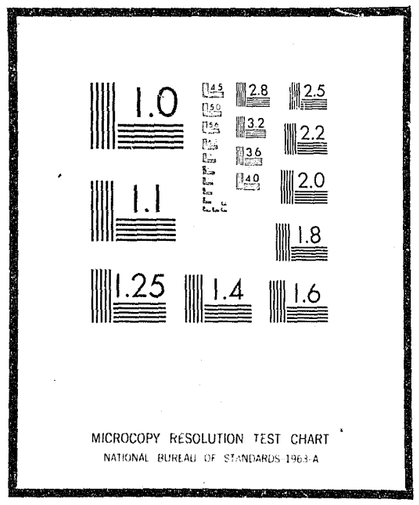

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Specialized Out of Home Care Project

Evaluation Report #2

Preliminary Process Assessment

Prepared By

State Planning Agency

of the

Oregon Law Enforcement Council

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Special thanks must be extended to the project director, Mr. Ron Jenkins, for his continual assistance in interpreting objectives and activities for all phases of the project. Ron also provided invaluable help in contributing to my understanding of the role and mechanics of out of home care in the child care and treatment matrix in Oregon.

Summary of Findings

The findings of this first process objective assessment report can be summarized under three headings corresponding to the three process objectives listed in the modified project proposals:

1. Increasing the amount of rehabilitative specialized out of home care resources for 150 target offenders.

   (a) The preliminary data in this report indicate that between August 1974 and March 1975, 136 case management clients were referred to the SOHC Project for consideration for out of home placement. Of this number 65 (47.8%) were placed by the project and 24 (17.6%) were channeled through the regular CSD system for out of home care placement. The 65 placed with the SOHC project represent (43.3%) of the projected 150 to be served by the project. These data are presented in the body of the report and in Table 1.

   (b) There is some problem with the proposal projection of a "maximum" average of nine (9) months in placement, per client in that this is technically impossible at this time.

   (c) Data summarizing types of placements developed and their costs per client per month are presented in the body of the report and in Table 2. A later report will summarize project data on services provided these clients by the contracted providers and comparisons between previous and current out of home care resources and placement experiences.

2. Develop a screening and placement model which provides, and improves the delivery of specialized out of home care services to youthful target offenders.

   (a) While the project data and evaluative data documenting the development of the project "screening and placement" model and the extent to which it improves the delivery of "specialized" out of home care services is not complete, our preliminary analysis indicates that the project has made some progress in establishing and routinizing client referral and placement and case monitoring procedures.

   (b) Like many other projects delivering human services, the limitations of this project to date lie in the absence of a well defined schema for classifying clients by types of needs and treatment requirements and a schema for classifying placement providers in terms of their capacity to meet certain types of client needs and provide treatments identified with these client needs. In the absence of such schema for matching providers and clients, the project has operated mainly on intuitive and usually partially definite notions of what provider and client are best for one another. While one is impressed with the enthusiasm of a youthful and aggressive staff and pool of apparently very capable providers, there is

really little we can document in terms of the matching and service delivery procedures as they have existed to date. (This situation will change, of course, as data on client and provider types is generated by the project and analyzed jointly by project staff and the OLEC evaluator.)

(c) It has not always been clear from project documentation how and in what ways the SOHC placements are "specialized." The assumption underlying the project is that the one distinguishing feature of an SOHC placement is that it is "tailor made" to the specific individual referred to the project. In several senses it does appear that SOHC placements are unique: (1) There is indeed, a greater flexibility for purchase and utilization of services/ resources made possible by the different method of contracting; (2) an improvement in the quality of SOHC placements over regular OHC placements also is made possible through inter-agency coordination of resource development and utilization; (3) a methodology for joint case planning via the "dispositional teams" improves client program development, and (4) by providing continuous assistance, support, and monitoring for all placement activities the probability is greater that all client care needs can be better met. In addition, some attempt is made to select a provider for a client according to the case manager's recommendation. Location, environment, school, and recreation are important considerations.

Presently this evaluation can document only the potential for these service concepts (above) occurring rather than the reality of their occurrence. In addition, the crucial question of what services/resources are linked to what clients by need category (the best measure of the extent of specialization of placement) cannot be answered at this time.

We propose for future analysis that only valid schemata for classifying services/resources/providers and client needs/types together with the appropriate data and data analysis (via analysis of variance and factor analysis) will establish the extent to which these placements are truly specialized.

3. <u>Assisting provider agencies working with SOHC clients to improve their abilities to provide rehabilitative and specialized services</u>.

To date the attempt to render technical assistance and training to providers, has proceeded in somewhat unsystematic but energetic fashion. While little documentation exists on identification of individual provider training needs, increasingly more systematic and extensive attempts are being made to identify the training necessary for the aggregate of providers to operate effectively. Information for assessing training is now being gathered. To date the training and assistance has been in the following areas:

(a) Assistance for providers in bookkeeping, record keeping, and management of various material and non-material resources/services (available to all providers on a recurring basis).

(b) Assistance in the application of behavior modification techniques - especially setting up token economies. (Available to all providers on a recurring basis.)

(c) Red Cross Certificate Training (available to both providers and clients).

(d) Two sessions on the "testing out" or initial phase of a placement.

(e) Numerous handouts on aspects of provider treatment.

(f) Field trips to JDH detention and MacLaren-Hillcrest - institutional settings.

(g) Orientation session for case logging, reporting, and interviewing.

(h) Dr. Michael Ebner's (3) training sessions on diagnosing client problems, family patterns, and "game playing."

(i) Family effectiveness training (sponsored by YMCA).

Again, the crucial questions which haven't been answered revolve around what types of training are needed by what types of providers to work with what types of clients to bring about what types of effects. (Of course, the lack of precedence for such a project as SOHC is an important consideration here.) Answering these questions will be the major task of subsequent reports.

<u>Note</u>: Assessment of these three (3) process objectives (above) is necessarily incomplete at this point in time. This is due mainly to the following limitations:

(1) The incompleteness of project data and documentation at this point in the project evolution.

(2) The unavailability of data collection support from OLEC due primarily to a freeze on hiring data coders and interviewers.

(3) The failure of the project to develop stable and relatively crystalized activities and procedures. The state of project flux and evolution has compounded both the collection and analysis of data as well as the more important development of evaluative questions and research hypotheses.

It is hoped that these limitations can be overcome in subsequent reports.

Specialized Out of Home Care Project
Evaluation Report No. 2
Preliminary Process Assessment

Brief Description of the SOHC Project

The CSD (Children's Services Division) Specialized Out-of-Home Care (SOHC) project has an explicit tie-in to the Case Management Corrections Services (CMCS) project in that it is to provide specialized services to CMCS clients who are referred to CSD for out-of-home care. Specifically, the project activities are to: (1) implement an intake process and residential care unit to provide specialized services to juvenile target offenders; (2) develop a service delivery system for such youth through the use of joint planning and service coordination between CSD and the Multnomah County Juvenile Court; and (3) employ the use of a Disposition Team (composed of the CMCS case manager, the SOHC resource developer, potential care providers, etc.) to identify individual placement and treatment needs and explore alternative resources and services. The Disposition Team will also track each client through the service delivery system and continuously monitor progress and update diagnostic assessments.

As the SOHC project has evolved it has essentially become a demonstrative, experimental type project which attempts to develop a service delivery model and inter-organizational system for more intensively and extensively providing the target population (CMCS clients requiring out-of-home care) with specialized (as opposed to regular; i.e., general CSD) alternative out-of-home care. The specialized out-of-home care envisioned will involve three basic types of services as follows:

1. Intake Services

These are part of the initial screening, referral, and assessment process which facilitates an orderly transition from county to state custody; and which create the pre-placement planning, consultation with initial case and after-care planning essential to efficient utilization of out-of-home care services and resources. They are intended also to reduce the amount of time a client might spend in detention while a placement is being located.

2. Placement Services

These are the direct and indirect services provided by the SOHC resource developer and the casework services furnished by non-SOHC staff providers on a contractual basis. These latter may in many cases be services provided by new as opposed to existent resources. In either case, these services are aimed at increasing the quality and stability of Specialized Out-of-Home Care placements, which should have a behavioral impact in terms of reduced target offense incidence and recidivism among clients served by the SOHC Unit. Further, they should lead to greater self dependency on the part of clients and eventual return to the community.

3. After Care Services

These after care or transitional services include a specific plan for insuring the coordination of any appropriate after care activities. The rationale for effective after care services is inherent in the overall design of the SOHC Project and its purposes. This rationale is best reflected in the following passage from the "Revised SOHC Narrative":

> "All planning in terms of referrals to the specialized out of home care will be goal specific and time limited. It is seen that the primary task of this unit is to provide intensive specialized alternative care to youngsters who present unique and difficult behavioral problems; that the task of the unit is to bring stability in the child's life, help him toward more self dependency and prepare him either for eventual return home or to alternate placement within the broader range of services offered either by the county or by the state. It is anticipated that a youngster not be in the specialized out of home care unit more than nine months and that the unit accept responsibility for coordinating the after care activities if appropriate. The decision for this approach is based on the assumption that many youngsters are going to require 2 to 3 years of service either by the county or by the state and that if the specialized out of home staff were to carry for a long term basis all the cases that were referred to this unit eventually their caseloads would escalate and intake in specialized services would again be depleted. Many of the problems that are inherent in large caseloads and understaffing would soon develop in this unit. With this in mind, it becomes obvious that sophisticated case planning be done at the outset of the placement in the SOHC unit and that all agents acting within the case plan are aware of the plan and are working toward commonly established goals."

Two types of service providers will be utilized in this project: (1) the SOHC resource developer who will provide a minimum of direct services (such as counseling) and mostly indirect services (such as liaison work between other personnel providing both direct and indirect services), and (2) the provider agencies which provide such casework services as counseling, educational training, and supervision of various types.

