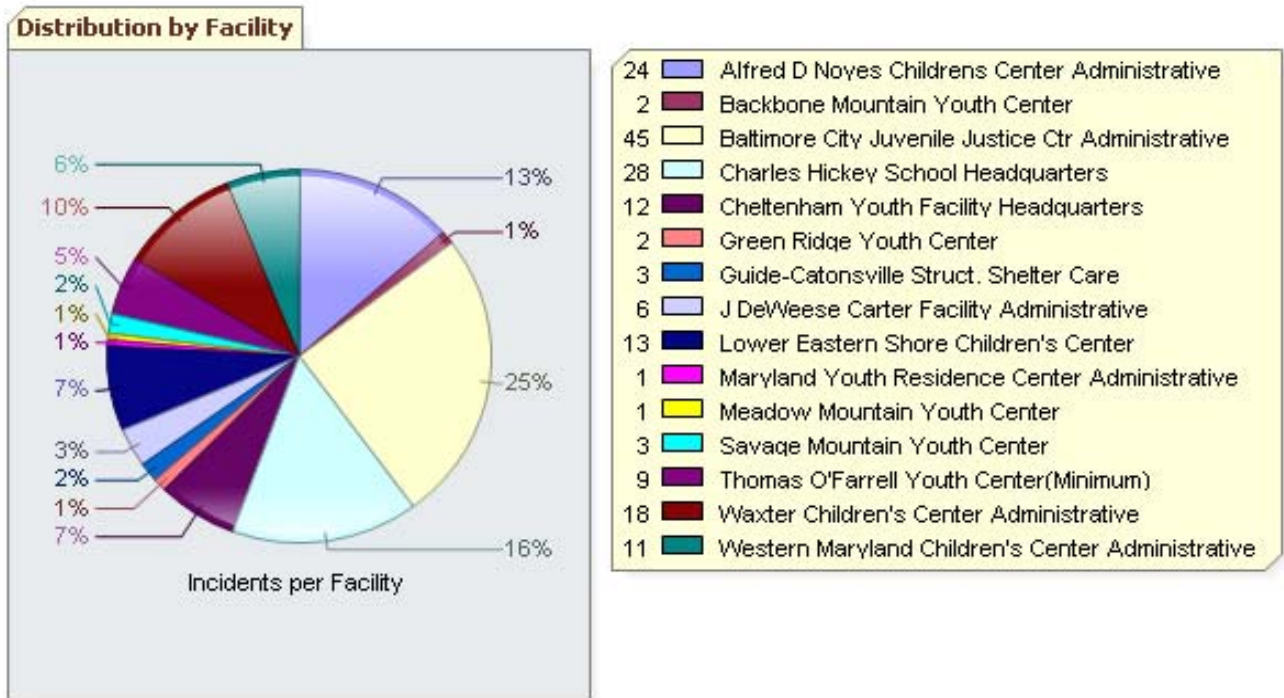
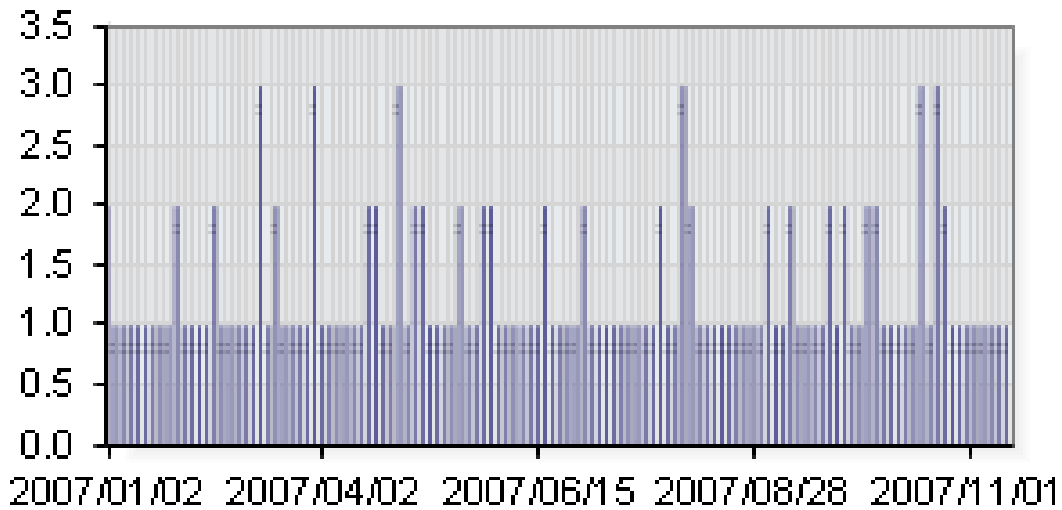
Distribution by Facility



Group Disturbances with Injury or Property Destruction per Day



Youth on Staff Physical Assaults per Day



The following summary of Quarterly and Special Reports submitted throughout the year highlights ongoing concerns for the life, health and safety of youth in our juvenile service system. One more Special Report concerning safety and a riot at the Baltimore City Juvenile Justice Center on November 15 is pending.

1. Group Disturbances

Numerous large group disturbances are not prevented or properly controlled, resulting in injuries to youth and staff.

Contributing factors include:

1. Different groups of youth being moved at the same time without proper supervision.
2. Staff failing to hold youth accountable for, and often contributing to, inappropriate horseplay or behavior.
3. When an incident occurs, staff may divert their attention to that incident and fail to work appropriately as a team to remain aware of potential threats from other youth who are not yet involved.
4. Staff persons inappropriately restraining or assaulting youth, creating feelings of unfairness and incentive for retaliation among youth.
5. Staff holding the entire group accountable for the inappropriate behavior of one or two youth.
6. Youth moving from table to table, with no apparent assigned seating.
7. Youth freely taking food from one another's plates, both with and without permission.
8. Intolerable noise levels.

Significant group disturbances this year included:

1. Waxter – A melee involving approximately 20 girls resulted in flooding of the unit, intervention by the State Police and the Fire Department, and mass lockdown of the girls, some for as long as 48 hours.
2. BCJJC - A group disturbance with at least 7 separate youth on youth assaults and restraints occurred at a basketball game between Cheltenham and BCJJC youth. The DJS Incident Report indicated 7 youth were treated for "injury or pain that required first aid treatment only;" however, a total of 5 youth were transported to the hospital for treatment of their injuries.
3. Hickey – A large group disturbance resulting in youth on youth assaults, restraints and injuries that was partially videotaped revealed a

staff striking a youth in the head with her hand and overall chaos as staff struggled to gain control.

4. Cheltenham - There was a large fight and group disturbance during a basketball game and thirty-two youth were placed in seclusion. One youth had an eye injury that was treated at the facility and another youth had an injury to his mouth and was transported to the hospital

2. Excessive Use of Force, Child Abuse, Staff Misconduct

Staff members frequently fail to follow proper Crisis Intervention Techniques. Police, Child Protective Services, and DJS Investigators must be thoroughly trained and familiar with Department-sanctioned intervention procedures to ensure competent investigation of Use of Force cases and appropriate staff accountability.

Although some staff members are quite skilled at interacting with youth in heated situations, many consistently resort to force against youth. Monitors observe that staff members disciplined for excessive use of force or misconduct involving youth are often transferred to another facility where they continue to cause problems.

Some of the contributing factors are:

1. Staff shortages and excessive overtime which overtax staff, and render them less able to successfully de-escalate situations. At several facilities staff report that they regularly are held over to work a double shift because of staff shortages.
2. Insufficient training in proper de-escalation methods and appropriate restraint techniques.
3. The culture inside some facilities which resembles an adult correctional model more than a youth rehabilitative model.

