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Community-Based Programming for Emotional Disturbance in Children

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COMMUNITY-BASED PROGRAMMING FOR EMOTIONAL DISTURBANCE IN CHILDREN

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COMMUNITY-BASED PROGRAMMING

FOR EMOTIONAL DISTURBANCE IN CHILDREN

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COMMUNITY-BASED PROGRAMMING FOR EMOTIONAL DISTURBANCE IN CHILDREN

Anna Marie Borders January 1981 81 pages

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Based upon local needs assessment data, review of the literature, and a survey of professionals in the field of children's services, a design for the development of a community-based diagnostic and treatment network for services to emotionally disturbed children was formulated. Addressing the needs of a seven-county area in Southern Kentucky, the program plan defines the processes and procedures for the implementation of regional diagnostic, educational support, and technical assistance services as the initial step toward the establishment of a regional day treatment and residential center providing the full spectrum of special services to the emotionally disturbed youth of the target area. Related issues were discussed, to include the mobilization of resources, program evaluation, and research.

Community-Based Programming for Emotional Disturbance in Children

Each year, a variety of special interest groups inundate the American public with a barrage of highly publicized activities pertaining to anniversaries viewed as important by these groups. Usually reflecting this country's base 10 mathematical structure, there are bicentennial celebrations for cities and states, 100th anniversaries of the births or deaths of prominent persons, presidential proclamations commemorating significant historical events, and similar activities.

The final decades of the 20th Century mark one milestone that is unlikely to receive the fanfare marked by formal announcements, celebrations, symposia, and accelerated public relations characteristic of other centennial anniversaries. This event is the close of the first century during which the issues of childhood emotional disturbance have been addressed in terms of theory development, research, treatment, and education.

Historically, the focus on childhood emotional disturbance among mental health professionals had its beginnings in the late 19th Century. The first clinical treatment center for children was established at the University of Pennsylvania by

Lightner Witmer in 1896. It was not until 1933 that the first child psychopathology text was published in the United States (Rie, 1974). The English publication of Anna Freud's basic techniques of child analysis was issued in 1946 (Lesser, 1972).

The education of the emotionally disturbed has a history characterized by either the obvious presence or noticeable exclusion of these children in public school programs. Larson (1978) notes that, traditionally, seriously disturbed children were believed to be uneducable or uncontrollable and that their treatment should be the responsibility of mental health professionals rather than educators.

With the passage of the Education for All Handicapped Children Act (PL94-142, 1975) came new direction for the education of emotionally disturbed children. The act, passed on November 29, 1975, mandates that all handicapped children have available to them a free and appropriate education which meets their unique needs in the most therapeutic, yet least restrictive environment feasible.

One response to this legislation has been the development of legal and operational compliance plans by each state. In Kentucky, the provisions for the implementation of PL94-142 are delineated in the Kentucky Revised Statutes (KRS, 1977) and the Kentucky Administrative Regulations (KAR, 1978). In addition to the general provisions of the Kentucky Revised Statutes 157.200 to 157.305, the Kentucky Administrative Regulations 707 KAR 1:054 mandate and define the following: eligibility criteria; Admissions and Release Committee functions;

child evaluation procedures; Individual Education Program requirements; placement, classroom plan and membership operations, and housing requirements.

The Kentucky Department of Education's Bureau of Education for Exceptional Children develops the state's annual program plan as required by PL94-142. This plan describes compliance activities to include the establishment of policies and procedures for meeting federal requirements, local and state activities using funds allocated as a result of this law, and direct and support services for the improvement and expansion of programs. (Kentucky Department of Education, 1980).

Despite the compliance efforts of Kentucky and other states, there are obvious gaps in the delivery of services to emotionally handicapped children. The 1978 report of the President's Commission on Mental Health estimates that from five to fifteen percent of the children between the ages of three to fifteen have persisting mental health problems. The Bureau for the Education for the Handicapped reports that two percent of the population between the ages three to twenty-one lack access to needed special education services for the emotionally handicapped. (Scheiber, Note 1). According to the National Institute of Mental Health, of the half million seriously disturbed children in the country, only ten thousand are receiving treatment (Long, 1971).

The impact of deficits in programs and services for emotionally handicapped youth can be especially devastating to local regions and communities, particularly those which are primarily

rural. Schrag (Note 2) reports that rural schools have twice the rate of non-enrollment of the handicapped when compared to urban schools and that a major reason given for this phenomenon is the lack of special education resources and/or the lack of parental information concerning such services. Trapps and Himelstein (1972) report that while 9,950 teachers and specialists in the area of emotional disturbance are employed in the schools, an additional 111,844 are needed. In rural areas, the availability of such resource personnel is greatly decreased.

The purpose of this paper is to address the educational and treatment needs of severely emotionally disturbed youth residing in a seven-county catchment area in Southern Kentucky. This requires an analysis of local need for such services, to include the identification of existing resources, the incidence of emotional disturbance among children, and areas of nonservice and underservice. The formulation of effective treatment modalities is contingent upon research pertaining to program planning and implementation, by way of literature review as well as through the direct survey of professionals responsible for services delivery. The result of these efforts is the development of a plan for the establishment of a comprehensive program which offers a complete range of services to emotionally disturbed children and their families.

Among the issues to be addressed are the creation of a parent-professional advocacy coalition, the development of a

network of regional diagnostic, support, and technical assistance services, and the establishment of a day treatment and residential facility.

In defining the scope of the program, the population to be served includes children from infancy to adulthood who can be categorized as experiencing some form of emotional disturbance. There exists a diversity of terms used to describe the groups targeted for treatment. Generalized labels, including childhood emotional disturbance, severe behavior disorders, emotionally handicapped, and behaviorally handicapped are examples of interchangable terms that have essentially the same meaning when applied to programming. In addition, a veriety of specific disorders are categorized in such a manner that leads to multiple interpretations depending upon the categorical referent and the orientation of the specialist. Autism and childhood schizophrenia, depressive neurosis and adjustment disorder with depressed mood are two examples of this. The intent of this project, however, is to focus less upon the categorization of specific disorders than the delivery of services to any child who is presently untreated or less than adequately served by existing programs.

The Joint Commission on Mental Health of Children (1970, p. 253) offers this definition of childhood emotional disturbance:

> An emotionally disturbed child is one whose progressive personality development is interfered with or arrested by a variety of factors so that he shows an

> impairment in the capacity expected of him for his age and endowment: (1) for reasonably accurate perception of the world around him; (2) for impulse control; (3) for satisfying and satisfactory relations with others; (4) for learning; or (5) any combination of these.

These five criteria of mental health are reflected in the Kentucky Administrative Regulations, 707 KAR 1:054 (1978, p. 27):

> Pupils shall be eligible for enrollment in a program for the emotionally disturbed (behavior disordered) who demonstrate one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance: (1) an inability to learn commensurate with the measured functioning ability because of emotional problems; (2) An inability to build or maintain satisfactory interpersonal relationships with peers and adults; (3) Inappropriate types of behavior under normal circumstances; (4) A general pervasive mood of unhappiness or depression; (5) A tendency to develop physical symptoms or fears associated with personal or school problems; (6) The term emotionally disturbed (behavior disordered) includes pupils who manifest symptoms characterized by diagnostic labels such as psychosis, schizophrenia, and autism. The term does not include pupils who are socially maladjusted, unless it is determined that they

are seriously emotionally disturbed.

This definition outlines the broadest parameters applicable to the individuals upon whom this paper is focused. Children meeting these criteria are presently eligible for special education services in the state of Kentucky, where such services are available.

An issue to be explored is whether children meeting the above criteria for enrollment in programs for the emotionally disturbed are receiving adequate services in the schools, and whether local communities have available the programs needed for effective treatment.

The area which is designated for research and program development activity is Warren County, Kentucky and its six surrounding counties: Edmonson, Allen, Simpson, Logan, Barren, and Butler. With the exception of Warren County, which is primarily urban, the area is 75.4% rural, with a population of 169,102. These counties cover a land area of 2,908 miles (Kentucky Desk Book of Economic Statistics, 1975), with Bowling Green in Warren County being the largest and most centrally located city. The county seats of the six surrounding counties are located within 18 to 34 miles from Bowling Green. These geographic factors make possible the research related to community needs and enhance the feasibility of program development and implementation.

Chapter II

Needs Assessment

The development of program strategies for community-based treatment of emotional disturbance in children necessitates research pertaining to the extent and degree of need for such services in the seven counties. Included among these research considerations are: a. the incidence of childhood emotional disturbance in the target area; b. the levels of services presently available to disturbed children; and c. the adequacy of these services and programs in terms of accessibility and appropriateness.

In approaching these issues, a multi-county needs assessment is necessary for the identification of existing and potential services recipients, and for an analysis of the adequacy of existing programs and resources in relation to comprehensive serivce delivery.

The methodology necessitated by this type of needs assessment consists of two major approaches. First, existing data is collected and analyzed. Information is obtained from local area development district libraries, state and local departments of government, community-based organizations, and educational resources at the local and state levels. A second approach involves direct contact with service providers at the local and

state levels. Interviews, on-site visitations, and other informal means of data collection are necessary components of local needs assessment (Robinson, Note 3).

In addressing the question of incidence of childhood emotional disturbance and concomitant treatment patterns in the seven counties, an immediate obstacle is found to be the inavailability of a unified system of documentation and recordkeeping. No single data source is maintained at the local or state levels. A survey of agencies and service providers found that many practitioners do not maintain service records that readily identify categories of clientele and/or services.

