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Residential treatment of emotionally disturbed adolescents

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RESIDENTIAL TREATMENT OF EMOTIONALLY

DISTURBED ADOLESCENTS

by

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INTRODUCTION

PURPOSE

This study was requested by Dr. Ira B. Korman, Administrator, Woodland Park Mental Health Center. Woodland Park Mental Health Center currently provides a program of short-term evaluation and crisis care for adolescents. The staff there find it is difficult to locate suitable out-of-home placements for certain of their adolescent patients concluding hospitalization. Their concern for this group of hard-to-place patients has led to this inquiry, the purposes of which are to (1) assess need, (2) design a residential program, and (3) consider the feasibility of its implementation.

METHOD

In order to fulfill the goal of a well-researched design for adolescent treatment services, one attuned to current environmental factors as well as the best of documented clinical knowledge about the treatment of disturbed adolescents, a multifaceted approach is required. A thorough review of the literature of the several disciplines historically involved with adolescent treatment is necessary. Of special concern is the effectiveness of various models of treatment. In

addition, other factors which may affect the outcome of residential treatment will be considered. Attention will be directed toward factors such as staffing patterns, staff role designations, administrative patterns, the location of policymaking, length of stay, the degree of interaction with the community, methods of structuring family involvement, and the use of a school program.

In order to design services to address those needs of troubled adolescents which are currently unmet in Northwest Oregon, it will be necessary to confer with the directors of existing programs to determine which services those programs offer and learn of any planned expansion. Additional contacts will be made with those agencies which are responsible for determining service gaps on a local, regional and state basis. These agencies (primarily the Mental Health Division, the Children's Services Division, and the Department of Human Resources) are in a position to monitor the changing need for service and thus occupy a vantage point from which to advise on the design of service components.

As these same agencies have the responsibility to recommend to policymaking bodies the most efficient use of scarce social service resources, the priorities for service identified by them may indicate the feasibility of implementing treatment programs which rely on any social service resources. Because of the high cost of residential treatment, it is likely that the unavailability of any social service money would severely limit the population which could be served.

The program must be designed in light of the accumulated knowledge of the professional literature, the informed assessment of service need, and the

obvious effect of the distribution of resources. Additionally, at the request of Dr. Korman, a key element in the design of the treatment program will be the collective clinical knowledge of those staff members at Woodland Park Mental Health Center who are currently working with adolescents.

CHAPTER II

THE REVIEW OF THE LITERATURE

HISTORY OF RESIDENTIAL TREATMENT

The majority of today's residential treatment facilities emerged from institutions whose original goals were the shelter, care, and training of dependent children. Maluccio and Marlow state, "Residential centers for children are a twentieth century phenomenon, stemming from Aichhorn's application of psychoanalytic concepts to work with children and youth." (1972, p. 230) Although Aichhorn's primary work, Wayward Youth, was not published until 1934, it was in 1920 that he first called attention to the planned use of the "milieu" as a therapeutic tool. Aichhorn described the milieu in terms of a psychoanalytic understanding of the individual child's needs. Other pioneers in exploring the effect of the milieu included Bruno Bettelheim, who established the Orthogenic School in Chicago, and Fritz Redl and (subsequently) David Wineman of Pioneer House in Detroit.

At the same time that child caring institutions were redefining their mission and new forms of care were evolving, psychiatric hospitals were debating the need for hospitalization for adolescents and children. A continuing debate was begun on the benefit of separating adolescent from adult patients in living unit and/or program. In 1937, Curran established the first strictly adolescent ward at

New York City's Bellevue Hospital. (Nichtern 1968, p. 115) The movement toward all-adolescent wards in treatment hospitals was slow enough that seventeen years later when Hillside Hospital established its girls' pavillion in 1954, it was still considered "one of the first." (Nichtern 1968, p. 131)

In Oregon, as late as 1965, none of the state hospitals had a program for children or adolescents. This was true even though state hospitals in Oregon had admitted seventy-two children under fifteen years of age in the fiscal year 1962-1963. (Taylor 1965, p. 79)

CHARACTERISTICS OF RESIDENTIAL TREATMENT

There appears to be no one clear definition of what a residential treatment center is or does although "residential treatment" is popular among child caring centers as a self-description. Maluccio and Marlow conclude that it could generally be defined as "a total therapeutic program for children whose emotional problems preclude treatment in the community on an outpatient basis." (1972, p. 232) They found that a residential treatment center generally included the following:

Structure or planned and controlled living.

Group living and individuation.

Identification through opportunities for significant relationships.

Child-staff interaction.

Integration and joint planning and evaluation of the child's treatment plan by all staff. (Maluccio & Marlow 1972, p. 232)

To that list Mayer would add the following characteristics to define residential treatment as he envisions it:

Treatment based on diagnosis.

Education included among the goals.

Interaction and coordination between the environment and treatment therapy.

Effective utilization of the therapeutic potential of all staff.

Provision for staff training.

Work with parents (noted as essential). (Mayer 1955, p. 667)

Adler simplifies to four the components of residential treatment. He lists these as diagnosis, a therapeutic environment, casework and psychotherapeutic services, and synthesis through ongoing communication of the various disciplines. The synthesis would include joint treatment planning and the evaluation and implementation of treatment objectives. (Adler 1968, p. 519)

In large part, residential treatment is characterized by a diversity of programs and services which have developed out of differences in history, population, purpose, and theoretical orientation. (Child Welfare League of America 1964, p. 10) One major difference, alluded to earlier in this review, has been the evolution from two separate directions, psychiatry and child care, of a treatment format called residential treatment. Psychiatric hospital care for adolescents and the program of child caring institutions have been influenced by each other and by other forces. One important factor has been sociological studies into the

residential treatment center as an institution and the effect of staff and patient interactions.

Although the boundaries between residential treatment of adolescents in psychiatric hospitals and in child care institutions are becoming less and less clear, attempts have been made to distinguish between them as providing "closed" as opposed to "open" settings. These are commonly differentiated in terms of the program provided and the criteria for admission.

According to Glickman, the "closed" setting provides a "hospital type" of treatment for children such as the schizophrenic, while the "open" setting designed for less disturbed children offers a diverse program and a "corrective emotional experience." (Taylor and Alpert 1973, p. 80-101) This statement, while making one useful suggestion for admission criteria, seems to neglect the substantial portion of adolescents who come to the attention of treatment facilities through delinquent activities and who may elope from the "diverse program" of the open setting before there is time for them to be affected by the "corrective emotional experience." There appears to be a group who needs more control than can be provided in an open setting and yet may need diverse programming and corrective experiences. Most programs seem to have a continuum of privileges, that is, various degrees of openness, to accommodate changing individual needs.

Taylor, in his 1965 report to Oregon's Mental Health Planning Board, suggested that hospitals are able to take children not suited for non-hospital

programs such as those with organic problems, the severely autistic, fire setters,

and, more generally, those needing a locked facility. (1965)

Kadushin noted the following major trends in children's institutions in

recent years:

1. Expanded use of the institution as a specialized resource rather than as an undifferentiated facility for all children needing substitute care.

2. Fewer referrals of children but of children with more severe problems.

3. The movement from custody to treatment.

4. Increased professionalization and upgrading of staff.

5. Efforts to "de-institutionalize" the institution.

6. Efforts to involve parents more actively in the program. (Kadushin 1967, p. 554)

Despite many changes in the characteristics of residential institutions,

they continue to be a major means of coping with certain societal problems, most

particularly to care for those labeled mentally ill, retarded or delinquent. (Hol-

land 1973, p. 241)

One predictable characteristic of residential treatment is that it is ex-

pensive. A 1964 study by the Child Welfare League of America found that costs

per child per year ranged from $4,403 to $17,947 for established programs. (Hyl-

ton 1964, p. 174) The average cost per child per year at ten "high quality pro-

grams" was $9,684. (Hylton 1964, p. 166) In 1973 the average yearly cost of

care was found to have increased to approximately $13,000 per child. (Taylor &

Alpert 1973, p. 2) In a major study attempting to discover why the cost of

residential treatment is so high, it was concluded that the number of professional staff in relation to the number of children in care is one of the major factors affecting the cost of residential treatment. Additionally, the cost of medically directed programs is significantly higher than those of non-medically-directed programs. (Hylton 1964, p. 187). On the other hand, the proportion of disoriented or extremely aggressive children in ten of the centers was tested in relation to cost with no significant correlation found. (Hylton 1964, p. 187)

POPULATION

One recurring issue is the question, "For whom is residential treatment appropriate?" Maluccio and Marlow find that the question is compounded by the lack of a clear definition of "emotional disturbance." (1972, p. 237) Kanner states that "[the term] emotional disturbance has been used widely, sometimes as a generality with no terminological boundaries whatever and sometimes with reference to certain psychotic or near-psychotic conditions." (1962, p. 101)

Residential treatment, then, is sometimes considered to be the appropriate treatment for emotional disturbance, but neither "residential treatment" nor "emotional disturbance" has been conclusively defined. Despite this problem, clinicians of many professions daily need to deal with the question of referral to residential treatment. As Taylor concludes,

> When serious emotional disturbance occurs in adolescence, it cannot be ignored. If he [the adolescent] attempts to solve his problems by aggressive behavior, his size and strength make it impossible for parents or teachers to

control his behavior. If he withdraws, attempts suicide, or acts out sexually, his family and community have to respond. (Taylor 1965, p. 39)

Presenting problems for youth admitted for residential care are likely to be self-injury, running away, aggressive acting-out, delinquency, and unacceptable sexual expression. (Levy 1971) Presenting problems of younger children may also include passive-aggressive behavior and hyperactivity. (Maluccio 1974, p. 229)

Linsey introduces another view of the population of residential treatment centers. He sees the mental hospital as a means of social control whose patients are there because the community has determined their behavior to be unmanageable (i.e., delinquent) or inappropriate (i.e., depressed, suicidal or annoyingly bizarre). (Lindsey 1974) Dettelback cautions that one should decide to admit a child to residential treatment only when his problems are so severe "qualitatively and quantitatively so as to preclude treatment within the family." (1955, p. 674) In Oregon, the Mental Health Division, in a study which eventually led to the establishment of several Child Study Treatment Centers throughout the state, suggested that the hospitalization of adolescents at the state hospitals was, in many cases, an arbitrary choice, caused by deviant behavior which the community feels unable to handle and "which could be treated through some active community intervention." (Oregon Mental Health Division 1969, p. 13) Even distant and arbitrary conditions, such as the overcrowding of juvenile corrections facilities, can influence placement in a state hospital. (Lindsey 1974, p. 140)

There has long been considerable concern for defining criteria for referral and placement but often these criteria are stated in vague, general terms. One common theme seems to be the need for a differential diagnosis as a basis for planning. *

General issues in admissions criteria are (1) the dynamics of family relationships, (2) the child's development history, (3) the nature and extent of symptoms, (4) the prognosis or change in the child and his parents, and (5) the availability of psychiatric outpatient or other rehabilitation facilities in the community. (Maluccio & Marlow 1972, p. 238; Levy 1971, p. 20) Lerner suggests other issues, such as the length of stay required, the age of the child and the amount of symptom tolerance in the family, school and community. (1952) D'Amato sees criteria for admission to full residential treatment in terms of the child's needs for separation, for special education, and for psychiatric treatment. He concludes that any one or two of these needs could be provided for in group homes, day centers or within the child's own family and that the child should be referred for treatment only if all three needs are present. (D'Amato 1969, p. 26) Despite concurrence of many authors on the issues involved in the decision to refer for residential treatment, Maluccio and Marlow insist that "the decision to place a child in residential treatment is presently a highly individualized matter based on a complex set of idiosyncratic factors defying categorization." (1972, p. 239)

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*This is the idea behind Oregon's established Child Study Treatment Centers and the Adolescent Study Treatment Centers to be proposed to the 1977 Legislature.

One side issue in residential treatment within psychiatric hospitals is the question of whether or not adolescents should be mixed with adults in a general treatment program, should share living units with adults but participate in an adolescent treatment program, or should be separate from adults both in living quarters and program. Gossett et al. cite a study by Beavers and Blumberg which strongly suggests that those hospitals offering a specialized adolescent treatment program had better long term results, especially for schizophrenic and character disordered patients. They conclude that this observation was supported in later studies. (1973, p. 607)

Gralnick, on the other hand, found that there were sufficient referrals to transform his hospital to an all-adolescent hospital, but held the adolescent population to 40 or 50 percent, seeing the all-adolescent hospital as an artificial climate which leads to the unmanageable behavior of the gang. (Nichtern 1968) Policy at the University of Texas Medical School Hospital reflects the conviction that the presence of adult patients among adolescents reduces tension and allows for mutual benefit. They limit the adolescent population on any ward to 70 percent of the total. (Beavers 1968, p. 10)

The importance of this issue became apparent when one considers that adolescents and young adults are being admitted to mental hospitals at rates higher than all other age groups. (Flomenhaft 1974, p. 66) In 1971 adolescents comprised 25 to 30 percent of the patient population in psychiatric hospitals. (Levy 1971, p. 18) In 1969 the N.I.M.H. predicted that the overall residential

population will decrease by 18 percent, but that the percent of those patients

who are young will increase by 90 percent. (Oregon Mental Health Division 1969,

p. 10) Other evidence that an increase in young psychiatric patients is likely is

found in the government prediction that by 1985 one-half of the United States

population will be less than twenty-one years old. (Nichtern 1968, p. vi)

PHILOSOPHY

A residential treatment setting must adhere to a coherent philosophy re-

garding the bringing up of children in general and a philosophy of treatment in

particular. (Levy 1971, p. 20; Beavers 1968, p. 11) Beavers ventures the opinion

that

> No special theoretical model of psychopathology seems to be needed to run
> a successful adolescent unit. However, it is essential that whatever treat-
> ment philosophy is used, we make its main outlines simple and clear enough
> to be transmitted [to everyone]. (1968, p. 11)

The treatment philosophy is necessary for continuity and predictability in

the living unit, and to enable all staff to be agents of the therapeutic experience

(or at least not to detract from therapy done by others). The philosophy usually

develops out of an understanding of the cause and/or cure of the pathology. Those

locating the "illness" in the resident are likely to develop a different philosophy

and to behave differently than those emphasizing a sick environment. (Stannard

1973)

Recurring issues in treatment philosophies are:

1. The cause of the disturbance (usually seen as a lack of something).

2. The goal or goals of treatment (usually an attempt to supply that which
   is/was lacking and how this might be done).

3. The desirable degree of structure and control--and acceptable methods
   for achieving and maintaining these.

4. The roles, responsibilities and decision-making power of staff members
   (and patients), particularly a concern with who is the "primary therapist"
   or a question of how members of "the team" will function together.

5. The role in treatment of the patient's family.

Maluccio and Marlow state that the prevalent form of philosophy of resi-

dential treatment has been that of "individual centered treatment." (1972, p. 235)

Before the 1960s, writers typically underscored the psychological aspects of treat-

ment. Major therapeutic objectives were the resolution of intrapsychic conflicts,

the development of insight, and the reorganization of the child's personality.

(Maluccio & Marlow 1972, p. 235)

The views of Donald Rinsley illustrate some of the ways this theory may

translate into practice. Donald Rinsley states that the great majority of adoles-

cents admitted to psychiatric hospitals are psychotic or borderline psychotic. They

are described in ego psychological terminology as symbiotic or pre-symbiotic and

the goal is defined as "reconstructive treatment" leading to lasting healthy per-

sonality change. Emphasis is not on the milieu but on the therapeutic relationship

with a psychiatrist. A three-phase course of treatment is expected to last approx-
imately three years. Staff roles are to be clearly delineated with the psychia-
trist making treatment decisions after seeking staff input. Families are to be
dealt with through casework. (Adilman 1973, p. 547)

The importance of the "environment" of residential treatment has been
recognized since Aichhorn delineated the idea of the therapeutic milieu in Way-
ward Youth. (Trieshman 1969) Bettelheim and Sylvester developed the concept
in 1948. (Maluccio & Marlow 1972, p. 234) A third primary figure is Redl.
Aichhorn, Bettelheim and Redl all had an ego-psychiatric orientation and were
concerned with how the living situation could be planned around the ego's func-
tioning for the purpose of supporting and nourishing its functioning and develop-
ment. (Trieshman 1969)

The views of Bettelheim give a clear example of how the emphasis on the
milieu blended with the theoretical stance which emphasized the psycho-dynamic
aspects of treatment. Bettelheim states that the cause of emotional disturbance
in children is emotional deprivation, particularly deprivation of a constant rela-
tionship from which to form a framework for interpersonal relationships. (Adilman
1973, p. 558) For Bettelheim, the goal of treatment is to provide this experience
through encouraging interpersonal relationships, peer group support and influence,
a formal school program, and adult protection. Rules are minimized to enable
"autonomous self-regulation." (Adilman 1973, p. 558) The main responsibility
for treatment is given to the residential staff because in order to deal

therapeutically with all types of behavior, they must have total responsibility.
.He recommends the use of young people because of their "enthusiasm, zeal and
contagious belief in human potentialities." (Adilman 1973, p. 558) Bettelheim
maintains that parents often sabotage their child's therapy and that one value of
residential treatment is that it lets the child live outside the reach of his parents.
(Adilman 1973, p. 558)

Other examples of theories emphasizing intrapsychic conflicts and person-
ality reorganization are available. Many of these are summarized succinctly in
Adelman's work. (1973, p. 554-565) Basic agreement on cause or cure does not
necessarily lead to similar approaches to control, staff role and therapeutic re-
sponsibility. This can be seen in a comparison of the philosophies of Bettelheim
and Rinsley above. One common understanding is that therapists will focus on
emotional turmoil in therapy hours while resident staff deal with behavior through-
out the day. The major theorists discussed so far have been psychiatrists who were
dealing primarily with hospital situations. A similar stance, however, is often
found within child caring institutions, in which the caseworker is considered the
"primary therapist" or "primary relationship," and the child care staff or house
parents are expected to deal with behavior.