Examples of excessive use of force, physical abuse against youth, and staff misconduct during the year include:

1. Hickey – One staff was terminated and one disciplined after handcuffing youth and elbowing him in the mouth during a verbal altercation.
2. Hickey – Sustained finding against staff for Unnecessary Use of Force after youth was “choked” and “punched” by staff, leaving “welts on his neck and marks on his chin and face.”

3. Hickey – Staff member was captured on video striking a youth in the head with her fist during a group disturbance. DJS sustained a violation of policy for Unnecessary Use of Force; however, the Baltimore County State’s Attorney declined to charge.
4. BCJJC – Staff caused injuries to youth’s face while using unnecessary force to stop an altercation. Child Protective Services “indicated” that abuse had occurred and DJS sustained findings against the staff for unnecessary use of force.
5. Cheltenham – There were a total of 220 incidents reported in the 3rd Quarter, including 70 youth on youth assaults, 6 youth on staff assaults and 3 allegations of child abuse by staff. Two of the allegations of child abuse by staff were sustained.
6. Carter – A staff member was charged with child abuse, 2nd degree assault, and reckless endangerment after throwing a youth to the ground and using a “chokehold,” a prohibited restraint technique, on him.
7. O’Farrell – While on the grounds, one staff person committed an assault against another staff person using some type of weapon. The suspect staff had been involved in previous aggressive incidents involving youth and staff and was terminated.

Regardless of whether allegations of child abuse or excessive force are sustained after investigation, the high number of reported cases raise questions about the extent to which staff resort to physical intervention with youth rather than using approved Crisis Intervention Techniques that seek to deescalate situations without physical intervention.

3. Seclusions

Seclusion continues to be overused as a behavior control mechanism, as punishment, and as a solution to staff shortages. At BCJJC, seclusions increased dramatically during the 3rd Quarter, from 59 incidents in April to 206 in September. Many of the seclusions were a result of staff shortages. Over the Labor Day weekend, a mass lockdown at Hickey was ordered due to staff shortages following a fight.

Due to staff shortages, mass seclusions were regularly used at Carter as described in the 3rd Quarter Report:

“At Carter youth were locked in their rooms for the night at 6:30 pm, often being required to eat their meals there, because of staff shortages. Extensive damage was done to the rooms during these lockdowns, including

youth taking apart metal beds to bang on the doors and walls, broken light fixtures and windows, and tiles ripped from floors.

Unit logs noted: '[Youth] urinated on the floor, it is running out from under the door;' and 'To Staff: do not give youth milk cartons and cups for urine unless you have time to remove them.' One youth had four cups of urine under his bed when he was finally released from his room."

The 3rd Quarter report described seclusion used as punishment at Cheltenham. "A review of the seclusion log indicates that seclusion in locked cells is used as punishment. Youth are placed in the cells at the same time, released at the same time, and reasons for seclusion are consistently noted as 'danger to others' with no further explanation for why the child is secluded for a particular period of time. Youth know when they go into seclusion how long they will be held there, whether they have regained control of their behavior or not."

In a sampling of seclusions at Noyes during one month, of 32 seclusions, 6 were imposed as punishment because of contraband, typically cigarettes. Youth are also sometimes placed in seclusion for refusal to attend school.

When a youth must be placed in seclusion, policy requires that he be released as soon as he has regained control and no longer poses a danger to himself or others. Reviews of door sheets documenting required 10 minute checks of youth in seclusion shows many entries such as "sitting quietly on bed", "reading", or "lying on bed", entered by both direct care staff and medical staff, indicating that the youth has regained control and should have been released.

4. Suicide Attempts

On September 4, a Hickey youth who had been on Suicide Level III Watch on August 24 slashed his arms repeatedly with pieces of glass and the blade from a pencil sharpener. Fortunately staff discovered him during a routine room check, sitting in the middle of his room with blood on his walls and door.

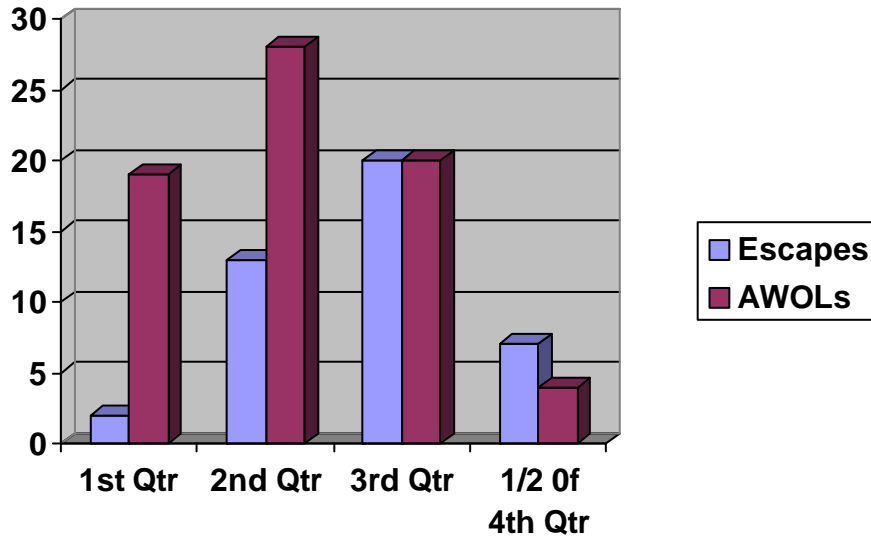
5. Escapes

By law, youth who leave staff or hardware-secure facilities without permission are "escapes." Facilities from which youth can "escape" include Noyes, BCJJC, Cheltenham, Hickey, Carter, LESCC Waxter, Victor Cullen, WMCC, and the Youth Centers. Youth who leave non-staff-secure facilities are considered "AWOL's."

DJS statistics in this area are ambiguous and confusing. The Incident Database mixes the reporting and labeling of these incidents, labeling many "escapes" as "AWOL's." For example, in 2007, seven escapes from Cheltenham, Carter and BCJJC were reported as "AWOL's." Some youth who left Thomas

O'Farrell this year were reported as "escapes" while others were reported as "AWOL's."

The following statistics consider escapes as those from hardware and staff-secure facilities, and AWOL's from shelters and non-secure programs.



There were 9 escapes from hardware secure facilities and 33 escapes from staff secure facilities (25 of those escapes were from a private program). In 2007 (through November 15), a total of 113 youth escaped or AWOLed from the facilities monitored by JJMU.

Escapes during 2007 included:

1. Hickey - Two youth walked off the campus from the West Campus Gym although 7 staff were reportedly supervising 15 youth during that time. One of the escapees had severe behavior problems, was on suicide watch and should have been monitored one-on-one by staff. Also, the youth had attempted to escape one week prior to this incident, attempted to force staff to hand over the keys to a transport van on another occasion, and assaulted staff with a shovel on three different occasions. The other youth had 6 previous escapes from placements. A DJS Investigative Report stated, 'Both students are high AWOL risks and should not have been allowed to leave from behind the [alarmed] fence.' The report also found that 'the side gate to the gym was left unlocked.'
2. Thomas O' Farrell Youth Center - Two youth stole a facility van and left the area in the early morning. The van was recovered in Ocean City, Maryland. The two youth had criminal records involving Possession of a Deadly Weapon, Arson, and Burglary. Subsequent

interviews confirmed that some night-shift staff brought in pillows and slept.

