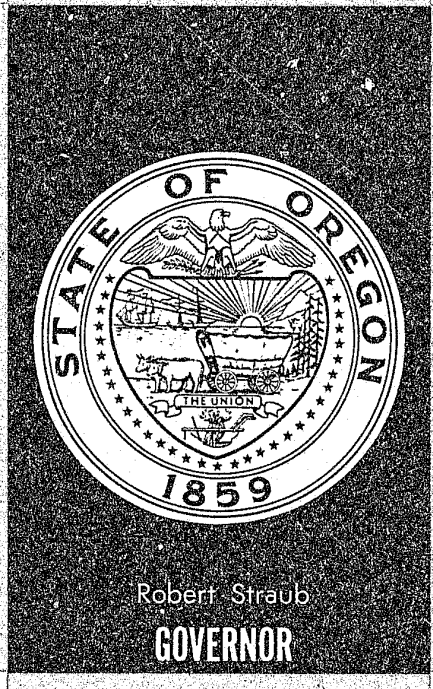

SPECIALIZED OUT OF HOME CARE (SOHC) PROJECT FINAL PROJECT EVALUATION REPORT

April 1978

SPECIALIZED OUT OF HOME CARE (SOHC) PROJECT

Evaluation Report #3

FINAL PROJECT EVALUATION REPORT

Prepared by

State Planning Agency
of the
Oregon Law Enforcement Council

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April 1978

Prepared under Grant Number 74-NI-10-0002 from the National Institute of Law Enforcement and Criminal Justice. Points of view or opinions stated in this document are those of the author and do not necessarily represent the official position or policies of the Department of Justice.

PORTLAND HIGH IMPACT ANTI-CRIME PROGRAM

Specialized Out-of-Home Care Project
(Oregon Children's Services Division)

Grant Number 74-ED-10-0102
Duration: 1/1/74 to 9/30/76

The State Planning Agency staff with responsibility for production of this report were:

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ACKNOWLEDGEMENTS

The staff of the Specialized Out of Home Care (SOHC) project contributed greatly to our understanding of this project and graciously assisted us in the process of obtaining data for our evaluation effort. These persons are as follows: Ron Jenkins, Hedy-Jo Powell, Jack Morgan, Rory Tate, Fred Murphy, Jeannie Toomey, Roberta Wolin, and Carla Bowles.

At the central Children's Services Division (CSD) office, both Robert Harris and Jackie Winters provided valuable information about the project and its goals, objectivities, activities, and funding.

A number of State Planning Agency (SPA) staff contributed to the data collection for this evaluation effort. We would like to thank Edward Vaughn, Gordon Rickles, Barbara Kakura, and especially Roberta Wolin.

Dr. Clinton C. Goff, supervisor of the SPA Evaluation and Research Unit reviewed the final draft of the report and provided valuable comments.

We want to especially thank both former SOHC project managers, Ron Jenkins and Hedy-Jo Powell, for their extended assistance in interpreting project philosophy, operations, and potential "system" impact for us.

A number of SPA Support Services Unit staff were involved in the typing of several drafts of this report. We would like to acknowledge the expert typing of LeeAnn Pugh, Jeanne Bittner, and Sue Legan. Barbara Brunkow, supervisor of the Support Services Unit also was of much assistance in the production of the report.

Lastly, we would like to acknowledge the assistance of Mrs. Pearl B. Heath who performed a number of asundry tasks for us--especially proofreading the various drafts.

SUMMARY OF MAJOR FINDINGS

[1]Cost data on this project reveal that the average monthly cost per out of home care placement slot (or bed) decreased the closer the project came to keeping all slots occupied and that maximum occupancy was closer approximated in the second six months period of the first year of operations.

[2]Client profile data revealed that clients referred to the project for out of home care were heavily involved in a variety of problem behaviors extending across the settings of the home, school, and community. Many of these problems did not occur in isolation, but were interrelated.

[3]The project exceeded its goal of providing "specialized out of home" care for 150 referrals and routed to Children's Services Division 37 of a projected 50 for "regular" out of home care.

[4]Data on out of home care provider training revealed that:

a. Providers were less professionally trained than anticipated,

b. Training sessions were attended on a selective basis, and

c. Training sessions were rated high in value and utility.

[5]Data bearing on project outcome (impact) or, at least, on the reduction of client problem behaviors which led to a project referral indicate the following:

a. For all clients referred and especially for those placed in SOHC project placements, there was a significant decrease over time in the average number of counsellor rated problem behaviors. In addition, for a majority of the 27 rated problems, there were significant reductions over time in the proportions with these problems. These reductions were somewhat more notable for those clients placed in SOHC project placements.

b. In addition, all clients referred and especially those placed in SOHC project placements showed improvement, in 3 of 6 areas where client's motivation and capacity to change problematic behaviors were rated by counsellors.

The report itself contains a wealth of descriptive information on project operations, training programs, client characteristics, services rendered, placement costs, client movements, and various appendices.

I. WHAT WAS THE SOHC PROJECT ALL ABOUT?

A. A Brief Description of the Project:

The Specialized Out of Home Care (SOHC) project was one of several projects funded in the early 1970's as part of Portland's High Impact Anti-Crime program. Federal funding in the amount of $859,644 came from the Law Enforcement Assistance Administration (LEAA) agency. The project was administered by the Children's Services Division (CSD) of the State of Oregon and served selected clients coming from a large target area of Portland. The project operated for two years--May 1974 through June 1976 under Grant Number 74-ED-10-0102.

The primary mission of the SOHC project was to provide viable alternative out of home or substitute care resources specifically designed to meet the needs of selected juvenile probation cases involved in certain adjudicated "target" offenses and between the ages of 10 and 18. The target crimes included burglary, robbery, aggravated assault, homicide, and rape as evidenced by police arrest. These offenses excluded incidents where acquaintance or interpersonal relationship was a precipitating factor in the offense. Target crimes were to be considered stranger to stranger and felonies if the offender was of adult status.

Client referrals to the SOHC project came exclusively through Multnomah County's Case Management Corrections Services Project, another Portland LEAA funded Impact program project which provided intensive community-based services (and resources) to target offenders on probation and supevised by juvenile court workers.[1]

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[1]See Diana Gray, Evaluation Report No. 6: Final Outcome Assessment, Oregon Law Enforcement Council, 1975 for a description and evaluation of the Case Management Corrections Services project.

The primary objectives of the SOHC project were as follows:

1. "To offer a responsive central intake point for all case management out of home care referrals.

2. To locate or develop substitute resources geared to meet the specific needs of referred youths.

3. To model a case planning method that was both goal specific and time limited (average placement six to nine months). Central to this was monitoring of individual case plans by coordinating the various agents involved in servicing these juveniles and their families via what was called the 'dispositional team' process."[1]

Following from these objectives, then, the project activities were to:

(1) Implement an intake process and residential care unit to provide specialized services to juvenile target offenders; (2) develop a service delivery system for such youth through the use of joint planning and service coordination between CSD and the Multnomah County Juvenile Court; and (3) employ the use of a Disposition Team (composed of the CMCS case manager, the SOHC resource developer, potential care providers, etc.) to identify individual placement and treatment needs and explore alternative resources and services.[2] The Disposition Team was also to track each client through the service delivery system and continuously monitor progress and update diagnostic assessments.

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[1]See Hedy Jo Powell, "Specialized Out of Home Care Project: Tailoring Placements for Target Offenders," n.d. in Appendix A for a fuller description of the project rationale and organizational structure.

[2]See Appendix B for a description of the "disposition team" and the case planning process during the "disposition phase".

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

1. Intake Services

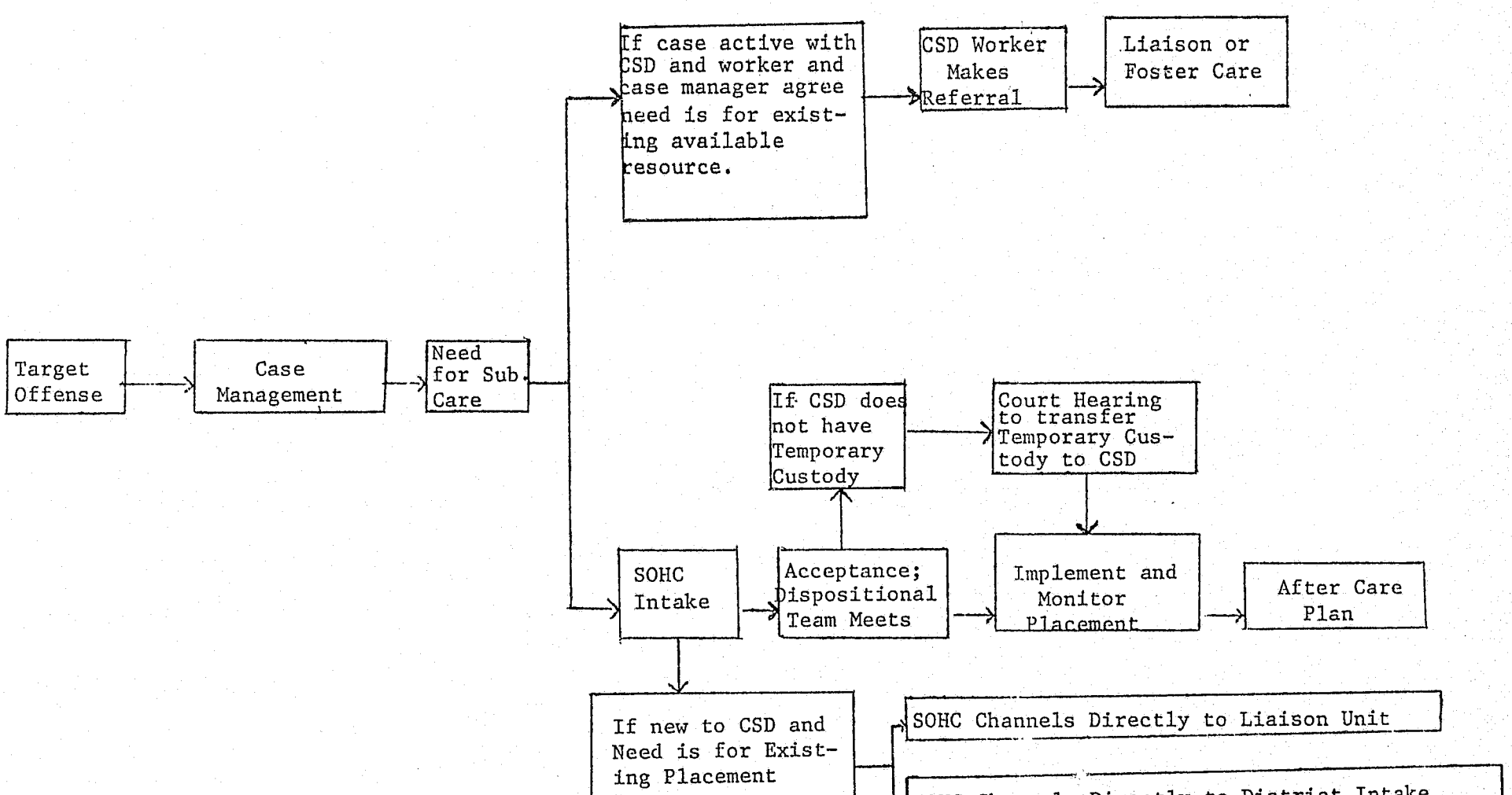
These were part of the initial screening, referral, and assessment process which was to facilitate an orderly transition from county to state custody; and which was to create the pre-placement planning and consultation with initial case and after care planning essential to efficient utilization of out of home care services and resources. They were intended also to reduce the amount of time a client might spend in detention while a placement was being located. (See Figure I-1 on the next page for a flow chart depicting the flow of case management clients to the SOHC project.)

2. Placement Services

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

FIGURE I-1

"Case Management Referral Procedures to Children's Services Division (Flow Chart)"



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

3. After Care Services

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

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

sophisticated case planning be done at the outset of the placement in the SOHC unit and that all agents acting within the case plan are aware of the plan and are working toward commonly established goals."

The SOHC project staff included a director, three (3) resource developers ("case workers") and two (2) secretaries. One of the resource developers served as an "intake and placement supervisor with whom CMCS project case managers or counsellors initiated placement requests. This worker and the other two resource developers carried caseloads of approximately 20 to 25 youth each. Each of the latter two resource developers was assigned an additional duty. One served as a liaison worker to the day care program (a major component of the network of out of home care services provided by the SOHC project). The other resource developer assumed the role of liaison to several group care facility providers under contract with the project.

B. A Description of Project Providers and Provider Settings

While the SOHC project did contract with four (4) child care (residential treatment) centers, both urban and rural, for group care services and with a day care center for a nonresidential day and weekend treatment program; the major program thrust was in the area of foster care (both one and two parent foster care).

Over the period of project operations, clients were placed with over 30 plus foster care providers who were recruited by the project to provide "professional foster care" services to one to four youths placed in their care. The foster care was termed "professional" in that providers were screened to determine those with prior experience and/or backgrounds in providing foster care which was specially

tailored to the needs of these clients. In addition, providers were furnished with intensive backup services and training designed to enhance provider skills in working with these hard-to-manage target offender youth.

In addition to staff support furnished by the three (3) SOHC project case workers, a full-time "relief parent"--seasoned in youth work and "recreation therapy"--was under contract to provide "respite care" via taking youths on field trips and on other organized outings. (This role was designed to supplement the general foster care program, to enrich the kinds of experiences available for youths, and most important--to alleviate the problem of provider "burn out.")

In general, the project sought to develop a "model" intake and case planning system and to build and nurture a network of professional foster parents and out of home care services which would broaden the range and increase the effectivenss of traditional substitute care alternatives for hard-to-manage delinquent youths.

This service delivery model also evolved from an attempt to have more freedom to contract with a wide range of providers to match the specific needs of referred youth and a freedom to negotiate "individualized" contracts for purchase of care using both flexible and set rates for payment. The project also experimented with new methods of contracting for services aimed at impacting specific client problems with professional services.

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

Several different types of out of home care provider settings were used by project staff in an attempt to tailor these placements to individual client needs. These were as follows:

1. Group Home Setting

   The focus here was to be on interaction in a group and using the group to provide behavioral models, behavioral limits, and activities, as well as, group support for the client.

2. Professional Foster Family Setting

In this setting, both husband and wife worked as a professional social work unit to expose the youth to family life, routines, and activities. In addition, there was to be extensive interaction with the school and community. Supervision and structure were emphasized for shaping client behavior.

3. Foster Family Care

"Same as #2 above, except the provider couple had less professional training."

Note to the Reader:

After the first six (6) months of project operations, the project director elected not to make a distinction between "professional" and "family" foster care. Instead, these two groups were later referred to as simply "two parent" foster care and all foster care provided was regarded as "specialized" and performed by "professionals" under contract to SOHC. The label professional simply referred to foster care providers in the service network of the project and appeared to be justified by project staff on the basis of the project's attempt to train and upgrade the skills of these people regardless of their entry level qualifications. This failure to document what constitutes "professional foster care" and indicate entry level requirements along with how much training a foster care provider needed to qualify as a "professional" foster care provider forces us to make some tenuous assumptions and inferences about SOHC as opposed to regular out of home care services.

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4. Big Brother/Big Sister

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

Note to the Reader:

Big Brother/Big Sister setting out of home care arranged by the SOHC project was eventually referred to as simply one parent foster care.

5. Independent Living Arrangement

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

6. Special Situations

These are specially tailored placements which are established by other actors. They are made on a one time by child basis.

C. Description of Population to be Served

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

D. Modification of the Target Population

Due to the late start-up of the SOHC project and funding restrictions, the above estimate for the target population was subsequently reduced to a figure of 150 clients who would be provided specialized out of home care over the duration of the project. In addition, the project was to arrange for out of home care through regular CSD resources for an additional 50 clients referred by CMCS for out of home placement for the duration of the project.[1]

[1]See Appendix C for a description of the criteria used to screen clients at intake for eventual placement in out of home care arranged through the project.

Note to the Reader:

In an earlier report[1] an attempt was made to provide some history of the early efforts and problems connected with this project's attempt to develop its particular service delivery model and network of out of home care services. The interested reader--especially one who seeks to implement a similar model--might consult this report as it provides details on these implementation efforts which might guide more realistic efforts in the future.

E. Descriptive Information on the Costs of the Out of Home Care Provided by the Project

During the course of the project, it was generally conceded by project staff that the "specialized out of home care" provided by the project was expensive compared to "regular" out of home care, but of greater potential for meeting treatment objectives than any traditional out of home care. In the course of this evaluation effort, attempts were made after six (6) and after twelve (12) months of operation to obtain detailed information on the costs of care in SOHC placement settings by type of setting and by provider. The first attempt to summarize these fiscal data was done in Report #2. Table 2 of that report provided a breakdown of the dollar costs per placement slot per month for four (4) major types of placement settings in use from July 1, 1974 to December 31, 1974.[2]

Table I-1 in this report updates Table 2 of the earlier report by repeating the analysis of the fiscal data (with some slight changes in categories) and focusing on all providers and slots available and occupied during the period January 1, 1975 to June 30, 1975.

[1]See Specialized Out of Home Care Project: Evaluation Report #2, Oregon Law Enforcement Council, 1975, especially pp. 3-5.

[2]See Specialized Out of Home Care Project: Evaluation Report #2, Oregon Law Enforcement Council, 1975, pp. 12-14.

Table I-1 PLACEMENT COSTS PER SLOT (AT MAXIMUM RATES) BY MAJOR PROVIDER SETTINGS CHARACTERISTICS FOR FY 1974-1975*

I. TWO PARENT FOSTER CARE SETTINGS[A] (Sixteen (16) provider couples with 38 contracted slots maximum occupancy and variable rates for reimbursement):

Provider Code	Availability and Use of Slots: Projected Capacity[1]	Availability and Use of Slots: Actually Occupied[2]	Average Dollar Cost Per Slot Per Month[4]: 1st Slot	2nd Slot	3rd Slot	4th Slot	Maximum Possible Total[3] Reimbursement Per Month
A	4	4	$ 950	$ 350	$ 200	$ 200	$1,700
B	2	1	820	420			1,240
C	2	2	614	314			928
D	2	0	600	400			1,000
E	3	3	635	635	410		1,680
F	4	2	1,430	165	165	165	1,925
G	4	4	500	500	500	500	2,000
H	2	2	925	325			1,250
I[a]	2	1	170	210			920
J	3	3	1,425	375	275		2,075
K[b]	1	1	770				770
L[c]	1	1	1,190				1,190
M[d]	1	1	600				600
N	2	2	715	285			1,000
O	4	3	1,185	285	385	385	2,240
P	1	1	550				550
Totals[3]	38	31	$13,619	$4,264	$1,935	$1,250	$21,068
ALL PROJECTED SLOTS: Means			$ 851	$ 355	$ 323	$ 313	
(St. Dev.'s)			(305)	(126)	(130)	(158)	
(N's)			(16)	(12)	(6)	(4)	
OCCUPIED SLOTS ONLY: Means			$ 868	$ 359	$ 354	$ 350	
(St. Dev's)			(308)	(136)	(118)	(212)	
(N's)			(15)	(9)	(5)	(2)	

SUMMARY STATISTICS FOR ALL SLOTS
(Per Month)

	All Projected Slots	All Occupied Slots
Means	$ 554	$ 604
(St. Dev's.)	(336)	(346)
(N's)	(38)	(31)

NOTE: See table footnotes on last page of table.

II. ONE PARENT FOSTER CARE SETTING[B] (Eleven (11) providers with 29 contracted slots maximum occupancy and variable rates for reimbursement):

Provider Code	Availability and Use of Slots: Projected Capacity[1]	Availability and Use of Slots: Actually Occupied[2]	Average Dollar Cost Per Slot Per Month[4]: 1st Slot	2nd Slot	3rd Slot	4th Slot	Maximum Possible Total[3] Reimbursement Per Month
A	2	1	$ 700	$ 450			$ 1,150
B	2	2	725	175			900
C	3	3	835	445	$ 445		1,725
D	3	1	935	235	335		1,505
E	4	4	1,050	250	350	$ 250	1,900
F[e]	2	2	625	425			1,050
G[f]	3	1	885	185	310		1,380
H	3	2	1,285	285	185		1,755
I	3	3	650	400	250		1,300
J[g]	1	1	1,005				1,005
K[h]	3	3	875	450	225		1,550
Totals[3]	29	23	$9,570	$3,300	$2,100	$ 250	$15,220
ALL PROJECTED SLOTS: Means			$ 870	$ 330	$ 300		
(St. Dev.'s)			(197)	(115)	(88)		
(N's)			(11)	(10)	(7)	(1)	
OCCUPIED SLOTS ONLY: Means			$ 870	$ 347	$ 291		
(St. Dev's)			(197)	(110)	(105)		
(N's)			(11)	(7)	(5)	(1)	

SUMMARY STATISTICS FOR ALL SLOTS
(Per Month)

	All Projected Slots	All Occupied Slots
Means	$ 525	$ 588
(St. Dev's.)	(309)	(315)
(N's)	(29)	(23)

III. SPECIAL SITUATIONS[C] (Three (3) providers with 6 contracted slots maximum occupancy and variable rates for reimbursement):

Provider Code	Availability and Use of Slots: Projected Capacity[1]	Actually Occupied[2]	Average Dollar Cost Per Slot Per Month[4]: 1st Slot	2nd Slot	3rd Slot	4th Slot	Maximum Possible Total[3] Reimbursement Per Month
A	3	1	$ 591	$ 291	$ 241		$1,123
B	1	1	132				132
C	2	1	875	475			1,350
Totals[3]	6	3	$1,598	$ 766	$ 241		$2,605

		1st Slot	2nd Slot	3rd Slot	4th Slot
ALL PROJECTED SLOTS	Means	$ 533	$ 383		
	(St. Dev.'s)	(375)	(130)		
	(N's)	(3)	(2)	(1)	
OCCUPIED SLOTS ONLY	Means	$ 533			
	(St. Dev's)	(375)			
	(N's)	(3)	(0)	(0)	

SUMMARY STATISTICS FOR ALL SLOTS
(Per Month)

	All Projected Slots	All Occupied Slots
Means	$ 434	$ 533
(St. Dev's.)	(272)	(375)
(N's)	(6)	(3)

IV. GROUP CARE SETTINGS[D] (Four (4) providers agencies with 19 contracted slots maximum occupancy and fixed rates for reimbursement):

Provider Code	Availability and Use of Slots: Projected Capacity[1]	Actually Occupied[2]	Average Dollar Cost Per Slot Per Month[4]: Data For First Four Slots Only: 1st Slot	2nd Slot	3rd Slot	4th Slot	Maximum Possible Total[3] Reimbursement Per Month
A	7	4	$ 800	$ 800	$ 800	$ 800...	$ 5,600
B	3	3	677	677	677...		2,031
C	6	6	1,094	1,094	1,094...		6,565
D	3	1	440	440	440...		1,320
Totals[3]	19	14	$3,011	$3,011	$3,011	$1,894...	$15,516

		1st Slot	2nd Slot	3rd Slot	4th Slot
ALL PROJECTED SLOTS	Means	$ 753	$ 753	$ 753	$ 947...
	(St. Dev.'s)	(272)	(272)	(272)	(208)...
	(N's)	(4)	(4)	(4)	(2)...
OCCUPIED SLOTS ONLY	Means	$ 753	$ 857	$ 857	$ 947...
	(St. Dev's)	(272)	(214)	(214)	(208)...
	(N's)	(4)	(3)	(3)	(2)...