Some have attacked the classic psychiatric diagnosis as too often self-
fulfilling. Expectations are communicated and the resultant behavior is described
as reflecting an "ego deficit," rather than as behavior appropriate to the immedi-
ate social situation. (Westmaas 1971) Staff admitting an adolescent in a state of

"ego disorganization" are seen as failing to account for the traumatizing effect of referral and admission to a facility for the emotionally disturbed. (Lindsey 1974, p. 143)

Abend et al. refute the need for long hospitalization which is assumed by many of those who seek personality reorganization. They cite the emphasis of Community Mental Health on minimizing the degree and duration of separation from the family. They also propose that significant interaction can take place with the child care personnel. (Abend et al. 1968, p. 949)

Others have also protested prolonged institutional care. Flomenhaft indicated that institutional care, especially at a distance from home, encourages chronicity. During hospitalization, the family often closes ranks against the patient and reorganizes by having other family members take over the patient's normal functions. He concludes that the longer the patient is away from home the more difficult it is to reintegrate into the family and community. (Flomenhaft 1974, p. 57)

In the early 1960s the residential treatment center was studied by social scientists who then discussed the importance of the social system which surrounds patients and staff in a treatment facility. (Maluccio & Marlow 1972, p. 233) Early examples are Stanton and Schwartz, The Mental Hospital, 1954; Goffman, Asylums, 1961; and Cummings and Cummings, Ego and Milieu, 1963. More recent commentary includes the works of Thomas Szasz and D. Laing. Significant work was done by Polsky et al. in 1962. They used sociological methods to analyze

the impact of various subsystems and subcultures of staff and residents. (Maluccio & Marlow 1972, p. 232) Levy, writing from the Children's Hospital of the Menninger Clinic, states that aside from separation from a destructive environment, what is therapeutic about the progress is "a chance to point out (confront) again and again, as it happens, the personality tendencies repeatedly expressed which are appropriate to the actual current circumstances." Patients can be made aware of their misperceptions. (Levy 1971, p. 21)

In The Other 23 Hours the authors define the goal of the milieu as "behavioral change" in the child, but do not limit the behavior to that which is observable. This change is to come through teaching, and five "teaching formats" are outlined. These include rules, routines, programming and activities, managing surface behavior, and conversations which may be general, psychotherapeutic or life-space interviews. (Trieshman et al. 1969)

Some, emphasizing the sociologically defined importance of the peer group, have tried to center treatment in the group. In Lewis's "Protreatment Group Process," the group is seen as responsible for individual behavior and when an individual acts out, the entire group is restricted until they explore their involvement in the act and find constructive alternatives. (Adilman 1973) Typically in such programs, the group determines privileges for the individual as well.

Maier has categorized treatment philosophies as:

1. Individually-centered treatment in which the one-to-one therapeutic relationship is the mainstay of the program.

2. Group-centered treatment in which treatment revolves around living,

   work or therapy groups.

3. Integrative treatment in which the child-care worker is the pivotal agent

   in a service stressing utilization of the total institution. (Maier 1965,

   p. 662)

Maluccio and Marlow conclude that the newer literature reveals a re-

conceptualization of treatment which approaches Maier's third alternative of

"integrative treatment." (1972, p. 235)

There is also a philosophy of residential treatment which maintains that

residential treatment should not exist. This theory will be explored subsequently

in the section on alternatives to residential treatment.

METHOD

Probably the primary methodological issue in residential treatment is how

to define and structure roles, responsibilities, and decision making of the staff

within the "treatment team."

The Menninger Clinic examined the functioning of their professional in-

terdisciplinary team in doing typical outpatient diagnostic evaluations. They

found that they had problems of role differentiation, leadership, and communica-

tion, and problems in relationships which they labeled "transference" and "counter-

transference." The problems of an inpatient staff, particularly when that staff is

considered a "team," are greater. Levy states, "Integrating the efforts of many

people, psychiatric as well as paramedical, into a meaningful whole is no mean

administrative task." (Levy 1971, p. 20) Browne elaborates further:

> The executive must lead his agency towards a solution of its confusion about
> roles and must help determine which are the most appropriate and effective
> ways of differentiating, defining and organizing roles in the institution; what
> alterations in conventional roles must be brought about; how the prestige at-
> tached to various roles can best be distributed; what value systems are asso-
> ciated with various roles and how role conflict develops: how various roles
> can complement each other and be integrated to provide the most effective
> therapeutic contact. (Browne 1963, p. 81)

Although it is not within the scope of this review to develop a thesis on

the cause of intrastaff tension within treatment programs, it is important to ex-

plore this issue a bit further, including at this point a discussion of two key ar-

ticles from sociology and administrative science.

An article by sociologists Fry and Miller explores the effects of using in-

terdisciplinary teams of helping or healing professionals practicing as members of

small work groups. They discovered a high degree of job tension. They cite a

1970 study by Horowitz which indicates that team effectiveness and authority

patterns arise as a result of concensus which itself derives from bargaining. They

found that professionals are not taught how to bargain about their roles and, thus,

are ill prepared to work on interdisciplinary teams. (Fry & Miller 1974, p. 417)

They also found that the individual's influence on the team is determined by the

ability to control organizational resources, and therefore, in different settings

the members of different professions will dominate. (Fry & Miller 1974)

Not only are professionals ill prepared to work together as a team (pro-

fessional identity and the assigned control of resources working against this goal),

but it is also difficult to combine professionals and bureaucracies. "From the perspective of formal organizational theory, a major contradiction has been noted in the combination of professionals and organizations structured along bureaucratic lines." (Fry & Miller 1974, p. 418) Theorists indicate that the traditional discussions of authority and hierarchical relationships in organizations are irrelevant to the professional-organizational question. (Fry & Miller 1974, p. 418)

In discussing the relationship between the treatment team and the larger organization, Horowitz sees that decision making and policy development are functions which are fundamental to the operation of the interdisciplinary team. The role of management is merely one of evaluating team performance and possibly influencing policy. The imposition of policy guidelines from outside the team is seen to impair the performance of the team and its morale. To function effectively, interdisciplinary teams must be given autonomy by the larger organization. (Fry & Miller 1974, p. 418)

The crux of the findings is this:

> Organizations which incorporate a quasibureaucratic administrative structure and also allow autonomy to accrue to professionals within the team structure are generating several potential sources of organizational strain. (Fry & Miller 1974, p. 430)

Of course, that is precisely the situation of many in-patient treatment facilities, and the problems between professional disciplines, between professionals and paraprofessionals, and between teams and the bureaucracy can be easily recognized in residential treatment settings.

A 1973 article by Holland discussed the concept of "unitization" which he describes as one proposal to improve institutional care, to decentralize decision making to lower levels in the organization closer to the clientele and those who are in direct contact with them. The goal is to increase individualization of client services. He concludes that organizational decentralization influences treatment away from an institution orientation and toward a greater individual orientation, and he recommends that decision making be further decentralized and that the role of direct care staff be emphasized in the planning of treatment plans. (Holland 1973, p. 248)

The inclusion of direct care staff in decision making is becoming more and more common. Maluccio and Marlow, citing the 1967 study <u>Child Welfare Services</u> by Kadushin and a similar study by Pappenfort and Kirkpatrick summarize,

> Although traditional treatment modalities prevail in most settings, they are increasingly being questioned . . . the trend is away from the medical model of one-to-one therapy, and the triumvirate of psychiatrist, psychologist and social worker is yielding to a team approach encompassing the total staff. (Maluccio & Marlow 1972, p. 235)

The inclusion of direct care staff (or "line" staff)in treatment teams has been to some extent influenced by sociological studies which demonstrated their substantial influence on treatment. One study by Polsky and Claster summarized the role of the child care worker in residential cottages as "pivotal." (Maluccio & Marlow 1972, p. 232)

Studies by Caudill and by Goffman demonstrated the substantial impact of nurses and orderlies in psychiatric hospitals. (Stannard 1973) This influence has

become greater with the increase of educated and energetic young people into paraprofessional roles. (Stannard 1973) Although professionals tend to minimize the influence of the line staff, the line staff commonly do not. Nurses and order-lies in Stannard's study felt they were more influential than the doctors in bring-ing about the patient's recovery. (1973, p. 145)

Works by Konopka and Schulze stressed the importance of the direct care done by group workers in children's institutions. (Maluccio & Marlow 1972, p. 234) More recently there are calls for the professionalization of the child care worker, traditionally a person without specific academic or professional training. Birnback argues for their inclusion as an integral part of the treatment team, challenging the traditional distinction between psychotherapeutic and custodial functions, and describing the child care worker as "the primary therapeutic agent." (Diggles 1970, p. 509)

The organizational problems generated by the inclusion of direct care staff onto the treatment team have been adequately explored in the literature. One problem is that there are usually more direct care staff than professionals and by instituting democratic decision making the professional group would lose power. Another problem, no doubt, rises from the huge differences in authority, prestige, job security, and salary which would tend to define professionals and direct care staff as unequal. Beavers mentions the need of all staff members for adequate income (to maintain morale), opportunity for prestige, opportunity for learning, clarity of role and praise. (1968) A third problem is that since most

direct care staff are not screened through any training process, some individuals who are unprepared for responsible decision making may fill these roles.

Some authors attributed a great many of the staffs' problems in dealing with each other and with the adolescents in treatment as "failures to communicate," via "parataxic distortions," premature and inaccurate labeling, and dealings based on "distorted personifications." (Westmaas & Westendorp 1971) It would appear, however, that there are sociologically observed organizational and even political problems not caused by poor communication but by a conflict over authority.

A reoccuring, methodological issue is that of the necessary or optimum child/staff ratio. While Hylton found that the child/staff ratio of residential treatment facilities ranged from 1:1 to 5:1 with a mean of 2:1 (1974, p. 152), Taylor recommends a 1:1 ratio. (1965) Beavers concludes that the staff ratio for a successful program with adolescents is higher than for any other type of program except perhaps an ambitious program for schizophrenics. (1968, p. 10)

Additional methodology issues in the residential treatment of adolescents are those of the extent and means of control and the components of program. Effective treatment of adolescents is considered to require effective controls (Nichtern 1968, p. 134), but the procedures by which control is obtained and purposes for which it is used vary. Beavers suggests that with adolescents the staff can err in two directions: by failing to be firm when the situation demands it (creating the anxiety of limits which are too loose); or by failing to create

"the kind of comfortable equal relationship that teaches the delight of mutual problem solving." (Beavers 1968, p. 12) Adolescent patients, especially those who act out their conflicts, place severe stresses on staff relationships. (Beavers 1968, p. 12) Many facilities have some system of assigning residents to one level of a continuum of responsibilities and privileges. (Beavers 1968, p. 11) Others use a more specific point system for the modification of behavior. (Muller 1964)

Authors generally agree on the need for programming activity for adolescents. Large blocks of uncommitted time are seen as undesirable and the need is recognized for sufficient workers to staff activities on evenings and weekends. Supplies, facilities, equipment, transportation and some financial resources are required for a good activity program. Also required is the knowledge to plan activities and recreation with potential for therapeutic benefit. Trieshman et al. (1969) urge that active programs be examined for what they give to, as well as demand of, the ego of the child. Child care workers need training on how to maximize the benefit of activities.

Provision of a school program is vital. (Beavers 1968; Gosset et al. 1973; Nichtern 1968; Maluccio 1974) Nichtern finds that most adolescents in a psychiatric hospital have a school problem of one type or another and recommends a school program which provides small classes, allows flexibility in scheduling and work assignments, and employs teachers who can work with emotionally disturbed adolescents. (1968, p. 137) Services for problem children within the public

school system are usually inadequate, but school systems typically aid in the provision of school programs within the treatment setting.

Most treatment programs provide some form of staff training. Levy maintains that extensive and continuing inservice training is necessary to create and maintain a quality treatment program. (1971, p. 20)

Finally, methods of staff communication must be designed. These typically include written notes in individual patient charts or files, oral "report" sessions at shift changes, staff meetings designed to address administrative matters, and patient-oriented "staffing" sessions. Some systems locate the most current information on patients with case managers who may have primary responsibility for that patient for the duration of his/her residence or whose responsibility may be quite brief. "Community meetings" are typically staff-resident meetings whose topics may be primarily administrative, such as planning recreation or making changes in routine, or may move into therapeutic areas as staff and residents share their feelings about the program and each other.

The Menninger Clinic is one of a small number of programs which have their written communication in "open charts" equally accessible to staff and residents. Residents can "chart on" the psychiatrist just as the psychiatrist "charts on" them. In a system like this, there is usually a small portion of "staff only" charting for especially sensitive material. (Levy 1971, p. 21) There are other ways in which the treatment process is becoming more available to the residents of the treatment facility. Because of the recent emphasis on "contracting" for

treatment, it has become more common for residents to have some part in decid-ing treatment goals and methods. Westmaas and Westendorp presented the tech-nique called "straight talk" through which they opened up the traditional "staff-ing session" to the resident being "staffed", giving the resident a participant-observer role. (1971)

THE FAMILY

Every source encountered by this author made at least passing mention of the importance of working with the families of adolescents in residence. Maluccio and Marlow concur with this finding, saying that the importance of parental in-volvement has long been stressed by many writers. (1972, p. 236) Similarly, a study for the Child Welfare League of America concludes, "Researchers feel the findings indicate that increased work with families as a unit is appropriate and is due even greater emphasis" and that from the beginning it is important to activate strengths and provide direction for family integration. (Taylor & Alpert 1973, p. 52)

The ways in which families are included vary. Some agencies prefer to work with children from intact families; some require court commitment for admis-sion to residence; others insist on parental involvement, usually through casework, group therapy, or educational groups. (Maluccio & Marlow 1972, p. 236)

Despite the concurrence of sources of the necessity for parental involve-ment, there appears to be a substantial gap between theory and practice.

Maluccio and Marlow summarize, "While the goal of parental involvement in treatment is pervasive as an ideal, the emphasis in most settings is on work with the child." (1972, p. 236) They cite as evidence for this conclusion a five-year study of Rhode Island children in residential treatment which showed that generally very little work was done with the parents either by the centers or by the referral agencies. They conclude, "Few substantive articles dealing with parents have appeared. There is need for further consideration of the role of parents and particularly the factors that interfere with their more consistent and meaningful involvement." (Maluccio & Marlow 1972, p. 236) One factor affecting parents' involvement with their children in residence is the distance parents have to travel to the treatment facility.

DISCHARGE/PLACEMENT/AFTERCARE

Discharge planning and aftercare services are among the primary problems in residential treatment. Maluccio found insufficient coordination among agencies, fragmentation of services, and inadequacy of supportive programs within the community. (1974, p. 230) The same study showed evidence that, although clear and thoughtful recommendations for aftercare services were made by the treatment institutions, there was little follow-up in the community. (Maluccio 1974, p. 233) Communities lack services. They lack the services which could have prevented the situations which require residential treatment. They lack the services which can serve as alternatives to residential treatment. They also lack the services

which can support and maximize changes made during the course of residential treatment.

One final issue deserves mention in the discussion of residential treatment method. Quality residential treatment requires adequate facilities, furnishings, equipment and supplies. The physical surroundings need to be pleasant, comfortable and durable. Superior and detailed accounts of the manner in which facility can facilitate program can be found in Maier and Kamps (undated) and Trieshman et al. (1969)

RESEARCH AND EVALUATION

Research on residential treatment is in its infancy. Practice would be qualitatively improved by clearer understanding of the effects of various forms of residential treatment. If practitioners knew how, why and for whom residential treatment "worked," they would be able to knowledgeably alter treatment programs or more discriminately admit clients for treatment. The purpose of this section is to explore what has been discovered about residential treatment and more specifically about residential treatment effectiveness.

By far the most succinct examination of research on residential treatment is presented in the 1972 literature review by Maluccio and Marlow. They found that most research in residential treatment has been descriptive research, describing specific centers or characteristics of children in residence or program components. They found little research on the process and outcome of treatment and

conclude, "Available studies represent isolated and fragmented efforts of indi-

vidual centers and reflect the lack of cumulative research in the field of child

welfare." (Maluccio & Marlow 1972, p. 240) These authors found a need to fill

the gap in research on the process of treatment and especially the factors that

produce change in children. They point out that although the works of Polsky

and other sociologists provide a lot of information about the interaction among

residents as well as between residents and staff members, there are no conclusions

about the effect (or effectiveness) of various patterns of child care. (Maluccio &

Marlow 1972, p. 241)

In summarizing their findings on the effectiveness of residential treatment,

Maluccio and Marlow state that available evaluative research consists primarily

of follow-up investigations focused on the relationships between adjustment in

residential treatment and adaptation after discharge. They continue:

> All of the available studies are descriptive, short-term and follow-up. None
> has the scope of a comprehensive or definitive work, each is concerned with
> a small number of children known to a particular center. There has been no
> longitudinal research, and there has not been any investigation encompassing
> a wide variety of treatment centers or comparing a number of programs. (1972,
> p. 241)

This criticism is echoed in the 1970 statement by the Joint Commission on

Mental Health of Children which indicates that "few residential programs evaluate

the outcome of their work in rigorously designed, well-controlled, scientifically

objective studies." (1970, p. 273)

Two primary methodological problems are those of defining and measuring

success. Success is usually viewed as the ability of the child to function

adequately after leaving the institution. (Maluccio & Marlow 1972, p. 241) This .definition overlooks the effect of post-institutional influences upon the resident, both supportive and debilitating. In a study of the Menninger Clinic, for example, it was determined that the degree of change achieved in residential treatment was not significantly related to post-discharge adaptation. (Taylor & Alpert 1973, p. 45)

The measurement of successful functioning is also problematic. No single instrument stands out as capable of locating and measuring successful functioning.

In 1973 one noteworthy study attempted to summarize the findings of long-term follow-up studies of adolescent residents of psychiatric hospitals. They found that thirteen studies had been published within the last thirty years. Six variables were found to be significantly correlated to the long-term outcome of persons who received in-patient psychiatric treatment. Three of these variables were related to patients: the severity of their psychopathology, the process-reactive nature of their psychopathology, and their intelligence. Two variables refer to the nature of hospital treatment: the presence of a specialized adolescent program, and completion of the in-hospital treatment. The final variable, which refers to aftercare, is continuation of individual psychotherapy following hospital discharge. (Gossett et al. 1973) Because methodological faults were apparent in the thirteen studies, the suggestion of new hypotheses for research may be the main value of this summary of their findings.

