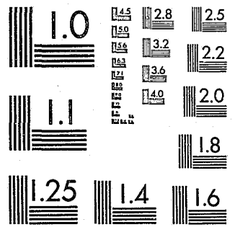

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dirty rotten kids?

A DESCRIPTION OF CHILDREN WHO ARE LABELLED AS BEHAVIOR PROBLEMS AND THEIR RELATIONSHIP TO THE HUMAN SERVICES SYSTEM

Robert L. Wilson, Patrick Miller, and Lee M. Mandell
The Center for Urban Affairs and Community Services
North Carolina State University

Sponsored by:
The Juvenile Justice Planning Committee of the Governor's Crime Commission *and* The National Council on Crime and Delinquency

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PREFACE

This report presents the results of research on children with behavioral problems in the State of North Carolina and the service system that attempts to serve them. Also contained in this report are recommendations of ways that the State can better provide services for these children. The information contained in this report was collected in the summer of 1980 and reflects the children and service history of those children at that time.

This research was conducted by the Center for Urban Affairs and Community Services at North Carolina State University. The Juvenile Justice Planning Committee of the Governor's Crime Commission oversaw this study in conjunction with the National Council on Crime and Delinquency, which provided funding for this report.

Two reports will be generated from the research. One will be a complete report of the research and the other will consist only of the Executive Summary (Chapter 1) of the complete report. The Executive Summary, which contains a brief description of the methodology, the major results of the study, and the recommendations of the Oversight Committee, will be the most widely disseminiated report. Copies of either of these reports can be obtained by writing: Manager, Applied Research Group, Center for Urban Affairs and Community Services, Box 5125, North Carolina State University, Raleigh, NC 27650 or Governor's Crime Commission, Dobbs Building, 403 North Salisbury Street, Raleigh, NC 27611.

ACKNOWLEDGEMENTS

The Center for Urban Affairs and Community Services acknowledges that this report is the result of many people's effort. Foremost, we would like to acknowledge the assistance of the members of the Oversight Committee and its staff (listed on the back of the front cover), and the members of the Juvenile Justice Planning Commitee who appointed the Oversight Committee and also assisted in more direct ways on the project. The Oversight Committee spent many long hours assisting in developing the purpose, scope, and design of the project, and assisting in obtaining permission to collect data at the many locations that the field staff visited, making suggestions on the report itself, and formulating recommendations that will better enable the State of North Carolina to provide adequate services for children with behavioral problems. Brenda Ball participated in many Oversight Committee meetings and served as a consultant for the Center for Urban Affairs and Community Services. Her expertise and knowledge of child clinical psychology and Mental Health Hospital service systems is greatly appreciated.

Other thanks for this report go to staff of the many agencies that we visited throughout the State of North Carolina. Almost all of the people contacted in connection with this project were cooperative and helpful, and were also interested in the outcome of this study. Service providers throughout the State realized the importance of conducting research on children with behavioral problems and were eager to assist with our research project.

A special acknowledgement must be made to Leonard Berman who wrote Chapter 13, Treatment Approaches: Innovative Treatments Nationwide. His expertise and knowledge of innovative treatments in the nation provided this report with a unique and necessary perspective.

Acknowledgements also must be made to the staff at the Center for Urban Affairs and Community Services. John McIntyre conducted almost all of the computer programming for this project. Karin Wolfe spent many long hours on the telephone gaining access to the various locations we visited and arranging appointments. Since we visited almost 100 locations, her job was extensive. The field staff who actually collected the information

should also be acknowledged: We wish to thank DeRamous Arrington, Randy Betancourt, Marc Blumenstein, Peggy Campbell, Ray Daniels, Mary Howard, Kenneth Diane Johnson, Donna Marion, and Ted Pattison for the long hours they spent on the road. Finally, we wish to thank the secretarial staff who typed, repeatedly, versions of this report. Sherry Humphries did most of the typing, usually under severe time pressures.

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CHAPTER 1

EXECUTIVE SUMMARY

This chapter presents a brief summary of the methodology and the results of the research and the recommendations of the Oversight Committee.

CHAPTER 1 - EXECUTIVE SUMMARY

INTRODUCTION

The following report addresses the problem of treating children with serious behavioral problems in the State of North Carolina. The Juvenile Justice Planning Committee of the Governor's Crime Commission initiated and oversaw this study in conjunction with the National Council on Crime and Delinquency, which provided the funding for this report.

Interest in children with behavioral problems has surfaced through many initiatives in the State of North Carolina. For example, As the Twig is Bent, an analysis of the impact of traditional institutional juvenile justice system on children, was published by the North Carolina Bar Association Penal System Study Committee. Also, "Critical Issues in Child Mental Health in North Carolina," an analysis of mental health policies to improve children's services, was published by The State-wide Planning Task Force for Children. As a further indicator of concern, the Juvenile Justice Planning Committee and the Juvenile Code Revision Committee, both of the Governor's Crime Commission, were created to recommend improvements in children's services to the Governor and the legislature. Most recently, several legal actions were started that should help define the roles and responsibilities of the state in providing services to children with special needs.

The children involved in many of these initiatives were children with behavioral problems. Serving these children in the existing human services system is difficult because the very behaviors which would cause them to be labelled as having behavior problems also make it likely that human service providers would label them as difficult to serve. This in turn would reduce the likelihood that they would be accepted for service. These children, and the service that system attempts to serve them, are the focus of this report.

METHOD

For this study, researchers collected information from the records of children (aged 10 through 17) at certain locations in the state. These locations were: the Youth Services Complex of the Department of Correction; Training Schools; Mental Health Hospitals; Wilderness Camps; and Group Homes. In addition, local agencies (Mental Health Centers, Departments of

Social Services, and Juvenile Court Counselors) were asked to identify the children for whom appropriate treatment or service could not be found because of their behavior or emotional disturbance. Basic demographic and background information was collected on the children at the above locations, as well as descriptions of their service history. Children whose records were obtained at one of the above locations were then classified into three categories of behavioral severity based on the behaviors that they had exhibited during their tenure in the human services system. These categories are a reflection of how these children would likely be labelled within the human services system rather than an indication of which children are the "worst." The behaviors on which this classification was based were: uncontrollable temper tantrums, attacking someone with a weapon, killing someone, public sexual activities, forcible sexual activities, prostitution or promiscuity, burning property, cruelty to animals, running away, attempting suicide, self-injurious behavior, vandalism, stealing, alcohol or drug abuse, and verbal aggression.

RESULTS

This study projected that there were at least 577 children in the state who exhibited behaviors that would result in their being labelled as children with high behavioral problems. Another 1,059 children had been identified as exhibiting behaviors that would result in their being labelled as having medium behavioral problems.

Over half (380) of the children classified as having high behavioral problems were identified at the local level as children for whom appropriate treatment or service could not be found because of the children's behavior or emotional disturbance. These children will be called "not appropriately served" in this report. Of the 380 children who were not appropriately served, 105 (28%) were currently residing at either: the Department of Correction facilities for children (5 children), Training Schools (65 children), Mental Health Hospitals (25 children),or Wilderness Camps (10 children). Another 55 children (14%) were residing either at group homes or foster care homes. More importantly, at least 155 of these 380 children (41%) were not residing at any kind of special facility. In other words, almost half of the children who were identified as being not appropriately served were living at home, be it with their parents, relatives, or whomever.

For these children who were living at home, there was evidence that they almost always were receiving services from a local service provider (either the Juvenile Court Counselors, the Mental Health Centers, or the Departments of Social Services) but that the service was considered to be inadequate. Researchers also found that the 380 children with high behavior problems who were identified at the local level as being not appropriately served had averaged over three previous residences, excluding moving in and out of home. Also, they had been served by an average of almost five previous service providers. Obviously, these children moved extensively through the human services network.

What are the characteristics of the children in this study labelled as having high behavioral problems? Approximately two-thirds of these children were male and two-thirds white. They had an average age of almost 15 years. A little over half of these children did unsatisfactory work in school and the records of three-quarters of them indicated that they were overly aggressive in school. Half of these children categorized as having high behavior problems lived with a male and a female adult, and a third with only a female. Almost two-thirds of these children had lived with their natural parent(s). However, for over half of these children, the family arrangement had changed more than once.

The family background of these children is perhaps the most interesting information found in the present study. The education of the primary wage earner was less than a high school degree for almost half of the children labelled as having high behavioral problems; over half of their families had been on some form of public assistance; and these children had, on the average, three brothers or sisters. There was an indication of the following types of family problems: over half of these children had been abused or neglected; over one-third had come from families that had family violence other than that directed at the child; and a quarter of these children came from homes that had completely disintegrated--there simply was no home for the children.

During their tenure in the human services system, the children labelled as having high behavior problems had exhibited an average of almost 14 uncontrollable temper tantrums, over 17 attacks without a weapon, almost 30 instances of alcohol or drug abuse, 44 instances of verbal aggression,

and 8 episodes of running away. Children labelled as high behavior problems exhibited more of all the behaviors considered in this study than children who were labelled as medium or low behavior problems and usually exhibited the behaviors at younger ages.

Separate analyses of the children who were identified as not appropriately served revealed small, but consistent, differences between them and the total population of children in the present study. Children not appropriately served exhibited most of the behaviors more frequently and usually at an earlier age. Furthermore, they had more problems in school and had more detrimental family backgrounds than that of all the children in the present study. These differences were found within each of the behavioral categories of low, medium, and high. It is important to note that the children who the local service providers identified as not appropriately served were in fact the children who exhibited greater frequencies of the behaviors and therefore appear to be most in need of services.

For all of the children in the study, there were consistent systematic differences between the categories of low, medium, and high behavior problems. For most of the information presented above, children labelled as medium behavior problems exhibited a greater frequency of behaviors, exhibited them at an earlier age, had more problems in school, and had more detrimental family backgrounds than children in the low behavior problem category but less than the children labelled as high behavior problems. For example, 55 percent of the children in the high behavioral problem category did unsatisfactory work in school, while 44 percent and 39 percent of the children in the medium and low categories, respectively, did so.

Similar patterns were found for the information about where children had lived and/or received services. Children labelled as high behavior problems tended to have been at the more restrictive settings, lived at more places, and had been treated by more service providers than children in either the medium or low groups. In addition, one of the clearest patterns revealed by the systems mapping data was that many children currently in a particular residential location had lived in that type of location before. For example, many children currently in a Training School had been in a Training School before. Furthermore, many of the children who had lived at a location more than once were at home between these placements indicating that many children were "bouncing around" within the

service system. This indicates a lack of service coordination at both the level of coordinating services for a particular child and at the level of allocating resources for services that are not currently available. This apparent lack of service coordination is further supported by the absence of interaction between Training Schools and Mental Health Hospitals. In the high severity group, few youths (7%) currently in Training Schools had ever been in a Mental Health Hospital, and few youths (7%) currently in Mental Health Hospitals had ever been in a Training School. This could result from early labelling of high severity youth as either criminal justice or mental health system material. Given the relatively large percentage of high severity youth whose first residential location was highly restrictive (Training School, 45% or Mental Health Hospital, 21%), there is strong support indicating the absence of a continuum of care in which children would move from the least restrictive to the most restrictive settings based upon their needs.

Other analyses for the children labelled as high behavior problems also revealed some interesting findings. Two residential locations housed different proportions of males and females: Training Schools were 76 percent male while Mental Hospitals were only 45 percent male. These percentages must be compared to the overall percentage of males in the study, which was 65 percent. Other than finding that males were overrepresented in Training Schools and underrepresented in Mental Hospitals relative to the overall percentage of males in the study, there were no other clearcut differences between males and females and their movement within the human services system.

When residential movement is analyzed by race, two locations stand out as having disproportionate representation. Instead of the overall division within the high severity group of 68 percent white, whites were overrepresented in both the Mental Health Hospitals (80%) and Group Homes (77%) There were no other consistent differences between race and movement within the human services system.

For the children labelled as high behavior problems, half were from small counties (population less than 85,000) and half were from large counties. However, for two locations children from large counties were overrepresented. Mental Health Hospitals and Group Homes had about two-thirds of their children coming from large counties. Furthermore, a higher percentage of youths in

Training Schools and Mental Health Hospitals had that location as their first location after home when they were from smaller counties than larger counties. This could reflect the fact that small counties have few alternatives for residential treatment of children labelled as high behavior problems and must therefore use Mental Health Hospitals and Training Schools.

GOALS OF OVERSIGHT COMMITTEE

Prior to the presentation of the policy recommendations made by the Oversight Committee for this research, it is essential that a clear statement be made of the goals that the recommendations are intended to achieve. The relationship between the research findings and the recommendations is more clearly delineated in Chapter 15. The Oversight Committee agrees on the following goals:

1. That a clear assignment of accountability and enforcement responsibilities is essential for the provision of services to children with behavioral problems and their families.
2. That the authority mandated to serve these children possess resources necessary to make a long-term commitment to these children and their families.
3. That in the development of treatment programs institutional resources be utilized only as an integrated part of a community-oriented continuum of care.
4. That children with behavioral problems be treated in the most appropriate, least restrictive, setting consistent with their needs.
5. That treatment services should focus on meeting the needs of these children within their families and as close as possible to their home communities.
6. That communities should develop a full range of treatment settings and program alternatives through which children with behavioral problems and their families might move as their treatment needs change.
7. That such a system of community care should have the capacity to provide individual chidren and their families with a planned and effective package of services including psychological, medical, educational, and vocational.

8. That the resource development necessary to implement these community-oriented programs be the result of a carefully planned, responsible and coordinated system at both the state and local level.

RECOMMENDATIONS OF OVERSIGHT COMMITTEE

Based on the goals presented above, a number of recommendations logically flow from the results of this study. These recommendations are organized under five general sections: (1) creation of system linkages, case management, and accountability functions; (2) treatment of individual children; (3) the concept of a continuum of care; (4) implementation of a continuum of care concept; and (5) need for early detection and treatment intervention programs.

CREATION OF SYSTEM LINKAGES, CASE MANAGEMENT, AND ACCOUNTABILITY FUNCTIONS. The recommendations made under this section are:

1. That case management responsibility for all children identified as having behavioral problems and their families regardless of where they are identified within the system, should be lodged with the area mental health authority of the child's home community. Referrals of such children would then be provided full case management services to include: diagnosis, referral, treatment services, and on-going monitoring against the treatment plan.
2. That administrative efforts be made by each area mental health authority to foster the kinds of referral linkages and inter-agency agreements that are essential if the case management function is to be effectively implemented.
3. That the Department of Human Resources be responsible for assisting each area mental health authority to move toward the implementation of a case management approach to meeting needs of children with behavioral problems. These efforts should include: the development and implementation of standards for case management and programs; a definition of the role of the referring agency; a strict definition of the proposed client population; the provision of technical assistance; and the monitoring of the implementation of this concept.

4. That the implementation of the above case management system be monitored independently and that an appeal process for individual children be established.

TREATMENT OF INDIVIDUAL CHILDREN. Four recommendations are made that involve the treatment of children:

1. That individual children with behavioral problems be provided program services, including medical treatment, education, vocational training and care, suited to their needs to afford them a reasonable chance to: 1) acquire and maintain those life skills that enable them to cope as effectively as their own capabilities permit in their environment, and 2) raise the level of his or her physical, mental, and social efficiency. Treatment should create a reasonable expectation of progress toward the goal of independent community living as much as possible for the individual. Treatment programs would not guarantee each child a "cure" but should guarantee each child a program of treatment which is a good faith effort to accomplish the goals set forth above.
2. That individual children be provided with the least restrictive, most normal living conditions appropriate for that person. Among the factors that should be considered in determining the least restrictive living condition appropriate for the individual are: 1) the need to minimize institutionalization, and 2) the need to minimize the possibility of harm to the individual and society. Whenever posssible, the child's family should be intimately involved in treatment.
3. That individual children should be provided such placements and services as are actually needed as determined by an individualized treatment plan rather than such placements and services that are currently available. If placements and services actually needed are not available, the person should be entitled to have them developed and implemented with a reasonable period of time (see Number 5, Implementation of a Continuum of Care Concept). Prior to development and implementation of needed placements and services, the person should be entitled to placement and services which best meet as nearly as possible his or her actual needs.

4. That individual children should be able to continue treatment for a reasonable period beyond their eighteenth birthday if: 1) the individual continues to be in need of such treatment and will benefit from continuing placement or involvement in the program in which they are receiving treatment on their eighteenth birthday, and 2) they voluntarily agree to continue treatment in that program in a manner consistent with state law or is confined pursuant to applicable state law.

THE CONCEPT OF A CONTINUUM OF CARE. The recommendations made under this subsection are:

1. That a continuum of services developed within a community allow children to move from more intensive to less intensive services as therapeutic progress is made. The community mental health authorities and their contractors should link mental health services and the community by:
   a. initially determining the nature of the child's problems through diagnostic studies;
   b. developing an appropriate treatment plan;
   c. entering the child into the appropriate treatment program; and
   d. consulting with parents and other relevant agencies, thereby assuring that there is appropriate and continuing understanding of the child's needs.
2. That development of a community-oriented continuum of services has the following advantages:
   a. it cuts down on bureaucratic "red tape" involved in moving the child from one component to another;
   b. it ensures a program of limited size allowing for more individualized attention; and
   c. it increases the probability of generalization of positive changes in behavior because the child is not removed from his or her environment but deals with his or her behavior with local family, schools, and peers participating.
3. That such services would probably consist of but not be limited to:
   a. Diagnostic and Consultation Services - local and state level
   b. Outpatient Services - local level

1. Individual and Family Treatment
2. Outpatient Group Treatment
3. Outpatient Emergency Treatment

c. Day/Evening Treatment - local level

d. Locked Residential Care - local and state level

e. Alternative Living - local and state level

1. Therapeutic Family/Specialized Foster Care
2. Group Homes
3. Independent/Apartment Living with Vocational Training
4. Wilderness Camps

f. Specialized Educational Programs - local and state level

g. Family Treatment and Support Services - local and state level

IMPLEMENTATION OF A CONTINUUM OF CARE CONCEPT. The recommendations under this section are as follows:

1. That Phase I of the Implementation of these recommendations consist of the funding during fiscal year 1981-1982 of a limited number of case management/continuum of care projects as a means of developing transferable models of the service delivery concept that might be applied to all areas of the state. The mental health program areas selected as Phase I project sites should be representative of all area mental health programs. These project sites should include:

   a. selected urban areas (i.e., single-county mental health programs) many of whom already possess the basic outline of a treatment continuum but would require additional resources to fill in the gaps in their existing continuum of care; and

   b. rural, multi-county areas composed of one or more area mental health programs. These rural Phase I projects would require additional funds to implement regional or multi-county treatment alternatives designed to develop a regional continuum of care. In many areas this banding together of counties and mental health program areas will be essential if cost-effective treatment programs are to be implemented.

2. That these Phase I projects be a joint effort of the Department of Human Resources (DHR) and selected area mental health programs. DHR should be held accountable for developing their implementation. The selected area mental health programs should be held accountable for the development of a local case management and resource development plan as well as for the ultimate implementation of the case management project.
3. That in addition to the implementation of these Phase I projects, the Department of Human Resources assist each area mental health program to: Inventory their existing treatment sources, assess their resource needs, and develop case management/resource development plans designed to implement a continuum of care concept within their areas.
4. That Phase II of this project be implementation of such community case management/continuum of care programs across North Carolina.
5. That, as a continuum of care/case management concept becomes a reality, there will be a significant need to develop a clear definition of the role which institutional resources are to play in the treatment continuum. As children are increasingly provided long-term treatment services within their home communities, Children and Adolescent Units of the state hospitals should move toward the provision of short-term intensive emergency and diagnostic services. As resources presently used in long-term care in state hospitals are freed up by the implementation of community-based programs, these funds should be transferred to the area mental health programs.
6. That while the implementation of a case management/continuum of care concept should effectively meet the needs of the vast majority of children with behavioral problems, each area mental health program will find itself faced with a very limited number of children whose special needs will necessitate the application of the treatment resources beyond the capability of local treatment programs. Therefore, it is recommended that a discretionary fund be established to meet the needs of these children. This fund would then be applied to meet these

special needs at the discretion of the Secretary of the Department of Human Resources.

EARLY DETECTION AND TREATMENT INTERVENTION PROGRAMS. Four recommendations are made under this section.

1. That increased efforts be made in the area of early detection and treatment services for children with behavioral problems and their families.
2. That early detection and intervention services be founded on the principal risk factors identified in this study (i.e., family violence, alcohol-related problems, and child abuse and neglect) and seek to identify these children and their families through contacts with such agencies as public instruction, law enforcement, juvenile courts, and local Departments of Social Services.
3. That the responsibility for the coordination of this early detection and intervention service be that of the area mental health authority.
4. That early detection and treatment intervention programs for high-risk children and their families be included as an integral element in the long-term plan of case management projects.

CHAPTER 2

INTRODUCTION

This chapter describes the national and state influences that have increased interest in children with serious behavioral problems. It also describes the purpose of this report and presents a brief discussion of some policy issues that must be dealt with but that may be independent of the results of the present study. An example of such a policy consideration is, "Who is ultimately responsible for the welfare of children with behavioral problems?"

CHAPTER 2 - INTRODUCTION

When children are frequently aggressive or display serious problems of behavior, the existing human services framework in North Carolina has difficulty helping them. These children, aged 10 through 17, are the concern of the study described in the following report. Reflecting increased concern on both national and state levels for children with special needs, the Juvenile Justice Planning Committee of the Governor's Crime Commission initiated and oversaw this study in conjunction with the National Council on Crime and Delinquency, who provided the funding. The report will describe the way in which the human services system in North Carolina relates to these children. It discusses some service alternatives which are being tried with these hard-to-serve children in other areas of the country. Finally, this report suggests ways in which this state's human services system can better meet the needs of these children.

HISTORICAL ORIGINS

NATIONAL. Three principles that began to receive national attention in the early 1960's greatly influenced many current practices in delivering services to children with special problems. The principles of deinstitutionalization, normalization, and the right of children to treatment have been discussed in academic treatises, debated among advocates, legislated, and at times implemented through the courts. The initial impetus for the concern with deinstitutionalization came with the publication of Asylums by Erving Goffman (1961) and was supported by Wolfensberger in The Principles of Normalization in Human Services (1972). These principles found legislative support in the passage of legislation such as the Community Mental Health and Retardation Centers Act (1974) and in court cases such as Wyatt v. Stickney (1972). The principle of "right to treatment" was established in Rouse v. Cameron (1966) and has been extended by a series of precedent setting cases [e.g., Creek v. Stone (1967), Wyatt v. Stickney (1972)]. A major legislative effort to enact this principle resulted in the passage of the Education for All Handicapped Children Act (1975). These three principles have formed the basis for

many national changes in the philosophies behind human services for children and in juvenile justice since the 1960's.

STATE. North Carolina has in many respects mirrored national efforts to implement the principles of normalization, deinstitutionalization, and right to treatment. These principles have brought about many changes in the human service and juvenile justice system. Examples in this state include establishment of community mental health programs and establishment of a community-based alternatives program for juvenile offenders. In spite of both state and local efforts to improve opportunities for children, many professional and lay persons continue to be concerned that appropriate services are not available for some children. This concern has been expressed in a number of ways: publication of As the Twig is Bent, an analysis of the impact of the traditional institutional juvenile justice system upon children; creation of the Juvenile Justice Planning Committee and the Juvenile Code Revision Committee of the Governor's Crime Commission to recommend improvements to the Governor and the legislature; publication of "Critical Issues in Child Mental Health in North Carolina," an analysis of mental health policies to improve children's services; and several legal actions intended to help define roles and responsibilities in providing services to children with special needs.

Therefore, this study is part of the continuing effort to enable decision makers to select the best possible alternatives in their efforts to improve existing services or provide new services for children. As such, it does not focus upon the needs of all children in North Carolina. Rather, it focuses upon those children with serious behavioral problems whose behavior frequently results in their being labeled as "aggressive," "violent," and "untreatable" and also frequently requires services that are difficult to provide.

PURPOSE OF THE PROJECT

The purpose of this project is to provide decision makers with information which will help them to decide policies which can improve services for children with serious behavioral problems in the State of North Carolina. Consequently, the report consists of information about the children and information about the service system in the state. Aided by the results of this report, policy makers can make specific recommendations

that will enable the state to better serve children with serious behavioral problems.

Information provided here will help address specific questions: 1) In order for decision makers to determine the appropriateness of the programs which are necessary to provide services, they will need estimates of the numbers of children that fit into the target group of this study. 2) In order to determine the nature of services that might be appropriate for treatment and prevention, decision makers will need descriptions of the social and demographic characteristics of children in the target group. 3) A review of "state-of-the-art" treatment practices will also assist in determining what types of services are appropriate. 4) Finally, so that decision makers may understand how children move through the service system and how it might be improved, the report describes and maps the system.

POLICY CONSIDERATIONS

While the information in the present report is a necessary factor in deciding what should be done for children with serious behavioral problems in the State of North Carolina, other policy considerations are important also. For example, who is ultimately responsible for these children? The possible answers to this question could be directed at the state or at local agency service providers. If the state is responsible for these children, should it be the Division of Social Services, the Division of Mental Health, or should a new Division be established that would serve as an advocate for children with serious behavioral problems in the state? If it is decided that local agencies are responsible for these children, should it be Court Counselors, Departments of Social Services, Mental Health Centers, Departments of Public Instruction, or should a new agency be formed that advocates for these children at the local level? Another important consideration is the philosophy behind the various treatments that these children can receive. For example, should the treatment of these children be residential, should it be non-residential, or should treatment efforts strive for a "continuum of care?" Also, should steps be made to treat these children and hopefully to alleviate their problems or should steps be taken to prevent these children from adversely affecting those around them? In other words,

should they be incarcerated? These policy considerations, while philosophical in nature, form the basis for any specific recommendations that can come from this study.

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CHAPTER 3

METHODS OF DATA COLLECTION

This chapter describes the methodology used in the present research. Included is the first of a two-phase process of defining the population of children to be studied. The first phase was collecting information on children at specific locations. Those locations were statewide residential locations (random selection of children were made) and local agencies (who were asked to identify the children who were not appropriately served or treated because of their behavior or emotional disturbance). Project staff examined the records of the children at the above locations and compiled information about the demographic, behavioral, social, and service history of each child. Also included is a discussion of the limitations of the present research.

DEFINING THE POPULATION: PHASE I

A two-stage process was used to define the population of children with serious behavioral problems. The first stage, discussed in this section, was directed at conceptual concerns. The second stage of the definition, discussed in Chapter 5, was based on an empirical examination of the frequencies of behaviors that were identified for each child in the present study.

The term "children" was defined to include ages 10 through 17. However, defining exactly what "serious behavioral problems" were was more difficult. In fact, in the absence of any empirical data, unanimous agreement about this term's definition was impossible. Therefore, one of the goals of this project was to derive empirically an operational definition of children with serious behavioral problems from the behaviors that were measured for each child in the present study.

The following types of information were collected from the existing records of each child: demographics, behaviors that the child exhibited, family background, characteristics of the home community, school behavior, specific test results such as IQ tests, the child's offense records, medical history, mental health diagnoses, and a detailed account of the service history of the child. Appendix A contains a copy of this client questionnaire.

LOCATIONS. Since they lacked an operational definition to identify the children to be included in the study, the researchers decided to examine the locations where these children would most likely be found. They expected that these children would be found in the Youth Services Complex of the Department of Correction, in Training Schools, in Mental Health Hopsitals, in Wilderness Camps, in Group Homes, or in Foster Care Homes. In addition, the Oversight Committee realized that there might be some children who would not be found in these locations because they could not be appropriately served. Therefore, certain county agencies were asked the following question: "Who are the children for whom you cannot find appropriate treatment or placement because of their behavior or emotional disturbance?" It was believed that children with serious

behavioral problems in the State of North Carolina would ultimately come into contact with either the residential locations or at least one of the county agencies. Therefore, the target population was initially determined not by a behavioral operational definition but by examining the locations that would be likely to serve or come into contact with these children.

RESIDENTIAL LOCATIONS. At each of the residential locations where children with serious behavioral problems were likely to reside, a random sample of all of the children at those locations was taken. However, for two of the locations, most of the information that was desired was provided by the location on a computer tape. These two locations were the Youth Services Complex of the Department of Correction and the Wilderness Camps. For these two locations, no random sample was necessary since a report could be derived from the computer tapes for all of the children as easily as from a random sample. However, random samples were taken for the children located in Training Schools, Mental Health Hospitals, and as many of the group homes in twenty counties as would agree to allow project researchers access their files (the selection of these counties will be described below). To obtain a random sample of the Foster Care homes, field staff visited the central files maintained in Raleigh. They completed 130 questionnaires on the approximately 600 cases from the Training Schools; 79 questionnaires for the approximately 160 children who reside in Mental Health Hopsitals; 21 questionnaires on the over 4,000 foster care children (this number was too small and this data was subsequently discarded from the analysis); and 52 questionnaires from the Group Homes.

NO APPROPRIATE SERVICE. In addition to information from random samples from the residential institutions in the state, project staff obtained data from service providers in twenty counties who were asked, "Who are the children for whom you cannot find appropriate treatment or service because of their behavior or emotional disturbance?" The twenty counties chosen and their populations appear in Table 3.1. The agencies that were contacted in each of these counties were the Court Counselors, the Mental Health Centers, and the Departments of Social Services. A client questionnaire was completed by project staff for each of the children who were identifed by the county agencies as being either

inappropriately served or not served at all. There were 256 questionnaires completed in the twenty counties.

TABLE 3.1
RANDOMLY CHOSEN COUNTIES AND POPULATION

County	Population
Brunswick	38,089
Camden	5,095
Carteret	39,123
Cleveland	81,605
Dare	10,945
Duplin	40,921
Durham	148,241
Greene	14,753
Harnett	56,665
Henderson	52,951
Mecklenburg	400,177
Montgomery	19,738
New Hanover	104,043
Orange	75,544
Pasquotank	29,081
Polk	13,121
Transylvania	22,351
Vance	34,174
Warren	17,229
Yadkin	28,408

Other locations that a child with behavioral problems in the State of North Carolina might receive service would be through an out-of-state service provider. Therefore, the researchers obtained information on out-of-state placements from two sources: the Mental Health Study Commission and the Legislative Commission on Children with Special Needs. This information contains how many children were served out of state, the cost of the service, the expected length of the service, and the location of the out-of-state service. The researchers considered sending the

full questionnaire described above to the out-of-state placements but decided that they probably would not take the time to participate at the level of cooperation required to complete the rather lengthy questionnaire for each child. Therefore, only the information obtained from the Mental Health Study Commission was used.

LIMITATIONS

For the results of this study to be properly interpreted, it is necessary to understand the limitations which are inherent in the data collection procedures. Major limitations are listed below:

1. The data collected in this study is based upon client records kept by service providers. It is thus subject to the biases of individual service providers and of agency record-keeping policy. This dependence upon secondary services for data procedures is a conservative count of the frequency of problem behaviors and thus a conservative estimate of the number of children with high behavior problems.
2. A second limitation of the study was imposed through the creation of a behavior-based definition of children to be included in the study. This definition ignores traditional legal and psychological definitions, although it includes elements that contribute to them.
3. A third limitation was imposed by the necessity of relying upon data collected for other purposes by the Department of Corrections and the Wilderness Camps Program. Data from these two locations was provided to the study on computer tapes for reasons of efficiency. However, this data did not include all of the information collected from case records by the research teams. Therefore, the analysis underestimates the number and import of children in the Department of Corrections and in the Wilderness Camps Program.
4. A final limitation was imposed by the differing interpretations of local service providers when asked about children's being not appropriately served due to behavioral or emotional problems. It is hoped that the final definition, based upon behaviors as opposed to opinions, helps to mitigate this problem.

It is important to note that these limitations are the result of intention not accident. The researchers have always sought to impart a conservative trend to the research reported here. An awareness of this conservative trend is essential to a proper understanding of this report.

CHAPTER 4

ORGANIZATION OF RESULTS CHAPTER

This chapter describes the organization and content of the results chapters.

CHAPTER 4 - ORGANIZATION OF RESULTS CHAPTERS

The chapters on results are organized in the following way:

CHAPTER 5 - RESULTS--DEFINING THE POPULATION: PHASE II

This chapter deals with the second phase of defining the target population. This second phase was to empirically determine a way of distinguishing the children who are most difficult or impossible to deal with because of their behaviors from the other children in the study.

CHAPTER 6 - RESULTS--MAKING STATEWIDE PROJECTIONS

This chapter explains the manner in which the samples obtained in the present study were used to make statewide projections. Also, the actual number of children in each of the three levels of behavioral severity (low, medium, and high behavioral problems) were estimated from the samples.

CHAPTER 7 - RESULTS--PROFILE OF CHILDREN WITH BEHAVIORAL PROBLEMS

This chapter gives the basic demographic data on each child (age, number of siblings, etc.). This information is given for each level of severity (low, medium, and high).

CHAPTER 8 - PROFILE OF CHILDREN IDENTIFIED AS not appropriately served

This chapter compares the profile of children obtained at the county level as not appropriately served with the profile of all of the children in the study that is given in Chapter 7.

CHAPTER 9 - RESULTS--SERVICE HISTORY

This chapter discusses the information that was obtained for the current residential location. This informtion includes reason for referral to the location, behaviors and offenses at the location, concurrent treatment locations and the number of residences and services.

CHAPTER 10 - RESULTS--SYSTEMS MAPPING

This chapter illustrates where clients are moving to and from in the service system. Two sets of tables are given: one for residential locations and one for the service providers who serve the client.

CHAPTER 5

RESULTS - DEFINING THE POPULATION: PHASE II

This chapter describes the second of a two-phase process of defining the population of children to be examined in this research. The second phase consisted of weighting each behavior and summing each child's frequency of occurrence across all of the behaviors to create a composite behavioral index. From this behavioral index, the population of children was divided into three categories. These categories reflect the extent to which children exhibiting a certain behavioral index score would be likely to be labelled as having either low, medium, or high behavior problems by the human services system.

CHAPTER 10 - RESULTS--SYSTEMS MAPPING

This chapter illustrates where clients are moving to and from in the service system. Two sets of tables are given: one for residential locations and one for the service providers who serve the client.

CHAPTER 5

RESULTS - DEFINING THE POPULATION: PHASE II

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CHAPTER 5 - RESULTS--DEFINING THE POPULATION--PHASE II

As indicated in Chapter 3, the definition of the population was a two-step process. In the first step, project staff decided to collect information on children aged 10 through 17 at certain locations throughout the state and that a further division of these children would be derived from the types and frequencies of behaviors that were reported in their records. Specifically, it was decided that information would be collected on children residing at the Youth Services Complex of the Department of Correction, Training Schools, Mental Health Hospitals, Wilderness Camps, Group Homes, and Foster Care Homes. In addition, researchers decided to collect information on children whom local service providers identified as being difficult to treat or serve appropriately because of their behavior or emotional disturbance. The local service providers were: Juvenile Court Counselors, Mental Health Centers, and Departments of Social Services. The methods of taking random samples from these locations were explained in Chapter 3.

For these locations, the field staff for the Center for Urban Affairs and Community Services recorded the number of times that the records indicated that each of certain behaviors had been exhibited. Frequently, these staff were required to make estimates of the behaviors. For example, a caseworker may have written that a child was verbally aggressive "just about every day." From this statement, the field staff would estimate the number of occurrences that would reflect "just about every day." In other words, the field staff had to make a quantitative estimate from a qualitative statement. Field staff were instructed to make estimates that were, if anything, minimum and conservative. There was a limit of 99 for the frequency of behaviors.

This chapter presents a way of dividing these children into three categories based on how often each child exhibited certain behaviors according to his or her records. While such a division into categories is justified, readers should realize that there is a continuum of severity, with children who have no behavioral problems at one end and children who have a great many behavioral problems at the other end. Any division of this continuum into categories is arbitrary to some extent, but it is

necessary so that the different parts of the continuum can be discussed separately and compared. There is no completely objective way of choosing points on this continuum that divide the population of children into categories, though some objective criteria can be used to assist in making these decisions. A major defense of any choice for the cut-off points is to choose a strategy for the selection of points that result in minimum conservative estimates of the children in the more severe categories. That was the strategy current researchers used in choosing the cut-off points, especially in choosing the point separating the high end of the continuum from the rest of the population. This point was chosen in such a way that all of the children in the high group exhibited a very high level of behavioral problems. Furthermore, an objective criteria was used to assist in making this decision.

