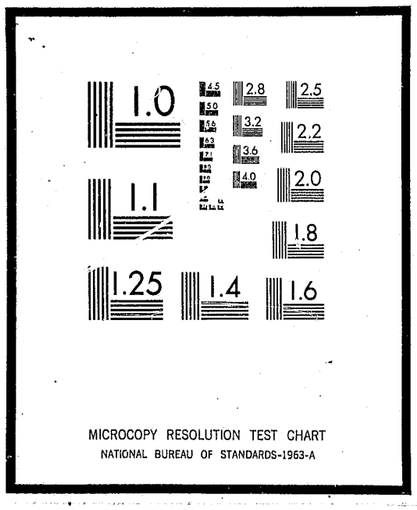
NCJRS



U.S. DEPARTMENT OF JUSTICE
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WASHINGTON, D.C. 20531

INTRODUCTION

Intensive care, or the secure handling of youngsters who represent a threat to themselves or to others, must be developed with a specific target population in mind. Failure eventually marks any security program which is developed in response to the apprehensions of some members of the public. There will always be those citizens who will demand harsh punishment for even the slightest offense. In early Massachusetts history, it was even possible for a parent to have his child put to death for disobedience.

Today, however, to follow the dictates of such a rigid philosophy would lead to the reopening of large lock-ups, or what have come to be called training schools, which offered little chance for troubled youngsters to learn the "life skills" necessary for successful reintegration into society. Such schools offered little more than punishment and isolation from the rest of society--a means by which the State could satisfy the limited public call for retribution.

The courts have identified two general categories of youths who do require intensive care programming. The first category encompasses those children who represent a threat to the security of society. The second includes children who are serious threats to their own well-being as well as to the safety of society.

Psychiatrists at Boston's Judge Baker Clinic have more specifically defined youths in need of intensive care as:

1. Highly disturbed youths whose actions may include self-destructive behavior, such as eating glass or razor blades. These children may also hallucinate.

2. Environmentally damaged, severely acting out youths who, in many cases, have no rational basis for their aggressive behavior. Chronic car thieves who only steal cars for "joyriding" would fall into this category.

In a seminar on the needs of a select group of highly disturbed youthful offenders, representatives of many youth-serving agencies in DYS Region I suggested the following characteristics as common to all of these children:

1. Institutionalization prior to the age of ten. This characteristic was considered the most important factor in damaging these youngsters.
2. Highly manipulative behavior.
3. Frequent runs from placements.
4. Extremely unstable home situations.
5. A lack of willingness on the part of local private and public agencies to become advocates for these children.
6. These children all demanded an immense amount of energy and attention by staff of public and private agencies.

These children under discussion seemed dissimilar in the following ways:

1. Severity of offense was not the most important factor in determining need for intensive care.
2. Mixed racial character with a slightly higher proportion of black children.
3. Intelligence levels among the children varied from bright to retarded.

Intensive care units are being designed to accommodate the youths described above. Development of the units will be undertaken with the understanding of the dissimilarities as well as the similarities among the target population of highly disturbed youths. Thus, program content among units will vary according to the type of intensive care youngsters they are designed to serve.

Traditionally, difficult-to-handle youths received the least rather than the most services. Simple warehousing of these children in tightly secure settings was common practice. Implicit in such action was the notion that these children had reached "the end of the line." The new programs, on the other hand, will instill the notion that youngsters held there are in their first phase of eventual reintegration into the community.

CRITERIA FOR INTENSIVE CARE

In developing a viable intensive care program, there are certain criteria which must be met. Two well-developed, structural levels must be organized--the program level and the case management level--in order that the opportunity for rehabilitation will be maximized. In addition, programs should be thoroughly developed, but flexible enough in design to permit changes when necessary.

