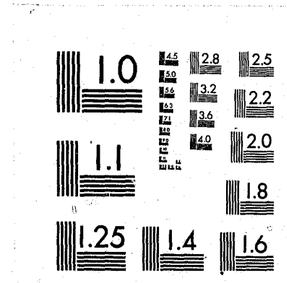

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TREATING THE SEVERELY DISTURBED JUVENILE OFFENDER: A REVIEW OF ISSUES AND PROGRAMS

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We also need to acknowledge that time is, indeed, like a river, and that several of the programs have undergone both administrative and programmatic changes since our site visits. We have tried to present the "facts" as we heard and knew them, but encourage the reader to contact programs directly for the very latest information on particular programmatic aspects.

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Chapter I

INTRODUCTION

Since the late 1960's, most notably since the publication of the 1967 report of the President's Commission on Law Enforcement and Administration of Justice, there have been widespread attempts to limit the number of juvenile offenders who are placed in secure correctional facilities. As a result, noninstitutional programs which rely on group homes, shelter homes, foster care, and independent living arrangements have been developed in many jurisdictions around the nation as alternatives to confinement in correctional facilities.

Despite efforts to develop noninstitutional programs for juvenile offenders, it is generally assumed that there will always remain a group of youths whose misbehavior is so threatening as to require secure confinement. In general these are youths who have committed offenses such as armed robbery, rape, aggravated assault, homicide, and arson. Further, it is well accepted that within this group of serious juvenile offenders can be found some youths who are considered severely emotionally disturbed. These are youths who are generally considered to suffer from some form of psychosis, manifestating such symptoms as severe thought disorders, seriously impaired judgment, delusions, and other schizophreniform illnesses.

For many years psychoanalytic theory held that "adolescent turmoil," which subsides with further maturation, is often the primary explanation for a symptomatic adolescent's clinical picture. Indiscriminate application of such a theory and the belief that troubled youth will eventually outgrow certain phase-specific difficulties can and has been responsible for the great disservice done to those youngsters whose problems will not be resolved or reversed through the natural growth process (Masterson, 1967: 1338). The conventional wisdom that has long guided the evaluation and treatment of disturbed adolescents does not fully account for those juvenile offenders whose psychopathology is clearly more than situational, reactive and transient.

Many professionals think that severely disturbed juvenile offenders ought to be cared for under the auspices of departments of mental health rather than departments of corrections. Those who have come to believe that certain youths could be better cared for in a mental health rather than a correctional program frequently argue that these youth require sophisticated clinical treatment which ordinarily cannot be found in correctional institutions. They also argue that emotionally disturbed youths are frequently difficult to handle in a correctional setting, can be very disruptive, and demand a disproportionate amount of staff time and resources.

Attempts to serve severely disturbed juvenile offenders in mental health facilities frequently meet with resistance from staff who presume that these youths are dangerous to other residents as well as staff. Correctional programs also resist accepting them, not because of the danger they represent, but because of the severity of their mental illness. As a result, emotionally disturbed youths have become "the kids nobody wants" (McKenzie and Roos, 1979). The practical consequence has been that these youths have been known to languish in juvenile correctional facilities without serious attention to their disturbance. In too many cases, they have been placed in adult facilities for the criminally insane where they may have suffered the physical and

emotional abuse which are sometimes commonplace in such institutions (Massachusetts Office for Children, 1974).

Our intent is to examine a number of important issues concerning the treatment of juvenile offenders who exhibit psychotic symptomatology, and to review a group of programs which have been designed for these youths as alternatives to confinement in conventional correctional facilities, state hospitals and adult prisons for the criminally insane. Our primary goal is to acquaint interested individuals with the complexities of caring for seriously disturbed juvenile offenders and with several programs which have been designed for them.

THE EXTENT OF THE PROBLEM

The problem of providing adequate care for the severely disturbed juvenile offender has been a persistent one. Because of the dual nature of their problems, in that severe psychiatric disturbance co-exists with some degree of delinquent behavior, these offenders are frequently subjected to repetitive and unproductive shuttling between the mental health and juvenile justice systems. The labyrinth into which these adolescents are dispatched is rarely able to provide much more than the same glaring and disappointing unresponsiveness that was instrumental in their first being brought to official attention. In addition to whatever other labels they may accumulate on their institutional odyssey, they are known as "turnstile children" who "fall between the cracks." They are, in essence, the unwanted casualties of social systems which have, as a rule, neither pooled existing resources nor created new alternatives to meet the unique demands of damaged youth. Drawing upon the expertise and services of mental health and corrections would seem logical when an adolescent is both delinquent and mentally disordered, but in reality, the worst responses of both worlds are usually encountered (Hogoboom and Hughes, 1975, p. 13). The gray area which routinely entraps these children is often a source of infinite frustration for both the systems which strain to develop humane and effective solutions and the child caught in the resultant crossfire.

When an adolescent with profound psychopathology is also an offender, the juvenile justice and mental health systems are presented with a thorny dilemma. By definition, the mentally abnormal offender qualifies for entrance into two systems, both of which may deny ultimate responsibility for him. The discretionary process which ensues (Blankenship and Singh, 1976: 472) is consequently fraught with legal, social and psychiatric complexities. While the argument continues over which system has jurisdiction over and responsibility for the severely disturbed offender, the frequent result is inappropriate treatment or a disposition that releases a juvenile into the community without any systematic intervention whatsoever (Committee on Mental Health Services, 1972: 6; Roos and Ellison, 1976: 27). Clearly, the issue of who is being treated, by whom, and for what purposes is all too often a professional conundrum.

INCIDENCE

It is hard to know the magnitude of the problem we seek to address. Simply stated, is the problem of seriously disturbed offenders indeed real, and if so, how extensive is it? Not surprisingly, this query is more easily framed than answered. Narrowing the boundaries of this inquiry to a specific cross-section of juvenile offenders does not, however, lead directly to a precise or even workable estimate of the number of delinquent youngsters who can justifiably be considered psychotic. There are no national indicators of the prevalence and scope of this problem, no

deliberately circumscribed studies designed with the sole purpose of measuring the incidence of psychosis in adolescent offenders. The limited data that do exist in this practically uncharted domain are strikingly dwarfed by the extensive interest and research on psychosis in adult criminals.*

Historically, the juvenile justice and psychiatric literature has been replete with theoretical and programmatic treatises on emotional disturbance and its assumed or disputed relationship to delinquency. In her discussion of deviancy as a factor in juvenile delinquency, Bender (1968: 37), noted that "schizophrenia...is increasingly recognized by psychiatrists in disturbed children and young people." Although several researchers (Healy and Bronner, 1926; Oltman and Friedman, 1941; Fleming, 1967; Kloek, 1968) have observed "that many antisocial individuals suffer from more serious psychopathology than neurotic and personality disorder" (Lewis and Shanok, 1978), in general, there have been few inquiries addressed to the specific proportion of adolescent offenders who meet the psychiatric criteria for psychosis. This may be due, in part, to the widely accepted view that childhood psychosis is itself proportionately rare in the general population (Treffert, 1971). On the other hand, many practitioners recognize that

> Adolescence doesn't precipitate schizophrenic reactions, rather it exposes young people to special pressures...which typically lead to fleeting states of ego fragmentation...These accumulated states...may serve as the straw that breaks the camel's back...they may suffice in certain situations to push a fragile and defectively functioning ego over the threshold into the schizophrenic reaction (Spotnitz, 1971: 225-226).

There is, however, clear evidence that concern for the severely troubled juvenile offender is growing among researchers, clinicians, and practitioners. Public sentiment and thoughtful examination of serendipitous as well as anticipated clinical observations are undoubtedly two of the many catalysts contributing to the current ferment in the field. Moreover, the challenge of exploring "an idea whose time has come" becomes an imperative once the demands of an outraged citizenry resonate within pressured legislatures. Although the rationale for initiating closer scrutiny of deeply disturbed delinquents appears clear, there is the subtle danger that the gathering momentum surrounding this particularly ripe issue is fashionable and consequently transitory. McKenzie and Roos (1979: 47) reiterate a frequently mentioned and powerful aspect of the fluctuating attention to mentally disordered juvenile offenders: "When public concern subsides, so, to a large extent, does academic and professional activity". Thus, though embryonic and vulnerable to the vicissitudes of the nation's social and political climate, recognition of the seriously disturbed offender's special needs appears to be an emerging and increasingly more central issue within the mental health and correctional communities.

Conceding that "exact figures on the number of delinquents who may be mentally disordered is [sic] unknown," a District of Columbia Department of Public Health report (1964) estimated that "the behavior of over 10 percent of the delinquents has been considered sufficiently disturbing to warrant serious evaluation". In a

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*For a comprehensive review of this literature, see Thomas J. Eynon, "The Mentally Disordered Offender", in Irvine and and Brelje, 1973.

later investigation of the disposition of mentally disordered offenders in the District of Columbia juvenile court (Zeitz et. al., 1968), one out of every four offenders were referred to a child guidance clinic for psychological evaluation. Furthermore, according to the participating probation officers and agencies, not only were more children with psychological problems identified than referred for diagnostic work-up, but "approximately one-third of the juveniles with mental disorders [were] not even mentioned as having such problems by the probation officers in their recommendation to the court" (p. 7). It should be noted that because neither study specifies a definition of "mental disorder," it is impossible to know what proportion of juveniles included in each sample were acutely disturbed.

Lewis et. al. (1973) found an unexpectedly high incidence of psychotic symptomalogy in a juvenile court population, a finding which runs counter to previous assertions that this is a relatively infrequent phenomenon (Shoor and Speed, 1969). Breer (1976) believes that adolescents with extreme psychopathology who come to the attention of the court are far more common than is generally realized. Huff and Porter (1972) reported that in a sample of 70 youths appearing before a Georgia juvenile court, 12 were diagnosed as having a schizophrenic disorder. Findings from a recent Pennsylvania Youth Development Center survey indicate that "the numbers of youth who manifest both deviant behavior and psychosis have been shown to be increasing in the population" thereby creating "a group of youth who 'fell between the cracks,' too delinquent to be treated in a hospital setting and too psychotic to be rehabilitated in a correctional setting" (1978: 45). Similarly, the need for improved classification and placement of severely disturbed youth was cited in a 1977 Virginia State Crime Commission report which concluded that these youths would be more appropriately served by programs designed by the state Department of Mental Health (p. v-vi). In a study of five California counties, approximately 3 percent of the 651 juveniles sampled in detention centers were evaluated as psychotic (Arthur Bolton and Associates, 1976: 5).

Perhaps the best estimate of the prevalence of severely disturbed juvenile offenders who come to the attention of law enforcement officials can be found in a carefully conducted study carried out under the auspices of the Massachusetts Department of Youth Services in 1977. This study was based on a random sample of youths in the custody of the state Department of Youth Services. A panel which included knowledgeable professionals from the fields of child welfare, law enforcement, probation, and social service research reviewed the files of the youths who were included in the sample to determine the number who required secure care and, in addition, the number who required secure care in a program operated by the state Department of Mental Health because of the severity of their emotional disturbance. The panel considered such factors as the youth's offense history, commitment and placement histories, clinical diagnoses, and caseworkers' treatment plans. The findings from this study indicated that a maximum of 11.2 percent of the youths required secure care, and that because of the extent of their emotional disturbance 23 percent of this group needed to be cared for in programs operated under the auspices of the Department of Mental Health. Thus, a total of 2.6 percent of the (1500) youths in the custody of the Department of Youth Services were considered to need placement in programs designed specifically for severely disturbed juvenile offenders (Commonwealth of Massachusetts, 1977).

Though research on the incidence of psychosis in juvenile offenders is not widespread, these scattered findings are clear indicators of an issue in need of further careful investigation. The extent of our present knowledge base regarding the nature and

degree of psychopathology in the delinquent population is an immediate and formidable obstacle to the planning and implementation of innovative programs that might intervene appropriately and compassionately in the lives of troubled youths. That there is little regular or systematic collection of information regarding the prevalence of severe emotional disturbance in juvenile offenders reflects a critical deficiency in the present functioning of the systems involved. Without an "accurate count," the design and delivery of special services are impeded and the complex constellation of issues that currently impinge on organizational collaboration are further compounded. While primarily concerned with the social, legal, and political factors that prohibit or perpetuate meaningful response to this group of unknown size, it is also hoped that the observations from this research will contribute to a more realistic measurement of the actual need for such specialized services.

TRADITIONAL RESPONSES

The relative scarcity of programs for severely disturbed juvenile offenders is due in part to controversy over which system--corrections or mental health--should serve them. Are they primarily clients of the corrections system, because they have committted delinquent acts, or are they appropriate for the mental health system because of the severity of their emotional disturbance? Controversy about which agency should be responsible for these youths arises from disagreement about whether emotionally disturbed juvenile offenders can--or should--be punished for their misbehavior while being cared for in a mental health program, or, conversely, provided with competent mental health services while confined in a correctional facility. Unlike corrections, mental health has never had to wrestle with the issue of its responsibility for punishment. Though some may regard certain therapeutic modalities as "punitive," the mental health system was not established to "correct" behavior that transcended the law. Being emotionally disturbed is a condition and not an act against person or property. On the other hand, the emendation of mental illness has traditionally not been viewed as part of the mission of corrections. In the criminal justice system, "no area. . . is murkier or more controversial than that legal and conceptual no-man's land that lies in the penumbra between corrections and mental health" (Rennie, 1978: 177). The intense punishment versus treatment debate which continues to escalate within juvenile corrections raises basic questions about the function and purpose of the juvenile justice system. While the tradition of insuring that treatment fits the offender reflects the historical shift from classicist to positivist attitudes, it is not clear whether this change has been paralleled by the growth of a "correctional" system equipped to handle the needs of offenders who suffer from serious mental illness.

Over a decade ago, one author stated that: "Society's perception of criminals is changing. Criminals now can be seen as bad or sick. If they are bad, they require custody; if they are sick, they require treatment. The treatment versus custody controversy has raged in the corrections field for several decades, but the treatment advocates appear to be winning" (Mathews, 1968). Fersh (1979), however, reflects the change in climate that has occured during the last decade in juvenile corrections. His "rethinking" model for corrections is based on the belief that the era of rehabilitation in juvenile justice is on the decline. As several authors before him have, he cites the failure of the treatment model as a means of deterrence, reform or cognitive improvement and suggests that offenses are merely occasions, not excuses, for mental health treatment: "The shift to punishment philosophy is coming. It is our contention that it is better to think clearly about punishment, to limit it, and to set guidelines. Some young people are bad. Increasingly, it has been recognized

that swift and sure punishment has deterrent effect. At the least, society will benefit from incapacitating the undeterrable while it attempts to deter others. The time for the rethinking method of punishing young criminals is at hand" (p. 31).

Despite their skepticism about the efficacy of treatment within the juvenile correctional system, Robison and Smith (1971) take a more moderate albeit earlier position than either Fersh or Mathews: "In correctional practice, treatment and punishment generally co-exist and cannot appropriately be viewed as mutually exclusive. Correctional activities (treatments) are undertaken in settings established as places of punishment. . . The real choice in correction, then, is not between treatment on one hand and punishment on the other but between one treatment-punishment alternative and another" (pp. 79-80).

While participating in such in intellectually engaging debate is an obvious temptation, the treatment-punishment issue is raised at this point primarily to explore its impact on the relationship between juvenile justice and mental health. Of utmost concern are the practical implications which arise from each system's definition and subsequent use of treatment and/or punishment. Without wishing to oversimplify an admittedly complex concept, it appears that the relationship between mental health and juvenile justice is largely determined by collective and conflicting perceptions of professional roles as well as entrenched attitudes toward juvenile offenders. Many scholars (Alexander and Staub, 1956; Halleck, 1967; Blankenship and Singh, 1976; McCarthy, 1976; Cammarata and Stott, 1977; Rennie, 1978; Seeley, 1978; Agee, 1979; Fersh, 1979) have either noted or experienced firsthand the existence of this phenomenon. Eynon (1973) succinctly expresses the widely held belief that "although the criminal justice system and mental health system run parallel with each other, they rarely integrate. The ways in which psychiatrists and lawyers attack problems are different because they have different value systems" (p. 14).