Another interesting study, this one by Kalman Flomenhaft, compared the effectiveness of two treatment programs at Colorado Psychiatric Hospital, one an inpatient program and the other an emergency outpatient program. Adolescents from the two groups were judged on four developmental tasks of adolescence, using the Developmental Task Inventory. No significant difference was found in outcome and it was noted that outpatient treatment was both faster by a 2:1 ratio and cheaper by an 11:1 ratio. (Flomenhaft 1974)

Another important finding may be that by Grob et al., who found that while "improvement" was reported by subjects or co-respondents in 75 percent of the cases studied, intrinsic in this was a lowering of expectations which was acknowledged by the families. (1970) The most pessimistic finding, derived from a ten-year follow-up study, was that "without question" the only therapeutic variables associated with outcome were those which described the severity of illness at the time of hospitalization. (Herrara et al. 1974, p. 773)

Generally, it would appear that the field is a long way from having a workable body of knowledge on the causes of pathology, the utility of various forms of treatment, or the methodology by which to find out. There is need for comparison studies, control groups, and the replication of studies to determine the reliability and validity of various methods. The increasing insistence of funding and regulatory sources for documentation and evaluation may be incentive for attention to research.

INNOVATIONS AND ALTERNATIVES

No literature review is complete without mention of the criticism of residential treatment and the innovations and alternatives being proposed and developed in response to those criticisms.

There are unintended consequences of institutional living. It has been described as debilitating and dehumanizing while returning few to more satisfactory levels of social functioning. (Holland 1973) Doud contends that in the hospital the patient is caught in the bind of being sick and having to admit to sickness but of not being allowed to "act" sick. (1969, p. 1745) Many persons look back on hospitalization as punitive and destructive of self-esteem. (Herrera et al. 1974, p. 773)

The decision to place a child in a residential facility often comes from the failure to provide resources for families. Resources which could be considered preventative or tertiary, are adequate income, health care, day care service, counseling, and family casework service. A more detailed presentation of this thesis can be found in William Ryan's Blaming the Victim. (1972) Ryan sees the concept of stress as the connection between poverty and mental illness. He cites the findings of Langner and Michaels, maintaining that their findings "show beyond doubt" that the more stresses a person experiences in his life, the more vulnerable he is to the development of emotional disorder. (Ryan 1972, p. 150) He continues:

Being poor is stressful. Being poor is worrisome; one is anxious about the next meal, the next dollar, the next day. Being poor is nerve-wracking, upsetting. When you're poor, it's easy to despair and its easy to lose your temper. And

all of this is because you're poor . . . Not because [your mother] broke
your bottle on your first birthday or breast-fed you until you could cut your
own steak. But because you don't have any money. (Ryan 1972, p. 150)

Kahn states, "While we don't separate children from poverty stricken

parents as a matter of public policy, we do tolerate a predictable chain of events

which has this inevitable consequence." (Kahn 1966, p.7) He cites the wide-

spread assumption that able, competent, "normal" people manage alone or obtain

family help but do not need assistance from the state. The inadequacies and im-

morality of a small number of unfortunate citizens are assumed to produce defec-

tive children in need of treatment. (Kahn 1966, p. 7)

Kahn suggests that it means little to develop qualified foster home place-

ments or residential treatment centers in communities which lack basic assistance

programs and the related family casework or child welfare services to children in

their own homes. He continues, "Otherwise poverty leads to placement, via a

well-marked pathway, and the child, by the time he reaches foster care, is often

disturbed." (Kahn 1966, p. 7)

It has been contended that the need for residential treatment of children

could often be prevented by the provision of services to families. It has also been

noted that there are often undesirable side effects of residential treatment. The

main theoretical response to this dilemma, and a part of the Community Mental

Health model of the mid-1960s, is the call for the development of a truly compre-

hensive, coordinated, and community-based network of treatment resources to meet

the varied needs of children faced with stress and experiencing emotional prob-

lems. (Maluccio & Marlow 1972, p. 232)

Two common recommendations are for a centralized diagnostic facility and

a continuum of treatment resources.

It is proposed that

More precise criteria and centralized intake for treatment centers in specific
geographical areas could reduce inappropriate or duplicate applications, al-
leviate the frustrations of both centers and referral agencies, and produce
more rapid and appropriate help for the troubled child. (Maluccio & Marlow
1972, p. 240)

Adler describes a sophisticated, comprehensive, community based child

placement service that emphasizes differential diagnosis and treatment planning

through the use of an interdisciplinary team to match each child's need and com-

munity resources. (1969) Maluccio and Marlow, however, point out that it is

difficult to make accurate diagnoses and treatment plans without strong and well-

researched theory. They state:

A frequently espoused view is that there should be differential planning for
the treatment of emotionally disturbed children . . . There is a paucity of
research as well as articulated theory in this area. . . . Particularly lacking
is comparative research into the appropriateness and effectiveness of different
types of . . . treatment. (1972, p. 239)

Kahn, too, proposes establishing centers for evaluation, referral and disposition,

but he would bias them toward keeping families together. (1966)

In Oregon this trend is evident in the Pilot Program for Emotionally Dis-

turbed Children. The goal of this program was to "identify, analyze, evaluate

and integrate the needs and resources for care of the emotionally disturbed

children in Oregon." (Oregon Mental Health Division 1969, p. 3) The documen-
tation of service need from this project led to the establishment of seven Child
Study-Treatment Centers throughout Oregon. Adolescent Study-Treatment Cen-
ters are now being proposed by the Mental Health Division. These Study-Treatment
Centers are modeled after the comprehensive community based, diagnostic center
proposed in the literature of the 1960s.

Two approaches are demonstrated in the development of treatment pro-
grams. One emphasis is on the coordinated availability of a continuum of non-
residential treatment resources in each community to minimize the need for resi-
dential treatment. The other emphasis is on the development of effective resi-
dential treatment resources which minimize the undesirable aspects of traditional
residential treatment.

Non-residential treatment includes resources such as casework services,
special school programs, day treatment centers, sheltered workshops, and out-
patient therapy. It is not within the scope of this review to discuss developments
in nonresidential care, except to mention that it is now more common for residen-
tial and nonresidential resources to interface and cooperate in the provision of
service. Residential treatment agencies, for example, may provide casework
service and family therapy for families of the residents. Psychiatric hospitals may
provide day treatment programs and outpatient therapy as alternatives to hospitali-
zation.

New forms of residential treatment are evolving. Foster care, of course, is an established alternative to the institutional care of dependent children. A new development is special foster care, which pays a salary to the foster parents to enable them to care for children full time. Group homes were originally developed as halfway houses to provide a gradual return to the community. They are now often seen as an alternative to institutional placement and as the treatment of choice for adolescents who are unable to return home. (Nichtern 1968, p. 42) Kahn, for example, favors agency-sponsored group homes or the smaller institutions with a relatively high staff-child ratio, a relatively small cottage grouping and with "live in" staff rather than a daily rotation of staff. (Kahn 1966, p. 9)

Sometimes agencies cooperate in the provision of treatment. A school district may provide educational resources to a treatment center. A hospital may contract to provide emergency backup for a treatment center without secure facilities and medical resources. (Nichtern 1968, p. 52) (In Oregon, the legislature has recently approved the establishment of a Secure Treatment Unit at Oregon State Hospital for adolescents and children. Part of their mandate is to provide residential centers across the state with backup for difficult children.) Hoffman et al. describe a model of community based group homes run by a child care agency which is affiliated with a psychiatric hospital with adolescent facilities (see appendix D). Considerable interaction of staff was expected since the adolescents were essentially clients of both institutions. Participating agencies had clear agreements

about the responsibilities of each and an advisory committee was formed to estab-

lish policy and to keep the relationship dynamic. (Hoffman et al. 1975, p. 288)

In contrast to the complex and precise model above is the La Amistad

program, described by Muller. The goal of this program is to provide a good, in-

expensive, easily duplicable, residential treatment program for severely disturbed

adolescents. (Muller 1974, p. 587) In reviewing the literature and visiting simi-

lar facilities, Muller concluded that "the most successful programs were unortho-

dox, had untrained residential staff, and were free of governmental controls" and

that "the warmest, homiest operations operated as a family and reflected the per-

sonalities of those in charge." (Muller 1974, p. 589) He bought a small house,

which was licensed, zoned, chartered, and "I.R.S. sanctioned" as a nonprofit

foundation. Development of this program was relatively simple and those in-

volved were enthusiastic about its program.

SUMMARY

In summarizing their review of the literature of residential treatment,

Maluccio and Marlow express succinctly the findings of this author:

> The field is characterized by insufficient conceptual clarity, fragmentation
> of practice theory, and limited substantive research. Available studies,
> which are largely descriptive, reveal a lack of cumulative building of knowl-
> edge and experience. Crucial questions raised decades ago relative to such
> aspects as selection of children and the effectiveness of programs remain un-
> answered. (Maluccio & Marlow 1972, p. 243)

There is evidence of evolution in the theory and practice of residential

treatment. Use of the milieu and emphasis on maximizing the treatment

effectiveness of all staff members, whatever the intra-staff pressures which result, seems to be firmly established. Emphasis on intra-psychic dynamics is waning and social learning as treatment is receiving emphasis. The importance of the present functioning of the family as a primary source of social learning is receiving greater emphasis.

There appears to be recognition that institutionalization can be regressive. The need for a continuum of treatment services and supports is commonly expressed. On the other hand, few mental health sources mention the argument of Ryan that stress from poverty causes emotional disturbance and the concern of Ryan and Kahn that the primary need is for basic services (income, housing, medical care, etc.) rather than for treatment services including preventative treatment services (parenting classes, early childhood education, teen "rap groups," etc.)

Expansion of the treatment center into a community-based comprehensive program, and experimentation with a variety of alternatives to institutionalization, appears to have support in the literature, but establishment and maintenance of such programs now depend on financial support, primarily support through federal programs.

The chapters which follow will focus on the programming options of Woodland Park Hospital in their specific context of contingencies and restraints. It is intended that this literature review aid the staff of Woodland Park Mental Health Center in their consideration of issues, values, and program alternatives.

CHAPTER III

NEED FOR SERVICE

The purpose of this chapter is to provide an overview of the need for post-hospitalization treatment facilities for Portland area adolescents experiencing mental and emotional problems. This information is not presented as a definitive need assessment, but as an overview of need as it was presented by service providers. Of importance in this chapter is the definition of the population, or populations, in need of treatment. Also important is a broad definition of the optimum treatment modality. In later chapters program options will be more fully explored and the feasibility of establishing these programs will be considered. Some of the information for this overview was obtained from personnel at Woodland Park Mental Health Center (WPMHC). In addition, interviews were held with persons who plan, administer, and provide service to disturbed adolescents within the community.

THE VIEW OF THE MENTAL HEALTH CENTER

Consensus of the WPMHC staff is that there is a serious problem with the post-hospital placement of a number of their adolescent patients. It was the problem in locating suitable aftercare which originated this study. While exact numbers of adolescents hospitalized and subsequently placed are not available,

independent estimates of WPMHC staff concur. Approximately fifteen adolescents are placed into residential treatment each month. Of these, approximately five are placed in residential situations which are inappropriate. (Wong 1976; Haley 1976) WPMHC staff outline as follows common problems in arranging aftercare:

The placement process takes too long.

Appropriate facilities have no openings for admission.

Appropriate facilities do not exist in Oregon.

Treatment recommendations requested are not followed.

These placement problems have consequences for the program at WPMHC, but more importantly, for the patients.

It appears that the delay in placement is usually a result of inavailability of appropriate treatment resources and of the time required for application and screening procedures at residential treatment programs. The delay in placing patients in post-hospital treatment when they are ready for hospital discharge slows admission into the hospital, creating a waiting list for the hospital's adolescent program.

In those cases in which appropriate treatment resources exist but have no openings for new admissions, there results either an unproductive wait in the hospital, a referral to a less than appropriate treatment resource, or an intermediate placement to await admission. Any of these courses results in some disruption of treatment in which treatment gains are diminished. The disruption may be simply a minimal irritation or may be the cause of substantial damage to the patient.

Consensus of the hospital staff appears to be that greater treatment capacity is needed in institutions and group homes providing quality treatment programs.

For certain adolescent patients there appears to be no adequate treatment resource within the state. These patients are usually placed in a less-than-appropriate treatment setting. Some are still able to adapt and grow in the placement. For others the placement essentially provides little or no treatment. Adolescents often run away from a placement for which they are not suited.

Two of the primary services provided by Woodland Park Mental Health Center are evaluation and treatment planning. When the recommended treatment plan is not followed (perhaps cannot be followed because of the treatment setting), the value of these services is lost. Of course, this is a waste of a costly service, but of greater importance is the fact that the patient suffers from the abrupt discontinuity of treatment.

The WPMHC staff was defined three populations of adolescents for whom it is particularly difficult to find a suitable placement. These populations are:

1. Those who are dangerous to themselves, others, or property.

2. Those who are experiencing severe psychotic or neurotic symptoms which require structure, external control, and/or close medical management.

3. Those who are likely to run away from any treatment setting.

The need for a "secure" treatment facility is seen as a factor in common in the programming requirements for all of these populations, but secure treatment is seen to be particularly important for the group judged to be dangerous to themselves or others. For purposes of discussion at this point, a "secure" facility may be defined

as one which is locked and in which the opportunity for violence is minimized. Placement in a secure facility does not preclude the possibility of the resident spending unsupervised time outside the facility, but doing so is subject to doctor's order, staff decision, or both.

Briefly summarized, the consensus of the staff of WPMHC appears to be that there is a need, for many of their patients, for easy access to a residential treatment program which will carry out the treatment recommendations of the hospital. There is believed to be a particular need for a secure facility to provide this service.

THE COMMUNITY VIEW

In order to accurately assess the need for residential treatment resources for adolescents, information and clinical judgment were sought from community sources. Existing and developing treatment resources within the community were explored. Emerging priorities, which can affect the feasibility of program ideas, were assessed. Interviews were conducted with the directors of several adolescent treatment programs and with representatives of the Mental Health Division, the Children's Services Division, and the Department of Human Resources. Community sources contacted are noted in the Bibliography. Finally, available need assessments and the Comprehensive Mental Health Plans of surrounding counties were consulted.

In general this inquiry supported the conclusions of the hospital staff. Community sources indicate the need for additional resources for residential treatment. (Guzie 1976; Doyle 1976). An unpublished need assessment conducted by the Multnomah County Mental Health Clinic indicated that in the year preceding, responding agencies had provided residential care for 240 clients and turned away an additional 109 applicants. (Multnomah County Local Needs Assessment of Services to Families and Children 1976, p. 6) The need for adolescent group homes was one of the two most often mentioned priorities for service. There is particular demand for secure treatment facilities, and the population defined as being in need of secure treatment appears to be essentially the same as that described by the hospital staff. The Region I Office of the Children's Services Division has been keeping extensive records of placement problems they encounter. Although the statistical computations are not complete, indications are that priority items for service are increased residential treatment capacity and, particularly, the provision of secure treatment for adolescents. (Doyle 1976)

One long awaited development is the establishment of the Secure Treatment Unit at Oregon State Hospital. This unit will provide secure treatment for fifteen adolescents from throughout the state. An additional five "crisis beds" will be used to provide emergency relief for communities and for adolescent treatment programs throughout the state. (The unit will provide equal capacity for the secure treatment of children.) Because it is anticipated that adolescents will be in residence for three to nine months or longer, none of the community sources who were

contacted expressed the opinion that this unit will meet the demand for secure

treatment resources.

The Children's Services Division has developed a description of placement

resources in the Portland area. (See appendix A.) This material indicates a gap

in treatment resources for certain groups of disturbed adolescents who are con-

sidered inappropriate referrals for any of the residential centers in the area.

(This material excludes hospitals.) Inappropriate for referral are those adolescents

who are actively psychotic, overtly homosexual, or have an I.Q. under eighty.

No indication was given in this material of the number of adolescents who are

hard to place because of these reasons. The Washington County Mental Health

Plan also placed high priority on the establishment of a group home for disturbed

adolescents with an I.Q. below normal. (Washington County Mental Health Plan

1975)

In addition to the need for greater availability of group homes, treatment

centers and secure treatment facilities, there is a small but growing demand in

the community for non-residential treatment services as an alternative for dis-

turbed adolescents. (Klesch 1976; Stern 1976; Kimmet 1976) Suggestions include

alternative school programs, more flexible out-patient programs, intensive and

comprehensive family therapy programs, and day treatment centers. Alternative

educational programs and therapy programs for adolescents and their families

both received support as priorities in the Multnomah County Needs Assessment.

(1976) The Washington County Comprehensive Mental Health Plan (1975)

indicates that the first priority for new service is more available and flexible

outpatient treatment which allows mental health personnel to respond to critical

situations and to see clients as often as is needed during crisis.

Adolescent day treatment is usually defined as a full five-day program

which includes a school and/or vocational program, therapy, and socialization

components. Day treatment is seen as a resource for post-hospital care for some

and as an alternative to hospitalization for others. The 1975 Comprehensive

Mental Health Plan for Clackamas County included, as second priority for service

to the mentally and emotionally disturbed, an expansion of their existing day

treatment program for adults. Their 1976 Plan may include a proposal for a day

treatment program for adolescents. A copy of that proposal is included as an

appendix of this study. (See appendix C.) In Oregon there are currently no day

treatment facilities for emotionally disturbed adolescents who live at home.

Oregon State Hospital does maintain an adolescent day treatment program, but

participants live in a form of group home at the hospital or on hospital wards.

An additional concern within the community is the need for accurate

evaluation for effective treatment planning. As one response to this concern, the

Mental Health Division and the Children's Services Division are submitting a

joint request to the 1976 legislature for the funding of several Adolescent Study

Treatment Centers to serve as regional diagnostic facilities. There also is ex-

pressed the need for a continuum of options for care and the need for continuity

of care. (Stern 1976; Hancock 1976; Kimmet 1976; Hoyt 1976)

SUMMARY

Hospital and community viewpoints highlight many of the same problems. The hospital's problem in locating suitable placements for adolescents in their program is matched by the community's concern that there is need for increased treatment capacity. Both hospital staff and community professionals place a priority on the need for secure treatment facilities. As the community laments the unavailability of evaluation and treatment planning, the hospital staff agonizes over evaluations and treatment plans which seem to be lost or ignored. Both hospital and community are experiencing the need for continuity of service.

Dissimilar is the growing emphasis within the community on the need for a serious non-residential alternative to hospitalization. Day treatment is being pictured as a missing resource in the needed continuum of care: a potential alternative to hospitalization for some adolescents and, for others, a post-hospitalization support to ease transition back into the community.

