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REVIEW OF A PARTIAL CARE PROGRAM
FOR SEVERELY EMOTIONALLY
DISTURBED YOUTH

by
Christina Schoener

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree in the Graduate Division
of Rowan College of New Jersey
May 2, 1995

Approved by

Professor

Date Approved 5/2/95

ABSTRACT

Christina Schoener
Review of a Partial Care Program
for Severely Emotionally Disturbed Youth
1995
Dr. John Klanderman
School Psychology

The need for research on programs for Emotionally Disturbed (ED) children and adolescents is great. The present study examined a partial care program for ED youth in New Jersey. There were 120 subjects in this study. Several characteristics of these subjects were examined - gender, race, age, diagnosis, and family status. The study also examined the subjects' average length of stay in the program and reasons for being discharged. In addition, the ratio of clients to staff was studied. The data was collected by examining the files of past and present clients to gather the necessary information. Descriptive statistics were used to analyze the results. The majority of the subjects were African American males between the ages of 12 and 15 years. Most were either diagnosed Conduct Disorder or Oppositional Defiant Disorder and most lived with a single parent. The overall length of stay for the subjects was 8 months. Most of them were discharged due to refusal of service or to another placement. The ratio of clients to staff varied from 6 to 1 to 3 to 1 over the three year period studied.

MINI-ABSTRACT

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The study examined a partial care program for Emotionally Disturbed youth. The subjects were examined in terms of their gender, race, age, diagnosis, family status, length of stay, and reasons for being discharged. The majority of the subjects were African American males living with a single parent, whose average length of stay was 8 months.

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CHAPTER 1

NEED/PURPOSE

There is a perceived need, by many states, for the development of a comprehensive continuum of care for severely emotionally disturbed (SED) children and adolescents. Although there are some SED youth who can, and do, benefit from treatment in institutional settings, there is an increased movement and interest in serving such children in community-based residential treatment centers and other less restrictive settings within or close to their communities. New Jersey is one such state trying to meet this goal of community-based care. This report will focus on one partial care program that was created in response to this need.

The viability of programs to serve SED children and adolescents depends upon public awareness of the problems presented by such children. It is a professional responsibility to make the public aware of the existence of services for these children. And once these programs are in place, the next step is to monitor and evaluate them. This report will describe one such program for SED youth and lay the groundwork for future evaluation.

RESEARCH QUESTIONS

This report will be a descriptive study of a partial care program. As such it will survey the program and attempt to answer the following questions:

1. What are the characteristics of the youth participating in the program?
2. What is the average length of stay for the clients in the program?
3. What are the reasons for discharging clients from the program and where do they go after discharge?
4. What is the client to staff ratio at the program?

HISTORY/THEORY

Until the late forties and early fifties, the movement to provide better services for emotionally disturbed children and their parents was spearheaded primarily by philanthropists, professionals and bureaucrats. At that time, parent groups became active and organized around various categories of handicap. In the beginning these groups initiated programs for their children which they funded and managed themselves. Through lobbying, litigation and cooperation with professional groups, these parent organizations played a major role in passing legislation mandating special education for all handicapped children during the middle sixties and early seventies.

During President John Kennedy's administration, major steps were taken to develop Comprehensive Community Mental Health Centers throughout the nation. The impetus for this movement was two-fold: (1) to reduce or eliminate the widespread "warehousing" and "institutionalizing" of adults, adolescents and children in giant State and Federal psychiatric hospitals throughout the country, and (2) to establish comprehensive community-based mental health services easily accessible to all communities. Generally speaking, such community mental health centers were expected

to provide an array of services which included emergency 24-hour services; screening programs for psychiatric in-patient services; partial hospitalization (Day Treatment) and Aftercare Services; out-patient services including medication follow-up and counseling programs; and community education/consultation services. Services could not be declined because of race, creed, origins or income levels (Committee on Emotionally Disturbed Children, 1981).

Two decades ago, the Joint Commission on the Mental Health of Children (1969) found that millions of children and youth were not receiving needed mental health services and that many others received unnecessarily restrictive care, often in state mental hospitals. The President's Commission on Mental Health (1978) echoed the Joint Commission's conclusions, finding that few communities provided the volume or continuum of programs necessary to meet children's mental health needs. Both Commissions recommended that an integrated network of services be developed in communities to meet the needs of children and youth who are severely emotionally disturbed. Knitzer (1982) asserted that the needs of severely emotionally disturbed (SED) children have remained largely unaddressed. She considers these children to be "unclaimed" by the public agencies with responsibility to serve them. Most recently, the Office of Technology Assessment (OTA) of the United States Congress (1986) found that many children do not receive the full range of necessary and appropriate services to treat their mental health problems effectively.

Currently, there is broad agreement about the critical need to improve the range, appropriateness, and coordination of services delivered to SED children and their families.

The development of comprehensive, coordinated, family-centered, and community-based "systems of care" for children and youth has become a national goal. New Jersey has a long, rich history in planning for mental health services for children and adolescents. The planning efforts which span over a ten-year period have been based upon a guiding principle that children and adolescents should be served in the most appropriate and least restrictive setting. For the last ten years, New Jersey has moved from a State operated psychiatric hospital system with limited outpatient services to a regional system with a greater range of community-based services.

Building upon the Regional Plan, a strong commitment was made to the community that future program development initiatives would be targeted toward local county development. The Division of Mental Health and Hospitals (DMH&H) received a \$2.0 million appropriation from the legislature for FY'89, specifically for children's services. This allowed the Division, in September of 1988, to announce a \$1.6 million "Challenge Grant" initiative designed to facilitate and encourage the development and expansion of county-based services. Four counties were selected for this special grant support -- Camden, Passaic, Atlantic, and Cape May (New Jersey State Mental Health Plan, 1989). With this additional support these counties have been able to expand or establish partial care programs and other children's services. This support also has enabled the counties to enhance their children's mental health planning functions. The partial care program which is the focus of this report, was established in July 1989 from this "Challenge Grant."

DEFINITIONS

Emotionally Disturbed Youth -- any youth whose emotional or psycho-social problems are so pronounced as to cause the youth to have difficulty functioning in the youth's home community and whose behavior causes the youth to come to the attention of a private or public institution such as the local school system, the family court, a church, or a community-based agency.

Severely Emotionally Disturbed Youth -- a child or adolescent is considered to have a severe emotional disturbance if he or she:

1. exhibits one or more of the following characteristics: behavioral, emotional, and/or social impairment that disrupts the child's or adolescent's academic and/or developmental progress and may also impact upon family, and/or interpersonal relationship; and
2. has impaired functioning that has continued for at least one year or has an impairment of short duration and high severity; and
3. is 0 to 18 years of age.

A child or adolescent who is experiencing a severe emotional disturbance may fall into one or more of the following categories which can occur with or without serious disorders, such as mental retardation, severe neurological dysfunction, or sensory impairment:

-Exhibits seriously impaired contact with reality and severely impaired social, academic, and self-care functioning. Thinking is frequently confused, behavior may be grossly inappropriate and bizarre, and emotional reactions are frequently inappropriate to the situation.

-Manifests long-term behavior problems that may include developmentally inappropriate behaviors, inattention, hyperactivity, impulsiveness, aggressiveness, antisocial acts, refusal to accept limits, suicidal behavior and substance abuse.