These categories are intended to reflect the extent to which these children are likely to be labelled as behavior problems by the human services system; they are not intended to differentiate the children on the basis of how severe their behavior problems are. In other words, the categories are not intended to indicate which children are "worse" than others. The behaviors were chosen in the present study because they are the types of behaviors that human service providers perceive as making treatment difficult and which therefore would result in these children's being labelled "dirty rotten kids." However, this label is as much a result of the system that uses the label as it is of the children's behavior. The staff of this study do not wish to further this labelling process that puts blame for the children's behavior solely on the children. If the children were solely to blame for their behavior, solutions would consist of doing something to "make the children behave," rather than in seeking change in the system that applies the labels and perhaps causes the behavior--which is frequently the human services system. The Oversight Committee and the researchers conducting the present study believe that strategies of what to do with these children labelled as behavioral problems should be applied to both the human services system and the children themselves.

As explained above, the field staff recorded the number of occurrences for each behavior. From the number of times each behavior occurred, the researchers determined, in a manner explained below, at what point each behavior would have occurred enough times to result in the child's being

labelled a behavior problem. For example, one uncontrollable temper tantrum would obviously not be considered an indication of serious behavioral problems by most people. However, at some frequency, uncontrollable temper tantrums would be considered evidence of serious problems. The researchers derived the frequency at which each behavior would be considered evidence of serious behavioral problems by examining the frequency distributions for each behavior. Two such distributions are given in Tables 5.1 and 5.2. The frequency distributions were collapsed over all different facilities (i.e., Mental Health Hospitals, Training Schools, Mental Health Centers, etc.). Also, these are the statewide projections, not the actual sample means; the manner in which these projections were made from the samples is explained in Chapter 6. As Chapter 6 also explains, the actual samples cannot be used because they would not reflect the relative distributions of children among the different locations. For example, approximately an equal number of children were sampled from both the Training Schools and Mental Health Hospitals. However, there are four times as many children in Training Schools as in Mental Health Hospitals throughout the state. If the samples were used rather than the statewide projections, the children from Mental Health Hospitals would have equal weight with children from Training Schools when in reality they should only be considered one-fourth the weight of children in Training Schools. For this reason, the statewide projections, based on a weighting procedure, were used in the frequency distributions for each behavior.

In looking at the distributions for all behaviors, it was discovered that most of the children's records indicated zero occurrences for any given behavior. This can be seen in Tables 5.1 and 5.2 for uncontrollable temper tantrums and attacks without a weapon. Furthermore, as the number of occurrences increased, the frequency of children who exhibited the behavior decreased. For example, in Table 5.1, the number of children for whom evidence was found for zero temper tantrums was 1,870 (remember, this is the statewide projection, not the frequency of the sample); for one temper tantrum, the frequency was 85; for two tantrums, the frequency was 34, etc. Across all behaviors, the most frequent occurrence was zero, the next most frequent was one, the next was 2, etc. In other words, as the number of occurrences increased, the frequency of children exhibiting that number of occurrences decreased.

TABLE 5.1

FREQUENCY DISTRIBUTION FOR UNCONTROLLABLE TEMPER TANTRUMS

	# of Occurrences	Frequency	Cumulative Frequency	Percent	Cumulative Percentage
	0	1870	1870	75.275	75.275
	1	85	1955	3.437	78.712
	2	34	1989	1.359	80.070
	3	50	2039	2.010	82.080
	4	29	2067	1.147	83.227
cut-off point	5	45	2113	1.820	85.047
	6	14	2127	0.564	85.611
	7	5	2132	0.201	85.812
	8	2	2134	0.081	85.893
	9	8	2142	0.341	86.233
	10	67	2209	2.697	88.931
	11	7	2216	0.282	89.213
	13	14	2230	0.564	89.776
	14	10	2240	0.421	90.197
	15	41	2281	1.651	91.848
	16	5	2286	0.201	92.049
	17	5	2291	0.201	92.250
	20	17	2308	0.684	92.935
	21	5	2313	0.201	93.136
	25	95	2409	3.835	96.971
	50	10	2427	0.403	97.695
	99	57	2484	2.305	100.000

TABLE 5.2

FREQUENCY DISTRIBUTION FOR PHYSICAL ATTACKS WITHOUT A WEAPON

	# of Occurrences	Frequency	Cumulative Frequency	Percent	Cumulative Percentage
	0	1342	1342	53.916	53.916
	1	237	1579	9.514	63.430
	2	99	1678	3.932	67.412
	3	145	1823	5.835	73.247
	4	55	1878	2.189	75.436
	5	87	1965	3.513	78.949
	6	30	1995	1.195	80.144
cut-off point	7	26	2021	1.044	81.189
	8	24	2045	0.964	82.153
	9	18	2063	0.733	82.886
	10	124	2187	4.971	87.857
	11	8	2195	0.321	88.178
	12	19	2214	0.753	88.931
	13	11	2225	0.442	89.373
	14	8	2233	0.340	89.713
	15	34	2268	1.384	91.097
	16	5	2273	0.201	91.298
	17	5	2278	0.201	91.499
	20	38	2316	1.545	93.044
	21	2	2318	0.080	93.124
	23	7	2325	0.281	93.405
	24	14	2340	0.572	93.978
	25	17	2357	0.693	94.671
	27	2	2359	0.090	94.761
	29	5	2364	0.201	94.962
	30	18	2382	0.723	95.685
	35	4	2387	0.161	95.846
	38	2	2388	0.080	95.926
	39	2	2390	0.080	96.006
	43	5	2395	0.201	96.027
	50	36	2431	1.443	97.650
	99	59	2489	2.350	100.000

To determine the cut-off point for each behavior (i.e, the number of occurences at which the behavior would be labelled as a serious behavioral problem within the human service system), the researchers decided to use the frequency that first fell below one percent of the total. In Table 5.1 this cut-off point was at 6 uncontrollable temper tantrums. By looking in the fourth column, the reader can see that this was the first point where the percentage of children exhibiting that frequency of the behavior was less than one percent of the total. Any child who evidenced less than the number of occurrences of any behavior at the cut-off point would therefore be defined as not manifesting behavioral problems severe enough to be labelled a behavioral problem; on the other hand, any child whose record indicated a number of occurrences for any behavior greater than the cut-off point would be labelled as manifesting behavioral problems. This particular cut-off point was chosen because any further increase in the number of occurrences of the behavior would result in an insignificant increase (less than one percent) in the number of children who would be labelled as behavioral problems. This point, the researchers posit, is the point that differentiates the children who have exhibited a high number of occurrences (those whose behavior would be viewed as evidence of a serious level of that particular behavior) from the rest of the population (those whose behavior was not at a level of occurrence labelled as serious). These cut-off points are indicated for each behavior in Table 5.3.

This manner of determining the cut-off points was applied to all of the behaviors except two: killing someone and forcible sexual activity such as rape. The researchers had decided prior to any analyses that even one occurrence of either of these behaviors would result in the child's being labelled as having behavioral problems. Therefore, the cut-off points for both of these behaviors were set at 1. In the case of killing someone, the same cut-off was obtained when using the one percent criterion. For forcible sexual activity, it was different; relying solely on the one percent level, the cut-off would have been 2 rather than 1.

Using these cut-off points for each behavior, one can be determine whether or not there is an indication in each child's records that he or she has exhibited any given behavior at a level that would result in the

TABLE 5.3

CUT-OFF POINTS FOR EACH BEHAVIOR

Behavior	Cut-off point (greater than or equal to)
temper tantrums	6
attack w/weapon	4
attack w/out weapon	8
killed someone	1
public sex activity	2
forcible sex activity	1
prositution/promiscuity	4
burning property	2
cruelty to animals	3
running away	8
attempted suicide	3
self-injurious behavior	3
vandalism	4
verbal aggression	7
stealing	7
alcohol/drug abuse	4

child's being labelled as having serious behavioral problems. This means that any child who has exbibited a behavior at above the cut-off level of occurrence would be labelled as a child manifesting behavioral problems. However, there may be children who have not exhibited behaviors at above the cut-off point levels for any of the behaviors but have evidenced several behaviors at below cutoff point levels. These children would not be defined as having serious behavior problems if the definition only examined whether they had exbibited any behavior at above cut-off point levels. To avoid this, the number of occurrences for each behavior was multiplied by the reciprocal of that cut-off point. For example, the cut-off point for temper tantrums was 6. The number of occurrences for each child was therefore multiplied by 1/6 to obtain a single behavior index score. This means that any child who had exhibited greater than the cut-off level for any behavior would have a single behavior index score of 1 or greater. For example, if a child had exhibited 6 temper tantrums, then the index for that child would be determined by multiplying 6 x 1/6 which equals 1. If a child had exhibited 3 temper tantrums, the index for that child would have been .5 (3 x 1/6). After the single behavior index score was determined for each behavior, they were summed for each child over all behaviors to form a behavioral index score. The distribution of behavioral index scores is given in Table 5.4.

It should be pointed out that two locations were omitted in determining the cut-off points for each behavior: the Youth Services Complex of the Department of Correction and Wilderness Camps. For the Department of Correction data, which were provided in computerized form, there was no indication of the level of occurrence for any of the behaviors. Since there is no way of determining a behavioral index score for the children in the Department of Correction, these data will be excluded from any analysis based on these index scores. For data on Wilderness Camps, also obtained in computerized form, there was only an indication of whether or not a behavior existed at some level, not its level of occurrence. In talking with the Division of Youth Services, from whom the computer tape for the Wilderness Camps was obtained, researchers determined when the presence of any given behavior would have been at or above the cut-off point determined in the present study. For example, if the child's data had indicated a history of temper tantrums, Division of Youth Services personnel indicated if that

TABLE 5.4

FREQUENCY DISTRIBUTION FOR BEHAVIORAL INDEX

	Behavioral Index Score	Frequency	Cumulative Frequency	Percent	Cumulative Percentage
low	0	724	724	26.819	26.819
	1	328	1052	12.140	38.959
	2	305	1357	11.311	50.269
	3	155	1512	5.747	56.016
medium	4	147	1660	5.459	61.475
	5	72	1732	2.676	64.151
	6	60	1792	2.204	66.355
	7	76	1867	2.806	69.161
	8	77	1944	2.852	72.012
	9	64	2008	2.370	74.383
	10	23	2032	0.861	75.244
	11	38	2070	1.416	76.661
	12	30	2100	1.111	77.772
high	13	45	2144	1.648	79.420
	14	42	2186	1.556	80.976
	15	73	2259	2.701	83.677
	16	14	2273	0.519	84.195
	≥17	427	2700	15.805	100.000

"history of" would have been consistently at or above the cut-off points determined in the present study. Then the present researchers set the level of occurrence for the Wilderness Camp data equal to the cut-off points derived from the present study for each behavior. This was only done when the Division of Youth Services indicated that their criterion was greater than the cut-off point. When they indicated that their criterion was less than the cut-off, then that behavior was set to zero. In no case could a child from a Wilderness Camp have the frequency of a behavior greater than the cut-off point used in the present study. This means that the number of occurrences for each behavior for the Wilderness Camps data was a conservative, minimum estimate of the actual number of times that a given behavior was recorded in their records.

Table 5.4 shows that 724 children had a behavioral index score of less than one and were therefore defined as children who would be labelled as possessing no or low behavioral problems; the remainder (1,976 children) had scores greater than or equal to one and were defined as children who would be labelled as having behavior problems. These figures are based on statewide projections and are, as Chapter 6 explains, conservative projections.

At this point the researchers, in collaboration with the Oversight Committee, decided that the upper category of the population should be divided into two sub-categories. The criterion for making this division was the same as the one discussed previously: that level of occurrence in the frequency distribution that first fell to less than one percent of the total population. As can be seen in the fourth column of Figure 5.4, this cut-off point for the behavioral index scores was 10. Using this cut-off point, the number of children defined as having low behavior problems was 724; the number of children labelled as having medium behavioral problems was 1,284; and the number of children labelled as having high behavioral problems was 692. A correction factor will be applied to these figures in Chapter 6 that will reduce them to 679, 1059, and 577 respectively.

The break down of children into these three categories would be seriously challenged if there were a relationship between the behavioral index scale (and therefore the number of occurrences for the behavior) and the age of the child or the length of time that the child had been in the service system. However, the correlation between age and the behavioral index score was .13, accounting for less than two percent of the variance. The

lack of a relationship between age and the three categories of behavioral severity also can be seen in Chapter 7, Table 7.2, which shows the percentage of children in each category of behavior severity for each age. Comparing across the three levels of behavioral severity, all ages were approximately equal. The correlation between length of service contact, as measured by the date of the first service contact, and the behavioral index score was .01. Obviously, the behavioral index score was independent of the age of the child and the length of time that the child had been in the service system. This adds considerable credence to the behavioral index scale that was used to classify children into the three categories of behavioral severity.

Table 5.5 gives the number of children in each of the three behavior categories by the facility where the information was collected. This table shows the number of children who were labelled as having low, medium, and high behavioral problems, for each location on which data was collected in the present study. As indicated above, the Wilderness Camp data are a minimum, conservative estimate due to the manner of data transfer from an existing computer tape to the Center's data base. Also, as mentioned above, a correction factor will be applied to these totals that will reduce them. The next chapter is devoted to making accurate statewide projections.

TABLE 5.5

STATEWIDE PROJECTIONS FOR EACH LOCATION BY LEVELS OF BEHAVIORAL SEVERITY

		Behavioral Severity			
		Low	Medium	High	Total
Department of Correction	%				
	N				(550)
Training Schools	%	18%	27%	22%	23%
	N	133	346	152	630
MH Hospital	%	03%	04%	12%	06%
	N	020	54	84	158
Wilderness Camp	%	04%	13%	00%*	07%
	N	026	166	000*	192
Group Home	%	34%	09%	11%	16%
	N	245	118	076	440
Not Appropriately Placed	%	41%	47%	55%	47%
	N	300	600	380	1,280
	%	100%	100%	100%	100%
	N	724**	1,284**	692**	2,700**

* This figure is zero probably due to incomplete data from Wilderness Camps. See text.

** Uncorrected, see Chapter 6.

CHAPTER 6

RESULTS - MAKING STATEWIDE PROJECTIONS

This chapter describes the process of making statewide projections based on the samples in the present study. It was estimated that there were at least 577 children in the state who were labelled as having high behavioral problems, and at least 1,059 children with medium behavioral problems. The present study also found 679 children who would be labelled as having low behavioral problems. The chapter explains how these estimates were obtained and describes the conservative nature of the measurement approach.

CHAPTER 6 - RESULTS--MAKING STATEWIDE PROJECTIONS

Table 6.1 shows the actual number of records sampled at each location, broken down by the three levels of behavioral severity. Actually, one of the Training Schools was oversampled and was multiplied by a weight to give it appropriate representation for training schools. The actual number of records sampled at Training Schools was 130 but after weighting, the number was 105 as shown in Table 6.1.) From Table 6.1 the number of children in each of the low, medium, and high groups can be determined for each location. For example, 24 percent of the children in Training Schools have been labelled as high behavioral problems. The statewide projections shown in the last column are the same as those given in Table 5.5. As can be seen, Table 6.1 illustrates there were no Wilderness Camp children who were identified as having high behavioral problems. This report has explained previously, that this is a function of the fact that the information from the computer tape for Wilderness Camps did not have the number of occurrences for each of the behaviors comprising the behavioral index score and estimates were made that resulted in Wilderness Camps children's not having behavioral index scores high enough to classify them in the high group. Therefore, any inferences based on the premise that Wilderness Camps do not serve children with high behavioral problems probably would be erroneous. Also excluded from this table are the data from the Youth Services Complex of the Department of Correction. As indicated earlier, the data tape from the Department of Correction had no information on whether or not the children had exhibited any of the behaviors used in the present study. Obviously, there are children in the Department of Correction who manifest behavioral problems. Another exclusion from the present study was the Foster Care children. This population was excluded because the sample from the foster care homes was too small (.5%) to be reliable. Again, there are obviously some children in foster homes who have behavioral problems, but the present study was not able to estimate reliably how many.

From the number of children given in Table 6.1, the reader can estimate the number of children in the state who are in each of the categories of behavioral problems. First, each location must be multiplied by a weight

TABLE 6.1

SAMPLE FOR THREE CATEGORIES OF BEHAVIORAL SEVERITY

		Behavioral Serverity							Statewide
		Low	Medium	High	Total		Weight		Projections
Department of Correction	%								
	N				550				
Training Schools	%	21%	55%	24%	100%				
	N	22	58	25	105	x	6	=	630
Mental Health Hospitals	%	13%	34%	53%	100%				
	N	10	27	42	79	x	2	=	158
Wilderness Camps	%	14%	86%	00%*	100%				
	N	26	166	00*	192	x	1	=	192
Group Homes	%	56%	27%	17%	100%				
	N	29	14	09	52	x	8.46	=	440
Not Appropriately Served	%	23%	47%	30%	100%				
	N	60	120	76	256		5		1,280

* This figure is zero probably due to incomplete data from Wilderness Camp data. See text.

that would obtain the statewide estimate. For example, since a one-sixth sample was taken from the Training Schools, the number of children in Training Schools in the state can be obtained by multiplying the sample by a weight of six, shown in the next to last column of Table 6.1 for each location. The weight for Mental Health Hospitals was 2 since half of the children in the hospitals were included in the sample. The weight for Wilderness Camp children was 1 since all of the children in Wilderness Camps were included in the data for the present project. The weight for group homes was 8.46. This weight was obtained by dividing the 22 possible group homes that could have been surveyed in the 20-county random sample by the 13 group homes that actually allowed the Center access to their children's records, which equals 1.69. In other words if all group homes in the sample had allowed the Center access to their records, the number of children surveyed should have been higher than indicated in Table 6.1 by a factor of 1.69. Since these group homes were only sampled from the 20 counties sampled in the state (out of 100 counties), this figure should be multiplied by 5 to reflect the statewide projections. The weight for the children not appropriately served was 5 since a 20-county sample was made for the total of 100 counties in the state.

Using these weights, researchers obtained statewide projections given in the last chapter (Table 5.5) for each of the locations sampled in the present study. While the statewide projections are accurate for each location, the total number of children in the state in each of the levels of behavioral problems (low, medium, and high) are inaccurate in that some of the children who were not appropriately served were residing in one of the other locations. This would result in some of these children's being counted twice. Therefore, a correction factor must be subtracted from the number of children in each category. The size of the correction factor is the number of not appropriately served children who were residing in Training Schools, Mental Health Hospitals, Wilderness Camps, or Group Homes. These totals are 45, 225, and 155 for the low, medium, and high groups respectively. These numbers are subtracted from the number of children in each category in the state to obtain the corrected statewide projections shown in Table 6.2.

Table 6.2 shows the corrected statewide projections for each of the three levels of severity; as well as the uncorrected projections. As the

TABLE 6.2

UNCORRECTED AND CORRECTED STATEWIDE PROJECTIONS
FOR THREE CATEGORIES OF BEHAVIORAL SEVERITY

		Low	Medium	High	Total
Uncorrected	%	27%	48%	26%	100%
	N	724	1,284	692	2,700
Corrected	%	29%	46%	25%	100%
	N	679	1,059	577	2,315

sample obtained in the present study shows, 577 children were estimated to have high behavioral problems, 1,059 children were estimated to have medium behavioral problems; and 679 children were estimated to have low behavioral problems. The reader should be reminded that this low group consisted of children at one of the locations examined and definitely should not be considered a population of "normal" children. As discussed earlier, these statewide projections are conservative because: 1) the Youth Services Complex of the Department of Correction was not included in the projections; 2) the data for Wilderness Camps caused the behavioral index scores to be low, which resulted in fewer children's being defined as having either medium or high behavioral problems; 3) the foster care children were not included because of a sample size that was unreliably small; and 4) only children at certain locations were included in the present study. If there were any children in the state who were not residing at Training Schools, Mental Health Hospitals, Wilderness Camps, or Group Homes, or who were not identified as not appropriately served children at the county level, they would not be included in the present projections.

CHAPTER 7

RESULTS--PROFILE OF CHILDREN WITH BEHAVIORAL PROBLEMS

This chapter presents the profiles of children in each of the three groups of low, medium, and high behavioral problems. The children who would be likely to be labelled as high behavioral problems were found to have had problems in school and have had detrimental family backgrounds. For example, 55 percent of the children labelled as high behavioral problems did unsatisfactorily in school, 61 percent had failed a class, 46 percent had been abused or neglected, and 45 percent had families who had court involvement other than with the child. Frequently, the percentage of children who experienced these problems was highest for the children labelled as having high behavior problems and lowest for the groups labelled as low behavior problems, with the medium group in between. Also presented in the present chapter are basic demographic such as age, race, sex, home county size, and other types of information from which a profile of the children included in the present study can be constructed.

CHAPTER 7 - RESULTS--PROFILE OF CHILDREN WITH BEHAVIORAL PROBLEMS

The profile presented here describes children who have been placed in a residential treatment facility or described by local service providers as not receiving appropriate services available within the local community due to the incidence of behavioral or emotional problems. These children have been categorized into three groups depending upon the nature and frequency of their behaviors, their classification depends on their behavioral index scores as explained in Chapter 5. These groups have been labelled as children who would be considered low, medium, and high behavior problems by human service providers. This dimension will be referred to as the three levels of behavioral severity. These categories are not intended to be a clinical or a legal definition of behavioral problems. Rather, they reflect the labelling process which is likely to make it difficult for these children to receive appropriate services.

The results presented in this section are presented in the form of percentage tables with the category of behaviors across the top and the variable to be profiled along the side of the table. Percentages are calculated within behavioral categories in order to allow comparisons of children with different behavior patterns. At the bottom of each column is a number which reflects the statewide projection for each group of behavioral categories; these are the uncorrected projections as explained in Chapter 6.

The profile will concentrate upon five areas of interest:

1. demographic information, such as race, sex, age, and county size;
2. school-related information;
3 family-related information;
4. behavioral and offenses information; and
5. health indicators and mental health diagnoses.

DEMOGRAPHIC INFORMATION

Table 7.1, which shows the relationship between levels of behavioral severity and sex of children, indicates first of all that males predominate in children selected for this study almost 2 to 1. Second, males seem to be more dominant in the middle behavioral category and less dominant in the extremes on either side.

TABLE 7.1

SEX BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
male	67%	79%	65%
female	33%	21%	35%
	100%	100%	100%
N	719	1,284	692
missing N	5	0	0

Table 7.2, which shows the relationship between behavioral groupings and age of children, indicates that there is a general pattern for most of the children included in this study to be between 14 and 16 years of age. This pattern did not seem to differ greatly among the three groups of behavioral severity. This general pattern, which exists across all three groups, has been widely recognized in studies of juvenile delinquents as being one in which children exhibit most of their behavioral problems in the ages of 15 and 16 years and perhaps mature out of that behavioral pattern. It is significant that the differences between groupings by behavioral categorization with respect to age are not very large. One can see that the percentages for 10, 11, and 12 year olds are slightly higher for the low group than the medium or high groups. This slight tendency for younger children to be in the low group can also be seen by the average ages for the three groups shown at the bottom of Table 7.2. This slight relationship between age and the levels of behavioral severity, however, does not account for the categories themselves. This point was explained in more detail in Chapter 5.

TABLE 7.2

AGE BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
10 yrs.	04%	01%	01%
11 yrs.	06%	02%	04%
12 yrs.	08%	04%	05%
13 yrs.	10%	10%	11%
14 yrs.	22%	18%	14%
15 yrs.	19%	28%	26%
16 yrs.	21%	25%	27%
17 yrs.	07%	10%	09%
18 yrs.	01%	02%	02%
	100%	100%	100%
N	719	1,284	692
missing N	5	0	0
average	14.2	14.9	14.7

Table 7.3, which shows the relationship between levels of behavioral severity and race, indicates that white children are the most frequent members of all three groupings. However, this predominance does not reflect as high a proportions of whites as exists in the general population (approximately 77%). Blacks are overrepresented almost 2 to 1 relative to the proportion of the general population they comprise (approximately 22%). The incidence of Indians is extremely small and therefore difficult to interpret. It is interesting to note that the overrepresentation of blacks decreases as the severity of the behavioral problem increases. While blacks comprise 45 percent of children who have low behavioral problems, only 31 percent of children with high behavioral problems are black.

TABLE 7.3

RACE BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
White	53%	56%	68%
Black	45%	42%	31%
Indian	02%	01%	01%
	100%	100%	100%
N	711	1,274	687
missing	13	10	5

Table 7.4 shows the percentage of children who come from counties with populations of more than 85,000 or less than 85,000. The 17 counties that have populations greater than 85,000 make up 49.83 percent of the total population in North Carolina. Those counties are: Alamance, Buncombe, Catawba, Cumberland, Davidson, Durham, Forsyth, Gaston, Guilford, Mecklenburg, New Hanover, Onslow, Randolph, Robeson, Rowan, Wake, and Wayne. The remaining 83 counties that have a population of less than 85,000 comprise 50.17 percent of the population in North Carolina. As can be seen in Table 7.4, there is a slightly greater percentage of children labelled as low behavior problems from the smaller counties. This slight relationship between county size and level of behavioral severity can also be seen at the bottom of Table 7.4; the average county size decreases slightly as the level of behavioral severity goes from high to low.

TABLE 7.4

COUNTY SIZE BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
< 85,000	53%	49%	50%
> 85,000	47%	51%	50%
	100%	100%	100%
N	724	1,284	692
missing N	0	0	0
average size of county	145,279	151,503	160,189
N	699	1,225	655
missing N	25	59	37

In summary, demographic tables indicate that the children in this study are predominantly male, predominantly between the ages of 14 and 16 years, and are predominantly white. Males and children 14 through 16 years of age are overrepresented among all groups of behavioral categorization relative to their proportion in the population while whites are underrepresented among all groups in accordance with their representation in the general population. This underrepresentation for whites approaches true representation as the severity of the behavioral problem increases.

SCHOOL-RELATED INFORMATION

Table 7.5 shows the current school status data by level of behavioral severity but only for those children who were not currently residing at a location that provided school for the children. In other words children who were residing at the Youth Services Complex of the Department of Correction, Training Schools, Mental Health Hospitals, or Wilderness Camps were excluded from the current analyses of whether or not they were currently in school because they all were as mandated by law. The most important information in this table is the proportion of children who were not in school. This proportion for the children who were labelled as high behavioral problems was 28 percent; for the medium and low groups, the percentages were 13 percent and 5 percent respectively. This same pattern can be seen

by examining the percentages of children who were currently in school for the three groups; these percentages were 48, 68, and 70 for the high, medium, and low groups respectively. Very few of the children were participating in vocational programs.

TABLE 7.5

CURRENTLY IN SCHOOL BY LEVELS OF BEHAVIORAL SEVERITY*

	Behavioral Severity		
	Low	Medium	High
full time	90%	68%	48%
part time	02%	00%	00%
vocational full time	02%	00%	00%
vocational part time	01%	00%	00%
not in school	05%	13%	28%
unknown	19%	19%	24%
	100%	100%	100%
N	435	513	311
missing N	30	0	0

*Children residing at the Youth Services Complex of the Department of Correction, Training Schools, Mental Health Hospitals, and Wilderness Camps were excluded.

Table 7.6, indicating the academic performance of the children by level of behavioral severity, must be interpreted carefully because of the high proportion of children for whom "no data" were available; however, it is clear that the children included in this study had a high rate of unsatisfactory academic performance ranging from 39 percent for those with low behavioral problems, to 44 percent for those with medium behavioral problems, and 55 percent for those with high behavioral problems. Clearly, there is a relationship between behaviors exhibited and satisfactory school performance.

TABLE 7.6

ACADEMIC PERFORMANCE BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
no data	29%	24%	24%
satisfactory	32%	32%	21%
unsatisfactory	39%	44%	55%
	100%	100%	100%
N	724	1,284	692
missing N	0	0	0

Table 7.7, which demonstrates the relationship between truancy and behavioral severity, further indicates this relationship. This table indicates the extent to which there were comments in the children's records about truancy and clearly illustrates that truancy was a much greater problem among children who had medium or high behavioral problems than among children who had low behavioral problems. This pattern of unsuccessful school performance is further demonstrated by Table 7.8, which shows that a higher proportion of children labelled as medium and high behavior problems had evidence of failing a class than those children who were categorized as having low behavioral problems. However, as Table 7.8 illustrates, the proportions for having failed a class are high across all three groupings.

TABLE 7.7

EVIDENCE OF TRUANCY BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
no comments	53%	45%	34%
comments of truancy	32%	23%	24%
comments of truancy and excessiveness	16%	32%	42%
	100%	100%	100%
N	724	1,284	692
missing N	0	0	0

TABLE 7.8

EVIDENCE OF HAVING FAILED A CLASS BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
yes	30%	44%	39%
no	70%	56%	61%
	100%	100%	100%
N	724	1,248	692
missing N	0	0	0

Further evidence of difficulty in school appears in Table 7.9 which displays the extent to which aggressive behaviors have been recorded for the children in the study. The frequency and severity of aggressive behaviors in school increased for those children who were labelled as having high behavior problems and decreased for those children who were labelled as having low behavioral problems, with children who were categorized as being medium in between the low and the high groups. These observations indicate, without implying causality, that the children included in this study had difficulty doing well in the school system. These observations are not intended to imply a failure either of the school system or the children. While the previous discussion indicates to some extent the way in which children react to the school system, it may also reflect the manner in which the school system reacts to the children.

TABLE 7.9

EVIDENCE OF AGGRESSIVE BEHAVIORS BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
no comments	70%	37%	24%
comments of aggressive behaviors	26%	46%	31%
comments of and excessiveness	04%	16%	45%
	100%	100%	100%
N	724	1,284	692
missing N	0	0	0

Table 7.10 indicates the extent to which children who were included in this study have received counseling from school. Among children with low behavioral problems, 39 percent had counseling; among children with medium and high behavioral problems, 59 and 66 percent, respectively, had received counseling. Further evidence appears in Table 7.11, which shows the extent to which children who have been classified as having medium or high behavioral problems had been placed in special classes within the school system. This table indicates that for children with high behavior problems, 54 percent have had no special classes; for children with medium behavior problems, 59 percent have had no special classes; and for children with low behavior problems, 62 percent have had no special classes. These figures indicate that as children's behavioral problems increase, they are more likely to receive special class attention, although this attention was given to less than half of the children in any problem behavioral grouping. Among children who were in the high group, the most likely special class placement was in classes for emotionally handicapped. Among children who were medium and low, the most likely special class assignment was among the mentally retarded.

TABLE 7.10

EVIDENCE OF COUNSELING FROM SCHOOL BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
yes	39%	59%	66%
no	61%	41%	34%
	100%	100%	100%
N	724	1,284	692
missing N	0	0	0

TABLE 7.11

PLACEMENT IN SPECIAL CLASSES BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
no special classes	62%	59%	54%
mentally retarded	14%	11%	06%
learning disabled	04%	08%	10%
emotionally handicapped	06%	08%	13%
gifted/talented classes	00%	01%	00%
special counseling	02%	05%	04%
other	12%	08%	12%
	100%	100%	100%
N	685	1,090	680
missing N	39	194	12

Clearly, children with medium or high behavioral problems do not do well in school. The reaction of the school system appears to be to provide counseling in the majority of cases, but in only a minority of cases have these children, who are either placed in an institutional facility or who have been labelled by local service providers as being not appropriately dealt with within the community, received special education classes within the public school system. While the evidence presented here is "scanty," it does appear safe to say that the response of the school system to these children with behavioral problems is less than overwhelming.

FAMILY INFORMATION

Examination of Table 7.12 reveals that approximately half of the children in each behavioral grouping lived with a male and a female adult. Approximately one-third of the children in each grouping lived in a household with a female adult only. This does not appear to be at great variance with the incidence in the general population. A similar pattern is reflected in Table 7.13 which shows the incidence of family arrangements by levels of behavioral groupings, the predominant being living with natural parents. There is a slightly increased percentage among medium and high categorized children for living with one natural and one step parent or living with unrelated persons, but these differences were very slight.

TABLE 7.12

WHO CHILD LIVED WITH BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
male & female adult	50%	54%	51%
male only	07%	07%	04%
female only	35%	32%	36%
child care facility	00%	00%	01%
varied	05%	02%	04%
other	02%	06%	04%
	100%	100%	100%
N	719	1,284	692
missing N	5	0	0

TABLE 7.13

FAMILY ARRANGEMENT BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
natural parents	72%	60%	62%
1 natural/1 step	11%	18%	14%
natural relative	08%	08%	07%
natural siblings	01%	00%	00%
not related	05%	05%	09%
other	02%	08%	07%
	100%	100%	100%
N	719	1,284	692
missing N	5	0	0

Table 7.14 indicates the frequency of change in family arrangements by levels of behavioral grouping, showing a slightly greater incidence of change among children who were grouped as medium or high than among those who were grouped as having low behavioral problems. There is also a slight difference shown in the category "sex of head of household" among children grouped as low, medium, or high in Table 7.15, with the medium and high children having a higher incidence of female heads of household than children who were not categorized as having behavioral problems. The incidence of female heads of households is higher across all three groups than is expected in the general population.

TABLE 7.14
HAS FAMILY ARRANGEMENT CHANGED MORE THAN ONCE?
BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
yes	47%	54%	55%
no	53%	46%	45%
	100%	100%	100%
N	676	1,111	681
missing N	48	73	11

TABLE 7.15
SEX OF PRIMARY WAGE EARNER BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
male head of household	60%	54%	48%
female head of household	40%	46%	52%
	100%	100%	100%
N	494	835	532
missing N	230	449	160

Table 7.16 shows that the proportion of children who live in households where the primary wage earner had less than a high school degree was quite high for all three behavior groupings. As can be seen at the bottom of Table 5.16, the average years of education was around 10 years. There does not appear to be a large difference among the three behavior groupings. Likewise, Table 7.17 shows that evidence of receiving public assistance was uniformly high across all three behavior groupings but that there was no patterned difference among behavioral groupings.

TABLE 7.16
EDUCATION OF PRIMARY WAGE EARNER BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
< high school degree	51%	56%	46%
high school degree	24%	22%	29%
< 4 years of college	02%	07%	06%
college degree	01%	02%	03%
post college	03%	02%	03%
no wage earner	18%	10%	13%
	100%	100%	100%
N	337	540	388
missing N	387	744	304
average years of education	10.74	9.88	10.24
N	277	484	339
missing N or no wage earner	447	800	353

TABLE 7.17

EVIDENCE OF PUBLIC ASSISTANCE BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
yes	56%	41%	53%
no	44%	59%	47%
	100%	100%	100%
N	724	1,284	692
missing N	0	0	0

Table 7.18 indicates that there was no pattern to the differences among behavioral categories for either birth order or number of siblings. It should be noted, however, that the number of siblings was uniformly high for all three behavior groupings.

TABLE 7.18

BIRTH ORDER AND NUMBER OF SIBLINGS BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
only child	10%	07%	06%
1st born	21%	22%	17%
middle born	49%	40%	48%
last born	20%	31%	29%
	100%	100%	100%
N	689	1,226	649
missing N	35	58	43
number of siblings	3.19	2.85	2.92
N	692	1,248	680
missing N	32	36	12

Perhaps the most interesting information included in this study relative to family and community life is to be found in Table 7.19. This table shows that there is a uniformly high percentage of children who came from families with a wide variety of problems and furthermore, that these problems tended to increase among children with more severe behavior problems. Thus, the reader can see that the percent of families with alcohol-related problems was high for all three groups but that it was higher for the medium and high groupings--likewise, the patterns for drug abuse was high for all three groupings but was highest for children who are categorized as exhibiting high behavior problems.

TABLE 7.19

PERCENTAGE OF CHILDREN FOR WHOM THERE WAS EVIDENCE OF FAMILY PROBLEMS BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
alcohol related, not child	41%	44%	58%
drug abuse, not child	06%	04%	13%
child abuse or neglect of child	47%	44%	46%
other family violence	22%	26%	38%
court involvement	46%	42%	45%
mental illness of parents or grandparents	31%	17%	22%
other mental illness in family	03%	06%	08%
disintegration of family	23%	27%	26%

The evidence on the existence of child abuse or neglect and other family violence indicated a uniformly high incidence across all three groupings of the behavioral problems. More than 40 percent of the families in each group indicated child abuse or neglect problems. For other family violence, predominantly spouse abuse, more than 20 percent of the families in each group indicated this problem. For children with high behavioral problems, the proportion of families with other family violence was as high

as 38 percent. The incidences for both abuse and neglect and other family violence were much higher than would be expected in the general population, and since the target population of this study was children with aggressive, "acting out" behavior problems, these findings must be viewed as very important.

Another significant finding in Table 7.19 is the extremely high incidence of court involvement by other family members. For all three behavior groupings, this incidence was in excess of 40 percent. There does not appear to be a patterned difference between the three behavior groupings, but the overall incidence was extremely high.

The rest of Table 7.19, dealing with mental illness in the family and family disintegration, was likewise higher than would be expected in the general population. However, there was no patterned difference among the three behavioral groupings.