The programmatic level involves implementation, management, and evaluation of intensive care programs. All units should share the following program characteristics:

1. Programs should be secure

   In the past, the word "security" has become synonomous with tightly locked, carefully guarded settings. This traditional definition should not encompass all intensive care units. In most instances, well-trained staff can provide

   the safety and security necessary within these programs. A resurrected reliance on bricks and mortar and untrained guards will not provide the security for which the public is asking. Such units make rehabilitation all but impossible, and give citizens only an illusion that dangerous youngsters are "being taken care of."

2. Programs should be kept small

   Population in intensive care programs should be kept small, and the units themselves should be at some distance from one another in order:

   a. To allow for more clinical and educational treatment on a one-to-one staff-youth ratio.

   b. To decrease the possibility of the program expanding into an institutional, non-rehabilitative facility.

   c. To provide a more personal atmosphere.

   d. To allow for greater public scrutiny.

3. Populations should be mixed

   To prevent a youth in an intensive care unit from identifying himself as just another member of a large delinquent subculture, or giving him (her) the recognition of being one of the most delinquent youth in the State, it is necessary to create a mixed population at the facility. This end may be achieved through hiring widely varied staff, or mixing in other types of residents such as college students, families, private referrals, etc.

The second level of structure necessary to the success of an intensive care project is case management. Many past programs have been bastardized because of administrative failures rather than program deficiencies. Therefore, it is essential to have a level of case management which will improve the decision-making process. The goals of this level should be fourfold:

1. A better definition of youth in need of intensive care.

2. A performance-oriented case management procedure.

3. Proper implementation of these procedures at the regional level through a technical assistance program.

4. The sharing of information about child care programs on a state-wide basis.

Case managers should serve in both the direct administration of projects and in the development of references for future projects. In this manner, positives and negatives of existing programs can be utilized in the planning process.

PROGRAM DESCRIPTIONS

There will be three intensive care programs operating statewide by August 1, 1974, Andros, Westfield, and Worcester.

Although each of the units will be in compliance with the criteria outlined earlier in this paper, each unit will be unique to the extent possible in order to individualize care.

The following section provides a brief description of the programs for each of the units.

ANDROS

Andros began operating in February of 1972 as a distinct section in the Connelly Youth Center, but administratively it came under the supervision of the non-profit Andros Human Development Foundation on December 1, 1973. There are presently thirty-four youngsters at Andros, and full capacity at the unit is thirty-six. Andros staff work with environmentally damaged, severely aggressive male youths. Being the only operating intensive care unit at present, Andros is forced to accept a variety of very troubled youths who, when different security placements are available, will be separated

according to specific emotional and behavioral needs.

The Andros program was most recently evaluated in mid-September, 1973, and administrative changes were made as a result of this study. On December 17th, a new director, Benjamin Tyree, was hired. Since that time, the following changes have been implemented:

1. An extensive staff evaluation has been made resulting in the termination of twelve people and the resignation of seven. New staff were hired to replace these employees, bringing the total staff complement to forty-five.

2. One of the new hires is a staff psychologist who was formerly employed at M.C.I., Concord, who has since established an orientation and training component for staff and a reporting mechanism by which a systematic flow of information regarding clients will become a part of the child's case record.

3. All existing program components have been evaluated, resulting in the establishment of an educational component, a clinical component, and therapeutic component.

4. A new and more clearly defined chain of command has been established for the staff.

5. Needed repairs on the building have begun.

6. Communication lines are becoming clearer between component directors, regional directors, and the central office.

7. Positive attitude changes on the part of both residents and staff has occurred.

Andros has, as its primary goal, the reintegration of the youth into society with appropriate supportive programming and follow through. The reintegration process is composed of seven steps:

1. Orientation to life in the community.

2. Group outings.

3. Leaving the Andros grounds on a one-to-one basis with a staff member.

4. Weekend passes.

5. Day passes.

6. Five day passes.

7. Ten day passes.

As mentioned earlier, the Andros program has three components. From 7 AM to 3 PM, the Andros population, which is divided into three groups, attends each program component on a daily basis. The education segment is headed by a teacher, the recreation program is run by a certified gym coordinator, and the group therapy section is conducted by the staff counselors. From 3 PM to 11 PM, youths attend family group sessions with their relatives and other residents of the program and participate in smaller group meetings.