As Woodland Park Mental Health Center considers expanding their range of services to adolescents beyond the existing inpatient program, there appear to be four options. Services can be expanded to provide secure residential treatment, nonsecure residential treatment (including group homes), adolescent day treatment, or some combination of these. In the following chapter these options will be discussed.

CHAPTER IV

PROGRAM OPTIONS

Chapter III presented a rough overview of the need for treatment services as defined by the staff of Woodland Park Mental Health Center and by persons in the community involved with the treatment of disturbed adolescents. This chapter will focus on presenting and discussing the three treatment modalities suggested by the study of need and mentioned in discussion with service providers: (1) secure treatment, (2) non-secure residential treatment, and (3) day treatment. A model which combines two of these options will also be discussed.

In this chapter certain program components are defined as desirable or necessary for the effective treatment of disturbed adolescents. The components were so defined by a consensus of opinion expressed by WPMHC staff, community service providers, and by the literature on residential treatment. On occasion there were contradictory opinions, or components commonly judged to be required for certain adolescents, but judged to be contraindicated for others. These differences are presented and considered in the discussion which follows.

The intent of this chapter is to present a consideration of the major components of various basic treatment modalities. A discussion of program particulars (staffing patterns, admission and discharge procedures, etc.) must be derived from

more basic policy decisions on the population to be served and the basic treatment modality.

An awareness of the constraints of feasibility is commonly present among staff and community service providers. Discussion of what is needed was blended with discussion of what is possible. Primary issues of feasibility are the availability of funds for capital expenditures, the availability of funds for purchasing care, and the requirements of licensing and regulatory bodies. Circular conversations were common, typically presenting the concern that "X" form of adolescent treatment is necessary but that (a) funds are not likely to be available for required capital expenditure and that (b) the available facilities would not really accommodate the treatment format necessary to reach the population in need, and (c) there probably would be no source of funds to purchase care anyway.

To avoid circular discussions such as this one, it eventually became apparent that the most useful way to present information would be to discuss each treatment option separately in terms of its benefits and shortcomings. Both programming issues and concerns of feasibility will be addressed in the discussion of each option.

SECURE TREATMENT FACILITY

A "secure treatment facility" is commonly defined as a facility which is locked and in which the danger of violence to self or others is minimized. Medication, use of a "quiet room" or restraints may be used to control behavior.

Placement in a secure facility does not preclude the possibility of the resident

spending unsupervised time outside of the facility, but doing so is subject to doc-

tor's order, staff decision or both. Adult clients voluntarily in treatment at a

secure facility have the right to leave treatment "against medical advice," but

in Oregon, children whose parents voluntarily place them in treatment are not

legally free to leave unless they have their parents' consent. The legal rights of

juvenile patients are currently under consideration. (Moss 1976)

Benefits

1. It would provide the secure facility felt to be necessary or desirable

for certain populations.

2. There is high demand for secure treatment in the community.

3. A treatment center could provide facilities for recreation, school pro-

gram, and possible vocational training.

4. A highly developed treatment program assumes sufficient staff to carry

out specific and detailed treatment programs, and to control acting-out behavior.

5. Funding is available through Title XIX directly from the Public Wel-

fare Department if the facility is accredited as a Psychiatric facility by the Joint

Committee on the Accreditation of Hospitals (JCAH).

Shortcomings

1. Would seem to require a large capital expenditure for purchasing,

building, or remodeling to meet treatment requirements and fire and health codes

(a major problem).

2. A high daily cost of care is probable.

3. It is likely to be the kind of "total institution" which with an all adolescent population creates an "adolescent culture" with resulting problems.

4. The total environment is not needed for some of the adolescents with problems in placement, and would tend to be regressive.

5. Removal from the family and the community may stigmatize the adolescent. Re-entry (or the next placement) may be more difficult.

Discussion

A secure treatment facility would provide much of what is felt to be important to meet the need. It would provide security and extensive treatment (school, recreation, medical supervision, psychotherapy). It would not provide for the socialization needed by many, because a secure treatment facility tends to be a total institution. Funding for the cost of care seems quite likely, but capital expenditures would probably preclude the establishment of such a program unless a facility was found which required little renovation.

NON-SECURE RESIDENTIAL TREATMENT (GROUP HOME)

Two basic models of residential treatment have been suggested by WPMHC staff. The first model is the secure treatment center discussed previously. The second model, and the form most often mentioned, is the group home.

A group home for disturbed adolescents is usually located as unobtrusively as possible in a family residence. There are a small number of residents under the

supervision of resident "house parents." Houseparents are chosen on the basis of their ability to deal with adolescents. There are commonly certain "house rules" governing behavior. The degree of structure provided by these expectations, the counsel and supervision offered by the houseparents, the support of the living group, and certain casework services, are the main elements of group home treatment. Occasionally staffing patterns differ, but the group home model of treatment is essentially as explained above.

In discussion with WPMHC staff it became clear that there are consistent expectations that the group home could provide treatment components beyond the scope of the traditional group home model. Staff emphasize the importance of providing a school program and the need to follow specific treatment plans for each resident. The provision of a highly structured environment with strict day and night supervision is considered necessary and there is concern that a locked facility, a quiet room, or an alarm system may be required. That these components are seen as necessary for the hard to place population is not unexpected. It is not clear, however, how those components might be accommodated in the group home model. Because of this dilemma, the consideration of program capabilities is of particular importance in the analysis which follows.

Benefits

1. There would be a smaller capital expenditure for a facility to meet state code for group homes than for a building termed a "residential treatment facility."

2. The program could operate with only a small group of adolescents and easily expand by adding a second group home as needed.

3. A hospital-run group home may possibly be eligible for some Title XIX funds if certified by the Mental Health Division as a psychiatric facility subcontracting to one or more county mental health programs.

4. Group homes usually cost less per day than institutional care.

5. A group home provides a more "normal" situation. Residents would be in greater contact with the community and thus be less institutionalized by their experience.

6. The group home would provide more opportunities for socialization than an institution providing secure care.

Shortcomings

1. It is unlikely that a set of house parents, even with support from a teaching staff or social service staff, will be able to provide the desired level of intensive care and treatment to a group of adolescents. Other staffing patterns would be more costly.

2. Children's Services Division funding is unlikely, since CSD funds for out-of-home care are limited.

3. It is unlikely that building codes would permit a group home to be locked or have a quiet room (both of which were considered highly desirable or necessary).

4. Children's Services Division regulations require treatment of no more than eight residents in a CSD licensed facility. (More than one house may be required.)

5. A very large house would be required to provide space for school programming and other treatment such as recreation, socialization, therapy. (A school program was judged very important by WPMHC staff.)

6. Receiving CSD out of home funding would probably mean dealing with the CSD bureaucracy (red tape).

Discussion

It would be fairly easy to establish a group home. Capital expenditures would be reasonable, and finding a facility in a desirable location would probably be feasible. (WPMHC staff stress the importance of a suburban or semi-rural setting.) The cost of group home care is usually quite reasonable, and it is possible that funding might be available through CSD out of home care monies or through PWD Title XIX. It seems, however, that a group home would not provide the kind of treatment which was outlined in the section on need. It would provide neither an intensive, individualized treatment program, nor a secure facility. A group home which was more heavily staffed, perhaps staffed on shifts, would be more expensive, would lose some of the "hominess" of a group home, and would still encounter the limits of the facility.

DAY TREATMENT PROGRAM

Day treatment for adolescents usually provides a program five days per week. It includes a school and/or vocational program, therapy, socialization, recreation, and the supervision of medication as required. Participants live at home, in group homes, or independently. For further clarification of day treatment, two models are included in the appendixes of this study. (See appendixes C and D.)

It should be remembered that the idea of a day treatment facility was not suggested by the WPMHC staff. It did, however, receive sufficient support in the literature and in the community to include it among a consideration of the options.

Benefits

1. Establishment of a day treatment program would require only a reasonable expenditure for the facility and materials.

2. The day treatment program could provide an extensive and intensive program of treatment, education, socialization, recreation.

3. Elements of day treatment are fundable through Title XIX provision.

4. A teacher or teachers could be provided through the Intermediate Education District.

5. Day treatment can function as a post-hospitalization support or as an alternative to hospitalization.

6. For adolescents able to live at home, day treatment provides a serious, intensive form of treatment without displacing the adolescent from the home, stigmatizing or institutionalizing him/her.

7. The idea has support of policy makers in the Mental Health Division, which has Title XIX funds earmarked for alternatives to hospitalization.

8. Multiple living options provide some continuity of care and allow an adjustment to individual needs.

Shortcomings

1. Day treatment does not provide a place to live for adolescents who are in need of a place to live.

2. Day treatment is not secure.

3. A day program may not be sufficient intervention for some adolescents who need a twenty-four hour milieu.

4. Clackamas County may receive funding to establish adolescent day treatment for Clackamas County residents, thus reducing some of the demand in the Portland area for adolescent day treatment.

Discussion

Day treatment seems to be able to provide a rich treatment program for those adolescents who already have a place to live either at home or in a foster home or group home. It is flexible, encompassing both the need for post-hospital support and the need for an alternative to hospitalization. Its flexibility would

allow it to provide continuity of care for an adolescent moving through a continuum of living situations. The main problems with a day treatment program attempting to serve the needs of the identified population are the fact that the program does not provide a place to live or secure treatment.

A FOURTH POSSIBILITY

Somewhere in the midst of deliberations on the dilemma presented by three less-than-ideal options for a treatment model, it became apparent that there was another option not mentioned by any of the sources. This option is a combination of the day treatment program and the group home program. A combination of these two models appeared to eliminate most of the major deficits of each. In a combined day treatment-group home model, the core of therapy and education would be carried by the day treatment program which would be supplemented by residence in a hospital-affiliated group home for those in need of a therapeutic living situation. A detailed model of inter-agency provision of group-home-hospital treatment is presented by Hoffman et al. (1975) (See appendix D.) The analysis of benefits and shortcomings of the day treatment-group home model follows.

DAY TREATMENT/GROUP HOME

Benefits

1. Initial costs for facilities and materials would be moderate.

2. A combination of funding sources may be possible.

3. An extensive treatment program could be provided without removing the adolescent from community contact (resulting in less regression and stigmatization than residential treatment).

4. Options for residence without the loss of the support of the day treatment program would provide for a continuum of care within the hospital program.

5. The Day Treatment/Group Home model could function as a post-hospitalization support for some and as an alternative to hospitalization for others.

6. Woodland Park Mental Health Center could act as a "back up" when there was a need for secure treatment.

7. Although day treatment for adolescents is a very new concept in this state, some existing programs could provide models for the establishment of a day treatment/ group home program. These include: the Adolescent Treatment Program at Oregon State Hospital, JANIS, which has an alternative school program and a number of group homes, and the Psychiatric Day Treatment Program at the Child Development and Rehabilitation Center--a program for children which includes significant work with families and with schools to which the children return.

Shortcomings

1. It would not provide secure treatment.

2. There could be problems in communication and role clarity between the group home staff and the day treatment staff.

3. Sources of funding are not clear at this time.

Discussion

This program option appears to be financially feasible if funds for the cost of care can be arranged through Title XIX monies (and/or CSD out of home money). The cost to establish the program would appear to be reasonable. This model could provide an extensive treatment program, not the least of which could be the social learning of the group home experience. It would be important that the group home be utilized as part of the total treatment rather than viewed as simply a place to board adolescents when they are "not in treatment."

The main problem with this program option is that it does not provide secure treatment. It would be possible to arrange fairly close supervision and structure, but not secure treatment.

SUMMARY

Four program options have been considered in this chapter. Before it is possible to further develop a program plan, a policy decision needs to be made as to which program option to pursue. To this author, there appear to be two program options which address the needs of the identified population: (1) a secure

residential treatment institution and (2) a day treatment/group home program.

While there appears to be great demand for secure treatment, the cost to build or

remodel a facility seems prohibitive. A day treatment/group home model, while

initially appearing to be a bit unwieldy, would appear to be worthy of considera-

tion.

CHAPTER V

SUMMARY AND CONCLUSIONS

This study was requested to aid the staff of Woodland Park Mental Health

Center in exploring options for the expansion of their treatment services for ado-

lescents. In particular, this study has been addressed to the needs of adolescents

for whom it is difficult to locate adequate residential treatment resources for post-

hospital placement.

Information was gathered on (1) the need for residential treatment resources,

(2) alternative models for treatment programming, and (3) the feasibility of estab-

lishing and maintaining a residential treatment program. Sources of this informa-

tion were staff members working with adolescents at Woodland Park Mental Health

Center, a wide range of planners and providers of mental health services to ado-

lescents, and the literature on treatment.

There appear to be two populations experiencing placement problems.

Individuals in the first population are appropriate for one or more of the existing

child care centers or residential treatment facilities but experience delays while

waiting for an opening at an appropriate facility or while the admission process is

completed. If no openings occur in appropriate treatment programs they may be

placed in a less-than-appropriate program. They may experience abrupt

discontinuity of treatment if treatment plans derived from hospital evaluation are not followed.

Few treatment resources exist for the second population comprised of (1) those who are dangerous to themselves, others, or property, (2) those who are exhibiting severe and debilitating psychotic or neurotic symptons, or (3) those who are likely to run away from any treatment setting at the time of hospital discharge. A secure treatment facility is seen as necessary for optimum treatment of this second population.

Staff of Woodland Park Mental Health Center recommended or discussed two models of treatment facility. The first is the secure treatment facility, the second is a group home with extensive treatment programming. Community sources contacted by the author confirm the need for secure treatment resources and for increased group home capacity, but maintain that there also exists a need for adolescent day treatment services.

Four treatment models were considered in light of what components of treatment programming each would provide and whether it would be feasible to establish and maintain that kind of treatment facility at this time. It was concluded that two options should be given further consideration, a secure treatment facility model and a day treatment/group home model.

This study will be presented to Dr. Korman, administrator of Woodland Park Mental Health Center. It is recommended that the study then be made available to the adolescent treatment team, and that the four options be presented and

discussed at a team meeting. Out of a consensus of the team, a recommendation should be made to Dr. Korman whether to further consider the development of the treatment models presented.

SOURCES CONSULTED

SOURCES CONSULTED

Abend, Sander M.; Kachalsky, Hyman; and Harvey R. Greenberg. "Reactions of Adolescents to Short Term Hospitalization," _American Journal of Psychiatry_, July, 1968, 124 (7).

Adilman, Phillip H. "Some Concepts of Adolescent Residential Treatment," _Adolescence_, winter, 1973. 8 (32)

Adler, Jack. "General Concepts in Residential Treatment of Disturbed Children," _Child Welfare_, November, 1968.

_____. "Diagnostic Considerations in Community Planning for Residential Treatment," _Child Welfare_, June, 1968.

Ananda, Mary. Tualitin Valley Clinc, Beaverton, Oregon. Interview, 7 May 1976.

Beaver, Steven R. Woodland Park Mental Health Center, Portland, Oregon. Interview, 5 May 1976.

Beavers, W. R. "Managing Adolescent Inpatients," _Hospital and Community Psychiatry_, 1968, January, 19 (1).

Birnback, David. "The Skills of Child Care" in _The Practice of Group Work_, William Schwartz and Serapio R. Zalba, eds., New York: Columbia University Press, 1971.

Browne, Clifton T. "Some Problems of Children's Institutions in Achieving Maturity," _Child Welfare_, February, 1963.

Carey, Bill. Children's Services Division, Salem, Oregon. Interview, 19 April 1976.

Child Welfare League of America. _Standards for Services of Child Welfare Institutions_, New York: Child Welfare League of America, 1964.

Clackamas County Mental Health Program. "Comprehensive Mental Health Plan," 1975. (mimeographed)

D'Amato, Gabriel. Residential Treatment for Child Mental Health, Springfield, Illinois: Charles C. Thomas, 1969.

Dettelbach, Mirian H. "Criteria for Agency Referral of a Child to a Residential Treatment Center," American Journal of Orthopsychiatry, October, 1955.

Diggles, Mary W. "The Child Care Counselor: New Therapist in Children's Institutions," Child Welfare, November 1970.

Doud, Robert M. "The Impact of Patient-Staff Social Structure on the Treatment of Adolescent Patients in a Mental Hospital," Dissertation Abstracts International, April, 1969, 30 (5-A).

Doyle, Jo Anne. Region I Office of the Children's Services Division, Portland, Oregon. Interview, 7 May 1976.

Eggars, Karen. Oregon State Hospital Day Treatment Program, Salem, Oregon. Interview, 25 May 1976.

Flomenhaft, Kalman. "Treatment of Emotionally Disturbed Adolescents," Dissertation Abstracts International, February, 1971, 31 (8-A).

_____. "Outcome of Treatment for Adolescents," Adolescence, Spring, 1974, 9 (33).

Fry, Lincoln J. and John P. Miller. "The Impact of Interdisciplinary Teams on Organizational Relationship," Sociological Quarterly, March, 1974, 15 (3).

Garrison, Jim. Washington County Children's Services Division, Beaverton, Oregon. Interview, 10 May 1976.

Glickman, Esther. Child Placement Through Clinically Oriented Casework, New York: Columbia University Press, 1957.

Gossett, John T.; Lewis, Susan B.; Lewis, Jerry M. and Virginia A. Phillips. "Follow-up of Adolescents Treated in a Psychiatric Hospital: I. A Review of Studies," American Journal of Orthopsychiatry, July, 1973, 43 (4).

Grob, Mollie; Edinburg, Golda; Stanton, Alfred H. and Norbett Mintz. "From Psychiatric Hospital to Community: What Happens to the Adolescent Patient?" American Journal of Orthopsychiatry, 1970.

Grob, Mollie C. and Judith E. Singer. Adolescent Patients in Transition: Impact and Outcome of Psychiatric Hospitalization. New York: Behavioral Publications, 1974.

Guzie, Fran. Multnomah County Children's Services Division, Portland, Oregon. Interview, 7 April 1976.

Haley, Mike. Woodland Park Mental Health Center, Portland, Oregon. Interview, 3 March 1976.

Hancock, Guy. Albertina Kerr Children's Center, Portland, Oregon. Interview, 24 March 1976.

Herrera, Elizabeth G.; Lifson, Betty G.; Hartman, Ernest and Maida H. Solomon. "A 10 Year Follow-up of 55 Hospitalized Adolescents," American Journal of Psychiatry, July, 1974, 131 (7).

Hoffman, Lee. Parrott Creek Boy's Ranch, Oregon City, Oregon. Interview, 16 March 1976.

