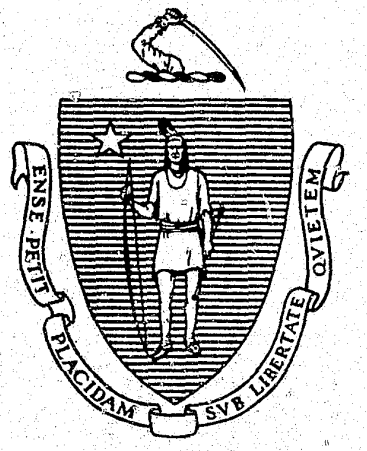
SECURE TREATMENT POLICY MANUAL



COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF YOUTH SERVICES

MARCH, 1976

PUBLICATION OF THIS DOCUMENT APPROVED BY ALFRED C. HOLLAND, STATE PURCHASING AGENT

200-1-76-129685

Est. Cost per copy $1.93

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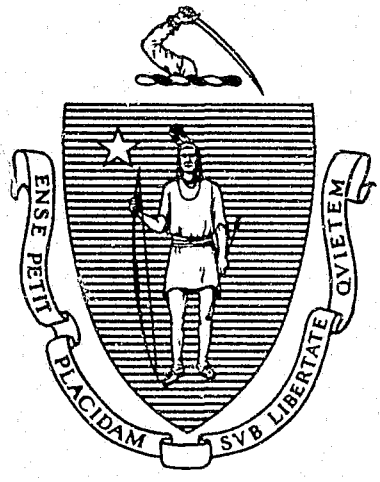

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Table of Contents

Introduction

The policies and procedures outlined in this manual have been conceived and developed through the efforts of the Intensive Care Team of the Department of Youth Services. This manual was created to aid in the implementation of Intensive Care programming from the initial referral to the eventual follow-through placement.

The manual makes no attempt to address itself to particular youth problems or individual Intensive Care programs. Instead, we have presented the responsibilities and obligations of involved decision makers at each and every stage of the Intensive Care process. Through this overview approach the working relationships between all involved parties will be shown in a simplified yet specific manner.

As a policy statement the manual reflects a number of critical concerns, ranging from the need for secure residential placements and intensive professional treatment to the need for increased departmental support and responsible case management. If it is to provide effective services for youth, Intensive Care must be viewed as a coordinated and supportive venture between the department, regions and programs.

Intensive Care Team

I. Introduction to Intensive Care

A. Description of Major I.C. Decision Makers and General Responsibilities

1. The Intensive Care Central Administrative Staff

The Central Administrative staff will be responsible for the overall administration of Intensive Care. This responsibility includes a number of tasks to be accomplished by the director and his/her staff, ranging from data collection to program development.

a. The Intensive Care Director carries ultimate responsibility for the operations of Intensive Care within the Department. The Director has among his/her responsibilities:

1) overall supervision of any and all Intensive Care programs utilized by the Department;
2) direction of all Intensive Care team meetings;
3) major input into any policy changes;
4) monitoring the use of Intensive Care slots and approving any requests for emergency slots;
5) direct supervision and training of all central administrative staff assigned to, or involved with, Intensive Care;
6) development of new I.C. programs and/or closing existing I.C. programs based on the needs of the department's youth; and
7) the monitoring of all federal funds as they pertain to I.C. programming.

b. The two Central Administrative Intensive Care Representatives are responsible for:

1) attending all Intensive Care meetings and assisting the director in leading these meetings;
2) voting on the appropriateness or non-appropriateness of all referrals;
3) aid in the development and implementation of Intensive Care policies and procedures; and
4) represent the central office in matters of Intensive Care as delegated by the Director of I.C.

c. The supportive staff works under the direction and supervision of the Intensive Care Director. They are responsible for the following:

1) to develop a system of monitoring the movement of youth through Intensive Care programs,
2) to establish and maintain a system of data collection and record keeping that will help a insure a level of accountability throughout the Intensive Care process,
3) to organize weekly meetings, regional workshops and departmental conferences concerning Intensive Care,
4) to work closely with the Director in the preparation and distribution of the policy manual and any new program development, and
5) to work with the regions and the Intensive

Care programs in the development and coordination of an Intensive Care system that meet both the needs of the youth and the concern of the Department.

2. The Region

The region is responsible for a number of major decisions concerning Intensive Care Youth. It is the region who will be responsible for:

- the proper management of all Intensive Care slots assigned to or borrowed by the region;
- providing adequate staffings to exhaust all possible alternatives prior to consideration of a youth for Intensive Care;
- determining which youth will be referred to the Intensive Care Team for possible placement;
- insuring regional support and involvement throughout a youth's stay within an Intensive Care Unit; and
- working closely with the Intensive Care Units to develop suitable follow-through placements.

The region will fulfill these responsibilities through the youth's Major Decision Maker and the region's Intensive Care Representative.

a. The youth's Major Decision Maker is the regional person who is most responsible for all decisions made concerning an individual youth. He/she may be a case worker, parole agent, or any person the regional director has assigned as most responsible

for the youth. Overall responsibilities will include:

1) periodic visits to the Intensive Care program to maintain a more personal relationship with the youth;
2) working closely with the youth and program in negotiating agreements on a regular basis;
3) keeping both the region and the Intensive Care Representative informed of the youth's progress within the Intensive Care Program;
4) planning and supporting a follow-through plan for the individual youth, and
5) assuring that agreements and visits are maintained on all I.C. youth after they leave an I.C. program.

b. The Intensive Care Representative is that person who represents the region in matters revolving around Intensive Care. He/she will be a member of the Intensive Care Team with the following responsibilities:

1) representing the region at all I.C. team meetings and any appeal cases;
2) presenting all regional youth referred to the team for I.C.;
3) voting on the appropriateness or non-appropriateness of all referrals;

4) making all regional requests for emergency slots;

5) informing the team of any progress, incidents or difficulties concerning I.C. and how it is meeting the needs of the region;

6) sending complete monthly status reports to the Intensive Care secretary;

7) insuring that all procedures are being followed regarding regional youth in Intensive Care; and

8) keeping the regions continually informed of all matters concerning I.C. programming.

3. Intensive Care Programs

The Intensive Care Program will be responsible for the security and treatment of all youth assigned to it by the Intensive Care team. It will be responsible for dealing with these youth's needs and problems and for informing the regions and the central staff of any progress or difficulty in returning these youth to community-based placements. The implementation of these responsibilities will depend on two program personnel: the program decision maker and the program Intensive Care representative.

a. The Program Decision Maker is that program person specifically assigned to be the principal counselor and advocate for an Intensive Care youth. He/she will have a number of responsibilities:

1) to work closely with the youth assigned to him/her while that youth is in an Intensive Care Program;

2) to work with the youth and the regional decision maker in developing effective and attainable agreements;

3) to submit monthly written progress reports to the Regional I.C. team representative,

4) to help in the development of follow-through plans for the youth.

b. The Program Intensive Care representative is that person who represents the program in various matters with the Department. He/she will be a member of the Intensive Care team with the following responsibilities:

1) representing the program at all Intensive Care team meetings and any appeal cases;

2) voting on the appropriateness or non appropriateness of all referrals;

3) being familiar enough with the program's capabilities to comment upon the appropriateness of any particular referral to the program;

4) insuring that all procedures are being followed regarding youth within an Intensive Care Program,

5) informing the team of any progress, incidents, or difficulties concerning the operation of the Intensive Care program; and

6) keeping the program continually informed of all matters concerning I.C. programming.

4. The Intensive Care Team

The Intensive Care Team will serve as an advisory and policy-making

body in decisions concerning Intensive Care. The team will be comprised of voting members with the following breakdown.

Regional Intensive Care Representatives

Program Intensive Care Representatives

Central Administrative Intensive Care Representatives

Director of Intensive Care (to vote only in the case of a tie)

In the event that a regular Intensive Care Team representative is unable to attend an I.C. meeting, his/her alternate will take his/her place. The alternate should be a person appointed by the regional or program director and identified to the Director of Intensive Care. This person should be trained by the regular I.C. team member, and is encouraged to attend meetings with the team member. The alternate may vote only when the regular team member is not present. No team member should have more than one regular alternate.

All team members are expected to be prompt in attending the weekly meetings. Basically, the responsibilities of the Intensive Care team will be:

1) to control intake of all youth entering Intensive Care programs, and to guard against hasty or improper decisions being made;
2) to develop and implement all policies and procedures concerning a youth's progress into, through, and from Intensive Care;
3) to act as a policy-making body in developing rules and regulations around the use and management of Intensive

Care;

4) to review all appeals, agreements, and grievances and to monitor the use of emergency slots; and

5) to train and inform regional personnel of the policies and procedures established around Intensive Care.

5. The Youth

In order to effectively service the needs of disturbed youth, Intensive Care programs must be designed with the needs of these youth in mind. Because many of these youth will have different and dissimilar needs, programs must also be flexible enough to deal with youth on an individual and specialized basis.

A youth entering an Intensive Care program will immediately be told of his rights, among them being the "right to have imput into program management." As a youth progresses through an Intensive Care Unit, his rights and responsibilities will increase in accordance with his ability to effectively function within the unit, and later within the community. Through the agreement system, the youth will play an increasingly greater role in the decision making process as it is proven that he/she is a responsible human being.

II. The Intensive Care Process

Intensive Care is an area which the department should approach with both caution and responsibility. Because it represents a major expenditure of departmental funds, responsibility must be exercised at all levels to insure the best possible return in services to youth. At the same time, there exists the possibility that these programs may degenerate into impersonal and ineffective institutions. Care must be taken to insure that no abuse or misuse is made of either the services available through Intensive Care or of the youth in need of these services.

To safeguard Intensive Care against such abuses and to establish a level of accountability throughout the system, a number of specific responsibilities have been outlines and must be fulfilled at each and every stage. The stages range from the initial referral to the eventual follow-through placement while the responsibilities involve the four major decision makers in cooperative support of each Intensive Care youth. If the procedures appear extensive and involved that is the point! They are designed to insure that alternatives are explored before a youth is referred, and that regional support continues throughout the Intensive Care process. Without such built-in accountability, Intensive Care will become little more than a dumping ground for problem youth.

A. The Referral Stage

1. Description of the Referral Process

For any youth to be considered for I.C. placement, the following procedure must be followed:

a. Identify the Client

This should be done by the person working closest to the youth. This person would most likely, though not necessarily, be a child's caseworker and would be called the "regional decision maker."

b. Prepare Background Material

The regional decision maker for the youth would prepare the necessary background material (see check list) to present to the regional staff. This would be done after all viable alternatives have been explored.

c. Regional Staffing

A regional staffing should be held on the youth. Before the I.C. Team Member is approached, the region should review the case and decide on the appropriateness of I.C. placement.

d. Presenting a Youth to the I.C. Team

The I.C. Team Member will inform the regional decision maker of what I.C. slots are available. The case cannot be presented unless a regional I.C. slot is available, or appropriate plans have been made to borrow a slot from another region. If the region decides that a youth is available, the regional decision maker should approach the I.C. team member with all necessary backgroung material (see check list) and a 2-4 page summary of the youth. The

I.C. team member will then present the case to the I.C. team at their next meeting.

e. Voting

The team reviews the case to decide the appropriateness of I.C. placement. A vote is taken after the case is presented. If the majority votes "appropriate", the youth can immediately go to the available approved program. If the majority votes "not appropriate", it becomes a regional responsibility to find an alternative placement.

2. Presentations

a. Presenting a Case

A youth can be presented to the Intensive Care Team for placement only after a region has taken all the necessary steps in determining that a youth is in need of I.C. services (see description of the Referral Process). When it has been decided that Intensive Care programming is the only viable program for a youth, a presentation can be made to the I.C. team in the following way.

1) The regional decision maker should meet with the I.C. team representative. Together they should decide who will give the presentation at the next I.C. meeting. It is encouraged that decision makers assist team members in making presentations, since he/she will be much more familiar with the facts concerning the youth to be presented.