Further evidence on the nature of family and community life of these children can be gained from Table 7.20. The family income data was based on a very small sample size (income data was very rarely available), though it seemed to indicate that there was an increase in family income among families of children classified as medium or high. An indication of the relationship of these children with their community is the fact that there was very little difference in the average number of years spent in community before the first residential placement among children in the three different behavior groupings. However, all three groups of children were in the community for at least ten years before their first residential placement.

TABLE 7.20

AVERAGE FAMILY INCOME, NUMBER OF YEARS IN COMMUNITY BEFORE FIRST PLACEMENT, AND SAMPLE SIZES (N) FOR EACH MEAN

	Behavioral Severity		
	Low/N	Medium/N	High/N
Family Income	$7782/81	$9711/146	14,208/50
Number of Years in Community	10.89/411	11.27/697	11.08/486

BEHAVIORAL AND OFFENSE INFORMATION

Tables 7.21 and 7.22 show the average number of behaviors and the average age for children exhibiting each of the behaviors used in defining the three groups of children as low, medium, and high behavior problems. Table 7.21 shows that for each behavior, the higher the level of behavioral severity, the greater the occurrences of any given behavior. Since the behavioral categories were based on the number of occurrences of these behaviors, these findings were expected. Table 7.22 shows that for each behavior (except suicide) the average age at onset was lower for children categorized as high than for the other children. There was a consistent pattern of agreement between the average age at which behaviors begin and the grouping by severity of behavioral problems.

TABLE 7.21

AVERAGE NUMBER OF BEHAVIORS EXHIBITED BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
temper tantrums	.19	2.38	13.70
attack w/out weapon	.32	2.55	17.39
attack w/weapon	.01	.34	2.24
killed someone	0	.01	.01
public sex activity	0	.05	1.07
forcible sex activity	0	.03	.43
prostitution/promiscuity	.05	.66	6.00
burning property	.03	.13	.56
cruelty to animals	.00	.07	.31
running away	.56	2.76	8.05
attempted suicide	.04	.18	.25
self-injurious behavior	0	.22	2.90
vandalism	.10	1.14	7.33
stealing	.87	3.46	7.88
alcohol/drug abuse	.05	2.59	28.75
verbal aggressions	.34	6.54	44.00

TABLE 7.22

AVERAGE AGE THAT BEHAVIORS WERE FIRST EXHIBITED
BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
temper tantrums	12.41	10.58	8.91
attack w/out weapon	11.79	12.28	10.71
attack w/weapon	12.00	12.16	11.53
killed someone	--	14.22	12.18
public sex activity	--	13.19	11.26
forcible sex activity	--	13.57	13.12
prostitution/promiscuity	11.43	13.65	12.39
burning property	13.32	11.69	11.03
cruelty to animals	17.00	10.34	11.34
running away	13.51	12.95	12.90
attempted suicide	13.98	13.72	14.04
self-injurious behavior	--	12.74	11.67
vandalism	13.33	12.59	11.39
stealing	13.47	12.84	12.12
alcohol/drug abuse	14.93	13.74	11.95
verbal aggressions	12.78	12.19	11.03

Table 7.23 shows the offenses for which the children had been convicted by the levels of behavioral severity. Interestingly, the adjudicated crimes do not show a consistent pattern with the three levels of behavioral severity. For example, 40 percent of the children labelled as medium behavior problems had been convicted of theft whereas only 26 percent and 29 percent of the children in the low and high groups, respectively, had committed theft. However, the offenses of "other" and "attacking someone" showed that a greater percentage of children had committed the crime when the level of severity was greater. Also, the percentage of children who had not been convicted of a crime was smaller for the children labelled as high behavior problems (33%) than the children in the low group (58%). The medium group (34%) was almost the same as the high group.

TABLE 7.23

MOST RECENT OFFENSE BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
Theft	26%	40%	29%
Murder/Manslaughter		01%	01%
Sex Offense		00%	02%
Arson	00%	00%	01%
Attack Someone	02%	04%	12%
Vandalism		03%	02%
Drug Offense	01%	03%	01%
Other	12%	15%	20%
None	58%	34%	33%
	100%	100%	100%
N	724	1,284	692
missing N	0	0	0

HEALTH INDICATORS AND MENTAL HEALTH DIAGNOSES

Table 7.24 shows the incidence of a wide variety of health problems for each behavioral grouping of children. Three of the problems listed appeared to occur very frequently. Physical trauma occurred more frequently among medium than low children, and even more frequently among children categorized as high. Likewise, the incidence of alcohol or drug abuse increased with behavioral categorization. The incidence of learning disabilities was higher for medium and high grouped children than for those who were low but was uniformly high for all three groupings. It is difficult to interpret these health disorders because no comparable, epidemiological evidence is available for children within this age group. However, the relatively high incidence of physical trauma, alcohol or drug abuse, and learning disabilities does merit notice.

TABLE 7.24

HEALTH DISORDERS BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
ear, nose, or throat	16%	13%	12%
respiratory	06%	03%	11%
gastronomical or intestinal	01%	03%	05%
obesity	02%	05%	06%
sexually transmitted disease	02%	02%	04%
musclo-skeletal problem	04%	05%	04%
skin problem	04%	03%	04%
physical trauma	12%	21%	30%
alcohol or drug abuse	15%	39%	42%
dental problems	11%	08%	07%
learning disabilities	17%	30%	28%
visual impairment	01%	05%	07%
hearing deficit	03%	04%	06%
prenatal or birth complications	06%	08%	08%
pregnancy or abortion	03%	02%	05%
congenital nuerological dysfunction	03%	07%	07%
other medical problem	16%	13%	17%

The information given in Table 7.25 came from the mental health diagnoses that were made either by the Mental Health Hospitals or the Mental Health Centers. These diagnoses are the major divisions of the GAP Codes (Group for the Advancement of Psychiatry). As can be seen in Table 7.25, a consistent pattern between mental health diagnoses and the three levels of behavioral severity was not found. However 31 percent of the children labelled as high behavior problems were given a diagnosis of a healthy response, and 35 percent were diagnosed as having psychoneurotic disorders. Children labelled low and medium behavior problems were diagnosed as either reactive disorders or personality disorders. It should be noted that these diagnoses were only completed on a small number of children which

can be seen by looking at the last row, which gives the number of children for whom there was no record of a mental health diagnosis.

TABLE 7.25

MENTAL HEALTH DIAGNOSES (GAP CODES) BY LEVELS OF BEHAVIORAL SEVERITY

	Behavioral Severity		
	Low	Medium	High
healthy reponse	02%		31%
reactive disorders	31%	18%	10%
developmental deviations	11%	09%	03%
psychoneurotic disorders		02%	35%
personality disorders	30%	29%	02%
psychotic disorders	04%	07%	01%
psychophysiologic disorders			02%
obs non-psychotic	01%	01%	01%
mental retardation	11%	14%	02%
other	09%	19%	06%
	100%	100%	100%
N	238	315	287
missing N	486	969	405

SUMMARY

A summary of the profiles of the children included in this study reveals that there were differences in distribution by age, sex, and race, and that these differences do in many ways associate with the level of severity of their behavioral problems; but the most compelling findings in this profile are those associated with school performance and family problems. In the area of school performance, it is clear that the children who were included in this study had difficulty relating to the school system and that the school system had difficulty relating to them. Furthermore, these differences seemed to correspond with the categorization of behavioral severity along which the data had been displayed. In the area of family problems, it is clear that there was an association for all of these children with family violence, both in the form of abuse and neglect and of other family

violence such as spouse abuse. Other types of family violence also appeared to correspond with the behavioral categories. The incidence of abuse and neglect did not but was uniformly high for all three behavior groupings. There was also a surprisingly high incidence of court involvement on the part of other family members.

Because the findings in the area of school performance and family problems have strong implications for prevention and intervention strategies for dealing with the behavioral problems of these children, they must form the core of any profile which adequately describes children with behavioral problems.

CHAPTER 8

RESULTS--PROFILE OF CHILDREN IDENTIFIED AS NOT APPROPRIATELY SERVED

This chapter presents the profile of children who were not appropriately served and compares their profile to the profile of all of the children in the present study (presented in Chapter 7). The comparison showed that there was a small, but consistent and systematic, difference between the children who were not appropriately served and all of the children in the study. The children not appropriately served were slightly more likely to have difficulty in school, slightly more likely to have detrimental family problems, and indicated a higher frequency for each of the behaviors.

CHAPTER 8 - RESULTS--PROFILE OF CHILDREN IDENTIFIED AS NOT APPROPRIATELY SERVED

As explained earlier, researchers asked local service providers (Mental Health Centers, Juvenile Court Counselors, and Departments of Social Services) at 20 randomly selected counties, "Who are the children for whom you cannot find appropriate treatment or service because of their behavior or emotional disturbance?" These 1,280 children (a statewide projection from a 20-county sample) have special implications for this study because they are the children for whom the local level of service providers cannot find appropriate services. Therefore, this chapter has been devoted to a comparison of the profiles of not appropriately served children with the profiles presented in Chapter 7, which are on all of the children in the present research. These comparisons are not between the children who were not appropriately served and the rest of the children but between the children who were not appropriately served and the total population of children in the present study, of which the not appropriately served children were a part. Therefore, the differences discussed in this chapter would be larger (by approximately a factor of two) if the not appropriately served children were compared with the rest of the children in the study.

Overall, the children labelled as not appropriately served had more problems in school, a more detrimental family background, and exhibited more of the behaviors at greater frequencies than the total population of children in the present study. The differences between all of the children and the children who were identified as not appropriately served were small but consistent and systematic. Furthermore, the relative comparisons of the low, medium, and high categories of behavioral problmes were similar to that of all of the children in the present study. For example, the average age for all children was 14.2, 14.9, and 14.7 years for the low, medium, and high levels of behavioral severity, respectively. For children not appropriately served, the means were 13.95, 14.75, and 14.35 years for the three groups respectively. Obviously, there was little difference in the ages for the whole population of children and those who were not appropriately placed, but the children who were not appropriately served were consistently younger.

Racial differences were also found. Table 8.1 gives the racial make-up of the children not appropriately served for the three levels of behavioral severity. As for all children (Table 7.3), the percentage of blacks decreased as the behavioral severity increased from low to medium to high. However, there were more blacks in the sub-population of children not appropriately served than for all of the children across all three levels of severity, and the size of this difference was about 5 percent or greater. Comparing Tables 7.3 and 8.1 illustrates this. For example, 45 percent of all of the children were black for the low behavior problem group; for children not appropriately served, 54 percent were black in the low behavioral group. Similar differences were found for the children labelled as medium or high behavior problems.

TABLE 8.1

RACE BY LEVELS OF BEHAVIORAL SEVERITY FOR CHILDREN NOT APPROPRIATELY SERVED

	Behavioral Severity		
	Low	Medium	High
White	46%	52%	64%
Black	54%	48%	36%
Indian	00%	00%	00%
	100%	100%	100%
N	295	590	375
missing N	5	10	5

Table 8.2 presents a similar pattern for the variable of county size; between 53 percent and 58 percent of the children not appropriately placed came from counties with populations less than 85,000. For all of the children in the study (Table 7.4), the percentages ranged between 49 percent and 53 percent. More of the children who were identified as being not appropriately served came from smaller counties than for the total population of children in the present study. The average county size for children not appropriately served was smaller than for all of the children in the study, as can be seen at the bottoms of Tables 8.2 and 7.4.

TABLE 8.2

COUNTY SIZE BY LEVELS OF BEHAVIORAL SEVERITY FOR CHILDREN NOT APPROPRIATELY PLACED

	Behavioral Severity		
	Low	Medium	High
< 85,000	58%	53%	54%
> 85,000	42%	47%	46%
	100%	100%	100%
N	300	600	380
missing N	0	0	0
average sized community	113,499	145,759	157,287
N	285	575	365
missing N	15	25	15

Comparing the school behavior of children not appropriately served with that of all of the children reveals the following: approximately 4 percent more of the not appropriately served children were not in school (i.e., 4 percent more than the percentages given in Table 7.5); approximately 7 percent more of them were doing unsatisfactory work in school (see Table 7.6); approximately 3 percent more had failed a class (Table 7.8); approximately 4 percent more exhibited aggressive behaviors in school (Table 7.9); approximately 4 percent more had received counseling in school (Table 7.10); and approximately 5 percent less had not been in some kind of special class (Table 7.11). In other words, more children identified as not appropriately served had evidenced problems in their school life, and the size of this difference was around 5 percent.

In the area of family background, comparing the children not appropriately served to all of the children revealed the following: approximately six percent more of these children had experienced more than one change in their family background (Table 7.14); approximately 8 percent more had evidence of their family receiving some type of public assistance (Table 7.17); approximately 4 percent more had alcohol-related problems in the family that were not related to the child (Table 7.19); approximately 9 percent more had been abused or neglected (Table 7.19); approximately 8 percent more had come from families where there was other family violence (Table 7.19);

and approximately 4 percent more of the not appropriately served children had experienced a complete disintegration of their home setting (Table 7.19). Furthermore, not appropriately served children came from families with smaller incomes by over $1,000 per year and had been in their community about a year less (Table 7.20). In summary, a higher percentage of children identified as not appropriately served had experienced detrimental family settings than all of the children in this study, and again the size of this difference was about 5 percent.

Another area where there were differences between the not appropriately served children and the total population of children for the present study was on the behaviors that the children had exhibited, and these differences were mainly found for the children labelled as high behavior problems. The largest differences here were that the children labelled as high behavior problems who were not appropriately placed had 18.92 uncontrollable temper tantrums (as opposed to 13.70 for all children; Table 7.21), 11.09 instances of running away (as opposed to 8.05); and 51.59 instances of verbal aggressions (as opposed to 44.00). There were other differences, but they were not as large. Obviously, the children who were not appropriately placed did exhibit these behaviors (and most others) at a greater frequency than all of the children in the present study.

In conclusion, children identified at the local level as those for whom appropriate treatment or services could not be obtained because of their behavior or emotional disturbance were different from all of the children in small, but consistent and systematic, ways. These children who were not appropriately served had more problems in school and had more detrimental family problems. In addition, their behaviors were more severe; they exhibited many of the behaviors at higher frequencies than the total population of children in the present study. The implication of this conclusion is that the children who were most in need of service were the ones that the local service providers identified as not appropriately served. In other words the children who most needed appropriate service were the ones who were not getting it.

CHAPTER 9
RESULTS--SERVICE HISTORY

This chapter contains information about children's stay at their current residential locations, such as reason for referral, distance from home, behaviors and offenses exhibited at the locations, concurrent treatment providers, and the number of residences and treatment providers they have had. The most interesting information in this chapter is that the children labelled as having high behavior problems have been at more residences and have had more service providers than children labelled as medium behavior problems who have had more moves than children in the low groups.

CHAPTER 9 - RESULTS--SERVICE HISTORY

Chapter 9 contains information on: 1) the reasons children were referred to their current residential location; 2) the distance from the child's home of his or her current residential location; 3) the percentage of children who exhibited certain behaviors at their current residential location; 4) the percentage of children who committed offenses at the current residential location; 5) the concurrent treatment locations while children were at their present residential location; and 6) the average number of residences and services that children have had.

The above information is only given for the children whose records were obtained from the Training Schools, Mental Health Hospitals, and Group Homes. It is not given for the Wilderness Camps children because the computer tape that was used did not contain the necessary information. It is not given for children who were not appropriately served because they were residing at many different places and because giving information such as the reason for referral or distance from home would not make sense for all these residential locations combined. For example, not appropriately served children may currently reside in Training Schools, Mental Health Hospitals, or at their homes. Giving statistics on the reason for referral for all of these residential locations combined would be meaningless. The optimal alternative would have been to break out the different residential locations of the not appropriately served children and give the reason for each. Unfortunately, there were too few children to do this. For example, of the not appropriately served children who were classified as having high behavioral problems, only five were currently residing at Mental Health Hospitals. To divide these five cases among the eighteen possible reasons for referral would be senseless. Furthermore, it was not valid to combine the not appropriately served children residing in Training Schools with the children who were sampled at Training Schools for two reasons: 1) this might result in some children's being counted twice in that they were sampled in the Training School and were also identified at the county level as being not appropriately served, and 2) the records that were obtained at the Training Schools were a random sample, and any alteration to that sample would reduce its representativeness of the Training School

population in general. Therefore, the not appropriately served children were completely dropped from the present analyses.

As indicated earlier, the numbers listed in the tables in this chapter are the statewide projections. However, the actual sample sizes can easily be derived by dividing the numbers by the weight of the populations. These weights are 6 for the Training Schools, 2 for the Mental Health Hospitals, and 8.46 for the Group Homes. Therefore, when a number in the Training Schools is given as 18, it is only based on three children (18 divided by 6).

Table 9.1 gives the reasons for referral for Training Schools, Mental Health Hospitals, and Group Homes. The percentages in each column add up to 100 percent, and "N" indicates the total statewide projection on which the percentages are based. By comparing the percentages in each row, one can compare the reason for referral for the children who were classified as low, medium, and high on the behavioral severity scale. For example, one can see that the client's behavior (presumably aggressive and/or violent behavior) was the reason for referral for 11 percent of the children classified as having low behavioral problems but that it increased to 15 percent and 17 percent for the medium and high children. This was as expected since the medium and high children had been identified as those who exhibited the highest frequency of the behaviors used in the present study. These same percentages were 33 percent, 33 percent, and 38 percent for the Mental Health Hospitals. In other words, the children's behavior was the reason for about one-third of the referrals in Mental Health Hospitals, but there was not much difference among the three levels of severity. A consistent relationship between the client's behavior and the three levels of severity was not found. The client's behavior was listed as the reason for referral for 37 percent of the high children and only 22 percent of the low children. However, the medium group, which one would expect to fall between the low and high groups, showed the client's behavior as a reason for referral fewer times than in the low group. This anomaly might be explained by the small cell size.

Other notable but not surprising aspects of the reasons for referral were that the greatest reason for referral for Training Schools was legal sentence; likewise, the greatest reason for referral to the hospitals was legal commitment. The reasons for referral for the children in Group Homes were more evenly distributed across more of the possible reasons.

TABLE 9.1

REASON FOR REFERRAL FOR DATA COLLECTED AT RESIDENTIAL LOCATIONS BY LEVELS OF BEHAVIORAL SEVERITY

		Training Schools			Mental Health Hospitals			Group Homes		
		low	medium	high	low	medium	high	low	medium	high
Completed stay	%							04%	07%	
	N							08	08	
Successfully terminated, planned	%						03%	11%	14%	25%
	N						02	25	17	17
Successfully terminated, unplanned	%							04%		12%
	N							08		08
Request of client or family	%	05%					03%	11%		
	N	06					02	25		
Lack of progress	%		03%	03%		07%	05%			
	N		9	5		04	04			
Client's behavior	%	11%	15%	17%	33%	33%	38%	22%	14%	37%
	N	14	53	26	06	18	30	51	17	25
Ineligible	%									
	N									
Client dropped out	%								07%	
	N								08	
No service at previous	%		01%	01%			05%	11%	14%	
	N		05	02			04	25	17	
Diversion	%									12%
	N									08
Legal Commitment	%				44%	26%	31%		07%	
	N				08	14	24		08	

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CONTINUED

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TABLE 9.1

(continued from previous page)

		Training Schools			Mental Health Hospitals			Group Homes		
		low	medium	high	low	medium	high	low	medium	high
Legal sentence	%	79%	76%	79%	11%	04%		04%		
	N	101	257	119	02	02		08		
Probation	%								07%	
	N								08	
Parole/pardon	%									
	N									
Parental neglect	%							07%	07%	
	N							17	08	
Unknown/missing	%							04%		
	N							08		
Other	%	05%	05%		11%	30%	15%	22%	21%	12%
	N	06	17		02	16	12	51	25	08
Not applicable	%									
	N									
TOTAL	%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	N	127	340	152	18	54	78	228	118	68

Table 9.2 gives the distance from the child's current residential location to his or her home. Most children were between 26 and 100 miles of their home. An interesting finding is that it did not appear that the medium and high categories of children were further from home than the children who were in the low category. One might have expected that the more severe children would be located further from home than the less severe children, but this was not the case. Perhaps this was because many of the services providers in the state are divided into regions. For example, Mental Health Hospitals serve specified geographic regions.

The behaviors that children exhibited at their current locations are given in Table 9.3. Unlike the previous table in which there was no relationship between the variable with the three levels of behavioral severity, Table 9.3 illustrates a consistent pattern. Children labelled as having medium behavior problems consistently indicated the behavior more than children who were labelled as having low behavior problems but less than children in the high behavior problem group. This was a consistent pattern for most behaviors and for all three residential locations. Another finding was that children in Group Homes appeared less likely to exhibit these behaviors than children in Training Schools or Mental Health Hospitals within each level of behavioral severity. However, this may be a function of the fact that Training Schools and Mental Health Hospitals kept better records than Group Homes.

Table 9.4 gives the percentage of children who had committed and been convicted of certain offenses at each of the locations. The most notable point about this table is the low numbers across the whole table. This can perhaps be explained by the rationale that if a child committed one of these offenses, he or she would be moved out of the location. This would make it unlikely that children would have had any offenses for their current location.

TABLE 9.2

DISTANCE FROM HOME FOR DATA COLLECTED AT RESIDENTIAL LOCATIONS BY LEVELS OF BEHAVIORAL SEVERITY

		Training Schools			Mental Health Hospitals			Group Homes		
		low	medium	high	low	medium	high	low	medium	high
< 6 miles	%		02%	04%	10%	07%	17%			
	N		06	06	02	04	14			
6-25 miles	%	09%	10%	19%	30%	15%	29%	60%	33%	100%
	N	12	35	26	06	08	24	93	17	34
26-50 miles	%	33%	29%	25%		30%	17%	35%	33%	
	N	44	97	35		16	14	51	17	
51-100 miles	%	45%	24%	26%	40%	44%	36%	05%	17%	
	N	60	79	36	08	24	30	08	08	
101-200 miles	%	12%	30%	24%	10%	04%	02%			
	N	17	99	34	02	02	02			
201-500 miles	%		02%	02%						
	N		02	02						
>500 miles	%				10%				17%	
	N				02				08	
TOTAL	%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	N	133	332	139	20	54	84	153	51	34

TABLE 9.3

PERCENTAGE OF CHILDREN WHO EXHIBITED BEHAVIOR AT RESIDENTIAL LOCATIONS BY LEVELS OF BEHAVIORAL SEVERITY

		Training Schools			Mental Health Hospitals			Group Homes		
		low	medium	high	low	medium	high	low	medium	high
Temper tantrums	%	04%	07%	19%	10%	19%	29%	04%	14%	11%
	N	06	24	29	02	10	24	08	17	08
Attack w/weapon	%	18%	38%	50%		26%	51%			11%
	N	24	131	76	0	14	42	0	0	08
Attack w/out weapon	%		08%	03%		04%	22%			
	N	0	29	05	0	02	18	0	0	0
Killed someone	%		01%							
	N	0	02	0	0	0	0	0	0	0
Public sex activity	%		02%	01%		04%	10%			
	N	0	08	02	0	02	08	0	0	0
Forcible sex activity	%	05%		01%						
	N	06	0	02	0	0	0	0	0	0
Prostitution/promiscuity	%		01%	04%		04%	05%	04%	07%	
	N	0	02	07	0	02	04	08	08	0
Burning property	%		02%	01%			05%	04%		
	N	0	06	02	0	0	04	08	0	0
Cruelty to animals	%									
	N	0	0	0	0	0	0	0	0	0

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TABLE 9.3

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		Training Schools			Mental Health Hospitals			Group Homes		
		low	medium	high	low	medium	high	low	medium	high
Running away	%	29%	33%	40%	10%	15%	31%	04%	29%	11%
	N	38	116	60	02	08	26	08	34	08
Attempted suicide	%		01%		10%	04%				
	N	0	05	0	02	02	0	0	0	0
Self-injurious behavior	%		01%	10%		22%	24%			22%
	N	0	05	15	0	12	20	0	0	17
Vandalism	%	14%	14%	18%		11%	33%			
	N	18	50	28	0	06	28	0	0	0
Verbal aggression	%	32%	52%	60%	10%	56%	74%	07%	14%	22%
	N	42	179	92	02	30	62	17	17	17
Stealing	%	23%	14%	15%	10%	07%	12%	07%		
	N	30	49	23	02	04	10	17	0	0
Alcohol/drug abuse	%	06%	07%	07%		07%	17%		07%	22%
	N	08	25	11	0	04	14	0	08	17
TOTAL N		133	346	152	20	54	84	245	118	76

TABLE 9.4

PERCENTAGE OF CHILDREN WHO HAVE COMMITTED OFFENSES AT RESIDENTIAL LOCATIONS BY LEVELS OF BEHAVIORAL SEVERITY

		Training Schools			Mental Health Hospitals			Group Homes		
		low	medium	high	low	medium	high	low	medium	high
Murder/manslaughter	%		01%							
	N		02							
Theft	%	09%	11%	05%						
	N	12	38	08						
Rape	%									
	N									
Other sex offense	%					04%	02%			
	N					2	2			
Arson	%		02%							
	N		06							
Attack someone	%	05%	06%							
	N	06	02							
Drug felony	%	05%	02%							
	N	06	06							
Drug non-felony	%	02%					02%			
	N	02					02			
Other	%	06%		04%		11%			07%	
	N	06		06		04			08	
TOTAL N		133	346	152	20	54	84	245	118	76

Table 9.5 gives the concurrent treatment locations for each of the current residential locations. As the researchers expected, the primary concurrent service provider for Training Schools was the Juvenile Court Counselors. Mental Health Hospitals appeared to use Mental Health Centers, Juvenile Court Counselors, and the Departments of Social Services approximately equally with perhaps a slight edge toward the Departments of Social Services. Children in Group Homes were also concurrently served by these same three local agencies, and again, Departments of Social Services appeared to have been a concurrent service provider more than the other two. This might have been because many children were in the legal custody at DSS. There did not appear to be any consistent trend between the concurrent service providers and levels of behavioral severity.

Table 9.6 gives the number of residences and the number of services that children have had, other than their present residence or service. The number of residences for the Wilderness Camp data is left blank because that data was not on the computer tape; only service providers which are frequently non-residential were included on the tape. Also, no children at the Wilderness Camps were identified as being labelled high behavioral problems. Again, as this report has pointed out earlier, the fact that no Wilderness Camp children have been identified as having high behavioral problems is a function of the computer tape that was used to obtain the data for these children, not that those children would not be classified in the high behavioral problem category if there were sufficient information.

As would be expected, children who were defined as having medium behavioral problems were relocated more often, among both residences and service providers, than the children who were in the low group. Likewise, children labelled as having high behavioral problems showed more moves than the medium group. This table supports the premise that the more severe the child's behavior is labelled, the more he or she is "bumped around" by the service system. The reader should also note that the average number of residences was smaller than the number of service providers. Finally, children in group homes appeared to have lived more places and to have been served by more providers than the other locations.

TABLE 9.5

CONCURRENT TREATMENT LOCATIONS FOR DATA COLLECTED AT RESIDENTIAL LOCATIONS BY LEVELS OF BEHAVIORAL SEVERITY

		Training Schools			Mental Health Hospitals			Group Homes		
		low	medium	high	low	medium	high	low	medium	high
Training School	%									
	N									
Mental Health Hospital	%									
	N									
Wilderness Camps	%		02%							
	N		06							
Mental Health Center	%					24%	25%	33%	10%	22%
	N					08	12	68	08	17
Juvenile Court	%	89%	82%	100%	25%	35%	33%	04%	20%	33%
	N	97	214	128	02	12	16	08	17	25
DSS	%		07%		75%	41%	33%	58%	70%	44%
	N		18		06	14	16	118	59	34
Other	%	11%	09%				08%	04%		
	N	12	24				04	08		
TOTAL	%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	N	109	262	128	08	34	48	203	85	76

TABLE 9.6

NUMBER OF RESIDENCES AND SERVICE LOCATIONS FOR EACH LOCATION FROM WHICH DATA WAS COLLECTED AND FOR EACH LEVEL OF BEHAVIORAL SEVERITY

		# of Residences			# of Services		
		low	medium	high	low	medium	high
Training Schools	X	1.24	1.84	2.26	2.26	3.13	3.12
	N	133	346	342	133	346	152
Mental Health Hospitals	X	1.6	2.15	3.02	2.60	4.44	5.29
	N	20	54	42	20	54	84
Wilderness Camps	X	-	-	-	2.08	3.14	-
	N	-	-	-	26	166	-
Group Homes	X	2.41	3.79	2.56	3.25	5.21	5.00
	N	245	118	76	245	118	76
Inappropriately Placed	X	1.22	2.44	3.13	2.77	4.12	4.91
	N	300	600	380	300	600	380

CHAPTER 10

RESULTS--SYSTEMS MAPPING

This chapter contains information on the movement of children in the human services system. Two types of movement are discussed--residential movement (where the child lives) and service treatment movement (where the child receives services). One of the major findings is that many children in highly restrictive settings (Training Schools or Mental Health Hospitals) had that residential location as their first residential location after home. This evidence suggests that there is no continuum of care where children start in the least restrictive setting and work toward the most restrictive setting. Another major finding is that of the children who were currently in either a Mental Health Hospital or a Training School most had started out in that track and had not received services from the other type of service provider. This chapter also presents information on movement broken down by sex, race, and county size. Few differences were found in making these comparisons.

CHAPTER 10 - RESULTS--SYSTEMS MAPPING

This chapter presents information on systems mapping--where children have lived and where they have received services. There are 62 tables in this chapter based on the statewide projections. Each table gives the sequence of residences or services for different sub-populations of children. For example, Table 10.1 presents the sequential list of residences for children whose records were obtained from Training Schools and who were in the category of children labelled as having low behavior problems. This table shows that all children were currently residing at a Training School and then shows the location of their previous residences (first through fifth). Also shown is the location of their first residence after home and the percentage of children who had ever lived in certain residences.

ORDER AND CONTENT OF TABLES

Tables 10.1 - 10.3 present the systems mapping for the three categories of behavioral severity (low, medium, and high) for children whose records were obtained from Training Schools. Tables 10.4 - 10.15 give the systems mapping for the three categories of behavioral severity for the different locations from which the children's records were obtained; in addition to Training Schools, these locations were Mental Health Hospitals, Group Homes, and the children identified at the county level as being not appropriately served. In addition, there are three tables given for the three levels of behavioral severity for a sub-population of the not appropriately served children; this sub-population consists of those children who were residing at home rather than one of the other residential locations. Residential movement for children from Wilderness Camps is not included because the data transferred from the computer tapes combined residences and services in such a way that they could not be separated. This information will be included in the next series of tables on movement.

Tables 10.16 - 10.32 present a similar series of tables for movement between service providers for each of the residential locations discussed above as well as certain locations that provide services but not on a residential basis, such as Juvenile Court Counselors. These tables are again in groups of three (low, medium, and high levels of behavioral severity) for Training Schools, Mental Health Hospitals, Wilderness Camps,

Group Homes, children not identified as not appropriately served, and the subpopulation of children who were not appropriately served who were living at home.

Tables 10.33 - 10.42 present the systems mapping only for children labelled as high behavior problems broken down by sex. These tables show where males and females lived for the locations of Training Schools, Mental Health Hospitals, Group Homes, children identified as not appropriately served, and children identified as not appropriately served who lived at home. Children from Wilderness Camps are not included because none of them were categorized as having high behavioral problems. As discussed in Chapter 5, this is probably a function of the fact that the computer tape that was borrowed to provide the information for Wilderness Camp children did not contain the frequencies that the behaviors measured in the present study had been exhibited. This resulted in the Wilderness Camp children having low behavioral index scores which made it unlikely that any would be classified as having high behavioral problems.

Tables 10.43 - 10.52 are only for children labelled as high behavior problems. These tables show where children from small (less than 85,000) and large counties lived for the locations given above.

FORMAT OF TABLES

Each of the tables adheres to the following format. The first column is a listing of either the residential or service locations. The next column indicates the current residential or service locations for the subpopulation presented in the table. The next five columns indicate the previous locations (first through fifth) for that population of children. The next to the last column lists the first residential or service location after home. The last column lists the residential or service locations that have ever been used after home, excluding the current locations. Tables 33-65 follow the same format except the final column on the percentage of children who had ever used a certain location is excluded.

The numbers in each table represent statewide estimates of population. In order to reconstruct the original sample size in each cell of a table, the statewide estimate should be divided by the sample weight listed at the top of that table. Within rounding error, this will yield the correct sample size. The percentages in the cells are column percents, with every column but one summing to 100 percent, within rounding error. The single

exception is the last column in the first 32 tables; here counts are duplicated and do not sum 100 percent. The percentage of missing data for each column (residence or service) has been listed first and also has been included in the column totals.

For example, in Table 10.1, of all children in the Training School sample who were labelled as low behavioral problems, 6 percent had another Training School as their first previous residential location. The first previous residential location for 59 percent of the children was home. The next to the last column reveals that for 82 percent of the low severity children currently in Training Schools, a Training School was their first residential location after Home. In addition, the last column shows that only 11 percent of these children had ever been in a Training School prior to their current stay.

When reading the tables it is important to remember that the rows, unlike columns, do not sum to 100 percent. There are no row totals or marginals, because there is no way of telling whether, over time, row entries across columns refer to the same individuals or different ones. It should also be kept in mind that the tables are a look backwards into the residential and service histories of the children who were in the sample. Therefore, the tables can account for the past locations of only those children whose current residential locations are known. In other words, from the present data, one cannot estimate how many children who started out in a Training School are currently in a Training School; but one can estimate how many children who are currently in a Training School started out in a Training School. This difference is subtle but very important in interpreting the information in these tables.

FINDINGS

One of the clearest patterns revealed by the data in Tables 10.1 - 10.5 is that many children currently in a particular residential location had lived in that type of location before. In addition, a substantial proportion of children labelled as having high behavioral problems had lived in at least three previous residential locations before their current one. These findings together with the high usage of Home as an intermediate residential location between institutions, indicate that many children are "bouncing around" within the service system. This is evidence of a lack of coordination of services for these children. The residential movement tables also reveal differences among the three levels of behavioral severity discussed below.

For children currently in Training Schools, Tables 10.1 - 10.3 show there were clear differences between severity groups in their past experiences in Training Schools. As can be seen in the last column of these tables, children were more likely to have ever been in a Training School if they were labelled as high behavior problems (42%) than if they were in the medium (30%) or low categories (11%). Looking at the next to last column in the three tables, 82 percent of the children labelled as low behavioral problems had a Training School as their first residential location other than home; while for the medium and high groups, 67 and 45 percent, respectively, had a Training School as their first residential location after home. This is a surprising finding. The researchers would have expected that the children with the less severe behavior problems would have been less likely, not more, to have had a Training School as their first residential location after home. Perhaps this result is due to the fact that the children labelled as high behavior problems exhibited the behaviors measured in the present study at an earlier age than either the medium or low severity group. Because of their younger age, Training School would not be as viable an option as it would be for older children. However, it is still noteworthy that 45 percent of the children labelled as high behavior problems had a Training School as their first residential location after home. Likewise, 51 percent of the children labelled as high behavior problems who were currently living in a Training School lived at home just before being sent to a Training School. In other words, half of the children went straight from living at home to living in a Training School. This is strong evidence against the existence of a continuum of care where children would start out in a less restrictive setting and move to a more restrictive setting based on their needs. Finally, Tables 10.1 - 10.3 indicate that the children with the more severe behavioral problems had lived in more places than the children with less severe behavioral problems. This can be seen by looking at the bottom row in the tables that shows the percentage of children in residence. The percentages decrease toward zero more quickly for the children labelled as having medium behavioral problems than for those in the low group but less quickly than those in the high group. This corroborates the evidence presented in Chapter 9 on the average number of residences.

Tables 10.4 - 10.6 reveal that of the children labelled as high behavioral problems who were currently in Mental Health Hospitals, 21 percent went to a Mental Health Hospital as their first residential location directly from home. However, 50 percent and 48 percent of the low and medium severity groups, respectively, had a Mental Health Hospital as their first residential location. Again, as for the Training Schools data, the researchers would have expected that the more severe groups would have been more likely, not less, to have had a Mental Health Hospital as their first residential location. As explained above, this may be a function of the fact that the category of children labelled as having high behavioral problems exhibited behaviors that would likely result in a need to treat them at an earlier age than the medium or low groups. Because they were younger, they were less likely to be placed in a Mental Health Hospital and less restrictive settings would be tried first. The data also reveal that the children labelled as having high behavioral problems had been to a greater number of previous locations and a greater variety of different types of locations than either the low or medium severity groups.