There is little doubt that any reasonable attempt to provide competent and decent care to severely disturbed juvenile offenders will need to be sensitive to the intellectual and ideological traditions which undergird the fields of mental health and corrections. It seems inevitable that programs designed for these youths will be required to borrow some of the means and ends of both of these fields. It is important to recognize that severely disturbed juvenile offenders need--often desperately--the care and treatment which mental health professionals have been known to provide; it is equally important to acknowledge that many of these youths represent a very serious threat to the safety of others and pose behavioral problems which juvenile justice and corrections professionals have had considerable experience confronting.

Our review of the many problems which professionals have encountered in their attempts to treat severely disturbed juvenile offenders has led us to conclude that practitioners around the nation could benefit from learning about programs which have been designed specifically for these youths. Our review of the literature concerning these youths and our conversations with individuals who work with them have told us that it is unlikely that severely disturbed juvenile offenders can receive competent and humane care within conventional correctional facilities or mental health programs. These youths tend to be viewed as exceptional clients in both of these settings; program staff complain that they are not equipped to respond adequately to youths who are both disturbed and dangerous. We reached a tentative conclusion that our efforts would best be spent examining and describing programs designed specifically for these youths, programs where staff have been trained to care for youths whose

symptoms bordered on the troubling terrain where emotional disorder and dangerousness merge.

Chapter II

METHODOLOGY

We began our search for programs by contacting criminal and juvenile justice state planning agencies and state departments of mental health in the 48 contiguous states. Our search was systematic, though probably not exhaustive. We did our best to locate in each state individuals who were knowledgeable of programs for severely disturbed juvenile offenders. It is impossible to know how successful we were. We have some confidence, however, that our search turned up most of the "major" programs designed for these youths.

We located programs in six states: California, Illinois, Massachusetts, Minnesota, New York, and Pennsylvania. In four of the states (Illinois, Minnesota, Pennsylvania, and New York) we located individual programs; in two states (California and Massachusetts) we located a group of programs operated under the auspices of state agencies. We will describe these arrangements in more detail below. All of the programs we identified were described as programs for severely disturbed or emotionally disordered juvenile offenders. The characteristics of the youths these programs were designed to serve were similar; they included such diagnoses as schizophrenia, seizure disorders, and various manifestations of psychosis.

We decided to visit and gather detailed information about programs in five of the six states (the New York program, located at Bronx State Hospital, was at the time undergoing extensive administrative and programmatic changes which left its future uncertain). It is important to stress that our sample of programs cannot be considered representative of all programs specifically designed for severely disturbed juvenile offenders; rather, it represents a group of programs selected because of the information they could provide concerning ways of treating this population of youths.

The information we gathered about each program was obtained during the course of two-day site visits. In each site we interviewed staff of the programs themselves, representatives from relevant state agencies, and other individuals who were involved in the development and administration of the programs.

THE PROGRAMS: A BRIEF OVERVIEW

The state of California operates several programs for severely disturbed juvenile offenders. All of the programs are administered by the Department of the Youth Authority, the state's juvenile corrections agency. The program we selected for review, the Intensive Treatment Program, is located in a secure cottage on the grounds of the Youth Authority's Southern Reception Center and Clinic in Norwalk, California, a community situated approximately 15 miles southeast of Los Angeles. The Intensive Treatment Program began in 1973; during its first six years the program was funded by the Los Angeles County Department of Health, and only youths from this county were admitted. Since 1979, however, the program has been operated by the California Department of the Youth Authority. The 40-bed program now accepts males between

the ages of 15 and 23 from throughout the state--though primarily the southern region--who are wards of the Youth Authority and considered to be severely disturbed.

The Tri-Agency Program in Illinois represents a collaborative effort among the state Department of Mental Health, Department of Corrections, and Department of Children and Family Services. The program began in 1970 following recommendations of the Illinois Commission on Children concerning the need for a program for severely disturbed juvenile offenders. This 20-bed program is located in a secure cottage on the grounds of a state hospital complex in Tinley Park, Illinois, approximately 25 miles southwest of Chicago. Between 1970 and 1974 the Tri-Agency Program (originally known as the Joint Children's Program) accepted referrals only from Cook County, which is comprised primarily of the City of Chicago; since 1974 the program has accepted male youths from throughout Illinois. It was originally designed to treat youths who were considered too dangerous for programs operated by the Department of Mental Health; the program now accepts referrals from the Department of Mental Health, the Department of Corrections, and the Department of Children and Family Services. Both admission and discharge decisions are made by representatives from each of these state agencies.

The state of Massachusetts administers a series of programs for severely disturbed juvenile offenders under the auspices of the Department of Mental Health. "Regional Adolescent Programs" are operated in five of the Department's seven regions. A unique feature of these programs is that while they are monitored and funded by the state Department of Mental Health, each is administered and staffed by a private vendor with which the Department contracts. For example, the program we focused on, the Medfield Regional Adolescent Program, is operated by a private, nonprofit organization, Norfolk Human Services, Incorporated. We will discuss this arrangement in more detail below.

The first Regional Adolescent Program began in 1976 at Danvers State Hospital. It was developed following the release of a report which documented the need for services for severely disturbed juvenile offenders in Massachusetts; in particular, this report, sponsored by the state's Office for Children, provided detailed information about disturbed youths who were being held in Bridgewater State Hospital--the state's facility for the adult criminally insane--because of the absence of suitable alternatives. The Medfield Regional Adolescent Program began in 1977. It was a co-educational program with a capacity of 12 and is located in a two-story secure cottage on the grounds of the Medfield State Hospital, approximately 35 miles southwest of Boston. The program accepts referrals from the state's Department of Youth Services (the state's juvenile corrections agency) and the Department of Mental Health. At least 50 percent of the youths accepted into the Medfield Regional Adolescent Program must be referred from the Department of Youth Services.

The Protective Component Unit is a 6-bed program for boys operated by the Minnesota Department of Public Welfare. The program is located in an adolescent treatment unit on the grounds of Willmar State Hospital, 90 miles west of Minneapolis-St. Paul. The Protective Component Unit began as a demonstration project in 1979. The program accepts youths from throughout the state of Minnesota who are referred by a state Probate Court or, on occasion, juvenile court. The program began as an alternative to placing severely disturbed juvenile offenders in the state's security hospital for adults, in the state's conventional juvenile corrections facilities, and in private residential facilities out of state.

The Juvenile Forensic Unit is a 20-bed demonstration program for boys funded by the Pennsylvania Department of Public Welfare. This program accepts youths between the ages of 14 and 17 from throughout the state, though primarily from five south-eastern counties (including the city of Philadelphia). The program is located in a secure unit on the grounds of the Norristown State Hospital, approximately 35 miles northwest of Philadelphia. Referrals to the Juvenile Forensic Unit are accepted from county courts of common pleas. The program began in 1980 following recommendations of a task force appointed by then-Governor Schapp to investigate the treatment of severely disturbed juvenile offenders.

Chapter III

GENERAL PROGRAM CHARACTERISTICS

It wasn't long before we realized that the programs we visited knew very little, if anything, about each other. This simple but startling discovery led us to conclude that each state had struggled through the beginning issues of organization, planning and implementation with little historical, let alone existing, information about programs designed specifically for aggressive and severely disturbed juvenile offenders. Unlike Thoreau's remark on the proposal to link Maine and Texas by "magnetic telegraph"--it may be, he said, that Maine and Texas "have nothing to communicate"--it is clear that the administrators and staff of these programs have a great deal to say to one another.* They are, after all, virtual pioneers in a rugged and still evolving terrain.

Although the programs' core designs are similar, based on the most recent advances and workable developments in the residential treatment of adolescents, there are fundamental and noteworthy points of divergence within each model. These differences range from the very general and more obvious, (such as regional location, physical plant and unit capacity) to the highly complex and sophisticated (admission procedures, level and point systems, discharge criteria and after-care arrangements).

Some programmatic aspects are common to all the units and can be discussed collectively; others require more detailed explanation since they represent diverse approaches to a particular programmatic component. A few of the programs, for example, have had to adhere to certain juridical requirements, while others have, for better or worse, much more margin for autonomy in areas as crucial as referral sources and hiring of staff. Whenever possible, program responses to specific issues will be compared, with further attention to whatever idiosyncratic and unique dilemmas any one program may have to address.

Of the six states which have programs for severely disturbed offenders, only one (Massachusetts) has a co-ed admissions policy. All of the other programs were designed for male offenders, after internal surveys of each state's delinquent population revealed that boys were proportionately much more in need of these specialized services than their female counterparts. Several programs expressed their belief in the necessity of similar programming for young women, but none had immediate plans to expand their admissions to include females or knew of efforts to establish separate models for them.

Program capacity was a veritable mix of small, medium and large. It is interesting to note that in some instances the size of the unit depended not only on the perceived state-wide or regional need, but also on the facilities available for use

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*Thoreau's remarks on the telegraph, and his little anecdote, are found in Chapter 1 of Walden. The idea for the use of this analogy is borrowed from Ysabel Rennie's elegant and literary treatise, The Search for Criminal Man.

and the extent to which the project was demonstrational or assured of continued funding. The six-bed Willmar Protective Component Unit in Minnesota represented one end of the capacity continuum, while the Norwalk, California Intensive Treatment Program with 40 beds, was the largest of all the programs visited. Contrasted with the Massachusetts RAP programs which are equipped to handle 12 youngsters each, the Illinois and Pennsylvania units were both closer to medium-sized, each with capacities of 20. These capacities are exceeded only occasionally, if at all, and then under extreme circumstances which require administrative flexibility and discretion.

Census also tended to vary among programs despite almost universal waiting lists of a few days to several months. Three units (Minnesota, California and Massachusetts) were full when observed; the California program was technically at capacity with 38 residents, but generally reserves its two remaining beds for crisis situations and emergency admissions. Tinley Park was utilizing 18 of its 20 beds and Norristown, which had only been open for three months, had accepted eleven of a possible twenty youths. Average length of stay in any of these intensive programs ranged from six to twenty-four months.

With the exception of the California Intensive Treatment Program, all units were located on the grounds of state mental hospitals. Since none of the programs had the luxury of being able to move into sites built expressly for them, most units were renovated and/or modified to accommodate the target population.

In addition to the usual hospital coverage and security patrol, all the units had security measures of their own, although their use and function differed considerably from program to program. The Minnesota Unit, for instance, had a distinctively high staff to resident ratio, and although physical lock-up was used on occasion, the unit clearly relied on intensive "eye-ball" supervision to minimize incidents. The Norristown unit, on the other hand, was as "guarded" as any maximum security setting could be, not because of an actual or demonstrated need for such hardware, but because the Department of Public Welfare had little choice in yielding to community demands that the unit be extremely secure. The Pennsylvania program is on the second floor of a building whose only other residents are adult forensic patients; this may have added to the perceived need for twice the security already in existence. As a result, a 24-hour team of eleven uniformed security guards routinely asks visitors to check their belongings in lockers before being ushered through a metal detector at the unit's entrance. In California, all visitors to the Youth Authority facility were required to pass through a similar electronic device at the main entrance, but no further security procedures preceded admission to the Intensive Treatment Program. According to its clinical director, the Tri-Agency Program is "as secure as juvenile corrections can be" given its lock-up capability and staffing patterns. The electronic equipment that was utilized when the facility housed adults awaiting trial was abolished when the building became a unit solely for juveniles. The Medfield Regional Adolescent Program is in a large, two-story rambling cottage in close proximity to other hospital structures; physical security consisted largely of locks and "Chamberlain" screens for the building's numerous doors and windows.

CHARACTERISTICS OF THE YOUTHS SERVED

Table 1 summarizes the age range, average age, sex, and ethnic distribution of each program's residents at the time of site visit. Since Massachusetts and California

have a higher age ceiling in their admission criteria, this factor may account, in part, for their slightly older population.

Table 1

	Age Range	Average Age	Sex	Race			
				Black	White	Hispanic	Am. Ind.
MINNESOTA Willmar PCU	12-17	14	all male	1	4		1
ILLINOIS Tri-Agency Program	13-17	15.5	all male	8	10		
MASSACHUSETTS Medfield RAP	14-21	17	8 males 4 females	2	10		
PENNSYLVANIA Norristown JFU	14-17	16	all male	10	1		
CALIFORNIA Norwalk ITP	15-23	17.9	all male	24	9	5	

The youths in these programs have strikingly similar offense and commitment histories. Although only two programs are treating juveniles charged with murder, attempted murder, accessory to murder or assault with a deadly weapon, all of the programs reported a consistent range of more or less serious offenses against person and property. These included arson, auto theft, use and/or unlawful possession of a weapon, burglary, forgery, rape, receiving stolen goods, possession of marijuana, property destruction, robbery, assault (simple, aggravated and/or deviate sexual), fraud, criminal trespass, disorderly conduct, lewd and lascivious behavior, and resisting arrest. Status offenses such as truancy and running away were also represented but were never the whole of a youth's offense history; rather they were a minor and usually less recent aspect of the composite profile that can be drawn from the information gathered. Almost all of the youngsters had extensive juvenile court records which illustrated the chronic nature of their violative or maladjusted behavior. A majority of the youths who are referred and admitted to programs such as the ones studied are repeat offenders whose delinquent careers are well established and of long duration. Thus, it is rare, although possible, that a youth would enter one of these intensive units as the result of a first but very serious offense. A juvenile whose initial brush with the law involves an extraordinary or serious act may very well be immediately routed to a psychiatric setting with a more mixed population.

The youths' commitment histories were more homogeneous than any and all of their combined "identifying characteristics". Each of their young lives had been marked by a long series of unsuccessful placements in mental health as well as correctional

settings. As young children, many had had contact with school personnel, social service agencies, truant officers, child guidance clinics and community mental health centers. Youth Service Bureau counseling may have been offered before or after varying lengths of stay in detention centers. Most had been in and out of foster care and group homes with disturbing regularity. Inpatient psychiatric hospitalizations frequently alternated with incarceration in correctional institutions. The records attest to the uninterrupted routine of being observed, tested, diagnosed, confined, treated, punished, ignored and, above all, transferred once again. By their early or mid-teens most of these youngsters had exhausted every possible avenue of the human services delivery network. One program director spoke for all when he said that "these kids have run the gamut of the system". For example, the nine youths served during the Minnesota Protective Component Unit's first year had a median of 3.5 years in treatment prior to admission in the PCU. After reading many of the youths' commitment histories, it appears that this finding may be conservative, and that many of the youths in these programs have spent considerably more time in short and long-term treatment settings.

ADMISSION CRITERIA

All programs had definite policies regarding age, gender and geographic area served. Nevertheless, it is the clinical criteria that are most fundamental, since they ultimately govern admission and determine the life and composition of each unit. Some programs had more elaborately detailed guidelines than others, but all sought to adhere to a selection process based primarily on evidence of severe psychopathology. Violent behavior was not a uniformly specified admission requirement. It is important to note that all programs viewed the severity of a presenting offense as less weighty than the extent of a youth's psychological disturbance. In fact, one program's admission criteria were exclusively diagnostic and did not call for consideration of offense history at all. Thus, a youth would not be admitted to any of these programs solely on the basis of violent behavior that was not supported by a finding of mental illness. This is a signficant distinction to make since such stringent admission criteria serve as a program's first formal means of gate-keeping. Not incidentally, it is also a source of the controversy and pressure which each program intermittently encounters.

Because there was noticeable variation in the articulation of admission critiria, the programs lend themselves to separate discussion on this issue. The following descriptions are composite statements that draw on written material provided by the programs and information gathered in interviews during the site visits.

The Minnesota Protective Component Unit has a two-fold admission criterion that must be met for entrance. In addition to evidence of a severe emotional disturbance which is confirmed by corroborating psychiatric diagnosis, difficulty with one or more of the following must also be present: physical aggression; history of weapon use in threatening aggression or use of a weapon in physical assault; extreme self-destructiveness; history of aggressive unmanageability in other treatment facilities; or other behaviors which have interfered with entrance into residential treatment. The unit automatically excludes youths who are profoundly retarded, those whose primary diagnosis is runaway reaction, and those who are drug and/or alcohol abusers.

Illinois' Tri-Agency Program requires that youths demonstrate a need for hospitalization and documentation that a less restrictive environment is not indicated. More than mildly developmentally disabled youths are automatically excluded. The program takes youths who are unable to adjust to other conventional communities, including their

own families, foster and group homes, and institutions operated by any of the three participating state agencies (mental health, corrections, and children and family services) that refer to the program. The criteria further require documentation of a youth's repeated difficulty or failure to respond to any and all of the referring department's internal resources. When reviewing a youth's suitability for the program, potential and ability to acquire the skills necessary for life in an open society are carefully considered.

