RESIDENTIAL FACILITIES FOR TREATING SUBSTANCE ABUSE PROBLEMS AMONG ADOLESCENTS IN THE UNITED STATES

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INTRODUCTION

Purpose

This monograph presents an analysis of residential group care programs in the United States providing services to children and youth with problems of abusing drugs or alcohol. The data have been taken from the National Survey of Residential Group Care Facilities for Children and Youth, carried out by Donnell M. Pappenfort, Thomas M. Young, and Martha Morrison Dore and their colleagues at the University of Chicago, School of Social Service Administration. The survey covered nine varieties of residential facilities,[1] one of which are those that were serving children and youth in need of services due to use of an illegal substance. The agencies and programs studied were those operating under the auspices of state, county, and municipal governments, and private religious and secular (not-for-profit) and proprietary organizations (for-profit).

The objective of the survey was to provide an accurate and comprehensive description of the facilities and their programs, some general characteristics of the children and youth they serve,[2] information on the kinds of services provided in order to

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[1]In addition to facilities that serve substance abusers, the survey included facilities providing services to children and youth considered dependent and neglected, abused, emotionally disturbed, mentally ill, in need of services due to pregnancy, in need of supervision (sometimes referred to as status offenders), in need of temporary shelter or emergency care, and those considered in need of detention care--secure and nonsecure.

[2]Information on the residents is limited to aggregated data collection by agencies: no individual residents were interviewed nor were records pertaining to individuals examined.

focus on the problems of, and possibilities for, improving care. The study was conceived of, from the beginning, as an effort to make available to agencies of state and local government, legislators, private volunteer organizations, and concerned citizens the accurate and complete information they need to set policies and formulate plans to improve the quality of care and services to children and youth in local communities. Thus, decisions about what should be the focus of study were shared with a National Advisory Committee selected to reflect the diversity of concerns of practitioners, planners, and administrators in the field.

The survey was begun in the fall of 1981 and completed in June of the following year. In all, nearly 4,200 residential group care facilities received a questionnaire; the response rate achieved was well over 90 percent.[3]

Background

In the years since the first privately conducted census of children's institutions was carried out in 1966[4] a new area of specialization in the residential treatment of children and youth with special needs has developed: treatment of substance abuse

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[3]The survey was supported entirely by a grant from the National Institute for Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

[4]Donnell M. Pappenfort and Dee Morgan Kilpatrick, comps., A Census of Children's Residential Institutions in the United States, Puerto Rico, and the Virgin Islands, 1966. Social Service Monograph, 2nd ser., Number 4: 7 vols. (Chicago: School of Social Service Administration, University of Chicago 1970).

in facilities specifically for children and youth with drug or alcohol problems.

Drug addiction and substance abuse have become increasingly prevalent in our society. Whereas, in the 1950's drug use was seen as limited to adults, minorities, and members of counter-cultures, drug use and related problems now cut across age, socio-economic, and racial-ethnic lines. Narcotics addicts in the United States, it was said, at that time numbered about 65,000.[5] In 1982 it was estimated that one in 11 Americans of all ages, or nine percent of the population, had problems of addiction.[6] For adolescents estimates ranged from one in every six -- about 17 percent[7] -- to as high as 40 percent.[8]

The issue of teen addiction is critical, mainly because the consequences -- both short and long range -- are grave. The effects of mood-altering substances on individuals varies inversely with body weight: the less the body weight, the greater the effect. Since, on average, teens weigh less than do adults, sessions of drinking or using drugs -- taking nothing else into consideration -- tend to lead to greater degrees of mood change for them.[9] Teenagers also tend to consume greater quantities of

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[5]Mandel and Feldman. "The Social History of Teen Drug Use," in Teen Drug Use, Beschner and Friedman. Lexington Books, Lexington, MA: 1986, p. 19.

[6]Stanton and Todd, (1982) p. 1.

[7]Stanton and Todd, p. 1.

[8]Singer and Isralowitz, p. 1.

[9]Singer and Isralowitz, p. 1.

alcohol per drinking session than do adults,[10] which increases intoxication and mood change. Drinking by teenagers has been linked to traffic accidents, the leading cause of death among that age group in the United States.[11]

Avoiding physical harm and fatality -- from traffic accidents, overdoses, and other drug-related causes -- and surviving to enter adulthood, when adolescence has been spent in states altered by alcohol or drugs, might leave young adults who are recovering from the addictions they acquired during their teens to face life obstacles that are difficult to surmount. The tasks of adolescence are developing the values, goals, and principles to guide behavior and to help define self-identity. These guides aid in gaining self confidence and the ability to interact successfully with others. The complex of guides and skills give young adults the tools to care for themselves, lead satisfying lives, and contribute in constructive ways to society. Struggling with an addiction preoccupies and leaves no time for these tasks, so that these adolescents enter the age of majority unprepared for adulthood. The long-range price -- for the youth caught up in substance abuse and for society -- is high, indeed.

The critical nature of addiction and the young has garnered national attention and often is covered by the media, which has in turn increased concern. However, this concern as yet has not produced much published research that can be used to inform the

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[10]Singer and Isralowitz, pp. 1-2.

[11]Singer and Isralowitz, p. 2.

design of programs for young drug users. There is a paucity of information on residential group care programs for adolescents abusing drugs and alcohol.

What literature that is currently available suggests a philosophy of adolescent drug use and intervention that links together the teen drug user, his or her parents, and a therapist into a system. These system members communicate, chiefly through the use of various talking and behavioral treatment methods. Parents are almost always included as an integral part of the intervention because "our society tends to hold parents responsible for the behavior of their adolescent children."[12] According to the New York Times, Nancy Reagan "all but blamed drug addiction on the nation's parents" in a press conference to announce that she would focus on the teen drug problem during her husband's tenure in the White House (11/10/81). Numerous factors outside of the parents' and family's control may "trigger the addiction cycle" among teens, but the view is that "the family's influence is primary" and "accentuates or attentuates the impact" of outside factors.[13]

Parents probably tend to agree that they have prime responsibility for their children's drug use, since parental guilt and self-blame are prevalent among the parents of adolescent

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[12]Daroff, Marks, and Friedman. "Adolescent Drug Abuse: The Parents` Predicament," in Teen Drug Use, p. 185.

[13]Stanton and Todd (1982), p. 26.

addicts.[14] Experts agree that such parental feelings do nothing to help, and may impede, the young person's recovery. Family therapy usually is included in the overall treatment program; this helps to promote communication, which helps the youth and also helps stem parental guilt feelings. These parents, as do those of many non-abusing adolescents, find their teenagers difficult to talk to. In addition, they tend to find substance-abusing children distant and aloof, showing a lack of respect, and, sometimes, frightening.[15]

For the teenager's part, just being an adolescent carries the burden of trying to exist in an awkward state of pluralism--coping with the restriction and comforts of childhood while struggling both for increased autonomy and against the responsibilities of near-adulthood. The complications of being adolescent may make teenagers more vulnerable to states of mind that lead to substance abuse. This view is expressed by Stanton et. al. (1982) and underscored by Blum and Singer (1983) whose position is that "substance abuse among adolescents should be viewed as rule/norm violating behavior," similar to, albeit potentially more damaging than other similar behaviors common to a period when the individual experiences "considerable physiological and psychosocial change and stress" (pp. 7-8).

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[14]Daroff, Marks, and Friedman, pp. 190-192.

[15]Daroff, Marks, and Friedman, p. 187.

Taking the characteristics of adolescence into consideration -- and the fact that the use of a mood altering substance tends to exacerbate difficulties -- emphasizes the importance of treating teenagers with drug and alcohol problems using programs designed especially for that age group. However, adolescent substance abusers frequently receive treatment from programs that were created for adult addicts or alcoholics.[16]

Specialized residential facilities for the treatment of substance abuse among adolescents are still few in number. Only 69 were enumerated in 1981.[17] Of course, they by no means constitute the only residential resources for youth with drug and alcohol problems. In addition to the adolescents in adult programs, many residential facilities for children and youth, although existing primarily to treat other problems, reported that care for substance abusers was a secondary function. In addition, a number of facilities reported children and youth in residence with these problems even though the facilities themselves considered the treatment of substance abuse neither a primary nor a secondary function. The facilities surveyed for this report were limited to those for persons 20 years of age and younger.

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[16]George De Leon and David Deitch, "Treatment of the Adolescent Substance Abuser in a Therapeutic Community," Chapter 15 in Treatment Services for Adolescent Substance Abusers, by Friedman and Beschner, pp. 216 and George Beschner, "The Problem of Adolescent Drug Abuse: An Introduction to Intervention Strategies," in Friedman and Beschner, p. 5 (1985).

[17]Sixty-two of them, located in 22 states, are included in this study. See Table 40.

Independent Variables

Three characteristics have been used to distribute into subgroups the 62 facilities that have treatment of substance abuse as a primary function: facility size measured by number of children and youth in residence, whether the facility is independent or affiliated with another organization (part of larger facility or operated by another agency providing other services), and the claimed level of emotional disturbance or behavior problems among the children and youth in residence.

The facilities were divided into two categories based on the median size: those that had fewer than 19 residents and those that had 19 or more residents. Each of the characteristics surveyed was analyzed to determine if relatively smaller or larger facilities systematically differed from one another in the eight groups of characteristics outlined above.

The facilities, also, were divided into those that were completely separate and independent versus those that were a unit of a larger residential facility (such as the children's psychiatric ward of a medical or psychiatric hospital) or a part of a larger unit, bureau, or department to determine if independence or affiliation makes a difference in the characteristics being studied.

Finally, the responses to an item that asked about the percentages of residents considered to have no, mild, moderate, or severe emotional disturbance or behavior problems were used to construct an "index of disturbance." The index was divided into

"high," "medium," and "low" to analyze whether level of disturbance related to differences among the characteristics studied. Table 1 presents the distribution of the facilities for the three independent variables.

Organization of the Monograph

The next section of the monograph discusses the facilities' characteristics. Included in this discussion are origins, sponsors, and functions carried out; governance, funding, and costs; various characteristics of childcare workers; and types of in-service training provided.

Following that is a description of the characteristics of the residents. These include number of residents (a one day count for the day the respondent completed the questionnaire) and characteristics of the residents, including their problems, conditions, and patterns of behavior.

Then follows the characteristics of the programs, including sources of referrals, frequency of therapy appointments and the types of professionals and treatment approaches used, family involvement, resident autonomy and participation in community activities, school attendance, discipline methods, grievance procedures, security, lengths of stay and aspects of residents' return to the community.

Finally, residential facilities are compared with nonresidential agencies designed specifically to treat substance-abusing adolescents.

CHARACTERISTICS OF THE FACILITIES

Origins, Sponsors, and Functions Carried Out

In the 1970s there emerged a new form of residential group care -- facilities with the primary function of providing care to children and adolescents with drug or alcohol problems. They are few in number -- just 62 in all by the year 1981. Most of them (83.9 percent) were operated by private rather than governmental organizations (Table 2).

Of the 52 private agencies, 36 (69.2 percent) were sponsored by secular, not-for-profit organizations. Seven others (13.5 percent) were Protestant, and eight (15.4 percent) were proprietary (for-profit).[18] One private facility operated under Jewish auspices. Of the ten public facilities, seven were state- and three were county-operated (Table 2).