Hoffman, Linda R.; Lehman, Virginia and Eli D. Zer. "A Group Home-Hospital Treatment Model for Severely Disturbed Adolescents." Child Welfare, April, 1975.

Hoffman, Pat. Multnomah County Mental Health, Portland, Oregon. Interview, 8 April 1976.

Holland, T. P. "Organizational Structure and Institutional Care," Journal of Health and Social Behavior, March, 1973, 14 (3).

Hoyt, Mary. Mental Health Division, Salem, Oregon. Interview, 18 February 1976.

Hrebiniak, L. G. and J. J. Alutto. "A Comparative Organizational Study of Performance and Size Correlates in Inpatient Psychiatric Departments," Administrative Science Quarterly, March, 1973, 18 (3).

Hylton, Lydia F. The Residential Treatment Center: Children, Programs and Cost, New York: Child Welfare League of America, Inc., 1964.

Inglis, Dorothy. "Authority and Reality in Residential Treatment," Child Welfare, June, 1964.

Joint Commission on the Mental Health of Children. Crisis in Mental Health: Challenge of the 1970's. New York: Harper and Row, 1969.

Jones, Elizabeth. Woodland Park Mental Health Center, Portland, Oregon. Series of interviews, March 1976-May 1976.

Juve, Jerry. Clackamas County Mental Health Program, Oregon City, Oregon. Interview, 4 May 1976.

Kadushin, Alfred. Child Welfare Services. New York: Macmillan Co., 1967.

Kahn, Alfred J. "The Social Scene and the Planning of Services of Children," Social Work, March, 1966, 7 (3).

Kamada, Dan. Woodland Park Mental Health Center, Portland, Oregon. Interview, 1 March 1976.

Kanner, Leo. "Emotionally Disturbed Children: An Historical Review," Child Development, March, 1962.

Kimmett, Yvonne. Clackamas County Mental Health Program. Interview, 23 March 1976.

King, Robert. Secure Treatment Unit Oregon State Hospital, Salem, Oregon. Interview, 26 March 1976.

Klesch, Marilyn. Region I Office of the Mental Health Division, Portland, Oregon. Interview, 5 May 1976.

Korman, Ira. Woodland Park Mental Health Center, Portland, Oregon. Series of interviews, October 1975-May 1976.

Leonard, C. F. "What Helps Most About Hospitalization?" Comprehensive Psychiatry, April, 1973, 14 (4).

Levy, Edwin Z. "Long-term Follow up of Former Inpatients at the Children's Hospital of the Menninger Clinic," American Journal of Psychiatry, December, 1969, 125 (12).

_____. "Inpatient Treatment for Troubled Adolescents," Menninger Perspective, April, 1971, 2 (3).

Lerner, Samuel. "The Diagnostic Basis of Institutional Care for Children," Social Casework, March, 1952, 33.

Lindsey, Duncan. "Adolescent Pathways to Residential Treatment: The Enforced Expedition," Adolescence, Spring, 1974, 9 (33).

Lowther, William. Public Welfare Department, Salem, Oregon. Interview, 28 May 1976.

Maddock, Richard C. and Charles T. Kenny. "Staff and Resident Attitudes in Two Child Care Institutions Observed Respectively, as Defensive and Participative in Their Management Practices," Journal of Psychology, November, 1972, 82 (2).

Maier, Henry W. "Residential Treatment," Encyclopedia of Social Work, Harry L. Lurie, ed. New York: National Association of Social Workers, 1965.

Maier, Henry W. and Franz X. Kamps. "Consultation Report on the Proposed Marin County Residential Treatment Center," undated (mimeographed).

Maluccio, Anthony N. "Residential Treatment of Disturbed Children: A Study of Service Delivery," Child Welfare, April, 1974, 53 (4).

Maluccio, Anthony N. and Wilma D. Marlow. "Residential Treatment of Emotionally Disturbed Children: A Review of the Literature," Social Service Review, February, 1972, 46 (2).

Mancini, Richard. Clackamas County Planning Commission, Oregon City, Oregon. Interview, 30 March 1976.

Mayer, Morris L. "The Role of Residential Treatment for Children: Introduction," American Journal of Orthopsychiatry, October, 1955, 25.

McDowell, Richard L. "An Evaluation of a Residential Treatment Program for Adolescents as Measured by Post-Hospital Adjustment: A Follow-up Study," Dissertation Abstracts International, 1970, 30 (7-A).

Menninger Foundation. Disturbed Children, San Francisco: Jossey-Bass, Inc., 1969.

Moss, Alice. Clackamas County Mental Health Program, Oregon City, Oregon. Interview, 4 May 1976.

Muller, Walter J. "La Amistad: Starting an Inpatient Program for Severely Disturbed Young Adults," Hospital and Community Psychiatry, September, 1974, 25 (9).

Multnomah County Mental Health Program. "Comprehensive Mental Health Plan," 1975 (mimeographed).

Nichtern, Sol. Mental Health Services for Adolescents: Proceedings of the Second Hillside Hospital Conference, New York: Frederick A. Prager, 1968.

Oregon Mental Health Division. "Pilot Program for Emotionally Disturbed Children," February, 1969 (mimeographed).

Russel, Lucille. Children's Services Division, Salem, Oregon. Interview, 28 May 1976.

Ryan, William. Blaming the Victim, New York: Vintage Books, 1971.

Silva, Jean. Multnomah County Department of Human Resources, Portland, Oregon. Interview, 8 April 1976.

Smith, Mike. JANIS Program, Portland, Oregon. Interview, 5 April 1976.

Stannard, D. L. "Ideological Conflict on a Psychiatric Ward," Psychiatry, May, 1973, 36 (2).

Stern, Tom. Mental Health Division, Salem, Oregon. Interview, 27 April 1976.

Sutherland, John. Woodland Park Mental Health Center, Portland, Oregon. Series of interviews, October 1975-May 1976.

Taylor, Delores A. and Stuart W. Alpert. Continuity and Support Following Residential Treatment, New York: Child Welfare League of America, 1973.

Taylor, Eugene. "Needed Services for Severely Emotionally Disturbed Children in Oregon: A Report to the Mental Health Planning Board," 1965 (mimeographed).

Trieshman, Albert E.; Whittaker, James K. and Larry K. Brendtro. The Other 23 Hours, Chicago: Aldine Publishing Company, 1969.

Van Scoy, Holly C. and Karen J. Bordelon. "Patient's Perceptions of the Residential Treatment Staff: Revisited," Adolescence, Summer, 1974.

Washington County Mental Health Program. "Comprehensive Mental Health Plan," 1975 (mimeographed).

Weiner, Irving B. Psychological Disturbance in Adolescence, New York: Wiley and Sons, 1970.

Westmaas, R. and F. Westendorp. "Straight Talk: An Approach to Team Treatment on an Adolescent Unit," Adolescence, Winter, 1971, 6 (24).

Wilkes, J. R. "Involving Parents in Children's Treatment," Canada's Mental Health, January-February, 1970 (18).

Wilson, Phil. Adolescent Treatment Program, Dammasch State Hospital, Wilsonville, Oregon. Interview, 19 March 1976.

Wong, Dennis. Woodland Park Mental Health Center, Portland, Oregon. Interview, 4 February 1976.

Woodland Park Mental Health Center. "Social Organization and Adjustment Program for Children and Adolescents," 1976 (mimeographed).

APPENDIX A

PURCHASE OF CARE PLACEMENTS THROUGH

CHILDREN'S SERVICES DIVISION

STATE OF OREGON   INTEROFFICE MEMO

TO   Branch Managers,   DATE: December 10, 1975
        Supervisors, Caseworkers
        CSD Region I

FROM   Linda Hogan, Supervisor
        Liaison Unit, Resource Branch

SUBJECT: PURCHASE OF CARE PLACEMENTS

Caseworkers in my unit carry liaison assignments to 13 private agencies and 8 child
care center programs. The programs are described below. This memo will outline
placement resources available through my unit, referral procedures, and liaison
responsibilities once the child is in care.

I. Description of Resources

    1. Albertina Kerr Homes (Louise-Tucker Cottage)
        722 N.E. 162nd Avenue
        Portland, Oregon 97232
        233-5247

        Population Served:
        Louise Home: 45 delinquent or emotionally disturbed girls 13-18,
        plus an aftercare group home for 4 girls. Common behavioral problems
        at time of referral include run away, out of control, school difficulties,
        shoplift, drug or alcohol abuse, promiscuity.

        Tucker-Cottage: 7 severely emotionally disturbed boys, ages 10-13.
        Common behavioral problems at time of referral include truancy,
        adjudicated delinquency, chronic runaway, inability to form relationships.
        Specialized Foster Care: 13 children who were released to Albertina Kerr
        for adoption but are unadoptable because of physical or emotional handi-
        caps. These children are supervised and cared for by Albertina Kerr
        foster parents and staff. We do not refer CSD children to this program.

        Inappropriate Referrals:
        Louise Home: I.Q. under 80, actively psychotic, homicidal, overtly
        homosexual

        Tucker: I.Q. under 90

        School:
        Both programs use Wynne Watts, a residential school located on the
        campus. Wynne Watts available to others on a limited basis.

        Program Components:

        Louise: Residential treatment center for 45 girls who live in three
        dorms of 15 each. Treatment model is mileau therapy. Family therapy is
        offered if appropriate, utilizing multiple impact therapy. Average length
        of stay is 12 - 14 months. Louise operates one group home for aftercare.
        Purchase of care monthly payment is $849.43 per child.

        Tucker: A locked, structured cottage for 8 boys who cannot be treated
        in an open setting. Treatment model is token economy, behavior modification.
        Average length of stay is 1½ years. Purchase of care monthly cost is
        $1,953.22 per child.

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Referral Process:
Send 147 to Resource Branch. Discuss the referral with the CSD Liaison
Worker. If the referral is appropriate, a social summary including any
psychological and psychiatric data available should be sent to Louise
with a copy to the liaison worker. Tucker referrals should be addressed
to Julie Plekan.

2. Boys and Girls Aid Society of Oregon
   2301 N.W. Glisan Street
   Portland, Oregon 97210
   222-9661

Population Served:
32 children 0-18 in need of specialized foster care. Pregnant women of
any age may also be referred within the 32 slots. Referrals must be child-
ren who would require special rate foster payments if placed in CSD foster
homes for example, children with severe physical or emotional problems
or retarded children. Pregnant women in need of out-of-home care
and counseling may also be referred.

Inappropriate Referrals:
Children who cannot be maintained in foster or group home placements.

School:
Boys and Girls Aid has a small residential school at their headquarters
which is used primarily for their pregnant clients.

Program Components:
Boys and Girls Aid social workers provide casework services to foster
family homes and individual counseling to children in care. About
half of Boys and Girls Aid population are children who were released
at birth to the agency but were unadoptable and are growing up in
long-term foster care. Length of stay for children referred by CSD
varies according to the case plan. Purchase of care monthly cost
is approximately $632.88 per child.

Referral Process:
Discuss the referral with the CSD Liaison Worker. If the referral is
appropriate, send a social summary to the agency with a copy to the
liaison worker.

3. Catholic Services for Children
   700 Loyalty Building
   317 S.W. Alder Street
   Portland, Oregon 97204
   228-6531

Catholic Services operates a specialized foster care program and three
child care center programs.

Specialized Foster Care:

Population Served:
45 children 0-18 in need of specialized foster care. Referrals must be

children who would require special rate foster payments if placed
in a CSD foster home; for example, children with severe physical or
emotional problems or retarded children.

Inappropriate Referrals:
Children who cannot be maintained in foster or group home placements.

School:
Children must attend public school.

Program Components:
Catholic Services social workers provide casework services to foster
family homes and individual counseling to children in care. About
1/3 of Catholic Services population are children who were released
at birth to the agency but were un-adoptable and are growing up
in long-term foster care. Length of stay of children referred by
CSD varies according to case plan. Purchase of care monthly cost
is $510.88 per child.

Referral Process:
After discussing the referral with the CSD Liaison Worker, a social
summary needs to be sent to Orv Garrison at Catholic Services.

Child Care Center Program:

Carroll House
3725 S.E. 80th
Portland, Oregon

Multnomah Boys Center
451 N.W. 1st
Gresham, Oregon

Seeghers House
9225 N.W. Leahy
Portland, Oregon

Population Served:
Carroll House: 10 delinquent or emotionally disturbed boys 11-18; age
for new referrals 11-16. Common behavioral problems at time of referral
include runaway, out of control, school problems including truancy,
adjudicated delinquency.
Multnomah Boys Center: 10 delinquent or emotionally disturbed
girls, ages 11-18; age for new referrals 12-16. Common behavioral
problems at time of referral include runaway, out of control, truancy,
minor delinquency.
Seeghers House: Temporarily closed while reprogramming to serve
11-18-year-old slow boys with behavioral problems. Should be
operational in February or March, 1976.

Inappropriate Referrals:
Carroll House: I.Q. under 80, actively psychotic, dangerously
assaultive or violent, overtly homosexual, cannot be maintained
in public school.

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Multnomah Boys Center: I.Q. under 80, actively psychotic, dangerously
assaultive or violent, overtly homosexual, cannot be maintained in
public school.

School:
Must be able to attend public school.

Program Components:
Carroll House and Multnomah Boys Center are community based programs
with a house parent model. Individual and group treatment are offered.
Both programs have a system of increasing privileges and responsibility
by levels. Both work with families when parents are a resource. Average
length of stay is 9-12 months. Purchase of care monthly cost is $741.61
per child.

Referral Process:
Discuss referral with the CSD Liaison person to determine if
Catholic Services is the most appropriate placement. The liaison
worker will then either arrange an intake staffing or place the
147 on the child care center waiting list until a vacancy occurs.
Child care center staffings are generally held at the facility
and attended by Catholic Services staff, the child and his family,
the referring caseworker, and the liaison worker. A social summary
needs to be sent to the Catholic Services at the time of the intake
staffing with a copy of the referral letter sent to the CSD Liaison Worker.

4. Christie School
Marylhurst, Oregon 97036
635-3416

Population Served:

35 emotionally disturbed girls, 9-16, 9-13 at time of referral.
Typically not beyond 8th grade at time of referral. Common behavioral
problems at the time of referral include: lying, stealing, disruptive
behavior in school and home, truancy, sexual activity, runaway,
learning problems.

Inappropriate Referrals:

I.Q. under 80, actively psychotic, homicidal or dangerously assaultive,
suicidal, runaway when very "streetwise", inability to relate when
in the upper limit of age range.

School:

A residential school is located on the campus. Some girls go out
daily to public school.

Program Components:

Residential treatment program for 35 girls who live in two large
living units housing 6 girls in each of 6 wings. Treatment model is
mileau therapy. Individual and group counseling is offered. Christie

social workers work with families when appropriate. Average length
of stay is 1½ - 2 years. Christie also operates one group home.
Purchase of care monthly cost is $968.38 per child.

Referral Process:

Discuss the referral with the CSD Liaison Worker. If the referral is
appropriate, send a social summary using the Christie referral informa-
tion outline attached. Send a copy of the referral to the liaison
worker.

5. Children's Farm Home
   4455 N.E. Highway 20
   Corvallis, Oregon 97330
   752-5105

Population Served:

39 boys and 10 girls, ages 12-18, who are emotionally disturbed or de-
linquent. Common behavioral problems at the time of referral include
runaway, out of control, school problems including truancy, adjudicated
delinquency, impulsivity, isolation, drug or alcohol abuse.

Inappropriate Referrals:

I.Q. under 85, actively psychotic, homicidal, overtly homosexual,
sexually acting out girls.

School:

Residential school located on the campus staffed by Corvallia School
System.

Program Components:

Residential treatment program located out of Corvallis. Co-ed program
consists of 3 living units of boys of 12-15 each and 1 for girls with
maximum of 10. Treatment model is mileau therapy with individual
and group counseling available. Average length of stay is 1½ to 2
years. The Farm Home operates a boys' group home for aftercare.
Purchase of care monthly cost is $882.98.

Referral Process:

Discuss the referral with the CSD Liaison Worker. If the referral is
appropriate, send a social summary using the Farm Home referral information
outline attached. Send a copy of the referral to the liaison worker.

6. Edgefield Lodge
   Route 2, Box 61
   Troutdale, Oregon 97060
   665-0157

Population Served:

Residential: 14 emotionally disturbed children 6-10 who reside at

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Edgefield Lodge 5 days per week and in the community on weekends.
Common behavioral problems at the time of referral include lying,
stealing, bed wettings, disruptive behavior in school and home.

Day Treatment: 28 emotionally disturbed children, ages 6-10, whose
behavior causes problems in public school and in their homes.

Out Patient: 35 emotionally disturbed children of any age.
Both the parents or foster parents and the child must be able to use
the child management and parenting skills offered by Edgefield staff.

Inappropriate Referrals:

I.Q. under 80, actively psychotic, children who do not have workable
families or a foster family resource. For the outpatient program,
children must have stronger ties to their families than to their peer
group.

School:

Residential school is available on Edgefield's campus for children in the
day treatment and residential programs. The school emphasizes behavior
modification - token economy techniques.

Program Components:

Edgefield offers intensive treatment for emotionally disturbed children
and their families utilizing a sophisticated behavior modification
and token economy system. School and residential living programs
are closely coordinated. There is a major emphasis on providing
parenting and child management skills to parents or foster parents
prior to the child's graduation and on providing follow-up service
after graduation. Average length of stay is 9-12 months for
residential and day treatment and 3-6 months for out patient.
Purchase of care monthly cost per child is $574.01 out patient,
$971.73 day treatment, and $2,001.11 residential.

Referral Process:

After discussing the referral with the CSD Liaison Worker, the caseworker
must have the parents or foster parents call the Intake Department
at Edgefield directly. Edgefield is the only agency which does
their own extended intake directly with the client. They may not
request a social summary from CSD in all cases.

7. The Inn Home
    3033 N.E. Bryce
    Portland, Oregon
    282-1545

    Population Served:

    Seven boys between the ages of 12-17, age at time of referral 12-16.
    Common behavioral problems at the time of referral include runaway,

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out of control, school problems including truancy, adjudicated
delinquency.

Inappropriate Referrals:

Actively psychotic, dangerously assaultive or violent, overtly homo-
sexual, cannot be maintained in public school, fire setters, and
I.Q. under 80.

School:

Must be able to attend public school or alternate school. Boys attend
Grant or Adams High School, Alameda Grade School and Open Meadows.