The Massachusetts RAP programs are limited to youths who meet four categories of admission criteria. First, there must be evidence of a substantial disorder in thought, mood, perception or memory which grossly impairs judgment, behavior, reality testing and the ability to meet the demands of daily life. Secondly, youths must display a lack of impulse control which results in repeated episodes of aggressiveness directed toward self or others. Furthermore, the likelihood of serious harm to self or others (suicidal or homicidal risk, as defined in the state's general laws), if not placed in a RAP has to be made clear. Lastly, candidates for admission have to exhibit an inability to respond to treatment in less restrictive settings through a documented history of placement failures. Although the clinical criteria for admission to all Regional Adolescent Programs are identical, procedures governing entrance do differ according to the client's legal status and what system (mental health or youth services) initiates the referral.

Youths admitted to Pennsylvania's Juvenile Forensic Unit are also supposed to meet the dual requirements of severe mental disability and a history of serious offenses against persons. In unusual circumstances, a single serious act could satisfy the offense history specification. Furthermore, admission rests on an involuntary commitment order in which the Court of Common Pleas determines the conditions of the "clear and present danger" posed by a given youngster.

California's Intensive Treatment Program is the one program whose admission criteria do not require commission of a serious act. That the severity of the offense does not necessarily bear on whether a youth is admitted is clearly one of this program's distinctive characteristics, particularly since the unit is part of the correctional system. The diagnostic criteria that have been developed reflect the program's adherence to admitting only the most psychiatrically disturbed wards. Admissions are given priority according to four basic categories: 1) acute functional psychoses (states of acute confusion, depersonalization, anxiety; delusional, hallucinatory, disorganized, undifferentiated, regressed, bizarre, catatonic or self-injurious behavior; affective/manic-depressive disorder); 2) decompensated borderlines; 3) severe neurotic disorders in crisis; and 4) psychophysiologic or somato-psychic disorders with symptoms from any of the preceding three groups. The program is unqualifiedly clear in its emphasis on selecting youths in acute states of psychosis, mania, depression, anxiety, hysteria and suicidal ideation. To underline this focus, they automatically exclude youths who are asymptomatic when referred or who present chronic and stable personality deviations such as character disorders.

INAPPROPRIATE ADMISSIONS

Despite each program's efforts to define and clarify their respective admission criteria, no program could deny that their guidelines were not air tight. Variation in interpretation of admission criteria is a very real and continuing problem which can directly influence the nature and volume of referrals, as well as the programs' relationships with referring agencies. Although inappropriate admissions may be less common than inappropriate referrals, they can and do occur from time to time.

The extent to which this was viewed as a serious problem did vary, however, from program to program. For instance, during its year long existence the Minnesota unit has not admitted any youths who were subsequently considered in need of a different setting; the one youngster who might have fit this description did so only on the basis of a lower cognitive capacity which diminished his ability to assimilate certain types of information. The directors of the Illinois and Massachusetts programs viewed inappropriate admissions as "almost impossible" and "rare"; they both believed that their stringent criteria and finely tuned referral mechanisms successfully insured against its occurence. California also reported isolated instances of this phenomenon; rather candidly, the ITP director admitted that their few inappropriate admissions are usually the result of "mistakes . . . we can't always tell." In general, programs will keep a youth who might not meet all aspects of their admission criteria; if the discrepancy is truly blatant and not justifiable, administrative or judicial transfer to a more suitable setting would be arranged. At the time of our visit, the Pennsylvania team believed that no inappropriate admissions had occurred in the short time the unit had been open. However, they indicated that it was difficult to reject certain youngsters given the number of empty beds during the beginning phase of the program. For them, the danger of bending admission criteria was greater than for any of the more established programs. A preliminary review of rejected referrals reported that inappropriate diagnosis, age and withdrawal of the referral by the court were among several reasons for denying a youth admission. However, since our visit, admissions decisions have been subjected to extensive administrative inquiry and criticism; it seems that the Department of Public Welfare maintains that the unit has a strong program for a population other than the one for which it was originally intended.

The growing pains and pressures currently being experienced by the Pennsylvania unit have, to some extent, been part of every program's formative stages. Even when admission criteria are clear, well publicized and wisely followed, the pressure to admit can be formidable. This apparently applies to appropriate as well as unacceptable referrals, since waiting lists of varying lengths are frequently unavoidable.

As the oldest of the programs, the Illinois program was well qualified to respond to this significant issue. While external pressures to admit persist, even after ten years, their intensity has diminished considerably. Because the program was new and unusual in its three-way administrative arrangement, the early days were characterized by competition among the departments of corrections, mental health and social services. Not surprisingly, each jockeyed to fill the unit's available beds with youngsters who were not in need of an intensive and secure placement. The number of inappropriate referrals, and the competition among the systems, decreased once the program received official definition as a mental health program through JCAH accreditation. The Illinois experience is illustrative of the organizational issues and concerns that bear so crucially on the smooth functioning of cooperative programs: much time and perseverance are needed to resolve the obstacles that threaten to divert or undermine their central intent.

The Minnesota program reported its share of being prevailed upon to accept youths whether or not they met the admission criteria. Although the program was announced and described through a series of Department of Public Welfare statements to county offices, accurate dissemination of the program's focus could only take place over time. Like the other programs, this unit received many inquiries when it opened, and the process of "educating" referral sources was soon begun. On occasion they have had to

confront "forced" admissions that are ordered by the juvenile court, rather than involuntarily committed through the probate court. Steady and open communication between the program and local DPW offices has helped clarify the program's objectives. As a result, referring agencies have neither inundated the unit with referrals nor unduly pressured it to admit beyond capacity.

In contrast to Minnesota, filling beds under pressure is somewhat more of a problem for the larger Pennsylvania and California units. The latter reported that pressure to admit generally increases when the census is low; they are able to manuever rather easily during these periods by moving down the priority system on which admission is based. In this way the Intensive Treatment Program can adhere to its stated criteria without undue compromise or overextension of resources. Since the Pennsylvania program has neither the longevity of the Illinois unit nor the built-in clinical safeguards of the California program, it has been grappling daily with pressures from many sources intent on seeing the unit at full capacity. The Medfield Regional Adolescent Program, on the other hand, experiences sporadic and minimal admissions pressure; however, Massachusetts' regional system provides a distinct advantage when such incidents arise: it can appeal to the Inter-Departmental Team (see section on Admissions Procedures) which will then explore possible vacancies in another Regional Adolescent Program. This mechanism may in fact serve dual purposes, since it increases a youth's chance for admission while mitigating the necessity of any one program's having to absorb more residents than it can handle. Not incidentally, this administrative practice also may help reduce any possible tension between the program and the referral source.

Chapter IV

REFERRAL AND INTAKE PROCEDURES

Youths admitted to the programs are referred by a variety of sources, including the court, social service and mental health facilities, and correctional programs. In many instances youths are referred to a program at the time of the disposition hearing in court. A judge may decide that a youth who has been adjudicated a delinquent should be placed in a program for severely disturbed offenders. In some instances, however, youths are referred to a program only after he or she has been placed in a correctional or mental health facility. For example, in Minnesota and Pennsylvania, most of the youths who are considered severely disturbed are referred to the programs in those states by the court prior to being placed in any other facility. In Pennsylvania, the Court of Common Pleas has the authority to place youths directly in the Juvenile Forensic Unit. In Minnesota, most of the youths in the Protective Component Unit are placed directly by the Probate Court, although on occasion a youth is placed in the program by a judge of the juvenile court. In contrast, in Illinois, some of the youths in the Tri-Agency Program are transferred from other programs operated by the state Departments of Corrections, Mental Health, and Children and Family Services. Similarly, in Massachusetts and California, youths are occasionally transfered to, respectively, the Medfield Regional Adolescent Program and the Intensive Treatment Program after having been placed originally in a juvenile correctional facility. Ordinarily, a youth is transferred from a mental health or correctional facility to a program for severely disturbed offenders because staff find him or her difficult to handle or are unable to provide the youth with adequate services.

Whether a youth is placed in a program for severely disturbed offenders at the time of a disposition hearing in court or after he or she has been placed in another facility is important. Youths who are placed at the time of a disposition hearing in court have the benefit of judicial proceedings and the due process protections which generally accompany them. In Minnesota and Pennsylvania, for example, youths are placed in the programs in those states only after commitment hearings have been held by the Probate Court (Minnesota) and the Court of Common Pleas (Pennsylvania). However, in Illinois, Massachusetts, and California, youths can be transferred to programs for severely disturbed offenders after only an administrative review of their cases. In Illinois, a committee comprised of representatives from the Departments of Corrections, Mental Health, and Children and Family Services makes admissions recommendations regarding youths who have been referred to the Tri-Agency Program. Judicial review is not required. In Massachusetts, administrative review is conducted by an Interdepartmental Team made up of representatives of the Departments of Mental Health, Youth Services, Social Services, Education, Public Health, the Office for Children, and the Massachusetts Rehabilitation Commission. Administrative transfers to the Medfield Regional Adolescent Program are accepted from the Massachusetts Departments of Mental Health and the Division of Youth Services. In California, youths who are wards of the Department of the Youth Authority can be transferred administratively to the Intensive Treatment Program without judicial review; conversely, a youth whose needs do not require the full complement of psychiatric services

offered at the ITP can be routed to another correctional program by similar administrative means.

The nature of the referring agency (for example, mental health or corrections) and the nature of the transfer (administrative or judicial) can have important consequences for the youths who are admitted to programs for disturbed offenders. For example, a youth referred by a department of corrections may be required to return to a correctional facility following discharge from a program; another youth, whose offense history and degree of emotional disturbance may be similar to those of the youth referred by the department of corrections, might be released directly to the community or to a half-way house because he was originally referred by the state department of mental health. The relevant characteristics of these two youths may be quite similar, and it may be only accidental that one was originally processed and referred by a department of corrections while the other was processed and referred by a department of mental health.

Whether youths are transferred to programs following judicial or administrative reviews can affect both the number and characteristics of youths admitted. It is well-known that the stringency of intake criteria and procedures can determine to a large extent whether programs admit the kinds of youths which they were originally designed to serve. If intake criteria are not monitored closely, it is possible that youths with problems which a program has not been designed to respond to will be inappropriately admitted, and that youths who should be served will not be admitted. While it is not necessarily the case that programs which accept youths after only an administrative review have a greater incidence of inappropriate admissions than programs which accept youths only after judicial review, the possibility is one which exists and one which is important to attend to.

Of equal importance is the quality and type of a program's relationship with referring agencies. Since referral is the first step of the intake process, which moves from initial contact to assessment and culminates in an admission decision, none of the programs could function without certain linkages to one or more systems and their various representatives. All programs therefore followed clear and recognizable patterns for referral. Within this framework, however, the nature and extent of a program's involvement with referral sources tended to range from the almost casual and uncomplicated to the highly formal and complex.

In Minnesota referral begins with a phone call to the program director; this is an approach which offers sources direct and immediate access to the program. It also allows for preliminary exchange of information with the person most able to encourage or advise against further assessment of a youth's suitability for the program.

Pennsylvania has adopted a format similar to the one used in Minnesota, in that neither requires contact with an intermediary. At the Norristown unit an admissions officer is responsible for handling referrals, all of which are made by the juvenile judge of the County Court of Common Pleas. Once the juvenile judge or a court representative (usually a probation officer) has presented a verbal summary of the youth's history and current situation, the admissions officer can recommend or discourage the more detailed exploration necessary for admission.

Illinois and Massachusetts have developed a much more structured method for referral. Instead of calling the program directly referral sources must contact what is best described as an "administrative screener." In Illinois, each sponsoring department (Children and Family Services, Corrections and Mental Health) has a specifically

appointed liaison to the program through whom all referrals are initially funneled; departmental caseworkers, probation officers and psychiatric social workers must go through their own representative to initiate the possibility of a youth's admission to the Tri-Agency unit. The three liaison workers are well acquainted with the admission criteria and are in a key position to evaluate the appropriateness of the referral. It is at this point that intake can be regulated and a decision made on whether or not to proceed toward formal case review. Similarly, in Massachusetts, the referring agency must first contact the Department of Mental Health Regional Children's Coordinator (RCC) in the region which contains the client's "community of meaningful tie." If the Regional Coordinator believes the referral is appropriate, he or she will contact the Area Children's Coordinator (ACC) who is then responsible for gathering all pertinent information from the referral source. After the Area Coordinator reviews the material, it is routed back to the Regional Coordinator who then recommends proceeding to another administrative review panel or seeking service for the youth elsewhere because RAP admission criteria have not been met.

The California Youth Authority, which administers the ITP, is in the unique position of having to maintain relationships only within its own system. Since the Intensive Treatment Program is administered by the Youth Authority, it need not depend on external referral sources, such as mental health or child welfare; the program's referral mechanisms are entirely self-contained within corrections. Whatever communication must exist to facilitate referrals is focused on the Diagnostic Center half of the facility, which is literally on the other side of the fence that separates the ITP from the rest of the compound. Every youth who is committed to the Youth Authority enters one of two diagnostic centers where he or she is evaluated for eventual assignment to any one of several Youth Authority programs. Most referrals to the ITP come directly from the Diagnostic Center; the staff considers this a distinct advantage since crises ordinarily can be handled quickly and the regular screening and admissions process can be accomplished without delay or interruption. In addition, the close proximity of the ITP and the Diagnostic Center allows for an uncomplicated transition for the youth who often times may spend the day within the ITP until a bed on the unit becomes available.

Despite the programs' respective referral procedures, which are designed to screen and expedite admissions, each program reported instances of inappropriate referrals. For the newer programs, this is frequently due to the difficulties inherent in start-up; how to publicize and relay the program's objectives, and how to circumvent the professional community's "wait-and-see-before-referring" attitude. Two of the more established programs cited the frustration and anger that referral sources may experience when a particularly hard to place youth does not qualify for a program which is often regarded as the last possible option. One program director said that misinformation and inaccurate diagnoses account for a large percentage of his program's inappropriate referrals; another suggested that referral material is sometimes purposely inflated or distorted to improve a youth's chances of gaining entrance.

ADMISSION PROCEDURES

Once a referral source clears the initial screening phase and is given the go ahead for further processing of a youth's application, another set of procedures swing into gear. These admission procedures tend to mirror the degree of organization that characterizes each program's protocol for referral; that is, states with clearly defined or complex referral procedures had correspondingly direct or elaborate approaches to case evaluation and admission.

In Minnesota, the initial phone call is followed by submission of a comprehensive information packet to the Program Director. This material contains a youth's social and developmental history, school records, current psychological and psychiatric reports, medical and neurological records, speech, language and hearing evaluations, and a summary of residential treatment placements. The Protective Component Unit Director or Assistant Director present the case to an Admissions Committee whose other members are the regular Adolescent Unit Director, the hospital Medical Director, a special education teacher, and a nurse or physician and educational coordinator from the Adolescent Unit. If the written material confirms a youth's appropriateness for the program, the Admissions Committee conducts a pre-admission interview which is attended by the youth, his parents and county social worker. The interview's purpose is to further determine the degree of a youth's motivation for and attitude toward treatment, as well as any special program or treatment needs. Although the Admissions Committee participates as a group in assessing potential residents, the final admissions decision rests with the program's director and assistant director. Technically, the state Commissioner of Public Welfare has ultimate power over an applicant's destiny, but no necessity for such administrative deference has arisen so far. If a decision to admit is reached, probate court proceedings to commit involuntarily are initiated. Without unforeseen delays, the entire process--from phone call to admission--can take anywhere from 4 to 6 weeks. During this time, a youth is usually held in detention.

With minor variation, admission procedures at the Pennsylvania Juvenile Forensic Unit are very much like those just described for Minnesota. Following the original contact, the referral source is asked to send the Admissions Officer a youth's complete psychiatric history and a report of psychiatric evaluation that was conducted within the 30 days preceding referral. Offense history and any other available and pertinent information are also solicited, as is the knowledge and participation of personnel from the appropriate Base Service Unit (the mental health resource center in each catchment area). This material is reviewed within 24 hours of receipt by the Unit treatment team which consists of the Director, the Admissions Officer, the Unit's psychiatrist, psychologist, social worker and a member of the nursing staff. If a youth appears to meet the program's criteria, several members of the unit treatment team conduct a pre-admission interview with the youth and his family. Often times and whenever possible, this interview is conducted in the youth's home so that the team can better observe the family as an interacting system. When a youth is believed appropriate, a commitment order is prepared to finalize admission. Differing opinions regarding a youth's entry into the program are resolved on the Unit Director's recommendation. Initial program design anticipated that controversial admissions decisions would be settled by arbitration involving the Department of Public Welfare's Office of Mental Health, Legal Division, and Office of Children, Youth and Families.