Most of the intensive care specialized SOHC placements will be of three main types: (1) Group Homes, (2) Foster Care, and (3) the Day Care Center. Concisely, then, the overall goal of the SOHC project is to contribute to the Impact program goal of reducing juvenile target offender recidivism by more effectively utilizing existent OHC placements and developing new and specialized placements which in turn will generate more stability and more conformity in terms of client behavior. This overall goal will be accomplished via a project which insures the following: (1) a greater ability to purchase OHC services, (2) a pre-placement and early placement planning process by case which is based on better diagnosis and greater collaboration between the parties involved, (3) the ability to pay better rates to guarantee better services for alternative care, (4) the active involvement of CSD in a kind of service brokerage role, (5) more collaboration between CSD and CMCS, (6) purchase of service which is guided and coordinated by improved case planning, and (7) an improved service delivery process from point of intake to point of discharge. All of these features reflect a "case management" approach rather than the traditional "casework" approach.

Definition of Population to be Served

The original projected population to be served by the SOHC project was to be approximately 300 juvenile target offenders, ages 12-17, in the Case Management Corrections Services project (and under the jurisdiction of the Multnomah County Juvenile Court), who have been referred to the Children's Services Division for out of home placement.

Modification of the Target Population

Due to the late start-up of the SOHC project and funding restrictions, the above estimate for the target population was subsequently reduced to a figure of 150 clients who would be provided specialized out of home care over the duration of the project. In addition, the project is to arrange for out of home care through regular CSD resources for an additional 50 clients referred by CMCS for out of home placement for the duration of the project.

Note to the Reader

All evaluation problems have some element of history. This project and its attempt to impact on CMCS client behavior through the provision of specialized out of home care can not be fairly evaluated without some understanding of project history. Several elements of this history bear directly upon any evaluation of the extent to which the project has met its process objectives. They are, then, contingencies or conditions which in some sense determine the extent to which the process objectives are reached and/or exceeded.* They can be listed as follows:

1. Inter-Agency Climate of CSD and Multnomah County CMCS Before Project Implementation

   While the notion of an "interface" between projects refers to a complex set of ideas and observations which will not be discussed here, three statements are in order. First, the development of CMCS (the Case Management Corrections Services Project) was viewed by CSD (Children's Services Division) with some trepidation - especially in that CSD envisioned case managers going into CSD child caring agencies with a strong child advocate role - one with a potential for CSD-CMCS conflict. Second, CSD viewed CMCS and the Multnomah County as being in the position of "dumping" Court clients on an already strained system of out of home care. And third, the issue of who was to be responsible to what clients for what services, resources, etc., where, when, and how required a great amount of work.

2. Lack of Start Up Planning

   Part of the failure of the project to develop at the outset a well-defined intervention strategy and set of supporting rationalizations (a theory of intervention and treatment in essence) can be attributed to several things. One, the role of SOHC as one component of the larger CSD child caring system lacked initial clarification. This was especially true given that SOHC was a highly specialized program within the more generalized CSD system. It was simply designed to do different things

*The discussion of these contingencies below was developed primarily from discussions with the Project Director, Mr. Ron Jenkins. They reflect primarily his interpretation of project history from the standpoint of the director's role.

for a different type of client in the CSD system ---the Impact target offender. This identified program population represents unique out of home care placement needs. SOHC was without precedent in Oregon at its inception and problems related to its logistical and procedural connection to the state system absorbed an enormous amount of the project director's time and energy - much of which could have gone into developing more of the logic and mechanics of out of home care intervention and treatment.

3. Lack of Anticipation of Intensity of Referral Flow

   The large numbers of clients initially referred to the project for out of home care placement; together with a continuous heavy flow of referrals (and a subsequent strain on available resources) resulted in further demands on the project director. Often, he and the project staff were in the beginning pressured to do something and many placements had to be made in a short time period to decrease the demands from both CMCS and CSD. To complicate these problems of initial project implementation, the restructuring of the Multnomah County Juvenile Court created an additional acute problem in the process of making out of home care placements. Specifically, the ruling that no child remain in detention for more than 20 days and the ruling that reports on children in detention be completed within 15 days heightened the necessity of both SOHC and CSD to make quick decisions on the placing of children in out of home care.

4. Meeting the Unexpected CMCS Commitment for Emergency Care

   Because CMCS considered any child in lock up (detention) as requiring emergency care and as the SOHC grant provided only for relatively long term care (rather than short term, emergency care), a further complication presented itself. How could SOHC provide for emergency care - especially for weekend and evening placements during crisis situations? The project director spent much time developing emergency care placement openings into the pool of all available placement openings. This necessitated extensive work on several placement provider contracts and the development of relief or "respite" care provider positions in the project to accommodate some of these emergency placements.

5. Problems in Implementing the Group Home and Day Care Center Component of the Project

   A number of problems arose with regard to the establishment of the specialized "group" out of home care placements. Namely, the establishment of a SOHC group home and a SOHC day care center encountered a number of problems chief of which revolved around zoning issues.

   To counteract the delays in getting specialized out of home group care the project director decided that the most rational and expedient choice was to utilize professional foster care placements in many cases where clients could not easily be placed in group care placements. The use of professional foster care, however, necessitated spending more time on screening potential providers and for developing professional services contracts with hired providers. It also should be mentioned

that no real precedent or model for contract development existed for a professional services contract for out of home care. The contracting process alone probably accounted for half the director's time during the first nine (9) months of the project. Developing a contract model with detailed statement of work sections and developing procedures for transferring from traditional reimbursement type contracts to earned income (or professional) type contracts required much time and energy. Also because SOHC represented enriched services, the matter of establishing special rates for services presented some problems.

6. The Problem of Continuity of Care

Though not fully anticipated in the beginning, it appears that the "after care" component of a case plan involved an extensive amount of work and involvement. The project simply can not "dump" clients on the larger system without prior planning for after care. As many clients require further placements and services after termination from SOHC, this problem continues to emerge on a larger scale. Since the transferring of cases in after care is a cumbersome process, it is sure to absorb more and more project time as the termination rate from SOHC increases.

7. The Role of the Family in the Rehabilitation Role of This Project

One less developed aspect of the project is its relation to the family and the role of the family in the rehabilitation process. As work processed on various client case plans, it became more apparent that in many cases the intensive involvement of the family in the case plan was required. However, it also became apparent that some families are "dysfunctional" and require some form of conjunct family therapy. One immediate response of the project was to develop training for working with problem families and parent effectiveness training.

8. The Relationship of the Project to CMCS and Other Agencies

The project's ongoing relationship to the Case Management Corrections Services (CMCS) project has remained in a state of flux. As the SOHC project has progressed the roles of both SOHC staff resource developers and CMCS case managers have required clarification and elaboration. This evolution in mutual client serving roles (both of which involve strong client advocate stances) required a sizable amount of dialogue on who is to do what to effectively monitor cases at some defined continua of service level. Along with establishing well-defined roles toward children, the issue developed of when and where to defer to the case manager the role of decision making in the case planning process and especially in the placement process. In all cases the case managers recommendations for placement were given high priority.

The Evaluation Design and Its Implementation

Process Evaluation

Our primary evaluative research concerns here revolve around the question: Does implementation of the SOHC project meet the process objectives indicated in the project proposal revisions? The evaluation here approximates what might be considered to be an intensive form of program monitoring and a description of project operation. Three major process objectives are listed for this project:

(1) Increase the amount of rehabilitative specialized out of home care resources for 150 target offenders.

(2) Develop a screening and placement model which provides and improves the delivery of specialized out of home care services to youthful target offenders.

(3) During the project duration, assist provider agencies working with SOHC clients to improve their abilities to provide rehabilitative and specialized services.

With regard to process evaluation, the intent of this will be to clearly describe those process objectives designated in the revised project proposal and to carefully compare the actual against the expected performance of SOHC in meeting these objectives. This attempt to compare actual with planned performance will be augmented with an in-depth description and analysis of the connections between project activities and process objectives.

Further Elaboration on Major Process Objectives - Sub-Objectives

As specified in the project director's SOHC Work Plan for the project period August 1, 1974 to July 30, 1975; each of the three (3) major process objectives is subdivided into a number of sub-objectives covering various three month quarters (the first of which covers August, September, and October, 1974). Because this report covers only the period August 1, 1974 to March 31, 1975; only the sub-objectives for which data can be collected, analyzed, and reported on will be included in the listing. These are as follows:

First Year Objectives

(1) Increase the amount of rehabilitative out of home care resources to approximately 60 target offenders during the year and at full operation maintain an average daily population (ADP) caseload of 40 youth being serviced in the SOHC project.

Sub-Objectives

(a) During the first quarter initiate service to 15 new referrals.

(b) During the second quarter initiate service to 15 new referrals.

(c) During the first quarter maintain an average daily population of 10.

(d) During the second quarter maintain an average daily population of 20.

(2) Develop a screening and placement model which provides and improves the delivery of specialized out of home care services to youthful target offenders.

(a) Document the percentage of referrals to the SOHC unit that were diverted from out of home placement due to utilization of resources identified both by Case Management and the SOHC Project.
(b) Document 25 cases wherein SOHC staff aided Case Management in placing clients in regular CSD resources.
(c) During each quarter be able to document a minimum of six cases diverted to regular CSD resources.
(d) During the first quarter, utilize the profiles as developed during the implementation phase as guidelines for resource development.
(e) In remaining quarters compile profile information on clients actually served and at six month intervals administer profiles for anticipated referrals and at end of year compile both the actual and projected profiles as utilized during the first year of operation.
(f) Provide 90% of the youths serviced by SOHC unit with preplanning and dispositional team and after care services. Provide data per client which compares original after care plan with actual care plan.
(g) During the first quarter have operational a service delivery logging procedure identifying how staff expends time on a functional basis.

(3) During the project assist provider agencies working with SOHC clients to improve their abilities to provide rehabilitative and specialized services.

(a) During the four quarters provide fiscal data documenting the costs of services on a per client per month served basis.

(b) Illustrate type and frequency of technical assistance and training provided by SOHC unit to providers.