2) The regional decision maker should collect all the necessary information on a youth (see check list).

3) A 2-4 page summary must be prepared by the youth's regional decision maker. This report must be given to the I.C. team member with an attached copy to be handed to the I.C. secretary at the next meeting. The purpose of this summary is to insure uniform and informative presentations at I.C. team meetings. This report must be prepared for the presentation, or the team is under no obligation to hear the case.

4) The summary presentation must include the following:

   a) Reasons for referring - to include types of offenses, the specific behavior pattern that led youth to being an I.C. referral and the youth's present status with the courts.

   b) Behavior evaluation - to include a description of the youth's behavior (rational or irrational) with imput from past and recent psychiatric evaluations, a suggestion of possible treatment modes, and mention of any abnormal or unusual physical or medical conditions.

   c) Past Placements - to include past placements and a brief description of the youth's behavior while in these placements.

   d) Relationships - to include a description of both positive and negative relationships.

e) Family background - to include a brief history of his/her family and the relationships within.

f) Post Intensive Care Plan - suggest possible types of follow-through plans for a youth if he/she is accepted for Intensive Care.

After a case is presented and all non-judgemental comments made, a vote is taken.

b. Re-presenting a Case

A youth may be referred for Intensive Care more than once if any of the following conditions exist.

1) A youth is referred to the I.C. team, accepted, enters an I.C. program, and is later discharged. If a time greater than two weeks after the youth is discharged elapses and the region feels that the youth again needs the services of Intensive Care, the case may be re-presented.

2) A youth who is referred to the I.C. team, accepted, but never enters an Intensive Care program. If a youth is sent to an alternative placement other than Intensive Care, the case must be re-presented if the region later decides that Intensive Care would have been a more appropriate placement. If a youth runs, however, before I.C. placement is made, two months may elapse before the case must be re-presented.

3) If a youth is presented to the I.C. team and voted as "not appropriate" for I.C. placement, the case can be re-presented only when additional information

becomes available.

3. Voting

After a case is presented for consideration to the I.C. team, a vote is taken by team members to determine the appropriateness or inappropriateness of a referral. The following process will be followed.

a. Each region, Intensive Care program, and the central administrative staff is allowed one vote. The Director of Intensive Care may vote only in the event of a tie. If a regular team member is not present at an I.C. meeting and is being replaced by his/her alternate, then the alternate may vote. An alternate cannot vote if the regular I.C. team member is in attendance.

b. There are two possible voting categories.

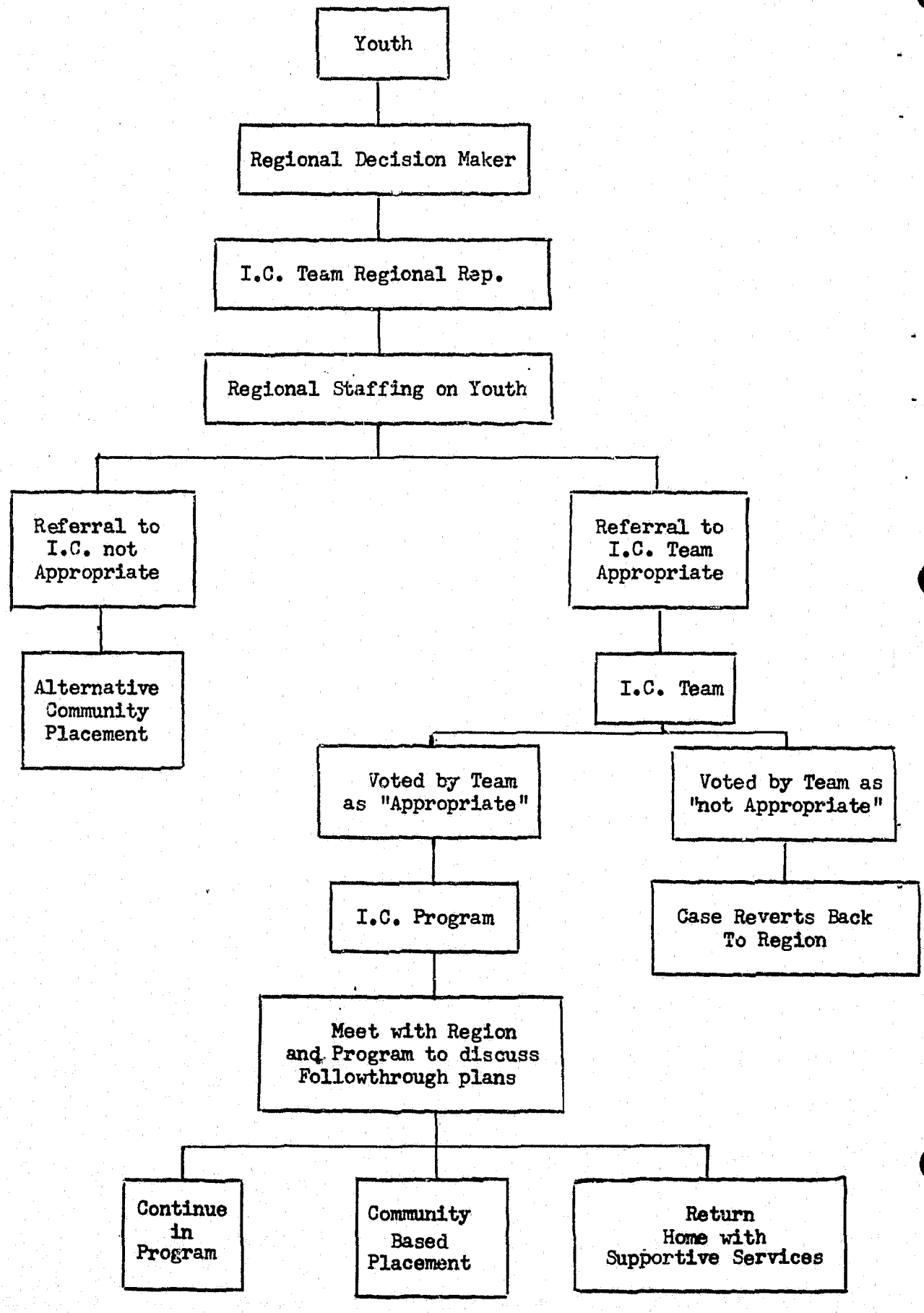
1) Appropriate - applies to those youth who are believed to be in need of I.C. services based on the criteria that have been established.

2) Not appropriate - applies to those youth for whom other services other than Intensive Care can or should be provided.

c. All team members are expected to be in the room when a presentation is being made. If an emergency arises and a team member has to leave the room, he/she may choose not to vote on the referral being given. All team members are expected to vote on every case, and may abstain only when they missed a substantial portion of the presentation.

d. Following the vote, each I.C. member must give his/her reasons for voting the way he/she did. If the majority votes "appropriately" in need of I.C. services, the youth is accepted for the approved I.C. program. If the majority votes "inappropriate", the case reverts back to the region.

4. Flow Chart for Intensive Care Youth



B. Intake Stage

The intake stage refers to the process whereby the youth is brought to and processed into an Intensive Care program. At this stage both the region and the program have a number of responsibilities.

1. Procedure for Intake

a. The region has responsibility for transporting a youth to an Intensive Care program following acceptance by the team. The region is also responsible for compiling all personal data and records on the youth and for any clothing needs. (see section on I.C. and Clothing Check List).

b. A youth must be brought to an I.C. program by the regional decision maker. If this is not done, the program is under no obligation to accept the youth. If a circumstance develops where it is impossible for a regional decision maker to transport a youth to the program, a substitute case worker may replace the regular case worker. The program must be notified in advance if the regular case worker is not delivering the youth.

c. When a youth first arrives at an I.C. program, he/she is assigned to a program decision maker. The youth, the program decision maker and the regional decision maker will then initiate the first contract. This contract is to be revised continually as a youth progresses through the program. At the I.C. meetings, these contracts will be reviewed on a monthly basis.

d. When a youth arrives at an Intensive Care program, he/she

will be informed of all his rights by the program staff.

(see section on Bill of Rights.)

2. Check List for I.C.

Before a youth enters an Intensive Care Unit, the following materials must be completed.

1. Previous Court Records.
2. Psychological Tests - to include a recent (no more than 6 months) psychiatric evaluation at the Judge Baker Clinic or another psychiatric resource.
3. School Records.
4. A summary of previous placements. Positive and negative behavior reported. Which programs worked? Which didn't? Why?
5. Probation Report.
6. Family Description.
7. List of placements approached and reasons for deciding that placement was inappropriate.
8. Present behavioral sheet.
9. Overall statement by caseworker.
10. Medical release signed by parents.
11. Medicaid number or Blue Cross Blue Shield number if they have one.
12. A facsimile of the birth certificate.
13. The social security number of the youth. If this is not available, the program should be so notified.

3. Clothing Check List

Before a youth enters an Intensive Care Unit, - the I.C. facility should be assured by the region that the youth will be supplied with the following articles of clothing within 10 days.

For Girls	For Boys
2 pair of pajamas	1 pair of pajamas
1 robe	2-3 pair of slacks
2-3 pair of slacks	2-3 shirts
2-3 blouses	1 jacket
1 jacket	4 pair of underpants
2 bras	1 pair of shoes
4 pair of underpants	1 pair of sneakers
1 pair of shoes	1 pair of short pants
1 pair of sneakers	1 bathing suit
1 pair of shorts	1 sweatshirt
1 bathing suit	3 pair of socks
1 sweat shirt	1 sweater
3 pairs of socks	4 T Shirts
1 sweater	

This is a suggested list of the minimum amount of clothing needed for a youth in an I.C. program. Because of the make-up of some I.C. programs, additional clothing may be requested. This should be worked out between the program and the region at the time of intake. It is the responsibility of the program, as well as the region, to insure that clothing requirements are met. It is not the program's responsibility to provide clothing for its youth, only to insure that they're received.

4. Bill of Rights for I.C. Youth

Intensive Care programming should be designed with the youth it is trying to serve, rather than around them. Too many programs in the past have been bastardized by administrators who neglect the rights of those they are attempting to aid.

Although Intensive Care youth have initially forced others to make decision for them, this does not mean their rights as human beings should be neglected or abused. In order to safeguard against these youth being objects of a program, rather than participants, certain rights should be established and all youth in an Intensive Care unit should be aware of these rights from the beginning. They are as follows:

1. Right to certain physical needs:
   a. proper clothing
   b. medical needs should be met - to include a complete medical examination, a psychiatric evaluation, and dental treatments if needed.
   c. decent food and housing
2. The right to be told by his/her caseworker why he/she is being sent to an I.C. program, and what the general concept behind I.C. is.
3. Right to know what is expected of him/her while in an I.C. unit.
4. Right to appeal an inappropriate placement.
5. Right to know the consequences when he/she abuses or neglects others rights, or breaks the rules of the unit.
6. Right to two stamps per week for their correspondence.
7. Right to freely practice his/her own religion.
8. Right to counsel by a clergyman.
9. Right not to be deprived of legal counsel.
10. Right to see his/her caseworker or parole officer bi-monthly.
11. Right to see a counselor daily
12. Right to have contact with family via telephone or family visit.
13. Right to report any incident involving staff or resident to the program director and have the disposition reviewed by the director of the Intensive Care.

14. Right to periodic reassessment of placement through the agreement system.

15. Right to have educational skills reviewed and evaluated.

16. Youth in the Department of Youth Services shall not be subjected to electrical shock treatment and DYS should develop a standard for drug treatment.

17. Right to know his responsibility to the program.

18. Right to have input into the program.

19. Right not to be subjected to medical and psychological experimentation.

20. All rights accorded youth in Office for Children regulations for the licensure of Group facilities for children effective April 19, 1974 Section 405.0 Behavior Management as follows:

405.0 Behavior Management:

405.1 Each licensee shall provide a written statement defining rules, regulations, policies, and procedures, for the behavior management of children.