The resulting analysis of service delivery patterns in the target area is derived from a series of meetings and other personal communications with program administrators and direct services personnel working with emotionally disturbed children. The types of programs and numbers of services recipients represent the descriptions and estimates of the professionals interviewed. These individuals caution that, due to the changing nature of human services caseloads, the estimated number of service recipients is subject to variation. In addition, it was noted by the respondents that a portion of the clients served by agencies and professionals in Warren County travel from outlying counties for service.

Table 1 indicates the results of a survey of professionals and agencies serving the emotionally handicapped in the seven-county area. The table lists the types of services provided in each county, and the number of recipients, by program.

Table 1

Agencies and Professionals Serving Emotionally Handicapped Youth with Number of Recipients, by County

Service/ Recipients	Al	Ba	Bu	Ed	Lo	Si	Wa
Public School ED Unit	0	0	0	0	0	1	7
Recipients	-	-	-	-	-	11	53
BRMH-MR Children's Unit	1	1	1	1	1	1	1
Recipients	10	47	19	19	24	24	106
Day Treatment Program	0	0	0	0	0	0	1
Recipients	-	-	-	-	-	-	*
Head Start Classes	1	0	2	2	2	2	7
Recipients	-	-	-	-	-	-	-
Early Childhood Center	0	0	0	0	0	0	1
Recipients	-	-	-	-	-	-	**
Residential Programs	0	1	0	0	0	0	1
Recipients	-	Adult	-	-	-	-	***
Psychologists (Private)	0	0	0	0	0	0	3
Recipients	-	-	-	-	-	-	Unk
Psychiatrists (Private)	0	0	0	0	0	0	2
Recipients	-	-	-	-	-	-	Unk
WKU Psy. Clinic	0	0	0	0	0	0	1
Recipients	-	-	-	-	-	-	53

*Juvenile offenders

**No ED enrollees

***Mentally retarded-adult and children

Agencies serving emotionally disturbed children but not maintaining categorical records of service:

- -Crippled Children's Services
- -Bureau of Social Services
- -Public Health Departments (host of Bureau of Health Services Developmental Disabilities Clinics)

(Clark, Note 4; Honeycutt, Note 5; Hughes, Note 6; Cook, Note 7; Cline, Note 8; McClain, Note 9; Cashman, Note 10; Oldham, Note 11; Walker, Note 12; Murphy, Note 13; Armstrong, Note 14; Robe, Note 15; Hill, Note 16; Pash, Note 17; Hunt, Note 18)

Comprehensive program information related to childhood emotional disturbance is maintained by the Barren River Mental Health-Mental Retardation Board. This agency serves the seven targeted counties, with a total service area of ten counties. The agency's records are maintained as a part of a computerized management information system. Children's Unit activity documentation indicates that the agency serves the largest number of emotionally disturbed children when compared to the area's other human services organizations (Walker, Note 12). Table 2 illustrates the level of child mental health service activity in the seven counties.

Table 2

Barren River Mental Health-Mental Retardation Board
Children's Unit Caseload from April to November, 1980
(Seven-County Service Area)

County	Active Cases	Closed Cases	Total	% Eligible for Title 19-20 Reimbursement (Low Income)	% Insurance/ Self-Paid (High Income)
Allen	8	2	10	90%	10%
Barren	14	33	47	68%	32%
Butler	7	12	19	79%	21%
Edmonson	5	14	19	89%	11%
Logan	8	16	24	92%	8%
Simpson	10	14	24	75%	25%
Warren	39	67	106	59%	41%
TOTAL	91	158	249		

(Smith, Note 19)

Table 2 also provides an indication of the economic characteristics of the target population. The percentage of clients receiving third party reimbursement from Title 19 (Medicaid) and Title 20 (of the Social Security Act) ranges from 59% to 92% in the seven counties. To be eligible for Title 19 and Title 20 payment of treatment costs, clients must meet federal income eligibility criteria. The overall poverty rate for the seven counties was 24.9% during 1978, (Kentucky Desk Book of Economic Statistics, 1978), with a median family income of $8,740 in 1976 (H.U.D., 1977).

The only available records pertaining to the incidence of emotional disturbance in children by categorical diagnosis are provided by the Barren River Mental Health-Mental Retardation Board. Table 3 represents a county-by-county breakdown of the DMS III diagnostic categories and their frequency among active cases. Data pertaining to cases that were closed within the past seven months were not available. (Smith, Note 19).

Tables 1, 2, and 3 indicate a greater number of children identified as needing special mental health services than slots presently available in ED classrooms in the public schools. It is true that an unknown percentage of these cases may be of a transient nature or may not require the delivery of special services in the schools. However, as one Director of Pupil Personnel observed, even those public schools that receive funding for ED classrooms find many students to be unmanageable (Oldham, Note 11).

Table 3

Barren River Mental Health-Mental Retardation Board Incidence of Treatment (Active Cases) by DSM III - Categories: Children's Unit, Age 2-18, April to November, 1980

DSM III DIAGNOSTIC CATEGORIES (PRIMARY DIAGNOSIS)	Al		Ba		Bu		Ed		Lo		Si		Wa		Total	
	AXIS		AXIS		AXIS		AXIS		AXIS		AXIS		AXIS		AXIS	
	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
317.00-318.20 Mental Retardation	2	0	1	0	1	0	1	0	0	0	1	0	1	0	7	0
312.00 Conduct Disorder/Undersocialized Aggressive	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
312.10 Conduct Disorder/Undersocialized Nonaggress	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
312.23 Conduct Disorder/Socialized Aggressive	0	0	0	0	0	0	1	0	0	0	0	0	1	0	2	0
312.21 Conduct Disorder/Socialized Nonaggressive	2	0	0	0	1	0	0	0	2	0	0	0	2	0	7	0
312.90 Atypical Conduct Disorder	0	0	0	0	0	0	1	0	0	0	0	0	1	0	2	0
309.21 Separation Anxiety Disorder	0	0	1	0	0	0	1	0	0	0	0	0	1	0	3	0
313.21 Avoidant Disorder Childhood/Adolescence	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
313.81 Oppositional Disorder	0	0	0	0	2	0	0	0	2	0	1	0	6	0	11	0
317.10 Anorexia Nervosa	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
299.00 Infantile Autism	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
305.22 Cannibis Abuse-Episodic	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
305.03 Alcohol Abuse in Remission	0	0	0	0	1	0	0	0	0	0	0	0	1	0	2	0
259.92 Schizophrenia/Chronic Undifferentiated	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
295.90 Schizophrenia/Undifferentiated	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
295.40 Schizophreniform Disorder	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
298.90 Atypical Psychosis	0	0	0	0	0	0	0	0	0	0	1	0	1	0	2	0
300.02 Generalized Anxiety Disorder	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
309.00 Adjustment Disorder with Depressed Mood	0	0	0	0	0	0	0	0	1	0	0	0	2	0	3	0
309.28 Adjustment Disorder w/ Mix Emotion Features	0	0	2	0	0	0	0	0	0	0	0	0	2	0	4	0
309.30 Adjustment Disorder w/ Disturbed Conduct	0	0	1	0	1	0	0	0	0	0	0	0	2	0	4	0
309.40 Adj. Dis. w/ Mixed Disturbance of Emotion/Cndct	0	0	2	0	0	0	0	0	0	0	0	0	6	0	8	0
309.23 Adj. Disorder w/ Academic Inhibition	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2	0
300.11 Conversion Disorder	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
300.30 Obsessive Compulsive Disorder	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
301.50 Histrionic Personality Disorder	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
662.89 Phase of life or other life circumstance Prob.	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
799.90 Diagnosis Deferred	0	0	0	0	1	1	0	0	1	1	0	0	4	0	8	2
661.20 Parent-Child Problem	0	0	0	0	0	0	0	0	1	0	1	0	3	0	5	0
671.02 Childhood Anti-Social Behavior	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
301.83 Borderline Personality Disorder	0	2	0	2	0	0	0	0	0	1	1	0	0	0	1	5
314.01 Attention Deficit Disorder w/ Hyperactivity	0	0	0	0	0	0	0	0	0	0	1	0	1	0	2	0
301.82 Avoidant Personality Disorder	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
671.09 No Diagnosis or Condition on Axis 2	0	5	0	12	0	5	0	5	0	6	0	10	0	37	0	80
671.02 Childhood or Adolescence Anti-Soc Behavior	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
300.40 Dysthymic Disorder	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
309.24 Adjustment Disorder w/ Anxious Mood	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
315.00 Developmental Reading Disorder	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0
307.80 Psychogenic Pain Disorder	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
301.20 Schizoid Personality Disorder	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
301.84 Passive Aggressive Personality Disorder	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TOTAL:	8	8	14	14	7	7	5	5	8	8	10	10	39	39	91	91

(Smith, Note 19)

Administrators from the public school systems having no E.D. units express concern that not enough is being done to appropriately diagnose and treat those students with emotional disturbance. "Frankly, we do not know how to serve these children, and several have severe problems. We can surely use some help." (McClain, Note 9). "We are simply not equipped or trained to work with these students. Some are in the regular classroom, and some receive homebound instruction. We can certainly use some help with these kids." (Cook, Note 7).

When the Joint Commission on Mental Health of Children's estimates of the incidence of emotional disorders are considered, the projected number of unserved children becomes even greater: "It is estimated that about .6 percent are psychotic and that another two to three percent are severely disturbed. It is further estimated that an additional eight to ten percent of our young people are afflicted with emotional problems (neuroses and the like) and are in need of specialized spervices; however, only about five to seven percent of the children needing mental health care are getting it...the present dearth of mental health services will become more acute in the immediate future." (Joint Commission on Mental Health of Children, 1970, pp. 253-254).

