6/12/87:KH:mb

INTRODUCED BY: RON SIMS

PROPOSED NO: 87-452

MOTION NO. 6916

A MOTION approving revisions to the program and establishing a project schedule for CIP Project No. 006041 Youth Service Center Special Program Unit Remodel and CIP Project No. 006039, Youth Service Center Surveillance Upgrade; and releasing the existing appropriation from contingency.

WHEREAS Section 75, of Ordinance 7864 establishes a project budget of $72,000 for CIP Project No. 6041, Youth Service Center Special Program Unit Remodel; and a project budget of $46,191 for CIP Project No. 6039, Youth Service Center Surveillance Upgrade, and

WHEREAS Section 75 of Ordinance 7864 provides that funds for the Special Program Unit Remodel be placed in a project contingency until a programmatic review of the Special Program Unit needs has been completed and a transfer of the funds is authorized by council motion, and

WHEREAS a programmatic review of the Special Program Unit has been completed, and

WHEREAS the department of youth services proposes closing the Special Program Unit and instituting a new program to restrict youth who are dangerous to themselves or others, and

WHEREAS it is understood that the proposed program change will not necessitate an increase in staff;

NOW THEREFORE BE IT MOVED by the Council of King County:

A. The proposed program, project budget and project schedule attached hereto are hereby approved.

PASSED this 27th day of July, 1987.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Gary Grant
Chairman

ATTEST:

Gerald A. Peterson
Deputy Clerk of the Council

PROPOSED RECONFIGURATION OF DETAINEES

Living Unit	Current Indiv. Beds	Proposed Beds	Number of Timeout Rooms/1
Senior Boys East	20	20	2
Senior Boys West	20	20	2
Girls	16	16+ /2	2
Junior	16	16+ /2	2
Sentenced Offender	0	18+ /3	2
Sentenced Offender	20	18	2
SPU	13 /4	0	0
TOTAL	105	108 /4	12

Notes:

1. Since time-out rooms will not be regularly occupied, it is anticipated that these units will accomodate overflows as needed. If both time-out rooms on a unit are utilized for overflow, and "time-out" is required for a youth, that youth will be sent to a time-out room in another unit.

2. 2 additional beds are available in dormitories in each of these units. These beds will be utilized only for overflow purposes.

3. Each Sentenced Offender Unit has 16 individual rooms. In addition, the North Unit has 3 dorm beds, and the South unit has 4. Addition of the time out rooms will result in the loss of 2 rooms within each unit. One additional dorm bed will be placed in the North unit to help offset this loss. Since it is anticipated that dorm use will increase as a result of this change, increased square footage in each dorm is recommended.

4. Of the 33 SPU beds available, by policy, a maximum of 13 have been used, for a total current bed capacity of 105. The proposed change reflects a programmatic increase in capacity to 108 beds.

A REPORT TO THE KING COUNTY DEPARTMENT OF YOUTH SERVICES CONCERNING THE KING COUNTY DETENTION FACILITY

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March 22, 1987

I. MISSION AND ACCOUNTABILITY

One of the most difficult shortcomings of any agency, but particularly a juvenile justice agency, is the lack of an articulated mission that is clearly understood by the community, administration, managers, supervisors, staff and youngsters. This is a problem that must be clearly faced by the King County Department of Youth Services. King County, because it is a juvenile system has the further complex problems of articulating this mission because of diverse and polarized beliefs as to what that mission should be. A number of staff draw the analogy to the adult jail; that the detention center is in existence to punish and strictly detain. Other staff view the facility as a humane, environment that recognizes juvenile problems and are desirous of evaluating, rehabilitating, and assisting youngsters to a more normalized development. These conflicting directions result in an environment that is inconsistent, at times inhumane, and certainly one that undermines staff and youth morale.

The mission of a secure juvenile justice detention facility can be divided into three essential components:

1. To insure that only appropriate youth are initially admitted to the facility;

2. To insure that once admitted each youth spends the shortest amount of time in secure detention, consistent with the need to protect the public's safety and the need to fulfill valid orders of the Juvenile Court;

3. To insure that while living in the facility all youth receive decent, safe and humane treatment which is consistent with nationally recognized standards for secure residential care.

