Juvenile Detention Standards in Washington State

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December 1998

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Document Number: 98-12-1202

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Special thanks to the detention managers for their cooperation and assistance. Bruce Moran, former chair of the Juvenile Court Administrators, helped facilitate the involvement of juvenile court administrators in this project.

EXECUTIVE SUMMARY

Engrossed Second Substitute Senate Bill 6445, Chapter 269, Laws of 1998 required the Washington State Institute for Public Policy to address six tasks regarding standards for juvenile detention facilities.[1] These six tasks were:

- What standards are in place and proposed for all existing and planned detention facilities in this state?
- What is the current compliance of detention facilities with recommended American Correctional Association standards and those delineated in RCW 13.06.050?
- What concerns, problems, or issues regarding current standards have a direct impact on the safety and health of offenders, staff, and the community?
- Identify and make recommendations with regard to the improvements needed, including a timeline for the implementation of such improvements.
- Recommend a schedule for periodic review of juvenile detention standards.
- Analyze the costs to implement the recommendations in accordance with the recommended timeline.

A summary of the findings follow.

Great Progress Has Been Made in Recent Years

Major reviews of local juvenile detention facilities were conducted in Washington in 1988, 1991, and 1998. With each successive review, major progress has been made. Our findings notwithstanding, there have been great improvements in physical conditions, overall system capacity, training, staff salaries, and health care. The state's juvenile court administrators and detention managers have worked hard to bring these changes about and are to be commended.

No Uniform Juvenile Detention Standards Operate in Washington State

While there have been attempts to develop and implement juvenile detention standards in Washington State since the Juvenile Justice Reform Act of 1977, there are no uniform standards in the state today. RCW 13.06.050 directs local jurisdictions that receive state juvenile justice funds to have standards in place, but non-compliance has been without consequence. In the absence of clear and up-to-date state standards, some of the juvenile court administrators who want to assess how well their facility and staff measure up have turned to the standards issued by the American Correctional Association (ACA). Other administrators still look to Washington standards proposed in 1987 or to a combination of ACA and the proposed Washington State standards. Among the juvenile court administrators and detention managers, however, there is little or no support for state-mandated detention standards at this time.

[1] The Washington State Institute for Public Policy contracted with Christopher Murray & Associates to assist in the review and analysis. Christopher Murray and Merlyn Bell, of M. M. Bell, Inc., visited all detention facilities, completed the analysis, and wrote this report.

A Few Jurisdictions Are Close to Meeting ACA Standards – Others Have Many Deficiencies

There are 376 different standards for local detention facilities published by the ACA, 26 of which are mandatory. To achieve accreditation, a jurisdiction must meet all mandatory standards and 85 percent of the discretionary standards. Out of 21 juvenile detention facilities in the state, only one would likely pass accreditation at this time. Several others are close to meeting ACA accreditation standards.

Overall, the 21 detention facilities are in compliance with 79 percent of the mandatory ACA standards and 72 percent of all ACA standards. Although these numbers indicate that few jurisdictions could be currently accredited, they also suggest that many deficiencies may be minor.

Some deficiencies, however, are not minor. The most serious deficiencies relative to the ACA standards include crowding, insufficient staff to provide interaction with and adequate supervision of juveniles, insufficient staff to provide back-up coverage on the night shift, and limited or infrequent health care services by licensed providers.

Recommendations

Capital Improvements. To be closer to ACA standards, juvenile detention facility crowding should be reduced in Washington by adding additional cells or sleeping rooms to most facilities. Additional program and activity space should also be provided to ensure adequate capacity for out-of-cell time. Because of building and site constraints, this may be difficult at some locations.

There are different ways to look at current levels of crowding relative to ACA standards. First, ACA capacity can be compared with the average daily population. This results in a minimum definition of crowding. Another way is to look at peak populations (assumed to be about 125 percent of average daily population) and compare this with ACA capacity.

Using these two definitions, there is a statewide need for 123 to 274 additional detention beds just to reduce current levels of crowding. This does not take into account future population growth nor does it try to measure the effect of booking restrictions or emergency release procedures that some jurisdictions now use to hold down crowding. In reality, current needs for juvenile detention in Washington State are likely to be higher than estimated here. Future needs will almost certainly be higher still. The state Office of Financial Management's latest population forecast (November 1998) estimates that the 10- to 17-year-old population will grow by 11 percent in the next eight years.

The estimated statewide cost of the capital improvements is between $31.1 million and $57.9 million, depending on which ACA definition is used. This is a one-time capital expense that includes the cost of replacing one facility and adding capacity at others to eliminate current crowding and provide more program and activity space.

Operating (Staffing-Related) Improvements. To be closer to ACA standards, changes should be made to detention facility staffing levels, staff training practices, staff wage levels, and the provision of health care services to detainees. Some facilities have very low

staffing levels on the night shift. In newer facilities that have a control room, one staff person must always be there. If there is an intake or other event that monopolizes the time of a second person, there may be insufficient staff to respond to an emergency. Having at least three people on duty at night in all facilities should be a high priority.

Training and staff professionalism is key to many important standards of operation. To promote the professionalism of detention workers, it is recommended that detention staff pay rates be made equivalent to the pay rates for correctional officers working in the jail in the same county. Pay increases for longevity and responsibility should also be similar. Budgets should be increased for staff training and for hiring relief staff so regular staff can attend training. Relief staff should also be trained.

In all but the smallest facilities, sick call should be provided by a nurse at least three times a week. At least one-and-a-half hours of a physician assistant's time and one-and-a-half hours of a physician's time should be provided each week as well. Contracts for health care services should include coverage of at least this amount. Steps should be taken to ensure licensed medical personnel oversight of medication dispensing.

The estimated annual statewide cost of adding night-time staff, improving training, increasing professionalism by providing wage parity with jail staff, and improving health care is approximately $3.3 million.

Schedule for Periodic Review of Juvenile Detention Standards. Conversations with individual juvenile court administrators, and group discussion at their fall conference, makes it clear that juvenile court administrators do not favor state-imposed juvenile detention standards. Administrators fear that standards will be an unfunded mandate which will increase liability if they are unable to comply.

If the legislature wants to develop and implement statewide standards, it is recommended that they take the form of outcome-based standards, leaving the means of achieving outcomes to each jurisdiction and flexibility in the specific standards. The establishment of such standards should follow a timeline similar to the draft standards developed by the Juvenile Disposition Standards Commission in the 1980s: that process took two years. Because there is currently no consensus among juvenile court administrators or juvenile detention managers favoring adoption of standards of any kind, no start date is recommended.

Outcome-based standards could entail annual reports by each jurisdiction with regard to their performance. This would be equivalent to an annual self-review of each program. It is recommended that outside review occur approximately every five years.

INTRODUCTION

There are 21 juvenile detention facilities in Washington State (see Table 1). All but Martin Hall are operated by a local juvenile court.[2]

Significant activity in the recent past has changed the picture of juvenile detention in Washington State. Six counties (Chelan, Kitsap, Mason, Snohomish, Spokane, and Thurston) began operation of new facilities in 1998. Cowlitz County has a facility under construction that will open in early 1999. Martin Hall Juvenile Detention, Benton-Franklin, and Walla Walla Juvenile Detention were opened in 1997 or early 1998. The latter three facilities serve jurisdictions that previously had no juvenile detention facility. When this report was written in November 1998, no new facilities were planned in jurisdictions that do not already have facilities.

Table 1
Juvenile Detention Facilities in Washington State

Facility (Location)	Last construction
Benton/Franklin (Kennewick)*	1997
Chelan (Wenatchee)*	1998
Clallam (Port Angeles)*	1994
Clark (Vancouver)	1966
Cowlitz (Kelso)*	1999
Grant (Ephrata)	1993
Grays Harbor (Aberdeen)	1982
King (Seattle)*	1992
Kitsap (Port Orchard)*	1998
Lewis (Chehalis)	1979
Martin Hall (Medical Lake)*	1997
Mason (Shelton)	1998
Okanogan (Okanogan)	1974
Pierce (Tacoma)*	1996
Skagit (Mount Vernon)	1995
Snohomish (Everett)*	1998
Spokane (Spokane)	1998
Thurston (Olympia)*	1998
Walla Walla (Walla Walla)*	1997
Whatcom (Bellingham)*	1994
Yakima (Yakima)*	1995

The 13 facilities marked with an asterisk in Table 1 have been constructed, or substantially remodeled, within the last decade. Each is what is called a " new generation facility," built with a block of sleeping rooms off a dayroom and with centralized electronic controls. Mason County's new facility is a temporary building designed to be replaced in 2002 and

[2] The Corrections Services Corporation (a private for-profit corporation) operates Martin Hall on contract for a consortium of nine eastern Washington counties.

does not have these characteristics. Other remodels within the decade were less extensive and did not generally result in new generation buildings.

Based on the reports made by the individual facilities in the summer of 1998, the 21 facilities housed an average of 968 juveniles per day in 1997. The smallest average daily populations were in Mason County (11) and Walla Walla County (14). The highest were in King County (179). These 21 facilities admitted 34,207 juveniles during 1997. Average length of stay ranged from 17 days in Okanogan County to 5.8 days in Kitsap County. The mean was 10.9 days. Counties with longer average lengths of stay (like Okanogan) generally had a higher percentage of sentenced Juvenile Rehabilitation Administration (JRA) juveniles. Sentenced JRA juveniles had longer average lengths of stay than most other juvenile offenders.