SUMMARY STATISTICS FOR ALL SLOTS
(Per Month)

	All Projected Slots	All Occupied Slots
Means	$ 817	$ 874
(St. Dev's.)	(229)	(218)
(N's)	(19)	(14)

Footnotes

*This tables excludes the following:

(a) A day care center providing twenty non-residential day and weekend slots at a fixed rate of $280 per month per slot (or $5,596 total per month) of which seven (7) slots were occupied as of June 30, 1975.

(b) One (1) "independent living subsidy" allowance which provided $230 per month for a client living alone, but supervised by a CMCS project case manager and an SOHC project staff member.

A. Originally, a distinction was made between "professional" and "family" foster care. After the first six (6) months of project operation, all foster care involving couples under contract was simply referred to as "two parent foster care."

B. One parent foster care settings also were referred to as "Big Brother/Big Sister" placements.

C. These were specially tailored placements which were established by providers or individuals outside the network of regular SOHC foster care and were developed on a "...one time by child basis."

D. "Group care" here refers to placement in both a group home or a residential treatment (or child care) center.

1. This was the maximum number of beds or slots provided (including any "emergency basis only" slots or beds.

2. "Actual occupancy" refers to the number of all slots actually occupied as of June 30, 1975 for providers with contracts extending into FY 1976 or highest number of slots occupied at any one time for providers terminated before June 30, 1975.

3. Row and column totals based on all entries in respective row or column.

4. Boxed in cell entries and summary statistics refer only to data on slots which were occupied as of June 30, 1975 or before termination of provider's contract during FY 1975. (Refer to footnote #2 above for the criteria used to determine occupancy).

a. Provider contract terminated on March 1, 1975
b. Provider contract terminated on February 1, 1975
c. Provider contract terminated on February 14, 1975
d. Provider contract terminated on June 3, 1975
e. Provider contract terminated on June 30, 1975
f. Provider contract terminated on November 18, 1974
g. Provider contract terminated on August 28, 1974
h. Provider contract terminated on February 28, 1974

Examination of data in Table I-1 reveal first that rates are paid providers vary considerably and that second, third, and fourth slot costs are much less than first slot costs with few exceptions. Second, if all slots are occupied, the average cost per slot per month improves regardless of setting. Settings can be ranked from greatest to least expense as follows:

Rank	Type of Setting	Average Per Month Per Slot Cost
1st	Group care	$817
2nd	Two parent foster care	554
3rd	One parent foster care	525
4th	Special situations	434
5th	Day care (nonresidential)	280

If we contrast data from the first to the second six (6) months period in FY 1975 in Table I-2[1], another pattern emerges in our fiscal data.

Namely, we find that the differences between the average costs of all available (or "projected") slots and the average costs of the maximum number of slots actually occupied vary by half of FY 1975 and setting listed here. For group care and for one and two parent foster care it appears that the difference between projected and actual average monthly placement costs per slot decreases from first half

[1]Note that the earlier distinction between professional and family foster care is replaced in these data with a distinction between one vs. two parent foster care.

Table I-2

FISCAL DATA--SOHC (Fiscal Year 1975)

Average Monthly Placement Costs Per Slot
(All Projected Slots and Occupied Slots Only)

	July 1974 - Dec. 1974	Jan. 1975 - 1975
GROUP CARE		
Projected	$\bar{X}$ = $510.63 (N=8)	$\bar{X}$ = $816.58 (N=19)
Occupied	$\bar{X}$ = $672.40 (N=5)	$\bar{X}$ = $873.93 (N=14)
2 PARENT FOSTER CARE		
Projected	$\bar{X}$ = $525.26 (N=19)	$\bar{X}$ = $554.42 (N=38)
Occupied	$\bar{X}$ = $755.00 (N=9)	$\bar{X}$ = $603.97 (N=31)
1 PARENT FOSTER CARE		
Projected	$\bar{X}$ = $527.50 (N=18)	$\bar{X}$ = $524.83 (N=29)
Occupied	$\bar{X}$ = $726.00 (N=10)	$\bar{X}$ = $587.83 (N=23)
DAY CARE		
Projected	----------	$\bar{X}$ = $279.80 (N=20)
Occupied	----------	$\bar{X}$ = $279.80 (N=7)
SPECIAL SITUATION		
Projected	----------	$\bar{X}$ = $434.16 (N=6)
Occupied *	----------	$\bar{X}$ = $532.66 (N=3)

*Excludes one independent living situation where the project paid for an "emancipated" client's rent only. ($\bar{X}$ = mean cost and N = number of slots).

(July 1, 1974--December 31, 1974) to second half (January 1, 1975--June 30, 1975). This lessening of the difference is due to the project's keeping more of their projected slots occupied as the project progressed. In terms of costs, maximum occupancy reduces the per slot per month costs considerably by placing more clients in the less expensive second, third, and fourth slots (especially in foster care settings.) The unexplored disadvantages of maximum occupancy might be a reduction in the effectiveness of treatment especially for those occupying first slots due to the drain on treatment services and resources posed by additional clients. While this research does not address this implied question of what constitutes optimum occupancy of slots, future research must eventually address this issue.

II. Description of Clients Referred to the Project in FY 1974-1975

This study is based on the results of analyzing the first 126 Case Management (CMCS) clients referred to the SOHC project for possible placement in out of home care (either with the project or via CSD in general). This section of the report is concerned with the problem of learning who these referred clients were in the aggregate sense of their "profile characteristics."

In general, we have seldom explored the issue of what children needing out of home care look like in an aggregate sense. A study of profile characteristics would enhance our understanding of both the professional service needs of these children and the special demands they seem to place on family, school, and community. Such a study is necessary also to understanding how this program attempts to deal with the special needs of a unique target population.

The following data were collected from a special project "client needs assessment form" (SOHC Form 1.0).[1] Whenever a CMCS project case manager referred one of his/her clients to the SOHC project for possible placement in out of home care, he or she was required to submit this form to SOHC project at or shortly after the date of official project referral. The form was designed to provide descriptive information on the child in need, on his/her family, and on specific behavioral/attitudinal problem areas requiring attention via placement in alternative or out of home care. In addition to this basic information on the child in need, information also was required on the desired characteristics of the placement setting to be arranged and other client information--including data on client assets and strengths.

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[1]See Appendix D for a copy of the initial SOHC Client Referral Needs Assessment form (SOHC Form 1.0).

The information here was extracted from these intake needs assessment forms on 126 clients referred by 18 case managers in four (4) CMCS offices during FY 1974-1975. The following information is arranged by general type of information and major question answered by the information presented:

A. Descriptive (Demographic and Other Questionnaire) Information on the Child in Need--Who Got Referred?

1. Source of Referral by CMCS Office--How Many From Each Office?

	%	N
North Office	20.6	26
N.E. Union (Albina)	23.0	29
N.E. Multi-Service Center	16.7	21
Southeast	39.7	50
	100.0	126

2. Use of SOHC by CMCS Case Managers in FY 1975--Number of Case Managers by Number of Referrals (with Mean and Standard Deviation)--How Many Did Each Refer?

# Referrals	# Case Managers
1	1
2	0
3	0
4	3
5	3
6	1
7	2
8	2
9	2
10	2
11	0
12	2
126	18

Summary Statistics on Distribution of Referrals by Case Manager

$\bar{X}$ = 7.00
SD = 3.01
Range = 0-12
N = 18

NOTE: During the total period in which the CMCS and SOHC projects operated concurrently, there were 21 case managers operating out of four field offices. Eighteen (18) of these were with the CMCS project in FY 1974-1975 and made at least one referral to SOHC. It must be remembered that the above data summarized referrals made only by these 18 case managers and only in FY 1975. It also should be pointed out that not all of these 18 case managers may have been with the CMCS project for the full 12 months of FY 1975.

3. Who Were These Referrals in Demographic Terms?

a. Age Distribution of Referrals (at Point of Referral)

Age	%	N
11	2.4	3
12	7.9	10
13	16.7	21
14	26.2	33
15	26.2	33
16	11.9	15
17	6.3	8
Unknown	2.4	3
	100.0	123

Summary Statistics on Age Distribution

$\bar{X}$ = 14.30 years
SD = 1.41
Range = 11-17
N = 123

b. Sex Distribution of Referrals

	%	N
Male	88.9	112
Female	11.1	14
	100.0	126

c. Distribution of Referrals by Ethnicity

	%	N
White	65.9	83
Black	26.2	33
Mexican American	0.8	1
American Indian	4.8	6
Unknown	2.4	3
	100.0	126

4. Were These Referrals Known to CSD and Did CSD have temporary Custody of the Child Before or At Point of Referral to SOHC?

a. CSD Worker Known?

	%	N
Yes	42.9	(4)
No	50.8	(64)
Unknown	6.3	(8)
	100.0	(126)

b. Did CSD Have Temporary Custody of This Child?

Yes	41.3	(2)
No	51.6	(65)
Unknown	7.1	(11)
	100.0	(126)

5. Had These Clients Ever Been in Out of Home Care Before Referral to SOHC?

Distribution of Referrals by Out of Home Care (OHC) Placement History--Number of Previous OHC Placements Prior to SOHC Referral)

	%	N
None (0)	57.9	73
One (1)	19.8	25
Two (2)	8.7	11
Three (3)	7.1	9
Four (4)	0.8	1
Five (5)	0.8	1
Six (6)	0.8	1
Seven (7)	1.6	2
Sixteen (16)	0.8	1
Unknown (?)	1.6	2
	100.0	126

Summary Statistics on OHC Placement Distribution

$\bar{X}$ = .959
SD = 1.95
Range = 0-16
N = 124

6. What Was Known About the School Backgrounds of These Children? (Distribution of Referrals by Type of Current School Program.)

	%	N
Regular public school	50.8	64
Alternative education program	14.3	18
One of above, but truant more than one third of last year	6.3	8
Not enrolled in any school program	26.2	33
Unknown	2.4	3
	100.0	126

7. What Was Known About the Family Backgrounds of These Children?

a. Parental Composition of Referred Child's Family[1]

	%	N
Two Parent	39.7	50
One Parent (Mother or Mother Figure Present)	39.7	50
One Parent (Father or Father Figure Present)	7.9	10
Other	11.9	15
Unknown	0.8	1
	100.1	126

[1]Parent = One who is doing the parenting.

b. Distribution of Referrals by Marital Stability of Child's Parents

	%	N
Stable Union	27.0	34
Unstable Union	13.5	17
Already Dissolved	39.7	50
Unknown	19.8	25
	100.0	126

c. Number of (Other) Children in Family Besides Client

	%	N
0-no others	7.1	9
1-one other	15.9	20
2-two others	17.5	22
3-three others	20.6	26
4-four others	10.3	13
5-five others	10.3	13
6-six others	7.9	10
7-seven others	3.2	4
8-eight others	1.6	2
9-nine others	0.8	1
14-fourteen others	0.8	1
Unknown number	4.0	5
	100.0	126

Summary Statistics on Family Size Distribution (excluding client)

$\bar{X}$ = 3.19
SD = 2.24
Range = 0-14
N = 121

d. Parental change most needed by "Mother" and/or "Father" to improve parent/child relationship functioning--Distribution of responses for client referrals

	MOTHER	FATHER
Resolve own emotional or personal problems	13.5% (17)	10.3% (13)
Learn or improve disciplinary techniques, etc.	19.0% (24)	8.7% (11)
Learn to be consistent in disciplining	1.6% (2)	0.8% (1)
Improve communications and interpersonal relationships with child	12.7% (16)	13.5% (17)
Learn to reward positive behavior of the child	0.0% (0)	0.8% (1)
Other	42.1% (53)	23.0% (29)
Unknown	11.1% (14)	42.9% (54)
	100.0% (126)	100.0% (126)

e. Mother's/Father's motivation/capacity to make above change on the following scale:
(low) 1 2 3 4 5 6 7 8 9 (high)

	Mean Score ($\bar{X}$)	SD	(N)
Mother's motivation to make change	4.23	2.42	(104)
Mother's capacity to make change	3.85	2.20	(105)
Father's motivation to make change	3.70	2.26	(71)
Father's capacity to make change	3.58	2.13	(71)

f. Number of other children in referral's family needing intensive services (excluding the client himself/herself)

Number	%	N	
0	45.2	57	Summary Statistics
1	18.3	23	on Distribution
2	11.1	14	
3	9.5	12	$\bar{X}$ = 1.10
4	5.6	7	SD = 1.40
5	0.8	1	N = (115)
6	0.8	1	
Unknown	8.7	11	
	100.0	126	

B. Information on the Client's Presenting Problems--Who Got Referred for What?

1. How Did the Case Managers Rate These Referred Clients in Terms of 27 Care Problem Areas? (N = 126 cases unless otherwise noted)

	% Rated as Having Problem
a. Bizzarre Behavior Pattern Problems	
1. Bizzare behavior in community	18.3%
2. Social taboos (public sex play, etc.)	3.2%
b. Property Destruction Pattern Problems	
1. Theft or vandalism of property with school	32.3%

2. Destruction of property in the neighborhood or community — 19.8%

3. Sets fires in the community — 3.2%

4. Sets fires in or near home — 2.4%

c. Assault Pattern Problems

1. Fighting physically with peers at school — 37.3%

2. Physically assaultive to neighbors, adults, peers, younger children in neighborhood — 26.2%

3. Physically assaultive to younger siblings — 22.2%

4. Physically assaultive to older siblings or those of same age — 18.3%

5. Physically assaultive to parents — 11.1%

6. Physically assaultive to adult school personnel — 10.3%

d. Drug/Alcohol Addition/Habituation Pattern Problems

1. Uses marijuana — 58.7%

2. Uses other drugs — 26.2%

3. Excessive use of alcohol — 15.1%

4. Pushing drugs at school or in the community — 7.1%

5. Uses heroin — 0.0%

e. Incorrigibility - Status Offense Pattern Problems

1. Non-production at school — 65.9%

2. Excessive truancy — 65.1%

3. Virtually no compliance to parental requests or limits — 64.3%

4. Refusal to accept/perform routine responsibilities at home — 60.3%

5. Verbally antagonistic so as to continually disrupt the family — 47.6%

6. Runaway from home — 42.9%

7. Continually disruptive to the class at school — 32.5%

f. Theft/Extortion Pattern Problems (Plus Vandalism)

1. Theft in neighborhood homes and stores — 75.4%

2. Stealing from family members — 40.5%

3. Theft or vandalism of property within the school[1] — 33.3%

4. Extortion from peers at school — 7.9%

2. Extent to which referred child was rated as having the capacity to change the above problem behavior(s) at home, school, or in the community using the following scale:

(low) 1 2 3 4 5 6 7 8 9 (high)

	Mean Score (X)	SD	(N)[2]
a. Extent to which child motivated to change his behavior at home	3.68	2.11	124
b. Extent to which child has capacity to change behavior at home	4.58	2.20	124
c. Extent to which child motivated to change his behavior at school	4.03	2.02	120

[1]This problem appears twice in the above list due to overlapping categories.

[2]Total sample size (N) varies according to number of cases with missing information on variables in question.

		Mean Score ($\bar{X}$)	SD	(N)
d.	Extent to which child capacity to change his behavior at school	5.49	2.26	120
e.	Extent to which child motivated to change his behavior at community	4.76	1.92	119
f.	Extent to which child capacity to change his behavior at community	5.88	2.04	118

3. Information on Case Manager Ratings of Other Problems (Physical or Mental)

   a. Distribution of Referrals by Presence of Physical/Mental Disabilities (as Rated by CMCS Case Managers):

	%	N
Present	13.5	17
Not Present	81.7	103
Unknown	4.8	6
	100.0	126

   b. Distribution of above 17 Referrals with Physical/Mental Disabilities by Type of Disability (as Rated by CMCS Case Manager):

	%	N
Epilepsy	5.9	1
Speech Impairment	5.9	1
Mild Mental Retardation	11.8	2
Other	76.5	13
	100.1%	17

4. Problematic and Other Peer Group Roles of Child as Loosely Rated by the Case Manager:

Type of Peer Role[1]	% of Total (N=126) Rated as Playing Role
(a) Planner	58.7%
(b) Loyal group member	54.8%

[1]These roles are somewhat vaguely and ambiguously defined and serve only to allow crude distinctions between youth and permit suggestive inferences. The notion of peer groups here also is problematic in that specific peer groups are not referenced in the intake questionnaire form.

(c) Leader	48.4%
(d) Tag along	45.2%
(e) Dare devil	42.9%
(f) Resource man	42.1%
(g) Victimizer	34.9%
(h) Lover	30.2%
(i) Puppet or easy mark	22.2%
(j) Scapegoat	21.4%
(k) Outcast	15.9%

C. Information on the Client's Presenting Assets--What Did the Referred Client Have Going for Himself/Herself in Terms of Recreational Habits and Special (Character) Strengths, Talents, and Abilities (N = 126):

1. Percent (of Total) Rated by Case Manager as Enjoying Recreational Activities[1] which are:

a. Competitive against peers	61.1%
b. Strenuously physical	58.7%
c. Using fine motor skills	46.8%
d. Spectator or receptor activities	45.2%
e. Competitive against adults	39.7%
f. Expressive	39.7%
g. Construction oriented	36.5%
h. Competitive against adults	34.9%
i. Oriented toward self development	31.7%
j. Service oriented	13.5%

2. Percent (of Total) Rated by Case Manager as Having the Following Strengths:

a. "Catches on quickly"	65.1%
b. "Fair degree of emotional control	56.3%
c. "Good listener"	52.4%
d. "Responds positively to those who try to 'help'"	50.0%

[1]As with peer group roles, these activities are loosely defined and inferences about the child's preferences for recreational activities are bound to be only suggestive.

e. "Good talker" (knows art of self-expression) 48.4%

f. "Good sense of humor (able to laugh at self) 48.4%

g. "Self Starter" (initiates activities) 42.1%

h. "Creative thinker" 39.7%

i. "Insightful into own behavior and others behavior" 27.8%

j. "Optimistic outlook on life" 19.8%

k. "Other qualities" mentioned 19.8%

3. Percent (of Total) Rated by Case Manager as Having the Following Special Talents and Abilities:

a. Athletic 45.2%

b. Mechanical 42.9%

c. Arts/Crafts 31.7%

d. Interest in Animals 20.6%

e. Musical 13.5%

f. Interest in growing things 10.3%

g. Other talents/abilities 8.7%

h. Dramatic 7.1%

i. Creative Writing 6.3%

D. Descriptive Information on Anticipated Placement Needs of Referred Clients

1. Type of out of home care system placement desired for referral (N=126):

Placement in existing CSD resource	27.8%
Placement in unspecified type of SOHC resource	53.2%
Uncertain	19.0%
	100.0%

2. Reason for change of placement for youth at time of initial referral:

Child continually runaway from from current placement	4.8%
Child is serious treat to others in current placement	2.4%
Child not benefitting from program at current placement	16.7%
Serious conflict between child and provider or parents	19.8%
Change in child's or placement situation	11.1%
Placement provider requests child's removal	1.6%
Other reasons (Includes two or more of above)	26.2%
Unknown	17.5%
	100.1%

3. Size of desired placement setting by number of other clients in placement setting for services:

One to Three Others	45.2%
Four to Six Others	7.1%
Seven to Nine Others	4.0%
Ten to Twenty Others	1.6%
Over Twenty	0.0%
Unknown	42.1%
	100.0%

4. Degree of supervision desired in placement setting using the following scale:

(maximum input by youth) 1 2 3 4 5 6 7 8 9 (maximum staff control)

Summary Measures on Distribution of Scores

$\overline{X} = 6.58$
$SD = 1.64$
$N = (101)$

5. Sources of behavioral control for client in desired placement setting:

Self-control/self discipline	27.8%
Peer pressure and control	12.7%
Staff pressure and control	31.7%
Other	1.6%
Unknown	26.2%
	100.0%

6. General type of placement setting desired:

Family foster care	18.3%	(Foster Care - 42.9%)
Professional foster care	24.6%	
Group home care	16.7%	
Residential treatment center care	7.9%	(Group Care - 27.0%
Institutional setting	2.4%	
Unknown	30.2%	
	100.1%	

7. Recommended degree of personal freedom to be permitted youth in desired placement setting:

Youth comes and goes at will - complete independence	0.8%
Youth notifies placement provider of whereabouts, but acts independently	0.8%
Minimal supervision of activities by placement provider	1.6%
Youth keeps to a determined schedule and curfew but his free time is his own	14.3%
Keeps to a schedule and curfew and obtains permission on how to spend free time	27.0%
Youth in unlocked setting, but his schedule is primarily determined by the placement provider	19.8%
Youth spends all his time in structured activities although the setting is open and unlocked	4.0%
Youth spends all his time in structured activities and is under lock up only at night	0.8%
Youth is under twenty-four hour lock up	0.0%
Unknown	30.2%
	100.0%

8. Recommended type of treatment approach to be used to change youth's behavior in desired placement setting:

Traditional, formal psychiatric treatment	2.4%
Counselling, insight therapy	4.0%
Behavior modification	22.2%
Learning approach/societal skills	19.8%
Reality therapy	7.1%
Milieu therapy	1.6%
Guided group interaction	0.8%
No particular therapeutic approach-just warmth and affection	3.2%
Other	16.7%
Unknown	22.2%
	100.0%

9. Recommended location of desired placement

Within the child's immediate neighborhood	1.6%
Within same community (S.E. Portland, N.E. Portland, etc.)	14.3%
Across town or in surrounding Portland area	31.7%
In a distinctly rural area	4.8%
In another area of the state a considerable distance from Portland	4.8%
Other	13.5%
Unknown	29.4%
	100.1%

10. Recommended type of education program needed by child in desired placement:

Educational program operating within the out of home care facility	9.5%
Specially designed school but operating outside the facility	9.5%
Use community based alternative education programs	18.3%
Use local public schools	35.7%
Other	7.9%
Unknown	19.0%
	100.0%

11. Educational areas where youth needs further development during desired placement:

a. Basic academic skills	27.8%
b. Vocational skills	7.1%
c. Survival skills	2.4%
d. "a" and "b" above	7.9%
e. "a" and "c" above	8.7%
f. "a", "b" and "c" above	24.6%
g. "b" and "c"	1.6%
h. Other areas (excluding above)	2.4%
i. Unknown	17.5%
	100.0%

12. Is it part of the case manager's case plan to return the child to his/her family (after out of home care placement)

Yes	28.6%
No	26.2%
Unknown	45.2%
	100.0%

E. Interrelatedness Between Client Problems (Total Sample, N = 126)

Throughout this analysis, we have measured client problems in a gross way by simply noting if a broadly defined problem is rated by the counsellor (i.e., the case manager) as being either present or absent in terms of "profile" characteristics presented by individual clients. While no more refined or detailed analysis of specific problems will be developed here, it is important to at least test to determine if any of these "rated" problems are interrelated (i.e., correlated) in a problem by problem (or bivariate) sense.

