

Settlement Agreement Between
The State of Maryland and the United States Department of Justice

FIFTH MONITOR'S REPORT

For the Baltimore City Juvenile Justice Center (BCJJC)
For the Period of July 1, 2009 through December 31, 2009

Submitted by

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Introduction

On June 29, 2005, the State of Maryland entered into a Settlement Agreement with the United States Department of Justice concerning the conditions of confinement at the Cheltenham Youth Facility (CYF) and the Charles H. Hickey, Jr. School (Hickey), two juvenile detention centers operated by the Maryland Department of Juvenile Services (DJS). A Monitoring Team was appointed to review, assess and report independently on the State's implementation of and compliance with the Settlement Agreement (the Agreement). In June, 2007, the State and the Department of Justice amended the Agreement to include the Baltimore City Juvenile Justice Center (BCJJC).

The initial one-year timeline was extended twice to ensure the full reform of the conditions covered by the Agreement. Most recently, the Agreement's timeline was extended until June 30, 2011 to ensure the full reform of facility conditions related to incident reporting and behavior management. This report discusses the State's progress toward substantial compliance with the remaining 4 of the original 29 provisions. The reader is referred to the previous four Monitors' Reports for a more detailed discussion on the depth of the State's reforms at BCJJC.

This is the Fifth Monitor's Report covering the period July 1, 2009 through December 31, 2009, a period that witnessed intense planning, thoughtfulness and action by BCJJC staff to implement additional strategies to protect youth from harm. At all levels, the facility staff's willingness to try new ideas and to take on additional challenges required creativity, courage and patience. Only through the outstanding leadership of the facility's administration, tireless efforts by shift commanders and supervisors, and ongoing dedication of direct care, behavioral health, case management, education and program staff, is the State poised to reach substantial compliance with the Agreement in the near future.

The report is organized as follows: using the numbering system from the Agreement, each of the remaining 4 provisions is provided, verbatim, followed by a compliance rating for the period, a discussion of the Monitor's findings, recommendations for reaching compliance, and the evidentiary basis for the Monitor's conclusions. Three compliance ratings were developed jointly by the Parties:

- Substantial Compliance. Substantial compliance with all components of the rated provision. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain sustained compliance. At the same time, temporary compliance during a period of sustained non-compliance shall not constitute compliance. The standards against which compliance will be assessed are those that are constitutionally required and required by Federal statute. Adherence to best practice is not required to achieve compliance with the Agreement.
- Partial Compliance. Compliance has been achieved on most of the key components of the provision, but substantial work remains.
- Non-Compliance. Non-compliance with most or all of the components of the provision.

¶ III.B-1.i	<u>Protection from Youth-on-Youth Violence</u> . The State shall take all reasonable measures to assure that youth are protected from violence by other youth.
Compliance Rating	Partial Compliance
Discussion	<p>The three subsequent provisions discussed in this report—incident reporting, senior management review, and behavior management—are tools used to achieve the outcome envisioned by this provision: protection from violence by other youth.</p> <p>As shown in the figure on the last page of this document, the rate of youth-on-youth assault has slowly begun to decrease.¹ During the current monitoring period (July-November, 2009) the average rate of youth on youth assaults was 1.53, compared to 1.86 for the previous 8 months. This represents a decrease of approximately 18%. The rate of group disturbances decreased more significantly. The current monitoring period’s average of .244 is approximately 55% lower than the preceding 8-month’s average of .541. While these decreases have many causes, DJS’ efforts toward reforming the conditions of confinement have certainly contributed to them. Hopefully, these reforms will gain momentum and will lead to further, sustained decreases in the rates of violence at BCJJC.</p> <p>Overlaying the DJS’ ability to implement the intended reforms is the extent to which it has been able to attract, hire, and retain qualified staff. Budget cuts and a recently-lifted hiring freeze have made filling existing vacancies very difficult. As a result, recent improvements to the On-The-Job training curriculum and protocol could not be engaged to improve the quality of care of youth at BCJJC. Compounding the vacancies is a large number of staff on long-term medical leave or light duty. Covering for these shortages tax the stamina and patience of staff, many of whom subsequently call out for their schedule shifts in order to recover. These call-outs exacerbate an already difficult situation. Maintaining the facility’s required 1:6 waking hours staffing ratios has demanded extraordinary efforts from BCJJC staff who often work several double shifts per week.</p> <p>Despite the everyday challenge to cover the required posts, the facility continues to make progress toward the reforms required by the Agreement. As discussed in the subsequent sections of this report, two of the remaining provisions (Incident Reporting and Senior Management Review) are now in substantial compliance. Further, all of the basic structures needed to satisfy the Behavior Management provision have</p>