The detrimental effects of secure confinement on children and youth has been widely recognized (see, for example, IJA/ABA Standards Relating to Interim Status, 1980). Since secure detention represents a complete deprivation of one's liberty, it should only be used when there are no other viable options.

Although in many ways the detention center itself serves as a processing center for those agencies (police, probation, public defender, prosecutor, etc.) who have separate and legitimate functions within our juvenile justice system, a youth should not be held in secure detention to accommodate the needs of the system. Since secure detention is the most restrictive, pre-trial alternative, it should only be used as a last resort.

Once a youth is admitted to secure detention, staff (the detention center's staff and Court's staff) need to work to insure that each youth spends the least amount of time in the facility as is possible. While living in the facility, each youth should receive decent human care.

The current Mission Statement of King County Detention Services explicitly recognizes the need "to house the juveniles in a safe, healthy and humane environment." Operationally, however, the administrative structure for insuring that the agency's mission to provide humane care to each youth is poorly carried out. The separate program staffs within the detention center seem not to regularly interact with one another on a policy level. Medical and psychiatric staff, for example, have little or no current program relationship with most of the residential staff. Although there is a decent educational program, there is little or no relationship between the school program and the unit life program.

Although administrative and medical staff verbally supported the need for youth to have outside recreation, no formal or informal mechanism seems to exist to insure that youth actually do play outside. This seems all the more paradoxical given the existence of large, secured, outside play areas.

Similarly, although psychiatric and medical staff bemoan the current use of the SPU unit, professional staff could identify no means by which their clinical judgments and expertise could be made more readily available to direct child care workers so that the SPU unit as it currently operates could be changed.

In truth the residential care staff acts in "splendid isolation" to most of the rest of the staff and services in the building. Administrative and psychiatric staff did not know that although the practice had been formally abolished by memo, some units staff routinely use "room restriction" (a method of discipline whereby a youth must sit on his bed, still and silent, hands folded, feet on the floor, for one and one half hours without any physical stimulation).

Clinical staff do not participate on the development of training for direct care staff, nor do they have any direct input into the system of rewards and sanctions or the use of discipline or the operation of the SPU unit.

Youth <u>are taken to</u> most of the program components. Few program supports are initiated in the units. Professional staff really don't have a <u>felt sense of responsibility to and for individual youth</u>. Unit staff are seen as being in charge of individual youth.

There are no regular unit meetings of staff and youth. Few if any professional (including probation) staff see youth on the units. The residential staff is forced to manage and cope with the behavior of large number of youth by themselves.

The mission of any organization is more than words on paper. Organizationally all staff have to be held accountable for actually delivering services in a way which insures that the agency's mission is fulfilled for each youth in the Center. (Who, for example, is responsible for cleaning and maintaining the units? Why couldn't the living units be painted and made more home-like? Why cover the windows with old blankets? Why frost over windows? Why not use the outside recreational areas?) As one of the review team stated at our exit interview, the mission of the facility must get off the paper of memos and into the blood of the facility.

The lack of integration and accountability among the various program units within the Detention Center is further exasperated by the relative lack of integration between Probation and Detention Services. Probation staff tend to use detention as a way of managing their case load (this is particularly true for technical violators). Most probation officers do not routinely visit their youth held in detention. Few of them would acknowledge or agree with the first two components of the mission statement outlined on page one--that only a limited number of youth should be eligible for secure detention and that, once admitted, youth should spend the shortest amount of time in secure detention as possible.

Officials responsible for detention services in King County immediately need to address these issues. The mission of the facility has to be translated into daily reality. Memos and administrative pronouncements will not resolve the problem. It is important to define and articulate this mission both internally and externally because only when the mission is agreed upon can standards of

service, health, safety and individual successes or failures will become the foundation for public and community support.

Minimally regular staff meetings have to be held with staff representing all the major disciplines and services in the building. Policies and operating procedures concerning discipline, discipline hearings, room isolation, outside recreations, building cleanliness, etc. need to be developed, implemented and monitored.

Administrative officials should meet regularly with youth in order to hear their concerns. All of their issues need not be addressed (e.g. most older youth want to smoke) but responsible issues responsibly articulated should be resolved (e.g. the need for outside recreation).