Table 4 uses the estimates of the Joint Commission on Mental Health of Children to illustrate the gaps in local service delivery when compared to national estimates of the incidence of childhood emotional disturbance.

Table 4

Comparison of the Joint Commission on Mental Health of Children's Estimates of the Incidence of Emotional Disturbance with Local Treatment Activity

County	Pop. Age 2-18	Est. # Psychotic Children	Est. # Severely Disturbed	Estimated # Requiring Spec. Service	# Active Cases BRMH-MR	# ED Served by Public Schools
Al	3,071	18	61 - 92	246 - 307	8	0
Ba	7,720	46	154 - 231	618 - 777	14	0
Bu	2,597	16	52 - 78	208 - 260	7	0
Ed	2,471	15	49 - 74	198 - 247	5	0
Lo	5,528	33	111 - 166	442 - 553	8	0
Si	3,782	23	76 - 113	303 - 378	10	11
Wa	17,413	104	348 - 522	1,393 - 1,741	39	53
Total	42,582	255	851 -1,276	2,408 - 4,263	91	64

(Joint Commission on Mental Health of Children, 1970)
(Smith, Note 19)

It is not possible from these comparisons to precisely identify the number of untreated or inadequately treated emotionally disturbed children of the seven county area. This data does point to the need for accelerated child find and program development activity in the field of children's services. The community needs assessment makes apparent the fact that outpatient mental health services are available to children and

that programming for emotional disturbance is offered by the public schools on an extremely limited basis. A comprehensive system of service delivery to emotionally disturbed children is not presently operational. As a beginning effort toward the remediation of this deficiency, a review of the causes and treatment of childhood emotional disturbance as well as the methods for program planning and development are to be explored in the ensuing chapters.

Chapter III

Review of the Literature: Etiology

The literature in the area of child psychopathology reflects the diversity of assumptions concerning causes for emotional disorders in children. The issues of etiology typically serve as bases for the espousal of specific theoretical perspectives, and reflect the theoretical orientation of the specialist. The categories and classifications of etiological factors are equally diverse, although many discussions of etiology fall within the broad parameters of two classes: organic (neurophysiological, biochemical, genetic, intrapsychic); and psychogenetic (environmental, sociocultural, psychological, situational, etc.).

Baker (1976) describes childhood psychosis as a complex reaction to a variety of factors in a developing personality and cites constitutional factors, the effects of physical disease and injury, and environmental factors as three areas of etiological significance. Duffy (1979, p. 197) describes disorders symtomatic of organic disturbances and those ordinarily considered as functional, outlining the following etiological factors in childhood psychosis:

Organic disorders.

1. Inherited predisposition to schizophrenic illness;

2. Infection, including meningitis, encephalitis; 3. Head injury; 4. Tumors, including epiloia; 5. Degenerations, including epiloia; 6. Vascular accidents; 7. Growth anamalies, Klinefelters, etc.; 8. Poisons, including drugs.

Emotional stress.

1. Disturbed parental attitudes or relationships; 2. Sibling rivalry; 3. Separations; 4. Feeding difficulties; 5. Severe physical desease in early life; 6. Sensory privation, blindness or deafness; 7. Exposure to sudden shock or terror.

Millon (1967) suggests that the organic and psychogenic causes for childhood emotional disturbance be classified into four areas: Biophysical (incorporating the theories of Blueler, Sheldon, Meehl, and others); Intrapsychic (Freud, Erickson, Horney, Jung); Behavioral (Skinner, Eyesenck, Dollard, Bandura); and Phenomenonological (Rogers, May, Maslow).

Organic Factors

Genetic factors are often the first included in discussion of etiology within the human organism. According to Chess (1969), in few cases can genetic factors be directly attributed as the cause for behavioral aberration. Phenylketonuria, a metobolic disorder which may manifest itself in psychotic behavior and/or mental retardation, Down's syndrome, a chromosomal defect affecting intellectual and physical development, and other syndromes (Turner's,

Klinefelter's) are among the few conditions believed to be genetically transmitted. Research designed to establish genetic or metabolic linkages to schizophrenia has been generally nonconclusive, Chess asserts. However, Hurst (1972) reports that Kallman and Roth contend that children who show schizophrenic changes at an early age are distinguished by a specific vulnerability factor in the enzymatic range, in addition to a general constitutional inability or lowered ability to compensate for this basic deficiency in the process of growth and maturation.

Hurst's (1972) review of genetic studies relevant to infant, childhood and adolescent psychiatric disorders found numerous genetic links. Psychoneurosis, personality disorders, mental subnormality, epilepsy, schizophrenia, early infantile autism, manic-depressive, psychosis, neurological conditions, congenital malformations, and severe communication handicaps were all in some way linked to a genetic abnormality, predisposition, or vulnerability factor leading to the onset of behavioral/functional disturbances. Hurst cites Eyesenck's use of factorial analysis in the study of monozygotic and dizygotic twins, where the "neurotic personality factor" was classified as a biological and largely gene-specific entity which contributed to the predisposition to neuroticism.

Hurst (1972) also refers to Rimland's argument that there is a genetic base for early infantile autism which differs significantly from schizophrenia, noting that those

who attempt to equate early infantile autism with schizophrenia find a lack of overt schizophrenia in the parents and families of autistic children.

Prenatal medical factors related to behavioral dysfunctioning include congenital rubella, drug addiction, the use of LSD, and maternal stress (Chess and Hassibi, 1978). Schechter (1972) refers to Masland's delineation of prenatal influences indicative of later childhood psychosis, to include: maternal age (over 40), parity beyond four pregnancies, maternal nutrition, pregnancy complications (toxemia, endocrine dysfunctioning), environmental factors (x-rays, drugs, toxins), and maternal emotional state.

Perinatal factors of an organic nature have been identified by Schechter (1972) as including severe jaundice which can lead to Kernicterus accompanied by severe mental retardation unless transfusions of Rh positive blood are administered and anoxic conditions leading to neurological and behavioral conditions.

Postnatal factors associated with emotional disturbance are hyperbilirubenemia in premature infants, central nervous system infections with meningitis and meningencephalitis, birth trauma, and malnutrition within the first 72 hours of life (Chess and Hassibi, 1978). Schechter (1972) found that disturbed behavior increased where there was a history of severe complications of pregnancy and/or delivery. Of special importance was prematurity, or low birth weight.

Drellen studied 112 children whose birth weight was three pounds or less and found that 70% exhibited some form of behavioral disturbance, with hyperactivity and distractibility as the most frequent problems (Schecther, 1972).

Werry (Quay, Werry, 1972) reports on organic factors in childhood psychopathology, to include the subjects of brain damage (particularly linked to specific conditions such as the hyperkinetic syndrome), childhood psychosis (where the organic component of etiology has less than unequivocal empirical support), and conduct disorders. One conclusion made by Werry is that, on the basis of present evidence, organic factors are simply one of several variables that react in a complex multivariate fashion in determining personality and behavior.

Psychogenic Factors

According to Knopf (1979), psychogenic models focus upon external variables rather than searching for causal factors within the organism. Determinants of abnormal behavior are cultural and social systems as they relate to emotional adjustment and development. Learning models suggest that abnormal behaviors are a product of learning and are modifiable through the appropriate application of learning principals, as advocated by Skinner, Rotter, Bandura, and others. Humanistic models emphasize experience and an individual's reaction both to self and the external world as essential determinants of behavior. The theories of Maslow and Rogers fall within the broad area of humanism.

There are syndromes in which the balance of etiologic forces seem to be on the situational side, according to Beiser (1972). War neurosis is an extreme example. Beiser cites examples of processes which show a relationship to, but not necessarily causality of, emotional disorders. Developmental processes (relating to early experiences) and functional processes contribute to the interaction of various forces which are associated with the development of symptoms. Beiser cites patternless discipline, migration, death and bereavement, deprivation, poor sex-role models, and sociocultural disintegration as situations significant to these processes.

Hetherington (1972) reports that the effects of family interaction on psychological development can be intense, particularly in cases of maternal absence, institutionalization, parental punitiveness, neglect, and extreme restrictiveness or permissiveness. Hetherington reports that parents of children referred to mental health clinics produced more deviant MMPI's than parents of a control group requiring no clinic services.

Werry (1972) makes four major conclusions which serve as a summary of the broadest sets of thinking regarding etiology in childhood psychosis.

1. The only common core in defining childhood psychosis that can be agreed upon by clinicians is the dimension of severity. Beyond this criterion, there is no uniform consensus of opinion in defining what exactly comprises

childhood psychosis.

2. Studies of etiology will not have much significance until the problem of classification is solved. Concepts of etiology generally fall into two classes: organic and psychogenic. There exists strong but largely circumstantial evidence of organic causes in the form of abnormal birth histories, associated neurological and physical abnormalities, a preponderance of males and severe cognitive abnormalities. Werry describes this avidence as credible but incomplete. Psychogenic evidence is for the most part poor and obtained from inadequate investigation.

3. There is little evidence that any specific treatment approach has lasting effectiveness in the treatment of childhood disturbances. Behavioral approaches have come closest to matching clinical effort and theorizing with outcome and process evaluations. However, these attempts have produced limited success, and are narrow in scope.

4. The outcome of treatment for most psychotic children is typically poor, with less than one-third capable of independent living. The best single predictor of final self-sufficiency is the level of intellectual functioning at the time of initial treatment.

Review of the Literature: Treatment Programming

As can be gathered by the preceding paragraphs, the issues of etiology in childhood emotional disturbance remain the subject of considerable debate and continued research. For educators and mental health practitioners in a given community, the task of treating and teaching the emotionally handicapped child is more likely to produce the question, "How do we serve these children?", than "What are the causes of childhood emotional disturbance?"