Note: All the above listed process sub-objectives are taken from the project director's work plan and reflect his interpretation of how to achieve implementation of the three major process objectives as listed in the project proposal (revised edition). These three process objectives along with set "productivity indicators" for each objective are listed from the revised project proposal and appear in Appendix A of this report. In the following analysis of the extent to which process objectives are being achieved, we will move back and forth between a discussion of the extent to which quarterly time-framed sub-objectives are reached and a discussion of the extent to which these quarter-by-quarter project activities are contributing to the overall achievement by the project of these major process objectives.

Project Data and Information Used to Assess the Extent to Which Process Objectives Have Been Reached During the First Two Quarters

Objective #1	Increase the amount of rehabilitative specialized out of home care resources for 150 target offenders.

Objective #1 is concerned with the rapidity with which the project "phases in" and accelerates its rate of making "specialized" and "regular" out of home care placements. Table 1 provides project data which will be used to assess this objective and the corresponding set of sub-objectives defined by the project manager in his work plan for the first two project quarters.

(TABLE I See Page 11)

If we conservatively define "initiating service" to new referrals as actually meaning that the new referrals are placed in the SOHC project; then, Table 1 data indicates that the work plan Sub-Objectives 1a and 1b were both met. During the first quarter (August, September, and October of 1974) 17 referrals were placed with SOHC providers, rather than the 15 projected; and during the second quarter (November and December of 1974 and January 1975) 25 placements were made rather than the 15 projected. For the two quarters combined, 42 rather than the projected 30 placements were made.

However, in terms of the overall project objective (Objective 1 above) for the 27-month period when clients were first given services (July, 1974) through September, 1976, there is no conceivable way that 150 clients can be served for a maximum average of nine months in placement with the restriction of maintaining an eventual average project caseload of forty (40 ADP) youths. To have accomplished this, the project would have had to have begun with an ADP of 50 clients in placement in July, 1974 and maintained this ADP figure throughout the remaining months of the project's duration.

The above observation suggests that the three major process objectives and the single outcome objective along with the "productivity indicators" listed in

the Revised Grant Proposal (see Appendix A) must be reassessed and modified in light of limitations in terms of phase-in restrictions, staff attrition (if any), client terminations (and other sources of client attrition), etc.*

A reduction in the "maximum average" of nine (9) months in placement per client also implies that the logic for differences in length of placement by child must be reconsidered. In the case planning process, a clear logic must be established then for designating short vs. long term out of home care by type of client and type of placement (or type of provider).

Having identified this problem of numbers to be served and average duration of service along with the precautionary note, let us move to consider Sub-Objectives 1c and 1d in the director's work plan which deal with the maintenance of certain ADP (average daily population) totals by project quarter. These ADP figures are a first quarter ADP of 10 and a second quarter ADP of 20.

Actually, an ADP concept and measure makes little sense outside of the institutional context where daily head counts are taken of those in custody or in residence. Even if the concept can be used in the context of this project, no daily figures are kept by project staff on head counts of those in placement.

It is possible, however, to use the notion of an average monthly population (AMP), which while somewhat vague in meaning at least gets at the idea of maintaining a quota of so many clients in placement during each project month. This AMP index can be computed in a couple of ways. Perhaps the easiest way is to use the following formula, which incorporates monthly data from the last column in Table 1:

A.M.P for any set of months 1....N = Sum of the cumulative total in placement for the set of months 1....N divided by the total number of months in the set (N)

Using this formula, the following AMP indices can be computed for the first and second project quarters:

Quarter #1 - AMP = 7.33 clients
Quarter #2 - AMP = 24.33 clients
Combined - AMP = 15.83 clients

Using the above figures, it appears that had the project director estimated "average monthly populations" of 10 for the first quarter and 20 for the second project quarter; the second (but not the first quarter) sub-objectives would have been reached. Again however, both the ADP and "AMP" estimates really have little utility here for judging process objectives for two reasons: (1) variation in numbers of clients placed during the phase-in period make any "average" (ADP or AMP) difficult to interpret and (2) variation by

*It should be pointed out that in the project's clearinghouse function of locating placements it became obvious that a determination of resources indicated there were few placements of certain types and an almost complete lack of short-term emergency care type placements.

type of placement setting (foster care, group home, weekend relief, and day care centers) make it difficult to compute and interpret such averages also. Eventually, the project may have to revise its proposal by defining service delivery in terms of numbers of clients given so many months of service in so many types of placement settings receiving different types of services.

Looking at Objective #1 not in terms of numbers of clients served, but rather in terms of productivity indicators B and C (listed in Appendix A), some data is available from the project on type of slots developed and length of stay per client through the end of 1974 - the period for which such data was collected.

Of the 26 clients in placement as of the end of December, 1974, data was available on time in placement for 23 clients. For these 23, the length of time in placement varied from 4.1 months at the maximum to 0.45 months at the minimum. The average was 2.1 months with a standard deviation of 1.1 months (indicating that roughly two-thirds of these clients had been in placement from one to three months approximately.

These 26 clients were distributed across several different types of "specialized out of home care" placement settings. These can be described as follows:

1. Group Home Setting

   The focus here is on interaction in a group and using the group to provide behavioral models, behavioral limits, and activities, as well as, group support for the client. (N = 5)

2. Professional Foster Family Setting

   In this setting, both husband and wife work as a professional social work unit to expose the youth to family life, routines, and activities. In addition, there is extensive interaction with the school and community. Supervision and structure are provided for shaping client behavior. (N = 4)

3. Foster Family Care

   "Same as #2 above, except the provider couple have less professional training." (N = 6)

4. Big Brother/Sister (N = 8/ N = 2)

   Involves a full-time person acting as "concerned" big brother or sister to the child. The child resides with the provider. The child is seen as not needing or not able to handle family type settings. Also, this placement is viewed as less threatening to parents. It can be of a "nurturing" or "supervisory" form - a kind of extension of the family setting. (N = 10)

5. Independent Living Arrangement

Designed for youth moving toward emancipation. The foster parents may work. There is less supervision. More resource counselors are used. There is less emphasis on limit setting. (N = 0)

6. Special Situations

These are specially tailored placements which are established by other actors. They are made on a one time by child basis. (N = 1)

Total (N = 26)

TABLE 1
S.O.H.C. Project Client Flow by Month During 1974 and 1975*

Month	Number of New Referrals	Number of S.O.H.C. Placements	Number of S.O.H.C. Terminations	Number[1] Channeled to C.S.D.	Cum. Total in Placement by Month[2]
Aug. '74	13	2	0	6	2
Sept.	18	5	2	3	5
Oct.	22	10	0	3	15
1st Quarter[3]	(53)	(17)	(2)	(12)	(15)
Nov.	13	8	4	3	19
Dec.	16	8	1	0	26
Jan.'75	21	9	7	4	28
2nd Quarter[3]	(50)	(25)	(12)	(7)	(28)
Feb.	16	17	5	2	40
Mar.	17	6	2	3	44
Total	(136)	(65)	(21)	(24)	(44)

*The Specialized Out of Home Care Project officially began processing clients in August 1974, although one client was "served" by the Project in July in that project funds were used only to pay for psychiatric treatment at Woodlawn Park Hospital.

1. Most of those channeled to CSD received regular out of home care, went home, or their parents found some other placement arrangement.

2. Determined cumulatively for each month by taking Column 2 minus Column 3 and adding the difference to the Column 5 entry for the previous month.

3. For purposes of this study the project director took August as the starting point for designating quarters during which clients were served by the project. The first quarter, then, is composed of the months of August, September, and October. The second quarter covers the months of November, December, and January.

Note: The project has not as yet produced any documentation which describes in detail the basis for this classification schema of provider settings and the basis for distinguishing between types of providers. For example, there is no documentation indicating exactly how much training a foster family care provider needs to have to qualify as a "professional" foster family care provider.

By way of a precautionary note, it must be pointed out that in the absence of any well-defined classification schema for either typing providers or clients, the whole process of matching providers and clients must be considered problematic. More details will be provided on this matching issue in ensuing evaluation reports.

Data is also available on the dollar costs per placement slot per month for the four (4) major types of placement settings in use through December, 1974.

These cost data are presented in Table 2.

(Insert Table 2 Here)

Reviewing these data, the following conclusions can be stated:

(1) In general, second, third, and fourth slot costs are much less than first slot costs for all providers (with the exception of the Klamath Lake Youth Ranch). The following data on all projected slots from Table 2 supports this fact:

	Type of Setting		Average 1st Slot Costs	Average 2nd Slot Costs	Average 3rd Slot Costs	Average 4th Slot Costs
(a)	Big Brother/Sister		$1048	$ 259	$ 276	-
(b)	Prof. Foster Family		796	323	-	-
(c)	Group Care		676	454	454	
(d)	Family Foster Care		759	233	-	-
	Total (a-d)	$\bar{X}$ =	$ 845	$ 286	-	-
		SD =	$ 286	$ 129		

These data indicate the average second slot rate is roughly one third that for the first slot. Data in Table 2 also indicate that maintaining 100% capacity reduces first, second, third, and fourth slot rates.

TABLE 2. PLACEMENT COSTS PER SLOT (AT MAXIMUM RATES) BY PLACEMENT SETTING CHARACTERISTICS*

Type of Provider Setting[1]	Code for Provider	Availability and Use of Slots: Projected Capacity[2]	Currently Occupied	Dollar Cost Per Slot Per Month[3]: Slot #1	Slot #2	Slot #3	Slot #4	Per Month Total
I Group (Home) Care Setting	A	4	1	$ 591.00	$ 241.00	$ 241.00	$ 241.00	$1314.00
	B	1	1	770.00				770.00
	C	3	3	667.00	667.00	667.00		2001.00
	Totals	8	5	$2028.00	$ 908.00	$ 908.00	$ 241.00	$4085.00
	All Projected Slots			$\bar{X}$=$ 676.00	$\bar{X}$=$ 454.00	$\bar{X}$=$ 454.00	-	
				S.D.=$ 89.84	S.D.=$ 301.23	S.D.=$ 301.23	-	
	Occupied Slots Only			$\bar{X}$=$ 676.00	-	-	-	
				S.D.=$ 89.84	-	-	-	

All Projected Slots	All Occupied Slots Only
$\bar{X}$= $ 510.63	$\bar{X}$= $672.40
S.D.= $ 228.41	S.D.= $ 63.72

* Excludes the "Independent Living Arrangement" setting (N=0 cases in the total of 26 in placement as of December 31, 1975) and one "Special Situation" setting for which $132.00 per month was being paid.

