The Human Impact of Crowding in Juvenile Detention

Sue Burrell

Abstract

Youth and staff in crowded juvenile facilities may be subjected to profound indignities and a range of physical and emotional harm. Their personal experiences are often lost in official discussions of population and square footage requirements. This article explores the human impact of crowding as actually observed in detention centers around the country through the eyes of juvenile advocates. It paints a dismal portrait of a system which is meant to humanely care for those youth who truly need to be securely confined, and shows how crowding and its effects are exacerbated by inappropriate detention decisions, systemic inefficiencies, and failure to consider other service or placement options.

The first thing that struck you on entering the detention center was the smell. The air was heavy with the odor of clothes worn too long, sweat, and a slight base note of urine. The long dingy halls were littered with piles of laundry and rolled up mattresses. The walls reverberated with the sounds of hoarse yelling, fists pounding on walls, and heavy doors being slammed.

We had been invited to the facility to give our opinion about potential liability issues faced by this and a number of other crowded detention centers. There was plenty to say about that. But the most haunting images we took away were not the violations of this or that constitutional provision, but the look on the faces of kids and staff who were forced to endure this hellhole. This was a facility built for 43 youth; on this particular day, it held 88.

Where did they put all those kids?

Anywhere there was space for a thin mattress on the floor. First, the rooms were double bunked; then mattresses were placed in utility rooms or along the hallway walls. When that space was filled up, mattresses were placed on moldy, wet bathroom floors. The night before our visit, three sleepers had passed the night in the bathroom next to reeking asbestos covered plumbing, under crumbling plaster and peeling paint, amid big wads of wet toilet paper.

In daytime hours, staff concentrated primarily on maneuvering groups of kids from one spot to the next. Because of state limits on classroom size, only half the kids could go to school at once, so everyone got only half the required amount of school time. During our visit, a huge number of kids were seated on the floor, elbow-to-elbow around the dayroom floor. They were just "sitting" because there were too many of them to allow normal recreational activity.

Sue Burrell is a Staff Attorney at Youth Law Center, a public interest law firm specializing in juvenile justice and child welfare issues from offices in San Francisco and Washington, D.C. She is a member of the project team for the OJJDP Project on Training and Technical Support to Reduce Juvenile Corrections and Detention Overcrowding and a technical assistant for the Annie E. Casey Foundations Juvenile Detention Alternatives Initiative. Sue Burrell, Youth Law Center, 114 Sansome Street, Suite 950, San Francisco, CA 94104, (415) 543-3379; fax (415) 956-9022, E-mail: sburrell@youthlawcenter.com

In a "single" room, two jumbo sized boys sat in their underwear on beds so close together that their knees had to be positioned sideways. Their mattresses were ripped and stained; deposits of food, toilet paper and human excrement decorated their walls. The room was unnaturally darkened by the presence of filthy screens and bars; the door held an enormous padlock that would have to be individually unlocked in an emergency.

In physical appearance and demeanor, these were kids that any high school basketball coach would love to meet. Detention in this setting, however, suggested a different assessment of their value as human beings. Surely, only worthless people would be crammed into this stinking, human sardine can. Their downcast eyes bespoke embarrassment at being viewed in these circumstances, and unmistakable despair.

Staff in this detention center were worried. There had been more fights as crowding increased, and they felt vulnerable to explosive behavioral incidents. There was no way to do meaningful classification, or even to separate out kids with serious medical problems such as gunshot wounds. Work-related illness and injuries had risen; administrators were concerned that many staff were "burning out" from the relentless pressures of working in the crowded facility. All of this translated into higher costs for overtime and relief workers.