For the children labelled as having high behavior problems, an interesting comparison can be made between those residing in Training Schools and Mental Health Hospitals. Only 7 percent of the high severity children in Training Schools had ever been to a Mental Health Hospital, and only 7 percent of high severity children in Mental Health Hospitals have ever been to a Training School. This points to a lack of interchange of clients between these two components of the service system. This could be a result of early labelling children as either criminal justice or mental health system material. Given the relatively large percentage of high severity children whose first residential location was highly restrictive (Training School--45% or Mental Health Hospital--21%), this early labelling hypothesis is partially supported. These data also offer strong support against the existence of a continuum of care.

Tables 10.7 - 10.9, which give the systems mapping for the children whose data was obtained from Group Homes all show a strong tendency for a Group Home to have been the first residential location after Home. These children also showed a fairly high tendency to have been in a foster care home previously, especially in the low and medium behavioral groups.

For the not appropriately served children (Tables 10.10 - 10.12) the most frequent current location was Home, with percentages ranging from 38 to 48 percent. In addition, 17 percent of both the medium and high severity groups were currently in Training Schools. A sizable proportion of the medium and high severity children had previously been in either a Group Home or a Foster Care Home, with percentages ranging from 29 to 39 percent.

The pattern does not change dramatically when one considers just the sub-population of the not appropriately served children who were living at Home, and not in a special care facility. As Tables 10.13 - 10.15 reveal, the previous locations for these children were fairly evenly divided among Mental Health Hospitals, Group Homes, and Foster Care Homes.

The pattern of multiple service contacts is also clearly revealed by the 17 service movement tables, Tables 10.16 - 10.32. A large percentage of children labelled as having high behavioral problems have had at least four service location contacts prior to their current one. The low and medium severity groups had proportionally fewer prior service locations. The number and variety of previous service contacts reinforces the findings from the residential movement tables: these children, especially the high severity ones, were moving from one service provider to another without an apparent pattern. In addition, the low level of interaction between Training Schools and Mental Health Hospitals is also supported by the service movement information.

Tables 10.16 - 10.18 show that about one third of the children currently in Training Schools had three service contacts prior to their current one. However, only in the low severity group did a majority of the children have the Juvenile Courts as their first service contact. In both the medium and high severity groups, the first service contact was spread over a variety of service providers.

For children in Mental Health Hospitals (Tables 10.19 - 10.21), a large percentage of children in the medium and high severity groups had four or more previous service contacts. Also, the children in Mental Health Hospitals have used the "Other" services category much of the time; the percentages for ever having used the "Other" services range from 37 to 60 percent. The "Other" category includes such service locations as general hospitals, detention homes and centers, emergency shelter facilities, clinics, and jails.

For children currently in Wilderness Camps (Tables 10.22 and 10.23) only data for the low and medium severity groups are presented: no Wilderness Camp children fell into the high severity category for the reasons discussed earlier in this chapter and in Chapter 5. The data for Wilderness Camp children is difficult to interpret because of irreconcilable differences between this study and Wilderness Camp records in the coding schemes used for residences and services.

For the children in Group Homes (Tables 10.24 - 10.26) previous service contacts are widely distributed over a variety of locations, especially in the medium and high severity groups. Over 40 percent of the children in the medium and high severity groups had four or more previous service contacts before their current one.

When the total not appropriately served population is looked at in Tables 10.27 - 10.29, the most used first service locations after Home are shown to be Mental Health Centers, Juvenile Courts, and Departments of Social Services. In addition, a large percentage of the children labelled as medium and high behavior problems had been to at least four previous service locations.

When just the sub-population of the not appropriately served children who were living at Home is examined (Tables 10.30 - 10.32), the pattern of first locations remains quite similar. The high severity groups in both sets of not appropriately served tables show high usage of "Other" services.

Looking at the data from the 30 tables containing demographic breakdowns of residential movement for the high behavioral severity group reveals some interesting findings. The most interesting finding shown by Tables 10.33 - 10.42 is that when the data on residential movement for children labelled as high behavioral problems is analyzed by the sex of the children, there is disproportionate representation in two of the residential locations. Training Schools have proportionally more males (76%) and Mental Health Hospitals have proportionally more females (55%) than would be expected by the proportion in the total population (65% male and 35% female). In addition, females show a slightly greater tendency to have been in two or more previous residential locations than males, across all locations. In other respects, there are few clearcut differences by sex at any of these five locations.

Tables 10.43 - 10.52 show that when residential movement is analyzed by race, two locations stand out as having disproportionate representation. While the overall division within the high severity group is 68 percent white and 32 percent non-white, both Mental Health Hospitals and Group Homes overrepresent whites. For Mental Health Hospitals 80 percent are white; for Group Homes 77 percent are white. There were no other consistent differences between the races on the systems mapping.

Tables 10.53 - 10.62 show that, although for the entire high severity population county size is split 50 percent to 50 percent between small and large counties, in two locations, Mental Health Hospitals and Group Homes, there was an overrepresentation of larger counties (67% from larger counties). With the children who were currently in Training Schools, small counties had a higher percentage of Training Schools as their first residential location than did larger counties. This same pattern was repeated for Mental Health Hospitals. This could reflect the relative scarcity of alternative residential locations for children labelled as high behavior problems in small counties. Otherwise, there was no consistent pattern of differences by county size.

TABLE 10.1 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools Weight: 6 (Dillon = 2.25)

Level of Behavioral Severity: Low

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	21%/29	82%/109	91%/121	100%/133	100%/133	0%/0	xxxx
Adult Corrections								
Training School	100%/133	6%/8	5%/6				82%/109	11%/14
MH Hospital								
Wilderness Camp		5%/6					5%/6	5%/6
Group Home			5%/6				5%/6	5%/6
Foster Care								
Child Care Facil.								
MH Center								
Juvenile Court		5%/6	5%/6				5%/6	9%/12
DSS								
Non-Resident Care								
Out of State								
Private Referral								
Home		59%/78	5%/6	5%/6				63%/84
Other		5%/6		5%/6			5%/6	5%/6
Total in Residence	100%/133	79%/104	18%/24	9%/12	0%/0	0%/0	100%/133	xxxx
%/N	100%/133	100%/133	100%/133	100%/133	100%/133	100%/133	100%/133	xxxx

TABLE 10.2 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools Weight: 6 (Dillon = 2.25)

Level of Behavioral Severity: Medium

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	26%/91	57%/198	69%/239	80%/276	85%/293	2%/6	xxxx
Adult Corrections		1%/2						1%/2
Training School	100%/346	19%/66	16%/55	3%/11			67%/233	30%/104
MH Hospital		3%/11	2%/8	1%/5	2%/8	4%/13	3%/12	10%/35
Wilderness Camp				1%/2	3%/12		2%/8	4%/14
Group Home		3%/12	6%/20	2%/6	3%/12	3%/12	11%/38	15%/50
Foster Care		3%/12	5%/17	4%/14	3%/12	2%/6	8%/26	12%/43
Child Care Facil.			3%/9	1%/2	1%/5		3%/9	6%/22
MH Center								
Juvenile Court				2%/6				2%/6
DSS			1%/2					1%/2
Non-Resident Care			1%/2		1%/2		1%/2	2%/7
Out of State							1%/5	
Private Referral		1%/2						1%/2
Home		44%/155	8%/26	16%/55	5%/17	6%/20	2%/6	55%/190
Other			2%/6	2%/6	1%/2	1%/2		5%/17
Total in Residence	100%/346	74%/255	43%/148	31%/107	20%/70	15%/53	98%/340	xxxx
%/N	100%/346	100%/346	100%/346	100%/346	100%/346	100%/346	100%/346	xxxx

TABLE 10.3 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools Weight: 6 (Dillon = 2.25)
Level of Behavioral Severity: High
Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	13%/20	36%/55	50%/75	68%/104	79%/120	8%/12	xxxx
Adult Corrections								
Training School	100%/152	19%/29	26%/39	5%/7	11%/17	1%/2	45%/68	42%/63
MH Hospital			4%/6			1%/2	3%/5	7%/11
Wilderness Camp								
Group Home		4%/6	3%/5	4%/6	13%/20		11%/17	24%/37
Foster Care		8%/12	12%/18	5%/8			25%/38	27%/41
Child Care Facil.			3%/5	4%/6	5%/8	1%/2	1%/2	11%/17
MH Center			4%/6					4%/6
Juvenile Court			4%/6				4%/6	4%/6
DSS								
Non-Resident Care								
Out of State								
Private Referral								
Home		51%/77	7%/11	29%/44		15%/23	3%/5	62%/94
Other		5%/8	1%/2	4%/6	1%/2	1%/2		14%/21
Total in Residence	100%/152	87%/132	64%/97	50%/77	32%/48	21%/32	92%/140	xxxx
%/N	100%/152	100%/152	100%/152	100%/152	100%/152	100%/152	100%/152	xxxx

TABLE 10.4 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: Low

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	40%/8	80%/16	80%/16	90%/18	100%/20	0%/0	xxxx
Adult Corrections								
Training School								
MH Hospital	100%/20						50%/10	
Wilderness Camp								
Group Home		10%/2						10%/2
Foster Care					10%/2		10%/2	10%/2
Child Care Facil.								
MH Center								
Juvenile Court								
DSS								
Non-Resident Care								
Out of State		10%/2						10%/2
Private Referral								
Home		30%/6					10%/2	30%/6
Other		10%/2	20%/4	20%/4			30%/6	20%/6
Total in Residence	100%/20	60%/12	20%/4	20%/4	10%/2	0%/0	100%/20	xxxx
%/N	100%/20	100%/20	100%/20	100%/20	100%/20	100%/20	100%/20	xxxx

TABLE 10.5 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: Medium

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	30%/16	44%/24	63%/34	78%/42	89%/48	0%/0	xxxx
Adult Corrections								
Training School		15%/8	15%/8	11%/6	7%/4	4%/2	15%/8	26%/14
MH Hospital	100%/54	4%/2	22%/12	7%/4		4%/2	48%/26	26%/14
Wilderness Camp								
Group Home			4%/2				4%/2	4%/2
Foster Care		7%/4	7%/4	7%/4	4%/2		11%/6	11%/6
Child Care Facil.		7%/4		4%/2			11%/6	11%/6
MH Center								
Juvenile Court								
DSS								
Non-Resident Care								
Out of State								
Private Referral								
Home		26%/14		4%/2	4%/2	4%/2		30%/16
Other		11%/6	7%/4	4%/2	7%/4		11%/6	19%/10
Total in Residence	100%/54	70%/38	56%/30	37%/20	22%/12	11%/6	100%/54	xxxx
%/N	100%/54	100%/54	100%/54	100%/54	100%/54	100%/54	100%/54	xxxx

TABLE 10.6 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: High

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	5%/4	24%/20	57%/48	67%/56	76%/64	0%/0	xxxx
Adult Corrections								
Training School		2%/2	5%/4				5%/4	7%/6
MH Hospital	100%/84	2%/2	17%/14	5%/4	7%/6		21%/18	26%/22
Wilderness Camp								
Group Home		10%/8	2%/2	2%/2	2%/2	2%/2	7%/6	19%/16
Foster Care		7%/6	10%/8	7%/6	2%/2	7%/6	17%/14	26%/22
Child Care Facil.			10%/8	5%/4		5%/4	10%/8	14%/12
MH Center		7%/6					2%/2	7%/6
Juvenile Court								
DSS								
Non-Resident Care		12%/10		2%/2	2%/2		2%/2	12%/10
Out of State							5%/4	
Private Referral		2%/2	2%/2				2%/2	5%/4
Home		21%/18	14%/12	7%/6	14%/12	7%/6	2%/2	48%/40
Other		31%/26	17%/14	14%/12	5%/4	2%/2	26%/22	52%/44
Total in Residence	100%/84	95%/80	76%/64	43%/36	33%/28	24%/20	100%/84	xxxx
%/N	100%/84	100%/84	100%/84	100%/84	100%/84	100%/84	100%/84	xxxx

TABLE 10.7 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46

Level of Behavioral Severity: Low

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	34%/85	45%/110	69%/169	86%/211	86%/211	0%/0	xxxx
Adult Corrections								
Training School								
MH Hospital		7%/17	3%/8				3%/8	7%/17
Wilderness Camp								
Group Home	100%/245	17%/42	7%/17			3%/8	41%/102	24%/59
Foster Care		28%/68	28%/68	17%/42	14%/34		41%/102	52%/127
Child Care Facil.			7%/17					7%/17
MH Center								
Juvenile Court								
DSS								
Non-Resident Care								
Out of State								
Private Referral								
Home		3%/8	7%/17	3%/8		7%/17	3%/8	21%/51
Other		10%/25	3%/8	10%/25		3%/8	10%/25	21%/51
Total in Residence	100%/245	66%/160	55%/135	31%/76	14%/34	14%/34	100%/245	xxxx
%/N	100%/245	100%/245	100%/245	100%/245	100%/245	100%/245	100%/245	xxxx

TABLE 10.8 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46

Level of Behavioral Severity: Medium

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	14%/17	29%/34	50%/59	64%/76	64%/76	7%/8	xxxx
Adult Corrections								
Training School		14%/17					7%/8	14%/17
MH Hospital							7%/8	7%/8
Wilderness Camp								
Group Home	100%/118	21%/25	29%/34	21%/25		14%/17	36%/42	64%/76
Foster Care		14%/17	7%/8	14%/17	29%/34	14%/17	29%/34	43%/51
Child Care Facil.		7%/8		7%/8				21%/25
MH Center								
Juvenile Court								
DSS								
Non-Resident Care								
Out of State								
Private Referral								
Home		21%/25	21%/25		7%/8			43%/51
Other		7%/8	14%/17	7%/8		7%/8	14%/17	36%/42
Total in Residence	100%/118	86%/101	71%/84	50%/59	36%/42	36%/42	93%/110	xxxx
%/N	100%/118	100%/118	100%/118	100%/118	100%/118	100%/118	100%/118	xxxx

TABLE 10.9 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46

Level of Behavioral Severity: High

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	11%/8	33%/25	67%/51	89%/68	89%/68	0%/0	xxxx
Adult Corrections								
Training School								
MH Hospital			11%/8				11%/8	11%/8
Wilderness Camp								
Group Home	100%/76	33%/25	11%/8		11%/8		44%/34	44%/34
Foster Care			11%/8	11%/8			11%/8	22%/17
Child Care Facil.		22%/17				11%/8		22%/17
MH Center		11%/8						11%/8
Juvenile Court								
DSS								
Non-Resident Care								
Out of State				11%/8			11%/8	11%/8
Private Referral								
Home			33%/25					33%/25
Other		22%/17		11%/8			22%/17	33%/25
Total in Residence	100%/76	89%/68	67%/51	33%/25	11%/8	11%/8	100%/76	xxxx
%/N	100%/76	100%/76	100%/76	100%/76	100%/76	100%/76	100%/76	xxxx

TABLE 10.10 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5

Level of Behavioral Severity: Low

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	17%/50	43%/130	68%/205	80%/240	85%/255	92%/275	33%/100	xxxx
Adult Corrections	2%/5		2%/5					2%/5
Training School	3%/10	2%/5			2%/5		7%/20	3%/10
MH Hospital		79%/20	2%/5		2%/5		5%/15	7%/20
Wilderness Camp	5%/15		2%/5				2%/5	2%/5
Group Home	7%/20	3%/10	7%/20	5%/15	2%/5		8%/25	12%/35
Foster Care	13%/40	20%/60	10%/30	7%/20	7%/20	3%/15	20%/60	27%/80
Child Care Facil.		2%/5	2%/5		2%/5		3%/10	3%/10
MH Center	3%/10		2%/5				3%/10	2%/5
Juvenile Court								
DSS								
Non-Resident Care								
Out of State			2%/5				3%/10	3%/10
Private Referral								
Home	48%/145	13%/40	3%/10	8%/25		3%/10	5%/15	18%/55
Other	2%/5	10%/30	2%/5		2%/5	2%/5	10%/30	12%/35
Total in Residence	83%/250	57%/170	32%/95	20%/60	15%/45	8%/25	67%/200	xxxx
%/N	100%/300	100%/300	100%/300	100%/300	100%/300	100%/300	100%/300	xxxx

TABLE 10.11 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5

Level of Behavioral Severity: Medium

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	8%/50	26%/155	41%/245	55%/335	68%/410	73%/440	16%/95	xxxx
Adult Corrections								
Training School	17%/100	12%/75	6%/35	2%/10	1%/5		12%/75	15%/90
MH Hospital	5%/30	7%/45	4%/25	3%/20		1%/5	7%/45	13%/80
Wilderness Camp	3%/20		1%/5	1%/5			1%/5	2%/10
Group Home	12%/75	12%/75	7%/45	7%/40	7%/45	4%/25	11%/65	33%/200
Foster Care	12%/75	12%/70	17%/100	16%/95	14%/85	9%/55	33%/200	38%/230
Child Care Facil.	1%/5	3%/20	2%/15	1%/5	2%/10	2%/15	3%/20	10%/60
MH Center			2%/10	1%/5	1%/5		1%/5	3%/20
Juvenile Court								
DSS								
Non-Resident Care		2%/10					1%/5	2%/10
Out of State			2%/10	1%/5	1%/5			3%/20
Private Referral			2%/10				1%/5	2%/15
Home	38%/230	16%/95	16%/95	10%/60	3%/20	8%/50	2%/15	38%/230
Other	3%/20	10%/60	2%/10	4%/25	3%/20	2%/15	12%/70	18%/110
Total in Residence	92%/555	74%/450	59%/360	45%/270	32%/195	27%/165	84%/510	xxxx
%/N	100%/605	100%/605	100%/605	100%/605	100%605	100%/605	100%/605	xxxx

TABLE 10.12 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5

Level of Behavioral Severity: High

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	11%/40	26%/100	37%/140	45%/170	54%/205	64%/245	16%/60	xxxx
Adult Corrections	1%/5					1%/5		1%/5
Training School	17%/65	8%/30	8%/30	3%/10	3%/10		5%/20	16%/60
MH Hospital	7%/25	7%/25	3%/10	1%/5	3%/10		3%/10	13%/50
Wilderness Camp	3%/10							1%/5
Group Home	4%/15	11%/40	5%/20	7%/25	5%/20	4%/15	12%/45	29%/110
Foster Care	11%/40	13%/50	13%/50	12%/45	16%/60	13%/50	29%/110	39%/150
Child Care Facil.		4%/15		4%/15		3%/10	4%/15	14%/55
MH Center	1%/5	3%/10	1%/5	1%/5			4%/15	4%/15
Juvenile Court								
DSS								
Non-Resident Care								
Out of State		1%/5	1%/5	1%/5			3%/10	4%/15
Private Referral						1%/5	1%/5	1%/5
Home	41%/155	8%/30	21%/80	11%/40	12%/45	8%/30	7%/25	43%/165
Other	59%/20	20%/75	11%/40	16%/60	8%/30	5%/20	17%/65	43%/165
Total in Residence	89%/340	76%/280	63%/240	55%/210	46%/175	36%/135	84%/320	xxxx
%/N	100%/380	100%/380	100%/380	100%/380	100%/380	100%/380	100%/380	xxxx

TABLE 10.13 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: Low
Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	41%/60	83%/120	90%/130	93%/135	100%/145	38%/55	xxxx
Adult Corrections								
Training School		3%/5					3%/5	3%/5
MH Hospital		10%/15	3%/5		3%/5		10%/15	10%/15
Wilderness Camp								
Group Home		3%/5	3%/5	7%/10			7%/10	10%/15
Foster Care		17%/25	7%/10				10%/15	17%/25
Child Care Facil.					3%/5		3%/5	3%/5
MH Center								
Juvenile Court								
DSS								
Non-Resident Care								
Out of State								
Private Referral								
Home	100%/145	3%/5		3%/5			7%/10	7%/10
Other		21%/30	3%/5				21%/30	21%/30
Total in Residence	100%/145	59%/85	17%/25	10%/15	7%/10	0%/0	62%/90	xxxx
%/N	100%/145	100%/145	100%/145	100%/145	100%/145	100%/145	100%/145	xxxx

TABLE 10.14 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: Medium
Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	26%/60	52%/120	72%/165	80%/185	87%/200	24%/55	xxxx
Adult Corrections								
Training School		13%/30	7%/15	2%/5			9%/20	17%/40
MH Hospital		15%/35	2%/5				11%/25	20%/45
Wilderness Camp								
Group Home		17%/40	4%/10	7%/15	2%/5	2%/5	13%/30	26%/60
Foster Care		7%/15	9%/20	7%/15	4%/10	4%/10	17%/40	22%/50
Child Care Facil.		2%/5	2%/5		4%/10		4%/10	7%/15
MH Center			4%/10				2%/5	4%/10
Juvenile Court								
DSS								
Non-Resident Care		2%/5					2%/5	2%/5
Out of State			2%/5					2%/5
Private Referral			2%/5					2%/5
Home	100%/230	4%/10	15%/35	13%/30	7%/15	4%/10	7%/15	26%/60
Other		13%/30			2%/5	2%/5	11%/25	17%/40
Total in Residence	100%/230	74%/170	48%/110	28%/65	20%/45	13%/30	76%/175	xxxx
%/N	100%/230	100%/230	100%/230	100%/230	100%/230	100%/230	100%/230	xxxx

TABLE 10.15 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5

Level of Behavioral Severity: High

Sub-Population:

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home	Ever in Residence
Missing Residence	0%/0	19%/30	35%/55	45%/70	58%/90	74%/115	13%/20	xxxx
Adult Corrections								
Training School		6%/10	10%/15	3%/5	3%/5		3%/5	16%/25
MH Hospital		13%/20	3%/5	3%/5	3%/5		3%/5	19%/30
Wilderness Camp								
Group Home		16%/25		3%/5		3%/5	10%/15	26%/40
Foster Care		16%/25	16%/25	10%/15	13%/20	3%/5	26%/40	39%/60
Child Care Facil.		3%/5		3%/5		3%/5	3%/5	13%/20
MH Center			3%/5				3%/5	3%/5
Juvenile Court								
DSS								
Non-Resident Care								
Out of State								
Private Referral						3%/5	3%/5	3%/5
Home	100%/155	6%/10	26%/40	16%/25	19%/30	10%/15	13%/20	45%/70
Other		19%/30	6%/10	16%/25	3%/5	3%/5	23%/35	42%/65
Total in Residence	100%/155	81%/125	65%/100	55%/85	42%/65	26%/40	87%/135	xxxx
%/N	100%/155	100%/155	100%/155	100%/155	100%/155	100%/155	100%/155	xxxx

TABLE 10.16 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools Weight: 6 (Dillon=2.25)

Level of Behavioral Severity: Low

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	14%/18	67%/89	89%/119	100%/133	100%/133	0%/0	xxxx
Adult Corrections								
Training School	100%/133	6%/8	5%/6				15%/20	11%/14
MH Hospital								
Wilderness Camp		5%/6						5%/6
Group Home		5%/6						5%/6
Foster Care								
Child Care Facil.			2%/2					
MH Center			5%/6	2%/2			6%/8	6%/8
Juvenile Court		60%/80	18%/24	5%/6			69%/92	79%/104
DSS		2%/2	5%/6	5%/6			5%/6	11%/14
Non-Resident Care								
Out of State								
Private Referral								
Home								
Other		9%/12					5%/6	9%/12
Total in Service	100%/133	86%/115	33%/44	11%/14	0%/0	0%/0	100%/133	xxxx
%/N	100%/133	100%/133	100%/133	100%/133	100%/133	100%/133	100%/133	xxxx

TABLE 10.17 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools Weight: 6 (Dillon=2.25)
Level of Behavioral Severity: Medium
Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	14%/49	51%/176	64%/223	79%/273	88%/305	0%/0	xxxx
Adult Corrections			1%/2		2%/6			2%/8
Training School	100%/346	16%/55	15%/53	1%/5		2%/6	18%/62	27%/94
MH Hospital		5%/17	1%/5	1%/5	1%/2	2%/8	2%/6	9%/32
Wilderness Camp				2%/5	2%/5		1%/2	3%/12
Group Home		5%/18	2%/6	2%/6	4%/14	3%/12	2%/6	15%/50
Foster Care		2%/6	2%/8	2%/8	2%/6		2%/8	3%/11
Child Care Facil.			1%/2	2%/7	1%/2		1%/2	3%/11
MH Center		2%/6	9%/32	7%/24	4%/13	2%/8	10%/35	24%/83
Juvenile Court		49%/171	5%/19	8%/29	2%/8		42%/145	64%/223
DSS		.	10%/35	6%/20	2%/7	1%/5	16%/55	21%/74
Non-Resident Care		1%/5	1%/2			1%/2		4%/15
Out of State				2%/6			1%/2	2%/6
Private Referral		2%/6	2%/6				3%/12	3%/12
Home		2%/6					2%/6	2%/6
Other		2%/8		2%/8	2%/8		1%/5	8%/27
Total in Service	100%/346	86%/297	49%/170	36%/123	21%/73	12%/41	100%/346	xxxx
%/N	100%/346	100%/346	100%/346	100%/346	100%/346	100%/346	100%/346	xxxx

TABLE 10.18 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools Weight: 6 (Dillon=2.25)

Level of Behavioral Severity: High

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	20%/30	43%/65	62%/95	83%/126	90%/137	4%/6	xxxx
Adult Corrections								
Training School	100%/152	18%/28	12%/18	4%/7	4%/7	1%/2	16%/25	26%/39
MH Hospital		4%/6				1%/2		5%/8
Wilderness Camp								
Group Home		4%/6	4%/6	11%/17	1%/2		4%/6	20%/31
Foster Care		8%/12	8%/12	7%/11		4%/6	21%/32	23%/35
Child Care Facil.		1%/2	9%/14	1%/2	5%/8			12%/19
MH Center		5%/8	12%/18	1%/2	4%/6		18%/27	24%/37
Juvenile Court		31%/47	8%/12	4%/6	1%/2		34%/51	46%/70
DSS		4%/6	1%/2	7%/11		1%/2	3%/5	18%/27
Non-Resident Care								
Out of State								
Private Referral								
Home		4%/6						4%/6
Other			3%/5	1%/2		1%/2		6%/9
Total in Service	100%/152	80%/122	57%/87	38%/57	17%/26	10%/15	96%/146	xxxx
%/N	100%/152	100%/152	100%/152	100%/152	100%/152	100%/152	100%/152	xxxx

TABLE 10.19 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: Low

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	20%/4	60%/12	80%/16	90%/18	90%/18	0%/0	xxxx
Adult Corrections								
Training School								
MH Hospital	100%/20						10%/2	
Wilderness Camp								
Group Home				10%/2				10%/2
Foster Care						10%/2		10%/2
Child Care Facil.								
MH Center		50%/10	20%/4				40%/8	60%/12
Juvenile Court								
DSS		10%/2	10%/2				10%/2	30%/6
Non-Resident Care								
Out of State								
Private Referral								
Home							10%/2	
Other		20%/4	10%/2	10%/2	10%/2		30%/6	40%/8
Total in Service	100%/20	80%/16	40%/8	20%/4	10%/2	10%/2	100%/20	xxxx
%/N	100%/20	100%/20	100%/20	100%/20	100%/20	100%/20	100%/20	xxxx

TABLE 10.20 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2
Level of Behavioral Severity: Medium
Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	4%/2	26%/14	48%/26	63%/34	70%/38	0%/0	xxxx
Adult Corrections								
Training School		15%/8	15%/8	4%/2	7%/4	4%/2	4%/2	22%/12
MH Hospital	100%/54	7%/4	15%/8	7%/4	4%/2	4%/2	7%/4	26%/14
Wilderness Camp								
Group Home		4%/2						4%/2
Foster Care								
Child Care Facil.		4%/2		4%/2			4%/2	7%/4
MH Center		22%/12	11%/6	7%/4	4%/2	11%/6	33%/18	56%/30
Juvenile Court		7%/4	11%/6	7%/4			11%/6	30%/16
DSS		11%/6	7%/4	7%/4	4%/2	4%/2	22%/12	37%/20
Non-Resident Care		4%/2	4%/2	4%/2			4%/2	4%/2
Out of State								
Private Referral			4%/2	4%/2	4%/2		4%/2	4%/2
Home								
Other		22%/12	7%/4	7%/4	15%/8	7%/4	11%/6	37%/20
Total in Service	100%/54	96%/52	74%/40	52%/28	37%/20	30%/16	100%/54	xxxx
%/N	100%/54	100%/54	100%/54	100%/54	100%/54	100%/54	100%/54	xxxx

TABLE 10.21 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: High

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	0%/0	7%/6	33%/28	50%/42	69%/58	0%/0	xxxx
Adult Corrections								
Training School		2%/2	2%/2				2%/2	5%/4
MH Hospital	100%/84	2%/2	10%/8	10%/8		5%/4		24%/20
Wilderness Camp								
Group Home		7%/6		5%/4	5%/4	2%/2	2%/2	19%/16
Foster Care		2%/2	2%/2	5%/4	5%/4	2%/2	2%/2	14%/12
Child Care Facil.			10%/8	2%/2		2%/2		12%/10
MH Center		12%/10	21%/18	17%/14	5%/4	7%/6	26%/22	62%/52
Juvenile Court		7%/6	12%/10	5%/4	5%/4	2%/2	17%/14	31%/26
DSS		14%/12	12%/10	2%/2	19%/16	5%/2	31%/26	52%/44
Non-Resident Care		5%/4	10%/8	7%/6		2%/2	7%/6	17%/14
Out of State				2%/2				2%/2
Private Referral		5%/4	2%/2	2%/2	2%/2		2%/2	12%/10
Home		2%/2				2%/2		2%/2
Other		40%/34	12%/10	10%/8	10%/8		10%/8	60%/50
Total in Service	100%/84	100%/84	93%/78	67%/56	50%/42	31%/26	100%/84	xxxx
%/N	100%/84	100%/84	100%/84	100%/84	100%/84	100%/84	100%/84	xxxx

TABLE 10.22 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Wilderness Camps Weight: 1

Level of Behavioral Severity: Low

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	58%/15	42%/11	65%/17	81%/21	92%/24	100%/26	xxxx
Adult Corrections								
Training School				4%/1	4%/1	4%/1		8%/2
MH Hospital								
Wilderness Camp	100%/26							
Group Home								
Foster Care			4%/1	4%/1				8%/2
Child Care Facil.								
MH Center		4%/1	12%/3	15%/4	4%/1			38%/10
Juvenile Court		12%/3	27%/7	4%/1		4%/1		46%/12
DSS		23%/6	12%/3	4%/1				27%/7
Non-Resident Care								
Out of State								
Private Referral		4%/1	4%/1	4%/1	12%/3			19%/5
Home								
Other								
Total in Service	100%/26	42%/11	58%/15	35%/9	9%/5	8%/2	0%/0	xxxx
%/N	100%/26	100%/26	100%/26	100%/26	100%/26	100%/26	100%/26	xxxx

TABLE 10.23 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Wilderness Camps Weight: 1

Level of Behavioral Severity: Medium

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	51%/84	45%/74	43%/72	57%/94	72%/119	100%/166	xxxx
Adult Corrections								
Training School		1%/1	2%/3	2%/4	2%/4	3%/5		13%/21
MH Hospital		2%/4	4%/7	6%/10	3%/5	2%/4		17%/28
Wilderness Camp	100%/166							
Group Home		2%/4	2%/4	1%/1				5%/9
Foster Care		3%/5	8%/14	5%/8	4%/7	6%/10		21%/35
Child Care Facil.								
MH Center		4%/7	10%/16	13%/22	7%/12	6%/10		39%/65
Juvenile Court		7%/12	8%/14	6%/10	3%/5	1%/2		27%/44
DSS		17%/29	9%/15	7%/12	11%/18			34%/57
Non-Resident Care								
Out of State								
Private Referral		12%/20	11%/19	16%/27	13%/21	10%/16		43%/71
Home								
Other								
Total in Service	100%/166	49%/82	55%/92	57%/94	43%/72	28%/47	0%/0	xxxx
%/N	100%/166	100%/166	100%/166	100%/166	100%/166	100%/166	100%/166	xxxx

TABLE 10.24 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46

Level of Behavioral Severity: Low

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	21%/51	34%/85	59%/144	79%/195	93%/228	0%/0	xxxx
Adult Corrections								
Training School								
MH Hospital		7%/17	3%/8	3%/8				7%/17
Wilderness Camp								
Group Home	100%/245	14%/34	7%/17			3%/8	3%/8	21%/51
Foster Care		24%/59	17%/42	17%/42	3%/8	3%/8	21%/51	41%/102
Child Care Facil.			3%/8					3%/8
MH Center		21%/51	14%/34		3%/8		21%/51	38%/93
Juvenile Court				3%/8			3%/8	3%/8
DSS		7%/17	10%/25	10%/25	14%/34		34%/85	41%/102
Non-Resident Care								
Out of State								
Private Referral								
Home							3%/8	
Other		7%/17	10%/25	7%/17			14%/34	17%/42
Total in Service	100%/245	79%/194	66%/160	41%/101	21%/50	7%/17	100%/245	xxxx
%/N	100%/245	100%/245	100%/245	100%/245	100%/245	100%/245	100%/245	xxxx

TABLE 10.25 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46

Level of Behavioral Severity: Medium

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	7%/8	14%/17	36%/42	57%/68	57%/68	0%/0	xxxx
Adult Corrections								
Training School		14%/17						14%/17
MH Hospital						7%/8	7%/8	7%/8
Wilderness Camp			7%/8					7%/8
Group Home	100%/118	21%/25	21%/25	21%/25	7%/8	7%/8		64%/76
Foster Care		7%/8			14%/17	7%/8		29%/34
Child Care Facil.			7%/8	7%/8				21%/25
MH Center		14%/17	14%/17				21%/25	29%/34
Juvenile Court		7%/8	14%/17	7%/8		7%/8	21%/25	29%/34
DSS		7%/8	7%/8	21%/25		7%/8	36%/42	43%/51
Non-Resident Care								
Out of State								
Private Referral								
Home		14%/17	7%/8	7%/8				29%/34
Other		7%/8	7%/8		21%/25	7%/8	14%/17	43%/51
Total in Service	100%/118	93%/110	86%/101	64%/76	43%/50	43%/50	100%/118	xxxx
%/N	100%/118	100%/118	100%/118	100%/118	100%/118	100%/118	100%/118	xxxx

TABLE 10.26 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46

Level of Behavioral Severity: High

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	0%/0	0%/0	11%/8	56%/42	89%/68	0%/0	xxxx
Adult Corrections								
Training School								
MH Hospital					11%/8			11%/8
Wilderness Camp								
Group Home	100%/76	22%/17	22%/17		11%/8		11%/8	44%/34
Foster Care			11%/8	11%/8				22%/17
Child Care Facil.		22%/17				11%/8		22%/17
MH Center		22%/17	22%/17	22%/17			11%/8	56%/42
Juvenile Court		11%/8	22%/17		11%/8		22%/17	44%/34
DSS			22%/17	11%/8	11%/8		33%/25	44%/34
Non-Resident Care								
Out of State				11%/8			11%/8	11%/8
Private Referral								
Home								
Other		22%/17		33%/25			11%/18	44%/34
Total in Service	100%/76	100%/76	100%/76	89%/68	44%/34	11%/8	100%/76	xxxx
%/N	100%/76	100%/76	100%/76	100%/76	100%/76	100%/76	100%/76	xxxx

TABLE 10.27 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5

Level of Behavioral Severity: Low

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	2%/5	37%/110	48%/145	70%/210	83%/250	93%/280	3%/10	xxxx
Adult Corrections	2%/5		2%/5					2%/5
Training School	3%/10	2%/5					2%/5	2%/5
MH Hospital		7%/20	2%/5		2%/5			7%/20
Wilderness Camp	3%/10				2%/5		2%/5	2%/5
Group Home	8%/25	2%/5	7%/20	7%/20				10%/30
Foster Care	12%/35	18%/55	8%/25	5%/15	3%/10	3%/10	3%/10	22%/65
Child Care Facil.					2%/5		3%/10	2%/5
MH Center	23%/70	13%/40	10%/30	3%/10		2%/5	13%/40	23%/70
Juvenile Court	22%/65	7%/20	5%/15	3%/10			23%/70	15%/45
DSS	23%/70	7%/20	8%/25	8%/25	5%/15		42%/125	25%/75
Non-Resident Care								
Out of State			3%/10				3%/10	3%/10
Private Referral								
Home								
Other	2%/5	8%/25	7%/20	3%/10	3%/10	2%/5	5%/15	13%/40
Total in Service	98%/295	63%/190	52%/155	30%/90	17%/50	7%/20	97%/290	xxxx
%/N	100%/300	100%/300	100%/300	100%/300	100%/300	100%/300	100%/300	xxxx