¹ The DJS Research and Evaluation Unit calculates the rate of various serious incidents as the *rate per number of youth days* which neutralizes the impact of fluctuations in the size of the facility’s population.

	been designed, and their early implementation suggests they will be effective.
Recommendations	To reach substantial compliance with this provision, the State must: <ol style="list-style-type: none"> 1. Sustain, and expand when possible, reductions in youth-on-youth assaults and group disturbances. 2. Develop and implement policies, procedures and documentation strategies sufficient to achieve compliance with the remaining provision related to Behavior Management.
Evidentiary Basis	<ul style="list-style-type: none"> ▪ DJS StateStat, November 2008-October 2009 ▪ Interviews with Superintendent, Assistant Superintendent, Shift Commanders, Superintendents and line staff ▪ Shift Briefing Reports, August-November, 2009

¶ III.B-1.ii	<p><u>Reporting of Youth-on-Youth Violence.</u> The State shall develop and implement appropriate policies, procedures, and practices to enhance the reporting to appropriate individuals of incidents of youth-on-youth violence and to provide that such reporting may be done through confidential means, without fear of retaliation for making the report. The State shall document and report appropriately and with sufficient detail all such incidents.</p>
Compliance Rating	Substantial Compliance
Discussion	<p>The facility has fully implemented procedures to ensure that all incidents of youth-on-youth violence are fully documented in an Incident Report. As discussed in previous Monitors’ Reports, DJS’ Incident Reporting policy and training provide a solid foundation upon which to build staff skill in reporting incidents. Several excellent written tools were developed and the facility recently redoubled its efforts to ensure that all staff received concrete and specific guidance to address deficiencies discussed in previous Monitors’ Reports. While all facility staff received the incident report writing module as part of the annual in-service training curriculum, a significant number staff were identified as in need of remediation so that their incident reports would meet the DJS’ standards. By the end of the current monitoring period, 90% of these staff had received additional remedial report writing training.</p> <p>The overall purpose of incident reporting is to inform facility administrators and staff about the situations (people, places, procedures, etc.) that appear to increase the risk of youth violence so that targeted prevention strategies can be developed. Consistently, incident reports (IRs) at BCJJC include sufficient detail to serve this function. A total of 39 incident reports describing youth-on-youth assaults and group disturbances that occurred between July and November, 2009 were reviewed. Particularly during the latter half of this period, the IRs included essential details regarding the youth and staff involved; contextual information that could lend insight into the underlying cause of the incident or that could help staff to prevent or anticipate the assault; and specific details regarding the nature of the assault. Many of the incident reports also included a detailed description of how staff ultimately brought an end to the altercation; however, others continued to use only generic statements such as “assisted with separating the youth” or “restrained the youth using the least amount of force needed.” While adequate on the whole, the descriptions of the physical interventions used by staff, remain the incident reports’ weak spot.</p> <p>A well-written incident report will not reduce violence by itself, but high-</p>

	<p>quality incident reports are essential tools for any effort to reduce the rate of youth violence in a facility. Maintaining the quality of incident reports and analyzing the information contained in them are essential steps to reducing assaults and disturbances at BCJJC.</p>
Recommendations	<p>The State is in substantial compliance with this provision as of December 4, 2009.</p>
Evidentiary Basis	<ul style="list-style-type: none"> • Training records for 43 staff identified as in need of supplementary report writing training • Interviews with Facility Superintendent, Assistant Superintendents, Shift Commanders, Supervisors and line staff • Incident reports, n=39, randomly selected from those generated July 1 through November 30, 2009 related to youth-on-youth assault and group disturbances • Video footage of approximately 18 incidents occurring between July 1 and November 30, 2009