3. Hickey - Ten youth escaped after a youth stole wire cutters from a teacher and secreted them in his room. At bedtime youth overpowered staff, opened doors from the control center, and used staff keys to let themselves out of the dorm. Then they cut a hole in the fence with the wire cutters and escaped.
4. Noyes - Ten youth exited from the dorm in a scenario similar to the escape at Hickey - at bedtime youth overpowered staff, took the keys, opened the exterior doors of the facility, and one youth exited into the courtyard.
5. Hickey - Two youth escaped from a van, exiting through unsecured rear doors while staff were either asleep or otherwise inattentive. The youth reportedly stole a vehicle in the community that was later recovered after being involved in a hit and run accident. According to investigative reports, one youth was involved in a vehicle chase during which a police officer was assaulted resulting in police firing shots in an attempt to apprehend the youth.
6. Youth Centers - Nine youth escaped in the 2nd Quarter, 2007, placing the community at risk. Youth have stolen vehicles, and in one case a youth entered a house at night while the owners were in bed, found keys, and unsuccessfully tried to take two different vehicles causing damage to both. He later found another truck and drove it to Baltimore.

Major contributing factors in escapes include:

1. [Lack of video surveillance equipment.](#)

This played a role in escapes at Noyes and Hickey, including the escape of 10 youth from Hickey in May. Had video cameras been in place, security would have seen the youth before they were able to cut through the fence and leave the grounds.

2. [Staff inattention](#)

This has played a role in escapes from Hickey, Noyes, Thomas O'Farrell and the Youth Centers in Western Maryland. Some episodes of staff inattention (sleeping while incidents were occurring) may be attributable to staff shortages and the large number of overtime hours worked by many staff.

3. [Contraband, Tool and Key Control](#)

Stolen scissors, wire cutters and keys played major roles in several escapes at Hickey and Thomas O'Farrell. Keys are often misplaced or not properly signed out by staff.

4. Community Wide Notification System

There was a breakdown in the community notification system at Hickey on May 6 and despite warnings from this Office and assurances from DJS that the system had been repaired, the system failed again during an escape on July 31. Community lack of awareness of the escape resulted in break-ins and stolen vehicles that were used to effect escapes.

5. Distress Alarms

Distress alarms for staff should be made available and DJS should ensure staff use them properly. Some facilities are not equipped with the alarms (Hickey, Cheltenham) while others have the alarms but staff have been observed not wearing them because they are "uncomfortable." Given the high number of escapes from Hickey this year, staff at Hickey should be provided with distress alarms immediately.

6. Fences and Locks

Fences and locks must be thoroughly inspected and maintained on a daily basis. Escapes and other disturbances at Hickey, Noyes and Waxter were the result of fences and/or locks that had not been properly secured and/or maintained. Electronic controls for door locks are either inoperable or vulnerable to abuse and operation by youth on the unit.

DJS blamed a lack of perimeter security by its own employees for escapes at Hickey in 2006 and hired a private security company to prevent future escapes from occurring. In September of this year, that same company was fired and blamed partially for escapes that occurred in 2007. DJS reassumed control of security at Hickey in September.

7. Failure to make corrective actions after escapes

DJS generally provides a corrective action plan following an escape, but the plans have a poor track record of preventing future escapes, either because they are not implemented or do not address the root cause of the security breach.

Escapes from facilities, especially detention facilities, often result in extensive searches by law enforcement and dangerous attempts to apprehend youth. An escape from Hickey resulted in a police officer firing his weapon to protect himself from being assaulted by a youth operating a motor vehicle. Youth have often been bitten by police dogs and/or injured during apprehension.

6. Contraband

Failure to control tools, keys and illegal contraband has resulted in several escapes, suicide attempts and make-shift weapons. A youth who was in seclusion at BCJJC set the sheets of his room on fire. The investigative report did not indicate how the youth was able to acquire matches or a lighter or take them to his room to set the fire. The mass escape from Hickey in May was accomplished by a youth stealing a tool from the Vocational Education building and secreting it in his room.

7. Reporting and Investigating Incidents

Numerous errors and omissions in incident reporting continue to occur, meaning that incidents are under-reported and raising questions about the validity of DJS self-reporting on incidents in facilities.

1. Incidents are frequently mislabeled – incidents that are actually assaults are labeled as “other.” An incident in which a staff member sprayed youth with a fire extinguisher was labeled “other.”
2. Paper records and the Incident Database often differ. For example, during the 3rd Quarter at Hickey paper records indicated there were 88 restraints, but no incidents labeled as physical restraints appeared in the Incident Database.
3. From the 3rd Quarter Report: “According to the DJS Incident Report Database, there were only 2 reports of Alleged Child Abuse/Neglect in the first quarter, 4 reports in the second quarter and 0 reports in this quarter. The Department of Social Services, however, notified this Monitor about 10 such allegations in the first quarter, 14 last quarter and 7 this quarter. DJS’ failure to self-report 24 allegations of child abuse or neglect raises additional questions about the accuracy of data it collects and reports.”
4. There are still some concerns about nurses and/or staff failing to report suspected abuse or neglect directly to DSS. Some of the nurses at the facilities feel they must notify their supervisor or the facility administrator and let them contact DSS for suspected abuse and neglect cases. This is contrary to both law and policy.

8. Additional Safety and Security Issues

Several years ago, the Department of Juvenile Services’ Office of Investigations committed to coordinating development of Memorandums for Understanding (MOU) for Child Abuse Investigations in every county. MOUs have not been implemented in any other Maryland counties except for Baltimore County and Anne Arundel County.

These agreements are essential to establish the cooperation and coordination necessary to protect the safety, security and rights of youth in the custody of the Department of Juvenile Services. Many of these youth are victims of abuse and neglect and we must assure they are not re-victimized by our institutions.

The Department of Juvenile Services' Office of Investigations also committed to completing Crisis Intervention Training for Maryland State Police and Child Protective Services investigators but there has been no training in this area. It is crucial for investigators of institutional abuse and neglect to review, experience and understand the Department of Juvenile Services Crisis Intervention Techniques. Investigators must be able to determine if restraints and crisis intervention techniques are being applied according to the training provided to each employee and they must be prepared to hold staff accountable for not following those prescribed techniques.

Medical and Mental Health

1. Medical Staff

In the 2007 legislative session, the General Assembly provided nearly 22 PINS for nurses (full-time permanent positions) to relieve the severe shortage of nursing staff in DJS facilities. In calendar year 2007, one facility hired a Nurse Practitioner, and 15 nurses were hired. DJS' October 1 StateStat report indicated that 13 nursing and Nurse Practitioner positions still remain open. System-wide, there has been significant improvement in this area although some facilities continue to be short of medical staff.

As with most DJS issues, staff at some facilities provide excellent medical care for youth, and at other facilities services are spotty at best. Among others, Cheltenham and Waxter staff provide good coverage and services in a difficult environment.

DJS' Medical Director responds quickly to problems, including stepping in to provide physicals and other health services in crisis situations.

2. Medical Services

Several facilities still have no night or weekend on-site nursing services, and the only option for youth who are sick is calling in a nurse or taking the youth to an emergency room. The DJS Medical Director consults with staff by phone regarding difficult medical cases, but the lack of full medical staff coverage complicates this task,

During the summer months, Carter had no medical staff at all for a six-week period. During the month of July, youth were admitted without full physicals or screening for communicable diseases such as tuberculosis or for chronic conditions such as asthma. From July – September, the Waxter Nursing Supervisor filled in at Carter. As of this writing one Nursing Supervisor is on duty during weekdays, and a par-time (25%) nurse covers every other weekend. A third nurse is scheduled to begin to cover evenings starting January 16.