405.1(a) When feasible and appropriate, children shall participate in the establishment of such rules.

405.1(b) The licensee shall inform children, parents, and guardians of rules in effect in the facility.

405.2 The licensee shall direct behavior management to the goal of maximizing the growth and development of the children and for protecting the group and individuals within it.

405.3 No child shall be subjected to cruel or severe punishment.

405.3(a) No child shall be subject to corporal punishment.

405.3(b) No child shall be subject to verbal abuse by staff about himself or his family.

405.3(c) No child shall be deprived of meals as punishment.

405.3(d) A locked room shall be used only when necessary to protect the child, other children, or staff from immediate danger of physical harm. Use of a locked room shall not exceed thirty (30) minutes

without consultation with and approval from supervisory or administrative staff. Such approval shall be necessary for each following sixty minute period. A staff member shall remain in close proximity to the locked room at all times while a child is in such locked room, and shall take appropriate measures to assure the safety of the child.

405.3(e) The licensee shall not use physical restraint for punishment or for the convenience of others. When necessary the licensee may hold a child to protest him from immediate physical danger to himself or to others.

405.3(f) No child shall be deprived of family visits or mail as punishment.

405.3(g) The licensee shall directly relate punishment to the specific misbehavior and shall apply such punishment without pronlonged delay.

C. Program Involvement Stage

It is the goal of all Intensive Care programs to provide the best possible services for youth within their facilities. This section, however, is designed not to describe I.C. programs but rather to delineate the responsibilities of all decision makers participating in the program involvement stage of I.C. Once a youth becomes a resident of an I.C. program, there are certain responsibilities and goals that he/she must accomplish. Similarly, programs and regions must assure that none of the policies and procedures governing I.C. are abused. This section describes those policies that occur or could occur while a youth is a resident in an I.C. program.

1. The Agreement System

The agreement system will be used as a case management tool to insure optimum responsibility and accountability for youth and staff involved in Intensive Care programming. The dual purpose of the agreement system is to:

- Guarantee that programs and youth are given continual regional support.

  Through the agreement system, all parties are given written assurance that visits will be made on a regular basis, and that all involved parties will be responsible for each youth in I.C.

- Involve each youth in his/her development in I.C.

  Hopefully, the youth's participation in the agreement system will increase as he/she progresses through the program. The agreement will be the device used to place responsibility and accountability on all people involved in intensive care case management. This will involve an initial agreement when a youth enters an I.C. program, a series of revised agreements as a youth progresses through I.C., a discharge agreement, and a series of monthly agreements for 6 months after a youth leaves an I.C. program.

a) Initial Agreement

An agreement must be written on each youth as he/she enters an I.C. program. To guarantee this initial agreement, the regional decision maker must accompany each youth to the I.C. program that he/she is entering. The programs need the advice and knowledge of the caseworker to better understand and predict the youth's reaction to intensive care. If for

some reason this is not possible (e.g. regional decision maker is on vacation), than a substitute decision maker must accompany the youth. The Director of Intensive Care and the appropriate program should be informed of any such substitutions. All I.C. programs reserve the right to refuse a youth if a regional decision maker (or substitute) is not present to sign the contract.

b) Revised Agreements

Agreements will be continually revised as a youth progresses through an I.C. program. It is not enough that initial and discharge agreements are written. The length of time for revising agreements should be established between the region, the program, and the youth. Every agreement should be revised at least once a month.

c) Discharge Agreements

When it is agreed by the program and region that a youth has successfully completed an I.C. program a discharge agreement will be written. Included in this agreement should be future plans. This will not, however, substitute the discharge letter still needed from the regions to the programs and central office.

d) Follow-through Agreements

In order to later evaluate the success or failure of I.C. programming, it is important to know what happens to a youth once he/she leaves an I.C. program. A simple way of monitoring a youth's progress once he/she leaves an I.C. program is through the agreement system. New agreements should be written monthly between the regional decision

maker, the youth, and the new program decision maker (in the follow through placement) for 6 months following a youth's discharge from an I.C. program. The follow-through placement should be made aware of the youth's involvement in an I.C. program. The regional decision maker should explain the agreement system to the new program counselor. Involvement of the new counselor in the agreement system should be encouraged. If for some reason the new program decision maker is unable or unwilling to participate in the agreement, then the youth and regional decision maker alone should write the agreement.

e) Monitoring use of Agreements

To insure that agreements are being written, and written efficiently, the Intensive Care team will review all agreements monthly. Any agreement abuses (e.g. a regional decision maker not visiting a youth as promised) should be reported immediately by the program to the region, and if no action is taken, to the I.C. team. The form on the following page will continue to be used as the agreement. These have been printed on a 5-part NCR paper and should be distributed as follows:

White page - to the program decision maker
Blue page - to the regional decision maker
Green page - to the central office
Pink page - to the regional director
Yellow page - to the youth.

Please check to insure that all copies are legible before mailing! The central office will keep a list of all youth in I.C. programs with an updated account of received

agreements. An example of our records will read:

Name	Program	Date Entering	Date Discharged	Date of Initial Contract - Jan 1, 1975 Revised - Jan 22, 1975 Revised - Feb 22, 1975 Revised - Mar 3, 1975 Revised - Apr 3, 1975 Discharge- Apr 26, 1975 Follow-through - June 1, 1975
John Doe	Andros	Jan 1, 1975	April 28, 1975	

etc.

DATE:_____

f) A G R E E M E N T

YOUTH'S NAME:_____ STATUS:_____
REGION: 1 2 3 4 5 6 7 INTENSIVE CARE UNIT: A E W

MAJOR D.Y.S DECISION MAKER:_____
HOME PHONE:_____ OFFICE PHONE:_____

PROGRAM COUNSELOR:_____
HOME PHONE:_____ OFFICE PHONE:_____

ESTIMATED REMAINING TIME EXPECTED TO BE IN PROGRAM:_____

COUNSELLING HOURS PER WEEK PROMISHED 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:_____

_____

AGREEMENT 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_____

g) Explanation of Agreement Form

Date: The date that the agreement is being written.

Youth's Name: self explanatory.

Status: Refer to the status code.

Region: Circle the appropriate region.

Intensive Care Unit: Circle the appropriate unit, A=Andros, WE-Westfield, WO=Worcester, or write in DARE, ACID, or RKF.

Major DYS Decision Maker: This is the regional person who is most responisble for all decisions made concerning the youth. It may be a case worker, a parole agent, or any person the regional director has assigned as most responsible for the youth. This person must be a D.Y.S. personnel unless previously approved by the Regional Director.

Major Program Decision Maker: This is the person assigned by the program director to act as counselor in making programatic decisions concerning the youth.

Home Phone Numbers: These numbers are needed in case of any emergencies that may arise around the youth. In the case that a program or regional decision maker refuses to write in their home phone number, then they should give that number to the program director to keep on file.

Time Expected to be in Program: This section of the contract needn't necessarily be filled in initially. Until some clear cut decisions are made, in some cases, it may be best to wait until the youth is further along in the program before a written commitment is made in answer to this question.

Counselling Hours Per Week Promised by the Program Counselor: The amount of time weekly that the program decision maker plans to work directly with the youth.

Visits Per Week Agreed to by the Regional Decision Maker: This will include the total number of visits the regional decision maker will make to the program.

Phone Calls Per Week by the Regional Decision Maker: to include the total number of calls to be made weekly to the youth and the program (This figure will be logged in by the program) each day, and recorded on weekly program reports.

Future Goals for Youth: Initially, these goals will be general, with specificity increasing as the youth progresses through program, and needs become more defined.

Short Term Goals: In the beginning, this may simply mean the meeting of some very specific physical needs. Short-term goals will be continually changing while a youth is in the unit.

Services to be Provided by the Program: This will include the means by which the program intends to achieve it's short and long term goals.

Services to be Provided by the Region: i.e. what the region intends to do for the youth.

Responsibilities of Youth: Initially, this may simply mean abiding by the rules and regulations of the Unit. The youth will eventually, however, take part in making programatic decisions. This section then, will be worked out with the youth.

Agreement to be Revised on or Before: The date set for a new agreement to be written.

Written Progress Report to be Made on (date): This report is to be written monthly by the program decision maker with regional decision maker. Copies are to be received by the regional decision maker, the program decision maker, the regional I.C. team member, and the Central Office.

Court Appearance Date (s): The day(s) the youth is to appear in court.

Transportation: This should be arranged between the program and region and written into the agreement.

Case Material to be Provided by Region: See Check List. It is the program's responsibility as well as the region's to insure that these things are received.

All Materials to be Received by (date): Keep a separate checklist attached to each contract - dating each item as it is received.

Signatures: The regional director and the I.C. team member will not be involved in the signing of most agreements. One must also expect that the youth will not sign all agreements-that is his/her right. All decision makers, however, should be aware of all agreements that are written and should receive copies.

2. Secure Detention

a. The Need for Secure Detention in Intensive Care

Intensive Care programs were developed for the small percentage of youth in the Department who are in the most dire need of services. For those youth who qualify for I.C. programming, security is necessary to insure that a youth is held long enough to receive intensive, individualized treatment. It was never the intent of Intensive Care to hold a youth without providing him/her with necessary care and treatment. However, due to a lack of secure detention facilities for females statewide, and for males in regions 1 and 2, I.C. programs have had the added responsibility of housing a small number of detention youth. In order to insure that I.C. programs are not transformed to detention centers, the same process used for referring a committed youth to I.C. is applied to detention youth, with the exception of males from regions 1 and 2.

When Westfield and Worcester Detention Centers were converted to I.C. facilities, adequate alternatives for housing secure detention youths were not developed. As a result, Westfield and Worcester I.C. programs have had to accomodate detention youths from regions 1 and 2. These youths can fill regular I.C. slots from their respective regions (1 and 2 only). In addition, agreements must be written on all detention youth in I.C. facilities, among the youth, the program, and a regional representative. Weekly reports submitted to the central administrative staff must list all region 1 and region 2 slots used for detention purposes.

Regions 3 through 7 will not be allowed to use any Intensive Care slots for purposes of secure detention for males since these Regions will be provided with two secure detention facilities in Regions 6 and 7. Since Regions 1 and 2 are not required to present males for secure detention at either Westfield or Worcester, most referrals to the I.C. team for purposes of secure detention will be female. The only case where a male would be presented to the team would be if a male youth in Region 1 or 2 needed an Intensive Care slot in a facility other than Westfield (for Region 1) or Worcester (for Region 2).

b. Description of Secure Detention Youth

Secure detention youth all have one common characteristic:

They all have a charge pending, for which he/she has been arraigned and bail has been set.

Almost all secure detention youth will fall into the first category; the youth who:

1. has at least one or more previous commitments.
2. has a history of failing to show up for court appearances.
3. has a history of not staying in residential placements for more than a week or two.

The second and least likely category is for those youth who:

1. have an extremely serious charge against them (e.g. murder).
2. the court has seen fit to set a relatively high bail.
3. have some fairly substantial evidence against them (e.g. confession).

Many questions have been raised around the issue of "mixing" Intensive Care youth with those on secure detention status. Because most secure detention youth will fall into the former

category, it is reasonable to assume that a "mixed population" will not result. While in an I.C. unit, however, a youth on secure detention status will not be required to participate in any of the psychological or psychiatric programming with the exception of evaluations which can be mandated by the courts. Secure detention slots should not be used as dumping grounds for quasi difficult youth. A youth considered for secure detention could be equally qualified as a contender for a long-term Intensive Care slot.

3. Incident Policy

a. Definition

All incidents occuring at any Intensive Care Unit shall be reported to the Central Office and the Region. The following acts are considered to be incidents:

1) An injury caused to staff or youth either through other staff or youth, or through individual initiative.

2) A youth who leaves the program without authorization from the program director.

