DEPARTMENT OF YOUTH SERVICES - INTENSIVE CARE PROGRAMMING, JANUARY, 1975

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Intensive Care

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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 on a crisis basis 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 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 -- 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-servicing 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 involved implementation, management, and evaluation of intensive care programs. All units should share the following program characteristics:

1. Program should be secure

   In the past, the work "security" was synonymous 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 indentifying 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 system 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 permanent case-oriented case management procedure.
3. Proper implementaion 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.

*All six I.C. programs will have a mixed population with the exception of D.A.R.E. I.C. Because the D.A.R.E. program will stree strenous physical activities, this program has been limited to males.

Six Intensive Care Programs will be operating by March, 1975. Presently, three I.C. programs are being utilized: Andros I.C., Worcester I.C., and Westfield I.C. Over the past year, evaluations of the present programs have been made, and have resulted in the following changes:

1. Three new I.C. programs, (A.C.I.D., D.A.R.E., and R.F.K.) are to have commenced by March, 1975.
2. The existing Andros program will be substantially modified by
   a. decreasing the number of youth from 36 to 12 (9 males, 3 females),
   b. physically relocating the program which is presently housed at the Roslindale facility, and
   c. changing the staff pattern.

   The above changes will be incorporated in a new program structure.
3. The boy/girl ratio at Worcester I.C. will be reversed from 8 males, 16 females, to 8 females and 16 males. This will not decrease the number of female slots* since these 8 slots will be incorporated into the new programs.
4. The overall number of slots will be increased from 84 (60 M, 24F) to 96 (71 M, 25F).

Although each of the units will comply with the criteria outlined earlier, 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.

*Refers to beds, i.e. one slot implies one bed.

Worcester

The Worcester I.C. program which began September 1,1974 will continue to offer long-term placements for twenty-four youths. The original plan to provide placement for 16 females, and 8 males, has been changed to 8 females and 16 males. Aside from the population change, the program itself will continue as originally designed. Those youngsters placed at Worcester will require careful case management and professional supervision in order to assist them in dealing more constructively with their problems. Negative self-images and the evasion of problems are two significant characteristics of the youngsters who will continue to be referred to the Worcester program.

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 youngster in the program.

Westfield

Westfield I.C. will continue to house those youth who are highly disturbed and aggressive. There are presently, and will continue to be, 24 youth (16 M, 8 F) in the program.

The Westfield staff participated in an intensive training program organized and operated at Liberty Street in Danvers, Massachusetts by psychologists and psychiatrists. Staff monitoring and evaluations have been continued on a regular basis, aiding the central office in determining the staff effectiveness in treating disturbed aggressive youth.

The daily programming is 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 involing 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 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 those feelings in an irresponsible way. He learns to c o n t r o l 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

7:30-9:00 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 minor program changes have been insituted in transferring the Liberty House Program to an enclosed unit, the bulk of the concepts have been successfully utilized at Westfield.

Anros (Human Development Corp.) I.C.

The Andros I.C. program will deal primarily with inner-city youths who are extremely serious offenders. According to the director of Andros, the program is designed to serve those youths who are rational, realistic, and who see crime as a way of life rather than those having deep-seated psychiatric problems. These youngsters will tend to have strong survival skills and are characterized as 'slick'. They are environmentally damaged and have been institutionalized. Also they have been taught through long-term involvement in the criminal justice system to manipulate and con. The Andros program will provide housing for 9 males and 3 females.

The program itself will be divided into 3 major areas:

1. Intake - Immediate needs of the youth, (clothing, food, etc.) will be met. Subsequently, they will be involved in a orientation process.

2. Program Involvement - A decision making coordinator will be assigned to each youth within the program. In conjuntion with this co-ordinator the youth will develop a treatment action plan. The ultimate goal will be to move the youth out of the program. This is to be accomplished by setting up educational experiencies which will provide him/her with the necessary skills to survive in the community.

   The program will be realistically oriented, with emphasis on success, primarily in the areas of physical activity, arts and crafts, and reading.

3. Output - Will be initiated only after a youth has successfully completed the program, and has negotiated an agreed upon plan of action with a living situation and a vocational training, educational or employment component.