The emergence of Public Law 94-142 came at the time when these specialists were confronted with sobering research findings that questioned the efficacy of traditional psychotherapeutic efforts. Levitt's (1971) review of psychotherapy with children found that, in 35 studies, two-thirds of the children treated for emotional disturbance exhibited improvement at the close of treatment, and three-fourths showed gains when follow-up studies were conducted. Control groups of children receiving no treatment were found to have gained no less than the groups provided psychotherapy. These findings supported the conclusions of Hans Eyesenck, as quoted by Levitt (1971, p. 225): "Roughly two-thirds of a group of neurotic patients will recover or improve to a marked

extent within about two years of the onset of their illness, whether they are treated by means of psychotherapy or not." A follow-up to Levitt's study conducted by J. Hood-Williams (1971) resulted in a similar conclusion, i.e., there is little to support that psychotherapy with neurotic children is effective. Woody (1969) and Stephens (1970) concur, describing conventional modalities of treatment as being either counterproductive or producing minimal results. This evidence, coupled with the mandate to serve emotionally disturbed children in the schools, leads many community-based organizations to explore the numerous theoretical models that might be adopted to meet local needs. As Rhodes and Gibbins (Quay and Werry, 1972, p. 349) note, "The program planner must soon come to grips with the fact that within the scientific fraternity there is conflicting data and sometimes strong disagreement over what constitutes psychopathology and how it is to be construed and managed...the theoretical model that prevails in a particular locale at a particular time and the kinds of derived organizational structures and facilities that are dominating in that locale at a particular period of time will set the dimensions, directions, and limits of program actions and program development."

Those practitioners who elect to search the literature in lieu of succumbing to the factors noted by Rhodes and Gibbins (1972) find a diversity of categorical treatment models. Bommarito (1977) outlines four major theoretical

models: Psychodynamic, psychoeducational, neurological, and behavioral. Rhodes and Gibbins describe four models that show similar categorization: psychodynamic, biophysical or biogenetic, behavioral or learning theory, and sociological or ecological.

Morse, Cutler, and Fink (1974) identify seven operational models for teaching emotionally disturbed children. Four demonstrate the application of systematic prccesses and theoretical principles to day-to-day program operations. These include: psychiatric dynamic; psychoeducational; pyschological behavioral; and educational program types. Naturalistic, primitive, and chaotic operational models represent program types which rely upon immediate solutions to problem behaviors and have no observable referent to organized systems or theory. No easily definable teaching or treatment patterns are recognized in the latter three program types.

Long (1971) conceptualizes five teaching models, as follows: the psychoeducational model, which uses knowledge from the study of human growth and development, group dynamics, mental health, and tests and measurement, with the belief that the teacher is the basis of behavioral change in the child; the behavior modification model, which employs the use of learning theory, and views the teacher as learning specialist rather than therapist; the educational model, which emphasizes success experiences in the classroom, with teachers providing self-concept enhancement; the behavioral

science model, which is based upon theories and methods from clinical, social, experimental and educational psychology, sociology, and anthropology, and which views teachers as integrators of theories and approaches; and the social competence model, where the child is an inseparable part of an ecological unit consisting of family, neighborhood, school, and community. Teachers modify both the student and the ecological system until a balance of demands is achieved.

The literature teems with descriptions of a variety of program designs which incorporate or combine elements of the various models. Most attempt to integrate education and mental health services in order to close the gap described by Larson (1978). The majority of those reported in the literature are programs that receive at least a part of their funding from federal grants in collaboration with local and state education agencies.

Of programs surveyed in the literature, the vast majority use separate classrooms or facilities, as apposed to "mainstreaming" severely disturbed enrollees with non-handicapped students. Vaac (1968) found that emotionally disturbed students performed better on the WRAT and the Behavior Rating Scale and were significantly more accepted among classmates when placed in Emotionally Disturbed special classrooms.

Of those programs represented in the literature, a large number utilize a multidisciplinary approach to educational and treatment planning. Northcutt and Tipton (1978) describe the effectiveness of a community-based multidisciplinary team

consisting of psychiatrists, psychologists, psychiatric nurses, social workers, occupational therapists, mental health workers, and special education teachers. Zaslaw (1977) advocates the use of multidisciplinary teams for treatment as well as for community outreach. But, as the Joint Commission on Mental Health of Children (1970, p. 293) reports, "very little systematic research has been devoted to evaluating the effectiveness of the various treatment theories and methods....and strategies." Bardon and Bennett (1972) note that the difficulties in substantiating claims of program effectiveness are compounded by the immense difficulties in identifying and measuring positive change in the behavior of children.

Harth (1971) offers the viewpoint that no single type of program will readily meet the needs of emotionally disturbed children. Rather, a variety of techniques and procedures must be developed in order to provide a full range of services thus necessitating the involvement of all local resources. "We will need people to go into the community and mobilize the positive forces to help the child." (Harth, 1971, p. 656)

Rhodes and Gibbins note that specific approaches and techniques are less important to the overall effectiveness of treatment programs than their ability to activate the positive involvement of the community systems which directly or indirectly govern them. "The time has come for us to have a better grasp of this total community process and the meaning it has for our activities. We can no longer think in terms of

small, specialized programs, in individual facilities or settings for children. We must look at the way in which children are caught up in deviance dynamics of communities and the way in which the 'service' complex must be altered." (Rhodes and Gibbins, 1972, p. 380)

In review of the literature, there can be found several examples of the successful mobilization and utilization of community systems to the benefit of emotionally handicapped children. Nichtern, Donahue, O'Shea, et al. (1971) describe a community educational program for the emotionally disturbed child. Residents of Elmont, New York, have integrated the efforts of the public and private sectors in a total community move to serve its severely emotionally handicapped youth. Planning groups established the goals of individualized training with final reintroduction to the regular classroom. Within a short time, the local Jewish Community Center offered classroom space, the Kiwannis Club pledged financial support, the local mental health center provided a part-time psychiatric director, the Board of Education offered the services of teachers, the school psychologist and school physician, and agreed to transport enrollees. There was a high response from volunteers, resulting in a totally individualized treatment setting as well as the provision of music therapy. As a result of these efforts, 50% of the original enrollees returned to the regular classroom after one and a half years, and the remaining 50% were in the process of being transitioned.

Larson (1978) describes the years of "painful struggle"

that have resulted in the establishment of an ongoing and effective relationship among schools, community mental health, and other agencies in Fairfax County, Virginia. Once program control-the single most destructive obstacle to successful implementation-was overcome and cooperative planning initiated, a cost effective and comprehensive program of multidisciplinary services emerged.

In Oregon, a region of the state which was large in area and diverse in terms of sociocultural groupings, town size, and access to mental health services, developed an effective multidisciplinary treatment program for emotionally disturbed children. Cherry (1976) describes how community-based social welfare, child care, university, psychological, and medical organizations collaborated in the provision of comprehensive services to children and their families. The variables viewed as critical for the success of such programming are described by Cherry as centering around the combination of three concepts: (1) family-child-community orientation; (2) interdisciplinary approach; and (3) community ownership.

These three examples of interdisciplinary community-based programming represent but a small sampling of the numerous successful programs cited in the literature. They were selected for mention because of their applicability to the problems of the seven Kentucky counties addressed by this paper. These programs, and other similar programs, have demonstrated the effectiveness of interagency cooperation in the provision of treatment services for emotionally disturbed children.

This documentation of feasibility and potential facilitates the exploration of specific strategies for program planning and implementation at the local level.

Chapter IV

Program Design

The establishment of a community based treatment program for emotionally disturbed youth in a multi-county area requires consideration of the experiences and observations of those specialists reporting in the literature. Although the needs of specific communities may vary, the conclusions made by those who analyze the successes and failures of programs for the emotionally disturbed represent a starting point for the local program planner. Another necessary component of successful program implementation is the interest and cooperation of the administrators and direct service providers of those community-based organizations to be involved in joint programming.

The needs assessment section of this paper reflects the potential for effective program planning and implementation. When interviewed, the representatives of each community-based organization, without exception, affirmed both the need for and the intent to become involved in a collaborative community effort to serve the emotionally handicapped child in a comprehensive treatment setting.

The design for this proposed multidisciplinary, community-based treatment program is derived from a diversity of sources. The review of the literature produced information pertaining

to history, etiology, legal issues, research, theory, programming, and other prominent issues related to the area of childhood emotional disturbance. During the 1½ year needs asssessment and general research phase of this project, practitioners, program developers, and program administrators in Kentucky, Minnesota, Alabama, and Georgia were asked to comment about their child treatment programs and to make recommendations regarding the establishment of a new program. And finally, considerations for program design are the result of the writer's observations and experiences during 4½ years spent in the target area as a direct services provider, regional program administrator, and regional program planner in the field of human services. Although brief, these years of participation in community mental health, vocational rehabilitation, preschool mental health and handicap services, and anti-poverty programming have assisted the writer in the application of theory and research findings to the pragmatic tasks of program development.

Programmatic Milestones

The establishment of a comprehensive, regional approach to services for emotionally disturbed youth in an area where children are heretofore unserved and underserved requires that a series of steps be initiated and carried out over an extended period of time. The complete remediation of gaps in programming requires long-range planning and cooperative efforts on the part of those involved. Major milestones in this movement are as follows:

Milestone 1: Parent Advocacy.