¶ III.B-1.iii	<u>Senior Management Review.</u> The State shall develop and implement a system for review by senior management of youth-on-youth violence.
Compliance Rating	Substantial Compliance
Discussion	<p>By DJS policy, each incident report must be reviewed by the Shift Commander prior to being submitted to the Administration. These reviews should critique staff performance in preventing, anticipating, or intervening in the incident. Feedback surrounding the use of de-escalation and physical intervention techniques, staffing ratio and posting, supervision strategies, institutional security, conflict resolution, environmental hazards, policy and procedures will help to improve staff skill and knowledge and may lead to a decline in youth violence over time.</p> <p>Across the 39 incident reports reviewed, all of the Shift Commanders at least attempted to critique the incident—no longer are they simply summarizing the event as they were at the time of the First Monitors’ Report. Over time, the quality of their reviews was enhanced by several factors.</p> <p>First, during the current monitoring period the quality and completeness of the incident reports improved significantly. As a result, Shift Commanders had a more complete set of facts from which to draw conclusions about why the incident occurred and how it was handled by staff.</p> <p>Second, during the current monitoring period, Shift Commanders were provided access to a terminal for reviewing the videotaped footage of the event question. No longer do Shift Commanders have to rely solely on the staff’s written account. Instead, they can observe the incident first-hand and dissect the various points at which staff did or could have intervened. In October, Shift Commanders watched and critiqued approximately 70% of the youth-on-youth assaults and group disturbances. In November, approximately 80% of the videotapes were reviewed and critiqued.</p> <p>Finally, over the years, the facility’s senior managers (Superintendent and Assistant Superintendent) conducted painstaking audits of each incident report, suggesting areas in which Shift Commanders should be more vigilant during their reviews. Together, these efforts have resulted in Shift Commander reviews that are one of the facility’s strongest assets for developing supervision skills among line staff.</p> <p>As noted above, by DJS policy, once reviewed by the Shift Commander, a member of the senior management team must review the complete</p>

	<p>incident report packet within 72 hours. These audits should not only verify the completeness of the incident reporting package, but should also comment on the quality of the staff's responses to each portion of the incident report and confirm that all of the sources of information hang together without contradiction. Particularly during the latter half of the monitoring period, nearly all incident reports were audited and corrected within the timelines established by policy.</p>
Recommendation	<p>The State is in substantial compliance with this provision as of December 4, 2009.</p>
Evidentiary Basis	<ul style="list-style-type: none"> ▪ Interviews with Facility Superintendent, Assistant Superintendents, Shift Commanders and Supervisors ▪ Incident reports, n=39, randomly selected from those generated July 1 through November 30, 2009 related to youth-on-youth violence and group disturbances. The IR packets included the Shift Commanders' reviews and Audits. ▪ Video footage of approximately 18 incidents occurring between July 1 and November 30, 2009 ▪ Video Review Log, September through November, 2009 ▪ Incident Report Audit Log, August through November, 2009

¶ III.B-1.v	<p><u>Behavior Management Program.</u> The State shall develop and implement an effective behavior management program at the facility throughout the day, including during school time and shall continue to implement the behavior management plan. The State shall develop and implement policies, procedures and practices under which mental health staff provide regular consultation regarding behavior management to direct care and other staff involved in the behavior management plans for youth receiving mental health services, and shall develop a mechanism to assess the effectiveness of interventions utilized.</p>
Compliance Rating	Partial Compliance
Discussion	<p>The development and implementation of an effective behavior management program is one of the key strategies for reducing youth violence. Behavior management encompasses all of the facility’s tactics for shaping youth’s behavior—its system for awarding incentives; consequences for breaking facility rules; immediate responses to youth violence; and strategies for keeping youth occupied with pro-social activities. Throughout all of these, case management, education and mental health staff should be involved to ensure consistency and increasing support for youth who struggle to comply with facility rules.</p> <p><u>Point/Level System</u></p> <p>The basic structure of the current point/level system remains solid—youth are able to earn up to 100 points per day and as points accumulate, youth are promoted to a higher level that is associated with greater privileges. Point deductions, or fines, are issued when youth do not follow facility rules.</p> <p>Although simple in concept, the system is actually quite complex, which may account for the persistent implementation problems discussed below. At the appropriate time, the facility should consider revising the point/level system to emphasize the behaviors it is trying to promote and to reduce the current focus on negative behaviors. Such systems have been shown to produce better outcomes among incarcerated youth.</p> <p>On each of my three visits during the current monitoring period, I reviewed youths’ point sheets from 3 units across a one-month period (August, September, and November, 2009). These records continue to be complete and well-organized. Administrative staff and supervisors are responsible for overseeing the daily operation of the point/level system. Although they accurately identify various errors made by staff, often their feedback is not incorporated into the youth’s point/level sheets for several days. A</p>

significant number of examples were noted where youth committed major rule violations, but were not demoted until several days later. The failure to immediately impose consequences (i.e., level drop) for youth involved in violence limits the effectiveness of the point/level system.