The facilities for substance abusers were created in recent years, apparently in recognition of a need for a unique variety of residential care. Forty-four percent were founded between the years 1976 and 1981, 51.6 percent between 1970 and 1975, and just 4.8 percent earlier -- between 1966 and 1969 (Table 3). Eighty-two percent (51 out of 62) had been established as new facilities specifically to provide care to children and youth with drug or alcohol problems. The rest had been serving other categories of children and had subsequently changed function to serve substance

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[18]Although small in number, the eight proprietary facilities made up 12.9 percent of the total of 62. This was the second largest proportion among the nine types of facilities surveyed, exceeded only by psychiatric facilities (17.1 percent).

abusers. In large part the directors of the facilities appear to share a common general view of their mode of operation: nearly two-thirds of them described their facilities as residential treatment centers.[19]

Governance, Funding, and Costs

All but seven facilities operated under the supervision of a Board of Directors, ranging in size from three to thirty members, with no one size predominating (Table 4). Fifteen of them (24.2 percent) also reported having a Citizens' Advisory Committee -- "a group of representatives from the community established to provide a formal link between the facility and the community and/or to advocate for the residents within both the facility and the community."

Directors of the privately-run facilities were asked: "From which of the following sources have you received funds during the past year?" Their responses, ranked from the largest to the smallest percentages, are in Table 5. The largest number -- three-quarters of the total -- answered "payments by public agencies and courts that place children/youth in the facility." The second largest was "payments by the parents of children/youth in the residence." Other informative answers were "government grants" (49.0 percent), "private insurance such as Blue Cross and Aetna" (41.2 percent), and "third party payments such as CHAMPUS

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[19]Other names applied were "group home," "halfway house," "ranch," and "hospital."

and Medicaid" (35.3 percent). Perhaps because many of the facilities were founded recently, only 17.6 percent had endowments and investments and only 13.7 percent received funds from United Way or other federated fundraising bodies.

The distribution of annual operating budgets is in Table 6. The range is from "$50,000 up to $250,000" to "three million up to four million" dollars. However, almost three-fourths had budgets under $500,000. One-quarter reported a per diem cost of less than $45 per day per resident. One-quarter had a cost of $84 or more with ten reporting a cost per day per resident exceeding $100 (Table 7). As a group, then, these tend to be facilities that are not inexpensive to operate.

Criteria for Hiring Childcare Workers

Childcare workers -- sometimes called houseparents, youth workers, aides, attendants, or technicians -- perform a vital function in residential group care facilities. They are the direct service staff persons who have a primary responsibility for the day-to-day care of children and youth in residence.

Facilities were asked: "When hiring childcare staff for your residential facility, which three of the following criteria do you consider most important?" Their responses were summarized to show the number of times each criteria was selected (Table 8). Four criteria were reported to be especially important. Three of the four are not unexpected: (1) formal education in a field appropriate for the position in question, (2) previous experience

in such a position, and (3) related experience with children. However, a considerable number emphasized (4) personal experiences or conditions similar to those of the youth in the program -- an answer of interest given the function of these facilities. This finding is underscored by literature on the topic.

> "Senior staff, as recovered ex-addicts, are visible role models who illustrate the reality of personal change. Their own rehabilitative experience qualifies them to teach, to sanction, and to serve as guides and rational authorities."[20]

Training for Childcare Workers

Most of the facilities provide in-service training for full-time childcare workers, and most in-service programs are either continuous or combine continuous elements with training that ceases after a set period of time. Information about in-service is not available for 17 facilities (27.4 percent). To arrive at the statement that "most provide training," as well as related generalizations, we have percentaged the non-responses to guard against error in our statements.

The facilities appear to be somewhat successful in retaining childcare personnel once they are hired. They were asked: "About how long does the average childcare worker remain employed

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[20]Description of Phoenix House, therapeutic community, George De Leon and David Deitch, "Treatment of the Adolescent Substance Abusers in a Therapeutic Community," Ch. 15, p. 219 of Alfred S. Friedman and George M. Beschner, eds., Treatment Services for Adolescent Substance Abusers. Rockville, Md.: National Institute of Drug Abuse, DHHS Publication No. (ADM) 85-1342, 1985.

at your facility?" Only one said that the average childcare workers remained employed for "less than one year." Forty-five percent answered "about two years," and 25.8 percent, "about one year."[21] A few reported retention for longer periods (Table 9).

Childcare Workers Salaries

Childcare workers beginning annual salaries ranged from $903 (probably part-time) up to $14,000. The bulk of those reported were under $10,000 per year. The highest possible salaries were from $1,300 up to $25,000, with no one salary category predominating. The distribution, grouped in categories, is in Table 10.

Childcare Worker Duties

It is clear from the answers summarized in Table 11 that childcare workers are not just supervising the children and youth in residence, preparing their food, and cleaning the living units. They are heavily involved in all forms of treatment -- with individuals, groups, families, -- and in planning residential programs. They also act as liaison with community resources and participate in community relations.[22] They much less often

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[21]In addition, about half reported that forty-five percent or less of their newly hired childcare workers leave within the first year of employment. However, the number of places for which there is no information is very large -- 21 or 33.9 percent -- so the answers as summarized may be misleading.

[22]The 16 nonresponses to each item are treated in the Table as if each facility had answered "no" to the item. The "yes" answers are, therefore, the smallest percentage possible for each item.

perform even light housekeeping duties or prepare meals. It seems apparent that childcare workers are a major component of the treatment strategy of these facilities.

Childcare Worker Staffing Models

The basic staffing model most often used for the childcare staffs was a shift model with a certain number of hours on duty followed by a certain number of hours off duty. Exclusive reliance on the live-in model was infrequent, although some facilities used both (Table 12).

In-Service Training
Childcare Workers and Professionals

We asked facilities a series of questions to learn the types of in-service training being given to staff. Training for childcare and professional staff was asked about separately from training for administrators. In general, in-service training was more often provided to childcare and professional staff than to administrative staff. Responses indicates of the eight childcare and professional trainings asked about, seven were provided by half or more of the facilities. Of the nine administrative trainings asked about, six were provided by half or more of the facilities.

The most frequent type of in-service training provided for administrators was "Communication skills" (67.7 percent). Also provided quite frequently were "Program evaluation"

(64.5 percent), and "Personnel management" (62.9). The type of training provided least frequently was "Grantsmanship" (21.0 percent). (See Table 13).

The three most frequent in-service training programs provided to childcare and professional staff were "Behavior management" (87.1 percent), followed by "Case management methods" (83.9 percent), and "Knowledge of child development and age appropriate behavior" (75.8 percent). (See Table 14).

CHARACTERISTICS OF THE RESIDENTS

Number and Demographics

There are 1,629 children and youth in the 62 residential facilities. The residents tend to be white males who are halfway through adolescence, have one chance out of two of not being in the custody of parents -- biological or adoptive -- and usually have involvement with the court system.

About two-thirds (68.8 percent) were males and one-third (31.2 percent) females. Nearly half (49.6 percent) were 16 or 17 years of age; the rest (50.4 percent) were distributed among four other age categories (Table 15).

About three-quarters of the youth were white. The remaining one-fourth included blacks (12.3 percent), Hispanics (10.2 percent), American Indians (2.5 percent), and Asians (0.4 percent). (See Table 16).

Problems, Conditions, and Patterns of Behavior

What do the statistics on emotional disturbance imply? Of the youth in care, 85.8 percent were judged to reveal some degree of emotional disturbance or behavior problems. Of these, 16.1 percent were classified as severely disturbed, 40.0 percent as moderately so, and 29.7 percent as mildly disturbed. The rest (29.7 percent) were considered to display no particular disturbance or behavior problems (Table 17). To get a more concrete description of the population of the youth served, we asked each facility to provide an estimate of the percentages of children

and youth in care having each of 17 problems, conditions, or patterns of behavior: violent to self/suicidal; violent toward others; abused by parents; depressed; difficulties in peer relationships; family problems; problems regarding property; disruptive behavior; accused or adjudicated delinquent offenders; learning and perceptual problems; chronic physical illness; mentally retarded; thought disorders and bizarre behavior; physical handicaps; drug or alcohol abuse; problems beyond the control of child/family; problems and conditions relating to sexuality. The percentages were multiplied by the numbers in residence to provide the estimated displayed in Table 17.[23]

Nearly all of the youth in residence (93.9 percent) had problems of drug or alcohol abuse. It is also not surprising that large proportions had experienced family problems (77.8 percent), difficulties in peer relationships (68.2 percent), and were depressed (60.5 percent). Those are characteristics that apply to large numbers of children in all types of residential group care. Less predictable is the 65.3 percent who had engaged in disruptive behavior, a proportion exceeding that for all other varieties of residential group care except the facilities specifically for status offenders (78.4 percent). Large numbers also were accused or adjudicated delinquents (46.3 percent), had problems regarding property (42.7 percent), and had been abused

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[23]The percentages rest on staff judgments and should not be interpreted as estimates that would be produced by a national testing and evaluation program applying standardized criteria. Such a program does not exist.

(40.7 percent). [Although among the smaller proportions in Table 17 it may be of importance to note that the 17.6 percent who were considered violent to themselves or suicidal was the largest pertaining to any variety of facility except those primarily providing psychiatric care (27.9 percent), and that 17.9 percent were violent toward others.] When one considers these and the other numbers in Table 17, it is clear that the staffs of the facilities have provided a profile of youths with very difficult problems, conditions, and patterns of behavior.

There was no consistent pattern of differences in the reports of larger and smaller facilities, the independent or affiliated facilities, or according to the index of disturbance.

CHARACTERISTICS OF THE PROGRAMS

Sources of Referrals and Court-related Placements

The court system plays major role in the functioning of these facilities and, potentially, has great influence over the lives of the youth who receive treatment in their programs. Only four facilities -- out of the total 62 -- indicated that they had no residents, at the time of the survey, whose placements were related to the court system.

Facilities were asked: "For those children/youth whose placement is court-related, please write the numbers of children/youth who are currently in residence at your facility, either awaiting court action or as a result of a court order (disposition), for the following reasons..." They were then presented with a list of eleven possible reasons for a resident to await, or to have been placed at the facility as a result of court action. Not surprisingly, the largest single reason for residents having contact with the court is "Drug/alcohol abuse." Half (50.9 percent) of the "Numbers in residence as a result of a court order" and four out of ten of the "Number in residence awaiting court action" are in this category. "Status offense" and "Delinquency" are also frequent reasons for residents having, or expecting to have, court contacts (Tables 18 and 19).

"Court" also was prominent in the results of questions that asked about (1) all referral sources and (2) the three most frequent sources of referral. Fifty-eight of the facilities

(93.6 percent) said that "court"is a referral source, and 34 (54.8 percent) indicated that it is one of the three most frequent sources of referral (Tables 20 and 21).

