Revised 6/86 Dave Guthmann

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

DIVISION OF JUVENILE REHABILITATION

Olympia, WA

SPECIAL OFFENDERS ISSUE ANALYSIS
TASK FORCE REPORT

CR-Sent

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APRIL 1986

SPECIAL OFFENDER ISSUE ANALYSIS
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TABLE OF CONTENTS

1. Executive Summary . . . . . **GOLDENROD**

2. Chronic Sex Offender Report . . . . . **YELLOW**

3. Chronic Offender Report . . . . . **BLUE**

4. Mentally Ill Offender Report . . . . . **GREEN**

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

The Special Offenders Task Force made recommendations concerning three groups within the Division of Juvenile Rehabilitation: chronic sex offenders who have developed deviant patterns of sexual arousal and engage in repetitive sexual offense behavior, chronic offenders who keep reappearing in the DJR and mentally ill offenders.

CHRONIC SEX OFFENDERS

Chronic sex offenders were identified as having: a previous sex offense conviction; sexually victimizing others while incarcerated; a sex offense within 2 years of receiving treatment; or more than 3 victims. Of the sex offenders, 53% (N = 47) met at least one criterion. There were no differences between chronic and other sex offenders in terms of non sex offense criminal history, individual and family counseling, sex education, social skills training or counselor's prognoses. Chronic offenders were more likely to receive group therapy, keep journals, have arousal patterns studied and have parole follow up planned. They were more likely to have deviant sexual fantasies, and were more likely to receive behavioral treatment.

Several needs became apparent:
- There is no systematic approach to the chronic sex offender.
- Community treatment is inconsistent throughout the state.
- Additional training for sex offender treatment is needed.

Recommendations:

A. The DJR should develop standards of treatment and supervision.
   1. A full time central office administrator.
   2. A plan for providing specific behavioral services.
   3. Transfers and setting of release dates should be based on progress in sex offense specific treatment.
   4. Parole supervision procedures should be standardized.
   5. Chronic sex offenders should be initially placed in Echo Glen, Maple Lane or Green Hill.

B. Echo Glen, Maple Lane and Green Hill should develop a service delivery plan for all sex offenders.

C. Improve community based aftercare services for sex offenders.
   1. Increase CJS funding for sex offender treatment.
   2. Provide DJR funding for non CJS counties.
   3. Fiscal impact: $41,000; no FTEs. (See Appendix D)

D. Improve staff training programs.
   1. Current training by DJR and CJTC should continue.
   2. An advanced training program is needed.
   3. Fiscal impact: $41,000; no FTEs. (See Appendix E)

CHRONIC OFFENDERS

Chronic offenders were defined as youth serving their third or more distinct commitment or those serving a second commitment who have a criminal history with eight or more prior offenses. In 1983, 11.2% were defined as chronic. By 1986, 14% were.

Some differences were noted in comparing chronic offenders to the others. Chronic offenders were older by almost five months. They were significantly less likely to be a Serious Offender, have a B+ or higher offense, or have a Manifest Injustice commitment. They are more likely to have minimal self control. There was no difference in average minimum sentence or degree of dependency on drugs or alcohol.

Chronic offenders were no more likely to be held beyond their minimum sentences or discharged. Differences in time on parole were insignificant. Chronic offenders were, however, more likely to transfer to community placements. They were more likely to be recommitted. They did not have a higher escape rate, nor did they fail in group homes more often.

Most supervision options had no significant impact on recommitment. Group home placement, retention beyond minimum sentence and parole or discharge made little difference. Those on parole more than four months were less likely to be recommitted.

Recommendations:

1. Develop an improved means for the early identification of chronic offenders. It is recommended that the Juvenile Risk Assessment Tool be used to identify potential chronic offenders.

2. DJR should continue with offense-specific case management for the supervision of chronic offenders.

3. Continue to place chronic offenders in group homes.

4. Retain chronic offenders on parole for a longer period of time.

MENTALLY ILL OFFENDERS

There are youths inappropriately placed within DJR. Some have psychiatric diagnoses who are too aggressive, assaultive or bizarre for the mental health system. Some have less definable diagnoses, but are disturbed rather than delinquent. The mental health system needs a program to deal with these. Even if there were such a program, though, DJR would continue to receive some of these youths because of serious crimes or behavior.

Analysis found 83 youths who exhibited symptoms of mental disturbance. A significant portion of these were Manifest

Injustice commitments and 18 had no criminal history. Staff surveys revealed additional concerns about inadequate psychiatric services, training and resources.

Recommendations:

1. Form an inter-agency group to screen multiple need youth, develop resource packages for them, analyze factors that inhibit treatment delivery and make recommendations.

2. Establish a secure mental health facility jointly funded and operated by the Divisions of Juvenile Rehabilitation and Mental Health.

- Fiscal impact:

$950,000	Construction
$500,000	Annual operating cost
$1,450,000	Total

14 additional FTEs
(See attachment: Recommendation 2)

3. Establish one mental health cottage at both Echo Glen and Maple Lane. This recommendation is necessary only if number 2 is not viable.

- Fiscal impact:

$500,000	Unit conversions
$197,000	Annual staff costs
$ 40,000	Annual consultation and training costs
$737,000	Total

6 additional FTEs
(See attachment: Recommendation 3)

CHRONIC SEX OFFENDER REPORT

Division of Juvenile Rehabilitation

SPECIAL OFFENDERS TASK FORCE

CHRONIC SEX OFFENDER SUBCOMMITTEE

Final Report

Subcommittee Members:

Tim Kahn, Chairperson
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Brad Garner
Mary Anne Harrington

Submitted April 10, 1986

DIVISION OF JUVENILE REHABILITATION

SPECIAL OFFENDER TASK FORCE

CHRONIC SEX OFFENDER SUBCOMMITTEE
FINAL REPORT

INTRODUCTION

The chronic sexual offender subcommittee of the Special Offender Task Force was assigned the task of assessing the service needs of the more violent, chronic sexual offenders that were thought to be located generally at Green Hill School. The subcommittee was given a copy of a summary paper written by Julie Blackburn several years ago that proposed opening an intensive treatment cottage for 14 chronic and violent sexual offenders. The original proposal was based on the hypothesis that the most dangerous sex offenders are sent to Green Hill School which was considered at the time to offer few specific treatment resources for those offenders. The subcommittee's charge has been to further study the problem of the chronic sexual offender in DJR and provide recommendations to Central Office concerning how to meet the needs of this special population.

THE PROBLEM

The issue of the chronic/violent sex offender was originally brought to the attention of the special offenders task force as a result of concern expressed by DJR staff about the lack of treatment resources available for the sex offenders at Green Hill School. The assumption has been that the type of sex offender commonly found at Green Hill represented a greater risk to public safety than did other sex offenders, and therefore, efforts should be made to provide services for those offenders. There was a belief expressed that perhaps a different and more intensive type of treatment program would be necessary to effectively reduce their reoffense risk. Continuing staff training efforts coupled with the hiring of several new staff members have enabled Green Hill School to recently improve its services to sexual offenders. The subcommittee found that Green Hill has recently started a sex offender therapy group and individual therapy is provided on a regular basis to all sex offenders in the institution. In addition, the DJR violent offender unit has recently accepted a chronic and violent sex offender into its program with the proviso that sex offense specific therapy continue.

Through numerous contacts with DJR staff engaged in the treatment of sex offenders, the subcommittee ascertained that the subgroup of sex offenders that is of greatest concern is the chronic or repetitive sex offender who seems to have developed a deviant pattern of sexual arousal and has been engaging in repetitive sexual offense behavior. The treatment specialists contacted voiced frustration that some sex offenders were continuing their pattern of sexual offenses despite having already been through the sex offense specific treatment programs in the institutions. The improved services offered at Green Hill School and concerns expressed by the DJR sex offender specialist provided the impetus for the subcommittee to focus its study on the chronic sexual offender in the DJR.

A computer search done by MAPPER in February 1986 found 25 recommitted offenders in the DJR who were serving a current sentence for a sexual offense (see Appendix A). Of those 25, only 12 had been committed previously for a sexual offense. The other 13, though currently incarcerated for a sexual offense, have been incarcerated previously for non-sexual crimes. It became clear, in reviewing the data from MAPPER that additional information would be required in order to effectively study the needs of sex offenders with a demonstrated pattern of continued or repetitive sexual offenses.

In preparing for this study of the chronic sex offender in the DJR, the subcommittee reviewed a variety of available research and literature related to the treatment of adolescent and adult sex offenders. While a complete research and literature review was beyond the scope and resources of this task force, the information reviewed points to the following generally accepted

conclusions:

> The majority of adult sex offenders began their offense behavior during adolescence (Groth, 1983). A majority of chronic adult offenders report having developed deviant sexual interests and fantasies as early as 12 or 13 years of age (Abel, 1984). Chronic sexual offenders (child molesters) are responsible for up to ten times as many victims as is the typical rapist (Abel, Mittleman, and Becker, 1983). Recent revelations about the early onset of sexual offense behaviors in chronic adult sex offenders have significant implications for the adolescent sex offender treatment community. Development of assessment and treatment strategies that have the potential for intervening in these patterns before they become habitual or compulsive is an extremely important rehabilitation and public safety concern (Knopp, 1985).

The chronic sex offender subcommittee has attempted to assess the scope of the chronic sex offender problem in the DJR and determine what treatment methods are currently being utilized with this population. A further task for the subcommittee has been to provide recommendations about how to better meet specific treatment and supervision needs of this special DJR population.

METHODOLOGY

Data was collected in March of 1986 on the chronic violent offender population housed within the DJR's institutions by utilizing a survey instrument developed by the subcommittee. In addition, a telephone survey of selected professionals within the juvenile justice system requested information as to the service delivery needs and recommendations for this population. The time limitations of this study did not allow for the use of a more sophisticated methodology.

The survey instrument (see Appendix B) was circulated to case managers in all DJR institutions and group homes, requesting specific criminal and sexual deviancy history data on each sex offender currently in residence. A previous computer study in February of 1986 revealed 114 sex offenders within the DJR system, the majority of whom were located at Echo Glen Children's Center and Maple Lane School (refer to the survey results for more detailed information).