Similarly, the directors of detention services and probation need to meet regularly and develop new policies regarding the 72 hours hold, technical violators, probation officers meeting with youth on units as well as the overall agenda of improving communication between probation and detention services.

One gets the impression that many caring and talented people work in detention services in King County. Without becoming confrontational, this talented staff needs to continually confront themselves and each other regarding the quality of the services and the environment within the King County detention facility. It is an old but nonetheless true cliche: what type of services would King County officials expect in the Detention Center if their own children were to be held there?

King County Detention Center can take several initiatives to address this important need:

1) Through a combination of the Community Advisory Board, the judiciary, all levels of staff and youth, a small representative group could be assembled to review existing materials relative to the center's mission.

2) The result should be a statement that is clear, concise, and easily understood, and reflects a humane attitude toward youngsters, recognizing that youth in its care can make positive changes, while reflecting concern for the health and safety of youngsters, staff and the community.

3) This statement must be articulated and communicated to all youth, staff and the community at large through agency literature, news releases, policy statements and actions of all affiliated with the Center.

There are several means available to King County to assist in the administrative/structural dissemination of the mission statement.

1) Introduction of unit management. This concept will allow for the Mission to be consistently articulated between various disciplines within the Center i.e., medical education, direct care, social workers, probation officers, etc. It will also allow for special need units to be consistent with total agency Mission while recognizing the individual and various program and personal needs of youngsters.

2) Clear definition of responsibility and authority. All staff members from the Director of the Department of Youth Services through support workers, direct care workers, etc. must have clearly defined job descriptions outlining

their responsibilities and the authority to assume those responsibilities that is consistent with the Center's mission.

3) Organizational structure. The management structure level must clearly define the chain of command and reflect at what level decisions can be made, what decisions are subject to review, and that all decisions programmatic and administrative reflect the articulated mission and the best interest of the youngsters. The success of the articulated mission will be assured if all the procedures and the statement itself can be clearly viewed and always considered from an attitude and belief that is "youth centered."

II. HUMAN DIGNITY/ENVIRONMENT

King County can achieve major strides in operating a Youth Services system and particularly its detention center with increased human dignity by simply recognizing that all levels of staff and particularly youngsters committed to the system's care are "people". The technical assistance team's observations for three days clearly indicated that managers responded to subordinates, staff responded to staff and staff responded to youngsters in most instances as "objects".

A concentrated and conscious effort of all levels of staff to recognize colleagues, and youngsters as human beings with individual needs, different levels of skill, feelings that can be hurt, deadened, or positively elevated would benefit greatly the Center's atmosphere and morale. The most basic rule of all can be easily followed if it becomes the expectation and norm of all levels of management. The rule is simply treat and respond to others as you would want or expect to be treated or responded to. Basic human needs that we all have

are not perceived important to staff and/or youth at King County at this time. This certainly does not mean that staff or youth do not wish to be treated as persons not objects, nor does it mean that they don't have the capacity to respond in this way; it only indicates that because of a lack of mission, people-based philosophy, etc., staff and youngsters feel that the expectation is not there from administration and/or the community.

Some specific examples of this attitude are:

1) A decision is made to commit a youth to the commitment unit for failure to appear in court; he is thus admitted on a warrant. All persons involved failed to recognize that this 10-day commitment would result in a loss by the youth's job and his home. It was in this case an object not a person.

2) A youth out of touch with reality and possibly psychotic is admitted to S.P.U., the secure unit. This is done on his community failures in group homes and his prior drug history. The medical and clinical department were not informed of his needs or admission. He was an object not a person with special medical and psychiatric needs.

3) A level system program has been initiated in the commitment unit. The concept calls for youngsters to receive rewards and opportunities for less restrictions based on positive behavior the staffing patterns, program areas, or capability at the unit level to reduce time in the Center or level of restriction are not available to go with the program initiative. The unit including staff are responded to as objects that don't have the capability to see through this conflict or the human need to express anger or frustration with the system.

4) A staff person obtains additional training and skill development while in the detention center's employ. She tells her supervisor of the skills and offers

to share the experience with her colleagues. She receives no response to her offer or positive support for her effort. She feels like an object not a person.

The human dignity of staff and youth in the detention center is basic to all other management, administrative and programmatic needs. The entire administration must be sensitized to their needs and the foundation for immediate and lasting response to youth and staff will be in place.