WORCESTER

The Worcester intensive care program will offer long-term placement for twenty-four youths (sixteen females, eight males) who previously have been unsuccessful in adjusting to community-based programs. These youngsters will require careful case management and professional supervision to assist them in dealing more constructively with their problems. Negative self-images and running from problems are two significant characteristics of the youngsters who will be referred to the Worcester program.

The program will be located in what is now the Worcester Detention Center. Action is now being taken to relocate the youths who are now at the Center on detention status (awaiting court disposition of their cases). A shelter care unit established at the Worcester YMCA is being utilized for some of these transfer cases.

Agency involvement from the surrounding community will be an important part of the Worcester program. This feature will be stressed there because the type of youngsters being served are those who feel uncomfortable in the social structures of day-to-day community life.

In addition to outside support, the unit will include the following components:

1. Educational programming

   Many of the youths who come to Worcester will be educationally deficient. The educational coordinator will evaluate needs and devise proper learning programs for each youngster. Teachers, graduate students, and volunteers will be among those who will be utilized in this component.

2. Group therapy

3. Individual therapy

4. Specialized services

   Vocational training, family counseling, sex education, and job/school placement would be among the services available for youngsters in the program.

WESTFIELD

Westfield intensive care programming will be located in the detention center in that community. The center is designed in the same manner as the Worcester unit. Relocation plans for the youths now at Westfield on detention status are being implemented.

There will be twenty-four youths (sixteen males, eight females) when the program reaches capacity. William Layfield, presently the Director of Liberty House in Danvers, Mass., will be in charge of the Westfield program. The unit will house those youths who are highly disturbed and aggressive. Average stay at the unit is targeted for between two and six months.

The project will utilize the staff of the Westfield facility, but only after a thorough training program has been conducted for these employees. Continual monitoring and program evaluation will assist the central office in determining staff effectiveness with this type of youngster.

The daily programming will be largely based on the schedule as developed at Liberty House in Danvers. This schedule follows:

9:00 AM - Morning meeting. The House Concept is read. This concept serves as a focal point of identification. Each resident can identify with various sections of the Concept, at the same time that it carries the implication that all the residents are going in the same direction. Discussion follows the reading.

Following the Concept reading, reports of the various department heads are made. A department head for the kitchen will announce the menu for the day. The department head of laundry will detail cleaning procedures. The head of communications relays any messages to residents. The housekeeping head will discuss any pertinent matters involving clean-up or repairs.

About fifteen minutes are spent in general discussion,and the morning session is ended with a joke or a song.

9:30 AM - The House separates into department head meetings. The various department heads give directions to their peers in order to carry out particular responsibilities.

9:45 AM - The work period begins. This time serves both as a means of keeping the house in order and as a way of fostering awareness of responsibility and cooperation. Placement of a resident in a particular job is carefully considered to facilitate growth in an area of weakness. The house resident is taught to function under stress and pressure, to increase awareness, and to develop responsibility for himself and others.

The work period is directly tied to the clinical program. The work periods are used to put each resident in a particular situation with the expectation that he will experience strong feelings within that situation. For example, a resident who has difficulty asserting himself would be assigned to a department head position; a person who has difficulty taking orders would be assigned a more menial task where he must respond frequently to an authority figure. Eventually, the youngster will learn to become more comfortable with the feelings he has. In order to develop self-reliance, he must learn not to"act out" about these feelings in an irresponsible way. He learns to control their expression until group session, or another appropriately designated time.

12:00 Noon - Lunch

1:00 PM - Seminar. The seminar varies, depending on the particular need of the house. It may be geared toward an action, such as trust walks, relationships, images, interpersonal skills, art activities, or a discussion on what juvenile delinquency means or other similar topics.

2 - 4 PM - Individual independent development is the goal of this time period. An individual's interest is fostered and programs are developed around this interest.