Following is a proposed daily schedule:

	7:00 - 9:00	Wake up Personal hygiene Breakfast House Maintenance General clean up Laundry Repairs

	9:00 - 10:00	Recreational Activities
	10:30 - 12:00	Individual Counseling Education Classes
P.M.	12:00 - 1:00	Lunch
	1:00 - 2:00	Community Meeting
	2:00 - 4:00	Educational Activities Art - pottery Workship/leather and wood Sewing Typing Skills
	4:00 - 5:30	Physical Activities Modern Dance Yoga Basketball Trampoline Touch football Running
	5:30 - 6:00	Break Rest, discussion Preparation for dinner
	6:00 - 7:30	Dinner Clean up

D.A.R.E. (DYNAMIC ACTION RESIDENCE ENTERPRISE) INTENSIVE CARE

D.A.R.E. Intensive Care will begin on January 1, 1975. The facility will be located in Chelmsford, Mass., and will house 12 males - ages 7 to 17 (average age - 15). The purpose of D.A.R.E. I.C. is "to manage the youth's behavior to the extent that the youth, the staff, and other residents are able to conduct themselves in a mutually respectful manner."

The treatment aspect of the program will focus primarily on the following three components:

1. Physical Accomplishment: Strenuous physical activity will include daily exercise, individual confidence courses, group competition, camping, group athletics, and other outdoor activities. As the youth progresses through the other stages of the program this strenuous physical activity will be progressively de-emphasized.

2. Intellectual Development: This will be achieved through written and oral testing in addition to pragmatic work assignments. Included will be practice with employment applications, employment interviews, public speaking, and current events. This component is designed to provide a degree of intellectual mastery for the youths and will also give staff a realistic assessment of each child's ability.

3. Social Development: Living in a structured group situation will enable the youth to encounter and come to grips with the different conflicts, pleasures, and pressures which are inevitable when dealing with other people. Much emphasis will be placed on the perception, clarification and internalization of vital social and individual values as they relate to the social development of these youth.

The entire treatment process will take approximately 12 weeks. Each stage within the process should be viewed as an integral part of the entire program.

A.C.I.D. (ADOLESCENT COUNSELING IN DEVELOPMENT) I.C.

A.C.I.D. is to provide a secure and therapeutic program for those youth the department feels are in the greatest need of services. The ACID program is designed to achieve its goals via the utilization of multiple modalities and a strong staff team approach. Engagement with the residents will, from the initial phase, include the family or a family substitute and at a later appropriate point in treatment, other social and health resources and other pertinent supportive entities.

The A.C.I.D. I.C. program will house 12 D.Y.S. youth, 9 of which will be males and 3 females. The treatment objectives of the program can be divided into seven components:

1. Intake: like other I.C. programs, A.C.I.D. will have an intake process which will consider and evaluate all previous records of the youth, a psychiatric workup, psychological intelligence and projective tests, a compilation of a social, familial history, and a comprehensive medical physical.

2. Orientation Period: To help each new resident understand the new environment in which he/she has been placed. This will include meetings with the youth and his/her family.

3. Long and Short Term Goals: To be formulated during the intake and orientation process and subsequently communicated to the youth.

4. Treatment Modality: To include an individual counselor for each youth, peer group counseling, and milieu therapy under the direct supervision of professionally trained staff.

5. Educational Services: Will be designed to assess the learning capabilities and disabilities of all youth in the program.

6. Milieu Therapy: Will a) carefully monitor each resident's response to his/her physical environment, peers, heterosexual interests, sexual identification, relationships with staff, with authority figures, and family utilizing recreational and resocializational activities and b) provide constant, consistent and constructive feed back to the residents concerning their respective growth and development.

7. Evaluative Process: To monitor the progress in the residents and progress or lack thereof, in a period of followup and subsequent discharge.

A.C.I.D. with its professional staff, will provide a highly clinical residential setting for youth who are unable to function within existing community basad placements.

R.F.K. (ROBERT F. KENNEDY ACTION CORPS) INTENSIVE CARE

R.F.K. I.C. will house 12 adolescents (9M, 3F) between the ages of eleven and seventeen. This program will be set up to serve those youth "who have been evaluated as severly disturbed and who have been involved in repeated criminal offenses". R.F.K. will be working closely with the Department of Mental Health, as well as D.Y.S. Other supportive services will include:

1. a highly structured residential component which places great reliance upon well-trained child-care workers;

2. a psychiatric component, which will include the consulting services of a psychiatrist and psychologist supported by a full-time psychiatric social worker;

3. an educational component which will stress the resolution of major learning disabilities and the development of vocational skills in order to prepare the youth for re-entry into the community;

4. a caseworker component to be supervised by the Program Director and social worker who will jointly develop and implement appropriate case plans for the reunification of each child's family;

5. community service component which will actively encourage the development of supportive community services for the youth and his family; and

6. a group counselling component within the residential unit, to be supervised by the consulting psychiatrist and psychologist, the social worker and the childcare staff.

The R.F.K. I.C. programs will provide a highly structured program to deal with severely disturbed adolescents. Each hour the youth spends in the program will be carefully planned by staff in an effort to deal with behavior problems. Although the program itself will be highly structured, there will be a sense of openness within the residence itself.