The first phase of program development is the activation and mobilization of an advocacy group composed of the parents of emotionally disturbed children. This type of organization has the advantage of first-hand knowledge of the problems and needs of the emotionally disturbed, coupled with familiarity with the political and social dynamics of the local communities. For increased effectiveness, the parent group formed under the sponsorship of a professional organization familiar with the spectrum of services available for the emotionally handicapped has the added advantage of professional consultation and coordination.

There presently exists in the target area a community-based volunteer organization known as the Barren River Child Protection Committee. This committee administers the Parent Aid Program, Parents Without Partners, the Wee Care Center for developmentally disabled and other children needing temporary day care, and a spouse abuse center. Composed of community mental health, social services, public health, university, child care, legal aid, parent aid, and private sector professionals, this organization holds potential for serving as sponsor for the parent advocacy group (Lopez, Note 20).

Included among the goals of this parent-professional coalition are the increased community awareness of the unique needs of emotionally disturbed children, the establishment of a base of mutual interest and support, a unified approach to advocacy efforts, and the mobilization of local

and state resources for the purpose of institutional change at these levels.

Milestone 2: Resource Mobilization - Area-wide ED Classrooms and Educational Support Network.

One consequence of the successful organization of the parent advocacy group in cooperation with the Barren River Child Protection Committee is the actualization of a second milestone in program development for the emotionally disturbed children of the seven counties. This second phase is the creation of classrooms for emotionally disturbed children with the support of a regional diagnostic and treatment support system.

Planning and needs assessment. The accomplishment of this objective is contingent upon successful planning and needs assessment conducted by the parent and professional organizations. The first step in this process is data collection which identifies the incidence of emotional disturbance among children in the targeted counties, the present levels of services available, and projected needs for classroom units and special services for the emotionally disturbed. This activity, when conducted in cooperation with local board of education representatives, results in the justification for the addition of classroom units for the emotionally disturbed in those school systems needing ED units.

Prior to the submission of a formal request to the Kentucky Department of Education for special classroom funding, the parent-professional group conducts additional planning

for the purpose of conceptualizing a comprehensive, workable network of support to families and schools. Activities include the development of a systematic plan for diagnostic evaluation, educational support to teachers and other direct services providers in the schools, and training and technical assistance to administrators charged with implementing special services to emotionally disturbed enrollees. Funds to support the efforts of this proposal are available through demonstration grants from the Kentucky Department of Educations's Bureau of Education for Exceptional Children (Kentucky Department of Education, 1980) or through separate county board of education contracts with the state using Title VI-B funds (Oldham, Note 11).

Consortium of services: organization. Following the submission and approval of proposals for the establishment of local ED units and the regional educational support network is the organization of a formal consortium of services from which school systems are able to draw as needs arise.

The organizational structure of this consortium consists of a Governing Board, program director, and direct services personnel working in collaboration with local educational and human services agencies. This organization would achieve legal status with the completion of articles for incorporation designating it as the Southern Kentucky Child Evaluation and Treatment Program (SKCETP).

The Governing Board for the SKCETP is composed of directors of pupil personnel from participating boards of education,

parents of emotionally handicapped children, locally elected officials, university representatives, private practitioners, agency personnel, and representatives of the private sector. The Governing Board is responsible for serving as the grantee and fiscal manager for funds received for the program, for the development of program policies and procedures, for ensuring that the conditions of the funding source are fulfilled and that program operations are in compliance with all applicable mandates and directives. The Governing Board is also responsible for conducting monthly meetings for the purpose of program monitoring and decision making.

The director is supervised by the Governing Board and is responsible for the coordination of program activities to ensure the involvement of local school personnel, various departments of Western Kentucky University (Psychology, Social Work, Special Education, Home Economics and Family Living, Counselor Education, Theatre and Communications), local agencies (Barren River Mental Health-Mental Retardation Board, Bureau for Social Services, Crippled Children's Commission, Special Early Childhood Training Center, Head Start, Bureau for Rehabilitation Services, Public Health Departments), and private service providers (physicians, psychologists, psychiatrists). The director serves as the coordinator of the three components of program operations which include multidisciplinary diagnostic evaluation, educational support services to the schools, and administrative training and technical assistance to local boards of education.

Diagnostic evaluation. The multidisciplinary diagnostic evaluation component consists of a team of professionals similar to the University of Louisville's Child Evaluation Center's mobile diagnostic team which conducted its activities through Kentucky's local health departments' Developmental Disabilities Clinics prior to 1980. This operation lost its funding in 1980, leaving all Child Evaluation Center diagnostic activity to be carried out at the organization's Louisville offices (Hunt, Note 18).

The SKCETP's diagnostic team consists of a clinical child psychologist, a school psychologist with clinical training, and a social worker. These professionals, along with a clerical worker, are employees of the SKCETP. Other members of the diagnostic team may include psychiatrists, pediatricians, neurologists, or other specialists under contractual agreements with the program. When appropriate, diagnostic services are obtained from school and local mental health professionals, according to need and the availability of these services.

The end product of the multidisciplinary diagnostic team effort is a comprehensive report of intellectual, psychosocial, medical, and psychological functioning to be used as documentation for appropriate school placement, along with recommendations for the provision of special services for individual enrollees.

An advantage of this approach is the fact that diagnostic team members are able to travel to the various school districts,

allowing children to receive comprehensive evaluations in their home community, reducing the burden of travel for families and schools.

Educational support network. The second component of the Southern Kentucky Child Diagnostic and Treatment Program is the educational support system to the schools. In this component area, the clinical child psychologist and school psychologist arrange with each participating school system the provision of ancillary services to the special education program for emotionally disturbed students. Activities include participation in Admissions and Release Committee and IEP meetings, periodic staffings to identify problem areas and to assess individual student needs as they emerge, routine classroom visitations to provide direct services to students, and meetings with teachers and teacher aides to provide consultation and technical assistance on an ongoing basis. The social worker assists the schools by augmenting the services of counselors and other personnel and by serving as a liaison between parents and the schools.

Training and technical assistance. The third component of the SKCETP involves the provision of training and technical assistance to school superintendents, directors of pupil personnel, and other administrative staff. The program director, being familiar with federal and state requirements for the establishment and maintenance of ED units, is the primary resource of this component. The program director is responsible for the coordination of services provided by the

SKCETP and other agencies to facilitate the cooperative efforts of the schools and outside resources. Other activities include inservice training for school personnel, materials development, administrative consultation in the area of special services to emotionally handicapped children, and ongoing information dissemination.

The total cost of operations for this service network is within the $100,000 limitation for special projects as defined by the Kentucky Bureau of Education for Exceptional Children (Kentucky Department of Education, 1980). The impact of such a program is the reversal of past trends of non-service and underservice of emotionally disturbed children in the seven county service area.

Milestone 3: Facilities and Program Expansion.

The final phase of program development is the advancement and expansion of the SKCETP to include preschool services and the establishment of a facility for residential and day care for the severely emotionally handicapped.

Preschool programs. Services for emotionally disturbed infants and preschoolers are developed using the needs assessment and program planning strategies delineated earlier in this paper. Funds for the operation of preschool programs are obtained from a variety of state, federal, and private sector resources, including Social Security Act Title XX funds available from the Kentucky Department of Human Resources (Armstrong, Note 14).

Joint programming with existing agencies such as the

Special Early Childhood Training Center and Head Start represents one approach to serving emotionally handicapped infants and preschoolers. The Southern Kentucky Head Start Program serves children ages three to five and has a Special Services component for the provision of limited services to the severely emotionally disturbed (Murphy, Note 13). The Special Early Childhood Training Center provides infant stimulation to developmentally disabled infants three years of age and under (Armstrong, Note 14).

The SKCETP provides services to augment the activities conducted by these two programs by expanding its professional staff to include a specialist in early childhood development. The three components of diagnostic evaluation, educational support, and training and technical assistance continue with activities similar to those carried out in the public schools. The establishment of a facility for day treatment makes possible the creation of a preschool unit contiguous to the program for school age children.

Regional facility. The achievement of securing a centrally located facility for use as a regional child evaluation and treatment center makes possible the provision of the total spectrum of special services for the emotionally disturbed youth of the area. A facility of this type serves the most severely disturbed children for whom the least restrictive educational environment is a special education program in a milieu conducive to intensive psychotherapy and behavioral intervention. The facility makes available the provision of

day treatment, extended diagnostic evaluation, respite care, and residential services, in addition to the core services of evaluation, support, and technical assistance.

Funding for a residential and day treatment center is possible through federal construction grants, local revenue sharing, local fund raising, county bond issues, ad valorem taxes (a levy on local property), and area development district funds composed of coal severance taxes redistributed through Kentucky's counties (Wright, Note 21).

The most feasible location for a comprehensive services facility is Bowling Green, by merit of its central location, its proximity to existing service providers, and the large proportion of the target population residing in Warren County. In Bowling Green, there are several sites to be considered for use as a child evaluation and treatment center in the event that construction funds are unavailable. There is a publicly-owned hospital which is presently vacant, a tuberculosis hospital converted to a mental health center in a location where expansion is feasible, a partially occupied school building, and several large privately owned residences suitable for conversion.

The design for services provided through the facility, hereafter designated at the Southern Kentucky Child Evaluation and Treatment Center (SKCETC), consists of two related areas: day treatment and residential programming.

Day Treatment Program

The day treatment program is an accredited public school

program, offering the same services as are available in other educational facilities in the state of Kentucky, with those additions and modifications necessitated by the special needs of its enrollees. The school program is characterized by highly structured daily scheduling, individualized cirricula, and intensified parent training and involvement efforts, in addition to psychotherapeutic activities for enrollees. Pupils are referred to this program by the schools, local agencies, and private practitioners.