In Illinois, referral sources are asked to send an information packet to their departmental representative if the initial phone conversation indicates further follow-up. The liaison subsequently routes the material to the Admissions and Discharge Committee. This decision-making body meets every Tuesday and is composed of the three representatives from the Department of Corrections, Mental Health, and Children and Family Services, the Program Administrator and the Clinical Director. Referral sources are encouraged to attend the conference in which their case is reviewed. In general, the gathered information is sufficient grounds for a decision; if the Committee has reservations, they will arrange to interview the youth. Because the

Admissions and Discharge Committee meets weekly, evaluations can be done as soon as the liaison receives all the necessary information. Each member of the Admissions and Discharge Committee is entitled to one vote regarding a youth's appropriateness for the program; however, the clinical staff may reject their decision if they believe that clinical diagnosis did not take precedence in the Committee's evaluation. There is very little lag time in the Tri-Agency's admissions procedures; if a youth is accepted and a bed is available, he enters the program on the Monday following the Admissions and Discharge Committee meeting. The days between the admissions decision and a youth's arrival are devoted to debriefing the treatment team and developing a preliminary service plan. Youths are usually at home, in detention, correctional institutions or psychiatric hosptials during this relatively short interval. On rare occasions, intake will be closed for as long as 30 days and referrals discouraged because the unit is already at capacity. Although Tri-Agency's waiting list can be lengthy, every effort is made to admit a youth in severe crisis who clearly belongs in the program.

The intricate organization that characterizes referral and intake in the Massachusetts Regional Adolescent Programs is also apparent in their highly selective admissions process. These procedures are purposefully stated in a meticulously detailed compendium of regulations which govern and delineate all aspects of program functioning. What follows the previously described exchange between the Area and Regional Coordinators in regard to referral, is illustrative of the multi-level monitoring mechanisms that Massachusetts has developed. After the preliminary exchange, the Regional Coordinator evaluates the material that was gathered by the Area Coordinator. The program regulations stipulate that referral information contain 1) a written evaluation which summarizes a psychiatric examination conducted within the preceding three months and includes a diagnostic assessment of intellectual, social and emotional functioning; 2) a written psychological evaluation which includes standardized tests of intelligence and social and emotional functioning; 3) a written and complete current case history which relates the number and type, length of stay and reason for discharge from previous placements; family history and an evaluation of eligibility for public assistance; 4) a joint report by the examining psychiatrist and psychologist which states that the youth meets the admissions criteria; 5) a copy of a youth's most recent core evaluation; and 6) a written statement from the Local Educational Authority that it will absorb the cost of the RAP educational component.

The Regional Coordinator then takes the completed documentation to a Regional Interdepartmental Team. This is primarily an administrative panel composed of professionals from several social service systems. Thus, RAP referrals are further screened by representatives from the Department of Mental, the Division of Youth Services, the Department of Public Welfare, the Department of Social Services, the Office for Children, the Department of Public Health, the Massachusetts Rehabilitation Commission, and the Department of Education. The Interdepartmental Team meets weekly to consider the case histories of children whose needs are not being met by any agency; its power of review is neither exclusively clinical nor limited to RAP referrals. The Interdepartmental Team evaluation concludes with a written determination that the clinical criteria are satisfied and that a less restrictive setting is not indicated. In collaboration with the Regional Coordinator, the Interdepartmental Team considers the present population of the RAP in the youth's service area. If the designated program can absorb a new resident, the Regional Coordinator contacts the Department of Mental Health Regional Services Administrator who then takes the case directly to the program's director. At this point, another abbreviated admissions procedure is required. The Regional Services Administrator must have the referring

agency's written consent that placement in a Regional Adolescent Program is appropriate. The Regional Coordinator must submit the following written materials to the Program Director before a youth can be admitted: an interdisciplinary clinical team report from the referral source; an Interdepartmental Team determination of eligibility; a referral statement from the Regional Services Administrator; and, in the case of youths in correctional custody, a letter of placement from the Commissioner of the Division of Youth Services.

By the time the referral reaches the program itself, there is very little possibility of rejection, even though the program director reserves this option. Once the program director concurs with the findings of the many reviews the referral has weathered, he will consult with the clinical director, begin the orientation and treatment plan, and arrange the date and time of admission with the Regional Coordinator and referral source. Youths may be in detention, on the run or in other institutions while awaiting admission.

This elaborate process, which begins with referral and ends with admission to one of several regional adolescent programs, can take anywhere from two weeks to two months to complete. The numerous "checkpoints" which are intentional regulatory mechanisms, may also function as obstacles to admission. Massachusetts' carefully conceived approach to admissions may actually be part blessing and part curse; in practice, the order of steps toward admission is not always identical to those proscribed in the program regulations. Clearly, not all referrals are or need be of the textbook variety; to a great extent, the precision of the process and the ability to circumvent some of its hurdles, may depend on a referral source's relationship with the area and/or regional coordinator--both of whom are capable of expediting or delaying action.

Admission procedures at the California Intensive Treatment Program are comparatively streamlined and centralized because they are organized around the Diagnostic and Reception Center work-up which precedes all Youth Authority dispositions. Referrals from the Diagnostic Center are evaluated within a week by a Screening and Admissions Committee whose members include a psychiatrist, a psychologist, a social worker and a senior youth counselor. Screenings are generally held on Fridays for cases which are not considered critical or in need of immediate intervention. Having read the Diagnostic Center's comprehensive evaluation of a youth's past and current psychiatric, psychological, medical, and academic and social history, the Screening and Admissions Committee will interview the referred youth. This Committee has ultimate discretion to admit and is capable of exercising it with relative dispatch. Painstaking and time-consuming gathering of referral material is neither a necessity nor an obstacle in the program's admission procedure given the proximity of the Diagnostic Center and the availability of a youth's records. Indeed, because of the Intensive Treatment Program's crisis component, a youth can even be admitted for observation on short notice that may or may not be accompanied by the Diagnostic Center's completed assessment. Immediate admission is frequently used as a short-term crisis intervention which seeks to stabilize a youth for subsequent release; in other instances, the unit's capability for temporary observation and treatment can be extended into a long-term regular admission.

The organization and handling of admissions procedures are crucial issues in the design of programs developed for severely disturbed offenders. The procedural variation which exists in this area is considerable. It is, moreover, indicative of

the programs' diverse and thoughtful efforts to regulate the flow of referrals in the service of maintaining their clear and stringent standards of admission.

Chapter V

PROGRAM GOALS

Our interviews with program administrators and clinical directors revealed that, more often than not, two types of goals were operating simultaneously. These are aptly conceptualized as the organizational or overall objectives of the program as a whole, and the more specialized and circumscribed individual treatment goals that are developed for each youth. Every program in our small purposive sample agreed that their primary goal was the provision of intensive and varied services to adolescent offenders whose degree of emotional disturbance precluded placement in other child care settings. Beneath this general purpose, there frequently existed other important agendas. For instance, one of the goals of the deliberately demonstrational Minnesota unit is the possible replication of this model in other state institutions and private facilities; to this end, the project has tried to identify the particular training needs which must be addressed in working with disturbed and aggressive youngsters. Thus, very early on, the development of an "exportable" training package was seen as one of the program's organizational objectives. Similarly, when the Illinois unit opened with the intention of providing "long-term treatment for high-risk male delinquents with multiple previous unsuccessful placements within the system," it also was knowingly testing the efficacy of inter-agency efforts to serve this population.

Despite differences in the language used to express the programs' treatment goals, there was a shared emphasis on the reduction of psychopathology and the development of social skills. Modification of dysfunctional behavior, improved self-image, enhancement of coping abilities and preparation for re-entry into the community were regarded as central treatment considerations. Programs tended to give equal weight to psychological issues and social situations; that is, no program concentrated solely on a youth's personality structure and "inner" life. Substantial attention was paid to important practical matters such as living arrangements, employment, family relationships and extended support systems, and the ability to negotiate the world in general. One director's immediate response to the query "what would you say are the overall goals of your program?" was "cured kids." Although this was quickly amended and recognized as overstatement, it provided a clue to the perceived expectation (from within the professional community as well as the public), that this is what should result from intensive and expensive intervention. "Cured kids" is undoubtedly the ideal; it is rarely, if ever, the achieved outcome, however.

Reaching a balance between unattainable and realistic treatment goals is an on-going process for programs such as these. Though the temptation and pressure to "cure" is difficult to combat, the concensus among program directors was that more reachable goals could and must be set for the youths served in secure treatment units. For example, the Minnesota unit was clear on its modest but realistic goal of "establishing enough self-control and symptom relief in these individuals to enable them to enter into and benefit from a traditional residential program." They soon realized that the task of stabilizing and readying a youth to live in a less restrictive but

still structured environment far exceeded the average length of stay that was originally projected. While the goal of moving a youth to the regular adolescent unit or a group home has not changed, the time frame for achieving it has been re-evaluated and made more workable. In a similar vein, the clinical director of the Massachusetts Medfield RAP reported that an initial focus on "restructuring and overhauling character" has given way to a more concentrated approach to helping youths "get their feet on the ground."

Beyond the goals of improving social functioning and alleviating emotional distress, there was the less unilaterally stated aim of reducing further delinquent behavior. Only two programs directly identified recidivism as a central concern; a third saw it as secondary to other treatment objectives. Though not explicitly mentioned by two programs, attempts to minimize anti-social behavior were very much part of an overall treatment approach which encouraged the development of stronger inner controls and self-esteem. The relationship between self-perception and delinquent activity was recognized in each program, as was the potential for positively affecting one by stressing the other.

THEORETICAL ORIENTATION

The setting in which each program's goals are implemented is, of course, residential. Although a pure and universally acceptable definition of residential treatment has yet to be established, the literature suggests that two basic philosophies have emerged which most frequently shape this particular type of intervention. In their simplest form, the two modalities are conceptualized as the clinical services model and the milieu treatment approach. The former focuses on the individual therapeutic relationship between worker and client; the group context in which this dyadic relationship is fostered is regarded as a supplement to the clinical program. Milieu treatment, on the other hand, stresses the importance of the group and its surroundings as the major instruments of change; this modality is centered on the explicit structuring and active manipulation of the total therapeutic environment. The purpose of both approaches is change, but the means to that end are rooted in differing schools of thought on how to achieve it.

In the abstract, these two philosophies of residential treatment appear conceptually clear-cut and theoretically tidy. In practice, however, it is often difficult to separate the two approaches and identify a program as "clinical" or "milieu." This is particularly true in programs such as the ones described in this report. Despite the apparent homogeneity of their populations, programs are not dealing with static and uniformly endowed youngsters; they must inventively and flexibly respond to the great range of individual needs and developmental tasks which are so pressing and visible during adolescence and, a fortiori, in disturbed adolescents. One administrator summed up this programmatic dilemma by citing the widely acknowledged professional belief that "no one model has yet been devised which meets all of the needs of any given individual."

Although all of the programs drew on strategies associated with both theories, it was possible to discern which modality--clinical service or milieu--was emphasized. The Minnesota, Pennsylvania and Illinois units were clearly based on the milieu approach to residential treatment; the two Massachusetts Regional Adolescent Programs that we visited emphasized individual psychotherapy to a much greater extent, while California represented a rather balanced, integration of both models.

TREATMENT INTERVENTIONS

Whatever their theoretical orientation, all programs were required to develop formal treatment plans for each resident; these plans were frequently derived from a combination of the referral and intake material and initial observation of the resident following admission. Plans were comprehensive and documented all aspects of the proposed treatment including education. There was some variance in who develops and reviews individual treatment plans. The California program, for example, has seven treatment teams, each headed by a social worker or a psychologist who is also the youth's primary therapist; this team, which includes members of the child care and nursing staff, is responsible for formulating and evaluating the treatment plan at monthly intervals. Among the measures used is a detailed psychopathology rating scale that gauges monthly gains. A case conference is held every sixty days, unless needed sooner, after which a formal report of the ward's progress is written. The report specifically outlines and addresses three discrete areas: needs, treatment methods and expected outcome.

In Illinois, a tentative treatment plan based on the hospital's traditional problem-oriented-record system is developed within 72 hours of admission. The treatment team that contributes to the plan's formulation includes the entire clinical staff and representatives of the direct care, activities and educational staff. A more definitive and complete service plan is required within fourteen days; thereafter, formal review is scheduled monthly. Every two weeks youths must attend full staffings which focus on overall participation in the program, extent of relationship development with staff and peers, and the degree of intervention effectiveness thus far. In addition, charting is done three times a day--once for each care staff shift; individual and group therapists each enter treatment notes in a youth's record twice per week.

Pennsylvania's two treatment teams are directed by a social worker and a psychologist who each have primary responsibility for submitting individual treatment plans. A preliminary plan is established after a youth has been on the unit for three days; two weeks later the plan is re-examined and refined. Regular review occurs monthly. Daily exchange meetings are scheduled in the morning and afternoon; these meetings allow the outgoing staff to debrief and update the incoming shift on important as well as routine unit occurrences.

After outlining a youngster's major problem areas, the Minnesota treatment team formulates a plan according to a four category system which specifies the long-term treatment objectives, treatment modalities, staff responsibilities, and method of measurement. The plan is reviewed after one month's time. Following that, full staffings which include the youth, his parents, probation officer, social worker and therapist, are held every two months until discharge. Less formal case conferences occur weekly at team meetings.

Clinical impressions and early observation form the basis of a preliminary intervention plan at the Medfield Regional Adolescent Program. This is followed by a more in-depth assessment of personality developed against an elaborate set of diagnostic protocols. There is quarterly review of this plan by the Clinical Director, the youth's primary therapist, the educational coordinator, a member of the nursing staff and any "significant others," including the cook.

For sheer clarity of framework, the Minnesota unit was a notable example of a program based on the concepts of milieu treatment. There is a very definite commitment to

and use of the small group to effect behavioral and psychological change. Individual therapy is available (the program director serves as therapist to each of the six residents), but is not a major component of the program. The individual counseling that does occur is not regularly scheduled or formal; rather, it consists of on-the-unit daily exchanges between the youths and the director. This program also relies heavily on reality therapy and "life-space" interviewing, both of which are consonant with the principles of milieu treatment.

The Minnesota unit uses highly structured and varied group treatment to reflect and reinforce the importance of the milieu. A major portion of a youth's time is spent in groups which deal with family problems, life skills, and goal setting and evaluating. Educational groups on topics such as drug and alcohol use, sex information, assertiveness training, study skills, and awareness, sensitivity and tolerance training are regularly scheduled. In addition to these socialization and therapeutic groups, the program also offers many different team and individual recreational activities. The program uses an elaborate point and level system which guides and gauges a youth's daily progress in all possible areas of functioning. There is no concentrated focus on family therapy; the staff would like to involve families more intensively, but is hindered by the program's distance from most of the youths' home communities. Very frequently, families are also dysfunctional and disorganized and therefore hard to engage on any regular basis. It should be noted that every program commented on the minimal opportunities to conduct family therapy; working with families was by far one of the most serious challenges faced by each of the programs.

The other program that was more clearly milieu than clinically oriented was the Juvenile Forensic Unit in Pennsylvania. Group treatment, and to a very great extent, family therapy were the two therapeutic interventions around which the program was built. Since the time of our visit, however, the program has come under fire for its emphasis on family treatment. Apparently the program director and Department of Public Welfare administrators were in disagreement on the advisability of focusing so heavily on family counseling. Work with families had subtly begun to become part of the unwritten admission criteria. Although the unit is now in the process of clinical and administrative change, much of the information gathered during our site visit is still relevant and can be used to illustrate one approach to residential treatment with a specialized population.