Program Components:

The Inn is a community based program with a combination live-in
and shift staffing model. Individual and group treatment are offered.
The treatment model is eclectic with emphasis on a behavior modification
point system for privileges and individual contracts to work on
identified problems. Counselors work with families when parents
are a resource. Average length of stay is 1 year to 15 months.
Purchase of care monthly cost is $780.80.

Referral Process:

Discuss referral with the CSD Liaison person to determine if
the Inn is the most appropriate placement. The liaison worker
will then either arrange an intake staffing or place the 147 on
the child care center waiting list until a vacancy occurs. Child
care center staffings are generally held at the Inn and attended
by Inn staff, the child and his family, the referring caseworker
and the liaison worker. A social summary needs to be sent to the
Inn by the time of the intake staffing with a copy of the referral
letter sent to the CSD Liaison worker.

8. Parry Center for Children
    3415 S.E. Powell Boulevard
    Portland, Oregon 97202
    234-9591

    Population Served:

    48 seriously emotionally disturbed children, ages 6-17; age at time of
    the referral 6-10. Common problems at time of referral include disruptive
    behavior at home and school, lying, stealing, bed wetting, serious
    symptoms of emotional disturbance such as soiling, hiding food, open
    masturbation, cruelty and violence. Autistic and psychotic children
    are appropriate referrals.

    Inappropriate Referrals:

    I.Q. under 80, inability to relate in older children. Will consider
    lower I.Q. if it appears to be functional rather than organic.

School:

Residential school on campus. Some children go out daily to public school.

Program Components:

Children live in units of no more than 10 each. Treatment model is mileau therapy. Individual and group therapy are available. Parry Center works with families when appropriate. Average length of stay varies according to the treatment plan but is usually around 2-4 years, which is longer than at most other agencies. Parry Center operates two group homes for children able to leave the institution. Purchase of care monthly payment is $1,306.32 per child.

Referral Process:

Discuss the referral with the CSD Liaison worker. If the referral is appropriate, send a detailed social summary including psychological or psychiatric data to Parry Center with a copy to the liaison worker. See attachment for referral information guide.

9. Providence Child Care Center
    830 N.E. 47th Avenue
    Portland, Oregon 97213
    234-9991

Population Served:

52 physically and/or mentally handicapped non-ambulatory children who require skilled nursing care. Children at Providence commonly have serious medical problems such as congenital deformities, hydrocephalus, microcephaly, and/or severe retardation. Many are terminally ill. Providence is the only specialized children's nursing home facility in the state.

Inappropriate Referral:

Children who are ambulatory, who do not have a diagnosis which necessitates skilled or semi-skilled nursing home care and who are larger in size than will fit into a 60" crib.

School:

The majority of the children are not educable. I.E.D. places children in education programs when the children are able to use such programs.

Program Components:

Children reside in 3 wings at the facility. A very good physical therapy unit is available. The program offers skilled and semi-skilled nursing home care, social work services, and physicians' services. The Providence social worker works with families and plans after care in conjunction with CSD. Purchase of care monthly cost is funded

81

3 ways: (1) $20.64 per day is paid by P.W.D. (2) If eligible,
S.S.I. pays $25.00 per month for personal incidentals. (3) CSD
pays $20.20 per month fee Social Services and $10.54 per month
for personal incidentals for children not eligible for S.S.I.

Referral Process:

After discussing the referral with the CSD Liaison worker, call
Mrs. Carroll at Providence. Referrals must include medical documentation
of the need for nursing home care and a social summary. Send a
copy of the written referral to the liaison worker.

10. St. Mary's Home for Boys
16535 S.W. Tualitan Valley Highway
Beaverton, Oregon 97005
649-5686

Population Served:

42 delinquent boys or emotionally disturbed boys 9-15 years old.
Common behavioral problems at the time of referral include run
away, out of control, severe school problems including truancy,
disruptive behavior, poor impulse control, adjudicated delinquency.

Inappropriate Referrals:

I.Q. under 80, actively psychotic, dangerously assaultive or violent,
overtly homosexual, history of fire setting.

School:

St. Mary's has a residential school on campus which uses a behavior
modification token economy system and is closely coordinated with
the overall program. Some boys go out to public school on a daily basis.

Program Components:

St. Mary's is a residential treatment center with two large cottage
living units for 20-25 boys each. The primary treatment modality is a
behavior modification token economy system which is tied in to a levels
system. Work with parents is available on a very limited basis and only
when the parents are willing to come to St. Mary's for counseling. Average
length of stay is 1-2 years. Purchase of care monthly cost is $852.17
per child.

Referral Process:

Discuss the referral with the CSD liaison worker. Send a social
summary to St. Mary's with a copy to the liaison worker, using
the St. Mary's referral outline (See attachment). Note that
St. Mary's requires a WISC with subtest scores and detailed school
information.

11. Villa St. Rose
    597 North Dekum Street
    Portland, Oregon 97217
    285-3030

    Population Served:

    47 delinquent or emotionally disturbed girls 13-18. Common behavior
    problems at the time of referral include runaway, out of control,
    poor impulse control, school difficulties, shoplifting, alcohol or
    drug abuse, promiscuity, hostile or defiant attitude toward authority.

    Inappropriate Referral:

    I.Q. under 85, actively psychotic, homicidal, overtly homosexual.

    School:

    Villa operates a residential school on campus.

    Program Components:

    Villa operates a structured residential treatment program utilizing
    mileau therapy. Girls reside in two large living units. Both
    individual and group counseling are available with a heavy emphasis
    on therapeutic group work. Family therapy is offered if the parents
    are a resource. Villa operates a group house for aftercare.
    Average length of stay is 1-2 years.

    Referral Process:

    Discuss the referral with the CSD liaison worker. If the referral is
    appropriate, send a complete social summary,using the attached outline,
    to the agency,with a copy to the liaison worker.

12. Volunteers of America:
    538 S.E. Ash Street
    Portland, Oregon 97214
    235-8655

    Emergency housing and counseling for mothers and children who are
    homeless or in crisis. Funding is jointly through Children's Services
    Division and Public Welfare Division. Referrals may be by Public
    Welfare Division, Children's Services Division, or self-referrals
    by clients. Please telephone referrals directly to the facility.
    The CSD liaison person need only be involved if there are questions
    or concerns about the placement.

    Volunteers of America Shelter Evaluation Center is a separate program.
    For referrals or information, call Judy Fretta.

13. Waverly Children's Home
    3550 S.E. Woodward
    Portland, Oregon 97202
    234-7532

Population Served:

58 children in three programs: trainable mentally retarded, emotionally disturbed, and shelter care.

Trainable Mentally Retarded: 10 children, 8 or under, who function in the trainable range of retardation (50-55 I.Q. and below). Waverly provides 24-hour residential care for children who need to develope self-help skills such as dressing, feeding and toileting and who are unable to live in the community.

Emotionally Disturbed: 30 boys and girls, boys ages 4-12, girls ages 4-8. Common problems at the time of referral include lying, stealing, bed wetting, disruptive behavior in school and home, and runaway, out of control for boys 9-12.

Shelter Care: Emergency housing and casework services for children removed from their own homes by law enforcement. The liaison unit is not involved with the shelter care component of Waverly's program.

Inappropriate Referrals:

Trainable Mentally Retarded: I.Q. in educable range, non-ambulatory or seriously physically disabled child.

Emotionally Disturbed: Actively psychotic, seriously assaultive or violent, history of arson.

School:

Waverly operates a residential school on campus and some children also go out to public school daily.

Program Components:

Trainable Mentally Retarded: Residential care for children unable to live in the community. Program focus is on teaching self-help skills such as toileting, dressing and feeding.

Emotionally Disturbed: Children live in two units, one coed and one boys' unit. Treatment model is mileau therapy. Individual counseling is available. Average length of stay is 1 year to 2 years. Purchase of care monthly cost is $850.04 per child.

Referral Process:

Discuss referral with CSD Liaison person. If referral is appropriate, send social summary following outline attached. Send copy of referral to CSD liaison person.

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14. Salvation Army White Shield Home
    2640 N.W. Alexandra
    Portland, Oregon 97210
    226-4053

Population Served:

20 unwed mothers and 15 mothers and children. Maternity services
are provided irregardless of age but residents in both programs tend
to be 12-18. Pregnant women referred tend to need confidential maternity
care, help in making decisions to keep or release their baby, and a
structured residential living situation. The Infant Maternal Program
for mothers and babies serves mothers who are immature, need to
develop parenting skills, are in a vocational or school program
and have babies 0-36 months.

Inappropriate Referrals:
Prenatal: Pregnant women who are psychotic, have an I.Q. under 80
and are dangerously assaultive or violent.
Infant Maternal Program: Mothers who are psychotic, have an I.Q.
under 80 and are dangerously assaultive or violent; mothers who
cannot tolerate group living and who will not attend school or
vocational training.

School:

There is a residential school on campus.

Program Components:

White Shield offers traditional residential maternity counseling
and care. There is a hospital and a school for pregnant women on
campus. The prenatal girls live on the top floor of the residential
building; the mothers and children live on the bottom floor. The
I.M.P. Program offers residential care for young or immature mothers
who feel unable or unready to live in the community with their
infants. Mothers attend school or vocational training until they
are economically ready to live on their own. A day care center
on campus serves children 0-3. Mothers receive supervision and
training in parenting skills as well as individual and group
counseling. Average length of stay is until delivery in the
prenatal program and 6 months in the I.M.P. Program.

Referral Process:

Discuss referral with CSD liaison worker. If referral is appropriate,
send a written referral to White Shield using the referral format
attached with a copy to the worker. Please note that parents need
to sign consent for placement and medical authorization for pregnant
girls under 18.

15. Youth Adventures, Inc.
    P.O. Box 770
    Oregon City, Oregon 97045
    656-7081

Population Served:

Girls' Program: 18 girls, 14-18, 14-17 at time of referral.
Common behavioral problems at the time of referral include:
runaway, out of control, poor impulse control, school problems
including truancy, minor delinquency, promiscuity, drug or alcohol
abuse.

Boys' Program: 12 boys, 14-18, 14-17 at time of referral. Common
behavioral problems at the time of referral are the same as for the
girls' program except that adjudicated major delinquency, such as car
theft, is more common.

Inappropriate Referrals:

I.Q. under 85, actively psychotic, dangerously assaultive or
violent, overtly homosexual, cannot be maintained in public school;
and adolescents who are not motivated, cannot identify personal
problems to work on, and will not contract to give up sex and drugs
and alcohol.

School:

Children must attend high school, usually Oregon City High School.

Program Components:

Youth Adventures operates a co-ed program with adolescents living
in three girls' group homes and one boys' residence at the main
lodge on the Clackamas River. Youth Adventures utilizes a house-
parent staffing model. Individual and group treatment are offered.
There is a heavy emphasis on transactional analysis and gestalt
techniques. Individual contracts with adolescents are used frequently
and as adolescents progress through the program they may be assigned
junior counselor responsibilities with new residents. A group home
in Milwaukie is used for after care for 5 girls. Some work with
families is done but most adolescents at Youth Adventures are emancipated
or go into alternate care rather than returning to their families.
Average length of stay is 1 to 2 years. Purchase of care monthly
payment is $838.75 per child.

Referral Process:

Discuss referral with the CSD liaison person to determine if Youth
Adventures is the most appropriate placement. The liaison worker
will then either arrange an intake staffing or place the 147
on the child care center waiting list until a vacancy occurs.
Staffings are held at Youth Adventures and attended by Youth Adventures
staff members, the adolescent and his family, the referring caseworker
and the CSD liaison worker. By the time of the intake staffing,

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a social summary needs to be sent to Youth Adventures with a copy
to the liaison worker.

16. Youth for Christ
604 N.E. 20th Avenue
Portland, Oregon 97232
234-9776

Population Served:

Girls' Program: 9 girls, 12-18, 12-16 at age of referral. Common
behavior problems at time of referral include runaway, out of control,
poor impulse control, school problems including truancy, minor
delinquency.

Boys' Program: 13 boys 11-18, 12-16 at time of referral. Common
behavior problems at time of referral are the same as for the girls'
program except that adjudicated major delinquency, such as car theft,
is more common.

Youth for Christ Shelter Evaluation Center is a separate program.
For referrals or information, call Judy Fretta.

Inappropriate Referrals:

I.Q. under 80, actively psychotic, dangerously assaultive or
violent, overtly homosexual, cannot be maintained in public school.

School:

Must be able to attend public school. Girls attend Corbett High School
and boys attend Welches Grade School or Sandy High School.

Program Components:

Youth for Christ operates two child care centers: one for girls,
near Corbett; one for boys, on the Salmon River at Wemme. Both
programs utilize a combination live-in houseparent and shift coverage
model. Individual and group treatments are offered. Both programs
have a system of increasing privileges and responsibility by levels.
Both work with families when parents are a resource. Average length
of stay is 9-12 months. Purchase of care monthly cost is $743.29
per child.

Referral Process:

Discuss referral with the CSD liaison person to determine if Youth
for Christ is the most appropriate placement. The liaison worker
will then either arrange an intake staffing or place the 147 on
the child care center waiting list until a vacancy occurs. Child
care center staffing are usually held at the Resource Branch and
attended by Youth for Christ staff, the child, the referring case-
worker, and the liaison worker. By the time of the intake staffing,
a social summary needs to be sent to the Youth for Christ, with a
copy to the liaison worker.

APPENDIX B

SUBCONTRACTING FOR TITLE XIX PAYMENTS

THROUGH THE MENTAL HEALTH DIVISION

MENTAL HEALTH DIVISION

DATE: November 25, 1975

TO: Community Mental Health Programs
Subcontract Agencies

FROM: Pat Krieger
Medicaid Consultant

SUBJECT: Subcontracting for Title XIX Payments

Attached are the completed guidelines for implementation of Title XIX in a subcontract agency. The need for this kind of information came out of our September Title XIX workshop.

It is important to remember that these are only guidelines and not rules. The process may work somewhat differently in your county, and for this reason you may want to make some modifications.

If you have any questions, please feel free to call me at 378-2161.

tkm
Attachment

COMMUNITY PROGRAM RESPONSIBILITIES

I. Determine if proposed program meets identified need in the county plan.

II. Determine whether program is a duplication of services existing within the Community Mental Health Program.

   A. Does it serve a different population?
   B. Is it needed in a different geographic area?

III. Determine if the proposed program adds to comprehensive mental health system.

   A. Is it a needed new service?
   B. Does it meet a population need not served?
   C. Does it have a high utilization by a target population?

IV. Request Title XIX information booklet from Medicaid Office if you do not already have one. 378-2161

V. Look at the proposed program budget and fiscal design to determine if:

   A. Local match money (40.96% of billings) is available. Match money is defined as local or State dollars used to claim Federal financial participation in the cost of providing services to eligible Welfare recipients. If Federal dollars, such as revenue sharing or CETA funds, go through the county, they may be considered local funds. (See ORS 430.655) The match money is sometimes called "front money" and is sent back to Public Welfare, who uses it to claim the Federal dollars.

   B. The proposed program has the capacity to:

      1. Keep necessary accounting of all funds.
      2. Do necessary billing.

   C. The Community Mental Health Program will be making a financial contribution to the program through grant-in-aid.

Community Program Responsibilities
Page 2

    D. The funding mechanisms for Title XIX are clearly understood.

        1. If there are no mental health state dollars in the program, the Subcontractor keeps the 59.04% of the billings and is responsible for sending in the front money each month.

        2. If there is a grant-in-aid contribution, you need to know what percent it is to the proposed program's total budget. That percentage will be deducted from the 59.04% Federal share. The mechanism used is for the Mental Health Division to deduct the amount from grant-in-aid, and therefore you'll have to deduct from monthly payments to the Subcontractor, or bill for the amount on a monthly basis.

VI. Use Title XIX information packet from Medicaid Office and determine if the proposed program:

    A. Is operationally sound - capable management system.
    B. Meets appropriate standards (Mental Health Division and Community Mental Health Program).
    C. Can meet Title XIX requirements as outlined in the Administrative Rule and Mental Health Division-Public Welfare agreement.
    D. Has an adequate record-keeping system? If not consultation may be provided in this area by Medicaid Office and Mental Health Division staff.

VII. If program meets above criteria, a contract and utilization review plan should be developed. A model is available in the Medicaid booklet.

VIII. Bring in the Medicaid Office and Community Mental Health Specialist for consultation as needed.

IX. Amend county plan and include proposed program in umbrella contract.

X. Contract, signed by county and Subcontractor, should be submitted to the appropriate Community Specialist, who will secure approval from appropriate Assistant Administrator.

Community Program Responsibilities
Page 3

XI.   Once contract is approved and standards are met, you may ask your
Community Mental Health Specialist to request a vendor number from
the Medicaid Office.

XII.   Supply application for "letter of approval" according to Administrative
Rule 12.010.

XIII.   Monitor contract with ongoing consultation from Mental Health Division
Regional Office and Medicaid Office as needed and requested.

XIV.   The Medicaid Office may be used as liaison with Public Welfare to help
you resolve issues as they arise, if you feel it is necessary.

RESPONSIBILITIES OF SUBCONTRACTORS

I. Survey client population for Welfare eligibles or potential eligibles.
    Look at Welfare case number. Programs 1, 2, 3, 4, 65, 82, and 92, are
    some of the programs eligible. Only program 5 is not eligible. If you
    have clients on SSI or whose eligibility is unclear, please refer them
    to your local Welfare office for determination. If your survey shows a
    significant number of eligible clients ...

II. Telephone Tricia Mortell, Medicaid Office, 378-2161, requesting Title XIX
    information packet.

III. Contact your Community Mental Health Program Director to see if subcon-
     tracting is a possibility.

IV. Once the Title XIX information packet is received, determine if require-
    ments can be met.

    A. Administrative Rule

        1. If you plan to bill for a socialization program, does your
            program meet the definition?
        2. Fire and health codes can be met?
        3. Medical prescription or medical supervision? (See page 6 of the
            Administrative Rule)

    B. Mental Health Division - Public Welfare Division Agreement

        1. Does your program now provide a service outlined in the agree-
            ment, or can it provide such a service by making slight program
            improvements?

    C. Funding Relationships

        1. If there is no mental health State dollar participation, you
            need 40.96% match money (local money) to be used to claim the
            Federal financial participation. A monthly check for 40.96%
            of the billings, must be sent into the Mental Health Division.
            CETA or revenue sharing funds may be considered match, if they
            go through the county system.