TABLE 10.28 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5

Level of Behavioral Severity: Medium

Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	2%/15	9%/55	26%/155	55%/330	65%/395	74%/445	1%/5	xxxx
Adult Corrections								
Training School	16%/95	11%/65	2%/15	2%/10	2%/10	1%/5	2%/10	12%/70
MH Hospital	5%/30	7%/40	4%/25	2%/10		1%/5		10%/60
Wilderness Camp	3%/20		1%/5	1%/5			1%/5	2%/10
Group Home	8%/50	10%/60	9%/55	7%/45	2%/15	4%/25	2%/10	26%/155
Foster Care	7%/45	7%/45	12%/70	13%/80	11%/65	8%/50	3%/20	26%/160
Child Care Facil.	1%/5	4%/25	1%/5	2%/10	1%/5	2%/15	2%/10	8%/50
MH Center	14%/85	19%/115	13%/80	5%/30	3%/20	4%/25	22%/135	41%/250
Juvenile Court	17%/105	12%/70	10%/60	7%/45	3%/20		27%/165	33%/205
DSS	21%/125	9%/55	7%/45	2%/10	5%/30	4%/25	33%/200	31%/185
Non-Resident Care		2%/10	1%/5				2%/10	2%/15
Out of State			2%/10					2%/10
Private Referral		1%/5	2%/10		1%/5		2%/10	3%/20
Home	2%/10	2%/10	3%/20	1%/5	2%/15			8%/50
Other	3%/20	8%/50	7%/45	4%/25	4%/25	2%/10	4%/25	22%/135
Total in Service	98%/590	91%/550	74%/450	45%/275	35%/210	26%/150	99%/600	xxxx
%/N	100%/605	100%/605	100%/605	100%/605	100%/605	100%/605	100%/605	xxxx

TABLE 10.29 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5
Level of Behavioral Severity: High
Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	3%/10	12%/45	29%/110	36%/135	57%/215	66%/250	1%/5	xxxx
Adult Corrections	1%/5					1%/5		1%/5
Training School	18%/70	7%/25	5%/20	3%/10	1%/5	1%/5	1%/5	14%/55
MH Hospital	7%/25	5%/20	1%/5	3%/10	1%/5			12%/45
Wilderness Camp	3%/10					1%/5		3%/10
Group Home	4%/15	4%/15	8%/30	4%/15	7%/25	4%/15	1%/5	22%/85
Foster Care	1%/5	7%/25	7%/25	8%/30	5%/20	11%/40	3%/10	26%/100
Child Care Facil.		4%/15		1%/5				8%/30
MH Center	18%/70	18%/70	11%/40	13%/50	4%/15	4%/15	29%/110	46%/175
Juvenile Court	11%/40	13%/50	7%/25	3%/10	4%/15		17%/65	29%/110
DSS	26%/100	11%/40	7%/25	7%/25	1%/5	4%/15	30%/115	26%/100
Non-Resident Care				1%/5				1%/5
Out of State			1%/5		1%/5	3%/10	3%/10	4%/15
Private Referral			1%/5	1%/5				3%/10
Home	3%/10	1%/5	7%/25	3%/10	4%/15	1%/5		8%/30
Other	5%/20	18%/70	17%/65	18%/70	14%/55	4%/15	14%/55	49%/185
Total in Service	97%/370	88%/335	71%/270	64%/245	43%/165	33%/130	99%/375	xxxx
%/N	100%/380	100%/380	100%/380	100%/380	100%/380	100%/380	100%/380	xxxx

TABLE 10.30 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: Low
Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	0%/0	55%/80	62%/90	79%/115	86%/125	97%/140	0%/0	xxxx
Adult Corrections								
Training School		3%/5						3%/5
MH Hospital		10%/5	3%/5		3%/5			10%/15
Wilderness Camp								
Group Home	3%/5		3%/5	7%/10				7%/10
Foster Care		14%/20	3%/5					14%/20
Child Care Facil.					3%/5		3%/5	3%/5
MH Center	24%/35	7%/10	7%/10	3%/5		3%/5	17%/25	17%/25
Juvenile Court	34%/50						24%/35	
DSS	38%/55		10%/15	3%/5	3%/5		48%/70	17%/25
Non-Resident Care								
Out of State								
Private Referral								
Home								
Other		10%/15	10%/15	7%/10	3%/5		7%/10	14%/20
Total in Service	100%/145	45%/65	38%/55	21%/30	14%/20	3%/5	100%/145	xxxx
%/N	100%/145	100%/145	100%/145	100%/145	100%/145	100%/145	100%/145	xxxx

TABLE 10.31 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: Medium
Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	2%/5	13%/30	30%/70	74%/170	78%/180	85%/195	2%/5	xxxx
Adult Corrections								
Training School		13%/30	4%/10	2%/5			2%/5	15%/35
MH Hospital		13%/30	2%/5					15%/35
Wilderness Camp								
Group Home		11%/25	9%/20	7%/15	2%/5		2%/5	24%/55
Foster Care		4%/10	2%/5	9%/20		4%/10		15%/35
Child Care Facil.		2%/5	2%/5		2%/5	2%/5		7%/15
MH Center	28%/65	20%/45	15%/35		2%/5	4%/10	24%/55	39%/90
Juvenile Court	39%/90	2%/5	7%/15	4%/10	4%/10		41%/95	22%/50
DSS	24%/55	9%/20	7%/15		2%/5		15%/35	22%/50
Non-Resident Care		2%/5	2%/5				4%/10	4%/10
Out of State			2%/5					2%/5
Private Referral			2%/5		2%/5			4%/10
Home	4%/10	2%/5	2%/5	2%/5	4%/10			9%/20
Other	2%/5	9%/20	13%/30	2%/5	2%/5	4%/10	9%/20	26%/60
Total in Service	98%/225	87%/200	70%/160	26%/60	22%/50	15%/35	98%/225	xxxx
%/N	100%/230	100%/230	100%/230	100%/230	100%/230	100%/230	100%/230	xxxx

TABLE 10.32 SERVICE MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: High
Sub-Population:

	Current Service	1st Prev Service	2nd Prev Service	3rd Prev Service	4th Prev Service	5th Prev Service	1st Service After Home	Ever in Service
Missing Service	6%/10	19%/30	35%/55	39%/60	65%/100	77%/120	3%/5	xxxx
Adult Corrections								
Training School	3%/5	6%/10	6%/10			3%/5		13%/20
MH Hospital		10%/15	3%/5	3%/5				16%/25
Wilderness Camp								
Group Home		6%/10	6%/10			3%/5		13%/20
Foster Care		3%/5	6%/10	3%/5	3%/5	6%/10		16%/25
Child Care Facil.		3%/5						6%/10
MH Center	26%/40	10%/15	10%/15	13%/20	6%/10		23%/35	35%/55
Juvenile Court	23%/35	6%/10	3%/5	3%/5			19%/30	16%/25
DSS	35%/55	10%/15		6%/10		3%/5	29%/45	16%/25
Non-Resident Care								
Out of State								
Private Referral			3%/5	3%/5				6%/10
Home	3%/5	3%/5	6%/10	6%/10	6%/10			6%/10
Other	3%/5	23%/35	19%/30	23%/35	19%/30	6%/10	26%/40	52%/80
Total in Service	94%/145	81%/125	65%/100	61%/95	35%/55	23%/35	97%/150	xxxx
%/N	100%/155	100%/155	100%/155	100%/155	100%/155	100%/155	100%/155	xxxx

TABLE 10.33 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools
Level of Behavioral Severity: High
Sub-Population: Male
Weight: 6 (Dillon = 2.25)

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	12%/14	37%/43	50%/57	67%/77	76%/88	5%/6
Adult Corrections							
Training School	100%/115	21%/24	27%/31	4%/5	8%/9	2%/2	43%/50
MH Hospital							2%/2
Wilderness Camp							
Group Home		5%/6	4%/5		18%/20		9%/11
Foster Care		10%/12	16%/18	7%/4			31%/36
Child Care Facil.			2%/2	5%/6	5%/6	2%/2	2%/2
MH Center			5%/6				
Juvenile Court			5%/6				5%/6
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home		51%/59	2%/2	29%/33		18%/20	2%/2
Other			2%/2	5%/6	2%/2	2%/2	
Total in Residence	100%/115	88%/101	63%/82	50%/58	33%/38	24%/27	95%/109
%/N	100%/115	100%/115	100%/115	100%/115	100%/115	100%/115	100%/115

TABLE 10.34 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools
Level of Behavioral Severity: High
Sub-Population: Female
Weight: 6 (Dillon = 2.25)

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	16%/6	33%/12	49%/18	71%/26	88%/32	16%/6
Adult Corrections							
Training School	100%/37	12%/5	22%/8	6%/2	22%/8		49%/18
MH Hospital			16%/6			6%/2	6%/2
Wilderness Camp							
Group Home				16%/6			16%/6
Foster Care							6%/2
Child Care Facil.			6%/2		6%/2		
MH Center							
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home		49%/18	22%/8	29%/11		6%/2	6%/2
Other		22%/8					
Total in Residence	100%/37	84%/31	67%/25	51%/19	29%/11	12%/5	84%/31
%/N	100%/37	100%/37	100%/37	100%/37	100%/37	100%/37	100%/37

CONTINUED

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TABLE 10.35 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: High

Sub-Population: Male

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	5%/2	42%/16	74%/28	79%/30	79%/30	0%/0
Adult Corrections							
Training School		5%/2	11%/4				11%/4
MH Hospital	100%/38	5%/2	21%/8	5%/2	5%/2		26%/10
Wilderness Camp							
Group Home		11%/4					5%/2
Foster Care		11%/4			5%/2	5%/2	5%/2
Child Care Facil.							5%/2
MH Center		5%/2					5%/2
Juvenile Court							
DSS							
Non-Resident Care		16%/6					5%/2
Out of State							5%/2
Private Referral		5%/2					
Home		21%/8	5%/2	11%/4	5%/2	11%/4	
Other		16%/6	21%/8	11%/4	5%/2	5%/2	32%/12
Total in Residence	100%/38	95%/36	58%/22	26%/10	21%/8	21%/8	100%/38
%/N	100%/38	100%/38	100%/38	100%/38	100%/38	100%/38	100%/38

TABLE 10.36 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: High

Sub-Population: Female

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	4%/2	9%/4	43%/20	57%/26	74%/34	0%/0
Adult Corrections							
Training School							
MH Hospital	100%/46		13%/6	4%/2	9%/4		17%/8
Wilderness Camp							
Group Home		9%/4	4%/2	4%/2	4%/2	4%/2	9%/4
Foster Care		4%/2	17%/8	13%/6		9%/4	26%/12
Child Care Facil.			17%/8	9%/4		9%/4	13%/6
MH Center		9%/4					
Juvenile Court							
DSS							
Non-Resident Care		9%/4		4%/2	4%/2		
Out of State							4%/2
Private Referral			4%/2				4%/2
Home		22%10	22%/10	4%/2	22%/10	4%/2	4%/2
Other		43%/20	13%/6	17%/8	4%/2		22%/10
Total in Residence	100%/46	96%/44	91%42	57%/26	43%/20	26%/12	100%/46
%/N	100%/46	100%/46	100%/46	100%/46	100%/46	100%/46	100%/46

TABLE 10.37 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46
Level of Behavioral Severity: High
Sub-Population: Male

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	20%/8	40%/17	80%/34	100%/42	100%/42	0%/0
Adult Corrections							
Training School							
MH Hospital							
Wilderness Camp							
Group Home	100%/42	40%/17	20%/8				60%/25
Foster Care							
Child Care Facil.		20%/8					
MH Center							
Juvenile Court							
DSS							
Non-Resident Care							
Out of State				20%/8			20%/8
Private Referral							
Home			40%/17				
Other		20%/8					20%/8
Total in Residence	100%/42	80%/34	60%/25	20%/8	0%/0	0%/0	100%/42
%/N	100%/42	100%/42	100%/42	100%/42	100%/42	100%/42	100%/42

TABLE 10.38 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Home Weight: 8.46
Level of Behavioral Severity: High
Sub-Population: Female

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	0%/0	25%/8	50%/17	75%/25	75%/25	0%/0
Adult Corrections							
Training School							
MH Hospital			25%/8				25%/8
Wilderness Camp							
Group Home	100%/34	25%/8			25%/8		25%/8
Foster Care			25%/8	25%/8			25%/8
Child Care Facil.		25%/8				25%/8	
MH Center		25%/8					
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home			25%/8				
Other		25%/8		25%/8			25%/8
Total in Residence	100%/34	100%/34	75%/25	50%/17	25%/8	25%/8	100%/34
%/N	100%/34	100%/34	100%/34	100%/34	100%/34	100%/34	100%/34

TABLE 10.39 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5
Level of Behavioral Severity: High
Sub-Population: Male

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	16%/40	33%/85	45%/115	53%/135	57%/145	67%/170	22%/55
Adult Corrections	2%/5					2%/5	
Training School	24%/60	10%/25	12%/30	2%/5	4%/10		8%/20
MH Hospital	4%/10	4%/10	2%/5		4%/10		4%/10
Wilderness Camp	4%/10						
Group Home	2%/5	10%/25	4%/10	6%/15	6%/15	4%/10	12%/30
Foster Care	6%/15	12%/30	14%/35	12%/30	12%/30	12%/30	25%/65
Child Care Facil.		6%/15		4%/10		4%/10	4%/10
MH Center	2%/5		2%/5				4%/10
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home	37%/95	2%/5	16%/40	8%/20	12%/30	6%15	8%/20
Other	4%/10	24%/60	6%/15	16%/40	6%/15	6%/15	14%/35
Total in Residence	84%/215	67%/170	55%/140	47%/120	43%/110	33%/85	78%/200
%/N	100%/255	100%/255	100%/255	100%/255	100%/255	100%/255	100%/255

TABLE 10.40 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5

Level of Behavioral Severity: High

Sub-Population: Female

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	12%/15	20%/25	28%/35	48%/60	60%/75	4%/5
Adult Corrections							
Training School	4%/5	4%/5		4%/5			
MH Hospital	12%/15	12%/15	4%/5	4%/5			
Wilderness Camp							
Group Home	8%/10	12%/15	8%/10	8%/10	4%/5	4%/5	12%/15
Foster Care	20%/25	16%/20	12%/15	12%/15	24%/30	16%/20	36%/45
Child Care Facil.				4%/5			4%/5
MH Center		8%/10		4%/5			4%/5
Juvenile Court							
DSS							
Non-Resident Care							
Out of State		4%/5	4%/5	4%/5			8%/10
Private Referral						4%/5	4%/5
Home	48%/60	20%/25	32%/20	16%/20	12%/15	12%/15	4%/5
Other	8%/10	12%/15	20%/25	16%/20	12%/15	4%/5	24%/30
Total in Residence	100%/125	88%/110	80%/100	72%/90	52%/65	40%/50	96%/120
%/N	100%/125	100%/125	100%/125	100%/125	100%/125	100%/125	100%/125

TABLE 10.41 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: High
Sub-Population: Male

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	21%/20	42%/40	58%/50	63%/60	79%/75	16%/15
Adult Corrections							
Training School		5%/5	16%/15		5%/5		5%/5
MH Hospital		11%/10			5%/5		5%/5
Wilderness Camp							
Group Home		16%/15					5%/5
Foster Care		16%/15	16%/15	11%/10			16%/15
Child Care Facil.		5%/5		5%/5		5%/5	5%/5
MH Center			5%/5				5%/5
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home	100%/95		16%/15	16%/15	21%/20	11%/10	16%/15
Other		26%/25	5%/5	11%/10	5%/5	5%/5	26%/25
Total in Residence	100%/95	79%/75	58%/55	42%/40	37%/35	21%/20	84%/80
%/N	100%/95	100%/95	100%/95	100%/95	100%/95	100%/95	100%/95

TABLE 10.42 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: High
Sub-Population: Female

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	17%/10	25%/15	25%/15	50%/30	67%/40	8%/5
Adult Corrections							
Training School		8%/5		8%/5			
MH Hospital		17%/10	8%/5	8%/5			
Wilderness Camp							
Group Home		17%/10		8%/5		8%/5	17%/10
Foster Care		17%/10	17%/10	8%/5	33%/20	8%/5	42%/25
Child Care Facil.							
MH Center							
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral						8%/5	8%/5
Home	100%/60	17%/10	42%/25	17%/10	17%/10	8%/5	8%/5
Other		8%/5	8%/5	25%/15			17%/10
Total in Residence	100%/60	83%/50	75%/45	75%/45	50%/30	33%/20	92%/55
%/N	100%/60	100%/60	100%/60	100%/60	100%/60	100%/60	100%/60

TABLE 10.43 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training School
Level of Behavioral Severity: High
Sub-Population: White
Weight: 6 (Dillon = 2.25)

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	15%/14	37%/37	56%/55	64%/63	75%/74	6%/6
Adult Corrections							
Training School	100%/98	14%/14	17%/17	5%/5	7%/7		42%/41
MH Hospital			6%/6				2%/2
Wilderness Camp							
Group Home		6%/6	2%/2	6%/6	21%/20		15%/14
Foster Care		6%/6	18%/18	2%/2			31%/30
Child Care Facil.			2%/2	6%/6	6%/6	2%/2	2%/2
MH Center			6%/6				
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home		53%/53	8%/8	19%/19		21%/20	2%/2
Other		6%/6	2%/2	6%/6	2%/2	2%/2	
Total in Residence	100%/98	85%/84	63%/62	44%/43	36%/35	25%/24	94%/92
%/N	100%/98	100%/98	100%/98	100%/98	100%/98	100%/98	100%/98

TABLE 10.44 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training School
Level of Behavioral Severity: High
Sub-Population: Non-White
Weight: 6 (Dillon = 2.25)

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	11%/6	34%/18	38%/20	76%/41	87%/47	11%/6
Adult Corrections							
Training School	100%/53	28%/15	42%/23	4%/2	20%/11	4%/2	49%/26
MH Hospital						4%/2	4%/2
Wilderness Camp							
Group Home			4%/2				4%/2
Foster Care		11%/6		11%/6			15%/8
Child Care Facil.			4%/2		4%/2		
MH Center							
Juvenile Court		11%/6					11%/6
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home		45%/24	4%/2	46%/25		4%/2	4%/2
Other		4%/2					
Total in Residence	100%/53	89%/47	66%/35	62%/33	24%/12	13%/6	89%/47
%/N	100%/53	100%/53	100%/53	100%/53	100%/53	100%/53	100%/53

TABLE 10.45 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: High

Sub-Population: White

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	6%/4	29%/20	68%/46	71%/48	79%/54	0%/0
Adult Corrections							
Training School		3%/2	6%/4				6%/4
MH Hospital	100%/68	3%/2	12%/8	6%/4	3%/2		21%/14
Wilderness Camp							
Group Home		3%/2	3%/2		3%/2	3%/2	6%/4
Foster Care		6%/4	6%/4	3%/2	3%/2	3%/2	12%/8
Child Care Facil.			9%/6	3%/2		6%/4	9%/6
MH Center		6%/4					3%/2
Juvenile Court							
DSS							
Non-Resident Care		12%/8		3%/2			3%/2
Out of State							6%/4
Private Referral		3%/2	3%/2				3%/2
Home		24%/16	15%/10	6%/4	15%/10	6%/4	3%/2
Other		35%/24	18%/12	12%/8	6%/4	3%/2	29%/20
Total in Residence	100%/68	94%/64	71%/48	32%/22	29%/20	21%/14	100%/68
%/N	100%/68	100%/68	100%/68	100%/68	100%/68	100%/68	100%/68

TABLE 10.46 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: High

Sub-Population: Non-White

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	0%/0	0%/0	13%/2	50%/8	63%/10	0%/0
Adult Corrections							
Training School							
MH Hospital	100%/16		38%/16		25%/4		25%/4
Wilderness Camp							
Group Home		38%/6		13%/2			13%/2
Foster Care		13%/2	25%/4	25%/4		25%/4	38%/6
Child Care Facil.			13%/2	13%/2			13%/2
MH Center		13%/2					
Juvenile Court							
DSS							
Non-Resident Care		13%/2			13%2		
Out of State							
Private Referral							
Home		13%/2	13%/2	13%/2	13%/2	13%/2	
Other		13%/2	13%/2	25%/4			13%/2
Total in Residence	100%/16	100%/16	100%/16	87%/14	50%/8	37%/6	100%/16
%/N	100%/16	100%/16	100%/16	100%/16	100%/16	100%/16	100%/16

TABLE 10.47 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46
Level of Behavioral Severity: High
Sub-Population: White

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	0%/0	29%/17	57%/34	86%/51	86%/51	0%/0
Adult Corrections							
Training School							
MH Hospital			14%/8				14%/8
Wilderness Camp							
Group Home	100%/59	29%/17			14%/8		29%/17
Foster Care			14%/8	14%/8			14%/8
Child Care Facil.		29%/17				14%/8	
MH Center		14%/8					
Juvenile Court							
DSS							
Non-Resident Care							
Out of State				14%/8			14%/8
Private Referral							
Home			43%/25				
Other		29%/17		14%/8			29%/17
Total in Residence	100%/59	100%/59	71%/42	43%/25	14%/8	14%/51	100%/59
%/N	100%/59	100%/59	100%/59	100%/59	100%/59	100%/59	100%/59

TABLE 10.48 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes
Level of Behavioral Severity: High
Sub-Population: Non-White
Weight: 8.46

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	50%/8	50%/8	100%/17	100%/17	100%/17	0%/0
Adult Corrections							
Training School							
MH Hospital							
Wilderness Camp							
Group Home	100%/17	50%/8	50%/8				100%/17
Foster Care							
Child Care Facil.							
MH Center							
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home							
Other							
Total in Residence	100%/17	50%/8	50%/8	0%/0	0%/0	0%/0	100%/17
%/N	100%/17	100%/17	100%/17	100%/17	100%/17	100%/17	100%/17

TABLE 10.49 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5
Level of Behavioral Severity: High
Sub-Population: White

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	17%/40	29%/70	40%/95	46%/110	54%/130	60%/145	21%/50
Adult Corrections	2%/5					2%/5	
Training School	13%/30	10%/25	6%/15	2%/5	2%/5		4%/10
MH Hospital	8%/20	6%/15	4%/10	2%/5	2%/5		2%/5
Wilderness Camp	4%/10						
Group Home		13%/30	6%/15	6%/15	4%/10	4%/10	8%/20
Foster Care	8%/20	10%/25	13%/30	15%/35	17%/40	15%/35	27%/65
Child Care Facil.		4%/10		2%/5			6%/25
MH Center	2%/5	2%/5					2%/5
Juvenile Court							
DSS							
Non-Resident Care							
Out of State		2%/5		2%/5			2%/5
Private Referral						2%/5	2%/5
Home	40%/95	6%/15	21%/50	8%/20	15%/35	8%/20	6%/15
Other	6%/15	17%/40	10%/25	17%/40	6%/15	8%/20	19%/45
Total in Residence	83%/200	71%/170	60%/145	54%/130	46%/110	40%/95	79%/190
%/N	100%/240	100%/240	100%/240	100%/240	100%/240	100%/240	100%/240

TABLE 10.50 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5
Level of Behavioral Severity: High
Sub-Population: Non-White

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	22%/30	33%/45	44%/60	56%/75	74%/100	7%/10
Adult Corrections							
Training School	26%/35	4%/5	11%/15	4%/5	4%/5		7%/10
MH Hospital	4%/5	7%/10			4%/5		4%/5
Wilderness Camp							
Group Home	11%/15	7%/10	4%/5	7%/10	7%/10	4%/5	15%/20
Foster Care	15%/20	15%/20	11%/15	4%/5	15%/20	11%/15	33%/45
Child Care Facil.		4%/5		7%/10		4%/5	
MH Center		4%/5	4%/5	4%/5			7%/10
Juvenile Court							
DSS							
Non-Resident Care							
Out of State			4%/5				4%/5
Private Referral							
Home	41%/55	11%/15	22%/30	15%/20	4%/5	7%/10	7%/10
Other	4%/5	26%/35	11%/15	15%/20	11%/15		15%/20
Total in Residence	100%/135	78%/105	67%/90	56%/75	44%/60	26%/35	93%/125
%/N	100%/135	100%/135	100%/135	100%/135	100%/135	100%/135	100%/135

TABLE 10.51 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: High
Sub-Population: White

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	16%/15	37%/35	42%/40	58%/55	68%/65	11%/10
Adult Corrections							
Training School		11%/10	11%/10	5%/5	5%/5		5%/5
MH Hospital		16%/15	5%/5	5%/5			
Wilderness Camp							
Group Home		16%/15		5%/5		5%/5	11%/10
Foster Care		11%/10	11%/10	11%/10	11%/10		26%/25
Child Care Facil.		5%/5					5%/5
MH Center							
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral						5%/5	5%/5
Home	100%/95	5%/5	32%/30	11%/10	26%/25	16%/15	11%/10
Other		21%/20	5%/5	21%/20		5%/5	26%/25
Total in Residence	100%/95	84%/80	63%/60	58%/55	42%/40	32%/30	89%/85
%/N	100%/95	100%/95	100%/95	100%/95	100%/95	100%/95	100%/95

TABLE 10.52 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: High
Sub-Population: Non-White

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	27%/15	36%/20	55%/30	64%/35	91%/50	18%/10
Adult Corrections							
Training School			/5				
MH Hospital		9%/5			9%/5		9%/5
Wilderness Camp							
Group Home		18%/10					
Foster Care		18%/10	18%/10		18%/10	9%/5	27%/15
Child Care Facil.				9%/5			
MH Center							9%/5
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home	100%/55	9%/5	18%/10	27%/15			18%/10
Other		18%/10	9%/5	9%/5	9%/5		18%/10
Total in Residence	100%/55	73%/40	64%/35	45%/25	36%/20	9%/5	82%/45
%/N	100%/55	100%/55	100%/55	100%/55	100%/55	100%/55	100%/55

TABLE 10.53 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools Weight: 6 (Dillon = 2.25)
Level of Behavioral Severity: High
Sub-Population: Community Size 85,000 or Less

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	24%/20	38%/32	53%/44	63%/53	75%/63	14%/12
Adult Corrections							
Training School	100%/84	13%/11	29%/25	5%/5	18%/15	3%/2	54%/45
MH Hospital							3%/2
Wilderness Camp							
Group Home			3%/2		10%/8		3%/2
Foster Care		7%/6	7%/6	3%/2			21%/18
Child Care Facil.			3%/2		7%/6	3%/2	3%/2
MH Center			7%/6				
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home		48%/41	10%/8	39%/33		17%/14	3%/2
Other		7%/6	3%/2		3%/2	3%/2	
Total in Residence	100%/84	76%/64	62%/52	47%/40	37%/31	25%/21	86%/72
%/N	100%/84	100%/84	100%/84	100%/84	100%/84	100%/84	100%/84

TABLE 10.54 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Training Schools Weight: 6 (Dillon - 2.25)

Level of Behavioral Severity: High

Sub-Population: Community Size Greater Than 85,000

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	0%/0	33%/23	46%/31	76%/51	84%/57	0%/0
Adult Corrections							
Training School	100%/68	26%/17	21%/14	3%/2	3%/2		33%/23
MH Hospital			9%/6			3%/2	3%/2
Wilderness Camp							
Group Home		9%/6	3%/2	9%/6	18%/12		21%/14
Foster Care		9%/6	18%/12	9%/6			30%/20
Child Care Facil.			3%/2	9%/6	3%/2		
MH Center							
Juvenile Court			9%/6				9%/6
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home		53%/36	3%/2	16%/11		12%/8	3%/2
Other		3%/2		9%/6			
Total in Residence	100%/68	100%/68	67%/45	54%/37	24%/17	16%/11	100%/68
%/N	100%/68	100%/68	100%/68	100%/68	100%/68	100%/68	100%/68

TABLE 10.55 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2
Level of Behavioral Severity: High
Sub-Population: Community Size 85,000 or Less

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	7%/2	21%/6	79%/22	93%/26	100%/28	0%/0
Adult Corrections							
Training School		7%/2	7%/2				7%/2
MH Hospital	100%/28	7%/2	21%/6				36%/10
Wilderness Camp							
Group Home		14%/4					7%/2
Foster Care		7%/2	14%/4				14%/4
Child Care Facil.			7%/2				7%/2
MH Center		7%/2					
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral		7%/2					
Home		29%/8	14%/4	7%/2			
Other		14%/4	14%/4	14%/4	7%/2		29%/8
Total in Residence	100%/28	93%/26	79%/22	21%/6	7%/2	0%/0	100%/28
%/N	100%/28	100%/28	100%/28	100%/28	100%/28	100%/28	100%/28

TABLE 10.56 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Mental Health Hospitals Weight: 2

Level of Behavioral Severity: High

Sub-Population: Community Size Greater Than 85,000

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	4%/2	25%/14	46%/26	54%/30	64%/36	0%/0
Adult Corrections							
Training School			4%/2				4%/2
MH Hospital	100%/56		14%/8	7%/4	11%/6		14%/8
Wilderness Camp							
Group Home		7%/4	4%/2	4%/2	4%/2	4%/2	7%/4
Foster Care		7%/4	7%/4	11%/6	4%/2	11%/6	18%/10
Child Care Facil.			11%/6	7%/4		7%/4	11%/6
MH Center		7%/4					4%/2
Juvenile Court							
DSS							
Non-Resident Care		18%/10		4%/2	4%/2		4%/2
Out of State							7%/4
Private Referral			4%/2				4%/2
Home		18%/10	14%/8	7%/4	21%/12	11%/6	4%/2
Other		39%/22	18%/10	14%/8	4%/2	4%/2	25%/14
Total in Residence	100%/56	96%/54	75%/42	54%/30	46%/26	36%/20	100%/56
%/N	100%/56	100%/56	100%/56	100%/56	100%/56	100%/56	100%/56

TABLE 10.57 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46

Level of Behavioral Severity: High

Sub-Population: Community Size 85,000 or Less

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	0%/0	33%/8	67%/17	100%/25	100%/25	0%/5
Adult Corrections							
Training School							
MH Hospital							
Wilderness Camp							
Group Home	100%/25	67%/17					33%/8
Foster Care				33%/8			33%/8
Child Care Facil.							
MH Center							
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home			67%/17				
Other		33%/8					33%/8
Total in Residence	100%/25	100%/25	67%/17	33%/8	0%/0	0%/0	100%/25
%/N	100%/25	100%/25	100%/25	100%/25	100%/25	100%/25	100%/25

TABLE 10.58 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Group Homes Weight: 8.46

Level of Behavioral Severity: High

Sub-Population: Community Size Greater Than 85,000

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	17%/8	33%/17	67%/25	83%/42	83%/42	0%/0
Adult Corrections							
Training School							
MH Hospital			17%/8				17%/8
Wilderness Camp							
Group Home	100%/51	17%/8	17%/8		17%/8		50%/25
Foster Care			17%/8				
Child Care Facil.		33%/17				17%/8	
MH Center		17%/8					
Juvenile Court							
DSS							
Non-Resident Care							
Out of State				17%/8			17%/8
Private Referral							
Home			17%/8				
Other		17%/8		17%/8			17%/8
Total in Residence	100%/51	83%/43	67%/24	33%/16	17%/9	17%/9	100%/51
%/N	100%/51	100%/51	100%/51	100%/51	100%/51	100%/51	100%/51

TABLE 10.59 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5
Level of Behavioral Severity: High
Sub-Population: Community Size Greater Than 85,000

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	6%/10	11%/20	26%/45	29%/50	43%/75	60%/105	9%/15
Adult Corrections							
Training School	26%/45	9%/15	14%/25	3%/5	3%/5		3%/5
MH Hospital	9%/15	6%/10	3%/5		6%/10		3%/5
Wilderness Camp	6%/10						
Group Home	6%/10	14%/25	6%/10	9%/15	9%/15	6%/10	14%/25
Foster Care	6%/10	14%/25	9%/15	9%/15	17%/30	14%/30	29%/50
Child Care Facil.		9%/15		9%/15		3%/5	9%/15
MH Center		3%/5	3%/5	3%/5			6%/10
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home	34%/60	6%/10	31%/55	17%/30	9%/15	11%/20	6%/10
Other	9%/15	29%/50	9%/15	23%/40	14%/25	6%/10	23%/40
Total in Residence	94%/165	89%/155	74%/130	71%/125	57%/100	40%/70	91%/160
%/N	100%/175	100%/175	100%/175	100%/175	100%/175	100%/175	100%/175

TABLE 10.60 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served Weight: 5
Level of Behavioral Severity: High
Sub-Population: Community Size 85,000 Or Less

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	15%/30	39%/80	46%/95	59%/120	63%/130	68%/140	22%/45
Adult Corrections	2%/5					2%/5	
Training School	10%/20	7%/15	2%/5	2%/5	2%/5		7%/15
MH Hospital	5%/10	7%/15	2%/5	2%/5			2%/5
Wilderness Camp							
Group Home	2%/5	7%/15	5%/10	5%/10	2%/5	2%/5	10%/20
Foster Care	15%/30	12%/25	17%/35	15%/30	15%/30	12%/25	30%/60
Child Care Facil.						2%/5	
MH Center	2%/5	2%/5					2%/5
Juvenile Court							
DSS							
Non-Resident Care							
Out of State		2%/5	2%/5	2%/5			5%/10
Private Referral						2%/5	2%/5
Home	46%/95	10%/20	12%/25	5%/10			
Other	2%/5	12%/25	12%/25				
Total in Residence	85%/175	61%/125	54%/110	41%/85	37%/75	32%/65	78%/160
%/N	100%/205	100%/205	100%/205	100%/205	100%/205	100%/205	100%/205

TABLE 10.61 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5

Level of Behavioral Severity: High

Sub-Population: Community Size 85,000 Or Less

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	26%/25	42%/40	53%/50	58%/55	68%/65	16%/15
Adult Corrections							
Training School			5%/5	5%/5			5%/5
MH Hospital		16%/15	5%/5	5%/5			
Wilderness Camp							
Group Home		11%/10		5%/5		5%/5	16%/15
Foster Care		21%/20	21%/20	16%/15	16%/15	5%/5	32%/30
Child Care Facil.						5%/5	
MH Center							
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral						5%/5	5%/5
Home	100%/95	11%/10	21%/20	5%/5	26%/25	5%/5	11%/10
Other		16%/15	5%/5	11%/10		5%/5	16%/15
Total in Residence	100%/95	74%/70	58%/55	47%/45	42%/40	32%/30	84%/80
%/N	100%/95	100%/95	100%/95	100%/95	100%/95	100%/95	100%/95

TABLE 10.62 RESIDENTIAL MOVEMENT BY DATA COLLECTION LOCATION

Data Collection Location: Not Appropriately Served (Home) Weight: 5
Level of Behavioral Severity: High
Sub-Population: Community Size Greater Than 85,000

	Current Residence	1st Prev Residence	2nd Prev Residence	3rd Prev Residence	4th Prev Residence	5th Prev Residence	1st Reside After Home
Missing Residence	0%/0	8%/5	25%/15	33%/20	58%/35	85%/50	8%/5
Adult Corrections							
Training School		16%/10	16%/10		8%/5		
MH Hospital		8%/5			8%/5		8%/5
Wilderness Camp							
Group Home		25%/15					
Foster Care		8%/5	8%/5		8%/5		17%/10
Child Care Facil.		8%/5		8%/5			8%/5
MH Center			8%/5				8%/5
Juvenile Court							
DSS							
Non-Resident Care							
Out of State							
Private Referral							
Home	100%/60		33%/20	33%/20	8%/5	17%/10	17%/10
Other		25%/15	8%/5	25%/15	8%/5		33%/20
Total in Residence	100%/60	92%/55	75%/45	67%/40	42%/25	15%/10	92%/55
%/N	100%/60	100%/60	100%/60	100%/60	100%/60	100%/60	100%/60

CHAPTER 11

METHOD AND RESULTS--OUT-OF-STATE PLACEMENTS

This chapter presents the manner in which a survey on the out-of-state placements was conducted. It was determined that only 15 children were placed out-of-state due to behavioral or emotional problems. The average cost of placement for these children was $16,793 per year. Also presented in this chapter are excerpts of responses from county officials to requests for information on out-of-state placements.

CHAPTER 11 - METHOD AND RESULTS--OUT-OF-STATE PLACEMENTS

One concern of this study has been to estimate the impact that "out-of-state placements" are having upon the system in North Carolina that attempts to serve children with behavior problems. This concern is limited to those children who are being placed out of state through the use of public funds. A major reason for examining the role of out-of-state placements is the possibility that there are a sufficient number of children involved to justify support for a program in the state which would better meet the needs of the children currently being placed out of state. This is also an issue because of the difficulty others have had in estimating the number of children placed out of state and the implied criticism to the existing service system in the possible existence of a large number of out-of-state placements of children with behavior problems or emotionally disturbed children. Thus, estimates of the number of children placed out of state because of their emotional or behavioral problems has been both a guide to new programming and a critique of existing program operations. The purpose for this part of the research effort is to estimate the number of out-of-state placements and their cost and to see if the reasons for these out-of-state placements are similar.