The survey conducted in all DJR programs requested information as to the number of prior offenses (both sexual and non-sexual), the extent to which an identified sex offender has been involved in sexual victimizing within the institution, whether the sex offender reoffended within two years of receiving treatment, and whether or not the offender has more than three victims. Treatment data requested involved the number of hours an offender

had experienced individual and/or family counseling, whether or not these offenders were involved in a specialized sex offender treatment group, sex education classes and general social skills training. Other more specific treatment data requested included involvement in journal writing, offender arousal pattern assessment, identification of deviant sexual fantasies, the use of behavioral treatment methods in addressing the arousal patterns, an assessment of whether follow-up services will be available for the offender, and the offender's counselor subjective rating of offender prognosis.

The telephone survey of selected sex offender specialists (see Appendix C) requested specific information as to perceptions of current service delivery gaps with this population, recommendations for improvement of services and minimal standards for treatment and supervision while on parole status, and if behavioral treatment services exist within reasonable proximity.

Data from the above surveys were compiled and analyzed by arithmetic averaging techniques and synthesis of the opinions of respondents. No formal statistical methodology was employed, as the time limitations of this study did not allow for the development of survey instruments which would provide for a more sophisticated analysis. Subcommittee members viewed this methodology appropriate for the examination of preliminary trends in available data.

FINDINGS

CASE MANAGER SURVEY RESULTS

Surveys were distributed to the case managers of all 114 sexual offenders in DJR identified by MAPPER in February 1986. To date, a total of 88 surveys have been returned, giving a response rate of 77%, which is considered adequate for a survey of this type.

Definition of Chronicity

The subcommittee identified four specific indicators that were used to define chronicity. A "yes" response to one or more of the following four items is sufficient for inclusion in the chronic sex offender subgroup. "No" responses to all four items resulted in offender's inclusion in the non-chronic sex offender subgroup.

Specific items used to identify chronic sex offenders:

A. Conviction for a previous sex offense (includes convictions that resulted in probation, detention, incarceration, diversion).

B. An offender has been involved in some sexually victimizing behavior while incarcerated (hands-on

behavior only counted).

C. Offender has reoffended sexually within two years of receiving any treatment services.

D. Offender has a total of more than three victims (admitted or adjudicated). This item is more sensitive than item 1 in that admitted/non-adjudicated offenses are included. The item is based on a well-established operational definition of the chronic sex offender. The assumption is that offenders with four or more different victims are more predatory and higher risk than those with fewer victims.

Table 1 indicates that 47 of the 88 responses received (53%) met one or more of the subcommittee's criteria for inclusion in the chronic offender subgroup. This means that more than half of the DJR's sex offender population can be described as chronic. The set of four criteria used to identify the chronic sex offender is considered to be conservative rather than liberal. For example, it is possible that a sex offender who has molested one victim numerous times over several years, but had never been caught, would be considered non-chronic according to the criteria utilized in this study. Since sexual offending behavior commonly follows a course of gradually escalating incidents, it was felt that the criteria should focus on predatory patterns of behavior involving numerous victims and lack of responsiveness to treatment or sanctions.

Scope of the Chronic Sex Offender Problem

The most significant finding of this study is that more than half (53%) of the DJR sex offender population can be considered to have a chronic pattern of sexually offending behavior. The study found that the vast majority of all sex offenders (including the chronic sex offenders) are located at Echo Glen and Maple Lane. Green Hill has relatively few sex offenders, but of the seven sex offenders in residence five are considered chronic. It is apparent that some (N = 8) chronic sex offenders are scattered among other DJR programs including camps, state group homes, and CRP's.

The survey found no meaningful differences between subgroups in areas of non-sex offense criminal history, individual counseling, family counseling, sex education, social skills training or counselor's subjective rating of the offender's future. Differences were found in several other areas, however; 52% of the chronic offenders are currently involved in offense specific group therapy, while only 29% of the non-chronic offenders are involved in group therapy. 45% of the chronic offenders are currently involved in keeping personal journals, while only 30% of the non-chronic offenders were keeping journals. 80% of the chronic offenders have had their sexual arousal patterns studied or discussed versus only 44% of the non-chronic offenders. It

CHRONIC SEX OFFENDER SUBCOMMITTEE

TABLE 1

Location	Total Sex Offenders Identified by MAPPER (2/86)	Number of Surveys Returned	Number of Surveys Returned/% Identified Chronic	Number of Survey's Returned %Identified Non-Chronic
Echo Glen	43	37	21 (54%)	18 (46%)
Maple Lane	36	23	13 (57%)	10 (43%)
Green Hill	7	7	5 (71%)	2 (29%)
Naselle	7	4	1 (25%)	3 (75%)
Mission Creek	2	1	0 (0%)	1 (100%)
State Group Home	14	10	5 (56%)	4 (44%)
CRP'S	5	4	2 (50%)	2 (50%)
TOTALS	114	86 (77%)	47 (53%)	41 (47%)

Table 2 provides some additional information about the chronic sex offender subgroup. It shows that more than half (58%) of the chronic offenders met two or more of the four specific criteria. Of the 20 offenders (42%) that only met one criterion, ten had more than three victims (Item 4) while six had a previous conviction for a sex offense (Item 1).

TABLE 2

SURVEY RESULTS

Sex Offense History		Specific Item #	Number of Offenders
Number of offenders identified as Chronic by any one of four criteria	20 (42%)	#1 only	6
		#2 only	1
		#3 only	3
		#4 only	10
Number of offenders identified as Chronic by any two of four criteria	14 (30%)		
Number of offenders identified as Chronic by any three of four criteria	8 (17%)		
Number of offenders identified as Chronic by all four criteria	5 (11%)		
TOTAL	47 (100%)		

Comparison of Chronic vs. Non-chronic subgroups: Table 3 provides detailed survey findings comparing treatment issues and services of the chronic vs. the non-chronic subgroups.

TABLE 3

COMPARISON OF CHRONIC VS. NON-CHRONIC SEX OFFENDERS

Chronic N=42
Non-chronic N=34

TREATMENT SERVICES CURRENTLY PROVIDED

Type of Offender	Non-Sex Offense History	Hours/Week Individual Counseling	Hours/Month Family Counseling	Currently Involved In Sex Offender Treatment Group	Currently Involved In Sex Education	Currently Involved In Social Skills Therapy	
Chronic	Yes-48% No -52%	Range .5-6 Hrs. mean 2.0 Hrs/week	Range 0-5 hrs. Mean .7 Hrs/ Month	Yes-52%	Yes-43%	Yes-60%	
Non-Chronic	Yes-53% No -47%	Range 1-5 Hrs/ Mean 1.7 Hrs Week	Range 0-4 Hrs. Mean .8 Hrs/ Month	Yes-29%	Yes-47%	Yes-60%	
TYPE OF OFFENDER	Involved in other Treatment	Currently involved In Journal Work	Offender Arousal Patterns Studied or Discussed	Has Offender Identified Any Deviant Sexual Fantasies	Have Any Behavioral methods Been used to Change Deviant Arousal Patterns	Will Any Follow-up Services Be Available when When Offender is Released to parole	Counselors Subjective Rating Of Offenders' Future 1. Optimistic 2. Neutral 3. Pessimist
Chronic	Yes-45%	Yes-45%	Yes-80%	Yes-53%	Yes-14%	33%	Mean Score 2.2
Groups Listed In Approximate Order of Frequency Attended	Victims Group Anger Mgmt. Drug/Alcohol Family Group Prob. Solving Assertiveness						
Non Chronic	Yes-18%	Yes-30%	Yes-44%	Yes-9%	Yes-3%	12%	Mean Score 2.2
Groups Listed In Appropriate Order of Frequency Attended	Victims Group Drug & Alcohol Family Group Prob. Solving						

TABLE 4

Comparison of Treatment Services at Echo Glen Children's Center, Maple Lane School, Green Hill School to DJR Mean*

	Non Sex Offense Criminal History	Hrs. WK of Individual Counseling Received	Hrs. Month Of Family Counseling Received	Currently Involed S.O. Treatment Group	Currently Involved Sex Ed	Currently Involved Social Skills Training	Currently Involved in Other Treatment (e.g. Anger Management, D/A, etc.
Echo Glen N=39	33%	1.2 hrs.	1.0 hr	44%	64%	59%	41%
Maple Lane N=23	43%	2.7 hrs.	.5 hr.	57%	30%	74%	26%
Green Hill N=7	86%	2.1 hrs.	0	43%	29%	57%	0
DJR Mean N=76	50%	1.9 hrs	.7 hr.	40%	45%	60%	33%

	Currently Involved in Journal Work	Offender's Arousal Pattern Studied	Deviant Fantasies Identified	Behavioral Methods To Change Arousal	Follow up Treatment Available On Parole	Counselor's Rating of Offender's Future
Echo Glen N=39	54%	69%	26%	8%	31%	2.4
Maple Lane N=23	17%	57%	17%	4%	4%	2.2
Green Hill N=7	43%	43%	43%	29%	0	2.4
DJR Mean	38%	64%	33%	9%	24%	2.2

1. Optimistic
2. Neutral
3. Pessimistic

*Where percentages are displayed, the numbers given refer to the total of "Yes" responses for each item.

should be noted that the question about arousal patterns was phrased in such a way that case managers would respond "yes" if they had ever asked the offender any question about sexual fantasies. The responses to this item indicate that some attention is being given to a sex offender's arousal patterns, but it does not necessarily mean that a thorough assessment has been completed. More than half (53%) of the chronic sex offenders demonstrated deviant sexual fantasies, while only a small number (9%) of the non-chronic subgroup had identified any deviant sexual fantasies. The survey indicates that very little work is being done to help offenders change their deviant arousal patterns. Only 14% of the chronic subgroup is receiving any behavioral treatment services to help them change their deviant arousal patterns, versus just 3% of the non-chronic subgroup.

Interestingly, case managers indicated that 33% of the chronic offender subgroup would be receiving follow-up services when they are released to parole, while only 12% of the non-chronic subgroup are anticipated to receive any follow-up services on parole. This finding seems to indicate that the chronic subgroup does receive better follow-up treatment; it also indicates that follow-up treatment services for sex offenders are either not available or that case managers are not well informed of resources that are available.