Responsibilities of Subcontractors
Page 2

2. If the Mental Health Division is financially contributing, we
   must recover State percent of the total program costs from the
   Federal share. We do this by deducting from county grant-in-
   aid payment.

3. A sliding fee schedule, for non-Title XIX patients, must be
   developed. You may not bill Public Welfare more than you would
   bill a private patient, however, you may develop a sliding
   fee schedule based on client's income.

4. The Title XIX fee schedule for billing Welfare is a part of
   the information packet. You will need to use this to esti-
   mate your Title XIX income as well as for billing.

D. Is the service you wish to bill Medicaid for already identified in
   another contract you may have with CSD, VRD? You may not bill two
   agencies for the same service to the same client.

E. Is local match money available? Is it clearly identified?

V. Contact Community Mental Health Program Director. He needs:

A. Assurance that your program provides needed service to identified
   population.
B. Budget.
C. Program description.
D. Assurance Medicaid rules can be met.
E. Narrative supplement to county plan.

VI. Once Community Mental Health Program Director has agreed on your
    program, he may:

A. Bring in a Community Mental Health Specialist and the Medicaid
   Office to help in:

1. Contract development - see example in Medicaid booklet.
   The contract needs to be signed by county and Subcontractor.

2. Record-keeping system development.

   a. Contact sheet to provide documentation of service for
      billing.

Responsibilities of Subcontractors
Page 3

b. Treatment plan.
 1. Goals
 2. Progress towards meeting goals

c. See problem-oriented record samples, in Medicaid booklet,
 (these are only examples, you may develop your own forms
 if you wish).

3. Development of a utilization review plan. Send a copy to the
 Medicaid Office.

VII. Request "letter of approval" from Mental Health Division, according to
MHD Administrative Rule 12.010. Discuss with your Community Mental
Health Program Director.

VIII. When contract has been signed and approved by the Division, (Regional
Assistant Administrators) and Community Mental Health Specialists are
assured program meets minimum program standards and all Title XIX re-
quirements, a vendor number will be requested. The process is through
the appropriate Community Mental Health Specialist to the Medicaid
Office, who in turn requests the number from Public Welfare.

IX. Once your vendor number has been received, request 501-A billing forms
from your local Public Welfare branch office. Tricia Mortell is
available for consultation on billings. (378-2161)

X. Send billing forms directly to Public Welfare State Office for payment.

Public Welfare Division
Fiscal Section
Public Service Building
Salem, Oregon 97310

Responsibilities of Subcontractors
Page 4

XI. If there is no State mental health participation in your program, send a check (40.96% of billings), and a copy of the billings to:

Donalee Muir
Administrative Services
Mental Health Division
2570 Center Street, NE
Salem, Oregon 97310

If the State is making a financial contribution, 40.96% match money plus a percentage of Federal share equal to State's participation in your total program will be deducted from your grant-in-aid or "alternatives" funds. Determine this deduction so you will be certain of the amount of Federal dollars recovered for every billing.

XII. You are responsible to the Community Mental Health Program Director who will monitor and provide supervision for your program.

XIII. You need to work out any financial arrangements with the Community Mental Health Program. If there are State mental health dollars in your program, he'll need to deduct from your monthly check, or to collect through billing.

XIV. You may expect a site visit re: your request for a "letter of approval" from the Mental Health Division. Appropriate notification of time of site visit will be arranged.

RESPONSIBILITIES OF REGIONAL OFFICE

I.. Discuss proposed new program with Mental Health Division Program Office to insure it meets minimum standards set forth by the Division.

II. Has it been made a part of the county plan?

III. Help in budget development as needed.

IV. Provide help in contract development as needed.

V. At request of Community Mental Health Program Director, act as liaison between Subcontract, Community Program, and the Mental Health Division.

VI. Secure Title XIX consultation as needed.

VII. Make sure all Title XIX requirements are met.

VIII. Is budget proper, and is match money clearly identified?

IX. Secure contract approval from Regional Assistant Administrator.

X. Receive request for "letter of approval" for service element; arrange with Program Office to comply with Administrative Rule 12.010.

Responsibilities of Regional Office
Page 2

XI. Once contract is signed and all Title XIX requirements have been met,
     request Medicaid Office (in writing) to ask PWD for a vendor number.

XII. Provide ongoing support, take part in utilization review as needed.

RESPONSIBILITIES OF MEDICAID OFFICE

I. Keep Regional and Program Offices informed of contacts with Community Programs and potential Subcontractors

II. Provide informational materials to Subcontractors and Community Programs on request.

III. Provide consultation as needed in following areas:

   A. Budget-funding relationship
   B. Utilization review
   C. Record-keeping
   D. Title XIX requirements
   E. Billing instructions
   F. Contract information

IV. Make sure all conditions of Administrative Rule and Mental Health Division - Public Welfare Division requirements have been met.

V. Once Community Mental Health Specialist has informed Medicaid Office that all requirements have been met and the contract has been approved by the Division, the Medicaid Office will send a memo to the State Public Welfare Division requesting issuance of a vendor number.

VI. Do an onsite visit, after notifying and working with Community Mental Health Program Director, Community Mental Health Specialist, and agency regarding time of onsite.

VII. Monitor billings.

VIII. Keep utilization review plan on file. Continue consultation on utilization review and records.

Responsibilities of Medicaid Office
Page 2

IX. Supply MHD, Business Services, with necessary financial information
regarding vendor numbers and percentage of recovery.

X. Provide ongoing support and relay any new information on Title XIX
to ommunity rograms and ubcontractors.

XI. Liaison to Public Welfare Division regarding issues relative to the
subcontracting process or billing problems.

PROGRAM OFFICE RESPONSIBILITIES

I. Set minimum program standards.

II. Establish evaluation and review procedures.

III. May take part in initial development of programs.

IV. Receive and act on application for "letter of approval" for service element. Comply with Administrative Rule 12.010 regarding onsite visit report and issuance of letter.

APPENDIX C

PROPOSED DAY TREATMENT PROGRAM

FOR CLACKAMAS COUNTY

PROPOSED DAY TREATMENT PROGRAM FOR ADOLESCENTS

The following is a proposal for an adoloscent day treatment program for residents of Clackamas County. This program would be administered through the Clackamas County Mental Health Clinic in full cooperation with, and with staff participation from the following Clackamas County Human Resources agencies: Children's Services Division, The Intermediate Education District, The Juvenile Court and Parrott Creek Boy's Ranch.

Section I   PROGRAM OVERVIEW

One of the major reasons for consideration at this time of a Day
Treatment Program for the adolescent is an awareness of the lack of re-
sources providing the intensity of service needed. Existing programs are
designed to provide service for youngsters who need residential treatment
or for those who can respond to treatment in a traditional outpatient
setting of a less intensive and extensive nature. There is an absence of
resources for a large population of adolescents for whom existing programs
are inadequate and who could respond to a program which is designed to bridge
the gap between outpatient and residential care.

The purpose of a Day Treatment Program would be to reach the adolescent
and his family as early as possible before the labeling process has occurred
and prior to involvement with the Juvenile Court, suspension from school or
serious deterioration of the family situation. It is anticipated that this
program would be a community-based and community-supported resource with staff
and support coming from all agencies within the human resources network in
Clackamas County. Primary overall goal of this program would be to alter
dysfunctional behavior patterns in both the child and family in such a way
to allow them to return to the community with tools and resources to function
without the intensive support of the program. Supportive followup services
would be offered by the agencies in the community..

Target population

The primary target population for this project would be adolescents
(age 14 - 18, both sexes) with a high probability for residential placement
or for serious delinquent behavior without intensive therapeutic interven-

tion. In addition, this program would be open to those youngsters in a transitional phase, returning to the community from residential programs, such as Dammasch State Hospital, Parrott Creek Boy's Ranch, Youth Adventures, etc. Two groups not appropriate for this program would be the actively psychotic youngster and/or the truly drug addicted youngster. This would not screen out drug users or youngsters whose problems include drug abuse.

Referrals to this type of program would come primarily from the Public Schools, but also from such agencies as Children's Services Division, Juvenile Court, Mental Health Clinic and the Public Schools as well as the numerous residential programs in the area. Referrals are also anticipated from such sources as ministers in the community and individual families themselves. Special priority will be given to adolescents from larger families with younger siblings who are in the elementary schools.

Treatment philosophy

The program is designed to include 10 - 12 adolescents and their families for a period of three months. (This approach would allow 40 - 48 adolescents and their families to be served each year.) The rationale for this approach comes from research findings which show that an intensive program of shorter length has more impact than a long-term, less intensive treatment program. Research also demonstrates that the most significant changes in family patterns occur during the initial period of counseling.

As a community we are committed to a philosophy of working with families. We believe the family unit is the key to individual growth and nurturance. The multiple impact approach proposed here has been shown to be effective in working with the family, who has an adolescent who has been excluded from the community, or whose exclusion is imminent. While this program has a variety of treatment approaches; they are unified in their adherence to the growth model.

"The growth model is based on the notions that people's behavior

changes through process and that the process is represented
by transactions with other people. Illness is believed to
be an appropriate communicative response to a dysfunctional
system or context. It is therefore believed that illness
goes away when the individual is removed from the maladap-
tive system or the system is changed to permit healthy
responses and communication. Growth occurs when the system
permits it."

Our commitment is to a multi-faceted approach designed to impact on the
family to promote growth in the individuals and to make changes in the
family to promote growth in the individuals and to make changes in the
family system which will allow the family to serve its nurturing role. In
keeping with this philosophy, emphasis will be placed on treatment at adolescents
from families with younger siblings. This intervention would provide a strong
preventative component, as well as an ameliorative component.

Goals and objectives

Goals for this program may be stated in three major areas: Overall
goals for the project; goals for the individual youngster in the program, and
goals for the family.

A major project goal may be stated in terms of reduction of inappropriate
referrals and placements in residential and other treatment programs in the
community. The screening aspect of this program would result in appropriate
referrals and a more efficient use of existing community resources. A second
goal would be to provide followup consultation for the adolescent family in the
community resource providing service to the family. This consultation would
insure continuation of the growth process begun during involvement with the pro-
gram. A third goal would be to provide a transitional resource to the community
for those adolescents leaving residential care. A fourth important goal of this
project is to continue the interagency cooperation and involvement in identifying
community needs and working toward efficient utilization of community resources.

There are three primary goals for the adolescent involved in the program. The first, a significant reduction in antisocial behavior which would alter the individual's identity to an identity which has legitimacy within the community. Second, an improvement in social adjustment as reflected in peer and family relationships. Third, an improvement in self-image as measured by discrepancy scores on scales of personal adjustment.

Goals for the family would include a development of problem-solving techniques to be used within the family structure; improved communication between family members; greater parental understanding of adolescent behavior; and a better family self-image through improved self-image of all family members. A related goal would be one of prevention of similar problems experienced by the identified adolescent from developing with younger siblings in the family.

Section II   PROGRAM DESCRIPTION AND IMPLEMENTATION

The Day Treatment Program would consist of two basic commitments:
1. a program designed specifically to facilitate the development of a more
functional behavior pattern in the adolescent and 2. a strong emphasis on
therapeutic intervention with the family.

Screening and evaluation for admission

The screening procedures following referral would include obtaining a social
history and a psychological summary of each child. The social history should
include the complete summary of family interactions, identifying significant
family members and their present relationships to the youngster. School progress
and behavior would be appraised. This would include information from the
referring school, in cooperation with the IED. This would insure that the
educational component of the program would be met for the adolescent and the
school

The adolescent's primary family (own or foster family) must be willing to have
intensive involvement with the program and be amendable to change in the family
structure. Upon referral, the case will be reviewed by an impact team composed of
staff from the Day Treatment Program, a representative from the referring school,
and from agencies within the community. This will include an intensive inter-
view with the family for the purpose of evaluation and planning. Following this
the case would be staffed with recommendations being provided for the intervention
with the adolescent and his family. Recommendations might include referral to the
Day Treatment Program, referral to other existing community resources, a referral
to a residential program, whichever might be deemed more appropriate by the screen-
ing staff.

Program components

As a result of screening and evaluation, one or more of the components of
the direct treatment program and the educational and vocational program will
be included in the individual plan designed for each adolescent and his

family.

A. Direct treatment

The adolescent program will include intensive group experience and may include individual counseling sessions, as indicated. The educational and vocational aspects of the program will involve an individually designed combination of the following:

1) attending a local high school

2) a mini-course program

3) tutorial program - students teaching students

4) adolescents teaching in local grade schools

5) community college involvement

6) neighborhood youth corps.

In addition to the treatment plan developed for the adolescent there would be a variety of treatment modalities available for the parents and family, most of which would be conducted during evening hours to facilitate full participation of all appropriate family members. These would include Family Counseling, Parent's Groups, Parenting classes and Marital Counseling.

The Family Counseling, Parents Groups and Marital Counseling would be staffed by members of the cooperating agencies and would include at least one member of the individual family's impact team. The Parenting Class would be taught by a member of the Mental Health Clinic who has had past experience in teaching such classes and would be aimed at broadening parents' understanding of adolescent behavior and teaching effective techniques for dealing with both desirable and undesirable behavior.

3. Educational - Vocational activity

Cooperation and coordination with local public schools is considered essential to the educational-vocational activities of this project. Clackamas County IED has agreed to coordinate the communications with cooperating schools

in arranging credits, curriculum, tutors and other activities utilizing school facilities or staff members. A school consultant will be a member of the staff and will be available for consultation with the referring school.

Credits will be offered for academic accomplishments particularly in the skills areas of reading, math, English, history. Courses necessitating equipment, tools or materials will be arranged through the public schools. Students will acquire credits for social and personal development and communication skills based on their intensive involvement in group, individual and peer counseling sessions. Credits will also be available for efforts in career development or training. Placements will be sought in part or full time jobs and in vocational courses in public schools and the community college. Community cooperation will be sought for training placements sufficiently diverse to provide growth experiences for all students.

Under the supervision of one teacher who is extremely proficient in interpersonal communication and counseling, the concept and techniques of "children teaching children" will be fundamental to the educational program. It has been found that learning takes place at a much accelerated rate when students are involved in the teaching process. While tutors learn and retain the material more rapidly, and completely, the students also learn more rapidly when taught by peers rather than "adult" teachers. While this concept is used by some schools on a limited basis, and usually reserved for "good" students, it is completely practicable as a fundamental educational philosophy. Benefits range far beyond simple skill building into role exploration, communication and interpersonal relationships, and self-concepts and worth. Students from the project and from the public schools will be offered credits and/or salaries for tutoring time.

On first entering the program, each person will determine the subject areas in which he is deficient and needs remediation, as well as areas of interest and motivation. When needed, standardized tests are available through Clackamas County IED. Initial educational efforts will be to bring the

deficient areas up to a survival level, after which individual interests
will determine curriculum.

Initial contacts with local school district administrators and
counseling departments have indicated strong support, particularly in that
most schools have been frustrated in serving, even in coping with, the
population identified in this project. While direct referrals will initi-
ally be quite limited in number, project results and effects, expertise and
consultation will be welcomed by public school personnel. Communication and
interaction between schools and human resource agencies can definitely
benefit by the processes involved in this project.

Evaluation

A. The individual and family:

At the end of the three month involvement in the Adolescent Day
Treatment Program an evaluation of progress will be made and recommendations
concerning the followup program. Optional recommendations might include con-
tinued involvement in the Day Treatment Profram, referral to a community
resource, or termination / followup by the Day Treatment consultation staff.
It is possible that a recommendation for residential care might follow a
period of time in the Day Treatment Program. Criteria for evaluation will be
relevant to the individual and may differ with each individual. In dealing
with adolescent and family with critical adjustment problems, it is impossible
to set a specific standard as a success criteria. Movement toward more positive
attitudes and behaviors within the family and within the community will be the
anticipated direction and can be measured progressively as the program is
carried out. Followup procedures after the family is terminated from the
program will be made and success of program will be measured to some degree

by the stability of the changes which occur.

B. The program

Evaluation of the program is regarded as essential in order to find areas of success and areas on which the program could be improved. Therefore, in addition to a valuation recommendation concerning the adolescent and his family, an evaluation of the program itself will occur at the end of each three month period. This will be accomplished by allowing for a two week break between the three month term before each group is begun. The program evaluation will be conducted by an outside organization (such as the Teaching Research Program at OCE) contracted for this purpose.

Staffing

The Adolescent Day Treatment Program staff would be comprised of the following positions: Director, Counselor-Teacher, Counselor, a community school consultant, organization worker for volunteer coordination and liaison with the lay community, a graduate student in field placement, undergraduate students and volunteers and secretary. The agencies involved in the project would also make staff members available for the family therapy, parents' groups and marital therapy.

The director and counselor would be mental health professionals, such as a psychiatric social worker or a clinical psychologist with extensive training and experience in working both with groups and with adolescents. The Counsenior-Teacher would be a certified teacher with special proficiency in communication skills and interpersonal behavior. Experience in counseling adolescents would be required. The director, counselor and counselor-teacher would be responsible for the functioning of the program as well as the supervision and training of the remaining staff. A more detailed outline of proposed staff may be found in the section dealing with the budget.

Appendix A: PROPOSED BUDGET

Position	Rate	Annual Salary
Director	1192 x 6, 1252 x 6	14,664
Counselor	845 x 6, 888 x 6	10,398
Counselor-Teacher	845 x 6, 888 x 6	10,398
Community Organization Worker	662 x 6, 695 x 6	8,142
Clerk/Stenographer	$\frac{1}{2}$ x 492 x 6, $\frac{1}{2}$ x 517 x 6	3,027
School Consultant	845 x 6, 888 x 6	10,398
		57,027
Payroll Costs	20%	11,405.40

Item	Annual Cost
Psychological Consultation	2,500
Psychiatric Consultation	2,500
Rent and Utilities	3,600
Telephone	240
Janitorial Service	480
Transportation	1,500
Inservice training	750
Equipment and Supplies	300
Food	3,000
Research and Evaluation	3,000
	17,870
	57,027
	11,405.40
TOTAL	86,302.40

In Kind Services Provided by Cooperating Agencies (Based on an annual salary of
$ 15,000)

1.	Therapists - parents groups (8 hours per week)	3,000
2.	Parenting class (2 hours per week)	750
3.	Marital Therapy (4 hours per week)	1,500
4.	Impact team (Equivalent of 1 full time staff)	15,000
5.	Supervisors - Students and Volunteers (4 hours -week)	1,500
6.	Planning and coordination (2 hours per week)	750
		$ 22,500

In addition:

Office space.