3) Any serious behaviorial infractions. To include assaultive behavior by youth and/or staff, serious acting out, etc.

4) Any actions that seriously disrupt the normal functioning of the program.

5) An allegation by a boy or girl alleging physical mistreatment or harassment.

6) The death of any youth.

b. Participants and Procedure

A youth, a line staff, or a director can file an incident report form. The procedure is as follows:

1) Verbally report the incident to the Director of Intensive Care immediately. In the case of a youth, either his program counselor or major decision maker may report the incident.

2) Fill out the following attached incident report form and mail to the Director of Intensive Care within 48 hours. Copies of this form must be sent to the Commissioner of Youth Services, the Supervisor of Parole, the Department's Investigator, and the appropriate program and the Region.

3) INCIDENT REPORT FORM

TO:

FROM: _____

RE: _____ (Resident's Name)

HOME ADDRESS: _____

DATE: _____ Time_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Writer

4) The report itself should include the following information:

   a) Complete name of youth.

   b) Home address and age.

   c) Location - date, time of incident.

   d) Nature of the incident.

   e) Circumstances of the incident.

   f) Full names - work classification of all personnel involved.

   g) Action taken.

   h) If hospitalized - name of and title of person attending the youth. (name of hospital or medical unit), and copy of the medical report.

   i) Plausible reasons for incident.

   j) Written signed statements by youth - personnel or witnesses.

   k) Recommendations of administration at unit.

5) Commissioner Leavey and his staff will immediately review these reports to determine:

   a) If they are complete.

   b) What action was taken concerning the incident by the administration at the unit.

   c) What action the Commissioner and his staff feel is necessary to prevent future occurences.

4. Escapes, Runs, A.W.O.L.'S

a) Definition

1) Escape

The most serious non-authoritative exit - when a youth physically breaks out of an intensive care unit.

2) Run

When a youth who is allowed to leave the building with a person approved by the Director, leaves the supervision of the person responsible.

3) A.W.O.L.

When a youth who is allowed to leave the building without a staff member does not meet his/her commitment.

b) Procedure

1) The following agencies will be notified:

a Local Police

b State Police - should be notified only if the local police do not automatically notify them.

c The local police from the community where the boy/girl is from.

d Regional Decision Maker

Every program should have the home telephone number of each youth's regional decision maker. These numbers will be kept on file and will not be used except for emergency situations, e.g. - incidents, escapes, etc.

e Regional Director

The regional decision maker should report any escapes, runs, or A.W.O.L.'S to his/her respective regional director.

f The Director of Intensive Care

The Director of Intensive Care should be informed of any youth who leaves without authority from an I.C. program.

2) Under no circumstances will information other than home address and physical description be made available to any police agency without first contacting the Director of Intensive Care.

3) A full incident report will be filled out and sent to the Department of Youth Services, 73 Tremont Street, Suite 735, Boston 02108 at the earliest possible time (no more than 5 working days) by those staff involved at the time of the child's departure. Copies of the report will be kept on file at the I.C. program, the appropriate region and the Central Office. The report should include the circumstances of the departure, and be followed through with an additional report when/if the youth is found.

5. The Appeal Procedure

a. What is it?

The I.C. team will have, as one of its major responsibilities, the task of advising regions on the best possible placements for their difficult youth. All community-based alternatives will be exhausted before Intensive Care is even considered. Once it is decided that an Intensive Care facility can best serve the needs of a youth, then consideration will be given to the Intensive Care unit which seems most appropriate for that youth. All possible measures will be taken to match youth with the placement (either Intensive Care or community-based) that can best serve his/her needs.

However, even with an I.C. team, it would be naive of us to believe that all chosen placements will ideally match all youth. In order to be able to revoke bad decisions, then, an appeal process must be instituted.

An appeal can be made when one party disagrees strongly with a decision made by another party. There will be three types of decision makers who will be allowed to make an appeal - the youth, the region, and the program.

b. Who can Appeal?

1) The Youth

A youth can make an appeal only after he has been in an Intensive Care unit for at least one month. Since most youths will probably enter I.C. units with highly negative attitudes, to assume that a youth would not want to appeal in the first month would be naive. Through his/her program

counselor or major decision maker, a youth will be able to submit an appeal form to the I.C. team. When writing an appeal, the youth may use the help of other youth in the unit, his program counselor or the major decision maker. The process of writing the form can be of educational value, and he/she should be encouraged to do so.

Examples of circumstances that may warrent an appeal are:

a) A youth feels the placement is inappropriate for his/her needs.

b) A youth feels strong clashe within the unit with other specific youth.

c) Follow through placement is inappropriate.

A youth must stay in an I.C. program until the appeal is acted upon.

2) The Region

A region can make an appeal 5 days after a youth has been placed in an Intensive Care unit.

3) The Program

The program cannot make an appeal until 5 days have elapsed since the time of placement. Examples of situations in which a program may issue an appeal are:

a) Program feels that their particular Intensive Care unit is not best serving the needs of that youth.

b) A program transfers a youth to another I.C. program temporarily, and then feels that the transfer should be permanent.

c) A region discharges a youth from an I.C. unit before the program feels that the youth is ready to be discharged.

c. Procedure

1) If a youth, region or program wants to make an appeal, the following form should be completed and presented at the next I.C. meeting.

2) Involved parties should have discussed the situation before presenting the appeal to the team.

3) All appeal applications will be discussed and reviewed by the I.C. team after involved parties have presented their cases.

4) Final decisions will be authorized by the Director of Intensive Care.

d. Appeal Form

Name of Youth:

I.C. unit: A WE WO ACIP DARE RFK Region: 1 2 3 4 5 6 7

Regional Decision Maker:_____ Program Decision Maker:_____

Date Youth Entered Unit:_____

Appeal Made by: Youth Program Region 1 2 3 4 5 6 7

Reason for Appeal: (continue on separate sheet if necessary)

Alternative Placements and Reasons for these Placements: (Continue on separate sheet if necessary)

Signature _____

Date _____

D. Discharge

1. When the youth with his/her regional and program decision makers decide that he/she has successfully completed the I.C. program, an initial meeting will be held to discuss follow-through plans.
2. Subsequent meetings will be held among the above mentioned people to solidify and further discuss the aftercare placement.
3. An agreement will then be written for the follow-through plan describing conditions and responsibilities.
4. These plans will then be presented to the I.C. team. This does not mean that the I.C. team will control discharge, only that they will be informed of proposed plans.
5. If the program and the region determine it to be necessary, the program may be obligated to hold a youth's bed for up to two weeks after a youth leaves the program.
6. The region must send a letter to the program finalizing discharge. The person(s) authorized from each region to discharge a youth must be identified to the program beforehand.

E. Follow-through

1. Creative transitions should occur between discharge and follow-through; e.g. a program or regional decision maker moving into a follow-through program with the youth.

2. One month after a youth has left an I.C. program, a meeting will be held at the aftercare placement to discuss the youth's involvement and progress in the follow-through placement. Participants will include the youth, the new program decision maker, the regional decision maker, and the original Intensive Care program decision maker if possible.

3. In order to better evaluate the effectiveness of I.C. programming, the activities of a youth must be followed after he/she leaves the I.C. program. This will be done through the agreement system. For six months after a youth leaves an I.C. program, monthly agreements must be written among the youth, the regional decision maker, and the new program counselor. Copies of these contracts should be sent to the old I.C. program and the central office.

III. The Management and Distribution of Slots

Across the state, there will be a specific number of available Intensive Care slots for youth within the Department. These slots will be allocated among the regions for their principal use in requesting Intensive Care services. Since the Department can never exceed this number of available slots, it is incumbent upon the regions to make every possible effort to stay within their specified slot allocation. Only through such responsible management will Intensive Care be able to provide needed and effective services on an on-going basis.

To assist the regions in the daily management of their allocated slots, a number of provisions have been made to provide a degree of flexibility. These provisions range from the use of emergency slots and the borrowing and lending of slots to the periodic review of existing allocations.

A. Slot Allocation

Historically, the youth who today are being presented for I.C. placement were in the past sent to large institutions. The difficulty of dealing with these youths has not changed, the quality has. In order to prevent small I.C. programs from growing into impersonal and large institutions, some control must be placed on both the numbers and types of youth's needing I.C. services. The I.C. team will serve as a monitoring unit, hearing referrals to I.C. and then making decisions as to the appropriateness of a case. This will insure that no youth is admitted to an I.C. program unless representatives from the regions, the I.C. programs and the central administrative staff view the youth as "appropriate" for I.C. placement. (See section on the referral stage). In addition, a set number of beds (or slots) has been allocated to the regions for purposes of I.C.

Slots were allocated to the regions based on a variety of factors.

1. Percentage of youth in secure settings before I.C. Programs were implemented.
2. Percentage of total commitments and referrals.
3. Percentage of total caseloads.
4. Percentage of youth referred to I.C. compared to the percentage of allocated slots (prior to this revised allocation) per region.

(See appendix II for the results of the allocation.)

One of the purposes of Intensive Care is to refute the fact that more slots should be established to accomodate the growing number of difficult youth. By limiting the number of available I.C. beds, more pressure will be placed on the regions to find appropriate and alternative placements for those youth who at first glance may appear to need a secure placement, but in reality do not.

Through the I.C. team weekly meetings, regions will be made aware of those placements from other regions that have been successful in servicing the youth who may incorrectly be classified as "Intensive Care". It is our hope that the number of statewide I.C. slots be reduced, and that this year serve as a planning year for projecting our future needs. With the use of emergency slots, and the availability of borrowing and lending slots from other regions, the number of beds presently in existence for Intensive Care should be adequate.

Regional slot allocations will be reviewed periodically. All regions are responsible for working within their present quota, with their eventual goal being the reduction, rather than increase, of their present slots. By working cooperatively with other regions in identifying placement alternatives, hopefully this goal can be achieved.

B. Borrowing - Lending Slots

1. The Need

Each region has been allocated a certain number of slots. It therefore is a regional responsibility to plan, as best as possible, the use of these slots within each program. Circumstances may develop, however, with a region where the number of youth needing I.C. programming exceeds the number of slots allocated. It then becomes necessary for the region to either find alternative placements for these youth, or to arrange the borrowing of a slot from another region.

Because of varying staff patterns, internal programming, and location, different I.C. programswill evolve as better serving specific types of I.C. youth. For this reason, a region may find itself needing more slots at a particular type of I.C. program and less at another. An exchange of slots may thus be arranged to accomodate specific types of youth into I.C. programs.

2. Procedure

a) Slots can be exchanged by regional I.C. team representatives at the I.C. meetings, or at any time prior to the meetings. The exchange of slots is an interregional responsibility.

b) An agreement must be written between the involved parties. A copy of this form must then be sent to the central office, the appropriate borrowing or lending region, and the named program(s).

c) Any exchange of slots must be announced at the next I.C meeting.

d) When a regional slot opens in a program where a slot is being borrowed, the youth automatically is transferred to that slot. At that time, the original agreement is revoked, but if appropriate, a new agreement may be negotiated.

e) If a youth runs from a borrowed slot, that slot is returned to the lending region after two weeks, unless stated differently in the agreement.

f) Following is a suggested copy of the agreement that must be signed by both the borrowing region and the lending region. This can be done at the end of the I.C. meeting. Copies must be sent to the central office, and the appropriate region(s) and program(s) within 7 days.

g)

Date Effective:
Borrowing Region:
Name of Youth:
Program:
Lending Region:

* Conditions:

** _____ _____
Signature Borrowing Region Date

_____
Signature Lending Region

* To be decided by involved parties

** Approved signatures would include I.C. team representatives, or if not available, regional directors.

C. Emergency Slots

1. What is an Emergency Slot?

It is the intent of I.C. to review every youth before he enters an I.C. unit. A list of criteria has been developed to decide the appropriateness of an I.C. referral, as well as a corresponding list needed for intake. It is realized, however, that some youth may need the immediate services of an I.C. program. Any youth entering an Intensive Care Program without prior approval from the I.C. team constitutes an emergency.