I. THE NATIONAL CONTEXT

In the 1970s and 1980s, professionals in the field were increasingly concerned with the less than adequate, and even dangerous, conditions in prisons, jails, training schools, and juvenile detention facilities in many states. The courts were often actively involved. For example, inmate-on-inmate assault cases resulted in case law on separation and classification of violent from non-violent inmates. Courts required that juveniles be given medical screening, regular sick call, and other types of medical and mental health care. The courts were especially concerned with access to education for juvenile detainees. Facilities were required to remedy environmental conditions in dirty and overcrowded physical plants.

In the late 1970s, various national bodies were advocating and developing standards for the operation of juvenile facilities. These discussions generally included explicit assumptions about accreditation or monitoring for compliance with standards. Foremost among these groups were the American Bar Association, the American Correctional Association (ACA), and the National Institute for Juvenile Justice and Delinquency Prevention (NIJJDP). The National Advisory Committee of NIJJDP completed its standards in 1980. The ACA issued theirs in 1979. A second edition of juvenile detention standards was published by the ACA in 1983, and a third in 1991. Most recently, ACA issued a supplement to its juvenile detention standards in 1998. New editions and supplements generally respond to changes in case law.

II. THE HISTORY OF JUVENILE DETENTION STANDARDS IN WASHINGTON STATE

In Washington State, the Juvenile Justice Reform Act of 1977 mandated that the juvenile justice system " develop effective standards and goals for the operation, funding, and evaluation of all components of the juvenile justice system and related services at the state and local levels" (RCW 13.40.010). Other statutory language (RCW 13.04.037) charges juvenile court administrators with the responsibility to adopt standards for " the regulation and government of detention facilities for juveniles . . . " The same statute notes that " each detention facility shall keep a copy of such standards available for inspection at all times. Such standards shall be reviewed and the detention facilities shall be inspected annually by

the administrator." Further legislative action (RCW13.06.050) penalized counties that did not comply with minimum standards prescribed by the Department of Social and Health Services (DSHS) by withholding state funds. In 1983, the Juvenile Court Administrators and the DSHS Division of Juvenile Rehabilitation (now the Juvenile Rehabilitation Administration) adopted voluntary advisory standards without a mechanism for determining local adoption or compliance.

In 1986, the Legislature charged the Juvenile Disposition Standards Commission with the task of developing standards for juvenile detention.[3] The act was quite specific as to what was to be included in the standards: intake procedures, use of punishment, security and control mechanisms, health care, management of detainee property, access to counseling, communication, and information gathering pertinent to monitoring compliance. Staff was assigned to the Commission. Four working committees were convened.

Committee members included: court administrators; detention managers; prosecuting attorneys; public defenders; sheriffs and police chiefs; juvenile parole and probation officers; physicians; nurses; legislative committee members and staff; the Governor's Juvenile Justice Advisory Committee; the Alliance for Children, Youth and Families; the Washington Council on Crime and Delinquency; teachers; and citizens. Their tasks focused on intake, health care, operations, and monitoring. Meetings were held. Standards were drafted and redrafted. The Commission reviewed and amended standards. They solicited and received public comment, further amending the standards. After months of work, they proposed 171 detention standards in 11 areas: intake; medical and health care; communication, correspondence, and visiting; security and control; sanitation and hygiene; juvenile rights; rules and discipline; juvenile records; safety and emergency procedures; programs; discharge; and inter-jurisdictional movement.

In 1988, the Governor's Juvenile Justice Advisory Committee (GJJAC) funded an assessment of compliance with these standards. Two national experts, Charles Kehoe and Joseph Rowan, evaluated 13 of the 18 detention facilities in Washington.[4] They found several important areas that needed improvement. These included conclusions that juvenile detention personnel were underpaid; few facilities had enough staff on duty to meet minimum operational standards; some physical plants were "woefully inadequate;" many facilities had "an absence of any structured programming;" and health care in most facilities "fell below nationally recognized standards." Following this report, and as part of the process for developing standards, the juvenile court administrators did their own estimate of the cost of compliance. This estimate was prepared for the 1988 legislative session.

While the Juvenile Disposition Standards Commission was doing its work, local officials were complaining about the actions of the Corrections Standards Board, the agency that established standards and monitored the compliance of local and state facilities for adults. In this environment, the 1987 Legislature did not reauthorize the Corrections Standards Board. Because of Washington State's sunset provisions, the Corrections Standards Board

[3] The material that follows was drawn from the Juvenile Disposition Standards Commission's report, *Proposed Detention Standards*, October 1987.
[4] Charles J. Kehoe and Joseph R. Rowan, *Evaluation of Juvenile Detention Facilities in Washington*, Completed for the Governor's Juvenile Justice Advisory Committee, 1986.

was eliminated just as the Commission's report was completed for submission to the 1988 Legislature. The proposed juvenile detention standards were not presented.

More recently RCW 13.06.050 was amended in 1993 to add the following language:

> " . . . any county making application for state funds under this chapter that also operates a juvenile detention facility must have standards of operations in place that include intake and admissions, medical and health care, communication, correspondence, visiting and telephone use, security and control, sanitation and hygiene, juvenile rights, rules and discipline, property, juvenile records, safety and emergency procedures, programming, release and transfer, training and staff development, and food service."

The list included in RCW 13.06.050 paralleled the standards proposed in 1987. Passage of this amendment ignored the fact that the 1987 standards were probably somewhat out of date (due to changes in case law) and that counties had no mechanism or resources for updating the standards. Local juvenile courts could not, and did not, respond. Since DSHS continued to distribute funding, non-compliance had no consequences.

The legislation originally proposed in the 1998 session was drafted because of concerns for the safety of detainees. It would have required GJJAC to adopt standards and monitor local compliance. However, juvenile court administrators opposed the bill. In general, they felt that state standards would increase their liability. Administrators with serious deficiencies were especially concerned, since they are powerless to solve problems if they do not have the resources to do so. This feeling was particularly acute in those counties where the commissioners were willing to provide more funding, but the voters were not. The compromise was this study, another assessment of compliance with ACA standards and the cost of achieving compliance.

III. THE CURRENT STATE OF JUVENILE DETENTION STANDARDS IN WASHINGTON

Since the legislature did not adopt statewide juvenile detention standards in 1988, local jurisdictions remain responsible for their own standards. However, even if a juvenile court administrator has identified standards in the recent or distant past, that action has tended to fade into obscurity. There are several reasons for this development. One, there is no compulsion for commissioners to adopt standards as had been the case with jail standards. Furthermore, there was no indication that a third party would use those standards to assess how well the facility was doing. If the evidence from the jail standards experience is a guide, then adoption of standards by elected local officials is no guarantee that standards will remain an important guide for funding or management.

Moreover, adopting detention standards once is not enough. Detention standards are based on case law. Case law evolves and, if they are to be coordinated with case law, so must the standards (witness the multiple editions of ACA standards). To the extent that they have been adopted at all, local standards, as originally proposed for juvenile detention and jails, have remained static since 1987. In the absence of clear and up-to-date state standards, some of the juvenile court administrators who want to assess how well their

facility and staff measure up have turned to the standards issued by ACA. Other administrators still look to the standards proposed in 1987 or to a combination of ACA and the proposed Washington State standards. In addition, there are other sources of standards for specific areas. For example, the National Commission on Correctional Health Care has issued standards for health services in juvenile detention, and the Correctional Education Association has issued standards for educational services.

IV. ACA Juvenile Detention Standards

ACA develops its standards in a process similar to the Juvenile Disposition Standards Commission. It has broad-based committees to work on standards for all types of correctional agencies. The group that formulated the juvenile detention standards includes representatives from state and local juvenile justice agencies, national associations of juvenile and family court judges, attorneys, architects, physicians, detention managers, and juvenile correctional agencies. The current version of their product has 376 standards, 26 of which are mandatory for accreditation by ACA. ACA juvenile detention standards are divided into the following categories: administration and management, physical plant, institutional operations, facility services, and juvenile services.

V. Recent Trends in Juvenile Detention Standards

Performance-Based Standards

ACA standards, like most others, usually specify activities that should occur or conditions that should exist. For example, there is a medical standard that says sick call should be conducted by a physician or other qualified health personnel at least once a week in small facilities (less than 20 detainees) and three times a week in larger facilities. Similarly, physical plant standards specify temperatures appropriate for comfort and designs that facilitate interaction between staff and juveniles.

In 1993, Abt Associates produced a report entitled *Conditions of Confinement*.[5] Among other things, this nationwide study of juvenile detention facilities found that specific outcomes were related to specific practices and circumstances. For example, the authors found that a substantial proportion of confined juveniles had inadequate living space due to crowding. (Almost half the facilities exceeded their design capacity.) Significantly, they found that rates of injuries to staff and juveniles were higher in crowded facilities and that injury rates were higher in facilities where living units were locked 24 hours a day. While staffing ratios and injury rates were not related, staff turnover and juvenile-to-staff injury rates were. Facilities that conducted suicide screening at admission and trained staff in suicide prevention had lower rates of suicidal behavior.