We will begin by coding all 27 rated problems in dichotomous (two value) fashion using the following coding rules:

1. If the problem is rated as "yes" or "present" (in the client needs profile), code as "1."
2. If the problem is rated as "no" or "absent" (in the client needs profile), code as "0."
3. If there is no response listed (in the client needs profile), code as "0."[1]

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[1]The decision to force the yes/no choice responses out of these data rests first on the rationale that an attempt should be made to use all available cases (especially in that the number of "no responses" numbered a mere handful for most items usually less than eight (8). (The only exceptions were the following items: (a) "pushing drugs at school" (11), (b) "excessive alcohol use" (13), (c) "Uses marijuana" (20), and (d) "Uses herion" (9). Second, because many of these ratings such as the above require some evidence or proof, it was felt that anything less than a definite marked "yes" response should constitute a "no" response.

Since we are now working with the problem of correlating dichotomous or "dummy" variables, some explanation of the use of the Pearson product--moment correlation coefficient with such "variables" is in order.

Let's illustrate the use of this correlation coefficient with the attributes or categoric variables of "pushing drugs at school" and "uses marijuana" (with both coded "yes" = "1" and "no or unknown" = "0").

The Pearson correlation coefficient of $r = +.23$ indicates that there is a slight positive correlation (or association) between the presence of one of these problems and the presence of the other problems--that is, the presence of a marijuana problem tends (in some significant number of cases) to be associated with the presence of the problem of pushing drugs. Since we can't really make a case here for a causal relation between these attributes in the sense of one problem leading to the other, we limit ourselves to only examining statistical association between variables.[1] The positive value of the correlation coefficient indicates that those with one problem present are more likely to have the second problem present than those with the first problem absent. In our example

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[1]To establish a causal link between problems in the sense of the occurrence of one (A) leading to occurrence of the other (B), three requirements must be met (to say that A causes B):

1. "A and B are statistically associated.
2. A is causally prior to B.
3. The association between A and B does not disappear when the effects of other variables causally prior to both of the original variables are removed"

Travis Hirschi and Haran C. Selvin, Delinquency Research: An Appraisal of Analytic Methods, New York: Free Press, 1967, p. 38.

here, more marijuana "users" than "non-users" were rated as being involved in "pushing drugs at school." (Note: A negative correlation coefficient indicates that not having one problem is associated with having a second problem.)

Part 1 of Appendix E provides the means and standard deviations of each of the 27 problem variables. Part 2 of the same appendix lists out the values (and significance levels) of all the correlation coefficients for the 27 x 27 inter-correlation matrix. The coefficients range in value from +.58 to -.15. The main value of presenting such a matrix lies in the fact that it documents the fact that many of these problems are inter-related. This gives us some basis for saying that in terms of these referrals, many of them have problems which overlap different behavioral domains or operating arenas (such as the home, school, and community) and that different problems can not be analyzed in isolation from one another. For example, in terms of different domains, many of those referrals who case managers indicated had assaulted their parents also were listed as having assaulted adult school personnel. Or in terms of inter-relatedness of problems, it appears that non-production at school and truancy are possibly linked in some way indicating that perhaps inability to perform and non-compliance to a school norm (attendance) are not isolated events.

The inter-relatedness of problems and the extent of the behavioral territory covered by a child in his problem and devicant behaviors ought to be the subject of additional research and inquiry. More adequate information on the intensity and extensity of a child's problems certainly is needed if we are to realistically place a child in various therapuetic settings and expect improvements.

III. ASSESSMENT OF THE EXTENT TO WHICH THE PROJECT MET ITS THREE MAJOR PROCESS OR ACTIVITY OBJECTIVES

III-A

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

The two key performance or productivity measures underlying the above process objective involve quotas of clients served.

First, if the project was to have met the above process objective, it had to place clients in the specially tailored placements it designed and contracted for during the period of project operations. The most important productivity indicator under this objective (See Appendix F) specified that the project would provide specialized out of home care for 150 clients referred for such service from the case management (CMCS project).

Second, as not all clients would require specialized placements and could be referred for "regular" or traditional out of home care; it was necessary to establish a second productivity measure to set the parameters for channeling referrals on to the Children's Services Division (CSD) for regular out of home care. The performance indicator specified that fifty (50) referrals would be channeled to CDS for placement in regular out of home care.

Table I-A-1 provides data on the numbers of referrals the project actually placed in the two types of out of home care--i.e., specialized (SOHC) or regular (ROHC).

Table III-A-1 Numbers of Clients Referred and Placed by Month and Type of Placement for Entire Period of SOHC Project Operations (August 1, 1974 to June 30, 1976)*

Year	Month	1 Number of Referrals[1] to SOHC Project	2 Number of Referrals Placed in SOHC Placements[2]	3 Number Referrals Channeled to ROHC Placements[3]
1974				
	August	13[4]	2	6
	September	18	5	3
	October	22	10	3
	November	13	8	3
	December	16	8	0
	(Sub-totals)	(82)	(33)	(15)
1975				
	January	21	9	4
	February	16	17[b]	2
	March	17	6	3
	April	14	10	0
	May	12	10	0
	June	19	15	2
	July	8	8	1
	August	11	12[b]	0
	September	16	6	0
	October	14	14	0
	November	21	14	1
	December	12	8	0
	(Sub-totals)	(181)	(129)	(13)
1976				
	January	18	11	5
	February	13	9	1
	March	11	9	2
	April	1	1	0
	May	1	1	0
	June	0	0	1
	(Sub-totals)	(44)	(31)	(9)
Total		307	193	37

*Source: Memo from SOHC project director (Ms. Hedy-Jo Powell) dated July 6, 1976.

[1]The monthly entries in this column (1) refer to "new" case management (CMCS) project clients referred to the specialized out of home care (SOHC) project for possible placement in out of home care.

[2]These referrals were placed in those "specialized" placements specifically designed by the SOHC project staff.

[3]In general, these referrals were channeled on to the Children's Services Division (CSD) for placement in the network of "regular" out of home care placements routinely maintained by this agency.

[4]One client was unofficially referred in July 1974 and officially entered as an August 1974 referral. This client was "served" by the project in July in that project funds were used only to pay for psychiatric treatment at Woodlawn Park Hospital. He was then referred for an SOHC project placement in August of 1974.

Examination of the data in this table indicates that in toto, 307 CMCS clients were referred to the SOHC project during the period of project operations. Of this total, 193 were placed in SOHC designed and contracted out of home care placement settings.[1] This figure indicates that the project surpassed its goal of placing 150 referrals in specialized out of home care.

On the regular out of home care side of the coin, 37 referrals were routed on to CDS for placement in that agency's system of (regular) out of home care settings. That is, 37 (or 74%) of the projected 50 were so placed. In toto, the project arranged for out of home care for 230 (or 75%) of the 307 clients referred to it. This total of 230 exceeds the 200 figure projected for eventual placement. It appears, then, that in purely quantitative terms the project served as the out of home care resource it was designed to be for during the period the SOHC and CMCS projects jointly operated.

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[1]Thirty-eight of these referrals were referred for placement in the non-residential day care center component of the SOHC project and 30 were actively placed in this program (some in addition to placement in a residential setting).

III-B

Objective #2 Develop a screening and placement model which provides and improves the delivery of specialized out of home care services to (150) youthful target offenders.

The second evaluation report on this project[1] deals extensively with an initial assessment of the extent to which the project appeared to meet this somewhat subjectively defined objective. This third report will not extend that discussion for two main reasons. First, the attempt to gather additional data linking client needs to actual services delivered proved overly time consuming and abortive for both project and evaluation staffs. Second, the data which was collected for this additional assessment was seriously limited in that it was collected on only a portion of all those clients actually placed with the SOHC project and incomplete on a majority of these clients. The important research question posed by the need to match appropriate services to clients with specific, well-defined needs must await further research in a more opportune setting.

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[1]See Specialized Out of Home Care Project: Evaluation Report No. 2 (Preliminary Process Assessment), Oregon Law Enforcement Council, 1975, pp. 17-25.

III-C

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

INTRODUCTION

During the project, efforts were made to provide for an assessment of the training needs of each individual provider or provider group. Though the effort to assess these training needs proceeded unsystematically and somewhat intuitively, the project staff responded rather zealeously to what they conceived to be the emerging training and technical assistance (TA) needs of providers. Throughout the history of the project, the technical assistance and training given SOHC providers as a group appeared to be innovative, broad ranging, and inclusive. This reflected the attempt, at the aggregate level at least, to respond to provider needs in the most appropriate ways.

Measuring the extent to which this loosely worded objective was accomplished during the project meant that it was necessary to obtain some specific information from providers on their opinions about the value of various major training sessions and technical assistance (TA) made available to them through the joint efforts of the SOHC project staff and CSD.

Consequently, to assess this objective in terms of the value of the training and TA provided, the SOHC staff developed in conjunction with the evaluator and his assistant a questionnaire/interview instrument for assessing the value of all major training rendered project providers.[1] Analysis of the data from this survey of providers is

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[1]This survey research instrument was developed during the closing months of the period of project operations and just after the presentation of the last training sessions held in late 1975.

provided in the next section of this report. By examining these data, a number of insights can be gained as to the kinds of assistance this project gave its provider staff and the value of such assistance in enhancing both the quality and quantity of service/resource delivery. The findings also are suggestive in terms of the value of this assistance for enhancing the ultimate effectiveness of service/resource delivery in altering undesirable client attitudes and behaviors.

Description and Evaluation of Major SOHC Technical Assistance and Training Sessions

The major purpose of this section of the report is to present the major findings from the analysis of a sample survey of project providers which required that they assess the value of training and other technical assistance made available to them by the SOHC staff. The survey results are organized here under the following headings: (1) details of the survey study; (2) provider characteristics and background experience; (3) provider ratings of the value of each major group training session organized by both staff and CSD; and (4) a summary of other related findings.

1. Details of the Provider Training Survey

During the period of project operation, SOHC contracted for provider out-of-home care services with one day care center, four group care facilities (group homes and residential treatment centers), and 47 individuals involved in providing foster care. This latter group can be further subdivided into two major subgroups--one group of eleven (11) individuals providing one parent foster care and 18

couples providing two parent foster care. In addition, one individual was listed in project files as a "special certification" provider, i.e. an individual providing what was described by the first project director as "...a specially tailored placement established by non-SOHC staff and made on a one-time by child basis."

In terms of both organizational structure and program thrust, the main emphasis of the SOHC program centered on the rigorous use of foster care settings and service delivery to meet the needs of a majority of project referrals. During the early developmental phase of the program, much emphasis was placed on hiring and developing "professional" foster care providers. Loosely, this meant couples with college social work degrees and other related credentials who would continue their skill development through in-service training in the program.

To meet the needs of such professionals and to enhance their skills, as well as, to improve the skills of less qualified and/or certified providers; the project staff embarked on a course of intensive training and technical assistance development for foster care providers. This effort was consistent with the implicit assumption of project staff that professionalized foster care was the most appropriate response for most referrals and that the target gains in terms of program achievement could be made in this area of service delivery.

Project staff began planning and implementation of a training and technical assistance package in late 1974 and continued this effort through the end of 1975. Training session schedules and the availability of technical assistance were announced using the vehicle of a

periodically released project newsletter.[1] In addition, the project staff made available to all providers a series of handouts (newspaper articles, article reprints, and miscellaneous printed materials) which served to augment the training effort and also provided for elaboration of project procedures and useful hints for maintaining logs, case records, and other paperwork.

These training activities also served to provide an opportunity for providers to informally discuss client-related problems and "ventilate" feelings.

From an evaluation standpoint, our major interest is on the formal training sessions arranged by staff to assist providers in working with the everyday problems of living with delinquent clients, coping with their behaviors, and impacting or modifying their attitudes/behaviors in socially acceptable directions.

To appreciate the range and volume of training offered, the following annotated list of major documented training sessions/workshops summarizes each session or set of related sessions:[2]

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[1]The newsletter also was used by providers to communicate useful ideas for saving money on food and clothing purchases and for reducing other maintenance expenses. On an informal level, the project also arranged and announced through the newsletter certain recreational and outdoor activities (picnics, camping trips, etc.) for both providers and clients.

[2]Training is summarized for the period December 1, 1974 to October 31, 1975. It should be noted that this interval marks the period from initiation of training to the point where data collection cut off occurred. Training did extend beyond October 31, 1975.

A. McGregor Seminar - December 7, 1974

This was a seminar for providers on bookkeeping, tax information, and procedures for reporting earned income. Bookkeeping tips were provided by Mr. Malcolm McGregor, (a Gresham, Oregon CPA) which were intended to aid providers in money management. The intent of the presentation was not to have Mr. McGregor assist providers in reporting income but to provide tips on reporting income for taxes, etc. The assumption was made that better bookkeeping procedures: (1) Free up the providers time to allow more client contact; (2) provide a clearer delineation on a line item basis of services provided a client; and (3) that better bookkeeping and consumerism permits the provider an opportunity to save money on material resources (food, clothing, etc.) permitting a greater expenditure on treatment (counseling, testing, etc.).

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

B. Workshop in Problems Encountered During the Initial Phase of Placement January 21, and 23, 1975

Two SOHC staff and a provider conducted this workshop which was designed to outline problems and solutions identified with situations where new providers meet new clients and attempt to establish rapport and develop a treatment relationship. The provider, Mr. Ken Keisel, discussed the applications of behavioral modification techniques in addressing some of these problems. Specifically, the workshop dealt with the following:

(1) ...The need to find ways to positively motivate the client in placement - especially in terms of his/her school behaviors.

(2) ...The need to develop the client's sense of individual responsibility for his/her own behaviors.

(3) ...How to deal with specific client problem areas: introversion, school hassles, drug use, non-compliant behavior, etc.

(4) ...How the provider could stay objective and not "feel responsible" for everything that the child does wrong.

In the course of the workshop, certain behavioral modification system tools were presented for establishing token economics (ex. school slips), for "charting" behaviors (i.e. for logging the child's performance), and for reporting important behaviorally relevant incidents.

NOTE: Behavior Modification Techniques Assistance

On an on-going basis, the above provider, Mr. Ken Keisel was to have provided a monthly average of 20 hours consultation to any providers who wished to use behavior modification techniques in working with clients to reduce certain target behaviors. These sessions provided assistance in identifying target behaviors, developing behavior modification charts, setting up token economics, etc.

C. Red Cross Training - January 28 and 30, 1975

Course for Red Cross First Aid Certification conducted by two SOHC providers.

D. Dispositional Assessment Form Training - March 6, 1975

A small group of SOHC providers and CMCS case managers were trained by the SOHC staff in the use of the OLEC-developed Dispositional Assessment and Case Plan Review form (no. 2.0). This form served two project related functions in addition to its use in the project evaluation. First, it was a tool for diagnosis and treatment in case planning for a client. Second, it was an instrument which allowed the treatment or dispositional team to use a common terminology for need description and case planning. Additionally, it served for identifying areas of treatment and interventive techniques where the provider needed additional training and assistance.

The small SOHC provider group initially trained in the use of these forms (during the March 6 session) in turn, helped to train other providers in the use of this instrument.

E. N.E. Provider's Meeting No. 1 - March 12, 1975

The agenda for this meeting included the following:

(1) ...Filling out monthly and quarterly reports on clients in placement.

(2) ...Logging client behaviors.

(3) ...Procedures for emergency placements, client's home visitations, and summer vacation plans.

(4) ...Problems related to establishing case plan goals, working with clients in juvenile detention settings (before placement) and assessing client's educational needs.

NOTE: Session on Completing Case Plans - March 20, 1975

Though not included in the training assessment survey, a group of seven providers were given an orientation session on the mechanics of case logging and reporting and case interviewing.

F. "Mind Development" Session - April 3, 1975

One provider conducted a class based on Alex Merkingar's "Mind Development" for providers and clients. The session covered such topics as expanding the limits of consciousness and techniques for relaxation and meditation. Tapes and books also were presented.

G. Workshops on Ego Defense Mechanism - April 3, 1975

SOHC staff conducted this workshop on dealing with problems posed by clients who frequently and extensively use ego defense mechanisms. A number of small groups training exercises were used during the workshop.

H. Dr. Ebner's First Session - April 7, 1975
("Diagnosing Client Problems and Needs")

Dr Michael Ebner, a clinical psychologist and consultant to both the Impact Case Management Correctional Services (CMCS) Project and the JANUS Program, conducted three training sessions for SOHC providers.

The first session utilized the Dispositional Assessment and Case Plan Review Form (2.0) and manual used during dispositional meetings by providers and project staff. During the session, Dr. Ebner explained and gave illustrations of various client personality and behavioral problems and the means for dealing with them.

I. Dr. Ebner's Second Session - April 22, 1975
("Family Patterns and Kids")

This session focussed on various family patterns (interrelationships) and the kinds of kids (and client problems) they produce.

J. Dr. Ebner's Third Session - April 29, 1975
("Games People Play")

This session focussed on identifying client game playing behaviors and how to deal with them.

K. First Transactional Analysis (Family Focus) Session - May 6, 1975[1]

L. Second Transactional Analysis (Family Focus) Session - May 13, 1975

M. Third Transactional Analysis (Family Focus) Session - May 20, 1975

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[1]Concepts dealt with in these six transactional analysis sessions included: ego states, structural analysis, transactions, "communication with our children," life positions, discipline, freedom from limits, stroking, ways to spend time, games, stamps, scripts, winners and losers, and "johari window".

N. Fourth Transactional Analysis (Family Focus) Session - May 27, 1975

O. Fifth Transactional Analysis (Family Focus) Session - June 3, 1975

P. Sixth Transactional Analysis (Family Focus) Session - June 10, 1975

Q. N.E. Provider's Meeting - No. 2 - May 30, 1975
Agenda not available

R. Thomas and Rosalie Booth's Workshop on "Children and Homes" - June 27, 1975

Workshop dealt with an agenda including such topics as types of children, types of homes, traumatic effects of environmental change, and use of various problem solving (communications) models.

S. Picnic/Workshop (Chuck Sterin) - July 11, 1975

The agenda included informal sharing of ideas related to the comforts and meaningfulness of daily life. Topics included self actualization theory, self hypnosis, the "Meaning Evaluation System", crisis theory, and other related topics focusing on the meaningfulness of various processes of foster parenting.

T. N.E. Provider's Meeting with Thomas and Rosalie Booth - No. 3 - (Three sessions - August 19, 1975; August 26, 1975; and September 30, 1975)

Agendas not available.

U. Back to School Problems Workshop - August 21, 1975
("Back to School - Fun or Frency?")

The agenda included the following:

(1) ...Methods of establishing a relationship with schools in the provider's area.

(2) ..."Effective school tracking."

(3) ...Coordinating school attendance and performance monitoring with provider home situations.

V. Foster Parent association Council Lectures - September 9, 1975

Agenda not available.

W. P.C.C. - Parent Effectiveness Training - (Kelly Fried) - 8 Sessions in October and November, 1975

Agenda not available.

X. "Living and Working with the Mentally Handicapped" - (Metropolitan Foster Care Association - October 7, 1975

An introductory course for home providers and support workers...

Y. Miscellaneous Conference and Workshops[1]

Not listed above (no specific dates given).

[1]This is a residual category in that it consists of all those training sessions and workshops that the providers became aware of and attended as a result exposure to the project and the larger CSD network. (Note: A number of training sessions and workshops were held in November of 1975 and later, but they were not included in this survey of providers.)

A sample of 27 providers were interviewed in December of 1975[1] and asked to provide the following information on each of the twenty-five (25) training sessions he or she attended during their period of tenure with the project:

(1) Did he/she attend the session (or set of sessions).

(2) If the provider did not attend or only attended part of the session (or some of the sessions), he/she was asked the reasons for partial or non-attandance.

(3) Next, the provider was asked to rate the general value or utility of the session or set of sessions using the following scale:

0	1	2	3	4	5
none	little usefullness				very useful

(4) Then, the provider was asked to indicate whether or not he/she had any previous background for the session.

(5) The following question asked whether or not the training provided increased the providers understanding of the problems or identified needs of those clients they served in their placement settings.

(6) Next, the provider respondent was asked to indicate whether or not the training increased his/her awareness of the kinds of services or techniques available to him/her for "treatment" of the clients placed.

(7) Then, the provider respondent was asked to indicate whether or not he/she attempted to incorporate these techniques in their own work with those clients placed with them.

(8) Lastly, the providers were asked to indicate the most important of several other benefits which could have been derived from exposure to the training in each of these sessions or sets of training sessions.

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[1]The characteristics of this provider sample are discussed in the next section of this report.

In addition to these items of information above, the providers interviewed were asked to give their name, the date they started the project, the type of placement setting they provided SOHC clients referred to them, and their background experience for their provider roles and functions (school credentials, volunteer work, and paid employment). The characteristics of the providers sampled are summarized in the next section of the report.

2. Description of the Provider Respondent Sample

The respondents to this provider survey were or had been with the project as of December 1975 when the interviews were conducted. Of the 27 providers interviewed, 17 were interviewed by the OLEC evaluation staff's research assistant and the remaining 10 were interviewed by a provider who was also under contract with the project to coordinate some of the training efforts and to provide technical assistance to various other providers involved in using behavioral modification techniques in their work with children.

No one was interviewed from either the day care center staff or the four group care facilities under contract with the project. All 27 interviewers were involved in providing foster care. Table III C-1 presents a cross tabulation of all persons involved in foster care placements by those actually interviewed.

The low response rates reflected in Table III-C-1 undoubtedly are the product of the fact that many of the providers who started with the project were no longer with it at the time of these interviews. In an attempt to obtain and retain qualified and motivated providers, the project director did a lot of shifting and screening as the project progressed.

Table III-C-1

Number and Percent of All Foster Care
Providers Actually Interviewed

Numbers of All Foster Care Providers Assigned to Project	Percent (and Number) Actually Interviewed
One Parent Foster Care (N=11)	45.5% (N=5)
Two Parent Foster Care (N=36)	61.1% (N=22)

In terms of "provider" educational background, however, it does not appear that many of the providers interviewed possessed college education credentials for the work they were doing. Table III-C-2 presents data on the distribution of provider responses to the item requesting information on their college backgrounds related to their current work in the project.

We can conclude here that the data can lead to either of two possible inferences. First, it is possible that there is an underenumeration of college courses and workshops in the social sciences which can be due to the way in which the question on educational background was posed or; second, it is possible that the data represent accurately the actual state of affairs. Since no additional items were used to probe for added detail on educational background some uncerainty will remain here. For the purposes of this report, we will assume that the research assistant and provider interviewer made a good faith effort to accurately and fully obtain this information. Therefore, we conclude that while the project attempted to use the model of professional foster care, most of the providers interviewed during this latter phase of the project did not possess social work and social science educational credentials to any great extent.

In terms of past work experience related to their current work in the project, most of the providers were involved in both volunteer and paid employment positions which involved work in the area of human services--particularly that related to out-of-home care.

Table III-C-2

Distribution of Responses to
Item Asking for Information on College Background
Related to Current Work

	Percent	(Number)
No college social science coursework or workshops taken	70.4%	(19)
Some college social science* coursework or workshops taken	11.1%	(3)
Majored in social sciences* in college	3.7%	(1)
Possess college social science* degree	14.8%	(4)
Totals	100.0%	(27)

*Social science is broadly defined here to include any coursework or curriculum in the areas of social work, social science, or human behavior.

Table III-C-3 reveals that 88.9 percent of the providers (24 of 27) were involved in some volunteer work related to the project prior to their tenure with the project.

Of the 24 providers involved with some sort of volunteer work prior to SOHC, a majority (54.2 percent) or 13 of 24 were not involved in volunteer work related to foster care or group care facilities (the two major types of out-of-home care settings). The remaining 11 (45.8 percent of 24) all had at least some volunteer work with out-of-home group care facilities.