-Experiences extreme anxiety, depression, irrational fears and concerns. Symptoms may include: eating and sleeping disturbances, sadness of suicidal proportion, maladaptive dependence on parents, persistent refusal to attend school, and/or avoidance of non-familial social contact.

Partial Care Programs - programs structured to promote higher levels of functioning in social skills, activities of daily living, prevocational skills, and personal development; to enhance the quality of life and to provide an option for social interaction to the client.

Systems of Care - comprehensive spectrum of mental health services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents who are severely emotionally disturbed and their families.

ASSUMPTIONS

One assumption that has to be made is that the information on each individual client in the program is correct. I will be collecting my data based on the records already indicated in the charts and I am assuming that information is correct (i.e. reasons why the client was admitted, where the client went after discharge).

Another assumption that I am making is that each client received the same quality of care and counseling. There have been different staff employed at the program since it began and there are three different groups within the program (based on the clients' age). I am assuming that all clients have received equal treatment.

LIMITATIONS

A major limitation of this report is the sample. The clients at this program are from a small geographical area and are predominantly inner city minority males. This limits the generalizability of the findings. Another limitation is that since this report is an ex post facto study, I often have to rely on other people's record keeping. Not only may some of their information be incorrect, some of it may have been lost over time.

OVERVIEW

In this report I will conduct an ex post facto study of a partial care program for Severely Emotionally Disturbed youth. I will review the files of present and past clients and interview staff to gain the information I need to answer my research questions. I will

also question appropriate staff and agencies to help verify the information in the files. I will then use descriptive statistics to analyze my results. Finally, I will present my summary and conclusions. First, however, I will review some of the research on programs for SED youth. I will discuss some studies that describe and evaluate such programs. While this report will be a descriptive study of the partial care program, it is the hope of this writer that outcome measures could be put in place, so that the program could be evaluated in the future as well.

CHAPTER 2

This section will review some of the research on programs for emotionally disturbed youth. There seems to be a general consensus in the field that the number of studies focusing on these programs is limited. This is due in part because the implementation of programs for emotionally disturbed youth, particularly community-based programs, is fairly recent. Also, there is a lack of funding for researching and evaluating these programs. In this chapter I will first look at research related to program descriptions (of residential and day treatment programs) and then look at research that attempts to evaluate programs for emotionally disturbed youth. Finally I will discuss an article that presents a model detailing the components of program evaluation and the relation of these components to the purposes and uses of the evaluation. The model presented in this article will be used as a guideline for my research report.

DESCRIPTION OF PROGRAMS

Mareasa R. Isaacs and Sybil K. Goldman (1985) presented a comprehensive report describing 11 residential and day treatment programs serving seriously emotionally disturbed youth. These programs were selected to illustrate certain principles for providing care to emotionally disturbed children and youth that tend to be important in the development of effective services. Thus, a description of each program was provided that included information about the program's origins, type of children served, its guiding philosophy and treatment approach, the services offered, its work with families, and linkages with other child-serving agencies. The programs included: Advances of Wiley House (Mohrsville, PA); City Lights (Washington, DC); Poyama Land (Independence, OR); Alpha Omega (Littleton, MA); Children's Village (Dobbs Ferry, NY); Lad Lake, Inc.

(Dousman, WI); Whitaker School (Butner, NC); Youth Residential Services (Akron, OH); Regional Institute for Children and Adolescents (Rockville, MD); The Spurwink School (Portland, ME); and Tri-County Youth Programs, Inc. (Northampton, MA).

The descriptions of the programs and the types of youth served revealed common characteristics and elements that were a part of many of the programs despite location, organizational structure or revenue sources. The following characteristics and elements were mentioned again and again by staff when discussing services for seriously emotionally disturbed children and adolescents.

DESCRIPTION OF YOUTH SERVED

Demographic Characteristics

The SED children and adolescents served by the selected programs ranged in age from 3 to 22 years. While the majority of the programs selected admitted both males and females, the admissions were heavily skewed toward males. The percentage of the programs' population from ethnic/racial minority groups tended to reflect the geographic location of services for the most part.

Many of the youth in these programs came from families that were afflicted by poverty. Many of these youth were growing up in single-parent families or foster homes. Their family systems were marked by chaos, personal tragedies and other circumstances that mitigate against the development of successful coping and behavioral functioning.

Diagnostic/Behavioral Characteristics

There were five major diagnoses that the majority of youth in these programs received: conduct disorders, attention deficit disorders, disorders of impulse control, affective disorders, and adjustment disorders.

Just as there were similarities in diagnoses, there were similarities in the behavioral characteristics of the youth in these programs. The majority of these youth had learning

disabilities and other educational deficits. Most of the youth in these programs had experienced multiple out-of-home placements. Many were court-involved and had been involved in some type of criminal activity. Many had a history of violent and assaultive behavior without court involvement. A large percentage of the youth had been the victims of physical or sexual abuse.

The youth in these programs suffered from low self-esteem and feelings of worthlessness and rejection. They were programmed to expect failure, rejection, and alienation. These attitudes, even within the treatment system, became a self-fulfilling prophecy.

COMMON PROGRAM CHARACTERISTICS

Creation of a Safe and Nurturant Environment

Staff of the programs visited consistently stressed the importance of creating an environment that is consistent, nurturing and structured. The researchers noted that one of the overriding characteristics of SED youth is that their lives have been marked and marred by confusing, inconsistent and chaotic ecological environments. To counteract these influences, a treatment program must be able to create a sense of intimacy and closeness for the youth.

Clearly Articulated Program Philosophy

The major finding from these programs was that the type of philosophy of treatment espoused was not that important. Rather, it was the presence of a clearly articulated philosophy that was most critical. Over and over, directors of the programs noted the importance of having underlying philosophical tenets that permeate every aspect of the program.

Client-Centered Focus

According to the researchers, programs tend to work best when there is a commitment to meet the needs of the children in the programs rather than expecting youth to conform to a pre-existing program format. This ability to provide a structured environment in a flexible manner was one of the most outstanding characteristics of the selected programs. These programs had the ability to be creative in meeting the specific needs of each youth admitted. Given this strong client-centered focus, the authors stressed the importance that plans and expectations for each youth be realistic and based on an accurate and careful assessment of his/her skills and abilities.

Clearly Articulated Discipline Processes

Given the nature of the youth served by many of these programs, discipline and how to maintain control was a very important aspect of the program approach. Sometimes disciplinary activities were incorporated into the treatment approach, such as behavioral modification and reward (point) systems for managing and modifying behavior. In other programs, specific disciplinary processes such as quiet rooms or time-out periods were used.

Development of Strong Linkages with the Community

Almost all the programs selected met the principle of good community linkages and relationships. Some had good relationships because they had staff that had the specific function of liaison with the community. Other programs had enhanced community relationships and linkages through volunteers, community boards and other such affiliations that encouraged the community-at-large to learn more about the program.

CHARACTERISTICS OF THE TREATMENT PROGRAMS

Basic approach is to establish relationships with the youth

Establishing meaningful and positive relationships with the youth enrolled in the program seemed to be the main goal of all the treatment approaches established by the selected programs. Since SED youth often have great difficulty in developing and maintaining close relationships, a major focus of these programs was on encouraging trust and closeness, as well as building self-esteem and social competency.