In 1995, the Council of Juvenile Correctional Administrators was funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to develop performance-based

[5] Dale Parent, *Conditions of Confinement: A Study to Evaluate Conditions in Juvenile and Corrections Facilities*, U.S. Department of Justice, April 1993.

standards. These standards incorporate outcome measures rather than proscribed statements of expected practice. The shift was spurred by the 1993 Abt study and confirmed by recent findings indicating that compliance with current standards does not necessarily ensure adequate conditions of confinement or increased health and safety of those detained.[6] The Council used working groups of juvenile justice practitioners to define their performance-based standards. The standards cover six areas: security, order, safety, programming, health/mental health, and justice.

Although the Council's proposed outcome measures are still being refined and tested, early drafts give us an idea of how these new approaches may look. For example, *Conditions of Confinement Study*, completed in 1993 by Abt Associates for OJJDP, documented a significant link between isolation and suicidal behavior. That finding suggested one outcome measure based on the rates of isolation and room confinement per 100 days of juvenile confinement and another based on the average duration of isolation and room confinement. Another proposed outcome measure is based on the rate of intentional injury in cases where the injury was caused by another juvenile.

The Council approved draft performance-based standards in October 1996, has now field-tested them in 18 locations, and is implementing them in another 45 sites. During the implementation phase, facilities will use outcome data to identify and test improvements. The implementation phase will be completed by October 1999.

Alternatives to Accreditation and Litigation

In January 1998, the American Bar Association Juvenile Justice Center issued *Beyond the Walls: Improving Conditions of Confinement for Youth in Custody.*[7] They note that under case law and federal statutes, youth " have a right to protection from violent inmates, abusive staff, unsanitary living quarters, excessive isolation, and unreasonable restraints. They must also receive adequate medical and mental health care, education (including special education for youth with disabilities), access to legal counsel, and access to family communication, recreation, exercise, and other programs."

They contend that accreditation and litigation are " often expensive and time consuming and sometimes allow for only minimal monitoring of existing conditions." Instead of accreditation and litigation, they suggest other tools that can be used to improve conditions. These include the Civil Rights of Institutionalized Persons Act, ombudsman programs, Individuals with Disabilities Education Act, Protection and Advocacy Systems, the Administrative Procedures Act, and self-assessment.

Vulnerability Assessment

Another new approach focuses on fewer conditions and outcome measures. The Youth Law Center in San Francisco developed a " vulnerability assessment list" to diagnose problems in juvenile detention facilities. The list targets overcrowding, safety,

[6] Unpublished material from *Performance Standards Project*, Council of Juvenile Correctional Administrators and Abt Associates, June 1998.
[7] Patricia Puritz and Mary Ann Scali, American Bar Association Juvenile Justice Center, *Beyond the Walls: Improving Conditions of Confinement for Youth in Custody*, Office of Juvenile Justice and Delinquency Prevention, United States Department of Justice, January 1998.

restraints/isolation, education, health care, recreation, staffing/training, and environment. Some items on this list are quantifiable: e.g., staffing ratios, overcrowding, and hours in education or exercise/recreation.

VI. WASHINGTON STATE COMPLIANCE WITH ACA STANDARDS IN 1991

In 1991, GJJAC funded a study to determine compliance with the standards proposed for Washington State. In addition, the study looked at ACA standards that covered areas (such as physical plant) that were not in the proposed Washington State standards. The 1991 study, completed by one of the authors of this report (M. M. Bell), had three phases: a self-assessment completed by local staff, an on-site assessment completed by the consultant, and an analysis of the cost of remedying deficiencies.[8]

In the 1991 study, juvenile courts and detention facility managers were found to have made significant efforts to bring their facilities into compliance with good operating practice. Facilities were well run, and staff were committed and concerned. Each facility had areas in which they were doing unusually well. Some facilities were doing well despite serious handicaps, particularly in the areas of funding and space.

Several facilities had insufficient space and/or infrastructure. Most had too few staff to provide expected programs for youth (i.e., to have youth out of their sleeping rooms 14 hours a day). Medical care was inadequate in many facilities. Staff were underpaid and not adequately trained. Policy and procedure manuals were out of date, incomplete, or non-existent.

The 1991 team recommended that four facilities be replaced: Chelan, Okanogan, Skagit, and Yakima. Since then, two (Chelan and Yakima) have been. Skagit has undergone extensive remodeling. Other counties (Benton/Franklin, Clallam, King, Kitsap, Pierce, Snohomish, Thurston, and Whatcom) have also replaced or extensively remodeled their facilities. A new facility is opening soon in Cowlitz County. Nine eastern Washington counties formed a consortium to operate Martin Hall. Since 1991, 14 out of 21 detention facilities in the state are new.

In addition, Grays Harbor had a facility that was almost new in 1991. Grant, Skagit, and Spokane have had some remodeling and renovation work. Only Clark, Lewis, and Okanogan Counties have older detention facilities that are essentially the same as they were in 1991. Even here there is progress: Clark County has secured funding and is finishing working drawings on a major expansion and remodel of its facility.

Also in the intervening years, Spokane County Juvenile Court developed a model policy and procedure manual based on ACA standards. The manual was adapted for their own use by nearly all the other detention facilities.

[8] M. M. Bell, Inc., *Juvenile Detention Standards Study*, prepared for the Governor's Juvenile Justice Advisory Committee, December 1991.

VII. WASHINGTON STATE COMPLIANCE WITH ACA STANDARDS IN 1998

Methodology

Assessing compliance with 376 standards is a formidable task. Assessment was made possible only by the willingness of juvenile court staff to assist in this effort. As in 1991, a self-assessment instrument listed every standard with checkboxes for full, partial, or non-compliance and space provided for written comments. Every detention manager completed substantially all of the self-assessment.

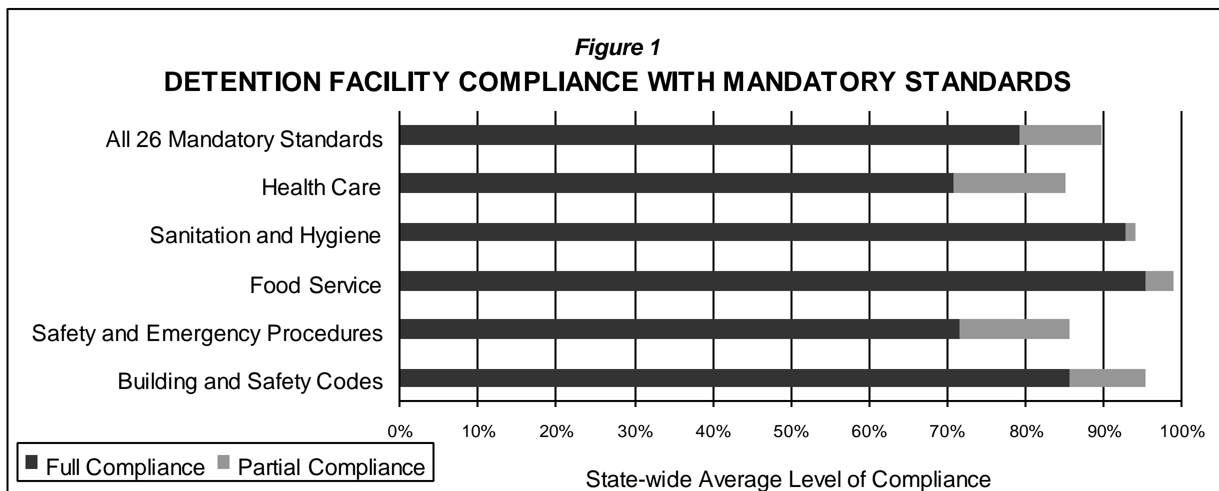
The consultant team identified four areas on which to focus their efforts: physical plant conditions, staffing, medical care, and mandatory ACA standards. The ACA standards have a heavy emphasis on safety and security issues. The result was a shorter list of 85 items. In addition, team members selected items from each self-assessment that were outside the team's targeted list whenever those areas might have important implications for operations.

One team member visited every facility. During the site visit, the team member toured the facility and viewed an architectural plan; observed the operations; interviewed detention and medical staff; and collected data on populations, staffing, and budgets. During the visits the team member responded to 85 standards on a shorter list, responses not always in agreement with the detention manager's self-assessment. Following the site visit, the information was compiled and checked with each facility for accuracy.