Group treatment at the Pennsylvania unit was centered around goal meetings which took place twice each day. Goals set at the morning meeting are evaluated in the afternoon. Each meeting provides an arena for review and reassessment and is designed to promote a sense of ongoing work and consistent feedback among the group members. Although these meetings are attended by the staff, their participation is intentionally restrained and generally limited to suggesting goals. The momentum and major force behind these groups are the members themselves; chairmanship is rotated and most of the observations and exchanges that occur are generated among the members. Thus, though the staff may serve to facilitate, the bulk of interaction and feedback is the group's collective responsibility. Goal meetings are also the forum in which a youth's progression through the program's step system is monitored; requests for advancement to the next level are discussed and decided at goal meetings, although final say in this area depends on a youth's "contact person" (see description of individual treatment below). Each member keeps a "goal book"; this is a record of a youth's passage through the program and includes significant milestone information: date of entry, level achievement, set-backs, court history, kinship diagram and copies of the monthly reports prepared for the court. Besides the two daily goal

meetings, ward meetings are held twice a week; staff may or may not be invited to attend or to submit an agenda for the members' consideration. A third type of group was just beginning when we observed the unit. This was an intensive psychotherapy group for youngsters who had reached levels two and three of the step system. It was to meet twice a week in addition to goal setting groups and was being conducted by the program's psychiatrist.

The "contact person" mentioned earlier was another unique feature of the Pennsylvania unit. More akin to a case manager than an individual therapist, contact persons function as liaison, intermediary and shadow; they are nurses, line or clinical staff assigned to a youth before admission, and are often present at the screening interview that precedes entry to the program. Contact persons are responsible for "weaving together all the components of treatment"; this entails developing an individual relationship with the youth and becoming the person to whom he is most attached. The task of involving families in treatment is also a contact person's responsibility. This individual staff member also monitors the course of therapy, from initial adjustment to discharge, and plays a crucial role in decisions effecting home visits and level changes.

The clinical director of the Illinois program whimsically described the unit's method of intervention as "Freudian confrontive." Treatment is based on the concept of the therapeutic milieu in which residents are regarded as members of a community. The Illinois program relies on two types of group treatment: "structured" and "laboratory." The structured groups are held twice each week and are conducted by a social worker and a psychiatrist. Interpersonal problems and self-perception are explored through role-playing and trust-building exercises as well as ventilation and support. Encounter, guided group interaction, gestalt, reality therapy, and empathy training constitute the most frequently used group methods. In the laboratory groups, which also meet twice weekly, a more free-wheeling and experimental atmosphere prevails. These groups are run by a nurse and a bachelor's level social worker; they are primarily designed for discussion of dormitory events, daily routine, and whatever tension and stress are generated by living in a secure unit. The purpose of laboratory groups is to raise and solve day-to-day problems through verbal communication and re-direction of individual and group energy.

Each youth has an individual therapist and is seen in regularly scheduled psychotherapy twice a week, or more if indicated. All the clinicians are graduate level social workers or psychologists who are free to use whatever therapeutic techniques they know and feel are appropriate. Most often these will center around psychodynamic theory, reality therapy and behavior modification. Family therapy is available, but families are usually not motivated or within commuting distance for this kind of counseling to really be effective. At best, three or four youngsters and their families are engaged in any structured family treatment. Although the program recognizes that changes in the youth are often difficult for families to absorb and keep pace with, they also believe that for many of their residents, re-integration into the family is secondary to preparing for independent living. Thus, when separation from home is the developmental task to be mastered, treatment is geared toward issues of autonomy and life apart from a home situation. This is not to say that no efforts are made to reunite families or to help them adjust to the shifts in the family system that are inevitable when one member changes. On-going, though relatively informal, contact is maintained whenever there is a family to reach.

When asked if the Medfield Regional Adolescent Program subscribed to any one theoretical

orientation or an amalgam of modalities, its clinical director replied that being "eclectic" was the equivalent of "not knowing what you're doing." A primarily psychodynamic approach is advocated and practiced in this program; each youth has an individual therapist and is seen from three to five times a week in intensive psychotherapy. It is important to note that the Medfield RAP has changed its therapeutic emphasis in the past year; according to the program administrator and clinical director, the unit used to be based almost totally on a group model. Over time this "intense but ineffective" approach was changed to the present focus on psychoanalytic psychotherapy. Group treatment continues to be an integral part of the program, however. Groups lasting two hours are run four times a week. Like the individual treatment that each youth receives at Medfield, there is one general purpose to this group: therapy. Thus, group sessions are specifically geared to ventilation and conflict resolution.

In contrast to the Medfield program, the director of the Solomon Carter Fuller Center (a Regional Adolescent Program in the greater Boston area which we visited briefly), believed that "treatment is everything that might work." Although the program's major orientation is individual therapy, the director willingly admitted that he "isn't certain it's the key" to positive inroads with severely disturbed adolescents. He also acknowledged the importance of family treatment and cited the well known phenomenon of the compelling bond that exists between parents and children despite the abuse and deprivation that frequently characterizes their interaction. At both Medfield and Solomon Carter Fuller, family treatment was perceived as a rarity; their success in engaging families was similar to that of other programs where families are unavailable, unwilling or too far away to participate.

The Solomon Carter Fuller program fully recognized the validity of milieu treatment and saw it as a proper vehicle for teaching youngsters how to get their needs met within a supportive environment. No formal behavior modification component was apparent at the Medfield RAP, but at Solomon Carter Fuller it was used as "a way of ordering the chaos. . . it concretizes issues and conflicts." Both programs strongly supported the need to hold youngsters immediately responsible for their behavior; "life-space" interviewing was regularly used in such instances.

The California program seemed to defy categorization as clinical services or milieu oriented, since both these modalities appeared to be given equal emphasis. A primary therapist is assigned to each youth upon admission; formal counseling sessions are held at least once a week, although more casual contact with an individual therapist usually occurs in the course of a day. Clinicians are encouraged to use a variety of treatment techniques, which generally encompass reality, rational emotive, psychoanalytic and and gestalt therapies. In addition, the program uses psychodrama and biofeedback. Since the program is largely based on a social learning model, behavioral therapy is a central aspect of the community milieu. Each ward receives a detailed description of the unit's rules and regulations, from which an elaborate point and level system is derived. A daily record and tally is kept in each area in which a youth may earn points toward the next level. Scores depend on evaluation of participation in school, gym, work, recreation, tutoring, scouting and contract completion. Points are not earned for attending group or individual therapy.

Some structured family therapy occurs, but this is the exception rather than the rule. The staff of the California program echoed the sentiments expressed in Illinois regarding the wisdom and necessity of involving families following discharge. Thus, the California program also emphasizes independent living through emancipation from one's family.

Two kinds of groups are conducted at the California Intensive Treatment Program. A weekly management and housekeeping group is run by a youth counselor; the primary focus of this community meeting is the smooth functioning of the unit's daily schedule and routine. Small therapy groups consisting of five to six youths are run weekly by the seven clinicians who serve as treatment team supervisors. Problem-solving and conflict resolution are the major areas of concentration.

Besides the individual, family and group treatment that characterized each program, we also found that medication was a common component of overall program design. Psychotropic drugs were used to stabilize and moderate psychotic symptomatology and to control seizure disorders. Although a sizable proportion of each program's population was being treated with anti-psychotic or anti-convulsant medication, there was no evidence that youths were indiscriminately or unnecessarily medicated. None of the programs viewed drugs as a means of social control; all dosages were closely monitored by the units' medical director, psychiatrist, or nurses. Most medication was prescribed with the intention of alleviating severely depressed, disorganized or bizarre behavior so that the youth would be more available to the other therapeutic interventions offered by the program. Medication was uniformly seen as an adjunct to and not a substitute for other treatment modalities.

All of the units had seclusion rooms which were reserved for instances of extreme uncontrollable behavior. They were typically institutional in appearance--empty, serve for a mattress, and devoid of any form of stimulation. Most of the programs' use of seclusion is governed by hospital regulations or guidelines developed specifically for the program. Physical restraint is occasionally required in situations where a youth becomes dangerous to others or self-destructive, but program personnel reported only isolated and intermittent need for such steps. None of the programs used any kind of mechanical restraining devices.

EDUCATION AND RECREATION

Education and recreation were also integral elements in each program's comprehensive treatment approach. Youths in each of the five programs surveyed spend a substantial part of their day in a school setting where a core curriculum is adjusted to individual needs and abilities. Not surprsingly, the programs' educational components were similarly designed. Most school days began after breakfast and morning chores and ran until noon; they resumed after lunch and concluded in the mid-afternoon. All of the educational programs were structured around small classes and highly individualized, almost tutorial, instruction. Content tended to focus on several academic and creative areas. In California, for instance, three basic tracks were offered concurrently: general education for high school credit, arts and crafts, and remedial skills buildling. Massachusetts offered a variation on this model through a combination of basic courses (language, mathematics, social studies and science), expressive arts and classes geared toward acquisition of daily living skills (banking, budgeting, consumer issues, nutrition and hygiene). While the programs did not differ radically on this dimension in either form (small classes and individually formulated educational plans) or content (regular high school subjects and GED preparation and credit), there was some variation in where and by whom educational services were provided. The residents of the Minnesota program attended school in the larger, adjacent adolescent unit, thus sharing facilities as well as teachers. Although the unit does have one teacher and one teacher's aide who are attached to the Protective Component only, the school program is, in the main, an integrated part of a pre-existing educational arrangement.

Illinois, Massachusetts and Pennsylvania had educational programs which had been created to serve only their own residents. California's school program was also primarily in-house, but it included a unique provision for public school attendance during the pre-release final stage of the program.

Instructors are all state certified and many, but not all, are trained in special education. In four of the programs, teachers are secured through the county or state department of education. In some instances, a youth's local school district absorbs the cost of his educational program; in others, expenses are paid through special grants filtered through the district in which the program is located. In Massachusetts, however, each youth's individual educational plan is dependent on an agreement between the Department of Mental Health Regional Services Administrator and the Director of the Department of Education's Bureau of Institutional Schools. In effect, this agreement stipulates that the Department of Education will contract with a vendor to provide educational services in compliance with the individual educational plan. The "vendor" is then recruited from Massachusetts' system of local educational consortiums.

Recreational facilities varied considerably according to the grounds and setting of the institutions in which programs were located. Pennsylvania's Juvenile Forensic Unit was part of a sprawling and immense state hospital campus, but the building was a far-removed and self-contained environment with intra-mural recreational facilities. The Illinois program was similar to the Pennsylvania unit this regard: it was some distance from other hospital structures and had its own on-site physical education equipment. Minnesota's Protective Component Unit and Massachusetts' Medfield Regional Adolescent Program were also situated in pastoral and rolling landscapes; however, they were not as isolated from other units and the surrounding outside areas were infinitely more accessible for recreational activities. The Solomon Carter Fuller Regional Adolescent Program was on the eighth floor of a modern community mental health center; this imposing and austere high rise may have contained many technological and recreational advantages, but to the program staff, the logistics of transporting twelve youngsters to the gym by elevator presented continual problems. The California Intensive Treatment Program had its own fenced in spacious grounds for outside recreation and a variety of sports activities.

Overall, recreational offerings seemed creative and well-rounded; they were, nevertheless, pretty much confined to the units and their grounds. Several factors contribute to the programs' rather limited use of community recreational resources. For most of the programs, distance from the community may hinder regular outings. The Minnesota program, for instance, is even further handicapped in this area by a practical constraint. Since they have no transportation, access to community events and facilities is virtually impossible. In Illinois, community contact was described as "minimal"; the severity of the population was cited as one consideration governing this programmatic aspect. Though the rules and regulations for Massachusetts' Regional Adolescent Programs stipulate inclusion of educational and recreational activities in the community, actual contact reportedly varied from "none to a lot." California youths were minimally exposed to their immediate neighborhood until shortly before release; at that point, they frequently attended sports events or visited community libraries and museums. The Pennsylvania program had not been operating long enough to respond to inquiries regarding this area of program planning.

Our impression was that all of the programs recognized the necessity and value of a wider experience for their residents, but that in reality this was one of the more

difficult and least frequently achieved objectives. At best, the community came to the unit through volunteers. For most of the programs, however, such contact occurred intermittently, if at all. One program director warned against the sporadic use of volunteers who played the "lady bountiful, do-gooder" role on specific occasions; he felt that this was ultimately detrimental to youths who need an enduring commitment from a stable cadre of community supporters. This, of course, is no easy task for any of the programs, particularly since they frequently feel compelled to establish and maintain a low profile. As a result, they find themselves in the somewhat ironic position of sacrificing the potentially positive effect of community participation for the safer ground of program anonymity. This may protect residents from inconsistent attention but it also may serve to inhibit community acceptance of the program. Furthermore, at least one director pointed out that training volunteers is time-consuming and requires a commitment from the staff which daily scheduling does not always permit. Here again, possible opportunities for community involvement may put programs in the peculiar double bind of needing the service but not being able to avail themselves of it.

STAFF COMPOSITION AND CHARACTERISTICS

Much has been said of the youngsters that these programs serve. They have been described in many ways--psychiatrically, behaviorally, legally--but none of these quite captures the response they elicit in those who work with and for them. Given the nature of their psychopathology, they challenge many of our assumptions about ourselves and our attitudes toward the helping process. These youngsters are hard to idealize; they shake our instinctive wishes to see all children as innocent, all adolescents as searching, experimenting and growing, all men as good. They make daily, unrelenting demands of workers whose unflagging belief in their treatability is a youngster's strongest ally. In this section, we turn to the "other" special population--the staff. We will examine several aspects of program design related to staff composition, attitudes and training, recruitment and incentives, supervision and the common problems shared by programs which treat these youngsters.

Organizational theory suggests that an individual administrator's values and personal style are often reflected in the philosophy and methods of his or her staff. There was an extra dimension of this often cited hypothesis in the programs we visited, since all of the administrators were originally clinicians. Massachusetts, Illinois, Pennsylvania and California have administrative structures in which the "program director" and the "clinical director" were separate positions held by two different people. This was not the case in Minnesota where one clinican functioned as both program administrator and treatment coordinator. Although we did not have time to talk with many of the child care workers who are crucial to the smooth running of residential unit, we did get a clear sense of overall administrative structure and approach. We found strength, determination, humor and deep commitment in each of the programs we visited, and were impressed with the degree of thoughtfulness and care that characterizes both the trivial and momentous aspects of working with this special population. Above all, there was, as one director said, "a commitment to accept the unacceptable and make it easy for that person to grow and difficult for them not to." While our observations in this area are impressionistic and subjective, it did appear that administrative tenor was a likely indicator of a staff's overall cohesion and morale.

Nor suprisingly, we observed that professional identification was more clear-cut for the clinical staff than it was for the child care workers. In programs such as these,

where the boundaries between pathological illness and anti-social behavior may be vague and confusing, clinical issues may be expected to seem functionally discrete from management concerns. While treatment and socialization need to be integrated with protection and custody, it is not uncommon to find factional disagreements between the two groups of practitioners responsible for these tasks. All of the programs were designed with the team concept at the center, but there was clear variation on how well distributed or blended the therapeutic responsibilties were. Despite obvious attempts to equally involve all members of the treatment team in an individual resident's care, there are bound to be certain tensions and divisions over the real or imagined locus of influence. The structural differentiation that results may then become an administrative nightmare and a dangerously counter-productive environment for those it is seeking to positively affect--the residents. At the root of this not so rare phenomenon is a form of dependence between the clinical and the day care staff. More specially, it is generated by a lack of interdependence. That is, in many ways the clinical staff is dependent on the child care staff for effective accomplishment of therapeutic goals, but the child care workers who on balance spend more time with the residents, are in strategically powerful positions to block the efforts of the clinical staff. Smucker notes that in many residential settings "clinical staff is considered responsible for behavioral change (socialization and treatment) goals while the child-care workers are given primary responsibility for the day-to-day care of the residents (custodial care and protection). Although this division of labor may seem logical, it is the basis for intra-organizational conflict" (1975: 11). We encountered one striking example of this during the site visits, where the friction and opposition between clinicians and line staff were evident. Though there is little reason to believe that that clash was representative of the unit's daily functioning and ambience, it did seem to highlight an area which may be intermittently problematic for all the programs.