Comparison of Institution Treatment Services

Since one of the original charges of the chronic sex offender subcommittee was to assess the treatment services provided at Green Hill School to chronic sex offenders, the case manager survey data was separated out to provide information about treatment services offered at Echo Glen, Maple Lane, and Green Hill. Due to the small number of sex offenders located in other DJR programs it was decided not to do a comparative study of that data. Table 4 provides a comparative analysis of survey results for each institution. It should be noted that in this comparison no break-down of chronic or non-chronic subgroups was done. Table 4 provides a summary of data from all surveys received from each institution, and also provides a mean DJR response derived by combining the data from all 76 survey responses from across the Division.

Review of the data provided in Table 4 yields interesting findings. Sex offenders at Echo Glen are least likely to have a non-sex offense criminal history (33%), while Maple Lane is somewhat higher (43%), and nearly all of the sex offenders at Green Hill School (86%) have a non-sexual criminal history. This would seem to indicate that Echo Glen and Maple Lane are more likely to deal with the "pure" sex offender while Green Hill tends to house sex offenders with histories of other criminal behavior. Individual counseling ranged from 1.2 hours per week at Echo Glen to 2.7 hours at Maple Lane. It should be noted that the Maple Lane figure may be skewed by the fact that many sex offenders were involved in marathon treatment groups during the

week the survey was distributed and some case managers may have mistakenly included group counseling time as individual counseling. Family counseling ranged from an hour per month at Echo Glen to none whatsoever at Green Hill school. This figure makes sense given the fact that Echo Glen deals with the younger offender who are more likely to have family involvement as well as being located closer to large population centers in the state. Approximately half of all sex offenders are currently involved in some kind of offense specific treatment group. It should be noted that the question was phrased to ascertain how many sex offenders were currently involved in group therapy, therefore, the number of sex offenders who received or will receive group therapy at some other time during their sentence will be greater than the number reflected in the survey.

Sex Offenders involved in sex education range from 64% at Echo Glen to roughly 30% at Maple Lane and Green Hill. Skills training was provided to roughly 60% of sex offenders at Green Hill and Echo Glen, while 74% of those at Maple Lane were involved. Participation in other treatment such as anger management, drug and alcohol, victims therapy, range from high of 41% at Echo Glen to 0 at Green Hill School. Offenders involved in keeping journals ranged from 54% at Echo Glen to 43% at Green Hill School and 17% at Maple Lane. Arousal patterns are being at least discussed fairly consistently across the Division, with an average of 64% of the sex offenders having discussed their sexual arousal. Deviant fantasies are identified an average of 33% of the time with sex offenders across the Division and behavioral methods are used to change arousal only a small percentage of the time (9%). Case manager's knowledge of follow-up treatment available on parole ranged from 31% at Echo Glen to 4% at Maple Lane and 0 at Green Hill. There does not seem to be any significant difference between the counselor's ratings of the sex offender's future at various institutions with scores ranging from neutral to pessimistic attitudes at each location.

Summary of Case Manager Survey Findings

The comparative survey data currently indicates that sex offenders are receiving offense specific treatment services in all three institutions. Individual counseling, group therapy, social skills training, journal work, and some study of sexual arousal patterns are all being provided to a large percentage of sex offenders in all locations. Noted differences in family counseling, sex education, related treatment activities, treatment for deviant arousal patterns, and availability of follow-up treatment may be attributed to a variety of factors including staff training deficits, differences in offender characteristics, inadequate resources, or lack of administrative/fiscal support.

The case management survey clearly has demonstrated that substantial numbers of sex offenders in the DJR should be considered chronic in that they have a well established pattern

of sexual offense behavior. The chronic sex offenders are located throughout the Division, with the majority of them residing at Echo Glen and Maple Lane. Chronic sex offenders are somewhat more likely to receive certain treatment services than are non-chronic sex offenders. The survey found that sex offenders in the DJR are receiving offense specific treatment, and that all three institutions do provide basic treatment services to sex offenders.

TELEPHONE SURVEY RESULTS

The telephone survey of selected sex offender specialists was reviewed by subcommittee members and was found to contain the following common themes:

A. There currently exists no formal, systematic approach to address the problems of the more serious, chronic sex offenders.

   1. There are no concrete standards of treatment with respect to movement through the DJR system based on progress in treatment.

      a. Youth are placed in camps and group homes without receiving treatment or without making minimal progress in treatment.

      b. Setting of release dates is not covered by standards based on progress in treatment.

      c. Case reporting for sex offenders needs improvement (e.g., Treatment Reports refer to youth having been in sex offender groups, but lack discussion of specific progress in group).

   2. DJR staff are not aware of treatment methods that are commonly used with more serious, chronic sex offenders (behavioral methods for addressing deviant arousal patterns) and DJR staff are not trained in the use of these methods of treatment.

B. Parole supervision and community treatment of Sex offenders are not provided on a consistent basis throughout the state.

   1. There are no standards for treatment when a youth is released to parole.

a. Frequency of contact, nature of contact (home, work, etc.), and LOS on parole vary widely throughout the state.

b. Parole staff are not uniformly trained -- not all CJS staff or contracted group home personnel received DJR Academy training or other DJR sponsored training regarding work with sex offenders.

2. Community resources are not uniformly available for sex offenders.

C. There is a need for additional sex offender training for staff working with DJR clients.

1. There is a need for on-going, general sex offender treatment information and training to all staff working with DJR clients.

2. More advanced training in the use of behavioral techniques is needed for staff treating chronic offenders having deviant arousal patterns.

RECOMMENDATIONS

Over 50% of the DJR sex offender population have been identified as chronic and appear to be well on their way toward developing habitual and compulsive patterns of sex offense behavior. It is clear that most sex offenders in the DJR are receiving basic offense-specific treatment. There is a need, however, for further program development, fiscal support, and staff training to remain abreast of current treatment methods with chronic sex offenders.

The chronic sex offender subcommittee has concluded that a specific intensive treatment cottage focusing on the chronic and violent sex offender should not be developed at Green Hill School. The subcommittee found that Green Hill typically houses relatively few sex offenders and while those sex offenders do tend to have a more lengthy criminal history than other sex offenders in the DJR, treatment resources are presently available at Green Hill. Furthermore, the availability of the violent offender program represents an appropriate resource for some sex offenders at Green Hill. The subcommittee found substantial merit in the concept of a specific sex offender cottage with an intensive treatment focus, but also found that the large number of chronic sex offenders in the DJR requires that significant division-wide efforts be made to effectively serve this population.

The subcommittee is offering two program recommendations that will have a minimal fiscal impact. The program recommendations, if accepted, would represent a significant first step in eliminating present service gaps to the chronic sex offender population. The subcommittee is also submitting two fiscal recommendations that are designed to improve the clinical expertise of staff working with the chronic sex offender and improve aftercare services for the population.

PROGRAM RECOMMENDATIONS

A. Through the Central Office projects manager and the standing sex offender coordinator's group, the DJR should reaffirm its commitment to provide quality rehabilitative services to sex offenders by developing specific standards of treatment and supervision:

1. The Division should designate/appoint a full time central office administrator to develop/coordinate/monitor services to sex offenders in the DJR.

2. A comprehensive plan for providing specific behavioral services to chronic sex offenders should be developed and approved by Central Office.

3. Transfers and setting of release dates should be based on sex offense specific treatment progress.

4. Parole supervision procedures should be standardized to ensure maximum services for the chronic sex offender.

5. The chronic sex offender should be placed initially at one of the three large institutions due to the generally greater availability of specific sex offender treatment resources.

B. Each institution (Green Hill, Maple Lane, Echo Glen) should be directed to develop a service delivery plan to assure effective programming for all sex offenders, including those sex offenders identified as chronic. Each service delivery plan should address the specific treatment gaps identified in the case manager's survey. In addition, each plan should provide a means whereby sex offenders identified as chronic are at a minimum provided with an in-depth assessment of their sexual arousal patterns. Services delivery plans may include:

1. Increased use of consultants (private or DJR staff) for staff training and guidance.

2. A staff training plan for assessment and treatment of deviant arousal patterns.

3. Development of comprehensive treatment resources (e.g., mandatory sex education, journal work, anger management, etc.).

4. Clustering of sex offenders and treatment services in one or more cottages at Echo Glen or Maple Lane.

FISCAL RECOMMENDATIONS

C. Improve/increase community based aftercare services for sex offenders.

1. Efforts should be made to increase funding for community based treatment programs for sex offenders. Counties should be encouraged to use CJS monies to provide sex offender treatment not currently available or accessible.

2. In counties not able to utilize CJS funds, the DJR needs to provide monies for aftercare services for sex offenders (See decision package, appendix D).

D. Continue to develop, support and improve staff training programs in order to provide DJR staff with more advanced treatment expertise for use with the chronic sex offender.

1. Current training efforts by the DJR and the Criminal Justice Training Commission should be supported and continued in order to help all staff working with DJR clients achieve a baseline level of skills and knowledge for dealing with the sex offender.

2. An advanced clinical training program designed to provide selected staff throughout the Division with training in specific advanced treatment methodologys for use with the chronic sex offender should be developed (See decision package, appendix E).