Treatment strategies are eclectic

Almost all of the programs stated that the treatment strategies used were eclectic, i.e. that a combination of treatment and intervention approaches were incorporated in the program's philosophy. Many relied on a combination of milieu therapy, behavior management techniques, peer group counseling and psychodynamic therapies.

Treatment plans are individualized and regularly revised

The researchers believe it is important that treatment needs be individualized, based on assessments of each child. All the selected programs developed individual treatment plans for each child. These plans were also systematically reviewed and revised.

Group activities are viewed as important

Many SED youth have very poorly developed social and communicative skills. A part of developing skills is interacting with others in various group activities and encounters. Although some programs offered individual counseling, almost all had class meetings, residence meetings or other types of activities that promoted and enhanced peer group relationships and interpersonal skills.

Family involvement is considered an essential aspect of treatment

All the programs stressed the importance of family involvement in the treatment process. Parents were involved in the intake process and update of treatment plans. Oftentimes programs offered parents therapy sessions, education and support groups and other services to assist them in helping their child.

EVALUATION OF PROGRAMS

EVALUATION BY FAMILIES

James Greenley and Christine Robitschek (1991) evaluated a program for youth with severe emotional disorders. This evaluation was done by means of a self-administered questionnaire survey of family members. It surveyed their perception of service needs and usage, difficulty obtaining services, and satisfaction with services.

Prior to their report, there were no community-based program evaluations from the perspective of the families. There have, however, been efforts to evaluate family satisfaction with service delivery in settings other than these innovative programs.

In one study 80 parents were asked to evaluate an inpatient psychiatric program (Löff, Trigg, & Cassels, 1987). Mean satisfaction scores reported by parents fell within the "good" or "moderately satisfied" range. Another study was conducted by Wersh, Tritt, Stambrook, and Dushenko (1982). They briefly examined family satisfaction as part of a larger assessment of a model that placed psychology trainees in a private pediatric clinic. Their 30 respondents reported generally high levels of satisfaction with the psychological service.

In a recent related effort, Friesen (1989) conducted a nationwide survey of parents of children with emotional disorders. She found that most parents rated four aspects of service provision as highly important: 1) inclusion of parents in decision making; 2) a respectful, non-blaming attitude in the part of service providers; 3) supportiveness toward the child; and 4) supportiveness toward the parents. This study was significant in establishing the importance of parents being involved and accepted, but was not designed to evaluate particular programs.

Greenley and Robitschek's report evaluated a pilot program in Dane County, Wisconsin called COMPASS (Communities Organized to Maintain Parents and Pre-

Adolescents in Safe/Secure Surroundings). Six program objectives were selected that could be measured in terms of family members' reports of their experience with these programs. These objectives specified that services be: 1) less restrictive, 2) integrated or coordinated, and 3) individualized; and that families 4) participate in treatment planning and delivery, 5) have easier access, and 6) would experience greater satisfaction with services.

The research design was a before-after comparison, or A-B design, with time A data supplied retrospectively. A single cross-sectional survey of children's caregivers was done in the late fall of 1989. Caregivers reported on the services they were "currently" receiving. They also reported retrospectively, relying on their memories, on services received before their children entered the pilot project.

A total of 22 caregivers of 22 children that were currently served in Dane County responded to the survey, representing 63% of the 35 households surveyed. The children of caregivers in this sample ranged in age from 6 to 14, were 18% minority, and 75% male.

Results of this study were reported for the six different objectives. The first question examined whether services were provided in less restrictive settings. Respondents were asked to check off "whether or not your child or family needed and/or used these services both prior to joining the COMPASS project and currently." A list of 12 services for the child and another six services for the family followed. The general pattern was a significant increase in the total services provided and a decrease in institutional service use.

A major goal of the project was to integrate and coordinate services. Ninety percent of caregivers in the survey agreed, and none disagreed, that "the services which my child receives are more coordinated" after beginning the COMPASS project than before.

In response to the goal of individualization of services, some 95% of caregivers agreed with the survey statement, "The treatment program is tailored to my child's individual needs." None disagreed.

The COMPASS project also appeared to have achieved the other goals and objectives examined in this study--family involvement and participation, access to services, and satisfaction with services.

The authors list several limitations of their study. They suggested future research should make use of comparison groups to discern whether the programs being evaluated are more effective than other programs. They also thought future research should try to obtain higher response rates and more information on those who do not respond, since dissatisfied families may be overrepresented among nonresponders.

EVALUATIONS BY INDIVIDUALS

There is some research that has attempted to evaluate program effectiveness based upon studying the individuals that participate in these programs. Adams (1990) for example, studied the effectiveness of a residential treatment center. The program was evaluated by the Goal Attainment Scaling Technique which was developed by Kiresuk and Sherman (1968). Each individual is given certain goals and the level of success can be measured for different behaviors. Adams ascertained that those students who completed the program scored much higher on the Goal Attainment Scale than those who dropped out. He concluded that "behavior change is possible and measurable for acting-out adolescents."

A study by Wagner and Breitmeyer (1975) indicated that individuals have less difficulty returning to the community after completing a residential treatment program. The authors investigated two variables: 1) the success or failure of the individuals in adapting to the community, and 2) the completion or noncompletion of the program.

Success was defined as "the absence of reinstitutionalization, pending reinstitutionalization, or community effort through legal channels which excludes or removes the individual from the community after the subjects return to the community." Failure was defined as the presence of the above criteria. They found that 69% of the clients who completed the program were "successes," while 71% who did not complete the program were "failures." The relationship between success and failure and completion of the program was statistically significant.

A more detailed study was conducted by Munson and Blincoe (1984). They examined a residential center for emotionally disturbed female adolescents by comparing changes in personality as measured by objective tests given while in residence and by a questionnaire sent to former residents at least six months after release.

Two criteria of effectiveness were examined. The first was that girls released from the treatment program will be successful when they return to their communities. The second concerned the High School Personality Questionnaire and the Jesness Inventory. The girls who were released were hypothesized to show significant improvement on the two personality tests taken at the time they were admitted and the time they were released.

The High School Personality Questionnaire (HSPQ) measure a set of 14 dimensions of personality. The Jesness Inventory was created to differentiate between delinquents and nondelinquents, to categorize personality types and to provide a scale that would show change in an individual. Most of the scales in the Inventory indicate positive change when the posttest score is lower than the pretest score.

A questionnaire was sent to 21 girls who were released from the program. The data supported the prediction that the girls would be successful upon their return to the community. The success of each girl was reflected in her additional comments (which were not required). For example, one girl said that she would recommend the center to any girl "who has no place to go and who has a lot of problems."

The second hypothesis was also supported. The girls who were released from the program showed significant differences in a positive direction on the two personality tests. The results on the HSPQ indicated that the girls were less assertive, dominant, aggressive, and impulsive; and more insightful, organized, responsible, and emotionally disciplined. The changes on the Jesness Inventory indicated that the girls became significantly more socially adjusted.

The researchers of this study did note that more longitudinal and comparative studies were needed to evaluate the real effectiveness of a residential treatment center.

COMBINED EVALUATION

Combining family and individual evaluation can be a more effective and worthwhile endeavor. A study by Blackman, Pitcher, and Rauch (1986) reported on the results of a multivariate analysis of pre- and post-individual and family measures on patients in a community based day and evening program.