1 These were as follows: (1) Group Homes - Klamath Lake Youth Ranch, Janis Project, and a group home established by an independent provider, (2) Professional Foster Families - four (4) provider "couples" with an unspecified level of professional competence, (3) Foster Families - six (6) provider "couples" with an unspecified level of competence, and (4) Big Brothers/Big Sisters - five (5) male providers acting as big brothers and one (1) female acting as big sister.

2 Number in parentheses refers to provider setting capacity when "emergency basis only" slot is included.

3 Boxed in slot amounts and summary statistics refer only to currently occupied slots. It must be pointed out that while mean ($\bar{X}$) and standard deviation (S.D.) statistics have been computed by the various groupings in the above table and while these statistics have well-defined meanings as measures of "central tendency" and "dispersion"; visual inspection of the values themselves is recommended to complete an inspection of the average or most typical monthly costs by slot and the variation in these per slot per month costs.

TABLE 2. PLACEMENT COSTS PER SLOT (AT MAXIMUM RATES) BY PLACEMENT SETTING CHARACTERISTICS*

Type of Provider Setting[1]	Code for Provider	Availability and Use of Slots: Projected Capacity[2]	Currently Occupied	Dollar Cost Per Slot Per Month[3]: Slot #1	Slot #2	Slot #3	Slot #4	Per Month Total
II Professional Foster Family Setting	A	2(3)	1	$1325.00	$ 375.00	$ 175.00		$1875.00
	B	2	1	770.00	270.00			1040.00
	C	1	1	540.00				540.00
	D	1	1	550.00				550.00
	Totals	6(7)	4	$3185.00	$ 645.00	$ 175.00	0	$4005.00
	All Projected Slots			$\bar{X}$=$ 796.25 S.D.=$ 368.13	$\bar{X}$=$ 322.50 S.D.=$ 74.25	-	-	
	Occupied Slots Only			$\bar{X}$=$ 796.25 S.D.=$ 368.13	-	-	-	
III Family Foster Care	A	2	1	$ 950.00	$ 350.00			$1300.00
	B	2	0	475.00	175.00			650.00
	C	2	0	725.00	175.00			900.00
	D	2	1	710.00	210.00			920.00
	E	1	1	540.00				540.00
	F	2(3)	2	1155.00	255.00	$ 255.00		1665.00
	Totals	11(12)	5	$4555.00	$1165.00	$ 255.00		$5975.00
	All Projected Slots			$\bar{X}$=$ 759.17 S.D.=$ 255.14	$\bar{X}$=$ 233.00 S.D.=$ 73.19	-	-	
	Occupied Slots Only			$\bar{X}$=$ 838.75 S.D.=$ 269.70	$\bar{X}$=$ 302.50 S.D.=$ 67.18	-	-	

All Projected Slots	All Occupied Slots Only
$\bar{X}$= $ 572.14 S.D.= $ 386.29	$\bar{X}$= $ 796.25 S.D.= $ 368.13

TABLE 2. PLACEMENT COSTS PER SLOT (AT MAXIMUM RATES) BY PLACEMENT SETTING CHARACTERISTICS*

Type of Provider Setting[1]	Code for Provider	Availability and Use of Slots: Projected Capacity[2]	Currently Occupied	Dollar Cost Per Slot Per Month[3]: Slot #1	Slot #2	Slot #3	Slot #4	Per Month Total
III Family Foster Care (Continued)		All Projected Slots		All Occupied Slots Only				
		$\bar{X}$=$ 497.92		$\bar{X}$=$ 722.00				
		S.D.=$ 325.62		S.D.=$ 350.30				
IV Big Brother/Sister Settings	A	3	3	$1430.00	$ 165.00	$ 165.00	$	$1760.00
	B	2(3)	2	835.00	445.00	445.00		1725.00
	C	3	1	1050.00	250.00	350.00		1650.00
	D	3	1	1285.00	185.00	185.00		1655.00
	E	2(3)	2	800.00	200.00	200.00		1200.00
	F	2(3)	1	885.00	310.00	310.00		1505.00
	Totals	15(18)	10	$6285.00	$1555.00	$1655.00	$ 0	$9495.00
	All Projected Slots			$\bar{X}$=$1047.50	$\bar{X}$=$ 259.17	$ 275.83	-	
				S.D.=$ 259.05	S.D.=$ 104.95	$ 110.97	-	
	Occupied Slots Only			$\bar{X}$=$1047.50	$\bar{X}$=$ 270.00	-	-	
				S.D.=$ 259.05	S.D.=$ 152.56	-	-	
		All Projected Slots		All Occupied Slots Only				
		$\bar{X}$= $ 527.50		$\bar{X}$= $ 726.00				
		S.D.= $ 412.07		S.D.= $ 464.37				

(2) If all slots are occupied, the average cost per slot per month figures indicate that the settings can be ranked from the greatest to least expense as follows:

Rank	Type	Per Month Cost ($\bar{X}$)
1st	Big Brother/Sister Care	$ 1047.50
2nd	Prof.Foster Family Care	572.14
3rd	Group Care	510.63
4th	Family Foster Care	497.92

Note: Future evaluation reports will address the issue of variation in monthly rates between and within provider setting groups. These reports will also attempt to examine these varying rates by services delivered by types of providers by type of client. Comparisons also will be made between regular and specialized out of home care settings.

For now it is sufficient to point out the following regular out of home care rates:

(1) For a comparable group of children 14-21 years old with "acting out problems" the rates are $139 per month (fixed amount) plus an additional amount (variable amount) averaging $60 per month for additional services (tutoring, psychiatric investigations, etc.) for foster care.

(2) For family group care the average is about $440 per month per client.

(3) Lastly, for those institutionalized in MacLaren or Hillcrest the average monthly rate is about $1500 per month.

These data on cost per slot illustrate the value of some level of cost benefit analysis as being a part of the evaluation and the value of merely describing the costs to provide what sorts of services/resources to what types of clients using certain providers in specific settings.

A unique part of the overall evaluation of this project will be an attempt to describe how this project tries to improve (in a service delivery model sense) the way in which CSD projects costs and contracts for out of home care services. A unique feature of this project is the fact that contracting for services is made an area of special concern.

In this regard, the project director is attempting to accomplish three basic goals as follows:

(1) Improve the "method of statement" of contracts by improving the terminology used to specify the details describing how certain types of services/resources are to be provided certain types of clients.

(2) Special emphasis is to be placed on the statement of work sections of contracts. The intent of contracting here is to provide statements of work in enough detail to provide a clear understanding of how certain treatment activities will result in reaching certain stated treatment objectives for each client.

(3) Lastly, the contract should provide an initial basis for outlining the service delivery role of the provider, as well as, the service delivery roles of others on any particular client's "treatment team."

In a sense, these contracts will be unique in the degree of detail used to describe how specific identified services will be provided identified clients by providers of special abilities devoting certain amounts of time to well-defined treatment tasks and obligations.

Presently, no data is available for analysis on the assessment of services provided clients. This data is being collected currently by project staff and will be provided in future reports. Likewise, data documenting actual length of stay in specialized out of home care per client and regular out of home care per client will be collected and analyzed in forthcoming reports.

Objective #2	Develop a screening and placement model which provides and improves the delivery of specialized out of home care services to youthful target offenders.

The SOHC Project has two primary objectives which are:

1. "To locate or develop out of home care resources designed to meet the rehabilitation needs of this population.

2. To coordinate the service activities of the various agents or agencies providing services to these juveniles and their families."

As the project has evolved documentation has been generated on the referral, intake, and placement processes. An example of this SOHC documentation is the binder and manual materials furnished CSD Intake and Case Management (CMCS) supervisors. Excerpts from this set of documents is attached in Appendix B.