Slightly more than half of the facilities reported a waiting list for admission (Table 23). Many of the larger facilities -- two-thirds of them -- had waiting lists compared with only 41.7 percent of the smaller facilities. There was a tendency for the facilities with less disturbed populations to have accumulated a waiting list more frequently than those with more disturbed populations, but the tendency is not a strong one. Facility independence or affiliation is not related to the existence of a waiting list.

Frequency of Therapy Appointments, Professionals Used, and Treatment Approaches

Directors were asked if the residents of their facilities received regularly scheduled therapy sessions, about the types of professionals used at their facilities for regular sessions with the residents, and about the treatment approaches utilized in their programs. Regrettably, answers to some of these items are incomplete. The information that is available is presented below.

More than eight out of ten of the directors (85.5 percent) indicated that the children and youth in their facilities had regular therapy or counseling sessions (Table 23). Social workers are among the professionals most frequently employed -- by three-fourths, or 74.2 percent, of the facilities that say the

youths at their facilities have regularly scheduled treatment appointments. Psychologists and a collection of "Other professionals" were represented frequently. Psychiatrists were least frequently employed for the regularly scheduled therapy sessions (Table 24).

The same proportions of large and small facilities indicated that they use psychologists and "Other professionals" -- 7.0 percent for psychologists and 77.4 percent for "Other professionals." Slightly more large facilities indicated using social workers (77.4 percent of the large and 71.0 percent of the small). There is a greater difference in employing psychiatrists: 61.3 percent of large facilities indicated employing psychiatrists compared to 48.4 percent of the small facilities. High-disturbance facilities consistently reported employing all four categories of professionals more frequently than did low-disturbance facilities, but medium disturbance facilities were not consistently between the low- and high- disturbance groups. Facilities with affiliated departments or organizations more frequently reported employing each of the categories of professionals than did independent facilities.

We used the facilities' responses to questions about use of professionals to construct a typology of clinical staffing patterns (Table 25). The largest group (27, or 43.6 percent of the total) used representatives of all professional categories for therapy or counseling sessions. The next most frequent

clinical staffing pattern was a combination of social workers, psychologists, and other professionals.

These are not programs that depend primarily on psychotropic medication to help youth function in the programs. In fact, only five programs reported any use of such medication (Table 26). (However, information is missing for 16 programs.) Instead, the treatment methods reported, and displayed in Table 27, appear to indicate in general eclectic approaches to working with individuals, groups, and families.

Two generalizations can be inferred from the data in Table 29, at least tentatively. First, the facilities are fairly heavily invested in group as well as in individual modes of treatment. For example, the 47 facilities answering the question named 217 approaches used with groups of residents, an average of 4.7 per facility. They had mentioned 241 approaches used with individual residents, a slightly larger average of 5.1 per facility. Also, it appears to the writers (and others may well disagree with our interpretation of the number in Table 27) that the modes of intervention used more often are those traditionally associated with treatment of delinquents and status offenders. For example, the two approaches reported more frequently as "not used at all" are gestalt therapy and psychotherapy. In contrast, the approaches less frequently listed as "not used at all" are behavioral therapy, guided group interaction, reality therapy, and positive peer culture. If one looks at the numerically

dominant modes of intervention for each constellation of resident/families we find the following:

INDIVIDUAL RESIDENTS: behavioral therapy, reality therapy

GROUPS OF RESIDENTS: guided group interaction, behavioral therapy, positive peer culture, reality therapy

FAMILIES OF RESIDENTS INCLUDING THE CHILD/YOUTH: parent effective training, teaching family model (a behavioral oriented intervention), guided group interaction, reality therapy

FAMILIES OF RESIDENTS WITH THE CHILD/YOUTH: parent effectiveness training

Others, of course, may draw different conclusions based on the information.

Family Involvement

The majority of these youths, like those in almost all types of residential group care, have some sort of family problems: nearly 9 out of 10 facilities (88.1 percent) indicated that at least fifty percent of their residents had family problems, and half (51.6 percent) said that at least fifty percent had been abused by parents (Table 17). Still, it is generally accepted that involving parents, as well as other important family members, is an essential component of helping substance abusers to stop drinking and taking drugs. We included several items in the questionnaire that were intended to give us information on how involved the parents of these youth are.

It seems reasonable to expect involved parents to see the youth fairly frequently. We asked directors: "About how often does the average child/youth in your residential facility see

his/her family? They were to indicate their answers by selecting a category as presented in Table 28.

Sixteen percent reported "Several times a week." The largest single category was "About once a week." Over one-quarter (27.5 percent) of the facilities picked this category for the average resident. The category of "Twice a month" was the next largest (24.2 percent). Together, the latter two categories were selected by more than half of the facilities. "Once a month" (17.7 percent) and "Several times a week" (16.1 percent) account for another third (33.8 percent) of the facilities. The remaining nine facilities (14.6 percent) are divided among "Once every 2 or 3 months" (9.7 percent), "Once every 6 months" (3.2 percent), and "Varies according to length of time in program" (1.6 percent).

Examining these responses within categories of the three characteristics of size, level of disturbance, and affiliated vs. independent facilities identified no clear pattern of difference.

Seven out of 10 facilities (71.0 percent) said that "Family involvement is a requirement," (Table 29) yet a fairly large percentage (40.3 percent) said that parents or families are "Less involved than is desirable." [No facility reported that families were "More involved than is desirable," and 22.6 percent did not answer.]

One reason for a level of parent involvement that is less than desirable could be the distance of facilities from the youths' home communities. We asked: "What is the approximate

percentage of the children/youth currently in residence in your facility whose home community is one of the following: (a) under 5 miles from your facility, (b) 5 to 25 miles from your facility, (c) 26 to 50 miles from your facility, (d) 51 to 150 miles from your facility, (e) more than 150 miles from your facility." The responses indicate that about half of the youth had home communities more than 50 miles from the facilities at which they were residents (Table 30). While 50 miles is not an extremely long distance, traveling that far might deter families without easy transportation or with limited resources. The fact that nearly one-third of the facilities (30.6 percent) indicated that they made home visits suggests the possibility that administrators and boards saw a need to reach out in this way. Facilities that are affiliated with other organizations are more likely than are independent facilities to have large proportions of residents with home communities nearby. The same is true of the smaller, compared with larger, facilities.

Resident Autonomy

Directors were asked a series of questions that explored the extent to which the residents of these facilities are allowed to begin taking responsibility for themselves and an active role in shaping their environments:

> To help describe your residential program in more detail, please indicate whether or not the following are characteristics of your program for the majority of your residents. [PLEASE CIRCLE YES OR NO FOR EACH ITEM].

The percentage answering "yes" to each of the items is given in Table 31. Directors of facilities with 18 or fewer residents answered "yes" to items more frequently than did directors of facilities with more than 18 residents. This result may not be surprising, since it may be easier in smaller facilities than in larger ones to provide the supervision that permits resident autonomy to operate.

Accepting new residents with high levels of emotional disturbance did not produce a consistent pattern of responses across the seven responsibilities asked about. Being an independent facility, rather than being affiliated with another department or organization, also was not consistently related to answering "yes" to these items.

Resident Participation in Community Activities

The directors were asked about the rates at which residents participate in various activities in the community. (Table 32). We asked facilities about the rates at which their residents participated in ten community-based or community-oriented activities. The reported rates for the activities ranged from a high of almost 80 percent to a low of just over 16 percent. The activity most frequently done -- by 79.9 percent of the youth -- was "Go to the movies." Also frequently done (i.e., by 50 percent or more of the residents) were "Use parks or playgrounds" (73.7 percent), "Visit museums" (67.1 percent), and "Shop in downtown stores" (53.9 percent. The least frequent activity was

"Visit homes in the neighborhood" (16.2 percent), "Do paid chores or have jobs in the community (18.0 percent), "Attend sports events, dances, etc." (25.5 percent), and "Use public transportation" (40.4 percent).

School Attendance

The overwhelming majority of the youth (86.6 percent) were in school (Table 33). Of those in school, most (86.9 percent) attended classes at their facilities (Table 34).

Discipline Methods Used

We wanted to learn about the discipline methods used with the children/youth and the grievance procedures, if any, available to them. We asked:

> We realize that choice of discipline method will reflect the unique circumstances of the infraction: however, we would like to know what methods of disciplines are usually employed in your residential program. [PLEASE CIRCLE YES OR NO FOR EACH ITEM]

In response directors were to indicate which of the 11 methods asked about are ever used at their facilities. Overall, as may be seen in Table 35, the three methods most often used were "Individual discussion with the child/youth at the time of the misbehavior" (77.4 percent), "Removal of privileges such as television viewing or attending a movie" (75.8 percent), "Group discussion of the misbehavior" (74.2 percent). The least often used appear to be "Spanking or paddling" (1.6 percent) and "Withholding food" (6.5 percent).

A few subgroup differences can be seen. "Loss of tokens" is claimed more frequently among large facilities than small ones (61.3 percent, compared to 38.7 percent).

There are clear patterns of differences in the disciplinary methods used by independent facilities and facilities affiliated with other departments or organizations. For example, almost half (47.8 percent) of the independent facilities used "Restriction of physical activity" while only slightly over one-quarter (26.3 percent) of the affiliates used that method. Nearly two-thirds (65.2 percent) of the independent facilities, compared to about four out of ten of the affiliated (39.5 percent), reported using "Loss of tokens." Also, 87.0 percent of the independents used "Removing privileges" compared to 68.4 percent of the affiliated facilities. The differences were in the same direction for "Removal to a quiet room" (43.4 percent and 26.3 percent), "Group discussion" (87.0 percent and 65.8 percent), "Group imposed sanctions" (65.2 percent and 47.4 percent), and "Dismissal" (82.6 percent and 63.2 percent).

Grievance Procedures

We also asked about grievance procedures:

> Does your facility have any of the following internal grievance procedures for the children/youth in residence who feel they have been treated unfairly? [PLEASE CIRCLE YES OR NO FOR EACH ITEM]

The rate of non-response is large, so interpretations must be regarded as tentative, but the numbers of facilities that had prepared themselves to handle grievances seem small. For

example, only 43.5 percent had written grievance procedures. Even smaller proportions had organized some more formal mechanism for processing complaints (Table 36).

Security at the Facility

A majority (53.2 percent) of the facilities described their security arrangements as minimal, and 4 facilities reported that they had no security arrangements at all. Most of the others reported medium security arrangements, with only 8 places claiming strict security (Table 37).

Apparently security, for these facilities, is defined mainly in terms of staff members accompanying the children or youth. It is the only security arrangement used by a majority -- nearly three-quarters (72.6 percent) -- of the facilities. The next most frequently used security arrangement, having locked floors or areas, is used by only one-quarter (27.4 percent) of the facilities (Table 38). No facility locked sleeping rooms at night, and just a few used electronic monitoring devices such as closed circuit television.

Length of Stay and Leaving the Facility

The average lengths of resident stay at the facilities range from two to days up to three years. Three-quarters of the facilities (77.4 percent) have average resident stays of less than one year. The directors were asked to indicate "about how long children or youth remain in residence" at their facilities in terms of the categories as presented in Table 39. Four out of 10

(41.0 percent) reported an average stay of "6 months up to 12 months." A majority of the remaining facilities reported either "2 days up to 30 days" (4.9 percent) or "1 month up to 6 months" (32.8 percent). Only one out of five said either "1 year up to 2 years" (14.8 percent) or "2 years up to 3 years" (6.6 percent).