In addition, there are two parts of the system that are not being utilized as designed. First, the daily 100 points are distributed across the various activities in which youth are involved. By design, staff are supposed to address non-compliant behavior verbally, then inform the youth that he will not earn the points allocated to the activity at hand, and then, if the youth remains non-compliant, assess a fine. In past monitoring periods, staff often exceeded the allowable fine amounts prescribed by policy. While this problem appears to have been largely resolved, many staff now appeared to skip a step in the path toward correcting youth's behavior. Instead of withholding the smaller number of points allotted to the activity at hand, many staff take the much larger point deduction instead. For example, if a youth is not following directions in the dining hall, rather than withholding the 5 points allocated to that meal, the staff assess a 50 point deduction instead. The point/level system was constructed to be proportional—if non-compliant behavior can be effectively addressed with smaller point deductions, this is preferable to levying a fine that subtracts half of the day's points. While the effectiveness of the smaller point deductions cannot be known, it is essential that staff implement the program as it was designed and explained to the youth.

Second, the BMP was designed with a rebate option. Youth who are assessed fines for minor rule violations should be permitted to engage in some sort of restorative activity so that they can earn a portion of the points back. This does not occur with any regularity, although I do not know the reasons underlying staff's failure to use this option. The State should consider making rebates mandatory, which would shift the focus on the BMP toward reinforcing the behaviors that are desired, rather than its current singular focus on attempting to extinguish undesirable behaviors through fines.

On a positive note, all youth interviewed were aware of their points and level and reported that they received all of the incentives that had been promised to them. The range of incentives has dramatically increased over the past six months and now includes commissary, special late night activities, access to game rooms, extra phone calls and special visits. Youth reported that these incentives are meaningful and that they made striving for Level 4 "worth it." Youth of any level are also permitted to apply for an extended stay in each unit's Honors Room which features upgraded

bedding, a videogame console and other activities. A review of applications for the Honor's Room indicated that the privilege is granted to youth of all levels.

Guarded Care Plans

Case management and mental health staff are involved in the behavior management of certain youth with serious behavioral and mental health problems, through the development of Guarded Care Plans (GCPs). The concept of the GCP reflects the requirements of this provision related to mental health consultation. In practice, GCPs lacked important content during the first half of the monitoring period but showed significant improvements in the latter half. At first, GCPs did not include sufficiently detailed behavioral goals, relying instead on vague terms such as "improve safe behaviors," nor did they establish a specific performance threshold for the youth to receive a reward. By November, these problems were resolved, and youth's GCPs now include specific targets and cues, along with specific behavioral objectives. Further, frequent performance reviews for all youth, and the delivery of rewards when earned, are well-documented.

Only a small glitch in this process remains: the extent to which all members of the multi-disciplinary team (MDT) have been engaged. While ideally all members of the team would be involved in the plans' development, more importantly, they should all be at least aware of their obligations for implementing the plans. Mental health staff develop the plans; case managers are provided copies of GCPs for youth on their caseload; unit staff have access to all GCPs in a binder in the Pod Offices. The only remaining piece is to ensure that teachers who have the youth in class are aware of their responsibilities under the GCP. A mental health staff is currently assigned to the school—this individual could be made responsible for informing all of a youth's teachers of the requirements of his GCP.

Seclusion

While the facility is not permitted by State law to use disciplinary isolation, youth may be confined to their rooms when they represent a legitimate safety threat to other youth or staff (e.g., immediately following a fight). The period in seclusion is used to de-escalate the youth so that he may be safely returned to the general population. In order to prevent an over-reliance on the use of seclusion, staff must seek authorization from an Administrator to place a youth in seclusion. Toward the end of the current monitoring period, staff were also required to collaborate with Mental Health staff when determining whether a youth was prepared to be

released from seclusion. This is an excellent practice.