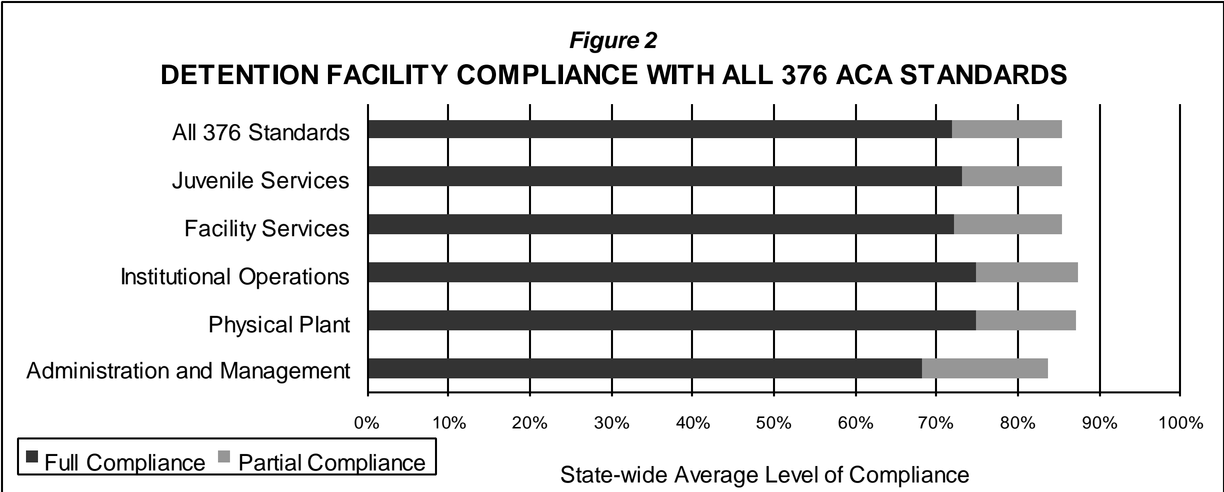
Overall Levels of Compliance

ACA sets its threshold for accreditation at 100 percent compliance with mandatory standards and 85 percent compliance with discretionary standards. Using this benchmark and the detention managers' self reports as the indicator, only one juvenile detention facility in Washington State would be accredited.

While only one detention facility reported compliance with all mandatory standards, several were close. On average, the detention managers reported full compliance with 79 percent of the mandatory standards and partial compliance with an additional 10 percent (see Figure 1). Compliance rates were lower on safety and emergency procedures and on health care. They were highest on food service and sanitation and hygiene. In several counties, the move into new facilities should eventually bring them into compliance with safety and emergency procedures.



Detention managers reported full compliance with 72 percent of all ACA standards (mandatory plus discretionary) plus partial compliance with another 14 percent (see Figure 2). Levels of compliance were lowest in administration and management, primarily because of deficiencies in training. They were highest in physical plant and institutional operations. The spread between the two was small. The managers reported compliance with 75 percent of the plant and operational standards and 68 percent of the administrative and management standards. They complied with 72 percent of the facility services and 73 percent of the juvenile services.



Although these numbers show that many Washington State juvenile detention facilities could not currently be accredited by the ACA, they also suggest that many deficiencies may be minor. When selected standards are pulled out of the context, problems may look more serious than they really are.

Compliance With Facility Issues

Detention managers reported compliance with 75 percent of the ACA physical plant standards. The highest reported rates of compliance were with Building and Safety Codes and Security. The lowest rates were with Juvenile Housing and Size, Organization and Location. We focused on housing and program spaces, areas for which remedies would be expensive. We also looked at Building and Safety Codes that are mandatory requirements. There are a total of 44 physical plant standards within the seven categories listed in Table 2. The number of standards within each category is listed in parenthesis.

Table 2
Juvenile Detention Facilities in Washington State
Self-Reported Compliance Rates on Physical Plant Standards

3-JDF-2: Physical Plant Standards	Compliance Rate
2A: Building and Safety Codes (4)	88%
2B: Size, Organization, and Location (8)	71%
2C: Juvenile Housing (12)	69%
2D: Environmental Conditions (3)	73%
2E: Program and Service Areas (13)	77%
2F: Administrative and Staff Areas (2)	76%
2G: Security (2)	88%
Total (44 standards)	**75%**

Compliance With Juvenile Housing Standards

ACA standards for sleeping rooms require 35 square feet of unencumbered floor space per occupant (ACA 3-JDF-2C-02). Each room is to be equipped with a bed, desk, chair or stool, hooks or closet space, and a wash basin with hot and cold running water (2C-03). Sleeping rooms must have a toilet or juveniles must have 24-hour access to a toilet without asking staff to unlock doors (2C-04). ACA standards for the adjoining dayrooms call for a minimum of 35 square feet of space per user (2C-04). ACA Standard 2C-01 specifies that multiple occupancy rooms account for no more than 20 percent of a living unit's capacity.

The 13 new-generation facilities were constructed to provide 35 square feet of unencumbered floor space in single occupancy sleeping rooms. Multiple occupancy sleeping rooms were generally designed to meet the square footage requirements. The sleeping rooms are equipped with bed, desk, stool, and wash basin. Because juvenile court staff are concerned about suicide, few facilities have sleeping rooms with clothes hooks. With the exception of one facility, all have toilets in the rooms. With two exceptions, one of which is in a facility that has double-bunked sleeping rooms originally built for one occupant, the new facilities have adjoining dayrooms with a minimum of 35 square feet per user.

Seven of the eight old-generation facilities have sleeping rooms of sufficient size, if rooms are limited to one occupant. In these older facilities, sleeping rooms rarely have a desk and stool but do have a bed, wash basin, and toilet. The older facilities may not have dayrooms in the sense of a room adjoining a group of sleeping rooms. And when they do, due to crowding in these older and smaller facilities, the dayrooms have fewer square feet per user than the newer facilities.

Two-thirds of the facilities exceed the standard limiting multiple occupancy sleeping rooms to 20 percent of the unit's capacity. Eight new facilities, as well as six old facilities, have doubled up in more than 20 percent of their rooms. One new facility has 60 percent of its sleeping rooms double bunked. In short, two-thirds of the detention facilities would meet square footage standards for juvenile housing only by converting more sleeping rooms to single occupancy.

Excessive use of double occupancy cells is potentially a serious deficiency that can affect the safety of juveniles while in their rooms. Safely placing juveniles in multiple occupancy settings requires knowledge about each youth so that aggressive and vulnerable youth, or mutually antagonistic youth, are not placed in the same cell or in other situations where they may be out of line-of-sight supervision. ACA also has a standard (3-JDF-2C-02) that outlines the minimum requirements for a classification system that should be used to make such an assessment. The ACA standard limiting the use of double occupancy cells recognizes that there should be sufficient current knowledge about some of these youth to be able to safely place them in multiple occupancy housing. At the same time, the 20 percent limit is recognition of the fact that such decisions should err on the side of safety.

The importance of this issue is underscored by the strong position taken by several jurisdictions. At least three counties have taken the position that—despite ACA's new standard permitting limited multiple occupancy cells and sleeping rooms—no juveniles will *ever* be put in multiple occupancy cells. One seriously crowded jurisdiction sleeps large numbers of juveniles on the floor of a small gymnasium (under constant supervision of a staff member located in the gym) rather than put two juveniles together behind a locked door.

Other areas of non-compliance relating to housing, such as furnishings, are minor. There is, however, one facility that has no toilets in most of its sleeping rooms, thus requiring youths to have staff assistance to use the restrooms. Unless there are plenty of alert staff, this could also be a serious deficiency.

Compliance With Space Standards

ACA Standard 2G-01 states that secure facilities should have a 24-hour control center. ACA Standard 2E-05 states that school classrooms should be designed in conformity with local or state educational requirements. Regulations from the Office of the Superintendent of Public Instruction (OSPI) specify that high schools must provide 110 square feet per student.[9] *Per ACA Standard 2E-01, the total combined indoor activity area should provide space equivalent to a minimum of 100 square feet per juvenile. Dayrooms, dining rooms and classrooms are counted separately. ACA Standard 2E-02 requires that outdoor exercise areas be sufficient to ensure each juvenile one hour of outdoor exercise a day. ACA Standard 4C-06 states that medical services should have adequate space and equipment, providing (at minimum) space where medical staff can examine and treat juveniles in private. ACA Standard 2E-03 provides for contact visiting, including areas for screening and searching juveniles and visitors. ACA Standard 2E-04 specifies that an interview space be available. ACA Standard 2E-06 calls for a separate dining room with 15 square feet of floor space per occupant.*

Overall, according to ACA standard 2E-01, the combined indoor activity area is to provide a minimum of 100 square feet per occupant. This area is computed with classroom space, dayroom, and dining area excluded. The dining room should provide 15 square feet per occupant. An earlier edition of the ACA standards stated that outdoor recreation areas should provide 100 square feet per occupant. (The current standard does not specify how much space should be provided for outdoor recreation.)

[9] This standard refers to the entire school facility, not just the classroom.

Most facilities have a school space separate from other activity areas. For purposes of this report, multi-use space that was the only location for school activities was counted as school space rather than dayroom or activity space since education has priority over other uses.

There was an average of 35.4 square feet of education space per occupant in 1998 when the 1997 average daily population was used as a surrogate for occupant.

Old-generation facilities are more likely to have combined dayrooms and indoor activity rooms. Some new-generation facilities have separate dayrooms and indoor activity rooms. Some have gyms. Others have no indoor activity rooms other than in the dayrooms and in the school area. Only four facilities have a separate dining room. In all but one new-generation facility, detainees eat in the dayroom.

Statewide, classrooms account for 24 percent of the common area. Dayrooms are another 44 percent. Other indoor activity areas—dining rooms, gymnasiums, multi-purpose areas—are one-third.