Facility staffs were asked: "During the past year about what percentage of the children/youth in resident left your facility before you felt they were ready?" The results should be regarded cautiously because there are a large number of non-responses (15, or 24.2 percent of all facilities). However, seven out of 10, three-fourths directors (44 out of 62 or 71.0 percent) responded that at least some residents had left their facilities prematurely. It appears that a variety of reasons may account for the residents leaving early. Responses to: "Why did these children/youth leave your facility before they were ready?", indicate that the three main reasons are (1) youth running away from the facility, (2) youth leaving because they had been inappropriately placed at the facility, and (3) youth transferring to another facility. Youth running away is also a likely factor in the frequency with which "Staff accompanying youth" is used as a security arrangement (Table 40).

Aftercare

An overwhelming majority of facilities indicate that they provide planned aftercare to residents who leave the program. We asked: "Does your facility itself provide a formal, planned program of aftercare?" Fifty-one of the 62 facilities (82.3

percent) said "yes." Smaller facilities were more likely to do so than larger ones.

COMPARISON OF RESIDENTIAL AND NONRESIDENTIAL ORGANIZATIONS

General Characteristics

The nonresidential agencies that specialize in treating substance abuse problems among adolescents tend to be much older, more likely to operate under public sponsorship, and more frequently located in commercial areas than are residential facilities that specialize in treating the same age group.

More than half (54.7 percent) of the nonresidential agencies were founded before 1970; fewer than one out of 20 (4.8 percent) of the residential facilities were founded before that year (see Tables 45A-45C). While the majority of both the residential and nonresidential organizations are private, the percentage of nonresidential public organizations is more than twice as great as the percentage of residential organizations (42.2 percent compared to 17.7 percent; see Table 46).

Over one-third (35.9 percent) of the nonresidential organizations are located in business or commercial areas, compared to less than one-tenth (8.1 percent) of the residential organizations. There are other differences between residential organizations with respect to location of service delivery. Residential organizations are somewhat more likely to be located in residential areas than are nonresidential organizations (59.7 percent, compared to 46.5 percent) and they are also more likely to be situated in rural areas (12.9 percent), or in the open countryside (also 12.9 percent); none of the nonresidential agencies are so located (see Table 47).

Budgets

The annual operating budgets of both the residential and nonresidential organizations tend to be under one-half million dollars. Three-fourths (75.7 percent) of the residential and seven out of 10 (71.7 percent) of the nonresidential had budgets that fell within that range (see Table 48A). Among these organizations (i.e., those with budgets under one-half million dollars), residential facilities tend to have budgets that are larger than those of the nonresidential agencies. While half or nearly half fall within the $100,000 to one-quarter million dollar range (48.9 percent of residential and 46.2 percent of nonresidential), the rest of these nonresidential (40.3 percent) are more likely to have budgets that are smaller than $100,000, while a good portion of the rest of these residential (36.2 percent) have budgets that are in the one-quarter to one-half million dollar range (see Table 48B; also see Table 48C).

Funding Sources for Private Organizations

Both residential and nonresidential organizations were very likely to indicate that "Individual Contributions" is a funding source. Residential organizations were much more likely to say that collecting fees -- from families or from other private agencies -- is a funding source than were the nonresidential organizations (see Table 49). Also, nonresidential agencies names "Private Foundations" as a funding source almost three times as often than did residential facilities (Table 49).

Family Involvement

Residential facilities were slightly more likely to require parent or family involvement than were nonresidential agencies, but not much. Seventy-one percent of the residential, compared to 64.6 percent of the nonresidential said they require family involvement (see Table 50).

Problems, Conditions, and Patterns of Behavior

Nothing unexpected was found when the residential and nonresidential organizations were compared on percentages of clients having certain problems. Residential facilities were much more likely to indicate that at least half of their clients had one of the problems listed in Tables 51A and 51B than were nonresidential agencies.

Use of Social Workers, Psychologists, and Psychiatrists

Responses to items that ask about the frequency with which three professional groups--social workers, psychologists, and psychiatrists--are used at the two types of organizations indicate that all three types are used more frequently at residential ones than at nonresidential ones. This appears to indicate the most frequent use of teams, composed of more than one professional, at the residentials and the more frequent use of single professionals at the nonresidential agencies. Also, while "Social Worker" is the professional most often used at both the residential and nonresidential organizations, "Psychologist" is

the next most often used at residential facilities and "Psychiatrist" is next at nonresidential agencies (see Table 52).

Methods Used with Clients

Residential and nonresidential organizations differ in the frequency with which psychotherapy, social casework, reality therapy, and peer counseling are used. They do not differ in the rates of usage of behavior therapy, group therapy, and parent effectiveness training (see Table 53).

Residential facilities are more likely to use reality therapy and peer counseling than are nonresidential agencies. Over seven out of ten (73.6 percent) residential organizations indicated that they use reality therapy, compared to six out of ten (60.3 percent) nonresidential organizations. Two-thirds (66.1 percent) of the residential organizations utilize peer counseling, while fewer than half (45.2 percent) of the nonresidential ones employ this method.

Nonresidential organizations are more likely to use psychotherapy and social casework than are residential organizations. Nonresidential agencies use psychotherapy with their clients at a rate of 54.9 percent, while 45.2 percent of the residential facilities use psychotherapy. Social casework, the method most frequently used among the tertiary nonresidential agencies, is used at more than eight out of ten (83.6 percent) nonresidential organizations, compared to somewhat more than half (56.5 percent) of the residential organizations.

Client Groups Worked With

Unfortunately, over one-fourth (27.4 percent) of the residential facilities did not respond to an item that asked about client groups (individuals, families, groups) that the organizations work with, so valid comparisons between residential and nonresidential organizations cannot be made. It can be noted, however, that the information available indicates that, as might be expected, both residential and nonresidential organizations more often work with individuals than they do with either groups or families (see Tables 54A and 54B).

Table 1

Distribution of Facilities
By Categories of the Three Independent Variables

	Number	Percent
SIZE		
Small (<19 residents)	31	50.0
Large (19+ residents)	31	50.0
	62	100.0%
INDEPENDENT/AFFILIATED		
Independent	23	37.1
Affiliated	38	61.3
No answer	1	1.6
	62	100.0%
INDEX OF DISTURBANCE		
Low	21	33.9
Medium	20	32.3
High	20	32.3
No answer	1	1.6
	62	100.1%*

*Does not sum to 100.0 due to rounding.

Table 2

Auspices of Facilities
(in percentages)

Auspices of Facilities	Percent
Public	21.6
State	19.3
Local	2.3
Private	68.5
Protestant	6.3
Catholic	1.3
Jewish	0.0
Secular	60.3
Proprietary	10.6
TOTAL	100.1
Total of Facilities	62

Table 3

Year Founded (in percent)

Year	Percent
Before 1966	0.0
1966-1969	4.8
1970-1975	51.6
1976-1981	43.5
TOTAL	99.9*
Base Number	62
Total of facilities	62

*Does not sum to 100.0 due to rounding.

Table 4

Size Distribution of Boards of Directors
(in percent)

Size	Percent
3 - 6	10.9
7 - 9	32.1
10 - 15	28.3
16 - 30	20.8
TOTAL	100.1*
Base Number	53
No answer	2
No boards	7
Total of facilities	62

*Does not sum to 100.0 due to rounding.

Table 5

Funding Sources for Private Facilities
(in percent)

Source	Percent using source	Percent no answers
Payments by public agency placed child	76.5	5.9
Client payments	68.6	5.9
Own fund-raising	62.7	3.9
Bequests, other individual contributions	51.0	5.9
Government grants	49.0	5.9
Private insurance	41.2	9.8
Third party public payments	35.3	9.8
Private foundation or corporate grant	31.4	5.9
Payments by private agency placed child	29.4	11.8
Sponsoring bodies	27.5	5.9
Endowments or investments	17.6	9.8
United Way, other foundations	13.7	9.8
Other private source not listed	2.0	7.8
Base Number	51	
Public Facilities	11	
Total of facilities	62	

Table 6

Distribution of Annual Operating Budgets
(in percent)

Budget	Percent
Less than $50,000	0.0
$50,000 up to $100,000	11.5
$100,000 up to $250,000	36.1
$250,000 up to $500,000	27.9
$500,000 up to $750,000	9.8
$750,000 up to $1,000,000	3.3
$1,000,000 up to $3,000,000	8.2
$3,000,000 up to $4,000,000	3.3
$4,000,000 or more	0.0
	100.1*

*Does not sum to 100.0 due to rounding.

Table 7

Per Diem Costs: Percent of Facilities by Cost Per Resident Per Day

Per Diem Cost	Percent
$20 or less	13.8
$21 - $30	15.5
$31 - $40	15.5
$41 - $50	17.3
$51 - $60	8.6
$61 - $75	6.9
$76 - $100	6.9
$101 - $200	8.6
$201 - $350	6.9
Over $350	0.0
TOTAL	100.0

Base Number	58
No Answer	4
Total of Facilities	62

Table 8

Frequency Distribution of Criteria for Hiring Childcare Workers

Criteria	Number
Formal education or training	31
Previous experience	40
Personal history similar to that of residents	26
Ethnicity, race, or religion	5
Special interest or commitment	29
Language other than English	0
TOTAL	131
No answer	16

Table 9

Length of Time the Average Childcare Worker Remains Employed at the Facility (in percentages)

Less than one year	1.6
About one year	25.8
Two years	45.2
Three years	12.9
Four years	3.2
Five years or longer	4.8
No answer	6.4
TOTAL	99.9*
Total of Facilities	62

*Does not sum to 100.0 due to rounding.

Table 10

Percent of Facilities Reporting the Ranges for "Lowest Beginning" and "Highest Possible" Salaries for Childcare Workers

Salary Range	Lowest Beginning	Highest Possible
$5,000 or less	6.5	3.2
$6,000 - $7,999	9.7	--
$8,000 - $9,999	25.8	8.1
$10,000 - $11,999	17.7	9.7
$12,000 - $13,000	6.5	14.5
$14,000 - $15,999	1.6	8.1
$16,000 - $17,999	--	9.7
$18,000 - $19,999	--	3.2
$20,000 or more	--	4.8
No answer	32.3	35.5
TOTAL	100.1*	100.0
Total of Facilities	62	62

*Does not sum to 100.0 due to rounding.