The researchers of this study hypothesized that adolescents who attended the evening program (an after-school program) would generally show less psychopathology than those adolescents that attended the full time day program (could not be maintained at school). It was also hypothesized that the scores on each assessment instrument in both components of the program would show positive change with attendance in the program over time.

The study examined 46 consecutive case records of adolescents who completed the program in 1982. When the files were pulled, however, it was found that sufficient pre- and post-data was only available for 31 adolescents, who then became the subjects of the study. The four measures that were used in the study were: Piers Harris Self Concept Scale, Kovacs Child Depression Inventory, Beck Depression Inventory, Child Behavior Checklist, and Family Assessment Measure. Data was then examined to determine any

pre- and post-program differences and day-evening program differences utilizing a two way analysis of variance with repeated measures.

Based on the results of the Child Behavior Checklist, the program seemed to be effective in reducing the total number of disturbed behaviors as seen by mothers. It also appeared that the only difference in psychopathology between the day and evening program adolescents was the level of externalizing behaviors.

On analysis of the family assessment measure there were no significant differences noted in the pre- and post-test scores.

A further area of interest was the adolescents' perception of self. It was noted that the adolescents rated themselves significantly higher in self concept at the end of the program.

The results of the depression scales indicated that there was a significant decrease in depression scores for both the mother and adolescents. There were no significant changes in fathers' depression scores over time.

The researchers concluded that the program appeared to be very successful in dealing with the intrapsychic manifestations of the adolescents' psychopathology, but not as successful in dealing with interfamilial behavioral difficulties as measured by the test instruments used.

A MODEL FOR EVALUATION

David Wilson, Steven Prentice-Dunn, and Sandy Wurtele (1983) described a project designed to monitor and evaluate residential treatment programs for emotionally disturbed youth. The dual purposes of the Residential Treatment Evaluation Project (RTEP) were: (a) to provide the funding agency with information to aid in decision-making, and (b) to help the individual providers to more adequately monitor and evaluate their own programs.

The researchers identified four critical components of program evaluation. These are: defining and measuring client, treatment, and outcome variables, and instituting methodologically sound designs. While this project focused on residential treatment programs, I believe that the same components could be used for evaluation of day treatment programs.

Child characteristics. The authors of this report believe that delineating specific child characteristics is important for two reasons: First, the determination of placement should include a thorough analysis of the child's presenting problems, strengths and weaknesses, family structure, and other demographic indicants. Second, once the child has been placed in a residential facility, descriptive client information can be used for treatment planning and internal program analyses, such as determining what characteristics are related to outcome.

For the RTEP, they obtained demographic data on the children and their parents, descriptions of initial referral problems, and assessments of behaviors exhibited in the treatment setting. Information on behavioral problems was obtained via global ratings on several behavioral dimensions and ratings obtained from the Residential Treatment Behavior Rating Scale (RTBRS), a scale which measures both problem and positive behaviors occurring in residential treatment settings.

Defining and measuring treatment. A second component of residential treatment evaluation involves defining and measuring interventions. In order to make judgements about the utility of residential treatment, evaluations must first specify the components of treatment, and subsequently, assess whether the program, as conceptualized, was actually carried out.

Program characteristics data gathered in this project included cost per child, staff/child ratio, number of children, staffing model, average length of treatment, types of

services and treatment available, age and sex served, and a rating of success in treating specific classes of behavior.

Measurement of outcome. A third major element of evaluation is the determination of outcomes experienced by children during and after treatment. The authors noted several issues that should be considered when choosing outcome measures. They include: (a) outcome should be conceptualized and measured multidimensionally and multidirectionally, i.e., allowing for positive and negative changes in a variety of behavioral areas; (b) programs should adopt quantifiable measures to correct the overreliance on narrative information; (c) when possible, programs should use standardized measures; (d) programs should employ measures assessing behaviors relevant to the post-treatment environment; and (e) the child's perception of treatment and improvement should be considered.

Outcome information utilized in RTEP included a global rating of progress and behavioral ratings obtained using the RTBRS, with both measures taken at three-month intervals during treatment. Follow-up data was still being established but was to include: (a) a statement of placement at discharge; (b) a global behavioral rating made at regular intervals following discharge; and (c) a RTBRS at these times.

Research design. The fourth evaluation component, research design, provides the framework for obtaining, interpreting, and using outcome data, as well as determining relationships between treatment and outcome variables. In the residential treatment literature, classical experimental designs with random assignment are rare. One approach applicable to any program concerned with evaluation is to use pre-placement, in-program, post-treatment, and follow-up measures. If these measures are representative of the changes which take place during residential treatment, improvement should be revealed, if the program is effective. If positive changes are indicated, then higher level analyses could be employed.

Multivariate statistical models are also useful in the evaluation of residential treatment when a large number of subjects and variables are involved. The researchers of this project used multiple regression and path analyses to investigate the relationships between child characteristics, treatment variables, and outcome measures. Such an approach would yield valuable predictive statements when optimal research tools are not feasible.

This chapter looked at some of the research on programs for emotionally disturbed youth. Current research of these programs, particularly program evaluations, is limited. However, it was continually stated that descriptions and evaluations of programs serving these youth is of extreme importance. As the number of children with emotional disturbances increases, so does the need for this type of research.

Overall, the research reviewed in this chapter was favorable for the programs studied. They gave good descriptions of the programs, stated the importance of the programs, and shed some light on the effectiveness of the programs. The programs presented here for evaluation seemed to be successful. Based on the measures used, the youth served in the programs improved in a variety of areas.

The model presented in the research for residential treatment programs is a good standard to use for day treatment programs also. The researchers stated the importance of beginning with simple measures and analyses before moving up to higher level evaluations. I will use this model as a basis of my study of a partial care program. My report will focus on a description of this program with hope that in the future an evaluation can also be done.

CHAPTER 3

This chapter will discuss the methods of the present study. It will include a description of the subjects, research design, and procedures used in the study.

SUBJECTS

The subjects in this study are past and present clients of a partial care program in southern New Jersey. They are classified emotionally disturbed and have a DSM-III diagnosis. A total of 120 subjects are used. The subjects have various ethnic backgrounds and range in age from 7 to 18 years. In addition, the subjects come from both urban and suburban environments.

DESIGN

This report will be a descriptive study of a partial care program. It will rely on ex post facto data since the subjects used in this study were examined after being placed into the program.

PROCEDURES

In this study I will collect my data for the subjects by reviewing the information in their files. In addition, I will contact families and other agencies when information needs to be confirmed. I will also review program documents and interview staff to collect my data for the program elements I will be studying.

The partial care program in this report began in July 1989. Due to the large number of clients that have attended the program since that time, I will only be examining those clients who were admitted into the program after January 1, 1992.

Once I have collected all of my data, I will then use that information to answer my research questions. I will use descriptive statistics to present and analyze my results.

CHAPTER 4

ANALYSIS OF DATA

This chapter will present and illustrate the results of the data collected. From this data, the four research questions of this study were answered. An analysis was done by means of descriptive statistics.

The first research question explored various characteristics of the youth participating in the partial care program. Specifically, this study looked at gender, race, and age, diagnosis, and family status upon admission. Figure 1a illustrates the results of gender and race. Of the 120 subjects studied, 96 were male and 24 were female. In other words, the population of clients at the program was 80% male and 20% female. The racial breakdown of the subjects was 58% African American, 32% Caucasian, 9% Hispanic, and 1% mixed race.