Table 3

Program Areas: All Juvenile Detention Facilities

	School	Dayroom	Indoor Activity	Total
Square Footage	43,761	79,667	58,945	182,373
% of Total	24%	44%	32%	100%
Sq Ft/Reported Capacity	32	58	43	133
Sq Ft/ACA Capacity	39	72	53	164
Sq Ft/1997 ADP	35	82	61	178

Since some facilities do not make a clear distinction between education, dayroom, and indoor activity areas, we combined these before comparing their use to the standards. ACA standards call for 210 square feet of indoor space for each occupant: 110 square feet of school space and 100 square feet of activity space. When all indoor spaces, school, dayroom, and activity areas are combined, the facilities averaged 188 square feet per occupant. If all beds had been occupied, the average would have been 134 square feet.

This comparison is less reassuring when individual facilities are the focus. Four facilities have less than 100 square feet per occupant, and 11 others have over 200. It is important to note that even most of the new facilities are out of compliance with standards on program space.

Most facilities have an outdoor recreation area. Some are large enough for serious physical activity. Some are only large enough to offer an opportunity for fresh air. A few have no outdoor recreation at all.

Virtually none of the detention facilities in Washington State—including the very newest—can meet all square footage standards for program areas. This is not necessarily a serious deficiency if facility staff can still provide programs to occupy most of the youths' waking hours.

Compliance With Capacity and Crowding Standards

ACA Standard 2B-06 states that the number of juveniles should not exceed the facility's rated capacity.

We noted in the section on juvenile housing that two-thirds of the facilities could comply with ACA housing standards only by reducing their populations. In a juvenile detention facility, crowding has a profound impact on operations: It stresses juvenile detainees and staff. It stresses the physical plant. It makes it harder to provide programming, health care, or other services.

Utilization is the relationship between detention population and capacity. When utilization exceeds 100 percent, the facility is, by definition, crowded. The two factors in this equation—population and capacity—are both somewhat elusive. Is capacity the number of beds now in a facility, i.e., the actual number of beds (not on the floor) where juveniles can sleep? Is it the number of beds when the facility was built, i.e., the design capacity? Is it the number of beds when sleeping room size and multiple occupancy constraints are applied, i.e., the ACA capacity?

Even detention population can be defined in many ways. Is detention population the daily average take over some period of time, i.e., average daily population? What is the period of time? Is it the year, the season, the month? What about seasonal variation? Is detention population counted at its peak, i.e., the population for the highest day during the time period under consideration. Is it the average number during the day or the maximum number during the day?

In the discussion that follows, we report the detention managers' comparison of rated bed capacity to the number of juveniles in the facility. We also compare 1997 annual average daily population to reported bed capacity and to ACA capacity.[10]

First, half the managers reported that the number of juveniles did exceed their design capacity. Five counties with new facilities are overcrowded; four others are trying to remedy their crowding by remodeling or new construction but do not have approved plans or funding. One county will not be crowded when its new facility opens. Another county is in the midst of a remodel that will add some space.

Second, we counted beds. Using actual bed capacity and 1997 average daily population as the measure, three facilities were over capacity at least half the year. One of these facilities

[10] ACA standards require that the number of juveniles not exceed the original design capacity. Sleeping rooms are to have 35 square feet of unencumbered space per occupant, that is, space not filled with furnishings or fixtures. Multiple occupancy rooms are not to exceed 20 percent of the bed capacity of a living unit. Using these standards, we calculated ACA capacity for every facility.

opened after the 1991 report. Seven facilities were at two-thirds of their capacity. The state average for bed utilization was 81 percent; 12 facilities were over this level and nine below.

Third, we calculated ACA capacity. Thirteen facilities had ACA capacities below their actual bed capacity. Most had lower ACA capacities because of double bunking. Three facilities are using only part of their building. Their ACA capacity is higher than their reported bed capacity. The state average for ACA utilization was 104 percent. Ten facilities were over this level. Using ACA standards, two facilities had 1997 average daily populations twice what they should have had. Four others were at 120 percent of ACA capacity. Four of the ten facilities that were over capacity have been constructed since 1991.

Fourth, we looked at the effect of peaking. Peak populations can add as much as 25 percent to average daily populations, suggesting that detention facilities should operate at 75 percent of their capacity during normal times in order to accommodate peak demand. Thirteen facilities had 1997 average daily populations at or above 75 percent of their actual bed capacity. Fourteen facilities had 1997 average daily populations at or above 75 percent of their ACA capacity.

In 1999, only eight out of the 21 detention facilities in Washington will have enough beds, even by their own standards, to keep juvenile detainees from sleeping on mattresses on the floor from time to time.

Compliance With Staffing Standards

In 1986, Kehoe and Rowan found that detention facilities in Washington were often understaffed. They noted that one result was a lack of structured programming. A dozen years later, we expected improvements. Instead, we found smaller facilities with only two staff on duty at night. We found larger facilities with too few staff to spend much structured time with youth. We found a new facility scrambling to add staff because their staffing levels were not high enough to empty the building during a nighttime fire drill. We also found detention managers concerned over deficiencies in training both new and old staff.

Unlike plant standards, staffing standards are not neatly packaged in one section of the ACA standards manual. Staffing standards are only explicitly spelled out in sections on personnel (1C-17) and training for detention workers (1D-09).

Other staffing issues can be inferred from other standards. For example, standard 2B-01 speaks to a building design that facilitates personal contact between staff and juveniles and, by implication, requires there be enough staff to facilitate interaction between staff and juveniles. Standard 3A-04 specifies that staff be located in, or immediately adjacent to, juvenile living areas so that workers can hear and respond promptly to emergencies. Standard 3A-07 notes that when both boys and girls are in the facility, at least one male and one female staff member are to be on duty at all times.

The comment attached to the 1983 version of standard 3A-07 states that juveniles are not to be left unsupervised at any time and that one staff person should always be available to perform functions not directly connected with supervision. The same commentary also states that the general guideline is one FTE staff member per juvenile, including maintenance personnel, supervisors, cooks, detention workers, counselors, etc. (This does

not mean there should be one staff member available for each detainee. Rather, it means the number of staff needed to cover a facility 24 hours a day, 365 days a year, is about equal to the number of detainees the facility is designed to hold.)

Supporting the concept that facility design should encourage interaction, the commentary with this standard (2B-01) says, " separation of supervising staff from juveniles reduces interpersonal relationships and staff awareness of conditions on the housing unit. Staff effectiveness is limited if the only staff available are isolated in control centers as observers or technicians in charge of electronic management systems." Abt Associates found that in facilities with locked living units, security became the primary concern of staff.[11]

In their 1998 self assessments, detention managers usually reported that their building design did facilitate interaction between staff and juveniles. This was a standard we had identified as critical and one where we disagreed with many detention managers. We found that the new generation of detention facility, designed with a secure control center, did separate at least one staff person from direct contact with juveniles. In the facilities with only a few staff, the loss of a single person results in reduced interaction between staff and juveniles.

Detention managers all reported that staff were located in, or immediately adjacent to, juvenile living areas and that workers could hear and respond promptly to emergencies. Technically they were correct. However, if one staff person is required to stay in the control room, and the second (and perhaps third) staff are busy with a new intake, a suicide watch, or a medical emergency, then prompt response may be difficult. Prompt response to a health emergency is defined in 4C-27 as within four minutes. This is a mandatory standard that all managers said their staff could meet.

Coeducational facilities, such as juvenile detention facilities, should have both male and female staff on duty at all times. This was an issue in the 1980s and continues to be. Forty percent of the detention managers said they did not have both male and female staff on duty at all times.

Building configuration, program structure, and the court's philosophy all affect the number of staff needed to operate a detention facility safely and effectively. Still, a simple staff-to-juvenile ratio is often used to measure staff's ability to perform critical tasks. Although the ratio is only a rough measure, it is a useful summary of staffing levels and suggests how many more staff may be needed.

We found an average ratio of one staff to 1.5 juveniles in the 1997 average daily population. To reach the recommended ration of 1:1, detention facilities would have to add 50 percent more staff. The problem is even greater if peak populations are used. Peak populations are generally about 25 percent above the average daily population. At the peak, the current average ratio would be one staff to 1.9 juveniles in the facilities. To bring it down to 1:1, current staff levels would almost have to double.

Staff-to-juvenile ratios of 1:1.5 influenced how and where staff spent their time. They did not spend much time in the living units or interacting with the youth. Detention staff offered

[11] Parent, Op. Cit.

few programs, relying heavily on school personnel to do it for them. They did spend time in the control stations, moving detainees from one area to another, and processing new intakes.

A significant number of facilities have full-time and part-time staff. In many, the part-time staff are on-call, i.e., they do not have a regular schedule. Some facilities now have a cadre of permanent part-time staff who come in when other staff are sick, on vacation, etc. Most facilities simply draw from an extra-help or relief pool. These non-permanent relief staff frequently have little training. Turnover may be high. In small facilities, with few staff on duty at any one time, one or two extra-help staff can constitute 50 percent or more of the staff in the facility. Parent, *et al.*, conjecture that inexperienced and less well trained staff are more likely to be injured.[12] We were told of cases in which the high percentage of untrained staff resulted in injury to detainees. We recommended to several facility managers that they convert their "extra help" or "on-call" staff to permanent part-time and provide them with a full 120 hours of training.