Two sources of information have been used for this analysis. One is "A Special Report to the 1980 General Assembly on the Out-of-District and Out-of-State Placements of Children with Special Needs" conducted by the Legislative Commission on Children with Special Needs. This report focuses upon children whose placement is being funded through the Department of Public Instruction. The second source of information has been provided by the Mental Health Study Commission. This information consists of responses from county Departments of Social Services to a letter from the Study Commission requesting the counties to respond if they were "paying for placement and treatment of any children or adolescents from your county in out-of-state facilities because they are so behaviorally or emotionally disturbed that we do not have facilities in North Carolina to meet their needs?" Combining information from these two sources should identify all of the children who have been placed through funding sources that use the state or local funds.

Examination of these two sources of information indicates that at the time of data collection, the Department of Public Instruction had nine children placed out of state, all for reasons of emotional disturbance at an average cost of $15,486 per year per child. Local Departments of Social Services, at the time of data collection, had six children placed out of state at an average cost of $16,793 per year per child. This reflects a total of fifteen children across the state who would be placed out of state with costs ranging between $2,000 and $22,000 per year.

Reasons for these placements were unclear. Most of the children were considered long-term placements and seem to involve children with multiple problems. There is very little overlap in the locations or types of programs to which these children are being sent. While the evidence is minimal, it seems that the relatively small number of out-of-state placements exist for different reasons and do not occur within a homogenous population.

As a final note, it must be added that the request for information to the county Departments of Social Services brough forth a consistent reaction. The excerpts below are representative of that reaction:

Letter 1

At the present, our agency is not paying for treatment of a child or adolescent in out-of-state facilities.

However, we have assisted one family in submitting applications to facilities in Georgia, Pennsylvania, Texas, and Florida for their teenage son who is not able to function in the county school system becaues he is a behavioral problem and is considered emotionally disturbed. The costs at all of these facilities was from $1,000 up to $2,000 plus a month, and there are no known resources in _____ County to purchase care needed for this teenager and the family cannot afford it. His needs have not been successfully met at any of the facilities in Butner. He is being seen weekly at the local Mental Health Center; however, the family sees little if any progress. I believe your committee may have access to correspondence written to various State officials from the mother of this teenager.

Letter 2

Thank you for your request for information regarding the placement dilemma of children in our County's custody who have behavioral and emotional problems. At the present time we are not paying for any child's treatment outside the state. The local social services budget does not have any funds designated for the treatment of children over and above medicaid.

Although there have been other children in the past who have fallen through the cracks of treatment resources in the state, we are most concerned at the present time regarding a twelve-year old Black female who is in our custody. This child is severely emotionally disturbed, mildly retarded, has a learning disability, and is diabetic. Every facility and institution we have contacted has refused admission based on one or more of her conditions. The institutions for the retarded say she is too intelligent for their program. A medicaid-approved facility for the emotionally disturbed refused her because she was too old. A children's home with an E.D. component said they could not handle diabetes.

She has been placed at a Children's Treatment Center for a period of about two years. The Center's treatment program was helpful to the child, but it is short term and encourages family involvement which is not feasible for this child, whose mother receives SSI for mental disability.

The child has been evaluated by N.C. Memorial Hospital and referred to Dorothea Dix. After a four-month stay there, it was determined that she was not able to benefit from their long-term program that is insight oriented. It was verbally recommended that she could benefit from a structured environment similar to the re-education program being established at Umstead. We have been told that there are only two female beds for the South Central Region and many more than our child who need that type of treatment.

It has been very frustrating to us to be responsible for this child, to care about her as we do and to be unable to provide her with the structure and protection she needs. We appreciate the opportunity to tell you about just one of our children here in _____ County. It is our sincere hope that your Study Commission will reveal the very real plight of these children and make some concrete recommendations for the establishment of state-owned treatment facilities or the encouragement of the location of private concerns who give this type care in our state. As you know when this type of child goes untreated, their adjustment to adulthood is at best limited. It is unrealistic to expect these persons to be productive members of society.

Letter 3

At the present time, we are not paying for out-of-state care for any _____ County children. We have one severely disturbed child in our custody who is in serious need of placement and treatment not available in North Carolina. This child is not receiving the care he needs due to a lack of financial resources. Would you please send me any information on funding sources for out-of-state care of which you are aware.

Best of luck in your study. I strongly feel that North Carolina needs better facilities for placement and treatment of children with behavioral and emotional problems.

Letter 4

We are responding to Senator Hardison's letter of August 22 requesting information about children placed in out-of-state facilities due to special treatment needs. At the present time, _____ County is not paying for any such placement and treatment of any children or adolescents in out-of-state facilities.

This is not to imply, however, that there have been times when obtaining in-state treatment and/or placement for our children and adolescents was quite difficult. Just a short while ago, we placed a sixteen-year old boy at Falcon School after several local resources proved ineffective. We are currently involved with an eleven-year old girl who is undergoing extensive psychiatric evaluation and a twelve-year old boy who has temporarily returned home after exhausting local and regional resources--both of whom may need placement and treatment that is not available in North Carolina.

With more cases such as these coming to our attention, as well as those involving adolescents whose families cannot or will not be involved in treatment, the need for appropriate treatment and placement resources is growing. Finding foster homes and group homes for acting-out teenagers is increasingly difficult, while the appropriate treatment units of the regional mental health hospitals seem to have very limited space and highly selective admission criteria. We hope that the efforts of the Mental Health Study Commission will help in the development of more needed resources for our children and youth.

CHAPTER 12

TREATMENT APPROACHES: SYSTEM REQUIREMENTS

This chapter discusses some of the requirements for a systems approach to dealing with children with behavioral problems. A system for dealing with children with behavioral problems would provide linkages to coordinate individual programs. The coordinating activities of assessment, planning, monitoring, advocacy, and follow-up will ensure that children receive appropriate service.

CHAPTER 12 - TREATMENT APPROACHES: SYSTEMS REQUIREMENTS

This chapter, and the one which follows, identifies some of the alternatives that should be considered when attempting to serve children with serious behavioral problems. They focus on two different levels of alternatives. One level is that of program and service content. This level is presented in Chapter 13. The other level addresses the issue of combining a set of programs, agencies, and services into a coordintated system. At the systems level, which this chapter will address, there are two major concerns: 1) to ensure that an adequate range of high quality services is available to meet the needs of children with behavioral problems; and 2) to ensure that children with behavioral problems receive services that are appropriate for them.

When considering the range of services that need to be available in a system serving children with behavioral problems, it becomes necessary to operate in an area in which the unknowns outweigh known factors. The current state of the art is primitive, and no one can say that a particular service configuration is "best." In general it is possible to identify a set of services which constitute the beginning of a continuum of care for children with behavioral problems. This has been done in detail through examples in the following chapter. It can be summarized in the following list:

- individual and family counseling
- educational counseling
- special education classes
- vocational training/job placement
- intensive family support services
- intensive psychiatric day care
- group homes
- foster care/specialized foster care
- non-residential crisis intervention
- short-term crisis oriented residential placement
- long-term residential placement
- secure residential placement

This list is not exhaustive. It assumes additional provision of a full battery of traditional services, such as day care where needed and also assumes that all services can be provided in a coordinated fashion based upon the needs of the client.

In order for a list of services that are available, or a list of existing service providers, to operate as a system, their efforts must be coordinated. It is the linkage between services or providers that defines a "system." It is the responsibility for these linkages, and the cordinated service provision that they represent, that creates a point of accountability for the well being of any human service client.

In order to accomplish these linkages, establish some accountability, and coordinate service delivery for children with behavior problems, responsibility must be assigned (and authority and resources delegated or created) for conducting five activities in order to manage the service delivery system. These activities are assessment, planning, monitoring, advocacy, and follow-up.

ASSESSMENT. Assessment is the process of determining the child's current and potential problems. Possible problems include those directly related to the child's family or behaviors and sometimes other unrelated human service problems such as nutritional, school related, and clothing needs. Assessment is also the definition of the results or outcomes the child and family want to achieve for each problem; these desired results can either be the resolution or lessening of problems.

PLANNING. Planning is the process of locating and procuring services that can deliver results the same as or close to the child's desirable results. These results may be related to diagnosis or evaluation or service delivery. When received, the results of diagnoses or evaluations are studied to determine whether they indicate additional problems or the need for additional service planning.

MONITORING. Monitoring is the continuous evaluation of the child's progress through service delivery towards the agreed-upon results.

ADVOCACY. Whenever the agreed-upon results are not being achieved, the system intercedes on the child's behalf to overcome impediments to achieving results. Advocacy is only necessary when the child's service plan is not being carried out.

FOLLOW-UP. Follow-up is a process which begins after service results have been achieved. This process verifies that the child is maintaining results and has no new problems. Follow-up occurs periodically throughout the child's life. Whenever new problems occur or results are not maintained, tracking ensures that the child is referred to services that are needed.

A final note on the requirements for a system dealing with children with behavior problems, systems, by their very nature, tend to create stable, sometimes rigid, roles and procedures. One major characteristic of the children who have been the focus of this study is their lack of stability. Therefore, in order for a system to meet the needs of these children, it will have to avoid the rigidity that is characteristic of most systems. This requirement will create additional strains upon any system that attempts to deal with these children but must be a major factor in developing a coordinated service delivery approach.

CHAPTER 13

TREATMENT APPROACHES: INNOVATIVE TREATMENTS NATIONWIDE

This chapter presents innovative methods of treatment that are being used nationwide for children with behavioral problems. These innovative treatments range from non-residential programs that are based in the community to residential, institutional programs. These programs range between preparation for jobs to Outward Bound-type programs to intensive care, high severity, psychiatric treatment facilities.

CHAPTER 13 - TREATMENT APPROACHES: INNOVATIVE TREATMENTS NATIONWIDE

Leonard Berman

INTRODUCTION

The desire to provide effective services to children and youth experiencing severe emotional, behavioral, and legal difficulties has led to the implementation of a variety of treatment programs across the country. Often differing in the types and numbers of services provided, these programs generally develop following the acknowledgement of gaps in current service provision and respond to the particular demographic characteristics and problems of the juveniles in the respective jurisdiction. These programs may be organized by human services professionals, paraprofessionals, or concerned citizens. Financial support may come from public or private sources, with supervisory and administrative responsibility retained unilaterally or shared by governmental and private authorities.

ORGANIZATION OF CHAPTER

This chapter discusses several approaches to dealing with these emotional, behavioral, and legal problems of juveniles. In order to present these various approaches in an organized manner, the authors have, to the maximum extent possible, grouped programs by similarities along the dimensions of non-residential/residential and community-based/institutional approaches. Specifically, the programs are listed under the headings of Community Based, Non-residential; Community Based, Non-residential/residential; Community Based, Residential; and Institutional, Residential. There is also a section of Semi-residential Programs, which are programs based on an Outward Bound model of program. These Semi-residential Programs occur after the Community-Based, Non-residential Programs.

Within the major groupings, programs have been further delineated and rank-ordered for presentation, according to the diversity and comprehensiveness of the services provided. For example, community-based, non-residential programs will be discussed together, with those programs providing a single service (e.g., remedial education) presented prior to those offering a variety of services (e.g., remedial education plus vocational rehabilitation and psychotherapy). This format is not intended to imply that the groups are

mutually exclusive and that the placement of any particular program in one groups overlap in scope, and some programs provide services applicable to group precludes its applicability to a second. On the contrary, many more than one category. However, for clarity of presentation, each program will be discussed only once under that heading most representative of its programs and intensity of services.

This presentation strategy, moreover, approximates what is generally referred to as the "continuum of care." This continuum has been defined according to the degree of restrictiveness on the participating juvenile as determined primarily by his or her continuing contact and involvement with his or her home community while in treatment, and secondarily by the comprehensiveness of services provided. The least restrictive end of this continuum would include community-based, non-residential programs while the most restrictive side would include institutional, residential, multidimensional programs.

This chapter is a review of innovative programs for children with serious behavior problems throughout the nation. This means that the traditional programs of treatment, such as therapy in a Mental Health Hospital, are not included in the chapter. Another implication is that the programs given in this chapter are just generic examples of such programs in the country. While none of the programs discussed in this chapter are located in North Carolina, there are some similar programs in the state. The fact that programs in North Carolina were not used as examples of the types of programs is a reflection of the national scope of this chapter. Furthermore, the programs given in this chapter usually have good documentation and/or evaluations.

Addresses for each of these programs appear at the end of the chapter. References for this chapter also appear at the end of the chapter.

COMMUNITY-BASED, NON-RESIDENTIAL PROGRAMS

Community-based, non-residential programs are defined as those providing services to the juvenile while he or she continues to reside at home. These programs are also the least restrictive of the programs discussed in this chapter.

JOB PREP. Job Prep is the first community-based, non-residential program to be discussed. It is located in Hartford, New Haven, and

Bridgeport, Connecticut. Job Prep was established in 1975 as an innovative demonstration project whose goal was "to reduce the severity of anti-social conduct (by juveniles) and to provide a constructive alternative to institutionalization through vocational rehabilitation. Participants were to include delinquent boys and girls under the jurisdiction of the Juvenile Court or the Department of Children and Youth Services (DCYS). These youths were further categorized as "seriously deficient in academic performance, de facto or potential school dropouts, lacking work motivation and basic job skills, from economically deprived families (and) for whom no other appropriate program is available." Most of the juveniles referred by the Court would have been committed to DCYS for possible institutional placement, had Job Prep not been available.

According to P. M. Leighton, Project Director, the "target group...were selected for the reasons other agencies had refused them." Additionally, participants were to be 16 years old at the completion of a 6-month job-readiness program. The program included two phases. During Phase I, juveniles were thoroughly assessed and given individualized treatment plans geared toward employment. These plans included vocational guidance, career exploration, and training in job-seeking skills. In Phase II, youth were to receive work experience at selected sites, with companion counseling and remedial classes as required. The program encompassed 6 months (5 hours/day, 5 days/week). Funding for Job Prep was obtained from Law Enforcement Assistance Administration/Office of Juvenile Justice and Delinquency Prevention (LEAA/OJJDP) and Comprehensive Employment and Training Act (CETA). Average daily population in the program was 34 youths, with 7 full-time and 2 part-time professional staff.

CAREER AWARENESS PROGRAM (CAP). A second employment specific program is the Career Awareness Program (CAP) of Omaha, Nebraska. The objectives of this program include the provision of on-the-job training and improved "cognitive skills to complete tasks needed to enter the job market." CAP is open to young women who have contact with the courts and lack basic skills and motivation to stay in schools and obtain jobs. The program begins with a two-week orientation during which basic skills needed to obtain a job are taught. Upon successful completion of orientation, each youth begins on-the-job training with employers having established working relationships with CAP. Placements at these positions generally last two,

three, or six weeks, although the youth may spend the duration of the program (encompassing a school year) at one site. While working, girls also attend career orientation sessions one evening per week at the CAP center, regular school, or GED classes. CAP's annual budget has been $49,500, although an increase of $200,000 was recently granted. Funds come from LEAA and CETA. Two individuals comprise the CAP staff.

EARN-IT PROGRAM. A third work-oriented program, but one with a slightly different structure, is the Earn-It Program of Quincy, Massachusetts. This program, with a total annual budget of $225,000 provided by LEAA/OJJDP (95%) and the state government (5%) is a juvenile offender restitution project. Originally developed for use with initial offenders, it proved so successful that it was expanded to include all offenders. Under this program, offenders work to compensate the victims of their crimes for their losses. (If victim restitution is not applicable, offenders work for the community on community service projects.) Jobs are provided by over 100 different businesses throughout the community. According to Judge Kramer, its founder and prime advocate, "...we know of no program of rehabilitation more successful than work. Once a juvenile or youthful offender is employed, we know we have begun to win the war against crime." A recent offshoot of the Earn-It project, using CETA funding, has been a work/restitution program of the probation department. In this program, juvenile probationers perform community service. For example, one group refurbished several outmoded structures on Peddock Island in Quincy Bay. According to Chief Probation Officer Klein and Judge Kramer, respectively, these youth were "the toughest, least employable juveniles" and "some had violent behavior on their record. Others were suffering from drug or alcohol abuse. Most were not felt to be trustworthy enough for placement in private jobs." Work was conducted 4 days/week, 9 hours/day.

BASICS, INC. Another Massachusetts project, Basics, Inc., is a private, non-profit community-based program providing remedial education to delinquent youth through its alternative school and outreach program. Funded by state and local government sources (annual budget of about $1 million), Basics accepts emotionally disturbed and delinquent youth and those experiencing family, school, and drug problems. Forty-six full-time professional staff provide intensive remedial education and counseling services to an average daily population of 140 youths, aged 12 to 18 years old. The alternative

school operates daily from 9 a.m. to 2:30 p.m., while the Outreach Program operates 9 a.m. to 5 p.m., with emergency "on-call" service. The goal of the program is to return youths to a regular school setting. Youths participate in the Basics program for at least one year.

PHOENIX SCHOOL. Phoenix School is a day-treatment program which is mandated to take boys (13-1/2 - 16-1/2) who are the most difficult to serve in the five boroughs of New York City. These youths are either already in trouble with the law or are potential risks for becoming involved with the law. The goal of Phoenix School is to prepare socially and academically the youths to return to the public school system or to prepare the boys for job placement.

Phoenix School is funded by New York State Mental Health Department, New York City Department of Social Services, and the Jewish Board of Children and Family Services. The youths are not required to have an intact home; they can live at home with one or both parents, in a group home, or be in custody of the Department of Social Services. All that is required is that they have a place to return to at night. Most of their clients cannot pay any fee since they cannot afford it. If a child came from a middle-income family, they would pay on a sliding scale.

The program uses Board of Education teachers for the academic day's work (classes from 9-3 and care from 3-5). There are also social workers, psychologists, and psychiatrists to provide individual and group and family therapy when necessary. Referrals to Phoenix School come from private sources, other agencies, schools, courts, and self-referrals.

NEIGHBORHOOD ALTERNATIVE CENTER. The next three programs to be discussed in this section have been developed to provide alternatives to the secure detention of youth. The first program is the Neighborhood Alternative Center of Sacramento, California. This program was selected as an Exemplary Project by the National Institute of Law Enforcement and Criminal Justice in 1974. Funding has come from LEAA and the Ford Foundation. The Neighborhood Alternative Center provide crisis intervention services to families of youths charged with status offenses. Service is available 24 hours per day, 7 days per week and is provided by specially trained probation officers and graduate student interns who serve as co-therapists.

METROPOLITAN SOCIAL SERVICE DEPARTMENT. A second alternative to detention program is the Metropolitan Social Service Department (MSSD) Home Detention Program in Louisville, Kentucky. Caseworkers assigned to these cases provide intensive daily supervision to youths residing in their own homes. This supervision includes daily contacts by telephone or home visits. Two types of children and youth are considered appropriate for this Home Detention Program:

1. children whose offenses are serious but who have a stable home; and
2. children whose offenses are less serious but whose home adequacy is questionable.

Thus far, of those placed on home detention, 71.4 percent of the males and 4.2 percent of the fenales had at least one prior major offense. The Project is supported by funds from LEAA.

URBAN COUNTY HOUSE DETENTION PROJECT, PRINCE GEORGE'S COUNTY. The third alternative to secure detention program is the Prince George's County (Maryland) Urban County House Detention Project. The purpose of this project is to demonstrate the effectiveness of supervising juveniles in their own, or surrogate, homes instead of detaining them in a typical institutional setting. Youth are referred to the program by the Court; they must be 10-18 years old and have a home in which he or she may be placed. Moreover, the parents must be responsive to the provision of close supervision of the child, and a Community Detention Worker must be available to provide additional supervision. The Court must also determine that the child need not be removed from the community and that juvenile court jurisdiction is not waived. In this program, the Community Detention Workers are required to have two daily personal contacts with each child. This project maintains a two-person administrative staff and four Community Detention Workers. The project is funded by LEAA and is entering its third year with a project budget of nearly $65,000.

GIRLS COALITION. Advocacy and coordination of service delivery to "at risk" girls served by the YWCA, Girls Clubs, Girl Scouts, and Teen Aid in Philadelphia are the goals of the Girls Coalition. "At risk" is a comprehensive definition which includes young women involved in the juvenile justice process who have dropped out of school, been classified as truant, run away from home, become pregnant, or are victims of physical/sexual

abuse. Referral sources include the police, juvenile court, social agencies, parents, and others. The Coalition is supported by a grant from LEAA. One purpose of the Coalition is to coordinate youth referrals and program planning among participating agencies so that youths receive services which best meet their needs. In this respect, a wider variety of services have resulted, service gaps have been filled, and duplication of effort has been avoided. At the present time, a program priority is to improve job and career opportunities for girls served by these programs. The Coalition is developing career information and new jobs; it has also secured funding to sponsor a conference on the problems of unemployment among these girls. The Coalition also sponsors research on problems of young women for the Youth Services Commission, participates in Title XX planning, and provides services and activities which the individual agencies would otherwise not be able to support. According to Stehno and Young (1980), "the Coalition plans to become a powerful influence in getting more services to young women that are responsive to their needs and those of their communities."

NEW DIRECTIONS FOR YOUNG WOMEN. A second program providing advocacy plus individual counseling, GED classes, vocational training, public education and community outreach is New Directions for Young Women in Tucson, Arizona. New Directions attempts to provide alternatives to the use of secure detention and the development of other flexible program alternatives. The program began in 1976 with funds from LEAA/OJJDP, made available through the Deinstitutionalization of Status Offenders special emphasis project. Since that initial funding, New Directions has received additional funding from private and government sources. The Center maintains a staff of seven. As with the Philadelphia Coalition, New Directions identifies and publicizes service gaps, sponsors conferences on young women in the juvenile justice system, and coordinates service delivery among local agencies.

HOMEBUILDERS, CATHOLIC CHILDREN'S SERVICES. Advocacy, counseling, and intensive services to families of the Tacoma, Washington, area comprise the system of the Homebuilders program of Catholic Children's Services. In this program therapists are on call 24 hours per day to enter the homes of families in crisis. The goal of this intervention is to prevent the removal of family members to out-of-home placement, an occurrence which will necessarily follow unless this intensive assistance is provided. Therapists

can remain within the home of the family "for as long as necessary within a six-week period to facilitate resolution of the immediate crisis and to teach new skills to help prevent recurrence of future crises" (Kinney, Madsen, Fleming, and Haapala, 1977). Youths served include those that are emotionally disturbed, retarded/developmentally disabled, deliquent, dependent/neglected/abused, as well as those suffering from family, school, and drug problems. A full-time staff of 14 professionals provides services to these children and their families. Treatment modalities employed by Homebuilders include Parent Effectiveness Training, Behavior Modification, Rational Emotive Therapy, and Values Clarification. Homebuilders generally refers families for outpatient counseling and case management services to allow for longer term treatment than they provide. This project has received funding from LEAA/OJJDP, HEW, the United Way, and state government. It estimates the cost of service provision to be about $1400 per intervention.

A study of homebuilders indicates its first year effectiveness. During that time, Homebuilders intervened with 80 families with a total of 134 family members judged as having potential for removal from the home. Precipitating problems included physical violence, suicide potential, drugs/alcohol, emotional exhaustion, runaway, and delinquency. The majority of the youth provided with services ranged from 11 to 15 years old. Results showed that, as a result of Homebuilders' services, 121 of these individuals were no longer in need of out-of-home placement. Followup at a 16-month interval showed that 117 (or 97%) of those avoiding placement in an institutional setting continued to do so. Homebuilders attempted to assess what the likely outcome of the case would have been had they not intervened. These outcomes ranged from foster care to group care and psychiatric hospital programs. From a financial perspective, they determined that it cost "$2,331 less per client to provide intensive family crisis services than it would have to place these people in foster, group, or institutional care."

Homebuilders attributes their success to a variety of factors. First, they limit their services to only "those families in which the crisis has gotten so severe that one or more family members will be institutionalized without intervention. (Thus) families are seen at a time when motivation to change and potential for growth may be at their peaks." Second, staff provide the "equivalent of two years of therapy in most outpatient clinics" in a six-week period. Third, "when therapy occurs within the home, staff

are able to see the problem situations as they are happening." Homebuilders states that these results "indicate this service delivery strategy has potential for indicating ways to revise traditional methods of handling severely disturbed families."

COMMUNITY ARBITRATION. Community Arbitration of Anne Arundel County, Maryland, is a multi-faceted approach to the rehabilitation of juveniles. In this program an arbitrator from the County Juvenile Services Department hears the case, much as a judge would do, and based on the "data" presented decides if informal adjustment is appropriate. If the arbitrator so decides, an alternative community sentence is constructed. This sentence may include community-based counseling, volunteer community service, referral to an educational program, etc. All assignments are geared towards "experiences which would be meaningful and positive for the juvenile" while still impressing the youth with the seriousness of his actions. The project was initially funded by LEAA, but since May, 1977, has been financed by state government monies; total annual budget is about $72,000. Approximately 150 youth are handled per month, with the majority falling in the 12-16 year old age bracket. Referrals originate from the police. Staff include five paraprofessionals, two attorneys, and two social workers. As of December 31, 1976, a total of 8,736 volunteer hours of work had been completed and $10,000 in restitution payments collected.

HUCKLEBERRY HOUSE, INC. Huckleberry House, Inc., Columbus, Ohio, provides emergency intake, crisis counseling, 24-hour temporary shelter care of very limited duration, crisis followup, consultation, and education to runaway juveniles. Presenting problems of the youth served include school, family, and behavior problems. Youth may be emotionally disturbed, dependent, neglected, and abused. The focus of Huckleberry House is on helping youth to regain control over their lives and on effecting family reconciliation. Huckleberry House staff, which include eleven house managers/coordinators, five counselors/program coordinators, and five administrators, provide 24-hour intensive services to families.

The program is funded by state and local government (50%), HEW (23%, United Way (13%), Children's Services (9%), and public contributions (5%); its total annual budget is $284,000. During 1979 Huckleberry House served 610 youths. According to W. Douglas McCoard, Executive Director, "The service model Huckleberry House uses has been repeated in over ten locations

in Ohio and many more nationally. A visible and accessible service which helps young people and their families regain control over their lives is a valid, useful, used, and needed service.

PROJECT NEW PRIDE. A multi-faceted approach to dealing with "fairly serious juvenile offenders in a community setting" is Project New Pride, Denver, Colorado (Alexander, Smith, and Rooney, 1980). Referrals to New Pride come from the Denver Juvenile Court Probation Placement Division; they must reside in Denver; they must be between the ages of 14 and 17 years old; they must have a recent arrest or conviction for burglary, robbery, or assault related to robbery; and they must have two prior convictions (preferably for robbery, burglary, or assault). Ninety-five percent of the referrals are male. Project New Pride offers four major services:

1. Education. The Alternative School provides one-to-one tutoring with emphasis on reintegrating students into the regular school system. The Learning Disabilities Center works with students to correct perceptual and cognitive disabilities. Learning disability therapy and academic tutoring are equally important. In the first two years of operation, Project New Pride found learning disabilities present in 78 percent of its clients.
2. Counseling. Clients are matched to counselors according to role model needs and personalities. Counseling is intensive and involves contacts with family, teachers, social workers, and significant others.
3. Employment. Job preparation is a cornerstone of Project New Pride. Youths attend job skills workshops, receive individual vocational counseling, and "on-the-job training." Employment also provides much needed income for the youths.
4. Cultural Education. Staff introduce youth to a variety of experiences including educational and recreational trips, restaurant dinners, visits to television stations, etc.

New Pride's approach is "to integrate all services providing comprehensive treatment to clients," all of whom are "hardcore delinquents--multiple offenders with a myriad of social adjustment problems."

New Pride maintains a staff of eleven at its central location, seven at its Learning Disabilities Center, a psychologist, a sociologist, and an optometrist. Volunteers and student interns are recruited from the community and nearby colleges. Initial financial support for the Project came from the Denver Anti-Crime Council (DACC). it has subsequently been funded by the Colorado Division of Youth Services and DACC.

New Pride has been designated as "Agency of the Year" by the Colorado Juvenile Council and an Exemplary Project by the National Institute of Law Enforcement and Criminal Justice. Some of its achievements include a low 27 percent recidivism rate (based on rearrests for referral offenses), placement of 70 percent of its clients in jobs (following vocational training), and a return to regular school for 40 percent of the youth. New Pride spends approximately $4,000 per year to keep a juvenile out of an institution. Of 161 youth completing the program, 89 percent have not been incarcerated, a savings of over $1.1 million dollars for one year.

SEMI-RESIDENTIAL PROGRAMS

In this section four similar programs are grouped for discussion. These programs, based on the Outward Bound Model, do require the continual 24-hour/day presence of participating juveniles. However, this "residence," while necessary, is not the primary function of these programs, and these service systems would no doubt be mislabelled as residential programs. Therefore, the term "semi-residential" has been employed.

COLORADO OUTWARD BOUND. Colorado Outward Bound, headquartered in Denver, serves a delinquent population of 200 youths. These juveniles are referred to the program by probation, the courts, schools, and corrections. According to its Director of Corrections, Gerald Golins, "Outward Bound is a series of programmed physical and social problem-solving tasks conducted in a high-impact environment, such as the outdoors or the inner-city... The whole point of an Outward Bound's adaption in corrections is to dramatically impel a youngster to positively reconstruct his self-image so that he can function more effectively in society." For the Colorado program, physical challenges are created by backpacking, rock climbing, canoeing, sailing, route finding, etc., in the Rocky Mountains. On-site activities are time-limited, usually to a few weeks. However, youths are introduced to "a responsive communication network and pertinent school and vocational

placement at the conclusion of the expenditionary phase." Funding for this program, totaling to an annual budget of $200,000, is received from a variety of sources including LEAA, state and local governments, private foundations, corporate funding, and public contributions.

DARTMOUTH-HITCHCOCK MENTAL HEALTH CENTER. A second "Outward Bound" program is that of the Dartmouth-Hitchcock Mental Health Center, Hanover, New Hampshire. One particular expedition exemplifies the adaptations which can be made depending upon client characteristics. Seven disturbed adolescents (five diagnosed as psychotic and two as having characterological problems), aged 16 to 23, who had been hospitalized from one to six times for between two weeks to several months, comprised the "experimental therapeutic project" (Kistler, Bryant, and Tucker, 1977). The group met once a week for two hours, with a four-day meeting (including an overnight camping trip) the last week. Participants were challenged, as is Outward Bound philosophy, with such complex psychomotor tasks as balance exercises, rock climbing, and rappelling. The project proved successful with all participants completing the program, including the camping trip. Staff feit the success atttributable to two factors: all patients were involved in on-going therapy, of which this project was but one segment; and the project was promoted not as "treatment," but as an opportunity to do something "normal."

GIRLS ADVENTURE TRAILS. Girls Adventure Trails, Dallas, Texas, is a third Outward Bound-type program. This program is a "wilderness" program serving only young women, referred by schools, youth agencies, juvenile authorities, mental health professionals, or parents. These girls are characterized as "delinquent or in danger of becoming delinquent." Girls Adventure Trails provides a four-week supervised therapeutic camping program with six months extensive follow-up. Participants range in age from 10-15 years old. Each camping trip is staffed by a married couple and a single woman. Parents participate in intake and orientation meetings as well as group meetings while the girls are camping. As of December, 1977, 710 young women had completed the program. Referrals came from police or courts (122), a state training school (30), social service agencies (191), schools (279), and other sources (88). Funding comes from both public and private sources, with an estimated cost of $1,400 per youth for seven months' services.

ENCOUNTER FOUR. The fourth program incorporating the Outward Bound approach is Encounter Four. Termed an "Adventure Course for Youth in

Trouble," Encounter Four is a non-profit project of the Butler County Community College in Pennsylvania. According to its brochure, "Since its beginning in the Fall of 1974, Encounter Four has sought to provide a meaningful alternative to the incarceration of youth in trouble... The program is licensed to provide services within Pennsylvania by both the Governor's Council on Drug and Alcohol Abuse and the Department of Welfare." Recidivism rates of participants, acording to an internal study, were found to be 15 percent.

COMMUNITY-BASED, NON-RESIDENTIAL PROGRAMS

In this section, programs which provide both non-residential and residential services in the community will be discussed. As the reader proceeds through this section, he or she will note that the programs discussed in this section are among the most diverse and comprehensive programs in this chapter. Through the provision of both non-residential and residential services, many of these programs, by themselves, span the full community-based portion of the continuum of care. Many of these programs coordinate all aspects of a youth's care, and once accepted into the program, the youth is not released for want of appropriate service availability. As will be seen below, many of these programs include the flexibility needed to adapt a service plan to the needs of the child or youth.

PRESSLEY RIDGE SCHOOL. Pressley Ridge School offers day (120 children) and residential treatment (48 children) to severely emotionally disturbed children in southwest Pennsylvania. The goal of the school is to return a child back to his or her community in as short a time as possible. The school offers: an educational model to develop a child's social skills through education within groups; individual programming directed toward a child's goals; and management of the family ecology. About two-thirds of the children are referred from the Child Welfare Division and one-third from the courts. Most of the children who are residing at the school participate in the day treatment programs. Pressley Ridge School is a privately endowed and publicly funded school using federal, state, and local monies. Very few clients can afford to pay any fee and they do not. The adjudicated youths are put on probation and released to the school in an effort to keep them out of Youth Development Centers, comparable to Training Schools in North Carolina.

FAMILY ADVOCACY COUNCIL. The next program to be discussed is the "Special Programs for Special Families" model of the Family Advocacy Council, Auburn, Maine. This model program provides both nonresidential and residential services according to the following components:

Therapeutic Family Homes (TFH): Therapeutic Family Homes are community-based, residential programs for children unable to remain in their home environments. The goal of the TFH is to establish a family group milieu that offers the greatest opportunity for normalizing and humanizing the life style of the children. Nine elements constitute the operation of each home:

1. A heterogeneous group of four or five children, according to age and sexes, is placed in a regular home in a normal residential community.
2. The home is staffed with non-professional therapeutic parents and child-care workers who are selected on their demonstrated ability to establish a normal family environment and to normalize the life style of the participating children.
3. Each child is part of a family of three or four other children. He or she has people who act as his or her parents and relate to him or her in that manner. He or she attends school, plays with other children, takes part in social and sporting activities, and in summary, lives in an environment as close to that of a normal home as can be achieved.
4. The therapeutic family operates on a budget, in the same way as any other family. It receives a weekly allowance; does its own shopping; and manages all items such as transportation, household expenses, etc. By participating in these family activities and budget administration, children learn to be wise family managers and learn basic skills in raising a family.
5. The therapeutic parents and child-care workers, whenever possible, work intensively with the family of children under their care. On a regular basis, visits are arranged and activities planned with the family.

6. The therapeutic parents and child-care workers have available a resource bank including psychiatrists, psychologists, nurses, medical doctors, and social workers.
7. Children unable to attend regular school attend, for an interim period, the Family Advocacy Council School.
8. In summer the child, with the rest of the children in the family, attends camp. The intent is to help the child develop self-esteem and self-reliance.
9. After a child is discharged, regular follow-up visits are made to the child and his family.

Family Outreach Program: The Family Outreach Program provides the services of the Therapeutic Family Home to the individual in his or her own home. The idea underlying this program is relatively simple: instead of bringing the person to the services, take the services to the person and his or her family. In the process of treating a particular family member, services and resources extend to the whole family and, thus, reach other siblings who may be in need of such care. Family workers are not professionals but are particularly experienced in caring for people. A Professional Resource Bank similar to the one available to TFH's is available to the family workers and the families receiving services. A centrally located "Family House" is used for group, recreational, and therapeutic purposes.

Alternative Life Style Program: The Family Advocacy Council's Alternate Life Style Program is designed to serve best the unique needs of particular individuals. Relying on the resource bank, staff or clients can call for crisis intervention, medical help, legal assistance, therapy, evaluation, educational programs, or vocational training.

Education. Every effort is made to utilize existing community resources in education. Children are enrolled in special education, regular public school, and vocational programs. The Council also has educational resource staff who can contract for educational programs. The Family Advocacy Council School provides a less formal atmosphere for the presentation of a wide variety of educational experiences for children who have not been able to integrate into other school settings. Academic, industrial, cultural, and daily living subjects are included.

Supervised Independent Living: This program is geared toward the older adolescent who is inappropriate for the group milieu, unable to remain

at home, and is in need of supportive community link-up services. This program focuses on the 16-19 year old who needs job placement, vocational training, GED preparation, and other independent living assistance. Each youngster is helped by a young adult advocate, who generally begins working with the youth at least two months prior to his completion of a residential program.

Evaluation. Ongoing monitoring, site visits, utilization reviews, audits, etc., are essential program evaluation and expanding activities.

Training. All staff participate in an extensive training program that includes quarterly three-day seminars away from program sites, visits to similar programs in other locales, attendance at national conferences and seminars, enrollment in related college course work, and weekly meetings with co-workers, supervisors, and professional consultants.