Staff were also depressed at what they saw themselves doing to keep the institution going. There wasn't time to use the rehabilitative and counseling techniques they had learned in training. Their main focus was on structure and safety. They were frustrated at the seeming indifference of the public and officials to the impact of crowding on their deteriorating facility. In another year and facility, we met kids who spent as much as 20 hours a day in their rooms because of crowding. This was a 64 room (rated capacity 76) facility that often housed more than 200 youth. This meant, for example, that 59 youth would be housed in a 12 room living unit. Rooms built for one housed five, and rooms built for two held seven youth.

When you opened the door to the sleeping rooms at almost any time of day or night, you saw kids just lying there on thin mattresses on the floor. In many of the rooms, the mattresses were so close together, there was no room to walk on the floor between them. In some, kids literally slept underneath the single built-in metal frame bed in the room.

What minimal personal belongings each youth had were worked into the narrow crannies between the mattresses. They were allowed only two books, a Bible, cards, and a few personal letters in their room (possession of pencils or pens was a punishable offense) — a stingy allotment which contributed to extreme boredom or depression in some and aggressive behavior in others. Youth told us that they spent their time at night spitting on the walls, trying to smoke banana peels, and making electrical shocks come out of the night lights.

Privacy in this facility was non-existent. Among the consequences was that when youth needed to use the bathroom, and staff did not respond quickly enough to requests for release (because of too many kids and too much responsibility), they had to relieve themselves in their room in full view of the other youth. One boy told us he defecated into a towel in an effort to minimize the impact of his personal needs on other youth in his room.

Staff in this facility candidly expressed their fear of violence. They had tried to minimize incidents by placing younger kids in rooms with older youth. This had backfired because the older youth routinely harassed and sometimes physically or sexually assaulted the younger ones. One boy told of being housed in a room with two older youth who demanded oral sex from him. When he refused, they tied him up with sheets, stuffed a sock in his mouth, and beat him up. After this happened the third time, he overcame his fear of snitching and told the nurse. He was then placed in an isolation room (where he was allowed out of the room only one hour a day), since that was the only place they had left for protective custody. A second boy, similarly, was pummeled in both eyes, and forced to perform oral sex on his three roommates (in a "single" room) while the onlookers called him a "bitch" and threatened to kill him if he told staff. Another boy, age twelve, whose institutional issue t-shirt and pants dripped off his small frame, had gotten his ribs cracked in a living unit fight two weeks before we interviewed him. Several boys told us of being "bulldogged" by older, bigger boys in their room to fight other kids, and being forced to give them their food. A lawsuit had been filed in connection with at least one of the forcible sexual incidents, and charges had been filed in relation to several other physical and sexual attacks.

Out of concern for safety, even recreation occurred in shifts — only half the population in a living unit was allowed out in the dayroom at a time. There was space in the school for about half the kids, and they only received three hours of academic work. With so many students, there was no special education program. Education was considered a privilege, and those not chosen to attend school stayed locked in their rooms. Meals were sometimes served in sleeping rooms because of staffing shortages. Outdoor recreation was sporadic, and some youth told us they hadn't been outdoors for weeks. Because of staffing

limitations, visits were limited to half an hour, and parents were turned away once the scheduled time slots were filled; attorney visits with the public defender were often conducted in groups.

In this atmosphere, trivial incidents such as not getting out of the shower fast enough, often escalated into behavioral crises. Tensions ran high, and there had been "riots" in which youth barricaded their doors and flooded "wet rooms" (rooms with toilets). Staff acknowledged that many such incidents could have been anticipated and prevented if they had more opportunity to interact with youth, but crowding prevented them from spending the kind of time they needed to be proactive. Instead, they resorted quickly to after-the-fact disciplinary measures, almost invariably involving more locked room time and sometimes resulting in shackling youth to beds.

This facility was so crowded, that even kids sent to isolation had roommates. One youth told us that when he was locked up for fighting, he was placed in isolation with a kid who had tried to kill himself, and another youth who was also being disciplined for fighting. The isolation rooms had their own toilet, which meant that one of the kids had to sleep with his head near the commode used by all three. Monitoring logs for these rooms were sometimes two or three hours behind schedule.