2. How Many?

Ninety-one (91) slots have been allocated to the regions for purposes of I.C. Every youth entering I.C. through one of these slots (with the exception of male detention youth from regions 1 and 2) must be reviewed and approved by the I.C. team. The remaining 5 beds have been designated as emergency slots and will initially be controlled by the central administrative staff. Emergency slots have been established for males at Westfield, A.C.I.D., and R.F.K. and for females at Westfield and Worcester.

3. What Constitutes an Emergency?

A youth may be considered for use of an emergency slot if:

a. He/she has just been convicted or arrested for a serious crime (rape, murder, etc.)

b. He/she has a long history of past crimes, and is considered a serious threat to him (her) self, and/or others.

c. An escapee, runner, or A.W.O.L. is found and returned to the program, and the region's quota is full.

d. A youth is so physically large, aggressive and obviously threatening to life and property that placement at any other program is impossible. This will be a very closely scrutinized use of emergency slots.

e. A youth has run from another intensive care program. An emergency slot may then be used for purposes of holding the youth overnight, until transportation is arranged to return the youth to his/her original I.C. unit.

f. An incident at another Intensive Care Unit necessitates a youth being temporarily removed from that program.

4. Procedure

A region may request the use of an emergency slot after having exhausted all possible placements for a youth. This can be done in the following manner.

a. The I.C. team member will be the person making any requests for use of emergency slots. In cases where the I.C. team member is not available, regional directors or their assistants may substitute. In no cases should a caseworker or program make a request for an emergency slot.

b. The I.C. team representative must be contacted by the regional person requesting the use of an emergency slot and approve such use before contacting the central office.

c. The I.C. team member may request the use of an emergency slot by contacting the Director of I.C.

d. At the time of the request, the following card will be filled out by the central office and copies sent to the

I.C. team member and the appropriate program.

Region_____ Regional Caller_____

Date Requesting Emergency Slot_____

Name of Youth_____ Male Female

Brief Description of Youth_____

_____

_____

_____

Slot Approved: WE ACID Andros RFK

Date Emergency Slot Expires_____

Future Plans_____

_____

_____

Signature Central Office Staff Member

By keeping accurate records of the use of emergency slots, a clearer understanding can be gained of the type of youth, as well as the regional distribution of youth, needing emergency I.C. services.

e. A region can use an emergency slot no longer than seven (7) days. Within this time, alternative placements must be explored, or provisions made for that youth to enter an I.C. unit on a long term basis.

f. At each I.C. meeting, all emergency slots in use will be reviewed. If extenuating circumstances warrant a youth being in an I.C. program longer than 7 days, approval must be gained by the I.C. team. If it is

decided that a particular youth should be in an emergency slot longer than 7 days, then an agreement must be worked out between the region, the program, and the youth. A program will not be expected to hold a youth in an emergency slot if no support and cooperation is given by the region. If, however, the I.C. team decided that a particular youth should not be in an I.C. program longer than 7 days, then the region must abide by that decision, and make immediate plans to discharge the youth from the I.C. program that he/she is in. The program at that time, is under no obligation to hold the youth any longer.

g. Every three months the I.C. team will review the emergency slot policy.

5. Summary

When dealing with delinquent youths, it is not always feasible to predict and anticipate behavior. It would be erroneous to assume that all youth needing I.C. services can be identified in advance. The emergency slot system was developed to take into consideration those instances where immediate intensive services are needed. Once a youth is placed in an I.C. facility, be it on an emergency or regular intake process, the same care and consideration should be given. I.C. was developed with a set of controls to assure that maximum care be given to youth. In order to protect I.C. youth, these controls must not be abused.

D. Program Transfers

If a program and a region cooperatively agree that a youth should be transferred from one Intensive Care program to another the procedure described below must be followed.

1. Temporary transfers - Any transfer from one I.C. program to another for a period not greater than two weeks.
    a. An agreement must be reached between the region and program that a transfer to another I.C. program is needed.
    b. In order to transfer a youth to another I.C. program, the region has to have an open slot in the other I.C. program, or arranged to have borrowed a slot from another region.
    c. When the above two conditions have been met, the director if I.C. should be notified of the reasons for the transfer, and the plans being made. This will be done before the actual transfer occurs.
    d. Once the director of I.C. agrees to the plan, the transfer may take place.
2. Long-term or Permanent Transfer - Transfers to another program for a period of time greater than two weeks.

The initial procedure is the same as that followed for temporary transfers. In addition, however, an appeal must be made to the I.C. team for any youth transferred to another I.C. unit for a period of time greater than two weeks. (See Appeal Section of this manual). The appeal should be initiated by both the program and region and must be made within 14 days.

IV. Reports

A. Status Code

A status code has been developed by individual I.C. programs to aid youths, program, and regional staff in identifying the movement of residents in I.C. programs. The code varies from program to program and is described under Appendix 5 of the manual.

B. Status Reports

In order to later evaluate the effectiveness or lack thereof of I.C. programming, continual updated records must be kept of all youth in I.C. so that the central administrative staff may have these records. Weekly reports by the program, and monthly reports by the regions, must be submitted to the central staff. Although it may appear that much of the information on the program form is duplicated on the regional form, in order to simplify the measurement of programs and regions this was necessary.

Following are copies of the two report forms and explanations of each.

1. Weekly Program Report Forms

Week Beginning _____
Week Ending _____
I.C. Program _____

Name of Youth	Reg.	Date Entering Program	Date Leaving Program	R., SD E, R/D	Status First Day of week	Status Last Day of week	Vistis by Region Give name of Person who Visted
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							

Totals

Total Population First Day of Week

Total Population Last Day of Week

Total Reception Youth

Total Secure Detention Youth

Total Emergency Youth

Total # of Normal Intake

Total # of Secure Detention Intake

Total # of Transfers from Emergency to Long Term

Total # of Emergency Intake

Total Admissions (should be total of above)

Total # Successful Discharges

Total # Discharges Emergency to Outside

Total # Discharges Escapes, Runs, or Awol's

Total Secure Detention Discharges

Total Other Discharges (specify)

Total Discharges (should be total of above)

Total # Escapes (Give names)

Total # Runs (Give names)

Total # A.W.O.L.'S (Give names)

Total # E.R.A.'S (total of above)

	Region	1	2	3	4	5	6	7	Emergency
Number of Vacancies	Male								
	Female								
	Total								
Number over Allocation	Male								
	Female								
	Total								
Number of Visits	Male								
	Female								
	Total								
Number of Phone Calls	Male								
	Female								
	Total								
Number of Incidents	Male								
	Female								
	Total								
Number of Run's	Male								
	Female								
	Total								
Number of Agreements Written this Week	Male								
	Female								
	Total								

a) Explanation: Weekly Program Reports

Page 1

Name of Youth - List the name of each youth who has been in the I.C. program during the specified week. Please list all youth by region. i.e. all Region I youth in the program will be listed first, then all youth from Region 2, etc. Star (*) any youth who is on the run.

Region - Specify the region. If a youth is in a borrowed slot from another region still list the youth with others from his/her region but double star (**) the name.

e.g.	Susan Abel	1	10/12/75
	David Bean	1**	6/18/75
	Robert Ellis	1	6/18/75

Date Entering the Program - the date the youth is admitted to the program.

Date Leaving the Program - fill in only if a youth has left the program during the specified week. This only includes discharges. If a youth is on the run and has not been discharged from the program, this category does not apply.

R., S.D., E., or R/D - R refers to any reception youth in the program. This should include all committed youth who have been referred and accepted by the I.C. team for I.C. programming. S.D. refers to any youth who have been referred to the I.C. team and accepted for purposes of secure detention. This category also applies to youth from regions 1 and 2 on detention. E refers to any youth in an emergency slot. R/D refers to any youth on a dual status.

Status First Day Week - see section on status code.

Status Last Day of Week - see section on status code.

Visits by Region - give the name of the person visiting the youth. In most cases this person will be the regional decision maker. If not, please specify.

Page 2

Total Population First Day of Week and Total Population Last Day of Week - to include all youth, i.e. reception, secure detention, region 1 and 2 detention, and emergency.

Total Reception Youth - all regular I.C. youth referred and accepted through the I.C. team.

Total Secure Detention Youth - all secure detention youth referred and accepted.

Total Emergency Youth - all youth who have been in emergency slots during the specified week.

Total Number of Normal Intake - to include any committed youth referred to the I.C. team, accepted, and entering the I.C. program during the specified week.

Total Number of Secure Detention Intake - to include all secure detention youth.

Total Number Transfers from Emergency to Long Term - refers to any youth in an emergency slot who is later referred to the I.C. team and accepted.

Total Number Emergency Intake - all youth placed in emergency slots.

Total Admissions - includes all youth described above.

Total Number Successful Discharges - refers to any youth who successfully completes the I.C. program and for whom appropriate followthrough plans have been made.

Total Number Discharges Emergency to Outside - any youth who has been discharged by the region after having run from the I.C. program.

Total Secure Detention Discharges - refers to all secure detention discharges.

Total Other Discharges - if for any reason other than those listed above a youth is discharged from a program (e.g. - an appeal by the youth, program, or region).

Total Discharges - all youth discharged from the care of the program during the specified week.

Total Number Escapes - refers to any youth who physically breaks out of an I.C. program.

Total Number Runs - refers to any youth outside of the building who leaves the supervision of the person responsible.

Total Number AWOL'S - refers to any youth approved to go outside of the facility unsupervised who does not meet his/her commitment.

Total E.R.A.'S - total number of escapes, runs, and A.W.O.L.'S

Page 3

Number of Vacancies - refers to the number of open beds within each region. If a youth is on the run and has not been discharged his/her

bed is not counted as vacant.

Number over Allocation - refers to any region whose youths in an I.C. program exceed there number of allocated slots. A borrowed slot is considered "over allocation", a filled emergency slot is not.

Number of Visits - refers to the number of visits by any regional staff member for purposes of discussing or meeting with youths in I.C. programs.

Number of Phone Calls - includes all calls made by the region either directly to an I.C. youth or to a program staff member concerning an I.C. youth.

Number of Incidents - see section on "incidents" for definition.

Number of ERA'S - regional breakdown of escapes, runs, or AWOL'S.

Number of Agreements Written this Week - refers to regional breakdown of all agreements written, i.e., intake, revised, and discharge agreements.

If more than 19 youths were in I.C. during this month, make a copy of this page and attach. All detention youths must be included in this report.

Month of_____
Region _____

Monthly Regional Report

Name of Youth	Date Entering Program	Date Leaving Program	Date Referred	R., SD E, R/D	Normal Intake	Emergency Intake	Successful Discharge	Placement	Run Discharge	Other Discharge	Escapes	Runs	AWOL's	I.C. Program
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														
12.														
13.														
14.														
15.														
16.														
17.														
18.														
19.														

Total Number of Youth in I.C.

	Last Day of Month		
	Male	Female	Total
Westfield			
Worcester			
Andros			
A.C.I.D.			
D.A.R.E.			
R.F.K.			
Total			

Youth in Borrowed Slot	Program	Lending Region

Youth Referred this Month	Not Accepted	Date Referred	Placement (if not I.C., where?)

Total Number Normal Intake

Total Number Emergency Intake

Total Number Detention Intake

Total Number Successful Discharges

Total Number Youth Transferred

Total Number Runs Discharge

Total Number Runs

Total Number Escapes

Total Number AWOL'S

a. Explanation: Monthly Regional Reports

Youth's Name - list all youth by program in I.C. If additional space is needed, attach a copy of this page.

Date Entering Program - original date the youth entered the I.C. program. If a youth runs from a program and is returned, the date entering the program does not change. If a youth, however, is admitted to an I.C. program through an emergency slot and is later referred and accepted for long term I.C., two dates are necessary.