Recently, a youth went through serious drug withdrawal at Carter. According to medical staff at the facility, the youth should have been in the hospital, but he had been discharged from the hospital earlier that day after two overdoses and several days of hospitalization. After his release from the hospital, the youth's father appeared in court and the Judge ordered the youth brought to Carter that evening.

A detention center is clearly not an appropriate setting for a youth to move through drug withdrawal. Given the numerous "bad" options facing the medical staff, including the fact that the hospital would have likely turned him away, the youth's

symptoms were managed appropriately by Carter medical staff with frequent consultation by the DJS Medical Director.

This case highlights, however, the not-infrequent “dumping” of youth on inappropriate DJS detention facilities by court and law enforcement personnel. Youth undergoing drug withdrawal should never be sent to a detention facility, even one with 24-hour nursing services. Detention facilities are not designed to manage drug withdrawal, nor is that their purpose. Youth about to give birth (see below) should never be sent to an all-purpose detention facility without specialized prenatal services. Nevertheless, in difficult cases, DJS facilities appear to be the placement choice of last resort.

It is incumbent upon the Department, the judiciary, law enforcement, and other relevant agencies to develop appropriate alternatives for these youth. Facility staff should also be given authority to turn away youth who do not meet admission criteria.

3. Mental Health Services

Detention Centers and Shelters provide very limited mental health services. Therapeutic groups meet once per week, but most youth do not receive individual therapy, a critical need for youth in detention or shelter care who have been removed from their homes and experience anxiety about court proceedings and their futures.

Committed placement programs provide individual therapy and therapeutic groups run by qualified staff, particularly in the area of drug treatment, but besides limited medication management by psychiatrists, detention facilities and shelters offer little in the way of therapeutic services or treatment.

Youth entering detention are assessed for mental health treatment needs, but our observation is that only those with acute needs receive treatment. DJS standards require that youth identified as substance abusers receive one-on-one drug counseling and group counseling not less than once per week.

The FY 2008 Strategic Plan says that DJS will train all remaining behavioral health staff, facility-based staff and community supervision staff on the use of the CASII (Child and Adolescent Service Intensity Instrument) that helps to determine level of care each youth requires and to develop treatment plans and appropriate placement.

“Implementation of the CASII is the initial phase of an over-arching service plan assessment system. In the coming year, the department will develop a guiding document to list all assessments and identify gaps and what resources are needed.” The Strategic Plan also says the Department will issue an RFP with multiple vendors who will begin providing assessments which will result in regular reports and data tracking which will be reported monthly. (Strategic Plan, p. 27)

After issuance of the Strategic Plan, the Department made a decision not to implement the CASII system-wide and is now exploring other assessment tools. It plans to select a new assessment tool in early 2008.

4. Medical Space

Most facilities lack space to provide private examination and treatment of youth. (See 2nd Quarter Report on Critical Facility Needs, www.oag.state.md.us/jjmu) In a number of detention centers and some committed care programs, medical suite space consists of a small room which does double duty as an examination room, medical file room, and office for nursing staff. There is little private space for examining youth.

Medical suite space is particularly inadequate at Carter, O'Farrell, Waxter, Noyes, and Cheltenham. At Cheltenham, the infirmary is used for general administrative segregation.

5. Reports of Suspected Child Abuse

Nurses in some facilities continue to fail to report suspected child abuse and neglect as required by law. All DJS staff are mandated reporters (individually required to report suspected or alleged child abuse) – yet when youth are injured during restraints, altercations with staff, etc. Child Protective Services is not always contacted as required. In some cases, staff has not contacted Child Protective Services about a possible abuse until checking with the Facility Superintendent, a clear violation of law.

In one case at the Carter Center this fall, a staff member allegedly abused a youth, punching him in the eye and taking him to the floor in a “chokehold,” a prohibited restraint technique. Although staff witnessed the event, no one reported the case to Child Protective Services, and the child was not examined by the nurse until mid-day the following day. Although the nurse’s examination documented injuries consistent with abuse, still no one called Child Protective Services until late the following day when the acting Facility Director decided to call.

The staff member involved was later arrested and charged with Child Abuse, 2nd Degree Assault, and Reckless Endangerment. JJMU wrote the Department on November 15 expressing concern about Carter Center staff’s multiple failures to report suspected abuse as well as Incident Reports filed by Carter staff that were completely inconsistent with later statements they gave to police. No response has been received to date.

Staff at the Carter Center, in particular, should be retrained on their mandated reporting duties and Facility Superintendents system-wide should remind all staff of their responsibility to report alleged child abuse without checking with superiors.

6. Pregnant Girls

We continue to be concerned about pregnant girls detained at secure facilities. Some individual employees do an admirable job of caring for these girls and staff at Waxter provide prenatal education and counseling for girls detained there. All staff at facilities detaining girls have received gender-specific training.

Yet no system-wide program or regulations to deal with pregnant girls have been developed, and some staff express concern about these girls' condition while in detention.

In September, we wrote to the Secretary after a girl at Noyes was taken to the hospital to give birth, returned to the facility, and became depressed. The youth did not have access to her baby during this period because her mother declined to bring the baby to the facility, fearing it might contract an infectious disease. At that time, we questioned whether judges should be sending pregnant girls to secure detention facilities at all – violence and hygienic conditions at these facilities are inappropriate for pregnant girls.

If the Department has no choice but to accept pregnant girls in detention, we asked that a specific facility (and area of that facility) be designated where all pregnant girls statewide would be detained. In addition, we asked that staff dealing with these girls receive not only gender specific training but training in issues surrounding pregnancy, childbirth, and preparation for parenting. We asked that facilities also make special provision for pregnant girls and new mothers to maintain close contact with supportive individuals, family and otherwise, who would be important during their pregnancies and after.

We have not received a response to our request but are aware that staff at the 3 detention facilities that house girls (Waxter, Noyes, and LESCC) have completed gender-specific training.

7. Other Issues

Oversight of contractors should be enhanced. In the 3rd Quarter, we discovered that several private providers were engaging in questionable medical treatment practices. One required girls who said they were sick to sign a "Sick Contract" in which they agreed to stay in their rooms for the entire day (except to eat or do chores) and agreed to stay on a liquid diet for 24 hours, regardless of the type of illness.

Our report to the DJS Medical Director resulted in a prompt order to discontinue use of the Contract. Nevertheless, in a visit a month later, we discovered the facility was still using the Contract. Questionable approaches to dealing with sick youth appear to be more of a problem in privately-run shelters than DJS-run facilities.

Education

The Maryland State Department of Education is responsible for the schools at BCJJC, Carter, Hickey, LESCC, and Victor Cullen. GUIDE, Thomas O'Farrell, and Sykesville hold classes within the facility and teachers are programs are supervised by the contractor running the facility

The Department of Juvenile Services is responsible for the school programs at Cheltenham, Noyes, Waxter, WMCC, WDSH, and the Youth Centers. Youth at Allegany and Mount Clare attend public schools.

1. School Records

Like other State agencies with child custodial responsibilities, the Department has difficulty obtaining school records from youths' home schools. In some cases, DJS staff does not request the records in a timely fashion; in others, the home school fails to respond to a timely request.