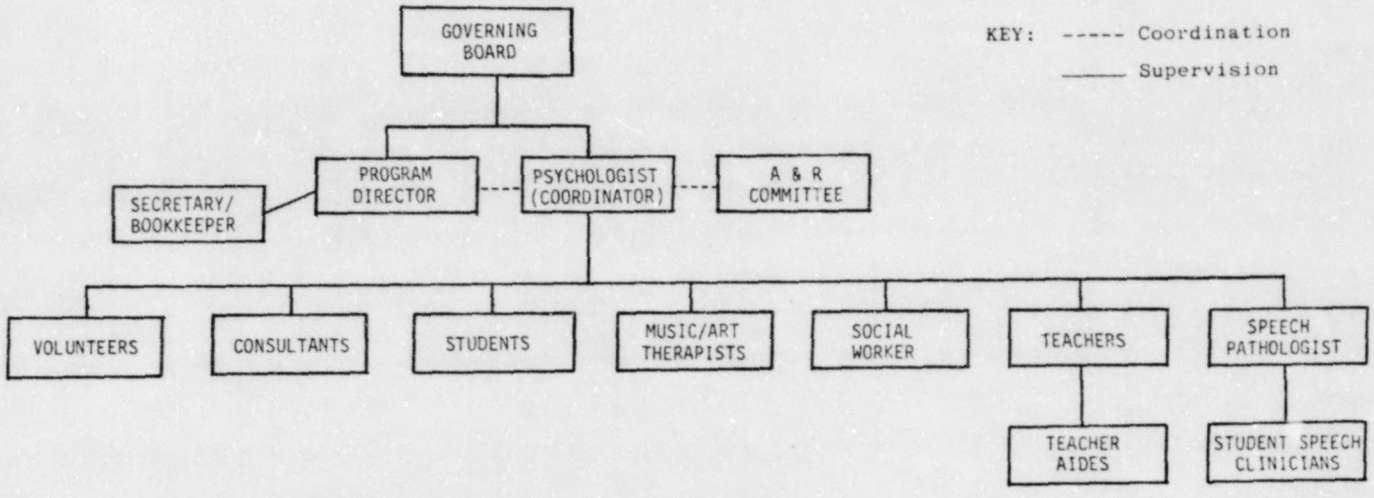
The activities and procedures related to staffing, selection and enrollment, Admissions and Release Committees, parent involvement, interagency coordination, and placement and follow-up reflect the day treatment program's efforts toward compliance with state and federal mandates regarding the education of exceptional children, while providing other services which extend beyond those required by law.

Staffing Pattern

The Governing Board is responsible for the recruitment and selection of key personnel (program director and staff psychologist). Other staff positions are filled by the appropriate supervisor. Funds for the employment of treatment center staff are available through federal or state staffing grants, contracts with local boards of education, joint agreements with community-based organizations, or other resources. Figure 1 illustrates the proposed staffing pattern and applicable lines of authority and coordination.

Figure 1

Staffing Pattern for SKCETC Day Treatment Program



Program Director

Qualifications: MA in Psychology, Special Education, or related field. Three to five years of administrative experience are required.

Responsibilities: The director is responsible for managing the administrative component of the program and for integrating the program into the larger network of university and community efforts to serve the emotionally handicapped. The director is accountable for the fiscal management of the program in accordance with the directives mandated by the university and funding sources. Additional responsibilities include staff supervision, documentation of program efforts and progress, location of additional funding sources, and coordination of program activities.

Staff Psychologist

Qualifications: Doctorate in Clinical or School Psychology

with three to five years experience in an educational setting. The psychologist must be licensed to practice in the state of Kentucky.

Responsibilities: The staff psychologist is responsible for the supervision of students, staff, and consultants providing direct services to enrollees. The psychologist reviews and signs all treatment plans and Individualized Educational Plan (IEP's) and supervises daily activities intended to carry out the objectives of the IEP's. Research related to the project will be conducted by the program's psychologist and disseminated to the appropriate entities. The psychologist is responsible for monitoring case records and other documentation of services provision.

Teaching staff

Qualifications: BA or MA degree, with E.D. certification for the state of Kentucky, and a minimum of two years' teaching experience.

Responsibilities: Responsibilities include the development of daily lesson plans and curriculum designed to meet the individual needs of enrollees. Teachers assist in the development and implementation of IEP's and are responsible for recording daily progress notes in the child's folder. Instructional responsibilities include individual, small and large group learning activities. When appropriate, teachers are expected to incorporate the recommendations of the staff psychologist and other involved professionals into the educational program. The direct supervision of paraprofessional teacher

aides is the responsibility of the teaching staff.

Social Worker

Qualifications: BSW or MSW degree and compliance with Kentucky Department for Human Resources licensing requirements. From one to three years of experience is required.

Responsibilities: The center social workers maintains ongoing communications with agencies, schools, and other professionals for the purpose of referral to the Southern Kentucky Child Treatment Center and other programs. The social worker coordinates all necessary appointments and student transportation to needed services. The primary responsibility of the social worker is parent involvement, to include home visits, parent orientation and training, facilitation of parent groups, and other activities.

Speech Pathologist

Qualifications: MS in Speech Pathology, with C.C.C.S.P. certification for the state of Kentucky, training in audiological assessment in compliance with A.N.S.I. standards, and one to three years of experience working with children.

Responsibilities: The speech pathologist's duties include speech screening (articulation and language) and audiological screening for all enrollees. In addition to screening, the speech pathologist is responsible for follow-up assessment and diagnostic evaluation for articulation and language disorders and the referral of possible hearing-impaired children for diagnostic evaluation by an audiologist. For enrollees having speech and/or language disorders, the speech pathologist will

develop individualized plans for therapy and implement the speech therapy program. Other responsibilities include parent education, materials development, and recordkeeping.

Secretary-Bookkeeper

Qualifications: High school diploma or G.E.D.

Responsibilities: The secretary-bookkeeper is responsible to the program director for the assignment of daily responsibilities, to include typing, filing, completion of financial records and reports, reception, and other clerical/bookkeeping duties.

Music/Art/Dance Therapists (part-time)

Qualifications: MA or MS degree in the specialty area and compliance with certification or licensing requirements, when applicable.

Responsibilities: The adjunctive treatment specialist is responsible for involving enrollees in specific forms of therapy as determined by the Individualized Education Plan. Art, music, or dance therapy objectives and activities are to be developed by the therapist. Progress reporting and the documentation of special therapeutic efforts are the responsibility of the therapist.

Teacher Aides

Qualifications: A high school diploma is preferred but not required.

Responsibilities: Teacher aides are responsible for the performance of tasks assigned by the supervising teacher. These duties include less specialized classroom activities such as

materials preparation, caretaking during feeding and other daily routines, nurturance, individualized instructional assistance, record keeping, and other tasks designed to free the teacher from less technical classroom matters.

Student Clinicians

Qualifications: Graduate students from participating departments (Speech, Psychology, Special Education, Social Work, Counselor Education, etc.) must meet the screening requirements of the staff psychologist.

Responsibilities: Students assigned to the program are responsible to the staff psychologist for the assignment of specific duties. Depending upon the discipline of the students, activities include: supervised assessment and diagnostic evaluation; supervised assessment and group psychotherapy; speech therapy; individual and group instruction; prescriptive program development; parent involvement activities, and notation of activities and progress reports in the child's folder.

Program Consultants. The program director and staff psychologist will establish service contracts and/or cooperative agreements with qualified consultants as dictated by the needs of enrollees. Program consultants must meet the requirements of their disciplines. Family counselors, psychiatrists, occupational therapists, physical therapists, physicians, parent trainers, and other professionals are among those considered for service.

Volunteers. All volunteers will be screened by the program director and/or staff psychologist prior to assignment to program activities. The educational and experiential levels of

levels of each applicant will determine his/her placement within the program. Job descriptions are to be developed for each volunteer to ensure a thorough understanding of the volunteer's role.

Selection and Enrollment

The process of selecting and enrolling program participants is dictated by the special needs of each applicant, based upon diagnostic evaluation results and the recommendations of school personnel and other involved professionals.

While the eligibility criteria established by the Kentucky Administrative Regulations (1978) for enrollment in a program for the emotionally disturbed apply to all potential program participants, the final determination of eligibility is based upon the degree to which the applicant requires special services outside of the school district of residence. The principal criterion is the severity of the presenting problem as indicated by the assigned DSM III categorical diagnosis. In most cases, all personality disorders coded on Axis II warrant intensive treatment because of their long-term nature and the significant impairment in social, academic, or occupational functioning (American Psychological Association, 1979). Axis I diagnostic categories indicative of specialized treatment may include, but are not limited to, schizophrenic, paranoid and psychotic disorders, the major affective disorders, nonphobic anxiety disorders, and conduct disorders of infancy, childhood, or adolescence.

Enrollees are identified and referred by the following programs, agencies, or individuals: private practitioners, WHAS Crusade for Children and local child find projects; local boards of education; public health departments; Head Start Special Services; Comprehensive Care Center; Department for Human Resources, Social Services Bureau; Special Early Childhood Training Center; University of Louisville Child Evaluation Center, Western Kentucky University's Psychological, Speech, and Reading Clinics and the University's Counseling Center.

Admissions and Release Committee

An Admissions and Release Committee (ARC) is responsible for review of all referral information and diagnostic evaluations to determine whether those referred to the program meet the established eligibility criteria. This committee is composed of the director, staff psychologist, diagnosticians, teacher, and school principal (if the child is referred by the local school system), parents, and the referred child, where appropriate.