Compliance With Training Standards

ACA Standard 1D-07 states that all staff should receive 40 hours of orientation training before beginning work. ACA Standard 1D-09 says that staff supervising juveniles should have 120 hours of additional training during their first year and 40 hours each subsequent year.

Managers were least likely to report compliance with staff training requirements. The lack of training extended across all types of personnel: administrative staff, detention workers, professional employees (such as teachers and nurses), support staff, and clerical staff. Only one facility reported that they met training requirements for professional staff. Three reported that they provided sufficient training to support staff who had regular contact with juveniles. Four facilities reported that they had enough training for support staff who had minimal contact with juveniles.

The Criminal Justice Training Academy has been re-doing their approach to training during these last months. Some new facilities had the Academy staff on-site to train their new hires as they moved into new buildings. Others could not make these arrangements. Training opportunities for existing staff have fallen due to the changes at the Academy. This is an area of great concern to detention managers. They have made it one of their top priorities and want to design a training package that will fit their needs.

We found nine facilities that were unable to provide the 120 hours of initial training for new detention staff. Detention facilities were even less likely to provide additional training in subsequent years. Only four of the 21 facility managers said they could provide sufficient initial and subsequent training for detention workers.

[12] Ibid.

Compliance With Parity Standards

ACA Standard 1C-17 states that detention staff should be paid at a level comparable to others in the area who are performing similar work.

Seventy percent of the managers reported that their staff salaries were comparable to similar occupational groups in the state. This is another area in which managers and the consultant team did not always agree. We found that the majority of facilities paid their detention workers less than the jail in the same county paid their correctional officers.

Statewide, the average hourly pay for entry-level detention workers is $13.59 (without benefits). The average pay for entry-level corrections officers in local jails is $14.18. In 15 of the 21 facilities, detention workers are paid less than their counterparts in the county jail. Although we did not collect data on parity for employees by longevity or for supervisors, in most cases detention managers believe that the disparity increases with length of employment and with responsibility.

Compliance With Health Care Standards

Health care was an issue raised by Kehoe and Rowan in 1986 and by M. M. Bell and her associates in 1991. Since these earlier reports, juvenile courts have made major improvements in their provision of health care. Today, only a few detention facilities have no medical staff scheduled into their facility. Some facilities now use medical staff to perform a second health screening shortly after intake. Nurses are the most common providers. Mid-level professionals, such as physician's assistants and nurse practitioners, are present in some facilities.

This should not suggest that all is well in detention health care. We heard repeated concerns from detention managers and health care providers about the management of medications. In too many facilities, as doctors prescribe more psychotropic and other complicated medication regimes, detention staff are relying on parents and telephone consultations with medical staff to sort out and distribute an ever more complicated array of pills. The connection between nurses and their consulting physicians can be rusty and little used. Overall, the approach to health care is often more a result of the availability of a provider and funding than a well thought out response to the health needs of detainees.

Health care ranges from non-existent to excellent. At one extreme, there are still a few counties that have no contracts with health care providers and spend less on health care than a typical family. From there, it ranges from a nurse who can be consulted by phone but who is rarely in the facility, to a visit by a physician's assistant who comes twice a week, to two-shifts of nursing staff seven days a week, to a full medical clinic with both general and psychiatric services available 24 hours a day. Medical staff services range from consultations, to health screening, to medications review, to medications dispensing and/or distribution, to sick call, to inpatient chronic care.

Some facilities provided us with their health care budgets. From these we can see that per capita health care costs ranged from $.41 per capita to $6.60 per capita. Reported capacity was our surrogate for the patient panel that health providers often use when calculating per capita costs. We also looked at 1997 average daily population in relationship to hours that

medical staff spent in the facility. We found that these ratios ranged from a maximum of two hours a week per occupant, to the more common 30 minutes or less per occupant per week. Thirty minutes a week is not much time to screen new admissions and their medications, dispense medications, and provide sick call for each detainee who needs it.

Detention managers reported compliance on 64 percent of the health care standards and 71 percent on the mandatory health care standards.

ACA Standard 4C-01, a mandatory standard, states that the facility should have a designated health authority with a written agreement or contract. If the health authority is not a physician, final medical judgments must rest with a single designated physician.

Only two facilities reported partial compliance with this standard. One did not have a contract or inter-local agreement with their provider. The other did not have a provider. By our interpretation, this is non-compliance.

More partial compliance would have been reported if detention managers focused more on the requirement that " . . . final medical judgments must rest with a single designated physician." As noted above, most of the actual providers are nurses. There are a few physician's assistants and nurse practitioners, both of whom have more authority than nurses. Standing orders are commonplace and define what a detention worker or the health provider should do under different circumstances. Nonetheless, conversations with some health providers suggest there is little interaction between the actual provider and the designated physician. Other health providers describe a more active, ongoing interaction.

ACA Standard 4C-21 requires that health screening be comprehensive, include questions and observations, and be done by health-trained staff at intake. ACA Standard 4C-24 speaks to the collection of health appraisal data.

Sixty percent of the detention managers reported problems with health screening. We found that, in most facilities, detention staff perform a two-tiered intake screen. In the first, they decide if the youth must see a doctor before admission to detention. The second screen is used for those who do not need to see a doctor before admission or when they returned from seeing the doctor. In this second screen, detention workers collect preliminary health information, usually on a form drafted with the assistance or approval of their health provider. They typically observe and ask about current health problems, current medications and treatments, suicidal behavior, and medical history. Staff are sometimes, but not always, trained in the use of these intake health forms.

Within a few days of admission (no more than seven[13]), medical staff should collect health appraisal data. This is essentially a more detailed medical history, diagnostic tests (especially for communicable diseases), identification of problems (such as substance abuse or mental illness), and necessary treatment, whether already ordered by another physician or as now indicated. The appraisal should be sufficiently thorough so that no medical problem becomes more serious during the youth's detention. Sixty percent of the detention managers reported that their medical provider did not complete a health appraisal

[13] National Commission on Correctional Health Care, *Standards for Health Services in Juvenile Detention and Confinement Facilities*, 1992.

on all youth remaining in the facility after the first few days. We found 13 facilities that did not complete health appraisals on all youth.

ACA Standard 4C-29 refers to the provision of sick call, conducted by either a physician or other qualified medical personnel at least three times a week in facilities with more than 20 beds and once a week in facilities with fewer than 20 beds.

All but three detention managers said a physician or other qualified medical personnel provided sick call in their facility. We found four facilities where medical personnel did not come into the facility to provide sick call. In two other facilities, medical staff were on-site less often than they should have been given the facility's size. In facilities without sick call, and in small facilities between medical staff visits, detention staff take sick call requests from youths and then transport them to their private physician or to the emergency room. In some facilities, a nurse will occasionally come into a facility to treat a youth who has no caregiver.

ACA Standard 4C-08 speaks to the physician's role in assuring access and quality of care and calls for the physician to be in the facility once a week.

Half the detention managers said that a physician assessed the quality of care and came into their facility on a weekly basis. When we assumed that a physician's assistant or nurse practitioner could substitute for a physician, we found that nine facilities had weekly visits of doctors and mid-level practitioners, and four more had monthly visits from doctors or mid-level practitioners. In five facilities, a physician or mid-level practitioner came in less than once a week. In four facilities, a physician or mid-level practitioner never came into the facility.

ACA Standards 4C-18 to 4C-20 speak to proper practices regarding management, dispensing, and distribution of pharmaceuticals. Dispensing should conform to state law. Medically-trained staff operating under the supervision of the health authority and the facility administrator may distribute medication.

Medical providers talked to us about their concerns with medications management. Detention managers also shared their concerns with how medications were being managed. Both are finding more and more of the youths coming to detention are taking medication, sometimes more than one medication, sometimes psychotropic medications. A youth may have the medication when he arrives at detention, or his parents, upon hearing of the detention, may bring the medication to the facility.

No correctional facility can permit medications to be in a detainee's possession. As a result, staff hold all medications in a secure location. This raises many issues. How do detainees get their next dosage? How does the staff know if this is the correct pill or a current prescription? How do staff know when the next dose should occur? Every facility has stories of pill bottles that are out of date or filled with pills that the reference book says are not what is written on the bottle.

If the medical provider is in the building, he or she can examine the medicine, check with the juvenile's physician, and dispense the medication. (By "dispensing" we mean that they put each dosage in an individual container.) The medical provider puts the dosage

containers together awaiting distribution. If the medical provider is still in the facility when the medications are to be distributed, he or she may distribute the medication. If the medical provider is not there, trained detention staff make the distribution. The distributor watches closely to be sure the juvenile actually takes the medication. Then the distributor documents that the youth took the medication. Detention staff are not always trained in these procedures. Some facilities have assigned a supervisor to distribute the medication.

How does this work when the health provider is not in the building to dispense the medication? Some facilities will only take individual bubble packs of medications that have been prepared by the local pharmacist especially for use in detention. Some routinely call their medical provider and describe the pill over the phone. Some just take the juvenile's or parent's word and give the juvenile the pill.