In general, however, the staffs struck us as tightly knit and mutually cooperative. Though sporadic irritations and misunderstandings may be an occupational hazard of working in such intense and demanding settings, their occurrence was not lost on any of the program administrators. There was, in fact, an unmistakable recognition of the interpersonal difficulties that arise within such organizations. Much thought is given to how these dilemmas can be avoided and how to handle them when they threaten the equilibrium of the unit. The clinical director of the Illinois unit recalled the program's early troubles with a uniform staff identification. The problem was apparently one of divergent professional views: the youth counselors' "punitive perspective" was in conflict with the "permissive and more sympathetic" mental health workers. Many of the youth counselors were streetwise but not much more formally educated than the residents; the clinicians, on the other hand, were highly trained specialists who were well-grounded in theory and technique. The resultant lack of sharing and cross-fertilization produced a potentially combustible atmosphere of suspicion, resentment and distrust. To promote intra-staff rapport, several changes were made. Some workers were replaced. Training procedures were reviewed and revamped to facilitate a merging of the disciplines. Special emphasis was placed on integrating the traditional values of the classroom within a practical and experiential framework. In time, both groups learned from each other and began to develop a mutual respect that had been so obviously lacking before.

Not all of a unit's conflicts are organizational or reflective of interpersonal difficulties between and among staff members. In many instances, the problem is individual and internal, the result of overwork and emotional fatigue. It is practi-

cally impossible to work in certain areas of the helping professions without observing in one's colleagues or experiencing on one's own the symptoms of burn-out. All of the administrators and clinicians we spoke to agreed that staff turn-over is a persistent issue, even in settings such as these where time shifts and week-ends may be regularly rotated and staff are not required to live on the premises. The clinical director of the Illinois program believed that more line staff are afflicted than those in professional positions; he cited the lack of perquisites accorded the direct care staff as one possible explanation of this phenomenon. The lowest turn-over in the Illinois program occurs in support services (clerical and housekeeping); they are followed by teachers, clinicians and, finally, the child care workers. In California, the program director reported receiving voluntary transfer requests from workers who wished to leave the Intensive Treatment Program for the adjacent Diagnostic Center. The Minnesota unit's program director told us that staff turn-over is more a matter of "growing out (of a job) than burning out." According to the Protective Unit's annual report, over 28 percent of its employees resigned before the end of the project's first year; most of these indivduals left for higher paying positions or more flexible working conditions. Most administrators try to circumvent the inevitable strain from what one director described as the "tremendous pressure. . . the few rewards. . . the kids' rage and vengeance" by making sure that employees get and take their vacations and personal days, and by carefully monitoring or even restricting overtime.

While specific administrative interventions are frequently used solutions to alleviating the cumulative effects of specific stresses, programs also need to create and incorporate mechanisms for other kinds of staff support and professional growth. Beyond the mutual support and understanding of one's colleagues and co-workers, there must also be organized opportunities to enhance staff members' self-esteem and competence in their roles as helping professionals. In most therapeutic settings this takes the form of supervision, in-service training and staff development programs. Here again, there was wide variation in the opportunities made available for this significant aspect of residential treatment.

Although there was genuine recognition of the importance of meeting staff needs through education and training, only one of the programs (Illinois) had what appeared to be a highly developed training curriculum. The others regretted the limited or non-existent avenues for further staff development, but reported that this unhappy state of affairs is generally due to a shortage of time as well as funds. For instance, the clinical director of the Medfield Regional Adolescent Program told us that getting the entire staff together in one place at one time is an insurmountable scheduling problem because, after all, "somebody has to watch the kids!" In Minnesota, however, efforts to draw consultants to the program are seriously hampered by quite another logistical problem--the program's distance from the state's center of professional activity. California reported that the program's professional staff sometimes take advantage of the seminars offered by a nearby state hospital; opportunities to attend training institutes elsewhere arise on a rather occasional basis. As for Pennsylvania, we were given to understand that no organized schedule of training outside of the unit had yet been developed; at the time of our visit the unit was functioning "independently."

Programming for basic orientation to the unit was regarded as separate from continuing education or in-service training opportunities. It was also distinct from the mandatory general orientation that all state hospital employees undergo when they are hired. More often than not, formal introduction to the unit emerged as another less organized program component. The two newer programs, Pennsylvania and Minnesota, were fortunate

(and foresighted) enough to build staff lead time into their program designs. As a result, the staffs were able to meet, work together and coalesce before any residents arrived. The Minnesota unit began recruiting and training staff (through an exchange agreement with the regular Adolescent Unit) four months before the unit was technically scheduled to admit youngsters. In addition, the program director had formulated an "introductory course" to the unit's three main treatment modalities (milieu, behavior modification and reality therapy) which was used in the month long interval prior to the unit's official opening. As the program has taken hold, however, most structured orientation has tended to wane. Aside from a general orientation that is required of all hospital employees and not related to the protective unit in particular, most incoming staff are initiated by shadowing staff members and using them as role models.

In Pennsylvania, an unusual reversal characterized the hiring of staff, in that the director was the last person to join the team. All of the other staff members had been interviewed and signed on by the hospital nursing department which oversees personnel. Thus, the entire staff, some new to the hospital and some furloughed from other departments, was in place before a director was found. Despite this somewhat unorthodox situation, which was the result of a series of random and unavoidable circumstances, the director was ultimately able to exercise some influence on the final composition of the staff. The team then had a good amount of lead time to organize themselves and collectively formulate the more specific components of the treatment program. The hospital's nursing education department offers a unique four-module training program which appeared longer and more extensive than the hospital orientation provided in Illinois, Minnesota or Massachusetts. During the last ten weeks of training, new staff members spend half the day in classes and the other half working on the unit. The staff we spoke with believed that this last segment of the training program was good preparation for eventual assumption of program responsibilities.

At the Illinois program new staff members are given a mandatory hospital orientation which consists of acquainting employees with issues such as patients' rights, Department of Mental Health regulations, medical record keeping protocols, safety and first aid information. The program has developed an employee handbook which defines staff responsibilities and expectations, and has instituted a system of ongoing documentation of job performance. In addition, youth counselors attend a short course at the Department of Corrections training academy in the state capitol. Non-credentialed new workers are considered trainees for the first six months of employment; during this period, much time is spent in exposing the line staff to the subleties of and relationship between diagnosis and treatment. The program's clinical director observed that many of the youth counselors approach these clinical tools and interventions with trepidation. Thus, a concerted effort is made to dispel the mystery and foreigness that surround them. Probationary status terminates when the worker successfully meets administrative guidelines of conduct and competence on the job.

Aside from a brief overall orientation to the facility, neither Massachusetts nor California had any formal mechanism for training new staff members. The director of the California Intensive Treatment Unit explained that most training takes place in team meetings or "through the ladder." When we asked the director of the Massachusetts Solomon Carter Fuller RAP what training for new employees consisted of, he replied with unhesitating candor: "Watch out and go to work." His response was a disarming and cryptic expression of a dilemma which all treatment programs grapple with, namely, the problem of untrained and inexperienced staff whose introduction to the program is a

hasty but sincere injunction. Although many administrators and seasoned clinicians know that there is no teacher like experience, the invaluable process of learning while doing is likely to be less anxiety-provoking or arduous if it is supported and supplemented by substantive didactic teaching.

While organized orientation and training was sometimes weak or absent, all of the programs did have supervisory processes which may, in part, supplant a more formal learning experience. Group supervision was a commonly used approach. The Minnesota treatment team meets weekly to discuss clinical and management issues; the Illinois unit uses a case study model in its twice weekly team meetings. Neither program offers any formal individual supervision, in contrast to the Medfield Regional Adolescent program where every clinician meets in scheduled supervisory sessions with the clinical director. In California, senior youth counselors supervise their less experienced co-workers and the head of each treatment team supervises them both individually and as a group. In Pennsylvania, responsibility for group and individual supervision seemed shared by the director and the program's full-time psychiatrist. Several of the programs had psychiatric consultants on a regular part-time basis; others had less frequent access to this form of professional exchange. In addition to conducting on-going case reviews with the clinical staff, consultants were often called upon in emergencies or to discuss particularly difficult treatment and management issues.

With the exception of Massachusetts, which uses private vendors to staff the Regional Adolescent Programs, all of the units must recruit their employees through the state civil service system. This can be a serious constraint for programs located in relatively isolated state institutions, particularly since these facilities tend to be a principle source of employment for surrounding small communities. Three of the five programs (Illinois, Pennsylvania and California) are near enough to major cities (Chicago, Philadelphia and Los Angeles) to attract more qualified staff. The Minnesota program, on the other hand, is quite far from the Minneapolis-St. Paul area and did not hide the fact that the potential pool of job applicants is somewhat static. Interestingly, the Pennsylvania program director told us that most of the clinical staff was drawn from the nearby metropolitan area, while the direct care staff tended to come from the local town. Besides the dilemmas of limited selection inherent in civil service systems, program administrators must also comply with the union policies and practices that govern and protect state employees. Thus, not only is hiring and firing affected by civil service, but shift scheduling as well.

Civil service lists and proximity to communities without large teaching centers or universities are not the only recruitment obstacles that these programs face. Low pay scales were the most frequently mentioned hindrance to acquiring well trained and experienced staff. In fact, every single program we visited was convinced that non-competitive salaries are a primary barrier to assembling a multi-disciplined and practiced staff. We gathered that this is especially true when it comes to hiring full-time psychiatrists. Several administrators mentioned that state hospitals are predominantly staffed by foreign medical graduates with little or no psychiatric training who are further hampered by a lack of fluency in English. Two of the programs were notable exceptions: Pennsylvania's full-time psychiatrist and California's part-time psychiatrist were both impressively credentialed, dedicated and sensitive clinicians which any program might envy. Another program had a seasoned and respected psychiatric consultant who conducted weekly clinical seminars. Although programs had access to psychiatric back-up (most usually for medication) most of these professionals

were a less integral part of the staff than several of the directors might have wished. Administrators cite the well known economic rule of thumb that many psychiatrists are not at all interested in committing themselves to low paying state hospital positions when they can do better on their own or in the private sector.

Another significant factor in attracting a diverse staff is the kind of practice experience offered by a particular setting. Despite low salaries and limited opportunities for training, consultation and supervision, Minnesota appears to attract young workers who are drawn by the promise of intensive on-line experience. For newcomers, this may be as important a preparation as any sophisticated training institute could provide. The staff at the Minnesota program is small and terribly invested in the unit, but they must frequently realign and absorb new workers when an inexperienced employee becomes more marketable as a result of his or her experience there. The bind this program is in is painfully clear: they must risk a certain continuity of care in order to keep the unit staffed with enthusiastic, hard working and committed workers.

Incentives for working in these programs may take many forms. To the minimally experienced worker it can mean a chance to be immersed in the daily drama and routine of a highly structured workplace. To an aspiring and talented young professional it may increase the likelihood of working with and learning from a highly trained and seasoned clinician who becomes a mentor. Individual motives for working in programs where the training opportunities and private rewards may be few and far between clearly very and depend on a myriad of factors. Furthermore, it may be that programs such as these are neither equipped nor obligated to be the staff's major source of professional information and knowledge. Although what constitutes an "average expectable (work) environment" is not so easily defined, it is clear that workers' expectations and program limitations are not always in harmony. We are not advocating a laissez-faire relinquishing of responsibility or an administrative stance of benign neglect. Rather, we are raising the issue of how answerable programs must be to individual and collective staff needs. At bottom, this may be as much an attitudinal issue as a practical one, for an administrator's active encouragement of staff's independent interests and skill development is not totally dependent on real budgetary constraints. The great contrast between the private sector where bigger budgets allow for tuition reimbursement, regular consultation, institutes, seminars and workshops, and publicly funded programs where the reverse often prevails, is no longer new or shocking. Reiterating it does, however, put into perspective the frustrating framework within which state programs must provide services. All things considered, it is our impression that the staffs at these five particular programs maintain themselves respectably under adverse conditions and with the very barest essentials.

As for the programs, they are eager to recruit from a broad range of disciplines, but they do have concrete ideas on the kind of distinguishing characteristics they value in prospective staff. All of the programs mentioned inclination and a conscious wish to become involved with deeply disturbed youngsters. Warmth, relatedness, composure and maturity were seen as essential for all program positions; educational level and experience in similar settings were also weighed in terms of their relevance to the job in question. The Minnesota program director added that the "ability to think fast under pressure without overreacting" was as important as "the ability to function on a team." The clinical director of the Illinois unit cited several attitudinal and intellectual qualities that are sought in new employees. For instance, when hiring child care workers he solicits an applicant's child-rearing philosophy and, if they are parents, what their own experience has been. In addition, an interviewee might

be asked to conceptualize adolescence or to express personal opinions on juvenile offender rehabilitation. In clinical staff, experience or background in multi-cultural environments was considered valuable, as were education and past employment. Not incidentally, in exploring sought after staff attributes, two program directors spoke with amused frankness about the not to be overlooked asset of physical dexterity and size. Finally, all of the programs supported equal opportunity employment but stressed that skilled minority counselors and clinicians were notably hard to find. Several administrators try, whenever possible, to balance their staffs both racially and sexually, but the data reveal that in every program there are at least twice as many males as females, and many more white than minority workers.

Examination of actual staff composition in each of the five programs yielded several intriguing findings along the dimensions of age, education, training and experience, and average length of time employed at the program.* Staff size ranged from 21 in Minnesota to 40 in Illinois; Massachusetts, Pennsylvania and California had 39, 30, and 35 employees respectively at the time these figures were collected. The average age of staff in all five programs (based on program supplied information which frequently conspiciously omitted the age of females employees) was 33.9 years. Both the youngest (21) and the oldest (63) employees were found in the support services area of the Illinois program. All of the units had staffs that were separated in age by as much as 24 to 38 years.

Only Pennsylvania and Illinois employed staffs on an entirely full-time basis. With the exception of the Medfield Regional Adolescent Program, which had 29 full-time and 10 part-time employees, the other two programs were almost completely staffed by full-time workers (out of 21 positions in Minnesota, 19 were full-time; in California only one of 35 staff members was part-time). Massachusetts and Minnesota had the highest overall staff to resident ratio, followed by Illinois, Pennsylvania and California. Interestingly, Massachusetts and Minnesota appeared to be the most "open" of the secure settings, while Pennsylvania and California, with the lowest overall proportion of staff to youngsters, were the most imposingly physically secure.

Other than the Illinois and California programs, which have been operating since 1970 and 1973 respectively, these intensive treatment programs have sprung up in just the last five years. Thus, for the two newest programs (Minnesota and Pennsylvania), figures on a worker's average length of employment are not very respresentative. This is particularly true in view of the sudden administrative change at one program and the inevitable first-year wrinkles at the other. At the three programs where this factor could be roughly assessed, it was found that, on the average, workers in all aspects of the program stayed for 3.2 years.

Experience prior to working in any capacity at the program ranged from absolutely none to 36 years. A combined average for all the programs indicated that employees came to work with 4.7 years of previous experience. This figure can, of course, be misleading if not irrelevant, since no attempt was made to distinguish among the many disciplines and responsibilities which formed a whole program. For instance,

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*We wish to emphasize that all data gathered on staff were based on questions which included the entire range of employee function and job description. That is, we did not compute any of the variables to be mentioned according to job classifications such as clinical services, direct care, clerical and housekeeping, but rather as averages, or parts of a whole. The reader is warned not to over-read these findings which are presented primarily for the purpose of general interest and information.

the youth worker who was completing his doctorate had had more educational and practical experience than is usually found in that particular job classification, yet our crude arithmetic would clearly not reflect this. Likewise, the program director at the time of our site visit to Pennsylvania was an extremely seasoned clinician whose 35 years of experience far outweighed and therefore skewed the average prior experience of his relatively young staff.

In the four programs which had organizational structures consisting of a program administrator and a clinical director, the administrators tended, not surprigingly, to be older. Average age for administrators was 51.8 years, while age range was from 44 to 60. Four of the five clinical directors were considerably younger; for them, average age was 36.2 years and ages ranged from 32 to 43. The fifth clinical director's age was not available.

Of the administrators, one had a masters in social work and 14 years of experience, two had masters degrees in counseling (information on one's prior experience was not available; the other administrator had had 12 years' experience in working with disturbed delinquents), another had a Ph.D in psychology and 35 years of experience. The fifth administrator, who was also the program's clinical director, had a masters in psychology and seven years of previous experience in adolescent residential treatment. Two of the five clinical directors were psychiatrists; one was a thoroughly seasoned clinician who also had a masters in social work and the other was a younger man with eight years of experience who had trained at one of the country's leading child guidance clinics. Of the other two clinical directors, one had a masters degree in social work and five years in the field; the other held a doctorate in psychology and had six years of experience prior to his four years at the program. A sixth clinical director, whom we interviewed but briefly (in Massachusetts) also had a doctoral degree in psychology. The two newer programs aside, both sets of professionals - administrators and clinical directors - had been with their programs from two to four years.