For example, during the 3rd Quarter, a random review of records at BCJJC revealed:

- Youth A - Admitted 8/26/2007. Records first requested on 9/13 – 2 ½ weeks later. As of 9/20, no response from home school.
- Youth B - Admitted 8/4/2007. Records first requested on 9/14 – nearly 6 weeks later. As of 9/20, no response from home school.
- Youth C - Admitted 8/16/2007. Records first requested on 8/23, second request on 8/28, no reply as of 9/20 – more than one month after admission.
- Youth D - Admitted 8/15/2007. First request to Baltimore on 8/28, no reply as of 9/20 – more than one month after admission.

Many student academic records are incomplete, lacking clinical forms and other documentation necessary to provide accurate assessment and appropriate educational placement of the youth.

Without home school records, DJS staff do not know whether the child has special needs and an Individualized Education Plan (IEP) entitling him/her to additional services and do not have sufficient history to place the child in classes appropriate for his/her level.

This problem seems particularly acute at Waxter, Carter, and BCJJC. The General Assembly provided funding for 3 new DJS positions this year to improve

educational records transfer, but the Department continues to experience stubborn challenges on this issue.

2. Quality of Classroom Experience

During visits, our Monitors observe many devoted and caring classroom teachers who do their best to meet each individual child's needs in a very challenging environment.

Particularly in smaller facilities, teachers struggle to teach to a variety of levels within one classroom and most do not appear to know or employ effective strategies for teaching to youth at different educational levels. Varying youth ability levels are particularly difficult for teachers at GUIDE, Sykesville, and Carter.

Some teachers are unprepared for class and do not develop formal lesson plans. It is not uncommon for Monitors to walk into classrooms in which all youth are working on the same assignments regardless of academic level or in which no organized learning appears to be taking place at all. Youth may be flipping through books or watching movies – in one case, they were coloring.

Again, many teachers engage their students with creative learning approaches, but because the system has such difficulty recruiting teachers, others are allowed to serve as “place holders,” even though youth in their classrooms are completely disengaged.

System-wide, teachers lack audio-visual and tactile learning strategies for youth who may be better engaged by alternative learning approaches.

3. Vocational, GED, and College Courses

Vocational educational instruction is sorely lacking at DJS facilities. The exception is Cheltenham which has developed an inventive and vigorous program based primarily on the staff's enthusiasm for mentoring youth. Cheltenham's Voc Ed program includes construction and graphics design and should be a model to other facilities.

Many of the committed care programs, where youth live for 6-12 months offer virtually no vocational training beyond allowing youth to work in the kitchen or with maintenance staff. To date few vocational educational opportunities are provided for youth at Victor Cullen or Thomas O'Farrell, and programs at the Youth Centers should be expanded. Development of Vocational Education programs should be a high priority for the Department.

Fortunately, most facilities have successful GED programs, and many youth complete their GED's while in committed care facilities. Once a youth completes his/her GED, however, few educational options are available. Most work

independently, help other students in the classroom, or complete unchallenging assignments with the rest of the classroom. Career planning and life skills programs for older youth are rare.

The Youth Centers have developed a program with Garret County Community College program that allows youth to earn college credit while housed at the Centers, and the Victor Cullen Academy is developing a similar program. One youth at Waxter is enrolled in an online community college program, and one youth began a program at Thomas O'Farrell this year but was released soon thereafter.

4. Teacher and Staff Shortages

In recent months, JJMU has reported that youth at BCJJC sometimes do not attend school at all because there are not enough staff at the facility to escort them to the classrooms. Youth spend the day in their housing pods instead of school with teachers traveling to the housing pods to provide instruction – a less-than-optimal situation since teachers and students lack access to learning materials, desks, equipment, and other classroom resources.

Most facilities are short of Teaching Assistants and Special Education Teachers. A DJS direct care staff member must be present along with the teacher in each classroom, but often direct care staff are sitting or standing near the door and not engaged in the classroom experience. While these staff may not qualify to formally serve as Teaching Assistants, they should be trained to assist teachers and be required to participate in the classroom experience. Some staff already voluntarily assist teachers, significantly improving the teacher's ability to diversify teaching approaches.

5. Disruptive Youth

When youth are disruptive, they are usually sent back to their pods for “time out.” Sometimes the disruptions result in seclusion. A Behavior Alternative Classroom should be designated at each facility for disruptive youth – to ensure that they continue with their school work and to ensure that other youth are provided a classroom environment free from these interruptions.

Recommendations

1. School records should be requested in the timeframe mandated by State guidelines.
2. The Department should meet with local school systems, particularly in Baltimore City and Baltimore County to improve transfer of school records.
3. Teaching Assistant positions should be filled immediately.

4. Staff should consistently review each youth's file to ensure that it contains required forms and complete documentation.
5. Teachers should develop structured weekly lesson plans according to MSDE standards that are challenging and motivating for mainstream and special needs youth.
6. Teachers should utilize a variety of learning tools and resources that will accommodate each youth's individualized needs.
7. Volunteers and interns should be recruited from local colleges to assist in the classroom.
8. Youth who have obtained their GED should be provided with a continuing education program that includes college level education, career exploration, and vocational education.
9. A Behavior Alternative Classroom should be implemented so that youth who are disruptive in the classroom are not placed in seclusion or time out.
10. Direct care staff should be trained and required to assist teachers in the classroom.
11. Development of strong vocational education programs should be one of the Department's highest priorities.

Programming

1. Behavior Management Programs

Some facilities such as WMCC have implemented strong behavior management systems that are easy for youth to understand, focus on positive incentives, and are uniformly applied.

Still others are in the process of implementing systems and youth complain that “points” are taken from them at staff’s discretion or that they don’t understand the system. Few facilities use a rubric to record points. When youth do not understand the system or believe it is unfairly applied, they become discouraged and fail to actively participate – in some cases, misbehavior increases.

All Behavior Management Programs would benefit by focusing more on positive incentives and creating more meaningful opportunities for youth who excel in the BMP. Several facilities use food and snacks as incentives which have been shown to encourage theft and other problematic behaviors.

Positive and meaningful incentives include additional phone calls home, extended family visits, ability to participate in special groups such as construction projects, drumming classes, and off-campus trips.

2. Enrichment, Cultural, Life Skills, and Recreational Activities.

Again, some facilities, notably BCJJC and Cheltenham have significantly increased enrichment and recreation activities – including basketball games against external adult teams (Police, Coast Guard, etc.) and vocational educational classes.

More detention facilities have filled Recreational Specialist positions this year which relieves line staff of the responsibility of developing engaging activities for youth. But in several facilities, youth still spend too much time in unstructured activities - playing cards or video games, watching TV, or just sitting.

DJS Standards require that youth desiring to participate in religious services be allowed the space and time to do so, including being taken to a place of worship in the community if doing so presents no security risk. Most facilities still need to develop this capacity in a way that respects diversity of religious belief and cultural background.

3. Recreation Space

Lack of indoor and outdoor space for required large muscle exercise and recreation continues to be a problem at numerous facilities. Carter has no gym – all youth go to school, eat, and recreate in one room. There is an outdoor basketball

court with no cover which cannot be used in inclement weather. Waxter only has a “cafenasium” – a gym-type room where tables are set up for eating.

Several gyms need major repairs – Hickey (east gym) and Cheltenham (a beautiful historic facility), particularly need repairs to their gyms.

The Sykesville and GUIDE facilities have no outdoor recreation space save a basketball area that doubles as parking space. The Department should enhance outdoor recreational areas at these sites. Little outdoor recreation besides basketball is available at these facilities and staff must transport youth to local gyms to engage in sports or active recreation.