In terms of paid employment positions held prior to involvement with the project, 70.4 percent (or 19 of 27) were employed in work related to the provision of services for children in out-of-home care settings. Table III-C-4 provides information on the distribution of the providers over several types of settings.

Among the 19 providers employed in work settings related to their current work in the project, 21.1 percent (or 4 of 19) were involved in the provision of foster care. The remainder of these 19 (or 78.9 percent) were employed in jobs in the areas of day care, shelter care, or group home care.

Based on the information contained in Tables III-C-1, 2, and 3; it appears that most of the providers had some experience working in areas directly or indirectly related to the provision of out-of-home group care services. However, most had no prior experience with the provision of foster care services and most were not (by training at least) "professional" foster care providers.

Table III-C-3

Distribution of Responses to Item Asking for Information on Providers Prior Involvement in Volunteer Work Related to Current Work*

	Percent	(Number
Did not engage in past volunteer work related to current SOHC work	11.1%	(3)
Involved as volunteer in CSD sponsored group care facility	29.6%	(8)
Involved as volunteer in non-CSD sponsored group care facility	7.4%	(2)
Involved as volunteer in both CSD and non-CSD sponsored group care facility	3.7%	(1)
Involved as volunteer in CSD sponsored foster care program	0.0%	(0)
Involved as volunteer in non-CSD sponsored foster care program	0.0%	(0)
Involved as volunteer in other (non-OHC)** work related to current work	48.1%	(13)
Totals	100.0%	(27)

*Since the provider's current work involved their provision of specialized out-of-home care to clients placed with them, the question here required that they list the type of work performed in the last volunteer job they had prior to their involvement as SOHC project providers.

**Non-OHC refers to any other volunteer work not related to placements or group care facilities. Thus, we are talking about day care only programs and other non-residential programs for youth--such as the YMCA, Boys Clubs, and Boy Scouts.

Table III-C-4

Distribution of Responses to Item Asking for Information on Providers Prior Involvement in Paid Employment Related to Current Work

	Percent	(Number)
Not engaged in paid employment related to current SOHC work	29.6%	(8)
Involved in CSD sponsored foster care programs	14.8%	(4)
Involved in CSD sponsored day care/shelter care/group home programs	25.9%	(7)
Involved in non-CSD sponsored day care/shelter care/ group home programs	29.6%	(8)
Totals	99.9%	(27)

Of the 26 SOHC training sessions or training units identified earlier in this report, 22 of these (A through U) were arranged specifically by the project for the benefit of its out-of-home care providers. The remaining four sessions (V, W, X, and Y) were held independent of CSD and the project, but their availability was announced by the project director through memos and the project newsletter sent to all active providers.

Concentrating only on those 22 sessions arranged for providers by the project staff and by selected providers for one another, it is important that we establish the relationship between the availability of these sessions (in terms of whether or not they were held during the tenures of individual providers) and actual provider attendance.

Figure III-C-1 presents a scattergram showing the cross tabulation of all SOHC training sessions held during provider tenure by those actually attended during provider tenure in the project.

Each box in the scattergram locates one or more individuals by their "values" on the X and Y variables. For example, reading across the horizontal scale of the X axis to "10" and up the vertical scale to "3", we find that above the "10" and to the right of the "3" there is a box with a "2" in it.

This means that for 2 of the 27 provider respondents, there were exactly 10 training sessions available to them during their tenure with the project which they could have attended. Of the ten (10) each of these two providers attended three (3) sessions.

The line of perfect attendance runs through the set of data points or boxes where the X value equals the Y value. For example, if an individual case had 21 sessions held during his/her tenure as an SOHC project provider, he/she would have had to attend all 21 sessions to fall on the line of perfect attendance. The closest any one provider came to perfect attendance (and maximum use of the training offered) is one individual who attended 15 of 18 sessions available to him or her.

The summary statistics from the scattergram indicate that the group of 27 providers could have attended an average of 17.3 training sessions, but only managed to attend an average of 7.6 sessions. The correlation analysis done on these data indicates that the availability of training sessions (in terms of the number of sessions which were held during a provider's tenure) is a poor predictor of attendance (in terms of the number of sessions actually attended).

The line labeled with the equation Y = .1633 + .4264 X is called the estimating or least squares regression line. This line, together with the linear estimating or regression equation, is useful for estimating the value of Y for each value of X given certain information about the relationship between X and Y.[1]

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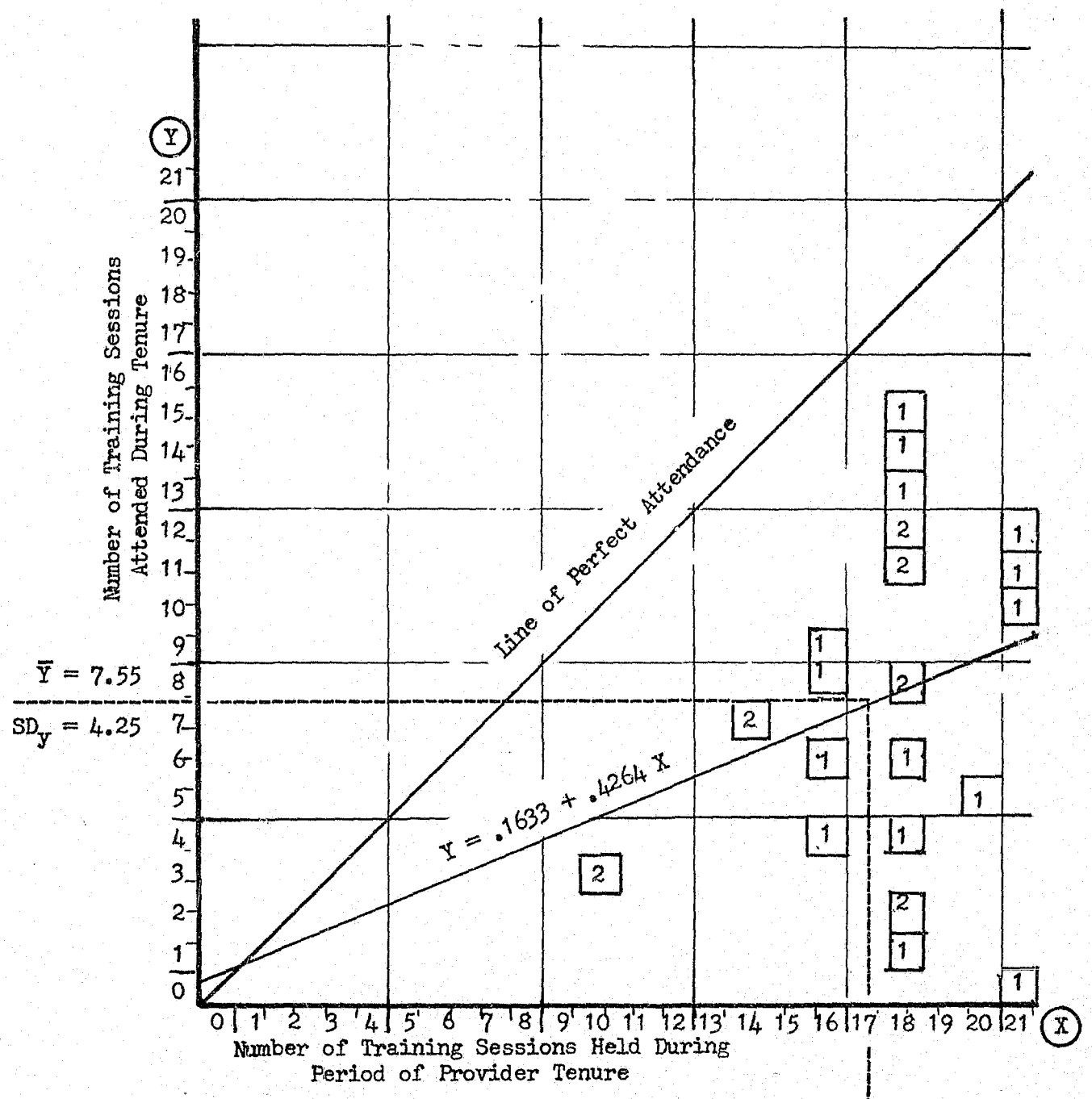
[1]Essentially, use of the least squares criterion in simple linear regression analysis of these data points in Figure III-C-1 requires that the estimating line be fitted to the scatter of points in such a way that the vertical distance between each data point and the line is minimized.

Figure III-C-1

"Scattergram" Showing the Cross Tabulation of All SOHC Training Sessions Held During Provider Tenure by Those Actually Attended During Provider Tenure

(Sample Size = 27 Providers)



We assume here that availability of training sessions and actual attendance are correlated. As it turns out, the Pearson correlation coefficient (r) for the relationship is .28 which indicates a weak correlation (significance = .07801). The coefficient of determination (r^2) equals .07883 which means that availability of training sessions explains only about 8 percent of the variation in attendance. The slope value of .42647 and the Y-intercept value of .16340 can be used in the regression equation to estimate the expected Y values given set values of X. In general, however, it does not appear that availability of the sessions was strongly related to number of sessions attended. This indicates that other factors tended to suppress attendance. Such factors as lack of knowledge of session, previous commitments, lack of applicability to one's work, and the demands of involvement with children placed could have contributed to this overall pattern of poor attendance.

3. Provider Ratings of the Value of Training Sessions

Using the 1 to 5 rating scale mentioned earlier and the previous listing of training sessions, providers in this survey were asked to rate the value of each of these 25 sessions. Table III-C-5 includes summary data on both attendance and average rated value of session. In general, providers attending these sessions rated sessions high in terms of general value or utility. The means ranged from 3.13 to 5.0. The standard deviations (the statistical measure of dispersion in terms of rated scores) ranged from 0.00 to 2.00 indicating differing degrees of consensus about the ratings for each attended session.

Table III-C-5

Summary Data and Statistics on the Rated General Value of SOHC Training Sessions and Workshops

Training Sessions/ Workshops	Rated Value of Session/Workshop Scores						Summary Statistics[1]		
	NONE	Little Usefulness				Very Useful	Number of Provider Raters	Mean Rated Value of Session	Standard Deviation
	0	1	2	3	4	5	(N)	(X)	(SD)
A				2	6	6	14	4.28	0.72
B				3		9	12	4.50	0.90
C						1	1	-	-
D	1	3		4	3	4	15	3.13	1.68
E						3	3	5.00	0.00
F							0	-	-
G				1	2	9	12	4.66	0.65
H		3	2	1		9	15	3.66	1.75
I		1		2	3	7	13	4.15	1.21
J		1		1	1	4	7	4.00	1.52
K		2	1	5	1	3	12	3.16	1.40
L		1	1	4	4	5	15	3.73	1.22
M			1	2	3	6	12	4.16	1.02
N		1	2	2	4	5	14	3.71	1.32
O			1	2	5	4	12	4.00	0.95
P		1	1	3	4	4	13	3.69	1.25
Q	1				1	4	6	4.00	2.00
R			2		2	4	8	4.00	1.30
S							0	-	-
T						4	4	5.00	0.00
U				1	2	3	6	4.33	0.81
V			4			6	10	3.80	1.54
W						1	1	-	-
X				1			1	-	-
Y						3	3	5.00	0.00

[1]Summary statistics are provided only for sessions rated by three or more providers in attendance.

As some of these training sessions were more relevant than others for the tasks of diagnosing and treating children in SOHC project placements and as some additional detail on how these sessions were useful is called for here, the following discussion examines additional provider survey data on selected training sessions:

1. Provider's Meeting on Behavioral Modification Techniques and on Problems During the Initial Phase of Placement (Session B)

Attendence:

A provider organizer acting as an instructor and 12 other providers

Previous Background for Session?

Yes = 41.67% (5 of 12)

Increased Understanding of Problems?

Yes = 50.0% (6 of 12)

Increased Awareness of Techniques?

Yes = 91.67% (11 of 12)

Incorporation of Techniques in Work?

Yes = 91.67% (11 of 12)

Specific Other Benefits:

Interesting Only	16.7% (2)
Direct Application	33.3% (4)
New Methods	8.3% (1)
Subject Awareness	16.7% (2)
Technique Awareness	8.3% (1)
Does Not Apply	16.7% (2)
Totals	100.0% (12)

2. Dispositional Assessment For Training Session (Session D)

Attendence:

Fifteen (15) providers

Previous Background for Session?

Yes = 13.3% (2 of 15)

Increased Understanding of Problems?

Yes = 73.3% (11 of 15)

Increased Awareness of Techniques?

Yes = 73.3% (11 of 15)

Incorporation of Techniques in Work?

Yes = 66.7% (10 of 15)

Specific Other Benefits:

New Methods	26.7% (4)
Subject Awareness	13.3% (2)
Technique Awareness	6.7% (1)
Behavior Awareness	6.7% (1)
New Concepts--ideas	13.3% (2)
Does Not Apply	33.3% (5)
Totals	100.0% (15)

3. Defense Mechanisms Session (Session G)

Attendence

Twelve (12) providers (plus one provider sponsor acting as instructor)

Previous Background for Session?

Yes = 66.7% (8 of 12)

Increased Understanding of Problems?

Yes = 91.7% (11 of 12)

Increased Awareness of Techniques?

Yes = 66.7% (8 of 12)

Incorporation of Techniques in Work?

Yes = 41.7% (5 of 12)

Specific Other Benefits:

Direct Application	8.3% (1)
Subject Awareness	33.3% (4)
New Problem Awareness	8.3% (1)
Different Approaches	33.3% (4)
Does Not Apply	16.7% (2)
Totals	99.9% (12)

4. Dr. Ebner's Three Sessions (Sessions H, I, J)

#1 "Diagnosing Client Problems and Needs"
#2 "Family Patterns and Kids"
#3 "Games People Play"

Attendence

#1: Fifteen (15) providers
#2: Thirteen (13) providers
#3: Seven (7) providers

Previous Background for Session?

#1: Yes = 26.7% (4 of 15)
#2: Yes = 38.5% (5 of 13)
#3: Yes = 14.3% (1 of 7)

Increased Understanding of Problems?

#1: Yes = 66.7% (10 of 15)
#2: Yes = 69.2% (9 of 13)
#3: Yes = 57.1% (4 of 7)

Increased Awareness of Techniques?

#1: Yes = 60.0% (9 of 15)
#2: Yes = 53.9% (7 of 13)
#3: Yes = 57.1% (4 of 7)

Incorporation of Techniques in Work?

#1: Yes = 26.7% (4 of 15)
#2: Yes = 30.8% (4 of 13)
#3: Yes = 14.3% (1 of 7)

Specific Other Benefits:

2. Interesting Only	6.7% (1)	15.4% (2)	14.3% (1)
3. Direct Application	20.0% (3)	7.7% (1)	14.3% (1)
4. Dealt with Problems	6.7% (1)	0.0% (0)	0.0% (0)
6. Subject Awareness	6.7% (1)	15.4% (2)	0.0% (0)
7. Technique Awareness	6.7% (1)	0.0% (0)	0.0% (0)
9. New Problem Awareness	6.7% (1)	15.4% (2)	14.3% (1)
12. Parent-Child Relations	6.7% (1)	0.0% (0)	0.0% (0)
16. Professional Counselling	0.0% (0)	7.7% (1)	0.0% (0)
99. Does Not Apply	40.0% (6)	38.5% (5)	57.1% (4)
Totals	100.2% (15)	100.1% (13)	100.0% (7)

5. Transactional Analysis Sessions (Sessions K through P)

Attendance:

#1: Twelve (12) providers
#2: Fifteen (15) providers
#3: Twelve (12) providers
#4: Fourteen (14) providers
#5: Twelve (12) providers
#6: Thirteen (13) providers

Previous Background for Session?

#1: Yes = 41.7% (5 of 12)
#2: Yes = 26.7% (4 of 15)
#3: Yes = 41.7% (5 of 12)
#4: Yes = 28.6% (4 of 14)
#5: Yes = 16.7% (2 of 12)
#6: Yes = 15.4% (2 of 13)

Increased Understanding of Problems?

#1: Yes = 16.7% (2 of 12)
#2: Yes = 13.3% (2 of 15)
#3: Yes = 33.3% (4 of 12)
#4: Yes = 28.6% (4 of 14)
#5: Yes = 33.3% (4 of 12)
#6: Yes = 23.1% (3 of 13)

Increased Awareness of Techniques?

#1: Yes = 91.7% (11 of 12)
#2: Yes = 93.3% (14 of 15)
#3: Yes = 91.7% (11 of 12)
#4: Yes = 92.9% (13 of 14)
#5: Yes = 91.7% (11 of 12)
#6: Yes = 84.6% (11 of 13)

Incorporation of Techniques in Work?

#1: Yes = 25.0% (3 of 12)
#2: Yes = 40.0% (6 of 15)
#3: Yes = 58.3% (7 of 12)
#4: Yes = 35.7% (5 of 14)
#5: Yes = 41.7% (5 of 12)
#6: Yes = 30.8% (4 of 13)

	#1	#2	#3
2. Interesting Only	16.7% (2)	(0)	(0)
3. Direct Application	(0)	(0)	(0)
5. New Methods	8.3% (1)	6.7% (1)	16.7% (2)
6. Subject Awareness	8.3% (1)	6.7% (1)	8.3% (1)
7. Technique Awareness	8.3% (1)	13.3% (2)	8.3% (1)
9. New Problem Awareness	(0)	6.7% (1)	(0)
11. Perception-Motives	(0)	(0)	(0)
99. Does Not Apply	58.3% (7)	66.7% (10)	66.7% (8)
Totals	99.9% (12)	100.1% (15)	100.0% (12)

	#4	#5	#6
2. Interesting Only	(0)	(0)	(0)
3. Direct Application	(0)	8.3% (1)	(0)
5. New Methods	7.1% (1)	(0)	7.7% (1)
6. Subject Awareness	7.1% (1)	25.0% (3)	7.7% (1)
7. Technique Awareness	21.4% (3)	(0)	7.7% (1)
9. New Problem Awareness	(0)	8.3% (1)	(0)
11. Perception-Motives	7.1% (0)	(0)	(0)
99. Does Not Apply	57.1% (8)	58.3% (7)	76.9% (10)
Totals	99.8% (14)	99.9% (12)	100.0% (13)

6. Thomas and Rosalie Booth's Workshop on "Children and Homes" (Session R)

Attendence:

A provider couple (acting as instructors) and eight other providers

Previous Background for Session?

Yes = 25.0% (2 of 8)

Increased Understanding of Problems?

Yes = 62.5 % (5 of 8)

Increased Awareness of Techniques?

Yes = 62.5% (5 of 8)

Incorporation of Techniques in Work?

Yes = 62.5% (5 of 8)

Specific Other Benefits:

Direct Application	12.5% (1)
New Methods	25.0% (2)
Technique Awareness	12.5% (1)
New Problem Awareness	12.5% (1)
New Concepts-Ideas	12.5% (1)
Does Not Apply	25.0% (2)
Totals	100.0% (8)

7. Back to School Problems Workshop

Attendance:

A provider sponsor (acting as instructor) and six other providers

Previous Background for Session?

Yes = 66.7% (4 of 6)

Increased Understanding of Problems?

Yes = 83.3 % (5 of 6)

Increased Awareness of Techniques?

Yes = 83.3% (5 of 6)

Incorporation of Techniques in Work?

Yes = 83.3% (5 of 6)

Specific Other Benefits?

Interesting Only	16.7% (1)
New Methods Awareness	16.7% (1)
Technique Awareness	16.7% (1)
Different Approaches	16.7% (1)
Does Not Apply	33.3% (2)
Totals	100.1% (6)

IV. OUTCOME ASSESSMENT - ACHIEVING RESULTS IN TERMS OF OVER TIME CHANGE IN CLIENT ATTITUDES AND BEHAVIORS.

A. Introduction

Originally, an experimental design was anticipated for the evaluation of this project. Our rationale for such an approach was that since the SOHC project was designed to provide alternative or out-of-home care for those clients participating in the Case Management Corrections Services (CMCS) project,[1] than a logical approach would have been to "piggyback" an evaluation of this project on to that project. Specifically, SOHC was designed to serve the CMCS experimental group, whereas, the CMCS control group was not eligible for these services. If the CMCS control group clients required out-of-home care, they had to be referred to CSD by the regular court counsellors. Of course, these counsellors could not use the SOHC project staff, as could the CMCS experimental group case managers. This meant that CMCS controls getting out-of-home care by-passed the project (and its special referral mechanisms) and when placed with CSD the out-of-home

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[1]CMCS has been described as a Portland High Impact Program, community based correctional project which attempted to provide intensive probation supervision, counseling, and other services to juveniles aged 10 to 17 who had committed certain targeted offenses, who lived in Portland's high crime areas, and who were adjudicated or informally determined eligible for community supervision by the Multnomah County Juvenile Court. See Diana Gray, CMCS Evaluation Report No. 6, Oregon Law Enforcement Council, 1975 for a description of this project plus results of the project evaluation.

care placements should have been traditional type placements in the sense of not being specially tailored to the needs of these Impact program target offenders.[1]

The major problem with this approach, however, was that due to the disproportionate numbers of CMCS experimentals as compared to controls (better than a 6 to 1 ratio)[2] and the small proportions of clients needing out-of-home care (less than 20% of the combined CMCS evaluation study groups); there were insufficient numbers of cases to permit comparisons between proposed study groups. In fact, only seven (7) CMCS controls had been placed in out-of-home care at the time that the decision was made to drop an experimental design for the SOHC project evaluation effort.

In place of an experimental design to assess possible impacts of project services on client attitudes and behaviors, the researcher decided upon a "one-group pretest-posttest design." Such a design while limited in terms of making inferences about the direct effects of project services on client attitudes/behaviors, still permits one to

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[1]Target offenders were those who had committed such crimes as those identified as burglary, robbery, assault, homicide, rape, and menacing with a weapon as shown by the police arrest when such crimes did not involve relatives, friends, or persons well known to the victim.

[2]For the CMCS evaluation report previously quoted, control group cases identified from July 1, 1973 to January 31, 1975 numbered 72, while 466 clients were assigned to the experimental group from May 1, 1973 (when the project funds were officially awarded through January 31, 1975. See Diana Grey, CMCS Evaluation Report No. 6, Oregon Law Enforcement Council, 1975, p. 5.

(21) Pushing drugs at school or in the community. yes no

(22) Excessive use of alcohol. yes no

(23) Uses marijuana. yes no

(24) Uses heroin. yes no

(25) Uses other drugs. yes no

(26) Bizzare behavior in community. yes no

(27) Social taboos (public sex play, etc.) yes no

(28) To what extent is the child currently motivated to change his behavior at home?

(low) 1 2 3 4 5 6 7 8 9 (high)

(29) What is the child's current capacity to change that behavior at home?

(low) 1 2 3 4 5 6 7 8 9 (high)

(30) To what extent is the child currently motivated to change his behavior at school?

(low) 1 2 3 4 5 6 7 8 9 (high)

make inferences about the degree and magnitude of changes occurring over time irrespective of the sources or causes of such change (i.e., inferences that the project alone produced the differences).