An ARC meeting is conducted to assess the immediate therapeutic and educational needs of each new enrollee. The staff social worker presents all available information to include:

1. A health screening which would indicate there are no primary visual, auditory or physical handicapping conditions;
2. a compilation of specific behavioral data collected over a period of time by the referral source;
3. a written compilation of data from direct observation of the referred pupil in familiar surroundings by a person other than the referral source;

4. an individual educational assessment of the referred pupil's specific strengths and weaknesses in basic skill areas;

5. an individual psychological or psychiatric evaluation;

6. a developmental and social history;

7. a record/evidence of previous educational/behavioral intervention strategies that have been utilized. (KAR, 1978 p. 28)

In cases where enrollees have not been previously evaluated, or when referral information is insufficient for program planning, the interdisciplinary team develops an appropriate evaluation plan. The plan includes methods for observation, assessment, and diagnostic evaluation to extend no longer than 30 days.

Within 30 days following program entry, an Individual Education Program (IEP) is developed by the Admissions and Release Committee. The IEP outlines short and long-term educational objectives, the provision of support services, individuals responsible for program activities, and time frames within which objectives are to be met. The development of the IEP is a team effort in which parents play an active role, with staff functioning as facilitators to the process.

Weekly staffings are conducted thereafter, to review progress toward IEP objectives and to determine the effectiveness of the treatment and instructional strategies being employed. Northcutt and Tipton (1978) describe the multidisciplinary

staffing as essential to effective service delivery in programs for emotionally disturbed children.

Parent Involvement

Dreikurs and Chernoff (1970) suggest that parents and teachers possess great potential for improving educational services to children if they would only join forces toward the accomplishment of their mutual objectives. Karnes, Zerbach, and Teska (1972) developed a model for family involvement in an education program for handicapped children. The model, ASTEM, is a longitudinal process which involves five principal areas: Acquaint, Teach, Support, Expand, and Maintain. Case histories indicate substantial positive outcomes resulting from this type of model, according to the authors.

The treatment center focuses upon parent involvement as a resource more valuable than other forms of treatment in view of the parent's potential to achieve long-range benefits to their children, provided training and support are given by the professionals involved.

Parent involvement is the responsibility of all program staff, although the social worker is the principle figure in this process. The activities of the parent involvement program are as follows:

Home visits. At the time of referral, the social worker visits each enrollee's home to provide information regarding the Southern Kentucky Child Treatment Center, to establish rapport with the enrollee and family members, and to explain the parent involvement component of the program. Parents are given

a manual describing the program and its policies and procedures. The social worker records pertinent observations about the visit in the event that the family requires additional services from the center or from community agencies.

Parent training. As a condition of each child's enrollment, parents must participate in at least monthly parent training programs. These activities are designed to instruct parents in a variety of areas relevant to the treatment, management, and education of their children. The training sessions topics are in part determined by the parents themselves, since the interest and involvement of family members is a significant factor in long-range treatment success.

Parent groups. Contingent upon interest and need, parent groups of a therapeutic and/or affiliative nature are offered by the program. The direction of parent groups is determined by the participants according to their expressed needs. Criss and Goodwin (1972) describe the success of short-term group counseling for parents of emotionally disturbed children, and Black (1972) advocates the benefits of group therapy for parents of children with emotional handicaps. The staff psychologist and/or consultants provide such therapy upon the consent of the participants. Parent groups may elect to use their meetings for the purpose of sharing information and experiences, providing support, or organizing and implementing advocacy efforts for the behalf of their children.

Decision-making. Parents are encouraged to serve on the Governing Board to provide input concerning policies and

procedures relating to the program.

Interagency Coordination

Largely the responsibility of the director and the social worker, interagency coordination is an ongoing process of communication and resource sharing.

The director is responsible for informing agencies and the community of the services provided by the Southern Kentucky Child Treatment Center. This individual attends a variety of community Inter-Agency Council meetings, meetings with individual agency representatives, public speaking engagements, and news releases to the mass media. The director would also coordinate arrangements for the provision of professional services to students and facilitate the development of cooperative agreements between the Center and other agencies.

The social worker works with agencies and professionals on a direct services level by scheduling appointments for students and transporting them to the appropriate service providers.

Community-based organizations are involved with center activities at all operational levels. Representatives of these organizations have membership on the SKCETC Governing Board in order to provide input into program planning and decision-making. In addition to ARC and IEP participation, service providers attend weekly staffings pertaining to their clients. The center maintains an open-door policy allowing involved professionals the opportunity to observe clients in the program setting, to discuss progress and treatment with staff, and to meet with clients and parents, when needed.

Placement and Follow-up

Each student leaving the program requires a written placement plan. Depending upon the circumstances involved, placement activities take a variety of forms:

Students successfully completing the program. At any point, the student demonstrating adaptive skills sufficient for successful functioning in the normal classroom is placed into the public school. Recommendations for placement come from the teachers, psychologist, and other staff. Public school personnel are consulted and advised of the student's status. Regular follow-up is the responsibility of the center social worker and student clinicians.

Partial placement. Students demonstrating marked progress have the option of being mainstreamed into the public school for ½ or ¼ day, while receiving special services at the center. Procedures are the same as those listed for successful program completion.

Hospitalization. In cases where a student exhibits active psychosis, uncontrolled by medication and other treatment, presenting a danger to himself or others, referral is made to Norton-Children's Hospital's Children's Psychiatric Unit or Central State Hospital's Children's Unit, both in Louisville, Kentucky. Follow-up by the social worker determines when program re-entry is feasible.

Inelegibility due to age. Those students who have reached adulthood require special placement planning. A cooperative agreement between the Exceptional Industries Sheltered Workshop (co-sponsored by the Bureau of Rehabilitative Services (BRS) and

the Barren River Mental Health-Mental Retardation Board,) and the Southern Kentucky Child Treatment Center make available vocational evaluations to students age 18 and above. Recommendations for vocational placement and/or training form the basis for the placement plan. At that time, referral to BRS is made by the social worker.

Each student leaving the child treatment program receives follow-up services designed to ensure the continuity of services, when appropriate, and to guard against recurrence of maladaptive behaviors. Follow-up information is also used as a method of data collection for program-related research.

Follow-up is primarily the responsibility of the social worker, who assists the student and his parents during the placement and transition period. During the first month of placement, follow-up activities occur weekly, or as needed. After the one-month transition period, semi-annual follow-up is conducted by way of client contact, home or worksite visit, or other direct means. All follow-up information is documented and in the client folder.

Residential Services

The accessibility and availability of the full range of services provided by the SKCETC is ensured all residents of the seven-county area by the establishment of a residential unit at the regional evaluation and treatment center. A 15 to 20 bed attachment to the facility enables residents of the outlying counties to participate in a variety of program activities unavailable in their local communities. This expansion also makes possible the addition of new options for service delivery

Extended Evaluation

A residential unit affords diagnosticians the opportunity to conduct more extensive and less restricted evaluations of severely emotionally disturbed children. Depending upon the individual needs of clients, arrangements are made for diagnostic evaluations ranging from a few days to a few weeks or longer, making possible the use of behavioral observations, a wider variety of assessment instruments, and other evaluation methods.

Partial Residency

In those situations where day treatment center enrollees are unable to commute the distance between their home communities and the center, arrangements are made for accommodations at the residental unit. This option enables students to spend the school week of five days and four nights at the regional center and return to their homes during holidays and weekends.

When the expenses and inconvenience necessitated by long

distance travel are considered, the partial residency plan is most efficient logistically and in terms of cost effectiveness.

Full-week residency

For some students, the least restrictive program option is full-week residency at the SKCETC. Children who are experiencing the severest forms of psychosis, who are uncontrollable at home, who are wards of the state and unable to be placed in foster care are among those who may require seven-day residential care. These students receive 24-hour services to include the day treatment program, along with chemotherapy, psychotherapy, and other prescribed modalities of treatment.

Respite care

A service made possible by the residential unit is the provision of respite care for families needing temporary placements for their emotionally disturbed children. In cases of family emergency, illness of parents, or simply the need for parents to obtain relief from the pressures of day-to-day coping with the problems of raising an emotionally disturbed child, the SKCETC is able to provide temporary care and assistance. The length of stay might vary from a weekend to several weeks, depending upon individual circumstances.

Additional considerations

The staffing requirements for a residential program necessitates the employment of a supervisor of residential services, a registered nurse or LPN to administer medication and to be available for emergency first aid, and one to two

aides to maintain 24-hour staff coverage. Prior to entrance into the residential program, physical examinations, medical histories, parent releases, and other safeguards are necessary to ensure the protection of residents. Since Medicaid funding is available for residential programs, (Schell, Note 22), the supervisor of residential services is responsible for ensuring compliance with the standards established for residential facilities reimbursed by Medicaid and other third party payors.

Residential students are provided frequent opportunities to visit their families, to engage in social activities, and to participate in activities outside of the center. The overall objective is to provide therapeutic and educational services in as normalized a setting as feasible to facilitate the rapid return of students to their home environments.

Chapter V

Related Issues

There exist a number of pragmatic concerns related to programming in the area of human services. To ensure the long-term endurance and continuity of cooperative efforts, program planners and administrators must address the issues of long-term funding, program evaluation, and research.

Funding

An obvious essential for program implementation is the development of a funding base sufficient for the establishment and maintenance of operations. Potential sources of financial assistance include local, state, federal, and private funding entities.

Local Resources. Although limited in terms of available cash contributions, local entities hold the potential for enhancing the quality of, and for ensuring the longevity of, community-based programs. While federal and state funding sources are subject to changing administrations and funding priorities, local resource personnel are more likely to observe program operations directly and to obtain first-hand information concerning activities and successes. The personal involvement of county judges and other locally elected officials enhances the possibility of obtaining financial

support in the form of cash contributions, donated space, and donated equipment.