Another most critical area to establishing human dignity in the detention center involves the environment. How the center chooses to let youngsters live and their employees work reflects greatly on the attitude and commitment to human dignity. The environment is an area that can have immediate impact and reflection upon the desire for a youth centered humane environment. The following immediate steps can be taken to display this attitude:

1) Immediately close off and lock the four back isolation rooms in S.P.U., the secure unit.

2) Remove the opaque and shaded materials from all the external windows. Allow for staff and youth to see the outside.

3) See that all youth bathroom facilities are always equipped with toilet paper, soap, etc. It's degrading for a young person to have to leave the toilet areas, ask for toilet paper and return to the toilet to complete basic human functions.

4) Remove any lines on the floor "used as youth barriers" since such symbols as this only further make both staff and youth objects.

5) The general attitude of cleanliness toward the environment is below standard. An immediate house-cleaning and emphasis on cleanliness

If these considerations relative to human dignity and environment are addressed considerable attitudinal and morale changes can assist in changing the feeling and atmosphere of the King County Detention Center.

III. ABOLISHING A CORRECTIONAL ANACHRONISM

Traditions die hard in secure institutions. Confronted with the daily pressures of running a facility, line staff often find it difficult to think about discharging their daily functions in a different and professionally responsible way. Thus staff routinely use the SPU unit to lock up special needs youth (e.g. youth needing detoxification services) as well as routine discipline cases. It is impossible to justify the facility's current reliance on the SPU.

The very name, itself, SPU (Special Program Unit) gives cause for concern. In truth what happens in that unit is neither special nor a program. No special educational, counselling, medical or remedial services are available. Youth can be locked into three types of isolation cells; each type of cell more barren and sterile than the next. The solid doors and the impossibility of staff who remain in the staff area to monitor any of the cells are open invitations to disaster.

All youth in SPU face long periods of lock down--cell confinement--broken only by short periods of unit recreation, pool or ping pong, for those youth permanently based at SPU. By the educational director's admission, the school program would not meet state or national constitutional standards.

Youth who are brought to SPU from the living units because of a discipline problem are immediately locked into cells. No crisis counselling or

even routine (eye ball) supervision is available to these youth, many of whom are upset and agitated because of their recent forced removal from the general population.

Although the current location and physical design of the SPU present major problems (located in the basement, accessible only by long hallways and open stairwells from many of the living units), simply closing the SPU and moving it to another location within the facility will not address the underlying problems with SPU.

The facility needs to close SPU and replace it with appropriate interventions designed to address the individualized needs of the population and staff. Isolation itself does nothing but serve to escalate problems.

Replacing the SPU

1. Youth with Special Needs

The medical and psychiatric staff should be immediately charged with developing a small (4-6 bed) living unit located in the medical/mental health unit. This unit would have specialized medical and psychiatric services directed and delivered by the professional staff. Residential staff would be assigned to this unit to insure that all youth in this unit had access to other appropriate services in the building (e.g., education and recreation). The unit would be the initial placement for youth who are admitted with:

a. severe medical problems - detoxification drug and alcohol;
b. suicidal youth;
c. youth with extreme mental health problems (e.g. severe depression)
d. youth who are retarded or developmentally delayed.

The medical and psychiatric staff would design and implement a program for these youth. When the clinical staff felt it was appropriate, youth could be moved to the general population; however, the psychiatric and medical staff would closely monitor (track) any youth released into the general population.

Residential staff (as well as other Center staff) could make referrals to this unit for youth in the general population who they believed to be suicidal or depressed (or they thought suffered from other major mental health problems). It would be the psychiatric staff's responsibility to screen and evaluate such youth; however, if they did not admit such a youngster, the psychiatric staff would have to design special supports so that the staff could readily handle the originally referred youth on a regular unit. The analogy is clear: medical and psychiatric staff would direct and supervise medical and psychiatric interventions. When in their judgments, individual youth needed to be treated in an "in-patient" capacity, that youth would be transferred to this new unit. When in the judgment of the medical and psychiatric staff a youth (and his problem) could be better managed in the normal residential units by the direct care staff, professional staff would "prescribe" the appropriate intervention. Thus psychiatric staff in consultation with the residential staff would have to develop specific behavioral management strategies for youth returned to the regular units.