In some respects, this latter pre-experimental design is more appropriate in that the project as implemented did not take the form of a true test of the differential effectiveness of "specialized" vs. "regular" out-of-home care for a specific class of juvenile delinquents and youthful offenders. Rather than attempt to clearly articulate the differences between "specialized" and "regular" out-of-home care and assert the superiority of the former over the latter, the project directors and staff refrained from pushing for clear contrasts between the two types of care. Even the outcome objectives fail to establish that specialized out-of-home care is quantitatively and predictably superior to regular out-of-home care. The thrust of the program was clearly directed toward reducing problem behaviors (particularly recidivism of project clients) by comparing post-program problems to problems noted during a pre-project baseline period. This implies that each subject is his/her own control since we are comparing each individuals current performance with past performance in terms of problem behaviors. If the program thrust had been on comparing clients receiving with those not receiving the specialized out-of-home care; then, we would have had to have constructed an experimental design to test for differential effectiveness.

As it stands, the one group only design is consistent with program emphasis and appropriate to the tasks of evaluating a project in its formulative stages.

Before examining the results of employing the single group pretest-posttest design, some appreciation should be gained of the process by which clients moved through the project and the results of various decisions related to placing or not placing youths in various provider settings for differing lengths of time.

B. A Description of Client Movement

This evaluation effort is based on the results of analyzing the first 126 case management (CMCS) project clients referred to the SOHC project for possible placement in an out-of-home care setting--whether it be furnished by the regular CSD system or specially developed by the project.[1]

Beginning with these 126 initial clients referred, it is possible to map out their flow through a number of placement settings arranged by SOHC staff. Of the 126 clients in this sample of initial referrals to the project, 19 (15.1%) were not placed in any out-of-home care setting. Of the remaining 107 cases, 73 (68.2%) of these received only one placement during the period examined by this report (roughly July 1, 1974 to October 30, 1975).[2]

Of the same 107 clients, 24 (22.4%) went on to have exactly two out-of-home care placements, 8 (7.5%) went on to have exactly three out-of-home care placements, and 2 (1.9%) went on to have exactly four out-of-home care placements arranged by the project. This information can be further summarized in Table IV-1.

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[1]In general, the project tended to use CSD for group care placements as these were difficult for the project to develop on its own. Most of the emphasis in SOHC produced placement settings was on the development of one and two parent foster care.

[2]It should be pointed out that for first or any subsequent placements, the duration of placement ranged from a few days to several months. At certain points is this report the duration in months was computed as "zero" (0) for placements lasting less than 15 days (or 1/2 month).

Table IV-1

Distribution of Study Sample by Numbers of Out-of-Home Care (OHC) Placements Received During Study Period (July 1, 1974 to October 31, 1975)[1]

A.	Total Sample	100.0%	(126)
	(1) No OHC Placements.....	15.1%	(19)
	(2) One or More OHC Placements..	84.9%	(107)
B.	Sub-Sample with OHC Placements	100.0%	(107)
	(1) One Placement Only	68.2%	(73)
	(2) Two Placements Only	22.4%	(24)
	(3) Three Placements Only	7.5%	(8)
	(4) Four Placements Only	1.9%	(2)

[1]It should be noted that we are talking about either out-of-home care placements furnished directly by CSD or indirectly by the SOHC project as a special appendage to CSD. Of course, the number of OHC placements is, in part, a function of the date the client was initially referred to the project.

Besides movement information on numbers of placements received via SOHC referral to CSD or placement with its own contracted providers, it is also possible to track clients placed by the types of placement settings arranged for the client. Our classification scheme for grouping types of settings begins with a major distinction between "regular" out-of-home care (CSD) and "specialized" out-of-home care (SOHC). Sub-classifications are possible by dividing out-of-home care into foster care (both one and two parent), group care (both group homes and residential treatment), and special situations (day care center placements, "emancipation" living expense subsidy, and other special arrangements). Table IV-2 is divided into four sub-tables designed to provide information on the movement of clients from one to another type of placement setting.

A number of inferences can be extracted from this table. First, we know that most of those CMCS clients referred to the project (85% or 107 of 126) actually received one or more out-of-home care placements.[1] Second, among those receiving one or more placements,

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[1]It should be remembered that number of placements in the project depends upon several factors including date of initial referral. For the entire study group of 126 clients, three major groupings can be constructed using period of intial referral to project as a reference point. These groups and the resultant distribution can be presented as follows:

Period of Referral To SOHC for OHC Placement	%	(N)
July 1, 1974 to December 31, 1974	42.9%	(54)
January 1, 1975 to May 30, 1975	45.2%	(57)
June 1, 1975 to September 30, 1975	11.9%	(15)
	100.0%	126

92% (or 98 of 107) had at least one placement in a specialized out-of-home care placement. Third, when clients were placed in specialized out-of-home care placements (which happened frequently) more likely than not the foster care setting was the predominant choice for a placement setting. Of the 98 receiving at least one placement in an SOHC project out-of-home care placement setting, 75 of these (or 76.5%) had one or more of these placements in an SOHC foster care setting.

CONTINUED

1 OF 3

Table IV-2

Cross-tabulations of OHC Placement Order by OHC Placement Setting
(Sub-sample with One or More OHC Placements, N=107)

A. Sub-Sample with Only One OHC Placement (N=73)

First Placement Setting Type[1]	%	(N)
(1) SOHC-Foster Care[2]	64.4%	(47)
(2) SOHC-Group Care[3]	15.1%	(11)
(3) SOHC-Other[4]	12.3%	(9)
(4) ROHC-Foster Care[2]	0.0%	(0)
(5) ROHC-Group Care[3]	4.1%	(3)
(6) ROHC-Other	4.1%	(3)
	100.0%	73

B. Sub-Sample with Two OHC Placements (N=24)[6]

First OHC Placement Setting Type	Second OHC Placement Setting Type: SOHC Foster Care	SOHC Group Care	SOHC Other	ROHC Foster Care	ROHC Group Care	ROHC Other	Sub-Totals
SOHC-Foster Care	41.7% (10)	8.3% (2)	4.2% (1)		4.2% (1)		58.3% (14)
SOHC-Group Care	12.5% (3)	4.2% (1)		4.2% (1)			20.8% (5)
SOHC-Other							0.0% (0)
ROHC-Foster Care	4.2% (1)						4.2% (1)
ROHC-Group Care		4.2% (1)		4.2% (1)	8.3% (2)		16.7% (4)
ROHC-Other							0.0% (0)
Sub-Totals	58.3% (14)	16.7% (4)	4.2% (1)	8.3% (2)	12.5% (3)	0.0% (0)	100.0% (24)

Table IV-2 (Continued)

C. Sub-Sample with Three OHC Placements (N=8)[7]

Third Placement Setting Type: SOHC Foster Care	Third Placement Setting Type: SOHC Group Care	Third Placement Setting Type: ROHC Foster Care
Second Placement Setting Type (SOHC Foster Care)	Second Placement Setting Type (SOHC Foster Care)	Second Placement Setting Type (ROHC Group Care)
First Placement Setting Type	First Placement Setting Type	First Placement Setting Type
SOHC Foster Care 25.0% (2)	SOHC Foster Care 37.5% (3)	SOHC Foster Care 12.5% (1)
	SOHC Group Care 12.5% (1)	
	ROHC Group Care 12.5% (1)	
	Total = 100.0% (8)	

D. Sub-Sample with Four OHC Placements (N=2)

Placement and Setting

First - SOHC Foster Care
Second - SOHC Foster Care
Third - SOHC Foster Care
Fourth - SOHC Group Care

Number of Cases = 2

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[1]ROHC = Regular Out-of-Home Care
SOHC = Specialized out-of-Home Care

[2]Foster care includes both one and two parent foster care settings in the table.

[3]Group care includes both group homes and residential treatment centers.

[4]"SOHC-other" includes 8 cases placed in a special day care center program and one case in a specially tailored placement setting.

[5]"ROHC-other" is composed of three cases where clients were placed in regular OHC with CSD but the type of setting was unknown or unspecified.

[6]Percentages in cell entries in Sub-Table IV-2-B are computed on the base of 24 cases (the sub-sample N).

[7]Percentages in cell entries in Sub-Table IV-2-C are computed on the base of 8 cases (the sub-sample N).

Having gained some sense of client movement through the project in terms of number, sequence, and type of placements at least; it is possible to go on to a discussion of outcome objectives and an assessment of client changes occurring during the project period.

C. Project Outcome Objectives and the Findings of This Research

The final statement of project goals and objectives[1] lists one goal and three specific objectives related to project outcome or results. The overall goal of the project was listed as follows:

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

Three specific outcome or results objectives were listed for the project. These are listed as follows:

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

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

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

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[1]See Appexdix F for the final draft of the project goals and objectives list (with productivity measures.

These objectives, while useful for initiating action and guiding project development, do not really provide realistic, quantifiable standards against which to measure likely project impact on clients. If we are to assess program impact using the criterion of "target offense recidivism," we would find that the effects of SOHC placement services would be inextricably confounded with the effects of CMCS project services in general. In order to isolate and trace out the separate effects of these two types of services, we would need a factorial design. This would allow us to examine simultaneously the effects of SOHC or ROHC placement services and the effects of CMCS services as they impact in combination on target offense recidivism and other client behaviors/attitudes.

Second, SOHC is designed to provide supportive rather than primary treatment services for referred clients. This is particularly apparent given that problems and behaviors other than sole involvement in target offenses formed the basis for referral to the SOHC project. Commission of a target offense may have been the key criterion for inclusion in CMCS, but referral to SOHC (for placement in either specialized or regular out of home care) usually meant that one or more of the variety of client problems discussed in Section II of this report operated to compound the treatment problems posed by involvement in one or more target offenses. In a very definite sense the key criterion for referral to the project for possible out of home care placement is the judgement of the case manager--particularly his/her judgement as to the number, extent, and magnitude (or seriousness) of these additional problems. To be fair then, any assessment of the

possible impact of this program ought to be in terms of the behaviors which brought the client to the attention of the SOHC project and which drew him or her into the formal project referral process.

We take it for granted that pre-project and post (or during) program judgments by case managers of client behavior problems provide a soft criterion for assessing possible program effects. However, the failure to have an experimental setting and design for assessing program impact and the inability to extract or isolate program from non-program effects necessitated our approach of using counsellor-rated problem behaviors as our criterion of research interest and the single group pretest, post-test design for making inferences about the possible impact of SOHC placement services. As the program remained in an exploratory stage so has our evaluative research. In an initial stage of program exploration, we would expect the research effort to be commensurate with the program effort. Therefore, our emphasis has been on carefully documenting the emerging parameters of the program--such as mapping out the characteristics of clients served and services rendered and dredging through longitudinal or overtime data to detect positive and negative changes in client problem behaviors or attitudes which are correlated or associated with significant program events. Before we can argue convincingly that changes in client attitudes and behaviors can be attributed to the introduction of project services (in a causal sense); we must demonstrate that favorable changes in client attitudes and behaviors did occur (in a correlational sense) during the period of exposure to project services.

Having now presented our rationale for the use of the pretest, post-test single group research design and the use of CMCS case manager judgements of client behavioral and attitudinal problems as the criterion for measuring change; we can now outline the results of this research effort. We shall begin by outlining the characteristics of the study group(s) of most interest here.

Descriptions of Project Study Groups

From the data presented previously in Tables IV-1 and IV-2, we learned that: (1) Of the 126 CMCS clients referred to the SOHC project nearly 85 percent (107) received one or more OHC placements and (2) That several clients were placed with both OHC systems (SOHC and ROHC) and in different settings (foster care, group care, and "other").

To arrive at definitions and operational distinctions for further delimiting study groups for analyzing change data here, a number of criteria were established to form sub-samples for more refined, focused analyses. First, a decision was made that a client had to have been in an OHC placement for at least half a month (15 days or more) to establish that individual as a countable entry for determining membership in any sub-samples defined as receiving specific types of out of home care.[1] Second, while no explicit attempt was to be made to establish comparison groups for the analyses here, several different sub-samples of clients were isolated and analysed in terms of change.

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[1]The researcher arbitrarily determined that placement of less than two weeks duration in any out of home care setting hardly constituted a sufficient amount of exposure to any client change producing aspects present.

Besides the total sample (N=126), the sub-samples of interest to us in our analysis are designated with the numbers one (1) and two (2) resulting from the following crosstabulation:

		During the period between T_1 and T_2, was the referred client placed for at least 1/2 month in ROHC?	
		Yes	No
During the period between T_1 and T_2, was the referred client placed for at least 1/2 month in SOHC?	Yes	5 cases (Mixed)	#1 77 cases Pure SOHC
	No	6 cases Pure ROHC	#2 38 cases No OHC
		(X^2 = 1.205, N.S.)	Total N=126

Each of these sub-samples was selected on the basis of exposure or lack of exposure to OHC treatment differentiated on the basis of type of system (ROHC or SOHC). Lastly, the analysis of change was approached using different statistical criteria and procedures. In general, analyses focused either on changes in average number of case manager reported problems over time or changes in the type and seriousness of reported problems over time.

Drawing upon these various analyses using different sub-samples and change measurement criteria, we can organize the general findings from this study by sub-sample analyzed and by the criteria for measuring change. Each of the sections to follow reflect this organization of study findings in regard to client changes in attitudes and behaviors.

Findings on Changes Affecting All Referrals (N=126)

Looking at all 126 referrals in our total study sample first in terms of over time change in the average number of problem behaviors per client based on counts of the 27 client behavior problems discussed in Section II of this report, our major findings can be summarized from Table IV-3.

Bearing in mind that this table includes both those getting and not getting OHC services and that the interval length between Time One (T_1) and Time Two (T_2) varies considerably from client to client,[1] our first major finding emerges from our analysis of Table IV-3:

Finding #1:

For the complete study group of all CMCS clients (N=126) referred to the SOHC project in FY 1974-1975, there was a significant reduction in the mean number of counsellor rated or identified client problems in the 4 to 16 month interval between Time One (T_1) and Time Two (T_2). The average or mean decrease of 2.5 problems could have occurred by chance alone at odds of less than 1 in 1000. (See Table IV-3 for added details.)

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[1]The interval between T_1 and T_2 varies by individual case from four (4) to sixteen (16) months depending on the dates on which the case managers submitted the original and the updated client needs assessment forms. Time One (T_1) for any case refers to the month during which the case manager submitted an original "client needs assessment" form to the project. In most cases, this form was completed and submitted to the project within a few days of the date the client was officially referred to the project. Time Two (T_2) for most of the cases refers to the month during which the updated client needs assessment forms were circulated (October 1975 for about 72 percent of all cases). For those clients who were no longer with the CMCS project, Time Two (T_2) represented the last month during which the case manager had contact with the client and the information on the updated client needs assessment form represented the case manager's assessment of the clients problems and needs at the time of this last contact. (See Appendix G for a copy of the updated client needs assessment form.)

Table IV-3

Results of Comparing T_1 and T_2 Means for Number of Case Manager Judged Client Problems[1] Using the t-test for Repeated Measures (Sample = all 126 Clients Initially Referred to Project).

Time Period	Number of Cases	Mean Number of Problems[1]	Standard Deviation	Mean Difference	t-Value[2]	One-Tail Level of Significance
Time One (T_1)	(126)	8.151	4.172	(2.476)	6.46	p .001
Time Two (T_2)		5.675	4.456			

[1]The Pearson correlation coefficient for the relationship between the T_1 and T_2 number of problems for individuals in this sample equals .504.

[2]Degrees of freedom equal N-1 = 125.

Moving on to Table IV-4, the data here provide comparisons of the case manager's judgements as to the presence or absence of each of 27 different problems rated at T_1 and T_2 for all 126 SOHC project referrals in our major study group. The table presents summary data on the change distribution characteristics and an analysis of change results for each problem using either the McNemar test for the significance of changes[1] or the binomial test.[2]

Looking at all 126 SOHC project referrals under investigation here and the before/after measures for each of the 27 problems rated by the CMCS counsellors, we are interested in determining whether or not more people change from having a problem rated as present at T_1 to rated as absent at T_2 than change from problem rated absent at T_1 to problem rated as present at T_2. This can only occur if there is a decrease in the proportion of the total sample with a problem over time (i.e., P_2 will be less than P_1 in the table for a particular problem rating).

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[1]The McNemar (Chi Square) test for the significance of changes is particularly applicable to the single group before and after design employed here as each person is used as his/her own control and the measurement is in terms of a nominal scale (presence/absence of client problems as rated by case managers) used to assess the "before to after" changes. See Sidney Siegel Nonparametric Statistics, New York: McGraw-Hill, 1956, pp. 63-67 for a description of this test.

[2]The binomial test is used in lieu of the McNemar test whenever very small expected frequencies are encountered. This occurs in situations in Table IV-4 where the actual proportions with a problem either at T_1 or T_2 are very small - less than 10 percent with the problem rated as present. See Sidney Siegel, Nonparametric Statistics, New York: McGraw-Hill, 1956, pp. 36-42 for a description of this test.

Table IV-4

Results of Comparing T_1 vs T_2 Case Manager's Ratings of the Presence or absence of various Client Problems

(Total sample, N=126)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
1-Runaway from home	126	42.9%	31.0%	-11.9%	McNemar X^2=4.36	$P_{(1\text{-tail})}$ =.01845
2-Physically assaultive to parents	126	11.1%	7.1%	-4.0%	McNemar X^2=1.23	$P_{(1\text{-tail})}$ N.S.
3-Physically assaultive to younger siblings	126	22.2%	9.5%	-12.7%	McNemar X^2=9.38	$P_{(1\text{-tail})}$ =.0011
4-Physically assaultive to older siblings or those of same age	126	18.3%	11.9%	-6.4%	McNemar X^2=2.72	$P_{(1\text{-tail})}$ =.0495
5-Physically assaultive to adult school personnel	126	10.3%	7.1%	-3.2%	McNemar X^2=.75	$P_{(1\text{-tail})}$ N.S.
6-Fighting physically with peers	126	37.3%	23.0%	-14.3%	McNemar X^2=10.32	$P_{(1\text{-tail})}$ =.0007

Table IV-4 (Continued)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Proportion with Problem at Time: Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
7-Physically assaultive to neighbors adults, peers, and younger children in neighborhood	126	26.2%	19.0%	-7.2%	McNemar X^2=2.56	$P_{(1\text{-tail})}$ =.0548
8-Stealing from family members	126	40.5%	27.0%	-13.5%	McNemar X^2=8.26	$P_{(1\text{-tail})}$ =.0021
9-Theft or vandalism of property within the school	126	33.3%	21.4%	-11.9%	McNemar X^2=6.32	$P_{(1\text{-tail})}$ =.0051
10-Theft in neighborhood homes and stores	126	75.4%	47.6%	-27.8%	McNemar X^2=21.81	$P_{(1\text{-tail})}$ =.0000
11-Verbally antagonistic so as to continually disrupt the family	126	47.6%	40.5%	-7.1%	McNemar X^2=2.06	$P_{(1\text{-tail})}$ =N.S.
12-Virtually no compliance to parental limits	126	64.3%	45.2%	-19.1%	McNemar X^2=9.80	$P_{(1\text{-tail})}$ =.0009
13-Refusal to accept/ perform routine responsibilities at homme	126	60.3%	51.6%	+8.7%	McNemar P_1P_2	$P_{(1\text{-tail})}$ =.0592

Table IV-4 (Continued)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Proportion with Problem at Time: Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
14-Extortion at school from peers	126	7.9%	4.8%	-3.1%	Binomial	$P_{(1\text{-tail})}$ =N.S.
15-Excessive truancy	126	65.1%	50.0%	-15.1%	McNemar X^2=6.11	$P_{(1\text{-tail})}$ =.0067
16-Continually disruptive to the class at school	126	32.5%	17.5%	-15.0%	McNemar X^2=12.00	$P_{(1\text{-tail})}$ =.0003
17-Non-production at school	126	65.9%	46.8%	-19.1%	McNemar X^2=10.17	$P_{(1\text{-tail})}$ =.0007
18-Sets fires in or near home	126	2.4%	1.6%	-0.8%	Binomial	$P_{(1\text{-tail})}$ N.S.
19-Sets fires in the community	126	3.2%	2.4%	-0.8%	N.S.	$P_{(1\text{-tail})}$
20-Destruction of property in the neighborhood or community	126	19.8%	4.8%	-15.0%	McNemar X^2=14.09	$P_{(1\text{-tail})}$ =.0001
21-Pushing drugs at school or in the community	126	7.1%	9.5%	+2.4%	Binomial	$P_{(1\text{-tail})}$ =N.S.

Table IV-4 (Continued)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Proportion with Problem at Time: Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
22-Excessive use of alcohol	126	15.1%	19.0%	+3.9%	McNemar X^2=1.0667	$P_{(1\text{-tail})}$ N.S.
23-Use marijuana	126	58.7%	46.0%	-12.7%	McNemar X^2=6.6176	$P_{(1\text{-tail})}$ =.0055
24-Uses heroin	126	0.0%	0.8%	+0.8%	Binomial	$P_{(1\text{-tail})}$ N.S.
25-Uses other drugs	126	26.2%	15.1%	-11.1%	McNemar X^2=8.4500	$P_{(1\text{-tail})}$ =.0019
26-Bizzare behavior in community	126	18.3%	4.0%	-14.3%	McNemar X^2=12.0417	$P_{(1\text{-tail})}$ =.0003
27-Social taboos (public sex play, etc.)	126	3.2%	3.2%	0.0%	Binomial	$P_{(1\text{-tail})}$ N.S.

[1] In each case we are testing the hypothesis that $P_2 < P_1$.

[2] N.S. demotes "not significant."

From Table IV-4 a number of findings emerge in this study as follows:

Finding #2:

For ten (10) of the 27 rated problem areas, there were no significant changes in the proportions of subjects moving from one category to the other. We must reject the alternative hypothesis (H_{1a})[1] in each case that the number of T_1 to T_2 changes from problem present to problem absent is greater than the number of changes from problem absent to problem present. That is, we find no significant reductions in the proportions with these particular 10 problems during the varying interval between T_1 and T_2.

Finding #3:

For the remaining seventeen (17) rated problem areas, there were significant changes in the proportions of subjects moving from one category to the other. In these 17 instances, we must accept the alternative hypothesis (H_{1a}) in each case that the number of T_1 to T_2 changes from problem present to problem absent is greater than the number of changes from problem absent to problem present. That is, we find significant reductions in the proportions with these particular 17 problems during the varying interval between T_1 and T_2.

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[1] H_{1a}: (1-tailed)- The number of changes from the first to the second category is greater than the number of changes from the second to the first category. That is, it is hypothesized that $P_2 < P_1$.

Findings on Changes Affecting Only Those Referred Clients Designated as the Pure SOHC Group (N=77)

Turning our attention to the sub-sample of greatest interest (those designated as our "pure-SOHC" group), we can repeat the analyses previously performed on the total sample to determine what changes may have occurred between T_1 and T_2 in this group.

Keeping in mind the limitations and cautions which applied in our analyses of the total sample, we will begin by examining this sub-sample in terms of over time change in the average number of rated problem behaviors. Looking at Table IV-5, our first major finding is as follows:

Finding #1:

For the sub-sample of referrals placed only in SOHC placements (and for 1/2 month or more), there was a significant reduction in the mean number of counsellor rated client problems in the 4 to 16 month interval between Time One (T_1) and Time Two (T_2). The average or mean decrease of 3.2 problems could have occurred by chance alone at odds of less than 1 in 1000. (See Table IV-5 for added details).