Across my three visits to the facility during the current monitoring period, I reviewed approximately 50 seclusion records for youth involved in serious institutional misconduct from August through November, 2009. Consistently, these documents revealed that youth were monitored closely while they were in their rooms; they were visited by medical staff several times during their stay; and their readiness for release was monitored closely by the Shift Commanders. The facility's practices in this area have improved consistently since the Agreement was signed into effect.

Court Reports

In response to a historical lack of consequences in the facility's approach to behavior management, a system was devised to inform the Court of the youth's behavior while housed at BCJJC. Prior to all scheduled court hearings, facility case managers prepare a one-page summary of the youth's behavior while in custody that includes the youth's total points, level, involvement in institutional misconduct, participation in education and programming, and contact with parents. These reports are well-designed and capture the salient facts needed for a Judge to assess the youth's behavior while at BCJJC. Under the guidance of the Case Manager Supervisor, the process was implemented in November 2009. A review of records verified that reports were generated for all youth (n=58) with scheduled court appearances during that month. When interviewed, youth indicated that their Judges commented on their behavior during their court appearances and that this was an effective deterrent to their getting involved in misconduct. The current level of performance needs to be sustained over time to ensure that the court reporting process contributes to effective behavior management at the BCJJC.

Intensive Services Unit

As noted in previous Monitors' Reports, a significant number of youth-on-youth assaults at BCJJC involve a rather small proportion of youth. Because the point/level system had not until recently been effectively designed with an array of incentives for positive behavior, and the court reports had not yet been implemented, youth reported there were few reasons for them to refrain from involvement in serious misconduct. Further, staff indicated that they felt disempowered by the lack of serious consequences for youth who were involved in violent institutional misconduct.

A couple of months into the current monitoring period, the State committed to developing a segregated, highly-structured unit for the small number of youth with chronic involvement in violent misconduct. The

Intensive Services Unit (ISU) was designed to provide intensive programming and structure and to limit the youth's movement and access to potential victims. All services, including education, are brought to the unit. Any staff may refer a youth to the ISU; admission is determined by a committee that reviews the youth's facility record and is ultimately approved by the Superintendent. ISU staff were hand-picked and the esteem of the ISU was enhanced by the administration's formal recognition of the ISU staff's expertise.

While the ISU had been in operation for only two weeks at the time of my final visit to the facility, its initial implementation is promising. Youth had not been involved in any violent misconduct during their stay on the ISU. Strict enforcement of facility rules, near-constant programming, and collaboration among staff from various disciplines are among the reasons offered for the unit's effectiveness. As happens with all new program initiatives, the initial stage of implementation revealed a number of weaknesses that need to be addressed:

- *Length of Stay.* The original program design set a minimum stay of 7 days, which, for the first two cohorts of youth, ended up being the exact length of stay for all youth involved. ISU staff noted that 7 days was not sufficient for solid treatment planning, an assessment with which I agree. The length of stay on the ISU should be individually – derived and based on the youth's behavior as he is slowly re-integrated into the general population. Shortly after my visit, the State reportedly removed references to a specific number of days from the program design and the youth handbook.
- *Treatment Plans.* The ISU treatment plan should contain the wisdom of all of the facility staff and professionals who know the youth and understand the genesis of his behavior. They should not simply rely on the youth's own awareness of his triggers and problems. Further, the treatment plans must focus specifically on the youth's pattern of violent misconduct with the ultimate goal being a return to the general population. Too often, the youth's ISU treatment plans lacked substance and insight into the nature of the youth's challenges and did not identify specific interventions designed to address these challenges. Some were too broadly defined and listed goals such as "address substance abuse" or "prepare youth for placement." The various members of the multi-disciplinary ISU team need to develop specific, individualized treatment plans that anchor the triggers, behaviors and goals more clearly to violent misconduct. These modifications should keep the team, including the youth,

properly focused on the youth's assaultive behavior.