4:00 PM - Activity - This activity is physically oriented Basketball, touch football, or other activities that make use of the body are conducted.

5 - 6 PM - Break - This time is for informal discussion, rest, and preparation for dinner.

6 - 7:30 PM - Dinner

7:30 - 9:30 PM - Monday, Wednesday, Friday. Group meetings are held. The goal here is to encourage interaction among persons in the program Tuesday and Thursday. Planned group activities are held, such as plays, skits,etc.

While some program changes may be instituted in transferring the Liberty House program to an enclosed unit, it is expected that the bulk of the concepts can be utilized at Westfield.

SUMMARY

Intensive care is a new concept. Traditionally, security programs meant incarceration in physically confining buildings with supervision by staff who relied on their size and authority to enforce discipline within the unit.

While the Department does recognize that there is a need for secure placements for that small portion of youth offenders who represent a threat to themselves or to society (between 1% and 10% of the total commitments), the staff also realizes that security should not mean a lack of services for these hard-to-handle youngsters. In addition to "bricks and mortar" - and sometimes even instead of it, professional and caring staff can provide the public with safety from runaway, dangerous youth.

Program needs will change as the youth population changes, but the Department feels that it is embarking on a realistic and much needed effort to best serve those young people who require the most attention in order to maximize their change for rehabilitation.

APPENDIX I

SLOT DISTRIBUTION
INTENSIVE CARE PROGRAMS

	Boys	Girls	Total
ANDROS	36	--	36
WESTFIELD	16	8	24
WORCESTER	8	16	24
			84

APPENDIX II
THE CONTRACTING SYSTEM

The contracting system will be used as a case management tool to insure optimum responsibility and accountability for youth and staff involved in Intensive Care.

A contract will be written upon entry of a youth into an Intensive Care Unit. The initial contract may be written between the program and Regional decision maker, with the youth's involvement with the contract increasing as he progresses through the program.

The contract will be used every time a transaction occurs - either between administrators, program staff, and/or the youth. Thus, contracts should be revised continually throughout a youth's residence at an Intensive Care Unit. From the time of intake, through and including output, the contract will be the device used to place responsibility, accountability on all people involved in I.D. case management.

DATE: _____

C O N T R A C T

YOUTH'S NAME: _____ STATUS: _____

REGION: 1 2 3 4 5 6 7 INTENSIVE CARE UNIT: A WE WO

MAJOR DYS DECISION MAKER: _____

HOME PHONE: _____ OFFICE PHONE: _____

PROGRAM COUNSELOR: _____

HOME PHONE: _____ OFFICE PHONE: _____

ESTIMATED REMAINING TIME EXPECTED TO BE IN PROGRAM: _____

COUNSELLING HOURS PER WEEK PROMISED BY PROGRAM COUNSELOR: _____

VISITS PER WEEK PROMISED BY REGIONAL DECISION MAKER: _____

PHONE CALLS PER WEEK BY REGIONAL DECISION MAKER TO PROGRAM: _____

FUTURE GOALS FOR YOUTH: _____

_____

_____

SHORT TERM GOALS: _____

_____

SERVICES TO BE PROVIDED BY PROGRAM: _____

_____

SERVICES TO BE PROVIDED BY REGIONAL DECISION MAKER: _____

_____

RESPONSIBILITIES OF YOUTH: _____

_____

CONTRACT TO BE REVISED ON OR BEFORE (DATE): _____

WRITTEN PROGRESS REPORT TO BE MADE ON (DATE): _____

COURT APPEARANCE DATE(S): _____ TRANSPORTATION: REGION PROGRAM

CASE MATERIALS TO BE PROVIDED BY REGION: _____

_____

ALL MATERIALS TO BE RECEIVED BY (DATE) _____

REGIONAL DIRECTOR _____ REG, DECISION MAKER _____

YOUTH _____ PROGRAM COUNSELOR _____

INTENSIVE CARE TEAM MEMBER _____

END