Almost all facilities have some hours of the day when there is no health provider on site. During those hours, they must assess the medication, dispense it, distribute it, observe the recipient take it, and document what they did. It is easy to see how facilities with a nurse who comes only once a week may be taking on more responsibility for medication management than they feel comfortable with. Even managers in facilities with good health provider coverage talked about their concerns because detention staff sometimes must do more than just distribute medications. Some managers are doing all they can to get someone other than detention staff to distribute the medication.

As evidence of these concerns, half the detention managers reported that they were not in compliance with one or more of the three standards on medication management.

ACA Standard 4C-25 states that youths should receive dental screening, dental hygiene, dental exams and dental treatment, when health would be adversely affected in the absence of such services.

Facilities with health care usually provide for some dental screening. However, only one detention facility offers dental care that is sufficient to meet this standard.

ACA Standard 4C-39 speaks to services for screening, care, and referral for mentally ill juveniles. ACA Standard 4C-40 speaks to detoxification, 4C-41 to clinical management of chemically dependent youth, and 4C-21 to screening for alcohol and drug use.

Less than half the detention managers reported compliance with the standard on screening and care of mentally ill juveniles. We found mental health services usually included a second screening by the nurse who also checked with the doctor who prescribed psychotropic medication.

Just over half of the managers said they provided detoxification services or did not take intoxicated youth unless there was a doctor's approval. A third said that they could provide clinical management of chemically dependent youth. When we questioned them, we found that clinical management often meant that no one was toxic within hours of intake and that they provided education on alcohol and drug abuse. One facility is opening a substance abuse treatment living unit.

Compliance With Other Mandatory Standards

In the previous material, we discussed mandatory standards for health care and physical plant. There are 16 other mandatory standards that we also assessed in the site visits. Eight are specific to safety and emergency procedures: five refer to fire safety, and three refer to more general safety issues and staff response. Four other mandatory standards refer to food services and four more to sanitation and hygiene.

Compliance with mandatory safety and emergency procedures was about the same as with mandatory health care standards. Detention managers reported compliance with 71 percent of these required standards. Reported compliance was highest in the areas of fire prevention practices (90 percent) and control of flammable, toxic, and caustic materials (86 percent). Compliance was average on the standard requiring safe furnishings (71 percent), and below average for the handling of smoking materials, flammable liquids, and rags used with flammables (62 percent). The poorest compliance was on frequent fire inspections. Only 24 percent of the detention managers had a monthly inspection by a qualified fire and safety officer and a weekly fire and safety inspection by a qualified departmental staff member. We frequently recommended that facilities improve their inspection procedures.

Fire is the most common but not the only type of facility-wide emergency that detention staff may face. A disturbance is another less likely emergency, as is a hostage taking. Evacuation plans and staff training should cover all possibilities. Facilities should have a written evacuation plan, certified annually and shared with the local fire district. Seventy-one percent of the detention managers reported they have such a plan. Seventy-six percent reported that their staff are trained in the evacuation plan. Ninety percent reported that they have a means for immediate release of juveniles from locked areas and a manual backup system if power-operated locks fail.

Safety and emergency procedures are areas in which the consequences of non-compliance are apparent to all, yet three of the facilities met less than half of these mandatory standards. Only three met all the mandatory standards relating to safety and emergency procedures.

Compliance with mandatory food service standards was higher. Detention managers reported compliance with 95 percent of these standards. One reason for the high level of reported compliance is that a significant number of detention facilities do not operate their own kitchen. Facilities without their own kitchens contract with another provider, usually the jail. Their answers do not necessarily reflect compliance in the other facilities, rather the fact that it is not their problem.

All but one manager had a dietary review. All facilities provided special diets. All but one thought their food service complied with applicable sanitation and health codes. All but two complied with regulations for food service personnel. We suggested that managers of facilities without kitchens should monitor compliance in their vendor's kitchen.

Compliance with sanitation and hygiene standards was also quite high. Detention managers reported compliance with 93 percent of these mandatory standards. Reported compliance was 100 percent on standards applying to water supply and waste disposal. Only one manager questioned his compliance with federal, state, and local sanitation and

health codes. Reported compliance was lower on pest control, with only 76 percent saying they were in compliance with this standard.

Other Areas of Concern

Two other areas of concern came up during the site visits. One had to do with standard 1A-08 that states " detention facilities should not house abused, dependent or neglected children and juveniles charged with offenses that would not be crimes if committed by adults." Half the detention managers reported compliance with this standard. However, under one interpretation, no detention facility in the state can meet this standard. All hold status offenders, i.e., juveniles charged with offenses that would not be crimes if committed by adults.

At the time of the site visit, several facilities had applied to be Crisis Residential Center (CRC) providers. If successful, they would keep runaways and other non-offenders in the CRC. These managers planned to place their CRC beds in units separated from the other parts of their facility and to have separate staff providing direct supervision. The high rates paid CRC vendors, and their community's perceived need for CRC beds, were powerful motivators to make this work. Nonetheless, these facilities would clearly not comply with the standard of not housing abused, dependent or neglected children in the same facility as offenders.

In 1991, policy and procedure manuals were a major impediment to compliance. A model manual has since been adopted by many jurisdictions. Only one facility still operates without a policy and procedure manual. Several, especially those moving into new facilities, are still putting the finishing touches on their new manuals. Several believe their manuals are out of date and need revision. As a result, about 60 percent reported non-compliance on standards 1A-21 and 1A-22.

VIII. The Cost Of Compliance

Statewide estimates of the cost of compliance with ACA standards were developed for both capital and operating costs. Capital costs are one-time expenditures related to new construction. Operating costs are recurring expenditures. All estimates are in current (1998) dollars.

These costs are not incurred evenly throughout the state. Some counties have few deficiencies, others have many.

Capital Cost Issues

Many of the facilities, even some of the new ones, are crowded. Some old facilities are very crowded. In the opinion of local juvenile justice professionals, new laws have not taken into account the impact they have on juvenile detention facilities. For example, it is generally believed that changes in the Juvenile Justice Reform Act that limited parole will increase the number of probation violators confined in local facilities. The Becca Bill has also added

status offenders to the list of those who can be detained. Most counties view these changes as unfunded mandates.

It is also probable that some counties would not survive litigation regarding conditions of confinement due to crowding and/or lack of other space.

Reducing Crowding. There are different ways to look at current levels of crowding relative to ACA standards. First, ACA capacity can be compared to the average daily population. This results in a minimum definition of crowding. Another way is to look at peak populations (assumed to be about 125 percent of average daily population) and compare this to ACA capacity.

Using these two definitions, there is a statewide need for 123 to 274 additional detention beds just to reduce current levels of crowding.[14] This does not take into account future population growth nor does it try to measure the effect of booking restrictions or emergency release procedures that some jurisdictions now use to hold down crowding. In reality, current needs for juvenile detention in Washington State are likely to be higher than estimated here. Future needs will almost certainly be higher still. The state Office of Financial Management's latest population forecast (November 1998) estimates that the 10-to17-year-old population will grow by 11 percent in the next eight years.

Reasonably economical new construction for juvenile detention facilities costs about $150,000 per bed. (This is not just for cell space, but includes all the support services and infrastructure associated with the cell.) Using this figure, the cost of adding 123 to 274 beds is between $18.5 million and $41.1 million.

Adding additional capacity to reduce crowding so that no more than 20 percent of the detainee population is held in multiple occupancy cells or rooms is easier to say than do. Some facilities may only need a few additional cells. Where should they be put? Can they be put in areas where supervision is cost effective? In some cases, expansion may be logistically difficult or even impossible. These issues make the estimate very tentative. Detailed architectural review of each facility would be needed to arrive at better cost estimates.

It should be pointed out that one facility whose replacement was also recommended in 1991 still needs to be replaced in its entirety. This jurisdiction will need a facility of at least 40 beds. A new 40-bed facility would cost about $6 million.

[14] The calculated statewide ACA capacity of all detention facilities, including those currently under construction, is 1,118. The capacity of the 11 facilities that are currently crowded, based on their ACA capacity and 1997 average daily population, is 461. The capacity of the 13 facilities that are currently crowded, based on their ACA capacity and 125 percent of their averaged daily population, is 516. The 1997 ADP for the 11 facilities was 584. The 1997 peak population for the 13 facilities (1.25 times ADP) was 790. The projected current need is therefore between 123 (584 - 461 = 123) and 274 (790 - 516 = 274).

Adding Additional Program/Activity Space. Many jurisdictions lack sufficient activity space for youths while they are out of their cells. Comparing the ACA standard of 100 square feet per detainee to the current amount of activity space in juvenile detention facilities identifies a statewide deficit of between 38,000 and 62,000 square feet. The range depends on whether average daily population, or assumed peak population, is used.

The estimated cost of construction of general activity space is about $120 per square foot. Architectural and engineering fees, taxes, and contingencies would add about 45 percent more. The estimated cost of providing additional activity space is therefore between $6.6 million and $10.8 million.

As with adding cell space, adding activity space may be difficult or impossible at some sites.

Capital Cost Summary. Table 4 estimates the one-time capital costs of compliance with ACA standards.