APPENDIX A

SPECIAL OFFENDER TASK FORCE

February 19, 1986

CHRONIC SEX OFFENDER SUBCOMMITTEE

Computer Info on DJR Repeat Offenders Currently
Serving a Committment Sentence for a Sexual Offense

NAME	DJR#	CURRENT OFFENSE NAME & DATE	PRIOR SEX OFFENSE Y/N	OTHER PRIORS	CURRENT LOCATION
1. Timothy Schaaf	635 618	Indecent Lib. (7-08-85)	Yes (Ind. Lib. 5-18-83)	TMVWOP Burg. 2 (2 counts) Min. Poss. Alcohol Dis. Con. TMVWOP Eluding Police	Maple Lane
2. Bruce Gidican	662 610	Stat Rape 1 (5-27-84) Indecent Lib. (6-1-83)	Yes (Ind. Lib. 6-3-82)	Burg. 2 (3 counts)	Naselle
3. Marvin White	664 417	Indecent Lib. (9-30-85)	Yes (Ind. Lib. 12-17-83)	Burg. 2 (3 counts) Assault (Simple) Theft 3 (4 counts)	Maple Lane
4. Joel Reimer	635 447	Rape 1 (2-20-85) Assault 2 (2-20-85)	Yes (Ind. Lib. 8-12-82)	Theft 3 Burglary 2 (2 counts) Mal. Mischief 2 TMVWOP (2 counts) Escape 1 Hit & Run	Maple Lane
5. David Harshbarger	664 250	Indecent Lib. (5-26-85)	Yes (Ind. Lib. 6-1-83)	None	Maple Lane
6. David Tisdale	635 542	Indecent Lib. (9-09-84)	No	Assault TMVWOP Theft 3 Mal. Mischief 3 Burglary 2 (2 counts)	Maple Lane

NAME	DJR#	CURRENT OFFENSE NAME & DATE	PRIOR SEX OFFENSE Y/N	OTHER PRIORS	CURRENT LOCATION
7. Brent Metcalf	693 953	Indecent Lib. (9-10-85)	No	Escape 2 Forgery TMVWOP (3 counts) Poss. Stolen Prop. Theft 3 (2 counts)	Maple Lane
8. Sheila Riepma	664 702	Stat Rape 1 (11-01-80) Stat Rape 1 (11-01-82) Indec. Lib. (11-01-83)	No	Crim. Trespass Theft 3 (2 counts) Theft 2 Escape 2 Burg. 2	Echo Glen
9. Ken Day	663 801	Stat Rape 1 (12-20-84) Stat Rape 1 (12-20-84)	Yes (Ind. Lib. 5-03-83)	None	Echo Glen
10. Charles Holtorf	663 806	Stat Rape 1 (4-14-85) Stat Rape 1 (4-14-85)	No	Mal. Mischief (2 counts) Reck. Endangerment Robbery 2 Assault Other D (2 counts) Reckless Burning	Echo Glen
11. Markus Allen	664 782	Indecent Lib. (8-31-84) Indecent Lib. (8-31-84) Indecent Lib. (8-31-84)	Yes Rape 2 (7-05-84)	Unknown	Echo Glen
12. Travis Beasley	662 015	Indecent Lib. (11-12-83)	No	Burg. 2 (4 counts) Theft 1 TMVWOP Theft 3	Green Hill
13. William Deaville	664 274	Indecent Lib. (8-31-84) Indecent Lib. (8-31-84)	Yes Stat Rape 1 (1-01-84) Comm. with Minor for Immoral Purposes (3 counts 1982 & 83)	No	Green Hill
14. James Mriglot	661 284	Indecent Lib. (10-15-82)	Yes Indec. Lib. (9-15-80) Indec. Lib. (5-20-80)	No	Mission Cree

	NAME	DJR#	CURRENT OFFENSE NAME & DATE	PRIOR SEX OFFENSE Y/N	OTHER PRIORS	CURRENT LOCATION
15.	Leonard Danneels	661 968	Rape 1 (6-02-82)	Yes Indec. Lib. (7-06-81)	Theft 3	Naselle
16.	Roberto Chavez	663 924	Indecent Lib. (6-17-85)	No	Criminal Tres. Theft 3 Vehicle Prowl Assault 2	Naselle
17.	Bill Showers	635 571	Stat Rape 1	No	Mal. Mischief Theft 3 (4 counts) Robbery 2	Naselle
18.	Douglas Adcock	662 653	Stat Rape 1 (6-24-84)	No	Burg. 2 (3 counts) Reck. Endangerment Criminal Tres. Theft 3 (3 counts)	Oakridge Group Home
19.	Hezzie Baines	663 942	Indecent Lib. (6-01-84)	No	Criminal Tres. Assault Theft 3 (2 counts) TMVWOP Poss. Stolen Property Robbery 1	Parke Creek Group Home
20.	Vincent Veach	664 093	Indecent Lib. (8-31-84)	Yes Stat Rape 1 (10-30-83) Ind. Lib. (10-30-83)	No	Parke Creek Group Home
21.	Quinn Hart	663 914	Stat Rape 1 (3-14-84)	No	Theft 3 (2 counts) Robbery 2	Twin Rivers Group Home
22.	Percy Levy	663 946	Rape 2 (8-29-84)	No	Theft 2 Burg. 2 (4 counts) Theft 1 Assault	Twin Rivers Group Home
23.	Ronald Wold	662 458	Indecent Lib. (8-23-84)	Yes Indec. Lib. (2-01-81) Indec. Lib. (3-02-81)	Theft 3 Assault	Region 4 CRP

	NAME	DJR#	CURRENT OFFENSE NAME & DATE	PRIOR SEX OFFENSE Y/N	OTHER PRIORS	CURRENT LOCATION
24.	Jerald Brooks	663 757	Rape 3 (2-17-85)	No	Theft 3 (2 counts) Robbery 2 (3 counts) Burg. 2 (2 counts) Theft 2	Region 4 CRP
25.	Gregory Cowell	662 800	Indecent Lib. (7-01-84)	No	Burg. 2 (2 counts) TMVWOP (3 counts) Theft 3	Region 6 CRP

DIVISION OF JUVENILE REHABILITATION
SPECIAL OFFENDERS TASK FORCE

SEX OFFENDER DATA SURVEY

Resident's Name:_____ DJR#_____

Age:_____ Sex:_____ Current Offense:_____

SEXUAL OFFENSE HISTORY

Please answer the following questions for all known sexual offenses committed by the offender. Include admitted offenses as well as adjudicated offenses.

1. _____Y_____N Not counting the offender's current sexual offense, has he/she ever been convicted of a previous sexual offense? (Include convictions that resulted in probation, detention, incarceration, or diversion) If yes, list below:

   Description Date

   _____

   _____

   _____

   _____

2. _____Y_____N Has the offender been involved in any sexually victimizing behavior while incarcerated? (Include previous commitments) If yes, briefly specify:_____

3. _____Y_____N Has the offender reoffended sexually within two years of receiving any treatment services?

4. _____Y_____N Does the offender have a total of more than three victims? (Admitted or adjudicated)

OTHER CRIMINAL HISTORY

Refer to offender's computer intake print-out. List the offender's non-sexual criminal history below:

OFFENSE DATE

_____

_____

_____

_____ _____

Other Criminal History (cont.)

OFFENSE **DATE**

_____

_____

_____

_____

_____

_____

TREATMENT SERVICES

Please check all treatment services that the offender is currently receiving in your program:

_____Individual counseling (hours per week_____)

_____Family counseling (hours per month_____)

_____Sex offense group therapy (hours per week_____)

_____Behavioral therapy (specify:_____)

_____Sex education group

_____Social skills training group

_____Other group therapy (specify:_____)

_____Journal work

_____Other treatment (specify:_____)

_____Y_____N_____Unknown Has the offender's sexual arousal patterns been studied or discussed?

_____Y_____N_____Unknown Has the offender identified any deviant sexual fantasies?

_____Y_____N_____Unknown Have any behavioral techniques been used to help change the offender's arousal pattern? If yes, specify:_____

_____Y_____N_____Unknown Will any follow-up services or treatment be available when the offender returns to the community? If yes, specify:_____

TREATMENT AMENABILITY

1. _____Y_____N Is the offender willing to discuss offense issues?

2. _____Y_____N Is the offender willing to complete treatment assignments?

3. _____Y_____N Does the offender verbalize a desire to change his/her sexual behavior?

5. _____Y_____N Is the offender's family supportive of treatment?

5. How do you feel about this offender's future?

Optimistic_____
Pessimistic_____
Neutral_____

Thank you for your help.

Please return this survey no later than 2-21-86 to Tim Kahn, Echo Glen Children's Center, 33010 S.E. 99th Street, Snoqualmie, WA 98065.

DJR SPECIAL OFFENDER TASK FORCE

TELEPHONE SURVEY OF DJR SEX OFFENDER COORDINATORS

Name of Person Surveyed:_____ Date:_____

County:_____

1. What do you consider to be the most pressing service gaps with respect to the sex offenders in DJR?_____

2. What would you like to see DJR do to better meet the needs of the chronic/dangerous sex offender?_____

3. What would you like to see as minimal standards for treatment and supervision of the chronic/dangerous sex offender when they are released to parole from an institution?_____

4. Are any behavioral services available at present to sex offenders under your jurisdiction?_____Yes_____No. If yes, please specify:

Thank you for your help.

APPENDIX C

CHRONIC SEX OFFENDER SUBCOMMITTEE

TELEPHONE SURVEY RESPONDENTS

1. Anderson, Lynda, Supervisor, Mission Creek Youth Camp, Belfair, WA
2. Bagley, Nancy, Juvenile Parole Counselor, Yakima, WA
3. Blackburn, Julie, Supervisor, Mental Health Unit, Maple Lane School, Centralia, WA
4. Brunson, Karen, Supervisor, Green Hill School, Chehalis, WA
5. Chambers, Heather, Sex Offender Treatment Specialist, Snohomish County Sex Offender Project, Everett, WA
6. Crabtree, Thomas, Administrator, Naselle Youth Camp, Naselle, WA
7. Davis, Lynn, Juvenile Parole Counselor, Region I, Spokane, WA
8. Lafond, Mary, Supervisor, Echo Glen Children's Center, Snoqualmie, WA
9. Mattson, Janie, Caseworker, DSHS Division of Children & Family Services, Region V, Bremerton, WA
10. Ramseyer, Judy, DJR Sex Offender Specialist, OB II, Olympia, WA
11. Rawlings, Leslie, Ph.D., Clinical Psychologist, Seattle, WA
12. Wilder, Grant, Sex Offender Treatment Specialist, Snohomish County Sex Offender Project, Everett, WA
13. Zock, Pat, Juvenile Parole Counselor, Region V, Bremerton, Wa

DIVISION OF JUVENILE REHABILITATION
CHRONIC SEX OFFENDER SUBCOMMITTEE ANALYSIS
1987 - 1989 BIENNIUM

RECOMMENDATION C

PROBLEM STATEMENT:

Recent surveys indicate that aftercare services for sex offenders are not consistently available throughout the state. Some regional administrators indicate that current monies are inadequate to provide these services. Effective intervention in offense patterns of chronic sex offenders require on-going aftercare treatment and supervision.