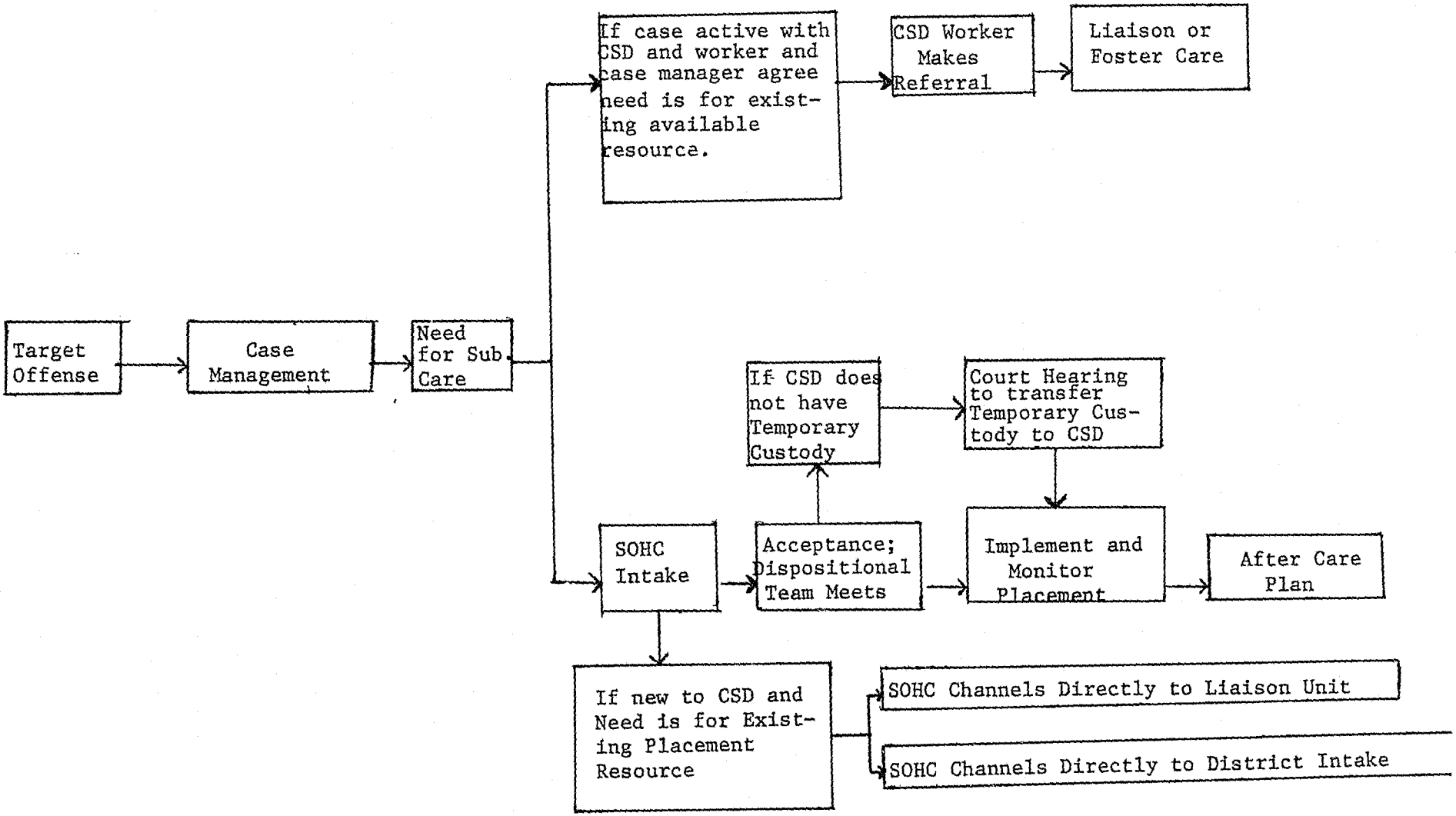
By way of summarizing the growth and development of the projects screening and placement model; let us first refer to Figure 1 which contains a graphic portrayal of the intake flow for CMCS clients referred to CSD for out of home placement and care. This chart was developed by the project manager and modified by the OLEC evaluator.

(Insert Figure 1 Here)

Using this flow chart as a guide we can briefly describe the SOHC referral and intake processes leading up to eventual placement in either regular or "specialized out of home care."

FIGURE 1

CASE MANAGEMENT REFERRAL PROCEDURES TO CSD*



*Prepared by the Project Director, Mr. Ron Jenkins, and the Assistant Project Director, Ms. Heddy Jo Powell.

Once the CMCS case manager (the key to referral input) and/or the CMCS unit supervisor establishes that a particular CMCS client requires substitute (out of home) care, the referral process begins. The case manager contacts the SOHC intake and placement supervisor indicating that his client requires out of home care. Next the case manager fills out a "Needs Assessment" form on the client. This form developed jointly by CMCS, SOHC, and the OLEC researchers provides the SOHC staff (the intake/placement supervisor and the resource developer) with information on the client in need, his/her family, the client's behavioral/attitudinal problem areas, the case managers description of why the placement need exists and his recommendations along with a description of other client information, which assesses positive aspects of the client's behaviors/attitudes.

The SOHC staff then makes a judgment as to whether regular or specialized out of home care is required and selects an appropriate provider. After provider selection the project performs an introduction and hosting function for integrating clients into provider settings. While the project staff makes an honest, concerted effort to make use of the needs assessment information on clients and whatever (unsystematic) information is available on providers, the whole process of matching client to provider and tailoring placement settings and services to client needs proceeds in a somewhat undefined way. This situation is not unique in projects of this sort.

There is some indications, however that this situation will change. Currently, work is progressing on a more systematic approach to classifying both clients and providers and in terms of linking appropriate services to the more salient needs manifested by clients.

Evaluation forms developed to facilitate the work of the Dispositional Teams hold out the most potential for allowing more systematic information about client needs profiles and mode of counseling and service delivery engaged in by the providers. This Dispositional Assessment and Case Plan Review form is discussed in more detail in Appendix C. Appendix C also contains project information on the dispositional phase of the project. Subsequent evaluative reports will address these issues surrounding "matching" and the maximum utilization of provider services and resources in casework.

In terms of the project directors' sub-objectives listed under major objective #2 the following comments are in order:

Sub-Objective 2a

No project data is available for "illustrating the percentage of referrals to the SOHC unit that were diverted from out of home placement due to utilization of resources identified both by the Case Management and SOHC projects."

Sub-Objective 2b

Table 1 data indicate that the project SOHC aided Case Management by placing 24 of 136 referrals (17.6%) in regular CSD resources. Or 24 of the projected first year total of 25 cases to be diverted were diverted during these first eight (8) months.

Sub-Objective 2c

The project director anticipated that the project would divert a minimum of six cases per quarter to regular CSD resources. The actual totals for the first and second quarters were twelve (12) and seven (7) respectively. For the first two months of the third quarter five (5) were diverted.

Sub-Objective 2d

The project director's monthly report for August 1974 containing the first Needs Assessment Report (OLEC Evaluation Report #1) together with Jack Morgan's (the first resource developer's) SOHC memos of July 29, 1974 and September 11, 1974 indicate that during the first quarter a real attempt was made to utilize "needs assessment" profile information as guidelines for resource development.

The only real discrepancy to date in the conclusions of Ms. Diana Gray's OLEC SOHC Evaluation Report #1 and the actual direction resource development has taken exists in the following areas:

1. In the early group of 38 referrals to the project the first choice by the Case Manager for the type of resource needed was some form of institutional setting. Table 6 of Report No. 1 indicated that for the total sample of 38, the proportions distributed across type of resource most needed were as follows:

Group Care

26% Institutional (mini-MacLaren or Hillcrest)
16% Residential Treatment Center
5% Family Group Home
18% Professional Group Care
65% Sub-Total

Foster Care

21% Family Foster Care (with and without other children in the family)
13% Professional Foster Care
34% Sub-Total
99% Total

However, in the data reported in Table 2 of this report, those in placement as of the end of December 1974 (N=24), the group care-foster care categorization was as follows:

Group Care

21% Group Home Care
21% Sub-Total

Foster Care

17% Professional Foster Family
21% Family Foster Care
42% Big Brother/Sister
80% Sub-Total

100% Total

These data indicate that at the time the project began most of the referrals carried the recommendation for group or institutional care (nearly two-thirds) as opposed to foster care (the remaining one-third). However, in terms of placement slots available as of December 31, 1974 these proportions are the reverse of those recommended for the early group of referrals in that approximately one-fifth were in group care placement slots and four-fifths were in foster care placement slots. Given the fact that we have no idea as to how representative these early 38 referrals of all referrals made during the first few months of the project, we have a problem in interpreting the meaning of the above findings. Several points, however, are in order:

1. As the project has phased in, it has tended to place a greater emphasis on the initial development of "specialized" foster care placements and has relied on the regular CSD system for making its group care placements (with the exception of one SOHC provider with a group home for 4 clients and 4 slots in regular CSD group care agencies tailored for specialized (SOHC) care). For example, of 21 referrals between August 1974 and February 1975 placed with the regular CSD system, 16 (or 76%) were placed in group care settings, 4 (or 19%) were placed in foster care settings, and one (5%) was placed in a day care setting.

2. Within a month from this date both the SOHC group home (with a capacity of 5 slots) and the SOHC day care center (with a capacity of 15-20 enrollment) will augment the project's ability to provide "specialized" group out of home care settings for referred clients from Case Management.

3. There is some indication that the case manager's recommendations for out of home care are dependent upon their ideas of what is available in the project. In the early stages the case managers making the initial referrals knew little about what types of "specialized" slots would be available and their numbers. At this point they probably assumed that the group care type of settings would be most available and given the severe problems of their clients would offer the greatest level of professional care. As the project began developing its specialized foster care slots the availability factor probably influenced placement recommendations made by the case manager. Some evidence of this is indicated by the analysis of a second and later group of referrals made between September and December 1974. Although there is a question as to the representativeness of these 28 referrals, the following breakdown of responses to the needs assessment instrument item on recommended placement settings is probably indicative of this shift in placement preferences on the part of case managers:

Form 1.0 (Needs Assessment Profile)

Item: "General Type of Placement Setting"
(Only make one choice)

21%	Unknown -	
25%	Family Foster Home	Foster Care 46%
21%	Professionally Staffed Foster Home	
11%	Group Home	Group Care
14%	Small Residential Treatment Center	32%
7%	Institutional Setting	
99%		N = 28

Comparing the foster care and group care recommendations of case managers for the early referrals (N = 38) and later referrals (N = 28); then, we have the following results.

Early Referrals (August 1974) N=38	Later Referrals (September-December 1974) N=28

Recommended Placement Type

34%	..... Foster Care.....	46%
65%	..... Group Care	32%
0%	..... Unknown	21%
99%		99%

4. It is also possible that case managers are reconsidering the viability of the group care option as an out of home care alternative. Apparently, the project emphasis on the potential of foster care - especially the "specialized" variety which involves "professionals" may be influencing the case managers recommendations. At the moment there is no data available on the extent to which either the availability of a type of resource or the belief in the actual treatment value of a resource shapes the case manager's recommendation for a particular placement setting/resource.