The involvement of professionals in a community-based effort can result in in-kind contributions in the form of training and technical assistance, direct services, and donated goods and equipment. Physicians, psychologists, teachers, administrators, and other professionals in small communities may have access to materials and equipment that might be shared, loaned or donated to special projects. In addition, the involvement of these resource personnel during the planning and/or program implementation stages can lead to added participation in the form of in-kind volunteer services of a more lasting nature.

Community service organizations (Jaycees, Kiwannis Club, Lion's Club, United Way, Junior League, Civitan, Optimist Club, et al.) are potential resources for general fund-raising efforts. Local parent groups hold potential for the mobilization and utilization of these and other resources.

An important supplement to funding is the use of university and community volunteers. Fraternities, sororities, and service organizations sponsored by the university are potential sources of donated time and other contributions. Other possible volunteers include unemployed or retired community residents.

State resources. For the 1979-80 school year, the Kentucky Department of Education's Bureau of Education for Exceptional Children designated 10% of the state's share of Education of

the Handicapped Act, Part B funds to be used to meet the needs of handicapped children. The Bureau of Education for Exceptional Children determined three areas of need to be addressed through the Request for Proposal (RFP) process: 1. Field-based preparation models for teachers of severely/profoundly handicapped; 2. Area diagnostic centers; and 3. Secondary program models. (Downing, Note 23).

In the state of Kentucky, a total of nine projects were funded during the 1979-80 school year. Funding levels ranged from $40,000 to $100,000 and reflected the state's efforts toward compliance with the federal mandate. "Funds must be used according to the priorities established by federal regulations under PL 94-142; that is, for handicapped children unserved and for the most severely handicapped children who are inadequately served." (Kentucky Department of Education, 1980).

The requirements for submission of a proposal for funding from the Bureau of Education for Exceptional Children include the adherence to a specified format and the assurance that an agency other than a local school district be in compliance with federal and state regulations ensuring the protection of individual rights of handicapped children. These rights include: "1. Free Appropriate Public Education; 2. Individual Education Program; 3. Child Identification; 4. Due Process Procedures; 5. Protection in Evaluation Procedure; 6. Least Restrictive Environment; and 7. Confidentiality of Personally Identifiable Information." (Downing, Note 23).

In order to receive state funding, proposals must include seven components: 1. front materials (cover page, submission statement, abstract, summary data, etc.); 2. work statement (introduction, procedures, action plan, expected outcome and impact); 3. administration, internal monitoring, and staffing (organization, staff roles, evaluation, reporting, etc.); 4. facilities and equipment; 5. interagency coordination, formal agreements and contracts; 6. budget, and 7. appendices. (Kentucky Department of Education, 1980).

Proposals for state funding are reviewed by out-of-state specialists using a checklist and point system. Agencies receiving approval must then comply with monitoring, reporting, and other requirements of the Bureau of Education for Exceptional Children (Kentucky Department of Education, 1980).

Federal resources. The federal government is a major source of financial support to human services programs. Institutions, agencies and organizations serving the emotionally disturbed are eligible for federal assistance from the U.S. Office of Education, which received a total of more than $11.3 billion from Congressional appropriations during 1979. (Smith, 1979).

Information pertaining to the availability of federal funds and the requirements of eligible applicants may be found in the Federal Register, Office of Management and Budget Catalog of Federal Domestic Assistance, and the Catalog of Federal Education Assistance Programs (Smith, 1979). These publications specify the type and purpose of assistance, authorizing legislation,

appropriations, eligible applicants, and where to apply.

Examples of federal allocations available during 1979 for the education of emotionally disturbed children include funds earmarked for early education programs ($22 million), regional resource centers ($9.75 million), personnel training ($14 million), regional education centers ($2.4 million), severely handicapped projects ($5 million), and other elementary and secondary programs. (Smith, 1979).

Private sources. In addition to donations from local citizens and organizations, funding is available from a variety of private sector sources. There are approximately 26,000 private foundations in the United States providing more than $26 billion in grant support annually. (Annual Register of Grant Support, 1978). These foundations can be broken down by type: national foundations (usually quite large, e.g., Ford Foundation); special interest foundations (grant efforts are limited to a single interest, e.g., Joseph P. Kennedy Foundation); corporate foundations (Sears-Roebuck et al.); family foundations (the largest in number, but with fewer assets); and community foundations (the fastest growing area of private philanthropy, due to fewer restrictions by the Tax Reform Act of 1969.) Other potential sources for assistance are corporate giving which includes charitable donations and volunteer services, and federated giving, where a number of small organizations combine their efforts as with the United Negro College Fund. (Annual Register of Grant Support, 1978).

The application process for private sector funds is similar to that required by the federal government. However, foundations usually require a brief letter in lieu of the structured format required for federal assistance proposals.

Funding Process. The general funding process begins with the authorization, prioritization and delegation of funds by Congress. Once requests for proposals are announced in the Federal Register or are passed along to state institutions, the local program planner begins the process of proposal development and submission. (Martinson, Note 24). Project review begins at the Regional Clearinghouse, where Councils of Government (COG's) or Area Development Districts (ADD's) determine whether applications comply with regional planning objectives, and whether applications represent unduplicated efforts. Proposals are then reviewed by the State Clearinghouse. The funding source receives all clearinghouse comments, which are included for consideration along with the other specific review criteria. Each funding source develops individual selection guidelines for proposals, in accordance with the federal regulations established for programs (Martinson, Note 24).

Program Evaluation. In many cases, the factor which determines the continued existance of a human services program is the outcome of program monitoring and/or program evaluation (Larson, Note 25). Almost always a requirement of the funding source, program evaluation is used to improve program operations, assist in management decisions, justify continued support, analyze costs and benefits, and acknowledge the accomplishments of those

institution being evaluated (Eyman and Windle, 1976).

There are several approaches to program evaluation. Eyman and Windle (1976) describe methods of internal evaluation, to include experimental and quasi-experimental designs, clinical approaches (e.g., Kiresuk's Goal Attainment Scaling), cost benefit models, and client satisfaction ratings. These internal approaches assist program administrators in general decision-making and, indirectly, in staff performance evaluations.

External program evaluation, as explained by Eyman and Windle (1976), requires the involvement of outside reviewers. The results of such evaluations are highly consequential for programs, since funding often depends upon their outcome. Three external approaches are delineated by Eyman and Windle:

Use of standards. Third party payors use program evaluation as a method of determining minimum eligibility for reimbursement. Professional groups use evaluation criteria to regulate their own membership. Standards for facilities, and other accreditation standards, are the basis for evaluation by outside reviewers.

Peer review of utilization. This process is also necessary for third party reimbursement. The primary criteria for successful performance are appropriateness, adequacy, and effectiveness of treatment.

Use of the community for performance evaluation. Eyman and Windle emphasize the rights and responsibilities of local taxpayers in program evaluation. The involvement of residents and elected officials ensures that the wishes of the community

are being carried out, and can lead to local support by way of referendums or use of facilities. In addition, the assessments of community representatives may be more valid than those of the service providers, since studies have documented differences between therapists and clients or their families in the expected goals or outcomes of treatment.

Specific requirements for performance evaluation are typically established by the funding source (Larson, Note 25) and can involve internal and/or external methods.

Implications for Research

In contrast to the predetermined obligations of internal and external program evaluation, the treatment center operated with university linkages has access to a variety of research opportunities that extend beyond the assessment of program effectiveness. It is feasible that each component of the SKCETP/C and each community-based organization contributing to the delivery of program services might determine a need for data collection and/or experimentation related to the operations of the treatment facility. The supervisor of program related research is the staff psychologist, whose responsibilities include the screening of research proposals, the coordination of research activities, and the monitoring of all phases of investigation to ensure compliance with legal , ethical, and other standards.

Potential research areas. It is obvious that nearly all of the program components-psychotherapy, parent training, education, etc., lend themselves to the conduct of follow-up

research. As Robins (1972 p. 416) notes, "Follow-up studies are uniquely adapted to learning which children are most likely to develop behavior disorders, the outcome of behavior disorders, or the results of therapy." In respect to the evaluation of treatment effects, Robins suggests the comparison of treated versus intreated cases. The needs assessment information in Chapter 2 indicates the feasibility of this type of study.

Thomlinson (1969) describes the use of the projected longitudinal study design in the behavioral sciences. Since it is feasible that the child treatment center would serve some enrollees from the preschool years until adolescence or adulthood, this type of design is applicable, since there exists the opportunity for detailed, comprehensive recordkeeping, progress reporting, follow-up, and other forms of data collection.

Bucher (1972) has concluded that there are two research designs that represent effective methods of investigation of pathological behavior problems. The single-subject design is a useful tool for the functional analysis of treatment variables, primarily in the investigation of behavioral therapy techniques. The comparison-group design assists in the demonstration of the effectiveness of different schools of therapy.

Ongoing research. The staff psychologist is charged with the development of an ongoing system of data collection pertaining to individual enrollees, groups of program participants, and their families. This ongoing research represents a cooperative effort among program staff and participating agencies and practitioners. The end product of this effort is the accumulation of

a comprehensive body of information related to client and family characteristics, caseload composition, treatment modalities, length of stay, ancillary services, assessment results, follow-up findings, and other data. This information, when stored in the Western Kentucky University's Computer Center, makes feasible the systematic investigation of program effects and can serve to generate additional research as dictated by the needs of program principals and affiliates.

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