Date Leaving Program - refers only to the date that a youth is discharged from the program.

Date Referred - the date that a youth was referred to the I.C. team and accepted for placement.

R, SD, E, or R/D R = reception youth referred to the I.C. team and accepted for placement. SD = Secure Detention youth referred and accepted. E = youth on an emergency status. R/D = youth on a dual status.

If a youth on an emergency status is later referred and accepted, this should be indicated as "E/R".

Normal Intake - for all youth referred to the I.C. team, accepted, and placed in an I.C. unit, mark "X" in this space.

Emergency Intake - any youth during the month who was in an emergency slot mark "X".

Successful Discharge - any youth who successfully completes an I.C.

program and for whom appropriate followthrough plans are made, mark "X".

Placements - for youth who are successfully discharged from an I.C. program and placed, list the name of the placement or briefly explain followthrough plans.

Run Discharge - any youth who runs from a program and is discharged by the region mark an "X".

Other Discharges - to include all discharges other than the two previously listed. Specify type of discharge. Examples may include transferred from one I.C. unit to another, an appeal discharge, etc.

Escapes, Runs, AWOL'S - mark "X" if appropriate. See section on "runs" for definitions.

I.C. Program - list the name of the I.C. program that a youth was or is in during the month.

Page 2

Program Totals - list the number of all youths in I.C. programs for the last day of the specified month. Include all youths in borrowed slots from other regions.

Borrowed Slots - list any youth from your region who is in a borrowed slot, the name of the I.C. program he/she is in, and the region from whom the slot is borrowed.

Referrals - list all youth referred to the I.C. team during the month. If the youth was not approved for I.C. placement, mark "X" in the

appropriate place. Give the date the youth was referred. For youth approved for I.C. placement, list the I.C. program where the youth has been placed. If the youth is awaiting placement, state where he/she is presently and the name of the program for which he/she has received approval. If a youth who has been approved is diverted to an alternative placement, state the name of the placement. For youth not approved for I.C., list where the youth is presently.

Totals - give total monthly numbers for all categories listed.

C. Monthly Progress Reports

Monthly progress reports must be submitted by each Intensive Care program to the appropriate regional Intensive Care representative. Reports must be submitted on every committed youth who has been in an I.C. facility during the month designated. The form on the following pages indicates the information that should be included in this report. Any vital information other than that suggested should of course be included.

1. Monthly Progress Report

Name of Youth Region
Monthly Progress Report for_____
Date Youth Entered Program

This report should include the following information:

1. Any significant changes the youth has made during the designated month, and what these changes may be attributed to.

2. Family contact and relationships

3. Court activities

4. Any additional pertinent information on the youth.

D. Quarterly Reports

All programs using LEAA funds are required to submit quarterly reports. Copies of this report are kept on file centrally. Any regional or program I.C. team member may request access to this information by contacting the Director of I.C.

E. Grievance Policy

Because there does not exist an infallible system, parties involved in Intensive Care will sometimes have grievances. Any complaints or grievances initiated through anyone involved in I.C. programming should be channeled in the following way:

1. All grievances should be presented in writing to the I.C. team.
2. A section of each meeting should be used to air grievances.
3. Depending on the grievance, the procedure should be established at the meeting between the parties involved.
4. A time limit will be set by the Director of I.C. allowing the party to alleviate the grievance brought against them.
5. At the end of the time established, have the grievances not been alleviated, then a meeting should be set up with the Regional Director, the I.C. team representatives, the concerned parties (or the entire I.C. team, which ever is appropriate.)
6. Copies of all grievances should be kept on file at the Central Office.

V. Responsibilities of Major Decision Makers

A. REFERRAL STAGE

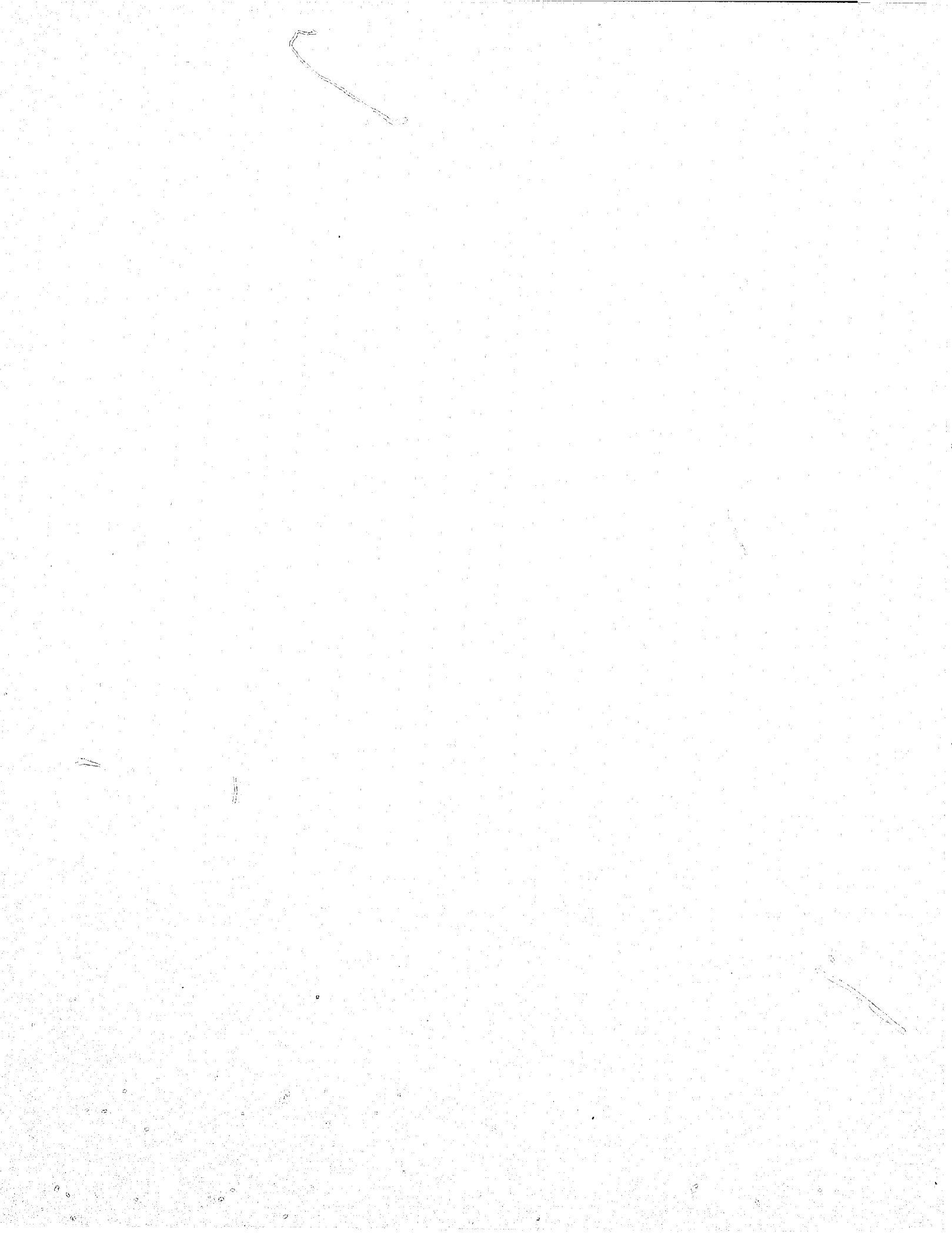
YOUTH	MAJOR DECISION MAKER	INTENSIVE CARE REGIONAL TEAM REP.	INTENSIVE CARE TEAM	PROGRAM
1. Meet with major decision makers to discuss and explain placement. 2. Meet with psychiatrist. 3. Understand that he/she is being considered for I.C. placement, and what I.C. is.	1. Clear identification of one major regional decision maker. 2. Set up and have psychiatric evaluation completed. 3. Assemble Referral Package Form to include: a. Previous court records. b. Psychological tests c. School records. d. Description summary of previous placements. Positive and negative behavior reported. Which programs worked which didn't and why? e. Probation report f. Family Description (first home) g. Present behavioral sheet on separate sheet of paper. h. List of placements approached; reason for deciding that placement was inappropriate. i. Summary Sheet: Management information j. Over all statement by caseworker.	1. If at a regional staffing it is decided that a youth should be referred to I.C., the team member must refer the case. (providing all necessary information has been made available, and that an open slot does exist.) 2. Meet with major decision maker to discuss youth 3. Exhaust all known placement alternatives. 4. Submit case to Intensive Care Team	1. Hear referral if all necessary information is available. 2. Share knowledge of state wide Resources. 3. Check to insure that no Community based alternatives exist. 4. Vote on the appropriateness of the case. 5. If youth is approved, appropriate placement in an I.C. program is made. 6. If youth is not approved, the case reverts back to the Region.	

A. REFERRAL STAGE (cont.)

YOUTH	MAJOR DECISION MAKER	INTENSIVE CARE REGIONAL TEAM REP.	INTENSIVE CARE TEAM	PROGRAM
	k. Medical release signed by parents. l. Medicaide number or Blue Cross Blue Shield number if they have one. m. A 2-4 page summary on the youth. 5. Check to insure that no community based alternatives exist. Submit list of those placements attempted prior to Intensive Care referral. 6. Assemble list of associated decision makers with phone numbers, probation officers, past placements, etc. 7. Present the youth at a regional staffing as a referral for I.C. 8. If a region decides the youth should be referred to Intensive Care, meet with Regional I.C. Team			

B. INTAKE STAGE

YOUTH	MAJOR DECISION MAKER	INTENSIVE CARE REGIONAL TEAM REP.	INTENSIVE CARE TEAM	PROGRAM
1. Meet with major and program decision - makers to learn the Rights and responsibilities while in an I.C. Program. 2. Write Agreement 3. Review Agreement 4. Acknowledge that Agreement has been written.	1. Provide adequate clothing for youth. 2. Transport youth to program. 3. Meet with youth and program counselor. 4. Write Agreement. 5. Sign Agreement. 6. Notify family of youth to explain the reason for I.C. 7. Notify I.C. Team member of start date. 8. Send copy of Agreement to Regional Director and Central Office. 9. Assure that I.C. Team Rep. has a copy of Agreement for monthly review.	1. Keep continual contact with major decision maker. 2. Receive copy of Agreement.	1. Schedule Intake.	1. Accept case and materials. 2. Assign program counselor immediately 3. Meet with major decision maker and youth. 4. Orient youth to the program explaining his/her rights and responsibilities. 5. Write Agreement. 6. Sign Agreement. 7. Program counselor should contact the family of the youth to explain morefully: a. Their child's involvement in I.C. b. Why it was decided that I.C. is the most appropriate placement for their child at this time. c. Explain visting rights. d. Whether or not the youth will be allowed



CONTINUED

1 OF 2

B. INTAKE STAGE (cont.)

YOUTH	MAJOR DECISION MAKER	INTENSIVE CARE REGIONAL TEAM REP.	INTENSIVE CARE TEAM	PROGRAM
				home to visit, if so when? for how long? e. The child's progress while in an I.C. Unit. f. The mode of treatment for the youth. 7. Appeal placement if inappropriate after five days.

C. PROGRAM INVOLVEMENT STAGE

YOUTH	MAJOR DECISION MAKER	INTENSIVE CARE REGIONAL TEAM REP.	INTENSIVE CARE TEAM	PROGRAM
1. Plan in the development of his/her program. 2. Participate in program. 3. Meet with Program and Regional Decision makers as contracted. 4. Renegotiate Agreement when appropriate. 5. Perform according to Agreement. 6. Appeal placement after three months if inappropriate.	1. Monitor progress of youth with visits, phone calls, and renegotiation of agreements. 2. Perform responsibilities agreed to within the alloted time. a. Clothing b. Visits, etc. 3. Work with the program decision maker in informing family of youth's progress. 4. Day passes - outside priviledges - if youth has no place to go having earned outside priviledges - regional decision maker should work with program counselor in finding a place for the youth to go. 5. Appeal placement if inappropriate. 6. Meet with I.C. Team member regularly to discuss the youth.	1. Maintain continual contact with major decision makers. 2. Report to all I.C. Team Meetings.	1. Review monthly Agreements. 2. Collate: Report success and failure or major and program decision makers in achieving goals of agreements on monthly basis. 3. Review youth's status in I.C. program and check for appropriateness. 4. Hear appeals and make decisions.	1. Report Progress with written reports and phone calls. 2. Work with Regional decision makers. 3. Together with regional decision maker, keep youth's family informed of his/her progress.