The Family Advocacy Council maintains an "open intake policy," meaning that if openings are available, all children will be accepted. (If a child is seriously retarded or has multiple physical handicaps, at the request of a referring agency, a special program will be established for that child). According to Dick Sammons, Director of FAC, the program accepts "emotionally disturbed, developmentally disabled, and delinquent youth that have been denied services by other private agencies and who would be sent out of state or institutionalized were FAC not available."

The Family Advocacy Council is 100 percent state government funded with an annual budget of $1.15 million. The per diem cost for children participating in the school program is $68; for those not in the FAC school, the cost is $32 per day. The average daily population is 49 youth, with 7 children under 12 years of age, 22 between 12 and 15 yeard old, 16 aged 16-18 years old, and 4 youths 18 or older. Staff include 17 full- and part-time professionals and 52 full- and part-time non-professionals.

MARTIN POLLAK PROJECT. Closely modeled after the Family Advocacy Council's program is the Martin Pollak Project of Anne Arundel County, Maryland. As with FAC, the Martin Pollak Project has adopted an "open intake policy," accepting referrals regardless of the severity of problems experiences by the child. Once accepted into the Project, all cases are subject to total, enduring commitment from the staff for as long as services are needed.

For the Martin Pollak Project's adaptation of the "Special Programs for Special Families" model, the following components have been identified:

Natural Family Outreach. This component will provide an alternative of in-home supportive services for the family and youth in cases in which the child(ren) would have to enter residential or institutional placement were in-home care not available.

Extended Family Home. This component will house a heterogeneous group of three to four children in a normal residential community setting. Children needing this placement may reside there upon intake while an adjustment is made in their individualized program or while awaiting return to their natural family.

Therapeutic Family Home. Placement in a Therapeutic Family Home will be developed only for children who are unable to remain in their home environment but who could benefit from a community-based residential program. Each Home will provide care to a single child.

The Martin Pollak Project does not at present operate its own alternative school. However, it is negotiating an agreement with the Chesapeake School, an alternative school in the County. Similarly, the resource bank of professionals, discussed in relation to FAC, is still in its formative stages.

The Martin Pollak Project, as is implied above, is a new project. It is seeking private and public funding to match the endowment donated by Mrs. Elizabeth Pollak. Its goal for its first year of operation will be to provide services to at least 14 children.

BALTIMORE FAMILY CENTER, INC. A second program recently adopting the FAC philosophy is Baltimore Family Center, Inc., Baltimore, Maryland. BFC is a private, non-profit, minority controlled organization which accepts "Maryland youths who have previously been considered undesirable, unusually hard to work with and viewed as excessive cost cases by the various social service administrations." BFC views itself as "an alternative approach to the current practice of transferring emotionally disturbed and criminally disruptive youth outside of the State of Maryland for rehabilitation or detention." Three basic interrelating components, modeled on those of the Family Advocacy Council, comprise the treatment program:

Resource Bank. A group of professional practitioners and mental health progrmas providing such services as therapy, educational assessment, vocational/career guidance, medical diagnostic services, and cultural/recreational programs.

Therapeutic Families. Residential households within the community, staffed with two full-time and one half-time therapeutic counselors, serving two youths per household. The therapeutic families will operate as a stable, structured, normalized family.

Enriched Structural Approach to Family Therapy. Provision of service to the natural family and continued contact between natural family members and the "alienated" youth.

As with the previous two programs, BFC is prepared to develop its services to the needs of the children of Metropolitan Baltimore, as required.

KALEIDOSCOPE, INC. Kaleidoscope, Inc., Chicago, Illinois, is a non-profit child welfare agency offering many services for severely disturbed youth similar to those of the other programs discussed in this section. Referrals originate from the Illinois Department of Children and Family Services, and the public child welfare agency. Youth are generally adjudicated minors who are in need of supervision, delinquent, or both; most have resided in several previous traditional substitute placements, with little or no success. Both non-residential and residential components are available:

The Satellite Program. This sub-program provides intensive in-home, family services in lieu/prevention of residential care. Caseworkers in this sub-program are assigned three families and provide services for "an average of 80 hours per month with each family" (Stehno and Young, 1980). Services provided may include crisis intervention, homemaking, financial planning, family therapy, and referral to other applicable resources (e.g., Department of Public Aid, mental health centers, etc.). A resource bank of clinical, medical, and educational professionals is available.

Special Foster Family Care. This sub-program provides residential care in foster homes staff by trained, licensed foster parents. Only one or two youths reside in each home. Youth either attend school or work during the day; receive medical and dental care, plus psychotherapy; and are provided vocational rehabilitation. Kaleidoscope operates an alternative school for those unable to enroll in public school. Foster parents, who "work" five days per week, also receive assistance from a Resident Counselor assigned to each home.

Administrative support for the program comes from five professional staff (which include a nurse and an education specialist). Approximately

55 young men and women are served in the program, and as in the previous non-residential/residential programs, Kaleidoscope has sufficient flexibility to adjust to the needs of its clientele.

NORTHEASTERN FAMILY INSTITUTE, INC. The Northeastern Family Institute, Inc., located in Massachusetts, is another private, non-profit organization dedicated to comprehensive service delivery for adolescents. According to NFI's informational materials, it is their "belief that an intervention program must address the entire family's needs." The following listing describes its various programs:

Outreach Counseling. Provides education, job counseling, emplcyment, court advocacy and family counseling while the youth remains in his or her own home.

Experimental Learning Program (ELP). Provides an alternative school program offering tutorial academic sessions, job training and placement, recreational field trips, and individual counseling.

Comprehensive Counseling Program (CCP). Similar to ELP, provides educational components, intensive advocacy, counseling, and family therapy.

Foster Care Program. Provides residential care for adolescents aged 11-17 years old. Placements span six months or more and provide counseling, long-term life planning, and court advocacy.

Intensive Foster Care Program (IFC). Provides intensive long-term placement (six months or longer) for girls up to 18 years old who have been committed to the Department of Youth Services. Services include: counseling; frequent staff visits; advocacy with courts, school, and community agencies; and monthly foster parent meetings.

Shelter Care Facility. Provides a small, structured, unlocked residential detention center for boys, aged 7-17, with placement lasting up to six weeks.

Diversion Home. Provides a four-bed foster home for adolescents and young adults as an alternative to commitment to Danvers State (Mental) Hospital.

Back-Up Group Home. Incorporates a long-term residential program for DYS-committed girls. Services include intensive group and individual counseling. The Home may accept girls from other NFI programs or directly from the community.

37 Gregory State. Offers a transitional program for eight former residents of Danvers State Hospital. Services available include training/education in basic hygiene, household upkeep, transportation skills, and social adjustment.

According to Dr. Yitzhak Bakal, originator of CCP, this program provides "a multi-impact program with massive support systems that adjust to a child's changing needs" (Kiersch, 1979). Multiple funding sources support NFI, including state government, the Department of Mental Health, the Division of Youth Services, and the North Shore Guidance Center.

PHOENIX INSTITUTE. At the current time, a new program is developing in Utah with similarities to those immediately above. Entitled the Phoenix Institute, this program was awarded a "Social Services Contract from the State of Utah to provide a community-based alternative for delinquent females." The program will accept girls from the Youth Development Center (the state's training school) or girls who would otherwise be referred to YDC. According to the request for proposals put out by Social Services, in October, 1979 this program "should have the capacity to provide a flexible response to the differing needs of the individual girls (and) may contain... the following components: residential (mini-group home, specialized foster care, proctor or independent living); tracking; and/or day treatment (educational, vocational, counseling, etc.)." Funding for the program was set at $70,000 with services to be provided to five to ten girls. (The time period for this funding encompassed seven and a half months.)

YOUTH ADVOCATE PROGRAMS, INC. Youth Advocate Programs, Inc., still another non-residential/residential system of juvenile services provision, is headquartered in Harrisburg, Pennsylvania. YAP describes its intake policy as "an inclusive admissions policy...providing service to...adjudicated delinquents, status offenders, adjudicated dependents, drug and alcohol offenders, truants, runaways, emotionally disturbed, mildly retarded, and socially maladjusted young people." However, YAP does maintain the ability to "review each referral individually and to attempt to develop a plan that meets that young person's individual needs." All YAP services are designed for about six to nine months of delivery, with cases reviewed periodically and plans adjusted accordingly.

The program provides each youth with an "advocate," i.e., a person who establishes an on-going relationship with the youth and is responsible for

working with the juvenile toward establishment and achievement of short- and long-term treatment goals. This individualized plan incorporates needed community resources such as legal, medical, cultural, recreational, educational, and employment programs. Advocates spend either 7 1/2, 15, or 30 hours per week with the youth assigned to him. Advocates are paid a stipend according to the number of hours, as listed. (Advocates may spend more time, if they desire, but are not compensated for the extra time.) Expenses for activities resulting from approved social, recreational, educational, and employment activities are reimbursed up to $15/client/week. The youth receives a weekly allowance of $5. Should residential placement be required, the youth enters the Residential Advocate Program (RAP) in which room, board, supervision, and other living necessities are provided. The type of placement secured depends on the needs of the child or youth. For example, older youths, without a family, in need of learning financial responsibility may be placed in an independent living environment. Advocates assigned to youths in residential care work closely with the RAP to determine the service plan. As with YAP, above, they devote 7 1/2, 15, or 30 hours of service to each youth.

Presently, YAP units operate in Pennsylvania, New Jersey, and Washington, D.C. The total annual budget for a client population of about 100 is $400,000. This money is provided by local government through reimbursement procedures with state government. Twelve professional and 65 support staff comprise the personnel. The program has been in operation since November, 1975. An in-house evaluation of the program has shown that "75% of the time the cause for referral is no longer a problem" after service provision.

UNIFIED DELINQUENCY INTERVENTION SERVICES. The next two programs to be discussed are characterized by state child-serving agencies purchasing a wide range of needed services from private contractors. The Unified Delinquency Intervention Services (UDIS) program in Illinois provides "effective alternatives to the Illinois State training school in handling repeat juvenile offenders." The typical UDIS referral is 16 years old, had a first arrest at 12 years old and an average of 13 arrests (Alexander et al., 1980). Guidelines for the program include keeping the youth at home if at all possible; local as opposed to remote service delivery; and

individualized, intensive, and short-term treatment. Each youth has a case manager who "brokers" services for him, monitors the case, and reports to the court. Services are purchased from private vendors and include:

1. secure residential care for youths posing a threat to themselves or their community, (e.g., private psychiatric hospital and mental health unit);
2. non-secure residential care including group and intensive foster care home (cost = $400 - $800/month);
3. advocacy by paraprofessionals who spend approximately 15 hours per week with a juvenile (cost = $75/youth/week);
4. educational and vocational services including alternative schooling and job preparedness; and
5. professional counseling from individual therapists and agencies.

According to Stehno and Young (1980), the UDIS program found the community agencies more willing to accept adjudicated delinquents whose parents could not afford the services once the state paid the fees. Moreover, service availability for children in need, generally, increased because private agencies added new services which they could not previously afford.

According to Alexander et al., the results of the UDIS program are "mixed." Both UDIS clients and a companion training school population did show improvements. While UDIS proponents point to that program's effectiveness, others (e.g., researchers at the University of Illinois) argue that the resultant improvement in functioning evidenced by both groups is "completely explained by three tendencies of delinquent populations: regression (natural lessening of recidivism), maturation (youths grow out of delinquency), and case mortality (cases get lost)." However, Alexander et al. states that regardless of which interpretation of the results is accepted,

> it still seems true that it is possible to handle chronic and quite serious juvenile offenders in community-based programs with about equal effectiveness as in the large secure training schools, and with no increase in danger to the community. The large training schools are expensive to build and maintain

old, accepts the youths, one at a time, into his or her home. While living with his proctor, the youth receives 24-hour care and supervision; training in such living skills as food preparation, grooming, and household maintenance; and exposure to a variety of cultural and recreational activities. Additionally, the proctor assists with work and school plans and the securement of therapy and/or medical care. Proctors receive a salary ($9,600 in 1976) for 32 weeks of service provision. Supportive services for the proctor and youth are provided through Child and Family Services. Counselors from Child and Family Services meet with youths weekly for counseling and development of aftercare programs. During the project's first two years of operation, 220 youth entered placement and 203 (92.3%) remained there until appearing in court.

SOJOURN, INC., AND BOSTON YWCA. Two independent living programs, administered under purchase of service agreements with the Girls Services Unit of the Massachusetts Division of Youth Services (via LEAA funding), are Sojourn, Inc., and the Boston YWCA. Participants in the YWCA program live at the "Y," with staff available on a 24-hour basis. Those girls referred to DYS also have caseworkers assisting them with work, school, and recreational activities. Girls receive regular counseling while in placement and participate in GED classes and vocational rehabilitation. The Sojourn, Inc., program places young women, in pairs, into apartments. The girls in Sojourn's Independent Living program have "carefully planned schedules for attending school, working, and using leisure time" (Stehno and Young, 1980). As with the YWCA program, GED preparation and "life management skills" are emphasized. Girls participate in both programs for an average of 18 months. Future goals include expansion of educational, vocational, and counseling services. The YWCA "would like to develop the capacity to work with young mothers and their babies."

CAMERON HOUSE. A third residential program administered under a purchase of service agreement with the aforementioned Girls Service Unit is Cameron House. This program is operated by Key, a private agency in Cambridge, Massachusetts. Girls accepted into this program are "considered to be severely emotionally disturbed (with) many ... characterized as being severely depressed and/or suicidal, and (as having) run away from other programs repeatedly." A secure residential placement for five girls,

(although no more expensive in program cost than UDIS), and the long-term effects of the secure institution may be considerably more negative. Given a choice, the UDIS alternative may be preferable.

MINNESOTA SERIOUS JUVENILE OFFENDER PROGRAM. A second approach to brokering for needed services, similar to UDIS, is the Minnesota Serious Juvenile Offender Program, initiated in 1977. The target population for this system is fifty to sixty 16-17 year olds who at the time of referral have been adjudicated for "murder, manslaughter, aggravated assault, robbery with a prior felony-level offense of burglary with three priors." According to Alexander et al. (1980), these "youths move from an initial phase in a secure facility, to a non-secure residential setting, to community supervision. A case management team develops behavior contracts, purchases community services, and maintains liaison with significant persons in the offender's home community." This case management team supervises treatment throughout the active portion of the case. This approach has been characterized as "thoughtful and well-planned," although hard data are not yet available.

COMMUNITY-BASED RESIDENTIAL PROGRAMS

Community-based residential programs are defined as those approaches which provide services for the child while he or she is in substitute, out-of-home placement within the community setting. The geographic location of this alternative placement may be within the same city or county as that of the youth's own home, but need not be limited to this area. Residential placements characterized as community-based (as opposed to those institutional programs discussed in the following section) are linked integrally to the community resources from which services are provided.

PROCTOR PROGRAM. Such a community-based residential program is the Proctor Program of New Bedford, Massachusetts. This program is administered by the New Bedford Child and Family Services and funded through a purchase of service agreement with the Massachusetts Division of Youth Services. It operates as an alternative to secure detention for boys and girls. Each youth referred to the program is assigned to and lives with a "proctor." This proctor, who is a single adult between 20 and 30 years

Cameron House assigns "Trackers" to these girls. These "Trackers" are "adult women trained to work on a 24-hour basis with only two young women at a time." The goal of the program is the development of skills to permit the girls to live independently in their own homes. Girls move from the secure Cameron House into non-secure group homes, foster homes, and the "Trackers'" own homes. "Trackers" follow the case until service provision is no longer necessary. The time of treatment is variable, with each juvenile proceeding at her own pace.

TRANSITIONAL LIVING PROCESS. A program similar to the Cameron House with its "Trackers" is the Transitional Living Process in Chicago, Illinois. This latter program recruits and trains young adults to become "resident counselors." These counselors are licensed by the agency as foster parents, following four weeks of training. Assignments of youths to counselors are made by Primary Contact Workers, who are professional staff of the agency. These assignments pair a youth with a counselor through a series of preliminary meetings among all three players. When agreement to the pairing is achieved, the youth moves into the resident counselor's home. Initially, the Primary Contact Worker assists the youth and counselor in the development of a schedule of activities. At the end of this initial period, the youth, resident counselor, Primary Contact Worker and the counselor from the referring agency "negotiate a service agreement - a written statement of the responsibilities of the youth and the workers toward achieving the youth's goal of independent living." Typical agreements include conditions for school, employment, household responsibilities, budgeting, and group counseling. The agreement also specifies how privileges will be increased and supervision decreased as the youth's level of responsibility increases. The ultimate goal is the release of the youth to an independent living situation. TLP also provides a "resource bank" of therapists, doctors, lawyers and employers, much the same as that incorporated in the "Special Programs for Special Families" model discussed above. The Primary Contact Worker is available to resolve difficulties between resident counselor and youth.

Youth served by the Transitional Living Process are referred by the Illinois Department of Children and Family Services and the Illinois Status Offender Service. In 1979, 24 youth were served (12 males, 12 females) with nearly all having experienced a multiplicity of placements prior to referral to TLP. Also, most were alleged or adjudicated Minors in Need of Supervision and/or Delinquent.

INSTITUTIONAL RESIDENTIAL PROGRAMS

In this section, those innovative residential programs which are institutionally based will be discussed. Institutionally based programs are those in which the program is operated either as a separate entity or in conjunction with a larger institution (e.g., as part of a training school program). Almost by definition of being an institutional program, services very often are provided in a geographic location removed from the community in which the youth normally resides. For example, an institutionally based program which operates on the grounds of the state training school accepts youth from all over the state (or a large portion of it). Services geared toward reintegration of the youth into the community are required if the program is to experience ultimate success with the juvenile.

WEAVERSVILLE INTENSIVE TREATMENT UNIT. Weaversville Intensive Treatment Unit in Pennsylvania is a secure, institutional program for males. It was opened in 1976 following a ruling by the state's attorney general that juveniles could not legally be confined at the Camp Hill Correctional Institution, a medium security penitentiary then housing 800 adult and 400 juvenile inmates. Weaversville is located in a single, red brick building, the size of a large house, in what was once the geriatrics wing of the state mental hospital. Described as a "group home with security," the facility is operated for the state but administered by RCA Service Company's Educational Services Department. The cost per youth is $38,000 per year with the maximum length of stay set at nine months (the average being six months).

Although the Unit is a secure residential program, the atmosphere is not "repressive." Visible security measures are limited to wire mesh over the windows and a tall fence surrounding the outdoor recreational area. Less visible security, at least from the exterior, includes a high staff-to-youth ratio and locked doors. Thus, the facility has been characterized as presenting an "aura of normalcy, based on a strong sense of mutual respect between staff and residents."

The youth, who have all been through "several" institutions prior to placement at Weaversville and half of which have been convicted of violent crimes against people, dress casually and wear contemporary hair styles. The program is based on a behavior modification point system.

Youths can earn cash rewards and privileges as they participate in counseling, educational vocational programs, and perform housekeeping chores. Counseling is considered the most important aspect of the program as staff seek to provide youths with an understanding of their behavior. Since few will return to regular school, the educational program stresses living skills, remedial help, and GED preparation. Vocational training is available during the pre-release phase; the facility maintains a small shop in which small engine repair and motorcycle repair are taught. Youths may also participate in the CETA work-release program, working with local road crews prior to release. The Bureau of Vocational Training is available after release. Field trips and weekend passes can also be earned. During the final phase, youths attend job interviews.

Weaversville is a private and state approach to the problem of treating these youths. It is estimated that, although the per youth cost is high, the state saves $100,000 per year with this private-state arrangement. Moreover, 52 percent of the 60 residents followed after their release showed no rearrests.

CLOSED ADOLESCENT TREATMENT CENTER. Labelled as the "end of the road" for delinquents in Colorado's Division of Youth Services, the Closed Adolescent Treatment Center (CATC) offers the most intensive treatment program in the Division. Concurrently, CATC also offers the most security. Prior to the opening of the Center, there were no locked, intensive, psychiatric treatment facilities in the state that could contain, manage, and treat extremely difficult youth. Located on the grounds of the Montview School (one of the state's two training schools), CATC was established to deal with the toughest, most resistive to treatment juveniles in the Division. These youth are those falling into that 5 percent to 10 percent of the population characterized as the most "disturbed." Four characteristics define the youths at the Closed Center. These youths exhibit what is termed a "flight pattern"; that is, they are constantly running away from any placement in which they are placed. When not actually "on the run," they are planning their escape. Second, they exhibit extremely coercive, manipulative behavior. They are very assaultive and violence-prone and use people, generally in harmful ways. Third, they are very self-destructive, including overt suicide attempts to repeated involvement in life-threatening situations. Last, these youths have a history of not

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profiting from previous attemps at treatment. Youths typically have been in an average of nine previous placements prior to arrival at the Center.

The Closed Adolescent Treatment Center houses 26 youths (of which 2/3 are generally males) at one time. Youths range in age from 12 to 18 years old with an average age of 16.5. The per day cost of treatment is $43 (compared to a per day cost of $33 for youths at either of Colorado's training schools).

The treatment program consists of a three-pronged approach. First, youths are classified according to the Interpersonal Maturity Level System (I-Level) so that they may be appropriately matched to staff and peers in the program. (I-Level is a system whereby the youth's perceptions of the world and his or her ways of reacting to these perceptions determine his or her level of maturity and subtype within that level, respectively.) Second, youths earn increasing responsibilities and privileges, as they grow, based upon a team (or level) and point system. Teams are indicative of the youths' level of responsibility for their behavior and those of their peers. Points, which form the basis for team changes, are awarded three times a day. Both team and points are designed so that youths can quickly see the results of their behaviors.

The third treatment component, perhaps the most important of the three, is Guided Interaction Therapy (GIT). GIT is the basis for the establishment and maintenance of a therapeutic community, or positive peer culture. "A basic premise of Guided Interaction Therapy (GIT) is that each youth entering the program needs help in learning responsible behaviors and that this cannot be done without the deep involvement of their peers and staff ... Each peer has as much responsibility to help others as he does himself ... At the same time, the role of the staff is to provide concerned models or guides for the process of treatment."

Although the cost of service provision at CATC is higher than that of the training schools, "intensive research has shown that the Closed Adolescent Treatment Center more than pays for itself. A cost-benefit analysis over three years showed that the released youth return $1.70 to the community for every $1.00 invested in their treatment." Such a return on investment was not true for training school releases. According to CATC administrators, "At the current time, the need for this kind of program is much greater than one twenty-six bed unit can provide."

SPECIAL TREATMENT UNIT, BRONX PSYCHIATRIC HOSPITAL. This high management, secure unit operates under the auspices of the New York State Office of Mental Health (it is part of the Bronx Children's Psychiatric Center). They currently can serve only six boys (plans call for a move to another facility where they will serve ten boys and five girls). The unit serves only those boys, aged 12-17, who have a demonstrated history of violence and have been sentenced through either Family or Juvenile Court, only from the Bronx. The majority of clients' families cannot afford any payment, and there is a sliding scale for those who can. A child could voluntarily commit himself but that does not usually happen because they all come through the justice system. Admission is based on a recent psychiatric interview and a team (psychiatrist and social workers) review and recommendation. The director has the authority to make final admission or rejection decisions. All the children have lawyers, so a youth may be discharged once the sentence expires and he wants out. Placement time can voluntarily be extended if the child so desires and staff feel it is still advisable. A child sometimes moves from the long-term secure psychiatric setting to a day treatment (9-3) program. Each child has a full physical, neurological, cognitive, dental, etc., examination and work-up upon admission. Medication is evaluated every week for continuation, increase, and/or decrease. The child may receive a full range of intensive inpatient services: diagnostic; psycho-educational remediation; individual, group, family, art/recreational therapies. The staff at the hospital may plan for the child's release with other agencies, and in fact may plan for an overlap of services for a period of time.

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CHAPTER 14

SUMMARY OF RESULTS

This chapter is a listing of the major results of the present study.

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1. It was estimated that there were at least 577 children in the state aged 10 through 17 who exhibited behaviors that would likely result in their being labelled as manifesting a high level of behavior problems. The corresponding estimates for the medium and low level of behavior problems were 1,059 and 679 respectively.

2. For the group that was labelled as having high behavior problems:
   a. 65 percent were male
   b. the average age was 14.7
   c. 68 percent were white
   d. 50 percent came from counties with populations greater than 85,000.

3. The children who were labelled as having high behavior problems had difficulty in school. The medium and low groups also had difficulty in school but to a lesser extent. Specifically,
   a. 55 percent of the high behavior problem children did unsatisfactorily in school, while only 44 percent and 39 percent of medium and low behavior problem children did so.
   b. 42 percent of the high behavior problem children had an indication of excessive truancy in their records, but only 32 percent and 16 percent of the medium and low behavior problem children had indications of excessive truancy.
   c. 61 percent of the high behavior problem children had failed a class, while the comparable figures for the medium and low groups were 56 percent and 70 percent.
   d. 45 percent of the high behavior problem children had an indication of excessive aggressiveness in school, but only 16 percent and 4 percent of the medium and low behavior problem children had such an indication.
   e. 66 percent of the high behavior problem children had evidence of counseling from their schools, while only 59 percent and 39 percent for the medium and low groups had evidence of counseling.

4. A high percentage of the children examined in the present study had evidence of family problems, but the problems were usually more severe for the children with high behavioral problems.
   a. 55 percent of the high behavior problem children had evidence of their family arrangement changing more than once; the percentages for the medium and low groups were 54 percent and 47 percent.
   b. 26 percent of the high behavior problem children had experienced a complete disintegration of any semblance of a home; they had no home. A high percentage of the children with medium and low behavioral problems had also experienced a disintegration of their home: 27 percent and 23 percent.
   c. 58 percent of the high behavior problem children had a family that had alcohol-related problems other than with the child; 44 percent and 41 percent of the medium and low groups had such problems.
   d. 46 percent of the children labelled high behavior problems had been abused or neglected as a child. The percentages were also high for the other two groups: 44 percent and 47 percent for the medium and low groups.
   e. Even if the children were not abused themselves, 38 percent of the children with high behavioral problems came from families where there was other family violence; however, the percentages were only 26 percent and 22 percent for the medium and low groups.
   f. A high percentage of the high, medium, and low behavior problem children came from families that had some kind of court involvement other than with the child: 45 percent, 42 percent, and 46 percent respectively.

5. Across all of the behaviors measured in the present study, children labelled as high behavior problems exhibited a higher frequency of the behavior than children in the medium group, who in turn were higher than the low group. Also, children in the high group tended to exhibit the first occurrence of any behavior at a younger age than children in the medium and low categories of behavioral problems.

6. Separate analyses of the children who were identified as not appropriately served revealed small, but consistent and systematic, differences between them and the total population of children in the present study.
   a. Children not appropriately served exhibited most of the behaviors at a higher frequency than the total population of children.
   b. Children not appropriately served had more problems in school.
   c. Children not appropriately served had a more detrimental family background.

7. All of the children included in the present study had lived at a number of locations and received treatment from a number of service providers. However, the number of residential locations and service providers was greater for the children labelled high behavior problems than the medium or low groups.
   a. Children labelled high behavior problems lived at 3.72 residences and had 5.57 service providers.
   b. Children labelled medium behavior problems had lived at 3.38 residences and had 4.84 service providers.
   c. Children labelled low behavior problems had lived at 2.65 residences and had 3.8 service providers.

8. The current research indicated that many children move from home directly to a restrictive setting; in other words, there does not appear to be a continuum of care.
   a. Of the children labelled as having a high level of behavior problems who were currently at a Training School, 45 percent had a Training School as their first residence after home.
   b. Of the children labelled as high behavior problems who were currently residing at a Mental Health Hospital, 21 percent had a Mental Health Hospital as their first residence after home.

9. Only 7 percent of the children labelled as high behavior problems currently in Training Schools had ever been in a Mental Health Hospital; only 7 percent of the high severity children currently in Mental Health Hospitals had ever been in a Training School. This could indicate early labelling of children as either criminal justice or mental health system material and a subsequent lack of service coordination.

10. 41 percent of the children who were identified at the county level as not appropriately served and who were labelled as children with a high level of behavioral problems were living at home; i.e., they were not residing at any kind of special facility. 15 percent were residing in either a Group Home or a Foster Care Home; 3 percent in a Wilderness Camp; 7 percent in a Mental Health Hospital; 17 percent in a Training School; and 1 percent in the Youth Services Complex of the Department of Correction.

11. Within the category of children labelled as high behavior problems, a greater percentage of males were in Training Schools (76%) and a smaller percentage in Mental Health Hospitals (45%) than would be expected from looking at the total proportion of males in the whole study (65%).

12. While 68 percent of the children in the category labelled as high behavior problems were white, a greater proportion of whites was found in Mental Health Hospitals (80%) and Group Homes (77%).

13. While 50 percent of the children labelled as high behavior problems came from large counties (greater than 85,000), children from larger communities were clearly overrepresented in Mental Health Hospitals (67%) and Group Homes (67%). Furthermore, a higher percentage of children in Training Schools and Mental Health Hospitals had that location as their first residence after home when they were from smaller counties than larger counties.

CHAPTER 15
RECOMMENDATIONS OF THE OVERSIGHT COMMITTEE

This chapter presents the recommendations of the Oversight Committee. These recommendations include specific actions that can be taken to offer objective services and programs to children with behavioral problems. In addition, a presentation is made of the goals of the Oversight Committee and the way that individual children should be treated.

CHAPTER 15 - RECOMMENDATIONS OF THE OVERSIGHT COMMITTEE

This study on children with serious behavioral problems in North Carolina has been completed by the Center for Urban Affairs and Community Services at North Carolina State University. It seeks to provide a unique, and much needed, data base from which to formulate service delivery policy in this critical area. Both the uniqueness and utility of this data base are clearly demonstrated by the following:

1. The study provided a valid projection of the statewide demand for services for children with serious behavioral problems (i.e., 1,636 children statewide were classified as having either medium or high behavioral problems). A significant number of these children were also identified by local Mental Health Centers, Departments of Social Services, and Juvenile Court Counselors as not receiving appropriate treatments or services.
2. The study also provided a profile of these children including such characteristics as: family background and problems, demographic characteristics, behavioral descriptions, and school-related information.
3. Perhaps most importantly, the study sought to trace the treatment history of each child. It traced the service path which each child followed prior to the time the study was conducted. This information constitutes a unique picture of how services were provided to these children on a statewide basis--a mapping of the service delivery illustrating the flow of children from one treatment program to another.

The data presented in this study created a foundation on which policy issues in this treatment area might be discussed and alternative program strategies explored. The purpose of this chapter lies in the effort to present the policy concerns raised by the study, while also suggesting alternative strategies for addressing these concerns. The policy issues raised by this study respond most appropriately to a systems-oriented

perspective. Accordingly, the issues discussed below will stress such functions as: the development of service linkages within the treatment system, the implementation of coordination mechanisms such as case management and accountability efforts, the clear definition of roles within the service system, and the funding of additional service efforts designed to assure the availability of a full continuum of treatment services. It should be noted that most of the concerns addressed in this chapter are consistent with those raised by a Department of Human Resource's position paper entitled "Critical Issues in Child Mental Health in North Carolina" developed by the State-Wide Planning Task Force for Children (January, 1980; see references for chapter 2).

Before the specific recommendations are made, a clear statement of the goals of the Oversight Committee will be presented; these are the objectives that the Oversight Committee hopes to achieve through the recommendations. Next a brief presentation will be given on the way the Oversight Committee believes that individual children should be treated. Then will come the specific recommendations as to what should be done in the state for children with serious behavioral problems.

GOALS OF THE OVERSIGHT COMMITTEE:

1. That a clear assignment of accountability and enforcement responsibilities is essential for the provision of services to children with behavioral problems and their families.
2. That the authority mandated to serve these children possess resources necessary to make a long-term committment to these children and their families.
3. That in the development of treatment programs institutional resources be utilized only as an integrated part of a community-oriented continuum of care.
4. That children with behavioral problems be treated in the most appropriate, least restrictive, setting consistent with their needs.
5. That treatment services should focus on meeting the needs of these children within their families and as close as possible to their home communities.

6. That communities should develop a full range of treatment meetings and program alternatives through which children with behavioral problems and their families might move as their treatment needs change.
7. That such a system of community care should have the capacity to provide individual children and their families with a planned and effective package of services including psychological, medical, educational, and vocational.
8. That the resource development necessary to implement these community-oriented programs be the result of a carefully planned, responsible and coordinated system at both the state and local level.

TREATMENT OF INDIVIDUAL CHILDREN

The Oversight Committee makes four recommendations with regard to the treatment of individual treatment.

1. That individual children with behavioral problems be provided program services including medical treatment, education, vocational training and care, suited to their needs to afford them a reasonable chance to: 1) acquire and maintain those life skills that enable them to cope as effectively as their own capacities permit in their environment, and 2) raise the level of his or her physical, mental, and social efficiency. Treatment should create a reasonable expectation of progress toward the goal of independent community living as much as possible for the individual. Treatment programs would not guarantee each child a "cure" but should guarantee each child a program of treatment which is a good faith effort to accomplish the goals set forth above.
2. That individual children be provided with the least restrictive, most normal living conditions appropriate for that person. Among the factors that should be considered in determining the least restrictive living conditions appropriate for the individual are: 1) the need to minimize institutionalization; and 2) the need to minimize the possibility of harm to the individual and society. Whenever possible, the child's family

should be intimately involved in treatment.

3. That individual children should be provided such placements and services as are actually needed as determined by an individualized treatment plan rather than such placements and services that are currently available. If placements and services actually needed are not available, the person should be entitled to have them developed and implemented within a reasonable period of time (see Number 5, Implementation of a Continum of Care Concept). Prior to development and implementation of needed placements and services, the person should be entitled to placement and services which best meet as nearly as possible his or her actual needs.
4. That individual children should be able to continue treatment for a reasonable period beyond their eighteenth birthday if: 1) the individual continues to be in need of such treatment and will benefit from continuing placement or involvement in the program in which they are receiving treatment on their eighteenth birthday, and 2) they voluntarily agree to continue treatment in that program in a manner consistent with state law or is confined pursuant to applicable state law.

CREATION OF SYSTEM LINKAGES, CASE MANGEMENT AND ACCOUNTABILITY

A review of the treatment or service history of the children included in this study provides an illustration of the fragmentation of the service delivery system which seeks to meet the needs of these children. The extent of this fragmentation is indicated by the following:

1. Children with behavioral problems in the present study had their first contact with different human service providers (e.g., Juvenile Courts, Departments of Social Services, Mental Health Centers, local school systems, private programs). Each of these represents to one degree or another a separate organizational entity with its own referral patterns and service delivery capability.
2. The services which children received and the treatment paths which they followed seemed to be, at least partially,

dictated by which agency first came in contact with the child. There seemed to be little permeability in the boundaries between various components of the service delivery system. For example, children initially identified in juvenile court tended to follow a path which led toward training school admission; while children identified within the mental health system tended to follow a path leading toward admission to one of the adolescent units in a Mental Health Hospital. There appeared to be little interaction between the two systems as reflected by the treatment histories of the children in this study.

3. Children classified as having a high level of behavioral problems averaged between three and four prior residences and between five and six prior treatment contacts. For example, the children with high behavioral problems who were classified as not appropriately served had 3.1 prior residences and 4.9 prior treatment contacts. Many of these children had received services, both residential and non-residential, from a number of agencies. This fragmented movement of children around the service system is also clearly illustrated by a review of the service paths followed by those children classified as not appropriately served. Many of them have been at one time or another in their treatment history served by: Training Schools, Mental Health Hospitals, Group Homes, Juvenile Court, foster care, Departments of Social Services, child caring facilities, and mental health out-patient services. Despite these intervention efforts, these children were still classified as having a high level of behavioral problems, were not being apropriately served, and were in need of service.

The information presented above seems to portray a service environment in which: (1) the services which children received and treatment paths they followed were often determined by the agency to which they were initially referred, (2) most individual agencies lacked the array of services necessary to meet the needs of the child or his/her family, (3) agencies were often focused on areas of concern (i.e., abuse, neglect or criminal involvement)

which took precedence over the child's behavioral disturbance, and (4) children were often bounced around the service delivery system from one agency to another. While the conclusions presented above certainly do not apply to all areas of the state, they do present a clear indication of the need for a significant increase in case management capability in many mental service areas as well as components of the service delivery system.