Following is a proposed schedule:

Typical Daily Schedule

7:30 A.M.	Wake-Up
7:30 - 8:00	Dress, Clean room
8:00 - 8:30	Breakfast
8:30 - 9:00	House Jobs
9:00 - 10:30	School
10:30 - 10:50	Recess
10:50 - 12:00	School
12:00 - 12:30	Lunch
12:30 - 1:15	Recreation
1:15 - 2:45	School
2:45 - 3:15	Group Meeting (Behavior)
3:15 - 4:30	Activity Group
4:30 - 5:30	Community Meeting
5:30 - 6:00	Dinner
6:00 - 7:30	Club Activity
7:30 - 10:00	Reading, Television, Movies
10:00 - 11:00	Preparation for bed
11:00 P.M.	Lights Out

The Intensive Care Team

Intensive Care Programs are being developed in an attempt to answer correctional problems which institutions have failed to solve. In order to prevent proliferation of these small I.C. units, a carefully structured case management level has been created. A central decision making body comprised of representatives from each of the seven D.Y.S. regional offices, each of the I.C. programs, and central administrative staff has been formed. It is known as "The Intensive Care Team".

At its first meeting on April 16, 1975, the I.C. team established a specific set of gaals. These goals are:

1. To monitor and evaluate all I.C. programs, insuring that policies and procedures governing I.C. are not violated.
2. To serve in an advisory capacity in aiding regions and programs in making decisions.
3. To act as a valuable resource to all regions in identifying alternative placements for those youth referred to I.C.
4. To control intake of all youth entering I.C. programs, preventing youth who should not be placed in I.C. from being erroneously placed.
5. To support the implementation of follow through plans for each youth as they leave an intensive care setting.

The I.C. system is thus comprised of two carefully structured components- a case management level (via the I.C. Team) and a programatic level (via 6 I.C. programs). These two components work harmoniously attempting to provide maxumum growth experienced for I.C. youth.

Name of Program	A.C.I.D.	Andros	D.A.R.E.	R.F.K.	Westfield	Worcester
Location	The Marlboro Mass. area	Boston area	Chelmsford, MA	The Danvers MA area	51 E. Mountain Rd. Westfield, MA	363 Belmont St. Worcester, MA
Starting date	January, 1975	March, 1975	January, 1975	March, 1975	June 3, 1974	September 1, 1974
Maximum # of Residents	9M 3F 12	9M 3F 12	12M	9M 3F 12	16M 8F 24	16M 8F 24
Brief Description of Target population	Highly disturbed, aggressive youth. Most appear as having deep psychological problems. Primarily non-rational delinquents.	Rational and realistic heavy offenders. Mostly third world youth. Characterized as having strong survival skills and "slick," very manipulative.	Verbal, extroverted youth. The type of youth who would profit best from an Outward Bound type program.	"Rational" delinquent whose problems include school and family, and would participate in educational, as well as social, programming.	Same as A.C.I.D.	Same as R.F.K.
Brief Description of Program	Like the present Westfield program, A.C.I.D. I.C. will offer, through a clinically trained staff, a milieu therapy consisting of much group and individual counseling.	Realistically oriented program to deal with street-smart youth. Much physical activity, educational programming, and cultural enrichment. Thrust of treatment will be to develop a personal, positive sense of self that is balanced with a positive value system.	Empasis on the development of physical, intellectual and social strength. Overall plan of program is similar to a long-term (3 mo) Outward Bound Program.	Highly structured program, with much imput from the Dept. of Mental Health and Community agencies. Vocational and educational programming will be an important part of the overall programming.	Strong clinical imput by trained professionals, both as staff and and outside consultants. Program based on Liberty House model in Danvers MA (concept house). Much use of group, family, and individual counseling in treatment program.	Like R.F.K., much use of communit resources. Program has a structured educational component, as well as imput from outside psychiatric consultants

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 young offenders who represent a threat to themselves or to society (between 1% and 5% 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 hopefully 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 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.C. case management.

CONTRACT

DATE_____

YOUTH'S NAME_____ STATUS_____

REGION 1 2 3 4 5 6 7 INTENSIVE CARE UNIT: A WE WO
A.C.I.D. D.A.R.E

MAJOR D.Y.S. DECISION MAKER_____

HOME PHONE_____ OFFICE PHONE_____

PROGRAM COUNSELOR_____

HONE PHONE_____ OFFICE PHONE_____

ESTIMATED REMAINING TIME EXPECTED TO BE IN PROGRAM_____

COUNSELING 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 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)_____

REGION DIRECTOR_____ REGION DECISION MAKER_____
YOUTH_____ PROGRAM COUNSELOR_____
INTENSIVE CARE TEAM MANAGER_____