Table 11

Duties of Child Care Workers
(in percentages)

Duties	Percent Performing
Parenting	48.4
Individual counseling/therapy	66.1
Group counseling/therapy	66.1
Family counseling/therapy	48.4
Behavioral treatment/management	71.0
Teaching life skills	64.5
Supervising personal hygiene of children/youth	69.4
Planning and carrying out recreation	69.4
Meal preparation	29.0
Supervision of meals	64.5
Light housekeeping	24.2
Dispensing psychotropic medication	8.1
Tutoring	29.0
Accompanying children/youth away from facility	69.4
Providing aftercare or follow-up	45.2
Individual treatment program planning	64.5
Recordkeeping	64.5
Liaison with community resources (schools, clubs, recreational facilities)	59.7
Participating in public relations/community education	51.6
TOTAL 46	
No answer 16	
Total of Facilities 62	

Table 12

Staffing Model for Childcare Workers

	Percent
Shift model	45.2
Live-in model	9.7
Both	16.1
No answer	29.0
Total	100.0%

Table 13

Number of Facilities Providing In-Service Training to Administrative Staff, By Focus of Training (in percent)

Focus of In-Service	Percent Providing	Percent No Answer
Communication skills	67.7	3.2
Program evaluation	64.5	4.8
Program management	62.9	3.2
Personnel management	62.9	3.2
Legal issues affecting the residential care of children/youth	58.1	4.8
Development of community resources	50.0	6.5
Fiscal management	45.2	3.2
Fund raising techniques	27.4	4.8
Grantsmanship	21.0	6.5

Base Number	62
Total of facilities	62

Table 14

Number of Facilities Providing In-Service Training to Childcare and Professional Staff

Focus of In-Service	Percent Providing	Percent No Answer
Behavior management	87.1	3.2
Case management methods	83.9	3.2
Knowledge of child development and age appropriate behavior	75.8	4.8
New diagnostic and/or treatment methods/techniques	67.7	3.2
Legal issues affecting the residential care of children/youth	61.3	4.8
Use of community resources	58.1	4.8
Program evaluation	45.2	3.2

Base Number	62
Total of facilities	62

Table 15

Percent of Children or Youth, By Age and Sex

Age	Male	Female	Total
Infants under 2 years of age	0.0	0.0	0.0
Preschool children, 2 through 5 years of age	0.0	0.0	0.0
Primary school children, 6 through 11 years of age	0.2	0.0	0.1
Adolescents, 12 through 15 years of age	28.9	35.2	30.9
Adolescents, 16 through 17 years of age	49.7	49.5	49.6
Persons 18 through 20 years of age	16.9	11.4	15.2
Persons 21 years of age and older	4.4	3.9	4.2
TOTAL	100.1%	100.0%	100.0%
Base numbers	1,007	457	1,464
No answer: age or sex			165
Total of children or youth			1,629

Table 16

Race/Ethnicity of Children and Youth
(in percentages)

White	74.6
Black	12.3
Hispanic	10.2
American Indian	2.5
Asian	0.4
TOTAL	100.0

Base Number of Children/Youth	1,424
No answer	205
Total number of Children/Youth	6,629

Table 17

Reported Problems, Conditions, or Patterns of Behavior: Percent of Children or Youth, By Type of Problem (in Rank Order)

Behavior	Percent of Youth
Drug or alcohol abuse	93.9
Family problems	77.8
Difficulties in peer relationships	68.2
Disruptive behavior	65.3
Depressed	60.5
Accused or adjudicate delinquent offenders	46.3
Problems regarding property	42.7
Abused by parents	40.7
Problems and conditions relating to sexuality	25.2
Learning and perceptual problems	21.5
Problems Beyond the control of child/ family	19.7
Violent toward others	17.9
Violent to self/suicidal	17.6
Thought disorders and bizarre behavior	7.2
Chronic physical illness	6.1
Physical handicaps	3.3
Mentally retarded	1.7

Table 18

Percent of Court-Related Children and Youth
By Reason for Court Contact
(in Rank Order)[a]

Reason for Contact	Awaiting Court Action	As a Result of Court Order	Total
Drug or alcohol abuse	42.5	52.9	51.0
Delinquency	12.6	21.4	19.8
Status offence	16.4	7.0	8.7
Treatment for mental health problems	0.0	7.2	5.9
Neglect	4.8	2.4	2.8
Dependency	3.4	2.5	2.7
Abuse by parents	2.9	2.5	2.6
A reason not listed[b]	10.1	0.6	2.3
Unknown reason	7.2	0.8	2.0
Mental health diagnosis	0.0	1.8	1.5
Medical treatment	0.0	0.7	0.6
Adoption	0.0	0.1	0.1
TOTAL	99.9%*	99.9%*	100.0%
Total number of contacts	207	957	1164

[a]A child or youth may have court contacts for more than one reason.

[b]Possible other reasons include: awaiting transportation to another facility, aftercare, custody hearing, needing supervision, special education for the retarded, and criminal offense.

*Does not sum to 100.0 due to rounding.

Table 19

Placement Into Facility is Court-Related

Reason for Placement	Number Awaiting Court Action	Number Placed as Result of Court Action	Total Number of Court Related Cases
Adoption	0	1	1
Medical treatment	0	7	7
Mental health diagnosis	0	17	17
Treatment for mental health	0	69	69
Dependency	7	24	31
Neglect	10	23	33
Abuse	6	24	30
Status offense	34	67	101
Delinquency	26	205	231
Drug-alcohol abuse	88	506	594
Reason unknown	15	8	23
Other	21	6	27

Number of facilities responding	61
No answer	1
Total of facilities	62

Table 20

Sources of Referral: Percent of Facilities

Referral Source	Percent
Court	93.5
Probation	90.3
Parent/family	88.7
Social agencies other than those listed	85.5
Medical hospital, clinic	77.4
Private psychiatrist, psychologist, social worker	74.2
Self referral	72.6
School	69.4
Mental health center	69.4
Other short-term residential setting	66.1
Psychiatric facility	62.9
Correctional facility	58.1
Welfare department	56.5
Private physician	56.5
Clergy	46.8
Other long-term residential settings	41.9
Police	38.7
Other	8.1

Base number	62
Total of facilities	62

Table 21

Percent of Facilities Reporting Referral Source
As one of Three Most Frequent Used

Referral Source	Percent
Court	55.7
Parent/family	42.6
Probation	42.6
Welfare department	26.2
Social agencies other than those listed	21.3
School	18.0
Other short-term	16.4
Mental health center	11.5
Medical hospital, clinic	9.8
Self referral	6.6
Private psychiatrist	6.6
Correctional facility	6.6
Clergy	4.9
Private physician	4.9
Psychiatric facility	4.9
Police	3.3
Other long-term residential setting	1.2

Base number	61
No answer	1
Total of facilities	62

Table 22

Percent of Facilities Having and Not Having A Waiting List

		Percent
Has a waiting list		54.2
Does not have a waiting list		45.8
Base Number	48	
No Answer	14	
Total of facilities	62	

Table 23

Percent of Children and Youth Receiving and Not Receiving Regularly Scheduled Therapy or Counseling Appointments

	Percent
Receiving regular appointments	85.5
Not receiving regular appointments	14.5
TOTAL	100.0
Base number 62	
Total of facilities 62	

Table 24

Frequency of Seeing Each of the Professionals Asked About
(in percent)

Frequency	Psychiatrists	Social Workers	Psychologists	Other Professionals
Less often than once a week	33.9	32.1	30.2	11.3
Once a week or more	9.5	41.6	30.3	66.0
Varies to much to generalize	20.8	13.2	22.6	13.2
No youth meet with this professional	26.4	3.8	11.3	5.7
No Answer	9.4	9.4	5.7	3.8
TOTAL	100.0	100.1*	100.1*	100.0

Base Number	53
Number with no regular appointments	9
Total of facilities	62

*Does not sum to 100.0 due to rounding.

Table 25

Pattern of Professional Staffing

Professional Groups(s)	Percent	Number
. Social workers only	4.8	3
. Social workers and unspecified "other professionals"	1.6	1
. Social workers, psychologists, and "other professionals"	16.1	2
. Social workers, psychiatrists, and "other professionals"	3.2	10
. Psychiatrists and psychologists, and "other professionals"	3.2	2
. All; social workers, psychiatrists, psychologists and others	43.6	27
. No regular scheduled appointment/N.A.	27.5	17
TOTAL	100.0	
Base number	62	
Total of Facilities	62	

Table 26

Percent of Facilities Using Psychotropic Medication

		Percent
Uses psychotropic medication		10.9
Does not use psychotropic medication		89.1
TOTAL		100.0
Base Number	46	
No answer	16	
Total of facilities	62	

Table 27

Approaches in Working With Individual Residents, Groups of Residents, and Families of Residents By Type of Method (in percent)

Method	Used with: Individuals	Groups	Families	More than One	Not Used	No Answer	Total
Psychotherpy	12.9	1.6	0.0	30.6	30.6	24.2	100.0
Behavior Therapy	11.3	3.2	1.6	56.4	4.8	22.6	99.9*
Guided Group Interaction	4.8	16.1	0.0	50.1	6.5	22.6	100.1*
Reality Therapy	12.9	6.5	1.6	51.7	4.8	22.6	100.1*
Parent Effectiveness Training	1.6	0.0	19.4	32.2	21.0	25.8	100.0
Positve Peer Culture	4.8	14.5	1.6	45.1	11.3	22.6	99.9*
Gestalt Therapy	4.8	4.8	0.0	27.4	35.5	27.4	99.9*
Social Casework	19.4	0.0	3.2	33.8	17.7	25.8	99.9*
Teaching Family Model	6.5	0.0	9.7	30.6	25.8	27.4	100.0

*Does not sum to 100.0 due to rounding.

Table 28

How Often the Average Child or Youth Sees Family, Including Home Visits and Visits at the Facility (Percentages of Facilities)

Frequency	Percent
Several times a week	16.1
About once a week	27.5
Twice a month	24.2
Once a month	17.7
Once every two or three months	9.7
Once very six months	3.2
Once a year	0.0
Less than once a year	0.0
Never	0.0
Varies too much to generalize	1.6
TOTAL	100.0
Base number 62	
Total of facilities 62	

Table 29

Percent of Facilities Requiring and Not Requiring Family Involvement

	Percent
Family Involvement Required	71.0
Family Involvement Not Required	29.0
TOTAL	100.0
Base Number	62
Total of Facilities	62

Table 30

Distance of Facilities From Residents' Home Communities:
Distribution of Children and Youth
(in percent)

Distance		Percent of Children and Youth
Under 5 miles from facility		12.0
5 to 25 miles from facility		28.2
26 to 50 miles from facility		11.5
51 to 150 miles from facility		31.3
More than 150 miles from facility		17.0
TOTAL		100.0
Base Number	1,588	
No answer	41	
Total of Children and Youth	1,629	

Table 31

Percent of Facilities that Allow their Residents to Carry out the Indicated Autonomous Activities

Activity	Percent Allowing	Percent No Answer
Most children/youth in our facility are able to leave campus by themselves as long as they tell a staff member where they are going	25.8	0.0
Most children/youth in our program are able to make and receive phone calls with adult supervision	48.4	0.0
Children/youth in our program are able to send and receive mail without monitoring	46.8	0.0
The children/youth in our facility select and purchase their own clothing	82.3	1.6
The children/youth in our program are able to work outside the facility to earn extra spending money	43.5	0.0
The children/youth in our facility have individual cabinets or closets that lock for important personal possessions	41.9	0.0
The children/youth in our facility frequently participate in planning field trips, special events, and other activities	87.1	0.0
The children/youth in our facility actively participate in formulating the rules and procedures that affect their daily lives	53.2	0.0
Base Number	62	
Total of Facilities	62	