Individuals with college and graduate degrees were more prevalent than those without, although each program did have a sizable number of non-credentialed workers. Four of the programs had nursing staff with associate, bachelor's and/or masters degrees. Most of the bachelor's level workers had earned degrees in psychology; many more were in social work and related helping disciplines such as child development, education, art therapy, sociology, criminal justice and health administration. There was also the usual representation of liberal arts degrees, including a Ph.D. in religion and an M.A. in English. Workers without degrees of any kind generally comprised the maintenance and clerical staff, though some were also youth workers who may or may not have had experience in similar settings.

The administrators, clinicians, teachers and line workers at these five intensive treatment units were a varied and multi-talented mixture of background, training and experience. Indeed, their skills are the nuts and bolts and their commitment the very heart of such programs. Without reservation we can say that in each program we encountered a level of professional conduct and concern that was both heartening and commendable.

DISCHARGE PLANNING AND AFTER-CARE SERVICES

Of the range of services and diversity of staff offered by these five programs, discharge and after-care planning appeared to be the most lacking in organization and substance.

All of the programs felt that the extent and quality of this programmatic component were decidely weaker and less developed than they could and should be. After many months of intensive and consistent intervention in areas such as psychological development, academic achievement and social adaptation, it is both ironic and unfortunate that post-treatment placements and opportunities are so scarce and inadequate. How a youth leaves a program and what he takes with him is surely as crucial as the treatment received during his or her stay in the program. Sadly, the valuable experience that intensive residential treatment affords can rarely be replicated after discharge. For some of these youngsters, the intensive treatment setting may have provided the only calm and structure they have ever known; to be released without definitive plans or options becomes the most threatening prospect of all. In many instances, the gains made in treatment are undermined and lessened by the absence of resources to support and reinforce them once a youth has left the program. Although this in no way renders the therapeutic work meaningless, it does raise critical questions about the program's emphases and limitations, the effectiveness of long-term residential treatment and the delegating of responsibility for continued care. These three areas touch on issues of theoretical orientation and program goals, outcome evaluation, and administrative policy. Though seemingly discrete, they converge forcefully during the final and some would say, most important, stage of treatment. Even when handled well, leaving a residential setting is a complicated and many sided process. It is not only a reworking of all that has gone before, it is a very particular form of separation and self-assertion. Most youngsters enter these programs with very few internal or environmental resources of their own; during their stay they are the focus of all manner of sophisticated treatment plans and strategies. Leaving the program often means having to sustain what was learned and integrated without benefit of a supporting social network. Proper discharge planning is therefore inestimably important to this special population since their vulnerability to certain stresses may be reactivated in very short order. Because the most recently achieved level of personality development is often the first to fragment under stress, it is imperative that youngsters be released from these programs with as much concrete back-up as can be mustered.

Ideally, discharge planning needs to begin on the day a youth enters the program. Readying a youngster for eventual separation is achieved through a combination of interventions aimed at different levels of functioning and developmental ability. Although every program recognized the importance of concrete planning for job and/or educational placement as well as living arrangements, they are frequently stymied in one of two ways. Programs may "lose" youngsters prematurely through satutory or administrative complexities. For instance, under the California Youth Authority system, a youth's stay in the Intensive Treatment Program is concurrent with and dependent on the length of sentence imposed at adjudication. Thus, it is not uncommon for a youth to face discharge before he is ready. In such cases, which also occur in other states, the technical and legal aspects of release are sometimes in clear conflict with clinical issues. Another no less serious obstacle to discharge planning is the difficulty programs may encounter in locating appropriate channels of community linkage for youngsters whose release is anticipated.

California's Intensive Treatment Program had what was by far the most ambitious and well constructed discharge plan of any of the programs visited. Known as "transition," it is essentially a pre-release manuever which is initiated by the primary therapist prior to parole; transition precedes release on parole by the Youth Authority Parole Board by 30 to 90 days. Youths earn their way to transition through the point system, achievement of treatment goals, evaluation of clinical and educational progress, and treatment team approval. There are, however, specific criteria governing referral

to transition. Only youths who are 18 and over are eligible for consideration, although exceptions are made for those 16 and older who have valid student work permits. Evidence of emotional stability must be shown as well as approval for day passes and furloughs for school or work. When the primary therapist believes a youth is ready for transition, the transitional coordinator is notified in writing and a staffing is scheduled. This meeting is attended by the ward, the transitional coordinator and two youth counselors. They familiarize themselves with the youth's situation and begin building a relationship within which strengths can be capitalized and weaknesses shored up in the service of transition goals. In some cases, the transition staff may decide against admitting a youth to this latter stage of the program. In other instances, such as those in which a youth is nearing the end of a determinate disposition, they have no choice but to begin planning for release. Youths in this category are frequently put in a variation of formal transition called "transitional services." Although their work and school placements may be similar to the youths in full transition, they usually have fewer privileges than those in "across the board" transition. If a youth meets the requirements of transition and the Board approves the referral for parole, a set of practical goals is developed and a series of graduated privileges are instituted. For example, youths may attend public schools at this point and are allowed passes of increasing length and decreased supervision. Staff members will transport the youth to school or work or initially accompany him on home visits until an acceptable degree of autonomy can be demonstrated. Youths on full transition are also allowed a weekly movie in the community with staff in attendance. Transition is really the reverse of the day hospital concept since wards spend their days in the community but return to the unit to live until total dependence from the institution is gained. On the average, there are seven youths in some form of transition at a time.

One social worker and two youth counselors comprise the transition team. With the assistance of the parole agent, they coordinate all the various aspects of transition. Working closely with parole; the transition team insures that a youth leaves the program with a job, school placement or training opportunity, a place to live and, if indicated, a referral for out-patient counseling. They arrange for necessities such as drivers licenses and social security registration; they recruit employers and help youths explore further educational possibilities such as colleage enrollment.

Therapy is officially over when transition begins. Although primary therapists are active in the process leading up to transition, they are less involved in the formal aspects of this final stage. In a very real sense, the transition team replaces the treatment team; the transitional coordinator monitors and re-evaluates the youth's progress in much the manner as the primary therapist once did. The major difference is in the nature of the task and the content of the service plan. The one other key player in the transition process is the youth's future parole agent, who is expected to assume continuing responsibility for the ward once he is released from the Intensive Treatment Program. Although the transition team does most of the leg work and community contact necessary for placements, the final handling of a ward's immediate future rests with the parole agent. For example, a youth may leave the program with a recommendation for some form of counseling, but only the Parole Board has the authority to order this by making it a condition of parole. According to the transitional coordinator, transition is as much a service to parole as it is to the wards; if the program did not provide discharge planning, the responsibility would eventually fall to the parole agent. From all accounts, the relationship between the Intensive Treatment Program and the Youth Authority Parole Board appears to be cordial and cooperative. The program goes to great lengths to develop plans that parole will approve; when problems arise, such as the program recommending a resource which parole's budget cannot absorb, the transitional coordinator and the parole agent work together to locate a mutually acceptable alternative.

Since all the youths in the California program are wards committed to the Youth Authority, they are subject to only one system's administrative structure. This is not the case in Massachusetts where transfer to after-care status and discharge planning are governed by one of three separate systems and their respective statutory guidelines. Program rules and regulations stipulate that a resident be transferred to after-care when the level of secure treatment provided by Regional Adolescent Programs is no longer warranted. After-care plans are part of the discharge process and entail collaboration between a specifically appointed program worker and the system that initially referred the youth to the program. Although regulations call for three months' lead time prior to transfer to after-care status, more often than not, the process does not begin much more than two months before the anticipated date of transfer. It is important to emphasize that Massachusetts has drawn a notable distinction between after-care and discharge. Technically, youths are maintained and monitored an after-care status for at least one but not more than three years. According to the programs' regulations, "discharge shall take place one year after the participant attains independent living status or after three years, whichever comes first." The after-care component includes a specific service plan for living arrangements, designation of the mental health, educational, social, employment and recreational services required, and details of negotiations with the vendors who agree to provide these services. It also includes a schedule of contacts with the program (if any) and the case manager, a review and assessment plan, the name of the individual responsible for coordinating service provision and a statement of acceptance and intent to comply signed by the youth. Massachusetts Regional Adolescent Programs are required to have a full time social worker whose sole responsibility is after-care monitoring. Contact is maintained with the youth's case manager for the first year in an effort to insure a smooth transition from the program to the community. Although the proposed model for after-care states that "the program clinical director or his/her designee shall continue to provide clinical services to the client for the first year after discharge," actual provision of clinical services may be more likely to come through other channels. Indeed, it is difficult to know whether all the conditions enumerated in the discharge planning model are met or how closely the specifics of the after-care contract are followed. It is a thorough and ambitious concept whose ideal formulation may not match practical reality.

The Minnesota unit reported that discharge planning takes as long as three months to accomplish. It should be remembered that this program seeks to ready a youngster for transfer to its regular Adolescent Unit or another residential but less secure and intensive setting. Because the unit does not have to arrange for independent living or employment, the tasks that usually characterize discharge planning are much less complex and demanding. This is not to say that locating another residential facility is always easy, but that the Minnesota program faces comparatively fewer obstacles as well as options in this phase than the other treatment units. The original discharge design anticipated that in the latter part of his stay in the Protective Component Unit a youth would spend most of his time within the adjacent Adolescent Unit. Successful functioning in a larger environment was seen as a valid measure of preparedness to make the transition to a less secure setting. In certain ways, this set up provides both insurance and an alternative all in one. That is, should the youth need more time in a more closely supervised setting, he can remain in the Protective Component Unit; if he is able to function with fewer external controls the logical setting is at hand. This plan serves two purposes: it not only allows for a "half-way" approach between two supportive and proximate environments but also provides a "dry run" for transfer to another facility entirely. If a youth is leaving the unit for a residential setting, the program works with the referring agency's caseworker to find a suitable resource.

During its first year the unit discharged three youngsters; two are reportedly doing well in traditional residential facilities. The third, whose adjustment to the program was tenuous and fraught with difficulty, apparently did not fare as well; he was discharged to a secure correctional institution where specialized out-patient treatment was initiated.

In Illinois, a tentative after-care plan is included in the original treatment plan. While subject to re-evaluation and revision, it serves as a proposed guideline for movement through the program. The Admissions and Discharge Committee reviews the treatment team's after-care recommendations and has final decision-making authority in approving discharge. The role that this Committee plays in discharge planning is no less crucial than the one assumed by the system that initially referred the youth to the program. Primary responsibility for after-care falls to caseworkers from the Departments of Corrections, Mental Health, and/or Children and Family Services. Thus, community linkage with schools, vocational training and out-patient counseling resources are engineered not by program staff but by the system to which the youth is returned.

The Pennsylvania program's original design for discharge also called for immediate long-range planning. That is, the Base Service Unit (the mental health facility or referral source in a youth's catchment area) is kept informed and involved from the day of a youth's admission and is expected to cooperate with the court and the program in developing an appropriate discharge plan. In all instances, the court makes a judgment on the suitability of whatever plan has been formulated by the program's representative and the Base Service Unit Staff. When the program began, it was anticipated that most youths would return to their families or be placed in group homes.

Although there are youths who leave these five intensive treatment programs remarkably strengthened and stabilized, with jobs, school plans and living arrangements, there are many others whose ultimate adjustment may be more marginal and less socially integrated. We gathered that this was characteristic of most of the youths discharged from any of the programs. A very few did extraordinary well, while some made reasonably successful adjustments to community life and responsibilties. Many, however, required either continued care in group and foster homes and out-patient counseling or intermittent institutionalization.

Two distinct patterns of discharge planning appear to characterize the programs' approaches to this important stage of long-term residential treatment. One model suggests that most, if not all, after-care arrangements are made by program staff; in other cases, such planning is a more or less collaborative effort between the program and the referring system. In the latter instance, programs have less responsibility than they do in the former, but in both instances, plans are subject to review and approval by an outside agent. The difficulty that these programs seem to experience in developing strong after-care components may stem from a fundamental confusion about precisely where the responsibility for after-care lies. Is it a service which programs can or should provide? Or is it the legitimate province of the larger state social agencies involved? Surely the point can be argued either way. All of the programs are committed to the treatment and well-being of these youngsters while they are in residence; they also believe in the principle of continuity of care. They are, however, neither staffed nor funded to provide a level of after-care commensurate with the amount of intensive treatment necessary for eventual discharge. On the other hand, the state systems which shepherd youngsters into these programs are usually no better equipped or more resourceful upon a youth's release than they were at the time of referral. For them, the programs may provide a strange sort of temporary respite from

a hard-to-place, troublesome population. Nevertheless, they are inescapably faced with securing other and different services for these children once they are ready to re-enter the community. When further residential treatment or school placement are not indicated, employment and independent living may be. Settling a youth in both or either of these areas may actually result in an instant replay of previous frustration for the caseworker as well as the youth. As "stabilized," "cured," "rehabilitated" or "resocialized" as they may be when discharged from intensive treatment programs, these youths are yet to confront what for many will be the most difficult crisis of all: limited and circumscribed opportunities. The need to develop community resources remains constant; whether this task falls to the program staff or the referring system is the enduring issue in question.

Chapter VI

DISCUSSION

There is little question that severely disturbed juvenile offenders represent one of the most challenging and troubling groups of youths who encounter the juvenile justice system. The severity of their disturbance and dangerousness has led many professionals to keep these youths at arm's distance. We are not quite sure how to feel about these youths and, consequently, how to handle them. They tend to evoke both our sympathy and our ire, given the dual nature of their problems. As a result of the confusion and ambivalence, severely disturbed juvenile offenders have frequently suffered the worst of both the juvenile justice and the mental health worlds. As we observed earlier, juvenile justice professionals have tended to be uneasy about working with youths who manifest clear symptoms of emotional disturbance; mental health professionals have resisted assuming responsibility for disturbed youths who are considered dangerous. The sad consequence is that the severely disturbed juvenile offender has frequently fallen between the proverbial crack.

Our survey of programs around the country has demonstrated to us that sophisticated, secure, and humane programs can be designed for these youths. A handful now exist. These programs are not without their problems; however, they serve as evidence that it is possible to develop alternatives for disturbed youths who would otherwise languish in conventional correctional facilities or adult facilities for the criminally insane.

Every state in the nation has its share of severely disturbed juvenile offenders. Several have made deliberate attempts to develop programs specifically for this population. Many, however, have not. We have come to firmly believe that every state needs to identify those juvenile offenders who are severely disturbed and provide decent care for them. In many states this will require a conscientious effort to locate disturbed youths who are currently being held in traditional correctional facilities and a sincere attempt to develop programs for them. Our intent here has been to acquaint readers with existing programs so that lessons about what may and may not be possible can be learned.

We have noted a number of features of existing programs which we believe require thoughtful attention, including program auspices, physical setting, referral and admission procedures, treatment goals and techniques, staffing patterns, and after-care. Our experience suggests that, in addition to these important aspects of programs designed for severely disturbed juvenile offenders, there is a series of issues which demand attention by those who are in a position to pursue the development of programs for these youths.

SERVING THE APPROPRIATE POPULATION

We have learned from our review of programs that it is important to pay close attention to the characteristics of the youths admitted and served. This so for several reasons. First, these programs tend to be used as a last resort for youths who cannot be handled satisfactorily in conventional corrections and mental health facilities. The activities of the youths in these programs are monitored very closely. It is

important to avoid admitting youths to these programs who do not require such intense supervision. There is an important distinction between admitting a youth to a program because it appears that he or she might benefit from the treatment and services available, and admitting a youth to such a program primarily because he or she is too difficult to handle elsewhere.

A second reason why it is important to pay close attention to the characteristics of youths served is related directly to the clinical or treatment goals of these programs. Program staff told us repeatedly that their goals and methods were designed primarily for youths who manifested psychotic symptomatology, and that problems can arise when youths diagnosed as character disordered or psychopathic are mistakenly admitted. Several staff emphasized that one psychopathic youth can seriously disrupt a program.

Third, the programs we visited were expensive to operate, costing on the average nearly twice the amount per youth per year required to care for youths in conventional correctional facilities.* These programs are among the most expensive social service programs supported by public funds. Attempting to prevent inappropriate admissions is thus important in order to avoid the unnecessary expenditure of public funds.