While some of the youth became more aggressive in this crowded atmosphere, others became more depressed. A significant number of kids we spoke with had made suicidal gestures by "carving" on themselves, or tying sheets around their neck. Fear was expressed by staff and roommates of suicidal youth that something really bad could happen. Staff were also frustrated that, because they spent so much of their time managing crises, they had little time to spend with youth who were upset about

court hearings, girlfriends/boyfriends, and institutional pressures.

Physically, this place was a disaster. A contemporaneous public health inspection¹ found the facility to be dangerously understaffed, filthy, and in poor repair. The walls and floors in some rooms were smeared with blood, mucous, and feces. Mattresses were tattered and unsanitizable. Dirty linen and clothing were present in every area of the facility. Vents were occluded with dirt, toilet paper and toothpaste. Toilets were filthy, and bathroom floor drains were covered with pubic hair and coagulated dirt. Bathroom walls and showers were covered with black mold. A strong odor of old urine pervaded the air. Lighting fixtures, electrical outlets, and fire sprinklers had been tampered with and were nonfunctional. Walls were damaged, and holes had been poked through the graffiti covered walls between the rooms. With the ongoing physical stress of serious crowding, the facility was unable to cope with even the most minimal maintenance and repairs.

In a third facility, the Youth Law Center filed an amicus curiae (friend of the court) brief on behalf of youth in a lawsuit stemming from detention center crowding that had persisted for more than a decade. Although its rated capacity was 219, the facility had regularly held as many as 422 youth. The "extra" youth had no room assignments; they were shuffled around all day, and assigned to sleeping rooms or dormitories only when it was time to go to bed.

The trial court's findings revealed a facility in crisis.² The instability of room assignments meant that youth were constantly faced with unpredictable and potentially hostile new environments. There were complaints from some that roommates had engaged in sexual behavior in their presence or had made sexual

advances. In some cases, youth quietly submitted to avoid being hurt by stronger or more aggressive youth. Earlier in this facility's history, youth had been assigned to sleep in the dayroom area, but when they began breaking up cots to use as weapons, that practice was halted.

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Crowding made it especially difficult to separate rival gang members from one another. Efforts to separate particular groups further complicated housing, recreation, and dayroom use decisions. Even with such efforts, gang aggression in the crowded dayrooms was frequent enough to require a responsive procedure. Whenever rival gangs confronted each other, staff would yell "BELLIES," and all the noncombatant youth would drop to the floor in a face down position, leaving the combatants more visible to staff.

High population meant that dayrooms had to double as classrooms. This meant, in turn, that dayrooms were less available for recreational purposes. Furniture needed to be moved several times a day to accommodate changing use of dayrooms, and youth were locked in their rooms during the ongoing rearrangements. This added to the pervasive sense of chaos experienced by youth and staff alike.

With population at double the facility's rated capacity, it was difficult for youth in sleeping rooms to get staff's attention (through a signal light outside the door). When staff didn't respond to bathroom requests, children often urinated out the window and sometimes defecated in their rooms. The trial judge noted that the practice of urinating out the window was so common that steel windows were corroded and had to be replaced.

Psychiatric testimony about the impact of crowding confirmed a rise in violent incidents,

sexual acting out, and suicide attempts. Scarce mental health resources were stretched thin by the sheer number of youth needing services. Suicidal youth were dressed in paper gowns and placed in cold, bare rooms with only a suicide blanket—interaction with other human beings was at a minimum for these youth, and staff supervision was infrequent. There had already been one serious suicide attempt, and staff were rightfully frightened that one of the youngsters in their charge would succeed in killing him or herself.

Although this was designed as a short term detention center, some youth spent six months or more in the facility awaiting placement or commitment to another facility. The trial court described many of these children as angry, unsocialized, frightened, violent, or mentally ill. Unfortunately, the facility was so focused on dealing with emergencies and moving children through the day, that post-disposition youth received none of the rehabilitative services that ostensibly justified their detention. Because the youth most in need of services were often the most difficult to place, they also spent the longest time simply locked up in this overwhelmed facility.