Sub-Objective 2e

At the moment all referrals to the project are being recorded[1] and the referral process requires that the case manager fill a needs assessment form on the client which is then kept in an SOHC folder and is available for future data collection and processing. Aside from the original profile report on the needs assessment data (Evaluation Report #1 on an original group of 38 referrals) and tabulated, but unreported data on needs assessments of an undefined

[1] These recorded referral records have been maintained in an informally kept and unsystematically arranged log book. Due to the inability of the project director to hire needed, additional secretarial help, tickler cards designed to maintain periodic status change and contact information on all clients ever referred to the project were not filled out until only recently. At the moment cards have been either partially or completely filled out on about 100 of the 160 to 175 clients referred to the project between mid-July 1974 and late April 1975.

sample[2] of 28 referrals, no additional profile information on clients has been generated. Three major reasons exist for this deficiency.

1. Non-Comparability of Needs Assessment Information on Some Clients (Referrals).

   Any one of three drafts of the Needs Assessment form exist in the files of most of those referred to the project in 1974. The first draft was designed jointly by CMCS and SOHC staff members in July 1974 for identifying potential SOHC referrals and their out of home care needs. This draft was "pretested" in only one of the CMCS neighborhood offices.

   From this first draft a second draft was developed by the same staff members and was used in all four neighborhood CMCS offices in late July and early August 1974 to identify clients in the CMCS caseloads who at that time might be in need of specialized or regular out of home care.

   This survey resulted in the sample of 38 clients referred to previously in this report (and the basis of the first SOHC evaluative report). For the reason that the needs assessment instrument was to provide the OLEC staff with baseline data on clients referred to SOHC and also the SOHC project staff desired more useful and reliable information on the needs of referred clients, a third draft of the instrument was developed. This new draft was developed jointly by the SOHC staff and the OLEC evaluators in early August and copies of the completed forms were made available to the project for use in the field in late August 1974.[3]

   It was intended and assumed that beginning in late August all clients actually referred to the project (whether accepted or not for specialized or regular out of home care) would have the latest version completed by the referring case manager and filed with the SOHC project. However, in the early rush to establish SOHC placement resources and to process client referrals, many new forms were not completed on referrals. Instead, where the project had either a draft #1 or a draft #2 form (the earlier forms) already on these initial referrals from the earlier attempt to gather data on "potential" SOHC clients, little (if any) attempt was made to have the "new" form completed on these referrals.

[2] This sample of 28 referrals made between September and December 1974 is "undefined" in the sense that all we know is that they represent clients referred during this time who had completed needs assessment forms filled out on them and whose forms were available in the project files. In addition, all these clients' forms were of the third version which is currently in use. (The earlier two drafts contained less information. Draft #3 represented an evolution in the collection of information deemed necessary for adequately assessing out of home care needs.)

[3] A fourth draft of the needs assessment instrument was developed later, but "scrapped" in an effort to maintain consistently needs assessment information on clients.

2. Missing and Incomplete Needs Assessment Information on Some Clients (Referrals)

   In late December 1974 when the OLEC SPA coder became available for coding SOHC needs assessment data on project referrals; it became apparent that (aside from variation in the format of these data) there was considerable variation in the degree to which complete data was available on referrals.

   For example, project records indicate that through the end of 1974, 82 clients of CMCS were referred to SOHC for consideration for out of home placement. The SPA coder located files on 73 of these referrals (some cases were pending in late December and files hadn't been developed on these). Of these 73, records indicated that 40 had completed "new form" needs assessment instruments - but the coder was only able to locate 28 (most of these being those actually placed in SOHC rather than referred and routed on to the regular CSD out of home care system); twenty had "old form" needs assessment instruments and 13 had no form at all. Although some confusion existed in tracking down forms - due to their being in three separate file locations and constantly in use - it appears that many case managers were quite lax in completing and filing these forms. Because the SOHC project director and staff were committed in the beginning months to establish rapport between themselves and the case managers, little pressure was exerted (in the beginning) on them to promptly file Needs Assessment forms. Often, the case manager wouldn't file a form until after he was certain that his client would be placed.

   In addition, many of the forms were hastily prepared and there was a sizable number in which large sections were blank.

3. Unavailability of SPA Coders

   A third reason for the minimal utilization of the needs profile information on referrals lies with the lack of availability of coders. Aside from two weeks in December, no SPA coders have been available for work on the needs assessment data generated by this project.

NOTE: It is hoped that the eventual availability of coders, the use of practicum student researchers, the hiring of more SOHC secretarial help, and the development of more routinized data collection procedures will resolve the above three difficulties.

Sub-Objective 2f

Currently 100% of all youths serviced by the SOHC unit receive case planning, dispositional team and after care services. Subsequent reports will contain data on a per client basis which compares original after care plans with actual after care plans.

Sub-Objective 2g

After an abortive attempt by project staff to log time spent on various project activities, few if any records are being maintained on how much time each staff member expends on each service delivery task identified on a per client basis. Both the project director and the researcher-author agree that such a service logging procedure would yield little, if any, information of value to the project, at least for this research effort.

Objective #3	During the project duration, assist provider agencies working with SOHC clients to improve their abilities to provide rehabilitative and specialized services.

Meeting this process objective implies that two basic types of information can be and is being collected systematically on each provider or provider agency. These types are as follows:

(1) Specific information on the type(s) of services (both rehabilitative and "specialized") provided each client in placement - subdivided by incidence, intensity, and extensity.

Until we can know (and measure) how often what services are provided what clients to what degree and over what range of needs, we won't be able to realistically say in what ways we can recommend means for improving the delivery of these services.

(2) Specific information of an evaluative nature which provides an objective assessment of the provider's ability to provide these services and the actual role of service provision by individual client case.

To assess this objective, then, it is first necessary to be able to determine what services are being provided at what rate; and second, it is necessary to measure provider ability to improve the rate (and presumably the quality) of service provision.

At the moment a rigorous (if somewhat unsystematic) attempt is being made to provide project data on service provision. The project staff is collecting data on a quarterly basis which documents the costs of services on a per client per month served basis, but this data is not in a form which can be easily compiled and summarized at this time.

In addition to fiscal data, two other forms are in use which provide a monthly statement of the client's progress while in placement, a summary of his/her behavior, and a statement of any existing problems. Again, no systematic attempt has been made here to collect data consistent with a schema for classifying type, amount, and quality of services rendered clients. In addition, there are problems with these project data in terms of their reliability, validity, and completeness.

To resolve the problem of not having adequate project data for assessing provider service delivery, the "Dispositional Assessment and Case Plan" forms developed by the evaluator will be utilized to provide information

on the topic of what provider services are given clients in response to identified client needs/problems. In addition the evaluators have developed a provider interview schedule to be completed upon client termination from a placement and contains additional information on the services rendered a particular client.

Efforts are now underway to provide for an assessment of the training needs of each individual provider. This questionnaire instrument will allow the project staff to determine not only general training needs, but also those specific to a type of placement setting and a type of client.

Current Technical Assistance and Training Supplied Providers By The SOHC Unit (and CSD) And Others.

To date the technical assistance and training provided SOHC providers as a group has been innovative, broad ranging, and inclusive. It reflects an attempt at the aggregate level at least to respond to provider needs in the broadest sense. The following list of major documented training sessions/workshops and technical assistance illustrates the wide ranging character of this effort to upgrade and increase the professional competence of this staff:

McGregor Seminar - December 7, 1974

Seminar for providers on bookkeeping and procedures for reporting earned income. These bookkeeping tips were provided by Mr. Malcolm McGregor, CPA, and are intended to aid money management as most providers have difficulty here. The intent of the presentation was not to have Mr. McGregor assist providers in reporting income but to provide tips on reporting income for taxes, etc. Rather, the assumption was made that better bookkeeping procedures: (1) Free up the providers time to allow more client contact; (2) provide a clearer delineation on a line item basis of services provided a client; and (3) that better bookkeeping and consumerism permits the provider an opportunity to save money on material resources (food, clothing) permitting a greater expenditure on treatment (counseling, testing, etc.) (N=7)*

NOTE: This CPA is currently under contract to SOHC for on-going bookkeeping assistance. Providers can arrange appointments with him for the purpose of reviewing their bookkeeping system, point out deductibles and advise on their responsibilities for paying social security, etc. He was not hired, however, to do any provider's taxes.

Behavior Modification Techniques Assistance:

On an on-going basis one provider, Mr. Ken Keisel, (an expert in behavior modification) is to provide a monthly average of 20 hours consultation to any providers who wish to use behavior modification

* Numbers in parentheses refer to number of providers trained or assisted.

techniques in working with clients to reduce certain target behaviors. These sessions provide assistance in identifying target behaviors, developing behavior modification charts, setting up token economics, etc. (Half of providers assisted to date.)

January 21st and 23rd

Workshop in Problems Encountered During the Initial Phase of Placement

Two SOHC staff and a provider conducted this workshop which was designed to test out problems and solutions identified with situations where new providers meet new clients and attempt to establish rapport and develop a treatment relationship.

(N = 8 on January 21st and
N = 9 on January 23rd.)

Red Cross Training - January 28th and 30th, 1975

Course for Red Cross Certification. (N=3)

Handouts

Numerous handouts have been provided SOHC providers. These cover such information as how to aid clients in developing self-esteem, and how to recognize and deal with mental depression.

Newsletter

A weekly newsletter has been used by the project as a vehicle for informing providers of the availability of training sessions and technical assistance.

Dispositional Assessment Form Training

All SOHC providers and CMCS case managers have been trained by the SOHC staff in the use of the OLEC-developed Dispositional Assessment and Case Plan Review form (No. 2.0). This form serves two project related functions in addition to its use in the project evaluation. First, it is a tool for diagnosis and treatment in case planning for a client. Second, it is an instrument which allows the treatment or dispositional team to use a common terminology for need description and case planning. Additionally, it serves for identifying areas of treatment and interventive techniques where the provider needs additional training and assistance.

(All providers)

Session on Completing Case Plan Materials (March 20, 1975)

The SOHC staff provided an orientation session for a small group of providers on case logging, reporting, and interviewing. (N=7)

Workshop for Dealing with Client Ego Defense Mechanisms-April 3, 1975

This workshop consisted of a description of a series of techniques clients use to adapt to stress and cope with certain obstacles in life. The "ego defense" mechanisms included denial, repression, rationalization, projection, and displacement (or substitution). The intent of the workshop was to allow providers to be able to detect and treat the underlying causes.