(NOTE: With minor renovations, such a small unit could easily be developed in the current medical/mental health area. With the closing of SPU, the facility would also gain more than enough positions in order to help staff this new unit and locate a mobile crises intervention team--see below.)

2. Discipline Problems--The Need for Crisis Resolution

The current discipline system needs to be reviewed and revised. More creative ways have to be developed to reward good behavior. The entire system is based on punishing negative behavior by locking a youth in his room (room-restriction) on the unit and when that doesn't work, removing him to the SPU. The over-reliance on lock down is increasing, not solving the problem. This is particularly true for younger boys (12-15). Minor misbehavior (e.g. talking across the luncheon tables) results in room restriction; a subsequent argument between staff and youth results in the youth plugging up his toilet and finally a forced and somewhat violent removal to SPU.

Locked room isolation should only be used as the last possible possible resort and then for only a short period of time; one-two hours. Under no circumstances should residential staff be able routinely to lock a youth in his room for a protracted period of time (in excess of two hours) or remove him to a discipline cell in another unit of the building.

At a minimum, the new discipline process should include:

- a system by which youth can earn privileges for positive behavior; good behavior needs to be rewarded as we go about the process of punishing negative behavior;

- a series of minor sanctions (e.g. loss of privileges) for minor infractions;

- a concretely defined definition of the types of infractions that can result in room isolation which stipulates the length of time an individual youth would spend in isolation as a result of a specific infraction;

- an upward limit for use of isolation that stipulates the responsible administrative staff who must approve any room isolation longer than two hours;

- a description of what services a youth gets during

isolation (i.e., education, large muscle activity, etc.);

- a provision to have psychiatric staff see all youth who are placed into room isolation for more than two hours;

- a real due process and appeal procedure which covers the use of all sanctions.

In order to assist direct care staff, as part of the restructuring of the discipline system, the facility should develop a mobile crisis intervention team. This team comprised of staff from all the divisions within the detention center would be trained by the clinical staff. This would not be a SWAT team. The mobile crisis intervention team would be available in all shifts.

When a unit staff could not resolve a management problem with a youth, the team would be called in. Once called, the team would have complete authority to resolve the issue.

The team could:

1. Counsel the youth and resolve the problem on the unit;

2. Request that other staff come to the unit to resolve the problem;

3. Take the youth off the unit for a short period (for a walk, to the gym, to the outside recreational area) and then return the youth to his unit;

4. In exceptional cases, the crises intervention team could refer the youth for screening and evaluation to the in-patient service unit run by the psychiatric staff.

Once the crisis was resolved, line staff could request a disciplinary hearing, if they felt that the youth's initial behavior needed to be sanctioned.

A system such as this separates two related issues: crisis management and the disciplinary system. For sustained disciplinary infractions, youth would be liable to legitimate sanctions (e.g., loss of privileges and extra clean ups and assignments for minor infractions, short periods of room confinement for more serious infractions). Unit staff would have immediate supports available to manage crises, but they could not exclude youth from the living unit by placing them in a separate segregated discipline unit.

3. The Extreme Cases: Youth with Serious Charges and Extreme Management Cases

Youth with serious charges (or previously problematic youth) would not be placed in isolation as a result of their alleged crimes or prior behavioral histories. First of all, King County has a relatively few number of youth charged with violent crime. Assuming no serious mental health problem, after intake these youth should be placed into the general population. Youth should not be informally sentenced to isolation before being tried for their alleged offense. If in the opinion of the staff, these youth have a serious mental health problem, they should be referred to the psychiatric staff for review and evaluation as outlined above. If they present a management problem while in the general population, the mobile crisis intervention team would be called in (as described above).

For youth (and this would be an extremely small number, perhaps one or two a year) who persisted in violently acting out in a destructive manner, the facility should take the following steps:

a. Conduct a complete and updated medical, clinical and social history;

b. If indicated, seek the Court's approval to place the youth in a mental health, hospital setting offsite.