D. RUN

YOUTH	MAJOR DECISION MAKER	INTENSIVE CARE REGIONAL TEAM REP.	INTENSIVE CARE TEAM	PROGRAM
1. Contact program counselor and/or regional major decision maker.	1. Actively pursue youth. 2. Inform associated decision maker 3. Notify Central Office.	1. Should be informed of all runs. 2. Should insure that Regional director is informed of all runs. 3. Should insure that when a youth runs, someone from the region will pick up the youth's clothing and lock them away from other residents.		1. Actively pursue youth. 2. Inform major decision maker and appropriate authorities. 3. Notify region and Central Office if a youth is found.

E. EMERGENCY

YOUTH	MAJOR DECISION MAKER	INTENSIVE CARE REGIONAL TEAM REP.	INTENSIVE CARE TEAM	PROGRAM
1. Go through orientation	1. Call I.C. Team Member to request use of emergency slot. 2. Insure that youth moves to alternative within 7 days.	1. At weekly meetings learn of availability of slots. 2. Call Central Office to request use of an emergency slot. 3. Insure that youth is moved to alternative or long term slot within 7 days.	1. Assign emergency slots on weekly basis. 2. Review cases of youth in emergency slots.	1. Accept and run special orientation for youth. 2. Appeal Placement over 7 days.

F. DISCHARGE STAGE

YOUTH	MAJOR DECISION MAKER	INTENSIVE CARE REGIONAL TEAM REP.	INTENSIVE CARE TEAM	PROGRAM
1. Meet with major decision makers to discuss follow-through plans. 2. Help develop contract for follow through.	1. Meet with the youth, and the program counselor to decide on follow through plans. 2. Devise a list of possible placements in order of priorities. 3. Establish contact with placement several weeks before youth is to leave I.C. 4. Have an alternative in case placement fails. 5. Report all decisions to I.C. Team Member. 6. Keep family informed.	1. Review list of placement alternatives in order of priorities. 2. Submit to I.C. Team.	1. Insure coordination between major decision maker and program in achievement of responsibilities outlined in discharge contract. 2. The I.C. team will be made aware of follow-through plans for a youth leaving an I.C. program.	1. Meet with major decision maker and youth to decide on follow through plan. 2. Work with Regional decision maker in laying groundwork for follow through. 3. Communicate with program and Regional Director if a specific number of days will be held for a bed after a youth leaves an I.C. unit.

G. FOLLOW THROUGH STAGE

YOUTH	MAJOR DECISION MAKER	INTENSIVE CARE REGIONAL TEAM REP.	INTENSIVE CARE TEAM	PROGRAM
1. Accept follow through plan. 2. Develop agreement with major and program decision makers. 3. Sign agreement describing conditions and responsibilities. 4. Appeal an inappropriate placement after one month to major decision maker and I.C. Team Member.	1. Negotiate agreement with youth and implement follow through plan. 2. Request special support from Program Decision Maker when appropriate. 3. Report Progress monthly to the I.C. Team Member.	1. Receive monthly progress reports, and monthly agreements.	1. Acknowledge implementation of follow through plan.	1. Support implementation of follow through plan or appeal.

VI. Appendices

A. Appendix 1 : The Intensive Care Team, 1975

Director of Intensive Care - Robert Watson

Assistant Director of I.C. - John Gardner

Central Administrative Team Member - Lyn Familant, Author

Region 1 - Diane McCafferty

Region 2 - Jane Pastore

Region 3 - Walter Hutcheon

Region 4 - Neal Brown

Region 5 - Gail Barlow

Henry Tuohy

Region 6 - Albert Holland

Janet Sumperer

Region 7 - Robert Murray

A.C.I.D. - Barbara Galvin

Andros - Jack Summons

D.A.R.E. - undecided

R.F.K. - undecided

Worcester - Father Paschal Smith

Westfield - Phil Toy

Supportive Central Office Staff

Denise Edmunds - I.C. Team Secretary

David Gannett

Andrew Zaikis , Author

B. Appendix 2 : Addresses

Joseph Leavey - Commissioner of Youth Services	727-2733
Edward Budelmann - Acting Assistant Commissioner of Clinical Services	727-7614 or 8840
Robert Watson - Director of Intensive Care	727-7614 or 8840
John Gardner - Asst. Director of I.C.	727-7614 or 8840
Lyn Familant - I.C. Staff	727-7614 or 8840
Denise Edmunds - I.C. Secretary	727-7614 or 8840
Len Avery - Department Investigator	727-7655

For all the above:

Department of Youth Services
73 Tremont Street
Suite 735
Boston, Massachusetts 02108

Ed Dimock
Supervisor of Parole
Department of Youth Services
14 Somerset Street
Boston, Massachusetts 02108 — 727-2753 or 7944

Andros I.C.
450 Canterbury Street
Roslindale, Massachusetts 02131 — 288-9890

A.C.I.D. I.C.
406 Hemingway Street
P.O. Box 386
Marlboro, Massachusetts 01752 — 485-3218

D.A.R.E. I.C.
Box 955
Chelmsford, Massachusetts — 458-6871

Worcester I.C.
363 Belmont Street
Worcester, Massachusetts 01604 — 757-3471

Westfield I.C.
51 East Mountain Road
Westfield, Massachusetts 01085 — 413-568-8636

Region I
Department of Youth Services
1618 Main Street
Springfield, Massachusetts 01103 413-736-0362

Region 2
Department of Youth Services
75B Grove Street
Worcester, Massachusetts 01605 791-9220

Region 3
Department of Youth Services
221 Baker Avenue
Concord, Massachusetts 01742 369-8711

Region 4
Department of Youth Services
290 Essex Street
Salem, Massachusetts 01970 745-8750

Region 5
Department of Youth Services
1073 Hancock Street
Quincy, Massachusetts 02169 472-6300

Region 6
Department of Youth Services
14 Somerset Street
Boston, Massachusetts 02108 727-7952

Region 7
Department of Youth Services
Lakeview Hospital
P.O. Box 522
Lakeville, Massachusetts 02346 947-7650

C: Appensix 3: Slot Allocation

The final Allocation of Slots for the 6 I.C. Program is as Follows:

	Regions	1	2	3	4	5	6	7	Emergency	Total
A.C.I.D.	M	1	1	1	0	1	3	1	1	9
	F	0	0	1	0	0	1	1	0	3
	Total	1	1	2	0	1	4	2	1	12
Andros	M	1	2	0	2	0	4	0	0	9
	F	0	1	0	0	1	1	0	0	3
	Total	1	3	0	2	1	5	0	0	12
D.A.R.E.	Total M	2	0	3	1	1	4	1	0	12
R.F.K.	M	0	0	0	3	1	3	1	1	9
	F	0	0	0	1	1	1	0	0	3
	Total	0	0	0	4	2	4	1	1	12
Westfield	M	8	1	1	0	1	3	1	1	16
	F	2	0	0	0	1	2	2	1	8
	Total	10	1	1	0	2	5	3	2	24
Worcester	M	1	6	2	1	1	3	2	0	16
	F	1	3	1	0	0	1	1	1	8
	Total	2	9	3	1	1	4	3	1	
Total	M	13	10	7	7	5	20	6	3	71
	F	3	4	2	1	3	6	4	2	25
	Total	16	14	9	8	8	26	10	5	96

D. Appendix 4 : I.C. Meeting - Rules and Regulations

1. All meetings will begin promptly at 10 a.m. unless otherwise stated by the I.C. Director.

2. A rotating schedule for the location of Intensive Care Meetings will be issued to team members. Location sites will include all I.C. programs, and all regional offices.

3. The regions, programs, and central administrative staff are expected to be represented at every meeting. If a regular team member is unable to attend an I.C. meeting, the Director of I.C. should be notified in advance.

4. Every team member should have one trained I.C. team alternative. The alternatives must be identified to the director of I.C. These alternatives may attend I.C. team meetings with the regular team member. In the case that a regular team member is unable to attend a meeting, the alternate should take his/her place.

5. All referrals (including those for secure detention) must be written and submitted to the I.C. secretary, and be in compliance with the guidelines established for presentations.

6. All referrals will be presented to the entire I.C. team except when there are more than 5 cases to be heard. When there are more than 5 referrals, the team will divide into two smaller groups.

7. Each program, region and central staff will be allowed one vote.

If a region, program, or central administrative staff has more than one regular team member, the member voting must be identified at the beginning of each meeting. Only I.C. team members are allowed to vote. Alternate team members may vote only in the event that the regular team member is not attending the meeting. The Director of I.C. or his appointee will only vote in the case of a tie.

8. Major regional decision makers of youth being referred for I.C. placement are encouraged to assist I.C. team members in making presentations.

9. Any additional people wishing to attend an I.C. meeting may do so only upon the approval of the I.C. Director, and should be introduced to the team before the meeting.

E: Appendix 5: Status Codes

Each Intensive Care Program has their own system of determining a youth's progress in the program. Following are descriptions, written by each Intensive Care Program describing their status code.

1. Westfield Intensive Care Coding System

Westfield Intensive Care utilizes a color coding system in order to identify briefly the status of a youth in residence. The colors facilitate a monitoring of a youth's status by staff when decisions must be made regarding the youth's movement in and out of the unit. The color coding system is as follows:

Green - the youth's behavior, inclusive of work, group participation, general attitude, and educational involvement, allows the youth to go outside of the building on unsupervised trust walks. The green tag is a general indicator of excellent progress by the youth as deemed by both peers and staff resulting in a high degree of trust.

Yellow - this color identification indicates that a youth is allowed outside of the unit only on supervised activities, i.e. basketball, movies, store trips. Behaviorally, yellow indicates that the youth is making progress, but has not acheived a level of performance and trust which would allow him out of the building unsupervised.