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[1]While an additional five clients with SOHC placements existed in our total sample; it was decided that due to their exposure to both types of placements (ROHC and SOHC) and the small number it would be more appropriate to exclude them. This preserves the purity of the sub-sample for comparison purposes and limits the possibility that changes in client behaviors (attitudes could have been associated with placement in non-out of home care services).

Table IV-5

Results of Comparing T_1 and T_2 Means for Number of Case Manager Judged Client Problems Using the t-test for Repeated Measures (Sample = 77 "pure-SOHC" placement clients)

Time Period	Number of Cases	Mean Number of Problems[1]	Standard Deviation	Mean Difference	t-Value[2]	One-Tail Level of Significance
Time One (T_1)	(77)	8.3117	3.958	3.2078	6.40	.000
Time Two (T_2)		5.1036	4.376			

[1]The Pearson correlation coefficient for the relationship between the T_1 and the T_2 number of problems for individuals in this sample equals .446.

[2]Degrees of freedom equal N-1=76.

The data in Table IV-6 provide comparisons of the case manager's judgements as to the presence or absence of each of 27 problems rated at T_1 and T_2 for these (N=77) "pure-SOHC" placement clients. As with the total sample, the summary data here include the change distribution characteristics and an analysis of change results for each problem rated employing either the McNemar test or the binomial test.

From an examination of Table IV-6 two findings emerge:

Finding #2:

For only eight (8) of the 27 problem areas, there were no significant changes or reductions in the proportions with these problems rated present during the interval between T_1 and T_2.

Finding #3:

For the remaining nineteen (19) rated problem areas, there were significant changes in the proportions of subjects moving from one category to the other. In these cases we find significant reductions in the proportions with these problems rated present during the varying interval between T_1 and T_2.

Table IV-6

Results of Comparing T_1 vs T_2 Case Manager's Ratings of the Presence or Absence of Various Client Problems (Pure-SOHC Sub-sample, N=77)

	Change Distribution Characteristics				Analysis of Change Results	
	Number of	Proportion with Problem at Time:		Percentage Difference	Type of Test Used[1]	
Description of Problem	Cases (N)	One(T_1) (P_1)	Two(T_2) (P_2)	(P_2-P_1)	and Results	Probability[2]
1-Runaway from home	77	48.1%	29.9%	+18.2%	McNemar X^2=6.500	$P_{(1\text{-tail})}$ =.0054
2-Physically assaultive to parents	77	9.1%	2.6%	+6.5%	Binomial	$P_{(1\text{-tail})}$ =.0312
3-Physically assaultive to younger siblings	77	24.7%	7.8%	+16.9%	McNemar X^2=7.57	$P_{(1\text{-tail})}$ =.003
4-Physically assaultive to older siblings or those of same age	77	18.2%	10.4%	+7.8%	McNemar X^2=2.50	$P_{(1\text{-tail})}$ =.0569
5-Physically assaultive to adult school personnel	77	10.4%	9.1%	+1.3%	Binomial	$P_{(1\text{-tail})}$ N.S.
6-Fighting physically with peers at school	77	37.7%	20.8%	+16.9%	McNemar X^2=9.60	$P_{(1\text{-tail})}$ =.0009

Table IV-6 (Continued)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Proportion with Problem at Time: Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
7-Physically assaultive to neighbors, adults, peers, and younger children in neighborhood	77	28.6%	19.5%	+9.1%	McNemar X^2=2.77	$P_{(1\text{-tail})}$ =.048
8-Stealing from family members	77	41.6%	27.3%	+14.3%	McNemar X^2=4.76	$P_{(1\text{-tail})}$ =.0145
9-Theft or vandalism of property within the school	77	33.8%	19.5	+14.3	McNemar X^2=5.26	$P_{(1\text{-tail})}$ =.0109
10-Theft in neighborhood homes and stores	77	80.5%	42.9%	+37.6%	McNemar X^2=21.19	$P_{(1\text{-tail})}$ =.0000
11-Verbally antagonistic so as to continually disrupt the family	77	48.1%	37.7%	+10.4%	McNemar X^2=2.45	$P_{(1\text{-tail})}$ =.0587
12-Virtually no compliance to parental requests or limits	77	74.0%	42.9%	+31.1%	McNemar X^2=13.92	$P_{(1\text{-tail})}$ =.0001

Table IV-6 (Continued)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Proportion with Problem at Time: Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
13-Refusal to accept/ perform routine responsibilities at home	77	67.5%	50.6%	+16.9%	McNemar X^2=4.65	$P_{(1\text{-tail})}$ =.0155
14-Extortion at school from peers	77	5.2%	3.9%	+ 1.3%	Binomial	$P_{(1\text{-tail})}$ N.S.
15-Excessive truancy	77	68.8%	48.1%	+20.7%	McNemar X^2=6.62	$P_{(1\text{-tail})}$ =.0050
16-Continually disruptive to the class at school	77	33.8%	14.3%	+19.5%	McNemar X^2=13.07	$P_{(1\text{-tail})}$ =.0001
17-Non-production at school	77	68.8%	40.3%	+28.5%	McNemar X^2=12.25	$P_{(1\text{-tail})}$ =.0002
18-Sets fires in or near home	77	1.3%	1.3%	0.0%	Binomial	$P_{(1\text{-tail})}$ N.S.
19-Sets fires in the community	77	1.3%	2.6%	+1.3%	Binomial	$P_{(1\text{-tail})}$ N.S.
20-Destruction of property in the neighborhood or community	77	22.1%	5.2%	+16.9%	McNemar X^2=8.47	$P_{(1\text{-tail})}$ =.0018

Table IV-6 (Continued)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Proportion with Problem at Time: Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
21-Pushing drugs at school or in the community	77	2.6%	5.2%	+2.6%	Binomial	$P_{(1\text{-tail})}$ N.S.
22-Excessive use of alcohol	77	13.0%	16.9%	+3.9%	McNemar X^2=0.55	$P_{(1\text{-tail})}$ N.S.
23-Uses marijuana	77	53.2%	37.7%	+15.5%	McNemar X^2=5.04	$P_{(1\text{-tail})}$ =.0123
24-Uses heroin	77	0.0%	1.3%	+1.3	Binomial	$P_{(1\text{-tail})}$ N.S.
25-Uses other drugs	77	19.5%	9.1%	+10.4%	McNemar X^2=4.90	$P_{(1\text{-tail})}$ =.0134
26-Bizzare behavior in community	77	18.2%	2.6%	+15.6%	McNemar X^2=8.64	$P_{(1\text{-tail})}$ =.0016
27-Social taboos (public sex play, etc.)	77	1.3%	1.3%	0.0%	Binomial	$P_{(1\text{-tail})}$ N.S.

[1] In each case we are testing the hypothesis that P2<P1.

[2] N.S. denotes "not significant."

Findings on Changes Affecting Only Those Referred Clients Not Receiving Out of Home Care (N=38)

While we indicated earlier that we are foregoing any experimental design with a true comparison group in favor of the single group pre-test, posttest quasi-experimental design; we will isolate, however, the group not receiving out of home care and report the preceeding analyses of change data. This provides at least a basis for some crude "eye balling type" comparisons between the two major sub-samples in our total sample of all FY 1974-1975 referrals.

NOTE: There is some basis for concluding that this "eye balling exercise" for making comparisons is not a trivial exercise. First, the difference between mean number of T_1 problems for both of these groups is not great (the pure-SOHC group mean equals 8.3 and the no-OHC group mean equals 7.8) and not statistically significant (t=-.61, df=113, p=.542 using a pooled variance estimate). Second, the difference between mean number of T_1 assets for these groups is not great (with means of 6.4 and 6.2 for the respective groups) and not statistically significant (t=-.33, df=113, p=.740 using a pooled variance estimate. Third, the two groups appeared to be comparable in terms of proportion with problem for all but the following two (of 27) client problem types:

No Compliance to Parental Limits:

Proportion with Rated Problem (% yes)	Group
74.0%	Pure-SOHC (N=77)
47.4%	No-OHC (N-38)

(X^2=6.84, df=1, p=.009)

Uses Other Drugs:

Proportion with Rated Problem (% Yes)	Group
19.5%	Pure=SOHC (N=77)
39.5%	No-OHC (N=38)

(X^2=4.29, df=1, p=.038)

The reader should be cautioned, however, that when "eye-balling" or comparing these respective study groups in terms of mean change in average number of rated problems, several considerations make any derived inferences suggestive rather than conclusive. The main consideration in terms of the group comparability issue is that there are some differences between the two groups in terms of the time periods during which clients were referred to the project and in terms of the average length of the time interval between Time One (T_1) and Time Two (T_2) for clients in each group. First, in terms of time periods during which clients were referred to the project; there is a slight difference in the proportions of both groups referred to the project in the second half of CY 1974 as opposed to the first half of CY 1975. For the group of 38 referrals getting no out of home care placement, 36.8 percent were referred during CY 1974 as opposed to 42.9% of the 77 CY 1974 referrals placed with SOHC project providers (statistical examination of this percentage difference yielded a corrected X^2 value of .172 with one degree of freedom which is not significant.)

Second, and more importantly these two groups differ in terms of the mean difference in months between Time One (T_1) and Time Two (T_2)--i.e., in terms of average length of the interval between these points for each client in each group. For the group getting no out of home care, the average was 5.6 months; and for the group receiving "specialized" out of home care arranged by and through the project, the average was 8.4 months. The difference between these "average differences" was statistically significant ($t = -4.34$, $df = 113$, $p < .0001$).

Any scientific examination of the differences between these groups in terms of "improvement" in terms of reduction in average number of problems or frequency of problems by type would have to adjust for these differences and undoubtedly many others.

Looking first at Table IV-7 and again keeping in mind the limitations and cautions which applied in our analyses of over time change for both the total sample and the pure-SOHC sub-sample, our first major finding is as follows:

Finding #1:

For the no-OHC sub-sample (i.e., those referrals not placed for at least two weeks in an out of home care setting during the project period, there was a significant reduction in the mean number of counsellor rated client problems in the 4 to 16 month interval between Time One (T_1) and Time Two (T_2)). The average or mean decrease of 1.5 problems could have occurred by chance alone at odds of slightly less than 2 in 100. While both the pure-SOHC group and the no-OHC group showed significant reductions in average number of problems over time, the decrease was somewhat more dramatic for the pure-SOHC group (a decrease of 3.2 problems on the average) than the no-OHC group (a decrease of 1.5 problems on the average).

Moving on to Table IV-8, the data here provide comparisons of the case manager's judgements as to the presence or absence of each of 27 problems rated at T_1 and T_2 for these "no-OHC" clients. The summary data here include the change distribution characteristics and an analysis of change results for each problem rated employing either the McNemar test or the binomial test. From an examination of Table IV-8 two findings emerge:

Table IV-7

Results of Comparing T_1 and T_2 Means for Number of Case Manager Judged Client Problems[1] Using the t-test for Repeated Measures (Sample = 38 clients not placed in OHC)

Time Period	Number of Cases	Mean Number of Problems[1]	Standard Deviation	Mean Difference	t-Value[2]	One-Tail Level of Significance
Time One (T_1)	(38)	7.7895	4.944	1.4737	2.20	.017
Time Two (T_2)		6.3158	4.394			

[1]The Pearson correlation coefficient for the relationship between the T_1 and the T_2 number of problems for individuals in this sample equals .613.

[2]Degrees of freedom equal N-1=37.

Table IV-8

Results of Comparing T_1 vs T_2 Case Manager's Ratings of the Presence or Absence of Various Client Problems (No-OHC Sub-sample, N=38)

	Change Distribution Characteristics				Analysis of Change Results	
Description of Problem	Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Type of Test Used[1] and Results	Probability[2]
1-Runaway from home	38	28.9%	34.2%	+5.3%	McNemar X^2=.08	$P_{(1\text{-tail})}$ N.S.
2-Physically assaultive to parents	38	18.4%	18.4%	0.0%	Binomial	$P_{(1\text{-tail})}$ N.S.
3-Physically assaultive to younger siblings	38	18.4%	13.2%	-5.2%	Binomial	$P_{(1\text{-tail})}$ N.S.
4-Physically assaultive to older siblings or those of same age	38	18.4%	10.5%	-7.9%	Binomial	$P_{(1\text{-tail})}$ N.S.
5-Physically assaultive adult school personnel	38	13.2%	2.6%	-10.6%	Binomial	$P_{(1\text{-tail})}$ N.S.
6-Fighting physically with peers	38	39.5%	23.7%	-15.8%	McNemar X^2=2.50	$P_{(1\text{-tail})}$ =.0569
7-Physically assaultive to neighbors, adults, peers and younger children in neighborhood	38	23.7%	15.8%	-7.9%	Binomial	$P_{(1\text{-tail})}$ N.S.

Table IV-8 (Continued)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Proportion with Problem at Time: Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
8-Stealing from family members	38	34.2%	23.7%	-10.5%	Binomial	$P_{(1\text{-tail})}$ N.S.
9-Theft or vandalism of property within the school	38	34.2%	23.7%	-10.5%	Binomial	$P_{(1\text{-tail})}$ N.S.
10-Theft in neighborhood homes and stores	38	68.4%	50.0%	-18.4%	McNemar X^2=2.77	$P_{(1\text{-tail})}$ =.0480
11-Verbally antagonistic so as to continually disrupt the family	38	42.1%	44.7%	+2.6%	Binomial	$P_{(1\text{-tail})}$ N.S.
12-Virtually no compliance to parental limits	38	47.4%	50.0%	+2.6%	McNemar X^2=0.0	$P_{(1\text{-tail})}$ N.S.
13-Refusal to accept/ perform routine responsibilities at home	38	50.0%	57.9%	+7.9%	Binomial	$P_{(1\text{-tail})}$ N.S.
14-Extortion at school from peers	38	10.5%	5.3%	-5.2%	Binomial	$P_{(1\text{-tail})}$ N.S.

Table IV-8 (Continued)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Proportion with Problem at Time: Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
15-Excessive truancy	38	55.3%	47.4%	+7.9%	McNemar X^2=0.27	$P_{(1\text{-tail})}$ N.S.
16-Continually disruptive to the class at school	38	34.2%	23.7%	10.5%	McNemar X^2=0.90	$P_{(1\text{-tail})}$ N.S.
17-Non-production at school	38	60.5%	50.0%	-10.5%	McNemar X^2=0.75	$P_{(1\text{-tail})}$ N.S.
18-Sets fires in or near home	38	2.6%	2.6%	0.0%	Binomial	$P_{(1\text{-tail})}$ N.S.
19-Set fires in the community	38	2.6%	2.6%	0.0%	Binomial	$P_{(1\text{-tail})}$ N.S.
20-Destruction of property in the neighborhood or community	38	15.8%	2.6%	-13.2%	Binomial	$P_{(1\text{-tail})}$ =.0312
21-Pushing drugs at school or in the community	38	10.5%	15.8%	+5.3%	Binomial	$P_{(1\text{-tail})}$ N.S.
22-Excessive use of alcohol	38	18.4%	18.4%	0.0%	Binomial	$P_{(1\text{-tail})}$ N.S.

Table IV-8 (Continued)

Description of Problem	Change Distribution Characteristics: Number of Cases (N)	Proportion with Problem at Time: One(T_1) (P_1)	Proportion with Problem at Time: Two(T_2) (P_2)	Percentage Difference (P_2-P_1)	Analysis of Change Results: Type of Test Used[1] and Results	Probability[2]
23-Uses marijuana	38	63.2%	57.9%	-5.3%	Binomial	$P_{(1\text{-tail})}$ N.S.
24-Uses heroin	38	0.0%	0.0%	0.0%	Binomial	$P_{(1\text{-tail})}$ N.S.
25-Uses other drugs	38	39.5%	23.7%	-15.8%	Binomial	$P_{(1\text{-tail})}$ =.0351
26-Bizzare behavior in community	38	21.1%	5.3%	-15.8%	Binomial	$P_{(1\text{-tail})}$ =.0351
27-Social taboos (public sex play, etc.)	38	7.9%	7.9%	0.0%	Binomial	$P_{(1\text{-tail})}$ N.S.

[1]In each case we are testing the hypothesis that P^2 P^1.

[2]N.S. denotes "not significant."

Finding #2:

For 22 of the 27 problem areas, there were no significant changes or reductions in the proportions with these problems rated present during the interval between T_1 and T_2.

Finding #3:

For the remaining five (5) rated problem areas, there were significant changes in the proportions of subjects moving from one category to the other. In these cases, we find significant reductions in the proportions with these problems rated present during the varying interval between T_1 and T_2.

A Note on SOHC Findings on Changes Affecting Only Those Clients Placed in the Day Care Center

In addition to the pure-SOHC and the no-OHC group, there is one other group of some interest to us in this study. This is the small sub-sample of nine (9) clients who were placed in the SOHC sponsored Day Care Center run by the BECAP program.[1]

Examining data reported in Table IV-9 and once again keeping in mind the various limitations and cautions of analyzing over time changes in these study data, the first major finding is as follows:

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[1]It should be pointed out that one of these clients was placed with both the Day Care Center and an out of home care foster care provider. The remaining eight (8) clients only received day care from the project.

Finding #1:

For those clients receiving SOHC sponsored day care through the BECAP Day Care Center, there was no significant difference in average number of problems rated at two points in time. While the difference is not significant, the direction of the relationship is counter to that predicted in that there was a very slight increase in the average number of problems over time. It also is worth noting that these nine (9) day care clients had fewer T_1 problems on the average (4.4) than other study group clients.

Moving on the Table IV-10, we have attempted to at least present the numbers of clients (out of the total of nine) who were rated as having each of these 27 problems at both T_1 and T_2. Due to the limited numbers of clients in the sub-sample, no statistical analyses of changes were pursued here. Through visual inspection of the table, however, it does appear that the only substantial reduction in a problem area occurred in the area of theft-primarily in school and in the neighborhood settings. Rather than list a specific finding or findings, we will simply present these data in tabular form for visual inspection. (See Table IV-10)

Table IV-9

Results of Comparing T_1 and T_2 Means for Number of Case Manager Judged Client Problems Using the t-test for Repeated Measures (Sample = 9 Clients Placed in SOHC sponsored Day Care Center)

Time Period	Number of Cases	Mean Number of Problems[1]	Standard Deviation	Mean Difference	t-Value[2]	One-Tail Level of Significance
Time One (T_1)	(9)	4.4444	4.275	-.3333	-.26	N.S.
Time Two (T_2)		4.7778	3.563			

[1]The Pearson correlation coefficient for the relationship between the T_1 and the T_2 number of problems for individuals in this sample equals .541.

Table IV-10

Absolute Number of SOHC Clients in BECAP Day Care Center with Selected Problems at Time One (T_1 and Time Two (T_2) (N=9 Cases)

		Absolute Number and % with Problem Rated as Present at Time One (T_1)	Time Two (T_2)
1.	Runaway from home	0 (0.0%)	1 (11.1%)
2.	Physically assaultive to parents	0 (0.0%)	0 (0.0%)
3.	Physically assaultive to younger siblings	0 (0.0%)	1 (11.1%)
4.	Physically assaultive to older siblings or those of same age.	0 (0.0%)	0 (0.0%)
5.	Physically assaultive to adult school personnel	0 (0.0%)	1 (11.1%)
6.	Fighting physically with peers at school	3 (33.3%)	4 (44.4%)
7.	Physically assaultive to neighbors, adults, peers, younger children in neighborhood	2 (22.2%)	3 (33.3%)
8.	Stealing from family members	1 (11.1%)	1 (11.1%)
9.	Theft or vandalism of property within the school	6 (66.7%)	4 (44.4%)
10.	Theft in neighborhood homes and stores	8 (88.9%)	5 (55.6%)
11.	Verbally antagonistic so as to continually disrupt the family	1 (11.1%)	2 (22.2%)
12.	Virtually no compliance to parental request or limits	2 (22.2%)	2 (22.2%)
13.	Refusal to accept/perform routine responsibilities at home	1 (11.1%)	2 (22.2%)
14.	Extortion at school from peers	1 (11.1%)	1 (11.1%)
15.	Excessive truancy	2 (22.2%)	4 (44.4%)
16.	Continually disruptive to the class at school	3 (33.3%)	4 (44.4%)
17.	Non-production at school	4 (44.4%)	5 (55.6%)

Table IV-10 (Continued)

	Absolute Number and % with Problem Rated as Present at Time One (T_1)	Time Two (T_2)
18. Sets fires in or near home	0 (0.0%)	0 (0.0%)
19. Sets fire in the community	0 (0.0%)	0 (0.0%)
20. Destruction of property in the neighborhood or community	2 (22.2%)	0 (0.0%)
21. Pushing drugs at school or in the community	0 (0.0%)	0 (0.0%)
22. Excessive use of alcohol	0 (0.0%)	0 (0.0%)
23. Uses marijuana	2 (22.2%)	3 (33.3%)
24. Uses heroin	0 (0.0%)	0 (0.0%)
25. Uses other drugs	1 (11.1%)	0.(0.0%)
26. Bizzare behavior in community	1 (11.1%)	0 (0.0%)
27. Social taboos (public sex play, etc.)	0 (0.0%)	0 (0.0%)

Findings on Over Time Changes in Counsellor Ratings of Client Capacity and Motivation to Improve His/Her Behavior at Home, in School, and in the Community for All Referrals (N = 126) and for Those Receiving Specialized Out of Home Care (N = 77)

In addition to measures at two points in time on case manager assessments of changes in ratings on the presence or absence of 27 key client problems, our research effort included data from the case managers for assessing changes in these client's capacity and motivation to change their problem behaviors in the social arenas of the home, the school, and the community. In both the original and the updated client needs assessment data forms (See Appendices D and G), case managers were asked to assess the referred clients (N = 126) capacity and motivation to change problemmatic behaviors (in terms of the 27 listed client problems and others) in the home, school, and community. Six (6) items of information (each requesting a rating) were included in each administration of the needs assessment form (at Time One (T_1) and Time Two (T_2). These items are listed as follows:

To what extent is the child (currently)[1] motivated to change his behavior at home?

(low) 1 2 3 4 5 6 7 8 9 (high)

What is the child's (current)[1] capacity to change that behavior at home?

(low) 1 2 3 4 5 6 7 8 9 (high)

To what extent is the child (currently)[1] motivated to change his behavior at school?

(low) 1 2 3 4 5 6 7 8 9 (high)

What is the child's (current)[1] capacity to change his behavior at school?

(low) 1 2 3 4 5 6 7 8 9 (high)

To what extent is the child (currently)[1] motivated to change his behavior in the community?

(low) 1 2 3 4 5 6 7 8 9 (high)

What is the child's (current)[1] capacity to change his behavior in the community?

(low) 1 2 3 4 5 6 7 8 9 (high)

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[1]The words "current" or currently" were included in the wording of these items for the updated or T_2 needs assessment forms. "Current" was defined as at the present for clients still in placement and/or actively on the case manager's caseload as of October 31, 1975 or as of the date of last contact for clients terminated from placement and/or not actively on the case manager's caseload as of October 31, 1975.

In terms of changes in ratings on these six items, two groups are of major concern to us here. These are the total sample of 126 referrals and the sub-group of 77 receiving specialized out of home care. Looking at both of these groups and the change in ratings, two general and major findings emerge.

Finding #1

Looking at all referrals in Table IV-11, there was a significant improvement in three of the six ratings. Specifically, all referred clients were rated as being significantly more motivated over time to deal with their problem behaviors in the social arenas of the home and school. Case manager ratings of their capacity to change their problem behaviors at home was revised upward indicating a greater capacity than originally anticipated. While there were no significant changes in the other three ratings, one change approximated significance. This was in the area of capacity to change client problem behavior in the community where rated capacity was revised slightly downward.