The age of the subjects upon admission was also recorded. The youngest subject was 7 years and the oldest was 18 years. Figure 1b displays the ages of all the subjects admitted into the program. The majority of clients (65%) were between the ages of 12 and 15 years. The mean age upon admission was 13.3 years.

The diagnoses of the subjects are displayed in Figure 1c. The largest categories are Conduct Disorder and Oppositional Defiant Disorder, making up 33% and 31% of the subjects respectively. Attention Deficit Hyperactive Disorder made up the next largest group with 16% of the subjects. Adjustment Disorder, Post Traumatic Stress Disorder,

Gender and Race of Subjects

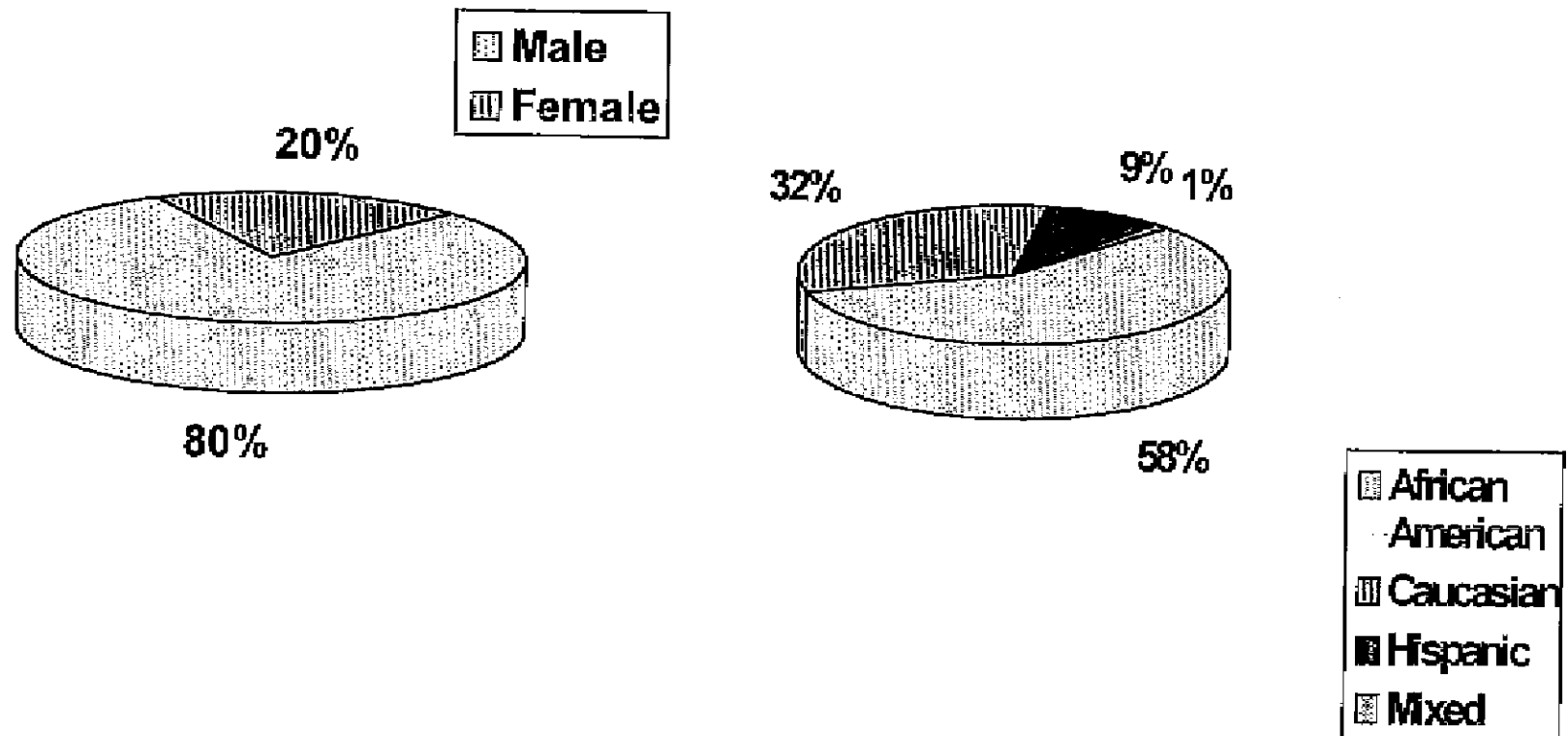


Figure 1a

Age of Subjects

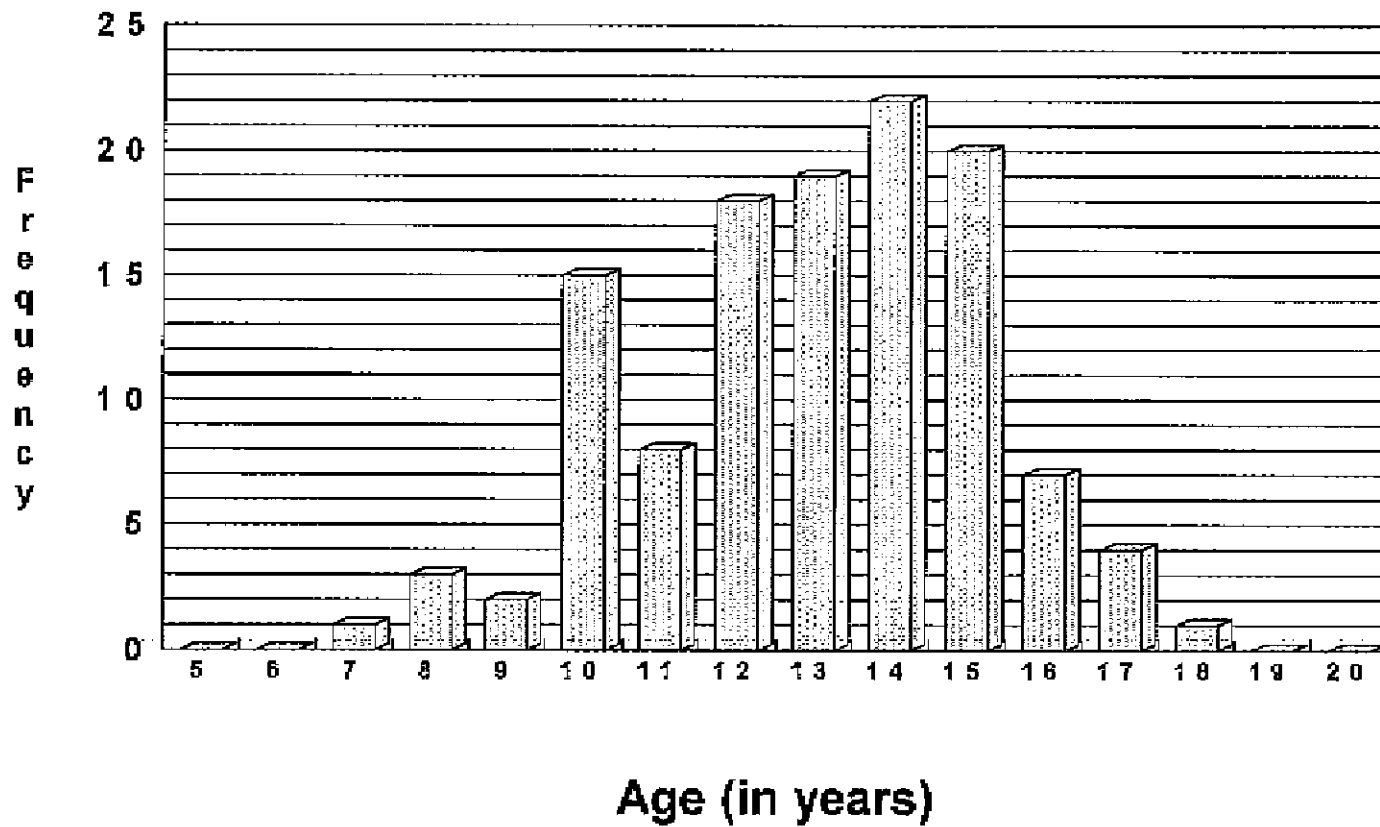


Figure 1b

Diagnosis of Subjects

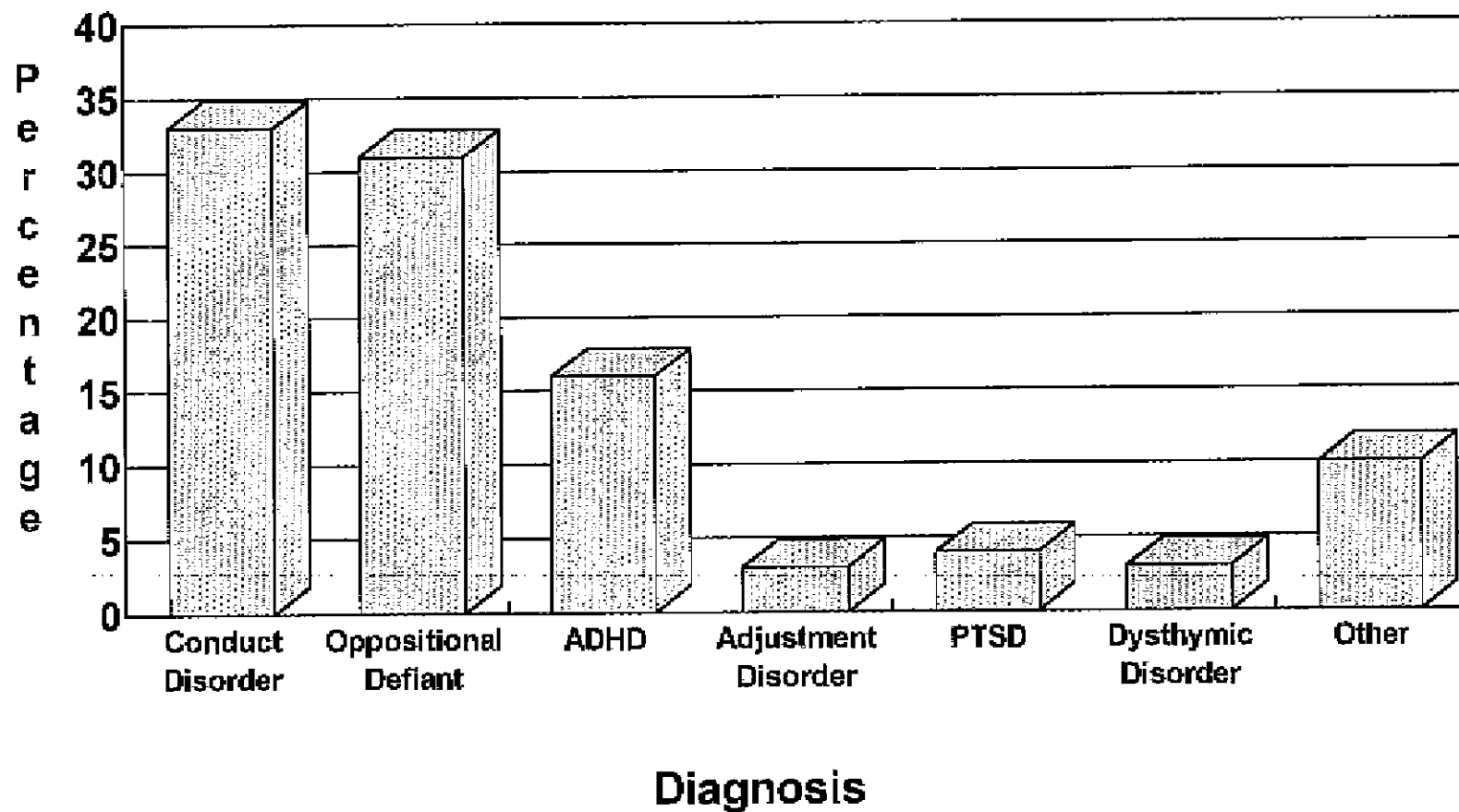


Figure 1c

and Dysthymic Disorder each accounted for about 3% of the subjects. Various other diagnoses represent the final 10% of the subjects.

The last characteristic looked at was family status, or who the client was living with when admitted into the program. Specifically, this study examined whether the client lived with one parent, two parents, a relative(s), in foster care, or in a shelter. Almost half of the subjects (46%) lived with only one parent. In all but three cases, the parent was the mother. Only 11% of the subjects lived with two parents (either biological, adopted, or remarried). Another 15% of subjects lived with a relative(s) of the family. A large number of subjects (25%) lived in foster care, and a small number lived in a shelter (see Figure 1d).

The second research question was concerned with the average length on stay for the clients in the program. The clients are divided into three groups in the program. One group is for clients 11 years and under. The second group is for 12-14 year olds. The third group is for clients 15 years and older. Therefore, this study looked at the average length of stay for clients in each of these groups. Figure 2 illustrates the results. For subjects between the ages of 7 and 11, the average length of stay was 9.5 months. For subjects between the ages of 12 and 14, the average was 8.3 months. For subjects between the ages of 15 and 18, the average was 6.4 months. The average length of stay for all the subjects combined was 8 months.

The third research question was interested in looking at the reasons for discharging clients from the program and where they went after discharge. The results are displayed in Figure 3. The largest number of subjects (37%) were discharged because they refused