RECOMMENDATION:

The DJR needs to provide additional funding for treatment services to counties not currently having adequate funding through CJS. The DJR should provide funds for aftercare treatment of sex offenders in counties unable to utilize CJS funds.

PRESENT SERVICES:

Present aftercare services for sex offenders are not uniformly available. Where services are available, programming is funded by CJS or by limited DJR monies to provide contracted aftercare treatment.

PROPOSED SERVICE:

Aftercare treatment services for sex offenders would be made available by increasing existing funding in regions not currently having adequate access to sex offender treatment services. Money allocated to specific regions will be utilized to provide sex offender programs or to purchase contracted services. The level of service provided is proposed to be one hour per week of individual or group treatment provided by a CJS or contracted therapist.

IMPACT:

A. Fiscal

Region 1: Increase CJS funding by $15,000 per year.
Region 2: Increase CJS funding by $20,000 per year.
Region 3: Maintain current level of funding.
Region 4: Maintain current level of funding.
Region 5: Increase DJR contracts by $3,000 per year.
Region 6: Increase DJR contracts by $3,500 per year.

The above increases would provide the following:

- Sex offender treatment program in central Washington (Region 1)
- Sex offender programming for Kittitas, Yakima, Benton-Franklin, and Walla Walla counties (Region 2)
- Increase existing DJR personal services contracts (Region 5 & 6)

B. Positions: None

C. Clients: Sex offenders would receive an average of one hour per week of aftercare treatment while on parole supervision.

D. Related Agencies: None

E. Requirements for Implementation:

1. Contracts need to be amended in CJS counties.

2. DJR personal services contracts need to be amended.

Estimated Implementation Date: July 1987

APPENDIX E

DIVISION OF JUVENILE REHABILITATION
CHRONIC SEX OFFENDER ANALYSIS
1987 - 1989 BIENNIUM

RECOMMENDATION D

PROBLEM STATEMENT:

More than 50% of the current sex offender population in the DJR are considered to have well established patterns of habitual and compulsive sexual offense behavior. Effective intervention in such patterns of behavior requires clinical skills and knowledge not commonly found among DJR staff. The large number of chronic sex offenders (approximately 60) in the DJR contra-indicates development of one specific treatment program. Successful treatment and effective supervision of the chronic sex offender population requires that selected staff from throughout the DJR be provided with advanced clinical training.

RECOMMENDATION:

The development and funding of an advanced clinical training and certification program such as that found in the drug/alcohol treatment field.

PRESENT SERVICE:

Chronic sex offenders are located throughout DJR programs, but the majority are found at Echo Glen Children's Center and Maple Lane School. Training opportunities at present are limited to two courses that are co-sponsored by the DJR and Criminal Justice Training Commission. Advanced clinical training and ongoing case consultation is currently not accessible to DJR staff who work with chronic sex offenders.

PROPOSED SERVICE:

An advanced clinical training and certification program would be developed by the DJR. The program would consist of an initial five day intensive training course followed by two days of additional seminars and consultation each quarter for the remainder of the first year. During the second year a one day seminar and consultation session would be provided each quarter to program participants. The training program would consist of a total of 15 days or 140 hours of advanced training during the two year period. The program would be limited to 20 staff members working with DJR clients, with the majority being drawn from Echo Glen, Maple Lane, and Green Hill. 80% of the training program (12 days) would be provided by local and national sex offender experts, and 20% (3 days) would be provided by existing DJR sex offender specialists.

IMPACT:

a. Fiscal:

$ 6000 (Trainer's fees: National and local sex offender experts 12 days at $500 day)

$ 3000 (Airfare, mileage, and per diem for trainers)

$28000 (Coverage for staff attending all 15 days of training. 20 staff - each replaced by intermittent JRC I at $80 day)

$ 4000 (Mileage and per diem for training participants)

b. Positions: None

c. Clients: Chronic sex offenders will receive specific treatment services designed to help them change their patterns of habitual and compulsive sexual behavior. This treatment is currently provided to only a nominal number of DJR clients.

d. Related Agencies: None

e. Requirements for Implementation:

1. Training curriculum developed by DJR sex offender coordinator group.

2. Proposals/bids solicited for training program.

3. Criteria/prerequisites established for staff selection into training program.

4. Certification/completion standards established by sex offender coordinators group.

Effective Implementation Date: July 1987

CHRONIC OFFENDER REPORT

THE CHRONIC OFFENDER

I. INTRODUCTION

The Chronic Offender Subcommittee of the Division of Juvenile Rehabilitation (DJR) Special Offender Task Force was asked to examine the chronic offender population within DJR. The chronic offender has recently gained greater attention in the corrections arena based on research by Marvin Wolfgang and his associates. According to this research, the chronic offender (operationally defined as the juvenile offender with four or more offenses) is involved in a cycle of crime, that if stopped, could potentially impact the overall volume of juvenile crime. The mission of the Chronic Offender Subcommittee is to identify those supervision and treatment options that are likely to impact this cycle, and prepare recommendations for improving DJR's impact on these offenders.

II. THE PROBLEM

Wolfgang and his associates noted that a small population (about 7% of all juvenile offenders) commit the vast majority of juvenile crime (about 70%). The chronic offender population begins a pattern of offending at an earlier age and continues offending at a greater rate into the adult years. Wolfgang proposes that deterring this population from additional crimes will have a significant impact on juvenile crime in general.

In actuality, most of the DJR population fits within Wolfgang's definition of the chronic offender. Given the state's sentencing structure, most offenses ("B" offenses and below) do not allow commitment to DJR institutions without prior criminal offenses. The vast majority (73.5%) of DJR clients have at least four prior offenses. In effect, the approximately 800 DJR clients in residence represent a large portion of the "chronic offender population", as defined by Wolfgang, in the State of Washington.

Recent efforts by DJR to develop more comprehensive and effective case supervision (via the training academy and offense-specific case management) are directed at all DJR clients. The new system treats all clients with the assumption that their pattern of criminal behavior needs to be altered and should be the primary focus of case supervision. In many respects, treatment within DJR has been re-designed to impact the problems that Wolfgang and his associates address.

Yet, an especially "chronic" offender population seems to exist within the ranks of DJR clients. Approximately 10% of DJR offenders have extensive prior criminal records (i.e., at least eight offenses). Nearly 7% of the population are serving at least their third commitment in DJR. Though most DJR offenders

are part of the chronic offender population that Wolfgang discusses, this "extra" chronic population can often seem virtually "untreatable", and therefore serves as the focus of this report.

The question before the subcommittee, then, is how can the cycle of offending among this population be curbed. The repeat offender has been notoriously difficult to impact; counselors have frequently thrown up their arms because this type of youth seems to reoffend even after the most extensive effort. A review of the literature indicated that, thus far, no programs have been successfully able to rehabilitate the chronic offender. Yet this finding should not preclude that possibility that certain supervision options may be effective in deterring criminal behavior among this population. The task of the subcommittee, then, is to analyze the chronic offender population, and the supervision options available for that population, and to determine if there is a more appropriate course of action for their supervision.

III. METHODOLOGY

For most of the analysis in this report, DJR clients in residence on January 1, 1983 were examined. This 1983 sample was selected so that information about the youths' status after release from an institution (e.g., whether the youth was paroled, whether the youth was recommitted) could be analyzed. Additional findings are included, and noted, in the report that analyze the DJR population on January 1, 1986. This 1986 sample was selected so that results from the recently-implemented Client Substance Index (CSI) could be analyzed.

Two groups of youths were excluded from each sample: youths committed for diagnostic purposes only and youths committed from outside the State of Washington. Two additional groups of youths were excluded from the 1983 sample: youths still active on the sentence they were serving in January of 1983 and youths who were discharged for purposes of serving an additional sentence (i.e., they were not on their final sentence in January of 1983). Several youths who had not completed a CSI were also excluded from the 1986 sample. The 1983 sample included a total of 627 youths, while the 1986 sample included 612 youths.

Each sample was divided into two groups: chronic offenders and other DJR offenders. Chronic offenders were selected according to two criteria. First, all youths serving at least their third commitment were considered a chronic offender. Second, all those youths serving their second commitment and who had eight or more prior offenses were included. In 1983, 11.2% of the DJR population was defined as chronic. The proportion of chronic offenders increased to 14.0% as of January 1, 1986.

Information was collected through MAPPER, DJR's computerized management information system. Data were gathered in four areas of interest to the subcommittee: a description of the chronic offender population, the type of supervision they receive, how these offenders perform before and after their stay in DJR, and what types of supervision seem to impact DJR clients in general.

Indicators for the description of the chronic offender population included: age of the offender, the youth's assigned minimum sentence, whether the youth was a serious offender, the class of the youth's committing offense, whether the youth was committed under manifest injustice, and the youth's drug dependency and locus of control subscale scores from the CSI.

Indicators of the type of supervision the youth received included: whether the youth served time beyond the minimum sentence, whether the youth was assigned to a group home (including both state-operated and privately contracted homes) during their sentence, whether the youth was paroled or discharged, and the youth's length of stay on parole.

Indicators of client performance included: whether the youth escaped during the sentence, whether the youth failed (i.e., was returned to the institution) on a group home placement, and whether the youth was recommitted for a new crime after discharge from DJR supervision.

IV. FINDINGS

Characteristics of the Chronic Offender Population

Table 1 presents client characteristics of the 1983 sample, comparing chronic offenders with other DJR offenders, and indicating whether the difference between the groups is statistically significant at the .05 level. The results indicate that chronic offenders are significantly different than other DJR offenders in terms of age, the types of offenses for which they are committed, and their likelihood of receiving a manifest injustice commitment. Chronic offenders are somewhat older, are much less likely to be committed for a more serious offense (whether legally defined as a "serious offense" or not), and are less likely to be serving a manifest injustice sentence. The difference in average minimum sentence was not significant.