Finally, it is important to avoid inappropriate admissions in order to enhance the likelihood that a bed will be available for a youth who genuinely needs the services offered by such programs. This may seem to be an obvious point; it is one, however, worth emphasizing. Youths who are admitted inappropriately to a program with a limited number of beds may be occupying staff time and resources which could be better spent on other youths whose characteristics and problems are closer to those which the program was originally intended to address.

Youths can be admitted inappropriately to a program for a variety of reasons. In one state, a program was operating at 50% capacity during the first several months of operation. Considerable pressure was brought to bear on program staff by state officials to increase the number of admissions, in part to justify the large expenditure of funds required to support the program. There was even some pressure placed on the staff to admit serious juvenile offenders who were not considered seriously disturbed because of the shortage of beds elsewhere in the juvenile corrections system for these youths. Staff of this program strongly opposed accepting these youths because of the disruption they believed these youths would inject into their treatment approach and into the day-to-day functioning of the program. The program was housed in a facility which was perhaps larger than needed. The fact that staff were pressured to accept inappropriate youths may therefore have resulted primarily from what might be referred to as an "accident of architecture." The pressure to accept inappropriate youths might have been avoided if an attempt had been made to carefully assess the number of beds actually needed and to locate a facility more in line with actual need. It is of course possible that the number of beds available in this program was not excessive, and that, because of problem with referral procedures, youths who met the program's admission criteria were simply not being referred. Some public administrators in this particular state are apparently of the opinion that the unit's referral and admissions problems

*Precise figures on the cost per youth per year were not available for most of the programs. Several programs do not, in fact, have budgets separate from the budgets of the institutions of which they are technically a part. Estimates by several directors of average cost per youth per year were all near $40,000.

are more managerial than spatial. They have recently instituted a Case Review Panel composed of administrators, liaisons and clinicians who will examine admission records on a regular basis to ensure that the designated population is indeed being served by the program. It is quite possible, however, that the facility was simply larger than needed for the number of youths who actually meet admission criteria, and that this accounts for most of the pressure placed on program staff.

Inappropriate admissions can also result if strict intake criteria are not established or adhered to. The programs we visited varied considerably in the extent to which they relied on detailed, rigorous intake criteria. It happens, perhaps not coincidentally, that the program with the least detailed intake criteria was also the program which was under the greatest pressure from state officials to accept youths who were not considered severely disturbed.

The extent to which decisions to admit a youth to a program are monitored can also affect the likelihood of inappropriate admissions. For example, in several states youths are transferred into programs for severely disturbed juvenile offenders following only an administrative decision; for example, a youth who has been committed to the department of corrections might be transferred to a program for severely disturbed youths with only an administrative review of the transfer by program staff. Informal administrative reviews may not adequately prevent the problem of inappropriate admissions. Formal administrative reviews, where a committee comprised of representatives from the program, the department of corrections, the department of mental health, and any other relevant agency systematically reviews recommendations of transfer and admission, are far more preferable. We believe that judicial review of administrative decisions may provide the best safeguard against inappropriate admissions and violations of due process. At present, however, at least one-third of the states require only an informal administrative review of decisions to provide intensive mental health services to adjudicated delinquents (Turney, 1980).

DISCHARGE DECISIONS AND PLANS FOR AFTERCARE

As we indicated earlier, there was considerable variation in the average lengths of stay for youths in the programs we visited, ranging from six to twenty-four months. The variation in average length of stay may have been due in part to variation in the characteristics of youths served by the programs. Programs which admitted more "difficult" youths may have needed to retain them longer. However, this factor alone cannot account for all, or perhaps even most, of this variation. Several programs which had relatively short average lengths of stay accepted youths whose offense histories and emotional disturbance appeared to be at least as serious as those of youths in programs with longer average lengths of stay. It is possible that the average length of stay was influenced in large part by the level of funds available to support the programs, the demands placed upon the program for new admissions, and the beliefs program staff had about various psychotherapeutic approaches and the amount of time needed to help their residents. For example, we were told by one program director that ideally youths would remain in his program for at least 24 months, a period of time much longer than the amount of time many of these youths would spend in a correctional facility. It would be a mistake to conclude that it would necessarily be undesirable for youths to spend long periods of time in these programs. However, it is at least possible that without careful safeguards youths would spend unnecessarily long periods of time in confinement

The extent of the variation in the average lengths of stay among the programs suggests the importance of having a mechanism for regularly reviewing the status of each youth

who is admitted. It is possible that without adequate safeguards, youths who are admitted to programs for severely disturbed juvenile offenders will be confined for longer periods of time than they would have spent in a correctional institution. This is not, in fact, an uncommon occurrence.* It is therefore important that programs provide regular and systematic reviews of each youth's progress. In most programs this will occur as a matter of routine. It is important that such review occur with regularity in all of them.

Most of the youths served by programs for emotionally disturbed offenders will eventually be released to the community. Many will require regular or intermittent care in group home settings, and some will again be placed in an institution; most, however, will spend at least some time free in the community. It is therefore essential that programs pay particular attention to discharge and aftercare plans. We learned during our visits that it can be very difficult for program staff to develop an adequate aftercare plan. Funds available for services following release tend to be either in short supply or nonexistent, frequently making it difficult to formulate comprehensive plans for juveniles about to be released. Many staff complained that the lack of an adequate aftercare plan can seriously dilute the effects of the treatment the youths receive in the programs. It is thus important that considerable attention be paid to the development of sound aftercare plans. There are no simple formulae for designing and implementing effective aftercare plans. Their quality and very presence will depend upon the availability of social service funds, the quality of relationships among local agencies, and so on. What we can say, however, is that aftercare is important and should not be neglected.

ADMINISTRATIVE AUSPICES

The programs we visited were administered under a variety of organizational auspices. Several were operated by departments of mental health. These programs accepted referrals from various sources, including the juvenile court, probate court, state department of corrections, state department of social services, and other units of state departments of mental health. One program was administered exclusively by the state department of corrections and accepted only wards of that department. Another program was administered by a department of mental health, although admission and discharge decisions were made by a committee comprised of representatives of the state department of corrections, department of social services, and department of mental health.

There appear to be both advantages and disadvantages to these various organizational arrangements. In a world with unlimited funds and resources, it would perhaps be preferable for departments of mental health to design programs specifically for disturbed youths who are considered aggressive or dangerous and for departments of corrections to design programs for delinquents who are considered emotionally disturbed. Ideally, youths would be placed in the custody of the department which seemed best suited to respond to their particular needs. In many states, however, it may not be possible to support more than one program for seriously disturbed juvenile offenders. These programs are expensive to operate and there are relatively few youths who need them. As a result, many states may need to design programs which would accept youths

*For further discussion, see Turney (1980).

simultaneously from juvenile or probate courts, departments of corrections, departments of mental health, and, in some states, the department of social services. In such cases it would be important for staff to be sensitive to differences in the needs which youths from these various sources may have. Our impression is that the characteristics of youths referred by these various sources are sometimes very similar; which agency processes a youth initially is often an accident of bureaucratic decision-making rather than the result of rational referral procedures. This is not, however, always the case. Frequently there are meaningful differences among the characteristics of youths referred by different agencies. It is important that program staff do their best to respond to these differences.

In some states a program may be administered by a single agency. In others, a program may be operated collaboratively by several agencies; even in these programs, however, ultimate administrative authority would probably rest with one agency. Most of the programs we surveyed placed final administrative authority with a department of mental health; only one program was administered by a department of corrections. It is not possible for us to recommend which department should have ultimate administrative authority. We were impressed with the quality and commitment of staff in all of the programs we visited. The quality of life for the youths in the program operated by a department of corrections seemed quite comparable to the quality of life for youths in programs operated by departments of mental health. The degree of security and the extent of restrictions placed on the youths were generally similar among the programs, although there was some variation. An important point to make is that a program operated by a department of corrections is not necessarily more institutional and restrictive than one operated by a department of mental health. In fact, the program operated by a department of corrections was considerably less institutional and confining than several of the programs administered by departments of mental health.

It may be, however, that in states where only one program for aggressive and emotionally disturbed youths will be operated, it will be preferable to place administrative authority with the department of mental health. The reasoning behind this statement lies in our observation that in many states departments of mental health are willing to accept referrals from a department of corrections. This is, in fact, a common arrangement. It rarely happens, however, that a youth can be transferred from a department of mental health to a department of corrections, unless following admission he or she has committed an offense and has been adjudicated as a delinquent. Therefore, housing a program under the administrative auspices of a department of mental health may be necessary in order to make it possible for aggressive and disturbed juveniles, whether in the custody of a department of mental health or corrections, to be adequately served.

CIVIL SERVICE VERSUS PURCHASE OF SERVICE

Four of the five programs we visited were administered under public auspices with civil service employees. Most programs for juvenile offenders, disturbed or otherwise, who are considered to need secure custody are operated in this fashion. This was not the case, however, in Massachusetts. In this state there has been a tradition--ever since the former commissioner of the Department of Youth Services, Jerome Miller, closed down the state's juvenile correctional facilities in the early 1970's--of contracting with private service providers to administer programs for serious juvenile offenders. A similar strategy was used when the Regional Adolescent Programs were begun in this state. Although several of the Regional Adolescent Programs are housed in facilities on the grounds of state hospitals, the programs are administered by private service providers.

There has been considerable debate in recent years about the use of private service providers to administer programs for juvenile offenders. Proponents of the use of private providers have made several arguments. First, they have argued that the state and its employees are not well prepared for helping (as opposed to merely confining) juvenile offenders. John Conrad (1977: 47) has commented on this point eloquently:

> [The] state is not well adapted to the helping role. I think that is as it should be. The state should prevent avoidable misery, but it has no business making individuals happy or morally better. Its tools are those of management and order; its procedures are bureaucratic; its agents cannot express the state's love or concern because the state is not an entity capable of love and concern. Impersonality, fairness, and rationality are what we expect from the state. It is not to take risks, and although it may and does experiment, the experiments it conducts are directed at the improvement of state services, which sets a special boundary to the possibilities for improvement.

Second, it has been argued that individuals with the qualities needed to competently serve juvenile offenders who have serious problems tend not to be attracted to civil service careers. Programs for these youths ordinarily revolve around crises, irregular hours, and some degree of informality. These are conditions which contrast sharply with those which characterize many civil service posts and which attract many civil servants, such as relatively rigid rules, duties, and privileges, promotion based on seniority, and so on. Several staff of the programs in Massachusetts told us that it was necessary for the state to contract with private service providers in order to attract the kinds of individuals who had the talent and the commitment to work with troubled youths. Conrad (1977: 47) has again spoken perceptively:

> All of us know in our bones what the problem is. The best of intentions and the highest of motivations will erode with emotional fatigue. It is a rare man or woman who can confront hostility professionally and constructively for the duration of a normal civil service career. Someday, some salty young resident will sling a stereo speaker at the staff member and the response will be inappropriate, not because the counselor is new and unstrained, but rather because he/she is too experienced and burnt out. I suggest that ways have to be found to enlist energetic and well disposed young people to work for a few years only in facilities of this kind. I don't think that such a way can be found in the civil service.

A third problem which has been raised is related to the bureaucratic constraints which frequently characterize public agencies. Generally speaking, it is much less difficult to hire and release a private employee than it is a civil servant. It is not uncommon to hear program directors complain that being restricted to civil service guidelines and procedures affects the quality of staff which they are able to recruit and retain.

It would not be fair to conclude that it is always preferable for a state agency to contract with a private service provider to administer a program for severely disturbed juvenile offenders. Programs administered under private auspices certainly have their own difficulties. A state agency may not have the resources or be in a position to adequately monitor the quality of staff recruited, services provided, and intake and discharge procedures, and the quality of services provided can suffer as a result.

Some programs operated by private vendors conscientiously and respectably take advantage of the autonomy allowed them and administer services of high quality; others, however, have been known to abuse their autonomy, with rather unpleasant consequences. An additional problem which has surfaced in some areas is that a small number of private service providers may, over time, begin to monopolize services in a given geographical locale. This is not necessarily a problem, but a state agency can be placed in a vulnerable position if it has only a small number of private providers competing for its contracts.

Our review of programs suggests to us that the use of private service providers to administer services to emotionally disturbed juvenile offenders has much to commend it if adequate steps are taken to guard against some of the problems which occasionally arise. The programs we visited which were operated under a civil service system were also of high quality and apparently well run. In some areas, however, arranging with private service providers to administer programs can skirt some of the difficulties state agencies have encountered in their attempts to run programs under their own civil service systems.

COMMUNITY INVOLVEMENT

In recent years there have been extensive efforts to remove juvenile offenders from secure correctional institutions and to place them instead in group care facilities located in the community. This trend began in earnest with the passage of the 1974 Juvenile Justice and Delinquency Prevention Act. The primary rationale behind this emphasis on deinstitutionalization has been that confinement in secure facilities can have very damaging effects on youths and that the likelihood that the youths will successfully integrate with the community will increase if they reside in the community and have meaningful contacts with its residents and service providers.

The development of community-based programs for youths who would otherwise be placed in secure correctional institutions is a noble goal. Unfortunately, community-based programs as we know them today are probably not well-suited for severely disturbed juvenile offenders. This is so for two reasons. First, it is hard to deny that many of these youths are dangerous and represent security risks. It is unlikely that the general public would be willing to tolerate a group home for these youths in their vicinity. It is unfortunate but true that the community's fear of these youths is not unfounded. The second reason is related to the goals of community-based programs. One of the principal reasons for placing youths in their own communities is to enable them to maintain contact with their families, schools, and other community residents and facilities. In many states, however, it would be difficult to reach this goal. On the one hand, it is unlikely that severely disturbed juvenile offenders would be permitted to spend time in public schools or with community residents, primarily because of the security risk they represent. On the other hand, given their expense, it is unlikely that most states would be willing to establish the number of programs which would be needed to enable severely disturbed juveniles to be served near or in their own communities. Further, the pattern we have seen thus far suggests that the location of a program will be influenced more by the availability of a physical facility than by its proximity to the communities of the youths referred to it.

To the extent that it is possible, programs for severely disturbed juvenile offenders should be located close to the communities in which the youths who tend to be referred to them live. We know, for example, that many of these youths come from troubled families and that the quality of a youth's future may depend upon the quality of his

relationship with his family. Program staff frequently mentioned to us that in many cases it is very important to work with both the youth and his family, but that because of the physical distance between the program and the family (and at times disinterest on the part of the youth or family members) such work is often difficult to carry out. Programs located in or near the communities of its residents will, of course, not necessarily have better "success rates" than programs which are located a considerable distance away, but the probability may be enhanced.

The location of a program can also affect the quality of staff which a director is able to recruit. Most of the programs we visited were located well outside the nearest urban area. Several program directors complained that the sorts of individuals most qualified to work with severely disturbed juvenile offenders tended to live in cities which were a considerable distance from the program and were therefore reluctant to accept a position which would require a long daily commute. It is probably fair to conclude that most urban areas contain larger numbers of individuals who are capable of working with severely disturbed youths than do outlying, suburban or rural areas. For this reason, and because a high percentage of the youths referred to such programs tend to come from urban areas, it may be important to consider locating programs for severely disturbed juvenile offenders in or near major cities.

EXTREME NEED AND EXTREME CARE

Juvenile offenders who are severely disturbed have serious problems. They are caught in the web of both mental illness and delinquency, though both the mental health and corrections systems have been reluctant to assume primary responsibility for their care. As a result, these youths have been sporadically shuttled among agencies and institutions without, in most cases, receiving the kind of treatment which they so desperately need.

It is hard to know how to respond to these youths. The severity of their delinquent behavior frequently draws out our resentment and irritation. Their case histories tend to be both extensive and sad. However, despite the ambivalence we may feel about these youths, we must acknowledge their right to competent and humane care. We must be willing to concede that these are people who have enormously serious problems and who frequently have little capacity, for whatever reason, to do anything about them without a considerable amount of help. Massive amounts of assistance do not, of course, guarantee success and at times seem futile. But extreme need frequently requires extreme (and often expensive) forms of care. Severely disturbed juvenile offenders are extremely vulnerable; they are often mistreated. It is incumbent upon us to provide them with care which is both competent and humane, being mindful of our obligation to simultaneously protect the public from whatever threat these youths represent. Our review of programs which have been designed for these youths suggests that this challenge is a substantial one. It also suggests that the challenge is one which can be met.

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