If staff felt it was absolutely necessary, one room in the intake area could be equipped to safely handle youth undergoing violent episodes. However, placement into that special room could only be made with the written approval of the medical doctor, the psychiatrist, and the detention center's administrators. All such placements would have to be reviewed and approved every four hours. In no case would a youth remain confined in that room for more than 12 hours. If a youth were that disturbed, he should be referred to a hospital setting. (Youth placed in any such special room would be under the constant visual and audio observation of staff. Every half hour the crisis resolution team would attempt to resolve the youth's difficulty.)

The restructuring of the disciplinary system, the developing of a small mental health living unit and mobile mental health unit could be achieved within current budgetary limits and within a reasonable time frame (30-60 days). If King County is committed to quality services in its detention center, SPU or a relocated version of it ought not to be allowed to exist.

IV. CLASSIFICATION, ISOLATION, GENERAL PROGRAMMING AND PHYSICAL PLANT LIMITATIONS

In addition to the issues identified above by the study team, King County officials requested that specific responses be developed regarding the policies and practices surrounding classification, isolation, general programming and physical plant limitations.

Classification

The current classification system, which is intended to group relatively homogeneous populations into living units is based, primarily on age. The exceptions to this classification are for those youngsters whose behavior suggests an "older" or "younger" living arrangement might be better suited to unit management. Additional classification criteria involve the separation of sentenced offenders, and those offenders who are thought to need the added structure of the Special Programs Unit.

In the visit to the facility, classification was generally adequate, given the criteria described above. The population was equally divided between Senior Boys units and the Junior Boys Unit . The S.P.U. contained a population which ranged from fourteen to sixteen during the visit.

The classification system does not appear to lead to unnecessary solitary confinement or other restrictions, although, as noted earlier in the report, the staff use of disciplinary procedures (especially S.P.U.) has produced more isolation than the team felt necessary. This is to say, that the classification procedure is not inadequate, but staff reliance on room confinement and unit transfers appears to be excessive.

Of particular importance in this regard is the transfer provision and utilization of S.P.U.. While discussed fully elsewhere in this report, it cannot be overemphasized that the routine use of S.P.U. is not necessary for adequate behavior control, and is probably, in fact, contributing to management difficulties.

While adequate, the classification system in King County could be revised to make additional use of staff observations of behavior. In an urban community like Seattle, there will be a broad range of "criminal sophistication" among age groups. The initial unit classification decisions could be based on factors such as past behavioral difficulties in detention, offense type, attitude and personal demeanor at intake. These "clinical" judgments would probably produce a more workable living unit. While age is important, it is but one factor to be considered in classification.

Use of Isolation

Isolation, room time, restrictions, and S.P.U. have been discussed at length earlier in this report.

It is the position of the study team that isolation is overutilized as a behavior management technique and should be replaced with a greater degree of intervention from teams of staff specifically constructed to impact behavioral difficulties on the unit. It is clear that room time is used early and often to control behavior. One unfortunate consequence of this practice is that there is a rapid "inflation" of disciplinary measures which leaves the staff few options for behavior management. It is one factor which produces the frequent transfers between units and placement in S.P.U.

The current practice does not differ substantially from the written policy. In fact, the policy manual details quite clearly the consequences of minor and major misconduct and lays out a series of restrictive reactions to be expected.

The facility has grown accustomed to imposing these restrictions and has not experimented with less drastic alternative measures to control behavior. It has not been able to effectively utilize its mental health component to intervene and assist in behavior difficulties, and in the process, has probably increased the incidence of misconduct.

The isolation policy should be reviewed carefully to determine where intermediate staff responses can be added to policy so as to avoid the rapid escalation of consequences.

It is clear from experience across the country that isolation is less desirable as a behavior control technique than other more staff-interactive approaches. One reason for this is the mounting evidence that suicide, depression and continued non-responsiveness to program are often natural consequences of locked restriction of liberty. Some facilities with populations not unlike King County have removed isolation practice altogether with successful results. Others have severely limited its use. In an effort to avoid disaster, some facilities have required that when a youngster is removed from the general population, he must be in the constant company of a staff member. In these instances, it has been found that staff respond by using isolation much less often.

Such isolation alternatives will reduce the potential for suicide in the King County facility and will, we believe, improve the security of the program and the positive interaction between staff and youth. A full description of an alternative strategy to reduce the use of isolation is presented in Section III of this report.

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