Increased operational needs caused by population pressures meant that staff frequently worked 16 hours a day, for several days in a row in the volatile institutional environment. The trial court observed that, while most staff came to work at the facility because they cared about children, working in this stressful situation "saps their enthusiasm," "steals their hope," and "makes some of them callous and cynical."

Conditions similar to those just described are playing themselves out in daily life in detention centers around the country. In 1994, some 319,806 children were admitted to facilities which exceeded their design

capacity.⁴ By 1995, 62% of detained juveniles were confined in overcrowded public detention centers.⁵ The 1994 study, Conditions of Confinement: Juvenile Detention and Corrections Facilities, found that 23% of juveniles held in public facilities (including detention centers, ranches, and training schools) were in institutions operating under a court order or consent decree. Among the lawsuits involving detention centers, 53% involved crowding.⁶

Pleadings in the juvenile detention crowding cases allege an all too familiar litany of horrors.7 In almost every case, crowding is associated with unhealthful, inhumane conditions that threaten children's physical and emotional health. Crowding-related issues include inadequacies in medical, dental and mental health care; school programs and special education services; recreation and physical exercise; counseling and rehabilitative services; clothing and laundry services; meals and meal service; visiting, mail and telephone use; access to attorneys; privacy; and clothing and laundry services. In addition, the cases challenge physical plant inadequacies in sleeping facilities (and use of floor mattresses), living space, sanitation, ventilation, fire safety, and building repair. The cases also link crowding with improper disciplinary practices; inappropriate use of restraints, isolation, and locked room time; inadequate due process protections and grievance systems; and verbal and physical abuse. Many of the cases tie crowding to increased danger of violence and suicidal behavior, and these issues are bolstered by allegations of deficiencies in staffing, staff qualifications and training, and failure to adequately classify youth in housing assignments. Finally, some of the cases challenge the inappropriate use of detention for certain categories of children, and failure to adequately utilize alternatives to secure detention.

What is most troubling about all of this is that so many of the youth held in such facilities are unnecessarily or even illegally detained. Sometimes this is a result of poor intake screening or inadequate risk assessment. Other times it results from gaps in local resources. Still other times unnecessary detention results from a misuse of detention to fulfill other goals, such as "punishment." This occurs even though a fair number of youth will have their cases dismissed; many will have less serious charges sustained; and a large proportion will have no further incursion into the juvenile or criminal justice systems.⁸

Whatever the purported justification for unnecessary detention, the practical results are disturbing. We have seen little pipsqueak children in detention — sometimes as young as 10 years old - and a surprising number of truants, underage drinkers, and runaways. There have even been a number of child welfare system children locked up in detention centers because of glitches in that system.9 We have met an increasing number of youth being detained (sometimes for months) on Immigration and Naturalization Services (INS) holds even though they had no delinquency charges, or committed very minor offenses (using false identification, misdemeanor drug possession).10

We have watched youth being detained at hearings where they had no lawyer and the court did not allow them to speak. Many such youth spent several weeks in custody before even meeting a lawyer. The fact that the vast majority were immediately released from custody upon being represented underlined the unfairness of their situation.

We have encountered youth who were locked up for being late to court, or because their parents didn't answer the phone (or had no phone) when the intake staff called. We have also seen youth locked up on "automatic detention" rules for minor probation violations or bench warrants. In both instances, unnecessary detention resulted from a failure to consider relevant information or engage in risk assessment.

We have witnessed detention decisions made apparently at the whim of intake screener, without reference objective standards or applicable law. In some places, too, the detention decision has been narrowly framed as "release," or "detain," with little attention to intermediate possibilities such as home detention, electronic monitoring, day or night reporting centers, placement with relatives, non-secure placement, or behavioral intervention through the education or mental health systems.