Table 4
Estimated Capital Costs of ACA Compliance, Statewide

	Estimated Range of Costs
Reduce Current Crowding	$18,500,000 to $41,100,000
Replace One Facility	$6,000,000
Add Program/Activity Space	$6,600,000 to $10,800,000
Total	**$31,100,000 to $57,900,000**

Operating Cost Issues

Operating costs have been broken down into four areas: (1) the cost of additional staff to provide minimum cover at night, (2) the cost of raising detention workers' wages to a level equal to that of jail workers in the same county, (3) the cost of providing increased training for staff, and (4) the cost of improving detention health care.

Providing Minimum Staff Coverage. Staffing is very low in some facilities, especially at night. This situation will occur more often as more facilities become crowded. This presents a safety issue for both offenders and staff. Low staffing at night is strictly the result of efforts to keep operating costs low. Not all counties need additional staff at night.

The estimated annual additional statewide cost of providing minimum staffing on the night shift is $1,260,000.[15] This amount is over and above the expenditures that counties currently make for detention officers.

Providing Wage Parity. Providing wage parity, along with sufficient training, per ACA standards relates to staff professionalism. While many correctional officers in jails and

[15] There is an estimated statewide need for 39 more FTE detention officers to provide minimum staff coverage. The statewide average starting salary, including benefits, for detention workers is estimated to be $32,300. The total cost of adding these 39 FTE's is therefore $1,260,000 (39 x 32,300 = 1,259,700).

prisons believe that their job is more dangerous than the job performed by juvenile detention officers, the skills required of juvenile detention officers are often as great or greater than those needed in a jail or prison. Interaction between staff and juveniles is a case in point. Much more interaction is needed, and expected, in a juvenile detention facility than in most jails. While the average adult offender may be bigger and stronger, juveniles are usually much more impulsive and less able to control their emotions.

The estimated annual additional statewide cost of providing wage parity for juvenile detention officers is $1,690,000.[16] This amount is over and above the expenditures that counties currently make for detention officer salaries and benefits.

Provide Forty Hours of Annual Training for all Detention Staff. Most jurisdictions do a good job of providing initial training for new hires. Most are also able to provide some, but not all, of the recommended 40 hours of annual training after the first year of employment that is specified by ACA standards. It is estimated that, on average, most detention staff need an additional 10 to 15 hours of training per year. Based on the estimated number of detention employees plus the additional hires recommended to provide minimum staff coverage on the night shift, between 5,600 and 8,400 additional training hours are needed statewide. By far the biggest cost component of training is the cost of compensating the employee for time in training. At the statewide average rate of $13.59 for entry-level workers, the cost of training is estimated to be between $76,000 and $114,000 per year.

Improving Health Care in Facilities With Deficient Coverage. A model was constructed to estimate the cost of adding additional health care coverage to facilities that do not have enough health care staff on duty during the course of a week. Minimum coverage was assumed to provide three sick calls per week at two hours per sick call, one-and-a-half hours per week of a physician assistant's time, and one-and-a-half hours per week of a physician's time. Assumptions were set about the average hourly cost of nurses, physician assistants, and physicians. Current expenditures were subtracted from the estimated total cost of the model. The difference was totaled for all jurisdictions where current expenditures were less than the cost of the model. Many counties meet this minimum standard and are not included in this calculation.

Based on these assumptions, the estimated annual additional statewide cost of improving health care to provide these coverage levels is $200,000.[17] This amount is over and above the expenditures that counties currently make for health care.

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[16]There are an estimated 522 juvenile detention officers (not including supervisors) in the 21 detention facilities. Statewide, the average salary for a juvenile detention officer (without benefits) is estimated to be $24,853 per year. Overall, the average wage disparity between juvenile detention workers and correctional officers in county jails is 10 percent. The statewide additional cost to eliminate wage disparity is therefore $1,690,000 (522 x 32,300 x .1 = 1,686,060).

[17]Ten of the 21 facilities have less medical care than recommended. Together, these ten facilities require approximately 3,120 nursing hours, 780 physician assistant hours, and 260 physician hours each year. In addition, we estimate they need about 624 telephone consultations per year with the physician. (Not all facilities require the same coverage. Some smaller facilities need less than average, some larger ones need more than average.) Using an average cost of $45 per hour for nurses, $65 per hour for physician assistants, $120 per hour for physicians, and $22 per telephone consultation, the total cost of these services is $236,028. Collectively, these ten facilities spend $33,250 per year on medical care. The estimated deficit is, therefore, about $200,000 per year (236,028 – 33,250 = 202,778).

IX. SUMMARY OF ADDITIONAL OPERATION COSTS

Table 5 summarizes the estimated statewide annual operating cost increases to be in closer compliance with ACA standards. As noted earlier, these are statewide estimates; some jurisdictions need nothing, others need a great deal of help.

Table 5
Estimated Annual Additional Operating Costs, Statewide

	Estimated Annual Cost
Providing minimum staff coverage at night	1,260,000
Providing wage parity with jailers	1,690,000
Providing additional training to detention staff	114,000
Providing minimum health care coverage	200,000
Total	**$3,264,000**

X. WHAT SHOULD THE STATE DO ABOUT JUVENILE DETENTION STANDARDS?

Seven steps are associated with uniform standards:

1. Proposing standards;
2. Adopting standards;
3. Revising standards;
4. Assessing compliance;
5. Providing incentives for compliance or imposing sanctions for non-compliance;
6. Providing technical assistance on how to remedy non-compliance; and
7. Remedying areas of non-compliance.

For each of these functions, two basic questions are asked:

1. Who should *fund* performance of the function; and
2. Who should *perform* the function?

At present, no state or local agency funds or performs any of these functions.

In the most centralized approaches, like the one under advisement when the Corrections Standards Board was eliminated by the state, all but the remedy function is performed by a state agency, and even that might be funded by the state. It should be noted that, although most local juvenile court staff are interested in whether their detention facility is in compliance with some basic standards, they do not want the state to impose the standards.

The most laissez faire alternative turns the function over to the local jurisdictions to do as they see fit. This is essentially the way the law is now written. The few jurisdictions that actively use standards generally use the ACA standards as was done for this assessment.

Several new facilities are planning to pursue ACA accreditation in the future. The ACA Commission on Accreditation makes site visits to assess compliance. If the program is

successful, a certificate of accreditation is issued. The cost of going through this process is several thousand dollars. Every facility that seeks accreditation must spend significant time compiling a record of their compliance with each standard. The cost and the tedious accumulation of the paperwork are big impediments for many. The advantages to the program are at least two. First, it raises the professionalism of the program because essentially everyone gets involved in the details of ensuring compliance. This makes staff more aware of standards, the reasons behind them, and what one has to do to comply with them. Second, accreditation reduces liability for agencies. While an accredited agency may still be found negligent, accreditation is generally recognized as a sign of good practice.

Another alternative follows the middle ground used by the legislature with the Community Accountability Act. It also draws on current national plans for outcome-based standards. With this alternative, local jurisdictions develop outcome-based standards which the legislature then adopts. The means to achieve desired outcomes would be left up to the discretion of each jurisdiction. Self-assessment reports would be sent to the legislature, perhaps on an annual basis. If financial incentives were to be used, the legislature could reward consistently positive outcomes or provide assistance to those that need it.

If standards are not adopted, what is the legislature's liability? Perhaps it has none. If standards are adopted, everyone, including the legislature, has some added liability, not just for good faith efforts to do a good job, but to the details of the standards as well. There are fundamental questions here. Does the legislature want to become involved in a local matter where it is generally unwanted? Does it want to face the consequences for legislative action in the face of non-compliance? If the answer is no, then what is the point of periodic reviews of compliance? If there are to be reviews—such as this one—then every five years is probably a reasonable interval.

CONCLUSION

Great progress has been made in recent years to improve the conditions and operation of juvenile detention facilities in Washington State. Many new facilities have been constructed, and the overall capacity of juvenile detention has increased, thereby reducing, but not eliminating, over-crowding. New and remodeled facilities address most of the issues affecting physical conditions of confinement. Pay and training for juvenile detention workers has increased the level of professionalism of staff. Health care services have improved greatly.

Despite these improvements, more needs to be done in order to be in closer compliance with ACA standards. Facilities, even newer ones, are often crowded. Low staffing levels in some facilities, particularly at night, endanger the safety of detainees and staff. Deficits in training and disparities between the wages paid to juvenile detention workers and jail correctional officers continue to place limits on the professionalism of detention workers. Limited or infrequent health care services by licensed professionals in many jurisdictions increase the liability of detention facilities and compromise the health of detainees.

The progress that has been made over the last ten years is testimony to the fact that juvenile court administrators and detention managers are dedicated to improving conditions and operations. Among the juvenile court administrators and detention managers, however, there is little or no support for state-mandated detention standards at this time.

If statewide standards are to be developed, a lengthy process, such as that used by the Juvenile Disposition Standards Commission in the 1980s, should be used to ensure local participation and control. Outcome-based standards, with local choice over the means to achieve desired outcomes, and flexibility in the level of acceptable outcomes are recommended over traditional, static standards. Such a system could produce annual self-assessments as well as have periodic outside reviews every five years or so.

In the absence of state funding, local jurisdictions are likely to strenuously oppose statewide standards. While cost estimates are provided for making recommended improvements, until such time as consensus is reached on whether to pursue statewide standards, no recommended timetable is proposed.