4. Team Building and Peer Conflict Resolution Programming

Historically, the Department has reacted to conflict and to gang activity by segregating youth who become involved in incidents. There is movement toward using these incidents as the opportunity to incorporate conflict resolution training and team building programming.

We hope the Department continues to expand these programs and takes advantage of the cadre of skilled conflict resolution professionals in the State.

5. Assessments to Guide Individual Treatment Plan Development

The FY 2008 Strategic Plan says DJS will train all remaining behavioral health staff, facility-based staff and community supervision staff on the use of the CASII (Child and Adolescent Service Intensity Instrument that helps to determine level of care each youth requires and to development treatment plans and appropriate placement.

“Implementation of the CASII is the initial phase of an over-arching service plan assessment system. In the coming year, the department will develop a guiding document to list all assessments and identify gaps and what resources are needed.” The Strategic Plan also says the Department will issue an RFP with multiple vendors who will begin providing assessments which will result in regular reports and data tracking which will be reported monthly. (Strategic Plan, p. 27)

After issuance of the Strategic Plan, the Department made a decision not to implement the CASII system-wide and is now exploring other assessment tools. It plans to select a new assessment tool in early 2008.

Recommendations

1. The Department should form contractual partnerships with community enrichment recreational programs and human resource agencies (e.g., YMCA and Boys and Girls Club).

2. The Department should renovate and expand the parking/recreation areas at the Sykesville and GUIDE shelters.
3. Staff should demonstrate team building, leadership, and sportsmanship by actively participating in events and activities.
4. Innovative cultural, life skills, and enrichment programming must be implemented system-wide.
5. Volunteers and college interns should be actively recruited from local colleges to assist with programming.
6. A clear Behavior Modification System should be implemented at all DJS facilities – the system should be easily understandable to youth, consistently applied, and based on positive incentives to the extent possible.
7. Opportunities to participate in religious programs that respect diversity of religious beliefs should be offered at all facilities.

Facility Maintenance

1. Large Detention Facilities

A. Hickey School and Cheltenham Youth Facility

Both Hickey and Cheltenham primarily rely on ancient buildings for housing, dining, recreation and programming. The ambience in these buildings is dark, and depressing. Innumerable layers of paint applied over many years no longer cover deteriorating surfaces, and grime that is impossible to remove can be seen collecting in every corner and crevice. Screens that cover the windows are so caked with dirt that it is impossible to see through them. These structures are difficult or impossible to clean and keep free of insects. And they are extremely expensive to maintain. What maintenance is done is rarely adequate despite the best intentions of youth, staff and maintenance personnel. These buildings have far outlived their usefulness for the treatment of troubled youth.

Further, housing units are of the old fashioned prison-type “telephone pole” design with heavy screens on windows, heavy steel doors that lock youth into the building and into individual rooms. There are no clear sightlines for the supervision of youth. If youth are locked in cells it is impossible to adequately supervise them. Even if staff stands at the door and observes through the glass, most of the glass has been scratched and marked so that vision is obstructed. This poor design makes it impossible to properly supervise youth. Poor design also contributes to over-use of seclusion and constant threat of escape. The threat of fire is a constant issue because youth spend so much of their time locked in individual rooms with inadequate locking systems.

Furnishings (beds, linens, furniture) are in poor condition. The threadbare furnishings that are provided do not meet the needs of youth. Appropriate beds (suicide proof) are not consistently provided to the population. Day room furniture is often torn and dirty. Fire safety is a constant issue because of the locked doors, lack of sprinklers and tampering with sprinklers and other fire safety equipment.

Hickey and Cheltenham are both on huge, beautiful tracts of land. There is a lot of room to construct new buildings and to increase outdoor activities. Hickey is located near an urban center which facilitates visiting, and minimizes transportation of youth.

A first step to significantly improve the atmosphere at both of these facilities would be to demolish the abandoned buildings. Then modular, portable buildings could be constructed where they are most needed, as older buildings are phased out of use.

B. Baltimore City Juvenile Justice Center

Unfortunately, the relatively new BCJJC is of very poor design. It is a grim, prison-like structure housed within the court and juvenile services building in downtown Baltimore City. It is too large for appropriate housing of youth and yet too small to provide adequate education, program, and recreation space for the number of youngsters who are housed there. Although it is of the more modern “pod” design, supervision is difficult because of the many nooks and crannies out of sight of the staff. Violence among youth is a chronic problem in this facility

There is a serious lack of space for indoor/outdoor activities, school, therapeutic activities (counseling, testing, visits with families). For example, there are no private offices for caseworkers and psychologists to work with clients.

BCJJC is blessed with an outstanding location within the same building with court and community services. The downtown location facilitates visiting and minimizes transportation. This facility should be re-designed and renovated to house no more than 48 youth in detention. Youth pending placement should be expeditiously moved to programs or transferred to foster care or detention alternatives. The space now used for housing should be converted to office, education and program space.

2. Small Detention Facilities

Waxter and Noyes

Youth at Waxter and Noyes are housed in old, dilapidated buildings with very poor design. They are difficult or impossible to clean and maintain. Bathrooms are beyond salvage and require major renovation.

Both facilities are prison-like environments with heavy screens on windows, and heavy metal doors that lock youth into individual rooms. The design makes it very difficult to supervise youth. The poor design, along with lack of program space, leads to over-use of seclusion and restraint.

There are worn and inappropriate furnishings throughout, including inconsistent use of suicide proof beds. Laundry facilities are inadequate and some dryers are dangerous fire hazards. Fire safety issues also exist due to individual key locking systems, vulnerability of sprinkler systems to tampering and extensive lockdown of youth.

Waxter and Noyes both house relatively small populations and are fairly well located in close proximity to population centers. Both facilities should be razed and replaced with new, modern design, modular/portable buildings on the existing location.

B. Carter Children's Center

Carter is different from the other facilities in that it was never designed to be a detention center for youth, and the design is inappropriate for that purpose. The program is housed in one wing of an adult mental health facility. Even though it is of relatively new construction, it should be abandoned and replaced by an appropriately designed building. The facility is also difficult to keep clean. Youth report regularly catching mice on the living unit. Bathrooms are completely inadequate. Early this fall new doors and suicide proof beds were installed on the housing units.

The most difficult problem at Carter is that there is no adequate program space (recreational, educational or therapeutic) either indoors or outdoors. This fact, along with the use of individual locked rooms, contributes to the over-use of seclusion and restraint. The poor design of the facility, which prohibits healthy activity, contributes to the difficulty in maintaining appropriate levels of staff and providing training to staff.

A trailer for the school was promised with the takeover by MSDE in July, but the trailer is not expected to be installed before March, 2008. A promised cover for the outdoor basketball court has not materialized to date.

This housing unit should be abandoned. Alternative housing should be found for the small population (15) of youth who require detention in the northern counties Eastern Shore. Under no circumstances should youth from the Western shore counties be housed with the Carter population.

C. Lower Eastern Shore and Western Maryland Children's Centers

LESCC and WMCC are both new facilities. Lower Eastern shore has the superior design because of the amount of light that enters the building. This design ameliorates the prison-like atmosphere and allows maximum ability to supervise youth. Both buildings are adequate for rated population but are problematic when over-populated or short staffed.

Program space is very limited, especially for outdoor activities. Neither facility has secure, functional outdoor space.

Vitreous china toilets remain in individual cells which house youth.

We recommend that the Department provide program space through new construction, repair, or renovation, especially for outdoor space.