We have met post-disposition youth doing months of "dead time" in detention waiting for the state training school or some other placement to pick them up. We have interviewed mentally ill youth housed for long periods in isolation on "suicide risk" status because there are no available treatment programs in the community. In almost every crowded facility, we have met youth detained on "lightweight" offenses because the non-secure shelter is full or there is no shelter.

The inescapable truth these youth face every day is that the system which is supposed to care for them and provide for their needs has instead locked them up in crowded, physically disgusting, dangerous facilities. This is bad enough for those who truly need to be detained because they pose a danger to the community or a flight risk; it is intolerable for the many children who do not. That the brunt of these conditions is experienced by an overwhelmingly disproportionate number of African-American, Latino (and in some instances, Native American) youth in these

facilities gives additional cause for concern.

As juvenile justice professionals we must not acquiesce in this deplorable state of affairs. Children in the juvenile justice system often come from backgrounds of economic deprivation, discrimination, physical or sexual abuse, neglect, mental illness, emotional disturbance, or devastating life experiences. A great many have come into contact with the juvenile justice system because they are already having trouble "making it" in the community. They deserve the best care we can give them, not the worst.

The good news is that, collectively, we have the knowledge to change this disturbing situation. Through projects, such as the Annie E. Casey Foundation Juvenile Detention Alternatives Project and the OJJDP Project on Training and Technical Support to Reduce Juvenile Corrections and Detention Overcrowding, juvenile justice professionals in jurisdictions around the country have successfully grappled with crowding and practices contributing to unnecessary detention. This special issue presents some of the wisdom gleaned from those efforts.

NOTES

- ¹ Summary of Inspection Findings, Colorado Department of Public Health and Environment (December 2, 1994).
- ² The facts presented here are taken from the Statement of Decision, *Keith G. v. Bilbray, et al.*, Superior Court of California, County of San Diego, Case No. 626554 (Oct. 21, 1992) [unpublished decision; judgment for plaintiffs later reversed on appeal].
- ³ *Id.*, p. 55.
- 4 "Number of Juveniles Admitted to Overcrowded

- U.S. Public Detention Centers 1984-1994," in National Council on Crime and Delinquency, *National Juvenile Detention Data* (December 1997), presented at the Juvenile Detention Alternatives Initiative Site and National Conference, Baltimore, MD., (December 9-12, 1997).
- ⁵ "Percentage of Juveniles in Overcrowded U.S. Public Detention Centers 1985-1995," in National Council on Crime and Delinquency, *National Juvenile Detention Data* (December 1997), presented at the Juvenile Detention Alternatives Initiative Site and National Conference, Baltimore, MD., (December 9-12, 1997).
- ⁶ Parent, Dale G., et al., Conditions of Confinement: Juvenile Detention and Corrections Facilities: Research Report, Abt Associates, Inc., prepared for the U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (August 1994), pp. 33-34.
- ⁷ Youth Law Center, Juvenile Detention and Training School Overcrowding: A Clearinghouse of Court Cases (1996).
- ⁸ Greenwood, Peter W., et al., Diverting Children From a Life of Crime: Measuring Costs and Benefits, Rand Corporation (1996), pp. 11-12.
- ⁹ Secure confinement of nonoffenders, and status offenders (except where there has been compliance with provisions for violation of a valid court order) violates the federal Juvenile Justice and Delinquency Prevention Act. 42 U.S. Code § 5633(a)(12)(A).
- 10 Secure confinement of children on INS holds alone violates the federal Juvenile Justice and Delinquency Prevention Act (42 U.S. Code § 5633(a)(12)(A)), and secure confinement of children on INS holds for "isolated" and "petty" offenses violates the national class action Stipulated Settlement Agreement in *Flores v. Reno*, CV85-4544-RJK, U.S. District Court for Central California, which took effect February 24, 1997.