Office equipment and supplies.

Supplemental secretarial help.

Inservice training.

To be provided by cooperating agencies. An actual cost estimate is impossible
to determine at this time.

STATISTICS

Table I   Shelter Care - Clackamas County C.S.D.

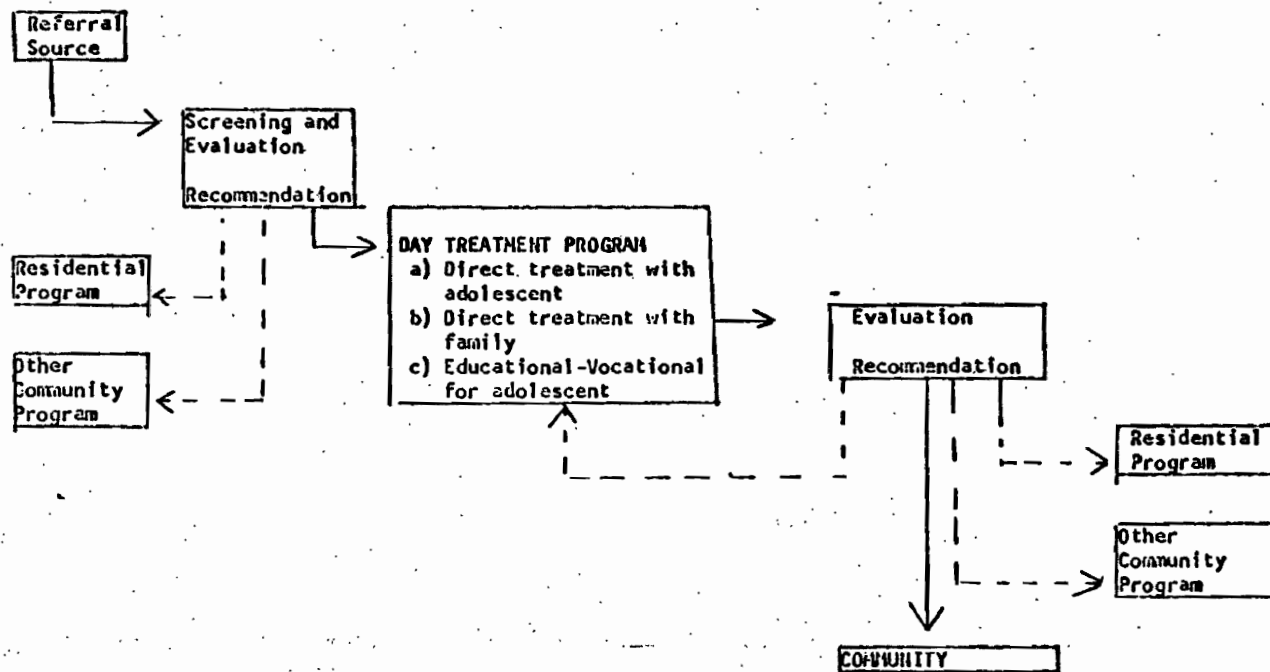| YEAR	Number of Children in Shelter Care
1970	118
1971	181
1972	243
Jan. - June 1973	237

a) Average length of stay in shelter care (1973) 10.7 days.

b) 73% of youngsters remaining in shelter care over 7 days.

were in the 13 - 18 year old age range (1973).

c) 77% of youngsters in shelter care were in the 13 - 18 year old range (1973).

Table II   Foster care - Clackamas County C.S.D.

Month	CSD Payment	No CSD Payment	Institutions
July '72	204	4	57
Aug '72	289	3	73
Sept. '72	333	9	66
Oct. '72	392	9	68
Nov. '72	421	12	76
Dec. '72	420	17	75
Jan. '73	408	11	79
Feb. '73	391	12	93
Mar. '73	391	32	104
Apr. '73	391	18	115
May '73	364	30	97
June '73	338	18	99
TOTAL	4342	175	1002

There were 144 new adolescent (13 - 18) cases opened at the Clackamas County
Mental Health Clinic during the period between July 1, 1972 and June 30, 1973

ADOLESCENT DAY TREATMENT FLOW CHART

SOURCES OF INPUT FOR ADOLESCENT DAY TREATMENT PROGRAM

PROGRAM COMPONENTS

1. DIRECT TREATMENT

2. EDUCATIONAL-VOCATIONAL

3. "BIG BROTHER"

4. SCREENING AND EVALUATION

5. Training

6. PROGRAM DEVELOPMENT
   AND EVALUATION

SOURCES OF INPUT

SOURCE	PROGRAM COMPONENTS
Mental Health Clinic	1, 4, 5 and 6
Childrens Services Division	1, 4, 5 and 6
I.E.D.	2, 5 and 6
Schools	2
Juvenile Court	1, 4 and 6
Parrott Creek	1, 4, 5 and 6
P.S.U. Graduate and Undergraduate Students	1, 2 and 3
Volunteers	1, 2 and 3

The Adolescent Day Treatment Program Staff will be responsible for coordinating and 6 components and be directly involved with their implementation.

TRAINING

It is anticipated that the proposed program will provide a vehicle which graduate students from the school of social work and counseling psychology Department at Portland State could receive practicum experience. Such students would be required to spend 3 terms, at least 2 days a week, in the program. This would assure some continuity of staffing during the time the adolescents were in the program. Undergraduate students, upper division level in behavior sciences could also be involved in a companion "big brother" program with some of the adolescents, as indicated by need. This would give the program a dual role, both providing direct services to emotionally disturbed youngsters and their families and supplying some much needed practicum experience for students.

Others involved in the training would include staff members from various community agencies. Paraprofessionals and a volunteer program would serve as an adjunct staff to the program and would be trained in this capacity.

Appendix F   FACILITY

A facility proposed for housing the program would be a building known as the Annex. This is owned by a local church and is rented to the Mental Health Clinic at the present time 2 days a week and houses the adult day treatment program. The building is a fairly large, comfortable house providing rooms of various sizes appropriate for both group and individual counseling and for the activities of the program. There is also a kitchen which would allow for serving a noon meal. It is anticipated that this facility would be available on a rental basis as it now is for the adult program.

Office space for the Adolescent Day Treatment Program Staff will be provided by the Mental Health Clinic and/or other cooperating agencies.

TYPICAL CASE HISTORY WITH DAILY DAY TREATMENT PROGRAM SCHEDULE

CASE HISTORY, M. N. Male
Birth Date: 6-26-58

M. first came to the attention of the Mental Health Clinic on September of 1965. The presenting problem at this time was a reaction to the death of his father who died during the summer of 1965. Both M. and his mother were seen at that time and no further contact was made with the Clinic until May 1972. At this time M. was 14 years old and a freshman in high school. The presenting problem at this time was some difficulty M. was experiencing in sleeping and subsequently some behavioral difficulties at school. He and his mother were not getting along well and he was resisting her attempts to discipline and control him. A psychological evaluation was done at that time and a recommended treatment program involved group therapy for M., individual therapy for his mother with occasional sessions with the two of them being seen together.

This program was undertaken with somewhat debatable success. Following this, M. became involved in some minor delinquent behavior which involved the Juvenile Court, the situation with his mother deteriorated and he, at her request was removed from the home and was in foster care for several months. He went through three foster homes during that period of time and did not make a successful adjustment in any of them.

M. manifested some symptoms of depression and was hospitalized at Dammasch Hospital for approximately one month for evaluation. During this time he made some improvement and upon a discharge was once again referred to the Clinic and has been involved in a group therapy program here.

During the period of time that M. has been involved at the Clinic he has not been in school, which means that at this point he is facing entering school once again as a freshman. He is expressing a great deal of apprehension about getting back in school and the present plans include enrolling him in a high school which he has not previously attended.

Had the Day Treatment Program been in existence last year M. would have been an excellent candidate for such a program. It is entirely possible that should his school adjustment not be satisfactory that such a program would again be feasible for M. during the coming year.

Monday: 9:00 - 9:30 a.m. M. arrives and mixes with others.

           9:30 - 12:00   M. attends Adolescent Group.

           12:00 - 1:00   Lunch

           1:00 - 1:30   Unstructured time.

           1:30 - 2:30   M. attends class at local high school. (music class)

           3:00 - 4:00   M. is tutored in reading and math skills at the Center.

           4:00   Program ends. M. returns home.

           7:00 - 9:00   Mrs. M. attends parent's group.

TYPICAL CASE HISTORY WITH DAILY DAY TREATMENT PROGRAM SCHEDULE

Tuesday: 7:30 - 9:30 p.m.   Mrs. M. attends parenting class.

                7:30 - 10:00 p.m.   M. spends evening with "big brother".

Wednesday: 9:00 - 4:00   M. repeats Monday's schedule.

Thursday: 7:30 - 9:30 p.m.   Family counseling - M. and his mother, Mrs. M. Occasionally significant others in the extended family constellation might be included in the counseling sessions.

Friday: 9:00 - 1:00   M. repeats Monday's schedule.

         1:30 - 3:00   M. tutors a grade school youngster in math.

         3:30 - 4:30   M. meets with his Juvenile Court counselor, "big brother" and staff person to review the activities of the past week and to plan for a coming week of activities.

APPENDIX D

A GROUP HOME/HOSPITAL TREATMENT MODEL

FOR DISTURBED ADOLESCENTS

PROGRAM DEVELOPMENTS

A Group Home—Hospital Treatment Model for Severely Disturbed Adolescents

LINDA R. HOFFMAN
VIRGINIA LEHMAN
ELI D. ZEV

For severely disturbed adolescents who are ready for discharge from hospitals but are experiencing long delays in placement elsewhere, a community-based group home operating in cooperation with a hospital may meet their need.

In 1972 child welfare statistics indicated that at least half of the New York City children ready for discharge from state hospitals on referral for placement to New York City's Bureau of Child Welfare were severely disturbed adolescents. Many had been awaiting placement anywhere from 3 months to 3 years. There also were many emotionally disturbed adolescents from municipal and private psychiatric hospitals who were ready for discharge, and had been awaiting placement for prolonged periods.

The majority of these disturbed adolescents were black and Puerto Rican, between 13 and 18 years old, from multiproblem ghetto families. They had histories of severe psychiatric disorders, long periods of institutionalization, acting-out behavior, suicidal and homicidal attempts, and drug use.

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Few child care agencies had programs that enabled them to serve this population. Special Services for Children, the administrative arm of the Bureau of Child Welfare, therefore embarked on an innovative approach. The concept was to open community-based group homes operated by a child care agency in affiliation with and located near psychiatric hospitals with adolescent services.

Special Services for Children would provide funding and administrative support. The child care agency would provide the programming and expertise required for servicing the adolescents in the group home. The hospitals would provide admission to their inpatient services if required and make a commitment to accept the children into their day treatment program. The day treatment program would include a specialized and individualized school program, as well as psychotherapeutic, vocational and recreational services.

Program Goal

The overall goal was to help adolescents with long histories of institutionalization in closed settings to adjust and function socially, educationally and vocationally in an open group home setting in the community.

Abbott House was the child care agency with which the group homes were to be developed. Bellevue Psychiatric Hospital, whose Adolescent Division's social work staff had submitted the original proposal for such a project, was selected as the psychiatric backup for the first group home for eight adolescents. Long Island Jewish-Hillside Psychiatric Hospital was selected as the psychiatric backup for the second group home for eight adolescents.

At the outset Special Services for Children and Abbott House formally agreed with both Bellevue and Hillside Hospitals as to the roles, responsibilities and services they would provide for their group home projects. This agreement permitted integration of their funding and resources to insure optimal delivery of service in the project.

Advisory committees for the Abbott House—Bellevue group home and for the Abbott House—Hillside group home, comprising representatives of the three facilities, were established. Jointly, the committees were to:

1) select a program director, to be on the Abbott House staff, directly responsible for programming and staffing the group home

and coordinating group home services with those of participating hospitals;

2) select a hospital staff psychiatrist responsible for providing therapeutic and consultation services for the group home;

3) monitor and evaluate the program;

4) establish program policy;

5) make intake decisions on the basis of the program director's and the psychiatrist's evaluations;

6) discuss discharge plans.

Through the efforts of the two committees the projects were both phased in during the spring of 1973. Each group home accommodated eight adolescents. Girls were selected as residents for both homes, because statistics indicated that there was a greater number of girls than boys awaiting placement at that time.

Program Model

The programs have been under evaluation during their operation. An attempt has been made to develop a single model upon which to base future program planning for residential facilities to service emotionally disturbed adolescents. Through experience, it has been found that the most successful approaches are:

A. Development of a therapeutic milieu involving a synthesis of child-care techniques with a psychiatric hospital's psychotherapeutic, educational, recreational, family planning and medical services.

B. Provision of an individualized program in relation to the youngsters' academic potential, current functioning and emotional stability, through the hospital's special intramural school.

C. Location of the group home in close proximity to the hospital. Such a location helps insure attendance at the hospital's school. It is also strategic for emergency psychiatric and/or medical hospital care.

D. Location of the group home in a community supportive of the concept.

E. Development of intake policy as follows:

1) The child is referred by the public agency or the participating hospital. Each hospital home is allotted a percentage of the referrals based on its original written agreement.

2) The child is interviewed in the referring hospital setting by the program director and hospital psychiatrist.

3) A determination is made that the child has the potential to

establish one-to-one and/or group relationships and is motivated to attempt to function in an open group home setting.

4) A one-day visit is made by the child to the group home and the hospital's school.

5) Upon acceptance, a written commitment is obtained from the referring hospital to readmit a child who is unable to adjust to the group home within 90 days.

6) The child is placed directly from the referring hospital into the group home.

F. Development of discharge policy as follows:

1) Discharge plans are discussed with the advisory committee.

2) Final discharge decisions for the group home are made by the program director. Followup planning for children is the responsibility of the child care agency.

3) Final discharge decisions for the day hospital program are made by the day hospital staff.

G. Provision of individual and group therapy by psychiatrists and professional social workers. These therapists, along with child care staff, may also conduct life-space interviews.

H. Provision of three shifts of child care staff within each 24-hour period, rather than live-in parental persons. This staffing pattern relieves the stress of working with such a severely disturbed population, unable to cope with the more intense parent-child relationship.

I. Promotion of awareness, understanding and involvement in the residents' total activities through combined meetings of the group home and hospital staffs.

J. Enhancement of positive feelings and relationships toward peers and community through emphasis on community activities such as joint shopping trips, movies, ice skating, courses at the "Y," volunteer work, etc.

Method of Program Evaluation

Evaluation of the group home programs has been based on whether they have achieved their overall goal of social, educational and vocational adjustment. Social adjustment has been measured on the basis of the youngsters' ability to remain and function in open community-based group home settings.

The criteria for educational adjustment have been school attendance and achievement. Academic achievement has been evaluated

by comparing current mathematics and reading scores with those obtained upon admission.

At this time it is not possible to evaluate vocational adjustment definitely, as there is only one child who requires vocational training. She is on referral to a vocational training program.

Social Adjustment

During the first year of operation of the two group homes (1973-1974) there were 29 admissions. Sixteen girls are currently in residence: eight from 9 months to a year, three from 6 to 9 months, and five up to 6 months from their admission dates.

The 13 children who did not remain were discharged during the first 6 months of the programs' existence. The majority of these youngsters left within a month of their admission dates. There have been no discharges during the last 6 months. The dropouts ceased simultaneously with the solidification of the tri-party relationships through the Advisory Committee, resolution of major administrative problems, development of a more relevant intake policy and more cohesive inter- and intra- staff-resident relationships in the group homes.

It is not possible to determine the degree of behavior modification that has occurred or its permanence, due to the relatively brief time in treatment in a community setting. Although positive and negative fluctuations have occurred in the youngsters' behavior over the last year, there has been no adverse community reaction to their presence. In general, the behavior of the residents has at least remained the same in the open group home setting as it was in a closed setting. In some cases there are indications of significant improvement. The acting-out, aggressive tendencies of at least six of the girls have noticeably subsided.

Educational Adjustment

The hospitals' special schools have been providing a structured social experience along with an individualized educational approach for these youngsters, most of whom have histories of poor school attendance, adjustment and achievement. All but one of the 16 girls in residence have been attending school regularly. Twelve are attending the hospitals' special schools, one is attending a community high school and two are attending college. Two of those attending hospital school are currently candidates for high school

equivalency examinations. The one child not attending school (the girl on referral to a vocational training program) is receiving remedial help at the group home.

The potential for academic achievement among these youngsters varies. Their IQs range from mildly retarded to above-average. Academic progress has been measured in terms of any improvement in reading and math scores from the date of admission to the present. Ten of the 15 residents who attend school have shown progress in reading and math scores, with clear indications that there is a correlation between the child's length of stay and her educational progress.

Conclusion

The programs have demonstrated that there are severely disturbed adolescents who are able to function and progress socially and educationally in these open community-based group home settings.

A major factor in the program's success is that optimal federal, state and local funding has been obtained for operational expenses. Another factor is that the participating agencies drew up agreements defining the services and responsibilities of each.

The most positive ongoing component in the programs' development has been the advisory committee of representatives of the three participating agencies. Though the agencies' interests and service mandates may have differed, the committee has been the vehicle for fostering the trust and understanding that enabled its members to develop the common goal of providing quality administration and services in the group homes. The support of the community also helped strengthen the group homes. As mentioned earlier, notwithstanding fluctuations in the adolescents' acting-out behavior there has been no adverse community reaction.

Finally, the therapeutic, educational and recreational program developed to maintain the youngsters' interest and involvement and the positive staff-resident relationships have provided the milieu essential for success.

Further research on this type of program is needed. It should include a determination of which severely disturbed adolescents can benefit from this kind of setting, which require a more structured setting, and what treatment modalities have the most positive long-range effects. Nevertheless, in view of the programs' current success, local child care agencies and psychiatric hospitals have begun

to show interest in developing their own services based on this model or modifications of it.

Special Services for Children recently opened another group home with Abbott House and Bellevue Psychiatric Hospital. This home is for eight emotional disturbed adolescent boys. Special Services for Children plans to open soon at least two more group homes for emotionally disturbed adolescents, using the tri-party approach or variations of this model. ◆