Future Training and Assistance

During April 1975, Dr. Michael Ebner, a clinical psychologist and consultant to both the CMCS and JANIS programs, will conduct three training sessions based on the diagnostic and interventive categories presented in the Dispositional Assessment and Case Plan Review form. He is to explain and give illustrations of personality and behavior problems and techniques of dealing with them.

During May 1975, providers will have the opportunity to attend Adrien Creek's six Family Focus sessions. This course will be sponsored by the YMCA and its purpose is to familiarize the (foster) parents with Transactional Analysis (T.A.) and specific T.A. skills.

Aside from these and other training and assistance sessions, the project has shown a unique spirit of cooperation and mutual learning among staff, providers and CMCS case managers. Particularly manifest is a willingness to innovate and to extend training and assistance beyond conventional limits. For example, one provider has initiated a Food Club to encourage quantity buying and save on food costs.

Future training anticipated for upgrading provider skills will doubtlessly center more and more on the techniques of treatment outlined in the Dispositional Assessment form.

Conclusions

In retrospect, it would appear that this project offers great potential for improving the quality of alternative (out of home) care. Future evaluation reports will attempt to quantify these assertions and offer data which supports or refutes these assertions.

APPENDIX A

SPECIALIZED
OUT OF HOME CARE PROJECT

GOALS

In collaboration with Case Management Services, work to reduce recidivism of target offenders referred to the Specialized Out of Home Care Unit.

OBJECTIVE

I. Increase the amount of rehabilitative specialized out of home care resources for 150 target offenders.

PRODUCTIVITY INDICATORS

A. Provide specialized out of home care to 150 clients. At full operation, maintain average caseload of forty youths. Provide service for a maximum average of nine months per client.

B. Maintain data indicating resources by type of slots developed and methods used to assess services provided client by contracted providers.

C. Document actual length of stay in specialized out of home care per client, contrast with previous placement experiences.

OBJECTIVE

II. Develop a screening and placement model which provides and improves the delivery of specialized out of home care services to youthful target offenders.

PRODUCTIVITY INDICATORS

A. Illustrate the percentage of referrals to the SOHC Unit that were diverted from out of home placement due to utilization of resources identified by Case Management and Specialized Out of Home Care staff.

B. Document fifty cases wherein SOHC staff aided Case Management staff in placing clients in regular CSD resources.

C. Illustrate criteria and procedures employed in determining provision of out of home care to individual clients.

D. Document that in all placements in SOHC, family, education, peers, and health of the client were considered items.

E. Provide ninty percent of youth served by SOHC Unit with preplanning, dispositional team, and after care plan services. Provide data per client which compares original after care plan with actual after care.

F. Develop and document procedures the SOHC Unit employes to communicate with both regular CSD and Case Management systems.

G. Document functional roles SOHC staff assumed in providing services to clients.

H. Document forms of casework services and collaborative relationships which develop between SOHC staff, Case Management staff, provider staff, on a per client basis.

OBJECTIVE

III. During the project duration, assist provider agencies working with SOHC clients to improve their abilities to provide rehabilitative and specialized services.

PRODUCTIVITY INDICATOR

A. Illustrate type and frequency of technical assistance and training provided by SOHC Unit to providers.

B. Provide data outlining methods and materials used by the SOHC Unit to identify training needs of providers.

C. Illustrate by case type and amount of field service provided by SOHC caseworkers.

D. Document noted modifications and program design innovations by provider programs that occur during service period.

E. Provide, at the end of the project, individual program summaries furnished by providers.

OUTCOME - RESULTS

A. Reduce the amount of target offenses committed by youth serviced by the SOHC Unit as compared to available baseline data.

B. Increase the quantity, quality, and stability of Specialized Out of Home Care Placements.

C. Improve planning and coordination between CSD, Case Management, and other agencies providing out of home services to juvenile target offenders.

SOHC PROJECT

DISPOSITIONAL PHASE:

AN EXPLAINATION

RATIONALE

The goal of the "dispositional phase" is to increase the level of cooperation among several social service systems who are simultaneously assisting a single client over that level which is normally attained in the community without any such aid. Coordination of services has become recognized as a problem in recent years with the increased attention being paid to the "multi-problem" clients, especially families, in the correctional and general social service literature. Such clients typically have been responded to by an increasing number of agencies which specialize in the resolution or treatment of specific problems. The results have tended to be unacceptable levels of: duplication of effort among agencies; making of inappropriate referrals through a lack of program information and eligibility criteria; and the development of conflicts arising from cross purpose planning performed by two or more agencies for a single client.

Juvenile target offenders are inevitably a part of this dilema as is indicated in the Specialized Out of Home Care grant proposal.

> "Many Oregon agencies having responsibility for child care often become specialized, and tend to operate independently of each other, offering piece meal approaches to complex problems. This frequently results in overlapping, conflict, and omission of services to the clients." [1]

Two of the three problem areas addressed by the SOHC grant involve the provision of rehabilitating services to juvenile target offenders and this essential 'inter-agency' coordination in particular. (See pages 7 through 9.) The third area concerns the frequency of juvenile arrests for target offenses in Portland.

In stating the needs of the service area, the grant's authors concur with the legislative Committee On Social Services report

(1972):

> Need-To provide coordinated services through identification of existing services and improved lines of communication, referral, accountability between appropriate parts of the corrections process.
>
> Need-Establish a method for greater and more effective inter-agency case management between CSD, Multnomah County Juvenile Department, and agencies providing child care and services.
>
> Need-Increase the quantity and quality of residential care facilities with treatment resources appropriate for the needs of target offenders in Portland through planning, locating, training, coordinating, and monitoring.[2]

Meeting the first two needs will be the essence of the two dispositional functions, namely, "staffing" and "contracting". The "dispositional team" will first discuss or define the problem and then formally agree on the steps each will take to alleviate or resolve the problem.

WHO:

The dispositional team will be composed of at least the SOHC Intake and Placement Supervisor, the Case Manager, and the SOHC Resource Developer. Other participants may include: a regular CSD worker (as opposed to a project staff member), a regular juvenile court worker (as opposed to a case manager), a public health nurse or other out-patient agency representative, a potential child care provider, a consulting psychologist, or the client (offender) and/or his/her parents. The assembly of any or all of the above, or others, will be the responsibility of the SOHC Intake and Placement Supervisor, (the dispositional team chairman). The basis of the attendance or nonattendance of "optional" participants will be as follows:

1. Is this person essential for clarification of the problem at hand;

2. Is it essential for this individual or his/her agency to coordinate activities with the dispositional team in order for the team to proceed on a sound basis for problem solving planning?

The dispositional team process can be made available to Case Management children being served by the regular CSD out of home care services via a request from either the Case Manager or CSD caseworker. The requests will be granted within the limits of the project's regular work load at the given time.

WHAT:

I. "Staffing":

Initially, the Case Manager will present the client's problem necessitating out of home care to the dispositional team. Included in his presentation will be material required by the SOHC Unit (see SOHC "intake packet") as well as other material he/she deems relevant. Other participants will then have an opportunity to present information in addition to (lending clarification) or in opposition to (lending balance) the Case Management prospective. The focus of the discussion will be directed at clarifying the client's needs, especially as they relate to out of home care. For example, the focal issues may include: A. Why is out of home care needed?

B. What services need to be provided this child while he is in out of home care?

C. What services does the child's family also require while the child is out of the home?

D. What services will most likely be required by the child (and possibly his family) during "after care"?

Once the child has been placed, subsequent meetings will be held to address the actual progress in the case plan, needed changes in the case plan, "after care" issues and so on. Though "after care" issues will be considered throughout, a complete "after care" plan will be developed by the dispositional team prior to the child's leaving out of home care.

II. "Contracting":

Assuming out of home care through SOHC is appropriate, the dispositional team will begin "contracting". Contracting here will mean: committing ones self professionally and/or his respective agency to performing some specific service tasks, e.g. to provide parent effectiveness training to parents prior to the child's return home, to monitor the child's use of medication, to provide three months tutoring in mathematics, to provide problem solving casework to alleviate some

specified emotional distress, and so on.

These formalized agreements will be the basis of defining areas of responsibility and activity among the participants while the child is in out of home care and during the after care period. For this reason, they require specificity, group consensus, flexibility (e.g. allowing for differential participation and renegotiation), and reciprocal accountability.

These committments are professional agreements and therefore are not legally binding, however, the participants should be made aware that "service task completions" are part of the project evaluation scheme. Moreover, the "dispositional team plans" containing these agreements will be presented to the Juvenile Court at the point "temporary committment" is awarded to the Children's Services Division for "planning, placement, and supervision".

WHEN:

The dispositional team will be used for ninty percent of the cases entering out of home care through the SOHC Project. The dispositional team will convene for the first time after the Case Manager's completed Intake Packet has been received by the SOHC unit, but prior to Case Management's request for a juvenile court hearing transfering the child's wardship to CSD for out of home care placement. The team will be reconvened approximately every three months to review the progress of the case plan and prior to "after care" allowing sufficient time to plan adequately for that phase. More frequent meetings may be held under special circumstances or as scheduled in the previous dispositional team agreement.

WHERE:

Generally, most dispositional team meetings will be held at the SOHC office which is located at 34 NE Killingsworth (telephone 280-6911). Meetings held elsewhere will be done so by special arrangement.

HOW:

Responsibility for the dispositional team will belong to the SOHC Intake and Placement Supervisor. These responsibilities will include: scheduling of meetings, determining if any "optional" participants should be included, notifying all participants of the meeting time and place, leading/focusing the discussions, recording the dispositional team agreements, and the subsequent use of these agreements during the juvenile court hearings and program evaluation, etc.