RECOMMENDATIONS

1. That case management responsibility for all children identified as having behavioral problems and their families, regardless of where they are identified within the system, should be lodged with the area mental health authority of the child's home community. Referrals of such children would then be provided full case management services to include: diagnosis, referral, treatment services, and on-going monitoring against the treatment plan.
2. That administrative efforts be made by each area mental health authority to foster the kinds of referral linkages and interagency agreements that are essential if the case management function is to be effectively implemented.
3. That the Department of Human Resources be responsible for assisting each area mental health authority to move toward the implementation of a case management approach to meeting needs of children with behavioral problems. These efforts should include: the development and implementation of standards for case management and programs; a definition of the role of the referring agency; a strict definition of the proposed client population; the provision of technical assistance; and the monitoring of the implementation of this concept.
4. That the implementation of the above case management system be monitored independently and that an appeal process for individual children be established.

THE CONCEPT OF A CONTINUUM OF CARE

The treatment history of the children who were the subject of this study depicted a fragmented service delivery environment composed of agencies

often lacking the administrative scope necessary to address their problems. The study also points to a service delivery environment which failed to provide the complete array of services necessary to treat each child in the most effective and least restrictive setting. This lack of services is particularly noticable in the area of community-based residential treatment programs for children with high behavioral problems. Thus, while these children have been the subject of numerous treatment or placement intervention efforts, few of them have had the opportunity to receive services from an adequately staffed, community-based residential treatment program. It should be noted that many of the existing group homes lack the necessary clinical and emergency backup services to allow them to treat safely and effectively the severely behaviorally disturbed, and often aggressive, adolescents. For example, 21 percent of the children with high behavioral problems in this study who were located in the state Mental Hospitals were admitted to those units from homes with no intermediate residence. A review of the training school children in this study indicated a similar situation with 51 percent of the children with high behavioral problems entering training schools straight from home. The impact of this lack of community-based residential treatment programs is also illustrated by the fact that 17 percent of the children with high behavioral problems who were classified as being not appropriately served were currently in residence in training schools, and 41 percent were residing at home because there were no appropriate services locations.

RECOMMENDATIONS

1. That a continuum of services developed within a community allow children to move from more intensive to less intensive services as therapeutic progress is made. The community mental health authorities and their contractors should link mental health services and the community by:
   a. initially determining the nature of the child's problems through diagnostic studies;
   b. developing an appropriate treatment plan;
   c. entering the child into the appropriate treatment program; and
   d. consulting with parents and other relevant agencies,

thereby assuring that there is appropriate and continuing understanding of the child's needs.

2. That development of a community-oriented continuum of services has the following advantages:
   a. it cuts down on bureaucratic "red tape" involved in moving the child from one component to another;
   b. it ensures a program of limited size allowing for more individualized attention; and
   c. it increases the probability of generalization of positive changes in behavior because the child is not removed from his or her environment but deals with his or her behavior with local family, schools, and peers participating.
3. That such services would probably consist of but not be limited to:
   a. Diagnostic and Consultation Services - local and state level
   b. Outpatient Services - local level
      1. Individual and Family Treatment
      2. Outpatient Group Treatment
      3. Outpatient Emergency Treatment
   c. Day/Evening Treatment - local level
   d. Locked Residential Care - local and state level
   e. Alternative Living - local and state level
      1. Therapeutic Family/Specialized Foster Care
      2. Group Homes
      3. Independent/Apartment Living with Vocational Training
      4. Wilderness Camps
   f. Specialized Educational Programs - local and state level
   g. Family Treatment and Support Services - local and state level

IMPLEMENTATION OF A CONTINUUM OF CARE CONCEPT

The flow of children with behavioral problems within the service delivery system strongly indicates that there is, in many mental health areas, a lack of appropriate community-based residential and non-residential

treatment interventions. Many area mental health programs do not have access to an appropriate array of child treatment services. This conclusion is supported by the State-Wide Planning Task Force for Children's Report which argues that "all area programs provide or have access to other treatment modalities at other stages of the continuum of mental health services which are appropriate for some of the emotionally disturbed children in their area. But no area in the state now has adequate access to appropriate treatment facilities for all the mental health treatment needs of all the children in that area." The present study supports the concept that there is a critical need to fill the gaps in the existing continuum of services available to each area child mental health program. The implementation of a continuum of care concept, together with the additional resources this would require, would provide each area mental health center with the ability to deal with children with behavioral problems and their families in the most effective, least restrictive manner consistent with their needs.

RECOMMENDATIONS

1. That Phase I of the implementation of these recommendations consist of the funding during fiscal year 1981-1982 of a limited number of case management/continuum of care projects as a means of developing transferable models of the service delivery concept that might be applied to all areas of the state. The mental health program areas selected as Phase I project sites should be representative of all area mental health programs. These project sites should include:
   a. selected urban areas (i.e., single-county mental health programs) many of whom already possess the basic outline of a treatment continuum but would require additional resources to fill in the gaps in their existing continuum of care; and
   b. rural, multi-county areas composed of one or more area mental health programs. These rural Phase I projects would require additional funds to implement regional or multi-county treatment alternatives designed to develop a regional continuum of care. In many areas this banding together of counties and

mental health program areas will be essential if cost-effective treatment programs are to be implemented.

2. That these Phase I projects be a joint effort of the Department of Human Resources (DHR) and selected area mental health programs. DHR should be held accountable for developing their implementation. The selected area mental health programs should be held accountable for the development of a local case management and resource development plan as well as for the ultimate implementation of the case management project.
3. That in addition to the implementation of these Phase I projects, the Department of Human Resources assist each area mental health program to: Inventory their existing treatment sources, assess their resource needs, and develop case management/resource development plans designed to implement a continuum of care concept within their areas.
4. That Phase II of this project be implementation of such community case management/continuum of care programs across North Carolina.
5. That, as a continuum of care/case management concept becomes a reality, there will be a significant need to develop a clear definition of the role which institutional resources are to play in the treatment continuum. As children are increasingly provided long-term treatment services within their home communities, Children and Adolescent units of the state hospitals should move toward the provision of short-term intensive emergency and diagnostic services. As resources presently used in long-term care in state hospitals are freed up by the implementation of community-based programs, these funds should be transferred to the area mental health programs.
6. That while the implementation of a case management/continuum of care concept should effectively meet the needs of the vast majority of children with behavioral problems, each area mental health program will find itself faced with a very limited number of children whose special needs will necessitate the application of the treatment resources beyond the capability of local treatment programs. Therefore, it is recommended that a discretionary fund be established to meet the needs of these children. This fund would then be applied to meet these special needs at the discretion of the Secretary of the Department of Human Resources.

EARLY DETECTION AND TREATMENT INTERVENTION PROGRAMS

A central theme emerging from this study is the critical need for an aggressive and coordinated effort in the areas of prevention and early detection and treatment of children with behavioral problems. More than this, it points out potential directions which these efforts might follow. For example, while 64 percent of the children classified as having a high level of behavioral problems were age 15 or older, the average age at which behavioral problems were initially noted was 11.7 years. For many of these children, behavioral problems were formally noted in their case records as early as 8 years old. Thus, while many of these children came to the attention of service agencies at a relatively early age and have a treatment history bridging 7 or 8 years or more, the service interventions offered these children failed to prevent their further involvement and penetration into the service system. This would seem to indicate the need for a more coordinative, intensive treatment effort at the initial point at which children are identified as having behavioral problems.

A review of the family history of these children strongly argues the need for aggressive family intervention efforts designed to strengthen families and decrease the likelihood of a child having to be removed from his or her family for treatment. The study provides a number of potentially useful measures which seem to serve as indicators of children and families in need of prevention and early treatment services. Among the type of family indicators which the study provides are the following: over 20 percent of the children classified as having a high level of behavioral problems were not living with either of their natural parents, 53 percent of their families were receiving some form of public assistance, 46 percent

of their families had evidence of some form of child abuse or neglect and 38 percent demonstrated other forms of family violence, and 58 percent of these families had some form of alcohol related problem. The children themselves were characterized by serious behavior problems initiating at an early age, by difficulties with academic performance and evidence of truancy, and by aggressive behavior within a school setting, while almost a third were characterized as having learning disabilities.

The background information which this study presents on children with behavioral problems and their families strongly supports the need for increased efforts in areas of prevention, early detection and treatment. These are often families with a history of violence; families in crisis whose problems often bring them into contact with law enforcement or social service agencies. Often these agencies seek to deal with only a limited aspect of the total family problem. It is these single problem-oriented contacts which, if recognized as indicators of families and children in need of help, can provide effective intervention points for a coordinated prevention and early intervention effort.

RECOMMENDATIONS

1. That increased efforts be made in the area of early detection and treatment services for children with behavioral problems and their families.
2. That early detection and intervention services be founded on the principal risk factors identified in this study (i.e., family violence, alcohol-related problems, and child abuse and neglect) and seek to identify these children and their families through contacts with such agencies as public instruction, law enforcement, juvenile courts, and local Departments of Social Services.
3. That the responsibility for the coordination of this early detection and intervention service be that of the area mental health authority.
4. That early detection and treatment intervention programs for high-risk children and their families be included as an integral element in the long-term plan of case management projects.

APPENDIX A

CLIENT QUESTIONNAIRE

Revised
8/18/80

Today's Date: _____

Seriously Disturbed Juvenile Offender Project
Center for Urban Affairs and Community Services

A 01

THE CLIENT DATA COLLECTION INSTRUMENT

id

FACILITY INFORMATION

Youth's ID # 02
Field Staff # 06

1. Facility Type (Location Codes): 08

00.	Home	08.	DSS
01.	Wilderness camp	09.	Foster care
02.	MH hospital	10.	Child care institution (Ap.B)
03.	Adult corrections	11.	Non-residential care
04.	Training Schools	12.	Out-of-state placement
05.	Group home (see Ap. A)	13.	Private referral
06.	MH center	14.	Other
07.	Juvenile court		

If other, name: _____

2. Facility name: _____ = ID# assign. 10
3. County location: _____ 12
4. Data type: 1. Residential institution
2. Local agency: No placement
3. Local agency: Placement 14

INDIVIDUAL DEMOGRAPHICS

5. Birth Date: ___ ___ - ___ ___ - ___ ___ (do not code "day") 15
Mo. Day Yr.
6. Sex: 1. male / 2. female 19
7. Age: ___ ___ 20
8. Race: 1. White / 2. Black / 3. Indian / 4. Other 22

EDUCATION

9. Grade Completed: ___ ___ 23
10. Currently in school? 1. yes, full-time, general
2. yes, part-time, general
3. yes, full-time, vocational rehabilitation
4. yes, part-time, vocational rehabilitation
5. no
6. u/k 25
11. Employment history: 1. Never employed
2. part-time at some point
3. full-time at some point
4. u/k 26

---

cut along lines and remove

Name: _____

ID # : ___ ___ ___ ___

---

30. # of prostitution and/or promiscuity occurrences: ___ ___

B id 01

31. Age at first occurrence: ___ ___ 06
32. Location at first occurrence: ___ ___ 08

10

33. # of property burning incidences: ___ ___
34. Age at first occurrence: ___ ___ 12
35. Location at first occurrence: ___ ___ 14 16

---

36. # of cruelty to animals occurrences: ___ ___ 18
37. Age at first occurrence: ___ ___ 20
38. Location at first occurrence: ___ ___ 22

---

39. # of running away occurrences: ___ ___ 24
40. Age at first occurrence: ___ ___ 26
41. Location at first occurrence: ___ ___ 28

30

42. # of attempted suicide incidences: ___ ___ 32
43. Age at first occurrence: ___ ___ 34
44. Location at first occurrence: ___ ___

---

45. # of physically self-injurious behaviors: ___ ___

46. Age at first occurrence: ___ ___

47. Location at first occurrence: ___ ___

48. # of vandalism incidences: ___ ___

49. Age at first occurrence: ___ ___

50. Location at first occurrence: ___ ___

51. # of stealing occurrences: ___ ___

52. Age at first occurrence: ___ ___

53. Location at first occurrence: ___ ___

54. # of alcohol and substance abuse occurrences: ___ ___

55. Age at first occurrence: ___ ___

56. Location at first occurrence: ___ ___

57. # of verbal aggressions: ___ ___

58. Age at first occurrence: ___ ___

59. Locations of first occurrence: ___ ___

FAMILY BACKGROUND

60. Child lived with:
1. Male & Female Adults
2. Male Only
3. Female Only
4. Child Care facility
5. Extremely varied
6. Alone
7. Other _____
8. u/k

61. Family Arrangement:
1. Natural parent(s)
2. 1 natural/1 step parent
3. Natural relative(s) - non-parent
4. Natural Sibling(s)
5. Non-biological-related people
6. Other _____
7. u/k

62. Has family arrangement changed more than once: 1. Yes 2. No

63. Primary wage earner is: 1. Male in household 2. Female in household

64. Present family income: $___ ___ ___ ___ ___

65. Education of primary wage earner (in yrs.): ___ ___

12. High School Degree
14. Two-Yr. Trade or other degree
17. Some grad school
18. Some grad degree
19. No primary wage earner

66. Any evidence of public assistance: 1. Yes 2. No

67. Number of siblings: ___ ___

68. Birth order of client:
1. Only child
2. 1st of multiple siblings
3. Not 1st or last
4. Last of multiple siblings

HISTORY OF FAMILY PROBLEMS

69. Alcohol related, not child: 1. yes / 2. no

70. Drug abuse, not child: 1. yes / 2. no

71. Child abuse or neglect of child: 1. yes / 2. no

72. Other family violence: 1. yes / 2. no

73. Court involvement (except w/this child): 1. yes / 2. no

74. Mental illness (parents or grandparents): 1. yes / 2. no

75. Other mental illness in family: 1. yes / 2. no

76. Disintegration of the family: 1. yes / 2. no

COMMUNITY CHARACTERISTICS

Home town _____

77. Home county _____ — 14

78. # yrs in home county before 1st placement ___ ___ (99=u/k, 00=< .5) — 16

Raleigh

79. # of miles from present placement: 1 =<6 / 2 = 6-25 / 3 = 26-50 / 4 = 51-100 / 5 = 101-200 / 6 = 201-500 / 7 =>500 / 9 = u/k — 18

80. Number of services in the community: ___ ___ (see list for appropriate services) — 19

81. Size of community: ___ ___ ___, ___ ___ ___ (see list of community & size) — 21

SCHOOL BEHAVIOR

82. Academic performance: 1 = No data; 2 = Satisfactory; 3 = Unsatisfactory — 27

83. Truancy: 1 = No comments; 2 = Presence of comments; 3 = Presence of comments and an indication of excessiveness — 28

84. Aggressive behavior: 1 = No comments; 2 = Presence of comments; 3 = Presence of comments and an indication of excessiveness — 29

85. Placement in special classes:

1 = no; 2 = mentally retarded (MR); 3 = learning disabled (LD); 4 = emotionally handicapped; 5 = gifted/talented; 6 = other; 7 = special counseling — 30

Other special classes: _____

86. Counseling from school: 1. yes / 2. no — 31

87. Failed a class: 1. yes / 2. no — 32

INTELLIGENCE TESTS, MOST RECENT (Appendix E)

87. Test Name: _____ — 33

88. Test score: ___ ___ ___ — 35

89. Test score percentile: ___ ___ ___ — 38

90. Test Name: _____ — 41

91. Test score: ___ ___ ___ — 43

92. Test score percentile: ___ ___ ___ — 46

OTHER TESTS (Appendix E)

93. Test Name: _____ — 49

94. Test score: ___ ___ ___ — 51

95. Test score percentile: ___ ___ ___ — 54

96. Test Name: _____ — 57

97. Test score: ___ ___ ___ — 59

98. Test score percentile: ___ ___ ___ — 62

99. Test Name: _____ — 65

100. Test score: ___ ___ ___ — 67

101. Test score percentile: ___ ___ ___ — 70

102. Test Name: _____ — 73

103. Test score: ___ ___ ___ — 75

104. Test score percentile: ___ ___ ___ — 78

MEDICAL HISTORY: (Check if present = 1, not present = 0)

105. Seizure disorder ____
106. Ear, nose, or throat (including speech) ____
107. Respiratory ____
108. Gastronomical or intestinal disorder ____

109. Obesity ____
110. Sexually transmitted disease ____
111. Musclo-skeletal problem ____
112. Skin problems ____

113. Physical trauma (broken bones, injuries, etc.) ____
114. Alcohol or drug use ____
115. Dental problems ____
116. Learning disabilities ____

117. Visual impairment ____
118. Hearing deficit ____
119. Prenatal or birth complications ____
120. Pregnancy or abortion ____

121. Congenital neurological dysfunction ____
122. Other, ____
What is other _____

OFFENSE RECORD (CONVICTIONS)

123. Most recent offense (see offense codes) __ __
124. Second most recent offense __ __
125. Third most recent offense __ __
126. Fourth most recent offense __ __

DIAGNOSES, MENTAL HEALTH (Ap. G, Intake Form B, Item 41; use most recent)

127. Primary: __ __ __.__ __
128. Secondary: __ __ __.__ __
129. __ __ __.__ __
130. __ __ __.__ __

D id

105 06 07 08 09
109 10 11 12 13
113 14 15 16 17
117 18 19 20 21
121 22 23
24 26 28 30
32 37 42 47

1. CURRENT RESIDENTIAL LOCATION: ____ ____
2. Date of arrival: __ __ - __ __ - __ __
3. Length of stay: (Mo.) ____ ____ (00=<.5, all others to nearest mo.)
4. Reason for referral (Ap. H): primary _____
5. secondary _____

Raleigh) 6. Distance from home: 1=<6 / 2= 6-25 / 3=26-50 / 4=51-100 / 5=101-200 / 6=201-500 / 7=>500 / 9=u/k

Behaviors at location: (Check if present,=1; not present=0)

7. Uncontrollable temper tantrums: ____
8. Physical attacks w/out weapons: ____
9. Physical attacks w/weapons: ____
10. Killed someone: ____
11. Public sexual activity: ____
12. Forcible sexual activity: ____
13. Prostitution/promiscuity: ____
14. Burning property: ____
15. Cruelty to animals: ____
16. Running away: ____
17. Attempted suicide: ____
18. Physically self-injurious behavior: ____
19. Vandalism: ____
20. Verbal aggression: ____
21. Stealing: ____
22. Alcohol/Substance abuse: ____

Offenses at locations: (Check if present,=1; not present=0)

23. Murder/manslaughter: ____
24. Theft: ____
25. Rape: ____
26. Other sex offense: ____
27. Arson: ____
28. Attack someone: ____
29. Drug felony: ____
30. Drug non-felony: ____
31. Other: _____

Concurrent Treatment locations: (use location codes)

32. Most frequent: __ __
33. Others: __ __
34. __ __
35. __ __
36. __ __

48 50 56 59 61 63
E id
01
7 06 07 08 09
11 10 11 12 13
15 14 15 16 17
19 18 19 20 21
23 22 23 24 25
27 26 27 28 29
31 30
31 33 35 37 39

Treatments and Services at location: (use codes)??

37. Primary: __ __ — 41
38. Secondary: __ __ — 43
39. __ __ — 45
40. __ __ — 47

Diagnoses at location (GAP codes, AP. G, use most recent)

41. Primary: __ __ __ . __ __ — 49
42. Secondary: __ __ __ . __ __ — 54
43. __ __ __ . __ __ — 59
44. __ __ __ . __ __ — 64

45. Prognosis at location (use Mental Health if possible) — 69

1. Good
2. Bad
3. Guarded
4. None

Unsuccessful attempted referrals (location codes):

46. 1 __ __ — 70
47. 2 __ __ — 72
48. 3 __ __ — 74

49. Reason referral was not completed (for number one above) — 76

1. Client did not meet formal eligibility requirements
2. Client did not meet informal eligibility requirements
3. no documented reason given
4. rejected by client or family
5. appropriate service not available
6. space not available
7. unknown
8. other

specify _____

50. Reason referral was not completed for number two above — 77
51. Reason referral was not completed for number three above — 78

id — F — 01

1. PREVIOUS RESIDENTIAL LOCATION: __ __ — 06
2. Date of arrival: __ __ - __ __ - __ __ — 08
3. Length of stay: (Mo.) __ __ (00=<.5, all others to nearest mo.) — 14
4. Reason for referral (AP. H): primary _____ — 17

_____

5. secondary _____ — 19

_____ — 21

Raleigh) 6. Distance from home: 1=<6 / 2= 6.-25 / 3=26-50 / 4=51-100 / 5=101-200 / 6=201-500 / 7=>500 / 9=u/k — 7 — 22

Behaviors at location: (Check if present,=1; not present=0)

7. Uncontrollable temper tantrums: ____ — 23
8. Physical attacks w/out weapons: ____ — 24
9. Physical attacks w/weapons: ____ — 25
10. Killed someone: ____ — 11 — 26
11. Public sexual activity: ____ — 27
12. Forcible sexual activity: ____ — 28
13. Prostitution/promiscuity: ____ — 29
14. Burning property: ____ — 15 — 30
15. Cruelty to animals: ____ — 31
16. Running away: ____ — 32
17. Attempted suicide: ____ — 33
18. Physically self-injurious behavior: ____ — 19 — 34
19. Vandalism: ____ — 35
20. Verbal aggression: ____ — 36
21. Stealing: ____ — 37
22. Alcohol/Substance abuse: ____ — 23 — 38

Offenses at locations: (Check if present,=1; not present=0)

23. Murder/manslaughter: ____ — 39
24. Theft: ____ — 40
25. Rape: ____ — 41
26. Other sex offense: ____ — 21 — 42
27. Arson: ____ — 43
28. Attack someone: ____ — 44
29. Drug felony: ____ — 45
30. Drug non-felony: ____ — 31 — 46
31. Other: _____ — 47

_____ — 49

Concurrent Treatment locations: (use location codes) — 51

32. Most frequent: __ __ — 53
33. Others: __ __ — 55
34. __ __
35. __ __
36. __ __

Treatments and Services at location: (use codes)??

37. Primary: ___ ___ 57
38. Secondary: ___ ___ 59
39. ___ ___ 61
40. ___ ___ 63

Diagnoses at location (GAP codes, AP. G, use most recent)

41. Primary: ___ ___ ___ . ___ ___ G id 01
42. Secondary: ___ ___ ___ . ___ ___ 06
43. ___ ___ ___ . ___ ___ 11
44. ___ ___ ___ . ___ ___ 16
21

45. Prognosis at location (use Mental Health if possible) 26

1. Good 3. Guarded
2. Bad 4. None

Unsuccessful attempted referrals (location codes):

46. 1___ ___ 27
47. 2___ ___ 29
48. 3___ ___ 31
33

49. Reason referral was not completed (for number one above)

1. Client did not meet formal eligibility requirements
2. Client did not meet informal eligibility requirements
3. no documented reason given
4. rejected by client or family
5. appropriate service not available
6. space not available
7. unknown
8. other

specify _____

34

50. Reason referral was not completed for number two above 35
51. Reason referral was not completed for number three above

12

1. FIRST RESIDENTIAL LOCATION AFTER HOME: ___ ___ 36
2. Date of arrival: ___ ___ - ___ ___ - ___ ___ 38
3. Length of stay: (Mo.) ___ ___ (00=<.5, all others to nearest mo.) 44
4. Reason for referral (AP. H): primary _____ 47

_____ 49

5. secondary _____

_____ 51

Raleigh)6. Distance from home: 1=<6 / 2= 6-25 / 3=26-50 / 4=51-100 / 5=101-200 / 6=201-500 / 7=>500 / 9=u/k

Behaviors at location: (Check if present,=1; not present=0)

7. Uncontrollable temper tantrums: ___ 7 52
8. Physical attacks w/out weapons: ___ 53
9. Physical attacks w/weapons: ___ 54
10. Killed someone: ___ 55

11. Public sexual activity: ___ 11 56
12. Forcible sexual activity: ___ 57
13. Prostitution/promiscuity: ___ 58
14. Burning property: ___ 59

15. Cruelty to animals: ___ 15 60
16. Running away: ___ 61
17. Attempted suicide: ___ 62
18. Physically self-injurious behavior: ___ 63

19. Vandalism: ___ 19 64
20. Verbal aggression: ___ 65
21. Stealing: ___ 66
22. Alcohol/Substance abuse: ___ 67

Offenses at locations: (Check if present,=1; not present=0)

23. Murder/manslaughter: ___ 23 68
24. Theft: ___ 69
25. Rape: ___ 70
26. Other sex offense: ___ 71

27. Arson: ___ 27 72
28. Attack someone: ___ 73
29. Drug felony: ___ 74
30. Drug non-felony: ___ 75

31. Other: _____ 31 76

_____ H id 01

Concurrent Treatment locations: (use location codes) 06

32. Most frequent: ___ ___ 08
33. Others: ___ ___ 10
34. ___ ___ 12
35. ___ ___ 14
36. ___ ___

13

Treatments and Services at location: (use codes)??

37. Primary: ___ ___ — 16
38. Secondary: ___ ___ — 18
39. ___ ___ — 20
40. ___ ___ — 22

Diagnoses at location (GAP codes, AP. G, use most recent)

41. Primary: ___ ___ ___ . ___ ___ — 24
42. Secondary: ___ ___ ___ . ___ ___ — 29
43. ___ ___ ___ . ___ ___ — 34
44. ___ ___ ___ . ___ ___ — 39

45. Prognosis at location (use Mental Health if possible) — 44

1. Good 3. Guarded
2. Bad 4. None

Unsuccessful attempted referrals (location codes):

46. 1 ___ ___ — 45
47. 2 ___ ___ — 47
48. 3 ___ ___ — 49

49. Reason referral was not completed (for number one above) — 51

1. Client did not meet formal eligibility requirements
2. Client did not meet informal eligibility requirements
3. no documented reason given
4. rejected by client or family
5. appropriate service not available
6. space not available
7. unknown
8. other

specify _____

50. Reason referral was not completed for number two above — 52
51. Reason referral was not completed for number three above — 53

1. CURRENT SERVICE LOCATION: ___ ___ — 54
2. Date of arrival: __ __ - __ __ - __ __ — 56
3. Length of stay: (Mo.) ___ ___ (00=<.5, all others to nearest mo.) — 62
4. Reason for referral (AP. H): primary _____ — 65

_____ — 67

5. secondary _____ — Id 01

_____ — 06

Raleigh) 6. Distance from home: 1=<6 / 2= 6-25 / 3=26-50 / 4=51-100 / 5=101-200 / 6=201-500 / 7=>500 / 9=u/k — 7 07

Behaviors at location: (Check if present,=1; not present=0) — 08

7. Uncontrollable temper tantrums: ___ — 09
8. Physical attacks w/out weapons: ___ — 10
9. Physical attacks w/weapons: ___
10. Killed someone: ___ — 11 11

— 12

11. Public sexual activity: ___ — 13
12. Forcible sexual activity: ___ — 14
13. Prostitution/promiscuity: ___
14. Burning property: ___ — 15 15

— 16

15. Cruelty to animals: ___ — 17
16. Running away: ___ — 18
17. Attempted suicide: ___
18. Physically self-injurious behavior: ___ — 19 19

— 20

19. Vandalism: ___ — 21
20. Verbal aggression: ___ — 22
21. Stealing: ___
22. Alcohol/Substance abuse: ___ — 23 23

Offenses at locations: (Check if present,=1; not present=0) — 24

— 25

23. Murder/manslaughter: ___ — 26
24. Theft: ___
25. Rape: ___ — 27 27
26. Other sex offense: ___ — 28

— 29

27. Arson: ___ — 30
28. Attack someone: ___
29. Drug felony: ___ — 31 31
30. Drug non-felony: ___

31. Other: _____ — 32

_____ — 34

Concurrent Treatment locations: (use location codes) — 36

32. Most frequent: ___ ___ — 38
33. Others: ___ ___ — 40
34. ___ ___
35. ___ ___
36. ___ ___

Treatments and Services at location: (use codes)??

37. Primary: ___ ___ — 42
38. Secondary: ___ ___ — 44
39. ___ ___ — 46
40. ___ ___ — 48

Diagnoses at location (GAP codes, AP. G, use most recent)

41. Primary: ___ ___ ___ . ___ ___ — 50
42. Secondary: ___ ___ ___ . ___ ___ — 55
43. ___ ___ ___ . ___ ___ — 60
44. ___ ___ ___ . ___ ___ — 65

45. Prognosis at location (use Mental Health if possible) — 70

1. Good
2. Bad
3. Guarded
4. None

Unsuccessful attempted referrals (location codes):

46. 1 ___ ___ — 71
47. 2 ___ ___ — 73
48. 3 ___ ___ — 75

49. Reason referral was not completed (for number one above) — 77

1. Client did not meet formal eligibility requirements
2. Client did not meet informal eligibility requirements
3. no documented reason given
4. rejected by client or family
5. appropriate service not available
6. space not available
7. unknown
8. other

specify _____

50. Reason referral was not completed for number two above — 78
51. Reason referral was not completed for number three above — 79

16

J id — 01

1. PREVIOUS SERVICE LOCATION: ___ ___ — 06
2. Date of arrival: __ __ - __ __ - __ __ — 08
3. Length of stay: (Mo.) ___ ___ (00=<.5, all others to nearest mo.) — 14
4. Reason for referral (AP. H): primary _____ — 17

_____

5. secondary _____ — 19

_____ — 21

(Raleigh) 6. Distance from home: 1=<6 / 2= 6-25 / 3=26-50 / 4=51-100 / 5=101-200 / 6=201-500 / 7=>500 / 9=u/k

Behaviors at location: (Check if present,=1; not present=0)

7. Uncontrollable temper tantrums: ___ — 22
8. Physical attacks w/out weapons: ___ — 23
9. Physical attacks w/weapons: ___ — 24
10. Killed someone: ___ — 25
11. Public sexual activity: ___ — 26
12. Forcible sexual activity: ___ — 27
13. Prostitution/promiscuity: ___ — 28
14. Burning property: ___ — 29
15. Cruelty to animals: ___ — 30
16. Running away: ___ — 31
17. Attempted suicide: ___ — 32
18. Physically self-injurious behavior: ___ — 33
19. Vandalism: ___ — 34
20. Verbal aggression: ___ — 35
21. Stealing: ___ — 36
22. Alcohol/Substance abuse: ___ — 37

Offenses at locations: (Check if present,=1; not present=0)

23. Murder/manslaughter: ___ — 38
24. Theft: ___ — 39
25. Rape: ___ — 40
26. Other sex offense: ___ — 41
27. Arson: ___ — 42
28. Attack someone: ___ — 43
29. Drug felony: ___ — 44
30. Drug non-felony: ___ — 45
31. Other: _____ — 46

_____

Concurrent Treatment locations: (use location codes)

32. Most frequent: ___ ___ — 47
33. Others: ___ ___ — 49
34. ___ ___ — 51
35. ___ ___ — 53
36. ___ ___ — 55

17

Treatments and Services at location: (use codes)??

37. Primary: ___ ___
38. Secondary: ___ ___
39. ___ ___
40. ___ ___

Diagnoses at location (GAP codes, AP. G, use most recent)

41. Primary: ___ ___ ___ . ___ ___
42. Secondary: ___ ___ ___ . ___ ___
43. ___ ___ ___ . ___ ___
44. ___ ___ ___ . ___ ___

45. Prognosis at location (use Mental Health if possible)

1. Good 3. Guarded
2. Bad 4. None

Unsuccessful attempted referrals (location codes):

46. 1 ___ ___
47. 2 ___ ___
48. 3 ___ ___

49. Reason referral was not completed (for number one above)

1. Client did not meet formal eligibility requirements
2. Client did not meet informal eligibility requirements
3. no documented reason given
4. rejected by client or family
5. appropriate service not available
6. space not available
7. unknown
8. other

specify _____

50. Reason referral was not completed for number two above
51. Reason referral was not completed for number three above

57 59 61 63 K id 01 06 11 16 21 26 27 29 31 33 34 35

1. FIRST SERVICE LOCATION: ___ ___
2. Date of arrival: ___ ___ - ___ ___ - ___ ___
3. Length of stay: (Mo.) ___ ___ (00=<.5, all others to nearest mo.)
4. Reason for referral (AP. H): primary _____

_____

5. secondary _____

_____

Raleigh)6. Distance from home: 1=<6 / 2= 6-25 / 3=26-50 / 4=51-100 / 5=101-200 / 6=201-500 / 7=>500 / 9=u/k

Behaviors at location: (Check if present,=1; not present=0)

7. Uncontrollable temper tantrums: ___
8. Physical attacks w/out weapons: ___
9. Physical attacks w/weapons: ___
10. Killed someone: ___
11. Public sexual activity: ___
12. Forcible sexual activity: ___
13. Prostitution/promiscuity: ___
14. Burning property: ___
15. Cruelty to animals: ___
16. Running away: ___
17. Attempted suicide: ___
18. Physically self-injurious behavior: ___
19. Vandalism: ___
20. Verbal aggression: ___
21. Stealing: ___
22. Alcohol/Substance abuse: ___

Offenses at locations: (Check if present,=1; not present=0)

23. Murder/manslaughter: ___
24. Theft: ___
25. Rape: ___
26. Other sex offense: ___
27. Arson: ___
28. Attack someone: ___
29. Drug felony: ___
30. Drug non-felony: ___
31. Other: _____

_____

Concurrent Treatment locations: (use location codes)

32. Most frequent: ___ ___
33. Others: ___ ___
34. ___ ___
35. ___ ___
36. ___ ___

36 38 44 47 49 51 7 52 53 54 55 11 56 57 58 59 15 60 61 62 63 19 64 65 66 67 23 68 69 70 71 27 72 73 74 75 31 76 id 01 06 08 10 12 14

Treatments and Services at location: (use codes)??

37. Primary: ___ ___ 16
38. Secondary: ___ ___ 18
39. ___ ___ 20
40. ___ ___ 22

Diagnoses at location (GAP codes, AP. G, use most recent)

41. Primary: ___ ___ ___ . ___ ___ 24
42. Secondary: ___ ___ ___ . ___ ___ 29
43. ___ ___ ___ . ___ ___ 34
44. ___ ___ ___ . ___ ___ 39

45. Prognosis at location (use Mental Health if possible) 44

1. Good
2. Bad
3. Guarded
4. None

Unsuccessful attempted referrals (location codes):

46. 1 ___ ___ 45
47. 2 ___ ___ 47
48. 3 ___ ___ 49

49. Reason referral was not completed (for number one above) 51

1. Client did not meet formal eligibility requirements
2. Client did not meet informal eligibility requirements
3. no documented reason given
4. rejected by client or family
5. appropriate service not available
6. space not available
7. unknown
8. other

specify _____

50. Reason referral was not completed for number two above 52
51. Reason referral was not completed for number three above 53

Mid 01

SEQUENTIAL LIST OF RESIDENTIAL LOCATIONS

List in sequence the client's residential locations and the length of stay in each (from most recent to first):

1. Most recent (current) _____ 06
2. Length of stay (to nearest Mo.): ___ ___ 08
3. 2nd most recent _____ 11
4. Length of stay ___ ___ 13
5. 3rd _____ 16
6. Length of stay ___ ___ 18
7. 4th _____ 21
8. Length of stay ___ ___ 23
9. 5th _____ 26
10. Length of stay ___ ___ 28

11. 6th _____ 31
12. Length of stay ___ ___ 33
13. 7th _____ 36
14. Length of stay ___ ___ 38
15. 8th _____ 41
16. Length of stay ___ ___ 43
17. 9th _____ 46
18. Length of stay ___ ___ 48
19. 10th _____ 51
20. Length of stay ___ ___ 53

21. 11th _____ 56
22. Length of stay ___ ___ 58
23. 12th _____ 61
24. Length of stay ___ ___ 63
25. 13th _____ 66
26. Length of stay ___ ___ 68
27. 14th _____ 71
28. Length of stay ___ ___ 73
29. 15th _____ 76
30. Length of stay ___ ___ 78

Use additional sheets if necessary

Oi id 01

SEQUENTIAL LIST OF SERVICE LOCATIONS

List in sequence the client's service locations and the length of stay in each (from most recent to first):

1. Most recent (current) _____ 06
2. Length of stay (to nearest Mo.): ___ ___ 08
3. 2nd most recent _____ 11
4. Length of stay ___ ___ 13
5. 3rd _____ 16
6. Length of stay ___ ___ 18
7. 4th _____ 21
8. Length of stay ___ ___ 23
9. 5th _____ 26
10. Length of stay ___ ___ 28

---

11. 6th _____ 31
12. Length of stay ___ ___ 33
13. 7th _____ 36
14. Length of stay ___ ___ 38
15. 8th _____ 41
16. Length of stay ___ ___ 43
17. 9th _____ 46
18. Length of stay ___ ___ 48
19. 10th _____ 51
20. Length of stay ___ ___ 53

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21. 11th _____ 56
22. Length of stay ___ ___ 58
23. 12th _____ 61
24. Length of stay ___ ___ 63
25. 13th _____ 66
26. Length of stay ___ ___ 68
27. 14th _____ 71
28. Length of stay ___ ___ 73
29. 15th _____ 76
30. Length of stay ___ ___ 78

Use additional sheets if necessary

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END