Table 1: Client Characteristics by Group

	Chronic Offenders	Other DJR Offenders	Statistically Significant?
Average Age	16.6	16.2	Yes
Average Minimum Sentence in Days	381.2	427.7	No
Percent Serious Offender	20.0	41.2	Yes
Percent "B+" Offense or Greater	15.7	46.7	Yes
Percent Committed Under Manifest Injustice	21.4	45.3	Yes

The results in table 1 indicate that chronic offenders and other offenders receive similar sentences, yet for different reasons. Chronic offenders seem to be committed because of the number of offenses in their criminal history. Other offenders (consisting of a larger percentage of serious offenders) are frequently committed because of the nature of their committing offense or because they were committed under manifest injustice. In effect, the typical DJR offender who is not a serious offender is a chronic offender--if they weren't committed because of the seriousness of their most current offense, it was because of a history of chronic criminal involvement.

Table 2 presents results from the CSI for youths in the 1986 sample. The percent of youths who are dependent drug users is based on the number of CSI respondents scoring at level four (30% or higher) on the CSI total drug dependency scale. The percent of youths with minimal self control (i.e., they reported they have difficulty controlling their behavior) is based on the number of respondents who scored at least 70% on the CSI locus of control scale.

Table 2: Client Substance Index (CSI) Results by Group

	Chronic Offenders	Other DJR Offenders	Statistically Significant?
Percent Dependent Drug Abuser	70.6%	69.6%	No
Percent with Minimal Self Control	60.0%	47.6%	Yes

The results in table 2 indicate that chronic offenders are no more likely to be dependent drug abusers, yet are significantly more likely to have only minimal self control. Relative to other DJR offenders, chronic offenders more frequently reported that they were unable to control what they did (e.g., using a knife) or how they felt (e.g., being scared or excited).

Types of Supervision That the Chronic Offender Receives

Table 3 presents a comparison of the chronic offender population with other DJR offenders in terms of their likelihood of being assigned to a group home during their sentence. The results indicate that the chronic offender is significantly more likely to be assigned to a group home than other offenders. This finding is due to the fact that there are a large number of serious offenders among the "other DJR offender" population. Serious offenders are likely to be denied group home placements, while chronic offenders are not considered a special problem for that type of supervision.

Table 3: Likelihood of Group Home Placement by Group

	Chronic Offenders	Other DJR Offenders
Placed in a Group Home	50.0%	28.4%
Not Placed in a Group Home	50.0%	71.6%

Chi-square=12.7; $p<.05$

Table 4 indicates whether chronic offenders are more likely to be retained beyond their minimum sentences as compared to other DJR offenders. The results suggest that the difference between the two groups is not significant.

Table 4: Likelihood of Being Held Beyond Minimum by Group

	Chronic Offenders	Other DJR Offenders
Held Beyond Minimum Sentence	21.7%	23.4%
Released at Minimum	78.3%	76.6%

Chi-square=.02; Not Significant

Table 5 indicates that there is no significant difference between chronic offenders and other offenders in terms of whether they are paroled or discharged.

Table 5: Likelihood of Being Paroled by Group

	Chronic Offenders	Other DJR Offenders
Paroled	67.1%	73.2%
Discharged	32.9%	26.8%

Chi-square=.88; Not Significant

Table 6 indicates whether chronic offenders are significantly more likely to stay longer on parole than other offenders. The results show that they are not.

Table 6: Average Length of Stay on Parole by Group

	Chronic Offenders	Other DJR Offenders
More than Four Months	41.4%	48.1%
Four Months or Less	58.6%	51.9%

Chi-square=.86; Not Significant

The results in tables 3 through 6 indicate that, by and large, DJR does not provide significantly different services for the chronic offender population. There is a greater tendency to assign these offenders to group homes during their sentence, yet this finding is likely a result of the scarcity of serious offenders among the chronic offender population.

Success of Chronic Offenders Before and After DJR Supervision

The success of chronic offenders, relative to other offenders, was measured across three dimensions: escapes, group home failures, and recommitments. Table 7 examines the rate of escape across the groups. Chronic offenders were no more likely to escape than other offenders.

Table 7: Likelihood of Escape by Group

	Chronic Offenders	Other DJR Offenders
Escaped at Least Once	20.0%	14.7%
Did Not Escape	80.0%	85.3%

Chi-square=.96; Not Significant

If a youth was returned to an institution from a group home, the youth was considered to have failed in that placement. Table 8 indicates that chronic offenders were slightly more likely to fail in community placement, but the difference was not statistically significant.

Table 8: Likelihood of Group Home Failure by Group

	Chronic Offenders	Other DJR Offenders
Failed in Group Home	60.0%	48.9%
Did Not Fail in Group Home	40.0%	51.1%

Chi-square=1.03; Not Significant

Table 9 presents rates at which youths were recommitted after the commitment they were serving on January 1, 1983. Since data are unavailable for offenders who were either remanded or sentenced for crimes committed beyond age 18, inclusion of older youths in the analysis would skew the results. Youths released at age 17 or older were, therefore, excluded from the analysis of recommitment rates. The findings indicate that chronic offenders are more likely to be recommitted than other offenders.

Table 9: Likelihood of Recommitment by Group

	Chronic Offenders	Other DJR Offenders
Recommitted	66.7%	40.1%
Not Recommitted	33.3%	59.9%

Chi-square=5.21; $p<.05$

The findings in table 7 through 9 indicate that chronic offenders present difficulties within DJR in primarily one area: recommitments. They do not appear to be special problems in terms of day-to-day management; they do not escape or fail in group homes any more than other offenders. These findings indicate that concerns about chronic offenders should be focused on their greater tendency to return for additional commitments. While presenting no greater management problem for DJR, they do appear to continue their pattern of chronic criminal behavior after release from DJR.

The Impact of Supervision Options on Client Performance

To help prepare recommendations regarding which supervision options could potentially impact reoffending among chronic offenders, an analysis was performed on recommitment rates of DJR clients who participated in four supervision options. In table 10, recommitment rates are compared for: group home placement, release beyond sentence minimum, parole versus direct discharge, and long versus short length of stay on parole. (The data are for the total sample and not just the chronic offenders. The number of chronic offenders was too small to reach meaningful conclusions on that population alone.)

Table 10: Recommitment Rates by Supervision Option

	Recommitment Rates	Statistically Significant?
Assigned to Group Home	36.5%	
Not Assigned to Group Home	44.3%	No
Held Beyond Minimum	34.5%	
Released at Minimum	44.6%	No
Paroled	41.7%	
Discharged	52.2%	No
Paroled More than 4 Months	35.9%	
Paroled 4 Months or Less	51.5%	Yes

Though recommitment rates are lower for each of the supervision options, the findings in table 10 suggest that only one of the options had a significant impact on the likelihood of the youth being recommitted. Youths assigned to group homes did not have a significantly better chance of avoiding recommitment. Youths released beyond their minimum sentence did not fare much better

than those released at their minimum. Whether a youth was discharged or paroled made little difference in the recommitment rate. The length of time on parole was, however, significantly related to recommitment rate. Those youths held on parole more than four months were less likely to be recommitted than those held for a shorter period of time. (Youths who were terminated from parole specifically because they reoffended, thus potentially increasing the recommitment rates for short-term parolees, were excluded from the analysis.)

V. RECOMMENDATIONS

The subcommittee developed four recommendations for the assessment and supervision of chronic offenders. These include:

1. Develop an improved means for the identification of chronic offenders. For the purposes of this report, chronic offenders were defined after the fact in terms of their historical patterns of reoffending (i.e., prior offenses, prior commitments). A more viable approach is to begin to identify those offenders in terms of potential future behavior. Though past behavior is generally the best predictor of future behavior, additional factors, such as expected family or school situation upon release, may be useful in predicting whether the offender will demonstrate a pattern of chronic criminal behavior. The Juvenile Risk Assessment Tool (JRAT) has recently been developed by DJR to identify offenders' risk to reoffend. Though not yet validated, the instrument can potentially identify chronic offenders based on criteria other than prior criminal history. Identification would not be "after the fact", and would allow early prediction of chronic offenders so that early intervention could begin.

The recommendation of the subcommittee is to proceed with the evaluation and revision of the JRAT. The earlier that potential chronic offenders are identified, the better DJR will be able to develop strategies to prevent the escalation of criminal behavior.

2. DJR should continue with offense-specific case management for the supervision of chronic offenders. The knowledge that an offender's offense patterns are habitual and long-term is additional and useful information in the development of that offender's case plan. The finding that chronic offenders are less likely to demonstrate self control is also valuable information for the preparation of strategies in impacting the chronic offender population. Offense-specific case management may not be the panacea that eliminates the problem of repeat offending among chronic offenders, yet it speaks directly to the issue most relevant for this population--their patterns of behavior lead to continued contacts with the law, and, ultimately, DJR. Treatment/supervision for those behavior

patterns should recognize the chronicity of the behavior, and identify the factors that made that behavior possible in the past, and may make if possible in the future.

3. Continue to place chronic offenders in group homes. Chronic offenders are more likely to be placed in group homes than the rest of the DJR population. They are not a significantly higher risk to either escape or fail in a community setting. Group home placement does not affect the rate of recommitment either negatively or positively. Therefore, there is no reason, from the standpoint of either treatment effectiveness or public safety, to begin denying chronic offenders group home placement.

4. Retain chronic offenders on parole for a longer period of time. Youths on parole in excess of four months were significantly less likely to be recommitted. It is possible that longer stays on parole may have a positive impact on altering the offender's pattern of criminal behavior. The subcommittee recommends that chronic offenders be placed on parole for a maximum length of time within the parole standards that are presently under development.

MENTALLY ILL OFFENDER REPORT

THE MENTALLY ILL OFFENDER

I. INTRODUCTION TO THE PROBLEM

John Steiger's September 1984 report entitled Mentally Disturbed Youth Within the DJR Residential Population summarized the results of a 1983 survey of mental health problems of DJR residential clients. Checklists were completed on 772 youth in custody at that time. As noted in the results of this report,

> "... The results of the survey indicate that symptoms of mental disturbances are common among youth in DJR residential care ... these findings document the existence of a substantial mental health problem among youth committed to the DJR."

This report further indicated that the majority of the youth identified as mentally disturbed were located in camps and institutions.