3. Commitment Facilities

A. Victor Cullen Academy

Following the escape of two youth in late November, the Department assured neighboring residents that the fence will be repaired so that is it permanently escape-proof.

B. William Donald Schaefer House

WDSH is a beautifully renovated facility in good location. There is need for program space for indoor activities. The program also would benefit from the addition of a kitchen. Food is now brought in from BCJJC. Staff has no ability to provide bag lunches, off-time meals, and snacks when necessary.

C. Mount Clare House

The physical facility and equipment are in very poor condition. The kitchen and bathrooms are worn out. Mount Clare is in need of a complete renovation. Furniture is also worn out and in need of replacement.

Mount Clare is located in downtown Baltimore city in a gentrifying neighborhood. The location is ideal to meet the needs of residents. The Department installed a new air conditioner during summer 2007.

D. Allegany County Girls Group Home

This facility continues to need both indoor and outdoor maintenance work.

E. Thomas O'Farrell

O'Farrell needs numerous repairs and renovation in housing units, program space and administrative space. Modular buildings are dilapidated and need to be replaced. Maintenance is a major issue because of the poor conditions of the units.

There have been major problems with the kitchen equipment – some repairs have been completed but problems persist. Medical examination space is inadequate.

Fire safety has been approved by the fire Marshal, but concerns persist about alarms and lack of sprinklers.

F. Youth Centers

The Youth Centers are located on four tracts of scenic land in Western Maryland. One is in Allegany County, and the other three are in Garrett County. The

facilities were originally constructed as Conservation Corps Camps in the 19th century, but most of those building have been torn down. The Youth Centers, formerly known as Forestry Camps have served to help provide treatment services to troubled youth since the 1960's, and are comprised of cinderblock buildings, some small wood frame buildings, a few wood frame buildings covered with metal and some modular buildings.

Ongoing repair and renovation has taken place, but some of the wood frame buildings have surpassed their service life. It would be more cost effective to replace rather than to continue to repair these buildings. Examples of buildings that should be replaced are: the school building at Meadow Mountain, the storage building at Green Ridge, the storage building and the drug treatment double wide trailer at Savage Mountain, the office building and drug treatment building at Backbone Mountain.

4. Shelters

A. Sykesville and Guide

Both shelter programs are housed in run-down trailers. Numerous maintenance problems are noted. Furniture is worn and often inappropriate (bunk beds). There is very little outdoor recreation space which contributes to idleness of youth.

B. Maryland Youth Residence Center

MYRC was closed early this fall after Monitors noted severe fire safety issues at the facility.

5. Ongoing Facility Maintenance Issues

This year, the General Assembly allocated \$1.2 million for the lease purchase of trailers at Hickey and Cheltenham (health buildings) and O'Farrell and Noyes (classroom space). None of these trailers have been received to date.

The General Assembly also appropriated:

- \$450,000 for bathroom renovations at Waxter – bids on this project have been received.
- \$750,000 for renovations at Hickey – these renovations, including renovations of cottages, is ongoing.
- \$415,000 for handrails at BCJJC – the suicide-proof rails have been installed.

Suicide proof beds have been installed at Hickey, and Carter (and the beds at BCJJC, LESCC, and Victor Cullen are suicide proof). Some suicide proof beds have been installed at Noyes, Waxter, and Cheltenham, but the facilities need many more – beds for Noyes are on order.

JJMU has asked DJS for any centralized data or plans for construction or renovation of facilities and Department of General Services project requests, including emergency project requests. The Department responded that no final plans, other than the January 16, 2006 Facilities Master Plan exist, and the “DJS does not maintain” DGS project lists.

Advocacy, Grievances, and Monitoring

Child Advocates appear to visit most facilities regularly and work diligently with youth and staff to resolve grievances. DJS does not maintain centralized data on the number of visits Child Advocates make to facilities.

It is less clear how often Community Case Managers and AfterCare Case Managers visit youth. In response to a request from JJMU, DJS said that it does not keep aggregate records on numbers of Case Manager visits. Random inspections of facility visitation logs, however, show that some youth are visited infrequently by their Community Case Managers. Many youth do not know the name of their Community or Aftercare Case Managers. To ensure proper case management, the Department should begin collecting data on this issue and holding individual staff members accountable for making sufficient numbers of visits to youth assigned to them.

DJS provides copies of all grievances to JJMU after they have been completely reviewed and resolved. In the past, this has resulted in a lag time of up to six months between the time a youth filed a grievance and the time the Monitor received the grievance. Recently, DJS has processed grievances in a more timely fashion and the lag time has been reduced significantly.

Nevertheless, youth grievances provide Monitors with important information about potential trouble spots and facility environments. Providing JJMU with access to the DJS Grievance Database would allow Monitors to review grievances close to the time of filing and to follow up with DJS promptly on serious complaints.

Although JJMU is statutorily required to evaluate DJS' internal monitoring process, the agency has never regularly provided internal monitoring reports and has forwarded no reports this year. Recently, the Department agreed to allow JJMU to review monitoring reports for the past few years, an essential aspect of its preparation to take responsibility for 14 facilities monitored by DJS in past years.

Part of the DJS advocacy and monitoring process is fulfilled by the Office of Investigations and Audits. As discussed above, this office has declined to proactively provide JJMU with any information about incidents. Staff only respond to inquiries and do not voluntarily share information.

Finally, we express concern (see Safety and Security) about the accurate reporting of incidents and in some cases, suspected falsification of incident reports. Incidents appear to be underreported, calling into question the reliability of data reported by the Department.

Appendix A

History of the Juvenile Justice Monitoring Unit

In 1999, the former Maryland Department of Juvenile Justice received national media coverage over the treatment of youth in its boot camps facilities. A Task Force investigation concluded that the Department lacked oversight and recommended creation of an external monitoring agency to report to the Governor and members of the General Assembly on conditions in DJS facilities as well as safety and treatment of youth in DJS custody.

Legislation in the 2002 session established the Office of the Independent Juvenile Justice Monitor in the Governor's Office of Children, Youth, and Families. In 2006, the Monitor moved to the Office of the Attorney General and was renamed the Juvenile Justice Monitoring Unit (JJMU).

Appendix B

JJMU Staff

The Juvenile Justice Monitoring Unit (JJMU) includes a Director, four Monitors, and an Assistant Attorney General. Our staff members are experienced professionals with a broad range of educational qualifications, substantive knowledge and practical skills including juvenile programming, child abuse investigation, juvenile legal representation, systemic reform, counseling and casework, education, facility operations, and organization management.

Philip “Jeff” Merson served 26 years with the Maryland State Police and retired in 1999. He was instrumental in establishing the Child Abuse Sexual Assault Unit in Carroll County and spent the last six years of his law enforcement career with the FBI’s Violent Crime Task Force in Baltimore City. Mr. Merson worked in residential treatment facilities and as an investigator with the Department of Juvenile Services and joined the Juvenile Justice Monitoring Unit in 2001. Mr. Merson is an adjunct professor at Carroll County Community College where he teaches Criminal and Juvenile Justice courses. He is also certified by the Maryland Police and Correctional Training Commission to teach investigations of child abuse and has been training police officers and juvenile justice professionals for 15 years. Mr. Merson earned his M.Ed. and B.A. (Sociology) degrees from Loyola College.

Timothy Snyder joined the Juvenile Justice Monitoring Unit in 2001 after many years of working directly with troubled youth and their families. For eleven years, he served as Director of the New Dominion School in Maryland, an adventure-based residential treatment program for troubled youth. He also worked in direct care and family services at New Dominion School in Virginia. In private practice, Mr. Snyder consulted with numerous families experiencing difficulties with their children. He holds an M.A. in Pastoral Counseling (special emphasis in marriage and family counseling) from LaSalle University and a B.A. from Guilford College (Sociology).