Finding #2

Examining only those referrals placed in specialized out of home care in Table IV-12, it appears that the same pattern of results emerges. In comparing ratings over time on all items, there is significant improvement in terms of motivation to deal with problem behaviors in the area of the home and the school. Again, we also find that that case managers rate client capacity to deal with their problems in the school settings significantly greater at T_2. There were no significant changes in the other ratings--accept once again there is one change approximating significance. As with the total sample of all referrals, the SOHC sub-group is rated as having less capacity to change problem behaviors in the community at T_2.

Table IV-11

T-Test Comparisons of Mean Differences Between T_1 and T_2 Rating by Case Managers of Client's "Capacity and Motivation to Change[2]"Negative" Behaviors in Various Social Settings (Total Sample, N=126)

Variable[2]	Setting	No. of Cases[1]	Time Period	Mean Score[2]	(Standard) Deviation	T-value[3]	One-Tail Probability
Child's Motivation To Change	Home	117	T_1	3.66	(2.06)	-2.67	.005
			T_2	4.33	(2.08)		
Child's Capacity To Change	Home	117	T_1	4.60	(2.24)	-1.83	.035
			T_2	5.02	(2.16)		
Child's Motivation To Change	School	110	T_1	4.04	(2.02)	-1.79	.038
			T_2	4.47	(2.11)		
Child's Capacity To Change	School	109	T_1	5.47	(2.27)	0.16	N.S.
			T_2	5.43	(2.10)		
Child's Motivation To Change	Community	113	T_1	4.68	(1.90)	-0.13	N.S.
			T_2	4.71	(2.05)		
Child's Capacity To Change	Community	112	T_1	5.79	(2.05)	1.38	N.S.
			T_2	5.50	(1.94)		

[1]Number of cases varies somewhat due to exclusion of cases with missing information

[2]Each of these six (6) variables has a range from 1 (low) to 9 (high)

[3]With each matched t-value the degrees of freedom equals N-1.

Table IV-12

T-Test Comparisons of Mean Differences Between T_1 and T_2 Ratings by Case Managers of Client's Capacity and Motivation to Change "Negative" Behaviors in Various Social Settings (Pure SOHC Sub-Sample, N = 77)

Variable[2]	Setting	No. of Cases[1]	Time Period	Mean Score[2]	(Standard) Deviation	T-value[3]	One-Tail Probability
Child's Motivation To Change	Home	71	T_1	3.82	(2.16)	-2.60	.006
			T_2	4.73	(2.14)		
Child's Capacity To Change	Home	71	T_1	4.48	(2.10)	-2.72	.004
			T_2	5.32	(2.12)		
Child's Motivation To Change	School	65	T_1	4.19	(2.16)	-1.89	.032
			T_2	4.82	(2.22)		
Child's Capacity To Change	School	65	T_1	5.57	(2.31)	0.26	N.S.
			T_2	5.49	(2.20)		
Child's Motivation To Change	Community	66	T_1	4.97	(1.91)	-0.74	N.S.
			T_2	5.18	(2.06)		
Child's Capacity To Change	Community	65	T_1	5.92	(1.91)	1.12	N.S.
			T_2	5.59	(1.94)		

[1]Number of cases varies somewhat due to exclusion of cases with missing information

[2]Each of these six (6) variables has a range from 1 (low) to 9 (high)

[3]With each matched sample t-value the degrees of freedom equals N-1.

APPENDIX A

SPECIALIZED OUT OF HOME CARE PROJECT:

TAILORING PLACEMENTS FOR TARGET OFFENDERS

The Specialized Out of Home Care Project (SOHC) of Portland, Oregon, is administered by the Children's Services Division (CSD) of the state of Oregon. Federally-funded through the Law Enforcement Administration Assistance Agency (LEAA), the Project began May 1, 1974 and extends into September 1976. The mission of the Specialized Out of Home Care Project has been to provide viable substitute care resources specifically geared to meet the needs of Portland juvenile target offenders requiring out of home care. All of the offenders accepted into SOHC are between the ages of ten and eighteen and have been adjudicated for "target" crimes. Specifically, target crimes include burglary, robbery, weapon assault, homicide and rape as evidence by police arrests, excluding incidents where acquaintance or interpersonal relationship was a precipitating factor in the offense. Target crimes would be considered a felony if the offender was of adult status.

Referrals to SOHC come exclusively through Multnomah County's Case Management Corrections Services which is also LEAA-funded to provide intensive community based resources to target offenders on probation to these court workers. Operating in concert with Case Management, SOHC has already provided intake and placement services to approximately 300 juvenile offenders.

The primary SOHC objectives are:

1. To offer a responsive central intake point for all Case Management out of home care referrals.

2. To locate or develop substitute care resources geared to meet the specific needs of referred youth.

3. Model a case planning method that is both goal-specific and time-limited (average placement is six to nine months). Central to this is SOHC's monitoring of individual case plans by coordinating the various agents involved in servicing these juveniles and their families via what is called the "dispositional team" process.

Having first conducting a survey of all potential candidates for substitute care, SOHC opened intake in August 1974. Through March 1976, the Project has provided a range of services to a total of 305 referrals--the majority of whom were males. SOHC has placed 191 adolescents and maintained an average monthly population in care of 50 to 55 youth. Further, it has assisted in "channeling" 36 other youth to existing, i.e. residential care facilities, child care centers, regular foster care, etc., available through the larger agency system.

Analysis of the first 181 referrals to SOHC revealed that 90% were male, the mode age group was in the fourteen and fifteen year old range, 65% were Caucasian, and over one-half came from one-parent families. Interestingly, 57.9% of the first year referrals had no previous out of home care while 35% had had one to three prior out of home placements and 4.8% had between four and sixteen previous out of home care placements. In terms of identified client problem areas, truancy,

assaultive behavior problems, theft and extorsion, incorrigibility and marijuana habituation were common. Later referrals appear consistent with this initial pattern.

The SOHC Project staff includes a Director, three Resource Developers (case workers) and two Secretaries. One Resource Developer serves as the Intake and Placement Supervisor with whom Case Managers initiate a placement request. This worker as well as the other two Resource Developers carry a case load of approximately 20 to 25 youth. In addition to their case loads, each Resource Developer is assigned an additional responsibility. The Intake position has been discussed. The other serves as liaison worker to the Day Care Program which will be mentioned later and the third Resource Developer also assumes the role of liaison to several group care contractors.

It is the Project's intention to get a good "handle" on the youth being referred to form an adequate needs assessment and client profile upon which to make a decision for the type of placement most appropriate. All available SOHC settings are considered when the Project is determining the particular placement.

The thrust of resource development has been one of recruiting a cadre of "professional" foster parents, each of whom is under contract to CSD to provide specific services to the youth in their care. Unique is the concept of negotiating a contract for professional/personal services with care providers. Over the duration of the Project, 32 professional foster care providers have been under contract providing services for one to four juveniles in their settings. Most of the foster parents have been full time providers whose sole job is to monitor and work with the adolescents in their care while others have combined jobs outside of the home with intensive foster care. All providers are furnished with back-up services and training opportunities to enhance their skills in working with hard to manage target offender youth.

In addition to a great deal of staff support from the three Resource Developers, a full time "relief parent"-seasoned in youth work and recreation--has been under contract to provide "respite" care as well as taking youth on field trips and other organized outings. The merits of this component are a broadened experience for the youth as well as preventing provider "burn out".

We have found the professional foster care model most effective and are proud of its diversity. SOHC has contracted with two-parent families, singles, "big brothers and sisters", of various ages and ethnic backgrounds.

SOHC has had the freedom to bring on providers to match the specific needs of referred youth and then to negotiate a very individualized contract for purchase of care including flexible versus set rates. This type of experimentation in contracting for professional foster care is a forerunner of the trend toward contracting for above standard payments made to foster parents in line with Title XX.

SOHC also purchases care from several existing residential treatment programs--a ranch in southern Oregon and two group care programs in the Portland area. Further, it has developed two new programs. The first is the BECAP Day Center located in a racially mixed, lower income Portland neighborhood, which concentrates on target offenders who continue to remain in their own homes but have the need for supervision, cultural and recreational activities and peer group experiences during after school and weekend hours. The second is an experimental group home for five youth located in an outlying area which is geared toward individualized case planning and treatment and utilizes an outward bound/wilderness format.

The "dispositional process" serves several functions to coordinate the individuals and the agencies who, frequently, are simultaneously dealing with a client. A preplacement dispositional conference helps the Resource Developer determine the youth's placement needs. Once the child is placed, dispositional team meetings are held every four to six weeks with all parties engaged in the treatment plan. All participants are trained to use the "Dispositional Form and Codebook" originally developed by the now classic Seattle Atlantic Street Center several years ago. Use of the dispositional process enables participants to systematically record the needs, problems and types of treatment intervention involved. This tool is intended to help the Resource Developer, Case Manager, provider and any other team member monitor the progress toward the desired behavior and attitudinal impacts on the client. The care provider, who has the most direct contact with the client, plays a very major role in the dispositional. Not infrequently the client himself will sit in the dispositional team meeting.

Data gathered from the Dispositional Codesheet can be coded and computer runs can show shifts and reductions in problems over time. Thus, the dispositional recordings serve as a key component in total Project evaluation. It is also hoped that practitioners in other parts of Children's Services Division as well as child care agencies may find utility in this model.

In conclusion, the Specialized Out of Home Care Project has sought to model an intake and case planning system, build and nurture a network of professional foster parents, and broaden the range of substitute care alternatives for hard to manage delinquent youth. Even more important than the reduction of the incidents of both target and non-target offenses amoung clients served is the goal of having impacted upon these youth in such a way as to enable them to function more satisfactorily at home, in school and in their community. A significant reduction in the "revolving door" syndrome, i.e. a pattern of repeated out of home placements, so commonly experienced amoung this population will hopefully result. We look forward to the final evaluation report at the Project's conclusion.

For further information you may contact: Specialized Out of Home Care Project, Children's Services Division, 4520 S.E. Belmont, Box 23, Portland, Oregon 97215 (238-8271) or Children's Services Division--Region I, P.O. Box 146061, Portland, Oregon 97214 (238-8453).

APPENDIX B

SOHC PROJECT

DISPOSITIONAL PHASE:

AN EXPLAINATION

RATIONALE

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

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

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

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

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

(1972):

Need-To provide coordinated services through identification of existing services and improved lines of communication, referral, accountability between appropriate parts of the corrections process.

Need-Establish a method for greater and more effective inter-agency case management between CSD, Multnomah County Juvenile Department, and agencies providing child care and services.

Need-Increase the quantity and quality of residential care facilities with treatment resources appropriate for the needs of target offenders in Portland through planning, locating, training, coordinating, and monitoring.[2]

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

WHO:

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

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

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

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

WHAT:

I. "Staffing":

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

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

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

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

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

II. "Contracting":

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

specified emotional distress, and so on.

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

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

WHEN:

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

WHERE:

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

HOW:

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

MONITORING - EVALUATION:

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

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

FOOTNOTES

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

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

References:

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

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

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

APPENDIX C

SOHC INTAKE AND REFERRAL PROCEDURES

Selection Criteria

A. Inclusion
   1. Must be referred from Case Management (i.e. adjudicated for a target offense).

   2. 10 - 17 years old.

   3. Male or female

   4. Generally, an IQ of at least 70.

   5. Pattern of not responding to other forms of intervention.

   6. Not physiologically drug-dependent.

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

   1. Massively disturbed requiring long term psychiatric treatment.

   2. Serious physical disabilities which would prohibit normal mobility within the care setting, school or community.
   3. Mental retardation.

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

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

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

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

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

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

for placement with the appropriate provider would proceed.

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

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

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

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

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

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

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

Procedures:

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

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

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

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

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

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

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

APPENDIX D

CSD Information
SOHC use only
CSD No.
CSD Worker
District Office
Date Received
TC

CMCS Information
SOHC use only
CMCS No.
Case Manager
Neighborhood Office

SPECIALIZED OUT-OF-HOME CARE

NEEDS ASSESSMENT

Form 1.0

1. Case Manager _____ 2. Neighborhood Office _____

3. Client's Name _____ 4. CMCS ID Number _____

CHILD IN NEED

5. Client's Age ____ 6. Sex _____ 7. Ethnicity _____

8. Does client or family of client have a CSD caseworker?

0. Unknown
1. Yes
2. No

9. If you answered yes to above, in what district office is the CSD worker?

0. Not applicable
1. Southeast
2. West
3. East
4. Northeast
5. Model cities
6. Other district

10. Does CSD have temporary custody on this child?

0. Unknown
1. Yes
2. No

11. Does the child have any phyeical or mental disability?

0. Unknown
1. Yes
2. No

12. If you answered yes to the above, what is the specific disability?

0. Not applicable
1. Epilepsy
2. Speech impairment
3. Mild mental retardation
4. Other _____specify

13. What is the child's current living situation?

0. Unknown
1. In own family home
2. Out-of-home care

14. If the child is in out-of-home care, where is this?

0. Unknown, not applicable
1. Foster care
2. Child relatives
3. Other _____specify placement

15. If the child is in out-of-home care, how long has he been in the above placement?

0. Not applicable or unknown

Specify number of months _____

16. Has the child been in previous out-of-home care?

0. Unknown or not applicable
1. Foster care
2. Child's relatives
3. Other _____specify placement

17. What are the number of times the child has been in out-of-home care?

Specify number of times _____

18. How long ago did he leave his most recent out-of-home placement?

0. Unknown, not applicable
1. Still in out-of-home placement
2. Specify number of months up to 12 and if more than twelve months, specify number of years ____mos.____yrs.

19. For up to four previous placements, list the number of months lived in each placement, starting with the most recent.

_____mos. _____mos. _____mos. _____mos.

20. Youth's current grade in school. _____grade level

21. Youth's achievement level in math. _____grade level

22. Youth's achievement level in reading. _____grade level

23. Youth is currently in:

0. Unknown
1. Regular public school
2. Alternative education program
3. Enrolled in (1) or (2) but truant more than one-third of the last year.
4. Not enrolled in any school program

FAMILY INFORMATION

1. Parental composition of child's family. (Definition: Parent = One who is doing the parenting).

   0. Unknown
   1. Two parent family
   2. One parent, mother figure
   3. One parent, father figure
   4. Other composition _____ specify

2. Degree of marital stability of child's parent's marriage.

   0. Unknown, not applicable
   1. Stable
   2. Unstable
   3. Already dissolved

3. Indicate the parental change most needed to improve parent/child relationship functioning. (Answer for the mother)

   0. Unknown or not applicable
   1. Parent needs to resolve own emotion or personal problems
   2. Parent needs to learn or improve disciplinary techniques in order to better control, supervise and structure child's time
   3. Parent needs to learn to be consistent in disciplining
   4. Parent needs to improve communication and interpersonal relationship with child
   5. Parent needs to learn to reward positive behavior.
   6. Other _____

      _____

      _____ describe

4. Indicate the parental change most needed to improve parent/child relationship functioning. (Answer for the father)

   0. Unknown or not applicable
   1. Parent needs to resolve own emotional or personal problems
   2. Parent needs to learn or improve disciplinary techniques in order to better control, supervise, and structure child's time
   3. Parent needs to learn to be consistent in discipline

continued.....

4. Parent needs to improve communication and interpersonal relationship with child
5. Parent needs to learn to reward positive behavior
6. Other _____

_____

_____ describe

5. Mother's motivation to make that change during out-of-home care.

(low) 1 2 3 4 5 6 7 8 9 (high) circle one

6. Mother's capacity to make that change during out-of-home care.

(low) 1 2 3 4 5 6 7 8 9 (high) circle one

7. Father's motivation to make that change during out-of-home care.

(low) 1 2 3 4 5 6 7 8 9 (high) circle one

8. Father's capacity to make that change during out-of-home care.

(low) 1 2 3 4 5 6 7 8 9 (high) circle one

9. How many children are in the client's family (excluding client)?

_____ List actual number

10. How many of these children need intensive services (exclude the client)?

_____ List actual number

11. How many of these children needing protective services are receiving it?

0. Not applicable
1. None
2. None to two
3. Three to four
4. Five or more

12. How many of these children needing medical services are receiving it?

0. Not applicable
1. None
2. One to two
3. Three to four
4. Five or more

13. How many of these children needing court counseling are receiving it?

0. Not applicable
1. None
2. One to two
3. Three to four
4. Five or more

14. How many of these children needing residential treatment are receiving it?

0. Not applicable
1. None
2. One to two
3. Three to four
4. Five or more

PROBLEM AREAS

The out-of-home care provided through the SOHC unit is directed at behavior change. This change is deemed necessary for the child's continued stay at his current residence or in preparation for his/her placement in another setting, whichever is planned for. Without such change, the child's return or move CANNOT occur. In this context, please indicate the problem behavior for this youth.

Indicate which of all those listed are problems for the child. (Circle response).

1. Runaway from home.	yes	no
2. Physically assaultive to parents.	yes	no
3. Physically assaultive to younger siblings.	yes	no
4. Physically assaultive to older siblings or those of same age.	yes	no
5. Physically assaultive to adult school personnel.	yes	no
6. Fighting physically with peers at school.	yes	no
7. Physically assaultive to neighbors, adults, peers, younger children in neighborhood.	yes	no
8. Stealing from family members	yes	no

9. Theft or vandalism of property within the school. yes no

10. Theft in neighborhood homes and stores. yes no

11. Verbally antagonistic so as to continually disrupt the family. yes no

12. Virtually no compliance to parental request or limits. yes no

13. Refusal to accept/perform routine responsibilities at home. yes no

14. Extortion at school from peers. yes no

15. Excessive truancy. yes no

16. Continually disruptive to the class at school. yes no

17. Non-production at school. yes no

18. Sets fires in or near home. yes no

19. Sets fire in the community. yes no

20. Destruction of property in the neighborhood or community. yes no

21. Pushing drugs at school or in the community. yes no

22. Excessive use of alcohol. yes no

23. Uses marijuana. yes no

24. Uses heroin. yes no

25. Uses other drugs. yes no

26. Bizzare behavior in community. yes no

27. Social taboos (public sex play, etc.) yes no

28. To what extent is the child motivated to change his behavior at home?

(low) 1 2 3 4 5 6 7 8 9 (high)

29. What is the child's capacity to change that behavior at home?

(low) 1 2 3 4 5 6 7 8 9 (high)

30. To what extent is the child motivated to change his behavior at school?

(low) 1 2 3 4 5 6 7 8 9 (high)

31. What is the child's capacity to change his behavior at school?

(low) 1 2 3 4 5 6 7 8 9 (high)

32. To what extent is the child motivated to change his behavior in the community?

(low) 1 2 3 4 5 6 7 8 9 (high)

33. What is the child's capacity to change his behavior in the community?

(low) 1 2 3 4 5 6 7 8 9 (high)

Please check the appropriate peer group roles which this client might play. Indicate all those appropriate.

leader	yes	no
planner	yes	no
dare devil	yes	no
victimizer	yes	no
scapegoat	yes	no
puppet or easy mark	yes	no
resource man	yes	no
loyal group member	yes	no
outcast	yes	no
loner	yes	no
tag along	yes	no

PLACEMENT NEEDS

The SOHC project is designed to develop out-of-home care resources which are needed by Case Management children. To assist in that development, please indicate which resource characteristics would best serve this child.

1. What type of service do you desire from SOHC for this client?

   1. Placement in existing CSD resource, unspecified
   2. Placement in existing CSD resource _____ specify
   3. Placement in a SOHC resource, unspecified and to be developed
   4. Uncertain

2. Why do you wish to make a change of placement for the youth at this time? (indicate only one).

   0. Unknown, not applicable
   1. Child continually runaway from current placement
   2. Child is a serious threat to the safety of others in current placement
   3. Child is not benefitting from program at current placement
   4. Serious conflict between child and placement provider/ parent(s) ,
   5. Change in child's situation requires child's removal
   6. Change in placement's situation requires child's removal
   7. Placement provider request child's removal
   8. Other reasons _____

      _____

      _____
      specify

If you do not already have a specific existing resource in mind for this youth, would you respond to the following questions, as to what you think might be the most appropriate setting.

1. Size of placement setting by number of clients served. (Indicate one only).

0. Unknown or not applicable
1. One to three other clients in placement
2. Four to six other clients in placement
3. Seven to nine other clients in placement
4. Ten to twenty clients in placement
5. Over twenty clients in placement

2. Degree of supervision in placement. (Circle appropriate number):

(maximum input by youth) 1 2 3 4 5 6 7 8 9 (maximum staff control)

0. For unknown or not applicable

3. Sources of behavioral control for client. (Indicate one only).

0. Unknown and not applicable
1. Self-control and self-discipline, emphasis on own self responsibility
2. Peer group pressure and control
3. Staff pressure and control

4. General type of placement setting. (Indicate one only).

0. Unknown or not applicable
1. Family foster home
2. Professionally staffed foster home
3. Group home
4. Small residential treatment center
5. Large residential treatment center
6. Institutional setting

5. Degree of personal freedom permitted youth in placement setting. (Indicate one only).

0. Unknown or not applicable
1. Youth comes and goes at will - complete independence
2. Youth notifies placement provider of whereabouts, but acts independently
3. Minimal supervision of activities by placement provider
4. Youth keeps to a determined schedule and curfew but his free time is his own
5. Keeps to a schedule and curfew and obtains permission on how to spend free time
6. Youth in unlocked setting, but his schedule is primarily determined by the placement provider
7. Youth spends all his time in structured activities although the setting is open and unlocked
8. Youth spends all his time in structured activities and is under lock up only at night
9. Youth is under twenty-four hours lock up

6. Treatment approach to be used to change youth's behavior in placement. (Indicate one only).

0. Unknown or not applicable
1. Traditional, formal psychiatric treatment
2. Counseling, insight therapy
3. Behavior modification approach - cause and effect
4. Learning approach - train in basic societal skills so youth can make it
5. Reality therapy
6. Milieu therapy
7. Guided group interaction
8. No particular therapeutic approach, just warmth and affection
9. Other _____ specify

7. Location of placement. (Indicate one only).

0. Unknown or not applicable
1. Within the child's immediate neighborhood
2. Within same community (S.E. Portland, N.E. Portland, etc.)
3. Across town or in surrounding Portland area
4. In a distinctly rural area
5. In another area of the state a considerable distance from Portland
6. Other _____ specify

8. Type of education program needed by child in placement. (Indicate one only).

0. Unknown or not applicable
1. Educational program operating within the out-of-home care facility
2. Specially designed school but operating outside the facility
3. Use community based alternative education programs
4. Use local public schools
5. Other _____specify

9. Educational areas needing stress with youth during placement. (Circle all applicable).

0. Unknown or not applicable
1. Basic academic skills
2. Vocational skills
4. Survival skills

8. Other _____specify

10. Is it a part of your case plan that this child will return to his/her family following out-of-home care?

0. Unknown
1. Yes
2. No

OTHER CLIENT INFORMATION

Please indicate the types of recreational activities the youth enjoys. (Mark all applicable).

1. Strenously physical	yes	no
2. Competitive against self	yes	no
3. Competitive against peers	yes	no
4. Competitive against adult	yes	no
5. Use of fine motor skills	yes	no

continued .....