> "DJR youth with symptoms of mental disturbance are concentrated in DJR institutions and camps. It seems evident that these youths, in part because of their mental health problems, are least able to function in group homes and other community placements; they require the more extensive staffing available in institutions and the more controlled environment. These data raise the issue of the extent of which the criminal behaviors of these youth are related to their mental health problems and to what extent does the DJR have the resources necessary to prepare these youth for their return to the community. These questions should be addressed as soon as possible given the magnitude of the mental health problems among DJR youth."

Many key staff within DJR institutional programs have felt that the number of youth with severe disturbance or psychiatric problems has appeared to dramatically increase over the past few years. Given the relatively short time frame of this task group, the mental health subcommittee conducted a survey to determine if the current DJR institutional population includes a significant number of this identified group.

II. METHODOLOGY

A survey (see attachment A) was conducted in all DJR institutions and camps focusing on the portion of the DJR popluation who have demonstrated more severe symptoms of mental disturbance either in the institution or in the community. The goal of this approach was to formulate an idea of the number of impaired youth within our system and to identify those youth who may be "inappropriately" placed within DJR. The sample group consisted of 31 cottage directors and camp supervisors. This group, as the clinical supervisors of the DJR population, seems to be the appropriate target for an impression of the current status of this problem and to identify potential barriers and alternatives for the care and placement of these youth.

All 31 supervisors (excluding the DJR Exodus program) responded to the survey giving a complete sample of the DJR institutional population (as of 3/86).

In addition to the DJR survey, the subcommittee interviewed Dr. Jeff Mitchell, Chief of Outpatient Psychiatric Services at Children's Orthopedic Hospital in Seattle and consulting psychiatrist to Echo Glen Children's Center and King County Youth Services. Dr. Mitchell is well known as an expert in the field of child psychiatry and has testified in numerous court cases involving the incarceration of psychiatrically impaired youth in several states.

III. FINDINGS

Dr. Mitchell identified the key ingredient of youth who could be considered inappropriate for the DJR system as those "whose primary disorders are mental health rather than delinquent." Specifically, there are two classes of disturbed children who need more services than currently provided. Those include:

A.) Children with documented DSM III or psychiatric diagnoses who are hard to place within the mental health system as a result of aggressive/assaultive or bizarre behaviors.

B.) Children with less definable diagnoses (developmentally disabled, developing psychotic patterns, bizarre behavior and thoughts), but appear to be disturbed rather than delinquent.

In consideration of the solutions or implications for these populations within the DSHS as well as DJR systems, Dr. Mitchell offered the following as potential options for this difficult group:

1.) The mental health system needs a program to deal with these populations to decrease their commitments to DJR and to keep them within the mental health system where they belong. This program would need higher than traditional staffing levels, staff trained to deal with psychotropic medications, and an inhouse school program. Ideally, this program would be governed by an Admission and Discharge Committee not involved with the DSHS agency.

2.) DJR will likely continue to receive certain types of mentally disturbed offenders and, as a result of extreme crimes or behavior, probably should. DJR needs to address the needs of these youth within the DJR system similar to the methods outlined for the mental health system.

Dr. Mitchell added that King County Youth Services has recently increased their ability to deal with psychiatrically impaired youth through the addition of a halftime psychiatrist and two psychiatric registered nurses.

Results of the survey of clinical supervisors (JRS 3 & 4) appear to support Dr. Mitchell's recommendations as well as the problems outlined in Steiger's report of 1984. Forty two percent of those surveyed indicated that they had at least one resident in their current unit population who was inappropriately placed in DJR due to mental health problems. Several programs, including security cottages at the institutions and Oak Cottage at Maple Lane, identified significantly larger numbers of these youth within their programs. The breakdown of survey results is reflected in Table 1.

TABLE 1

"Of your current unit population, do you have any residents who you feel are inappropriately placed in DJR due to their mental health problems?"

	Echo Glen	Maple Lane	Green Hill	Camps
YES (42%)	4	5	4	0
NO (55%)	6	3	2	6
UNSURE	0	0	0	0

Table 1 supports the notion that the majority of the youth who are currently considered inappropriate for DJR reside in more secure institutional programs rather than in camps. Additional factors suggested for consideration of these results are that several DJR programs, including the violent offender program at Green Hill and various cottages with work crews (DNR), tend to screen out those residents with psychiatric impairments.

The issue of psychiatric services available in each DJR setting was also explored in the survey. Forty five percent felt they did not have access to adequate psychiatric services in their setting. The breakdown of survey results can be found in Table 2.

TABLE 2

"Do you have access to adequate psychiatric services in your setting?"

	Echo Glen	Maple Lane	Green Hill	Camps
YES (42%)	6	2	3	2
NO (45%)	3	4	3	4
NO NEED	0	1	0	1
UNSURE	1	1	0	0

Of the youth receiving psychiatric services within DJR (3/86), 18 are being treated through the use of psychotropic medications. At the time of the survey, 10 residents at Echo Glen and 4 at both Maple Lane and Green Hill were participating in medication programs for depression, thought disorders, aggression and stabilization of behavior. At least three of these youth were receiving medication for the purpose of controlling aggressive outbursts following numerous incidents of assaultive behavior within the institutional setting.

Through the survey instrument, an attempt was made to identify the number of residents within the institutional system who have previously or are currently demonstrating some more extreme symptoms of mental disturbance. The results indicate that 83 youth currently residing in DJR camps and institutions have exhibited at least one of the symptoms outlined in Table 3. Serious suicide threats/attempts were noted in 55 cases and 46 were identified as having prior mental health placements in residential or hospital settings. Serious depression was noted in 26 cases. Further results are noted in Table 3.

TABLE 3

"Are there residents in your current population who have demonstrated any of the following symptoms, or conditions, either in the institution or in the community?"

	YES	NO	# if YES
a. History of prior mental health placements.	46 (8%)		**total number identified = 83
b. Serious suicide threats/attempts.	55 (9%)		
c. Cruel/unusual torture of domestic livestock/ animals.	11 (2%)		
d. Repeats what is said in a mechanical way/ repeats phrases mechanically.	11 (2%)		
e. Speaks in disconnected, incoherent, nonsensical way.	12 (2%)		
f. Engages in bizarre and repetitive motor behavior, such as rocking.	3		
g. Exhibits severe depression	26 (4 %)		
h. Encopretic	4		

Following the survey of DJR clinical supervisors, admission reports were collected from the MAPPER system for the 83 youth identified as demonstrating severe psychiatric symptoms. These reports provided commitment and demographical information for this population as outlined in Table 4. Of particular interest is the comparison of commitment types to the various institutional settings. Echo Glen Children's Center appears to have the greatest number of youth who are committed with other than standard range sentences (46%) as compared to other DJR settings and the Echo Glen average (32%). These figures indicate that younger disturbed youth are committed through the use of the manifest injustice criteria more frequently than other offenders in the DJR system. Maple Lane School noted a smaller percentage (23%) of other than standard range commitments which is closer to the DJR average. The sample groups from Green Hill School and Mission Creek/Naselle Camps were too small to provide statistical significance.

A second area of interest in this portion of the report is that of the number of youths committed to Echo Glen who have no prior offenses. 32 per cent of the youth identified at Echo Glen had no prior offenses compared to 12 per cent at Maple Lane. These figures seem to support Dr. Mitchell's contention that these children may be inappropriate for DJR due to the presence of "...primary disorders that are mental health rather than delinquent." It would also seem noteworthy to address the fact that the population of Echo Glen is younger than that of the other DJR institutions and, as a result, the number of youth without prior offenses may be larger than the DJR average.

TABLE 4

Commitment and Demographic Information From Those Residents Demonstrating One or More Symptoms Identified

** COMMITMENT TYPE		ECHO GLEN	MAPLE LANE	GREEN HILL	CAMPS
Standard Range	(50)	22 (54%)	20 (77%)	4	4
Other	(33)	19 (46%)	6 (23%)	5	3
		41	26	9	7
** PRIOR OFFENSES					
YES	(65)	28 (68%)	23 (88%)	7	7
NO	(18)	13 (32%)	3 (12%)	2	0
		41	26	9	7
** OFFENSE (most serious)					
Burglary 2	(11)	3	2	0	6
Robbery 1	(10)	5	3	2	0
Indecent Liberties	(9)	6	3	0	0
Assault 2	(7)	4	2	1	0
Arson 1	(5)	3	2	0	0
Rape 1	(5)	3	1	1	0
TMVWOP	(5)	2	2	1	0
Stat. Rape 1	(4)	2	1	0	1
Simple Assault	(3)	1	2	0	0
Forgery	(3)	0	3	0	0
Escape 1	(3)	0	1	2	0
Rape 2	(2)	2	0	0	0
Detention	(2)	2	0	0	0
Exceptions	(2)	2	0	0	0
Other Offenses (only one)		6	4	2	0
		41	26	9	7
** RACE					
White	(65)	30	20	8	7
Black	(9)	6	2	1	0
Amer. Indian	(7)	5	2	0	0
Other	(2)	0	2	0	0
		41	26	9	7

		ECHO GLEN	MAPLE LANE	GREEN HILL	CAMPS
** COUNTY OF COMMITMENT					
Pierce	(15)(18%)	6	4	4	1
King	(11)(13%)	5	5	0	1
Snohomish	(10)(12%)	7	1	1	1
Kitsap	(8)(10%)	1	5	1	1
Yakima	(7)(8%)	4	3	0	0
Thurston	(4)	4	0	0	0
Lewis	(4)	3	0	1	0
Cowlitz	(4)	1	1	2	0
Grays Harbor	(3)	2	1	0	0
Benton	(3)	0	1	0	2
Whatcom	(3)	1	2	0	0
Spokane	(3)	2	1	0	0
Mason	(2)	1	0	0	1
Okanogan	(2)	1	1	0	0
Clark	(2)	2	0	0	0
Ferry	(1)	1	0	0	0
Skagit	(1)	0	0	0	0
		41	26	9	7
** BIRTHDATE(by year)					
1966 (19-20)	(2)	0	1	1	0
1967 (18-19)	(8)	0	5	2	1
1968 (17-18)	(19)	3	8	6	2
1969 (16-17)	(14)	3	8	0	3
1970 (15-16)	(19)	16	3	0	0
1971 (14-15)	(11)	9	1	0	1
1972 (13-14)	(8)	8	0	0	0
1973 (12-13)	(1)	1	0	0	0
1974 (11-12)	(1)	1	0	0	0
		41	26	9	7
** SEX					
Male		32	26	9	7
Female		9	0	0	0
		41	26	9	7

The final questions in the survey focused on "What DJR needs to better deal with the mentally disturbed portion of our population?" As anticipated, responses varied from setting to setting, yet most focused on separating the severely disturbed youth from the regular DJR population through the creation of specific mental health programs (living units) within DJR. In addition, the issues of increased psychiatric services and staff training were among those most often identified by the survey group. A final suggestion was that of developing Community Residential Placement beds for severely disturbed youth as a logical step in the DJR continuum of care.