Table 32

Resident Participation in Community Activities: Estimated Percent of Children and Youth Participating

Activity	Percent
Go to movies	79.9
Use parks or playgrounds	73.7
Visit museums	67.1
Shop in neighborhood stores	53.9
Shop in downtown stores	46.4
Use libraries	45.2
Use public transportation	40.4
Attend sports events, dances	25.5
Do paid chores, have jobs	18.0
Visit homes in neighborhood	16.2
Base Number	1,417
Not applicable: no children in residence	212
Total of children and youth	1,629

Table 33

School Attendance of Children and Youth

		Percent
Attend school		86.6
Do not attend school		13.4
TOTAL		100.0
Base Number	1,629	
Total of children and youth	1,629	

Table 34

Location of School Attendance
Among Residents Who Attend

		Percent
At the facility		86.9
At a public school outside the facility		8.5
At a private school outside the facility		1.6
Other arrangement		3.0
TOTAL		100.0
Base Number	1,410	
Do not attend	219	
Total of children and youth	1,629	

Table 35

Percent of Facilities Indicating Use of Selected Method of Disciplines

Disciplinary Method	Used	Not Used	No Answer
Restriction of physical activity, such as confinement to a bedroom	35.5	41.9	22.6
Loss of tokens or reduction in achievement level	50.0	27.4	22.6
Removal of privileges, such as TV viewing, attending a movie	75.8	1.6	22.6
Withholding food, e.g., no dessert after dinner	6.5	70.9	22.6
Removal to a quiet room or time-out room	32.3	8.1	24.2
Spanking or paddling	1.6	75.8	22.6
Physically holding an out-of-control child/youth	25.8	51.6	22.6
Group discussions of misbehavior	74.2	3.2	22.6
Group imposed sanctions	53.2	24.2	22.6
Discussion with child at time of misbehavior	77.4	0.0	22.6
Dismissal from the program	71.0	6.4	22.6
Base number		62	
Total of facilities		62	

Table 36

Grievance Procedures: Percent of Facilities by Type of Grievance Procedure Utilized

Grievance Procedures	Percent Using Procedure	Percent No answer
Written grievance procedures	43.5	25.8
A formal grievance committee made up of residents	14.5	25.8
A formal grievance committee made up of staff	25.8	27.4
A formal grievance committee made up of both residents and staff	21.0	25.8
A resident who acts as an ombudsman	12.9	27.4
A staff person who acts as an ombudsman	21.0	29.0
A advocate from outside the facility, such as a guardian *ad litem*	8.1	25.8
Base Number	62	
Total of Facilities	62	

Table 37

Security Level for most Youth
at the Facilities
(in percent)

Security Level		Percent
Strict		12.9
Medium		27.4
Minimal		53.2
None		6.5
TOTAL		100.0
Base Number	62	
Total of facilities	62	

Table 38

Percent of Facilities Using Various Security Arrangements

Security Arrangement	Percent Using	Percent No Answer
Buildings are locked during the day	11.3	0.0
Sleeping rooms are locked at night	0.0	1.6
There are locked floors or areas	27.4	0.0
Gates and fences are locked	11.3	1.6
Windows have security screens	16.1	0.0
Electronic monitoring devices such as closed circuit television are used	4.8	0.0
Staff members accompany children/youth	72.6	1.6
Another arrangement not listed	19.4	0.0

Base Number 62

Total of Facilities 62

Table 39

Average Length of Stay
(in percent)

Length of Stay	Percent
Less than 48 hours	0.0
2 days up to 30 days	4.9
1 month up to 6 months	32.8
6 months up to 12 months	41.0
1 year up to 2 years	14.8
2 years up to 3 years	6.6
3 years up to 4 years	0.0
4 years up to 5 years	0.0
5 years up to 10 years	0.0
10 years or more	0.0
TOTAL	100.1*
Base Number	61
No answer	1
Total of facilities	62

*Does not sum to 100.0 due to rounding.

Table 40

Number of Facilities in the Individual States

State	Number of Facilities
California	4
Colorado	3
Connecticut	1
Florida	3
Illinois	3
Indiana	1
Iowa	3
Massachusetts	2
Michigan	3
Minnesota	11
Mississippi	1
Montana	1
Nebraska	1
New Hampshire	1
New Jersey	3
New York	7
Ohio	5
Rhode Island	1
Texas	4
Virginia	1
Washington	1
Wisconsin	2
TOTAL	62

Table 41

NUMBER OF CHILDREN AND YOUTH IN THE INDIVIDU L STATES, 1981: BY PUBLIC AND PRIVATE AUSPICES OF FACILITIES

	Total Public	Total Private		Total Public	Total Private		Total Public	Total Private
Alabama	819	1,082	Kentucky	792	855	Ohio	4,545	2,296
Alaska	157	225	Louisiana	1,488	1,528	Oklahoma	734	1,352
Arizona	601	813	Maine	274	464	Oregon	862	737
Arkansas	436	722	Maryland	1,141	987	Pennsylvania	1,502	4,589
California	11,081	5,382	Massachussets	242	1,749	Puerto Rico	1,002	204
Colorado	778	1,278	Michigan	2,355	2,288	Rhode Island	216	465
Connecticut	887	1,105	Minnesota	683	1,822	South Carolina	1,040	1,136
Delaware	380	158	Mississippi	389	835	South Dakota	173	276
District of Columbia	132	305	Missouri	994	1,386	Tennessee	1,845	1,466
Florida	2,855	1,911	Montana	227	383	Texas	2,642	6,502
Georgia	1,474	2,032	Nebraska	354	993	Utah	269	460
Guam	26	11	Nevada	744	117	Vermont	6	312
Hawaii	175	66	New Hampshire	131	305	Virgin Islands	17	42
Idaho	198	144	New Jersey	2,037	801	Virginia	1,725	1,523
Illinois	1,870	2,439	New Mexico	461	528	Washington	1,518	1,017
Indiana	1,660	1,374	New York	4,934	8,667	West Virginia	238	384
Iowa	397	760	North Carolina	2,477	1,597	Wisconsin	920	1,286
Kansas	744	745	North Dakota	134	107	Wyoming	213	64

Table 42

PERCENT OF CHILDREN AND YOUTH IN THE INDIVIDUAL STATES, 1981: BY PUBLIC AND PRIVATE AUSPICES OF THE FACILITIES

	Total Public	Total Private		Total Public	Total Private		Total Public	Total Private
Alabama	43.1	56.9	Kentucky	48.1	51.9	Ohio	66.4	33.6
Alaska	41.1	58.9	Louisiana	49.3	50.7	Oklahoma	35.2	64.8
Arizona	42.5	57.5	Maine	37.1	62.9	Oregon	53.9	46.1
Arkansas	37.6	62.4	Maryland	53.6	46.4	Pennsylvania	24.7	75.3
California	67.3	32.7	Massachussets	12.1	87.9	Puerto Rico	83.1	16.9
Colorado	37.8	62.2	Michigan	50.7	49.3	Rhode Island	31.7	68.3
Connecticut	44.5	55.5	Minnesota	27.3	72.7	South Carolina	47.8	52.2
Delaware	70.6	29.4	Mississippi	31.8	68.2	South Dakota	38.5	61.5
District of Columbia	30.2	69.8	Missouri	41.8	58.2	Tennessee	55.7	44.3
Florida	59.9	40.1	Montana	37.2	62.8	Texas	28.9	71.1
Georgia	42.0	58.0	Nebraska	26.3	73.7	Utah	36.9	63.1
Guam	70.3	29.7	Nevada	86.4	13.6	Vermont	1.9	98.1
Hawaii	72.6	27.4	New Hampshire	30.1	69.9	Virgin Islands	28.8	71.2
Idaho	57.9	42.1	New Jersey	71.8	28.2	Virginia	53.1	46.9
Illinois	43.4	56.6	New Mexico	46.6	53.4	Washington	59.9	40.1
Indiana	54.7	45.3	New York	36.2	63.8	West Virginia	38.3	61.7
Iowa	34.3	65.7	North Carolina	60.5	39.5	Wisconsin	41.7	58.3
Kansas	50.0	50.0	North Dakota	55.6	44.4	Wyoming	76.9	23.1

Table 43

NUMBER OF CHILDREN AND YOUTH IN REGIONS OF THE UNITED STATES, 1981: BY AUSPICES OF FACILITIES

Auspices	Total	Region*									
		New England	Mid Atlantic	East North Central	West North Central	South Atlantic	East South Central	West South Central	Mountain	Pacific	Outlying Areas
Public	63,964	1756	8473	11350	3479	11432	3845	5300	3491	13793	1045
State	42,894	1710	4861	6843	2403	10160	3098	4135	2757	5882	1045
Local	21,070	46	3612	4507	1076	1272	747	1165	734	7911	0
Private	70,085	4400	14067	9683	6089	10033	4238	10104	3787	7427	257
Protestant	17,361	319	1592	2363	1883	3731	2120	3626	666	969	92
Catholic	10,217	780	3648	2156	694	844	435	622	146	822	70
Jewish	1,047	26	765	114	0	0	0	0	8	134	0
Secular	35,878	2579	7798	4530	3066	4559	1466	4613	2309	4863	95
Proprietary	5,582	696	264	520	446	899	217	1243	658	639	0
Total of Children	134,049	6156	22540	21033	9568	21465	8083	15404	7278	21220	1032

*Regions were as follows: New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont); Mid-Atlantic (New Jersey, New York, Pennsylvania); East North Central (Illinois, Indiana, Michigan, Ohio, Wisconsin); West North Central (Iowa, Kansas Minnesota, Missouri, Nebraska, North Dakota, South Dakota); South Atlantic (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia); East South Central (Alabama, Kentucky, Mississippi, Tennessee); West South Central (Arkansas, Louisiana, Oklahoma, Texas); Mountain (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming); Pacific (Alaska, California, Hawaii, Oregon, Washington); Outlying Areas (Puerto Rico, Guam, Virgin Islands).

Table 44

NUMBER OF CHILDREN AND YOUTH IN REGIONS OF THE UNITED STATES, BY TYPE OF FACILITY

Region	Total All Types	Type of Facility								
		Dependent and Neglected	Pregnant Adolescent	Temporary Shelter	Delinquent	Status Offender	Detention	Substance Abuse	Emotionally Disturbed	Psychiatric
New England	6,156	784	70	213	1619	64	164	88	2336	818
Mid Atlantic	22,540	3541	267	601	5489	822	3090	548	5676	2506
East North Central	21,033	3799	266	719	7284	932	2127	251	3404	2251
West North Central	9,568	1678	113	407	2859	445	545	294	2013	1214
South Atlantic	21,465	5604	288	468	7420	429	2705	115	2077	2359
East South Central	8,083	3112	129	324	2348	588	318	12	497	755
West South Central	15,404	5495	277	652	3446	456	682	222	2046	2128
Mountain	7,278	1091	84	536	2485	375	669	90	1156	792
Pacific	21,220	1034	315	400	8474	963	5703	164	2950	1217
Outlying Areas	1,302	846	0	11	291	35	82	0	37	0
Total of Children	134,049	26984	1809	4331	41715	5109	16085	1784	22192	14040

Table 45A

Year Founded: Residential Facilities Agencies
(in percent)

Year	Percent
Before 1966	0.0
1966-1969	4.8
1970-1975	51.6
1976-1981	43.5
TOTAL	99.9*
TOTAL OF FACILITIES	62

*Does not sum to 100.0 due to rounding.