6. Construction	yes	no
7. Spectator or receptor activities	yes	no
8. Service	yes	no
9. Expressive	yes	no
10. Self-development	yes	no

Please indicate the child's strengths. (Mark all applicable).

1. Good sense of humor-(able to laugh at self)	yes	no
2. Initiates activities (self-starter)	yes	no
3. Creative thinker	yes	no
4. Good listener	yes	no
5. Good talker (knows art of self-expression)	yes	no
6. Optimistic outlook on life	yes	no
7. Insightful into own and others behavior	yes	no
8. Responds positively to those who try to "help"	yes	no
9. Fair degree of emotional control	yes	no
10. Catches on quickly	yes	no

11. Other qualities describe _____

_____

_____

Does the child have special talents or abilities which could be further developed? (Note all applicable).

1. Musical	yes	no
2. Athletic	yes	no
3. Dramatic	yes	no
4. Mechanical	yes	no
5. Art/Craft	yes	no
6. Creative writing	yes	no
7. Interest in animals	yes	no
8. Interest in growing things	yes	no

9. Other talents _____

_____

_____

APPENDIX E

Part I Means and Standard Deviations of 27 Rated (Dichotomous Value) Problem Variables Used in This Study

Variable (Problem ([1]))	Mean (X)	Standard Deviation (SD)
1. Runaway from home	.43	.50
2. Physically assaultive (parents)	.11	.32
3. Physically assaultive (younger siblings)	.22	.42
4. Physically assaultive (same or older siblings)	.18	.39
5. Physically assaultive (school adults)	.10	.31
6. Fighting (school peers)	.37	.49
7. Physically assaultive (in community)	.26	.44
8. Stealing (in family)	.40	.49
9. Theft or vandalism (schools)	.33	.47
10. Theft (community)	.75	.43
11. Verbally antagonistic (disrupts family)	.48	.50
12. No compliance to parental limits	.64	.48
13. Refuses home responsibilities	.60	.49
14. Extortion (school peers)	.08	.27
15. Truancy	.65	.48
16. Disruptive at school	.33	.47
17. Non-production at school	.66	.48
18. Sets fires (home)	.02	.15
19. Sets fires (community)	.03	.18
20. Property destruction (community)	.20	.40
21. Pushing drugs (school/community)	.07	.26
22. Alcohol abuse	.15	.36
23. Uses marijuana	.59	.49
24. Uses heroin[2]	0	0
25. Uses other drugs	.26	.44
26. "Bizarre" behavior (community)	.18	.39
27. "Social taboos" (sex related)	.03	.18

[1]Number of cases for each variable equals 126.

[2]The sample of 126 contained no clients rated (at intake) as having a heroin use problem.

Part 2: Inter-Correlation Matrix of Rated (Dichotomous[1] Value) Problem Variables Used in This Study (Pearson Product-Moment Correlation Coefficients)[1]

1	2	3	4	5	6	7	8	9	10
1 --	-.05 N.S.	.08 N.S.	.05 N.S.	-.08 N.S.	.00 N.S.	-.08 N.S.	.27 **	-.27 N.S.	-.03 N.S.
2	--	.30 ***	.29 ***	.21 *	.30 ***	.19 *	.33 ***	.23 **	.03 N.S.
3		--	.44 ***	.32 ***	.46 ***	.42 ***	.26 **	.15 N.S.	.04 N.S.
4			--	.11 N.S.	.32 ***	.23 **	.20 *	.10 N.S.	-.06 N.S.
5				--	.44 ***	.39 ***	.04 N.S.	.26 **	.07 N.S.
6					--	.55 ***	.10 N.S.	.32 ***	.10 N.S.
7						--	.06 N.S.	.19 *	.13 N.S.
8							--	.21 *	.10 N.S.
9								--	.33 ***
									--

[1](Note: N = 126 in all instances)

* = significant at .05 level
** = significant at .01 level
*** = significant at .001 level
N.S. = not significant

Part 2 (Continued)

	1	2	3	4	5	6	7	8	9	10
11	.04	.27	.22	.21	.09	.15	.15	.28	-.10	.03
	N.S.	*	*	*	N.S.	N.S.	N.S.	***	N.S.	N.S.
12	.14	.16	.20	.18	.20	.10	.10	.28	.18	.07
	N.S.	N.S.	*	*	*	N.S.	N.S.	**	*	N.S.
13	.11	.24	.12	.13	.17	.16	.11	.37	.09	.06
	N.S.	**	N.S.	N.S.	N.S.	N.S.	N.S.	***	N.S.	N.S.
14	-.08	-.10	.13	.09	.29	.32	.36	.00	.10	.03
	N.S.	N.S.	N.S.	N.S.	***	***	***	N.S.	N.S.	N.S.
15	.20	-.01	.11	.22	.14	.22	.17	.13	.02	.16
	*	N.S.	N.S.	*	N.S.	*	N.S.	N.S.	N.S.	N.S.
16	-.19	.19	.40	.20	.43	.55	.51	.15	.37	.16
	*	*	***	***	***	***	***	N.S.	***	N.S.
17	.08	.04	.14	.08	.02	.14	.16	.05	.08	.33
	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	***
18	.08	.11	.04	-.07	0.05	.09	.03	.08	0.0	-.15
	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
19	.03	.22	.12	.03	-.06	.05	.10	.04	.06	-.11
	N.S.	*	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
20	-.11	.14	.16	.07	.16	.27	.29	.20	.45	.19
	N.S.	N.S.	N.S.	N.S.	N.S.	**	***	*	***	*
21	.01	-.10	-.07	.03	.01	-.02	-.03	.02	-.13	-.06
	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
22	.08	-.01	.04	.09	.08	.04	.15	.10	-.02	.09
	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
23	.17	-.01	-.09	.02	.07	.05	.06	.03	-.06	-.07
	*	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
24	--	--	--	--	--	--	--	--	--	--
25	.07	.08	.03	.14	.09	.06	.18	.06	.04	.05
	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	*	N.S.	N.S.	N.S.
26	-.08	.23	.19	.10	.11	.15	.23	.07	.10	.13
	N.S.	**	*	N.S.	N.S.	N.S.	**	N.S.	N.S.	N.S.
27	.12	.08	.01	.15	-.06	.05	-.11	.04	-.03	.00
	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.

Part 2 (Continued)

	11	12	13	14	15	16	17	18	19	20
1	.04	.14	.11	-.08	.20	-.19	.08	.08	.03	-.11
	N.S.	N.S.	N.S.	N.S.	*	*	N.S.	N.S.	N.S.	N.S.
2	.27	.16	.24	-.10	-.01	.19	.04	.11	.22	.14
	**	N.S.	**	N.S.	N.S.	*	N.S.	N.S.	**	N.S.
3	.22	.20	.12	.13	.11	.40	.14	.04	.12	.16
	*	*	NS.S	N.S.	N.S.	***	N.S.	N.S.	N.S.	N.S.
4	.21	.18	.13	.09	.22	.29	.08	-.07	.03	.07
	*	*	N.S.	N.S.	*	***	N.S.	N.S.	N.S.	N.S.
5	.09	.20	.17	.29	.14	.43	.02	-.05	-.06	.16
	N.S.	*	*	***	N.S.	***	N.S.	N.S.	N.S.	N.S.
6	.15	.10	.16	.32	.22	.55	.14	.09	.05	.27
	N.S.	N.S.	N.S.	***	**	***	N.S.	N.S.	N.S.	*
7	.15	.10	.11	.36	.17	.51	.16	.03	.10	.29
	N.S.	N.S.	N.S.	***	N.S.	***	N.S.	N.S.	N.S.	***
8	.28	.28	.37	.00	.13	.15	.05	.08	.04	.20
	***	**	***	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	*
9	-.10	.18	.09	.10	.02	.37	.08	.00	.06	.45
	N.S.	*	N.S.	N.S.	N.S.	***	N.S.	N.S.	N.S.	***
10	.03	.07	.06	.03	.16	.16	.33	-.15	-.11	.19
	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	***	N.S.	N.S.	*

Part 2 (Continued)

	11	12	13	14	15	16	17	18	19	20
11	--	.28 **	.35 ***	.13 N.S.	.07 N.S.	.25 **	.18 *	-.04 N.S.	.01 N.S.	.04 N.S.
12		--	.58 ***	.16 N.S.	.36 ***	.20 *	.27 **	-.10 N.S.	.04 N.S.	.04 N.S.
13			--	.12 N.S.	.36 ***	.25 **	.31 ***	-.09 N.S.	.05 N.S.	.12 N.S.
14				--	.09 N.S.	.23 **	.09 N.S.	-.05 N.S.	-.05 N.S.	.00 N.S.
15					--	.12 N.S.	.46 ***	.01 N.S.	.04 N.S.	.07 N.S.
16						--	.21 *	.00 N.S.	-.03 N.S.	.42 ***
17							--	-.11 N.S.	-.06 N.S.	.06 N.S.
18								--	.27 **	.05 N.S.
19									--	.02 N.S.
20										--

Part 2 (Continued)

	11	12	13	14	15	16	17	18	19	20
21	.11 N.S.	.14 N.S.	.10 N.S.	.03 N.S.	.20 *	-.06 N.S.	-.06 N.S.	.16 N.S.	.13 N.S.	-.14 N.S.
22	.09 N.S.	.13 N.S.	.02 N.S.	.04 N.S.	.17 N.S.	-.01 N.S.	-.07 N.S.	.08 N.S.	.05 N.S.	.10 N.S.
23	.19 *	.08 N.S.	.05 N.S.	.07 N.S.	.10 N.S.	.00 N.S.	-.06 N.S.	.03 N.S.	-.03 N.S.	-.03 N.S.
24	--	--	--	--	--	--	--	--	--	--
25	.08 N.S.	.22 **	.15 N.S.	.16 N.S.	.13 N.S.	-.07 N.S.	-.07 N.S.	.03 N.S.	.00 N.S.	-.07 N.S.
26	.17 N.S.	.18 *	.13 N.S.	.01 N.S.	.00 N.S.	.33 ***	.17 N.S.	.06 N.S.	.03 N.S.	43 ***
27	.01 N.S.	.04 N.S.	-.04 N.S.	-.05 N.S.	-.06 N.S.	-.03 N.S.	.13 N.S.	-.03 N.S.	-.03 N.S.	.02 N.S.

Part 2 (Continued)

	21	22	23	24	25	26	27
1	.01	.08	.17	--	.07	-.08	.12
	N.S.	N.S.	*		N.S.	N.S.	N.S.
2	-.10	-.01	-.01	--	.08	.23	.08
	N.S.	N.S.	N.S.		N.S.	**	N.S.
3	-.07	.04	-.09	--	.03	.19	.01
	N.S.	N.S.	N.S.		N.S.	*	N.S.
4	.03	.09	.02	--	.14	.10	.15
	N.S.	N.S.	N.S.		N.S.	N.S.	N.S.
5	.01	.08	.07	--	.09	.11	-.06
	N.S.	N.S.	N.S.		N.S.	N.S.	N.S.
6	-.02	.04	.05	--	.06	.15	.05
	N.S.	N.S.	N.S.		N.S.	N.S.	N.S.
7	-.03	.15	.06	--	.18	.23	-.11
	N.S.	N.S.	N.S.		*	**	N.S.
8	.02	.10	.03	--	.06	.07	-.04
	N.S.	N.S.	N.S.		N.S.	N.S.	N.S.
9	-.13	-.02	-.06	--	.04	.10	-.03
	N.S.	N.S.	N.S.		N.S.	N.S.	N.S.
10	-.06	.09	-.07	--	.05	.13	.00
	N.S.	N.S.	N.S.		N.S.	N.S.	N.S.

Part 2 (Continued)

	21	22	23	24	25	26	27
11	.11 N.S.	.09 N.S.	.19 *	--	.08 N.S.	.17 N.S.	.01 N.S.
12	.14 N.S.	.13 N.S.	.08 N.S.	--	.22 **	.18 *	.14 N.S.
13	.10 N.S.	.02 N.S.	.05 N.S.	--	.15 N.S.	.13 N.S.	-.04 N.S.
14	.03 N.S.	.04 N.S.	.07 N.S.	--	.16 N.S.	.01 N.S.	-.05 N.S.
15	.20 *	.17 N.S.	.10 N.S.	--	.13 N.S.	.00 N.S.	-.06 N.S.
16	-.06 N.S.	-.01 N.S.	.00 N.S.	--	-.07 N.S.	.33 N.S.	.03 N.S.
17	-.06 N.S.	-.07 N.S.	.06 N.S.	--	-.07 N.S.	.17 N.S.	.13 N.S.
18	.16 N.S.	.08 N.S.	.03 N.S.	--	.03 N.S.	.06 N.S.	-.03 N.S.
19	.13 N.S.	.05 N.S.	-.03 N.S.	--	.00 N.S.	.03 N.S.	-.03 N.S.
20	-.14 N.S.	-.10 N.S.	-.03 N.S.	--	-.07 N.S.	.43 ***	.02 N.S.
21	--	.23 **	.23 **	--	.33 ***	-.13 N.S.	-.05 N.S.
22		--	.26 **	--	.51 ***	.03 N.S.	-.08 N.S.
23			--	--	.46 ***	-.06 N.S.	.06 N.S.
24				--	--	--	--
25					--	.05 N.S.	.10 N.S.
26						--	.27 **
27							--

APPENDIX F

SPECIALIZED
OUT OF HOME CARE PROJECT

GOALS

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

OBJECTIVE

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

PRODUCTIVITY INDICATORS

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

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

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

OBJECTIVE

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

PRODUCTIVITY INDICATORS

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

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

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

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

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

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

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

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

OBJECTIVE

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

PRODUCTIVITY INDICATOR

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

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

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

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

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

OUTCOME - RESULTS

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

2. Increase the quantity, quality, and stability of Specialized Out of Home Care placements.

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

RBJ:cjb

CONTINUED

2 OF 3

APPENDIX G

SPECIALIZED OUT-OF-HOME CARE

NEEDS ASSESSMENT

Form 1.0
(Update)

Note: This special version of the SOHC Form 1.0 is to be re-administered to the CMCS case managers for all clients referred to the SOHC project during Fiscal Year 1975 (July 1, 1974 through June 30, 1975) regardless of whether or not the SOHC project placed them in specialized (SOHC) placements, channeled them to CSD for regular out-of-home care, or made no out-of-home care placement to the present. THE PURPOSE OF THIS FORM IS TO UPDATE INFORMATION ON THE ORIGINAL FORM 1.0 AND PROVIDE A VEHICLE FOR REPORTING POSITIVE OR NEGATIVE CHANGES OCCURRING IN THE CLIENT'S BEHAVIORS AND ATTITUDES OVER TIME.

1. Case Manager completing original form _____

2. Case Manager completing this form _____

3. Neighborhood Office _____

4. CLIENT'S NAME _____ CMCS ID Number _____

aka Name _____ SOHC ID Number _____

CHILD IN NEED

5. Client's Age _____ 6. Sex _____ 7. Ethnicity _____

PLACEMENT INFORMATION

From the time you first referred this child to SOHC for out-of-home care placement to the present, please summarize each out-of-home care placement by checking all information which applies. (Do not include informal placements with relatives, etc.)

6. Was there at least one out-of-home care placement arranged by SOHC during the above period?

_____ Yes _____ No

7. If you answered "YES" above, summarize each out-of-home care placement by checking all items which apply:

A. First Placement

(a) Type: _____ Specialized (SOHC) out-of-home placement with project

_____ Regular (CSD) out-of-home placement via channeling to CSD

(b) Setting: _____ One parent foster care _____ Independent living subsidy

_____ Two parent foster care _____ Special Situation

_____ Group care

A. First Placement (Continued)

(c) Total time in above placement in months and weeks:

Months _____ Weeks _____

B. Second Placement

(a) Type: _____ Specialized (SOHC) out-of-home placement with project

_____ Regular (CSD) out-of-home placement via channeling to CSD

(b) Setting: _____ One parent foster care _____ Independent living subsidy

_____ Two parent foster care

_____ Special Situation

_____ Group Care

(c) Total time in second placement in months and weeks:

Months _____ Weeks _____

C. Third Placement

(a) Type: _____ Specialized (SOHC) out-of-home placement with project

_____ Regular (CSD) out-of-home placement via channeling to CSD

(b) Setting: _____ One parent foster care _____ Independent living subsidy

_____ Two parent foster care

_____ Special Situation

_____ Group Care

(c) Total time in third placement in months and weeks:

Months _____ Weeks _____

D. Fourth Placement

(a) Type: _____ Specialized (SOHC) out-of-home placement with project

_____ Regular (CSD) out-of-home placement via channeling to CSD

(b) Setting: _____ One parent foster care _____ Independent living subsidy

_____ Two parent foster care

_____ Special Situation

_____ Group Care

(c) Total time in fourth placement in months and weeks:

Months _____ Weeks _____

E. Fifth Placement

(a) Type: _____ Specialized (SOHC) out-of-home placement with project

_____ Regular (CSD) out-of-home placement via channeling to CSD

(b) Setting:

_____ One parent foster care

_____ Two parent foster care

_____ Group Care

_____ Independent living subsidy

_____ Special Situation

(c) Total Time in fifth placement in months and weeks:

Months _____ Weeks _____

F. Sixth Placement

(a) Type: _____ Specialized (SOHC) out-of-home placement with project

_____ Regular (CSD) out-of-home placement via channeling to CSD

(b) Setting: _____ One parent foster care

_____ Two parent foster care

_____ Group Care

_____ Independent living subsidy

_____ Special Situation

(c) Total time in sixth placement in months and weeks:

Months _____ Weeks _____

G. Seventh Placement

(a) Type: _____ Specialized (SOHC) out-of-home placement with project

_____ Regular (CSD) out-of-home placement via channeling to CSD

(b) Setting:

_____ One parent foster care

_____ Two parent foster care

_____ Group care

_____ Independent living subsidy

_____ Special Situation

(c) Total time in seventh placement in months and weeks:

Months _____ Weeks _____

(Do not write in this space)

Totals: Type _____ Setting _____ Time _____

Delete Items 8 - 11

12. For the above period was this child ever in MacLaren/Hillcrest (institutionalized)?

_____ Yes _____ No

If yes, for how long: Months _____ Weeks _____ Days _____

13. For the above period was this child ever "on the run" (A.W.O.L.)?

_____ Yes _____ No ___ Does not apply (child institutionalized)

If yes, for how long: Months _____ Weeks _____ Days _____

FAMILY INFORMATION

(Definition: Parent = One who is doing the parenting.)

1. Parental composition of child's family (current).

0. Unknown
1. Two parent family
2. One parent, mother figure
3. One parent, father figure
4. Other composition, specify _____

2. Current degree of marital stability of child's parent's marriage.

0. Unknown, not applicable
1. Stable
2. Unstable
3. Already dissolved

3. Indicate the parental change currently most needed to improve parent/child relationship functioning. (Answer for the mother)

0. Unknown or not applicable
1. Parent needs to resolve own emotional or personal problems
2. Parent needs to learn or improve disciplinary techniques in order to better control, supervise and structure child's time
3. Parent needs to learn to be consistent in disciplining
4. Parent needs to improve communication and interpersonal relationship with child
5. Parent needs to learn to reward positive behavior
6. Other _____
_____
_____ describe

4. Indicate the parental change currently most needed to improve parent/child relationship functioning. (Answer for the father)

0. Unknown or not applicable
1. Parent needs to resolve own emotional or personal problems
2. Parent needs to learn or improve disciplinary techniques in order to better control, supervise and structure child's time

(Cont. p. 5)

3. Parent needs to learn to be consistent in discipline
4. Parent needs to improve communication and interpersonal relationship with child
5. Parent needs to learn to reward positive behavior
6. Other _____

_____

_____ describe

5. In comparison to the time when this child was first referred (date of first Form 1.0 needs assessment), rate the child/parent relationship functioning. (Do this first for the Mother)

   0. No need for change or "does not apply." (Leave Blank)
   1. Rate change as follows (See scale):

-2	-1	0	+1	+2
Much Worst	Slightly Worst	No Change	Slightly Better	Much Better

6. In comparison to the time when this child was first referred (date of first Form 1.0 needs assessment), rate the child/parent relationship functioning. (Do this for the Father)

   0. No need for change or "does not apply." (Leave Blank)
   1. Rate change as follows (See scale above):

-2	-1	0	+1	+2

7. Mother's motivation (currently) to make change(s) in #3 above.

   (low) 1 2 3 4 5 6 7 8 9 (high) Circle one

8. Mother's capacity (currently) to make change(s) in #3 above.

   (low) 1 2 3 4 5 6 7 8 9 (high) Circle one

9. Father's motivation (currently) to make change(s) in #4 above.

   (low) 1 2 3 4 5 6 7 8 9 (high) Circle one

10. Father's capacity (currently) to make change(s) in #4 above.

    (low) 1 2 3 4 5 6 7 8 9 (high) Circle one

PROBLEM AREAS

Indicate for this point in time which of the following are current problems for the child. (Circle response) If you indicate a problem, rate it as to whether the problem is worse or better as a result of time or indicate no change. For "yes" responses use the following scale:

-2	-1	0	+1	+2
much worst	slightly worst	no change	slightly better	much better

Indicate which of all those listed are problems for the child. (Circle response).

1.	Runaway from home.	yes	no
2.	Physically assaultive to parents.	yes	no
3.	Physically assaultive to younger siblings.	yes	no
4.	Physically assaultive to older siblings or those of same age.	yes	no
5.	Physically assaultive to adult school personnel.	yes	no
6.	Fighting physically with peers at school.	yes	no
7.	Physically assaultive to neighbors, adults, peers, younger children in neighborhood.	yes	no
8.	Stealing from family members	yes	no

9.	Theft or vandalism of property within the school.	yes	no
10.	Theft in neighborhood homes and stores.	yes	no
11.	Verbally antagonistic so as to continually disrupt the family.	yes	no
12.	Virtually no compliance to parental request or limits.	yes	no
13.	Refusal to accept/perform routine responsibilities at home.	yes	no
14.	Extortion at school from peers.	yes	no
15.	Excessive truancy.	yes	no
16.	Continually disruptive to the class at school.	yes	no
17.	Non-production at school.	yes	no
18.	Sets fires in or near home.	yes	no
19.	Sets fire in the community.	yes	no
20.	Destruction of property in the neighborhood or community.	yes	no

(21) Pushing drugs at school or in the community. yes no

(22) Excessive use of alcohol. yes no

(23) Uses marijuana. yes no

(24) Uses heroin. yes no

(25) Uses other drugs. yes no

(26) Bizzare behavior in community. yes no

(27) Social taboos (public sex play, etc.) yes no

(28) To what extent is the child currently motivated to change his behavior at home?

(low) 1 2 3 4 5 6 7 8 9 (high)

(29) What is the child's current capacity to change that behavior at home?

(low) 1 2 3 4 5 6 7 8 9 (high)

(30) To what extent is the child currently motivated to change his behavior at school?

(low) 1 2 3 4 5 6 7 8 9 (high)

(31) What is the child's current capacity to change his behavior at school?

(low) 1 2 3 4 5 6 7 8 9 (high)

(32) To what extent is the child currently motivated to change his behavior in the community?

(low) 1 2 3 4 5 6 7 8 9 (high)

(33) What is the child's current capacity to change his behavior in the community?

(low) 1 2 3 4 5 6 7 8 9 (high)

END - Thank You

END