Family Status of Subjects

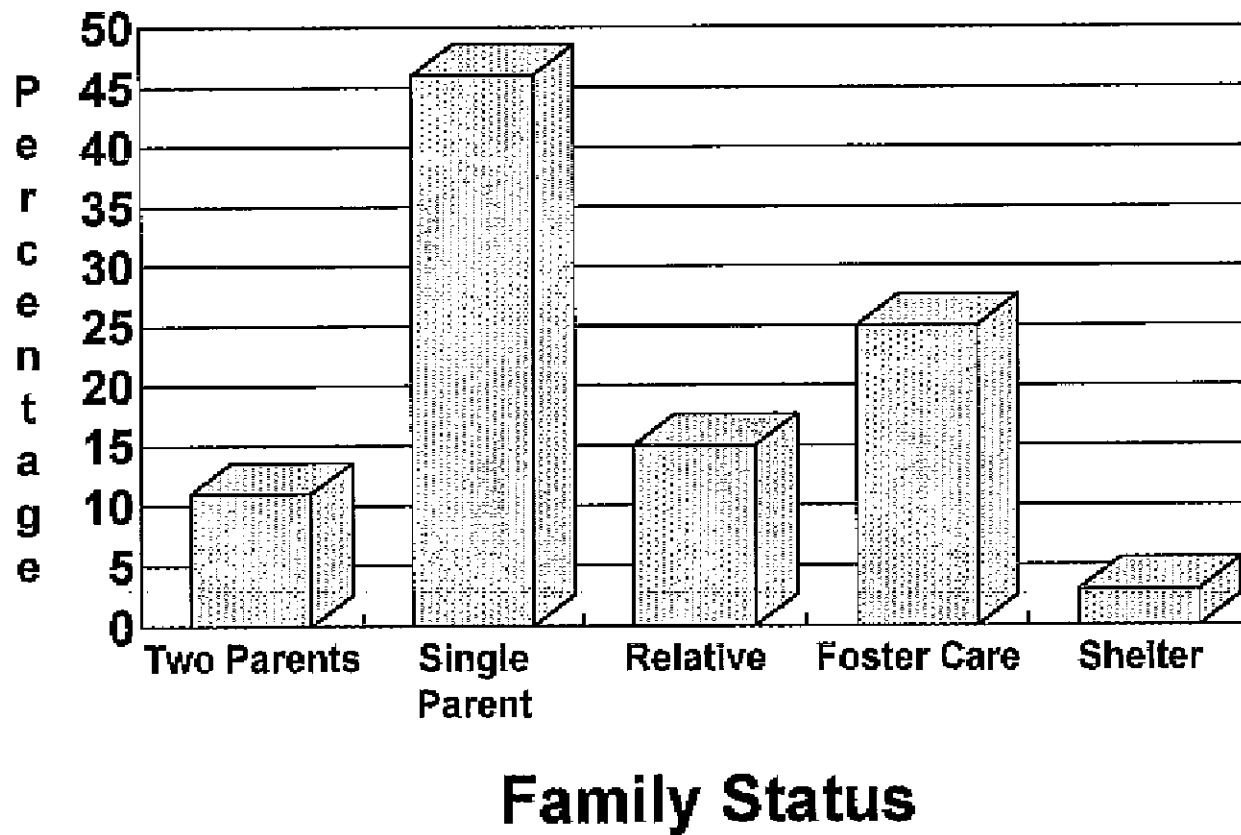


Figure 1d

Length of Stay for Subjects

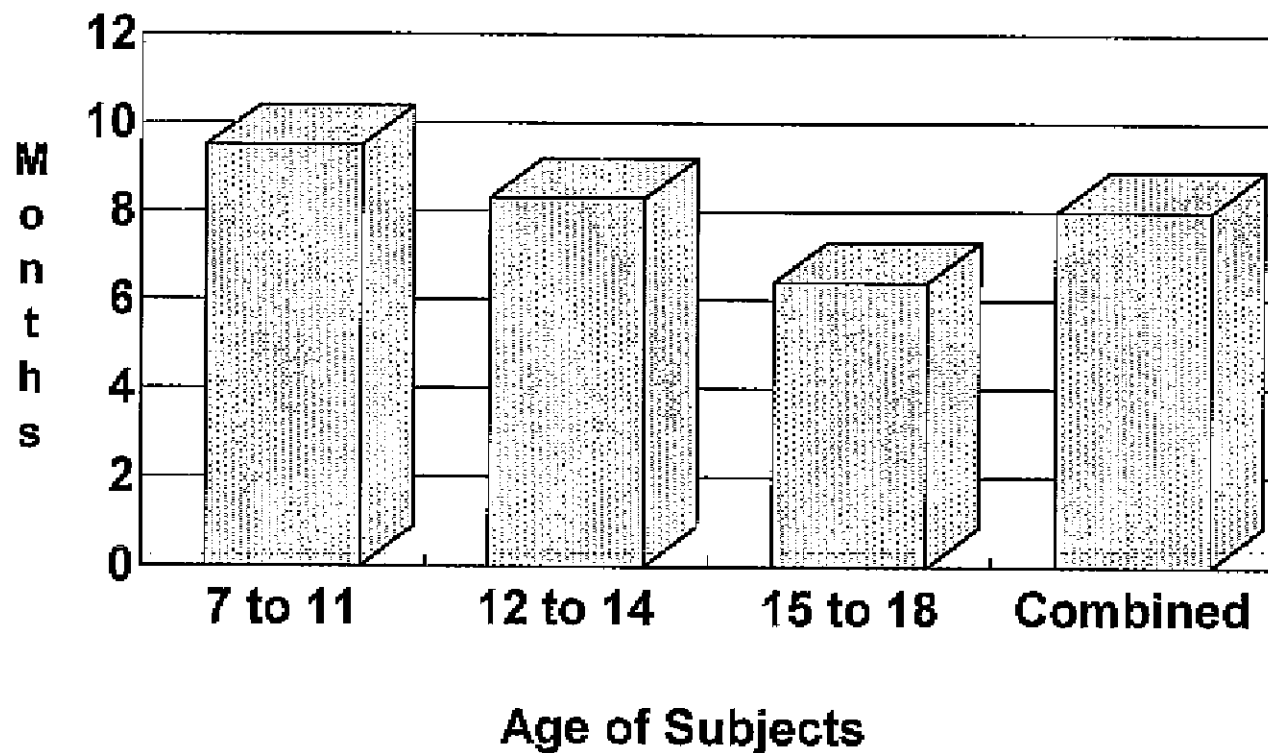


Figure 2

Reasons for Discharge

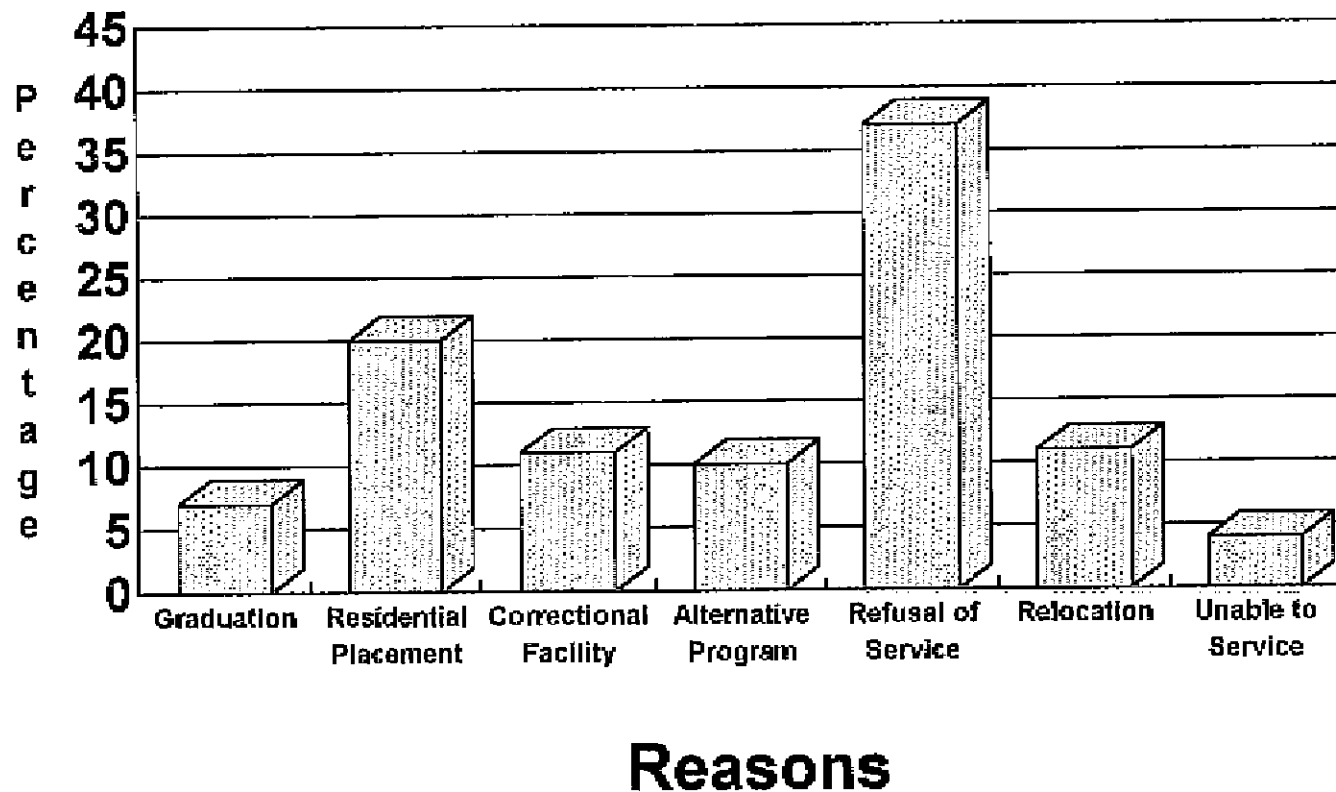


Figure 3

services. Some subjects were discharged due to another placement - 20% in a residential facility, 11% in a correctional facility, and 10% in an alternative program. An additional 7% of the subjects were discharged due to graduation from the program. Some subjects relocated (11%), and a few were unable to be serviced (4%).

The final research question explored the ratio of clients to staff at the program. The time frame of this study was from January 1992 to December 1994. The client-staff ratio was looked at in six month intervals during this time. The staff considered in these ratios are staff that work "hands on" with the clients on a daily basis. Figure 4 illustrates the results. In January 1992 the ratio of clients to staff was 5 to 1, in June 1992 the ratio was 4 to 1. In January 1993 the ratio of clients to staff was 6 to 1, in June 1993 it was 3 to 1. The remainder of the dates all had the same 3 to 1 ratio of clients to staff.

DISCUSSION

There are a few issues of this study that need further discussion. The first area concerns the subjects used in this study. Due to the location of the partial care program, a large number of subjects came from the same city. The rest were from the surrounding suburbs of that city. Therefore, generalizations are limited. One can not conclude necessarily that the characteristics of these subjects are the same for all emotionally disturbed youth. Also, as noted earlier, the program began in July 1989. Due to the large number of clients who have been admitted into the program since that time, this study only looked at the clients who were admitted after January 1, 1992. This could have had an

Client to Staff Ratio








Date	Number of Clients per Staff
Jan. 1992	
Jun. 1992	
Jan. 1993	
Jun. 1993	
Jan. 1994	
Jun. 1994	
Dec. 1994	

Figure 4

effect on the results if the clients admitted prior to that date were significantly different than the clients who were the subjects of this study.

The second area concerns the design of this study and the use of ex post facto data. If there were any mistakes in the original data, then the results of this study could be effected. Also, some of the clients who were admitted into the program after January 1, 1992 could not be included as subjects in this study since the data in their files was incomplete or missing. This exclusion of some of the clients could also effect the results.

CHAPTER 5

SUMMARY

Chapter 1 stated the need for the development of a comprehensive continuum of care for severely emotionally disturbed (SED) children and adolescents. There is an increased movement and interest in serving such children in community-based programs. The partial care program that is studied in this report was created in response to this need. This and other programs for SED youth need to be described and evaluated in research. While the present study focused on description of the partial care program, it is the hope of this examiner that an evaluation can also be done in the future.

The four research questions of this study were: (1) What are the characteristics of the youth participating in the program? (2) What is the average length of stay for the clients in the program? (3) What are the reasons for discharging clients from the program and where do they go after discharge? (4) What is the client to staff ratio at the program?

Chapter 2 reviewed some of the research on programs for emotionally disturbed youth. The number of studies focusing on these programs is limited, but some research related to program descriptions and program evaluations was presented. Finally, a model detailing the components of program evaluation was discussed. This model provided a guideline for the present research report.