- *Transition.* Following their discharge from the ISU, youth are currently placed on a "step-down unit." Although this unit is staffed by ISU staff, it otherwise operates like any of the facility's general population units. During the initial two weeks of operation, several fights occurred among ISU alumni. In part, these may have occurred because the lessons learned about effective interventions with these youth were not properly transferred to the youth's new setting or because youth were reintegrated too quickly into the general population. A more calibrated re-entry, including small opportunities for youth to re-engage with the general population (e.g., attending recreation with a general population unit; going to school for the morning session only; eating lunch in the dining hall) may ease the youth's transition and will give both youth and staff opportunities to practice new skills and ways of interacting that seemed to work while the youth was on the ISU.

Moving forward, the facility should strive for greater integration across the key components of its behavior management system: point/level system, guarded care plans, and ISU. Youth should exhaust the less restrictive options for behavior management before being transferred to the highly restrictive ISU, except in extreme cases. In addition to resolving these early-stage issues, the unit also needs to be fully and consistently operational for the majority of a monitoring period in order to be considered fully implemented.

Programming

Limiting youth's idle time is one of the most effective behavior management strategies available. The State has embraced this philosophy and has committed to providing additional programming to ensure that the youths' idle time is kept to a minimum. Some of these opportunities were in place at the time of my last visit to the facility.

In addition to indoor and outdoor recreation, youth at BCJJC also received programming from the following groups:

- Boys & Girls Club;
- Boy Scouts;
- Community Law in Action (CLIA);
- Aggression Replacement Training (ART), substance abuse education, and psychoeducational groups run by Hope Health staff;
- Structured activity time in the facility's game room; and
- Case Managers' groups on a variety of topics.

	<p>The recent increases in programming are supported by a 24-hour schedule recently put in place for all units. A review of these unit schedules revealed that all youth are receiving the prescribed number of hours of large muscle activity on both weekdays and weekends. However, the schedules do not yet support a full complement of structured programming and youth continue to have excess idle time, particularly on weekends.</p> <p>Shortly after my last visit to the facility, the State submitted a plan to further reduce the youths' idle time. By engaging a cross-section of facility staff (e.g., education staff, the Youth Advocate, Pod Managers, etc.), the facility plans to offer additional structured activities of the following types: Leadership Groups, Current Events group, structured time in the facility's Game Room, and Arts and Crafts. If implemented as planned, these enhancements to the schedule should greatly reduce the youth's idle time as required by this provision.</p>
Recommendations	<p>To reach substantial compliance with this provision, the State must:</p> <ol style="list-style-type: none"> 1. Ensure that corrections to points/levels made by Supervisors are reflected on the youth's point sheets the following day (except for weekends and holidays). 2. Ensure that staff utilize the full continuum of responses to non-compliant behavior (i.e., verbal prompts, withholding the points assigned to a particular activity) PRIOR TO levying a fine. 3. Fully implement the rebate option of the point/level system. 4. Ensure that teachers are aware of youths' GCP and how to implement them in the classroom. 5. Continue to provide court reports summarizing the youth's behavior at the BCJJC for all youth with scheduled court appearances. 6. Ensure that youth's length of stay on the ISU is individually-derived and based on the youth's behavior. 7. Address the deficits in the construction of the ISU treatment plans. 8. Ensure that the ISU transition process includes a gradual re-entry into the general population. 9. Increase the amount of time in which youth are engaged in structured activities on both weekdays and weekends.
Evidentiary Basis	<ul style="list-style-type: none"> • <i>BCJJC Student Handbook</i> • Behavior Management Point Logs for 9 units, August, September and November, 2009 • Honors Room applications, September-November, 2009 • Guarded Care Plans for approximately 15 youth, written August-November, 2009

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| | <ul style="list-style-type: none"> ▪ Interviews with Superintendent, Assistant Superintendents, Shift Commanders, Supervisors, and line staff ▪ Youth interviews, n=9 ▪ Seclusion records, n=50, randomly selected from those occurring August 1 through November 30, 2009 ▪ Court reports, n=58, created November, 2009 ▪ Interview with Case Manager Supervisor ▪ Observation of ISU development team meeting, October 2009 ▪ ISU Program Description ▪ <i>ISU Youth Handbook</i> ▪ ISU Logbook, November 15-December 3, 2009 ▪ ISU Treatment plans, n=10, written November, 2009 ▪ Unit Schedules for units 21, 30, 31, 32, 33, 40 and 41 ▪ BCJJC Plan to Increase Structured Programming, January 2010 |
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BCJJC Rates of Violence, 12-Month Trend