Sharon Street has served as Assistant Attorney General for the Juvenile Justice Monitoring Unit since August, 2006. She has also worked as an Assistant Attorney General in the Environmental Crimes Unit and the Correctional Litigation Division and as a Staff Attorney with the Division of Pretrial Detention and Services. Ms. Street began her legal career at the law firm of Brown, Goldstein and Levy. She received her J.D. degree from the University of Maryland School of Law and her undergraduate degree from the University of Delaware.

Tanya Suggs joined the Juvenile Justice Monitoring Unit in August of 2007. For six years she served as a case management specialist and activities coordinator at Big Brothers Big Sisters, assisting at-risk youth and their families. While working on her graduate degree, Ms. Suggs interned at a number of juvenile justice organizations in Washington, D.C. and Baltimore, including the Justice Policy Institute where she worked as a Researcher, and the Baltimore City State’s

Attorney's Office where she worked with youth in a first time offender program. Ms. Suggs received a B.S. (Education) from Morgan State University and an M.S. in Criminal Justice from Boston University.

Marlana Valdez joined the Juvenile Justice Monitoring Unit in 2007 after a 25-year career as a practicing attorney, professor, and management consultant. She started her career practicing family and children's law and served as General Counsel of the Texas Juvenile Probation Commission. For nearly two decades she taught family and children's law on the faculties at American University, George Washington University, and Georgetown University. In 2003, Ms. Valdez formed a management consulting firm, specializing in helping clients improve organizational performance and manage change. She completed a post-graduate program in Organization Development at Georgetown University and received both her J.D. and B.S. (Speech Communication) degrees from the University of Texas at Austin.

Claudia Wright has been a Juvenile Justice Monitor since January, 2007. Ms. Wright began her career as a public defender, serving as Chief of the Juvenile Division of the Public Defender's Office in Jacksonville, Florida. She later litigated major class action cases for the American Civil Liberties Union National Prison Project, including cases challenging conditions of confinement for children in training schools, jails and detention centers. She was lead counsel on *Bobby M. v. Chiles*, which was the catalyst for reform of the juvenile justice system in Florida. Ms. Wright was a founder of Florida State University's first juvenile law clinic and founded Gator TeamChild, a multi-disciplinary juvenile law clinic at the University of Florida. Her article, "Re-Thinking Juvenile Justice - Using the IEP Concept to Create a New Juvenile Justice Paradigm", appears in the Fall 2007 issue of *The Link*, a publication of the Child Welfare League of America.

Appendix C

Facility Monitoring Responsibilities

<ul style="list-style-type: none">• Cheltenham Youth Facility• J. DeWeese Carter Children’s Center• Mount Clare House• Thomas J. S. Waxter Children’s Center• William Donald Schaefer House	<p>Claudia Wright (410) 576-6957 cwright@oag.state.md.us</p>
<ul style="list-style-type: none">• Baltimore Juvenile Justice Center• Charles H. Hickey, Jr. School• Lower Eastern Shore Children’s Center• Thomas O’Farrell Youth Center• Victor Cullen Academy	<p>Jeff Merson: (410)-576-6959 pmerson@oag.state.md.us</p>
<ul style="list-style-type: none">• Alfred D. Noyes Children’s Center• Backbone Mountain Youth Center• Green Ridge Youth Center• Meadow Mountain Youth Center• Savage Mountain Youth Center	<p>Tim Snyder: (410)-576-6968 tsnyder@oag.state.md.us</p>
<ul style="list-style-type: none">• Allegany Girls Group Home• GUIDE Catonsville Structured Shelter Care• Sykesville Shelter Care• Western Md. Children’s Center	<p>Tanya Suggs: (410)-576-6954, tsuggs@oag.state.md.us</p>

Appendix D Facility Visitation Data

2006-2007 VISITATION BY THE JUVENILE JUSTICE MONITORING UNIT

FACILITY	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TTL
ALLEGANY GIRLS HOME	1	2	2	1	1	1	1	1	0	1	2	1	14
BALT. CITY JUVENILE JUSTICE CENTER	1	2	1	2	2	2	1	1	3	2	2	3	22
CARTER	1	0	1	0	1	1	1	1	3	0	2	1	12
CATONSVILLE SHELTER	1	0	1	0	0	2	0	1	1	0	2	0	8
CHELTENHAM	1	1	1	0	1	1	1	1	2	1	3	1	14
HICKEY	2	2	1	1	2	2	2	2	1	1	3	2	21
LOWER EASTERN SHORE CHILDREN'S CENTER	3	2	2	0	4	0	1	1	2	1	2	1	19
MD. YOUTH RESIDENCE CENTER	1	2	1	1	2	2	1	1	2	1	1	3	18
MOUNT CLARE HOUSE	0	0	0	0	0	0	0	1	1	0	1	0	3
NOYES	1	2	1	2	2	2	1	2	2	1	2	2	20
THOMASO'FARRELL YOUTH CENTER	1	2	1	3	2	0	0	2	2	1	3	3	20
WM. DONALD SHAEFER HOUSE	1	0	3	1	2	2	1	1	2	1	1	3	18
SYKESVILLE SHELTER	1	2	1	1	1	0	0	2	1	1	1	2	13
YOUTH CENTERS													
Green Ridge	1	2	1	1	1	1	1	2	1	1	1	1	14
Savage Mountain	2	1	1	1	1	1	1	1	1	1	1	1	13
Meadow Mountain	1	1	1	1	1	2	1	1	1	1	1	1	13
Backbone Mountain	0	2	1	1	1	1	1	1	1	2	1	1	13
THOMAS WAXTER	1	0	1	0	1	1	3	1	2	5	4	1	20
W. MD. CHLDRNS CNTR	2	3	2	2	2	2	2	2	2	1	2	2	24
TOTALS	22	26	23	18	27	23	19	25	30	22	34	30	299

DJS-Licensed Facilities	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
(JJMU Responsibility Effective 01-01-08)													
Aunt CC's Harbor House	1	1	1	1	1	1	1	1	1	1	1	1	12
Family Advocacy Grp. Home	1	1	0	1	1	1	1	1	1	0	1	1	10
Graff Shelter (San Mar)	1	1	1	1	1	1	1	1	1	1	1	1	12
Karma Academy Rockville	1	1	1	1	1	1	1	1	1	1	1	1	12
Karma -Randallstown	1	1	1	1	1	1	1	1	1	1	1	1	12
Kent Boys Group Home	1	1	1	1	0	1	1	1	1	1	1	0	10
Larrabee House Girls Home	1	1	0	1	1	1	1	1	1	1	1	0	10
Liberty House	1	1	1	1	1	1	1	1	1	1	1	1	12
Linkwood Girls Home	1	1	1	1	0	1	1	1	1	1	1	0	10
Morning Star (VisionQuest)	1	1	1	1	1	1	1	1	1	1	1	1	12
New Dominion	1	1	1	1	1	1	1	1	1	1	1	1	12
One Love Group Home	1	1	0	1	1	1	0	1	1	1	1	1	10
Salisbury Boys Home	1	1	1	1	1	1	0	1	1	1	1	0	10
The Way Home	1	1	0	1	1	1	1	1	1	0	1	1	10
Total Per Year	14	14	10	14	12	14	12	14	14	12	14	10	154