Chapter 3 discussed the methodology of this study. The subjects were 120 past and present clients of a partial care program in southern New Jersey. This descriptive

study relied on ex post facto data. The clients' files were reviewed to gain the information needed to answer the research questions. Once the data was collected, descriptive statistics were used to present and analyze the results.

CONCLUSIONS

Chapter 4 presented and illustrated the results of the data collected. From this data, the four research questions of this study were answered. First, the majority of the subjects were African American males between the ages of 12 and 15 years, who were diagnosed either Conduct or Oppositional Defiant Disorder. The majority of the subjects also lived with a single parent. Second, the overall average length of stay for the clients in the program was 8 months. It was noted, however, that the youngest group of subjects had the highest average length of stay (9.5 months) while the oldest group of subjects had the lowest average length of stay (6.4 months). Third, the largest number of subjects were discharged due to refusal of service. Many subjects were also discharged due to another placement. Finally, the ratio of clients to staff varied from a high of 6 to 1 to a low of 3 to 1 over the three year time period of this study.

Two concerns of this study were also discussed. Due to the small geographical area the subjects came from and the fact that the majority of the subjects were inner city youth, the results obtained are limited in the generalizability to all emotionally disturbed youth. Also, results could have been effected if the clients who were excluded from this study were significantly different than the subjects selected for this study. Clients were excluded if they were admitted prior to January 1, 1992 in an effort to reduce the overall

amount of data. Clients were also excluded if information in their files was incomplete or missing. Finally, the use of ex post facto data could effect the results if there were any mistakes in the original data.

IMPLICATIONS FOR FUTURE RESEARCH

The research on programs for emotionally disturbed children and adolescents is limited, particularly community-based programs. With the continuous growth of children and adolescents with emotional problems, the need for this type of research becomes even more important. Descriptions and evaluations of these programs for SED youth should be established and made available to those who are interested or could benefit from the findings.

The present study made an initial effort to add to the literature on SED youth. The descriptive nature of this report could serve as groundwork for future evaluations. The model discussed by Wilson, Prentice-Dunn, and Wurtele (1983) identified four critical components of program evaluation. The researchers stressed the importance of beginning with simple measures and analyses before moving up to higher level evaluations. The present study accomplished some of the former but outcome measures need to be established at the partial care program so the latter can be accomplished as well. It is important to monitor and evaluate progress of the youth participating in these programs. There are numerous evaluations that can be made, including those from the individual and from the family. To measure the success of the clients, baseline and periodic data covering a variety of areas should be taken while they are involved with the program. In

addition, follow-up data should be collected after discharge to assess if there are any long term changes in the clients' level of functioning.

Hopefully researchers can share what they have learned from their efforts with those individuals who work with emotionally disturbed children and adolescents. We need to be more aware of the problems presented by these youth and how programs can improve their functioning and quality of life. This is how we can best help them become more productive members of society.

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