THE PROBLEMS

1. Some youth committed to DJR are inappropriate for this system as a result of their mental health problems. As noted previously, 42 per cent of the DJR clinical supervisors felt they had at least one resident in their current population who is inappropriately placed within the DJR system. In addition, 46% of those residents identified at Echo Glen were committed through other than standard range sentences indicating they may have been placed as a result of inadequate community resources.

2. Inadequate DJR psychiatric services. 45 per cent of those surveyed felt they did not have access to adequate psychiatric services in their setting.

3. Inadequate DJR staff training. Many of the responses to survey questions and possible solutions mentioned the need for better DJR staff training focusing on treatment of the mentally disturbed offender. The programs who appeared to have the greatest concentration of these youth (security cottages and the Oak program at Maple Lane) identified this issue most often.

4. Inadequate DJR resources for treatment of severely disturbed, aggressive residents. This population is relatively small, yet perhaps the most visible in consideration of mentally disturbed offenders within DJR. Currently, these youth are placed in security cottages at the major institutions and housed with the more delinquent portion of the DJR population (level 1 youth and those with behavioral problems of a non-psychiatric nature). In some cases, these youth are treated with psychotropic medications to assist in controlling their more aggressive behaviors within these settings. In other cases, the younger members of this population are potential victims of the more predatory offender found in secure programs within the Division. Survey results indicated strong concern over the mix of delinquent and psychiatrically impaired youth within the DJR.

IV. RECOMMENDATIONS

1. Develop an interagency task group to meet on a regular and ongoing basis. Currently, there is no single agency or body committed to adequately treating or developing resources for these multi-problem children. They tend to be bounced between DJR, DDD, DMH, and DCFS with no consistent advocates or continuity of care.

An interagency task group would have two primary functions. First, to screen these difficult children and develop the best resource package possible for them. To be effective, this committee would need to be chaired by a person who had no agency affiliation and made the ultimate decision on a child's placement, thereby, preventing any agency loyalty or abdication from altering the decision.

The second purpose of this task group would be to analyze any legislative or agency factors that limit treatment options for these disturbed children and work to implement changes. For example, a legislative change in January of 1986 only allows DJR to transfer children to Child Study and Treatment Center for 14 days. After that, the child must voluntarily agree to remain there or be placed on an involuntary commitment by a mental health professional. This

is not a realistic option for a disturbed and incarcerated child. It limits resources for these children and makes mental health placement more difficult to obtain. Another area worthy of exploration is the significantly higher rate of commitment for younger disturbed youth, using the manifest injustice criteria. Lack of adequate mental health resources could be a prime factor in sentencing these children.

Issues like those just noted need to be fully explored. It was beyond the scope and timeline of this committee to adequately assess the legislative factors and agency procedures that inhibit treatment for the youth in this study. It is our hope that this interagency task group could meet this need. There would be no direct fiscal cost to this recommendation.

2. Establish a secure mental health facility jointly funded and operated by DJR and DMH. The staff team would need to be a blend of those with a mental health background and others with correctional experience. The program should be designed to be self-contained, including a specialized school, recreation, medical and psychiatric services, etc.

This type of program would require some legislative changes to enable children under DJR sentence to serve their time in a mental health facility. Committed youth thought to be mentally ill would be placed in this facility for evaluation and treatment if appropriate. When and if stabilization occurred, these children could then be transferred to another DJR or DMH program as deemed appropriate. This recommendation would have a major fiscal impact for both DJR and DMH. Please refer to recommendation 2 in the appendix section for more specific information.

3. Add one specialized mental health unit to DJR. If recommendation 2 is not a viable alternative, then it must be assumed that DJR will continue to receive youth with significant mental health problems who are inappropriate in our general population. The addition of one mental health cottage in DJR would provide better treatment options for these children. Based on our survey results, the institution with the largest population of disturbed youth is Echo Glen Children's Center. Therefore, it would seem appropriate to locate one cottage at this facility.

To develop quality programs in this specialized cottage, DJR would need to make a signficant commitment of additional resources. These should include the following at Echo Glen Children's Center:

-- Convert a cottage to a secure unit with some reinforced rooms and others adapted for suicide prevention.

-- The cottage should be self-contained, including a specialized school component and a recreation area.

-- Select/hire staff members with mental health training and/or background.

-- Increased staffing level.

-- Staff training on mental health issues.

-- Increased access to psychological and psychiatric services.

-- Consultants from other facilities to assist in program development.

Obviously, this recommendation would also have a fiscal impact for DJR. Please refer to recommendation 3 in the appendix section.

APPENDICES

ATTACHMENT A

SPECIAL POPULATIONS TASK FORCE

Mental Health Survey

NAME: _____ Agency: _____

Cottage: _____ Date: _____

1. Of your current unit population, do you have any residents who you feel are inappropriately placed in DJR due to their Mental Health problems?

   YES _____ NO _____ UNSURE _____

2. Are there residents in your current population who have demonstrated any of the following symptoms, or conditions, either in the institution or in the community?

	YES	NO	# if YES
a. History of prior mental health placements.			
b. Serious suicide threats/attempts.			
c. Cruel/unusual torture of domestic livestock/animals.			
d. Repeats what is said in a mechanical way/repeats phrases mechanically.			
e. Speaks in disconnected, incoherent, nonsensical way.			
f. Engages in bizarre and repetitive motor behavior, such as rocking.			
g. Exhibits servere depression.			
h. Encopretic			

3. Do you feel you have access to adequate psychiatric services in your setting?

   YES _____ NO _____ NO NEED _____ UNSURE _____ OTHER: _____

4. What do you feel DJR needs in order to better deal with the mentally disturbed portion of our population?

5. Additional Comments:

Please return to Brian Carroll, Echo Glen Children's Center, 33010 S.E. 99th St., Snoqualmie, WA 98065 by 02-19-86.

DIVISION OF JUVENILE REHABILITATION
MENTALLY ILL OFFENDER ANALYSIS
1987 - 1989 BIENNIUM

RECOMMENDATION 2

Problem Statement:
A large number (42%) of DJR program managers indicate that they have at least one resident in their current unit population who is inappropriately placed in DJR due to their mental health problems.

Recommendation:
Establish a secure mental health facility, jointly funded and operated by DJR and DMH.

Present Service:
Most youth currently in DJR are not served by DMH because they are too violent, exploitive, or prone to escape.

Proposed Service:
DJR and DMH would jointly operate a secure and highly staffed facility for youth who are both mentally ill and adjudicated delinquents.

Impact:

a. Fiscal:
	$950,000	(unit construction)
	$500,000	(annual operating cost)
Total	$1,450,000	

b. Positions: 1988 — 14 positions

c. Clients: Disturbed youth will benefit by treatment designed specifically to meet their mental health needs and separation from more sophisticated/delinquent peers.

d. Related Agencies: An extensive amount of work would need to be done to convince DMH that these clients are in need of their services and deserve some commitment of resources.

Requirements for Implementation:
1. Proposal submitted to DMH.
2. Proposal submitted to secure adequate funding.
3. Resolution of any legislative problems or obstacles.
4. Construction of the faciliity.
5. Hire specialized staff team.
6. Program development.

Estimated Implementation Date: June, 1989

DIVISION OF JUVENILE REHABILITATION
MENTALLY ILL OFFENDER ANALYSIS
1987 - 1989 BIENNIUM

RECOMMENDATION 3

Problem Statement:
DJR is receiving significant numbers of youth with mental health problems and a large number of program managers (45%) feel that they do not have access to adequate psychiatric services in their setting.

Recommendations:
The addition of one specialized mental health unit to DJR at Echo Glen Children's Center.

Present Service:
Many disturbed youth are presently housed in Oak Cottage at Maple Lane School and Copalis Cottage at Echo Glen Children's Center. However, Echo Glen does not have the resources or staffing needed to be effective. Other disturbed youth are dispersed throughout DJR's general population and receive little, if any, significant treatment.

Proposed Service:
A mental health unit would be developed at Echo Glen Children's Center with the following additional resources:

-- Conversion of a current cottage to a secure unit with some reinforced rooms and others adapted for suicide prevention. The cottage would have a capacity of 14 beds, totalling 28 mental health beds in DJR.

-- This cottage would be self-contained, including a specialized school and recreation area.

-- Staff members hired selectively for their mental health training and/or background.

-- Increase staffing level at Echo Glen Children's Center to allow 4 staff on during the day and 5 on during the afternoon shift; continue with 1 staff on the graveyard shift.

-- On-going staff training on mental health issues.

-- Increased access to psychological and psychiatric services.

-- Consultants from other facilities to assist in program development.

Impact:
a. Fiscal: Estimated cost per cottage
$500,000 (Unit conversion - includes heat pumps, recreation court, security fence, interior remodel, new sash, partitions, doors, and locking devices)

$ 78,736 (additional staffing annually - 2 JRC 2 & 1 JRC 1)
25,000 (staff training and psychiatric consultation annually)
75,000 (educational costs - includes addition of portable classroom, one full-time teacher, and one teacher's aide)

$678,736 Total DJR Expenditure

b. Positions: 1988 3

c. Clients: Disturbed youth will benefit by treatment designed specifically to meet their mental health needs and separation from more sophisticated/delinquent peers.

d. Related Agencies: None

Requirements for Implementation:

1. Conversion/improvements of existing cottage.
2. Use selective hiring to assemble specially trained staff teams.
3. Hire consultants to assist staff in program development.
4. Contract for regular psychiatric consultation and staff training.

Estimated Implementation Date: June, 1988