Table 45B

Year Founded: Tertiary Nonresidential Agencies
(in percent)

Year	Percent
Before 1900	4.2
1900-1919	0.0
1920-1929	0.0
1930-1939	0.0
1940-1949	9.6
1950-1959	4.9
1960-1964	6.6
1965-1969	33.6
1970-1974	15.3
1975-1977	21.6
1978-1980	4.2
TOTAL	100.0
TOTAL OF AGENCIES	71

Table 45C

Year Founded: Residential Facilities and Nonresidential Agencies, Collapsed (in percent)

Year	Type of Organization	
	Residential	Nonresidential
Before 1940	0.0	4.2
1940-1969	4.8	54.7
1970 or Later	95.1	41.1
TOTAL	99.9*	100.0
TOTAL OF ORGANIZATIONS	62	71

*Does not sum to 100.0 due to rounding.

Table 46

Auspices of Residential and Tertiary Nonresidential Organizations
(in percent)

Auspice	Type of Organization	
	Residential	Nonresidential
Public	17.7	42.2
Private	82.3	57.8
TOTAL	100.0	100.0
TOTAL OF ORGANIZATIONS	62	71

Table 47

Location of Organizations, Residential and Tertiary Nonresidential
(in percent)

Location	Type of Organization	
	Residential	Nonresidential
Residential Neighborhood	59.7	46.5
Business/Commercial	8.1	35.9
Rural Farmland	12.9	0.0
Open Countryside	12.9	0.0
Industrial	0.0	0.0
Other	4.8	8.5
No Answer	1.6	9.1
TOTAL	100.0	100.0
TOTAL OF ORGANIZATIONS	62	71

Table 48A

Annual Operating Budgets of Residential and Tertiary Nonresidential Organizations, Collapsed into Three Categories (in percent)

Budget Category	Type of Organization	
	Residential	Nonresidential
Under 1/2 Million	75.7	71.7
1/2 - 1 Million	13.1	9.7
1 Million & Over	11.5	13.8
No Information	0.0	4.8
TOTAL	100.0*	100.0
TOTAL OF ORGANIZATIONS	62	71

*Does not sum to 100.0 due to rounding.

Table 48B

Annual Operating Budgets Under One-Half Million Dollars
(in percent)

Annual Budget	Type of Organization	
	Residential	Nonresidential
Under $50,000	0.0	11.5
$50,000 to $100,000	14.9	28.8
$100,000 to $250,000	48.9	46.2
$250,000 to $500,000	36.2	13.5
TOTAL	100.0	100.0
BASE NUMBER	47	52
NUMBER WITH BUDGETS OVER $500,000	15	17
NO INFORMATION	0	3
TOTAL OF ORGANIZATIONS	62	71

Table 48C

Annual Operating Budgets of Residential and Tertiary Nonresidential Organizations
(in percent)

Annual Budget	Type of Organization	
	Residential	Nonresidential
Under $50,000	0.0	8.5
$50,000 to $100,000	11.5	20.4
$100,000 to $250,000	36.1	33.2
$250,000 to $500,000	27.9	9.6
$500,000 to $750,000	9.8	9.7
$750,000 to $1 Million	3.3	0.0
$1 Million to $3 Million	8.2	8.4
$3 Million to $4 Million	3.3	0.0
$4 Million or more	0.0	5.4
No Information	0.0	4.8
TOTAL	100.0*	100.0
TOTAL OF ORGANIZATIONS	62	71

*Does not sum to 100.0 due to rounding.

Table 49

Funding Sources for Private Residential and Private Tertiary Nonresidential Organizations (in percent)

Funding Source	Type of Organization	
	Residential	Nonresidential
Endowments/Investments	17.6	43.9
Sponsoring Body	27.5	43.6
Federated Fund-raising	13.7	44.8
Own Fund-raising	62.7	85.4
Fees to Families	68.6	48.0
Fees to Private Agencies	29.4	11.5
Public Agency Contracts	76.5	50.0
Government Grants	49.0	65.7
Private Foundations	31.4	81.2
Third Party Payments	35.3	35.2
Private Insurance	41.2	31.2
Individual Contributions	51.0	88.5
BASE NUMBER	51	41
PUBLIC ORGANIZATIONS	11	30
TOTAL OF ORGANIZATIONS	62	71

Table 50

Comparison of Residential and Nonresidential Organizations Requiring Family Involvement (in percent)

Family Involvement...	Type of Organization	
	Residential	Nonresidential
...Is Required	71.0	64.6
...Is Not Required	29.0	35.4
TOTAL	100.0	100.0
BASE NUMBER	62	71
TOTAL OF ORGANIZATIONS	62	71

Table 51A

Problems, Conditions, and Patterns of Behavior of the Program Participants: Residential (R) Tertiary Nonresidential (NR) Organizations (in percent)

	Proportion of Participants															
	None(0%)		1-24%		25-49%		50%		51-74%		75-99%		100%		No Response	
Behavior	R	NR	R	NR	R	NR	R	NR	R	NR	R	NR	R	NR	R	NR
Suicidal	22.2	24.0	52.8	62.2	13.9	4.2	5.6	0.0	5.6	0.0	0.0	0.0	0.0	0.0	4.2	9.7
Violent to Others	25.0	25.2	44.4	56.8	19.4	8.4	11.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.2	9.7
Abused by Parents	2.0	0.0	13.9	45.9	19.4	22.9	19.4	4.2	19.4	11.9	25.0	5.4	0.0	0.0	4.2	9.7
Depressed	0.0	0.0	5.6	40.9	16.7	22.8	16.7	9.1	11.1	17.6	30.6	0.0	19.4	0.0	4.2	9.7
Problems with Peers	0.0	0.0	0.0	30.0	11.1	10.9	11.1	28.5	30.6	9.1	27.8	11.9	19.4	0.0	4.2	9.7
Family Problems	0.0	0.0	0.0	12.0	2.8	19.8	0.0	9.7	22.2	4.2	44.4	40.5	30.6	4.2	4.2	9.7
Property Destruction	2.8	12.0	22.2	43.5	33.3	26.4	22.2	4.2	13.9	4.2	2.8	0.0	2.8	0.0	4.2	9.7
Disruptive Behavior	2.8	12.0	11.1	24.0	5.6	29.8	11.1	0.0	30.6	7.7	25.0	12.7	13.9	4.2	4.2	9.7
Delinquency	2.8	21.6	19.4	55.0	27.8	5.4	22.2	0.0	11.1	0.0	11.1	4.2	5.6	4.2	4.2	9.7
Learning Problems	11.1	0.0	44.4	59.8	27.8	14.4	11.1	0.0	2.8	11.9	2.8	4.2	0.0	0.0	4.2	9.7
Physical Illness	56.3	8.4	33.3	70.0	4.2	7.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.3	13.8
Mentally Retarded	79.2	28.7	16.7	61.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.2	9.7
Thought Disorders	35.4	19.4	47.9	47.9	8.3	13.1	0.0	0.0	2.1	0.0	0.0	0.0	0.0	0.0	6.3	9.7
Physical Handicaps	66.7	39.7	29.2	46.5	0.0	4.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.2	9.7
Problems beyond family's control	41.7	20.4	31.3	56.7	16.7	9.1	2.1	0.0	2.1	7.7	2.1	12.7	0.0	4.2	4.2	9.7
Problems related to sexuality	18.1	4.2	22.9	61.6	27.1	9.6	8.3	4.2	8.3	0.0	8.3	0.0	8.3	10.8	4.2	9.7

NOTE: 100% of Residential (R) = 62; 100% of Nonresidential (NR) = 71.

Table 51B

Problems, Conditions, Patterns of Behavior: Percent of Residential and Percent of Tertiary Nonresidential Organizations With Half or More of Their Residents Exhibiting the Indicated Behavior

	Percent of Organizations with Half or More of Participants Exhibiting Behavior	
Behavior	Residential	Nonresidential
Suicidal	11.2	0.0
Violent to Others	11.1	0.0
Abused by Parents	63.8	21.5
Depressed	77.8	26.7
Problems with Peers	88.9	49.5
Family Problems	97.2	58.6
Property Destruction	40.9	8.4
Disruptive Behavior	80.6	24.6
Delinquency	50.0	8.4
Learning Problems	16.7	16.1
Physical Illness	0.0	0.0
Mentally Retarded	0.0	0.0
Thought Disorders	2.1	0.0
Physical Handicaps	0.0	0.0
Problems Beyond Family's Control	6.3	24.6
Problems Related to Sexuality	33.2	15.0

NOTE: 100% of Residential Facilities = 62;

100% of Nonresidential Agencies = 71.

Table 52

Percent of Residential and Percent of Nonresidential Organizations Using Social Workers, Psychologists, and Psychiatrists

Professional	Type of Organization	
	Residential	Nonresidential
Social Worker	96.2	54.8
Psychologist	88.7	38.0
Psychiatrist	73.6	53.5
BASE NUMBER	62	71
TOTAL OF ORGANIZATIONS	62	71

Table 53

Percent of Residential and Percent of Tertiary Nonresidential Organizations that use Various Methods with Clients

Method	Type of Organization	
	Residential	Nonresidential
Behavior Therapy	72.6	71.2
Psychotherapy	45.2	54.9
Social Casework	56.5	83.6
Group Therapy	71.0	70.6
Reality Therapy	73.6	60.3
Peer Culture/Counseling	66.1	48.5
Parent Effectiveness Training	53.2	55.4
BASE NUMBER	62	71
TOTAL OF ORGANIZATIONS	62	71

Table 54A

Percent of Residential Facilities that Indicated They Work With Individuals, Groups, and Families

Client Grouping	Percent
Individuals	38.7
Groups	27.4
Families	27.4
No Response	27.4
BASE NUMBER	62
TOTAL OF FACILITIES	62

Table 54B

Percent of Tertiary Nonresidential Facilities that Work With Individuals, Groups, and Families

Client Grouping	Percent
Individuals	100.0
Groups	75.5
Families	85.1
BASE NUMBER	71
TOTAL OF AGENCIES	71

APPENDIX A
METHODOLOGICAL NOTE ON THE SURVEY OF RESIDENTIAL FACILITIES

This report summarizes information on group residential care facilities for children and youth considered to be in need of services due to use of an illegal substance.

The data were assembled through the National Survey of Residential Group Care Facilities for Children and Youth, the field work for which was carried out by Westat, Inc., under the supervision of the project staff at the School of Social Service Administration, the University of Chicago. This section covers methods used to complete the entire project, which included eight additional types of residential facilities for children and youth.[24]

Listing Facilities for Survey and Data Collection Procedures

The study covered all eligible facilities known to be operating in 1980 with a capacity to serve seven or more residents. In reporting the survey findings elsewhere, certain comparisons have been made with information assembled in 1966 at the Center for Urban Studies, the University of Chicago.[25]

In order to assemble a master list of facilities for survey, the project viewed an eligible facility as being administratively

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[24]See "Introduction," footnote 1 for listing of the nine types of residential facilities surveyed.