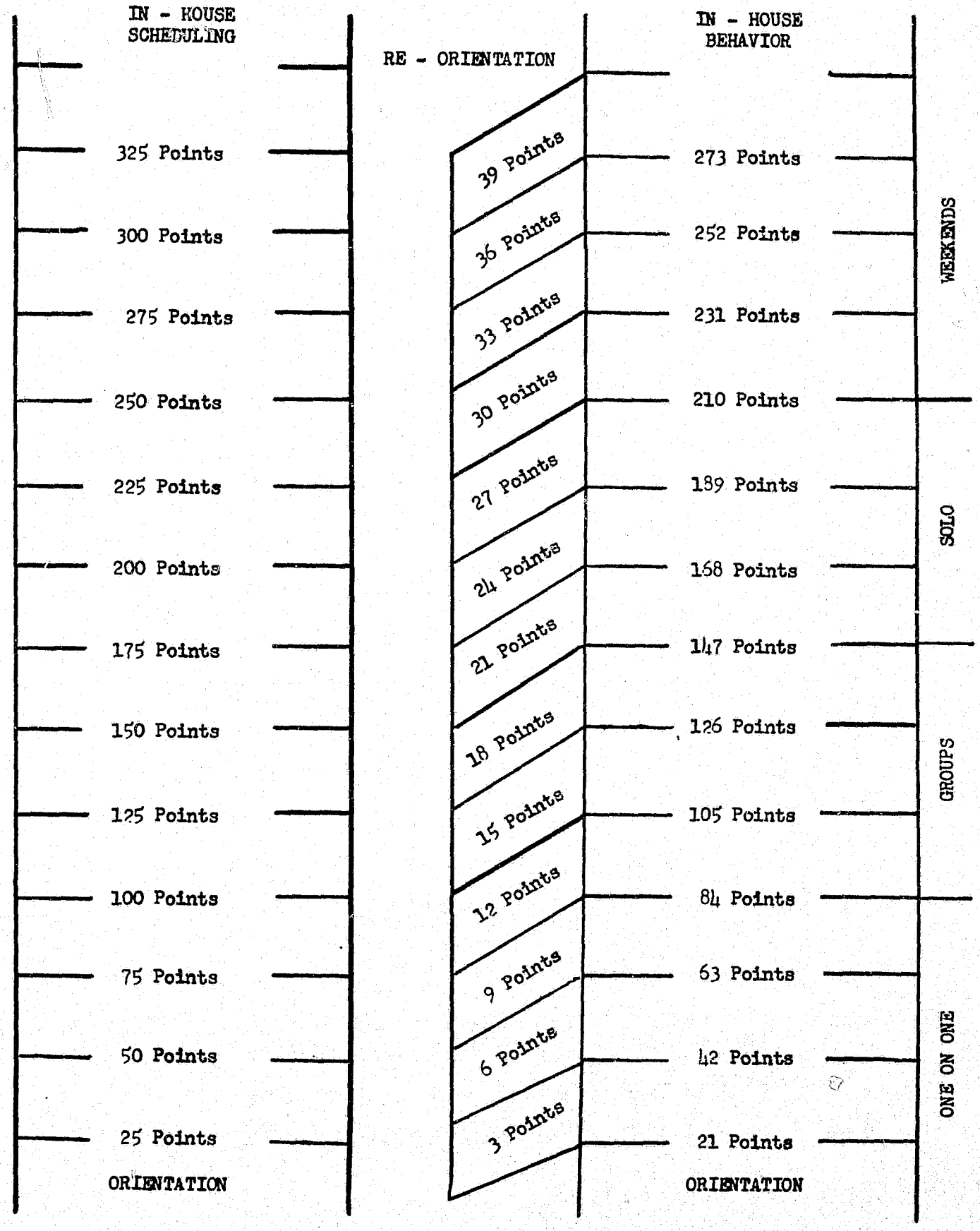
Red - this indicates that the youth is restricted to the building, no passes. A flagrant violation of house rules, i.e. violence, would result in a red tag. Any youth placed

in a continuously dealing room, or on a restriction, learning experience, or ban has a red tag. Youth who initially enter the program have a red tag.

Further explaination of the system - color tags are revieved weekly in a feed back evaluation seminar. Utilizing both staff and resident observation regarding a particular youth, a color code is assigned. Final authority for assignment of a tag lies with the program manager.

Youths progress one color code at a time, i.e. from red to yellow to green. Rate of progression depends on many variables, i.e. behavior, trust, participation. A green or yellow tag may be changed immediately to a red tag if a serious violation of rules occurs. Once the youth progresses backwards, the youth must make a substantial effort and overcome the difficulties which caused the youth to lose the tag.

2. Worcester Intensive Care Coding System



"Points" How They Work

8 points may be earned each day.

5 points may be earned for in-house scheduling.

+ 3 points may be earned for positive behavior.

8 possible points each day.

How you earn the points for in-house scheduling.

1 point for attending education #1 (10:00 - 11:00)

1 point for attending education #2 (11:00 - 12:00)

1 point for attending education #3 (1:00 - 2:00)

1 point for attending group (3:30 - 5:00)

+ 1 point for attending seminar (6:00 - 7:00)

5 possible points for in-house scheduling.

How you earn the points for positive behavior.

1 point for positive behavior on the 7 - 3 shift.

1 point for positive behavior on the 3 - 11 shift.

+ 1 point for positive behavior on the 11 - 7 shift.

3 possible points for positive behavior.

46 points may be earned each week.

25 points may be earned for in-house scheduling.

+ 21 points may be earned for positive behavior.

46 possible points each week.

How you earn all the points for in-house scheduling.

325 points needed for completion of in-house scheduling.

25 possible in-house scheduling attendance points each week.

x 13 weeks to gain 325 points.

325 points

How you earn all the points for behavior graduation.

273 points needed for in-house behavior.

21 points possible behavior points each week.

x 13 weeks to gain 273 points.

273 points

Note (You must complete in-house scheduling and in-house behavior (to graduate from the program.

DAILY SCHEDULE - BLOCK SYSTEM

8:00 -	WAKE - UP
8:30 -	BREAKFAST
9:00 -	CLEAN - UP
10:00 -	EDUCATION
11:00 -	EDUCATION
12:00 -	LUNCH
1:00 -	EDUCATION OR GROUP
2:00 -	RECREATION
3:30 -	GROUP
5:00 -	DINNER
6:00 -	SEMINAR
7:00 -	RECREATION
8:00 -	SHOWERS
8:45 -	BEHAVIOR REVIEW
9:00	FREE TIME
11:00	BED TIME

What is Reorientation?

Reorientation is a part of the in-house program designed to deal with acting-out behavior. It is time added to your program at Worcester because of your behavior.

How Do You Get Reoriented

You are reoriented for acting-out. The types of acting-out behavior for which you will be reoriented are:

suicidal behavior

fighting

escape or attempted escape

running

smuggling in or participating in contraband, ex. drugs, alcohol, weapons, etc.

damaging property, ex. tampering with locks, breaking windows, damaging house furniture, the malicious defacing of others belongings, etc.

away without official leave

What Happens During Reorientation?

You are restricted to the building until you work your way out of reorientation.

How Do You Work Out of Reorientation?

To get out of reorientation, and gain your priviledges back, you must gain the required number of behavior points. The required number of behavior points needed for this are:

3 behavior points X the number of reorientation days shown on your chart.

Example:

After earning 270 points, Mr. X had a fight with Mr. Y. Looking on the

chart we know that reorientation is 12 days. 12 days X 3 behavior points = 36 behavior points to gain priviledges back.

3. Dare Intensive Care Loding System

Here are the rights and responsibilities of our level system as listed on our bulletin board:

Prospect - Are you out or in?

Rules: Stay for one week.

No big hassles.

Get to know staff and other kids.

Level E - Can you take care of yourself?

Privileges - 1. One afternoon out with staff.

2. Walk on grounds with staff.

Responsibilities - 1. Do chores without hassling.

2. Get up on time.

3. Go to bed on time.

4. Participate in program.

5. Fulfill obligations of individual agreement.

Level D - Can you help others?

Privileges - 1. Go home once on a weekday.

2. Close bedroom door.

3. Walk alone on grounds.

Responsibilities - 1. Show positive influence and leadership on others in program.

2. Show initiative.

3. Fulfill obligations of individual agreement.

Level C -

Privileges - 1. Go home once on a weekday.

2. Bedtime at 12:30

3. Go into town with a Level B or A person.

Responsibilities - 1. Ability to handle freedom in a mature manner.

2. Show increasing responsibility and leadership in the program.

3. Fulfill obligations of individual agreement.

Level B

Privileges - 1. Go home once a week on a weekend day.

2. Freedom to go into town without a staff person.

Responsibilities - 1. Show increasing responsibility and leadership in the house.

2. Start to make input into your own future.

3. Fulfill obligations of individual agreement.

Level A

Privileges - 1. Go home on weekends.

Responsibilities - 1. Make decisions on your own future and begin to work on it.

2. Be reliable and dependable within the house.

3. Show leadership and responsibility within the house.

4. Fulfill obligations of individual agreement.

The level system is the major way in which we measure progress and personal growth within the program. Meetings are held weekly to discuss level changes. The person being considered gives his opinion about his level change first, followed by the opinions of the other residents and staff present. Each opinion must be supported by reasons

and/or examples. The discussions at these meetings are seen as recommendations to the staff which meets as a whole the next day to make the final decisions. After the staff meeting, each counselor meets with his "counselee" to explain individually the reasons for a level change or lack of change and to talk about what things the resident should work on for further level changes and graduation from the program.

The level changes, which measure personal growth within the program, are determined on an individual, flexible basis. For instance, a kid who "ran" 6 times in one week made a level because he had never stayed in any program this long, he always returned with a short time and he never ran beyond the grounds of the building. The residents and staff saw this as significant growth for this particular kid who has always been running. It was also taken into account that the level he made was on the lower end of the levels "ladder" so that he wasn't given too much freedom either. We see increasing self-control, ability to express feelings in a positive way, taking responsibility in helping out or leading other residents, program participation and ability to handle increasing degrees of freedom as some of the factors involved in judging an individual's personal growth. By Level A, we see the resident as a responsible program participant who can handle a limited degree of freedom - someone who is ready to transfer this responsible attitude to another program and to deal with the challenge of maintaining self-control with greater exposure to the streets.

4. A.C.I.C. I.C. Coding System

Adolescent Counseling Intensive Care Unit works with a level system which classifies the adolescents depending upon their behavior, attitude, and general progress within the program. This provides the guideline for staff and presents goals for the youths to strive for.

Step 1 - Adolescents on this level have seriously violated house guidelines. As a result:

a. they receive no allowance;

b. they are excluded from recreational activities;

c. they may not leave the house;

d. they are not eligible for privileges; and

e. they may not have visitors.

Step 2 - Adolescents on this level include those who have recently entered the program.

a. They may leave the house for selected group activities, however, they may not leave the house on a one-to-one (staff - resident) basis.

b. A $2.50 allowance each week for satisfactory completion of house chores is earned. An additional $2.50 through extra work may also be earned.

c. Relatives may visit.

Step 3 - In addition to the priviledges of step 2:

a. youths may leave the house with an individual staff person;

b. they are eligible for all individual and group recreation, education, and community activities; and

c. a day-time visit to home under staff supervision may be

earned. If successful, an overnight visit home will be arranged next.

Step 4 - In addition to the privileges of Step 3:

a. on a regular basis (every other week), weekends at home are allowed;

b. an increase in free time activities; and

c. people (screened first by staff) may visit that are not relatives.

Step 5 - In addition the privileges of Step 4:

a. youth at this level may go home every weekend;

b. unsupervised day in the community is permitted; and

c. part-time employment may be held.

Step 6 - In addition to the previous listed privileges:

a. a full time community job may be held; and

b. transition to community and home living will gradually take place.

A.C.U. does not see this step system as being iron-clad. Flexibility to meet the needs of the children we service takes precedent over strict adherence to every article.

5. Andros I.C. Coding System

Step 1 - Orientation

The orientation coordinator will meet with the residents once a week. Orientation consists of:

a. discussing personal growth.

b. consequences for negative actions;

c. rewards for positive actions; and

d. individual growth.

The orientation coordinator will be the leader of all departments with a resident sometimes running the orientation class. Orientation should be for 20 days. There will be no orientation classes on the weekends.

Step 2 - In the last week of orientation, the residents will be eligible for group supervised activities off the unit. Activities consist of:

a. sports,

b. movies,

c. touring, and

d. outings.

Step 3 - Residents will be eligible for one-on-one supervised activities off the unit after completing group activities. This is subject to the approval of the director.

Step 4 - After the residents complete the first three steps, the regional decision maker will report on their residents family situations, making the residents eligible for supervised group activities, one-on-one supervision, and family activities.

Step 5 - The conduct and individual growth of the first four steps will make residents eligible for day passes, weekend passes, and unsupervised activities.

Step 6 - A residents attitude, conduct, and recommendation by a staff member can make him/her eligible for off unit jobs, education, and/or activities on an every day basis unsupervised. At this point, placements can be worked out by the aftercare coordinator and regional decision maker.

Step 7 - A positive attitude can lead to extended passes, parole, or discharge. At this time, the regional decision maker should be in constant contact with the resident and make a recommendation to the director. When on a 10 day pass, the resident is required to call the unit at least 3 times within the 10 day period.

END