MONITORING - EVALUATION:

The type of out of home care provided by the SOHC unit is primarily short term treatment (six to nine months). It is assumed that most children entering this type of care will manifest one or more behaviors which make their continued stay in their own homes or placement in currently available "substitute" care resources impossible. Case Managers will be required to describe such behaviors in some detail, including their rate of manifestation over a reasonable period of time. This description and rate will provide a focal point and "baseline" against which the "planned for" progress will be measured. Indicators of success may include a decrease in the "problem behavior (s)" as well as an increase in desirable behaviors.

The agreements made among the participants will similarly include a "service rate" if the service is multi-step in nature. For example, some types of counseling or training require several contracts as opposed to the purchasing of a single item for a child which may require only one step. The actual rate of "service task completion" will then be measured against the "planned for" rate.

FOOTNOTES

[1] SOHC Grant Proposal (Original), page 8.

[2] Committee on Social Services, Report to Legislative Interum 57 Legislative Assembly, State of Oregon, November 1972, Pages 26 - 32. As in: SOHC Grant Proposal (Original), page 9.

References:

1. William J. Reid and Laura Epstein, Task-Centered Casework, (New York), Columbia University Press, 1972.

2. Allen Pincus and Anne Minahan, Social Work Practice: Model and Method.

3. Antohny Maluccio and Wilma Marlow, "The Case for the Contract", Social Work, Volume 19, Number 1, January 1974.

Selection Criteria

A. Inclusion
   1. Must be referred from Case Management (i.e. adjudicated for a target offense).
   2. 10 - 17 years old.
   3. Male or female
   4. Generally, an IQ of at least 70.
   5. Pattern of not responding to other forms of intervention.
   6. Not physiologically drug-dependent.

Individual consideration on a case by case basis, will be given the following kinds of children depending upon availability of appropriate resources:

1. Massively disturbed requiring long term psychiatric treatment.
2. Serious physical disabilities which would prohibit normal mobility within the care setting, school or community.
3. Mental retardation.

There are four basic formats envisioned for Case Management referrals for out of home care (please refer to flow chart):

1. Circumstance: Case already open with CSD and CSD worker and Case Manager agree that an existing and available substitute care resource is needed and a placement plan has been set-up.

   Procedures: "Business as usual!" SOHC would not get involved. (Note: for "tracking purposes", Case Managers are being asked to notify SOHC by phone or memo of such placements.)

2. Circumstance: Same as above, but are unable to locate care resources, e.g. lengthy waiting list, etc.

   Procedures: Case Manager with the CSD worker's knowledge, may contact SOHC Intake supervisor.

   If the referral to SOHC appears appropriate and feasible, Case Manager would then be asked to complete an SOHC Intake Packet. Having received this, a dispositional team would convene to develop a case plan and arrangements

for placement with the appropriate provider would proceed.

Note: If SOHC makes the placement, it accepts the youth's case. A shared (split) case can be set-up if the on-going worker has had extensive contact with the family and wishes to remain involved or if it looks like other siblings will need service in the future.

(a variation of this circumstance is when a child is currently but inappropriately placed and both the CSD worker and Case Manager want an SOHC placement resource. In this instance, the Case Manager, in concert with the CSD worker, may "refer back" to SOHC to determine if a new resource is available.

3. Circumstance: Case not currently open with CSD and Case Manager wants to refer youth to a specific current resource (e.g. St. Mary's, Farm Home, Youth for Christ, etc.)

   Procedures: Case Manager contacts SOHC Intake and Placement Supervisor. He completes the Needs Assessment (Intake Form) and furnishes other materials necessary to assess the child's needs and type of provider needed.

   Note: If the youth looks inappropriate for a specialized resource or if the Case Manager is requesting an existing resource, SOHC Intake Supervisor calls the appropriate CSD liason worker to assess the feasibility of referral to the liason unit, discuss length of waiting list, etc.

   On new cases, the SOHC can channel referrals approved by the liason worker for staffing, directly (vs. requiring the Case Manager to contact a district CSD intake unit who would, in turn, make the referral to the liason unit.) It is at liason unit staffings that the choice(s) of youth care facility is made. The Case Manager may be invited to attend, give his recommendations, etc.

SOHC INTAKE AND REFERRAL PROCEDURES

4. Circumstance: Case Not Active with CSD and Case Manager is requesting a specialized out of home care resource through SOHC.

Procedures:

1. Case Manager makes referral through SOHC Intake and Placement Supervisor.

   --Case Manager completes the Needs Assessment form and provides SOHC with school/educational needs information and a medical-dental review.

   --Case Manager identifies the after care plan. (return home, long term foster care, etc.) He sees as realistic following specialized out of home care placement.

2. SOHC Intake supervisor convenes a dispositional team to develop the case plan, determine type of provider needed, engage professionals in contracting for the services they will be responsible for while the youth is in placement, and outline the type of after care to be planned toward.

3. SOHC, having accepted the case, would have a staff person attending the court hearing at which time temporary commitment would be transfered to CSD.

4. Youth placed, SOHC monitors placement. Dispositional team meetings would be scheduled as needed.

Note: Since SOHC has neither the staff nor mandate to service siblings of a child placed by SOHC who may require CSD services, the appropriate CSD district intake unit would be responsible (split case).

INSTRUCTIONS FOR USE OF SOHC FORM 2.0 FOR

DISPOSITIONAL ASSESSMENT AND CASE PLAN DEVELOPMENT

Introduction

After three months of discussion and work and three different drafts, the Dispositional Assessment Form (SOHC Form 2.0) can now be introduced for use in the Specialized Out-of Home Care Project. This form has two vital functions in this project. First, it is an important tool for use in the dispositional phase and in treatment itself. It is an important spring board for clarifying client problems and needs; for selecting interventive strategies and tactics; for acting out treatment roles and providing services (and resources); and for getting feedback and attaining professional growth in the treatment process. In a word, it is intended to help the case manager, the provider, and other dispositional team members to do their jobs in such a way as to insure or help to insure that project activities lead to the achievement of stated objectives in terms of assisting CMCS clients in need of truly "specialized" out-of-home care. It is especially useful in the sense that it can help keep those responsible for treatment aware systematically of their clients needs and problems and systematically aware of what they are doing in treatment. Conscientious use of this form during the dispositional phase of this project coupled with an honest and creative attempt to deal with a client problems which are most directly related to his delinquent behaviors hopefully can lead to the desired behavioral and attitudinal impacts on the client. At the least this form is a vehicle for effective case planning.

Second, information and data gathered from these forms will be useful in allowing Dr. Heuser of the Oregon Law Enforcement Evaluation Unit to more thoroughly evaluate the overall impact of this project in providing out-of-home care more effectively and in reducing the incidence of both target and non-target offenses among clients referred to the project.

While no data form has magical qualities for doing what it is supposed to do, this form incorporates a recording system for defining a needs profile and

a service profile for each client which is amenable to the criteria of (1) ease in use, (2) consistency in language and definition of terms, and (3) adaptability to both intervention and evaluative research. The needs profile section of the form contains a listing of problems (delineated within distinct theoretical rationales of causality) which the dispositional staff agrees applies to the client and his delinquent/problematic behavior patterns. The service profile section contains a listing of the interventive techniques and methodologies the treatment staff on the dispositional team agree to employ in dealing with those observed problems which are judged amenable to intervention and (directly or indirectly) related to the client's delinquent/problematic behavior patterns.

Form 2.0 is divided into two sections. Section 2.01 contains information on the client and case staffing along with sections for providing narrative statements of case plan goals, treatments, treatment role definitions, performance expectations (measurement of results), and any statements of special problems and concerns pertaining to a special client and case plan.

Section 2.02 contains codes for defining client needs (both behavioral and non-behavioral needs/problems) and for defining particular techniques and methodologies for informally and formally treating a client. Both the needs and service profile sections contain listings of such periperal problems as mental health, dental health, physical health problems/needs, many of which are related to the client's current behavioral problems. In many cases, for example, one must deal with physical problems long before one can attack the basic behavioral problems. This is especially true of clients with severe hearing, visual, and motor response problems.

Mechanics of Filling Out and Processing These Forms

Responsibility for filling out and dissemenating copies of these forms lies with the SOHC Dispositional Team leader (Rory or Fred). The earliest this form will be used is 30 days into placement (or at least one month after a client has

been placed with a provider). The forms will be updated with new listings of problems/needs and services/interventive techniques/methods, as well as, case plan changes at each subsequent dispositional meeting (about once each 30 days). For clients now in placement, the forms will be used at the next scheduled dispositional meeting (any scheduled after March 14th).

Note

Anyone familiar with innovative intervention approaches in delinquency prevention will recognize that the recording system provided in these forms is to some extent merely an adaption and modification of the recording system developed by the Seattle Atlantic Street Center during the 1960's.[1] The rationale for using this system and modifying it for the SOHC project and its evaluation rests on two basic assumptions: (1) While this form does not permit us to look at degree of exposure to treatment services, it does permit us to examine the exposure to type of service by type of problem. This is important if we are to determine what types of services are effective in dealing with what types of problems. (2) Our purposes for this form were identical to those for the ASC recording system. The ASC stated these purposes as follows:

1. (The recording system)"...attempts to avoid the recording inadequacy of previous projects, i.e., the inability to state clearly the social worker's interventive techniques and to speculate as to their effect upon the client population;
2. "...to establish a uniformity of language for diagnostic purposes and for interventive techniques;
3. "...to keep the worker aware systematically of what he is doing;
4. "...to indicate which techniques or combinations of techniques are effective or ineffective with specific diagnostic problems;
5. "...to provide readily available data from which the worker can evaluate his intervention and initiate change in his interventive efforts;
6. "...to provide a source of data for research analysis of worker intervention;
7. "...to act as a device for defining the specific method of each worker;
8. "...to give an indication of the types of problems encountered in working with this type of population."[2]

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[1] Seattle Atlantic Street Center Recording System, 1964.
[2] Effectiveness of Social Work with Acting-Out Youth: Seventh Year Progress Report, Sept. 1968 - August 1969.

END