[25]Pappenfort, et. al. Census of Children's Residential Institutions, 1966.

more complex than a foster family home and organizationally at least as distinct as a physically separate section of a larger facility (for example, the children's psychiatric ward of a medical hospital), within which persons under 21 years of age were living apart from their families.[26] Specifically excluded from the study were medical facilities for acute or short-term care (including nurseries for the new-born), summer camps, and purely educational boarding schools. When the project began in 1979 there was no complete list of such facilities available. However, various published directories and unpublished information in the files of government agencies and private associations provided materials from which a list could be made. The first task in preparation for the survey was to bring together this information onto a master list of eligible facilities.

Eighteen months were invested in correspondence and consultation with directors of state agencies that licensed, supervised, or otherwise related to residential group care facilities for children and youth. The states varied in their abilities to provide information. Some had complete listings on computer tapes. A few had limited information in a centralized form. One large state had to survey its regional offices to obtain the information requested. The information received from individual states was compared with all known national directories,

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[26]An exception was made in order to include facilities for pregnant adolescents which sometimes house young mothers and their infants and also may be providing care to women 21 years of age and older.

computerized listings, and membership rosters of child care organizations. Religious organizations provided lists of affiliated facilities, many of them exempt from licensing. The staff of Children in Custody checked out listings of public correctional facilities and made comparisons with their confidential roster of private facilities to make certain we are not deficient in coverage. We are grateful for so much help. List of psychiatric inpatient units for children or adolescents in general hospitals were not available from any source. It was necessary to telephone each of the hospitals listed in the American Hospital Association Guide to the Health Care Field as having psychiatric services to determine which of them had inpatient units specifically for children and youth.

The information received from state government agencies was not uniform to the extent that it had been in 1965 when a similar process was undertaken for the 1966 Survey of Children's Residential Institutions. Also, the terminology used to refer to different kinds of facilities varied: 45 categories were reported to us. In many instances residential group care facilities were listed as serving more than one category of children. In other instances the licensing agencies did not know what categories of children and youth were being served. It is a comment on changes in practice that government agencies now could report capacity more often than numbers actually in residence. Near the conclusion of the listing process it was necessary to telephone 132 facilities directly to obtain information needed to determine eligibility for survey.

Through these procedures, 8,823 facilities were listed as operating in 1981 (Tables 41, 42, 43, and 44).

This master list provided the universe for survey, after exclusion of facilities for the physically handicapped, the mentally retarded, and the chronically ill. Additional facilities were excluded because they were reported as having a capacity to serve fewer than seven residents. The remaining list was composed of public and private facilities providing residential care to children and youth with the designated special problems and needs.

Questionnaire

The survey questionnaire was designed to gather information about programs and services that most types of residential group care facilities provide, regardless of function, rather than about those specific to a single type of residential care. For example, maternity homes were not queried about arrangements for delivery of infants, nor were psychiatric inpatient units requested to categorize the youth in their care according to formal diagnostic definitions. Instead, facilities were asked to describe, among other things, the problems, conditions, and patterns of behavior of their residents, the treatment programs for them, and the extent of their participation in community activities.

The items included in the questionnaire were selected with the assistance of a National Advisory Committee, whose members

had been chosen to reflect the diversity of opinion in the field.[27]

The 72 pages of questions and spaces for comments allowed directors of group residential care facilities to report a considerable amount of information about their programs and services.

Survey Methods

A letter dated September 1, 1981, was sent to the director of each facility announcing the National Survey of Residential Group Care Facilities. The questionnaire itself, together with a second letter from the project directors, was mailed about two weeks later.

In early November a second copy of the questionnaire, together with a new cover letter, was sent to facility directors who had not yet responded. This second mailing was followed by a postcard prompt on November 25, which asked nonrespondents to return the questionnaires or to telephone Westat if in need of technical assistance or if the questionnaire had not arrived.

During the later part of January and throughout February a telephone prompt was carried out: (1) to request return of a completed questionnaire; (2) to obtain the name of the director or designated respondent; (3) to eliminate facilities that had ceased to operate, were duplicates or separately listed parts of other facilities, or did not fit the project's working definition

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[27]Members of the National Advisory Committee are listed near the beginning of this report.

of a group residential facility; and (4) to collect information on four key items of information (auspices, current primary function, rated or licensed capacity, and number of children and youth in residence) for later use in the event that completed questionnaires could not be obtained. Through the prompt it was learned that in some instances the mailing address was the physical location of the facility rather than that of the central office where the director was located. Often the staff had not been able to complete the questionnaire and had not forwarded it to the director. Other nonrespondents had thrown away, lost, or had never seen the questionnaire. New copies were mailed, as needed.

On April 26, Westat began telephone interviews with directors who had not completed and returned questionnaires. A letter signed by Charles A. Lauer, Acting Administrator, Office of Juvenile Justice and Delinquent Prevention; Herbert M. Pardes, Director, National Institute of Mental Health; and Clarence Hodges, Commissioner, Administration on Children, Youth, and Families was sent nonrespondents asking them to complete and return the questionnaires or agree to be interviewed over the telephone.

By the end of June, the combination of mail and telephone initiatives had information for 3,955 facilities, 95.0 percent of the total remaining after eliminating facilities that had ceased to operate, were duplicate or separately listed parts of other facilities, or did not fit the working definition of a residential group care facility for children and youth established for

this research. (The Chicago staff later identified 41 of these facilities as duplicates, or otherwise ineligible for survey, reducing the number to be reported to 3,914.)

Quality Control of Data

Questionnaire-based research confronts many of the same issues of validity as does research dependent on personal interviews, with other problems added. The two special problems discussed here are the systematic biases potential in large rates of nonresponse to individual questions and the provision of internally inconsistent information.

Rates of Response and Inconsistent Information

The reason for attempting to obtain a nearly complete return of questionnaires is to minimize the possibility of biased answers to individual questions, which can occur because of differences between those who reply and those who do not. Research based on interviews both are subject to refusals to answer any questions. Questionnaire research, however, is subject to respondents' failure to provide replies to individual items to a degree much greater than when data are assembled through interviews, in which the interviewer has the opportunity to probe for an answer or interpret the schedule to the respondent. Answering patterns which selectively complete certain questions and leave others unanswered can produce bias as readily as can refusals to cooperate at all.

The initial study plan for the residential survey called for very limited data retrieval until the later part of the data collection period. Concentrating data retrieval at the end of the study has the advantage of allowing full consideration of the extent of missing -- or problematic -- data on a large number of questionnaires before deciding how much data should be retrieved. It also allows for flexible allocation of project resources between improving the response rate and data retrieval on selected items. However, leaving data retrieval until the end delays the editing process, since large number of changes have to be incorporated at the end of the data preparation period.

Planning for data retrieval included examining inconsistent answers to logically interrelated questions as well as the frequency of missing data for each question. A list of priority questions was formulated for use by Westat. Data retrieval was completed on as many of the questions having a greater than 5 percent error or nonresponse rate as budget restrictions would allow. Lack of data on any one of six questions identified as crucial to the Survey always caused a case to be included in data retrieval. Data retrieval was also attempted on all questionnaires in which there was inconsistency between the numbers of children reported in residence on various questions. Another reason for including a case in data retrieval was lack of reasonable correspondence between numbers of staff and size of budget reported.

In all, 32 percent of the facilities completing questionnaires were telephoned for data retrieval. Whenever a facility

was telephoned, an attempt was made to retrieve all missing data for that case.

Other Editing Efforts

After the field work was completed by Westat, the staff in Chicago began the work of editing the data. This task required considerable understanding of the programs surveyed: the search was for possible sources of error, not for logical inconsistencies. During the editing process, facilities were telephoned as the result of the their responses to certain questions:

1. Facilities reporting that 25 percent or more of their residents were 21 years of age or over;

2. Facilities providing a suspiciously low per diem cost;

3. Facilities with budgets that appeared large, given the number of youth in care;

4. Facilities where capacity exceeded number in residence by 75 or more children or youth;

5. Facilities reporting that "most" or "all" of the children and youth were subject to chronic physical illness, mental retardation, or physical handicaps;

6. Facilities reporting few or no youth in residence in categories of problems or conditions corresponding to their current primary functions; and

7. Psychiatric inpatient children's units that appeared to have given, in answer to particular questions, information that pertained to the larger hospitals rather than to the units themselves.

In addition, many other places had to be telephoned to correct what appeared to be less systematic misreporting.

In a few instances, directors reported their current primary functions to be care of either the dependent and neglected, delinquents, or status offenders. They had already stated in

answering an earlier question, that they were operating either a detention facility or a maternity home or a shelter. These cases are carried in tables of current primary function as facilities for detention, pregnant adolescents, and shelter.

A control ledger was set up in which all editing decisions, the reasons for them, and the new information obtained over the telephone were entered. The corrections made during the editing process were entered on a tape separate from the one provided by Westat containing the raw results of the field work. Thus the original information has been retained.

APPENDIX B

METHODOLOGICAL NOTE ON THE SURVEY OF NONRESIDENTIAL SUBSTANCE ABUSE PROGRAMS[28]

As a companion to the national survey of residential programs for children and youth with special needs, a sample survey of nonresidential programs serving the same populations was carried out. Its purpose was to examine the services being offered to children and their families as community-based alternatives to out-of-home placement.

Population

Like the larger survey of residential facilities, the eligibility criteria for inclusion in the nonresidential study focused on agencies providing services to special needs populations, including children and youth who were dependent and neglected, abused, status offenders, emotionally disturbed, mentally ill, abusing drugs or alcohol, or pregnant. As in the residential study, only those programs specifically designed to serve persons under 21 years of age were eligible for study. While it was recognized that, particularly in services for youth with drug and alcohol programs and those for pregnant adolescents, this criterion could potentially eliminate many programs in which young people are served along with adults, it was decided that, given the unique needs of youth with such problems, programs purposely

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[28]The description of the nonresidential survey was adapted from "Nonresidential Substance Abuse Programs Children and for Youth" by Martha Morrison Dore.

designed with these needs in mind would be the subject of study. They were also most comparable to residential programs providing care only to persons under 21.

Sample

The sample was chosen to reflect a cross-section of the population according to the 1970 United States Census. It consisted of 49 geographical areas ranging in size from the nation's most populous cities--New York, Chicago, Los Angeles--to small, rural counties such as Marquette County, Michigan, and Iredell County, North Carolina. Because the population of these geographical areas was representative of that of the country as a whole, it was assumed that the agencies and services located in them were representative as well. The 1,448 agencies that returned questionnaires (making the response rate 97.6 percent) mathematically represent 9,157 agencies nationwide.

Types of Nonresidential Agencies

Of the agencies that returned questionnaires, 1,422 were in the final analysis. These are divided into three types: primary, which focus on educational programs to prevent substance abuse; secondary, which are preventive and therapeutic in nature; and tertiary, which treat substance abuse problems. Only the tertiary agencies, which number 71, are included in the comparisons between residential facilities and nonresidential agencies.